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**A Critical Analysis of the Law On Health Service Delivery in South
Africa**

By

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INDEX

Abstract

Preface

i

Introduction

viii

Chapter 1

International Law and the Right To Health Care

| | | |
|-------|--|-----|
| 1.1 | Introduction | 1 |
| 1.2 | Monism and Dualism | 12 |
| 1.3 | The Constitutional Approach to International Law | 16 |
| 1.3.1 | Section 39(1) | 18 |
| 1.3.2 | Sections 231, 232 and 233 | 24 |
| 1.3.3 | Section 231 – International Agreements | 29 |
| 1.3.4 | Section 232 – Customary International Law | 34 |
| 1.3.5 | Section 233 – International Law | 37 |
| 1.4 | Customary International Law and the Right to Health | 41 |
| 1.5 | Public International Law and the Right to Health | 51 |
| 1.6 | Minimum Core | 57 |
| 1.7 | International Legal Principles Applied Locally | 61 |
| 1.8 | Rights of Vulnerable Groups | 67 |
| 1.8.1 | The Status of One Right Relative to Another | 68 |
| 1.8.2 | Preference of the Rights of Certain Groups | 75 |
| 1.9 | Rights of Children | 77 |
| 1.9.1 | The Convention on the Rights of the Child | 78 |
| 1.9.2 | WMA Declaration of Ottawa | 82 |
| 1.9.3 | African Charter on the Rights and Welfare of the Child | 83 |
| 1.10 | Rights of Women | 86 |
| 1.11 | Rights of Refugees | 88 |
| 1.12 | Rights of Prisoners | 90 |
| 1.13 | Jus Cogens and the Right to Health | 93 |
| 1.14 | Private International Law and the Right to Health | 101 |
| 1.15 | Summary and Conclusions | 103 |

Chapter 2

The Constitution and Health Care Services

| | | |
|-------|---|-----|
| 2.1 | Introduction | 113 |
| 2.2 | The Right To Health Care Services v The Right To Health | 116 |
| 2.2.1 | Life | 118 |
| 2.2.2 | Dignity | 120 |
| 2.2.3 | Bodily and Psychological Integrity | 121 |
| 2.2.4 | Privacy | 124 |



| | | |
|---------|---|-----|
| 2.2.5 | Environment | 125 |
| 2.2.6 | Emergency Medical Treatment | 126 |
| 2.2.7 | Relationship Between Rights to Health and Access to Health Services | 127 |
| 2.2.8 | In Summary | 128 |
| 2.3 | Understanding the Right of Access to Health Care Services | 130 |
| 2.3.1 | ‘Health Care Services’ | 131 |
| 2.3.2 | Access | 134 |
| 2.3.2.1 | Links to other rights | 136 |
| 2.3.2.2 | Rationing | 138 |
| 2.3.2.4 | Soobramoney v Minister of Health (KwaZulu-Natal) | 140 |
| | Facts | 141 |
| | Judgment | 141 |
| | Discussion | 142 |
| 2.3.2.5 | The Individual v The Collective | 143 |
| 2.3.2.6 | Government of the Republic of South Africa v Grootboom | 147 |
| | Facts | 148 |
| | Judgment | 148 |
| | Discussion | 148 |
| 2.3.2.7 | Minister of Health and Others v Treatment Action Campaign | 153 |
| | Facts | 158 |
| | Judgment | 158 |
| | Discussion | 161 |
| 2.3.4 | Progressive Realisation | 165 |
| 2.3.5 | Everyone | 167 |
| 2.3.5.1 | Temporary Residents | 168 |
| 2.3.5.2 | Illegal Immigrants | 170 |
| 2.3.5.3 | Health Tourists | 176 |
| 2.3.6 | Available Resources | 179 |
| 2.4 | The Right of Children to Basic Health Care Services | 185 |
| 2.4.1 | Section 28 Rights v Section 26 and 27 Rights | 185 |
| 2.4.2 | What is a Child? | 190 |
| 2.4.2.1 | Christian Lawyers Association of South Africa v Minister of Health | 191 |
| | Facts | 191 |
| | Judgment | 192 |
| | Discussion | 193 |
| 2.4.2.2 | Christian Lawyers Association of South Africa v Minister of Health (No 2) | 198 |
| | Facts | 198 |
| | Discussion | 199 |
| | Judgment | 216 |
| 2.5 | The Right of Prisoners to Medical Treatment | 228 |
| 2.5.1 | Van Biljon and Others v Minister of Correctional Services | 228 |
| | Facts | 228 |
| | Judgment | 229 |
| | Discussion | 231 |
| 2.6 | Conflicting Rights | 235 |
| 2.6.1 | Children’s Rights | 236 |
| 2.6.2 | HIV Positive Patients and Sexual Offenders | 239 |
| 2.7 | Rationing of Health Care Services and Limitation of Rights | 240 |



| | | |
|---------|---|-----|
| 2.2.1 | Constitutional Aspects | 242 |
| 2.7.2 | Limitations of Rights in the Health Care Context | 247 |
| 2.7.3 | Case Law | 249 |
| 2.7.3.1 | Minister of Health and Another v Malizewski and Others | 249 |
| | Facts | 249 |
| | Judgment | 251 |
| | Discussion | 253 |
| 2.7.3.2 | Reitzer Pharmaceuticals (Pty) Ltd v Registrar of Medicines | 254 |
| | Facts | 254 |
| | Judgment | 256 |
| | Discussion | 258 |
| 2.7.3.3 | Affordable Medicines Trust and Others v Minister of Health | 261 |
| | Facts | 261 |
| | Judgment | 262 |
| | Discussion | 271 |
| 2.7.4 | Rationing By Medical Schemes | 279 |
| 2.7.4.1 | Constitutional Issues | 281 |
| 2.7.5 | Rationing By The State | 283 |
| 2.7.5.1 | Certificate of Need | 283 |
| 2.7.5.2 | Foreign Health Professionals | 288 |
| 2.8 | Emergency Medical Treatment | 291 |
| 2.8.1 | No one may be refused | 292 |
| 2.8.2 | Emergency | 295 |
| 2.8.2.1 | Horizontal Application | 295 |
| 2.8.2.2 | Soobramoney | 298 |
| 2.8.2.3 | EMTALA | 302 |
| 2.8.3 | Medical Treatment | 308 |
| 2.8.4 | Intellectual Property Rights and Access to Technology | 310 |
| 2.8.4.1 | Patents on Medicines | 311 |
| 2.9 | Reproductive Health Care | 314 |
| 2.9.1 | Reproductive Rights | 315 |
| 2.9.2 | Reproductive Health Care In Relation to Reproductive Rights | 316 |
| 2.9.3 | The Ability to Reproduce | 319 |
| 2.9.4 | Assisted Reproduction | 320 |
| 2.9.5 | Sterilisation | 326 |
| 2.9.6 | Human Cloning | 327 |
| 2.10 | National vs Provincial Government Obligations | 334 |
| 2.11 | Horizontal Application of the Right To Health Care Services | 342 |
| 2.12 | Summary and Conclusions | 351 |

Chapter 3

Administrative Law and Health Service Delivery

| | | |
|-----|--|-----|
| | Introduction | 353 |
| A | PUBLIC SECTOR | 356 |
| 3.1 | Introduction | 356 |
| 3.2 | The Nature of Administrative Law | 357 |
| 3.3 | Classifications of Administrative Action | 358 |
| 3.4 | Administrative Agreements | 364 |



| | | |
|----------|--|------------|
| 3.5 | Private Law in the Public Health Sector | 368 |
| 3.6 | The Right To Lawful Reasonable and Fair Administrative Action | 377 |
| 3.6.1 | Lawfulness | 379 |
| 3.6.2 | Reasonableness | 384 |
| 3.6.3 | Procedural Fairness | 388 |
| 3.7 | Public Power and Judicial Review | 393 |
| 3.8 | Value of Administrative Law in Health Service Decisions | 397 |
| 3.9 | Administrative Law Theories | 400 |
| 3.9.1 | Application in Case Law | 408 |
| 3.9.2 | Administrative “Action” | 417 |
| 3.9.3 | Summary | 418 |
| 3.10 | Different Kinds of Power | 420 |
| 3.11 | Decisions Involving Rationing | 431 |
| 3.12 | The Right to Fair Administrative Action vs the Right to Health | 438 |
| 3.13 | Manner of Exercise of Public Power | 445 |
| 3.14 | Case Law | 448 |
| 13.4.1 | Applicant v Administrator, Transvaal and Others | 448 |
| | Facts | 448 |
| | Judgment | 449 |
| | Discussion | 451 |
| 3.15 | Remedies | 454 |
| 3.16 | Conclusions | 459 |
| B | PRIVATE SECTOR | 463 |
| 3.17 | Introduction | 463 |
| 3.18 | Private Entities, Public Functions | 466 |
| 3.19 | Public Private Entities | 469 |
| 3.20 | Case law | 478 |
| 3.20.1 | Pennington v Friedgood and Others | 478 |
| | Facts | 478 |
| | Judgment | 481 |
| | Discussion | 484 |
| 3.21 | Summary and Conclusions | 488 |

Chapter 4

Law of Contract: Health Service Delivery

| | | |
|-------|---|-----|
| 4.1 | Introduction | 489 |
| 4.2 | Fundamental Concepts | 495 |
| 4.2.1 | Public Interest | 495 |
| 4.2.2 | Bona Fides or Good Faith | 499 |
| 4.2.3 | Public Policy (Boni Mores) | 502 |
| 4.2.4 | Reasonableness | 508 |
| 4.2.5 | Fairness | 511 |
| 4.3 | Formation of a Contract | 513 |
| 4.4 | Informed Consent in the Context of Contract | 519 |
| 4.5 | Freedom of Contract | 527 |
| 4.6 | Emergency Medical Treatment | 533 |
| 4.7 | Damages | 542 |



| | | |
|------|---|-----|
| 4.8 | Statutory Considerations | 549 |
| 4.9 | Tacit Contracts | 551 |
| 4.10 | Implies Terms | 554 |
| 4.11 | Tacit or Implied Terms in Health Care Contracts | 570 |
| 4.12 | Issues Involving Contracts for Health Care Services | 575 |
| 4.13 | Summary and Conclusions | 585 |

Chapter 5

Law of Contract in Health Service Delivery – Public Sector

| | | |
|-------|--|-----|
| 5.1 | Introduction | 587 |
| 5.2 | Case Law | 595 |
| 5.2.1 | Behr v Minister of Health | 595 |
| | Facts | 595 |
| | Judgment | 596 |
| | Discussion | 597 |
| 5.2.2 | Shiels v Minister of Health | 598 |
| | Facts | 598 |
| | Discussion | 599 |
| | Judgment | 599 |
| 5.2.3 | Administrator Natal v Edouard | 600 |
| | Facts | 600 |
| | Discussion | 601 |
| | Judgment | 604 |
| 5.2.4 | Pizani v Minister of Defence | 607 |
| | Facts | 607 |
| | Discussion | 607 |
| | Judgment | 610 |
| 5.3 | Provincial Health Legislation and the Intention of the State | 611 |
| 5.4 | Arguments in Favour of Contractual Relationship | 622 |
| 5.5 | Arguments Against Contractual Relationship | 624 |
| 5.6 | Conclusions Regarding Health Care Relationships | 626 |
| 5.7 | Summary and Conclusions | 629 |

Chapter 6

Law of Contract: Health Service Delivery in the Private Sector

| | | |
|-------|---|-----|
| 6.1 | Introduction | 631 |
| 6.2 | Case Law | 637 |
| 6.2.1 | Argus Printing and Publishing Co v Dr Van Niekerk | 637 |
| | Facts | 637 |
| | Judgment | 637 |
| | Discussion | 638 |
| 6.2.2 | Tulloch v Marsh | 639 |
| | Facts | 639 |
| | Discussion | 640 |
| | Judgment | 642 |
| 6.2.3 | Sutherland v White | 647 |



| | | |
|-------|--------------------------------|-----|
| | Facts | 648 |
| | Discussion | 648 |
| | Judgment | 650 |
| 6.2.4 | Oates v Niland | 653 |
| | Facts | 653 |
| | Discussion | 653 |
| | Judgment | 654 |
| 6.2.5 | Hewatt v Rendel | 654 |
| | Facts | 654 |
| | Discussion | 655 |
| | Judgment | 658 |
| 6.2.6 | Recsei's Estate v Meine | 659 |
| | Facts | 659 |
| | Discussion | 660 |
| | Judgment | 664 |
| 6.2.7 | Friedman v Glicksman | 668 |
| | Facts | 668 |
| | Discussion | 670 |
| | Judgment | 676 |
| 6.2.8 | Afrox Healthcare Bpk v Strydom | 689 |
| | Facts | 689 |
| | Discussion | 691 |
| | Judgment | 701 |
| 6.2.9 | Oldwage v Louwrens | 713 |
| | Facts | 713 |
| | Discussion | 720 |
| | Judgment | 735 |
| 6.3 | Summary and Conclusions | 737 |

Chapter 7

Law of Delict: Health Service Delivery

| | | |
|---------|--|-----|
| 7.1 | Introduction | 742 |
| 7.2 | Fundamental Concepts | 750 |
| 7.2.1 | Conduct | 751 |
| 7.2.1.2 | Assault | 754 |
| 7.2.1.3 | Liability for Omissions | 762 |
| 7.2.2 | Causation | 763 |
| 7.2.3 | Wrongfulness (Unlawfulness) | 772 |
| 7.2.4 | Fault | 782 |
| 7.2.5 | Loss | 785 |
| 7.3 | Necessity | 801 |
| 7.4 | Vicarious Liability | 808 |
| 7.5 | Medicines | 817 |
| 7.6 | Constitutional Delicts? | 825 |
| 7.7 | Res Ipsa Loquitur and Strict Product Liability | 836 |
| 7.8 | Imperitia Culpae Adnumeratur | 864 |
| 7.9 | Class Actions | 873 |



Chapter 8

Law of Delict in Health Service Delivery – Public Sector

| | | |
|--------|---------------------------------------|------|
| 8.1 | Introduction | 879 |
| 8.2 | Case Law | 880 |
| 8.2.1 | Rex v Van Schoor | 880 |
| | Facts | 880 |
| | Judgment | 882 |
| | Discussion | 884 |
| 8.2.2 | R v Van der Merwe | 886 |
| | Facts | 886 |
| | Judgment | 886 |
| | Discussion | 887 |
| 8.2.3 | Esterhuizen v Administrator Transvaal | 895 |
| | Facts | 895 |
| | Judgment | 899 |
| | Discussion | 903 |
| 8.2.4 | Dube v Administrator Transvaal | 923 |
| | Facts | 923 |
| | Judgment | 925 |
| | Discussion | 927 |
| 8.2.5 | S v Mkwetshana | 931 |
| | Facts | 931 |
| | Judgment | 932 |
| | Discussion | 936 |
| 8.2.6 | Buls v Tsatsarolakis | 938 |
| | Facts | 938 |
| | Judgment | 940 |
| | Discussion | 943 |
| 8.2.7 | Magware v Minister of Health NO | 946 |
| | Facts | 946 |
| | Judgment | 948 |
| | Discussion | 951 |
| 8.2.8 | S v Kramer | 954 |
| | Facts | 954 |
| | Judgment | 958 |
| | Discussion | 964 |
| 8.2.9 | Pringle v Administrator, Transvaal | 972 |
| | Facts | 972 |
| | Judgment | 976 |
| | Discussion | 983 |
| 8.2.10 | Collins v Administrator Cape | 988 |
| | Facts | 988 |
| | Judgment | 992 |
| | Discussion | 1007 |
| 8.2.11 | C v Minister Correctional Services | 1015 |
| | Facts | 1015 |
| | Judgment | 1016 |



| | | |
|--------|---|------|
| | Discussion | 1021 |
| 8.2.12 | Silver v Premier Gauteng Provincial Government | 1027 |
| | Facts | 1027 |
| | Judgment | 1028 |
| | Discussion | 1030 |
| 8.2.13 | Korf v Health Professions Council of South Africa | 1035 |
| | Facts | 1035 |
| | Judgment | 1037 |
| | Discussion | 1043 |
| 8.3 | Summary and Conclusions | 1050 |

Chapter 9

Law of Delict In Health Service Delivery – Private Sector

| | | |
|-------|-------------------------------------|------|
| 9.1 | Introduction | 1057 |
| 9.2 | Case Law | 1059 |
| 9.2.1 | Mitchell v Dixon | 1059 |
| | Facts | 1059 |
| | Judgment | 1059 |
| | Discussion | 1060 |
| 9.2.2 | Webb v Isaac | 1061 |
| | Facts | 1061 |
| | Judgment | 1062 |
| | Discussion | 1064 |
| 9.2.3 | Stoffberg v Elliott | 1067 |
| | Facts | 1067 |
| | Judgment | 1068 |
| | Discussion | 1070 |
| 9.2.4 | Van Wyk v Lewis | 1072 |
| | Facts | 1073 |
| | Judgment | 1074 |
| | Discussion | 1080 |
| 9.2.5 | Dale v Hamilton | 1082 |
| | Facts | 1082 |
| | Judgment | 1083 |
| | Discussion | 1084 |
| 9.2.6 | Richter and Another v Estate Hamman | 1086 |
| | Facts | 1086 |
| | Judgment | 1087 |
| | Discussion | 1090 |
| 9.2.7 | Blyth v Van den Heever | 1092 |
| | Facts | 1092 |
| | Judgment | 1094 |
| | Discussion | 1100 |
| 9.2.8 | Correira v Berwind | 1101 |
| | Facts | 1101 |
| | Judgment | 1104 |
| | Discussion | 1107 |
| 9.2.9 | Clarke v Hurst NO and Others | 1108 |



| | | |
|--------|---|------|
| | Facts | 1108 |
| | Judgment | 1110 |
| | Discussion | 1124 |
| 9.2.10 | Jansen van Vuuren v Kruger | 1131 |
| | Facts | 1131 |
| | Judgment | 1133 |
| | Discussion | 1141 |
| 9.2.11 | Castell v De Greef | 1153 |
| | Facts | 1153 |
| | Judgment | 1157 |
| | Discussion | 1173 |
| 9.2.12 | Friedman v Glicksman | 1187 |
| | Facts | 1187 |
| | Judgment | 1188 |
| | Discussion | 1193 |
| 9.2.13 | Gibson v Berkowitz | 1199 |
| | Facts | 1199 |
| | Judgment | 1203 |
| | Discussion | 1210 |
| 9.2.14 | Broude v McIntosh and Others | 1211 |
| | Facts | 1211 |
| | Judgment | 1217 |
| | Discussion | 1222 |
| 9.2.15 | Mukheiber v Raath | 1222 |
| | Facts | 1222 |
| | Judgment | 1226 |
| | Discussion | 1234 |
| 9.2.16 | Michael and Another v Linksfield Park Clinic (Pty) Ltd and Others | 1260 |
| | Facts | 1260 |
| | Judgment | 1266 |
| | Discussion | 1268 |
| 9.2.17 | VRM v The Health Professions Council of South Africa and Others | 1272 |
| | Facts | 1273 |
| | Judgment | 1280 |
| | Discussion | 1281 |
| 9.3 | Summary and Conclusions | 1289 |

Chapter 10

The South African Law on Health Service Delivery: Conclusions and Observations

| | | |
|--------|---|------|
| 10.1 | Introduction | 1293 |
| 10.2 | International Law | 1301 |
| 10.2.1 | Criticisms of International Law | 1313 |
| 10.2.2 | Imbalance in the Formulation of International Law | 1319 |
| 10.2.3 | Compliance With International Law Affords No Protection | 1321 |
| 10.2.4 | 'Standard Setting' Approach Not Helpful To Developing World | 1324 |



| | | |
|---------------------------------------|--|-------|
| 10.2.5 | Absolute Rights v Relative Rights | 1327 |
| 10.2.6 | Conclusions Concerning International Law | 1329 |
| 10.3 | Constitutional Law | 1330 |
| 10.3.1 | Individual Rights vs Rights as Elements of a System | 1331 |
| 10.3.2 | The Right of Access to Health Care Services | 1338 |
| 10.3.3 | Realisation of the Right of Access to Health Care Services | 1341 |
| 10.3.4 | Horizontal Application | 1346 |
| 10.3.5 | Conclusions Concerning Constitutional Law | 1348 |
| 10.4 | Administrative Law | 1351 |
| 10.4.1 | The Promotion of Administrative Justice Act No 3 of 2000 | 1352 |
| 10.4.2 | The Nature of the Function Not the Functionary | 1354 |
| 10.4.3 | The Distinction Between Public and Private Powers | 1357 |
| 10.4.4 | Lawfulness | 1359 |
| 10.4.5 | Reasonableness | 1360 |
| 10.4.6 | Procedural Fairness | 1361 |
| 10.4.7 | Administrative Agreements | 1364 |
| 10.4.8 | Conclusions Concerning Administrative Law | 1374 |
| 10.5 | The Law of Contract | 1376 |
| 10.5.1 | Tacit or Implied Terms in Healthcare Contracts | 1377 |
| 10.5.2 | Contracts within the Public and Private Health Sectors | 1381 |
| 10.5.3 | Potential Solutions for Health Care Contracts | 1383 |
| 10.5.4 | Conclusions Concerning the Law of Contract | 1386 |
| 10.6 | The Law of Delict | 1392 |
| 10.6.1 | Constitutional Delicts | 1396 |
| 10.6.2 | Unlawfulness | 1397 |
| 10.6.3 | Medicines and Medical Devices | 1397 |
| 10.6.4 | Delict in the Public vs the Private Sector | 1400 |
| 10.6.5 | Conclusions Concerning the Law of Delict | 1401 |
| 10.7 | In Conclusion | 1405 |
| List of Abbreviations | | xxi |
| Bibliography | | xxiii |
| Table of Cases (South African) | | xli |
| Table of Cases (Foreign) | | lviii |
| List of Statutes | | lxiv |

ABSTRACT

This thesis examines the law relating health care in South Africa rather than medical law which is a subset of this field. It attempts to synthesise five major traditional areas of law, namely international, constitutional, and administrative law, the law of contract and the law of delict, into a legal conceptual framework relating specifically to health care in South Africa. Systemic inconsistencies with regard to the central issue of health care across these five traditional fields are highlighted. The alignment of the various pre-existing areas of statutory and common law with the Constitution is an ongoing preoccupation of the executive, the judiciary, the legislature and academia. In the health care context, the thesis critically examines the extent to which such alignment has taken place and identifies areas in which further development is still necessary. It concludes that the correct approach to the constitutional right of access to health care services is to regard it as a unitary concept supported by each of the five traditional areas of law. The traditional division of law into categories of public and private and their further subdivision into, for instance, the law of delict and the law of contract is criticized. It promotes a fragmented approach to a central constitutional construct resulting in legal incongruencies. This is anathema to a constitutionally based legal system. There is no golden thread of commonality discernible within the various public international law instruments that contain references to rights relating to health and it is of limited practical use in South African health law. The rights in the Bill of Rights are interdependent and interconnected. The approach of the courts to the right of access to health care needs to be considerably broader than it is at present in order to fully embrace the idea of rights as a composite concept. Administrative law, especially in the public health sector, offers an alternative basis to pure contract for the provider-patient relationship. It is preferable to a contractual relationship because of the many inbuilt protections and legal requirements for administrative action. Contracts can be unfair but courts refuse to strike them down purely on this basis. Administrative action is much more likely to be struck down on grounds of unfairness. The law of contract as a legal vehicle for health service delivery is not ideal. This is due to the antiquated approach of South African courts to this area of law. There is still an almost complete failure to incorporate constitutional principles and values into the law of contract. The law of delict in relation to health care services has its blind spots. Although it seeks to place the



claimant in the position in which he or she found himself prior to the unlawful act whereas the law of contract seeks to place him in the position he would have occupied had the contract been fulfilled, in the context of health care this is a notional distinction since contracts for health services seldom guarantee a specific outcome.

PREFACE

Many people question the validity of health law as a legal concept. They take the view that it is simply a compendium of aspects, taken within a particular context, of the more traditional legal categories such as constitutional law and the common law of contract and delict. This view is limited in that it ignores the immense value of a teleological approach. Logically speaking, law can never be an end in itself. Law only has meaning when viewed as a means. One can only assess the value and significance of law in the light of how successful and effective a means it proves to be in relation to a particular end. That end, hopefully, is justice within the specific context in which the law has been applied. Law begs the question of application and application begs the question of context. If general principles of law applied in a particular context lead to a result that is irrational or unfair then obviously such an application of the law is ineffectual. The recognition and compilation of a body of law within a particular context, such as health or communications, is thus of considerable value to persons whose daily lives are preoccupied by, and regulated within, that context.

The law relating to health care in South Africa has become significantly more complex of late. There have been many recent legislative changes which have materially altered the law governing both the funding and delivery of health care in this country and there are more such changes to come. A complicating factor in the legislative arena is that, in terms of Schedule 4 of the Constitution of the Republic of South Africa, each of the nine provinces has legislative competence in the area of health services. In addition, there is also a national legislative competence in the area of health services in terms of Schedule 4. The health services industry is therefore likely to be faced with the complexities of an unprecedented plethora of provincial and national legislation governing various aspects of health services. Some of the provinces have already enacted health legislation while others are in the process. The level of sophistication, the extent of the incorporation of constitutional principles and the manner of interpretation of the constitutional rights to

health care services vary considerably across the legislation of the provinces at the time of writing.

In South Africa, the health care arena is subdivided into public and private sectors, both on the side of health services and facilities and on the side of funding. The legal rules governing both the public and private sectors differ substantially in certain areas, for instance pharmacy ownership and the employment of health professionals, whilst in others, for example, licensing and legal operational issues, there is increasing convergence. New, constitutionally mandated human rights legislation such as the Promotion of Access to Information Act¹, the Promotion of Administrative Justice Act² and the Promotion of Equality and Prevention of Unfair Discrimination Act³, present considerable challenges to both private and public health sectors in their various spheres of operation.

The legislation governing the funding of health services in the private sector, and to an increasing extent, the public sector, has also undergone substantial alteration in the preceding six or seven years. In 1998, for the first time a mandatory package of minimum benefits was incorporated into the private health funding legislation and there is regulatory provision for monitoring and reviewing the package and its effects on the market on a regular basis. There is also a growing movement within the health sector towards partnerships between public and private providers of health care services. This has created a real need to explore or even create legal models which are able to successfully integrate the often disparate philosophies and approaches of these two sectors in a workable fashion.

Due to the unprecedented proliferation of legislative and market changes within the health care sector, legal analysis and critique at an academic level has fallen behind. There is presently no in depth, authoritative examination of and commentary on the new legal environment in which providers and funders of health care services in South Africa

¹ Act No 2 of 2000
² Act No 3 of 2000
³ Act No 4 of 2000

are operating. There has never, to the knowledge of the writer, been an attempt to synthesise within a single work the legal principles of South African law as they pertain to health service delivery. There has been some substantive work on the subject of medical negligence⁴, the doctor/patient relationship⁵ and on isolated issues such as informed consent⁶, HIV and AIDS⁷, termination of pregnancy⁸ and *res ipsa loquitur*⁹ but no in depth framework study of South African law in the health care context exists or has to date been attempted. Since 1994 when the Constitution came into effect, there has been no comprehensive academic scrutiny of the meaning and import of the constitutional Bill of Rights with regard to health service delivery and how it impacts on other law affecting health service delivery although there have been journal articles commenting on landmark cases decided by the constitutional court in this area.

There is also a dearth of case law involving statutes despite the considerable number of statutes that deal with various aspects of health service delivery. The Medicines and Related Substances Act¹⁰ is one of the oldest and most important of these yet since 1977, of the dozen or so cases that significantly featured this Act, the majority of them did not deal specifically with health service delivery issues in relation to medicines but rather

⁴ Burchell JM and Schaffer RP 'Liability of Hospitals for Medical Negligence' 1977 *BML* 6(4) p 109; Brownlie S 'Wrongful Life: Is It A Viable Cause of Action in South Africa' *Responsa Meridiana* 1985 5(1) p 18; Louw PF "'Wrongful Life': 'n Aksie Gebaseer op die Onregmatige Veroorsaaking van Lewe' 1987 *SALJ* (2) p 199; Carstens PA 'The Locality Rule in Medical Practice' 1990 *De Rebus* p 421; De Klerk A 'Middelike Aanspreeklikheid van 'n Hospitaalowerheid' 1990 *TSAR* (1) p 148; Carstens PA 'Nalatigheid in Verskillende Gedagterigtings Binne die Mediese Praktijk' 1991 *THRHR* 54 (4) p 673; Cleaver B 'Wrongful birth – the Dawning of a New Action' 1991 *SALJ* 108 (1) p 47; Hebblethwaite L 'Mishap or malpractice? Liability in Delict for Medical Accidents' 1991 *SALJ* 108(1) p 38; Claassen NJB and Verschoor T *Medical Negligence in South Africa* (1992) based on an unpublished dissertation entitled 'Aanspreeklikheid van Geneeshere Op Grond van Nalatige Wanpraktyk' written by NJB Claassen under tutorship of Prof R Verschoor as part of the requirements of the LLM degree at the University of the Orange Free State; Carstens PA 'Die Strafregetelike en Deliktuele Aanspreeklikheid van die Geneesheer op grond van Nalatigheid' (unpublished LLD thesis, University of Pretoria 1996); Strauss SA "'Wrongful conception", "wrongful birth" and "wrongful life": the first South African cases' 1996 *Medical Law* 15 p 161; Strauss SA 'An Unusual Case of Wrongful Pregnancy: Liability of Doctor Resulting From Misrepresentation' 1998 *Medical Law* 17 p 7; Strauss, SA 'Twee mediese regsrae: die Aanspreeklikheid van Private Hospitale met Ongevalle-Afdelings en die Aanspreeklikheid van Sportpromotors en Skeidregters Teenoor Beseerde Spelers' 2000 *TSAR* p 205

⁵ Strauss SA *Doctor, Patient and the Law* (1991)

⁶ Strauss SA 'Toestemming Deur 'n Jeugdige' 1964 *THRHR* p 116; van Oosten FFW, *The Doctrine of Informed Consent in Medical Law* (1989) doctoral thesis University of South Africa. See also van Oosten FFW 'HIV Infection Blood Tests and Informed Consent' *Essays In Honour of SA Strauss Joubert JJ* (ed) 1995 p 281; van Oosten FFW *International Encyclopaedia of Laws*, Vol 3 Medical Law – South Africa, (1996) Blanpain (ed);

⁷ Van Wyk CW 'VIGS en die Reg: 'n Verkenning' 1988 *THRHR* p 317; Van Wyk CW 'Aspekte van Regsprobleme rakende VIGS' (Unpublished thesis, University of South Africa (1991)); Van Wyk CW 'AIDS: Some Medicolegal Aspects' 1991 *Medicine and Law* p 139; Strauss SA *The Nurse and AIDS: Legal Issues* (in association with the South African Nursing Association)

⁸ Strauss SA 'Abortion Law Reform' (1995) 112 *SALJ* p 195

⁹ Van den Heever P unpublished doctoral thesis entitled 'The Application of the Doctrine of *Res Ipsa Loquitur* to Medical Negligence Actions: A Comparative Survey' (2002) University of Pretoria; Carstens PA 'Die Toepassing van *Res Ipsa Loquitur* in Gevalle van Mediese Nalatigheid' 1999 *De Jure* p 19

¹⁰ Act No 101 of 1965



with such subjects as search and seizure¹¹, copyright¹² and trade mark¹³, the repackaging of medicines at provincial hospitals¹⁴ for supply to district pharmacists, procedural issues at disciplinary hearings¹⁵ and the possession of dagga (marijuana)¹⁶. There are only three of substantial interest for health service delivery purposes, one relating to the definition of a medicine,¹⁷ one relating to product liability in respect of a medicine¹⁸ and the other relating to the supply of an unregistered medicine to an AIDS patient¹⁹. The case law with regard to the Health Act²⁰, the central legislation governing health service delivery by hospitals and other health establishments in South Africa, is even scarcer. Since 1977 cases that significantly involve this legislation are one relating to the licensing of a private hospital²¹, one relating to an administrative decision to terminate a contract for health service delivery²² and one relating to nuisance caused by offensive odours from sewage treatment works operated by a local authority²³.

While detailed analysis and exposition of statute law is important and valuable work, the practical application of South African health statutes seems to have been a relatively uncomplicated issue for those working within the South African health system judging by the number of cases and their central themes. Very few of these cases are relevant to issues of health service delivery within South African law. Where they are, they have been discussed in this thesis. For the most part, however, detailed discussion of statute law has been avoided because it was felt that a long and tedious exposition of such law would reflect only the views of the writer and very few others besides. There would be no

¹¹ *Mistry v Interim Medical and Dental Council Of South Africa and Others* 1998 (4) SA 1127 (CC)

¹² *Biotech Laboratories (Pty) Ltd v Beecham Group plc and Another* 2002 (4) SA 249 (SCA)

¹³ *Adcock-Ingram Laboratories Ltd v Lennon Ltd* 1982 (1) SA 862 (T); *Adcock-Ingram Laboratories Ltd v SA Druggists Ltd And Another; Adcock-Ingram Laboratories Ltd v Lennon Ltd* 1983 (2) SA 350 (T); *The Upjohn Company v Merck and Another* 1987 (3) SA 221 (T);

¹⁴ *Raats Röntgen and Vermeulen (Pty) Ltd v Administrator, Cape, And Others* 1991 (1) SA 827 (C); *Administrator, Cape v Raats Röntgen and Vermeulen (Pty) Ltd* 1992 (1) SA 245 (A)

¹⁵ *Suid-Afrikaanse Geneeskundige en Tandheekkundige Raad v Strauss en Anders* 1991 (3) SA 203 (A)

¹⁶ *S v Ndamase* 1979 (3) SA 346 (N); *S v Julius* 1984 (2) SA 480 (O); *Prince v President, Cape Law Society, And Others* 2000 (3) SA 845 (SCA); *Prince v President, Cape Law Society, and Others* 2002 (2) SA 794 (CC)

¹⁷ *Reitser Pharmaceuticals (Pty) Ltd v Registrar of Medicines and Another* 1998 (4) SA 660 (T)

¹⁸ *Wagener v Pharmacare Ltd; Cuttings v Pharmacare Ltd* 2003 (4) SA 285 (SCA)

¹⁹ *Applicant v Administrator, Transvaal, and Others* 1993 (4) SA 733 (W)

²⁰ Health Act No 63 of 1977

²¹ *Medforum Hospitaal (Edms) Bpk v Departementshoof, Departement Gesondheid en Welsyn: Administrasie Volksraad en Anders* 1994 (4) SA 852 (T)

²² *Independent Municipal And Allied Trade Union and Others v MEC: Environmental Affairs, Developmental Social Welfare And Health, Northern Cape Province, and Others* 1999 (4) SA 267 (NC)

²³ *Eskom v Rini Town Council* 1992 (4) SA 96 (E)

dynamic in the arguments presented and no way of evaluating them against academic or judicial opinion in order to ascertain their weight or validity. As such they would simply exist until either proven correct or incorrect in the judgment of a court or the relevant section is amended. Furthermore, at the time of writing certain key sections of the Medicines and Related Substances Act relating to pricing of medicines and the licensing of dispensing doctors have only just come into operation and with regard to the latter, the National Department of Health is presently engaged in litigation with the National Convention on Dispensing. The decision of the court in this matter has yet to be handed down. It is thus too early to start discussing the relevant sections of this Act as regards their impact on health service delivery. The National Health Act, destined to repeal the Health Act²⁴, has been signed by the President and is presently awaiting proclamation. Its regulations have not yet been written. Since much of the mechanics of the legislation will be contained in the regulations, detailed discussion and analysis of the Act at this time would have been premature and largely speculative.

Legislation such as the Hazardous Substances Act²⁵, the Foodstuffs, Cosmetics and Disinfectants Act²⁶, the Occupational Injuries in Mines and Works Act²⁷, the Sterilisation Act²⁸ and the Choice on Termination of Pregnancy Act²⁹, while clearly of relevance to specialized issues in health care, are not of sufficient general relevance that it was felt that they should be discussed in any detail in a thesis of this nature. Sterilisation and termination of pregnancy are aspects of health care which undoubtedly raise a number of interesting legal debates but they fall specifically into the category which the Constitution calls 'reproductive health care' and the relevant case law is thus dealt with in the section of this thesis dealing with constitutional rights. In a subject as vast as this, one has to set realistic boundaries in order to be able to cover most of the material in sufficient depth to make a meaningful contribution to the field rather than to cover all of the material at a superficial level that, at the end of the day, brings no value.

24 Fn 20 *supra*
25 Act No 15 of 1973
26 Act No 54 of 1972
27 Act No 78 of 1973
28 Act No 44 of 1998
29 Act No 92 of 1996



The scope of the present work is therefore, of necessity, broad. It is an attempt to uncover the central legal principles governing the South African health care system from a critical, analytical perspective. Since critical analysis requires a convergent, as opposed to divergent, conceptual approach, international comparisons are confined to pointed examples of instances in which a particular issue or principle has been dealt with in other jurisdictions by a more or less effective or efficient method. References to international cases and situations are sometimes as much, if not more, for the purpose of demonstrating a particular legal principle from a practical, factual point of view as for examining the relative merits of that principle in the context of a foreign legal system. A selection of more specific issues is canvassed in this work in order to illustrate, in practical terms, the relevance and impact of the general legal principles discussed.

It was felt that broad-brush comparisons with other jurisdictions were neither appropriate nor particularly illuminating in trying to establish the essence of the local legal framework on a particular subject. It is of no use, for instance, to persons operating within the South African health care industry to be told that the right to health care services in Bulgaria is very different, in terms of its content, to that in South Africa. International comparisons are more appropriate at the legal policy level. At the level of practical implementation of the law, careful dissection, analysis and exposition are of greater value.

The Court in *B and others v Minister of Correctional Services and others*³⁰ expressed much the same sentiments in quoting the words of Lord Simon of Glaisdale in *Miliangos v George Frank (Textiles) Ltd*³¹:

“...the training and qualification of a judge is to elucidate the problem immediately before him, so that its features stand out in stereoscopic clarity. But the beam of light which so illuminates the immediate scene seems to throw the surrounding areas into greater obscurity: the whole landscape is distorted to the view. A penumbra can be apprehended, but not much beyond; so that when the searchlight shifts a quite unexpected scene may be disclosed. The very qualifications for

³⁰ *B and others* [1997] 2 All SA 574 (C)

³¹ *Miliangos* [1976] AC 443 481-482



the juridical process thus impose limitations on its use. This is why judicial advance should be gradual. 'I am not trained to see the distant scene: one step is enough for me' should be the motto on the wall opposite the judge's desk. It is, I concede, a less spectacular method or progression than somersaults and cartwheels; but it is the one best suited to the capacity and resources of a judge. We are likely to perform better the duties society imposes on us if we recognize our limitations. Within the proper limits there is more than enough to be done which is of value to society."

It is therefore the object of this work to focus largely on South African law and to provide the necessary dissection, analysis and exposition of this law for the practical benefit both of those whose responsibility it is to ensure or effect the delivery of health services in South Africa and of those whose lives are affected by the delivery of those services.

Introduction

Law neither arises nor operates in a vacuum. It is a medium for the distillation and implementation of the fundamental beliefs and values of the society by and for which it is written. Public policy and the public interest, as determined by the legislature and the judiciary, underpin the creation and application of law. Whilst the preamble¹ and founding provisions² of the South African Constitution are obvious examples of legislative expression of the underlying importance of public values to law, it is by no means a new idea. It was central to Roman law³ and is very much in evidence in the Roman law of contract⁴. From the Roman-Dutch writers it is clear that it survived beyond the time of Rome⁵. Thence it found its way into the South African common law⁶. In the present instance, the question is whether public policy supports a right to health care and if so, on what basis⁷. The issue of whether a person has a fundamental

¹ The Preamble of the Constitution of the Republic of South Africa (Act No 108 of 1996) states that the Constitution is adopted as the Supreme Law of the Republic *inter alia* so as to –
“heal the divisions of the past and establish a society based on democratic values, social justice and fundamental human rights” and “improve the quality of life of all citizens and free the potential of each person”.

² Section 1 of Act No 108 of 1996 states that:

“the Republic of South Africa is one, sovereign democratic state founded on the following values:

(a) Human dignity, the achievement of equality and the advancement of human rights and freedoms.

(b) Non-racialism and non-sexism.

(c) Supremacy of the constitution and the rule of law.

(d) Universal adult suffrage, a national common voters roll, regular elections and a multi-party system of democratic government, to ensure accountability, responsiveness and openness.”

³ Ulpian declared that the basic principles of law are to live honourably, not to harm another and to render to each his own (*Dig 1 1 10 1*). At *Dig 45.1.26* Ulpian says: ‘Generaliter novimus turpes stipulationes nullius esse momenti’. (We generally recognise that immoral stipulations have no validity.) See also Papinian (*Dig 28.7.15*): ‘*Nam quae facta laedunt pietatem, exstimationem, verecundiam nostram et ut generaliter dixerim contra bonos mores fiunt, nec facere nos posse credendum est.*’ (For acts which offend our sense of duty, our reputation or our sense of shame, and if I might speak generally which are done against sound morals, it is not to be accepted that we are able to do them.)

⁴ They created remedies such as the *exceptio doli* and the doctrine of *laesio enormis* which effectively allowed a contracting party to escape his obligations on equity grounds. See also the Digest: Paul (*Dig 2.14.27.4*): ‘*Pacta quae turpem causam continent non sunt observanda; veluti si paciscar ne furti agam vel injurlarum, si feceris: expedit enim timere furti vel injurlarum poenam.*’ (Pacts founded on shameful ground are not to be enforced: an example would be if I make a pact that I will not bring an action for theft or insult if you commit either of these delicta. For it is generally beneficial that there be fear of the penalty for theft or insult.)

⁵ *Grotius* 3.1.42 and 43 stated that obligations are void “whereby something is promised which is regarded as dishonourable by municipal law and morality; as to do or omit to do anything wicked or to remit the punishment of some crime not yet committed. In like manner obligations are invalid which arise from some immoral cause or consideration.” See also du Pleasis P “Good faith and equity in the law of contract” 2002 *THRHR* 397, 405-406 where it is stated that “Prominent Roman –Dutch jurists such as Dionysius van der Keessel, Johannes Voet, Ulrik Huber and Johannes van der Linden later adopted the regulatory function of equity and applied it to the various fields of Roman-Dutch law. When taking the influence of Grotius’s concept of equity into account, it seems that equity in Roman-Dutch law was viewed as a sophisticated regulatory concept with prohibitive and corrective functions that could be employed to address inequality in performance.”

⁶ *Robinson v Randfontein Estates GM Co Ltd* 1925 AD 173; *Minister van Polisie v Ewels* 1975 (3) SA 590 (A); *Administrateur Natal v Trust Bank van Afrika Bpk* 1979 (3) SA 824 (A); *Schultz v Butt* 1986 (3) SA 667 (A); *Marais v Richard en 'n Ander* 1981 (1) SA 1157 (A); *Pakendorf en Andere v De Flamingh* 1982 (3) SA 146 (A); *Edouard v Administrator Natal* (2) SA 368 (D).

⁷ In South Africa, the Constitution itself is a powerful indicator of public policy. Thus in *Ryland v Edros* 1997 (2) SA 690 (C) the court observed that: “It is true that public policy is essentially a question of fact (see the statement by Aquilius (the late Mr Justice F P van den Heever) in his article ‘Immorality and Illegality in Contract’ (1941) 58 *SALJ* 337 at 346: ‘what is immoral is a factual not a legal problem’, on which Mr Trengove strongly relied. This is so even though in most cases the factual finding in question is not based on evidence before the Court but on facts regarded as so notorious that



right to an economic commodity or good strikes at the heart of many of the ideologies of Western society and consequently, the legal principles that entrench them. Examples are the common law principles of freedom of contract and ownership of property. In the context of socio-economic rights, such as a right to health care, these principles take on a new dimension that requires a re-examination of their role in the legal fabric. Many are not keen to undertake such re-examination, perhaps fearful of where it might lead⁸.

the Court takes judicial notice of them. In the present case it would be difficult to find that there has been such a change in the general sense of justice of the community as to justify a refusal to follow the Ismail decision if it were not for the new Constitution. In the circumstances I prefer to base my decision on the fundamental alteration in regard to the basic values on which our civil policy is based which has been brought about by the enactment and coming into operation of the new Constitution... In his judgment in *Du Plessis and Others v De Klerk and Another* (case No CCT 8/95), a decision of the Constitutional Court delivered on 15 May 1996, Ackermann J referred (in para [106] of his judgment) to 'the marked similarity between the provisions of s 35(3) . . . and the indirect horizontal application of the basic rights in the (German Basic Law) in German jurisprudence.' In paras [103] and [104] of his judgment Ackermann J said: '[103] Any attempt at a detailed discussion on the operation of mittelbare Drittwirkung (indirect horizontality) in German constitutional law would be out of place here. There are some features, however, which bear on the construction of our own Constitution. The Federal Constitutional Court refers to the radiating effect (*Ausstrahlungswirkung*) of the basic rights on private law. In the *Lüth* case the Federal Constitutional Court held as follows: 'The influence of the scale of values of the basic rights affects particularly those provisions of private law that contain mandatory rules of law and thus form part of the *ordre public* - in the broad sense of the term - that is, rules which for reasons of the general welfare also are binding on private legal relationships and are removed from the domination of private intent. Because of their purpose these provisions are closely related to the public law they supplement. Consequently, they are substantially exposed to the influence of constitutional law. In bringing this influence to bear, the courts may invoke the general clauses which, like art 826 of the Civil Code, refer to standards outside private law. 'Good morals' is one such standard. In order to determine what is required by social norms such as these, one has to consider first the ensemble of value concepts that a nation has developed at a certain point in its intellectual history and laid down in its constitution. That is why the general clauses have rightly been called the points where basic rights have breached the (domain of) private law. . . .' [104] Thus, in private litigation, the German courts are obliged to consider the basic rights in interpreting concepts such as 'justified', 'wrongful' 'contra bonos mores' et cetera. The basic rights therefore have a radiating effect on the common law through provisions such as, for example, s 138 of the Civil Code, which provides that "legal acts which are contrary to public policy are void."

In a footnote giving the reference to the *Lüth* case, Ackermann J said: "The word 'radiating' seems preferable to the somewhat pejorative term 'seepage'. In my view it is clear that if the spirit, purport and objects of chap 3 of the Constitution and the basic values underlying it are in conflict with the view as to public policy expressed and applied in the Ismail case then the values underlying chap 3 of the Constitution must prevail."

Further support for this view may be found in the dictum of Mahomed AJ (as he then was) in *S v Acheson* 1991 (2) SA 805 (Nm) at 813A-B (1991 NR 1 at 10A-B): "The Constitution of a nation is not simply a statute which mechanically defines the structures of government and the relations between the government and the governed. It is a 'mirror reflecting the national soul', the identification of the ideals and aspirations of a nation; the articulation of the values bonding its people and disciplining its government. The spirit and the tenor of the constitution must therefore preside and permeate the processes of judicial interpretation and judicial discretion."

In *Mthembu v Letsela and Another* 1998 (2) SA 675 (T), the court accepted as correct the conclusion of Farlam J in *Ryland v Edros* that if existing notions and views as the public policy are in conflict with the spirit, purport and objects of chapter 3 of the Interim Constitution, and the basic values underlying it, "then the values underlying chap 3 of the Constitution must prevail"

In *Coetzee v Comitis and Others* 2001(1) SA 1254 (C) the court took the view that "... considerations of public policy cannot be constant. Our society is an ever-changing one. We have moved from a very dark past into a democracy where the Constitution is the supreme law, and public policy should be considered against the background of the Constitution and the Bill of Rights. One can think of many situations which would, prior to 1994, have been found not to offend public policy which would today be regarded as inhuman. Examples are so plentiful that I do not believe that it is necessary for me to mention them."

There is thus argument for the fact that in South Africa, public policy does support a right to health care in the terms in which it is couched in the Constitution.

8

See for instance Kelley D "The rights angle - the consequences of a "right" to health care", *Reason Magazine*, January 1994. Kelley was at the time the executive director of the Institute for Objectivist Studies in Poughkeepsie, New York. He argues that: "the very concept of such a right is corrupt in theory" because "a right is a principle specifying something that an individual should be free to have or do." One of his main objections to so-called 'welfare rights' is the fact that they "impose on others the positive obligation to provide the goods in question." He describes welfare rights as "rights to goods: a right to food, shelter, education, a job etc" - and contrasts them with 'liberty rights' which are "rights to freedom of action but don't guarantee that one will succeed in obtaining any particular good one may be seeking." He observes that every right imposes some obligation on others and questions the practicality of this in the light of limited resources.

It is trite that for a right to exist there must be some legal basis for it. The content of a right is shaped by that branch of law from whence it arises. Because, rights tend to be flavoured by the jurisprudence that gave birth to them, when a particular right⁹ is reflected as the subject matter of more than one area of law and is developed separately on different legal fronts, and to varying degrees given the conceptual and doctrinal limitations of that particular legal area, there is the potential for dissonance in attempts to conceptualise the right as a single legal construct. In other words, when one encounters the question of a right to health care, one must ask whether there is in fact a single right with a number of different facets, depending upon the legal perspective of the viewer, or whether there are rather many discrete rights to health care within the various branches of law across which synthesis is not possible. In South African law, the idea of a right to health care is addressed to varying degrees in a number of different legal areas notably, international law, constitutional law, the common law of contract, the common law of delict and statutory law. The extent to which these various areas of law may be reconciled to yield a single, multifaceted right to health care is one of the issues explored in this thesis. Some practical implications of a right, or various rights, to health care will be examined by way of a series of situational questions. The relevance and importance of an attempt at synthesis is highlighted by the comparatively recent introduction into South African law of a constitutional Bill of Rights which, in terms of both the Constitution itself¹⁰ and the legal theory behind its construction, must serve as a grundnorm for the further development, in terms of both modification and edification, of the entire legal system.

Synthesis: Some Legal Questions

To illustrate the importance of the possibility of synthesis of various branches of the law, the question has been posed whether the Constitution can give rise to a 'constitutional delict' as distinct from a common law delict¹¹ or whether the common

See also Faria MA "Is there a right to health care?" *Medical Sentinel*, Vol 4 No 4, July/August 1999, 125-127. Faria questions whether health care is really a basic human right on essentially the same grounds as Kelley, namely that a right to medical care "imposes an obligation on a physician".

⁹ Conceptually, as opposed to legally, speaking.

¹⁰ See section 39(2) of Act No 108 of 1996 which requires every court, tribunal or forum to promote the spirit, purport and objects of the Bill of Rights when interpreting any legislation and when developing the common law or customary law.

¹¹ Neethling J, Potgieter JM, Visser PJ, *Law of Delict* (1999) 22-23. The authors submit that a clear distinction should be made between a constitutional wrong and a delict even though these two figures may overlap on the basis that the

law of delict should be used to underscore and remedy violations of constitutional rights that satisfy the recognised common law requirements for delict. In other words, does the constitution create another, new, category of delict outside of the common law, which must be developed in accordance with constitutional law principles or is it more logical to develop the common law of delict so as to accommodate certain violations of the constitutional law therein. A further question could be posed in relation to the law of contract? Would breach of a contractual right, which in itself involves a constitutional right, render the breach of contract unconstitutional? Must one consider two separate actions for the same wrong, one in terms of constitutional law and one in terms of the law of contract - in which case, would the relief claimed differ depending on the basis of the action - or must one regard it as a simple breach of contract?

Even at a purely constitutional level, there is a need to synthesise provincial and national legislation. There is apparently scope for variation in the content of the constitutional right to health care services across provinces insofar as health care services are a Schedule 4, Part A, competency. This means that the provinces and the national government have concurrent legislative power in this area. In terms of section 41(1) (e) all spheres of government and all organs of state within each sphere must respect the constitutional status, institutions, powers and functions of government in the other spheres. The national government may not simply override a provincial government by way of legislation on a particular issue. Section 104(1) of the Constitution gives a provincial government the power to pass legislation for its province with regard to any matter within a functional area listed in Schedule 4. In terms of section 104(3) a provincial legislature is bound only by the Constitution and, if it has passed a constitution for its province, also by that constitution. Given the fact

"requirements for a delict and those for a constitutional wrong differ materially." They also point to the fact that "...unlike a delictual remedy which is aimed at compensation, a constitutional remedy (even in the form of damages) is directed at affirming, enforcing, protecting and vindicating fundamental rights and at preventing or deterring future violations of chapter 2". According to the authors a constitutional wrong and a delict should not be treated alike and for conceptual clarity the term constitutional 'delict' or 'tort' should rather be avoided. They do state, however, that where a delictual remedy will also effectively vindicate the fundamental right concerned and deter future violations of it, the delictual remedy may be considered to be appropriate constitutional relief and in this way may serve a dual function. The view of the authors that a constitutional wrong must be viewed as distinct from a delict is apparently at odds with the provisions of section 8(3)(a) and (b) of the Constitution which states that in order to give effect to a right in the Bill, a court must apply, or if necessary, develop, the common law to the extent that legislation does not give effect to that right and may develop rules of the common law to limit the right, provided that the limitation is in accordance with section 36(1). This section promotes the understanding that the vehicle for giving effect to rights in the Bill is the common law in the absence of relevant legislation. The concept of constitutional 'wrongs' as a discrete category of wrongs apart from common or statutory law does not seem to be in keeping with what is intended by the Constitution itself. Rather the Constitution is to be regarded as the base reference for the edification of the legal system generally.

that the right to health care services is tempered by the state's¹² obligation to ensure the *progressive* realisation of the right within available resources¹³ and the possibility that "the state" can mean a provincial or even municipal government as much as it does the national government, how does one reconcile this potential for variation in the content of the right across provinces with the fact that in terms of section 9(1) of the Constitution, "Everyone is equal before the law" and in terms of section 9(2), "Equality includes the full and *equal* enjoyment of all rights and freedoms"? (writer's italics).

Does the Constitution in fact create a right of access to health care services which exists independently of any other legislative or other measure taken by the state in order to achieve the progressive realisation of that right within available resources or does it effectively only impose an obligation upon the state to create instances or facets of such a right by way of legislation as and when the resources are available? The implications of each of the possible answers to this question are profound. If the answer is the former then there exists a fundamental and underlying right of access to health care services which in certain circumstances, could be enforceable against any number of potential suppliers of health care services irrespective of any other specific legislative provisions relating to access to health care services. The idea, in terms of this view, is that the nature, content, level and method of delivery of the particular health services in question would be determined by a court in the given circumstances

¹² In analysing what is meant by "the State" in the case of *Greater Johannesburg Transitional Metropolitan Council v Eskom* 2000 (1) SA 866 SCA, at 876 the court stated that: "In its ordinary meaning for the purposes of domestic law the word is frequently used to include all institutions which are collectively concerned with the management of public affairs unless the contrary intention appears. In this sense the State may manifest itself nationally (through the executive or legislative arm of central government), provincially, locally and, on occasions, regionally." In *R v Bethlehem Municipality* 1941 OPD 227 Van den Heever J said the following at 231: "A facile distinction is sometimes drawn between municipalities and other entities with legislative and executive powers on the ground that municipalities are mere creatures of statute. This is undoubtedly so, but so are provincial councils and, for that matter, the Union Parliament. With respect to authority of course they differ vastly and are ordered in a definite hierarchy, but the function of each is government. A municipality is not merely a corporation like a company; it is a phase of government, local it is true, but still government." And in *Hleka v Johannesburg City Council* 1949 (1) SA 842 (A) the same Judge commented at 855: "The modern trend is to recognise that municipal government may be local, yet it is a phase of government." In *Chandler and Others v Director of Public Prosecutions* [1962] 3 All ER 142 (HL) the phraseology that had to be construed was 'the safety and interests of the State'. Lord Devlin, after asking "what is meant by 'the State'?" gave the following answer at 156D - E: "Counsel for the appellants submits that it means the inhabitants of a particular geographical area. I doubt if it ever has as wide a meaning as that. I agree that in an appropriate context the safety and interests of the State might mean simply the public or national safety and interests. But the more precise use of the word "State", the use to be expected in a legal context, and the one which I am quite satisfied for reasons which I shall give later was intended in this statute, is to denote the organs of government of a national community." And in the same case Lord Reid suggested that the 'organised community' comes as near to a definition of 'State' as one can get. As Baxter points out in *Administrative Law* at 95, although the expression 'the State' is extensively employed in legislation, it is not used with any consistency. The precise meaning of 'the State' depends on the context within which it is used. It is submitted, in view of the foregoing and in view of the nature of the Constitution itself that the word 'state' as it appears in section 27(2) cannot be interpreted to mean anything other than all of the spheres of government established by and recognised in the Constitution.

¹³ Section 27(2) of the Constitution states that: "The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights."

of a particular case. If the answer is the latter then it is a right enforceable against the state only and then only to the extent that the state is obliged to take reasonable legislative and other measures to achieve the progressive realisation of the right. The nature, content, level and method of delivery of the health services would be the subject of other legislation and other measures to be adopted by the state and no further legal action to obtain health care services could be taken until those legislative and other measures were in place. In terms of the latter view, the content of the constitutional right of access to health care services is restricted to the state's obligation to take those legislative and other measures to achieve the progressive realisation of the right. The appropriate relief on the latter view, in terms of a Constitution based action, would be a simple order directing the state to enact legislation or adopt certain measures to achieve this. Further discussion of this issue will be undertaken in a later section dealing more closely with the constitutional right of access to health care services.

In the context of statutory law, for example the Compensation for Occupational Injuries and Diseases Act¹⁴, can the fact that section 73 of this Act provides for the payment by the Director-General, the employer or the mutual association concerned, as the case may be, of the reasonable costs of medical expenses for occupational injuries and diseases for a period of two years be seen as a legislative measure taken by the state to progressively realise the constitutional right of access to health care services? In other words can the right embodied in section 73 of the Compensation for Occupational Injuries and Diseases Act now be regarded as a subset of the constitutional right of access to health care services or is it merely a right conferred by a statute independently of section 27(1) of the Constitution? If the answer is the former then the section 73 right must be tested against the provisions of section 27 of the Constitution. Is it a reasonable legislative measure?¹⁵ Does it sufficiently take into account the availability of resources? Should the state take further steps to develop the content of this particular right in this particular context or should it rather be supplemented or complemented by other rights relating to access to health care

¹⁴ Act No 130 of 1993

¹⁵ See section 27(2) of the Constitution quoted at fn 13 *supra*.

services in other contexts?¹⁶ Would the fact that this particular law predates the Constitution mean that it cannot be seen in the broader context of the constitutional right of access to health care services or should it nonetheless now be interpreted in this context irrespective of when it was promulgated?

Synthesis: Some Practical Questions

The questions posed above and the manner in which they are answered have a direct impact on practical questions of health service delivery in South Africa. Some of these questions go to the heart of health care delivery systems generally. They relate to the implementation of socio-economic rights in the realities of a less than perfect world. They confront issues such as the rationing and equitable distribution of health care services, acceptable levels of quality and standards for health care, interfaces between the public and private sectors on issues of health care delivery and the need for a balancing of the various interests that contribute to the dynamic of the health sector. Some of practical questions in this context are:

Is there a difference between a right of access to health care services and a right to health care services?

Must the health care services be supplied irrespective of a patient's ability to pay?

If there is a right to health care services from the perspective of the consumer, is there a corresponding obligation to deliver those health care services, and if so, who bears it and to what extent?

If there is a right to health care services, is it restricted to the indigent or do all consumers, including members of medical schemes, have such a right and, if so, against whom?

Is there a specific level of health care service to which a right to health care applies? For example, is the right restricted to health care services at a primary care level or at

¹⁶ For instance in the context of Social Health Insurance legislation or even a National Health Act which provides for access to health care services for the population generally.

an emergency care level, or does it extend through all levels of care, including secondary and tertiary levels?

Would the state, and private institutions such as managed care organisations and medical schemes, be able to legitimately restrict access to, or ration, health care services?

Is there a certain standard of health care services implied in the constitutional right to health care services e.g. one which demands that the provider of such services exercises reasonable care in their delivery so as to optimise the efficacy of the services provided?

When a person contracts for certain health care services with a supplier of health care services how does this affect that person's constitutional right of access to health care services?

Can a person contract out of his or her right to life in a health care setting or contract for a lower standard of health care services than is generally regarded as acceptable?

Would consumers in a particular locality be able to insist that the government constructs and equips a clinic or hospital in the area to serve their health care needs on the basis of a constitutional right of access to health care services?

Would consumers in a particular locality be able to prevent the closure of a state owned hospital or clinic in their area on the basis that such closure would constitute a denial of their right of access to health care services?

Can an individual insist on receiving life prolonging medical treatment when such treatment does not improve the quality of life of the patient and holds no hope of a cure but prolongs his or her life such as it is?

Does a right to health care services imply a right to funding of those services by the state or by a medical scheme?

Is it equitable to institute the implementation of a particular health intervention for select groups of people with a view to increasing coverage to the remainder of the population over a period of time?

What are the rights of providers of health care services in the light of the existence of a constitutional right to such services on the part of consumers?

Approach and Methodology

This thesis explores the questions raised above and others in the context of five broad areas of law namely international law, constitutional law, administrative law, the law of contract and the law of delict. These areas of law have in some instances been covered separately with regard to the public and private sectors in order to restrict the size of the chapters and to highlight some of the differences between the two sectors. More particularly the research material is divided into ten chapters in the following way:

- Chapter one explores the concept of a right to health and a right to health care at the level of international law and the usefulness of these concepts in international law to the South African legal system.
- Chapter two deals with the right to health care services and health service delivery from a constitutional law perspective and discusses the relevant judgments of the constitutional court in this area;
- Chapter three examines the significance and relevance of administrative law to health service delivery. The relevant case law in the area of administrative law is discussed;
- Chapter four covers the general principles of the law of contract within the context of health service delivery;
- Chapter five considers the law of contract within the context of the delivery of health services by the public sector and focuses on the case law in this area;

- Chapter six considers the law of contract within the context of the delivery of health services by the private sector and includes focuses on the relevant case law;
- Chapter seven covers the general principles of the law of delict as applicable in the health care context;
- Chapter eight considers the law of delict as it relates to health service delivery within the public sector and focuses on the relevant case law;
- Chapter nine deals with the law of delict as it related to health service delivery within the private sector and focuses on the relevant case law;
- Chapter ten consolidates the conclusions and observations that were made in each of the preceding chapters and offers some concluding thoughts on the subject matter of the thesis.

There are numerous references to articles and publications that have been sourced from the internet in this thesis. This is for a number of reasons. From a practical perspective, given the time that it takes to cover a subject of this magnitude, the internet offers extremely fast and detailed access to many sources of law that would take weeks to uncover in a paper library - assuming that they were available in hard copy in that library to begin with. Sometimes there is as much of an advantage in knowing what is *not* available as there is in seeing what is present on the shelves. The internet is fast becoming *the* central repository of knowledge worldwide and it would be nothing short of foolish not to search it for material that is relevant to the topic at hand. It is also much quicker, easier and cheaper to download and store electronically legal articles and reference material for subsequent perusal and study than to physically stand making photocopies in a law library for days. In the context of South African source materials with regard to health law in particular, reference has already been made to the relative paucity of material compared to that available in many foreign jurisdictions. While this thesis does not purport to be anything resembling a

comparative legal study, due largely to the fact that its scope within the South African legal context is extremely broad, it was useful to seek out and include, for illustrative purposes, examples from other jurisdictions of the manner in which they have dealt with issues similar to those under discussion. The internet makes this task a pleasure as opposed to the labour of sweat and tears it would quite literally have been if the writer had been obliged to trawl the law libraries. Most South Africa law libraries have in any event converted to electronic indices that are in some cases offered via subscription services on the internet. When one is attempting a work as substantive as this, it is wise to make the most efficient and effective use of one's time and other resources in order to be able to arrive at a finished product within externally imposed time constraints.

Although this work could be criticised as somewhat voluminous, some of its size is attributable to detailed coverage of the court judgments in the cases discussed. It was felt that such detailed coverage was necessary and useful for a number of reasons not least of which are -

- The thesis covers a wide expanse of law and few readers will be intimately familiar with every area;
- It was the intention to create a source reference for non-lawyers and those with no ready access to the law reports;
- In order to fully explore the nuances of the cases discussed, it is important to see the detailed thinking of the judges. Law is not a science but an art.

It was also important to cover these five areas of law because a central point of this thesis is the unity of all law in South Africa on the basis of the Constitution. It would not be exaggeration to say that it is as much a work of constitutional law as it is of health law. The Constitution requires consistency of all other law not only with itself but also between various fields of law since it embodies the essence of the central themes and the guiding principles of law in this country. One cannot establish the extent to which such constitutional consistency prevails without examining major fields of law. One cannot identify inconsistencies without undertaking the same exercise. The structure of the thesis therefore reflects its approach to law – that there

is a single legal system with many facets rather than a number of different systems that operate discretely and independently of each other.

The Constitution directs South African courts to consider international law and allows them a discretion to consider foreign law. The same approach has been adopted in this thesis. It is not a comparative study of health care law across different jurisdictions. An entire chapter has been devoted to international law but there are comparatively few and highly selective references to foreign law throughout the various chapters. Such references are made where they serve to further illustrate, contextualise or highlight a principle of South African law that is under discussion. In some instances they are the references found within the judgments of South African courts. The dearth of case law in South Africa in the area of health service delivery is one of the principal reasons for these references to foreign law. They serve as practical examples of ‘real life’ situations in which a particular legal principle has been applied and to what effect.

H Nys in the entry for Belgium in the *International Encyclopaedia of Laws*¹⁷ explains medical law as follows:

“Medical law is an area of law, medical law does not respect traditional compartments with which lawyers have become familiar, such as torts, contracts, criminal law, family law and public law. Instead, medical law cuts across these subjects and today must be regarded as a subject in its own right. We maintain that it is a discrete area concerned with the law governing the interactions between doctors and patients and the organisation of health care.”

This work is voluminous for yet another reason. It explores more than just medical law. Its focus is South African health law – a much wider concept - and there is no pre-existing foundation upon which to build in this specific context in South African law. It thus had to be done ‘from scratch’. Nys observes that often the term “health (care) law” is used instead of medical law. He states:

“According to Leenen¹⁸, ‘health law is that branch of law which covers studies on both the individual and social aspects of the right to health care. It can be defined as the body of rules that relates directly to the care for health as well as the application of general, civil, criminal

¹⁷ Blanpain R (ed) Chapter III ‘Medical Law’ p 26-27

¹⁸ Leenen HJJ ‘Health law and legislation’ *Health Services in Europe*, 3rd ed vol 1: Regional Analysis, World Health Organisation, Copenhagen 1981, p 60



and administrative law designed to provide healthy conditions. Medical law (“the study of the juridical relations to which the doctor is a party’ according to a widely accepted definition of Savatier) is part of health law. In health care there is a large range of juridical relations in which the doctor is not involved.”

Furrow *et al*, authors of a leading American textbook on health law¹⁹ observe that health law is both broader and narrower than law and medicine as it has been traditionally taught in American law schools. Law and medicine in the past generally focussed on two issues – professional malpractice and forensic medicine. In more recent years, however, law and medicine courses have been expanded to cover new issues that arise at the interface of law and medicine. They state:

“This book grows out of a belief that no longer can one course cover all the issues that now arise from the interaction of law and medicine... We do cover many subjects not previously covered in depths in law and medicine texts: health care financing and cost control, organisation and management of health care institution and access of the poor to health care, to name a few. We shift the focus from law and medicine to law as it affects the health care industry, and examine this law as an integrated whole.”

The present writer could do worse than to echo their words in introducing this thesis to the reader.

¹⁹ Furrow BR, Johnson SH, Jost TS, Schwartz RL *Health Law: Cases, Materials and Problems* 1st ed West Publishing Company, 1987 p XVII. (Note: There is a third, much later edition of this work but the illustrative quotation above is taken deliberately from the first because it was introducing a new approach at that time).



LIST OF ABBREVIATIONS

| | |
|--------------|--|
| AJIL | American Journal of International Law |
| AJLM | American Journal of Law and Medicine |
| ALR | Albany Law Review |
| Am U LR | American University Law Review |
| ARV | Anti Retroviral |
| ASIL | American Society of International Law |
| AYBIL | Australian Year Book of International Law |
| BLR | Buffalo Law Review |
| BMJ | British Medical Journal |
| BML | Businessman's Law |
| CEDAW | Convention on the Elimination of All Forms of Discrimination Against Women |
| Ch JIL | Chicago Journal of International Law |
| Ch K L Rev | Chicago-Kent Law Review |
| CJIL | Connecticut Journal of International Law |
| CLJ | Cambridge Law Journal |
| CMAJ | Canadian Medical Association Journal |
| CMAJ | Canadian Medical Association Journal |
| CMJ | Clinical Medicine Journal |
| CRC | Convention on the Rights of the Child |
| DSU | Dispute Settlement Understanding |
| EJCL | European Journal of Comparative Law |
| EJIL | European Journal of International Law |
| ESR Review | Economic and Social Rights Review |
| FDA | Food and Drug Administration (USA) |
| HHR | Health and Human Rights |
| HJLPP | Harvard Journal of Law & Public Policy |
| HLJ | Health Law Journal |
| HLR | Harvard Law Review |
| ICCPR | International Convention of Civil and Political Rights |
| ICESCR | International Convention on Economic, Social and Cultural Rights |
| ICJ | International Court of Justice |
| I.CON | International Journal of Constitutional Law |
| IJLP | International Journal of Law and Psychiatry |
| ILO | International Labour Organisation |
| ILP | International Law and Politics |
| ILR | Indiana Law Review |
| ILT | International Legal Theory |
| Int Leg P | International Legal Practitioner |
| Is L Rev | Israel Law Review |
| JAMA | Journal of the American Medical Association |
| JIEL | Journal of International Economic Law |
| JLME | Journal of Law, Medicine & Ethics |
| LAWSA | Law of South Africa |
| LQR | Law Quarterly Review |
| M&L | Medicine and Law |
| MGLJ | McGill Law Journal |
| MLR | Michigan Law Review |
| N Mex L Rev | New Mexico Law Review |
| NEJM | New England Journal of Medicine |
| NHS | National Health System (UK) |
| Nw U. L. Rev | Northwestern University Law Review |
| NYACAD SCI | New York Academy of Science |
| SAJHR | South African Journal of Human Rights |
| SALC | South African Law Commission |
| SALJ | South African Law Journal |
| SAPL/SAPR | South African Public Law/ Suid-Afrikaanse Publieke Reg |
| SAYIL | South African Yearbook of International Law |



| | |
|--------------|--|
| SLR | Stellenbosch Law Review |
| THRHR | Tydskrif Vir Hedendaagse Romeins-Hollandse Reg |
| TLR | Texas Law Review |
| TRIPS | Agreement on Trade Related Aspects of Intellectual Property Rights |
| TSAR | Tydsrif vir Suid Afrikaanse Reg |
| UDHR | Universal Declaration of Human Rights |
| UMLR | University of Miami Law Review |
| UN | United Nations |
| UPenn JCL | University of Pennsylvania Journal of Constitutional Law |
| WHO | World Health Organisation |
| WILJ | Wisconsin International Law Journal |
| Wis. L. Rev. | Wisconsin Law Review |
| WMA | World Medical Association |
| WTO | World Trade Organisation |
| WULQ | Washington University Law Quarterly |
| YLJ | Yale Law Journal |

Chapter 1

International Law and the Right To Health Care

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|-------|---|-----|
| 1.1 | Introduction..... | 1 |
| 1.2 | Monism and Dualism | 12 |
| 1.3 | The Constitutional Approach To International Law..... | 16 |
| 1.3.1 | Section 39(1)..... | 18 |
| 1.3.2 | Sections 231, 232 and 233 | 24 |
| 1.3.3 | Section 231 – International Agreements | 29 |
| 1.3.4 | Section 232 – Customary International Law | 34 |
| 1.3.5 | Section 233 – International Law | 37 |
| 1.4 | Customary International Law and the Right To Health | 41 |
| 1.5 | Public International Law and the Right To Health | 51 |
| 1.6 | Minimum Core..... | 57 |
| 1.7 | International Legal Principles Applied Locally | 61 |
| 1.8 | Rights of Vulnerable Groups..... | 67 |
| 1.8.1 | The Status of One Right Relative to Another | 68 |
| 1.8.2 | Preference of the Rights of Certain Groups..... | 75 |
| 1.9 | Rights of Children..... | 77 |
| 1.9.1 | The Convention on the Rights of the Child | 78 |
| 1.9.2 | WMA Declaration of Ottawa..... | 82 |
| 1.9.3 | African Charter on the Rights and Welfare of the Child..... | 83 |
| 1.10 | Rights of Women | 86 |
| 1.11 | Rights of Refugees | 88 |
| 1.12 | Rights of Prisoners | 90 |
| 1.13 | Jus Cogens and the Right To Health..... | 93 |
| 1.14 | Private International Law and the Right To Health | 101 |
| 1.15 | Summary and Conclusions | 103 |

1.1 Introduction

International law generally is a dynamic concept upon which there are widely differing views amongst lawyers and nation states¹. In fact it would probably not be unfair to say

¹ Savaneli B, 'Transformation Of International Law Into Universal Human Rights Law In The Framework Of Pure Theory Of Law', www.iatp.org.ge p3 " There are four classical views of the international system: a 'Hobbesian' or realist tradition, a 'Vattelian' or internationalist tradition, a 'Grotian' or communitarian tradition, and a 'Kantian' or universalist tradition. In the Hobbesian or 'realist' tradition, states are seen in a permanent situation of cold or hot war. It is the world of power politics, temporary alliances, and national interest, a world which knows only zero-sum games. International law merely duplicates this power structure. A new strand of realism substitutes the rivalry of civilizations for that of states. Some 'critical' scholars of international law also seem to embrace a view which emphasizes the difficulty of a legal system attempting to bind different cultures, albeit from a completely different angle... On the other side of the spectrum we find a view labelled by Bull (see below) as 'Kantian' or universalist: this view 'sees at work in international politics a potential community of mankind'. Writers adhering to this view, although acknowledging that the state is here to stay for quite a while, do not regard the state as an aim in itself - or even as the 'primary unit' of international society. Rather, they tend to underline the role of international 'civil society', multinational cooperation and non-governmental organizations. The systemic value promoted by these authors

that for every statement one makes about international law, there are variations or contradictions that can be argued with as much justification. Since the concerns of this thesis are fundamentally pragmatic, an approach that is entirely in keeping with the real world concerns of the delivery of health care services, one of the issues that will be explored in this chapter is the value or usefulness of international law at this level. The concept of international law is explored in this chapter in its various aspects and as perceived and acknowledged by the South African Constitution. Specific attention is given to international law relating to the right to health or health care and the boundaries and content of this construct in order to establish the level and extent of its interface with the domestic legal system. The cogency of international law is considered against the backdrop of South African law and its validity and value for the domestic legal system are critically examined.

The term “international law” in its widest sense includes private and public international law, customary international law and the body of peremptory norms commonly referred to as ‘*jus cogens*’². Article 38(1) of the International Court of Justice Statute states that

is justice, which may entail a justification of community intervention for the protection of individuals against their own state. In the middle, Bull places a view, which he refers to as ‘Grotian’ or internationalist. According to this conception, international society is composed of states. Individuals, in principle, count only as representatives of their collectivity. However, cooperation between states is possible, and even to be encouraged in order to realize common values and interests. One view of international society may be called ‘Vattelian’, or inter-national in the narrow sense. It emphasizes the individual interest of states. Cooperation is the exception, not the rule. In most instances, common interests have to be accommodated in bilateral settings. International institutions may be useful for stabilizing cooperation, but their role is limited by the national interest. This is the view of classical international law, the famous ‘Westphalian system’. Its main value is not cooperation, but order. A truly ‘Grotian’ (or, because of its modern emphasis on institutions, ‘neo-Grotian’, ‘Friedmannian’ or ‘communitarian’) view, on the contrary, sees the international system on its way to an ‘organized state community’ with an emphasis on common interests, the development of common values, and the creation of common institutions. In the words of Christian Tomuschat, ‘it would be wrong to assume that states as a mere juxtaposition of individual units constitute the international community. Rather, the concept denotes an overarching system which embodies a common interest of all states and, indirectly, of mankind’.”

² McManus H ‘International Law: Constructing Power?’ observes that: “The creation of public international law relies on negotiation and ratification of formal treaties and conventions, and on the formation of custom. Customary international law arises through the “general practice” of states’ legally relevant actions resulting in stable expectations, and ultimately in rules widely believed by states to be legal requirements. This is to be contrasted with international law arising from treaties or other formal legal arrangements, which are negotiated by states, and must be signed and ratified in order to be considered legally binding upon a state. States cannot fail to participate in the formation of customary international law concerning their behavior, as it is a product of long term, legally relevant interactions. Conversely, a state may fail to contribute, through choice or through non-recognition by other states, to negotiations of treaties.”

<http://www.missouri.edu/~polawww/papers/pp011105.pdf>

These distinctions are far from clear cut. The precise nature and content of *jus cogens* in relation to other types of international law are the subject of argument. The only South African case which appears to have dealt expressly with the *jus cogens* is *Azanian Peoples’ Organisation (Azapo) and Others v Truth and Reconciliation Commission and Others* 1996 (4) SA 562 (C) in which the court observed that: “It is, however, unnecessary, in our judgment, to consider further the applicability of the *jus cogens* to the interpretation of the Constitution. That is because there is an exception to the peremptory rule prohibiting an amnesty in relation to crimes against humanity contained in Additional Protocol II to the Geneva Conventions, which was adopted on 8 June 1977 by the Diplomatic Conference on the Reaffirmation and Development of International Humanitarian Law Applicable in Armed Conflicts, and which came into force on 7 December 1978. In terms of Article 1(1) thereof this Protocol applies to ‘all armed conflicts . . . which take place in the territory of a High Contracting



international law has its basis in international custom, international conventions or treaties and general principles of law³. A detailed analysis of international law, a vast subject, is not within the scope of this thesis. However it is necessary to examine a few basic precepts and principles in order to acquire some background understanding of international law as it relates to health and health care.

Public international law generally consists of international conventions and treaties that expressly recognize rules and principles that bind the states parties. Only those states who are parties to such instruments are bound by them. According to some views, international law does not apply to relationships between states and persons or between persons *inter se*. It applies between nation states⁴. According to others the doctrine that

Party between its armed forces and dissident armed forces or other organised armed groups which, under responsible command, exercise such control over a part of its territory as to enable them to carry out sustained and concerted military operations . . ." This case involved section 231(4) the interim Constitution and not the final Constitution which is differently worded in regard to international law. However it does seem that the court in *AZAPO* preferred to use an express rule of public international law rather than to explore the *jus cogens* which does suggest a ranking by the court of *jus cogens* as being of less significance than an express rule of public international law. Although there are not many South African cases that refer to the *jus cogens* there are one or two southern African *dicta* worth mentioning. In *S v Banda and Others* 1989 (4) SA 519 (BG) the court observed at p544 with regard to the arguments of Dugard in that case: "I mean no disrespect to Mr Dugard's remaining contentions if I do not deal with them specifically. Having arrived at this conclusion, it is unnecessary to consider the remaining submissions in detail, as they are not necessary for the determination of the issue before me. However, I pause only to consider certain of them. These are: (a) An entity does not qualify as a state, notwithstanding that it has the attributes of statehood expounded in the Montevideo Convention, if its creation is a result of a violation of a peremptory norm of international law (*jus cogens*). From the authorities that he has referred me to, it would appear that the doctrine of the *jus cogens* relates primarily to the question of invalidity of treaties. It is also correct that several jurists have contended that the *jus cogens* is applicable to unilateral acts of states in violation of peremptory norms. Furthermore, the implications of the *jus cogens* have also been advanced in support of the concept of non-recognition. I cannot agree with, nor accept the doctrine of *jus cogens* concerning the question of recognition or non-recognition. As I have already found, the fact of non-recognition is immaterial, provided the norms of international law, which I have accepted, have been complied with." In *Mwandimi v Minister of Defence, Namibia* 1991 (1) SA 831 (Nm) the court observed at p862 that: "...counsel submitted that the words 'which would not otherwise have been recognised by 'international law' refer to that body of international law which Brownlie *Principles of Public International Law* 3rd ed at 512 - 15 termed *jus cogens*. This embodies rules such as the prohibition of aggressive war, the law of genocide, the principle of non-racial discrimination, slavery, etc, and which, according to some opinions, are overriding principles of international law'. See also Perritt H Jr 'Symposium on the Internet and Legal Theory: The Internet is Changing International Law' 73 *Chicago-Kent Law Review* 997

www.kentlaw.edu/perritt/publications/73_CHI_KENT_L_Rev_997.htm; Rosenthal E, and Sundram CJ 'International Human Rights and Mental Health Legislation' 2002 *New York Law School Journal of Comparative and International Law* (also at <http://www.bazelon.org/legal/resources/internationallaw.pdf>)

³ Yasuaki O 'Is the International Court of Justice an Emperor Without Clothes' *International Legal Theory* (2002) Vol 8 No1, p1 states that: "The failure to understand realistically the significance of the ICJ has influenced the attitude of international lawyers toward the question of the "sources" of international law. When discussing the problem of the "sources" of international law, most lawyers begin their argument by referring to Article 38 of the ICJ Statute. Even those who do not explicitly refer to Article 38 generally assume that discussion of the categories of international law should start with, the list of "sources" provided in Article 38(1). Although many leading international lawyers such as Jennings, Cheng, McDougal, Higgins, Falk and Abi-Saab have recognized that using Article 38 for the purpose of explaining the categories of contemporary international law has "an element of absurdity", a tacit reliance on Article 38 still prevails. This fact suggests that most international lawyers tacitly and unconsciously equate the norms of conduct among states with the norms of adjudication to be applied by the ICJ. This further suggests that most international lawyers tacitly accept a domestic analogy and base their argument on this analogy when arguing about the sources of international law." http://law.ubalt.edu/oicj/ilt/8_1_2002.pdf

⁴ Rosenthal E, and Sundram CJ (fn 2 *supra*) state that: "International human rights law creates direct legal obligation only on governments and not on private actors although governments can be required to adopt legislation that protects vulnerable populations in the private sphere. They refer in footnote 171 to Ramoharan "Equality and Non-Discrimination", *The International Bill of Rights*, Henkin, ed., and note that one member of the Human Rights Committee observed that "article 26

states are the only subjects of international law is not an accurate statement of the actual legal position⁵. International law is capable of creating legal requirements for relationships between nation states, between states and persons and between persons. There is a view that international human rights law is a separate branch of international law completely⁶.

Clearly international law is a subject that, as a whole, is far from crisp in terms of both content and theory. It is also in a very real sense far less robust than systems of domestic

could not be interpreted as referring only to public acts. It must cover the internal system of a country and the authorities who decide who could work, occupy land, and so forth. If the state owned all housing and was the sole employer then its provisions applied to the state. In a different system, however, with private housing and numerous private employers, it was the latter who must be prevented from practicing discrimination. They observe further than in General Comment 14 on the right to health, "the Committee stresses the need to ensure that not only the public health sector but also private providers of health services and facilities comply with the principle of non-discrimination in relation to persons with disabilities."

5 Lauterpacht H "The Subjects of the Law of Nations" *Law Quarterly Review* (1947) at 438-439, 451, 452 and (1949) at 97, 112-113. He states that there is no principle in international law which prevents states, if they so wish, from securing to individuals access to international courts and tribunals and goes on to show that there is no rule of international law which precludes individuals from acquiring directly rights under customary international law and that similar considerations apply to the question of subjects of duties imposed by international law, in particular the field of international criminal liability. (Referred to in Savanelli "Necessity of Transformation of International Law into Universal Human Rights Law in the Framework of Pure Theory of Law After September 11", www.iatp.org.ge).

See Savanelli B fn 1 *supra* who observes that: "The system of universal human rights provides for the monitoring of the implementation of human rights worldwide. But it does not confer a legal capacity upon individuals to enforce these rights. Hence, in most instances, individuals are still 'objects', not subjects of international law. On the other hand, international criminal tribunals attempt to render individuals personally accountable at a global level. Neither should we discard developments towards an 'international civil society', in which non-governmental actors increasingly influence international decisions."

6 Savanelli B (fn 1 *supra*) comments that "International Human Rights Law already have (sic) been separated from international law and by the (sic) its universal feature should be called as (sic) Universal Human Rights Law. The process of separation of Universal Human Rights Law from international law originated from Nuremberg (1945) and has been completed with the adoption of the Vienna Declaration and program of action on the World Conference of Human Rights (1993)." Savanelli draws a number of distinctions between what he calls 'Universal Human Rights Law' and other forms of international law. One of these distinctions is on the basis of sources. He says that the sources of international law are basically collections of rules which govern the relations among states whereas the sources of universal human rights law consists of rules which directly govern relations between individuals and states. He points out that obligations of states to each other is the subject of international law but the obligations of states to individuals is the subject of human rights law. He also observes that there is a distinction in terms of mechanisms of protection. Protection of human rights says Savanelli, consists of two stages: internal and international, the latter being a continuation of the former. Palmer observes in an article entitled 'Human Rights and Treaty Obligations' (<http://www.kennett.co.nz/law/indigenous/2000/33.htm>)- that "Human rights became legally recognised at international law. And international law, which had previously been the concern of states alone, has gradually provided a framework for the delivery of human rights to individuals and in some cases to peoples... The Universal Declaration of Human Rights was a declaration and not a treaty, and did not give rise to binding international obligations except to the extent that its provisions entered the realm of customary international law, as arguably, some of the articles of the Declaration have... There is little doubt that that body of international law known as human rights law is, as Her Excellency Judge Rosalyn Higgins has pointed out in an essay: 'strikingly different from the rest of international law in that it stipulates that obligations are owed directly to individuals (and not to the national government of an individual); and it provides, increasingly, for individuals to have access to tribunals and for the effective guarantees of those obligations' (footnotes omitted). Kantsin I 'No Rights Without Remedy: in Search of an ICHR' (<http://www.eumap.org/articles/content/40/401/index.htm?print=1>) notes that from one perspective it is surprising that human rights ever even entered international law. He states that in contrast with other international legal affairs such as territorial integrity, fishing rights, trade relations, or diplomatic immunity, violations of human rights norms do not have direct consequences at the international level. He observes that "Curiously, the body of international treaties covering putative human rights violations with an explicit *international* dimension, such as those addressing war crimes or the treatment of refugees - the humanitarian laws of war and the Geneva Conventions - are not treated as integral to the core of human rights machinery embodied in the UDHR and the subsequent UN Covenants. At the heart of this differentiation is that human rights treaties explicitly protect persons, not as citizens or representatives of a given state but as human beings *regardless* of state affiliation."



law⁷. There is considerable debate as to where one area of international law leaves off and the other begins. To complicate matters the content of one area, such as public international law, can by a process of seepage become the content of another, for example, customary international law, depending upon the theory of customary international law to which one subscribes. The steps of this process of seepage and the question of when it is complete are also unclear. For a principle of international law to become customary international law there must be a certain critical mass of support in terms of domestic and international judicial decisions and practice. However, the notion of what that mass should be remains vague. It also does not help that there is an apparently wide variety of types of international law instruments and their relative importance and significance is not always obvious. As the International Labour Organisation (ILO) points out in its definition of key terms used in the UN Treaty Collection, over the past centuries, state practice has developed a variety of terms to refer to international instruments by which states establish rights and obligations among themselves⁸. Commonly used names for these various instruments are “statutes”, “covenants”, “accords”, “treaties”, “conventions”, “declarations” etc. The ILO observes that in spite of this diversity, no precise nomenclature exists and that the meaning of the terms used is variable, changing from state to state, region to region and instrument to instrument. The title of the instrument should not therefore be used as a guide to its relative weight and significance compared to other instruments. The two Vienna

⁷ This is evident from a number of different sources. See for instance Yasuaki fn 3 *supra* who has noted that: “The ICJ [International Court of Justice] is a refined and extremely fragile construction based on a delicate balance among sovereign states. Once this delicate balance is lost, its power will fall into pieces.” According to him the ICJ is nonetheless, “the most important of the various agents that can settle international conflicts by means of law. It is the only agent that can give authoritative interpretations of international law in an international society made up of sovereign states holding fast to their own conceptions of international law... The ICJ has the image of being the most important judicial organ in international society.” Yet elsewhere he states: “Domestic lawyers can study the law applied by the judiciary (norms of adjudication) with some confidence that it will determine actual disputes. The situation in international society is very different from this domestic model. The ICJ does not have compulsory jurisdiction. The number of states that accept the jurisdiction of the ICJ under Article 38 is only 63 out of some 190 states as of July 1999. Even those states that do accept the Court’s jurisdiction do so with various qualifications. States are generally reluctant to settle international conflicts by means of the ICJ. This is especially the case with politically important issues. Moreover, there is no guarantee of enforcement of the judgment, once given. There have been conspicuous cases in which the losing party has not complied with the judgments. Therefore, the shadow of the court can influence the bargaining process between states much less in international society than it would in domestic disputes. States cannot expect to influence others very much by threatening recourse to the ICJ. Under such circumstances, one can hardly presume to equate norms of conduct with norms of adjudication. States, especially those concerned with their reputation of compliance with international law, may generally seek to behave in accordance with norms of international law, without considering how their conduct will be judged by the ICJ.” Savaneli (fn 1 *supra*) points out that: “More than a dozen years after the signature of the Vienna Convention on the Law of Treaties, the theory of *jus cogens* has not yet been put to any practical test. Some scholars are arguing the applicability of principles of ‘*jus cogens*’ and ‘*ergo omnes*’ to the Human Rights category.” Alston P observes that the enforcement mechanism for human rights at the international level is seriously flawed (referred to in Kantain fn 6 *supra*).

⁸ International Labour Organisation (ILO) <http://www.ilo.org/english/astrav/telearn/global/ilo/law/keyterm.htm>



Conventions⁹ contain rules for treaties concluded between nation states but neither of them distinguishes between different types of instruments on the basis of their nomenclature. As the ILO points out, although the General Assembly of the United Nations has never laid down a precise definition for the terms “treaty” and “international agreement” and has never clarified their mutual relationship, Article 1 of the General Assembly Regulations to give effect to article 102 of the Charter of the United Nations provides that the obligation¹⁰ to register treaties and international agreements applies to every treaty or international agreement whatever its form and descriptive name. It would seem that there is no absolute truth in international law – only past experience and present perception¹¹.

To add another layer of complexity to international law, treaties and other international law instruments can be the subject of a number of different actions by states. It is necessary to clarify the nature of these actions in view of subsequent discussions of the various international legal instruments in which South Africa has some involvement. Treaties and international agreements can be adopted, accepted or approved, acceded to, signed or ratified. These various actions do not all mean the same thing. According to the ILO’s Glossary of terms relating to Treaty Actions¹²:

“adoption” is the formal act by which the form and content of a proposed treaty text are established. Treaties can be adopted *inter alia* by an international conference which has specifically been convened with the purpose of setting up the treaty – usually by a vote of

⁹ The 1969 Vienna Convention on the Law of Treaties which came into force on 27 January 1980 and the 1986 Vienna Convention which, at the time of writing has not yet come into force.

¹⁰ Article 102 of the Charter of the United Nations requires that “every treaty and every international agreement entered into by any Member State of the United Nations after the present Charter comes into force shall as soon as possible be registered with the Secretariat and published by it.”

¹¹ D’Amato A, ‘Customary International Law: A Reformulation’ 4 *International Legal Theory* 1-6 (1998) suggests that the governing rules that result from international controversy are the birth of rules of customary international law. A rule of customary international law joins the body of customary international law precisely because it has led to the resolution of a controversy. He also suggests that the international system adopts controversy-resolving rules because with each adoption, the chances of further interstate controversy and war are reduced. He states that there are two qualifications to the principle that a rule expressed in a treaty can generate customary international law. The first is that the rule must be generalizable. The second is that any provision in a multilateral convention that is subject to reservation cannot generate customary law by virtue of the fact that customary law binds all states and thus there cannot, in principle, be any exceptions. In conclusion he notes that customary law is formed in much the same way that common law is formed – through dispute resolution - but that the difference between the domestic case and the international controversy is that in the latter there is normally no authoritative decision-maker.

¹² ILO <http://www.ilo.org/it/english/actrav/learn/global/ilo/law/glossary.htm>

two thirds of the states present and voting unless they have agreed to apply a different rule;

“acceptance” or “approval” usually means that the state is expressly consenting to be bound by the treaty and have the same legal effect as ratification. Where national constitutional law does not require a treaty to be ratified by the head of state, states have used acceptance and approval instead of ratification;

“accession” is an act whereby the state accepts an offer or opportunity to become a party to a treaty already negotiated and signed by other states and has the same legal effect as ratification. The provisions of the treaty dictate the conditions under which accession may occur and the necessary procedures for it to take place.

“ratification is an act whereby a state indicates its consent to be bound by a treaty if the parties intended to show their consent by such an act. Ratification grants states time to seek approval for the treaty in terms of their domestic law and to enact domestic legislation to give effect to the treaty;

“signature” can be subject to ratification, acceptance or approval in which case mere signature of a treaty by a nation state does not mean that the state is bound by it. In such circumstances signature reflects a willingness on the part of the state signatory to continue the treaty-making process and qualifies the state to proceed to ratification, acceptance or approval. It also creates a good faith obligation to refrain from actions that would defeat the object and purposes of the treaty.

Rosenthal and Sundram¹³ point out that there are a number of important legal differences between international human rights conventions such as the International Convention of Civil and Political Rights (ICCPR), the International Convention on Economic, Social and Cultural Rights (ICESCR), and the General Assembly Resolutions of the United Nations Assembly such as the “Principles for the Protection of Persons with Mental

¹³ Rosenthal and Sundram in 2 *supra*

Illness and for the Improvement of Mental Health Care” (the MI Principles)¹⁴ and the resolution on “The Standard Rules on Equalization of Opportunities for Persons with Disabilities” (Standard Rules)¹⁵. They observe that Conventions fall into the category of “hard” international law whereas General Assembly resolutions fall into the category of “soft” international law and note that the latter in the human rights field are also referred to as international human rights “standards”. Soft law is “non-binding” and hard law is “binding”.

The distinctions between the various areas of international law are also important for constitutional purposes. The Constitution¹⁶ distinguishes between public international law, in the sense of treaty law, customary international law, and international law as a whole, in terms of sections 231, 232 and 233 respectively. There is also a difference between section 35(1) of the interim Constitution and section 39(1) of the final Constitution in that the former uses the term ‘public international law’ whereas the latter refers to ‘international law’. In terms of section 39(1), when interpreting the Bill of Rights a court, tribunal or forum must consider ‘international law’. Private international law, although it is of specific relevance to a right to health care in that it includes international intellectual property law and therefore has a significant impact on access to medicines, is not as directly concerned with universal issues as is public international law. It is thus of less general significance in the context of section 39(1) of the Constitution than is public international law which is directly involved in matters of human rights. This said, it must be borne in mind that the values which underlie both public international law and private international law must be the same¹⁷. In the context

¹⁴ The MI Principles are a UN General Assembly resolution that can be used as a guide to the interpretation of related provisions of international human rights conventions (Rosenthal E, and Rubenstein LS, *International Human Rights Advocacy Under the “Principles of the Protection of Persons with Mental Illness* 16 *International Journal of Law and Psychiatry* 257 (1993). According to Rosenthal and Sundram (fn 2 *supra*), the Inter-American Commission on Human Rights adopted this analysis in *The Case of Victor Rosario Congo*, (Inter-American Commission on Human Rights Report 29/99, Case 11, 427, Ecuador, adopted in Session 1424, OEA/Ser/L.V/II) Doc.26, March 9, 1999, para 54) the first case on the rights of a person with mental illness under the American Convention.

¹⁵ The Standard Rules are according to Rosenthal and Sundram (fn 2 *supra*) a revolutionary new international instrument because they establish citizen participation by people with disabilities as an internationally recognised human right. Governments are thus under an obligation to provide opportunities for people with disabilities, and representative organisations to be involved in drafting new legislation on matters that affect them. The Standard Rules call on every country to engage in a national planning process to bring legislation, policies and programs into conformity with international human rights standards.

¹⁶ Act No 108 of 1996

¹⁷ See Maier HG ‘Extraterritorial Jurisdiction at a Crossroads: An Intersection Between Public and Private International Law’, *American Journal of International Law*, No2 v76 1982 where he states that “Public international law regulates activity among

of access to medicines this has been recently highlighted with regard to the interpretation of the World Trade Organisation (WTO) agreement on Trade Related Aspects of Intellectual Property Rights¹⁸.

It is therefore not without significance that it has been noted that the relationship between human rights and trade is one of the central issues confronting international lawyers at the beginning of the twenty-first century and that any proposal which purports to marry, almost symbiotically, the two concerns warrants careful consideration¹⁹. In the field of health care in particular there has always been, and there is likely to always be, conflict between commercial interests and health service delivery issues due to the fact that health care goods and services are usually fundamental to survival and the capacity to be human in the fullest sense. The international community is unlikely to want to recognise that the right to health in international law must take precedence over the right to trade since it is driven by powerful global commercial interests. International human rights law and

human beings operating in groups called nation-states while private international law regulates the activities of smaller subgroups or of individuals as they interact with each other. Since the public international legal system co-ordinates the interaction of collective human interests through decentralized mechanisms and private international law coordinates the interaction of individual or subgroup interests primarily through centralized mechanisms, those coordinating functions are usually carried out in different forums, each appropriate to the task. The differences between the processes by which sanctions for violation of community norms are applied in the two systems and the differences in the nature of the units making up the communities that establish those norms tend to obscure the fact that both the public and private international systems coordinate human behaviour, and that the values that inform both systems must necessarily be the same."

18 Elliott R 'TRIPS and Rights: International Human Rights Law, Access to Medicines and the Interpretation of the WTO Agreement on Trade Related Aspects of Intellectual Property Rights' November 2001, www.aidslaw.ca, in which the author concludes that states' binding obligations to realize human rights have primacy in international law; that the TRIPS Agreement must therefore be interpreted in a fashion consistent with states' superseding obligations under international law to respect, protect and fulfil human rights; and where this is not possible, states' obligations under the TRIPS Agreement must be recognized as not binding to the extent that there is a conflict with their human rights obligations under international law. At the WTO Ministerial Conference in Doha in November 2001 a Declaration on the TRIPS Agreement and Public Health was issued which did not go quite as far but did include an agreement that the TRIPS Agreement does not and should not prevent members from taking measures to protect public health (www.globaltreatmentaccess.org/content/press_releases).

19 Alston P 'Resisting the Merger and Acquisition of Human Rights By Trade Law: A Reply to Petersmann' 1990-2004 *European Journal of International Law* www.ejil.org/journal/VolNo13/No4/art2 notes that George Soros has recently written: "The WTO opened up a Pandora's box when it became involved in intellectual property rights. If intellectual property rights are a fit subject for the WTO, why not labour rights, or human rights?" and that while Soros opposes such a development there is an increasing number of authors who have called for the 'constitutionalization' of the WTO and who consider that the inclusion of human rights within its mandate would help to overcome the democratic deficit from which it currently suffers. Alston states that: "In philosophical terms it is often difficult to distinguish means from ends and the same applies to abstract or scholarly discussions of human rights theory. But the international law of human rights - the most prominent, positivistic manifestation of which is contained in the UDHR and the two International Covenants - is clearly premised on the recognition of certain specific rights and the consequent downgrading of other values which can then be seen as means by which to attain certain rights but not as ends in themselves. It is true that this distinction has been blurred by governments which are more concerned to promote their ideological objectives than to protect the integrity of the corpus of human rights. This has been the case most notably in the context of the debates over the right to development, in which the right of individuals to an adequate standard of living has often been conflated with the 'right' of states both to limit the enjoyment of other human rights in the name of development and to receive development aid from richer states. But, far from justifying distortions of the concept of human rights in the name of higher ends, these largely unsuccessful and essentially unnecessary sorties have instead served to reinforce the need to respect the distinction between ends and means. Empirically, it is clear that human beings have been able to enjoy a full range of human rights in societies which do not recognize a human right to free trade as such. Indeed, given the rarity of such formal recognition and the constant threats to free trade in practice, it might not be an exaggeration to say that a list of countries respecting human rights including a right to free trade could be counted on the fingers of one hand."

international trade law would seem thus to be eternally bound on a collision course on a number of fronts.

Since international law is contained in a number of different instruments and doctrines it is necessary to examine these in greater detail in order to appreciate the implications at international law of a right to health care. Before an examination of the international law relating to the right to health care can be undertaken, the meaning of the term 'international law', particularly in the context of the Constitution, must be ascertained in order to understand the relationship between international law and domestic law as envisaged by the Constitution. More specifically, the concept of international law must be explored in view of the provisions of sections 39(1), 231, 232 and 233 of the Constitution.²⁰ The relationship between international law and domestic law is a complex one that depends largely upon the manner in which the particular domestic legal system concerned approaches international law.²¹ International law is a question of domestic legal perspective. With few exceptions there is no geographic area in the world in which international law exists independently of national or domestic law or where it is the only prevailing system of law. Even in those countries whose legal systems espouse automatic

²⁰ In terms of section 39(1), when interpreting the Bill of Rights, a court, tribunal or forum '(b) must consider international law'. In terms of section 231, only the national executive may negotiate and sign international agreements. An international agreement binds the Republic only after it has been approved by resolution in both the National Assembly and the Council of Provinces unless it is an agreement of a technical, administrative or executive nature or which does not require ratification or accession. According to section 231(4) any international agreement becomes law in the Republic when it is enacted into law by national legislation provided that a self-executing provision of an agreement that has been approved by Parliament is law in the Republic unless it is inconsistent with the Constitution or an Act of Parliament. Section 232 provides that: 'Customary international law is law in the Republic unless it is inconsistent with the Constitution or an Act of Parliament'. In terms of section 233: 'When interpreting any legislation, every court must prefer any reasonable interpretation of the legislation that is consistent with international law over any alternative interpretation that is inconsistent with international law'.

²¹ Opekin BR 'Constitutional Modelling - A Case Study of the Relationship between Domestic Law and International Law' <http://www.eur.nl/frg/jaol/papers/opekin.htm> highlights some of the significant questions that arise in this regard as follows:

- Do the rules of public international law have direct effect as part of the domestic legal system? Different answers may be given to this question in relation to different sources of international law, namely, treaties, customary international law, general principles of law or any combination of these.
- If rules of public international law do have direct effect, do they take precedence over domestic law?
- Whether or not there is general provision for rules of public international law to have direct effect as part of the domestic legal system, are some particular rules (for example, human rights norms) given that effect?
- Which institutions of government are recognised as competent to negotiate, sign and ratify treaties, and specifically, do these include the legislative organs of government?
- Which institutions of government have power to implement treaties in domestic law?
- Does the constitution permit or require consideration to be given to rules of public international law when interpreting domestic laws?
- In federal states, how is power allocated between central and regional authorities in respect of the negotiation, signature or ratification of treaties, on the one hand or the implementation of treaties on the other?

incorporation, as opposed to legislative incorporation, of international law into their domestic legal systems, this incorporation is by virtue of domestic, often constitutional, legal provisions rather than any stipulation within international law itself. Consensus of nation states is a key ingredient for the viability as law of international legal principles. An exploration of the approach of the South African Constitution to questions of international law is thus key to an examination of the extent to which international legal norms and standards concerning a right to health care are applicable in South Africa.

1. It has been proposed,²² for purposes of section 39(1) of the Constitution, that the term 'international law' should be interpreted with regard to Article 38(1) of the Statute of the International Court of Justice²³. The acceptability of this proposal depends upon one's location upon the spectrum of monism and dualism²⁴ - whether one is prepared to allow international law to define itself with regard to a domestic system of law or whether one looks to the domestic law's view of international law for the meaning of the term 'international law'. A further question is whether the description of international law in Article 38(1) of the Statute of the International Court of Justice may also be used with regard to the term 'international law' as used in section 233 of the Constitution. The context in which the term is used in the Constitution is relevant to the extent that 'international law' could be interpreted as including all forms of international law such as customary international law and *jus cogens* or it could be regarded as meaning only *public* international law. The term 'international law', in its Article 38(1) sense, may not be suitable for purposes of section 233 of the Constitution as further discussion will reveal. With regard

²² By Dugard J (see fn 23 *infra*) with reference to the equivalent provision in the Interim Constitution (section 35(1)) which, in contrast to the Constitution, uses the term 'public international law'. Section 35(1) states that: "In interpreting the provisions of this Chapter a court of law shall promote the values which underlie an open and democratic society based on freedom and equality and shall, where applicable, have regard to public international law applicable to the protection of the rights entrenched in this Chapter, and may have regard to comparable foreign case law."

²³ Article 38(1) states as follows:
"The Court, whose function is to decide in accordance with international law such disputes as are submitted to it, shall apply:
a. international conventions, whether general or particular, establishing rules expressly recognized by the contesting states;
b. international custom, as evidence of a general practice accepted as law;
c. the general principles of law recognized by civilized nations;
d. subject to the provisions of Article 59, judicial decisions and the teachings of the most highly qualified publicists of the various nations, as subsidiary means for the determination of rules of law."
The court in *S v Makwanyane and Another*, 1995 (3) SA 391 (CC) in footnote 46, referred to Dugard J in van Wyk D *et al* (eds) *Rights and Constitutionalism: The New South African Legal Order* at 192-5 in which Dugard suggested that s35 of the interim Constitution [the equivalent of section 39 of the current Constitution] requires regard to be had to "all the sources of international law recognized by Article 38(1) of the Statute of the International Court of Justice".

²⁴ See discussion at section 1.2 of the text below.

specifically to the right of access to health care services²⁵, the right to emergency medical treatment²⁶, the rights of the child to basic health care services²⁷ and the rights of prisoners to medical treatment at state expense²⁸, a meaningful consideration of international law must seek to ascertain –

1. Whether there is any customary international law relating to such rights and the extent to which it is law in South Africa in terms of section 232 of the Constitution;
2. Whether there is any public international law, for example international treaties and conventions, on the subject of such rights, which is binding upon South Africa in terms of section 231 of the Constitution, or which must be taken into consideration by a court, tribunal or forum in terms of section 39 of the Constitution when interpreting the Bill of Rights;
3. Whether there are any peremptory norms in terms of *jus cogens* regarding such rights and if so what these are and whether they are applicable in South Africa;
4. Whether there is scope for the application of legal principles embodied in private international legal instruments in terms of sections 39(1) and 233 of the Constitution.

It is the object of this chapter to explore these and related questions.

1.2 Monism and Dualism

²⁵ Section 27(1) of Act 108 of 1996

²⁶ Section 27(3) of Act 108 of 1996

²⁷ Section 28(1)(e) of Act 108 of 1996

²⁸ Section 35(2)(e) of Act 108 of 1996



There are two opposing views of international law, described as ‘monistic’²⁹ and ‘dualistic’³⁰ respectively³¹. According to the former, international law and national law comprise a single integrated legal system whereas according to the latter, international law and domestic law are two discrete legal systems. Permutations of these extremes complicate matters. Thus monism may be relevant within a domestic legal system with regard to one area of international law, for example, customary international law, and dualism to another, for example treaty law. Dualism at its most extreme proposes that international law exists only as manifested in domestic courts and that the only real law is the law of any given nation³². Hans Kelsen, on the other hand, expresses the opposite “monistic view” that international law is supreme over the domestic law of all nations. Whenever there is a rule of international law, it supersedes any domestic rule that is inconsistent with it. In terms of Kelsen’s theory, if a nation enacts domestic law that is inconsistent with a rule of international law, and if that nation’s courts proceed to apply the domestic rule instead of the international rule, then - as far as international law is concerned – that nation has violated international law³³.

From an international law perspective, irrespective of the provisions of the Constitution, states cannot invoke their domestic law as a justification for not adhering to international legal norms³⁴. The observation of basic human rights, it has been argued, is an international legal norm³⁵. In fact, it has been argued that observation of human rights

²⁹ See for example *S v Makwanyane and Another* (fn 23 *supra*) cited by Motale Z and Ramaphosa C *Constitutional Law: Analysis and Cases* as an example of monism. See, however the further discussion of *Manyane’s* case below in which it is questioned that the court’s approach is in fact monistic.

³⁰ See for example *Azanian People’s Organisation (Azapo) and Others v The President of the Republic of South Africa* (fn 2 *supra*) cited by Motale and Ramaphosa (fn 29 *supra*) as an example of dualism.

³¹ “The monistic tradition derives from natural law theories which see all law as the product of reason. On this view no conflict can arise between international law and domestic law because both are derived from the same source. International law is thus seen to be automatically a part of the domestic legal order, as it is in many civil law systems. The decline of natural law thinking and the rise of legal positivism led, however, to the development of dualism. Dualism sees international law and domestic law as operating on separate planes – the former stipulates norms governing the relations between national states, the latter those governing the relationship between individuals within the state or between individuals and the state. Under the dualist conception, international law plays no roles in the domestic legal order except in so far as domestic law adopts an international rule.” Opekin BR fn 21 *supra*

³² Chapter Eleven: International Law in US Courts p261 <http://anthonydamato.law.northwestern.edu/ILC-2001/INTLAW11-2001-edited.pdf>

³³ See Anthony D’Amato fn 11 *supra* p261

³⁴ According to the Vienna Declaration and Program of Action, World Conference on Human Rights, Vienna, 14-25 June 1993, U.N. Doc A/CONF.157/24, while ‘national and regional particularities and various historical, cultural and other religious backgrounds must be borne in mind, it is the duty of states, regardless of their political, economic and cultural systems, to promote and protect all human rights and fundamental freedoms.’

³⁵ Dugard J ‘Public International Law’, Chaskalson M, Kentridge J, Klaaren J, Marous G, Spitz D, Woolman S *Constitutional Law of South Africa* 13-7

forms part of the peremptory norms of the *jus cogens* from which no state can lawfully deviate. This aspect of international law will be dealt with in more detail below. South Africa is a party to the United Nations Charter and is therefore obliged to respect human rights³⁶. The validity and applicability of international law within a domestic legal system is dependent upon which theoretical view is supported. The dualist view has been criticised as anachronistic³⁷ and contrary to the principles of international law itself³⁸. It is, however, very much alive and from a practical viewpoint seems to be the norm rather than the exception³⁹. The sovereignty of states is a key factor in dualist arguments and it has been frequently invoked by even developed countries in international conferences and forums to ground an essentially dualist approach to the relationship between international and domestic legal systems⁴⁰. Some scholars dispute the existence of *jus cogens*⁴¹. Others observe that in international law the existence of a body of *jus cogens*, peremptory norms from which no state can derogate, has been evidenced by over forty years of thought and debate within the relevant scholarly and political communities⁴².

If one regards international human rights law as a separate, specialised branch of international law then the question of whether or not it operates monistically or dualistically in relation to domestic law cannot be answered with reference to the more general categories of international law such as public international law or customary international law. As noted previously there is quite a strong argument in favour of this view. It might be possible to argue that even if monism is not the state of affairs between

³⁶ Dugard 'Public International Law', Chaskalson Kentridge Klaaren Marous Spitz Woolman fn 35 *supra* at 13-8

³⁷ See Motale and Ramaphosa *supra* fn 29 at 38

³⁸ Article 53 of the Vienna Convention on the Law of Treaties, May 23, 1969, 1155 U.N.T.S states that "A treaty is void if, at the time of its conclusion it conflicts with a peremptory norm of general international law. For the purposes of the Convention, a peremptory norm of general international law is a norm accepted and recognized by the international community of states as a whole as a norm from which no derogation is permitted and which can be modified only by a subsequent norm of general international law having the same character."

³⁹ Countries that subscribe to dualism include: South Africa, the United Kingdom of Great Britain and Northern Ireland, Sweden, Mali, Lesotho, New Zealand, Nigeria, Senegal, Ireland, Japan, Italy, India, France, Belgium, the United States of America, Australia, Denmark, Canada, Norway and Thailand. (See International Humanitarian Law: National Implementation <http://www.help.icrc.org>)

⁴⁰ For example, it was used by France, the United States of America and Belgium in the course of proceedings concerning the United Nations Convention on the Law of the Sea (UNCLOS). See further discussion below.

⁴¹ Peritt Jr, 'Symposium on the internet and legal theory: The Internet is Changing International Law (fn 2 *supra*)

⁴² Kahgan C 'Jus Cogens and the Inherent Right to Self-Defense' www.nsulaw.nova.edu. See also Danilenko GM 'International Jus Cogens: Issues of Law-Making' *European Journal of International Law* 1990-2002 where he observes that: "The idea of international *jus cogens* as a body of 'higher law' of overriding importance for the international community is steadily gaining ground. First embodied in the 1969 Vienna Convention on the Law of Treaties, it was recently confirmed by the 1986 Vienna Convention on the Law of Treaties. In its judgement in the *Nicaragua Case* [ICJ Reports (1986) 100] the International Court of Justice (ICJ) clearly affirmed *jus cogens* as an accepted doctrine in international law."

the domestic legal system and other branches of international law, it could still be said to prevail in the relationship between the domestic legal system and international human rights law. In the case of customary international law one is beset with evidentiary problems as to its existence before even beginning to consider whether or not it is applicable and the nature of its relationship to a domestic legal system⁴³. To make matters worse customary rules are not static. They change in content depending upon the amplitude of new vectors (state interests)⁴⁴. Whilst public international law does not have the same evidentiary problems one can argue that unless a state is a party to the relevant treaty or international agreement, it is difficult to argue that it has accepted that particular law as being seamlessly integrated into its domestic legal system⁴⁵.

The problem with international human rights as law is that there is apparently no mechanism at international law for dealing with human rights violations. There is no international court of human rights⁴⁶. If states cannot be held responsible for human rights violations and they are not signatories to the relevant international human rights instruments, it is difficult to see how an argument for monism can be made except at the

⁴³ In 'General Principles and Sources of the Law' (<http://lawofwar.org/principles.htm>) it is noted that: "Custom is an important source of international law but proving its existence may be problematical. In determining whether a valid and binding custom exists the parties must consider not only the amount of usage, but also its weight; that is, whether the custom asserted is practiced by nations with an interest in the matter, and just how much of an interest they really have." In the case of *West Rand Central Gold Mining Company v The King* (2 K.B. 391 [1905]) the court observed that: "There is an essential difference, as to certainty and definiteness, between municipal law and a system or body of rules in regard to international conduct, which, so far as it exists at all (and its existence is assumed by the phrase 'international law') rests upon a consensus of civilized states, not expressed in any code or pact, nor possessing, in case of dispute, any authoritative interpreter; and capable, indeed, of proof, in the absence of some express international agreement, only by evidence of usage to be obtained from the action of nations in similar cases in the course of their history."

⁴⁴ D'Amato A 'Trashing Customary International Law' 81 *American Journal of International Law* 101 (1987). He points out that human rights interests, for example, have worked a revolutionary change upon many of the classic rules of international law as a result of the realization by states in their international practice that they have a deep interest in the way other states treat their own citizens.

⁴⁵ Mansson J 'EC Law vs National Law? A Brief Theoretical Examination' *Juridisk Tidskrift*, 1994-95 p 659 observes that "...pure monism is hard to defend since it fails to take into consideration the realities of political power relations." He states "Carefully analysing Kelsen's Stufenbau theory (by which states derive their powers from, and within the limits of, the superior system of international law, so that a states exercise of power rests on the Grundnorm provided by international law), Bleckman concludes that it runs into insurmountable problems when confronted with the realities of international law and power politics. An examination of the practices of states would, at the very most, leave Kelsen with a situation in which international law is recognized by, and sets some limits on, the legal systems of basically sovereign states."

⁴⁶ Kantsin (fn 6 *supra*) asks "How are victims of violations to seek remedy? Or more cogently, can remedy be sought at the international level at all?" He points to the observation of Cassese A, that: "The arrival of human rights on the international scene is, indeed a remarkable event because it is a subversive theory destined to foster tension and conflict among states" and goes on to remark that human rights treaties, like other international treaties, in the words of Fitzmaurice G, "are a source of obligation rather than a source of law. In their contractual aspect, they are no more a source of law than an ordinary private law contract." In keeping with this, states are not themselves criminally liable for breaching human rights treaties, not even in cases of crimes against humanity, according to the recently adopted Draft Articles on Responsibility of States for Internationally Wrongful Acts (2001), elaborated by the International Law Commission (ILC)."

most academic and abstract level⁴⁷. It has been pointed out that the most commonly held rationale for the relevance of international law, and especially treaties, to national conduct is based on the notion of consent. This argument begins with the claim that sovereign states are not subject to any obligation unless they have consented to it⁴⁸. If this theory holds then monism cannot. The applicability of international human rights law is then subject to the consent of individual nation states and does not exist independently of their goodwill and co-operation.

It is submitted that evidence in support of monism is scant to say the least even with regard to international human rights law. Savaneli⁴⁹ points out that the legal personality of the individual in the contemporary international law still remains controversial and that it seems still difficult to formulate one doctrine which reflects both a general consensus between scholars as well as lawyers of different legal systems. If the legal personality of the individual at international law is still the subject of such debate it is difficult to argue that the rights of the individual at international law are automatically the same as those within domestic legal systems.

1.3 The Constitutional Approach To International Law

Sections 232 and 233 of the Constitution do not lend complete support to the monistic view of international law⁵⁰. The fact that section 232 of the Constitution expressly singles out customary international law as being law in South Africa unless it is inconsistent with the Constitution or an Act of Parliament, means that other forms of international law do

⁴⁷ Moghalu KC 'Justice as a Global Commons: Global Responses to Judicial Challenges in Africa' (paper presented in 2002 at the African Dialogue II Conference Convened by the Office of the United Nations High Commissioner for Human Rights on the theme 'Promoting Justice and Reconciliation in Africa') points out that "the very idea of international criminal justice for violations of international humanitarian law is predicated for its workability on the cooperation of states with the international criminal tribunals." He asks "If decisions of the Security Council ought to be automatically binding on states, why does Article 2 of Resolution 955 request states to take any measures necessary under their domestic law to implement the provisions of the resolution and the Tribunals Statute?" and notes that in making it mandatory for states to take necessary measures under their domestic law, the Council, intentionally or not, makes a practical recognition of the theories of monism and dualism in the relation between international law and municipal law. According to monism, international law and state laws are mutually reinforcing aspects of one system – law in general...Dualists believe that the juridical origins of state law and international law are fundamentally different... Thus in the dualist view, for international law to apply within the domestic sphere, it needs to be enabled, empowered or validated by domestic legislation."

⁴⁸ Guzman AT 'A Compliance Based Theory of International Law' (<http://www.berkeley.edu>)

⁴⁹ Savaneli, (fn 1 *supra*)

⁵⁰ Dugard, 'Public International Law', Chaskalson Kentridge Klaaren Marous Spitz Woolman (fn 35 *supra*) 13-4

not necessarily enjoy the same status⁵¹. The provisions of section 232 also mean that domestic statutory law and the Constitution take precedence over customary international law⁵² - an essentially dualist approach. Under section 231(4) of the Constitution an

⁵¹ It has been observed that the provisions of section 232 may have little substantive effect because the codification of international law in the post-war era has significantly reduced the practical relevance of customary international law to the domestic legal system. (Opekin in 21 *supra*). This view may be overly simplistic. See, for instance, Kinney D "The International Human Right To Health: What Does This Mean For Our Nation and Our World?" *Indiana Law Review* 2001, 34, 1457 where she observes that under the principles for the development of customary international law, widespread ratification of UN and regional treaties and other instruments recognizing international human rights establishes an international customary law of human rights. She notes that specifically treaties, declarations and other instruments become evidence of a general state practice in which states engage out of a sense of legal obligation. As evidence of general practice followed out of a sense of legal obligation, they establish human rights obligations in the instrument as customary international law. Thus, for example, the International Convention on Economic, Social, and Cultural Rights (ICESCR) is arguably customary international law due to its widespread acceptance internationally. Kinney's approach would have the effect in many instances of bypassing the provisions of section 231 of the Constitution effectively implementing by way of customary international law, the provisions of international agreements which have not been negotiated, signed or ratified in terms of section 231. Her argument is an intriguing example of the lemniscate discussions that seem to characterise international law. It seeks to effect or promote a monistic outcome apparently by accepting and using an essentially dualist rationale.

⁵² The question is whether the same applies to provincial constitutions and legislation which does not technically constitute "the Constitution or an Act of Parliament". The Constitution refers to "Acts of Parliament and provincial Acts" in section 27 of Schedule 6. In terms of section 104(3) a provincial legislature is bound only by the Constitution and, if it has passed a constitution for its province, also by that constitution, and must act in accordance with the limits of the Constitution and that provincial constitution. The question is of particular relevance in the health care context due to the fact that health services are a functional area listed in Schedule 4 over which provinces have legislative competence. The Constitution itself does not define the term "Act of Parliament". In *Zantzi v the Council of State (Ciskei) and Others*, 1995 (4) SA 613 (CC) the constitutional court held that the term "Act of Parliament: as used in the sections of the Constitution relating to the jurisdiction of the supreme court included Acts of the Parliament of the Republic of South Africa passed before and after the coming into effect of the Constitution but excluded laws passed by the legislatures of the four nominally independent homelands. The Interpretation Act 33 of 1957 defines "law" as "any law proclamation ordinance, Act of Parliament or other enactment having the force of law" and "parliament" as the Parliament of the Republic". Many provinces currently have their own substantial health legislation in place. Municipal health services are listed in Part B of Schedule 4 and both the national and provincial governments have legislative competence over such health services subject to the conditions laid down in the Constitution. If there is a conflict between international customary law and a provincial Act or constitution what would be the legal position? Logic dictates that such a situation could be resolved with regard to sections 146 and 147 of the Constitution except that these sections deal only with conflicts between national and provincial legislation as opposed to national and provincial law. Customary international law is not legislation in the sense of codified law. If customary international law has the same status as national law then it should apply within the provinces to the exclusion of contradictory provincial law except under circumstances similar to those contemplated within sections 146 and 147 of the Constitution. For example, there prior to the National Health Act which was just recently enacted, there was no national legislation dealing with the right to health care services as expressed in the Constitution. However, the KwaZulu Natal Health Act conferred certain rights pertaining to health care upon residents of KwaZulu-Natal. One of these is that "A health care user is entitled to the progressive realisation within the Province's available resources, to the right of access to primary health care services" (Section 29(2)(b) of the KwaZulu-Natal Health Act, No 4 of 2000). The International Convention on Economic, Social and Cultural Rights, however, states that everyone has the right to the enjoyment of the highest attainable standard of physical and mental health. If one assumes, for purposes of illustration, that in terms of customary international law this has been consistently interpreted to mean a right of access to the full range of health care services available in a particular region as opposed to just primary health care services, how would the courts approach this provision in the KwaZulu-Natal Health Act in the absence of the national legislation? It is not an Act of Parliament. There would be no national legislation against which it could be measured except the Constitution. The Constitution states that customary international law is law in South Africa unless it is in conflict with the Constitution or an Act of Parliament. It might be possible to invoke the available resources argument to show that the KwaZulu-Natal Health Act is in fact consistent with the ICESCR but the fact of the matter is that more than just primary health care services are available in KwaZulu-Natal although the other services are probably not as widely available as the primary health care services. The KwaZulu-Natal Act has clearly adopted a 'lowest common denominator' approach to the subject of the right to health care services which, as discussion in later chapters will reveal, is not necessarily constitutional neither is it the best approach to adopt when dealing with human rights issues in which the interests of the individual as opposed to that of the group are often emphasised. The converse question is whether provinces can enact the terms of international agreements and other instruments of international law into provincial legislation which have not been enacted into national legislation. Strictly speaking, provided that a province has legislative competence (which it does in the case of health care services) in a particular area, there appears to be no legal obstacle to the enactment of legislation in terms that reflect those of an international agreement or other instrument of international law. It will probably not be possible to incorporate the treaty or covenant in question into provincial law by direct reference due to the provisions of section 231 but it is difficult to see how a province could be prevented from enacting the terms and provisions similar to those of an international covenant or treaty into provincial law - especially in the absence of national framework legislation on the

international agreement is not law in the Republic unless it is enacted into law by national legislation. The Constitution's support of the right of the South African people as a whole to self-determination⁵³ serves to underline the fact that the approach of the South African legal system to international law is dualist. In terms of section 2 of the Constitution, it is the 'supreme law' of the Republic and law or conduct inconsistent with the Constitution is invalid. The Bill of Rights applies 'to all law and binds the legislature, the executive, the judiciary and all organs of state'⁵⁴. However, the Constitution does require consistency with international law where this is reasonable since, when interpreting any legislation, every court must prefer any reasonable interpretation that is consistent with international law over any alternative interpretation that is inconsistent with international law⁵⁵. The relationship of international law to South African common and customary law is not directly expressed in the Constitution. In terms of section 39(2) when developing the common law or customary law, every court, tribunal or forum must promote the spirit, purport and objects of the Bill of Rights. Since in terms of section 39(1) when interpreting the Bill, courts must consider international law, this will result in an indirect influence by international law on customary and common law. The Bill of Rights, in terms of section 39(3) does not deny the existence of any other rights or freedoms that are recognized or conferred by common law, customary law or legislation, to the extent that they are consistent with the Bill. The provisions of section 231 explain in some detail at what point other forms of international law, such as international agreements⁵⁶ become law in South Africa. In view of the Constitution's largely dualistic approach it is therefore necessary to consider from a constitutional perspective, rather than an international law perspective, questions of 'international law' and 'customary law'.

1.3.1 Section 39(1)

subject. The existence of the National Health Act No 61 of 2003 now renders this discussion somewhat academic but it does illustrate the importance of being alive to these technical legal issues.

⁵³ Section 235 of Act 108 of 1996

⁵⁴ Section 8 of Act 108 of 1996

⁵⁵ Section 233 of Act 108 of 1996

⁵⁶ These include treaties, conventions, declarations, charters, covenants, pacts, protocols and exchanges of notes (see Dugard *fn* 35 *supra* at 13-1)

The primary difference between section 39(1) of the Constitution and the other sections that deal with international law is that the former requires the use of international law as an interpretational tool whereas the latter indicates the legal status of various areas of international law within the Republic⁵⁷. From the point of view of the interpretation of the rights relating to health care services in the Constitution, this is an important distinction because it means that a court can have regard to the numerous treaties, covenants, conventions and other international legal instruments on the subject whether or not they have been enacted into law in South Africa. How then does one use international law as an interpretational tool in understanding the rights in the Bill of Rights? A consideration of existing case law on the interpretation and application of section 35(1) of the interim Constitution⁵⁸ and section 39(1) of the Constitution would be beneficial to an understanding of the approach of the courts to the injunction to consider international law when interpreting the Bill of Rights. In *S v Makwanyane*⁵⁹ the court held with reference to section 35(1) of the interim Constitution that:

“In the context of section 35(1), public international law would include non-binding as well as binding law. They may both be used under the section as tools of interpretation. International agreements and customary international law accordingly provide a framework within which chapter 3 can be evaluated and understood, and for that purpose, decisions of tribunals dealing with comparable instruments, such as the United Nations Committee on Human Rights, the Inter-American Commission on Human Rights, the Inter-American Court on Human Rights, the European Commission on Human Rights, the European Court of Human Rights and, in appropriate cases, reports of specialised agencies such as the International Labour Organisation, may provide guidance as to the correct interpretation of particular provisions of chapter 3.”

Analysis of this statement reveals that the court is advocating a very wide definition of the term ‘public international law’. It must be seen as inclusive of international agreements, customary international law and decisions of international tribunals dealing with comparable instruments. The reference in the judgment to reports of “specialised agencies” such as the International Labour Organisation even suggest that for the purposes of section 39(1) in appropriate cases, private international law may be of relevance in the interpretation of particular provisions of chapter 3 of the Constitution. The court is thus effectively construing ‘public international law’ as ‘international law’ in

⁵⁷ *Government of the Republic of South Africa and Others v Grootboom and Others* 2001(1) SA 46 (CC) at 63

⁵⁸ Interim Constitution, Act No 200 of 1993

⁵⁹ *Makwanyane* fn 23 *supra*

the fullest sense⁶⁰. A further point deserving of attention is the fact that the section is being interpreted by the court to mean that the consideration of international law does not mean the application of international law but rather the application of national law interpreted in a manner that is consistent with international law if more than one interpretation of a particular right in the Bill of Rights exists. This would be in keeping with the provisions of section 233 which require the courts to prefer any reasonable interpretation of any national legislation that is consistent with international law. It should also be noted that the court did not regard the use of an interpretation of a similar right at international law to evaluate and understand a right in the Bill of Rights as mandatory but rather as a guideline. The injunction in section 35(1) to consider international law was not interpreted by the court to mean that international law interpretations of rights appearing in the Bill of Rights must be exclusively applied. In *Grootboom*⁶¹, the court held that:

“The relevant international law can be a guide to interpretation but the weight to be attached to any particular principle or rule of international law will vary. However where the relevant principle of law binds South Africa, it may be directly applicable.”

The court then went on to consider the question of minimum core content.⁶²

The statement of the court in *Grootboom* highlights the two different roles of international law. The one is that of interpretational tool. The other is its application as law where it satisfies the provisions of sections 231 and 232 of the Constitution. Where the rule of international law under consideration is customary international law which is not in conflict with the provisions of the Constitution or an Act of Parliament, the rule of customary international law may be used as an interpretational tool in terms of section 39 but, where applicable, it must also be applied as law in South Africa. Where the rule of international law is in conflict with the provisions of the Constitution or an Act of Parliament, it may only be used as an interpretational tool⁶³. Similarly where a rule of public international law has been enacted into law as contemplated by section 231(4), the

⁶⁰ This may explain the substitution of the latter term for the former in the final Constitution.

⁶¹ *Grootboom* fn 57 *supra*

⁶² See later for further discussion

⁶³ But see later the further discussion concerning the use of law that is in conflict with the Constitution or an Act of Parliament as an interpretational tool.

rule can be used as an interpretational tool and, where it is directly applicable as law, it must be applied as such. If the approach in *S v Makwanyane*⁶⁴ is adopted then all relevant international law must be considered whether or not it is binding since it is being used as an interpretational tool. Whether or not it is binding within South Africa and upon whom is a separate issue.

The question of the applicability of international law was also raised in the case of *Azanian Peoples Organisation (Azapo) and Others v The President of the Republic of South Africa*⁶⁵. The court observed with regard to the provisions of section 231(1) and 231(4)⁶⁶ of the interim Constitution:

“These subsections of the Constitution would, it would seem, enable Parliament to pass a law even if such law is contrary to the *jus cogens*. The intention to legislate contrary to the *jus cogens* would, however, have to be clearly indicated by Parliament in the legislation in question because of the *prima facie* presumption that Parliament does not intend to act in breach of international law.”

The idea that a nation state may legitimately enact law that is contrary to a principle of *jus cogens* is anathema to protagonists of the concept of *jus cogens* at international law⁶⁷. The interrelationship between section 35(1) and the other provisions of the Constitution dealing with international law was discussed in the same case by the constitutional court. Mahomed DP held in the *Azapo*⁶⁸ case that:

“It is clear from this section [section 231(1)]⁶⁹ that an Act of Parliament can override any contrary rights or obligations under international agreements entered into before the commencement of the Constitution. The same temper is evident in s 231(4) of the Constitution, which provides that: ‘(t)he rules of customary international law binding on the Republic, shall, unless inconsistent with this Constitution or an Act of Parliament, form part of the law of the Republic’. Section 35(1) of the Constitution is also perfectly consistent with these conclusions. It reads as follows:

⁶⁴ *Makwanyane* fn 23 *supra*. As to the post interim Constitution relevance of *Makwanyane*, the constitutional court has stated in *Mohamed and Another v President of the Republic of South Africa and Others (Society for the Abolition of the Death Penalty in South Africa and Another Intervening)* 2001 (3) SA 893 (CC): “There is nothing in the final Constitution of the Republic of South Africa Act 108 of 1996 to suggest that *Makwanyane* has ceased to be applicable - on the contrary, the values and provisions of the interim Constitution relied upon in *Makwanyane* are repeated in the 1996 Constitution.”

⁶⁵ *Azanian Peoples Organisation (Azapo) and Others v The President of the Republic of South Africa* (fn 2 *supra*)

⁶⁶ “The rules of customary international law binding on the Republic shall, unless inconsistent with this Constitution or an Act of Parliament, form part of the law of the Republic.”

⁶⁷ See below for further discussion.

⁶⁸ *Azapo* see fn 2 *supra*

⁶⁹ In the final Constitution this situation was remedied by section 231(5) according to which the Republic is bound by international agreements which were binding on the Republic when the Constitution took effect.

‘In interpreting the provisions of this chapter a court of law shall promote the values which underlie an open and democratic society based on freedom and equality and shall, where applicable, have regard to public international law applicable to the protection of the rights entrenched in this chapter, and may have regard to comparable foreign case law. The Court is directed only to ‘have regard’ to public international law if it is applicable to the protection of the rights entrenched in the chapter.’⁷⁰

The final Constitution is not as restrictive in that it does not specifically require that only public international law that is applicable to the protection of the rights entrenched in the chapter must be considered. It simply requires that international law be considered. This view of the constitutional court, as expressed in *Azapo*⁷¹ that domestic law takes precedence over international law has been criticised as being contrary to international law⁷². It is submitted that particularly in the context of section 39(1), this is not a valid criticism since the most that the courts are required to do is ‘consider’ international law. The Constitution adopts a dualist approach⁷³. Courts that seek to apply a monistic

⁷⁰ See *Dawood and Another v Minister of Home Affairs and Others; Shalabi and Another v Minister of Home Affairs and Others; Thomas and Another v Minister of Home Affairs and Others* 2000 (1) SA 997 (C) at 1034 in which the Cape Provincial Division observed that: Section 39(1) of the “Constitution provides that a court, when interpreting the Bill of Rights, ‘(b) must consider international law; and (c) may consider foreign law’. As pointed out by Chaskalson P in *S v Makwanyane and Another* (fn 23 *supra*) at para [39] “[i]n dealing with comparative law we must bear in mind that we are required to construe the South African Constitution, and not an international instrument or the constitution of some foreign country, and that this has to be done with due regard to our legal system, our history and circumstances, and the structure and language of our own Constitution. We can derive assistance from public international law and foreign case law, but we are in no way bound to follow it. It must, however, also be borne in mind that ‘the lawmakers of the Constitution should not lightly be presumed to authorise any law which might constitute a breach of the obligations of the state in terms of international law’ (per Mahomed DP in *Azanian Peoples Organisation (AZAPO) and Others v President of the Republic of South Africa and Others* 1996 (4) SA 671 (CC) (1996 (8) BCLR 1015) at para [26], read together with paras [27] and [28]; see also *Prince v President of the Law Society, Cape of Good Hope and Others* 1998 (8) BCLR 976 (C) at 985C - H and 989A - 990A).”

⁷¹ *Azapo* fn 2 *supra*

⁷² Motale Z and Ramaphosa C (fn 29 *supra*) who state at 38: “The Court erroneously adopted the position in *Azapo* that international human rights protections are not part of the South African Constitution unless they are adopted by the legislature. In the *Azapo* decision the Court should have interpreted s35(1) of the Constitution as Mokgoro J did in *Makwanyane*, as an obligation that requires ‘courts to proceed to public international law and foreign case law for guidance in constitutional interpretation, thereby promoting the ideal and internationally accepted values in the cultivation of a human rights jurisprudence for South Africa.’”

⁷³ Dugard J, ‘International Law and the South African Constitution’ *European Journal of International Law* argues that the South African common law “adopts the monist approach to customary international law. Customary international law is part of South African law and courts are required to ‘ascertain and administer’ rules of customary international law without the need for proof of law – as occurs in the case of foreign law.” He observes that as a species of common law, customary international law is subordinate to all forms of legislation. He then goes on to state that the common law is given constitutional endorsement by section 232 of the 1996 Constitution which, in language substantially similar to the Interim Constitution, provides that: “Customary international law is law in the Republic unless it is inconsistent with the Constitution or an Act of Parliament.” In saying that the Constitution has endorsed the common law position of international customary law in South Africa, Dugard is apparently saying that the Constitution is monist in its approach. If one looks closely at his discussion of the wording of section 231(4) of the Interim Constitution which provided that “the rules of customary international law binding on the Republic shall, unless inconsistent with this Constitution or an Act of Parliament, form part of the law of the Republic” [writer’s italics] the matter is not that out and dried. He points out that the omission of the word ‘binding’ from the final Constitution has led one commentator to argue that all rules of customary international law, including those to which South Africa may have ‘persistently objected’ are part of municipal law. In a neat bit of sophistry that fully exploits the looseness of the concept of customary international law, Dugard avoids this argument by saying that the better view is that the word ‘binding’ was dropped from the 1996 Constitution on the grounds that it was considered to be unnecessary and indeed tautologous. As far as South Africa is concerned, a practise to which it has persistently objected is simply not a customary rule.” He then goes on to concede that on the other hand there can be little doubt that the omission of the word ‘binding’ will facilitate the proof of customary international law. It is submitted that the sophistry lies in saying that South African law follows a monist approach only in terms of its own definition of customary international law. Thus where

approach therefore run the risk of acting unconstitutionally. International law must therefore be considered from the perspective of domestic law generally and the Constitution specifically. As stated previously, they are not obliged to apply international law unless it has become law in South Africa as contemplated in sections 231 and 232 of the Constitution. The courts have stressed the need to take cognisance of South Africa's legal system, its history and circumstances and the structure and language of its Constitution⁷⁴. It is clear from the various *dicta* of the courts on this subject that a cautious and rational approach to the consideration of international law when interpreting the Bill of Rights, which takes into account the unique identity of South Africa as a

South Africa has persistently objected to a rule of customary international law that other nation states regard as customary international law, it does not constitute customary international law for the purposes of the Constitution. This is despite the fact that Dugard goes on to recognize that while early South African decisions hold that only those rules of customary international law that have been *universally* recognized by states form part of South African law, later decisions hold that *general* acceptance is sufficient. Dugard's argument is also in conflict with the decision in *S v Petane* 1988 (3) SA 51 (C) in which the court observed that in *Nduli and Another v Minister of Justice and Others* 1978 (1) SA 893 (A), the Appellate Division accepted that customary international law was, subject to its not being in conflict with any statutory or common municipal law, directly operative in the national sphere. The Appellate Division described the attributes of a rule of customary international law which would make it applicable in South Africa. It would have to be either universally recognised or it would have to have received the assent of this country. In holding this, the court referred to a passage in Oppenheim *International Law (Lauterpacht)* 8th ed vol 1 at 39 which states the conditions concerning universal acceptance or state assent for recognition of a rule of customary international law as part of the law of England saying that: "Our law and English law in this respect is therefore the same. It is not clear to me whether Rumpff CJ in giving the judgment meant to lay down any stricter requirements for the incorporation of international law usages into South African law than the requirements laid down by international law itself for the acceptance of usages by states. International law does not require universal acceptance for a usage of states to become a custom. Margo J, in giving the judgment of the Full Transvaal Court in *Inter-Science Research and Development Services (Pty) Ltd v Republica Popular de Mocambique* 1980 (2) SA 111 (T) did not think that the word 'universal', despite its ordinary meaning, was really intended to mean universal. I do not think so either. In the present case, however, the distinction between universal and general recognition makes no difference. I am prepared to accept that where a rule of customary international law is recognised as such by international law it will be so recognised by our law [writer's italics]. Monism, it is submitted, contains the seeds of its own destruction in the sense that it is an all or nothing theory. Either international law applies equally within all domestic jurisdictions or it does not. How can it apply in some jurisdictions but not others if monism is a characteristic of international law itself rather than a concession of a sovereign state? Either it is binding at an objective level of certainty across all nation states or it fails as an argument. The moment that considerations of relativity come into play – one state subscribes to monism but another to dualism; one area of international law, eg *jus cogens*, applies within all states but another applies only with the consent of nation states; a single state, at its discretion, regards certain international legal provisions as binding but not others – monism is defeated. As such it is a concept of extremely limited value. It is clear from discussions elsewhere in this chapter that there are many powerful nation states that subscribe to dualism. This factor alone defies arguments in favour of the universal applicability of international law in all countries i.e. monism. Dugard's comment that the South African common law adopts the monist approach and the subsequent implication that the Constitution does as well because it endorses the common law is misleading in the sense that customary international law is only binding, in terms of both the common law and the Constitution, if it does not conflict with legislation. To the extent that its domestic legislation has the capacity to oust a rule of customary international law, it is submitted that to assert that a legal system follows a monistic approach is to hold an extremely weak view of monism – so weak in fact, that it approaches dualism. Dugard points out that as far as treaties are concerned before 1994, South Africa followed the English dualist approach to the incorporation of treaties and that the drafters of the 1996 Constitution elected to return to the pre-1994 position relating to the incorporation of treaties without abandoning the need for parliamentary ratification of treaties.

74

S v Makwanyane and Another (fn 23 *supra*) at para [39] quoted with approval 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* (fn 70 *supra*). See also *Park-Ross and Another v Director: Offices for Serious Economic Offences* 1995 (2) SA 148 (C) in which the court observed with regard to the interim Constitution: "While it is indeed so that s 35(1) of the Constitution provides that, in interpreting the provisions of chap 3 thereof, the Court may 'have regard to comparable foreign case law', this should be done with circumspection because of the different contexts within which other constitutions were drafted, the different social structures and milieu existing in those countries as compared with those in this country, and the different historical backgrounds against which the various constitutions came into being. I agree with Froneman J in *Qozlani v Minister of Law and Order and Another* 1994 (3) SA 625 (E) at 633F-G that one must be wary of the danger of unnecessarily importing doctrines associated with those constitutions into an inappropriate South African setting. The South African Constitution must be interpreted within the context and historical background of the South African setting' cited with approval in *Govender v Minister of Safety and Security* 2000 (1) SA 959 (D)."

nation, rather than a headlong rush to absorb willy-nilly every fashionable international legal principle into the South African legal system, is the correct one⁷⁵. *S v Makwanyane*⁷⁶ has been cited as an example of a monistic approach to international law⁷⁷ but closer examination of the judgment in this case reveals that this is not a necessary conclusion. The court in *Makwanyane* emphasised a value-based interpretation of the Constitution with specific reference to South African conditions and faithfulness to the Constitution⁷⁸.

1.3.2 Sections 231, 232 and 233

There is the question as to what extent if any the interpretation provisions of the Constitution in sections 231, 232 and 233 modify the meaning of section 39(1). In other words, should the fact that the drafters of the Constitution saw fit to write a separate section relating to the interpretation of the Bill of Rights be construed to mean that sections 232 and 233, do not apply to interpretations of the Bill of Rights or should the two sets of provisions be read in conjunction with each other? If the latter, then how does

⁷⁵ The court in *Park-Ross* (fn 74 *supra*) quoted with approval these words of Mahomed AJ as he then was in *S v Acheson* 1991 (2) SA 805 (Nm) at 813A-B: "The constitution of a nation is not simply a statute which mechanically defines the structures of government and the relations between the government and the governed. It is a 'mirror reflecting the national soul', the identification of the ideals and aspirations of a nation; the articulation of the values bonding its people and disciplining its government. The spirit and the tenor of the constitution must therefore preside and permeate the processes of judicial interpretation and judicial discretion."

⁷⁶ *Makwanyane* fn 23 *supra*

⁷⁷ *Motala and Ramaphosa* fn 29 *supra* at p37

⁷⁸ The court in *Makwanyane* (fn 23 *supra* at p415) said that: "In dealing with comparative law we must bear in mind that we are required to construe the South African Constitution, and not an international instrument or the constitution of some foreign country, and that this has to be done with due regard to our legal system, our history and circumstances, and the structure and language of our own Constitution. We can derive assistance from public international law and foreign case law, but we are in no way bound to follow it". See also the observations of Sachs J in *Coetzee v Government of the Republic of South Africa; Matiso and Others v Commanding Officer, Port Elizabeth Prison, and Others* 1995 (4) 631 (CC) who states at p 656: "If I might put a personal gloss on these words, the actual manner in which they were applied in *Makwanyane* (the Capital Punishment case) shows that the two phases are strongly interlinked in several respects: firstly, by overt proportionality with regard to means, secondly, by underlying philosophy relating to values, and, thirdly, by a general contextual sensitivity in respect of the circumstances in which the legal issues present themselves. I make these points because of what I regard as a tendency by counsel, manifested in this case, to argue the two-stage process in a rather mechanical and sequentially divided way without paying sufficient attention to the commonalities that run through the two stages. In my view, faithfulness to the Constitution is best achieved by locating the two-stage balancing process within a holistic, value-based and case-oriented framework. The values that must suffuse the whole process are derived from the concept of an open and democratic society based on freedom and equality, several times referred to in the Constitution. The notion of an open and democratic society is thus not merely aspirational or decorative, it is normative, furnishing the matrix of ideals within which we work, the source from which we derive the principles and rules we apply, and the final measure we use for testing the legitimacy of impugned norms and conduct. If I may be forgiven the excursion, it seems to me that it also follows from the principles laid down in *Makwanyane* that we should not engage in purely formal or academic analysis, nor simply restrict ourselves to *ad hoc* technicism, but rather focus on what has been called the synergetic relation between the values underlying the guarantees of fundamental rights and the circumstances of the particular case. There is no legal yardstick for achieving this. In the end, we will frequently be unable to escape making difficult value judgments, where, in the words of McLachlin J, logic and precedent are of limited assistance. As she points out, what must be determinative in the end is the court's judgment, based on an understanding of the values our society is being built on and the interests at stake in the particular case; this is a judgment that cannot be made in the abstract, and, rather than speak of values as Platonic ideals, the Judge must situate the analysis in the facts of the particular case, weighing the different values represented in that context." [footnotes omitted].

one reconcile the two. Kentridge and Spitz⁷⁹ ask whether there is any difference of principle between the interpretation of the Constitution as a whole and the interpretation of the Bill of Rights in particular and note that there is such a difference⁸⁰. They observe however, that:

“the differences between the interpretation of the Bill of Rights and the Constitution as a whole is a difference of degree rather than a difference in kind and that because the Bill of Rights is more widely worded, there is more room for explicit value judgments in interpreting the Bill. Where other chapters of the Constitution are being interpreted the words themselves tend to provide a clearer indication of what is required.”⁸¹

Despite these observations, it is submitted that this is a significant basis for an argument that sections 231, 232 and 233 in particular are not applicable to the Bill of Rights. The Bill of Rights must be interpreted, with reference to international human rights law generally as opposed to only those aspects of international law that are binding within the Republic because international human rights law is relevant to South Africa as a nation state insofar as it acknowledges and upholds the underlying values contained in the Constitution, irrespective of the provisions of other South African domestic law which is still in the process of reform. This would also explain why the constitutional court, in considering the rights in the Bill of Rights has not done so with specific reference to sections 231, 232 or 233 of the Constitution.

If the Bill of Rights must be interpreted in the same way as the remainder of the Constitution then one has to attempt a reconciliation of sections 39(1) and 232 to 233. In the light of the wording of section 232, it could be argued that it is superfluous to read the term ‘international law’ in section 39(1) of the final Constitution as inclusive of ‘customary international law’ that is binding in South Africa. The provisions of section 232 imply that a court must *apply* customary international law that is not in conflict with

⁷⁹ Chaskalson, Kentridge, Klaaren, Marcus, Spitz and Woolman, (fn 35 *supra*) at para 11.5.

⁸⁰ Chaskalson *et al* fn 35 *supra*. This difference is expressed at 11-12 where they observe: “understanding the character of the Constitution as a whole and the Bill of Rights in particular is necessary in order to comprehend the essential difference between statutory and constitutional interpretation. A statute is an instrument by means of which a legislature elected by a majority of citizens governs those citizens. It is a set of instructions from the legislature to the officials who enforce the statute and to the citizens who are required to comply with its provisions... Judges interpreting the Constitution are engaged in a different task altogether. They are attempting to understand and to clarify the way in which government itself is required to function. In doing so they are trying to establish a scheme or pattern of government which comports with the values which the Constitution claims to uphold. More particularly, in interpreting the Bill of Rights, the courts are attempting to establish those values which allow individuals to make claims against the majority.”

⁸¹ Chaskalson *et al* fn 35 *supra* at p11-15

the Constitution or an Act of Parliament since customary international law is law in South Africa⁸². Consideration is a subset of application. Must the inference then be drawn that the injunction in section 39(1) to *consider* customary international law must apply to customary international law that is in conflict with the Constitution or an Act of Parliament? Should section 39(1) be interpreted to mean that a court must consider those rules of customary international law that are in conflict with the Constitution or an Act of Parliament or should it be interpreted to mean that the term 'international law' in section 39(1) does not include customary international law at all because this is dealt with in section 232 of the Constitution? If one takes into account that the injunction in section 39(1) is to 'consider', as opposed to 'apply', international law and the fact that the Constitution itself leans towards dualism in terms not only of section 232 but also section 231, the latter interpretation is the most logical option from a domestic law viewpoint on the basis that the law that does not apply in South Africa and which is in conflict with an Act of Parliament is not relevant. A consideration of a rule of customary law which is directly in conflict with the declared intention of the legislature as expressed in an Act of Parliament seems more than a little subversive especially if such consideration would lead to an interpretation of a right in the Bill of Rights which is also in conflict with that particular Act of Parliament. However, many would argue that, at least to the extent that the customary international law in question contains a peremptory norm and is therefore a part of the *jus cogens*, such an approach cannot be valid⁸³. The rule stated in section 8 of the Constitution that the Bill of Rights is binding upon the legislature could also be invoked in support of the argument that an Act of Parliament cannot be validly contrary to a principle of *jus cogens*. If this argument holds then the next logical step would be that a court, taking into account a principle of customary international law that conflicts

⁸² Sarkin J 'The Effect of Constitutional Borrowings on the Drafting of South Africa's Bill of Rights and Interpretation of Human Rights Provisions' www.law.upenn.edu/oonlaw/issues/vol11/num2/sarkin/sarkin_of.html referring to section 231(4) of the interim Constitution which provides: "the rules of customary international law binding on the Republic shall, unless inconsistent with this Constitution or an Act of Parliament, form part of the law of the Republic" observes: "Thus a particular human rights standard, which has become accepted as a rule of customary international law, must be implemented by a South African court in a decision, unless this rule is incompatible with the Constitution or an Act of Parliament. The proviso sets an important limit, permitting parliamentary supremacy in this area as in the past."

⁸³ See for instance Dugard, in 73 *supra*, who states that: "Peremptory norms include the prohibitions on aggression, genocide, racial discrimination, slavery, the denial of self-determination, and the suppression of basic human rights. It is inconceivable that Parliament, as constituted under the interim or final Constitution, would violate a peremptory norm." He points out that the *obiter dictum* of the Cape Provincial Division in *Azanian Peoples Organisation (AZAPO) and Others v Truth and Reconciliation Commission & Others* 1996(4) SA 562 (C) that the interim Constitution would "enable Parliament to pass a law, even if such law is contrary to the *jus cogens*", "was both unnecessary and unwise as it seriously undermines the Constitution's clear intention of establishing harmony between international law and municipal law."

with the Act of Parliament in question, declares the Act to be unconstitutional to the extent that it conflicts with the court's interpretation of the rights in the Bill of Rights. The dualist principle expressed in section 232 of the Constitution would thus be avoided in favour of the more monistic vista of legal possibility.

The considerable differences in scope between a right to health as expressed at international law, and this right as expressed in the Constitution create a real possibility that courts could potentially read into the expression of the right in the Constitution a much wider interpretation than was initially intended and use it to overturn a statute dealing with the right to health care services which is based on the narrower interpretation. In this way, customary international law that is in conflict with an Act of Parliament could be introduced into the South African legal system via the backdoor of the constitutionally mandated manner in which the Bill of Rights could be interpreted. Admittedly it would take a court that was either ignorant of the implications of considering section 39(1) in isolation from section 232 or one that was determined to incorporate a principle of customary international law into the domestic legal system such as might happen where a principle of *jus cogens* is involved. So far, however, the constitutional court has sensibly adopted a fairly conservative approach which has meant that international law concepts such as minimum core content of socio-economic rights, have been rejected on the grounds of pragmatism. It is submitted that when faced with a conflict between a principle of *jus cogens* and an Act of Parliament, a court is likely to take into account the stipulation in section 39(1)(a) which requires it to "promote the values that underlie an open and democratic society based on human dignity, equality and freedom" to resolve such conflict. The values that underlie an open and democratic society are more likely to be consistent than inconsistent with the *jus cogens*. In practice such conflicts are seldom likely to arise given the spirit of the Constitution generally and the fact that Parliament is, as has been pointed out, unlikely to intentionally violate a peremptory norm. In the context of health care, however, a conflict between domestic law and the *jus cogens* could conceivably in future arise in the context of euthanasia⁸⁴ where a

⁸⁴ Proponents of euthanasia would find their arguments strengthened if a right to euthanasia based on fundamental human rights was more widely recognized internationally than at present. In *Pretty v United Kingdom* (application no 2346/02) the European Court of Human Rights held that there had been no violation of Article 2 (right to life) of the European Convention

law prohibiting assisted suicide is challenged on the basis that it constitutes a violation of the fundamental human rights of human dignity and the right to bodily and psychological integrity. While such rights in general may be part of the *jus cogens*, however, it is unlikely that they would be well received as specifically supportive of the idea of euthanasia given the decision of the European Court of Human Rights in the case of *Pretty v The United Kingdom*⁸⁵. It would be extremely difficult to argue that a right to euthanasia is presently a principle of *jus cogens*. Another potential area of conflict is in the rationing of health services⁸⁶. An example of this would be a domestic rule which allows health authorities to avoid the supply of anti-retroviral drugs to HIV/AIDS patients contrary to a principle of *jus cogens* which requires that states give their citizens access to life-saving drugs as part of the right to health⁸⁷.

If one sees section 39(1) as ousting the relevance of sections 232 and 233 of the Constitution to the Bill of Rights then the courts would still be engaged in a dual exercise concerning customary international law in that they would be considering and applying customary international law which is law in South Africa and merely considering customary international law which is not. A wide interpretation of section 39(1) carries the further implication that all international agreements, whether formal or informal,⁸⁸ must be taken into account in interpreting the Bill of Rights. The question is to what extent informal agreements and arrangements between states, which do not necessarily form part of international law for the purposes of section 231 of the Constitution⁸⁹, must be taken into account for purposes of section 39(1)? Do they form part of international law for the purposes of section 39(1) or not? Longstanding and widely supported informal agreements or arrangements between states can approximate customary international law and can serve as evidence that a practice has become a rule of

of Human Rights, no violation of Article 3 (prohibition of inhuman or degrading treatment or punishment); no violation of Article 8 (right to respect for private life); no violation of article 9 (freedom of conscience) and no violation of Article 14 (prohibition of discrimination). Mrs Pretty wished to be assisted by her husband to commit suicide but the Director of Public Prosecutions of the United Kingdom refused her request to guarantee her husband freedom from prosecution if he did so. Her appeals against this decision in the British courts were unsuccessful.

⁸⁵ *Pretty* fn 84 *supra*.

⁸⁶ See further the discussion of *Soobramoney v Minister of Health, KwaZulu-Natal* 1998 (1) SA 765 (CC) in chapter 2.

⁸⁷ This example is very close to the bone given the provisions of General Comment No 14 by the United Nations Committee on the ICESCR to the effect that a core obligation of States Parties is "to provide essential drugs, as from time to time identified under the WHO Action Programme on Essential Drugs". See the discussion on minimum core obligations *infra*.

⁸⁸ See discussion of informal international agreements under section 231 *infra*.

⁸⁹ See the discussion of *S v Harksen* *infra*.

customary international law. It is submitted, however, that in view of the fact that informal agreements and arrangements between states that do not constitute international agreements, as envisaged by section 231, are unlikely to constitute public international law or customary international law unless they have been recognised as such in terms of a treaty, convention or similar instrument or by an international forum such as the International Court of Justice, these should not as a rule be considered by a court, tribunal or forum as international law for the purposes of section 39(1). This would appear also to be in keeping with Article 38(1)(f) of the Statute of the International Court of Justice⁹⁰.

1.3.3 Section 231 – International Agreements

In terms of section 231(1) of the Constitution all international agreements must be negotiated and signed by the National Executive. An international agreement binds the Republic only after it has been approved by resolution in both the National Assembly and the National Council of Provinces, unless it is an agreement referred to in subsection (3) of section 231.

According to subsection (3) of section 231 an international agreement of a technical, administrative or executive nature, or an agreement which does not require either ratification or accession, entered into by the national executive, binds the Republic without approval by the National Assembly and the National Council of Provinces, but must be tabled in the Assembly and the Council within a reasonable time. The question of whether an international agreement is of a “technical, administrative or executive nature” is likely to prove problematic for South African courts until such time as they have built up a reasonable level of jurisprudence on the subject. There is a tendency for complex international agreements to be structured so that the principal agreement sets out the general framework and principles for the various activities or projects to be undertaken by the parties and then provides for subordinate agreements between various organs of state and the international partner in order to spell out the details of and implement in practical terms, those various projects or activities envisaged by the main agreement. It is

⁹⁰ Article 38 of the Statute of the ICJ *in 23 supra*

possible that the Constitution envisages subordinate agreements of this nature in referring to agreements of a technical administrative or executive nature. It is important to emphasise in this regard, however, that international agreements bind only the Republic vis-à-vis other nations. Generally speaking, they are not binding upon South Africans or inhabitants of South Africa since they are not law in the country until enacted as such by national legislation.

Any international agreement becomes law in the Republic when it is enacted into law by national legislation but a self-executing provision of an agreement that has been approved by Parliament is law in the Republic unless it is inconsistent with the Constitution or an Act of Parliament⁹¹. The power of a province to effectively, if not directly, enact into provincial legislation the provisions of an international agreement has already been discussed⁹². The absence of framework legislation in an area in which both the national and provincial spheres of government have legislative competence, such as health services, is likely to increase the possibility that provinces would exercise such a power. Whether such legislation would survive a challenge of unconstitutionality on the basis that it is effectively in violation of the provisions of section 231 is an interesting question.

In the context of health care currently, the only international agreement that has so far been expressly enacted into law is contained in the International Health Regulations Act⁹³. The object of this legislation is to apply the International Health Regulations, adopted by the World Health Assembly, in South Africa. The International Health Regulations are focused mainly on the control of malaria, yellow fever, cholera and small pox, and their hosts and (where applicable) insect vectors, across international borders. They also provide for notification of the World Health Organization by states of the occurrence within their territory of a disease that is the subject of the regulations.

The term “international agreement” in the context of section 231 refers to all kinds of international agreements which, in international law are known by many different names

⁹¹ Section 231(4) of Act No 108 of 1996

⁹² See discussion of provincial legislation at fn 52 *supra*

⁹³ Act No 28 of 1974



such as treaty, convention, charter etc. It must be observed that not all international agreements are such for the purposes of section 231 of the Constitution. The question as to what is meant by the term “international agreement” was considered by the court in *S v Harksen*⁹⁴. In that case the President of South Africa consented to Harksen’s extradition to Germany in terms of the Extradition Act⁹⁵. There was no extradition agreement or treaty between Germany and South Africa and it was argued that the President’s consent to the extradition brought into existence a bilateral international agreement in conflict with section 231 of the Constitution. The court held that in order to establish whether or not the relevant documentation gave rise to an international agreement, it must be carefully considered and that it must indicate that the parties intended to conclude an internationally binding agreement with reciprocal rights and duties or obligations⁹⁶. The court emphasised the importance of consensus between the parties and their intentions and held that although the Vienna Convention does not, in its definition of ‘treaty’, refer to the consensual aspect or intention underlying any international agreement, it clearly cannot be an agreement without the requisite intention or *consensus*⁹⁷. The court observed that it is this intention and consent which distinguishes treaties from informal or *ad hoc* agreements or arrangements.

The phrase ‘international agreements’ as used in section 231 must, it seems, therefore be given the narrow meaning of legally binding agreements. Informal agreements or arrangements of an international nature do not fall within the phrase ‘international agreements’ in section 231 which means that they would probably fall into the general category of international law as contemplated in section 233 of the Constitution and may fall within the scope of customary international law as contemplated in section 232 depending upon the circumstances.

⁹⁴ *S v Harksen; Harksen v President of the Republic of South Africa and Others; Harksen v Wagner No and Another* 2000 (1) SA 1185 (C)

⁹⁵ Act No 67 of 1962

⁹⁶ *Harksen* fn 94 *supra* at 1200 D-E.

⁹⁷ *Harksen* fn 94 *supra* at 1201 A-B. The court held that: “This appears unequivocally from the definitions (in art 2.1 (f) and (g) respectively of the Vienna Convention) of ‘contracting state’ and ‘party’. They are said to be a state or party which has ‘consented to be bound by the treaty.’ The means of expressing this consent is dealt with in art 11, which provides that ‘(t)he consent of a state to be bound by a treaty may be expressed by signature, exchange of instruments constituting a treaty, ratification, acceptance, approval or accession, or by any other means so agreed.” The court quoted from Reuter P *Introduction to the Law of Treaties* (translation of Mico and Haggemacher) at 30. A treaty is defined as ‘an expression of concurring wills attributable to two or more subjects of international law and intended to have legal effect under the rules of international law’.

The distinction between international agreements as contemplated in section 231 and informal international agreements or arrangements is important for the provinces because only the national executive may, in terms of section 231(1) negotiate and sign international agreements. Provinces have an obligation to respect, protect, promote and fulfil the rights in the Bill of Rights as much as does the national government. In the case of health care services in particular, the national department of health seldom if ever delivers these services itself. The provinces are responsible, in practical terms, for such service delivery. They own the various hospitals and health facilities and employ the various health professionals necessary to deliver health care services. The national department of health does, however, play a key role in issues of policy co-ordination and support of provinces in health service delivery and certain functions such as the procurement of pharmaceuticals are centralised. The national department has control over certain funding which it allocates to provinces in the form of conditional grants which are over and above the equitable share allocated directly to the provinces by the National Treasury.

When it comes to health care services which are the subject of international agreements, it is the role of the national department of health to enter into these agreements even if it only concerns a single province. There is no indication in the Constitution that provinces have the power to enter into such agreements in their own right. From a contractual point of view this can create problems for the national department of health which, in the absence of a back-to-back agreement between itself and the province, does not have direct legal authority to ensure performance by the province. It may also not have the resources to itself fulfil the obligations imposed by the contract. The legislation envisaged by the Constitution on the subject of co-operative government has not yet materialised and while the Constitution does require the different spheres of government in South Africa to govern co-operatively, the politics of the situation are such that it is not inconceivable for a rogue province to flout the terms of an international agreement, entered into by the national executive, which requires certain actions on the part of that province. The provisions of section 100 of the Constitution, may, depending on the

circumstances, be invoked to deal with the situation but it will not necessarily always be appropriate to do so.

The dynamic between the provinces and the national government on health care issues is complex and can be exploited by unscrupulous international agencies to further their own ends or simply to favour one province over another for various reasons. The fact of the matter is that if health care services in one province are superior to those in neighbouring provinces, for instance because a particular province is the beneficiary of substantial international donor funding, the more affluent province might find itself providing health care services to inhabitants of a neighbouring provinces at an unprecedented and unsustainable level or, alternatively, failing in its constitutional obligations to respect, protect, promote and fulfil the right of South African residents to health care services. The interface between the national government and nine provincial governments concerning the delivery of health care services rests upon a delicate balancing act in the distribution of health care resources and policy relating to the delivery of health care, which if disrupted, could lead to serious financial and other difficulties for a province.

A good example is the question of health tourism. A wealthier province which has health facilities of a generally higher standard, possibly even some of an international standard, compared to those of other provinces, may decide to embark on an active campaign to attract health tourists and may even wish to enter into an agreement with for example the British National Health System (NHS) for the treatment of British patients in provincial facilities. The agreement between the British National Health System and the province in question may not necessarily be an international agreement due to the fact that the NHS has an existence independent of the British government. The utilisation of public health facilities in this province by foreign nationals will affect the availability of those facilities to South African residents who may in turn be forced to seek certain levels of health care services in neighbouring provinces. The province that is servicing the health tourists could find itself faced with legal action for violation of constitutional rights. The power of the national executive to impose policy upon the provinces was discussed to a limited

extent in *Minister of Education v Harris*⁹⁸. In that case a statute gave the Minister of Education the power to determine national policy for the planning, provision, financing, co-ordination, management, governance, programmes, monitoring, evaluation and well-being of the education system. The constitutional court nevertheless observed that:

“Policy made by the Minister in terms of the National Policy Act does not create obligations of law that bind provinces, or for that matter parents or independent schools... In the light of the division of powers contemplated by the Constitution and the relationship between the Schools Act and the National Policy Act, the Minister's powers under s 3(4) are limited to making a policy determination and he has no power to issue an edict enforceable against schools and learners... Complex constitutional questions arise as to whether the Minister is permitted at all to oblige MECs to enforce national policy in this way. It is not necessary to decide such questions in this case, for s 3 of the National Policy Act does not accord the Minister such power. It follows that the notice purports to impose legally binding obligations upon independent schools and upon MECs, and is ultra vires the powers granted to the Minister by s 3 of the National Policy Act.”

Health services are in much the same constitutional position as education in that they are a Schedule 4 competency over which both the national and provincial spheres of government have jurisdiction.

1.3.4 Section 232 – Customary International Law

Customary international law is law in the Republic unless it is in conflict with the Constitution or an Act of Parliament.

As stated previously, for the purposes of the interpretation of the Bill of Rights, a tribunal or forum must apply customary international law since it is law within the Republic. The only ground for not doing so is that it would be inconsistent with the Constitution or an Act of Parliament. Customary international law, unlike other international law, is thus more than just a tool of interpretation in relation to the Bill of Rights. It is national law, applicable to the interpretation of the Bill of Rights, as law in its own right.

Does the provision in section 232 of the Constitution effect an increase or diminution in the status of customary international law within South Africa? According to the monist

⁹⁸ *Harris* 2001 (4) SA 1297 (CC)

view of international law, customary international law has a higher status than national or domestic law and in the event of a conflict customary international law prevails. However, if it is reduced to the status of national law within the Republic, then it cannot have a status higher than other national law. In fact it is only law in South Africa to the extent that it does not conflict with domestic law. One ends up with the tautology that certain customary international law is in fact not international law at all but domestic law by virtue of the Constitution. The alternative is a dual role for customary international law as both domestic and international law. Logically speaking the alternative is more appealing since it recognizes that South Africa as a nation state and also its inhabitants are both bound by the customary international law in question. However the boundaries of customary international law that binds South Africa as a subject of international law may not necessarily be coterminous with those of the body of customary international law that binds its inhabitants due to the requirement of consistency with Acts of Parliament and the Constitution.

The pertinent question, with regard to the provisions of section 39(1) as read with section 232, is what is the position of a court where a rule of customary international law is in conflict with the provisions of the Constitution or an Act of Parliament? Should the court still take into account the rule of customary international law in interpreting a right in the Bill of Rights or should it avoid it on the basis that Parliament has signified a rejection of it in another law or the Constitution itself? It is submitted that the answer is to be found in the judgement of the Cape Provincial Division in *Dawood*⁹⁹. It took the approach that although in dealing with comparative law one is required to construe the South African Constitution, and not an international instrument or the constitution of some foreign country, and that this has to be done with due regard to the domestic legal system, national history and circumstances, and the structure and language of the South African Constitution, it must also be borne in mind that 'the lawmakers of the Constitution should not lightly be presumed to authorise any law which might constitute a breach of the obligations of the state in terms of international law'.

⁹⁹ *Dawood* fn 70 *supra*



The view has been expressed that section 39(1) requires that binding and non-binding international law must be considered when interpreting the Bill of Rights¹⁰⁰. However, the Constitution itself provides for a situation in which statutory domestic law overrides international law in the event of a conflict. There is a significant difference between a rule of law that is merely 'non-binding' as opposed to a rule of law that has been quite clearly contradicted by an Act of Parliament. The approach of the court in *Dawood* suggests that one must adopt a cautious approach in concluding that the lawmakers would have intentionally breached an obligation of the state in international law does not detract from the requirement to construe the South African Constitution with due regard to the domestic legal system. If the lawmakers have in fact written a law that is contrary to a principle of *jus cogens* as contained in customary international law, the principle of *jus cogens* does not form part of the domestic law and should not be applied. The fact that principles of *jus cogens* seem in the main to be devoid of meaningful content renders it very unlikely that there will be such a conflict in practice. In the field of health care the closest one can perhaps come to an alleged principle of *jus cogens* is the concept of minimum core obligations but this concept does not seem to have been recognised as *jus cogens* largely because there are no clear criteria for identification of exactly when a rule becomes part of the *jus cogens*. A vague and indeterminate right to health can and does mean different things to different people as evidenced by the various approaches to this right in countries around the world. It could hardly be argued that such a right is a rule of *jus cogens* if the minimum content of the right cannot be convincingly identified by way of international consensus¹⁰¹. The criticism levelled against the judgment in the *Azapo* case is apparently based at least in part upon the notion that the customary international law in question formed part of the *jus cogens*. The cardinal question is whether this is in fact the case. There is apparently no agreement as to the point at which a principle of international law becomes part of the *jus cogens*. The apparent supremacy¹⁰² of *jus cogens* over even the Constitution raises some fairly tautologous arguments.

¹⁰⁰ *Motala et al* fn 7 *supra*

¹⁰¹ See further discussion of *jus cogens* *infra*

¹⁰² The manner and mechanisms for the creation of *jus cogens* norms, and therefore the question as to whether a particular rule constitutes *jus cogens*, are by no means clear. So too is the approach to *jus cogens* by various states. There is no consensus amongst states that their rights under international law can be altered without their consent. The United States for instance, has said that it could not accept the suggestion that, without its consent, other states would be able, by resolutions or statements to deny or alter its rights under international law. (IX UNCTLOS at 106) France has made it clear that 'no

1.3.5 Section 233 – International Law

International law, other than customary international law, is not law in South Africa unless it meets the requirements of section 231 i.e. it has been approved by resolution in the National Assembly and the Council of Provinces or it is a section 231(3) agreement¹⁰³. South Africa is asserting its sovereignty in such a provision. However, in terms of the view expressed by the court in *Makwanyane*¹⁰⁴, international law must be considered when interpreting the Bill of Rights irrespective of whether or not it is law in South Africa or binding upon South Africa.

In terms of section 233:

“When interpreting any legislation, every court must prefer any reasonable interpretation of the legislation that is consistent with international law over any alternative interpretation that is inconsistent with international law.”

The Bill of Rights and the Constitution logically both fall into the category of ‘any legislation’. The rationale behind the inclusion within section 39(1) of a specific injunction to consider international law when interpreting the Bill of Rights when such an injunction, and more, is also effectively contained in section 233 of the Constitution is

government could be bound under international law unless it agreed to be so bound in a treaty, and that in no case could a government be bound by a legal rule which others sought to impose on it.’ Belgium has said that ‘no state could be bound by international law without its consent’. “There are serious doubts as to whether an instrument which at best can lay down rules vaguely described as ‘soft law’ (meaning still not hard genuine law) may by some ‘alchemy’ become a legitimate vehicle for the creation of ‘higher law’. ‘In reality, only treaties of a truly universal nature establishing general international law may produce peremptory rules.... The existing experience clearly demonstrates that opposition by an important element of the international community, even if it constitutes a small minority, can effectively prevent the emergence of new norms of *jus cogens*’ See for further details concerning the above ‘International Jus Cogens: Issues of Law Making’ 1990-2002 *European Journal of International Law*. Mere majority support of a particular norm as *jus cogens* is not sufficient to make it so. There is also by no means consensus as to exactly when a particular rule or norm becomes part of the *jus cogens*.” The author points out that “An analysis of the negotiations at both UNCLOS and the 1983 Vienna Conference on Succession of States indicates that many states once again confirmed their traditional and widely shared view according to which the UN General Assembly resolutions are not even capable of producing ordinary legally binding obligations, let alone the norms of *jus cogens*.”

¹⁰³ The extent to which the terms ‘international agreement’ and ‘international law’ are synonymous is problematic given that there is no precise nomenclature for international instruments. It was concluded by the court in *S v Harksen; Harksen v President of the Republic of South Africa; Harksen v Wagner and Another*, (fn 94 *supra*) that informal or *ad hoc* agreements or arrangements between states do not constitute international agreements as contemplated in section 231 of the Constitution. The court quoted Olivier M, ‘Informal International Agreements under the 1996 Constitution’ (1997) *SAYL* 63 at 75 who states: “(T)he term ‘international agreement’ as it appears in s231 is used in the narrow sense of the word to refer only to legally binding documents. Informal or legally non-binding international agreements fall outside the ambit of section 231, although they can, strictly speaking, also be regarded as agreements of an international nature.” Olivier distinguishes between informal international agreements and treaties as follows: “The basic criterion for distinguishing between treaties and informal international agreements lies in the intention of the parties – in other words, whether or not the parties intended creating a legally binding document. Certain criteria have been developed to assist in ascertaining the intention of the parties. These criteria are, however, not always easy to apply and may lead to conflicting inferences.” Among the criteria she suggests are: language, designation, subject-matter, surrounding circumstances, whether or not the agreement has been internationally registered and the way in which municipal law describes and deals with the agreement.

¹⁰⁴ *Makwanyane* fn 23 *supra*



not entirely clear unless one adopts the view that the Bill of Rights must be interpreted differently to other legislation, including the remainder of the Constitution. The injunction in section 233 is more favourably inclined towards international law than that in section 39(1) in that it requires a court to *prefer* any reasonable interpretation that is consistent with international law over one that is not. Does this oblige a court¹⁰⁵ considering international law in the context of section 39(1), to prefer any interpretation of the Bill of Rights which is consistent with international law over one that is not? It is submitted that the answer is a qualified ‘yes’, the qualification being based upon the word ‘reasonable’ in section 233. Both sections 39(1) and 233 use the phrase ‘international law’ but the courts have held that for the purposes of section 39(1) both binding and non-binding international law must be considered whereas they have not yet expressed a view of what is meant by ‘international law in the context of section 233. Dugard¹⁰⁶ has observed that:

“it is inconceivable that Parliament as constituted under the interim or a final constitution would violate a peremptory norm. The *obiter dictum* of the *Cape Provincial Division in Azanian People’s Organization (AZAPO) & Others v Truth and Reconciliation Commission & Others* that the interim Constitution would enable Parliament to pass a law, even if such law is contrary to the *ius cogens*, was both unnecessary and unwise as it seriously undermines the Constitution’s clear intention of establishing harmony between international law and municipal law.”

But what of non-binding international law? In *Grootboom*¹⁰⁷ the court stated that the weight to be attached to any particular principle or rule of international law will vary. In *Makwanyane*¹⁰⁸, Chaskalson P emphasised the need to construe the Constitution with due regard to the South African legal system, South African history, and circumstances and the structure and language of the South African Constitution. He said that assistance can be derived from public international law but the courts were in no way bound to follow it. The courts have adopted a conservative approach to the absorption or alignment of international legal principles into or with domestic law. In terms of the ordinary rules of statutory interpretation, the phrase ‘international law’ should not be interpreted differently between the two sections unless there is a very clear intention to the contrary.

¹⁰⁵ This is despite the fact that Section 233 refers specifically to a court unlike section 39(1) which refers to a court, tribunal or forum.

¹⁰⁶ Chaskalson, Kentridge, Klaaren, Marcus, Spitz and Woolman (fn 35 *supra*) para 13.4 at 13-7

¹⁰⁷ *Grootboom* fn 57 *supra*

¹⁰⁸ *Makwanyane* fn 23 *supra*

The court in *Makwanyane*¹⁰⁹ has indicated that the term ‘international law’ as used in section 39(1) should be given a wide interpretation rather than a narrow one. It follows that, in terms of this rule of statutory interpretation, the same term as it appears in section 233 should be given the same interpretation. The question has, however, been raised as to whether the Bill of Rights and the remainder of the Constitution must be interpreted differently¹¹⁰. The commentators and courts, in their discussions of section 39(1) (or section 35(1) of the interim Constitution) have tended to focus on the provisions of section 39(1) exclusively, without reference to section 233. If the Bill of Rights is to be interpreted differently to the remainder of the Constitution then the meaning of the term “international law’ in sections 39(1) and section 233 need not be the same.

It is possible that the phrase ‘any legislation’ used in section 233 was not intended to include the Constitution, and therefore the Bill of Rights, in view of the fact that the Constitution, including the Bill of Rights, is not just ‘any legislation’ but rather the grundnorm for the South African legal system and therefore has supremacy over every other law in South Africa and in view of the fact that there is express provision for the ‘consideration’ of international law in section 39(1). The difference between constitutional interpretation and the interpretation of other legislation has been recognised in cases on constitutional interpretation throughout the world¹¹¹. The courts have espoused a purposive approach to interpretation of the Constitution¹¹². It is submitted that this approach, particularly in terms of the dynamic expounded by O’Regan J in *Makwanyane*¹¹³, would create considerable uncertainty if applied to legislation other than the Constitution. The message behind the purposive approach is that it is not static and that reliance upon judicial precedent in interpreting the Constitution and especially the

¹⁰⁹ *Makwanyane* fn 23 *supra*

¹¹⁰ *Chaskalson et al* fn 35 *supra*

¹¹¹ *Chaskalson et al* fn 35 *supra*. See para 11.4, pp 11-10 to 11-14 and the cases there cited, in particular *Matiso v Commanding Officer, Port Elizabeth Prison, & Another* 1994(4) SA 592 (SE)

¹¹² See for example, *Minister of Land Affairs and Another v Slandien and Others* 1999 (4) BCLR 421 (LCC) at 421B-C; *S v Mhlungu & Others* 1995 (3) SA 867 (CC); *Ferreira v Levin No & Others* 1996(1) SA 984 (CC); *R v Big M Drug Mart Ltd* (1985) 18 DLR (4th) 321 at 359-60 cited with approval in *S v Zuma* 1995 (2) SA 642 (CC). In *S v Makwanyane*, (fn 23 *supra*) O’Regan J states that: “This purposive or teleological approach to the interpretation of rights may at times require a generous meaning to be given to the provisions of Chapter 3 of the Constitution and at other times a narrower, specific meaning. It is the responsibility of the courts, and ultimately this court, to develop fully the rights entrenched in the Constitution. But this will take time. Consequently any minimum content which is attributed to a right may in subsequent cases be expanded and developed.”

¹¹³ *Makwanyane* fn 23 *supra*

Bill of Rights will not necessarily provide the same safeguards as reliance on judicial precedent regarding other legislation.

The requirement to prefer any reasonable interpretation consistent with international law over one that is inconsistent therewith does not contain the same qualification as does section 232 – the proviso that it is not inconsistent with the Constitution or an Act of Parliament. It is possible that an interpretation, consistent with international law, of a particular statute could be inconsistent with another statute or the Constitution itself. What would be the position in this event? It is submitted that one must look to the requirement of reasonableness in section 233 to resolve such situations. It is submitted that an interpretation which is inconsistent with the Constitution could not be considered reasonable, neither could an interpretation which clearly flew in the face of an Act of Parliament. Section 232 (3) of the interim Constitution provided that ‘no law shall be constitutionally invalid solely by reason of the fact that the wording used is *prima facie* capable of an interpretation which is inconsistent with a provision of this Constitution, provided that such a law is reasonably capable of a more restricted interpretation which is not inconsistent with any such provision, in which event such law shall be construed as having a meaning in accordance with the said more restricted interpretation’.

The constitutional court in particular does not seem to have taken specific cognisance of the provisions of section 233 when interpreting the Bill of Rights in two leading cases involving socio-economic rights¹¹⁴. In fact the court has expressly avoided the direct application of an international law interpretation of these rights which seems to have been favoured elsewhere. The interpretation in question relates to the concept in international law of minimum core obligations.¹¹⁵ In the case of *Mzeku and Others v Volkswagen SA (Pty) Ltd and Others*¹¹⁶, the court rejected an argument that the provisions of ILO Convention 87 on Freedom of Association and the Right to Organise and ILO Convention 98 on the Right to Organise and Collective Bargaining are part of South

¹¹⁴ *Government of the Republic of South Africa and others v Grootboom and Others*, (fn 57 *supra*) and *Minister of Health and Others v Treatment Action Campaign and Others (No 2)* 2002 (5) SA 721 (CC).

¹¹⁵ See further discussion of minimum core *infra*

¹¹⁶ *Mzeku* 2001 (4) SA 1009 (LAC)

African law on the basis of the provisions of sections 231(5) and 233 of the Constitution. Counsel in that case submitted that the result of these conventions being part of South African law is that an employer has no right to dismiss employees for participating in a strike of any nature. The effect of this submission was that employees can go on strike without having to follow the procedures prescribed by the Labour Relations Act 66 of 1995 and when they do that an employer has no right to dismiss them. The court said, “In our judgment it is a misrepresentation of the position to suggest that the ILO Conventions inevitably preclude national legislation from prescribing the type of conditions contained in the Act before there can be an exercise of the right to strike.”

1.4 Customary International Law and the Right To Health

Like many concepts in international law, customary international law is not easy to define. Although writers speak glibly of state practice and *opinio juris* as being the two elements of customary international law, when one makes any attempt to explore these two concepts in any depths, their ethereal nature becomes apparent.¹¹⁷ According to section 102 of the Restatement (Third) of Foreign Relations Law of the United States, international customary law is described as follows:

“Customary international law results from a general and consistent practice of states followed by them from a sense of legal obligation”¹¹⁸.

The distinction between international customary law and other types of international law is neither clear nor simple. It would seem that sufficiently widespread recognition of a principle within public international law, such that it amounts to general practice followed out of a sense of legal obligation, can bring that principle within the ambit of

¹¹⁷ “State practice refers to general and consistent practice while *opinio juris* means that the practice is followed out of a belief of legal obligation. This distinction is problematic because it is difficult to determine what states believe as opposed to what they say.” Roberts fn 118 *infra* at p757

¹¹⁸ Kinney ‘The International Human Rights To Health: What Does This Mean For Our Nation and World?’ (fn 51 *supra*). See also Dugard *International Law: A South African Perspective* 24-32 and *S v Petane* (fn 73 *supra*). According to Kinney the two major elements of customary international law are state practice and *opinio juris*. Dugard refers to them as “settled practice (*usus*)” and “the acceptance of an obligation to be bound (*opinio juris*)”.

customary international law¹¹⁹. According to this view, modern customary international law is therefore likely to be fed by and derived largely from international treaties and conventions although this is not without controversy¹²⁰. Traditional customary international law results from general and consistent practice followed by states from a sense of legal obligation whereas modern custom is derived by a deductive process that begins with general statements of rules rather than particular instances of practice.¹²¹ According to some views, the difference between customary international law and public international law is that whereas the latter is strictly speaking binding only upon the states parties, the former can bind states regardless of treaty ratification¹²². Some claim that customary international law is dying¹²³ whilst others speak of its growing importance¹²⁴. It has been claimed specifically with reference to global health governance that customary international law is ‘an awkward instrument’ in connection with dealing with global public health concerns and that it is ‘currently under attack as a source of international law for various theoretical and practical reasons’¹²⁵.

Despite these conflicting views, it would seem that the importance of customary international law should not be underestimated. Depending upon which view is held of international customary law, it may have the potential even to supersede the importance

119 Torres (fn 130 *infra*) and Kinney (fn 51 *supra*).

120 Roberts AE ‘Traditional and Modern Approaches To Customary International Law: A Reconciliation’ *American Journal of International Law* v 95 757

121 See fn 120 *supra*. Roberts points out that ‘Modern custom can develop quickly because it is deduced from multilateral treaties and declarations by international fora such as the General Assembly, which can declare existing customs, crystallize emerging customs and generate new customs.’

122 Kinney (fn 51 *supra*) and also Roberts fn 120 at p765 -766 who observes that “By contrast [to declarations and treaties], custom is generally binding except for the limited and contentious persistent objector rule. Transforming declarations and treaties into custom changes their nature because customs can bind non-parties to treaties and declarations and are not affected by reservations or denunciation...Modern custom evinces a desire to create general international laws that can bind all states on important moral issues”. See however, Perritt Jr Symposium on the Internet and Legal Theory: The Internet Is Changing International Law’ (fn 2 *supra*) who observes that “A sovereign state can opt out by refusing to sign a treaty or by manifesting its lack of consent for a norm of customary international law...Because customary international law is consensual, states can exempt themselves from a norm of customary international law by manifesting an intent not to be bound by it... The growing importance of customary law, along with treaty based law has spawned a lively debate in American legal literature as to whether federal courts should incorporate customary international law into federal common law”

123 Roberts fn 120 *supra* p757

124 Perritt (fn 2 *supra*) and Roberts fn 120 *supra* where she observes that “At the same time custom has become an increasingly significant source of law in important areas such as human rights obligations. Codification conventions, academic commentary and the case law of the International Court of Justice...have also contributed to the contemporary resurrection of custom”.

125 Fidler D ‘Global Health Governance: Overview of the Role of International Law in Protecting and Promoting Global Public Health’, May 2002 Discussion Paper No 3 of the Centre on Global Change and Health London School of Hygiene & Tropical Medicine and the Department of Health & Development of the World Health Organization at p41. Fidler says that while arguments from customary international law are made in many international legal contexts, ‘the real action takes place in treaty law’.

of the instrument of international law from whence it originated¹²⁶. Modern international customary law has been criticised for ‘normative chauvinism’¹²⁷. For example it has been stated that human rights obligations reflect a Western tendency to give primacy to individual rights over communal or group needs¹²⁸. The fact that section 232 of the Constitution stipulates that customary international law is law in South Africa creates an obligation to establish the content of the customary international law on the legal topic at issue.

It must be observed in passing that to the extent that the phrase ‘international custom, as evidence of a general practice accepted as law’ in paragraph b of Article 38(1) of the Statute of the International Court of Justice coincides with the term ‘customary international law’ in section 232 of the Constitution, such international custom is law in South Africa and the courts do not have a discretion as to whether to apply it¹²⁹. A failure on the part of a South African court to apply customary international law, except where it is inconsistent with the Constitution or an Act of Parliament, may therefore not only be a violation of international law but would also be unconstitutional in terms of section 232.

In view of the fact that section 39(1) deals with international law generally as an interpretational tool rather than as hard law, a court might well be able to use even conflicting customary international law as such a tool to arrive at an interpretation of a right in the Bill of Rights which is not itself necessarily in conflict with the Constitution

¹²⁶ This can become something of a chicken-and-egg debate if one takes into account the probability that for a legal principle to be expressed in an international treaty or convention it would very likely have gained widespread or significant international acceptance before being reduced to writing in such treaty or convention. In this sense, therefore customary law precedes the more formal international law instruments. Possibly the best term to describe the relationship between customary international law and other types of international law is ‘symbiotic’. See Roberts fn 120 *supra* p763 who gives the example that some rights set out in the Universal Declaration of Human Rights of 1948 are expressed in mandatory terms and have achieved customary status even though infringements are “widespread, often gross and generally tolerated by the international community”. As a result modern custom often represents progressive development of the law masked as codification by *lex feranda* [what the law should be] as *lex lata* [what the law is].

¹²⁷ Simma B and Alston P ‘The Sources of Human Rights Law: Custom, Jus Cogens and General Principles’, 1988-89 *Australian Year Book of International Law* 82.

¹²⁸ Roberts fn 120 *supra* at 769.

¹²⁹ The legal principle expressed in section 232 of the Constitution is not new to South African law. See *Nduli and Another v Minister of Justice and others* (fn 73 *supra*) and *S v Petane* (fn 73 *supra*) in which the court stated that: “In *Nduli and Another v Minister of Justice and Others* 1978 (1) SA 893 (A), the Appellate Division accepted that customary international law was, subject to its being in conflict with any statutory or municipal law, directly operative in the national sphere. The Appellate Division described the attributes of a rule of customary international law which would make it applicable in South Africa. It would have to be either universally recognised or it would have to have received the assent of this country. In holding this the court referred to a passage in Oppenheim *International Law* 8th ed v1 at 39 which states the conditions concerning universal acceptance or state assent for recognition of a rule of customary international law as part of the law of England. Our law and English law in this respect is therefore the same.”



or an Act of Parliament and which promotes 'the values that underlie an open and democratic society based on human dignity, equality and freedom'. The content of customary international law on the issue of a right to health or health care depends upon which view of international customary law is espoused. In terms of so-called modern customary international law, the various treaties and conventions dealing with human rights and socio-economic rights would be of relevance in establishing the content of a customary international law right to health or health care. However, in view of the fact that these instruments will be discussed in detail in the section on public international law, they will not be canvassed here. In the context of the right to health it has been observed that the absence of international case law on the right to health heightens the international legal importance of national cases brought pursuant to the right to health¹³⁰. Even if it may not constitute customary international law at this stage, the Venezuelan case of *Cruz Bermudez, et al v Ministerio de Sanidad y Asistencia Social*¹³¹ is of interest in this context because of certain similarities and contrasts with the leading South African case on access to health care, *Minister of Health and others v Treatment Action Campaign and Others*¹³².

It is a useful illustration of the need to ground the implementation of the human right to health care in the realities of the economic and sociological situation since law in the abstract is of no value outside of the world of ideas. In *Cruz Bermudez*, heard by the Venezuelan Supreme Court in 1999, the plaintiffs argued that the Venezuelan government had violated their rights to life, health and access to scientific advances under Venezuelan law by failing to provide them with antiretroviral (ARV) medication. They asked that the Venezuelan court order the Ministry of Health to remedy these violations by:

¹³⁰ Torres MA 'The Human Right To Health National Courts and Access To HIV/AIDS Treatment: A Case Study from Venezuela' *Chicago Journal of International Law* Spring 2002 105 who observes that "National court decisions can inform international legal analysis in a number of ways. First, national court decisions involving treaty obligations could be said to constitute subsequent state practice under those treaties for the purpose of treaty interpretation. Second, national court decisions can be considered evidence of state practice and *opinio juris* for purposes of determining rules of customary international law. Third, as Article 38(1)(d) of the Statute of the International Court of Justice provides, national court decisions are subsidiary means for interpreting rules of international law." Torres states that the cases being brought by people living with HIV/AIDS against various governments for failing to provide access to ARV therapies and this violating the right to health constitute an important set of materials for international legal analysis of the right to health.

¹³¹ See the report on this case by Torres (fn 130 *supra*)

¹³² *TAC* (fn 113 *supra*)

- providing periodically and regularly all medicines necessary, including ARV therapies and drugs for opportunistic infections, to persons living with HIV/AIDS in Venezuela,
- covering the expenses of persons living with HIV/AIDS for blood tests needed to monitor the disease and the effect of the medication; and
- developing and funding policies and programs to provide medical treatment and assistance for persons living with HIV/AIDS in Venezuela¹³³.

The Ministry of Health argued that the government could not pay for ARV therapy and related medicines for all persons living with HIV/AIDS in Venezuela because such expenses would be impossible to sustain. The Ministry in its defence pointed to its programs on HIV/AIDS prevention involving the distribution of informational booklets and condoms and the implementation of a safe sex initiative as evidence of its fulfilment of its obligations under Venezuelan law concerning health. It argued that it was progressively achieving improvements in connection with HIV/AIDS given the budgetary constraints it was facing as a health ministry in a developing country.

The Venezuelan court focused its opinion on the right to health. Under Venezuelan law there are strong expressions of the right to health in terms of Venezuela's constitution and its international law obligations. Venezuela is a party to the International Convention on Economic Social and Cultural Rights (ICESCR). Venezuela apparently has a monistically inclined view of international law in that treaty duties such as those in the ICESCR create obligations for the state of Venezuela that are directly enforceable by citizens against the government. Furthermore, Venezuela's constitution contains a constitutional right to health.

The Venezuelan court noted that:

- HIV positive people and people with AIDS are protected by the Venezuelan constitution and also by international law.

¹³³ Torres (fn 130 *supra*)

- that on the basis of the evidence presented by the parties, the Ministry of Health was not complying with its duty under the right to health, the immediate consequence of which was to place the lives of the plaintiffs at risk.
- that the Ministry's non-compliance was not intentional but resulted from its lack of financial resources.
- that despite the serious financial constraints the government had violated the plaintiff's right to health and that the Ministry had available mechanisms under Venezuelan law through which it could seek additional funds for the purpose of dealing with the medical requirements of persons living with HIV/AIDS.
- that the Ministry's failure to utilize these mechanisms contributed to the court's view that the Ministry had violated the right to health.
- that its ruling applied to all persons living with HIV/AIDS in Venezuela and not only the plaintiffs.

The court ordered the Ministry *inter alia* to:

- request immediately from the President the funds needed for HIV/AIDS prevention and control for the remaining fiscal year and an increase in budgetary allocations for future needs and
- provide ARV therapies and associated medicines to any persons living with HIV/AIDS in Venezuela¹³⁴.

Despite the court's ruling, the Venezuelan government has done 'little or nothing to improve the access to ARV therapies for persons living with HIV/AIDS.'¹³⁵

¹³⁴ Source: Torres (fn 128 *supra*)

The case is of interest because the court chose to ignore the Health Ministry's plea of poverty even though it acknowledged that Venezuela was facing an economic crisis. It chose to make an order which the Venezuelan government was apparently unable to fulfil. The Venezuelan situation highlights a number of practical problems relating to the right to health care and the monistic approach to international law. International law is as much an ideology as it is a system of law. In some cases, much like the South African Constitution, it is a postulation of what should be rather than what is. It is an instrument to indicate the direction in which nations should move rather than a map of where they currently find themselves¹³⁵. Practically speaking, unless the international community is prepared to rally support for international law as perceived by a domestic court in order to facilitate implementation of a court order supporting that international law, such orders are meaningless and so is the monistic approach to international law. If the international community had made funding available to the Venezuelan government such that it could reasonably implement the court order, the judgment of the Venezuelan Supreme Court would have been of more legal and practical significance. As things stand, however, it is apparently nothing more than a juristic white elephant, reflecting in Venezuelan domestic law, the ideological and abstract nature of much of the international law which informed it.

It is submitted that whilst such a situation may be acceptable in terms of international law, it is not acceptable in terms of domestic law because it not only calls into question the credibility and enforceability of all domestic law, elevating it in the process above the level of law to a lofty, but abstract, ideal, but also the power of domestic courts to uphold domestic law in any meaningful way. To a large extent, the manner of development of international law is very different to that of domestic legal systems. Enforcement is a

¹³⁵ Torres (fn 130 *supra*) She observes that the reality that the Venezuelan government ignores the court's ruling in the *Bermudez* case with impunity only contributes to the widespread perception that the right to health is symbolic rather than vital to the life of the nation and that the active and intelligent participation of the government is critical to improving a population's health, especially in the face of disease threats such as HIV/AIDS.

¹³⁶ *Khala v Minister of Safety and Security* 1994 (4) SA 218 (W) quoted with approval Dickson J, as he then was, in *Hunter et al v Southam Inc* (1985) 11 DLR (4th) 641 (SCC) ((1985) 14 CCC (3d) 97 SCC) at 649 (a case dealing with the Canadian Charter, which also incorporates a Bill of Rights) "A constitution . . . is drafted with an eye to the future. Its function is to provide a continuing framework for the legitimate exercise of governmental power and, when joined by a [Bill or] Charter of Rights, for the unremitting protection of individual rights and liberties... The judiciary is the guardian of the Constitution and must in interpreting its provisions, bear these considerations in mind."

major feature of the latter and its practical implementation is a question not of possibility but of fact. Very often domestic legal systems are reactive rather than proactive within their economic and social environments. They reactively reflect developments in trade practices, technology and societal beliefs and values that have usually preceded them by a number of years.

Legal certainty is a prerequisite for the fairness and credibility of a domestic legal system. Such certainty is necessary not only in relation to what the law is on any given topic but also on the reliability of the legal remedy upheld by the courts. Contrary to international law, domestic law, generally speaking, is not a plea for utopia but rather a periodically updated street map indicating the highways and byways of current commercial and cultural practices, social values and beliefs. Socioeconomic rights in particular are inextricably linked with social and, most importantly, economic realities. By definition, any attempt to divorce them from the economic realities of a given situation renders them empty of meaning and value. The judgment of the Venezuelan court directed the Ministry of Health to request more funding from the President for ARV therapies and related medication, despite the fact that Venezuela was facing an economic crisis. There does not appear to have been a concurrent obligation imposed upon the President to make such funds available, even assuming that they existed. If such funds did not in fact exist, any order imposing upon the President a duty to make them available would in any event have been pointless. Without the additional funding, the Ministry of Health could not implement the remaining injunctions to make ARV therapies available not only to the plaintiffs but to all Venezuelans. The Venezuelan court effectively wrote a prescription that the Ministry of Health could not fill. The value of such a prescription to the patient is severely limited.

The ethereal quality of the judgment of the Venezuelan court is in marked contrast to the groundedness of the judgment of the South African constitutional court in the *TAC* case¹³⁷. The South African constitutional court judgment not only recognised expressly the need for government to be able to set policy and determine the allocation of scarce

¹³⁷ *TAC* fn 113 *infra*

resources but also *‘that the corresponding rights themselves are limited by reason of the lack of resources’*¹³⁸. It observed that ‘Courts are ill-suited to adjudicate upon issues where court orders could have multiple social and economic consequences for the community.’ The court acknowledged that the Constitution ‘contemplates rather a restrained and focused role for the courts, namely, to require the state to take measures to meet its constitutional obligations and to subject the reasonableness of these measures to evaluation’¹³⁹. The result was an order far more capable of implementation which carefully balanced the power of the executive branch of government to make policy against the rights of the poor to access to medical treatment whilst maintaining the credibility of the court¹⁴⁰. The government was ordered without delay to –

- Remove the restrictions that prevented Nevirapine from being made available for the purpose of reducing the risk of mother-to-child transmission of HIV at public hospitals and clinics that were not research training sites.
- Permit and facilitate the use of Nevirapine for the purpose of reducing the risk of mother-to-child transmission of HIV and to make it available for this purpose at hospitals and clinics when in the judgment of the attending medical practitioner acting in consultation with the medical superintendent of the facility concerned this was medically indicated, which would if necessary include that the mother concerned has been appropriately tested and counselled.
- Make provision if necessary for counsellors based at public hospitals and clinics other than the research and training sites to be trained for the counselling necessary for the use of Nevirapine to reduce the risk of mother-to-child transmission of HIV.

¹³⁸ *Minister of Health and Others v Treatment Action Campaign and Others (No 2)* (fn 113 *supra*) quoting with emphasis *Soobramoney v Minister of Health, KwaZulu-Natal* (fn 86 *supra*).

¹³⁹ *TAC* fn 113 *supra* at 1047 E-F

¹⁴⁰ See chapter 2 for a full discussion of the case.

- Take reasonable measures to extend the testing and counselling facilities at hospitals and clinics throughout the public health sector to facilitate and expedite the use of Nevirapine for the purpose of reducing the risk of mother-to-child transmission of HIV.

The court expressly stated that the abovementioned orders did not preclude government from adapting its policy in a manner consistent with the Constitution if equally appropriate or better methods became available to it for the prevention of mother-to-child transmission of HIV. The drug, Nevirapine, was at the time of the judgment available to the government free of charge.

The efficacy and usefulness of customary international law with regard to enforcement of the right to health has been questioned by more than one writer¹⁴¹ despite the fact that customary international law has been identified as one of two major sources of international human rights law that are relevant to the right to health¹⁴².

Kinney points out that under the principles for the development of customary international law, widespread ratification of UN and regional treaties and other instruments recognizing international human rights can establish an international customary law of human rights. She says that specifically treaties, declarations and other instruments become evidence of a general state practice in which states engage out of a sense of legal obligation. As evidence of general practice followed out of a sense of legal obligation, they establish the human rights obligations on states, including the United States, that have not ratified treaties. She gives as an example the possibility that the International Convention on Economic Social and Cultural Rights (ICESCR) is arguably customary international law due to its widespread acceptance internationally. As a consequence it may be binding on all countries regardless of ratification¹⁴³. This said, Kinney concedes that recognition of an international right to health as a matter of

¹⁴¹ Fidler, (fn 125 *supra*) and Kinney (fn 51 *supra*)

¹⁴² Kinney 'The International Human Right To Health: What Does This Mean for Our Nation and our World?' (fn 51 *supra*) at p 1459.

¹⁴³ Kinney (fn 51 *supra*) at p1465. This view is not without its opponents both with regard to this method of derivation of customary international law and to the fact that customary international law can bind states without their consent.

international customary law ‘has some problems’¹⁴⁴, observing that ‘there is a circularity in the rationale for international customary law that is problematic’. She goes on to say that ‘Realistically, implementation and enforcement of the international right to health is difficult particularly if predicated on customary international law’ and that the United States and other nations would probably not tolerate excessive interference in their domestic affairs if they have not ratified the ICESCR¹⁴⁵.

Depending upon which approach one adopts to customary international law, and despite the claims of Kinney, it may well be that there is in fact no real customary international law right to health or health care and that the relevant international law is not customary international law at all but rather public international law in the form of written conventions and treaties. The reason for such a conclusion relates in part to the difficulty of establishing the content of a right to health or health care at customary international law. Kinney herself acknowledges that there are significant economic, social and cultural differences among the nations of the world which render it difficult to specify the content of a universal international right to health in a meaningful way¹⁴⁶.

1.5 Public International Law and the Right To Health

The right to health is expressed in different ways in a number of different international instruments. The preamble to the constitution of the World Health Organisation, adopted in 1946, states that:

“The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social conditions.”

¹⁴⁴ Kinney (fn 51 *supra*) at p 1467

¹⁴⁵ Kinney (fn 51 *supra*) at p 1472

¹⁴⁶ Kinney (fn 51 *supra*) proposes as a solution to these economic social and cultural differences that a first step would be to define universal outcome measures that measure compliance with the core state obligations of the human right to health. Unfortunately this begs the question. How does one go about establishing a set of core obligations given the diversity of the economic social and cultural circumstances in which different states find themselves? The very idea of a core assumes a certain common denominator in terms of economic, social and cultural factors. The South African constitutional court has rejected the direct application of the concept of minimum core in both the *Grootboom* (fn 57 *supra*) and the *TAC* (fn 113 *supra*) cases. The imposition upon a state of minimum core obligations which it cannot possibly fulfil for economic, social or cultural reasons simply invalidates the minimum core concept as a realistic method of ascertaining the contents of the right.

The variety of the language used in the various international instruments whose scope includes rights impacting on health illustrates the need for a detailed focus on the content of the rights that are recognised. There is also the question of whether the international instrument concerned should be interpreted using a textual approach so that the rights contained therein are interpreted purely with regard to the wording of the instrument itself or whether regard must also be had to other international legal instruments containing similar provisions. Put differently, are the various rights to health expressed in international treaties and conventions all expressions of different rights or different expressions of the same global right? If the latter, then what is the content and implications of such right? If it could be shown that there was such a single right, the arguments for the existence of such a right as part of customary international law and even *jus cogens* might be stronger than if there existed a number of different rights which were not widely supported or recognised by significant numbers of nation states. If the right is fragmented then it could be argued that certain fragments have passed into customary international law or *jus cogens* but not others. It is all very well to ardently allege that human rights are principles of *jus cogens* and that socio-economic rights as a sub-category of such human rights are thus also part of the *jus cogens* but if there is no significant agreement as to the content of such rights then their categorisation as *jus cogens* is academic.

South Africa is a signatory of the International Convention on Economic, Social and Cultural Rights (ICESCR) and has ratified the Convention on the Rights of the Child (CRC) and the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW). It has not, however, expressly enacted every provision of these international agreements into domestic law as contemplated by section 231(4) of the Constitution. The Constitution for instance contains a general prohibition on unfair discrimination, including discrimination on the basis of gender but this is not in the express terms of CEDAW. Whilst the Bill of Rights reflects the rights of children to certain essentials, it certainly does not reflect the sweeping language of the CRC. The

Promotion of Equality and Prevention of Unfair Discrimination Act¹⁴⁷ deals with issues of discrimination but does not expressly enact CEDAW. The constitutional obligation of the state to achieve the progressive realisation of certain socio-economic rights echoes the ICESCR obligation to achieve progressively the full realisation of the rights but the constitutional right of access to health care services does not contain the specific provisions of Article 12 of the ICESCR relating to reduction of stillbirths and infant mortality, the prevention and control of diseases and the improvement of all aspects of industrial and environmental hygiene. Thus, whilst these conventions are binding upon the Republic as a nation state at international law, they are not necessarily binding upon inhabitants of the Republic as domestic law.

There are a number of international commentaries upon the ICESCR which have attempted to add flesh to the bare bones of the rights expressed in the instrument itself. General comment number 14 of the United Nations Committee on Economic, Social and Cultural Rights is one such document. This comment observes that the ICESCR ‘provides the most comprehensive article on the right to health in international human rights law’. It is not clear whether this is a claim to supremacy over other international instruments referring to a right to health. However, it is of interest that the statement implies that there is a single right to health in international human rights law and that there may be different statements of this single right in other international law instruments. A further point of interest possibly in contrast to the implication that there is a single right to health in international law is that the Committee states expressly that in drafting article 12 of the ICESCR the Third Committee of the United Nations General Assembly did not adopt the definition of health contained in the preamble to the constitution of the WHO. The Committee is thus distancing the right as expressed in the ICESCR from that expressed in the WHO constitution. It observes that the reference in article 12.1 of the Covenant to “the highest attainable standard of physical and mental health” is not confined to the right to health care and that the drafting history and express wording of article 12.2 acknowledge that the right to health embraces a wide range of

¹⁴⁷ Act No 4 of 2000. See also the Domestic Violence Act 116 of 1998 and the Criminal Law (Sexual Offences) Amendment Bill (B50-2003), which is not yet law. They both acknowledge CEDAW in their preambles. The latter makes provision for sexual offences such as rape and compelled or induced indecent acts while the former provides for the issuing of protection orders with regard to domestic violence. They seek to give effect to CEDAW without necessarily enacting its express provisions.

socio-economic factors that promote conditions in which people can lead a healthy life. The Committee points out that this extends to the underlying determinants of health such as food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions and a healthy environment.

Significantly, the Committee refers to the right to health as a goal and observes that in many cases, especially for those living in poverty, this goal is becoming increasingly remote. The nature of the right to health contemplated in the ICESCR is thus an ideal rather than a practical reality.¹⁴⁸ The idea of using the law to attain ideals is in many respects peculiar to international law. Constitutions aside, domestic legal systems still tend to approach the question of rights from the perspective of what is presently reasonably attainable. Generally speaking, in domestic law terms a right which cannot be enforced or protected in a practical way is hardly worth the name. Furthermore, ideals of this nature, at least in the South African context, are very much the province of the executive and legislative branches of government as opposed to the judiciary, given the role of the judiciary as expressed by Chaskalson P in the *TAC* case¹⁴⁹. The progressive realisation of the right to health care services in South Africa, it is submitted, is rather more the task of the national executive than it is of the courts who by their own admission are ill-suited to make decisions which could have multiple social and economic consequences for the community. It is further submitted that an overly idealistic interpretation by the judiciary of the socio-economic rights granted in the Bill of Rights would diminish the effective value of the right in question by elevating it beyond the realms of what is practical and achievable. One ends up with judgments which, although laudable in their intentions and limitless in their scope, are not realistically capable of implementation. The right, when interpreted by the judiciary in such a manner, becomes hollow and the practical ends that the right is designed to achieve are thus defeated. A more limited and pragmatic judgment that can be put into

¹⁴⁸ This nicety appears to have escaped the Venezuelan court in the *Cruz Bermúdez* case (fn 130 *supra*)

¹⁴⁹ *TAC* fn 113 *supra*

effect is of considerably greater value as indicated by the outcomes for the holders of the rights in the *Grootboom*¹⁵⁰ and *TAC* cases.

When one comes to an examination of the right to health care services in terms of section 27 of the Constitution in the light of international law, it is submitted that one must bear in mind that direct comparisons, and inferences of direct relationships, between domestic rights and international ones may not always be appropriate due to the fact that the domestic rights must be considered for the most part in the light of present realities rather than that of dreams of the future.¹⁵¹ This precept has been clearly recognised by the South African constitutional court with regard to the concept of the minimum core content of socio-economic rights in both *Grootboom*'s and the *TAC* cases. It also illustrates the fact that whilst a nation state may recognise the basic principle of a right as stated in an instrument of public international law, the content of the right is subject to interpretation with regard to domestic legal and other circumstances. The relationship between international and domestic law is not as simple or direct as certain *amici curiae* have argued¹⁵². Comparisons of rights in international law with rights expressed in the

¹⁵⁰ *Grootboom* fn 57 *supra*

¹⁵¹ The Constitutional court in *TAC* (fn 113 *supra*) pointed to the statement in *Grootboom* (fn 57 *supra*) that "millions of people are living in deplorable conditions and in great poverty. There is a high level of unemployment, inadequate social security and many do not have access to clean water or to adequate health services. These conditions already existed when the Constitution was adopted..." as the relevant context in which socio-economic rights need to be interpreted. While it is true that Madala J in *Scoobramoney* stated that "Some rights in the Constitution are the ideal and something to be strived for. They amount to a promise in some cases, and an indication of what a democratic society aiming to salvage loss, dignity, freedom and equality should embark upon. They are values which the Constitution seeks to provide nurture and protect for a future South Africa" and so some of the rights in the Constitution are also ideals, they must have some degree of substance within the present in order to be meaningful. The fact that the test used by the courts to ascertain whether or not the state is fulfilling its constitutional obligations is one of reasonableness supports this assertion since it implies that the present circumstances in which the right is sought to be upheld are the relevant context for such test. Madala J in *Scoobramoney* acknowledges this need for present value in pointing out that "In its language, the Constitution accepts that it cannot solve all our society's woes overnight, but must go on trying to resolve these problems." The Constitutional Court pointed out in *Ex parte Chairperson of the Constitutional Assembly: In re: Certification of the Constitution of the Republic of South Africa 1996* (1996 (4) SA 744 (CC) at para 78) in dealing with an objection that socio-economic rights are not justiciable, that "At the very minimum, socio-economic rights can be negatively protected from improper invasion." The content of the right may change as circumstances change, but it must have some degree of content in the present. In the *TAC* case the court, referring to *Scoobramoney*, explicitly recognised the fact that "the corresponding rights themselves are limited by reason of the lack of resources". This observation, coupled with the fact that the test is one of reasonableness, leads to the inevitable conclusion that the content of the right may be subject to fluctuation, depending upon changing circumstances and the availability of resources. This is why, as Yacob J stated in *Grootboom* (fn 57 *supra* at 61) "The question is therefore not whether socio-economic rights are justiciable under our Constitution, but how to enforce them in a given case. This is a very difficult issue which must be carefully explored on a case-by-case basis." The concept of a minimum core is rigid and as such does not sit comfortably with the flexibility of the test of reasonableness in the prevailing circumstances. What is reasonable for today may not be reasonable for tomorrow if there has been a change in the available resources.

¹⁵² *In Government of the Republic of South Africa and Others v Grootboom and Others* (fn 57 *supra*) and *Minister of Health and Others v Treatment Action Campaign and Others* (fn 113 *supra*)

Constitution are further complicated by the postulate of international law that all human rights are indivisible and interdependent¹⁵³.

Whilst this postulate is not disputed within South African domestic law¹⁵⁴, the body of rights granted by the Bill of rights is not expressed in exactly the same terms as the body of similar rights at international law. One is therefore not engaging upon a simple comparison of a single right at international law with a single right at domestic constitutional law but rather a comparison at various levels of complex matrices of rights (one of which is openly recognised as an expression of ideals whilst the other also seeks to achieve tangible and practical legal realities) often beset with their own internal conflicts. Where there is an internal conflict between constitutional rights, a balancing of the rights must take place. Where there is an internal conflict between human rights at international law and an internal conflict between similar rights in domestic law, it is submitted that the internal conflict between the domestic rights¹⁵⁵ must first be resolved before any consideration of international law can fruitfully take place¹⁵⁶. Consistency is a prerequisite of a rational and clearly principled domestic legal system. Considerations of international law which do not promote such consistency are likely to lead ultimately to an internally fragmented and chaotic domestic legal order with diminution of the value of the body of rights it seeks to confer. Once a balance between the domestic rights has been

¹⁵³ Fact Sheet No 16 (Rev.1) The Committee on Economic, Social and Cultural Rights www.unhcr.org/html/menu6/2/fs16.htm and General Comment No 14: The Right to the Highest Attainable Standard of Health of the United Nations Committee on Economic, Social and Cultural Rights E/C.12/2000/4 where it is stated that: "The right to health is closely related to and dependent upon the realization of other human rights as contained in the International Bill of Rights, including the right to food, housing, work, education, human dignity, life, non-discrimination, equality, the prohibition against torture, privacy, access to information and the freedoms of association, assembly and movement. These and other rights and freedoms address integral components of the right to health."

¹⁵⁴ See for instance the observations of the court in *S v Makwanyane and Another* (fn 23 *supra*) concerning the centrality of the rights to dignity and life and their interrelationship with other rights. See also *Government of the Republic of South Africa and Others v Grootboom and Others* (fn 57 *supra*) where the court stated that: "The right of access to adequate housing cannot be seen in isolation. There is a close relationship between it and the other socio-economic rights. Socio-economic rights must all be read together in the setting of the Constitution as a whole. The state is obliged to take positive action to meet the needs of those living in extreme conditions of poverty, homelessness or intolerable housing. Their interconnectedness needs to be taken into account in interpreting the socio-economic rights, and, in particular, in determining whether the state has met its obligations in terms of them."

¹⁵⁵ Sachs J in *Soobramoney v Minister of Health, KwaZulu-Natal*, (fn 86 *supra*) at 783 observes that: "Traditional rights analyses accordingly have to be adapted so as to take account of the special problems created by the need to provide a broad framework of constitutional principles governing the right of access to scarce resources and to adjudicate between competing rights bearers. When rights by their very nature are shared and inter-dependent, striking appropriate balances between the equally valid entitlements or expectations of a multitude of claimants should not be seen as imposing limits on those rights (which would then have to be justified in terms of s 36), but as defining the circumstances in which the rights may most fairly and effectively be enjoyed." See also *Qoqeleni v Minister of Law and Order and Another* 1994 (3) SA 625 (E) which states that when rights clash a balancing of the rights must take place.

¹⁵⁶ Obviously if such conflicts have been encountered and resolved at international law this may serve as a useful guide for resolving similar conflicts within domestic law.

achieved, a balancing of the conflicting rights at international law should be undertaken and the result should then be considered with regard to the balance achieved with regard to the conflicting rights at domestic law. In view of the foregoing, the processes of legal reasoning envisaged by section 39(1) of the Constitution require at first, a wide angled, global consideration of both the relevant international and domestic law as *systems* of law, before the convergent, analytical approach of Lord Simon of Glaisdale¹⁵⁷ may successfully be applied to individual principles within those systems. Synthesis is thus as much a necessity as analysis in this particular area of law.

1.6 Minimum Core

Minimum core content has been described as the non-negotiable foundation of a right to which all individuals, in all contexts under all circumstances are entitled. The term 'core content' refers to the entitlements which make up the right. Minimum core content is not the same as the core content of a right¹⁵⁸. The question of availability of resources, although recognised by the ICESCR, is played down to some extent by the United

¹⁵⁷ *Miliangos v George Frank (Textiles) Ltd* [1976] AC 443 ([1975] 3 All ER 801 (HL)) at 481-2 (AC) and 834h-824a (All ER) in which Lord Simon of Glaisdale observed that: "(T)he training and qualification of a Judge is to elucidate the problem immediately before him, so that its features stand out in stereoscopic clarity. But the beam of light which so illuminates the immediate scene seems to throw surrounding areas into greater obscurity; the whole landscape is distorted to the view. A penumbra can be apprehended, but not much beyond; so that when the searchlight shifts a quite unexpected scene may be disclosed. The very qualifications for the judicial process thus impose limitations on its use. This is why judicial advance should be gradual. I am not trained to see the distant scene: one step is enough for me should be the motto on the wall opposite the Judge's desk. It is, I concede, a less spectacular method of progression than somersaults and cartwheels; but it is the one best suited to the capacity and resources of a Judge. We are likely to perform better the duties society imposed on us if we recognise our limitations. Within the proper limits there is more than enough to be done which is of value to society" as cited with approval by Brand J in *Van Biljon and Others v Minister of Correctional Services and Others* 1997 (4) SA 441 (C) at 451.

¹⁵⁸ Provea (a South American non-governmental organisation) 'Health as a Right: Framework for the National and International Protection of the Human Right to Health', Caracas, 1996 at 39. Provea states that: "We consider that by establishing a minimum, uniform "floor" below which a state may not descend does not weaken the right in question, provided that the content is understood as a starting point and not as the arrival point. Furthermore, establishing a framework assures a uniform basis to be respected, even by the states with insufficient economic resources or subjected to critical economic situations." See paragraph 10 of General Comment 3 of the United Nations Committee on the ICESCR referred to in *Grootboom* where it is said: '10. On the basis of the extensive experience gained by the Committee, as well as by the body that preceded it, over a period of more than a decade of examining states Parties' reports the Committee is of the view that minimum core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights is incumbent upon every state party. Thus, for example, a state party in which any significant number of individuals is deprived of essential foodstuffs, of essential primary health care, of basic shelter and housing, or of the most basic forms of education, is *prima facie*, failing to discharge its obligations under the Covenant. If the Covenant were to be read in such a way as not to establish such a minimum core obligation, it would be largely deprived of its *raison d'être*. By the same token, it must be noted that any assessment as to whether a state has discharged its minimum core obligation must also take account of resource constraints applying within the country concerned. Article 2(1) obligates each state party to take the necessary steps "to the maximum of its available resources". In order for a state party to be able to attribute its failure to meet at least its minimum core obligations to a lack of available resources it must demonstrate that every effort has been made to use all resources that are at its disposition in an effort to satisfy, as a matter of priority, those minimum obligations.' See also the reference in *Minister of Health and Others v Treatment Action Campaign and Others* [fn 113 *supra*] to General Comment 3 "The nature of states parties obligations (Art 2, par.1)" 12/12/90

Nations Committee in its General Comment No 3¹⁵⁹ possibly because this concept has been criticised as being a loophole for states parties to use in order to escape their obligations in terms of the Convention. The exact nature of the minimum core of the right to health care is not expressly stated in any instrument of international law¹⁶⁰.

In their arguments concerning the minimum core concept the *amici* in *Grootboom* referred firstly to Article 11.1 of the Covenant on Economic Social and Cultural Rights which provides that:

“The States Parties to the present Covenant recognise the right of everyone to an adequate standard of living for himself and his family including adequate food, clothing and housing and to the continuous improvement of living conditions. The States Parties will take appropriate steps to ensure the realisation of this right recognising to this effect the essential importance of international co-operation based on free consent.”

They then referred to the relevant general comments issued by the United Nations Committee on Economic, Social and Cultural Rights concerning the interpretation and

¹⁵⁹ In General Comment 3 on the ICESCR at paragraph 11, the United Nations Committee on the ICESCR notes that: “The Committee wishes to emphasize, however, that even where the available resources are demonstrably inadequate, the obligation remains for a state party to strive to ensure the widest possible enjoyment of the relevant rights under the prevailing circumstances. Moreover the obligations to monitor the extent of the realization, or more especially the non-realization, of economic, social and cultural rights, and to devise strategies and programmes for their promotion, are not in any way eliminated as a result of resource constraints.”

¹⁶⁰ There appears to be considerable controversy surrounding the definition of minimum core at international level. Some are of the view that it is too difficult to establish universally approved standards. The United Nations Committee on Economic, Social and Cultural Rights (CESCR) appears to support such a view. It has stated that: “As the ideal of the human being is to attain the highest possible standard of living, it is not possible to fix a uniform minimum limit below which a given state is considered to be in breach of its health-related obligations” (Juan Alvarez Vita, “Discussion note” in CESCR. Report on the ninth session, E/C.12/1993/19, p63. Vita is a former member of the CESCR) By contrast, Provea, a Venezuelan Non-Governmental Organisation (NGO), undertook a systematic research project on the right to health. An intensive bibliographical search revealed that most of the sources consulted either addressed specific aspects of the right to health, or treated it in an introductory or general manner. When it discovered that there was insufficient material defining the right to health, Provea attempted to delineate a conceptual framework for protecting the right to health. Some of the principles that informed the work of Provea were:

- Defining minimum core content is a relatively unexplored area, but it is necessary to arrive at an objective definition of each right;
- The minimum core content of a right establishes the minimal conditions that each individual should enjoy, in the absence of which the right is understood to be absent;
- Having a definition of content is a valuable instrument for enforcement, as it makes it possible to have a minimum standard for evaluating the observance of a right;
- Defining minimum contents needs to be understood as a dynamic process;
- The principle of universality is assumed, i.e. all human beings by nature are entitled to all human rights. The fact that different legal orders may establish different levels of protection does not mean that some have more of a right than others do;
- In a world of constant change and diverse scenarios, it is possible to identify common elements that constitute a core aspect of the right, independent of available resources or political, economic, social or cultural context;
- For health the starting point for arriving at a definition is to be found in the standards established in treaties that provide for the protection of the right, which are a necessary frame of reference but which always need to be improved;
- A secondary source is a comprehensive view of health emanating from the international doctrine as to what constitutes health that has been developed by the World Health Organization, among others.

See further www.hrusa.org/hrmaterials/THRIP/cirole/modules/module8.htm

application of the Covenant and argued that these general comments constitute a significant guide to the interpretation of section 26 of the Constitution. Paragraph 10 of general comment 3, issued by the Committee in 1990 states:

“10. On the basis of the extensive experience gained by the Committee, as well as by the body that preceded it, over a period of more than a decade of examining States Parties’ reports the Committee is of the view that minimum core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights is incumbent upon every State Party. Thus, for example, a State party in which any significant number of individuals is deprived of essential foodstuffs, of essential primary health care, of basic shelter and housing, or of the most basic forms of education, is *prima facie*, failing to discharge its obligations under the Covenant. If the Covenant were to be read in such a way as not to establish such a minimum core obligation, it would be largely deprived of its *raison d’être*. By the same token, it must be noted that any assessment as to whether a State has discharged its minimum core obligation must also take account of resource constraints applying within the country concerned. Article 2(1) obligates each State party to take the necessary steps ‘to the maximum of its available resources’. In order for a State party to be able to attribute its failure to meet at least its minimum core obligations to a lack of available resources it must demonstrate that every effort has been made to use all resources that are at its disposition in an effort to satisfy, as a matter of priority, those minimum obligations.”¹⁶¹

Yacoob J observed that it was clear from this extract that the committee considered that every state party is bound to fulfil a minimum core obligation by ensuring the satisfaction of a minimum essential level of the socio-economic rights, including the right to adequate housing and that a state in which a significant number of individuals is deprived of basic shelter and housing is regarded as *prima facie* in breach of its obligations under the Covenant. He also observed that it was to be noted that the general comment does not specify precisely what minimum core is although a guideline is given in that it is

¹⁶¹ Yacoob J in *Grootboom* (fn 57 *supra*) at 64-65. General Comment No 14: The Right to the Highest Attainable Standard of Health Document Number E/C.12/2000/4 of the United Nations Committee on Economic, Social and Cultural Rights identifies core obligations of the right to health as:

- (a) to ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups;
- (b) to ensure access to the minimum essential food which is nutritionally adequate and safe, to ensure freedom from hunger to everyone;
- (c) to ensure access to basic shelter, housing and sanitation, and an adequate supply of safe and potable water;
- (d) to provide essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs;
- (e) to ensure equitable distribution of all health facilities, goods and services;
- (f) to adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population; the strategy and plan of action shall be devised, and periodically reviewed, on the basis of a participatory and transparent process; they shall include methods, such as right to health indicators and benchmarks, by which progress can be closely monitored; the process by which the strategy and plan of action are devised, as well as their content, shall give particular attention to all vulnerable or marginalized groups.

The Committee also confirmed that the following obligations are of comparable priority:

- (a) to ensure reproductive, maternal (pre-natal as well as post-natal) and child health care;
- (b) to provide immunization against the major infectious diseases occurring in the community;
- (c) to take measures to prevent, treat and control epidemic and endemic diseases;
- (d) to provide appropriate training for health personnel, including education on health and human rights.

determined generally by having regard to the needs of the most vulnerable group that is entitled to the protection of the right in question¹⁶².

Yacoob J rejected the principle of minimum core with the following logic:

“It is not possible to determine the minimum threshold for the progressive realisation of the right of access to adequate housing without first identifying the needs and opportunities for the enjoyment of such a right. These will vary according to factors such as income, unemployment, availability of land and poverty. The differences between city and rural communities will also determine the needs and opportunities for the enjoyment of this right. Variations ultimately depend on the economic and social history and circumstances of a country. All this illustrates the complexity of the task of determining a minimum core obligation for the progressive realisation of the right of access to adequate housing without having the requisite information on the needs and the opportunities for the enjoyment of this right. The committee developed the concept of minimum core over many years of examining reports by reporting states. This Court does not have comparable information. The determination of a minimum core in the context of ‘the right to have access to adequate housing’ presents difficult questions. This is so because the needs in the context of access to adequate housing are diverse: there are those who need land; others need both land and houses; yet others need financial assistance. There are difficult questions relating to the definition of minimum core in the context of a right to have access to adequate housing, in particular whether the minimum core obligation should be defined generally or with regard to specific groups of people. As will appear from the discussion below, the real question in terms of our Constitution is whether the measures taken by the State to realise the right afforded by s 26 are reasonable. There may be cases where it may be possible and appropriate to have regard to the content of a minimum core obligation to determine whether the measures taken by the State are reasonable. However, even if it were appropriate to do so, it could not be done unless sufficient information is placed before a Court to enable it to determine the minimum core in any given context. In this case, we do not have sufficient information to determine what would comprise the minimum core obligation in the context of our Constitution. It is not in any event necessary to decide whether it is appropriate for a Court to determine in the first instance the minimum core content of a right.”

The court appeared to regard even the concept of minimum core as being variable in content depending upon the given context. Despite this reasoned and clear rejection by the constitutional court of the general concept of a minimum core obligation as expressed in international law, the *amici* in the *TAC* case renewed attempts to have it introduced into South African law. The constitutional court in this case referred to the judgements in both *Grootboom*¹⁶³ and *Soobramoney*¹⁶⁴ and stated bluntly that, “It is impossible to give everyone access even to a “core” service immediately. All that is possible, and all that can be expected of the state, is that it act reasonably to provide access to the socio-

¹⁶² *Grootboom* (fn 57 *supra*) at p65

¹⁶³ *Grootboom* (fn 57 *supra*)

¹⁶⁴ *Soobramoney* (fn 86 *supra*)

economic rights identified in sections 26 and 27 on a progressive basis.”¹⁶⁵ The constitutional court in the *TAC* case concluded that “section 27(1) of the Constitution does not give rise to a self-standing and independent positive right enforceable irrespective of the considerations mentioned in section 27(2). Sections 27(1) and 27(2) must be read together as defining the scope of the positive rights that everyone has and the corresponding obligations of the state to ‘respect, protect, promote and fulfil’ such rights.

It is submitted that the nomenclature ‘minimum core’ or “core obligations’ is in any event a misnomer when the extent of the enunciation of the United Nations Committee on the International Covenant on Economic, Social and Cultural Rights of what it considers to be core obligations in General Comment No. 14 is considered. The ‘core’ obligations listed in the Comment are so comprehensive that it is difficult to conceive of any obligations that might be on the periphery concerning the right to health¹⁶⁶.

1.7 International Legal Principles Applied Locally

The constitutional court’s rejection of the minimum core principle is indicative not only of the manner in which the constitutional court is implementing section 39(1) but also of the fact that international law interpretations of rights contained in instruments such as the International Convention on Economic, Social and Cultural Rights will not be applied without question to situations involving similar rights in domestic law. International legal principles are applicable within the South African legal system only to the extent that they are consistent with the principles of the Constitution and South Africa’s unique historical and social context¹⁶⁷. Arguments which attempt to import piecemeal international legal principles and doctrines into the South African legal system not only indicate an overly simplistic view of the South African legal system but are also distinctly

¹⁶⁵ *TAC* fn 113 *supra* at 1046 G

¹⁶⁶ General Comment of ICESCR Committee see fn 161 *supra*

¹⁶⁷ Yacoob J in *Grootboom* (fn 57 *supra* at p 62) stated: “Interpreting a right in its context requires the consideration of two types of context. On the one hand, rights must be understood in their textual setting. This will require a consideration of chap 2 and the Constitution as a whole. On the other hand, rights must also be understood in their social and historical context. Our Constitution entrenches both civil and political rights and social and economic rights. All the rights in our Bill of Rights are inter-related and mutually supporting.”

inadvisable given the holistic and teleological approach of the South African courts to questions of interpretation of constitutional rights and the consideration of international law. Yacoob J in *Grootboom* expressly detailed the differences between the right to housing expressed in the ICESCR and the right to housing expressed in the Constitution. He pointed out that the Covenant provides for a right to adequate housing while section 26 provides for right of access to adequate housing, that the Covenant obliges states parties to take appropriate steps which must include legislation while the Constitution obliges the South African state to take *reasonable* legislative and other measures. If one performs the same exercise with regard to Article 12 of the ICESCR and section 27 of the Constitution the differences that emerge are as follows:

1. The ICESCR recognizes the right of everyone to the enjoyment of the “highest attainable standard of physical and mental health” while section 27(1) of the Constitution refers explicitly to a right of *access* to health care services, including reproductive health care. The South African Constitution thus does not even recognise a right to health *per se* but rather a right to health care services in particular. This right is defined in terms of access which implies *inter alia* that the health services in question will not necessarily be free of charge. A standard of health, attainable or not, is not a feature of section 27(1).
2. The right to health in the ICESCR makes no specific mention of emergency medical treatment as does section 27(3) of the Constitution.
3. The right to health in the ICESCR details certain specific steps to be taken by states parties in order to achieve the full realization of the right to health such as the provision for the reduction of the stillbirth-rate and of infant mortality and for the development of the healthy child; the improvement of all aspects of environmental and industrial hygiene; the prevention, treatment and control of epidemic, endemic, occupational and other diseases; the creation of conditions which would assure to all medical service and medical attention in the event of sickness. Section 27 contains no such detailed prescriptions. Instead, section 27(2) provides that the state must take

reasonable legislative and other measures within its available resources to achieve the progressive realisation of each of these rights.

These differences are clearly considerable and even greater than those elucidated by Yacoob J with regard to the right to housing in *Grootboom*¹⁶⁸. Yacoob J stated in that case that “The differences between the relevant provisions of the Covenant and our Constitution are significant in determining the extent to which the provisions of the Covenant may be a guide to interpretation of section 26”.¹⁶⁹ The ICESCR is thus of limited value as an interpretational tool when considering the right to health care services under section 27 of the Constitution.

This said, a study of the judgments of the Constitutional Court relating to socio-economic rights reveals that the court is indeed developing its own jurisprudence on human rights generally and socio-economic rights in particular, many of which are not inconsistent, in broad terms, with international legal principles relating to such rights. From the judgments in *Soobramoney vs Minister of Health (Kwazulu-Natal)*¹⁷⁰, *Government of the Republic of South Africa and others v Grootboom and Others*¹⁷¹, and *Minister of Health and Others v Treatment Action Campaign and Others*¹⁷² it is clear that certain legal principles are gradually coalescing to flesh out the bare bones of the constitutional provisions relating to these rights. These principles are as follows:

1. There must be provision by the state within legislative and policy frameworks for mechanisms to address ‘hard cases’ or, as the constitutional court has put it, the situation of people “in desperate need”¹⁷³.

¹⁶⁸ *Grootboom* (fn 57 *supra*)

¹⁶⁹ *Grootboom* (fn 57 *supra*) at p64

¹⁷⁰ *Soobramoney* (fn 86 *supra*)

¹⁷¹ *Grootboom* fn 57 *supra*

¹⁷² *TAC* fn 113 *supra*

¹⁷³ *Government Of The Republic Of South Africa And Others v Grootboom And Others* (fn 57 *supra*): “The nationwide housing program falls short of obligations imposed upon national government to the extent that it fails to recognise that the state must provide for relief for those in desperate need. They are not to be ignored in the interests of an overall program focussed on medium and long-term objectives. It is essential that a reasonable part of the national housing budget be devoted to this, but the precise allocation is for national government to decide in the first instance” and also “The state is obliged to take positive action to meet the needs of those living in extreme conditions of poverty, homelessness or intolerable housing.”

2. There must be flexibility in state policies and programmes to address changing situations and needs¹⁷⁴.
3. The state is responsible for the creation of circumstances in which the rights of the individual may be realized and must take positive action¹⁷⁵.
4. Socio-economic rights and the corresponding obligations of the state must be interpreted within their social and historical context¹⁷⁶.
5. The test of reasonableness will be applied. State policies and programmes must be reasonable both in their conception and their implementation¹⁷⁷.
6. Urgency of the need is an important factor. Of relevance here is the degree of discrepancy between the “haves” and the “have-nots” with regard to the right in question¹⁷⁸.

¹⁷⁴ *Government Of The Republic Of South Africa And Others v Grootboom And Others* (fn 57 *supra*) “The program must be balanced and flexible and make appropriate provision for attention to housing crises and to short, medium and long term needs. A program that excludes a significant segment of society cannot be said to be reasonable. Conditions do not remain static and therefore the program will require continuous review.” Also *Minister of Health and Others v TAC and Others* (fn 113 *supra*) “The rigidity of government’s approach has affected its policy as a whole... A factor that needs to be kept in mind is that policy is and should be flexible.”

¹⁷⁵ *Government Of The Republic Of South Africa And Others v Grootboom And Others* (fn 57 *supra*): “A right of access to adequate housing also suggests that it is not only the state who is responsible for the provision of houses, but that other agents within our society, including individuals themselves, must be enabled by legislative and other measures to provide housing. The state must create the conditions for access to adequate housing for people at all economic levels of our society. State policy dealing with housing must therefore take account of different economic levels in our society” and also “to be reasonable, measures cannot leave out of account the degree and extent of the denial of the right they endeavour to realise.” Also *Minister of Health and Others v TAC and Others* (fn 113 *supra*): “The state is obliged to take reasonable measures progressively to eliminate or reduce large areas of severe deprivation that afflict our society”.

¹⁷⁶ *Minister of Health and Others v TAC and Others* (fn 113 *supra*) at 1043; *Scobramoney v Minister of Health, KwaZulu-Natal* (fn 86 *supra*); *Government Of The Republic Of South Africa And Others v Grootboom And Others* (fn 57 *supra*).

¹⁷⁷ *Government Of The Republic Of South Africa And Others v Grootboom And Others* (fn 57 *supra*) “The state is required to take reasonable legislative and other measures. Legislative measures by themselves are not likely to constitute constitutional compliance. Mere legislation is not enough. The state is obliged to act to achieve the intended result, and the legislative measures will invariably have to be supported by appropriate, well-directed policies and programs implemented by the Executive. These policies and programs must be reasonable both in their conception and their implementation. The formulation of a program is only the first stage in meeting the state’s obligations. The program must also be reasonably implemented. An otherwise reasonable program that is not implemented reasonably will not constitute compliance with the state’s obligations.” Also *Minister of Health and Others v TAC and Others* (fn 113 *supra*): “This does not mean, however, that until the best programme has been formulated and the necessary funds and infrastructure provided for the implementation of that programme, Nevirapine must be withheld from mothers and children who do not have access to the research and training sites. Nor can it reasonably be withheld until medical research has been completed.”

¹⁷⁸ *Government Of The Republic Of South Africa And Others v Grootboom And Others* (fn 57 *supra*) “In this regard, there is a difference between the position of those who can afford to pay for housing, even if it is only basic though adequate housing, and those who cannot. For those who can afford to pay for adequate housing, the state’s primary obligation lies in unlocking the system, providing access to housing stock and a legislative framework to facilitate self-built houses through planning laws and access to finance. Issues of development and social welfare are raised in respect of those who cannot afford to provide themselves with housing. State policy needs to address both these groups. The poor are particularly vulnerable and their needs require special attention. It is in this context that the relationship between ss 26 and 27 and the other socio-economic rights is most apparent. If under s 27 the state has in place programs to provide adequate social assistance to those who are otherwise unable to support themselves and their dependants, that would be relevant to the state’s obligations in respect of other socio-

7. The exclusionary effects of a policy or programme are constitutionally significant, especially exclusion of a significant segment of society. A programme for the realisation of socio-economic rights must be balanced and flexible¹⁷⁹.
8. Transparency and proper communication is an important aspect of programmes for the realisation of socio-economic rights¹⁸⁰.

Principles 1 to 8 listed above are in the spirit, if not the form, of the ICESCR and General Comment No 14. Principles 1, 2, 3,7 and 8 above are entirely consistent with core obligation (f) in General Comment No 14 to the effect that states must:

“adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population; the strategy and plan of action shall be devised, and periodically reviewed, on the basis of a participatory and transparent process; they shall include methods, such as right to health indicators and benchmarks, by which progress can be closely monitored; the process by which the strategy and plan of action are devised, as well as their content, shall give particular attention to vulnerable or marginalized groups.”

The statement in General Comment No 14 that:

“States parties are referred to the Alma-Ata Declaration which proclaims that the existing gross inequality in the health status of the people, particularly between developed and developing countries, as well as within countries, is politically, socially and economically unacceptable and is, therefore, of common concern to all countries” may be aligned with principle 6 above. Part (a) of the core obligations identified by the United Nations Committee on the ICESCR states that states must “ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups.”

economic rights” and (as cited with approval in *Minister of Health and Others v TAC and Others*) “Those whose needs are most urgent and whose ability to enjoy all rights therefore is most in peril must not be ignored by the measures aimed at achieving the realisation of the right.”

¹⁷⁹ *Government Of The Republic Of South Africa And Others v Grootboom And Others* (fn 57 *supra*) “A program that excludes a significant segment of society cannot be said to be reasonable.” (quoted with approval in *Minister of Health and Others v TAC and Others* (fn 113 *supra*)).

¹⁸⁰ *Minister of Health and Others v TAC and Others* (fn 113 *supra*) “In order for it to be implemented optimally, a public health programme must be made known effectively to all concerned... Indeed, for a public programme such as this to meet the constitutional requirements of reasonableness, its contents must be made known appropriately.”

Principle 7 above can be readily equated with core obligation (c) enunciated in General Comment No. 14 to the effect that states must “ensure equitable distribution of all health facilities, goods and services”.

Principle 8 above relates to the additional core obligations (d) and (e) of General Comment No 14 which stipulates that states must provide education and access to information concerning the main health problems in the community including methods of preventing and controlling them” and “provide appropriate training for health personnel including education on health and human rights”. The need for communication of this nature was a notable feature of the judgment in the *TAC* case¹⁸¹.

The significance of this is that the constitutional court has not rejected many of the basic principles to be found in public international law concerning minimum core obligations so much as it has rejected the idea that they constitute a minimum core. The content of a socio-economic right is defined *inter alia* by the resources that are available and since the availability of resources is not a constant in any given situation, there can be no hard and fast minimum core. The only constant against which the state’s performance can be measured is reasonableness viewed in the particular circumstances of each case. It is submitted with respect, that given the apparent inability of international legal forums to define minimum core content of the right to health, or even to agree that such definition is necessary, the rejection of the South African constitutional court of the concept of minimum core content was fully justified. The concept of minimum core content in relation to socio-economic rights is in any event a moving target since one cannot justify the implementation of only the barest legal necessities in the face of a greater than minimal supply of relevant resources. The court’s approach to the definition and determination of the content of the constitutional right of access to health care services and other socio-economic rights in South Africa is far more beneficial and pragmatic in terms of both its flexibility and its capacity to afford efficient, effective and appropriate relief to those the need it. For as long as the content of a right cannot be substantively defined at international level, the relevance and applicability of public international law

¹⁸¹ *TAC* (fn 113 *supra*)

within domestic legal systems will be limited. Perhaps that is as it should be. The South African judiciary has demonstrated its ability to effectively resolve key issues relating to the content of human rights using domestic constitutional precepts and legal principles as opposed to the direct application of rules of international law. Questions of the application or implementation of human rights must inevitably lead at some point to a discussion of the rights of vulnerable groups and the ranking of rights. In the context of the delivery of health care services this is of particular importance since resource allocation decisions have to be rational and justifiable. If there is some ranking or ordering of rights that is internationally recognised then this may have a bearing on such decisions. Furthermore it is evident from the foregoing discussions that the South African judiciary has expressly recognised a requirement to consider those who are in most desperate need. This clearly indicates that certain groups must receive some special attention. It is important, however, to justify the basis on which a particular group is given such special attention in the context of resource allocation decision. For the purposes of this chapter, it is thus necessary to explore the international law position in more detail on this issue. At the outset, however, it must be stressed that this is a topic worthy of a doctoral thesis in its own right and that it cannot possibly be canvassed in all its complexity in this thesis.

1.8 Rights of Vulnerable Groups

The question of whether the rights of vulnerable groups should take preference in health resource allocation decisions must be considered at two different levels. At the first level there is the nature of their rights as opposed to those of others and the question of whether there is a difference in terms of the legal status or weight of these rights relative to the rights of others. At the second level is the priority or preference, if any, that must be given to the implementation or enforcement of the rights of vulnerable groups over those of others, even if the rights themselves are of equal weight or status. This question of the prioritisation of rights will be considered in the context of South African constitutional law in the next chapter but it is necessary to look at relevant international law instruments and guidelines in order to establish the international position in this

regard. As stated previously, it is of considerable importance in the context of resource allocation decisions.

1.8.1 The Status of One Right Relative to Another

On the subject of a hierarchy of human rights generally there appears, as one has by now come to expect from international law, to be no agreement. The rights 'cake' can be sliced in a number of different ways in terms of hierarchies which makes for a number of different types of hierarchies and this, it is submitted, is part of the reason why there are such differing reactions to the issue of the ranking of rights. There is the hierarchy of one right over another for instance in terms of the balancing of rights in individual cases. Where one right cuts across another, which one must take precedence? An example of this in South African law is the power of a woman to terminate a pregnancy based on the right to freedom and security of the person in section 12 of the Constitution as opposed to the right of a health care worker to freedom of religion and conscience under section of the Constitution where the worker's religious beliefs condemn abortion. Can the worker be compelled to assist the woman to terminate her pregnancy? Then there is the concept of derogable as opposed to non-derogable rights such as is found in the South African Constitution but to which it is by no means unique¹⁸². Although non-derogable rights are usually referred to in the context of states of emergency, the concept certainly lends weight to the general idea that there are certain rights which are so fundamentally important that they may not be disregarded, even in the direst circumstances, and that there are others that do not enjoy the same status.

¹⁸² The International Covenant on Civil and Political Rights (ICCPR) names seven non-derogable rights. These are the right to life, freedom from torture or degrading treatment, freedom from slavery, freedom from imprisonment for breach of contract, freedom from retrospective criminality, recognition as a person before the law and freedom of thought, conscience and religion. It is interesting that Prasopa-Plaizier N in 'Life and Death Decisions' <http://cas.org/au/horizons/h26/life.html> should comment on this in the context of triage as practised by humanitarian agencies and workers in war zones. He points out that while "Agencies like Community Aid Abroad are committed to all of the rights housed in the Universal Declaration of Rights and the two associated Covenants: Economic and Social Rights; and Civil and Political Rights"... "trade-offs are becoming increasingly necessary between 'core' and 'long term' rights." He notes that in practice the recognition of certain non-derogable rights means "concentrating on survival and the protection and improvement of health." The United Nations Commission on Human Rights (53rd Session Agenda Item 16) in its statement of International Educational Development/Humanitarian Law Project states that "Because the non-derogable rights are *jus cogens*, they apply to any state at all times."

There is the other hierarchy of so-called first generation, second generation and third generation rights. Advanced by French jurist Karel Vasak and inspired by the three themes of the French Revolution, Vasak identified these as the first generation of civil and political rights (*liberté*), the second generation of economic, social and cultural rights (*égalité*) and the third generation of solidarity rights (*fraternité*)¹⁸³. This distinction has fallen into a measure of disfavour in some quarters¹⁸⁴. First generation rights are often perceived as individual rights whereas second generation rights are more likely to be perceived as group or collective rights¹⁸⁵.

The views of the international community on the subject of ranking of rights seem to be divided.

¹⁸³ Weston BH 'Encyclopaedia Britannica: Human Rights' <http://uihr.uiowa.edu/features/eb/weston4.shtml>. The author states that Vasak's mode is a simplified expression of an extremely complex historical record and it is not intended to suggest a linear process in which each generation gives birth to the next and then dies away. Nor is it to imply that one generation is more important than the other. He notes that the three generations are understood to be cumulative, overlapping and interdependent and interpenetrating. See also Lynoh OJ and Chaudhry S 'Human Rights, Environment, and Economic Development: Existing and Emerging Standards in International Law and Global Society' <http://www.siel.org/Publications/olp3v.html> who state that: Third Generation or "solidarity" rights is the most recently recognized category of human rights. This grouping has been distinguished from the other two categories of human rights in that its realization is predicated not only upon both the affirmative and negative duties of the state, but also upon the behaviour of each individual: "[Third Generation Rights]...may be both invoked against the state and demanded of it; but above all (and herein lies their essential characteristic) they can be realized only through the concerted efforts of all actors on the social scene: the individual, the state, public and private bodies and the international community." Rights in this category include self-determination, as well as a host of normative expressions whose status as human rights is controversial at present. These include the right to development, the right to peace, and a right to a healthy environment. Some texts such as the Final Report of the United Nations Commission on Human Rights, Sub-commission on Prevention of Discrimination and Protection of Minorities appear to take it as given that there is already an existing right to environment recognized in international instruments.

¹⁸⁴ See Stanley RH 'Human Rights in a New Era' Thirty-Eighth Strategy for Peace Conference Airlie Center, Warrenton, Virginia October 23, 1997: "That distinction can now be seen as artificial. The demise of the Cold War and an emerging global economic justice movement have blurred the lines between first-generation and second-generation rights and sparked debate over categories and priorities. Social, economic, and cultural issues are increasingly understood to be root causes of conflict."

¹⁸⁵ See Lynoh and Chaudhry (fn 183 *supra*) who note that: "Second generation rights have generally been considered as rights which require affirmative government action for their realization. Second generation rights are often styled as 'group rights' or 'collective rights', in that they pertain to the well-being of whole societies. They contrast with first generation rights which have been perceived as "individual entitlements," particularly the prerogatives of individuals contrary to those of collectivities. Principle advocates of collective rights have been developing countries and formerly the Socialist Bloc countries. Some countries supporting second-generation rights have argued for their realization first, as a pre-condition for the eventual realization of civil and political rights. Additionally, some advocates for the pre-eminence of second generation collective or group rights have postulated that contrary to Western conceptions, the substance of human rights is not universal and that economic, social and cultural factors determine the applicability of particular rights in different countries. This has been used as a justification for denying civil and political rights or delaying their protection until group rights have been realized. Religious, cultural or socio-economic factors in a state therefore might be relied upon to preclude recognition of "alien" western ideas such as freedom of conscience or press freedom. Human rights advocates such as Higgins disagree with this line of reasoning: "It is sometimes suggested that there can be no fully universal concept of human rights, for it is necessary to take into account the diverse cultures and political systems of the world. It is rarely advanced by the oppressed, who are only too anxious to benefit from perceived universal standards. The non-universal, relativist view of human rights is in fact a very state-centered view and loses sight of the fact that human rights are human rights and not dependent on the fact that states, or groupings of states, may behave differently from each other so far as their politics, economic policy, and culture are concerned." They point out that: The Vienna Declaration of 1993 disclaimed any priority of rights. It declared that "[w]hile development facilitates the enjoyment of all human rights, the lack of development may not be invoked to justify the abridgement of internationally recognized human rights."

Article 5 of the Vienna Declaration states that:

“All human rights are universal, indivisible and interdependent and interrelated. The international community must treat human rights globally in a fair and equitable manner and on the same footing and with the same emphasis. While the significance of national and regional particularities and various historical, cultural and religious backgrounds must be borne in mind, it is the duty of States, regardless of their political, economic and cultural systems to promote and protect all human rights and fundamental freedoms.”

The concept of a hierarchy of rights has been criticised and even denied by some¹⁸⁶.

It has been argued that:

“The danger in establishing a hierarchy of rights is that it reinforces the tendency to relegate the ‘ordinary’ rights that affect the majority of the world’s people to the sphere of international neglect... This narrow focus, this *de facto* establishment of a small category of fundamental rights, ultimately undermines the potential event to prevent future atrocities of the kind international criminal justice concerns itself with. It is likely to diminish the importance of the wide web of rights and the culture of rights that the idea of a ‘web’ signifies.”¹⁸⁷

Hathaway¹⁸⁸ refers to a hierarchy of human rights set out in the international human rights instruments based in order of importance as:

- those that are non-derogable in terms of the ICCPR. He says that the failure to ensure these rights under any circumstances is appropriately considered to be tantamount to persecution;

¹⁸⁶ Whelan ‘Women, Human Rights and Vulnerability to HIV: Findings From the Women and AIDS Research Program’ Oral Presentation delivered at the XI International Conference on AIDS, July 1996
<http://www.hsph.harvard.edu/Organizations/healthnet/HIV/docs/sea-aids/hrgt/hrgt11.txt>; See also Matas D ‘The Universal Declaration of Human Rights: Fifty Years Later’ (2000) 46 McGill L. J. 203 at 208 who states that: “The Universal Declaration of Human Rights does not rank rights, and quite properly so.” Robinson ‘Human Rights and Global Civilisation’ in the BP Annual Lecture of November 2001 states that: “The truth is that divisions and ranking of rights is artificial. When President Roosevelt spoke of the famous ‘four freedoms’, freedom from want stood equally alongside freedom from fear. Human rights will not be truly achieved until all accept economic, social and cultural rights as rights that deserve and require equal attention to civil and political rights and freedoms.” (http://www.bp.com/centres/press/a_detail.asp?id=142; Sidoti C in ‘Introducing Human Rights Law’ a speech delivered in May 1997 in Hanoi Vietnam, states that “Some states give priority to some rights over other rights or even accept some categories of human rights while rejecting other categories... The United States for example has ratified the ICCPR but not the ICESCR and China has clearly argued for a hierarchy of human rights. Its White Paper on Human Rights says “it is a simple truth that, for any country or nation, the right to subsistence is the most important of all human rights, without which all other rights are out of the question”... But this argument is now closed.... Virtually all nations now accept human rights law as indivisible and equally binding on nations.” (http://www.hreco.gov.au/speeches/human_rights/intro_hr_law.html)

¹⁸⁷ Silk ‘International Criminal Justice and the Protection of Human Rights: The Rule of Law or the Hubris of Law?’ www.yale.edu/lawweb/lawfac/fiss/csilk.pdf

¹⁸⁸ Hathaway JC *The Law of Refugee Status* p104-105

- those that are in the UDHR and concretised in binding and enforceable form in the ICCPR but which are derogable in times of public emergency. These rights include protection of personal and family privacy and integrity;
- those that are contained in the UDHR and carried forward in the ICESCR. With regard to this category Hathaway points out that in contrast to the ICCPR, the ICESCR does not impose absolute immediately binding standards of attainment but rather requires states to take steps to the maximum of their available resources to progressively realise the rights;
- those rights in the UDHR that were not codified in either the ICCPR or the ICESCR and which may thus be outside the scope of the state's basic duty of protection. Such rights are the right to own and to be free of arbitrary deprivation of property and the right to be protected against unemployment.

This hierarchy is apparently based on the relative immediacy of the rights coupled with the strength of the state's obligation to observe them in all circumstances.

The Council of Europe¹⁸⁹ has recognized the right to life as "supreme value in the international hierarchy of human rights". In a Background Paper¹⁹⁰ delivered by Fabra and Arnal at a joint UNEP-OHCHR in January 2002, the authors refer to the fact that the courts are moving the right to a healthy environment "up the hierarchy of human rights by recognising it as a fundamental right."

Koji¹⁹¹ notes that considerable confusion has surrounded the question of whether there exists a hierarchy of human rights in contemporary international law and that most human rights studies do not recognise such a hierarchy mainly because of their emphasis

¹⁸⁹ 'Protocol No. 13 to the Convention for the Protection of Human Rights and Fundamental Freedoms, concerning the abolition of the death penalty in all circumstances' (ETS No 187) <http://conventions.coe.int/treaty/en/reports/htm/187.htm>

¹⁹⁰ Background Paper No 6 available at <http://www.unhcr.org/environment/bp6.html>

¹⁹¹ Koji T 'Emerging Hierarchy in International Human Rights and Beyond: From the Perspective of Non-Derogable Rights' *European Journal of International Law* Vol 12 (2001), No 5 at p917 onwards.

on the indivisibility of human rights. His paper claims to provide a coherent understanding of this issue from the perspective of non-derogable rights which demonstrate the existence of a hierarchy of human rights most clearly in international law concepts. He observes that it is a serious mistake to regard non-derogable rights as a unitary concept and that such rights can be identified in at least three different ways i.e. by means of value-oriented, function-oriented and consent-oriented criteria and states that within this analytical framework, and particularly with respect to the first two criteria, non-derogable rights need to be distinguished from similar concepts such as core human rights, *jus cogens* and obligations *erga omnes*.

Arguments around cultural relativism and allegations that human rights law is fundamentally a Western concept further complicate questions of hierarchies of human rights.

It has been suggested that the right to life ‘stands head and shoulders above all the others’ but that even the right to life is preceded by the right to freedom from incitement to discrimination without which the right to life cannot be assured¹⁹². Whilst this is a view which sees the right to life relatively narrowly in the context of war and genocide¹⁹³ it illustrates the polycentric nature of human rights generally¹⁹⁴. The right to life is dependent upon the observation of many other rights, for example the right to bodily integrity, and cannot be seen in isolation from them. Killing a person is after all a fundamental invasion of his right to bodily integrity. All human rights are in this sense indivisible, interrelated and interdependent. This is why arguments about the importance of an individual right relative to those of others tend to be circular in nature. This does not, however, necessarily defeat the question of hierarchies of rights.

¹⁹² Matas (fn 186 *supra*) at 209

¹⁹³ Matas points out that the Holocaust began with hate speech.

¹⁹⁴ Matas (fn 186 *supra*) after observing that the UDHR does not rank rights and correctly so, goes on to state that ranking of rights nonetheless occurs. He refers by way of example to a statement by the editor of *The Globe and Mail* claiming that freedom of expression is the superior core human right – “a seminal, germinal, essential, necessary, prior right in the pantheon of rights”. After some debate about how and why people prioritise their ‘favourite’ right, however, he comes to the conclusion that “because human rights are an interconnected whole, it is easy to link one right to another. Free expression is important to other rights, as other rights are important to respect for freedom of expression. Take any thread out of the quilt of rights and the quilt unravels. To choose only one thread and proclaim ‘This is the thread that counts!’ is arbitrary.”



It is submitted that there is a sense in which both camps are correct. This is due in part to the oversimplification of these arguments in terms of polarisation i.e. the idea that rights hierarchies are either permissible or not with no room for debate. It is submitted that a hierarchy is simply a conceptual tool with many uses. Its primary function is to express relativities. If one accepts the polycentric nature of the human rights system then hierarchies remain useful tools with which to analyse the particular factual situation with which one is confronted in order to arrive at meaningful decisions since in a polycentric system one can only speak in terms of relativities. The concern of this thesis, in keeping with its exploration of the law relating to the delivery of health services, is pragmatism¹⁹⁵. Whilst there may be room for argument in the lofty world of ideals and human rights in the abstract that there can be no hierarchy of rights on the basis that the Universal Declaration of Human Rights (UDHR) does not recognise any hierarchy, it is submitted that when it comes down to the practical implementation of human rights, hierarchies play a useful role. The fact is that the UDHR has been fleshed out or concretized by two major instruments of international law, the ICCPR and the ICESCR, and the former, to the extent that it recognises that certain rights are derogable in times of emergency whilst others are not, implicitly accepts the broad concept of rights hierarchies. In human rights law there are apparently no absolute truths – only past experience and present perspectives. It is submitted that the real answer to whether or not there is a legitimate hierarchy of human rights depends on the circumstances of the particular situation in which the hierarchy is formulated and applied. The truth of this argument can be seen in the different contexts in which hierarchies of rights are in fact recognised as in the situation of a court having to balance competing rights against each other in a particular case and in the situation of national emergencies in which certain rights take superiority over others. It is submitted that the validity of hierarchies is as much dependent upon the purpose for which distinctions between the various types of rights are drawn as it is upon the circumstances in which the hierarchy is constructed.

195

Matsuda M 'Liberal Jurisprudence and Abstracted Visions of Human Nature: A Feminist Critique of Rawls' Theory of Justice', *Feminist Legal Theory: Foundations* note 84 at 476, 477, argues that political philosopher John Rawls' (Rawls, *A Theory of Justice*) construction of an imaginary "original position" from which rights can be deduced cannot adequately justify protecting rights that are particularly important to women, claiming that abstraction: "as a methodology [in law] encompasses the belief that visions of social life can be constructed without reference to the concrete realities of social life. The choice of abstraction is a key move that allows Rawls to ignore powerful alternative constructions and give his theory an attractive internal logic" as quoted by Splittgerber S in 'The Need for Greater Protection For the Human Rights Of Women: The Cases of Rape in Bosnia and Guatemala' 15 (1996) *Wisconsin International Law Journal* at p 185

It is submitted that a hierarchy such as the one postulated by Hathaway referred to previously is legitimate for the purpose of attempting to categorise the various rights in terms of the relative immediacy of the obligations they impose upon nation states. To contend otherwise would be to deny the manner in which the various rights have been conceptualised in the relevant international legal instruments themselves. The ICCPR is explicit that certain rights are non-derogable even in states of national emergency and the ICESCR is just as explicit that certain rights are subject to progressive realisation based on the availability of resources. Such a hierarchy does not diminish the value of the rights in question. It simply recognises them as being different from a particular perspective. There can be no valid objection to a hierarchy that classifies human rights into first, second and third generation rights in order to illustrate the history of their evolution or their type whilst stressing that such a classification does not illustrate their relative importance.

Apart from debates about the legitimacy of hierarchies of rights one cannot ignore the larger debates about the various types of international law and their relative or hierarchical status. The argument that *jus cogens* takes precedence over public and customary international law, that public international law takes precedence over customary international law etc and that certain rights form part of the *jus cogens* whilst others do not, renders nonsensical bald denials of the existence of hierarchies of rights in international law. Elsewhere in this chapter it has been pointed out that the fact that there is a number of significantly sized and powerful countries who do not accept that *jus cogens* is binding upon them without their consent cannot be ignored. It is all very well to make bold assertions in principle but if they do not reflect reality then it is submitted that they are of little value. A problem with international law at the broadest possible level is its enforceability and the power dynamics involved. The concept of the sovereignty of nations has a tendency to stick in the craw of international law at many different levels.

If the legitimacy in broad terms of a hierarchy of human rights can be tested against the purpose of the hierarchy and its context then there is nothing to fear from the idea of

hierarchies of human rights. To the extent that a hierarchy is used to defeat the objects of an international law instrument such as the ICESCR by a nation state that is bound by it, such a hierarchy is not legitimate. However, in a situation in which a nation state has expressly signified its intention not to be bound by an instrument of international law and uses a hierarchy to justify its decision, questions of a hierarchy of rights are largely irrelevant since any number of different reasons can be put forward by a powerful nation state as to why it chooses not to be bound. The real question in such a situation is the extent to which other nation states have the power to challenge such a choice.

1.8.2 Preference of the Rights of Certain Groups

Irrespective of whether all rights are of the same weight and standing and everyone's rights are essentially the same, there still seems to be a very strong view in international law that the rights of some groups should be given special attention. This view must be regarded at the level of implementation of human rights. On the basis that it is not possible to give effect to the rights of everyone at once – especially in the context of those rights which require extensive resources – and that one has to start somewhere, it is necessary to find and justify particular areas of focus. Enter the vulnerable groups. It is submitted that it is both logical and justifiable, even assuming that all human rights are equal, to give special attention to the rights of vulnerable groups. This is due to the fact that while at an abstract level all human beings are equal in their entitlement to the observation of their rights, such equality is not reflected at a practical level. Less powerful members of society are often victimised, oppressed and otherwise abused by the more powerful members of society. Most societies in the world are male dominated which means that women and children are often marginalized and abused. Ironically, the problem of rectifying this situation often becomes one of ranking if not of rights then of vulnerable groups themselves.

There is the question of children's rights versus women's rights (often in relation to questions of terminations of pregnancy and reproductive rights); the rights of future generations versus the rights of present generations in environmental issues; the rights of

the disabled child versus the rights of the non-disabled child; the rights of children as opposed to those of disabled adults; the rights of female victims of crime as opposed to those of prisoners; the rights of prisoners as opposed to those of refugees. International human rights instruments are divided along many different planes so that one has the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and the Convention on the Rights of the Child (CRC) on the one hand and the International Covenant on Economic, Social and Cultural Rights (ICESCR) and the Universal Declaration of Human Rights on the other. The latter tend to deal more with the rights of everyone to various 'goods' while the former deal with those rights as they relate to vulnerable groupings¹⁹⁶.

When one starts ascribing rights to specific groups of people it is easy to see how the logic that says that all rights are equal and indivisible can become clouded. If the rights of men and women are equally important and fundamentally the same then what is the significance of CEDAW in relation to the ICESCR? What is the purpose of specifically recognising the rights of children in a separate document if their rights are no greater or no different to those of all people as expressed in the Universal Declaration of Human Rights or the ICESCR? It could be, and in fact has been, argued that the rights of vulnerable groups are deserving of special attention and that this is why they have been singled out. But if the rights of these groups are given special attention, or are prioritised at the expense of others, is this not tantamount to adding a gloss on their rights to say that they are superior in some way to the rights of others?

To misquote George Orwell, it would seem that although all rights are equal some are more equal than others.

Vulnerable groups that have been identified in international law are women, children, prisoners, refugees, the disabled and people living with HIV/AIDS. In many countries,

¹⁹⁶ Note that this is just an example. There are others such as the International Guidelines on HIV/AIDS, and Human Rights res. 1997/33, U. N. Doc. E.CN.4/1997/150 (1997); the Standard Minimum Rules for the Treatment of Prisoners adopted by the First United Nations Congress on the Prevention of Crime and the Treatment of Offenders, held at Geneva in 1955, and approved by the Economic and Social Council by its resolution 663 C (XXIV) of 31 July 1957 and 2076 (LXII) of 13 May 1977; the Principles for the Protection of Persons with Mental Illnesses and the Improvement of Mental Health Care, G. A. res 46/119, 46 U.N. GAOR Supp. (No. 49) at 189, U.N. Doc. A/46/49 (1991); the Refugee Convention.

especially developing countries, these groups taken together make up the vast majority of the population. Even individually, they in some instances comprise majority groups rather than minority groups. This creates problems in the allocation of resources across vulnerable groups. In the context of HIV and AIDS this problem is highlighted by the question of whether one treats only the children of parents with HIV and AIDS when the growing numbers of AIDS orphans are creating problems of a different kind for governments of developing countries. This concern has been misconstrued by HIV and AIDS activists to imply that one should not treat the children but rather allow them to die than become yet another problem for society. In fact it has been used to support the logic that one cannot only treat the children. One must treat their parents as well. It is important to preserve the family unit and not just individuals. In practical terms, however, in the context of limited resources this implies that some adults and children must die whereas other adults and children can be saved. This logic says that children should not get preference simply because they are children. In such a scenario, in international law terms one is in effect weighing up the ICESCR against the CRC.

The choices involved in the allocation of resources to particular vulnerable groups in preference to others are often based on the values of the society that makes them but there is a certain utilitarian logic that comes into play in certain circumstances. Can a relatively youthful society where the number of economically active and productive adults is declining exponentially afford to devote all of its resources to saving children? Can an ageing society, in which laws significantly limit the number of children a couple can have, afford not to devote a significant percentage of its resources to protecting and saving its children? It is necessary to canvass in more detail the various international instruments and guidelines that deal with the rights to health care of vulnerable groups as opposed to others not only in order to lay the groundwork for the some of the discussion in chapter 2 of these rights in terms of the Constitution, but also to ascertain the nature and extent of the rights afforded to these groups in terms of international law.

1.9 Rights of Children

It is necessary to consider the rights of children in particular because of the specific recognition of the rights and interests of children in international law and in order to ascertain the substantial differences if any between the international law approach and the South African approach. *Grootboom*¹⁹⁷ and *TAC*¹⁹⁸ involved the rights of children and in both these cases, as has been noted previously, the constitutional court expressly rejected the application of the international law concept of minimum core. In this area South African law differs from international law. These two cases will be discussed in further detail in chapter two which deals with the constitutional aspects of rights involving health care services, including those of children. However the Convention on the Rights of the Child (CRC)¹⁹⁹ is a significant international law instrument relating specifically to children and in view of the fact that the Constitution also makes specific mention in section 28 of children's rights it is necessary to explore the rights of children as contemplated in the CRC in relation to the delivery of health care services. With regard to emotive issues such as treatment of HIV/AIDS and the preference of one group, e.g. children, over another, eg adults with a view to the allocation of scarce resources, for the purpose of antiretroviral treatment for instance, the question of whether the rights of vulnerable groups take precedence over those of other groups is of importance.

1.9.1 The Convention on the Rights of the Child

The CRC defines a child as every person under the age of 18 unless under a particular law, the age of majority is attained earlier²⁰⁰.

The question is whether the CRC contains any recognition that the rights of children are of greater force or deserving of more stringent recognition than those of others. In the preamble to the CRC there are acknowledgements of general human rights and there is

¹⁹⁷ *Grootboom* (fn 57 *supra*)

¹⁹⁸ *TAC* (fn 113 *supra*)

¹⁹⁹ On November 20, 1989, the United Nations General Assembly unanimously adopted the Convention on the Rights of the Child (CRC). It has been described as the most comprehensive treaty for the protection and support of children in existence today (Canadian Coalition for the Rights of Children 2002 <http://www.rightsofchildren.ca> and Rosenthal and Sundram (fn 2 *supra* at p34) who point out that the CRC has been ratified even more widely than has the ICESCR.) The USA and Somalia are the only countries that have not ratified the CRC.

²⁰⁰ CRC article 1

express reference to the Charter of the United Nations, and the Universal Declaration of Human Rights. Thereafter are the following statements:

“Recalling that, in the Universal Declaration of Human Rights, the United Nations has proclaimed that childhood is entitled to special care and assistance”

and

“Recognizing that, in all countries in the world, there are children living in exceptionally difficult conditions, and that such children need special consideration”.

At first glance these statements would seem to suggest that the rights of children should take precedence over those of others but if the wording is considered more carefully it is submitted that they are simply saying that children and the rights of children are deserving of special attention and should be the subject of a conscious focus in international law. It is submitted that the reason that childhood is entitled to special care and assistance is due to the fact that the circumstances of children, their power to cope with the world and to obtain benefits are different to those of adults. The rights themselves are not necessarily superior to the rights of adults or higher in terms of ranking. This reasoning is supported by statements such as that contained in General Comment No 14 (2000) of the United Nations Committee On Economic, Social And Cultural Rights (CESCR) which states in article 1 that:

“Health is a fundamental human right indispensable for the exercise of other human rights. Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity.”

It is difficult to conceive of a higher standard of health than “the highest attainable standard of health conducive to living a life in dignity”. Moreover it is an entitlement of ‘every human being’ and not just that of children. The International Covenant on Economic, Social and Cultural Rights (ICESCR) provides the most comprehensive article on the right to health in international human rights law. In accordance with article 12.1 of the ICESCR, states parties recognize “the right of *everyone* to the enjoyment of the highest attainable standard of physical and mental health” (writer’s italics). It is submitted that there is no higher standard than the “highest attainable standard”. At a

more practical level therefore, it is submitted that it would be difficult to justify in terms of international law the medical treatment of children at the expense of the treatment of adults in terms of resource allocation decisions. Furthermore such a decision may even run counter to the importance placed by the CRC on the child's rights to family relationships and family life. Children are generally recognised as more vulnerable than adults and therefore deserving of special efforts and attention but it is in the implementation of their rights rather than in the legal content of those rights that the difference becomes real.

In this context it is significant that the language of the CRC in article 24, which relates specifically to health rights, does not differ materially from the language of the other human rights instruments cited previously relating to the right to health. In terms of this Article:

"1. States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services."

The second paragraph of article 24 fleshes out some of the practical implications of this right as follows:

"2. States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures:

- (a) To diminish infant and child mortality;**
- (b) To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care;**
- (c) To combat disease and malnutrition, including within the framework of primary health care, through, inter alia, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking-water, taking into consideration the dangers and risks of environmental pollution;**
- (d) To ensure appropriate pre-natal and post-natal health care for mothers;**
- (e) To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents;**
- (f) To develop preventive health care, guidance for parents and family planning education and services."**

Article 24, at paragraph 3, requires states parties to take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.

In wording that is reminiscent of section 27(2) of the South African Constitution, paragraph 4 of article 24 stipulates that:

“States Parties undertake to promote and encourage international co-operation with a view to achieving progressively the full realization of the right recognized in the present article. In this regard, particular account shall be taken of the needs of developing countries.”

In terms of Article 3 of the CRC:

1. In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration.
2. States Parties undertake to ensure the child such protection and care as is necessary for his or her well-being, taking into account the rights and duties of his or her parents, legal guardians, or other individuals legally responsible for him or her, and, to this end, shall take all appropriate legislative and administrative measures.
3. States Parties shall ensure that the institutions, services and facilities responsible for the care or protection of children shall conform with the standards established by competent authorities, particularly in the areas of safety, health, in the number and suitability of their staff, as well as competent supervision.

This article sets the tone for the general obligations of states towards children. It is the best interests of the child which must be of primary consideration. The measures that must be taken by states parties are both legislative and administrative - similar to the legislative and other measures required of the state by section 27(2) of the South African Constitution in the progressive realisation of the right of access to health care services. The CRC recognises that parents have the primary responsibility to secure the health and wellbeing of their children but also clearly imposes certain obligations upon the state in article 24(2) and (3).

The CRC acknowledges the very wide right of children to health as well as the narrower right to health care services. It is a comprehensive international instrument that is concerned with the wellbeing of children on all fronts rather than just that of health care. In chapter 2 there is a discussion of the right to health as opposed to a right of access to health care services.

Geißler²⁰¹ observes that children were not completely unprotected from a legal point of view before the CRC came into force because there were other general human rights agreements in force prior to the CRC such as the International Pact on Civil and Political Rights (IPCPR) of 1966 and the Anti Torture Agreement of 1984 which applies equally to adults and children. He reflects that the CRC is part of a multi-layered complex of international and regional agreements on human rights which were mainly inspired by the Universal Declaration of Human Rights in 1948.

1.9.2 WMA Declaration of Ottawa

The World Medical Association Declaration of Ottawa on the Rights of the Child to Health Care was adopted at the 50th World Medical Assembly in Ottawa, Canada on October 1998. Whilst it is not necessarily of the same status and legal standing as the CRC it may nonetheless provide some useful guidelines on the rights of children to health care. In the Preamble it is stated that:

1. The health care of a child, whether at home or in hospital, includes medical, emotional, social and financial aspects which interact in the healing process and which require special attention to the rights of the child as a patient.
2. Article 24 of the 1989 United Nations Convention on the Rights of the Child recognises the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health, and States that nations shall strive to ensure that no child is deprived of his or her right of access to such health care services.
3. In the context of this Declaration a child signifies a human being between the time of birth and the end of her/his seventeenth year, unless under the law applicable in the country concerned children are legally recognized as adults at some other age.

²⁰¹ Geißler N "Creating a Procedure for submitting Individual Complaints pursuant to the Convention on the Rights of the Child" *Asserting the Rights of the Child* Documentation of conference in Berlin in April 2001 Kindemotilffe, Joint Conference Church and Development (GKKE)

Article 4 of the Declaration acknowledges that every child has an inherent right to life, as well as the right of access to the appropriate facilities for health promotion, the prevention and treatment of illness and the rehabilitation of health and stipulates that physicians and other health care providers have a responsibility to acknowledge and promote these rights, and to urge that the material and human resources be provided to uphold and fulfil them. The Declaration states as general principles that every effort should be made:

- I. to protect to the maximum extent possible the survival and development of the child, and to recognise that parents (or legally entitled representatives) have primary responsibility for the development of the child and that both parents have common responsibilities in this respect;
- II. to ensure that the best interests of the child shall be the primary consideration in health care;
- III. to resist any discrimination in the provision of medical assistance and health care from considerations of age, gender, disease or disability, creed, ethnic origin, nationality, political affiliation, race, sexual orientation, or the social standing of the child or her/his parents or legally entitled representatives;
- IV. to attain suitable pre-natal and post-natal health care for the mother and child;
- V. to secure for every child the provision of adequate medical assistance and health care, with emphasis on primary health care, pertinent psychiatric care for those children with such needs, pain management and care relevant to the special needs of disabled children;
- VI. to protect every child from unnecessary diagnostic procedures, treatment and research;
- VII. to combat disease and malnutrition;
- VIII. to develop preventive health care;
- IX. to eradicate child abuse in its various forms; and
- X. to eradicate traditional practices prejudicial to the health of the child.

To a significant extent it is simply a restatement of the principles contained in the CRC but it does add a few details that are more specific to health care services such as pain management, preventive health care and psychiatric care.

1.9.3 African Charter on the Rights and Welfare of the Child

This document has a comprehensive approach to the protection of disabled children.

Article 13 reads as follows:

‘Every child who is mentally or physically disabled shall have the right to special measures of protection in keeping with his physical and moral needs and under conditions which ensure his dignity, promote his self-reliance and active participation in the community.’

The states parties are required, subject to available resources, to ensure a disabled child, and to those responsible for his or her care, of assistance for which application is made and which is appropriate to the child's condition.

1.12.4 Comparison With The Constitution

In section 28(1)(b) and (c), the Constitution states that

“every child has the right-

- (b) to family care or parental care, or to appropriate alternative care when removed from the family environment;
- (c) to basic nutrition, shelter, basic health care services and social services”.

The Convention on the Rights of the Child (CRC) contains much more comprehensive provisions in its Article 24 (1) alone:

“States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.”

Part 2 of Article 24 elaborates even further as follows:

“States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures:

- (a) to diminish infant and child mortality;
- (b) to ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care;
- (c) to combat disease and malnutrition, including within the framework of primary health care, through, inter alia, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking-water, taking into consideration the dangers and risks of environmental pollution;
- (d) to ensure appropriate pre-natal and post-natal health care for mothers;
- (e) to ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents;
- (f) to develop preventive health care, guidance for parents and family planning education services.”

The Constitution does not expressly provide for such measures. The constitutional court in the *TAC* case²⁰² did not refer to the Convention on the Rights of the Child in its judgement although it did discuss the interpretation of section 28(1) and did refer to the fact that children are a highly vulnerable group²⁰³.

General Comment No 14 of the United Nations Committee on the ICESCR states that States parties should provide a safe and supportive environment for adolescents, that ensures the opportunity to participate in decisions affecting their health, to build life-skills, to acquire appropriate information, to receive counselling and to negotiate the health behaviour choices they make. Article 12.2 (a) of the ICESCR outlines the need to reduce infant mortality and promote the healthy development of infants and children.

The constitutional court in the *TAC* case has supported the view first expressed in *Grootboom* that while the primary obligation to provide basic health services rests on those parents who can afford to pay for such services, this does not mean that the state incurs no obligation in relation to children who are being cared for by their parents and families.

In *Grootboom*²⁰⁴ the court expressly referred to the Convention on the Rights of the Child as being ratified by South Africa in 1995 and observed that it-

“seeks to impose obligations upon State parties to ensure that the rights of children in their countries are properly protected. Section 28 is one of the mechanisms to meet these obligations. It requires the State to take steps to ensure that children's rights are observed. In the first instance, the State does so by ensuring that there are legal obligations to compel parents to fulfil their responsibilities in relation to their children. Hence, legislation and the common law impose obligations upon parents to care for their children. The State reinforces the observance of these obligations by the use of civil and criminal law as well as social welfare programs.”²⁰⁵

²⁰² *TAC* (fn 113 *supra*)

²⁰³ See *TAC* (fn 113 *supra*) at 1056 G where the court stated: “Their needs are ‘most urgent’ and their inability to have access to Nevirapine profoundly affects their ability to enjoy all rights to which they are entitled. Their rights are ‘most in peril’ as a result of the policy that has been adopted and are most affected by a rigid and inflexible policy that excludes them from having access to Nevirapine.”

²⁰⁴ *Grootboom* (fn 57 *supra*)

²⁰⁵ The court went on to state that: “In the first place, the state must provide the legal and administrative infrastructure necessary to ensure that children are accorded the protection contemplated by s 28. This obligation would normally be fulfilled by passing laws and creating enforcement mechanisms for the maintenance of children, their protection from maltreatment, abuse, neglect or degradation, 50 and the prevention of other forms of abuse of children mentioned in s 28. In addition, the state is required to fulfil its obligations to provide families with access to land in terms of s 25, access to adequate housing in

The court in *Grootboom* was more preoccupied with the interpretation of the constitutional rights of children with regard to housing and other basic necessities than it was with a critical analysis of the manner in which the Convention on the Rights of the Child has been implemented in South Africa. It did not use the CRC as an interpretational tool for the purposes of deriving the meaning of section 28 of the Constitution but rather referred to it as one of the international legal obligations of South Africa. This is possibly due to the fact that the court did not find any conflict between domestic legal provisions concerning the rights of the child and those of the CRC. The court did refer, however, to the overlap between a child's right to basic health care services in terms of section 28(1)(c) and the right to health care services created in terms of section 27(1). It observed that this overlap is not consistent with the notion that s 28(1)(c) creates separate and independent rights for children and their parents.

In constitutional terms, therefore, the right of a child to basic health services in terms of section 28 is a subset of the broader right of everyone in terms of section 27(1) rather than a separate and independent right. This supports the argument that the Constitution, at least, envisages a single right to health care services rather than multiple, fragmented rights. It remains to be seen whether this conceptualisation can be extended to other areas of South African law but the Constitutional support it enjoys is an important positive indicator at this stage.

1.10 Rights of Women

It has been said that "So pervasive and systematic are the human rights abuses against women that they are regarded as part of the natural order"²⁰⁶ and that to adequately address structural biases, theories of international law and human rights must take

terms of s 26 as well as access to health care, food, water and social security in terms of s 27. It follows from this judgment that ss 25 and 27 require the state to provide access on a programmatic and coordinated basis, subject to available resources. One of the ways in which the state would meet its s 27 obligations would be through a social welfare program providing maintenance grants and other material assistance to families in need in defined circumstances."

²⁰⁶ Kerr J "The Context and the Goal", *Ours By Rights: Women's Rights as Human Rights* 1, 3 as cited by Splittgerber (fn 195 *supra*).

account of the reality of women's lives²⁰⁷. The reality of women's lives is a justification for special consideration of women's rights. A denial that there can be hierarchies of rights on the basis that all rights are universal and all people equal in relation to all rights is a denial of the reality of people's lives and is more likely to hinder rather than help people in the exercise or realisation of their rights.

The rights of women to health or health care at international law are recognised in a number of different instruments²⁰⁸ the most notable being the Convention Against All forms of Discrimination Against Women (CEDAW).

Article 12 provides that:

- 12.1 States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.
- 12.2. Notwithstanding the provisions of paragraph 1 of this article, States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.

In its preamble, the states parties note their concern that in situations of poverty women have the least access to food, health, education, training and opportunities for employment and other needs.

²⁰⁷ See Splitzgerber (fn 195 *supra*) at p 8. He notes that international legal organizations must articulate program goals within legal discourse that acknowledge gendered disparities of power rather than assuming all people are equal in relation to all rights..." and that without greater female representation in international legal institutions, these goals will not be met.

²⁰⁸ In "The right to the highest attainable standard of health": 11/08/2000.E/C.12/2000/4, CESCR General Comment 14. (General Comments) there is a paragraph (21) entitled "Women and the Right to Health". It states that: "To eliminate discrimination against women, there is a need to develop and implement a comprehensive national strategy for promoting women's right to health throughout their life span. Such a strategy should include interventions aimed at the prevention and treatment of diseases affecting women, as well as policies to provide access to a full range of high quality and affordable health care, including sexual and reproductive services. A major goal should be reducing women's health risks, particularly lowering rates of maternal mortality and protecting women from domestic violence. The realization of women's right to health requires the removal of all barriers interfering with access to health services, education and information, including in the area of sexual and reproductive health. It is also important to undertake preventive, promotive and remedial action to shield women from the impact of harmful traditional cultural practices and norms that deny them their full reproductive rights." Other instruments that deal with the health of women are the Declaration on the Elimination of Violence Against Women 193 U.N.T.S. 135; Beijing Declaration and Platform of Action A/CONF.177/20(1995) and A/CONF 177/20/Add.1 (1995). Article 17 of the Beijing Declaration states that the governments who participated in the Declaration are convinced that: "The explicit recognition and reaffirmation of the right of all women to control all aspects of their health, in particular their own fertility, is basic to their empowerment". Included in the Platform of action is the statement the participants are determined *inter alia* to: "30. Ensure equal access to and equal treatment of women and men in education and health care and enhance women's sexual and reproductive health as well as education."

The Constitution does not expressly recognise the rights of women in the Bill of Rights. However, it could be said that in its prohibition of unfair discrimination on the grounds of *inter alia*, gender, it does recognise that the rights of women are equal to those of men. It is significant that the most prominent international law instrument dealing with the rights of women is CEDAW which is addressed specifically at the elimination of discrimination against women. In the context of access to health care services both CEDAW and the Constitution reflect the need to ensure that women's health needs are met and that they have at least as much access to health care services as do men. The implications of the specific reference in section 27(1) of the Constitution to reproductive health care are discussed in detail in chapter two.

The fact that the so-called 'women's Bill of Rights' is a document premised on discrimination against women indicates that although women enjoy equal rights to men generally, in terms of implementation they are not given the same recognition as men. It is thus at the level of implementation, rather than conceptualisation, that the rights of women are perceived as being in need of special attention²⁰⁹.

1.11 Rights of Refugees

The Convention relating to the Status of Refugees was adopted on 28 July 1951 by the United Nations Conference of Plenipotentiaries on the Status of Refugees and Stateless Persons convened under General Assembly resolution 429(v) of 14 December 1950. It came into force on 22 April 1954 in accordance with article 43. The Convention defines a 'refugee' as any person who:

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"In its 1995 Human Development Report, the United Nations plainly states that "in no society today do women enjoy the same opportunities as men. Similarly the U.S Department of State, in its 1995 annual report on human rights practice, left no doubt that as the global community approaches the turn of the century, the condition and status of women world-wide is one of social, political, educational, legal and economic inequality. Although the early human rights documents promised women a standard of non-discrimination on the basis of sex, that pledge, as the 1995 Country Reports and the U.N.'s Development Report indicates, is still, today, not a reality." (Hernandez-Truyol BE 'Sex, Culture and Rights: A Re-Conceptualization of Violence for the Twenty First Century' 60 (1997) *Albany Law Review* 607 - footnotes omitted)



- (1) Has been considered a refugee under the Arrangements of 12 May 1926 and 30 June 1928 or under the Conventions of 28 October 1933 and 10 February 1938, the Protocol of 14 September 1939 or the Constitution of the International Refugee Organization;...
- (2) As a result of events occurring before January 1951 and owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable, or owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable of, owing to such fear, is unwilling to return to it...

The Convention stipulates in article 20 that where a rationing system exists which applies to the population at large and regulates the general distribution of products in short supply, refugees shall be accorded the same treatment as nationals. In article 23 the Convention states that the contracting states shall accord to refugees lawfully staying in their territory the same treatment with respect of public relief and assistance as is accorded their nationals. Article 24 deals with social security and states that states must accord to refugees lawfully staying in their territory the same treatment as is accorded to nationals in respect of *inter alia* social security (legal provisions in respect of employment injury, occupational diseases, maternity, sickness, disability, old age, death, unemployment, family responsibilities and any other contingent which, according to national law or regulations is covered by a social security scheme) subject to the following limitations:

- (i) There may be appropriate arrangements for the maintenance of acquired rights and rights in the course of acquisition;
- (ii) National laws or regulations of the country of residence may prescribe special arrangements concerning benefits or portions of benefits which are payable wholly out of public funds and concerning allowances paid to persons who do not fulfil the contribution conditions prescribed for the award of a normal pension.

The Constitution does not recognise specifically the rights of refugees. However, its use of the word 'everyone' in connection with socio-economic rights is of considerable significance in this context and is canvassed in detail in chapter 2. The Refugees Act No 130 of 1998 has as its objects to give effect within the Republic of South Africa to the

relevant international legal instruments, principles and standards relating to refugees; to provide for the reception into South Africa of asylum seekers; to regulate applications for and recognition of refugee status; and to provide for the rights and obligations flowing from such status. In the Preamble to this Act it is observed that the Republic of South Africa has acceded to the 1951 Convention Relating to Status of Refugees, the 1967 Protocol Relating to the Status of Refugees and the 1969 Organization of African Unity Convention Governing the Specific Aspects of Refugee Problems in Africa as well as other human rights instruments, and has in so doing, assumed certain obligations to receive and treat in its territory refugees in accordance with the standards and principles established in international law. This is the background against which this legislation has been enacted.

1.12 Rights of Prisoners

It is obviously important from a human rights perspective to ensure that people who are vulnerable to infringement of their rights because they have been incarcerated should have some special attention devoted to their rights in order to preclude human rights abuses in penal institutions. This view is obviously based on the premise that even though people have been incarcerated and one of the rights, the right to freedom of movement, has thus been restricted, they are still human beings for the purposes of the remaining human rights.

The Standard Minimum Rules for the Treatment of Prisoners²¹⁰ (Standard Minimum Rules) were adopted by the First United Nations Congress on the Prevention of Crime and Treatment of Offenders, held at Geneva in 1955, and approved by the Economic and Social Council by its resolution 633 C (XXIV) of 31 July 1957 and 2076 (LXII) of 13 May 1977. Under the preliminary observations it is noted that the rules seek only on the basis of contemporary thought and the essential elements of the most adequate systems of today to set out what is generally accepted as being good principle and practice in the treatment of prisoners and the management of institutions. It is acknowledged that in

²¹⁰ Standard Minimum Rules http://193.194.138.190/html/menu3/b/h_comp34.htm

view of the great variety of legal, social, economic and geographical conditions of the world, not all of the rules are capable of application in all places and at all times. Under the heading 'Medical Services' the Rules of General Application stipulate various conditions that must be created or maintained in penal institutions in order to ensure that medical services are available to prisoners. Included in these conditions are the availability of at least one qualified medical officer who has some knowledge of psychiatry and the availability of the services of a qualified dental officer to every prisoner. In women's institutions there must be special accommodation for all necessary pre-natal and post-natal care and treatment and arrangements must be made wherever possible for children to be born in a hospital outside the institution.

The medical officer must see and examine every prisoner as soon as possible after admission to prison and thereafter as necessary with a view to discovery of physical or mental illness and "the taking of all necessary measures". The medical officer must have the care of the physical and mental health of the prisoners and must daily see all sick prisoners, all who complain of illness and any prisoner to whom his attention is especially directed. Whenever a medical officer considers that a prisoner's physical or mental health has been or will be injuriously affected by continued imprisonment or by any condition of imprisonment he is required to report this to the director. Upon the death or serious illness of or serious injury to a prisoner, or his removal to an institution for the treatment of mental illness the director is required to immediately inform the spouse of the prisoner or the nearest relative and must in any event inform any other person previously designated by the prisoner.

There are specific rules applicable to special categories such as "Prisoners Under Sentence", "Insane and Mentally Abnormal Prisoners" and "Prisoners Under Arrest or Awaiting Trial". In the case of "insane and mentally abnormal" prisoners, persons who are found to be insane must be detained in mental institutions and not prisons. Prisoners who suffer from 'other mental diseases or abnormalities' must be observed and treated in 'specialized institutions' under medical management. During their stay in a prison, such prisoners must be placed under the special supervision of a medical officer.

The Constitution in section 35(2) recognises the right of prisoners to adequate medical treatment and to communicate with, and be visited by, their chosen medical practitioner. This right is discussed in more detail in chapter 2. It is of interest that in South African law a prisoner has a right to be visited by his or her chosen medical practitioner. This implies a right to choose a particular medical practitioner to attend to him whilst a prisoner which means that the right is wider than the Standard Minimum Rules allow. The latter refers to an obligation on the part of the authorities to have available at least one medical officer to take care of the health needs of the prisoners.

Sections 4 to 35 of the Correctional Services Act²¹¹ are grouped in Chapter III under the heading 'Custody Of All Prisoners Under Conditions Of Human Dignity'. Section 4 stipulates that the minimum rights of prisoners entrenched in this Act must not be violated or restricted for disciplinary or any other purpose, but the Commissioner may restrict, suspend or revise amenities for prisoners of different categories.

The term, 'medical treatment' is defined in this Act as treatment, regimen or intervention prescribed by a medical practitioner, dentist or psychologist as defined in section 1 of the Medical, Dental and Supplementary Health Service Professions Act²¹² while 'medical practitioner means a medical practitioner as defined in section 1 of the Health Professions Act. Section 12 of the Correctional Services Act deals with health care. It provides that:

- (1) The Department must provide, within its available resources, adequate health care services, based on the principles of primary health care, in order to allow every prisoner to lead a healthy life.
- (2) (a) Every prisoner has the right to adequate medical treatment but no prisoner is entitled to cosmetic medical treatment at State expense.
 - (b) Medical treatment must be provided by a medical officer, medical practitioners or by a specialist or health care institution or person or institution identified by such medical officer except where the medical treatment is provided by a medical practitioner in terms of subsection (3).

²¹¹ Act No 111 of 1998

²¹² Act No 56 of 1974. Its name was subsequently changed to "Health Professions Act".



- (3) Every prisoner may be visited and examined by a medical practitioner of his or her choice and, subject to the permission of the Head of Prison, may be treated by such practitioner, in which event the prisoner is personally liable for the costs of any such consultation, examination, service or treatment.
- (4) (a) Every prisoner should be encouraged to undergo medical treatment necessary for the maintenance or recovery of his or her health.
- (b) No prisoner may be compelled to undergo medical intervention or treatment without informed consent unless failure to submit to such medical intervention or treatment will pose a threat to the health of other persons.
- (c) Except as provided in paragraph (d), no surgery may be performed on a prisoner without his or her informed consent, or, in the case of a minor, with the written consent of his or her legal guardian.
- (d) Consent to surgery is not required if, in the opinion of the medical practitioner who is treating the prisoner, the intervention is in the interests of the prisoner's health and the prisoner is unable to give such consent, or, in the case of a minor, if it is not possible or practical to delay it in order to obtain the consent of his or her legal guardian.

There appears to be no inconsistency between these provisions and the requirements of international law concerning the delivery of health care services to prisoners.

1.13 Jus Cogens and the Right To Health

In light of foregoing discussions one must ask whether a right to health has become a principle of *jus cogens*. Would an international instrument that was in conflict with a right to health be unlawful under international law? The general idea behind *jus cogens*, as stated previously, is that it represents a body of non-derogable, peremptory norms from which no domestic legal system or government may legitimately depart. Article 53 of the Vienna Convention States that a peremptory norm of general international law is a norm accepted and recognised by the international community of states as a whole as a norm from which no derogation is permitted and which can be modified only by a subsequent norm of general international law having the same character. It specifies that a treaty conflicting with *jus cogens* at the time of its conclusion is void. In terms of article 64, a treaty also becomes void if it is in contradiction with a peremptory norm of international law which has newly emerged (*jus cogens superveniens*). The International Law Commission observed in 1969 in its commentary on the draft articles for the

international law of treaties that there is no simple criterion which would allow one to determine whether a rule belongs to *jus cogens*. This is unfortunate as it does not take the concept of *jus cogens* very far in practical terms.

Although few would, in the abstract, dispute a right to health, inextricably linked as it is with those most fundamental of all human rights – the right to life and the right to dignity, the content of such a right is another matter. A right to health does not necessarily mean a right to health care services and *vice versa*. Furthermore, it seems that no two international instruments can express the concept of a right to health or even health care in the same language. Should health care services be provided as a matter of state obligation? Should they be free of charge or is it more a question of access? Are there special groups deserving of particular benefits or consideration? What level of care should be provided? Should only primary health care be provided or should all levels of care be provided? Should health care be both curative and preventive or only preventive or curative? What kinds of services must be made available? Does health mean a minimum standard sufficient that people are able to work or does it mean the highest level of health attainable? Should the public health care system carry the burden alone or should there be some reliance on private health care services? Should there be access to the highest levels of health technology or only certain minimum levels? Should there be access to the latest patented expensive drugs or only generics? Public international law is not particularly homogenous when it comes to establishing the content of a putative peremptory norm concerning a right to health or health care.

In terms of Article 25 of the Universal Declaration of Human Rights, each person has “... the right to security in the event of ...sickness...”.

Article 10 of the Additional Protocol to the American Convention on Human Rights in the Field of Economic, Social and Cultural Rights advises states to satisfy the health needs of the highest risk groups and of those whose poverty makes them most vulnerable.

In the African Charter on People's Rights, Article 18(4) stipulates that the disabled should have the right to special measures of protection in keeping with their physical needs whilst in terms of Article 13 of the European Social Charter, states are required to ensure that any person who is without adequate resources and who is unable to secure such resources be granted adequate assistance and the care necessary in the case of sickness.

In the Declaration of Alma-Ata, Article V states that governments are responsible for the health of their people which can be attained by the provision of adequate health and social measures whilst Article VII (6) states that those in need should have priority in health care and Article VIII advises governments, in co-ordination with other sectors, to formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national health system.

Article 12 of the International Covenant on Economic, Social and Cultural Rights recognises the right of everyone to the enjoyment of the highest attainable standard of physical and mental health and requires states to create conditions which will assure to all medical service and attention in the event of sickness.

In the Declaration on Social Progress and Development, Article 10(d) states that social progress and development should aim at the achievement of the highest standards of health and the provision of health protection for the entire population whilst Article 19 points out that free health services, adequate preventive and curative facilities and welfare medical services are the means to be used.

Article 7 of the Convention on the Rights of the Child states that whenever possible, the disabled child should be provided with health care services free of charge.

Article 7 of the Convention concerning Medical Care and Sickness Benefits states that the contingencies covered by the Convention should include:

- (a) need for medical care of a curative and preventive nature and

- (b) incapacity for work resulting from sickness and involving suspension of earnings, as defined by national legislation.

Article 8 states that medical care should comprise of at least:

- (a) general practitioner care;
- (b) specialist care at hospitals;
- (c) the necessary pharmaceutical supplies;
- (d) hospitalisation and
- (e) medical rehabilitation.

Article 18 states that sickness benefits are periodical benefits and that sickness means any morbid condition, whatever its cause. Articles 22 and 23 provide that a periodical payment shall be such as to attain at least 60 percent of the total previous earning of the beneficiary or 60 percent of the total wage of an ordinary adult male labourer. Article 29 states that every claimant shall have a right of appeal in the case of refusal of benefit or complaint as to its quality or quantity.

Article 7 of the Convention concerning Employment Promotion and Protection against Unemployment requires states to secure persons the benefit in respect of a condition requiring medical care of treatment of a preventive or curative nature which, according to Article 10, must include at least:

- (a) general practitioner care;
- (b) specialist care at hospitals;
- (c) the necessary pharmaceutical supplies; and
- (d) hospitalisation.

Article 13 advises states to secure persons the provision of sickness benefit whilst Article 16 requires the sickness benefit to be a periodical payment.

Article 5(4) (g) advises states to ensure the provision of medical care to persons in receipt of unemployment benefit as well as their dependents.

Paragraph 118 of the World Programme concerning Disabled Persons encourages the establishment and development of a public system of social care and health protection whilst paragraph 96 advises states to co-ordinate programmes for the prevention of disability which include community-based primary health care systems that reach all segments of the population, and for public health activities that will assist people in attaining lifestyles that will provide the maximum defence against causes of impairment.

The Preamble to the Constitution of the World Health Organisation states that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being.

Article 12(1) of the Convention on the Elimination of all forms of Discrimination Against Women requires states parties to take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those relating to family planning while Article 12(2) requires states parties to ensure to women appropriate services in connexion with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.

It is submitted that it is not possible to discern within the foregoing, a golden thread of commonality of content which could prove the universal acceptance of a right to health at some level. Some of them single out specific groups whilst others refer to specific levels of services. Others do not speak of services at all but rather a state of being. One could adopt the lowest common denominator approach²¹³ or alternatively, an approach which takes the widest expression of the right as being the overarching one of which all the others are simply subsets expressed at different levels and for various elements of the general population. Rights without content are a menu without a meal²¹⁴. It is possibly for

²¹³ This would effectively be the minimum core approach.

²¹⁴ Kinney (fn 51 *supra*) observes that "When all is said and done, legal rights should be enforceable."

this reason that the concept of minimum core obligations has been argued so strenuously by some protagonists of socio-economic rights.

The concept of minimum core, if recognised sufficiently widely, may go some way towards establishing a commonality of content for a right to health care although this would not in itself necessarily establish it as a rule of *jus cogens*.²¹⁵ However, despite reference to it in various international legal commentaries²¹⁶, it does not appear to have sufficient levels of acceptance amongst nation states and has certainly been rejected in South Africa as a key aspect of fundamental human rights both with regard to the right to housing and with regard to the right to health care services. The fact that the South African Constitution recognises not a right to health but a right to health care services is highly significant in an international law context. The court in *Grootboom*, which involved a right to housing, was at pains to point out the differences in the wording between the ICESCR on the subject of the right to housing and the expression of a similar right in the Constitution²¹⁷. The variance between the wording in section 27 of the right of access to health care services and article 12 of the ICESCR of the right to physical and mental health is even greater than that relating to rights to housing between the two documents. The South African Constitution does not expressly recognise a right to health – only a right of access to health care services.

All socio-economic rights are dependent upon the availability of resources. To imply otherwise is to lose touch with reality and to demote socio-economic rights to the world of academia. The public international law instruments dealing with socio-economic rights do recognise this limitation to some extent but there is a disturbing tendency amongst

²¹⁵ The language of the Maastricht Guidelines on Violations of Economic, Social and Cultural Rights (see fn 216 below) comes very close to implying that the minimum core obligations alleged to be inherent in the socio-economic rights are a part of the *jus cogens*.

²¹⁶ For example, the Maastricht Guidelines on Violations of Economic, Social and Cultural Rights, January 22-26, 1997 (www.edu/humanrts/instree/Maastrichtguidelines.html) which state at paragraph 9 that violations of the Covenant occur when a state fails to satisfy what the Committee on Economic, Social and Cultural Rights has referred to as “a minimum core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights [...]. Thus for example, a state party in which any significant number of individuals is deprived of essential foodstuffs, of essential primary health care, of basic shelter and housing, or of the most basic forms of education is, *prima facie*, violating the Covenant.” Such minimum core obligations apply irrespective of the availability of resources of the country concerned or any other factors and difficulties.

²¹⁷ *Government of the Republic of South Africa and Others v Grootboom and Others* (fn 57 *supra*). The Court observed at 66: “The right delineated in s 26(1) is a right of ‘access to adequate housing’ as distinct from the right to adequate housing encapsulated in the Covenant. This difference is significant.”



some writers to view this as a loophole – an escape route for states not wishing to ensure the fulfilment of the right²¹⁸. This argument, in the mouths of those who would argue that a right to health, including a right of access to health care services, is part of *jus cogens* appears to be something of a contradiction in terms since in order for a rule of international law to become part of the *jus cogens*, it should be a norm accepted and recognised by the international community of states *as a whole*. In theory therefore, states who plead poverty should at least be given the benefit of the doubt. The Committee on the ICESCR recognised the legitimacy of the phrase ‘progressive realisation’²¹⁹. If the concept of minimum core does not meet with general acceptance, if the concept of progressive realisation within available resources is legally valid, then it is submitted that it is difficult indeed to conceive of a right to health or even to health care services as being part of the *jus cogens*. What would be the content of such peremptory norm? To say that the peremptory norm incorporates the concept of progressive realisation within available resources allows for a great deal of variation in the scope of the right. How then, would one establish whether or not a state is acting in violation of the norm? Admittedly activities which deprive people of services they already have would be more obvious than those which fail to ensure the provision of services within available resources but this only advances the concept of a right to health services as *jus cogens* in a negative way. The obligations to respect and protect may be covered but not those to promote and fulfil. The availability of resources is an extremely complex issue since it goes to the heart of national resource allocation decisions and the right to self-determination which itself has been alleged to be a rule of *jus cogens*²²⁰.

A more general difficulty is how does one establish the point at which a rule becomes a norm, let alone a peremptory norm recognised by the community of states as a whole as

²¹⁸ See for example Torres (fn 130 *supra*).

²¹⁹ In paragraph 9 of general comment 3 of 1990, the Committee observed: ‘Nevertheless, the fact that realisation over time, or in other words progressively, is foreseen under the Covenant should not be misinterpreted as depriving the obligation of all meaningful content. It is on the one hand a necessary flexibility device, reflecting the realities of the real world and the difficulties involved for any country in ensuring full realisation of economic, social and cultural rights. On the other hand, the phrase must be read in the light of the overall objective, indeed the *raison d’être*, of the Covenant which is to establish clear obligations for state parties in respect of the full realisation of the rights in question. It thus imposes an obligation to move as expeditiously and effectively as possible towards that goal. Moreover, any deliberately retrogressive measures in that regard would require the most careful consideration and would need to be fully justified by reference to the totality of the rights provided for in the Covenant and in the context of the full use of the maximum available resources.’

²²⁰ Dugard fn 35, para 13.5 at p13-7

being non-derogable. A norm that enjoys general international acceptance is not necessarily a part of the *jus cogens*. It may be customary international law but *jus cogens* must, by definition, be something more than the customary international law. Similarly a norm of *jus cogens* must be more than mere public international law. It is after all the gold standard against which instruments of public international law must be measured. Kagan²²¹ tries to argue that the phrase “states as a whole” means that for a norm to be recognized by the international community as a whole, “it would suffice if all the essential components of the international community recognize it” and that “a considerable majority of those who have commented upon this seemed to accept the views of Yasseen”²²². Unfortunately when one is dealing with concepts as fundamental as *jus cogens*, the views of a majority of a majority are not necessarily convincing and the agreement of “most” that the “lack of acceptance or even the expression of opposition on the part of one of a few states is no obstacle to a norm having peremptory status”²²³ would have a hollow ring in the face of defiance of such a norm by a powerful nation such as the United States of America²²⁴.

In view of the fact that writers such as Kinney and Torres²²⁵ still try to argue the existence of a right to health at customary international law and, in the case of Kinney, observe that, “Realistically, implementation and enforcement of the international right to health is difficult, particularly if predicated on customary international law”, one cannot help but

²²¹ Kagan *C Jus Cogens and the Inherent Right To Self Defence* fn 42 *supra*

²²² Yasseen MK, chairman of the Drafting Committee of the Vienna Convention has observed that “By inserting the words ‘as a whole’ in article 30 the Drafting Committee had wished to stress that there was no question of requiring a rule to be accepted and recognized as a peremptory norm by all states. It would be enough if a very large majority did so; that would mean that, if one state in isolation refused to accept the peremptory character of a rule, or if that state was supported by a very small number of states, the acceptance and recognition of the peremptory character of the rule by the international community as a whole would not be affected.” Hannikainen L *Peremptory Norms (Jus Cogens) in International Law* (1988). Unfortunately it is still not clear what exactly is a “large majority” and whether the dissent of powerful nation states such as the USA, France and Belgium can be legitimately ignored in *jus cogens* debates. McManus (fn 2 *supra*) points out that: “Customary international law, to a greater extent than the treaty, favors powerful states, as their behavior is more likely to be unopposed and so evolve through general practice into customary law. Despite this, various principles of customary international law [transform] applications of raw power into legitimate power, thereby creating rights to apply power within certain structures using certain means.”

²²³ Torres fn 130 *supra*

²²⁴ Kinney (fn 51 *supra*) states at p 1457 that: “Throughout my career I have searched for ways to compel access to needed health services of all types for all people in need. My search would be simple if there were a legal mandate in some source of law that required societies to assure adequate and affordable health care services. Unfortunately, at least in the United States, the right to health is not generally a legal right. Thus, whether one recognizes a right to health depends on one’s political persuasion and moral values. In other words “right to health” is an option.”

²²⁵ Kinney “The International Human Right To Health: What Does This Mean for Our National and Our World?” (fn 51 *supra*) and Torres “The Human Right To Health, National Courts and Access to HIV/AIDS Treatment: A Case Study from Venezuela”, (fn 130 *supra*)

feel that if an international right to health cannot even be successfully argued at customary international law, it is even more difficult to argue such a right as part of the *jus cogens*.

The concept of *jus cogens* as non-derogable almost flies in the face of a principle that every lawyer comes to recognise intuitively as fundamental to the dynamics of any living system of law – for every rule there is an exception. Legal systems are not closed circles. They are spiralling reflections of the ever-changing communities which recognise and uphold them. The fact that the Vienna Convention on the Law of Treaties provides that a norm of *jus cogens* can be modified only by a subsequent norm of general international law having the same character simply begs the question. D’Amato²²⁶ points out that someone has yet to explain how a purported norm of *jus cogens* arises. However much the concept of *jus cogens* may be gaining acceptance and winning the support and approval of international lawyers, it is submitted that it remains of extremely limited practical efficacy in the area of a right to health. The principles of public international law in this area are more useful and are likely to remain so for some time to come.

1.14 Private International Law and the Right To Health

The question of *jus cogens* and the right to health is especially interesting in the context of the World Trade Organisation’s (WTO) activities and instruments. In the Report of the In-Depth Study Session on the WTO for Human Rights Professionals held in Morges, Switzerland in July 2001²²⁷, the first speaker in the session on the introduction to the international human rights regime and WTO dispute settlement considered the relationship between trade and human rights law and asked whether there was any legal obligation on WTO member states to help developing countries or to promote economic, social and cultural rights. Reference was made to Articles 55 and 56 of the UN Charter which state that UN Members shall cooperate in the UN’s promotion of *inter alia* higher

²²⁶ D’Amato A ‘It’s a Bird, It’s A Plane, It’s Jus Cogens! 6 *Connecticut Journal of International Law* 1 (1991). D’Amato argues that norms of *jus cogens*, when considered logically, serve only, illogically, to protect against the terms of treaties between states that are so senseless that no state is likely to incorporate them into a treaty anyway. He states that “What we require – like the third bowl of soup in the story of the three bears – is a theory of *jus cogens* that is Just Right. I do not know if such a theory is possible. I don’t even know if one is conceivable.”

²²⁷ Morges www.business-humanrights.org/Report-WTO-Human-rights-July-2001.htm

standards of living, full employment, solutions for international economic, social, health and related problems and universal respect of human rights. He also referred to the ICESCR and the CRC. The speaker identified different methods of approaching a conflict between WTO law and activities and human rights law. One of these was to resort to Article 103 of the United Nations Charter which gives the Charter priority over other conflicting international obligations. However, he observed that trade law might be considered a *lex specialis* and thus escape the article 103 presumption. Another identified approach was to qualify human rights as *erga omnes*, peremptory norms which would trump WTO law but this argument was discarded as weak *because there was little consensus as to the content of such erga omnes norms*. The view is thus that *jus cogens* norms are not even strong enough to trump WTO law due to their fundamental weakness-lack of content. The preferred solution was, in the view of the speaker, that of Article 41 of the CRC according to which nothing in the CRC shall affect any national or international provisions which are more conducive to the realization of the rights of the child.

Article 23 of the WTO Dispute Settlement Understanding (DSU) is of crucial importance for a dispute that involves WTO law and human rights law in that it specifies that if a dispute involves an allegation of a violation of WTO law, recourse to the WTO dispute settlement mechanism is compulsory and exclusive. It excludes the possibility of recourse to any other jurisdiction when WTO rules are at stake, even if other rules such as human rights are also affected²²⁸.

The WTO's Agreement on Trade Related Aspects of Intellectual Property Rights (TRIPS Agreement) was the subject of some discussion at the WTO's Ministerial Conference at Doha in 2001²²⁹. The TRIPS Agreement has the potential to interfere with access to medicines, affording as it does, international protection of intellectual property rights. The Declaration on the TRIPS Agreement and Public Health was issued in November

²²⁸ Second speaker in Morges (in 227 *supra*)

²²⁹ See further Abbott F M 'The Doha Declaration on the TRIPS Agreement and Public Health: Lighting a Dark Corner at the WTO' 2002 *Journal of International Economic Law* Vol 5 p469-505; Matthews D 'WTO Decision On Implementation of Paragraph 6 of the Doha Declaration On The TRIPS Agreement and Public Health: A Solution to the Access to Essential Medicines Problem' 2004 *Journal of International Economic Law* Vol 7 p73-107

2001 pursuant to the discussions at the Ministerial Conference. The states parties *inter alia* recognized that intellectual property protection is important for the development of new medicines and the concerns about the effects of intellectual property protection on prices. They also recognized the gravity of the public health problems afflicting many developing and least developed countries especially those resulting from HIV/AIDS, tuberculosis, malaria and other epidemics and agreed that the TRIPS Agreement does not prevent Members of the WTO from taking measures to protect public health. They affirmed that the Agreement can and should be interpreted and implemented in a manner supportive of WTO Members' right to protect public health and in particular, to promote access to medicines for all. One of the details upon which the Members agreed was that "The effect of the provisions in the TRIPS Agreement that are relevant to the exhaustion of intellectual property rights is to leave each Member free to establish its own regime for such exhaustion without challenge..."²³⁰

Private international law has the potential to impact significantly upon the right of access to health care services in general and medicines in particular unless there is conscious cognisance of human rights law in the formulation of instruments of international trade. The rapidly increasing globalisation of markets renders the penetration of private international law by human rights principles even more urgent. The legal aspects of access to medicines will be covered in more detail in another chapter. It should be noted, however that activists have observed that wealthy countries and drug companies refuse to compromise patent monopolies in poor countries that have no domestic capacity. The Doha declaration was criticised as being watered down in its language as a result of opposition by rich countries²³¹. It may be that in practice there is still much to be done in the area of private international law to ensure the proper observation of human rights.

1.15 Summary and Conclusions

²³⁰ www.globaltreatmentaccess.org/content/press-releases/01/111401_WTO-TRIPS

²³¹ www.globaltreatmentaccess.org.za



International law is fragmented and internally inconsistent between its different branches. It is a much more abstract and imprecise concept than domestic law. This makes it difficult to interpret and apply without reference to the relevant domestic legal system²³². It also contributes to the potentially large number of various interpretations and practical consequences of its application. It is debatable whether there is any kind of hierarchy within the different branches of international law or across international law governing different aspects of international relations²³³. Whilst a lack of a rights hierarchy may not necessarily be a bad thing²³⁴ there is no indication at international law as to how balancing exercises must be undertaken when there is a conflict of rights or how the different rights interrelate. Within public international law there is still a lack of harmony between human rights law and international trade law. In some instances, at a practical level, there can even be conflict between these two in the health care arena since the one seeks to promote access to health care services on the basis that it is a public good which everyone should have whether they can pay for it or not while the other seeks to obtain the greatest commercial benefit from health products and services through international agreements such as TRIPS and GATS²³⁵. There are no clear jurisdictions within international law and there is no real hierarchy of jurisdiction either. It is possible that a single dispute or

²³² Benvenisti E 'Margin of Appreciation, Consensus, and Universal Standards' *International Law and Politics* Vol 31 p 843, writes: "Judgments of the European Court of Human Rights (ECHR) and of the Inter-American Court of Human Rights (IACHR) and views of the Human Rights Committee (HRC) resonate in numerous national decisions concerning human rights issues. Their jurisprudence has become an indelible source of inspiration for judges in courts around the globe. Prominent among these international human rights organs is the ECHR, whose jurisprudence enlightens not only national judges but also judges and committee members of the other international human rights organs. The judicial output of the ECHR and other international bodies carries the promise of setting universal standards for the protection and promotion of human rights. These universal aspirations are to a large extent, compromised by the doctrine of margin of appreciation. This doctrine, based on the notion that each society is entitled to certain latitude is resolved in the inherent conflicts between individual rights and national interests or among different moral convictions."

²³³ In 'Three Interacting Human Rights Systems: UN, OSCE, Council of Europe' it is stated that: "There is not a hierarchy of rights nor priorities among rights... The effectiveness of international law in general depends upon the willingness of states to surrender some of their sovereign powers to wider international control, or on reciprocity, the understanding that each party will act in a certain way because the other will. International human rights law is largely based on a system of multilateral treaties that establish objective standards for state conduct, rather than reciprocal rights and obligations. And these treaties place duties on states in relation to individuals within their jurisdiction rather than to the other state parties. Perhaps because of their characteristics, most international human rights instruments are entitled charters or covenants, rather than treaties or conventions." <http://usinfo.state.gov/products/pubs/archives/humrts/three.htm>

²³⁴ See for instance Koskeniemi M "Hierarchy in International Law: A Sketch" *European Journal of International Law* Vol 8 No 4 www.ejil.org/journal/Vol18/No4/art2.pdf. See also the discussion by Weiler JHH and Paulus AL 'The Structure of Change in International Law or Is There a Hierarchy of Norms in International Law' Symposium: The Changing Structure of International Law Revisited (Part 2), essay published in *European Journal of International Law* Vol 8 No 4

²³⁵ Alston P (fn 19 *supra*) states that trade and competition rules, far from acting as a complement to human rights guarantees are the exact opposite. "A very limited and narrow range of economic freedoms, many of which are not per se recognized as economic rights within the framework of international human rights law, has assumed principal importance. As Besselink has recently observed in examining the relationship between these two sets of rights, 'it is not difficult to analyse the case law of the ECJ on human rights in terms of the predominance of economic (fundamental) rights over the classic human rights [Besselink 'Case Note' 38 CMLR (2001) 1307, at 1308 and 1335]...The EU is struggling even today, to determine the appropriate role for human rights in its future constitutional order."

related aspects of the same dispute may be adjudicated before different fora such as the Human Rights Committee, a national court, a regional court and a WTO panel or the Appellate Body. Different jurisdictions may reach different or inconsistent conclusions²³⁶. There is no clear hierarchy either of rights in international law or within the different branches of international law. Too frequently there is no certainty as to what exactly is international law as opposed to an international policy or viewpoint²³⁷. It is by no means clear that the international community regards international human rights law as paramount.²³⁸ International law at most tells nation states how they should behave and is binding upon them but it seldom gives guidance at the level of the individual citizen.

The other problem is that wealth is increasingly being held not by national states but by multinational corporations whose turnover in many cases far exceeds the Gross Domestic Product of many countries.²³⁹ It is becoming a legal challenge as to how to apply principles of international law to, and enforce them against, such entities.

²³⁶ Marceau G, 'WTO Dispute Settlement and Human Rights' *European Journal of International Law* Vol 13 No 4. She notes that at present international jurisdictions are multiplying. So far, however, co-ordination rules have not yet been agreed upon to limit states in their decision to choose between two jurisdictions. Marceau points out that: "A call for order was made by the President of the International Court of Justice, Judge Schwebel, and again by the present President, Judge Guillaume against the dangers of forum-shopping and the development of a fragmented and contradictory international law. Principles of international commercial law such as *forum non conveniens*, *res judicata* and, *lis pendens*, abuse of process, and procedural rights etc, cannot find application in the overlap of jurisdictions between public international law tribunals. States' choices seem based on economic, political and legal opportunities. Moreover, some treaties contain prescriptive jurisdiction clauses that can easily clash with other jurisdictions." She cites by way of example "NAFTA and the WTO, which both contain an exclusive jurisdiction clause for matters relating to SPS measures"

²³⁷ Alston P, fn 19 *supra*, states that: "There are, in fact relatively few rights which have achieved *jus cogens* status and it would be extremely difficult to argue that those that have, such as the prohibition against genocide and slavery, may be implemented in different ways depending on the state concerned or the treaty involved. All the more so since no particular treaty is involved, at least not in the sense of providing the foundation for, or the formulation of, a *jus cogens* norm."

²³⁸ Alston P fn 19 *supra* observes that human rights were, on virtually all accounts of the evolution of European integration through the common market, an afterthought. He writes: "They were not mentioned in the Treaty of Rome of 1957, which specifically eschewed the strategy of its failed forerunner, the proposed European Political Community, that would have incorporated the ECHR. Even when limited human rights provisions were included in the Treaty on European Union they were far from reflecting an integrated human rights vision for the Community. Instead, they were grafted on to a set of Treaties which, despite the broad range of powers and policies covered, were for a long time very largely focused on economic aims and objectives with very little reference to other values. The EEC Treaty was essentially a blueprint which sought to promote integration through a functional economic approach. The second reason is that when human rights in the form of fundamental rights began to make their way into the jurisprudence of the European Court of Justice it was in relation to a narrow range of rights, such as the right to property and the freedom to pursue a trade or profession, rather than to any balanced conception of human rights."

²³⁹ McCorquodale R 'Feeling the Heat of Human Rights Branding: Bringing Transnational Corporations Within the International Human Rights Fence' in Addo MK (ed) *A Review of Human Rights Standards and the Responsibility of Transnational Corporations* The Hague: Kluwer Law International, 1999 starts with two quotes: "The social responsibility of business is to increase its profits" - Milton Friedman and "Markets...cannot fairly allocate public goods, or foster social accountability in the use of resources or democracy at the workplace, or meet social and individual needs that cannot be expressed in the form or purchasing power, or balance the needs of present and future generations - Steven Lukes. He states that the tension evidenced in these two statements between the roles of corporations to increase profits for the benefit of shareholders or to act in a way that is beneficial to the community generally - and whether these are alternative roles - is a feature of the debates about the effects of globalization. He states: "In a world where more than half of the top economies are corporations and where an increasing amount of investment is private, including in areas formerly in public ownership, it is vital that

If one returns to the questions posed at the beginning of this chapter they may be answered as follows.

1. Depending upon which theory of customary international law one adopts, it may be possible to say that a right to health has passed into customary international law. However even those proponents of the more positive view that widespread observation of rules in public international law can give rise to rules of customary international law and who hope to use such customary international law as a tool for compelling nations that do not recognise a right to health to do so, concede that customary international law is not without its problems. At the other end of the spectrum is the view that customary international law is of little or no value with regard to a right to health and that the real action in respect of this right is in public international law. Certainly it has not been possible to establish any rules of customary international law relating to a right to health which could be said to be law in South Africa in terms of section 232 of the Constitution.
2. There is a considerable body of public international law on the subject of the right to health but much of it is not binding upon South Africa or its subjects. South Africa has not ratified the International Covenant on Economic, Social and Cultural Rights which contains the most comprehensive statement of the right to health in public international law according to its drafters. It is merely a signatory of this instrument. South Africa has ratified the Convention on the Rights of the Child and the Convention on the Elimination of all forms of Discrimination Against Women. However, it has not expressly enacted the provisions of these instruments into its domestic law. Section 231 of the Constitution adopts a distinctly dualist approach to international agreements in that they must be enacted into law by way of national legislation before they can become law in the Republic. The constitutional court has expressly and repeatedly refused to apply the public international law concept of minimum core obligations to socio-economic rights as expressed in the South

investigations occur into the giving effect of the activities of transnational corporations on individuals, and communities, particularly on their human rights".

African Constitution. This does not mean, however, that the approach of the constitutional court is entirely at odds with principles of international law. At a macro-level it is possible to conclude that there is a measure of consistency with the broad principles of international law in the area of socio-economic rights. Such consistency is more subtle, however, than a simple one-on-one comparison of domestic constitutional and international law rights.

3. There are at this stage no peremptory norms, or principles of *jus cogens*, concerning a right to health or even health care services. This may be as much because of procedural problems in identifying principles of *jus cogens* as it is due to lack of acceptance of a right to health or health care services by a majority of states.
4. Private international law presents more of a hindrance than a help with regard to the right to health at present in that it is only relatively recently that the need to reconcile the values of private international law and public international law has been openly recognized. Instruments such as the World Trade Organisation's Agreement on Trade Related Aspects of Intellectual Property Rights have proved to be problematic for the South African government in its attempts to respect, protect, promote and fulfil the right of access to health care services conferred by section 27(1) of the Constitution. In 1997, the Pharmaceutical Manufacturers Association of South Africa challenged on the basis of the TRIPS Agreement, legislation²⁴⁰ which was passed with the express intention of improving the access of medicines to South Africans. The challenge, although ultimately unsuccessful and settled out of court, served to effectively delay the implementation of the legislation in question for a period of five years.

In general it must be observed that the constitutional court has adopted a cautious and conservative approach to the application of international legal principles within South

²⁴⁰ The Medicines and Related Substances Control Amendment Act No 90 of 1997. Although the out of court settlement was effected some three years after commencement of the litigation, the government thereafter adopted a cautious approach to the development of the regulations which serve as the mechanism whereby the legislation is to be implemented with the result that it has taken a significant amount of time after the settlement to bring the law into effect. It was deemed further necessary to fine-tune certain aspects of Act 90 of 1997 relating implementation in the form of another amendment - Act 59 of 2002.



Africa. The essentially dualist approach of the Constitution itself is no doubt largely responsible for this. However, it is submitted with respect that it this sensible and pragmatic approach which renders the Constitution and the decisions of the courts in South Africa so effective in dealing with socio-economic and other constitutional rights.

The role of international law in interpreting the provisions of the Bill of Rights, whilst it is acknowledged as being important, has not been overplayed by South African courts and the need to consider international legal principles in the South African context, taking into account local conditions and the country's history has been repeatedly emphasised. It is submitted with respect that as long as South African courts continue in this vein, both domestic and international lawyers can look forward to a meaningful and significant body of South African jurisprudence on the subject of human rights generally which will enrich the culture of human rights within South African and international law.

Since the focus of this thesis is not international law and the right to health, a subject which undoubtedly deserves a thesis of its own, but rather an assessment of how international law and the right to health care interfaces with the South African legal system, it is not appropriate to consider the subject further. However there are a number of other references which are relevant to the subject of health and human rights which bear mention and for this reason are listed below²⁴¹. Although in general terms it can be said that international law has significantly influenced the South African legal system, more particularly the Constitution and many of the principles it endorses, it cannot be said that the Constitution is the result or product of international law. It is a product of the history and culture of South Africa and the values and aspirations of its people. The right to health is not expressly contained in the Constitution but the rights that are the essential

²⁴¹ Cosmas, C and Schmidt-Ehry B 'Human Rights and Health in Developing Countries: Barriers to Community Participation in Public Health In Cameroon' *Health and Human Rights* 1(3) p 244; Dworkin R *Life's Dominion: An Argument About Abortion, Euthanasia and Individual Freedom*; Giesen D 'A right to health care? A Comparative Perspective' *Health Matrix* 4 (2) p 277-95; Goldsmith M 'Health and Human Rights Inseparable' *Journal of the American Medical Association* 270 (5) p 553; Gostin L and Mann J 'Towards the Development of a Human Rights Impact Assessment for the Formulation and Evaluation of Health Policies' *Health and Human Rights* 1(6) p 58; Haslam MT, 'Human Rights: The Right To Receive Treatment and Care' *Medicine and Law* 12 (3-5) p 291-5; Hayes JA 'Health care as a Natural Right' *Medicine and Law* 11(506) p 405-16; Leary, V 'The Right to Health in International Human Rights Law' *Health and Human Rights* p 24; Mann J Human Rights and the New Public Health' *Health and Human Rights* 1 p 29; Otto, D 'Linking Health and Human Rights: A Critical Legal Perspective' *Health and Human Rights* 1(3) p 272; Roemer, R 'The Right to Health Care' in *The Right to Health in the Americas* Fuenzalida-Puelma, H and Scholle Connor, S (eds); Fidler, D P 'SARS and International Law' *American Society of International Law* April 2003 <http://www.asil.org/insights/insigh101.htm>; Frost L 'Mental Disability Rights in International Law' http://www.ilppp.virginia.edu/Research_Initiatives/mental_disability_rights_in_in.htm

building blocks for health are very much in evidence. The right to health care services in the Constitution has been recognised as justiciable and applied by the constitutional court on more than one occasion as the following chapter will demonstrate. The courts have not, however, treated the right to health care services in the light of international law principles. They have, for instance, expressly rejected the minimum core approach espoused by international law with regard to socio-economic rights. In South African law, the right to health care services has yet to fully permeate the law of contract and to a lesser extent, the law of delict as will be demonstrated in subsequent chapters. It can also not be said that the influence of international law is greater on the domestic legal system than it was prior to the Constitution. South African courts have long taken cognisance of international law where they felt the need. The Constitution has simply focused this practice and made it mandatory. Whilst international law will always be a guide to the domestic legal system, it is dependent for its authority and status on its recognition by the Constitution in its various aspects. As such, it is of limited value in defining, interpreting and applying the constitutional rights that relate to health care services in the South African context.

It is clear from the discussion in this chapter that the Constitution is the legal lodestone that guides the interpretation and understanding of the law of health service delivery in South Africa. It is the uniquely South African lens through which principles of international law must pass in order to acquire legal weight and validity within the domestic legal system. The importance to the people of South Africa of their past, their culture, and their values is such that it cannot be otherwise. Whilst the principles enshrined in the Constitution may well be consistent with those of international law in a general way, it is still to the Constitution that one must turn when seeking to apply those principles to particular circumstances in the South African context. International law does not override the Constitution for the purposes of the South African legal system. Section 2 of the Constitution clearly states that:

“This Constitution is the supreme law of the Republic; law *or conduct* inconsistent with it is invalid, and the obligations imposed by it must be fulfilled.” [writer’s italics]

International law, whether it is at the level of public international law, customary international law or even *jus cogens* (the latter two depend heavily upon ‘conduct’ for their legal status) that is inconsistent with the Constitution is invalid in South Africa. It is therefore necessary to consider issues of health service delivery in the context of the Constitution.



Chapter 2

The Constitution and Health Care Services

| | | |
|---------|---|-----|
| 2.1 | Introduction | 113 |
| 2.2 | The Right To Health Care Services v The Right to Health | 116 |
| 2.2.1 | Life | 118 |
| 2.2.2 | Dignity | 120 |
| 2.2.3 | Bodily and Psychological Integrity..... | 121 |
| 2.2.4 | Privacy | 124 |
| 2.2.5 | Environment | 125 |
| 2.2.6 | Emergency Medical Treatment..... | 126 |
| 2.2.7 | Relationship Between Rights to Health and Access to Health Services | 127 |
| 2.2.8 | In Summary | 128 |
| 2.3 | Understanding The Right Of Access To Health Care Services | 130 |
| 2.3.1 | ‘Health Care Services’ | 131 |
| 2.3.2 | Access | 134 |
| 2.3.2.1 | Practical Implications | 136 |
| 2.3.2.2 | Links to other rights | 138 |
| 2.3.2.3 | Rationing | 140 |
| 2.3.2.4 | Soobramoney v the Minister of Health (KwaZulu-Natal) | 141 |
| | Facts | 141 |
| | Judgment..... | 142 |
| | Discussion..... | 143 |
| 2.3.2.5 | The Individual v The Collective | 147 |
| 2.3.2.6 | Government of the Republic of South Africa v Grootboom | 148 |
| | Facts | 148 |
| | Judgment..... | 148 |
| | Discussion..... | 153 |
| 2.3.2.7 | Minister of Health and Others v Treatment Action Campaign | 158 |
| | Facts | 158 |
| | Judgment..... | 158 |
| | Discussion..... | 161 |
| 2.3.4 | Progressive Realisation..... | 165 |
| 2.3.5 | “Everyone” | 167 |
| 2.3.5.1 | Temporary Residents | 168 |
| 2.3.5.2 | Illegal Immigrants | 170 |
| 2.3.5.3 | Health Tourists | 176 |
| 2.3.6 | Available Resources..... | 179 |
| 2.4 | The Right of Children To Basic Health Care Services | 185 |
| 2.4.1 | Section 28 Rights v Section 26 and 27 Rights | 185 |
| 2.4.2 | What is a child?..... | 190 |
| 2.4.2.1 | Christian Lawyers Association of South Africa v Minister of Health..... | 191 |
| | Facts | 191 |
| | Judgment..... | 192 |
| | Discussion..... | 193 |
| 2.4.2.2 | Christian Lawyers Association vs Minister of Health (No 2) | 198 |



| | | |
|---------|---|-----|
| | Facts..... | 198 |
| | Judgment..... | 199 |
| | Discussion..... | 216 |
| 2.5 | The Right of Prisoners to Medical Treatment..... | 228 |
| 2.5.1 | Van Biljon and Others v Minister of Correctional Services | 228 |
| | Facts | 228 |
| | Judgment..... | 229 |
| | Discussion..... | 231 |
| 2.6 | Conflicting Rights | 235 |
| 2.6.1 | Children’s Rights | 236 |
| 2.6.2 | HIV Positive Patients and Sexual Offenders..... | 239 |
| 2.7 | Rationing of Health Care Services and the Limitation of Rights..... | 240 |
| 2.7.1 | Constitutional Aspects | 242 |
| 2.7.2 | Limitations of rights in the health care context..... | 247 |
| 2.7.3 | Case Law | 249 |
| 2.7.3.1 | Minister of Health and Another v Maliszewski and Others | 249 |
| | Facts | 249 |
| | Judgment..... | 251 |
| | Discussion..... | 253 |
| 2.7.3.2 | Reitzer Pharmaceuticals (Pty) Ltd v Registrar Of Medicines | 254 |
| | Facts | 254 |
| | Judgment..... | 256 |
| | Discussion..... | 258 |
| 2.7.3.3 | Affordable Medicines Trust and Others v Minister of Health | 261 |
| | Facts | 261 |
| | Judgment..... | 262 |
| | Discussion..... | 271 |
| 2.7.4 | Rationing By Medical Schemes | 279 |
| 2.7.4.1 | Constitutional Issues | 281 |
| 2.7.5 | Rationing By The State..... | 283 |
| 2.7.5.1 | Certificate of Need | 283 |
| 2.7.5.2 | Foreign Health Professionals..... | 288 |
| 2.8 | Emergency Medical Treatment..... | 291 |
| 2.8.1 | No-one may be refused..... | 292 |
| 2.8.2 | Emergency..... | 295 |
| 2.8.2.1 | Horizontal Application | 295 |
| 2.8.2.2 | Soobramoney..... | 298 |
| 2.8.2.3 | EMTALA..... | 302 |
| 2.8.3 | Medical Treatment..... | 308 |
| 2.8.4 | Intellectual Property Rights and Access To Technology | 310 |
| 2.8.4.1 | Patents on Medicines | 311 |
| 2.9 | Reproductive Health Care | 314 |
| 2.9.1 | Reproductive Rights..... | 315 |
| 2.9.2 | Reproductive health care in relation to reproductive rights | 316 |
| 2.9.3 | The Ability to Reproduce | 319 |
| 2.9.4 | Assisted Reproduction | 320 |
| 2.9.5 | Sterilisation..... | 326 |



| | | |
|-------|---|-----|
| 2.9.6 | Human Cloning..... | 327 |
| 2.10 | National vs Provincial Government Obligations | 334 |
| 2.11 | Horizontal Application of The Right To Health Care Services | 342 |
| 2.12 | Summary and Conclusions | 351 |

2.1 Introduction

The concept of values permeates the Constitution¹. It is thus hardly surprising that the constitutional court has committed itself to a purposive approach to interpretation of the Bill of Rights². Since the Constitution is the supreme law of the Republic and law *or*

¹ Act No 108 of 1996. Cookrell A, 'Rainbow Jurisprudence' (1996) *SAJHR* 1 notes that: "A convenient starting point is to focus on the one word which resonates like a leitmotiv throughout the judgements of the Constitutional Court in the past year: 'values'. Many commentators have foregrounded the permanent place of 'values' in our new constitutional dispensation. See for example Botha H, 'The values and principles underlying the 1993 Constitution' (1994) 9 *SAPL* 233, who states that "the Constitution is a repository of values" (at 233) and goes on to identify the following values in the constitutional text: national unity, limited government; liberty and equality, and pluralism. See also AJ van der Walt 'Tradition on trial: A critical analysis of civil-law tradition in South African property law' (1995) 11 *SAJHR* 169 at 191-192 who echoes those 'constitutional values' and concludes that 'the Constitution must be interpreted in terms of values which take the past into account, but in doing so it looks towards the future, towards reconstruction and reconciliation in an "open and democratic society based upon freedom and equality"...(at 192)... The impatient observer might be tempted to dismiss this persistent refrain regarding the role of 'values' in constitutional adjudication as mere verbiage or rhetorical bluster. In my view that would be a mistake. The Constitutional Court's pre-occupation with the intrusion of 'values' into the adjudicative process provides us with an important clue for understanding the changes that have occurred at a deep level within the South African legal system over the past year. In this article I wish to investigate that clue in detail, and probe some of the implications which are attendant on the value-based nature of constitutional adjudication....In essence my argument will be that the explicit intrusion of constitutional values into the adjudicative process signals a transition from a 'formal vision of law' to a 'substantive vision of law'."

² See de Waal, Currie, Erasmus *The Bill of Rights Handbook* (4 ed) p 130 and the cases referred to there in footnote 13, where it is observed that the purposive approach is also sometimes referred to as "value oriented" or "teleological". According to the court in *Baloro And Others v University Of Bophuthatswana And Others* 1995 (4) SA 197 (B), referring to the interim Constitution, (Act 200 of 1993): "Chapter 3 contains at least one section (s 35) which deals with its interpretation in explicit terms. According to s 35(1) a court interpreting the provisions of the chapter is firstly required to ("a . . . court . . . shall") promote the values which underlie an open and democratic society based on freedom and equality. This formula opens the door to the evolution of a teleological approach to the interpretation of chap 3 which, amongst others, allows for the interpretive adaptation of the human rights norms enshrined in it to constantly changing circumstances. This can be done without necessarily compromising the element of constancy inherent in the chapter and embodied in durable values fundamental to any (hypothetically) open and democratic society based on freedom and equality. The mandatory nature of this intrinsically teleological interpretation formula is bolstered up by two further provisions forming part of s 35(1), namely that, where applicable, a court shall have regard to applicable norms of international law (note the mandatory language) and that it may have regard to comparable foreign case law (the court, in other words, has a discretion)." Ackerman J in *Ferreira v Levin No And Others; Vryenhoek And Others v Powell No And Others* 1996 (1) SA 984 (CC) noted that: "A teleological approach also requires that the right to freedom be construed generously and extensively. In *Makwanyane*, O'Regan J, adopting such a teleological approach, correctly observed as follows: "Respect for the dignity of all human beings is particularly important in South Africa. For apartheid was a denial of a common humanity. Black people were refused respect and dignity and thereby the dignity of all South Africans was diminished. The new Constitution rejects this past and affirms the equal worth of all South Africans. Thus recognition and protection of human dignity is the touchstone of the new political order and is fundamental to the new Constitution. In my view exactly the same approach needs to be adopted in the case of the right to freedom." In *Thoroughbred Breeders' Association v Price Waterhouse* 2001 (4) SA 551 (SCA) O'Regan J, commenting on the virtues of the teleological approach stated at p623 that: "The last-mentioned approach, in particular, not only 'encapsulates in a synthesis the meritorious aspects of other theories and excludes their limitations' (Devenish *Interpretation of Statutes* (1992) at 53) but also gives expression to the fundamental principles and ethos of the legal system as a whole: it is a value-coherent approach which best accords with the values of our Constitution." O'Regan J in *S v Makwanyane And Another* 1995 (3) SA 391 (CC) commented at para 325, p506: "In giving meaning to s 9, we must seek the purpose for which it was included in the Constitution. This purposive or teleological approach to the interpretation of rights may at times require a generous meaning to be given to provisions of chap 3 of the Constitution and at other times a narrower or specific meaning. It is the responsibility of the courts, and ultimately this Court, to develop fully the rights

conduct inconsistent with it is invalid³, values must have a profound and pervading impact on the way that law is interpreted and applied in South Africa. The evolving South African legal order emphasises values⁴ in a way that the pre 1994 legal system did not. To the extent that values represent the spirit of the law, the Constitution and more especially, the Bill of Rights, in many respects embodies the spirit of the law leaving the letter of it to subordinate legislation⁵. The specific values it promotes are those that underlie an open and democratic society based on human dignity, equality and freedom⁶. This said, there existed

entrenched in the Constitution. But that will take time. Consequently any minimum content which is attributed to a right may in subsequent cases be expanded and developed."

³ Act No 108 of 1996 section 2

⁴ See for instance the judgement of Mahomed J in *S v Makwanyane And Another* (in 2 *supra*) at 487 where he states: "In some countries the Constitution only formalises, in a legal instrument, a historical consensus of values and aspirations evolved incrementally from a stable and unbroken past to accommodate the needs of the future. The South African Constitution is different: it retains from the past only what is defensible and represents a decisive break from, and a ringing rejection of, that part of the past which is disgracefully racist, authoritarian, insular, and repressive, and a vigorous identification of and commitment to a democratic, universalistic, caring and aspirationally egalitarian ethos expressly articulated in the Constitution. The contrast between the past which it repudiates and the future to which it seeks to commit the nation is stark and dramatic." See also the same judgment at p 498 where he states: "The Constitution makes it particularly imperative for courts to develop the entrenched fundamental rights in terms of a cohesive set of values, ideal to an open and democratic society. To this end common values of human rights protection the world over and foreign precedent may be instructive." At p 505, O'Regan J observes that: "In interpreting the rights enshrined in chap 3, therefore, the Court is directed to the future: to the ideal of a new society which is to be built on the common values which made a political transition possible in our country and which are the foundation of its new Constitution. This is not to say that there is nothing from our past which should be retained. Of course this is not so. As Kentridge AJ described in the first judgment of this Court (*S v Zuma and Others* 1995 (2) SA 642 (CC) (1995 (1) SACR 568)), many of the rights entrenched in s 25 of the Constitution concerning criminal justice are long-standing principles of our law, although eroded by statute and judicial decision. In interpreting the rights contained in s 25, those common-law principles will be useful guides. But generally s 35(1) instructs us, in interpreting the Constitution, to look forward not backward, to recognise the evils and injustices of the past and to avoid their repetition." In *Ryland v Edros* 1997 (2) SA 690 (C) at p709, the court stated that: "I agree with the submission that the values of equality and tolerance of diversity and the recognition of the plural nature of our society are among the values that underlie our Constitution. In my view those values 'irradiate', to use the expression of the German Federal Constitutional Court cited earlier, the concepts of public policy and *boni mores* that our Courts have to apply. Contrary to public policy (as opposed to those that are *contra bonos mores*) are contracts which might redound to the public injury; see Voet 1.14.16. The distinction is clearly put by Aquilius in the article to which I have already referred ((1941) 58 SALJ 335 at 346)... In my opinion the 'radiating' effect of the values underlying the new Constitution is such that neither of these grounds for holding the contractual terms under consideration in this case to be unlawful can be supported." In *S v Jordan And Others (Sex Workers Education And Advocacy Task Force And Others As Amici Curiae)* 2002 (6) SA 642 (CC), at p 670 the court observed that: "The Constitution itself makes plain that the law must further the values of the Constitution. It is no answer then to a constitutional complaint to say that the constitutional problem lies not in the law but in social values when the law serves to foster those values. The law must be conscientiously developed to foster values consistent with our Constitution. Where, although neutral on its face, its substantive effect is to undermine the values of the Constitution, it will be susceptible to constitutional challenge."

⁵ See for instance sections 9 (equality), 22 (freedom of trade, occupation and profession), 23 (labour relations), 24 (environment), 25 (property), 26 (housing), 27 (health care, food, water and social security) section 32 (the right of access to information), section 33 (the right to just administrative action) and section 41 (co-operative government) all of which contemplate legislative measures and expressly, in the case of sections 32, 33 and 41 mandate legislation to give effect to the principles enunciated in the Constitution. Section 39(2) provides that a court, tribunal or forum interpreting legislation and developing the common law must promote the 'spirit, purport and objects of the Bill of Rights'. It is submitted that the same holds true, subject to the provisions of section 36, for Parliament when exercising its legislative power. (Section 44 (4) of the Constitution states that "when exercising its legislative authority, Parliament is bound only by the Constitution, and must act in accordance with, and within the limits of, the Constitution. Section 36(2) states that 'except as provided in subsection (1) or in any other provision of the Constitution, no law may limit any right entrenched in the Bill of Rights.'")

⁶ Act No 108 of 1996, section 1 states that: "The Republic of South Africa is one, sovereign, democratic state founded on the following values: (a) Human dignity, the achievement of equality and the advancement of human rights and freedoms (b) non-racialism and non-sexism (c) supremacy of the constitution and the rule of law (d) universal adult suffrage, a national common voters roll, regular elections and a multi-party system of democratic government, to ensure accountability, responsiveness and openness." Section 7 states that: "The Bill of Rights is a cornerstone of democracy in South Africa. It enshrines the rights of all people in our country and affirms the democratic values of human dignity, equality and freedom". Section 39(1) requires that the rights in the Bill of Rights must be interpreted in such a way that the values that underlie an open and democratic society based on human dignity, equality and freedom are promoted".

before the Constitution a long established and well defined legal order which did not employ or apply the same principles and values that are now found in the Constitution. Whilst the importance of the South African historical background has been emphasised by the courts, they have also pointed to the need to break with the past and to retain from it only that which is defensible. For a legal system that is strongly premised upon precedent, this creates more than a little turbulence and a great deal of uncertainty in untried constitutional waters⁷. As a result, the transformation of the South African legal system, not only in terms of procedural law but also the substantive law, in line with constitutional principles and thinking is an ongoing process⁸. There is thus great value in the thoughtful application and consideration of constitutional legal principles, and the underlying values, in relation to factual situations that arise in the delivery of health care services. Such labour in the abstract is likely to produce fruit in reality because the individual facets of often complex and multi-faceted situations have been explored conceptually in a rational and methodical way so as to arrive at some conclusions which can be of considerable value in their practical application. Since a number of different branches of law are involved in the delivery of health care services, not least of which are the law of contract, delict and administrative law, it is critical to fully understand the nature of the rights conferred by the

⁷ De Vos P 'A Bridge Too Far? History as Context in the Interpretation of the South African Constitution', *South African Journal of Human Rights* (2001) 17 SAJHR 1 at p 3-4, expresses this tension in the following terms: "The fact that the text of the 1996 Constitution is often vague, ambiguous and seemingly contradictory, means that it cannot provide a self-evident and fixed meaning to those who read it. Instead, it requires interpretation, and to do so it seems necessary to invoke sources of understanding and value external to the text and other legal materials. Most judges, lawyers and legal academics in South Africa seem profoundly uncomfortable with the notion that judicial decision-making in the constitutional sphere is not (always) aimed merely at discovering a 'true', 'objective' or 'original' meaning of the text and hence is not based (solely) on predictable and neutral principle. For if this is so, the interpreter of the constitutional text will (often) have to rely on other, subjective and extra-textual factors – perhaps even the interpreter's own personal, political and philosophical views- to give meaning to that text. The discomfort flows from the fact that most judges, lawyers and legal academics in South Africa broadly adhere to the traditional liberal school of adjudication, a tradition that jealously guards the boundary between law and politics. As Karl Klare has recently pointed out, this traditional view of adjudication maintains a view of law as 'describing rational decision-procedures...with which to arrive at determinate legal outcomes from neutral, consensus-based general principles expressed or immanent within a legal order'." (Footnotes omitted)

⁸ Klare K 'Legal Culture and Transformational Constitutionalism' (1998) 14 SAJHR 146 argues that the 1996 Constitution can be understood as establishing a long-term project described as 'transformative constitutionalism' in terms of which the Constitution is seen as a transformative, dynamic document that requires continual reinvention to make sense of a changing world. It is a project with no instant solutions, requiring constitutional enactment, interpretation and enforcement committed to transforming South African social and political institutions and power relationships in a democratic, participatory and egalitarian direction. He points out that "transformative constitutionalism connotes an enterprise of inducing large-scale social change through non-violent political processes grounded in law. I have in mind a transformation vast enough to be inadequately captured by the phrase 'reform', but something short of or different from 'revolution' in any traditional sense of the word." It is submitted that the South African legal system itself must therefore be seen as being in a considerable state of flux as traditional legal doctrines, methods of statutory interpretation and legal principles stand in line to be tested against the new standard set by the Constitution. Uncertainty, at least in the beginning, is the price one pays for a new legal order. Brand D in "A Review of Important Cases and International Developments Relating to Economic and Social Rights" *ESR Review* Vol 1, No 1 March 1998 (http://www.community.awcentre.org.za/esr/esr1998/1998march_esss.php) observes: "A fledgling jurisprudence on economic and social rights is at last starting to develop in South African law." Khoza R in 'Understanding the Synergy Between the Bill of Rights and Commercial Activity' points out that the Bill of Rights is not an end in itself. Its overarching objective is to promote and to secure growth and prosperity for all. (<http://www.kas.org.za/publications/SeminarReports/Business%20&%20Human%20Rights/khoza.pdf>).

Constitution with regard to health care services in order to ascertain how the delivery of health care services is likely to be treated within these various branches. Constitutional law affecting the delivery of health care services must inform all other branches of law that relate to the delivery of health care services in light of the foregoing⁹.

In this chapter it is proposed to embark on a number of conceptual exercises in which the consideration and manipulation of constitutional principles and precepts will hopefully lead to an improved understanding of the constitutional aspects of health services delivery generally and of certain practical aspects of health services delivery in particular. The relevance of a right to health, as opposed to a right to health care services, will be examined in order to establish the approach of South African constitutional law relative to the principles of international law on health care, the latter having been canvassed in more detail in the preceding chapter. An analysis of the elements of the constitutional right of access to health care services will also be undertaken with the intention of arriving at a full appreciation of the scope and content of the right. Similar exercises will be conducted with regard to the rights of children and prisoners to basic health care services and medical treatment respectively and also the right not to be refused emergency medical treatment. No discussion of rights, especially socio-economic rights, is complete without an exploration of the question of the limitation of those rights and so a consideration of both implicit and explicit rationing of health care services is included. Lastly, the question of rights must provoke the question of obligations and so the chapter undertakes an examination of the roles of the various spheres of government in respect of the various constitutional rights relating to health care services.

2.2 The Right To Health Care Services v The Right to Health

⁹ Chaskalson, A notes in "The Impact of Seven Years of Constitutionalism on Law and Government in South Africa" that the Constitutional Court has stated in *The Pharmaceutical Manufacturers Association of South Africa in re: The ex parte Application of the President of the Republic of South Africa* 2000(3) BCLR 241 (CC) para 44 that: "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 from the Constitution and is subject to constitutional control." He also observes that in *Carmichele v Minister of Safety and Security and Another* 2001 (1) SA 489 (SCA) the court said that "where the common law deviates from the Bill of Rights the courts have an obligation to develop it by removing that deviation."
(<http://kas.org/za/Publications/SeminarReports/Constitution%20and%20Law%20iv/chaskalson.pdf>)

The Constitution contains a number of different references to health care services and medical treatment. Apparently in contrast to international law, there is no express mention of a broad right to health. This said, it must, however, be borne in mind that the rights in the Bill of Rights are not discrete legal concepts but rather elements of a system of fundamental rights that are inextricably interlinked¹⁰. There is a suite of rights which, when viewed collectively, could be said to constitute a right to health. These rights are, the right to life¹¹, the right to dignity¹², the right to bodily and psychological integrity¹³, the right to privacy¹⁴, the right to an environment that is not harmful to health or well-being¹⁵, the right to emergency medical treatment, the right of access to health care services¹⁶ and the rights to sufficient food and water and social security, including appropriate social assistance¹⁷. The overall result of this rights matrix would seem to be in general accordance with the World Health Organization's definition of health as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'¹⁸. However, for the purposes of legal exposition and practical implementation it is submitted that a right to health is unwieldy and less valuable than its component parts. Since it is not the intention in this thesis to embark upon an in-depths examination of all, or even the majority, of the rights in the Bill of Rights, the discussion of the various rights in this chapter is confined to

¹⁰ In *Government Of The Republic Of South Africa And Others v Grootboom And Others* 2001 (1) SA 46 (CC) the court observed at p83: "But s 26 is not the only provision relevant to a decision as to whether state action at any particular level of government is reasonable and consistent with the Constitution. The proposition that rights are interrelated and are all equally important is not merely a theoretical postulate. The concept has immense human and practical significance in a society founded on human dignity, equality and freedom. It is fundamental to an evaluation of the reasonableness of State action that account be taken of the inherent dignity of human beings."

¹¹ Act No 108 of 1996, section 11

¹² Act No 108 of 1996, section 10. Concerning the fundamental importance of the right to dignity, O'Regan J observed 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) at 962-962 that: "The value of dignity in our constitutional framework cannot therefore be doubted. The Constitution asserts dignity to contradict our past in which human dignity for black South Africans was routinely and cruelly denied. It asserts it too to inform the future, to invest in our democracy respect for the intrinsic worth of all human beings. Human dignity therefore informs constitutional adjudication and interpretation at a range of levels. It is a value that informs the interpretation of many, possibly all, other rights. This Court has already acknowledged the importance of the constitutional value of dignity in interpreting rights such as the right to equality, the right not to be punished in a cruel, inhuman or degrading way, and the right to life. Human dignity is also a constitutional value that is of central significance in the limitations analysis. Section 10, however, makes it plain that dignity is not only a value fundamental to our Constitution, it is a justiciable and enforceable right that must be respected and protected. In many cases, however, where the value of human dignity is offended, the primary constitutional breach occasioned may be of a more specific right such as the right to bodily integrity, the right to equality or the right not to be subjected to slavery, servitude or forced labour." (footnotes omitted)

¹³ Act No 108 of 1996, section 12 (2)

¹⁴ Act No 108 of 1996 section 14

¹⁵ Act No 108 of 1996 section 24 (a)

¹⁶ Act No 108 of 1996 section 27(1)(a)

¹⁷ Act No 108 of 1996 section 27(1)(b) and (c)

¹⁸ Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June 1946, signed on 22 July 1946 by the representatives of 61 states (Official Records of the World Health Organization, no. 2, p 100) and entered into force on 7 April 1948.

their relevance to the delivery of health care services. The elemental rights that could be said to comprise a right to health are discussed briefly below in order to obtain a clearer picture of their contribution to such right. Further and more detailed discussion of the rights that relate specifically to the delivery of health care services, and which are thus of central importance in this thesis, is to be found later in the chapter.

2.2.1 Life

The right to life has been characterized as the most fundamental of all human rights¹⁹ Without life, the other aspects of the right to health are meaningless. At the same time the right to life does not mean life ‘as mere organic matter... but the right to human life the right to live as a human being, to be part of a broader community, to share in the experience of humanity’²⁰. The right to life attaches only to persons recognized as such by the law. Since the law in South Africa does not recognize a foetus as a person, it does not enjoy a constitutional right to life²¹. The government has an obligation to protect the life of everyone in South Africa²². With regard to dying, the constitutional court observed in *Soobramoney*²³ that dying is part of life – its completion rather than its opposite, and that there is in reality no meaningful way in which it can constitutionally be extended to encompass the right indefinitely to evade death. In the context of the delivery of health care services the relevance of this observation cannot be overstated. Although the government has a constitutional duty to respect, protect, promote and fulfil the right to life, there are

¹⁹ Per Lord Bridge in *R v Home Secretary, Ex Parte Bugdaycay* [1987] AC 514 ([1987] 1 All ER 940 (HL)) at 531G (AC) cited in *Makwanyane* fn 2 *supra* at 429. Concerning the fundamental nature of the right to life and the interdependence of the rights to life and human dignity, O’Regan J observed in *Makwanyane* beginning at para 326, p506: “The right to life is, in one sense, antecedent to all the other rights in the Constitution. Without life, in the sense of existence, it would not be possible to exercise rights or to be the bearer of them. But the right to life was included in the Constitution not simply to enshrine the right to existence. It is not life as mere organic matter that the Constitution cherishes, but the right to human life: the right to live as a human being, to be part of a broader community, to share in the experience of humanity. This concept of human life is at the centre of our constitutional values. The Constitution seeks to establish a society where the individual value of each member of the community is recognised and treasured. The right to life is central to such a society. The right to life, thus understood, incorporates the right to dignity. So the rights to human dignity and life are entwined. The right to life is more than existence - it is a right to be treated as a human being with dignity: without dignity, human life is substantially diminished. Without life, there cannot be dignity.”

²⁰ See *Makwanyane*, fn 2 *supra*

²¹ *Christian Lawyers Association of SA and Others v Minister Of Health and Others* 1998 (4) SA 1113 (T). This issue is discussed in more detail later in this chapter.

²² *Mohamed And Another v President Of The Republic Of South Africa And Others (Society For The Abolition Of The Death Penalty In South Africa And Another Intervening)* 2001 (3) SA 893 (CC) at p 917

²³ *Soobramoney v Minister Of Health, Kwazulu-Natal* 1998 (1) SA 765 (CC) per Sachs J at para 57 p784. The facts of this case and the judgment are discussed in detail further on in this chapter.



limitations upon this duty when it comes to prolonging life indefinitely through health care services. This is a good example of a situation in which the protection aspect outweighs the promotion and fulfilment aspects of the state's obligations with regard to a right in the Bill of Rights. Protection of life implies a negative obligation to ensure that no one else can take it away²⁴. It may seem a fine distinction but the only apparent manner in which one can reconcile the government's duty to protect life and the view of the court in *Soobramoney* that this cannot be seen as a right to evade death indefinitely is to take the view that not all health care services serve to protect life. Some of them actively promote and fulfil it. Emergency medical treatment protects life. This is why, in terms of section 27(3) of the Constitution, it cannot be refused. Protection of a right as opposed to its promotion or fulfilment comes close to being something of a minimum standard of recognition of a right²⁵. Other health care services go further than protection. They are the positive as opposed to negative aspect of access to health services. This is why they are dependent upon the availability of resources. This argument is best understood if one regards life as a limited resource which inevitably dwindles over time, rather than as a binary state of life versus death, which is what Sachs J seems to be stating in his judgment in *Soobramoney*. Constitutionally speaking, one should not be robbed of the internal resource called life and one's possession of it should be respected but the extent to which one is entitled to have that resource replenished when it is running low is a question of the balancing of the rights of others to that same resource relative to the availability of the external resources which

²⁴ Ackerman et Goldstone JJ pointed out in *Carmichele v Minister Of Safety And Security And Another (Centre For Applied Legal Studies Intervening)* 2001 (4) SA 938 (CC) at paras 44-45 p 957-958: "Section 8(1) of the Constitution provides: 'The Bill of Rights applies to all law, and binds the Legislature, the Executive, the Judiciary and all organs of state.' It follows that there is a duty imposed on the state and all of its organs not to perform any act that infringes these rights. In some circumstances there would also be a positive component which obliges the State and its organs to provide appropriate protection to everyone through laws and structures designed to afford such protection. In the United States, a distinction is drawn between 'action' and 'inaction' in relation to the 'due process' clause of their Constitution (the 14th Amendment). In *De Shaney v Winnebago County Department of Social Services*, the majority declined to hold a government authority liable for a failure to take positive action to prevent harm. As stated in the dissent of Brennan J: 'The Court's baseline is the absence of positive rights in the Constitution and a concomitant suspicion of any claim that seems to depend on such rights.' The provisions of our Constitution, however, point in the opposite direction. So too do the provisions of the European Convention on Human Rights (Convention). Article 2(1) of the Convention provides that '(e)veryone's right to life shall be protected by law'. This corresponds with our Constitution's entrenchment of the right to life. We would adopt the following statement in *Osman v United Kingdom*: 'It is common ground that the state's obligation in this respect extends beyond its primary duty to secure the right to life by putting in place effective criminal law provisions to deter the commission of offences against the person backed up by law-enforcement machinery for the prevention, suppression and sanctioning of breaches of such provisions. It is thus accepted by those appearing before the Court that art 2 of the Convention may also imply in certain well-defined circumstances a positive obligation on the authorities to take preventive operational measures to protect an individual whose life is at risk from the criminal acts of another individual.'"

²⁵ It could be argued that respect of a right, rather than its protection, is the absolute minimum form of recognition but it is submitted that respect in many ways begs the question of protection since respect without protection, i.e. the enforcement of respect, is largely worthless in practice. In the real world, the obligation to respect is given teeth by machinery designed to protect rights. The checks and balances of the Constitution and the existence of the three branches of government are all designed to ensure *inter alia* that the rights enshrined in the Constitution are protected even from violation by a particular branch of government.

are necessary to replenish it. In this sense the right to life takes on some of the nature of a socio-economic right. This is because in the context of health care services, the preservation of life is dependent upon the availability of health care resources. This is no doubt the conclusion which is so abhorrent to critics of the decision of the judgment in *Soo Bramoney*. For idealists, life is sacrosanct and can under no circumstances be compromised. In reality this objection is simply yet another iteration within the larger fractal of the dynamic that pits the interests of the individual against those of the collective. In reality, life is a concept that is not readily described or defined, its complexity often highlighted by the many unique and emotionally charged situations that present in the context of health services delivery.

2.2.2 Dignity

There is a close connection between health and human dignity, another right that has been identified as central both in the founding provisions of the Constitution²⁶ and by the constitutional court²⁷. Health is an essential for life and for human dignity. Human dignity is both a constitutional value and a right²⁸. The enjoyment of the rights to life and human dignity is obviously significantly diminished by poor health. In the context of health care, situations which throw into stark relief the concepts of life and human dignity and their interdependence are those in which patients are so severely injured that they can no longer function as human beings yet remain biologically speaking, alive. Thirion J observed in the case of *Clarke v Hurst*²⁹:

“As it was put in 58 US Law Week 4936: ‘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.’

²⁶ Section 1(a) of Act No 108 of 1996

²⁷ In *Makwanyane*, in 2 *supra*, the court said that: “The importance of dignity as a founding value of the new Constitution cannot be overemphasised. Recognising a right to dignity is an acknowledgement of the intrinsic worth of human beings: human beings are entitled to be treated as worthy of respect and concern” at 507 ... and “The rights to life and dignity are the most important of all human rights, and the source of all other personal rights in chap 3. By committing ourselves to a society founded on the recognition of human rights we are required to value these two rights above all others” at 451.

²⁸ Act 108 of 1996 section 1(a) and section 10 respectively.

²⁹ *Clarke* 1992 (4) SA 630 (D) at p653

Patients may be resuscitated and maintained alive when there is not the remotest possibility that they would ever be able to consciously experience life.”

In the terminology of health care, dignity usually equates to quality of life. In a situation in which a person no longer has quality of life, his or her dignity is usually significantly impaired. Dignity is thus a prerequisite of health in the sense contemplated by the constitution of the World Health Organisation.

2.2.3 Bodily and Psychological Integrity

Section 12 (2) of the Constitution lends further support to the concept of a right to health in its provision to the effect that –

“Everyone has the right to bodily and psychological integrity, which includes the right-

- (a) to make decisions concerning reproduction;
- (b) to security in and control over their body; and
- (c) not to be subjected to medical or scientific experiments without their informed consent.

Although there is an express right of access to health care services, including reproductive health care³⁰, a right to health, being broader than a right to medical treatment, must also protect and respect a person’s physical and mental well being which includes bodily and psychological integrity. This right is a part of the larger right of freedom and security of the person. Kriegler J observed in *Ex Parte Minister Of Safety And Security And Others: In Re S v Walters And Another*³¹:

“What looms large in both the threshold and the limitation phases of the exercise in the present case is that the right to life, to human dignity and to bodily integrity are individually essential and collectively foundational to the value system prescribed by the Constitution. Compromise them and the society to which we aspire becomes illusory. It therefore follows that any significant limitation of any of these rights would for its justification demand a very compelling countervailing public interest.”

In the health care context, the right to bodily and psychological integrity implies a right to informed consent. This right is also used as support for the argument that a woman is

³⁰ Section 27(1) of Act 108 of 1996

³¹ *Walters* 2002 (4) SA 613 (CC) at para 28 p631

entitled to terminate a pregnancy. The post-constitutional legal position with regard to terminations of pregnancy differs significantly from the pre-constitutional legal position and the former now permits 'abortion on demand'. In *G v Superintendent, Groote Schuur Hospital, And Others*³² the pregnant woman, N, and her grandmother, agreed that she should terminate her pregnancy while N's mother opposed such action as the applicant in this case. At the time when the case was heard there was no recognised right to a termination of a pregnancy on demand³³. The court after examining the evidence and considering the relevant legislative provisions came to the conclusion that the termination of the pregnancy was legally permissible³⁴. The post-constitutional legislation that allows abortion on demand has been attacked twice by the Christian Lawyer's Association and the latest decision of the High Court is the subject of an appeal³⁵. Despite the fact that South African courts have recognised the right of the mother to terminate a pregnancy, and have

³² *G v Superintendent, Groote Schuur* 1993 (2) SA 255 (C).

³³ The applicable legislation, the Abortion and Sterilisation Act 2 of 1975, allowed a woman to terminate her pregnancy only in certain narrow and specific circumstances. The Act provided *inter alia* that a pregnancy may be terminated: "where the foetus is alleged to have been conceived in consequence of unlawful carnal intercourse, and two other medical practitioners have certified in writing, after such interrogation of the woman concerned as they or any of them may have considered necessary, that in their opinion the pregnancy is due to the alleged unlawful carnal intercourse." Other provisions, not in issue permitted abortion where the continued pregnancy endangers the life of the woman concerned, or constitutes a serious threat to her physical or mental health; 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 or she will be irreparably seriously handicapped; and where the pregnancy is a result of illegitimate carnal intercourse, and two other medical practitioners have certified in writing that the woman concerned suffers from a permanent mental handicap or defect resulting in an inability to comprehend the implications or to bear parental responsibility for the child. In *G v Superintendent Groote Schuur*, (fn 32 *supra*) the 14 year old mother claimed that she had been raped.

The court noted: "The Abortion Act does not deal expressly with the position of a minor in respect of whom a legal abortion is sought to be procured in terms of its provisions. In the normal course, under the common law, the consent of the minor's guardian would nevertheless have been required before an abortion could be carried out on the child pursuant to the provisions of the Abortion Act. The common law position has, however, been altered in a significant respect by the provisions of s 39(4) of the Child Care Act, [Act No 74 of 1983] which provides as follows:

'Notwithstanding any rule of law to the contrary -

- (a) any person over the age of 18 years shall be competent to consent, without the assistance of his parent or guardian, to the performance of any operation upon himself; and
- (b) any person over the age of 14 years shall be competent to consent, without the assistance of his parent or guardian, to the performance of any medical treatment of himself or his child.'

For the purposes of this application it was accepted by counsel for all the parties that the proposed abortion should be regarded as an operation, and not simply a form of medical treatment. This means that in the present case the consent of applicant as the minor's guardian was required, N being only 14 years of age; but applicant in fact refused such consent." Act No 2 of 1975 has been superseded by the Choice on Termination of Pregnancy Act No 92 of 1996.

³⁴ Seligson AJ noted that counsel for the applicant "raised the question whether the reference in the Abortion Act to a woman (the Afrikaans version has 'vrou'), and the absence of any reference to a child, excludes the application of the Abortion Act to females under the age of 18 years, the definition of 'child' in s 1 of the Child Care Act being any person under that age. He suggested, albeit somewhat faintly, that such a restrictive interpretation should be given to the term 'woman' in the Abortion Act. Seligson AJ held that: "Apart from the fact that the Afrikaans term 'vrou' used in the Act also connotes the feminine gender, it would have absurd results if the statute were interpreted to permit abortions in the case of females over the age of 18 years who have been the victims of rape and incest, but not in respect of females under that age. held that: "The Abortion Act was, in my view, intended to apply to any female who is carrying a live foetus. If she is a child for the purposes of the Child Care Act, then the provisions of s 39 of that Act govern insofar as consent to the abortion procedure is concerned."

³⁵ The Choice on Termination of Pregnancy Act No 92 of 1996 was first attacked in *Christian Lawyers Association of South Africa and Others v Minister of Health* fn 21 *supra* on the basis of the right to life of an unborn child. The attack was unsuccessful. A second attack took place in *Christian Lawyers Association of South Africa and Others v Minister of Health* in the Transvaal Provincial Division of the High Court case no 7728/2000 somewhat ironically on the basis that the definition of "woman" in the Act does not differentiate between minors and adults. The Christian Lawyers Association has appealed against the decision of the court in the second application.

stated that the unborn child does not have legal personality which is a prerequisite for the capacity to be a rights holder, they still acknowledge the need to balance the interests of the mother and those of her unborn child³⁶. However the mother's rights are taken very seriously as appears from the judgments of the High Court in the post-constitutional cases that are discussed in more detail in the pages that follow.

The right to bodily and psychological integrity carries the implication that a person may not be forced to receive medical treatment against his or her will. In *Minister of Safety and Security and Another v Xaba*³⁷, the court refused to grant an order allowing a bullet to be forcibly surgically removed from a prisoner's leg against his will on the basis that his section 12 rights would clearly be infringed if the proposed surgery were to take place without his consent in the absence of a law limiting these rights as contemplated in section 36 of the Constitution. In *Xaba*, The Durban and Coast Local Division of the high court criticised the decision of the Cape High Court in *Minister of Safety and Security and Another v Gaqa*³⁸ in which the latter concluded that the relevant sections of the Criminal Procedure Act and of the Constitution permitted a police official to use the necessary violence to obtain the surgical removal of a bullet in similar circumstances to those in *Xaba*. The decisions in these two cases revolved around interpretations of provisions of the Criminal Procedure Act and whether they constituted law of general application as contemplated in section 36 of the Constitution, capable of justifiably limiting a right in the Bill of Rights. It is submitted that the decision in *Xaba* is more consistent with the concept of both the right to bodily integrity

³⁶ *G v Superintendent, Grooteschuur* fn 32 *supra*. The court observed with regard to the rights of the unborn child that: "Mrs Steyn, [the unmarried mother's *curator ad litem*] quite correctly, pointed out in her report that in the circumstances there is a conflict between the interests of N and the unborn foetus she is carrying. She contended, however, that the appointment of a *curator ad litem* to represent the unborn child was neither competent nor necessary. In this regard she relied on the decision in *Christian League of Southern Africa v Rall* 1981 (2) SA 821 (O) in which it was held that an unborn child is not clothed with legal personality, that there were no legal grounds for the appointment of a *curator ad litem* to represent the foetus in connection with the termination of the mother's pregnancy, and that there is no scope or need for the appointment of such a curator when the provisions of the Abortion Act are applied. I have certain doubts about the correctness of that decision insofar as it holds that there is no scope for the extension of the nasciturus doctrine so as to provide protection for an unborn foetus against an abortion. It seems to me that there is much to be said for recognising that an unborn child has a legal right to representation, or an interest capable of protection, in circumstances where its very existence is threatened. This issue is discussed in an interesting and thought-provoking article by Professor L. M. du Plessis entitled 'Jurisprudential Reflections on the Status of Unborn Life' in (1990) 1 Tydskrif vir die Suid-Afrikaanse Reg 44 at 51-4. The learned author criticises the decision in Rall's case *supra* and contends that the law should provide what he calls 'preventive protection' for the unborn child. See also Barnard, Cronje and Olivier *The South African Law of Persons and Family Law* 2nd ed at 26 and Wille's *Principles of South African Law* 8th ed at 68, footnote 1, and the authorities there cited. It is, in my judgment, however, unnecessary for me to enter into this complex question since, unlike the position in the Rall case, in the instant matter the interests of the foetus are in fact being actively represented and advanced by the applicant and her legal representatives who seek to stop the abortion." See further the subsequent discussion in this chapter of the two *Christian Lawyers' Association* cases.

³⁷ *Xaba* 2003 (2) SA 703

³⁸ *Gaqa* 2002 (1) SACR 654 (C)

and a right to health since health in its broader sense is based as much on psychological integrity as it is on bodily integrity and the power of a person to refuse a surgical invasion of his or her person is essential for both.

2.2.4 Privacy

The right to privacy, in terms of section 14 of the Constitution, *includes* the right not to have one's person or home searched. The physical examination of a person in a health care context is very much an invasion of his privacy and such examination can only be lawfully conducted if that person waives his right to privacy for the purpose of examination. Information as to a person's health status is also inextricably bound to issues of privacy³⁹. It is information that is personal and confidential and if disclosed without permission could adversely affect his psychological integrity. This is recognised in the Promotion of Access to Information Act, Act⁴⁰ in which personal information is defined as including information relating to "pregnancy", "physical or mental health, well-being, disability", "medical, criminal or employment history of the individual" and "blood type"⁴¹. In terms of sections 34 and 63 of the Promotion of Access to Information Act, unreasonable disclosure of personal information about a third party is prohibited. The right to bodily and psychological integrity, which implies a right to give or refuse informed consent, the right to privacy, the right to dignity and the right to life together imply a wider approach to questions of health than simply a right of access to health care services⁴². The right to privacy may be breached by the wrongful disclosure of personal facts⁴³. Privacy in relation to the right to bodily

³⁹ See for instance *Seetal v Pravitha And Another No 1983 (3) SA 827 (D)* "Yet a blood test on somebody without his consent is unquestionably an invasion of his privacy. And the invasion is no less such because on just about every occasion the test is otherwise innocuous." The court also observed at p861 that: "In the end the debate about compulsory blood tests amounts, as I see it, to a showdown between the two ideas, these two ideas which cannot satisfactorily be reconciled, the idea that the truth should be discovered whenever possible and the idea that personal privacy should be respected. Both are important. Neither, however, is sacrosanct. Each, as it happens, gets sacrificed, the first on some occasions, the second on others. The clash between the two does not really lend itself to argument. How the conflict is resolved in this country when the law on the point is eventually settled will depend largely on the store the Court then sets by each idea, on its own sense of priority in that regard."

⁴⁰ Act No 2 of 2000

⁴¹ Section 1(a) (b) and (d) of Act 2 of 2000

⁴² *Leary V 'The Right To Health in International Human Rights Law' Health and Human Rights Vol. 1, No. 1, Fall 1994* states that: "The concept of a right to health implies that fundamental principles of human rights, dignity, non-discrimination, participation, and justice are relevant to issues of health care and health status."

⁴³ In *Bernstein And Others v Bester And Others NNO 1996 (2) SA 751 (CC)*, the constitutional court observed at para 73 p791: "The difficulty that remains is the determination of the scope of 'the provision as a whole' or, as it is commonly called, 'the right to privacy'. Use of this term has not been unproblematic, since in terms of a resolution of the Consultative Assembly of the

integrity is also recognised in the Choice on Termination of Pregnancy Act⁴⁴ in section 5(3) which acknowledges a pregnant minor's right to choose whether or not to consult with her parents, guardian, family members or friends before the pregnancy is terminated. The choice whether or not to disclose an intention to terminate a pregnancy is essentially based on principles of privacy. It does not relate to health care services directly but it does have an impact on the psychological and social well being of the pregnant minor.

2.2.5 Environment

In terms of section 24(1) of the Constitution everyone has the right to an environment that is not harmful to their health or well-being. This right is a key aspect of the international right to health as reflected in the ICESCR⁴⁵, the Constitution of the WHO⁴⁶ and similar instruments. It implies a right to health rather than a right to health care services⁴⁷. The

Council of Europe this right has been defined as follows: 'The right to privacy consists essentially in the right to live one's own life with a minimum of interference. It concerns private, family and home life, physical and moral integrity, honour and reputation, avoidance of being placed in a false light, non-revelation of irrelevant and embarrassing facts, unauthorised publication of private photographs, protection from disclosure of information given or received by the individual confidentially.'

And in the final conclusions of the Nordic Conference on the Right to Respect for Privacy of 1967 the following additional elements of the right to privacy are listed: "the prohibition to use a person's name, identity or photograph without his/her consent, the prohibition to spy on a person, respect for correspondence and the prohibition to disclose official information" and at para 73 p 795, "The German, European and American approach seems to accord with the analysis attempted above, namely that the nature of privacy implicated by the 'right to privacy' relates only to the most personal aspects of a person's existence, and not to every aspect within his/her personal knowledge and experience."

In *S v Jordan And Others (Sex Workers Education And Advocacy Task Force And Others As Amici Curiae)* 2002 (6) SA 642 (CC) the court stated at para 76 p673 "There can be no doubt that autonomy to make decisions in relation to intensely significant aspects of one's personal life are encompassed by the term. As Aokemamm J held in the *Gay and Lesbian Coalition (Sodomy)* case: "Privacy recognises that we all have a right to a sphere of private intimacy and autonomy which allows us to establish and nurture human relationships without interference from the outside community. The way in which we give expression to our sexuality is at the core of this area of private intimacy. If, in expressing our sexuality, we act consensually and without harming one another, invasion of that precinct will be a breach of our privacy" and at para 81 p 674 that: "One of the considerations is the nature of the relationship concerned: an invasion of the relationship between partners, or parent and child, or other intimate, meaningful and intensely personal relationships will be a strong indication of a violation close to the core of privacy. Another consideration is the extent to which the body of a person is invaded: physical searches or examinations are often invasive of privacy, as s 13 of the interim Constitution suggests. 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."

⁴⁴ Choice on Termination of Pregnancy Act fn 35 *supra*

⁴⁵ International Covenant on Economic, Social and Cultural Rights (art. 12); the Universal Declaration of Human Rights (art. 25); American Declaration on the Rights and Duties of Man (art. 33); European Social Charter (art. 11); African Charter on Human and Peoples' Rights (art. 16); The Constitution of the World Health Organization recognises the right to health as "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition."

⁴⁶ The World Health Organization developed and promulgated the understanding of health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." (Constitution of the World Health Organization, *Basic Documents*, Official Document No. 240 (Washington, 1991)). The Constitution of WHO was adopted at the International Health Conference held in 1946 in New York, where it was signed by the representatives of sixty-one states.

⁴⁷ Article 12(2)(b) of the ICESCR specifies the environment as one of the areas for state intervention in the realization of the right to health. This provision has traditionally been interpreted as relating simply to occupational health, but in state reporting to the

phrase “health and well-being” is very broad in its ambit and may well anticipate *inter alia* the considerable body of the law of nuisance which has developed in South Africa over a number of years. Air pollution, noise pollution and water pollution are just some of the issues which, even if they do not affect health *per se*, could certainly be said to affect the well-being of human beings. Occupational health issues also enter the equation in terms of this right since, it is submitted, the term environment is not confined only to a home or living environment but embraces also the working environment.

2.2.6 Emergency Medical Treatment

In terms of section 27(3): “No one may be refused emergency medical treatment.” The relevance of the prohibition of the refusal of emergency medical treatment to the right to life has already been discussed under the section dealing with the latter. A right not to be refused emergency medical treatment is a fundamental element of a right to health because it relates to the protection of life itself without which a right to health cannot be appreciated or enjoyed. A right of access to emergency medical treatment could in a sense be regarded as part of a minimum core of the right to health. The comforting knowledge that one will always receive medical assistance in an emergency is conducive to a state of psychological and social well-being. The nature of the right and its elements is discussed in more detail elsewhere in this chapter.

2.2.7 Access to Health Care Services, Food and Water Etc

Section 27 (1) stipulates that –

- (1) Everyone has the right to have access to-
 - (a) health care services, including reproductive health care;
 - (b) sufficient food and water; and

CESCR, it is increasingly being considered as relating to all environmental issues that affect human health. Primary health care strategies include access to clean drinking water and sewage services, and preventive health programs should include control over human activities that may expose people to environmental hazards detrimental to their health. (Circle of Rights – *Economic, Social and Cultural Rights Activism: A Training Resource*. Module 14 University of Minnesota Human Rights Research Centre)

- (c) social security, including, if they are unable to support themselves and their dependents, appropriate social assistance⁴⁸.

The rights expressed in section 27(1) are fully supportive of a more general right to health since health is dependent upon not only access to health care services but also sufficient food and water⁴⁹. Adequate nutrition and sanitation and social security for those unable to support themselves are essential ingredients for physical, mental and even social well-being yet do not qualify as health services *per se*.

2.2.7 Relationship Between Rights to Health and Access to Health Services

The inter-relationship between the whole and its parts in the case of the right to health and the rights that comprise it can be complex. A right to health and a right of access to health care services could in certain circumstances even conflict, for example, in the case where treatment severely adversely affects a patient's physical or mental well-being such as happens in the case of chemotherapy for cancer patients and some forms of radiation therapy. The spraying of dwellings with DDT to kill mosquitoes in order to protect the health of residents against malaria impacts on the right to an environment that is not harmful to health or well-being. DDT has been shown to be highly environmentally toxic. It is a persistent organic pollutant (POP) which can accumulate in the environment over many years and has been shown to be carcinogenic to humans and hazardous to the long-term survival of wildlife⁵⁰. At one level, the right to an environment that is not harmful to health or well-being could be said to be both adversely and positively affected by the DDT

⁴⁸ This is entirely consistent with the provisions of article 25 of the UDHR which emphasizes recognition of the right of all persons to an adequate standard of living, including guarantees for health and well-being. It acknowledges the relationship between health and well-being and its link with other rights, such as the right to food and the right to housing, as well as medical and social services.

⁴⁹ Thus for instance it has been observed with regard to reproductive health that: "Reproductive health is only a small component of reproductive rights. Further access to reproductive health services is only one part of the right to reproductive health, just as access to health services is only one aspect of the right to health. For women to have good reproductive health they have to have good general health and the physical, economic and social conditions that make possible good health overall. (Asian Forum for Human Rights and Development, *Report of a Consultation on Reproductive Rights and Human Rights* (Bangkok, 1997).)

⁵⁰ Smolen, Sang and Liroff, "Hazards and Exposures Associated with DDT and Synthetic Pyrethroids used for Vector Control" World Wildlife Fund, January 1999 (www.worldwildlife.org/toxics/progareas/pop/ddt5.pdf) See also Raloff "The Case for DDT: What do you do when a dreaded environmental pollutant saves lives?" *Science News* July 1 2000, www.malaria.org/raloff.html and "WHO calls DDT use vital for malaria control" (WHO text) available at <http://usinfo.state.gov/topical/global/ebviron/latest/00120406.htm>

spraying. This scenario constitutes, in logical terms, what a Möbius strip portrays spatially since it presents two apparently diametrically opposed situations that are in fact located upon a single boundary, i.e. the same right, and arise from the same external activity. If a court were faced with an action against the spraying of DDT to control malaria it would have to look at whether the short-term improvement in the environment caused by the elimination of the mosquitoes outweighed the long-term detriment to the environment caused by the DDT. It would have to ask itself, furthermore, whether the right of future generations to an environment that is not harmful to health or well-being is greater than the right of the present generation to life and human dignity which are adversely affected by malaria. In the examples given above, the composite right to health must be tempered with or balanced against the component rights to bodily and psychological integrity and the right to an environment that is not harmful to health or well-being. For instance, a person must be able to choose to exercise the right of access to health care services. It cannot be argued that because there is a right of access to health care services that there is no choice to be made by the holder of the right as to the nature or level of the services which are to be provided or by whom. The right to accept or refuse health care services is an aspect of the right to health since it impacts upon a person's psychological well-being as much as his or her physical well-being.

2.2.8 In Summary

It is evident in view of the foregoing that a right to health, although not expressly provided for in the wording of the Constitution, can conceivably exist in the interfaces of the various constitutional rights referred to above. It is not so much an element of the Bill of Rights as an inevitable result of the matrix formed by the interaction of the various rights therein contained⁵¹. One must thus be careful of overemphasising the right to health, which is only a result or effect of the various expressly stated constitutional rights, at the expense of those

⁵¹ Leary (fn 42 *supra*) notes that: "Human rights are interdependent. That is, particular rights may depend on other rights for their fulfilment. The right of freedom of association, for example, is closely related to that of freedom of expression. Many other examples could be cited. As has been frequently reiterated by human rights organizations, all human rights and fundamental freedoms are indivisible and interdependent.³⁹ Therefore, the right to health cannot be effectively protected without respect for other recognized rights. These include, in particular, both prohibition of discrimination, and the right of persons to participate in decisions affecting them."

rights. As Chaskalson P observed in *Soobramoney*⁵² with regard to the right to life: “Unlike the Indian Constitution ours deals specifically in the bill of rights with certain positive obligations imposed on the state and, where it does so, it is our duty to apply the obligations as formulated in the Constitution and not to draw inferences that would be inconsistent therewith”⁵³.

The value of a consideration of a broader right to health is that it emphasizes the need, when dealing with rights involving health care services, not to lose sight of the other rights conferred by the Bill of Rights, especially those to life and dignity, which the courts have identified as fundamental to the other rights in the Bill. However, a right to health is the result of, rather than a prerequisite for, the interaction of the various rights that are expressly awarded in the Constitution. The outcome of any exercise in the application of a right in the Bill of Rights is of necessity the result of a balancing of various relevant rights in the circumstances of the individual case. Ultimately the concept of a right to health in South African law is thus likely to be of limited value since it is the interaction of the various rights in the Bill of Rights which will determine the outcome of a particular case involving health care services rather than a global consideration of a right to health *per se*. It must also be borne in mind that although there may be many similarities between a right to health implied within the Bill of Rights and the right to health as contemplated in various instruments of international law, the emphasis of the South African courts has been on local conditions and the historical background of South Africa⁵⁴. Any right to health implied

⁵² *Soobramoney* fn 23 *supra*

⁵³ *Soobramoney* fn 23 *supra* at p 772

⁵⁴ “The historical background to the inclusion of the right to dignity in both the interim and final Constitutions is also of considerable importance in the interpretative enterprise. As pointed out by Du Plessis and Corder ... ‘(t)he history of systematic discrimination in South Africa, from segregation through apartheid, was premised on gross invasions of human dignity. The denial of this human right, protected in many international human rights instruments . . . was so pervasive that its inclusion here [in s 10 of the interim Constitution], immediately after the rights to equality and life, was completely uncontroversial.’” The importance of this historical background was also emphasised by O’Regan J in the *Makwanyane* case at para [329] and by Aokermann J, O’Regan J and Sachs J, in *Prinsloo v Van der Linde and Another* 1997 (3) SA 1012 (CC) (1997 (6) BCLR 759) at para [31]. *Dawood and Another v Minister of Home Affairs and Others; Shalabi and Another v Minister of Home Affairs and Others; Thomas and Another v Minister of Home Affairs and Others* 2000 (1) SA 997 (C)”. In *Makwanyane*, fn 2 *supra*, the court said: “Undoubtedly, this conclusion does involve in some measure a value judgment, but it is a value judgment which requires objectively to be formulated, having regard to the ordinary meaning of the words used in s 11(2); its consistency with the other rights protected by the Constitution and the constitutional philosophy and humanism expressed both in the preamble and the post-amble to the Constitution; its harmony with the national ethos which the Constitution identifies; the historical background to the structures and objectives of the Constitution; the discipline of proportionality to which it must legitimately be subject; the effect of the death sentence on the right to life protected by the Constitution; its inherent arbitrariness in application; its impact on human dignity; and its consistency with constitutional perceptions evolving both within South Africa and the world outside with which our country shares emerging values central to the permissible limits and objectives of punishment in the civilised community.”

within the Bill of Rights would in any event have to be construed in the uniquely South African context. This may lead to outcomes which would not be anticipated in an international human rights setting. In view of the fact that the constitutional court itself has deemed it inadvisable to deal with rights not expressly awarded by the Constitution⁵⁵, it is proposed that further discussion of a notional right to health be dispensed with in favour of a more concrete examination of the express rights within the Constitution that relate to the delivery of health care services.

2.3 Understanding The Right Of Access To Health Care Services

The right of access to health care services as expressed in the Constitution gives rise to many questions concerning its practical implementation. It is therefore important to clearly understand the various elements of the right of access to health care services and their practical significance. Examples of questions relating to its implementation are:

- What are the respective obligations of the state and the private health sector in relation to this right? The issue of the horizontal application of the right of access to health care services is of considerable importance to the private health sector in South Africa to the extent that it may require the utilisation of private resources to achieve public health goals.
- Does it mean that everyone has a right of access to all health care services no matter how expensive the technology involved?
- Is the rationing of health care services constitutional?
- To what extent may access to health care services be restricted at an individual level in order to ensure greater benefits to society as a whole?
- To what extent is utilitarianism an acceptable standard or basis upon which to ration access to health care services?

⁵⁵ In *Park-Ross and Another v Director: Office For Serious Economic Offences* 1995 (2) SA 148 (C): "The South African Constitution must be interpreted within the context and historical background of the South African setting." See also *Qozeleni v Minister of Law and Order and Another* 1994 (3) SA 625 (T) at 633F.

In *S v Jordan And Others (Sex Workers Education And Advocacy Task Force And Others As Amici Curiae)* (fn 43 *supra*) at para 53 p663 the court noted with regard to privacy that: "While we accept that there is manifest overlap between the rights to dignity, freedom and privacy, and each reinforces the other, we do not believe that it is useful for the purposes of constitutional analysis to posit an independent right to autonomy. There can be no doubt that the ambit of each of the protected rights is to be determined in part by the underlying purport and values of the Bill of Rights as a whole and that the rights intersect and overlap one another. It does not follow from this however that it is appropriate to base our constitutional analysis on a right not expressly included within the Constitution."

- What is reproductive health care as opposed to “health care services”?

The manner in which the right to health care services can be limited must also be considered in some detail in order to arrive at a proper understanding of the right of access to health care services. In general terms, the state is required to take reasonable legislative and other measures, within its available resources, to achieve the progressive realization of each of the rights referred to in section 27(1)⁵⁶. There is thus an acknowledgement within the Constitution that the socio-economic rights such as the right of access to food and water and health care services are limited by the available resources⁵⁷. Further discussion of the issue of available resources is to be found with reference to specific case discussions below. Possible answers to the questions posed above with regard to the right of access to health care services and its limitations are discussed in the rest of this chapter.

2.3.1 ‘Health Care Services’

The right of access to health care services expressed in section 27(1) is a socio-economic right⁵⁸. According to the constitutional court such rights are justiciable. In the *Certification*⁵⁹ judgment the court observed that⁶⁰:

“(T)hese rights are, at least to some extent, justiciable. As we have stated in the previous paragraph, many of the civil and political rights entrenched in the [constitutional text before this Court for certification in that case] will give rise to similar budgetary implications without compromising their justiciability. The fact that socio-economic rights will almost inevitably give rise to such implications does not seem to us to be a bar to their justiciability. At the very minimum, socio-economic rights can be negatively protected from improper invasion.”

Socio-economic rights must be considered as a suite of rights and not discretely when interpreting them⁶¹. Court decisions involving socio-economic rights generally, and not

⁵⁶ Section 27(2) of Act No 108 of 1996

⁵⁷ *Government of the Republic of South Africa and Others v Grootboom and Others* fn 10 *supra*, *Minister of Health and Others v Treatment Action Campaign and Others* (No 2) 2002 (5) SA 721 (CC);

⁵⁸ *TAC*, fn 57 *supra*

⁵⁹ *Ex parte Chairperson of the Constitutional Assembly: In re Certification of the Constitution of the Republic of South Africa*, 1996 (4) SA 744 (CC) at para [78]

⁶⁰ This was subsequently affirmed in *Grootboom* (fn 10 *supra*) at 60-61, where the court noted that: “While the justiciability of socio-economic rights has been the subject of considerable jurisprudential and political debate, the issue of whether socio-economic rights are justiciable at all in South Africa has been put beyond question by the text of our Constitution as construed in the *Certification* judgment...Socio-economic rights are expressly included in the Bill of Rights; they cannot be said to exist on paper only.” The court in the *TAC* case (fn 57 *supra*) at para [25] observed: “The question in the present case, therefore, is not whether socio-economic rights are justiciable. Clearly they are.”

only those directly concerned with the right of access to health care services are therefore of relevance to a consideration of the right of access to health care services⁶². The court in the *TAC*⁶³ case observed that in both of the previous cases involving the enforcement of socio-economic rights, these rights and the corresponding obligations of the state were interpreted in their social and historical context⁶⁴.

In *Grootboom*⁶⁵ the court observed that:

“Rights also need to be interpreted and understood in their social and historical context. The right to be free from unfair discrimination, for example, must be understood against our legacy of deep social inequality. The context in which the Bill of Rights is to be interpreted was described by Chaskalson P in *Soobramoney*: ‘We live in a society in which there are great disparities in wealth. Millions of people are living in deplorable conditions and in great poverty. There is a high level of unemployment, inadequate social security, and many do not have access to clean water or to adequate health services. These conditions already existed when the Constitution was adopted and a commitment to address them, and to transform our society into one in which there will be human dignity, freedom and equality, lies at the heart of our new constitutional order. For as long as these conditions continue to exist that aspiration will have a hollow ring.’”

The court in *Grootboom* pointed out that the question of how socio-economic rights are to be enforced is a difficult issue that must be carefully explored on a case-by-case basis considering the terms and context of the relevant constitutional provision and its application to the circumstances of the case⁶⁶.

The term ‘health care services’ is not defined in the Constitution. It is submitted that the scope of the health care services contemplated in the Constitution is very broad, including as it does ‘reproductive health care’. The express mention of reproductive health care is significant. It indicates that the contemplated health care services must not only address pathological or disease states but also healthy states⁶⁷. Health care services must, in other

⁶¹ In *Grootboom* (fn 10 *supra*) at para [24] the court observed that: “Socio-economic rights must all be read together in the setting of the Constitution as a whole. The State is obliged to take positive action to meet the needs of those living in extreme conditions of poverty, homelessness or intolerable housing. Their interconnectedness needs to be taken into account in interpreting the socio-economic rights, and, in particular, in determining whether the state has met its obligations in terms of them.”

⁶² This is the approach that was adopted in the *TAC* case (fn 57 *supra*) at para [23] in which the court noted that: “This Court has had to consider claims for enforcement of socio-economic rights on two occasions” and then referred to the *Soobramoney v Minister of Health, Kwazulu-Natal*, fn 23 *supra* and *Grootboom* fn 10 *supra*.

⁶³ *TAC* fn 57 *supra*

⁶⁴ *TAC* fn 57 *supra* at page 1043 para [24] and footnote 8.

⁶⁵ *Grootboom*, fn 10 *supra*

⁶⁶ *Grootboom*, fn 10 *supra*

⁶⁷ O’Sullivan and Bailey in Chaskalson M, Kentridge J, Klaaren J, Marcus, Spitz D and Woolman S (eds) *Constitutional Law of South Africa* at 16-16, quoting Fathalla MF ‘Reproductive Health: A Global Overview’ *Annals NYACAD, SCI* 28 June 1991 at p 1 as quoted in Cook R ‘Human Rights and Reproductive Self-Determination’ (1995) 44 *The American University LR* 975 at

words not only be curative but also preventive of disease states or protective of existing good health. A pregnant woman is not necessarily ill. There are nonetheless health services which she requires in order to successfully give birth to a living healthy baby. Reproductive health care may include advice on how to avoid the transmission of sexually transmitted illnesses, including HIV, or services involving the termination of a pregnancy. Similarly, a person with a terminal illness, although unable to benefit from curative care, may well have a right to palliative health care services if some of the other rights, such as the right to human dignity and the right to psychological integrity, in the constellation of rights that compose a right to health are taken into account. A holistic approach to health care services would be in keeping with the constitutionally imposed obligation to respect, protect, promote and fulfil the rights in the Bill of Rights. It is also supportive of the idea of a right to health if one considers the rights in the Bill of Rights as being different aspects of a central concept. The preservation of a person's health is just as important as its promotion and restoration. In the context of health care services the obligation to respect, protect, promote and fulfil covers the full spectrum of the various purposes or objectives of health care activities which range through disease monitoring and prevention, health maintenance and promotion programs, to curative and palliative care.

Whilst it could be argued that such a wide interpretation of the meaning of "health care services" is impractical and that it poses an impossibly wide obligation upon the state, it is submitted that as long as the limitation of the right within available resources is maintained⁶⁸, such an interpretation is not only reasonable but appropriate to the underlying humanitarian approach of the Constitution, based on the right to human dignity, as

1002, note that: "Reproductive health is: 'a condition in which the reproductive process is accomplished in a state of complete mental, physical and social well-being and is not merely the absence of disease or disorders of the reproductive process. Reproductive health therefore implies that people have the ability to practice and enjoy sexual relations. It further implies that reproduction is carried to a successful outcome through child and infant survival, growth and health development. It finally implies that women can go safely through pregnancy and childbirth and that fertility regulation can be achieved without health hazards and people are safe in having sex.'"

68

A fact recognised in both *Grootboom* (fn 10 *supra*) and *Minister of Health and Others v Treatment Action Campaign and Others* (fn 57 *supra*) in which the court, referring to *Grootboom*, said: "It is also made clear that 's 26 does not expect more of the state than is achievable within its available resources' and does not confer an entitlement to 'claim shelter or housing immediately upon demand' and that as far as the rights of access to housing, health care, sufficient food and water, and social security for those unable to support themselves and their dependants are concerned, 'the state is not obliged to go beyond available resources or to realise these rights immediately'. In *Soobramoney*, fn 23 *supra*, the court held that: "The appellant's demand to receive dialysis treatment at a state hospital must be determined in accordance with the provisions of s 27(1) and (2) and not s 27(3). These sections entitle everyone to have access to health care services provided by the State 'within its available resources'."

recognized by the constitutional court⁶⁹. One cannot escape such a broad approach because of the existence of other rights in the Bill of Rights such as the right to dignity, the right to bodily and psychological integrity and the right to life. By way of example, it could be argued that a person would be entitled to palliative care as much on the basis of the rights to psychological integrity and dignity as on the basis of a right of access to health care services. A person has a right to emergency medical treatment as much on the basis of the right to life as on the basis of the right to emergency medical treatment reflected in section 27(3) of the Constitution. The available resources limitation keeps the right within reasonable and practicable bounds⁷⁰.

2.3.2 Access

⁶⁹ See for instance *Khumalo and Others v Holomisa* 2002 (5) SA 401 (CC) where O'Regan J observed at 409: "The value of human dignity in our Constitution is not only concerned with an individual's sense of self-worth, but constitutes an affirmation of the worth of human beings in our society. It includes the intrinsic worth of human beings shared by all people as well as the individual reputation of each person built upon his or her own individual achievements. The value of human dignity in our Constitution therefore values both the personal sense of self-worth as well as the public's estimation of the worth or value of an individual". In *Dawood* (fn 12 *supra*) at para [35] the court stated that "The value of dignity in our Constitutional framework cannot . . . be doubted. The Constitution asserts dignity to contradict our past in which human dignity for black South Africans was routinely and cruelly denied. It asserts it too to inform the future, to invest in our democracy respect for the intrinsic worth of all human beings. Human dignity therefore informs constitutional adjudication and interpretation at a range of levels." Cited with approval in *Khumalo* fn 45 *supra*. Also in *Dawood* (fn 12 *supra*) the court noted that: "The value of dignity in our Constitutional framework cannot therefore be doubted. The Constitution asserts dignity to contradict our past in which human dignity for black South Africans was routinely and cruelly denied. It asserts it too to inform the future, to invest in our democracy respect for the intrinsic worth of all human beings. Human dignity therefore informs constitutional adjudication and interpretation at a range of levels. It is a value that informs the interpretation of many, possibly all, other rights." Cited with approval in *Prince v President, Cape Law Society, and Others* 2002 (2) SA 794 (CC). In *S v Dodo* 2001 (3) SA 382 (CC): "Human beings are not commodities to which a price can be attached; they are creatures with inherent and infinite worth; they ought to be treated as ends in themselves, never merely as means to an end." See also *Grootboom* (fn 10 *supra*) in which the court said: "The proposition that rights are interrelated and are all equally important is not merely a theoretical postulate. The concept has immense human and practical significance in a society founded on human dignity, equality and freedom. It is fundamental to an evaluation of the reasonableness of state action that account be taken of the inherent dignity of human beings. The Constitution will be worth infinitely less than its paper if the reasonableness of state action concerned with housing is determined without regard to the fundamental constitutional value of human dignity. Section 26, read in the context of the Bill of Rights as a whole, must mean that the respondents have a right to reasonable action by the state in all circumstances and with particular regard to human dignity. In short, I emphasise that human beings are required to be treated as human beings."

⁷⁰ See the discussion in Chapter 1 on minimum core content. It is important to realise that, unlike international law, the South African Constitution uses a top-down approach in terms of which the rights are construed widely but limited to the extent of the available resources. This approach obviates the need for the minimum core concept because the latter suggests a bottom-up approach in terms of which the content of the right is slowly increased or built up with the minimum core content as a base. It is submitted that the South African approach is preferable as it allows for changing circumstances in which resources may grow or dwindle without detracting from the value of the right or losing sight of its key objectives. It is more realistic than the minimum core concept which seeks to impose upon States a duty to provide a particular set of benefits irrespective of whether or not the resources exist for them to do so. There is an unfortunate tendency amongst some human rights lawyers to see socio-economic rights in the abstract, divorced from the economic realities of existence in which the notion of unlimited resources is a fairytale. This approach, it is submitted undermines and devalues these rights, rather than reinforcing and adding weight to them in practical terms.



The fact that the Constitution makes provision for “access” to health care services must be taken into consideration in seeking to understand the nature of the right. It is not a direct right to health care services but a right of access. A right of access, it is submitted, is not as direct a right, as a right to health care services *per se*. The meaning and implications of a right of access should not be underestimated⁷¹. It is submitted that this distinction allows for the possibility of payment for health care services by those who can afford to do so and also emphasizes the responsibility of the individual for his or her own health status. A direct right to health care services is likely to preclude the legitimacy of a payment requirement and also to preclude, to a significant extent, the responsibility of an individual for his or her own health status. A right that grants access implies that the holder of the right must also make some kind of an effort in order to obtain the services. A direct right to health care services tends to suggest rather that health care services must be brought to the right holder on whatever circumstances or situation he finds himself. The aspect of access suggests health care services must be placed within the reach, in terms of geographical, economic, sociological and physical factors, of people in South Africa. In this sense it could be much wider, in practical terms, than a direct right to health care services. For instance, a right of access can also imply that in a deep rural area, where it is not feasible to build a clinic and people do not have readily available transport, there is an obligation on the state to provide the necessary transport to the nearest health care facility, rather than building a health care facility in a location where it is not cost effective to do so. Similarly in a situation where for instance there is a natural disaster such as flooding, which is preventing people from accessing health services because they are stranded, a right of access means that the state must alter their circumstances so that they are able to freely exercise their right of access to health care services. A right of access also implies a greater degree of flexibility than a direct right to health care services in that the state could take a decision not to provide health care services at all but rather allow the private health sector to do so in a system in which the state is a funder of health care services rather than a supplier. “Access” widens the focus to include activities that may not themselves fall within the definition or scope of

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Liebenberg in Chaskalson *et al* in 67 *supra* at 41-26 states that: “The phrase ‘access to’ the rights in ss26 and 27 (as opposed, for example, to a ‘right to adequate housing’) appears to have been used to resist an interpretation that the state is obliged to deliver the rights directly and without charge to everyone. Those with sufficient resources will have the means of access to adequate housing (for example through rental, purchase etc) and will not need state assistance to secure housing. It thus limits the state’s responsibility to those individuals and groups who encounter particular difficulties in gaining access to the various rights. In the South African context, these will generally be members of disadvantaged and vulnerable groups.”

the term “health care services” *per se*. It includes state activities in the maintenance and upgrading of public hospitals and ambulances, referral systems between municipal, provincial and national health facilities, the licensing of public and private health establishments, programmes for the education and retention of sufficient numbers of health professionals necessary to provide health care services and the creation of a non-discriminatory environment in the health sector.

2.3.2.1 Practical Implications

The right of access, in its practical outworking, can imply obligations upon government departments other than the departments of health. For example, if the road that leads to a hospital becomes inaccessible due to lack of maintenance or a natural disaster it may be the duty of the department of public works or its provincial or municipal equivalent to ensure that it is cleared. The inappropriate or over regulation of health care markets by the department of trade and industry or the Competition Commission could conflict directly with the right of access to health care services where for instance it results in loss of access to medicines because trade conditions in South Africa are so unfavourable that major drug manufacturers are no longer prepared to supply the medicines and there is no alternative source of supply. If the department of education, and tertiary education facilities, for example, do not make provision for the education and training of suitably qualified pharmacists, this will impact upon access to health care services. Even within the narrower context of health establishments, access to health care services is dependent upon effective and efficient management that ensures that electricity and water bills are paid timeously so that these utilities are not cut off, that relationships with external suppliers of food and telephone services are maintained, that human resources are managed in a responsible manner so that strikes and other disruptive labour action are avoided where reasonably possible.

Liebenberg⁷² points out that:

⁷² Chaskalson *et al* fn 67 *supra* at 41-28 to 41-29.



“Deprivation of access arises when the state, through legislation or administrative conduct deprives people of the access they enjoy to socio-economic rights...Administrative conduct under a statute may amount to the deprivation of a substantive constitutional guarantee...In the absence of justification, administrative action that deprives people of their access to socio-economic rights is unconstitutional. Unreasonable administrative action and procedural unfairness also infringe the right to just administrative action and will require independent justification under the limitations clause. This illustrates the inter-relationship between socio-economic rights and the right to just administrative action.”

The relationship between administrative law and the rights involving health care services will be discussed in a subsequent chapter. The foregoing does not mean that the state is obliged to maintain all existing health facilities and programmes and may not shut any of these down, especially when they are shown to be inefficient and wasteful or resources could be better deployed elsewhere. Logically speaking the executive branch of government must have the flexibility to be able to reallocate resources in accordance with changing needs and circumstances⁷³. There may well be individuals who are adversely affected by such reallocation decisions and the debate is then likely to turn again to whether the interests of the individual must take preference over the interests of a larger group of people or even society as a whole. As noted elsewhere, whilst the constitutional court has acknowledged that there may be times when the interests of society as a whole must prevail over the interests of the individual⁷⁴ it has tended in other cases to prefer the interests of smaller groupings⁷⁵. It is clear that there are qualifiers as to when the interests of the whole will prevail against those of the individual. These will be discussed at a later stage. It is submitted that as the South African legal system and government develop and mature beyond the binary questions of access and no access and have and have-not, issues of access will increasingly become questions of degree. In other words, instead of whether or not a drug should be available, it will be a question of which one out of a choice of several alternatives should be preferred and included in the essential drugs list and why or how far

⁷³ Liebenberg (fn 67 *supra*) at 41-29 observes that: “In considering whether a person has been deprived of access to a socio-economic right, account must also be taken of the fact that access is not solely dependent on state provision. Not every scaling down or even abolition of a programme of state support will amount to a negative infringement of the rights in ss26(1) and 27(1). The effects of a particular measure will require close scrutiny to ascertain whether it deprives the affected beneficiaries of effective access to the particular right. A violation will not arise if suitable alternative programmes exist or if the beneficiary can gain access to the right through his or her private resources. This interpretation preserves a reasonable measure of flexibility for the state in its policy and legislative choices. At the same time it requires the application of heightened scrutiny to measures depriving poor and disadvantaged groups to state assistance.”

⁷⁴ In *Soobramoney* fn 23 *supra*

⁷⁵ Such as *Grootboom* and *TAC* fn 10 and fn 57 *supra*



away the nearest accessible emergency unit or pharmacy is situated and whether it is close enough.

For the present, as the recent *TAC* case⁷⁶ demonstrates, the early stages of development do require the resolution of such binary questions, and are still very much in evidence. That case was essentially about deprivation of public sector patients of a right of access to health care services, specifically a drug known as Nevirapine. It was not complete denial of access as the government had established a number of pilot sites which offered treatment using the drug to mothers and their newborn babies. However, the objection to the policy was that the drug was only available at a few pilot sites in each province and that it should be made available at all public sector health facilities. The drug was already available in the private sector as it had been registered with the Medicines Control Council as being indicated for the prevention of mother to child transmission of HIV. In that case the applicants, and subsequently the constitutional court, made much of the fact that the drug was available in the private sector but not in the public sector⁷⁷. The government's administrative decision to gradually introduce a treatment regimen for pregnant mothers and their babies in the public sector was unconstitutional deprivation of access to health care services because the public sector caters for the poor and disadvantaged who have no alternative means of securing the drug themselves. The fact that the drug was available to the state free of charge and that the treatment was relatively short term did not help the state's case.

2.3.2.2 Links to other rights

⁷⁶ *TAC*, fn 57 *supra*. See later for the facts of the case.

⁷⁷ *TAC* fn 57 *supra*. See the argument of the applicants at p 735 of the judgment where it is stated that: "There is no rational or lawful basis for allowing doctors in the private sector to exercise their professional judgment in deciding when to prescribe Nevirapine, but effectively prohibiting doctors in the public sector from doing so", at p 746 where the court observes that: "The risk of Nevirapine causing harm to infants in the public health sector outside the research and training sites can be no greater than the risk that exists at such a site or where it is administered by medical practitioners in the private sector", at p 733 "The crux of the problem, however, lies elsewhere: what is to happen to those mothers and their babies who cannot afford access to private health care and do not have access to the research and training sites?" at p 748 "In dealing with these questions it must be kept in mind that this case concerns particularly those who cannot afford to pay for medical services. To the extent that government limits the supply of Nevirapine to its research sites, it is the poor outside the catchment areas of these sites who will suffer. There is a difference in the positions of those who can afford to pay for services and those who cannot. State policy must take account of these differences" and at p750 "Here we are concerned with children born in public hospitals and clinics to mothers who are for the most part indigent and unable to gain access to private medical treatment which is beyond their means. They and their children are in the main dependent upon the State to make health care services available to them."



It is submitted that a right of access harks back to the fundamental constitutional value of and right to dignity and dignity in its turn is closely linked to equality. In the past, people were denied access to certain health facilities and health care services because the values of dignity and equality were not respected.⁷⁸ A right of access to health care services reflects more accurately the break with the past intended by the Constitution than a mere right to health care services would have done. It implies that in the private and public health sectors alike, people of all races and cultures must have equal access to health care services. Access may not be denied in the private sector on the grounds of unfair discrimination such as happened in the past. This is not to say that people of all races and cultures must have free access to health care services in the private sector. It is arguing rather that criteria for access must be applicable to everyone regardless of their race, culture and other characteristics on the basis of which they were previously the victims of unfair discrimination. The right of access to health care services as stated in section 27(1) imposes no specific obligations upon the state as opposed to the private sector. It is important to make this distinction in order not to conflate the right with the corresponding obligation of the state alone as expressed in section 27(2). It is submitted that the right in section 27(1) does not only give rise to a corresponding obligation on the part of the state to give access to health care services although the obligations of the state, as expressed in section 27(3), with regard to promotion and fulfilment of the right are undoubtedly broader than those of private entities. Questions of the ability to pay aside, a private sector health establishment that denied a person access to its facilities for a reason which is not legally justifiable is as likely to be acting in violation of the constitutional right of access to health care services as it is to be guilty of unfair discrimination. This demonstrates the link between access on the one hand and dignity and equality on the other.

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See for instance, Cowen S 'Can 'Dignity' Guide South Africa's Equality Jurisprudence?' (17) *SAJHR* 2001 p 34 at p 43 where she states that: "O'Regan J makes a useful distinction between a vision of dignity that is informed by the past and a vision for the future. Viewing dignity through the lens of history and humanity that was denied people in the past can provide a useful way to understand its meaning more fully. Such an historical approach is also evident in recent extra-judicial statements by Aokerman J. In his Bram Fischer speech delivered in May 2000, Aokerman J suggested that: 'it is permissible and indeed necessary to look at the ills of the past which [the Constitution] seeks to rectify and in this way, to establish what equality and dignity mean...What lay at the heart of the apartheid philosophy was the extensive and sustained attempt to deny to the majority of the South African population the right of self-identification and self-determination...Who you were, where you could live, what schools and universities you could attend, what you could do and aspire to, and with whom you could form intimate personal relationships was determined for you by the state... The state did its best to deny blacks that which is definitional to being human, namely the ability to understand or at least define oneself through ones own powers and to act freely as a moral agent pursuant to such understanding of self-definition. Blacks were treated as a means to an end and hardly ever as an end in themselves; and almost complete reversal of the Kantian imperative and concept of priceless inner worth and dignity.'"

It is submitted that questions of access are fundamental to government's obligation to respect, protect, promote and fulfil the rights in the Bill of Rights as envisaged in section 7(2) of the Constitution. It imposes both negative and positive obligations on the state.⁷⁹ In a consideration of whether access has been unlawfully denied in a particular instance, an examination of the state's obligation to respect, protect, promote and fulfil would have to be undertaken with regard to the specific circumstances of the case together with other limiting factors such as the availability of resources.

2.3.2.3 Rationing

A further question that is of importance in understanding the right of access to health care services is the question of the nature and level of care to which people are entitled. Whilst this question may be answered at one level on the basis of the limitation of available resources it does raise other issues which are not necessarily completely addressed by this argument. Take for example the situation of a terminally ill person or someone who is in a persistent vegetative state who can perhaps be kept alive by a particular health care intervention but with no improvement in quality of life or prospects of recovery. The treatment is of such a nature that it simply adds on a few more days or weeks of life but

⁷⁹ De Vos P, 'Grootboom, The Right of Access To Housing and Substantive Equality as Contextual Fairness' 17 *South African Journal of Human Rights* 2001 p258 at p 271-2 points out that: "The judgement in *Grootboom* confirms that the right of access to housing creates both negative and positive obligations for the state...But the fact that s26 creates a right that can be enforced by individuals does not mean that individuals have a right to claim access to shelter or housing on demand. The individual has a right to demand that the state take action to begin to address the housing needs of those individuals who cannot provide for themselves or who need assistance from the state before they would be able to gain access to adequate housing. The positive component of the right of access to adequate housing thus places a duty upon the state to take steps to address the housing needs of society. Given the constitutional vision of a society in which all individuals will have access to adequate housing, the failure by the state to take adequate steps to achieve this goal would constitute a failure to engage meaningfully with the transformative vision of the Constitution. In enforcing this right, a court will be required to evaluate the state's action, first, to determine whether *any* steps have been taken and second, whether *appropriate* steps have been taken. At the heart of the *Grootboom* judgment is the Court's interpretation of what would constitute such appropriate steps and when the steps taken by the state would not be satisfactory from a constitutional point of view. Where courts are called upon to consider whether the state has fulfilled its positive obligations to take appropriate steps to realise the right of access to adequate housing, the question will revolve around the *reasonableness* or not of the state's plan and the implementation of this plan."

It is submitted that the validity of these statements in the context of access to health care services is born out by the approach of the constitutional court in the *TAC* case. However these comments also add a subtle gloss to the significance of a right of *access*. A right of access in a sense precludes a claim to health care services on demand. In more developed countries access is likely in many instances to be a fairly subjective concept that involves questions of degree. Whilst there will always be new medical technologies and drugs that are out of the reach of many people because they are too expensive, there are very often other pre-existing, albeit slower or more cumbersome ways to address a health condition. An example is that of so-called 'keyhole surgery' or minimally invasive surgery which employs very small instruments to perform endoscopically certain types of surgery that would otherwise require much larger incisions and more physical injury to the body. Keyhole surgery by experienced surgeons usually takes less time than ordinary open surgery and the patient usually has a much quicker recovery rate. However the technology used for keyhole surgery can be more expensive than that used in ordinary open surgery and some public sector health establishments may simply be unable to afford it. This does not mean however, that they cannot treat the condition at all. It means that they simply use the older methods of doing so.

cannot necessarily do so indefinitely. It is expensive and its utilisation to prolong the life of the terminally ill person may entail an opportunity cost for saving the life of someone else who stands a better chance of recovery. Is a person entitled to such treatment? The question relates as much to the right to life as it does to the right to health care services. These questions are at the heart of the interface of the law and the profession of medicine. Medical personnel are faced with difficult decisions of this nature on a regular basis. At what point can and should the law interfere with such decisions? These questions were canvassed by the constitutional court in *Soobramoney v the Minister of Health (KwaZulu-Natal)*⁸⁰.

2.3.2.4 *Soobramoney v the Minister of Health (KwaZulu-Natal)*⁸¹

Facts

The applicant was a 41-year-old unemployed man, who was gravely ill. He was a diabetic, he suffered from an ischaemic heart disease and he had chronic renal failure. The province had refused to allow him access to provincial renal dialysis facilities and he could not afford to access these in the private sector because he was unemployed and was not a member of a medical scheme. The basis for the refusal of the province to dialyse the applicant was that he did not satisfy the criteria that had been laid down by the provincial health authorities in order to ensure that maximum benefit was derived from the limited number of renal dialysis machines available in the province. Patients suffering from irreversible chronic renal failure were not admitted automatically to the provincial renal dialysis programme but according to a set of guidelines in terms of which the primary requirement for admission was a patient's eligibility for a kidney transplant. A patient who was eligible for a transplant would be provided with dialysis treatment until an organ donor was found and a kidney transplant had been completed. According to the guidelines, patients were not eligible for kidney transplants unless they were free of significant vascular or cardiac disease. Since the appellant suffered from ischaemic heart disease and

⁸⁰ *Soobramoney v Minister of Health, Kwazulu-Natal* fn 23 *supra*

⁸¹ *Soobramoney* fn 23 *supra*

cerebro-vascular disease he was not eligible for a kidney transplant and therefore did not qualify for the renal dialysis program. The High Court⁸² noted that in the applicant's case, "[t]he word 'chronic' denotes a progressive deterioration and irreversible disease".

Judgment

The constitutional court upheld the decision of the High Court in favour of the Minister of Health (KwaZulu-Natal). It took the view that that the obligations imposed on the state by sections 26 and 27 of the Constitution dealing with the right of access to housing, health care, food, water and social security were dependent upon the resources available for such purposes, and the corresponding rights themselves were limited by reason of the lack of resources. Given this lack of resources and the significant demands made on them by high levels of unemployment, inadequate social security and a widespread lack of access to clean water or to adequate health services, an unqualified obligation to meet these needs would not at the time of the case be capable of being fulfilled.

On the subject of the allocation of scarce resources Chaskalson P quoting with approval from *R v Cambridge Health Authority, ex parte B*⁸³ in which the British court of appeals stated:

"I have no doubt that in a perfect world any treatment which a patient, or a patient's family, sought would be provided if doctors were willing to give it, no matter how much it cost, particularly when a life was potentially at stake. It would however, in my view, be shutting one's eyes to the real world if the Court were to proceed on the basis that we do live in such a world. It is common knowledge that health authorities of all kinds are constantly pressed to make ends meet. They cannot pay their nurses as much as they would like; they cannot provide all the treatments they would like; they cannot purchase all the extremely expensive medical equipment they would like; they cannot carry out all the research they would like; they cannot build all the hospitals and specialist units they would like. Difficult and agonising judgments have to be made as to how a limited budget is best allocated to the maximum advantage of the maximum number of patients. That is not a judgment which the court can make"

and then observed that:

"The provincial administration which is responsible for health services in KwaZulu-Natal has to make decisions about the funding that should be made available for health care and how such funds

⁸² *Soobramoney v Minister of Health, Kwazulu-Natal* 1998 (1) SA 430 (D)

⁸³ *Ex parte B* [1994] All ER 129 CA

should be spent. These choices involve difficult decisions to be taken at the political level in fixing the health budget, and at the functional level in deciding upon the priorities to be met. A court will be slow to interfere with rational decisions taken in good faith by the political organs and medical authorities whose responsibility it is to deal with such matters”⁸⁴.

The constitutional court rejected the argument that the applicant’s situation fell to be decided under section 27(3) which grants the right not to be refused emergency medical treatment. It held, given that the appellant suffered from chronic renal failure and that to be kept alive by dialysis he would require such treatment two to three times a week, that his condition was not an emergency calling for immediate remedial treatment. It was rather an ongoing state of affairs resulting from an incurable deterioration of the applicant’s renal function.

The court also rejected the right to life argument which claimed that on the basis of the right to life, everyone requiring life-saving treatment who was unable to pay for such treatment herself or himself was entitled to have the treatment provided at a state hospital without charge. Chaskalson P observed in this regard that:

“In our Constitution the right to medical treatment does not have to be inferred from the nature of the state established by the Constitution or from the right to life which it guarantees. It is dealt with directly in s 27. If s 27(3) were to be construed in accordance with the appellant’s contention it would make it substantially more difficult for the state to fulfil its primary obligations under ss 27(1) and (2) to provide health care services to ‘everyone’ within its available resources. It would also have the consequence of prioritising the treatment of terminal illnesses over other forms of medical care and would reduce the resources available to the state for purposes such as preventative health care and medical treatment for persons suffering from illnesses or bodily infirmities which are not life threatening. In my view, much clearer language than that used in s 27(3) would be required to justify such a conclusion.”⁸⁵

Significantly, the court held that the state’s failure to provide renal dialysis to all persons suffering from chronic renal failure did not constitute a breach of its constitutional obligations as reflected in section 27(1).

Discussion

⁸⁴ *Soobramoney*, fn 23 *supra*, para 29 p776

⁸⁵ *Soobramoney*, fn 23 *supra* at para 19 p 773 - 774

It is submitted with respect that the constitutional court made a number of significant pronouncements on the right to life and health care services in this case and provided some fairly solid answers to the questions posed previously. *Soobramomey*⁸⁶ is an extremely important decision in that it highlights the fact that there is justification in preferring the interests of the collective over those of the individual in certain circumstances. The individualistic approach must have limits if society is to function successfully as a whole. This principle applies as much with regard to constitutional rights as it does to criminal law. Chaskalson P recognised this in the *Soobramoney* judgment with the words:

“The state has to manage its limited resources in order to address all these claims. There will be times when this requires it to adopt an holistic approach to the larger needs of society rather than to focus on the specific needs of particular individuals within society.”⁸⁷

Another important point to emerge from the decision of the Court in *Soobramoney*⁸⁸ is that rationing of access to health care services is a legitimate, and necessary activity and that a constitutional right of access to health care services cannot detract from the hard fact of limited resources. Sachs J observed that:

“In all the open and democratic societies based upon dignity, freedom and equality with which I am familiar, the rationing of access to life-prolonging resources is regarded as integral to, rather than incompatible with, a human rights approach to health care,”⁸⁹

pointing out that:

“Section 39(1)(a) of the Constitution requires us when interpreting the bill of rights to promote the values that underlie an open and democratic society based on human dignity, equality and freedom.”⁹⁰

The concept of rationing is discussed in more depths elsewhere in this chapter. It is intricately linked to the issue of available resources and the progressive realisation of socio-economic rights which is essential to an understanding of the constitutional right of access to health care services.

⁸⁶ *Soobramoney*, fn 23 *supra*

⁸⁷ *Soobramoney* fn 23 *supra*, para 31

⁸⁸ *Soobramoney* fn 23 *supra*

⁸⁹ *Soobramoney* fn 23 *supra* para 52 p 782

⁹⁰ See *Soobramoney* fn 23 *supra*, footnote in judgment

It is clear from the judgment of the court in *Soobramoney* that there are boundaries beyond which the law should not interfere in matters involving the allocation of resources⁹¹. Even the right to life cannot found a right on demand to life-saving medical treatment in all cases. The criteria for the courts in deciding whether or not interfere with a decision of the political organs and medical authorities responsible for such matters as stated by the court are rationality (it is submitted that in the light of the *Grootboom* and *TAC* decisions⁹² this is better described as 'reasonableness'⁹³) and good faith. These criteria are in many respects simply a reflection of the administrative law principles of procedural fairness and administrative justice. After all, the decision by the KwaZulu-Natal health authorities to adopt the renal dialysis protocol which applied to Mr Soobramoney could be classified as an administrative decision although the court does not seem to have expressly regarded it as such. As with all administrative decisions, if one applies one's mind then one is likely to act rationally and take reasonable decisions. If one acts in good faith, there must be an absence of bias and the proper application of one's mind. It is submitted that these grounds are similar to the grounds of review that are often applied in order to judge the integrity and validity of administrative decisions. In the case of *Roman v Williams NO*⁹⁴ the court held that an administrative decision was:

⁹¹ See Roux T "Legitimizing Transformation: Political Resource Allocation in the South African Constitutional Court" http://www.law.wits.ac.za/cals/it/publications/pdf/norway_paper.pdf at p2 who observes that: "Judges, it is said, are neither mandated nor institutionally equipped to undertake the complex economic and interest balancing enquiries that inform the allocation of public resources. It is therefore unwise to give judges the power to review decisions taken by the political branches in this area and foolish for judges to assume this power when they are not compelled to do so. If these propositions are true for judges in established democracies, one would expect that they would apply with even greater force in new democracies where the judicial branch is by definition, still in the process of building the institutional legitimacy required to play a meaningful role in politics. It is therefore surprising that some of the most far-reaching decisions in this area have been handed down by constitutional courts in Hungary and South Africa – both countries democratised in the last fifteen years. It is even more surprising that, in the case of South Africa, the judicial review of political resource allocation has not as yet triggered any significant protest from the executive."

⁹² *Grootboom* fn 10 and *TAC* fn 57 *supra*

⁹³ See de Waal, Currie and Erasmus, fn 2 *supra* at p 439, where they observe that: "While there can be considerable disagreement about the best way to achieve these goals, the state has an obligation to justify its choice of means to the public. Put another way, the standard of reasonableness requires reason giving. But the court's role does not end with requiring an explanation. The explanation can be evaluated for its reasonableness, its ability to convince a reasonable person of its coherence. The obligation of justification means the provision of reasons that would satisfy most people of the rationality of a policy on its own terms, even if they are not convinced about the wisdom of choosing such a policy in the first place." See also Roux fn 91 *supra* at p 7 who states that: "It is therefore instructive to compare this review standard [as expressed in *Grootboom*] to the rational-basis and proportionality standards in South African and comparative constitutional law, which mark respectively the low and high ends of the continuum of review standards from which the court might have chosen. The reasonableness standard in *Grootboom* is clearly stricter than the rational-basis standard applied under section 9(1) of the 1996 Constitution." He refers as authority for this observation to *Bel Porto School Governing Body and Others v Premier of the Province, Western Cape and Another* 2002 (9) BCLR 891 (CC) para 46 where it was held that the *Grootboom* reasonableness review standard was a "higher standard" than the review standard applied under section 9(1) of the Constitution.

⁹⁴ *Roman* 1998 (1) SA 279 (C) at p 284 - 285

“reviewable administrative action within the purview of s 33(1) and (2) of the Constitution Act 108 of 1996 (as these subsections are to be deemed to be read in terms of item 23(2)(b) of Schedule 6 of the Constitution) and such a decision must be justifiable, in relation to the reasons given for it. Justifiability as specified is to be objectively tested. The scope of this constitutional test is clearly much wider than that of the common-law test and it overrides the common-law review grounds as set out in *Johannesburg Stock Exchange v Witwatersrand Nigel Ltd* ...

Administrative action, in order to prove justifiable in relation to the reasons given for it, must be objectively tested against the three requirements of suitability, necessity and proportionality which requirements involve a test of reasonableness. Gross unreasonableness is no longer a requirement for review.

The constitutional test embodies the requirement of proportionality between the means and the end. The role of the Courts in judicial reviews is no longer confined to the way in which an administrative decision was reached but extends to its substance and merits as well.”

The relevance of administrative law to health care delivery will be canvassed in more depths in a later chapter. On the question of the meaning of the right to life in the context of life prolonging health care services Sachs J observed that:

“However the right to life may come to be defined in South Africa, there is in reality no meaningful way in which it can constitutionally be extended to encompass the right indefinitely to evade death. As Stevens J put it: dying is part of life, its completion rather than its opposite. We can, however, influence the manner in which we come to terms with our mortality. It is precisely here, where scarce artificial life-prolonging resources have to be called upon, that tragic medical choices have to be made”⁹⁵.

There are thus circumstances in which, even if the resources may, technically speaking, be available, there is no right to their use for the purpose merely of evading death. The right of a person in a persistent vegetative state to be maintained in that state indefinitely is thus questionable. However, this calls into the play the fact that in South Africa, the withdrawal of life support could in certain circumstances amount to criminal conduct due to the fact that euthanasia is not legally recognised⁹⁶. One cannot avoid getting involved in discussions involving utilitarianism at this level. The hard question is that in a country in which there is a shortage of health care personnel to treat a patient, how can one justify keeping such a patient ‘alive’ when the nursing staff and possibly the bed may be required for the purpose of the delivery of health care services to other patients who have a good chance of

⁹⁵ *Soobramoney* fn 23 *supra*, para 57 p 784, footnotes omitted.

⁹⁶ *S v Hartmann* 1975 (3) SA 532 (C); *S v De Belloq* 1975 (3) SA 538 (T). The South African courts have not, however, been entirely unsympathetic. In *Clarke v Hurst No and Others* (fn 29 *supra*) the court observed that: “There are 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 decisions are taken to allow the patient to die rather than to prolong a life of suffering by taking life-support measures.”

recovery. At present it seems that an answer to the question of the legal acceptability of euthanasia lies somewhere between the fact that the right to life does not encompass the right to indefinitely evade death and the legal convictions of society upon which issues of wrongfulness depend⁹⁷.

There is a tendency in human rights law to favour the interests of the individual rather than those of society as a whole⁹⁸. This can create a considerable degree of tension for the policy makers in the executive and legislative branches of government who often have to make decisions and set policy at the level of society as a whole in order to obtain the most benefit for the greatest numbers of people. This approach is very likely to compromise the interests of particular individuals who fall on the borderlines of policy positions. The interests of an individual can at times seriously conflict with the broader interest of the collective and it becomes a question of achieving an acceptable balance between individual and group interests in setting policy. This is easier said than done.

2.3.2.5 The Individual v The Collective

It is necessary to examine the decisions of the constitutional court in *Government of the Republic of South Africa and Others v Grootboom and Others* and *Minister of Health and Others v Treatment Action Campaign and Others* in order to further explore the need to balance the interests of smaller groupings and individuals against those of society as a whole in resource allocation decisions and to understand how the constitutional court has

⁹⁷ See discussion of wrongfulness and relevant case law in *Clarke v Hurst No and Others* 1992 (4) SA 630 (D) from 652 onwards.

⁹⁸ This is possibly to some extent, in South Africa at least, a product of the perceived roles of the legislature and the judiciary. See for instance, the observations of Kentridge and Spitz, Chaskalson *et al*, in 60 *supra*, at 11-23 to 11-24 where, in a discussion of value-based interpretation, they state: "Like other interpretive approaches, value based interpretation is also grounded upon a vision of the appropriate institutional role of the judiciary and reflects a particular response to the countermajoritarian dilemma. Its proponents acknowledge the countermajoritarian nature of constitutional review and argue that this role is most appropriate to the protection of individual rights. The majoritarian institutions of government possess different institutional competencies from those of the judiciary. The role of the courts is not to make social policy but rather to articulate principle. Consequently, the relative insulation and weaker mechanisms of democratic accountability characteristic of the judiciary provide the necessary space within which to perform the proper judicial function. If the role of the legislature is to give expression to the majority will, the role of the courts, at least in constitutional matters, is to protect the individual rights which may be countermajoritarian in nature. The courts are far more than clearing-houses for the products of the legislature. They protect certain spheres of personhood against incursion by the majority. Meaningful enforcement of individual rights may have, as its consequence, large-scale social intervention. One of the functions of constitutional review is to determine when such intervention is justified by the duty to protect individual rights. Viewed in this light, insulation from the vagaries of the political process is an advantage. Instead of being a participant in majoritarian bargaining through the political process, the judiciary may consider questions of principle and political morality." (footnotes omitted). In practice this would seem to be the experience of the executive branch of government in the area of socio-economic rights.

dealt with socio-economic rights, of which the right of access to health care services is one, thus far.

2.3.2.6 *Government of the Republic of South Africa v Grootboom*⁹⁹

Facts

This case involved the right to housing of the respondents who had been evicted from their informal homes situated on private land earmarked for formal low-cost housing. They applied to a High Court for an order requiring the government to provide them with adequate basic shelter or housing until they obtained permanent accommodation. The High Court held that s 28(1)(c) of the Constitution obliged the state to provide rudimentary shelter to children and their parents on demand if the parents were unable to shelter their children, that this obligation existed independently of and in addition to the obligation to take reasonable legislative and other measures in terms of s 26 of the Constitution and that the state was bound to provide this rudimentary shelter irrespective of the availability of resources. The appellants were accordingly ordered by the High Court to provide the respondents who were children and their parents with shelter. The appellants appealed against this decision.

Judgment

The court held that the question of how socio-economic rights were to be enforced was a difficult issue which had to be carefully explored on a case-by-case basis considering the terms and context of the relevant constitutional provision and its application to the circumstances of the case. It said that that interpreting a right in its context required the consideration of two types of context. On the one hand, rights had to be understood in their textual setting, which required a consideration of chapter 2 and the Constitution as a whole. On the other hand, rights also had to be understood in their social and historical context.

⁹⁹ *Grootboom* fn 10 *supra*

The right to access to adequate housing could therefore not be seen in isolation but in the light of its close relationship with the other socio-economic rights, all read together in the setting of the Constitution as a whole. It observed that the interconnectedness of the rights and the Constitution as a whole had to be taken into account in interpreting the socio-economic rights and, in particular, in determining whether the state had met its obligations in terms of them. The court noted further that for a person to have access to adequate housing there had to be the provision of land, services (such as the provision of water, the removal of sewage and the financing of all these) and a dwelling. The right also suggested that it was not only the state who was responsible for the provision of houses but that other agents within society had to be enabled by legislative and other measures to provide housing. The state therefore had to create the conditions for access to adequate housing for people at all economic levels of society. With regard to the obligations of the state the court observed that s 26(2) made it clear that the obligation imposed upon the state was not an absolute or unqualified one. The extent of the state's obligation was defined by three key elements which had to be considered separately: (a) the obligation to take reasonable legislative and other measures; (b) to achieve the progressive realisation of the right; and (c) within available resources.

It went on to point out that reasonable legislative and other measures such as policies and programs had to be determined in the light of the creation by the Constitution of different spheres of government and the allocation of powers and functions amongst these different spheres thus emphasising their obligation to co-operate with one another in carrying out their constitutional tasks. A reasonable housing program capable of facilitating the realisation of the right therefore had to clearly allocate responsibilities and tasks to the different spheres of government and ensure that the appropriate financial and human resources were available to implement it. The formation of a program was therefore only the first stage in meeting the state's obligations. The program also had to be reasonably implemented as failure to do so would be a breach of the state's obligations.

The court said that in order to be reasonable, a program had to be balanced and flexible and make appropriate provision of attention to housing crises and to short, medium and long

term needs. It commented that a program excluding a significant segment of society would not be reasonable and noted that reasonableness had to be understood in the context of the Bill of Rights as a whole, especially the constitutional requirement that everyone be treated with care and concern and the fundamental constitutional value of human dignity.

The court held that the term 'progressive realisation' showed that it was contemplated that the right contained in section 26 could not be realised immediately. The goal of the Constitution was that the basic needs of all in South African society must be effectively met and the requirement of progressive realisation meant that the state had to take steps to achieve this goal. This in turn meant that accessibility had to be progressively facilitated, involving the examination of legal, administrative, operational and financial hurdles which had to be lowered over time. It was thus a requirement that housing was not only to be made accessible to a larger number of people but also to a wider range of people over time. It observed that the third defining aspect of the obligation to take the requisite measures is that the obligation does not require the state to do more than its available resources permit. This means that both the content of the obligation in relation to the rate at which it is achieved as well as the reasonableness of the measures employed to achieve the result are governed by the availability of resources. There is a balance between goal and means. The measures must be calculated to attain the goal expeditiously and effectively but the availability of resources is an important factor in determining what is reasonable.

The court said that the national government bore the overall responsibility for ensuring that the state complied with the obligations imposed on it by section 26. It found in particular that the programs adopted by the state fell short of the requirements of section 26(2) in that no provision was made for relief to the categories of people in desperate need and held that the Constitution obliged the state to act positively to ameliorate these conditions. This obligation, said the court, was to devise and implement a coherent, co-ordinated program designed to provide access to housing, healthcare, sufficient food and water and social security to those unable to support themselves and their dependants. The state also had to foster conditions to enable citizens to gain access to land on an equitable basis. Those in need had a corresponding right to demand that this be done.

It emphasised, however, that section 26 (and also section 28) did not entitle the respondents to claim shelter or housing immediately upon demand. With regard to the rights of children in section 28 vis-à-vis the more general rights in section 27 and 28 the court observed that there was an overlap which was not consistent with the notion that section 28(1)(c) created separate and independent rights for children and their parents. The court ruled that subsections 1(b) and 1(c) of section 28 must be read together and that they ensure that children are properly cared for by their parents or families, and that they receive appropriate alternative care in the absence of parental or family care. The section encapsulates the conception of the scope of care that children should receive in South African society. The court observed that it followed from subsection 1(b) that the Constitution contemplates that a child has the right to parental or family care in the first place, and the right to alternative appropriate care only where that is lacking. Through legislation and the common law, the obligation to provide shelter in ss (1)(c) is imposed primarily on the parents or family and only alternatively on the state. The state thus incurs the obligation to provide shelter to those children, for example, who are removed from their families. It follows, said the court, that section 28(1)(c) does not create any primary state obligation to provide shelter on demand to parents and their children if children are being cared for by their parents or families. The court noted, however, that this does not mean that the state incurs no obligation in relation to children who are being cared for by their parents or families. In the first place, the state must provide the legal and administrative infrastructure necessary to ensure that children are accorded the protection contemplated by section 28. This obligation would normally be fulfilled by passing laws and creating enforcement mechanisms for the maintenance of children, their protection from maltreatment, abuse, neglect or degradation, and the prevention of other forms of abuse of children mentioned in section 28. In addition, the state is required to fulfil its obligations to provide families with access to land in terms of section 25, access to adequate housing in terms of section 26 as well as access to health care, food, water and social security in terms of section 27. The court held that it followed that sections 25 and 27 require the state to provide access on a programmatic and coordinated basis, subject to available resources. One of the ways in which the state would meet its section 27 obligations would be through

a social welfare program providing maintenance grants and other material assistance to families in need in defined circumstances. The court ruled that in the circumstances of the case, there was no obligation upon the state to provide shelter to those of the respondents who were children and, through them, their parents in terms of s 28(1)(c) and that the High Court therefore erred in making the order it did on the basis of this section.

In conclusion the constitutional court observed that this case showed the desperation of hundreds of thousands of people living in deplorable conditions throughout the country, that Constitution obliges the state to act positively to ameliorate these conditions and that the obligation is to provide access to housing, health-care, sufficient food and water, and social security to those unable to support themselves and their dependants. It said that the state must also foster conditions to enable citizens to gain access to land on an equitable basis. Those in need have a corresponding right to demand that this be done. The court acknowledged that it is an extremely difficult task for the state to meet these obligations in the conditions that prevail in South Africa and that this is also recognised by the Constitution which expressly provides that the state is not obliged to go beyond available resources or to realise these rights immediately. It stressed, however, that despite all these qualifications, it was a matter of rights, and that the Constitution obliges the state to give effect to them. Consequently the state's obligation is one that courts can, and in appropriate circumstances, must enforce.

It made a declaratory order to the effect that the appeal was allowed in part, that the order of the Cape High Court was set aside and its own order substituted for it and that the state's housing program in the Cape Metropolitan Council area fell short of its obligation to provide to provide relief for people who have no access to land, no roof over their heads, and who are living in intolerable conditions or crisis situations. It made no order as to costs.

Discussion

*Grootboom*¹⁰⁰ was the first major constitutional court decision involving socio-economic rights. As such, it is respectfully submitted that it laid down some extremely important ground rules for similar situations involving such rights. It emphasised the plight of those in desperate need and pointed out that a state program that did not address the plight of such persons could not be considered reasonable no matter how considerable the advances in a socio-economic program might be. It is in this context that the court preferred, at a certain level, the interests of the individual over those of the collective. This aspect of the case is discussed in more detail below. After the facts and judgment of the *TAC*¹⁰¹ case have also been canvassed since they are also of relevance to this tension between individual rights and collective interests. It must be pointed out at this stage that this aspect of the *Grootboom* decision has to be applied with care, and not in isolation but in the broader context of the *Grootboom* judgement as a whole, in the context of health services delivery because, as is clear from the case of *Soobramoney* described previously, in health care it is not always those whose needs are most urgent who must necessarily be given priority. Taken out of context, the logic of *Grootboom* and its emphasis on those in most desperate need could easily be misapplied at a policy level in the context of health care. By way of example take the government's policy decision to boost health care services at primary care level with a view to improving the overall health of the general population. Since there are limited resources this means that funding for secondary and tertiary levels of care would have to be reduced in order to have sufficient funding for a successful primary health care programme unless one assumes that there were large additional injections of funding forthcoming from the fiscus. In the light of the judgment in *Grootboom*, how can the state justify its focus on primary health care which by definition tends to address the less desperate and less urgent health needs of the general population if it means a reduction in health facilities designed to address the more urgent and desperate health needs of those individuals who are served by the secondary and tertiary health care levels of the system? In medicine, primary health care does not generally address the health needs of so-called

¹⁰⁰ *Grootboom* fn 10 *supra*

¹⁰¹ *TAC* fn 57 *supra*

'acute' cases. It can assist very much with the treatment of chronic cases and with prevention of disease¹⁰². If a person has a heart attack or appendicitis or goes into a diabetic coma or renal failure these are not health conditions that can be addressed at primary health care level. Yet if Article VIII of the Declaration of Alma Ata¹⁰³ states that all governments should formulate national policies, strategies and plans of action to launch and sustain primary health care as a part of a comprehensive national health system and in co-ordination with other sectors, how unreasonable is a program to ensure the rendering of primary health care services? It is clearly a question of balance between the desperate and most urgent health needs of individuals and the less urgent but equally important health needs of communities. It is submitted that in seeking to achieve such a balance equality considerations must form an important guide for policymakers as will become evident from the judgment of the court in the *TAC*¹⁰⁴ case. In the *Grootboom* context this is evidence by the court's cautionary observation that the question of how socio-economic rights are to be enforced is a difficult issue which must be carefully explored on a case-by-case basis taking into account the terms and context of the relevant constitutional provision and its application to the circumstances of the case as well as its rulings that:

102

The Declaration of Alma Ata following on the International Conference in Primary Health Care, Alma Ata, USSR in 1978 states in Article VI that: "Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that that community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part of the country's health system of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process" and in Article VII that: "Primary health care:

1. reflects and evolves from the economic conditions and socio-cultural and political characteristics of the country and its communities and is based on the application of the relevant results of social, biomedical and health services research and public health experience;
2. addressed the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly;
3. includes at least: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs;
4. involves in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors; and demands the co-ordinated efforts of all those sectors;
5. requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end develops through appropriate education the ability of communities to participate;
6. should be sustained by integrated, functional and mutually supportive referral systems, leading to the progressive improvement of comprehensive health care for all, and giving priority to those most in need;
7. relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community."

(<http://www.who.int/hpr/backgroundhp/almaata.htm>)

103

Declaration of Alma Ata fn 102 *supra*

104

TAC fn 57 *supra*

- the interconnectedness of the rights and the Constitution as a whole have to be taken into account in interpreting the socio-economic rights;
- the real question in terms of the Constitution is whether the measures taken by the state to realise the right afforded by the Constitution are reasonable;
- the obligation imposed upon the state is not an absolute or unqualified one and that regard must be had to the three key elements of (a) the obligation to take reasonable legislative and other measures; (b) to achieve the progressive realisation of the right; and (c) within available resources; and
- that the term ‘progressive realisation’ showed that it is contemplated in the Constitution that the rights cannot be realised immediately.

The court in *Grootboom*¹⁰⁵ gives some critically important guidance for the executive with regard to the formulation of policy decisions. It asserts that the state’s duty to adopt reasonable legislative and other measures to achieve the progressive realization of socio-economic rights implies that the policy must be:

- Comprehensive – it must be inclusive of all significant segments of society¹⁰⁶;
- Balanced and flexible – it must be able to adapt to changing needs and circumstances across interest groups¹⁰⁷;
- Attentive to those whose need is most urgent and who have only the state to look to for assistance¹⁰⁸.

¹⁰⁵ *Grootboom* fn 10 *supra*

¹⁰⁶ *Grootboom* fn 10 *supra*, para 36: “In this regard, there is a difference between the position of those who can afford to pay for housing, even if it is only basic though adequate housing, and those who cannot. For those who can afford to pay for adequate housing, the state’s primary obligation lies in unblocking the system, providing access to housing stock and a legislative framework to facilitate self-built houses through planning laws and access to finance. Issues of development and social welfare are raised in respect of those who cannot afford to provide themselves with housing. State policy needs to address both these groups.” And para 40: “Thus, a co-ordinated state housing program must be a comprehensive one determined by all three spheres of government in consultation with each other as contemplated by chap 3 of the Constitution.”

¹⁰⁷ *Grootboom* fn 10 *supra* para 37: “The state’s obligation to provide access to adequate housing depends on context, and may differ from province to province, from city to city, from rural to urban areas and from person to person. Some may need access to land and no more; some may need access to land and building materials; some may need access to finance; some may need access to services such as water, sewage, electricity and roads. What might be appropriate in a rural area where people live together in communities engaging in subsistence farming may not be appropriate in an urban area where people are looking for employment and a place to live” and para 43: “The program must be balanced and flexible and make appropriate provision for attention to housing crises and to short, medium and long term needs. A program that excludes a significant segment of society cannot be said to be reasonable. Conditions do not remain static and therefore the program will require continuous review.”

¹⁰⁸ *Grootboom* fn 10 *supra*, para 36: “The poor are particularly vulnerable and their needs require special attention” and at para 44 “Those whose needs are the most urgent and whose ability to enjoy all rights therefore is most in peril, must not be ignored by the measures aimed at achieving realisation of the right.” *Grootboom* fn 10 *supra* at p 69 “Those whose needs are the most urgent and whose ability to enjoy all rights therefore is most in peril, must not be ignored by the measures aimed at achieving realisation of the right. It may not be sufficient to meet the test of reasonableness to show that the measures are capable of achieving a statistical advance in the realisation of the right.” *TAC* (fn 57 *supra*) at p749 referring to the language used in

Whilst there will always be the potential for constitutional challenge to state policy, this need not be seen as entirely pathological, especially if the political branches of government are able to learn from and implement the lessons expounded by the courts in such a way that such litigation is eventually no longer a viable proposition because it invariably ends in failure for the applicant. In this sense, frequent constitutional challenge can be seen as a feature of the developmental stages of the new legal order. Even at this stage, however, it is submitted that the determination and implementation of policy involving socio-economic rights by the executive could be legitimized in many instances by following a few simple guidelines based partly upon the principles of administrative law and partly upon the pronouncements of the constitutional court to date. These are:

1. The importance of objective decisions based upon scientifically obtained and credible information. The more comprehensive and reliable the factual information upon which the policy decision is based, the more reasonable the decision is likely to be. The kind of information and the nature of its source will depend upon the subject matter of the policy in question.
2. Related to the first principle above is the importance of interaction and communication with stakeholders. The court in *TAC*¹⁰⁹ dealt with it under the heading of 'transparency'¹¹⁰. It is submitted that transparency is more than just the communication of the existence of a particular programme however. It includes a programme of openness to representation by stakeholders before during and after the policy has been formulated and implemented and relates therefore to the requirement of flexibility referred to earlier with reference to the judgment in *Grootboom*¹¹¹. Even the executive has to take a hard decision to prioritise some needs over others, this will

Grootboom stated that: "The provision of a single dose of Nevirapine to mother and child for the purpose of protecting the child against the transmission of HIV is, as far as the children are concerned, essential. Their needs are 'most urgent' and their inability to have access to Nevirapine profoundly affects their ability to enjoy all rights to which they are entitled. Their rights are 'most in peril' as a result of the policy that has been adopted and are most affected by a rigid and inflexible policy that excludes them from having access to Nevirapine."

109 *TAC* fn 57 *supra*

110 *TAC* fn 57 *supra* at p762: "Indeed, for a public programme such as this to meet the constitutional requirement of reasonableness, its contents must be made known appropriately."

111 *Grootboom* fn 10 *supra*

ensure that it does so on an informed basis and is more aware of the legal risks and arguments attendant upon making a particular decision.

3. Related to the second principle enunciated above, procedurally and substantively, within the processes for both formulation and implementation of the policy, there must be a back door through which the executive can escape accusations of inflexibility and administrative unfairness. Since the executive is not superhuman and omniscient, there is the possibility that it could overlook a particular need or segment of society in formulating or implementing the policy. A backdoor, for example a process of review or interaction with stakeholders, or which makes provision for hearing or taking account of hard cases is likely to go a considerable distance in improving the reasonableness of the policy whilst at the same time encouraging the disaffected to approach the executive rather than the courts for a remedy. In this way, if a hard case is turned down or cannot be accommodated, this can be rationalized and the risk of judicial disapproval reduced to a minimum. The administrative law principle of *audi alteram partem* particularly informs this third principle but the principles of administrative justice generally are of assistance in this instance. It is clearly implied in this principle that the basic tenets of the policy should ideally be documented and if at all possible published or at least publicized. The advantages of this are that publication invites dialogue with and comment from the significant segments of society which enhances flexibility but also promotes a clear understanding of the policy intention and the reasons for it.

4. The fourth and last principle is to ensure that the policy is informed by legal knowledge and expertise that relates specifically to the subject matter of the policy. This is necessary in order to deal with the specifics of the policy rather than the generalities which are covered in the first three principles given above. Sound legal exposition and analysis in this context has to be both retrospective, with reference to decisions and judgments of the courts that have already been handed down, and prospective with regard to the potential manner in which new ground is likely to be

broken by the courts in a situation where existing jurisprudence offers only limited guidance.

2.3.2.7 *Minister of Health and Others v Treatment Action Campaign*¹¹²

Facts

The state instituted a policy whereby an antiretroviral drug, Nevirapine, was made available only in certain research sites within the public health sector for the purposes of testing the efficacy of a larger programme involving the drug for the prevention mother-to-child transmission of HIV. The respondents had applied for and obtained an order from the High Court obliging the state to make Nevirapine more widely available within the public health sector on the basis that the state programme was effectively denying access to Nevirapine to people who did not have access to the research sites. The state appealed against the order of the High Court on the basis, *inter alia*, that it did not have the capacity to make available the full package of treatment which included voluntary counselling and testing and the option of substitute feeding of which Nevirapine formed a part.

Judgment

The court held that although the concerns raised on behalf of the appellants were relevant to the ability of government to make a 'full package' available throughout the public health sector, they were not relevant to the question whether Nevirapine should be used to reduce mother-to-child transmission of HIV at those public hospitals and clinics outside the research sites where facilities in fact existed for testing and counselling. It said that the fact that the research and training sites would provide crucial data on which a comprehensive programme for mother-to-child transmission could be developed and, if financially feasible, implemented was clearly of importance to government and to the country. So, too, was ongoing research into safety, efficacy and resistance. This did not mean, however, that until the best programme had been formulated and the necessary funds and infrastructure

¹¹² *TAC* fn 57 *supra*



provided for the implementation of that programme, Nevirapine had to be withheld from mothers and children who did not have access to the research and training sites. Nor could it reasonably be withheld until medical research had been completed. A programme for the realisation of socio-economic rights had to be balanced and flexible and make appropriate provision for attention to crises and to short, medium and long term needs. A programme that excluded a significant segment of society could not be said to be reasonable. The court held that that the provision of a single dose of Nevirapine to mother and child for the purpose of protecting the child against the transmission of HIV was, as far as the children were concerned, essential, that their needs were most urgent and their inability to have access to Nevirapine profoundly affected their ability to enjoy all of the other rights to which they were entitled. The court observed that the children's rights were most in peril as a result of the rigid and inflexible policy that had been adopted which excluded them from having access to Nevirapine. The state was obliged to ensure that children were accorded the protection contemplated by section 28 that arose when the implementation of the right to parental or family care was lacking. The policy prejudiced children born in public hospitals and clinics to mothers who were for the most part indigent and unable to gain access to private medical treatment which was beyond their means. They and their children were in the main dependent upon the state to make health care services available to them. The court held that a factor that needed to be kept in mind was that government policy was and should be flexible. It could be changed at any time and the Executive was always free to change policies where it considered it appropriate to do so. The only constraint was that policies had to be consistent with the Constitution and the law. Court orders concerning policy choices made by the Executive should therefore not be formulated in ways that precluded the Executive from making such legitimate choices. The court held further that the state's policy failed to meet constitutional standards because it excluded those who could reasonably be included where such treatment was medically indicated to combat mother-to-child transmission of HIV. That did not mean, however that everyone could immediately claim access to such treatment, although the ideal was to achieve that goal.

The court referred specifically to the cases of *Soobramoney*¹¹³ and *Grootboom*¹¹⁴ noting that:

¹¹³ *Soobramoney* fn 23 *supra*

“In both cases the socio-economic rights, and the corresponding obligations of the State, were interpreted in their social and historical context. The difficulty confronting the State in the light of our history in addressing issues concerned with the basic needs of people was stressed.”

The constitutional court expressly rejected the argument that there was a minimum core obligation upon the state to provide a certain basic level of health care to everyone on demand saying that a purposive reading of sections 26 and 27 does not lead to any other conclusion. It is impossible to give everyone access even to a ‘core’ service immediately. All that is possible, and all that can be expected of the State, is that it act reasonably to provide access to the socio-economic rights identified in sections 26 and 27 on a progressive basis. It concluded that section 27(1) of the Constitution did not give rise to a self-standing and independent positive right enforceable irrespective of the considerations mentioned in s 27(2) but that sections 27(1) and 27(2) must be read together as defining the scope of the positive rights that everyone has and the corresponding obligations on the state to ‘respect, protect, promote and fulfil’ such rights. The court pointed to the fact that the rights conferred by ss 26(1) and 27(1) are to have ‘access’ to the services that the state is obliged to provide in terms of ss 26(2) and 27(2). The court made the important observation that in dealing with these questions it must be kept in mind that this case concerned particularly those who could not afford to pay for medical services. It said that to the extent that government limits the supply of Nevirapine to its research sites, it is the poor outside the catchment areas of these sites who will suffer. There is a difference in the positions of those who can afford to pay for services and those who cannot. State policy must take account of these differences. With regard to the powers of the courts in such matters, the constitutional court noted that the primary duty of Courts is to the Constitution and the law, ‘which they must apply impartially and without fear, favour or prejudice’. The Constitution requires the state to ‘respect, protect, promote, and fulfil the rights in the Bill of Rights’. Where state policy is challenged as inconsistent with the Constitution, Courts have to consider whether in formulating and implementing such policy the state has given effect to its constitutional obligations. If it should hold in any given case that the state has failed to do so, it is obliged by the Constitution to say so.

¹¹⁴ *Grootboom* fn 10 *supra*

Discussion

It is not meaningful to discuss the *TAC* case without constant reference to the judgment in *Grootboom* because of the number of references by the constitutional court in its judgment in the former to the latter. Consequently The constitutional court decisions in both *Grootboom*¹¹⁵ and *TAC*¹¹⁶, whilst emphasising the fact that the Constitution mandates the ‘progressive’ realisation of rights within ‘available resources’, see for instance the discussion of *Grootboom* in the judgement of Chaskalson P in the *TAC* case¹¹⁷ where it is stated that:

“It is also made clear that ‘s 26 does not expect more of the state than is achievable within its available resources’ and does not confer an entitlement to ‘claim shelter or housing immediately upon demand’ and that as far as the rights of access to housing, health care, sufficient food and water, and social security for those unable to support themselves and their dependants are concerned, ‘the state is not obliged to go beyond available resources or to realise these rights immediately’ ”

and¹¹⁸ that

“It is impossible to give everyone access even to a ‘core’ service immediately”

have tended to uphold the interests of the individual, or at least certain minority groupings, as opposed to the majority¹¹⁹. Whilst it can most certainly be argued that in upholding the interests of the individual, the interests of the majority are served, this is not necessarily always the case - especially in situations which demand the allocation of resources. In *Grootboom* the court went so far as to say that:

“Those whose needs are the most urgent and whose ability to enjoy all rights therefore is most in peril, must not be ignored by the measures aimed at achieving realisation of the right. It may not be sufficient to meet the test of reasonableness to show that the measures are capable of achieving a statistical advance in the realisation of the right. Furthermore, the Constitution requires that

¹¹⁵ *Grootboom* fn 10 *supra*

¹¹⁶ *TAC* fn 57 *supra*

¹¹⁷ *TAC* fn 57 *supra* at para 32 p739

¹¹⁸ *TAC* fn 57 *supra* at para 35

¹¹⁹ The court in *Grootboom*, fn 10 *supra*, took the view that it is not reasonable for the state to “exclude” a “significant segment of society” in its policy (at para 43 page 69)



everyone must be treated with care and concern. If the measures, though statistically successful, fail to respond to the needs of those most desperate, they may not pass the test.”¹²⁰

The point about statistics is that they are essentially concerned with the bigger picture - the whole rather than its parts, the average across the population rather than the position of the few individuals at either end of the Bell curve. Yacoob J is saying in *Grootboom* that the minorities, those at the lower end of the Bell curve, cannot be ignored and that it is insufficient for government to show that overall (statistically) it has achieved a great deal in the progressive realisation of the rights if the plight of those who are most in need has not been attended to. In statistical terms, the court’s view is that entire Bell curve may have to be shifted to the right, before the courts will find that government has acted reasonably. It may not be sufficient to simply increase the size of the middle (highest and largest part) of the curve relative to its lower end. Whilst this is a debate that goes far beyond the scope of this thesis, including as it does other disciplines such as health economics, statistics and sociology, it is important to make a few observations about the effect of this issue in law. It is not disputed that in the *Grootboom* and *TAC* cases¹²¹, from at least one perspective, the interests of the majority may well have been served by the judgments handed down and it is submitted, with respect, that the judgments in both cases have contributed significantly to South African jurisprudence on socio-economic rights. However, the tendency of the judiciary to adopt the perspective of the individual or those groups at the extreme right of the Bell curve that usually describes the ‘have-nots’, is likely continue to further the tension between the executive and the judiciary unless the former can find a way to accommodate within its own perspective the narrower approach of the judiciary without compromising its own capacity to fulfil its constitutional obligations as a whole¹²². By its own admission the

¹²⁰ *Grootboom* fn 10 *supra* at para 44, p 69.

¹²¹ *Grootboom* fn 10 and *TAC* fn 57 *supra*

¹²² Roux fn 91 *supra* is of the view that the constitutional court has shown itself to be particularly adept at exploiting ambiguities in the normative structure governing its decisions and has thereby managed its relationships with the political branches of government to a considerable degree. He seems to think that it is this skill on the part of the constitutional court which is largely the reason why there has as yet been no significant constitutional crisis caused by the objection of the political branches of government to the court’s decisions. It is submitted, however, that interference by the court in issues of allocation of resources is highly likely to provoke a constitutional crisis with regard to all but the most blatantly unjust political decisions unless the court exercises considerable judicial circumspection in the manner in which it approaches cases involving socio-economic rights. The balance between the executive, which is faced with the almost impossible task of ensuring that the right of ‘everyone’ to have access to health care services and other socio-economic amenities, is realized, and the judiciary which comes under extreme pressure from political and other interest groups when it is faced with decisions involving socio-economic rights of individuals and relatively small groups as a result of the high emotional content of such debates, is delicate. The lack of a constitutional crisis in the South African legal order thus far is due in no small part to the commendable reluctance of the executive to provoke one, despite often sensationalistic adverse press coverage and at times emotionally charged negative criticism and comment from stakeholders and the judiciary. (See the comments of the court in *TAC*, fn 57 *supra* at para 20 p735 where it notes that: “Many of

judiciary is not equipped to deal with issues which are faced by the executive on a daily basis – issues such as the equitable allocation of scarce resources. In *TAC* the court noted¹²³:

“As this Court said in *Grootboom*, ‘(i)t is necessary to recognise that a wide range of possible measures could be adopted by the State to meet its obligations’. It should be borne in mind that in dealing with such matters the Courts are not institutionally equipped to make the wide-ranging factual and political enquiries necessary for determining what the minimum-core standards called for by the first and second *amici* should be, nor for deciding how public revenues should most effectively be spent. There are many pressing demands on the public purse. As was said in *Soobramoney*: ‘The state has to manage its limited resources in order to address all these claims. There will be times when this requires it to adopt a holistic approach to the larger needs of society rather than to focus on the specific needs of particular individuals within society.’ Courts are ill-suited to adjudicate upon issues where Court orders could have multiple social and economic consequences for the community. The Constitution contemplates rather a restrained and focused role for the Courts, namely, to require the state to take measures to meet its constitutional obligations and to subject the reasonableness of these measures to evaluation. Such determinations of reasonableness may in fact have budgetary implications, but are not in themselves directed at rearranging budgets.”

The fact is that judgments on socio-economic rights in particular do have the effect of compelling a reallocation of resources if one works from the premise that all resources are scarce and that they have all been specifically allocated¹²⁴. In other words if the executive is doing its job properly and consciously applying its mind to resource allocation, then a judgment such as that in *Grootboom* requires that the executive must take resources from some other population group or programme in order to accommodate the one in whose

these disputes gave rise to a regrettable degree of animosity and disparagement, culminating in unsubstantiated and gratuitous allegations of untruthfulness being levelled at one of the attorneys on an insignificant side-issue. In our country the issue of HIV/AIDS has for some time been fraught with an unusual degree of political, ideological and emotional contention. This is perhaps unavoidable, having regard to the magnitude of the catastrophe we confront. Nevertheless it is regrettable that some of this contention and emotion has spilt over into this case. Not only does it bedevil future relations between government and non-governmental agencies that will perforce have to join in combating the common enemy, but it could also have rendered the resolution of this case more difficult.”). The threat of constitutional crisis is one which, with respect, both the judiciary and the executive need to consciously avoid if the new South African legal order is to have any credibility. It is encouraging to note that from the judgment in *TAC* (fn 57 *supra*) that the judiciary is apparently to some extent alive to these issues as Chaskalson P states at p759-760: “South African Courts have a wide range of powers at their disposal to ensure that the Constitution is upheld. These include mandatory and structural interdicts. How they should exercise those powers depends on the circumstances of each particular case. Here due regard must be paid to the roles of the Legislature and the Executive in a democracy. What must be made clear, however, is that when it is appropriate to do so, Courts may - and, if need be, must - use their wide powers to make orders that affect policy as well as legislation. A factor that needs to be kept in mind is that policy is and should be flexible. It may be changed at any time and the Executive is always free to change policies where it considers it appropriate to do so. The only constraint is that policies must be consistent with the Constitution and the law. Court orders concerning policy choices made by the Executive should therefore not be formulated in ways that preclude the Executive from making such legitimate choices.”

123

TAC, fn 57 *supra* at p 740

124

Haysom N at p 270 of Davis, Cheadle, Haysom *Fundamental Rights in the Constitution, Commentary and Cases*, recognises this in his observation that: “The courts will need to determine whether the level of the services delivered meets the basic needs. While s 30(1)(e) allocates to the judiciary a most important role of diverting resources from one area of social security spending to another area of need, the correct approach to be adopted to such a provision is to recognise that notwithstanding the resources are allocated through the political process, this basic need must first be met. In conformity with international jurisprudence in regard to the adjudication and enforcement of socio-economic rights, the courts may make use of orders compelling state delivery of resources as would enable the state to satisfy such claims. Under this subsection such orders may allow the state a period of grace within which to divert resources or to establish the necessary institutional machinery, or they may afford the state an opportunity to establish the necessary legislative or policy framework to meet this demand.” He notes that “In this regard the wording of s28 (1)(e) must be taken to emphasise that the state has a duty to fulfil these obligations even if it means diverting funds from other social projects.” [Note: the reference to s 30(1)(e) is a reference to the interim Constitution which, as Haysom point out on p 265, does not differ materially from the text of the final Constitution.]

favour the court has decided. In effect the judiciary is substituting its own rationing decision for a rationing decision of the executive branch of government. This clearly has the potential to create considerable problems for the executive if there is a proliferation of cases involving various sectors of society all clamouring that their need is the most urgent. The wealthy in most, if not all, countries tend to be in the minority by far and in developing countries it is often those whose various needs are most urgent which represent the majority of the population. This clearly has the potential to create significant problems with regard to availability of resources. In a developing country in which litigation contesting policy determinations of the executive branch of government becomes a cottage industry, in which a judiciary that by its own admission does not have the tools to consider the bigger picture consistently hands down decisions against the executive because it is in the words of Kentridge and Spitz protecting “certain spheres of personhood against incursion by the majority”, it is not difficult to imagine a situation in which the judiciary finds that it has become the executive in all of the ways that count.¹²⁵ Since this is a situation that is to be

¹²⁵

Bollyky R ‘If C>P+B: A Paradigm for Judicial Remedies of Socio-Economic Rights Violations’ *SAJHR* vol 18 2002 p 161 postulates in a lengthy article that socio-economic rights are subject to enforcement in the same manner as civil and political rights and that if a remedy requires extensive – both in quantitative and qualitative terms – policy and budgetary choices, the court will only make them for a constitutional violation which is proportionately extensive. The article was written before the judgement of the constitutional court in the *TAC* case (fn 50 *supra*) was handed down. Bollyky makes the point that the argument that judicial redress for constitutional violations may depend on the degree to which the remedy considered necessitates involvement in policy issues and has financial implications is not new. He suggests, however, that the paradigm proposed in the article goes much further in that it describes the intuitive process by which judges assess their legitimacy to issue a particular remedy within a constitutional democracy with separation of powers. He posits that judges intuitively weigh their mandate against the ‘illegitimacy’ of issuing the relief sought – as defined by the sum of the interference in policy and budgetary decisions. He says that judges ultimately make an assessment of remedies based on the proportionality of competing values. He admits, however, that the usefulness of the paradigm in predicting constitutional court decisions is limited by the difficulty of assigning precise values to variables in light of the different social, historical, moral and political forces at work in particular constitutional disputes. It is submitted that analyses that attempt to reduce the application of law to mathematical statements will always be of limited value due to the fact that the application of law is not a mathematical exercise involving bald numerical reasoning (no matter how abstract or algebraic) but rather an analytical exercise involving the richly textured values embedded in the culture and history of the society that made the law in question. It may even be dangerous to inject into the popular consciousness the idea that decisions involving the law can be reduced to a mere algebraic formula if there is a tendency to seize on such postulates as a substitute for genuine thought. If one considers the arguments of de Vos P “Substantive Equality After Grootboom: the emergence of social and economic context as a guiding value in equality jurisprudence” available at <http://www.uct.ac.za/depts/lrgu/equasaps/devos.pdf> that at the heart of the constitutional court’s approach to social and economic rights lies a particular understanding of the role of the Bill of Rights as a transformative document aimed at addressing the deeply entrenched structural inequality in South African society and that *Soobramoney* (fn 23 *supra*) and *Grootboom* (fn 10 *supra*) are entirely consistent decisions and do not represent opposing views to socio-economic rights, it is submitted that this is a far more elegant analytical base from which to work off than a dry formula whose object is to predict the court’s future decisions in this area. It is submitted that people confuse a perceived discrepancy in the outcomes of these two cases with a discrepancy in the approach of the court to socio-economic rights. It is facile to assume that an applicant in a socio-economic rights action must win every time in order to achieve consistency in the law on socio-economic rights and that the interests of the particular individual who happens to be in court will always prevail over the interests of those who are not. De Vos argues that the constitutional court’s understanding of the scope and content of social and economic rights is inextricably linked with its conception of the right to equality in section 9 of the Constitution. He says that the court sees the right to equality on the one hand and socio-economic rights on the other as symbiotically linked – the one providing some of the context within which the other can be understood. He observes that a very particular conception of the right to equality is required to give effect to the project of transformative constitutionalism identified by Klare, (fn 8 *supra*) pointing out that it requires a rejection of the traditional liberal conception of equality that is based on the notion of sameness and similar treatment. The court has adopted a contextual approach to equality in which the actual impact of an alleged violation of the right to equality on the individual within and outside the different socially relevant groups is to be examined in relation to the prevailing social, economic and political

avoided at all costs because it would represent a gross imbalance in the structures of government as envisaged by the Constitution, the judiciary and the executive need to be alive to these dangers and must within their respective fields of operation take the necessary measures to avoid it. In the case of the executive, for instance, policy decisions concerning the allocation of resources can be protected against judicial sanction in some respects by following the principles of administrative law in taking them¹²⁶.

2.3.4 Progressive Realisation

An important factor to emerge from both the *Grootboom* and *TAC* cases¹²⁷ is chronology. The timing of the activities of the executive in fulfilling its constitutional obligations relates implicitly to the term 'progressive' in section 27(2). In *TAC* the issue, by the time it reached the constitutional court, could be said to have boiled down to the issue of timing of the roll-out of the state's comprehensive package for the prevention of mother to child transmission of HIV as opposed to whether or not the drug should be made available at public health facilities in advance of the roll-out of the comprehensive programme.¹²⁸ The difference was, in the end, a matter of months. It was not that the state had no intention of introducing a

circumstances in the country, De Vos observes that the Lockean notion (on which traditional equality is based) that all humans are born free and equal and that the harm of discrimination is situated in the failure of government to treat all humans as equally free becomes untenable within the paradigm of transformative constitutionalism. He quotes from the judgement of the court in *Hugo* where it stated that: "We need to develop a concept of unfair discrimination which recognises that although our society which affords each human being equal treatment on the basis of equal worth and freedom is our goal, we cannot achieve that goal by insisting on identical treatment in all circumstances before the goal is achieved. If one considers the judgment of the court in *TAC* (in 50 *supra*) it was also very much about equality and transformative constitutionalism. It was about the fact that private sector doctors could prescribe the drug for their patients while public sector doctors could not. It was about the lives of wealthy private sector patients' babies being saved and not the lives of the babies of poor people who had nowhere else to turn.

126 Kinney D 'Administrative Law and the Public's Health', *Journal of Law, Medicine & Ethics* 30 (2002) 212-223 at 213 observes that "Administrative law can be particularly helpful in addressing the major challenges facing public health...namely, the proper allocation of scarce resources to address essentially insurmountable demands on public health agencies." She points out (at p215) that in the US administrative law and public health have had a long relationship with much of administrative law developing in a public health context and that state regulation of the professions has generated many important doctrines in state administrative law. Interestingly, she notes that the law of administrative inspections has also evolved almost entirely on the context of public health regulation.

127 *Grootboom* fn 10 and *TAC* fn 57 *supra*

128 In *TAC*, fn 57 *supra*, the constitutional court observed at para 118 p760-761: "During the course of these proceedings the state's policy has evolved and is no longer as rigid as it was when the proceedings commenced. By the time this appeal was argued, six hospitals and three community health care centres had already been added in Gauteng to the two research and training sites initially established and it was contemplated that during the course of this year Nevirapine would be available throughout the province for the treatment of mother-to-child transmission. Likewise, in KwaZulu-Natal there was a change of policy towards the supply of Nevirapine at public health institutions outside the test sites" and at para 132 p 764: "Government policy is now evolving. Additional sites where Nevirapine is provided with a 'full package' to combat mother-to-child transmission of HIV are being added. In the Western Cape, Gauteng and KwaZulu-Natal, programmes have been adopted to extend the supply of Nevirapine for such purpose throughout the province. What now remains is for the other provinces to follow suit." The question of whether it was the commencement of litigation that led to the acceleration of the programme or whether it would have happened regardless is a debate for politicians and civil society rather than lawyers.

programme for the prevention of mother to child transmission of HIV. By the end of the year in which the constitutional court handed down its judgment, a significant majority of public hospitals were offering the full package of care identified as appropriate by the State as opposed to just making Nevirapine available as contemplated in the court order. In *Grootboom* the court referred to those whose needs were ‘most urgent’.¹²⁹ The margins of error, from the point of view of the executive, are narrow. They are distilled to the question of whether the state was fulfilling its duties quickly enough with respect to certain interest groups and whether, in doing so, it was paying particular attention to certain groupings whose circumstances were more desperate than those of others. Whilst there is no denying that the needs of those in the most desperate of circumstances should be prioritized, it is submitted that litigation against the state on the basis of the timing of the delivery of access is especially problematic because, in the case of health care services for example, it potentially requires an overview and a review of the entire programme of health services delivery over the next five to ten years. This is not a task which it is appropriate for the judiciary to undertake. Time is a resource. Unfortunately unlike other resources it is not one that can be increased. Children, for instance, grow up and pass the stage where their physical and mental development can be boosted through appropriate nutrition. Those who specialize in emergency medicine speak of a ‘golden hour’ within which to reach and treat a trauma patient before serious and irreversible physical damage or death ensues. Other resources such as human resources, availability of medicines etc can be expanded over time but time itself cannot. This is why prioritisation of health programmes is a form of rationing in its own right. In the context of health care, and specifically the urgent need for HIV and AIDS counsellors to help with pregnant patients who have been diagnosed as HIV positive, nurses in rural clinics whose duties would have included a walk to the neighbourhood school to attend to the health needs of the children there in connection with vaccinations and nutritional needs are now in certain instances no longer able to fulfil those duties. Whilst it would undoubtedly be argued that the interests of these children are not as urgent as those of mothers and their babies in the prevention of mother-to-child transmission of HIV, those babies will eventually grow up and attend that same school where, due to lack of adequate nutrition and immunisation programmes, they may die

anyway. A well-rounded public health programme is not necessarily aimed predominantly at the postponement of death. The point is that an unbalanced focus on a particular area of health service delivery, due to the fact that its protagonists have the loudest voices, or that their issue is more emotionally charged or that they have the most money for litigation, and a resulting inappropriate prioritisation of service delivery is not in the broader interests of public health. Prioritisation of health programmes and the allocation of available resources on emotional grounds is a path to chaos.

2.3.5 “Everyone”

A further significant aspect of the manner in which the right is expressed is the use of the word “everyone”. Everyone has the right to have access to health care services. There are few rights in the Bill of Rights that are accorded only to South African citizens. These relate primarily to political rights such as the right to vote, the right to form a political party etc. This raises questions as to the rights of non-citizens, especially foreign nationals in South Africa, to have access to health care services, particularly when they are not in a position to make payment for such services. In *Larbi-Odam*¹³⁰ the constitutional court held that discrimination between permanent residents and citizens for employment purposes was not justified. It pointed out that:

“The government has made a commitment to permanent residents by permitting them to so enter, and discriminating against them in this manner is a detraction from that commitment.”¹³¹

It is submitted that the same argument holds for permanent residents in respect of a right of access to health care services¹³². But what of temporary residents and those who are illegally in the country?

¹³⁰ *Larbi-Odam and Others v Member of the Executive Council for Education (North-West Province) and Another* 1998 (1) SA 745 (CC)

¹³¹ *Larbi-Odam* fn 130 *supra* at p759

¹³² Klaaren J ‘Non-citizens and Equality’ 1998 (14) *SAJHR* 286 at 293 observes that: “the implications of the principle announced in *Larbi-Odam* go beyond the employment field. The two most prominent examples concern two categories of welfare payments depended upon heavily in rural areas of the country. As a matter of present legislation, old age pensions are restricted to citizens. Permanent residents are thus excluded. Likewise s 3(e) of the Social Assistance Act 59 of 1992 which came into effect on 1 March 1996 restricts social grants such as welfare payments to South African citizens. Both these restrictions are vulnerable to attack in light of the *Larbi-Odam* reasoning. If permanent residents are able to reside and compete for employment on equal terms with citizens, there would seem no reason why they should not enjoy the same social safety net underpinning the

2.3.5.1 Temporary Residents

There is a wide variety of purposes why people enter South Africa from other countries on temporary residence permits ranging from vacation through attendance of international conferences through exploration of business opportunities to obtaining medical treatment. Many of them have health insurance but some do not. If they enter the country with a health condition what is the duty of the South African government towards them? It could be argued that the government, in permitting them to enter the country, even if only for a limited period, accepted certain obligations towards them such as those contained in the Bill of Rights.¹³³ The national department of health often receives enquiries from temporary residents who have been in the country for periods of several months as to whether medication for chronic health conditions such as diabetes can be given to them free of charge by public hospitals because they receive it free of charge in their country of origin¹³⁴. The response of the department is usually that they are obliged to obtain the medication in the private sector and pay for it. However, if such a person presents in diabetic coma at a public hospital this poses a dilemma. Even if such a person presents at a public hospital in non-emergency circumstances requesting medication, if there are inadequate controls in place to ensure that foreign nationals are not treated at such facilities or if such a person says he has no money to buy insulin what are the choices? Ideally such people should not be permitted to enter the country without medical insurance but this does not necessarily

competition (at least beyond a reasonable initial restriction period to discourage unfounded applications for permanent residence). The line of argument that these restrictions are unconstitutional is directly supported by the text of the final Constitution. There is no constitutional restriction to citizens of the right of access to social security.”

¹³³ In fact Klaaren, fn 132 *supra*, at 294 points out that in terms of the criteria announced in *Larbi-Odam* (fn 130 *supra*) with respect to non-citizens in the equality context, temporary residents bear some similarities to permanent residents. He observes that like permanent residents, temporary residents constitute a political and largely powerless minority and would also be subject to threats and intimidation demonstrating their vulnerability. He states that: “The differences comes perhaps in regard to the second rationale to which Mokgoro J referred, the extent to which the status of a non-citizen is a personal attribute that is difficult to change. If anything, for temporary residents, this argument is stronger than for permanent residents, some of whom have the option to naturalise but choose not to. Indeed Mokgoro J’s reasoning as to the immutability of the attribute did not depend on its longevity but rather on the individual’s ability to change the attribute... Before leaving the topic we should note that *Larbi-Odam* did not present a case of differentiation on the grounds of temporary residence. Whether that distinction is proscribed in some way by the equality clause remains an open question.” Klaaren goes on to ask the question whether discrimination against temporary residents on the ground of citizenship is unfair, noting that the court in *Larbi-Odam* drew a distinction between permanent and temporary residents. It based its conclusion that the discrimination against permanent residents was unfair on the fact that permanent residents needed job security in the context of potential indefinite employment; that they would be allowed to become citizens in a few years; that they had been selected into the community; and that they had made a conscious commitment towards South Africa. Temporary residents, observes Klaaren, by definition do not meet these standards. This does not, however, rule out the possibility of unfair discrimination against temporary residents in other circumstances.

¹³⁴ They even try to cite non-existent international agreements between South Africa and their countries of origin as the basis for this boon!

always happen. It is submitted that a person who is a temporary resident and is in a diabetic coma would become the responsibility of the public health sector which then raises the question whether it would not be cheaper to supply such a person with the chronic medication, in this case insulin, and where possible charge him or her for it even in the public sector, rather than end up with a comatose and very expensive patient on one's hands. From a legal perspective, it is submitted that at least the bare minimum of health care services would have to be delivered sufficiently to enable the person to return to his country of origin but these issues are more difficult to control in the field without highly proactive management of the situation by government officials which in itself entails costs to the state. From a pragmatic perspective, such money could be better spent on treating South African citizens and permanent residents who have nowhere else to go and no other country to look to for health care services.

Klaaren¹³⁵ discusses four types of citizenship. These are cultural citizenship, membership citizenship, post-national citizenship and lawful status citizenship. The first has as its principal tent an identification between a particular culture and citizenship. He notes that it is often ruled out of the analysis on first principles by many liberal democratic theorists of citizenship. In any event this kind of citizenship is likely to find scant support within the parameters of the Constitution. The second adopts a sharp distinction between citizens and non-citizens, the latter being defined as aliens. He notes that this is a vision of citizenship as a status. The third, post-national citizenship, has at its centre the simple notion that persons are entitled to human rights in their capacity as human beings. The conception of citizenship most reflected in the jurisprudence of the constitutional court is, however, lawful status citizenship. Klaaren describes its core nation as being that all persons who are lawfully and permanently residing within a country are entitled to be full members of the community of that country. He observes that in contract to membership citizenship, lawful status citizenship accepts gradations within the granting of privileges of membership. It is submitted that purely from an economic and practical point of view in the light of the limited availability of resources in a developing country such as South Africa, this is the most pragmatic and practically feasible view of citizenship. However, the Constitution's

¹³⁵ Klaaren fn 132 *supra* at 296

use of the word ‘everyone’ in most instances, as opposed to the term ‘citizen’ renders such discussions of the meaning of the term ‘citizen’ largely irrelevant unless one is prepared to draw the illogical conclusion that the two terms are synonymous.

2.3.5.2 Illegal Immigrants

If this is the position of persons having temporary residence permits what then are the obligations of the South African government to persons who are in the country illegally? This question presents itself at a number of different levels within both the private and the public health sectors. Many people illegally enter South Africa from neighbouring countries with the express intention of obtaining medical treatment in the public health sector because such services are not available in their own countries. Do they have a constitutional right of access to health services as much as does any South African resident? If the answer is “yes” then this could clearly lead to unsustainable demands on South African resources at the expense of those who are legitimately living in the country. However, if the answer is “no”, then this would not accord with international and constitutional law principles of humanitarianism¹³⁶. In practical terms can a rural, primary health care clinic near the borders of South Africa legitimately turn away people who have illegally crossed into South Africa to obtain services at the clinic? It is submitted that logically there would have to be some kind of limitation imposed upon the delivery of health care services to such people in order to protect the constitutional rights of South African residents.

One of the ways of addressing the problem in practical terms is to enter into international agreements with neighbouring states in terms of which only limited numbers of their nationals will be treated, and in controlled circumstances, for payment. This does not, however, address the question of whether foreign nationals illegally present in South Africa have a constitutional right to health care services. One may be able to argue that the government has no legal duty to such persons because it has not permitted their entry into

¹³⁶ Pieterse M “Foreigners and socio-economic rights: Legal entitlements or wishful thinking?” 2000 (63) *THRHR* p 51, points out that “Migration is a feature of international reality which cannot be ignored, and which must not lead to violations of those rights essential to humanity. We cannot make all fundamental rights dependent on geographic location, for if we do, then we run the risk of replacing humanity with citizenship, a mere political category.”

the country and therefore has no legal obligations towards them. Section 36 of the Constitution allows for the justifiable limitation of rights but “only in terms of law of general application to the extent that the limitation is reasonable and justifiable in an open¹³⁷ and democratic society based on human dignity, equality and freedom, taking into account all relevant factors”. Some of these factors are the importance of the purpose of the limitation, the relation between the limitation and its purpose and the nature of the right. It is submitted that possibly with the exception of emergency medical treatment, a public sector health care institution may have an argument for turning away persons who are illegally in the country. However, this would have to be in terms of a law of general application. The Immigration Act may be such legislation. One of its objects is to ensure that “immigration control is performed within the highest applicable standards of human rights protection”. The Immigration Act provides specifically for entry of foreign nationals into South Africa for medical treatment reasons in section 17¹³⁸. In terms of section 29 of

137

Jordaan DW ‘The Open Society’ 2001 (64) *THRHR* p107 notes that “Since the dawning of our country’s constitutional era the phrase *open and democratic society* has become well known.” He explores what is meant by the concept ‘open society’ with reference to the work of Henry Bergson in the early nineteen thirties and Karl Popper in the nineteen forties and observes that in his definition of open society Popper emphasises the concepts of freedom, humaneness and rationality. He suggests that since these three concepts are used as the basis for measuring openness, they can most suitably be described as principles of an open society. In examining more closely the principle of freedom, Jordaan points out that Judge Ackerman, in his minority judgement in *Ferreira v Levin NO*; *Vryenhoek v Powell NO* (1996 (1) SA 984 (CC)) contends that the right to freedom and security of the person is a residual freedom right in the sense that it encompasses all the aspects of freedom which have not been specifically named in the rest of Chapter 3 of the interim Constitution. He gives a broad and generous construction to this right differing from the majority of his colleagues on the bench. Jordaan notes that the fact that the interim Constitution’s limitation clause demanded that the limitation on the right to freedom and security of the person be not only reasonable, but also necessary influenced the majority’s judgment to a considerable degree and that since the necessity requirement is not included in the 1996 Constitution, Judge Ackerman’s interpretation of the right to freedom and security of the person “can very likely be followed in future constitutional cases.” He distinguishes between an open society and a free society by saying that an open society encompasses a free society but is more than that. It embraces the principles of humaneness and reasonableness, asserting that these two principles have specific meaning and purposes independent of freedom. He continued to observe that in *S v Lawrence*; *S v Negal*; *S v Solberg* (1997 (4) SA 1176 (CC)) Sachs J inseparably links the open society to diversity and typifies it as pluralistic – “one in which there is no official orthodoxy or faith”. He refers to the words of Sachs J in *National Coalition of Gay and Lesbian Equality v Minister of Justice* (1991 (1) SA 6 (CC)) that: “What becomes normal in an open society, then, is not an imposed and standardised form of behaviour that refuses to acknowledge difference but the acceptance of the principle of difference itself, which accepts the variability of human behaviour” and goes on to observe that Sachs J states that the acceptance of the principle of difference does not imply an absence of a point of view or an absence of morality. In conclusion he proposes the following definition of an open society: “A society which rejects the absolute authority of merely established social arrangements, while trying to preserve and develop social arrangements based on the principles of freedom, humaneness, rationality and diversity.” In the health care context the principles of diversity, humaneness and rationality are especially relevant as evidenced *inter alia* by the Hippocratic Oath and the International Code of Medical Ethics of the World Medical Association. (See www.pbs.org/wgbh/nova/doctors/oath_classical for the classical version of the Hippocratic Oath and www.iit.edu/departments/cscp/PublicWWW/codes/oc/World_Medical_Association for the International Code of Medical Ethics of the WMA) A rational society might well be forced to limit the help it gives to persons who are not its members in keeping with limited availability of resources but would not act in a manner that was inhumane or unfairly discriminatory.

138

- “(1) A medical treatment permit may be issued to a foreigner intending to receive medical treatment in the Republic for longer than three months by-
- (a) the Department, as prescribed; or
 - (b) the Department through the registrar’s office or a designated official of an institution where the foreigner intends to receive treatment, provided that such institution-
 - (i) has been approved by and is in good standing with the Department;
 - (ii) certifies that it has received guarantees to its satisfaction that such foreigner’s treatment costs will be paid;

this same Act, foreigners who are infected with certain infectious diseases as prescribed from time to time are prohibited persons. As such they do not qualify for a temporary or permanent residence permit¹³⁹. Section 42 of this Act states that save for necessary humanitarian assistance, no person, shall aid, abet, assist, enable or in any manner help an illegal foreigner. It is not clear what exactly is encompassed by the phrase 'necessary humanitarian assistance' but it is submitted that, in the absence of an agreement or the status of the foreign nationals as refugees in terms of national law¹⁴⁰, it cannot reasonably include health care services that are not immediately necessary to save life. For purely pragmatic reasons, foreigners should not necessarily be entitled to socio-economic rights to the same extent and in the same circumstances as residents. This could change with time and the availability of resources but for the foreseeable future, it is submitted that the obligations of the state are primarily towards South African citizens and lawful residents. Some may argue that the temporary nature of the presence of foreigners in the country will itself limit the potential costs of affording them the benefit of the socio-economic rights enjoyed by South African residents. However, if there is a relatively large, albeit revolving population of foreigners constantly illegally present in the country the cost of fulfilling the full spectrum of socio-economic rights in their case is likely to be unaffordable, especially given the relatively low level of their contribution to the economy as a whole. Whilst it may be eminently sensible from a humanitarian perspective, from an economic perspective such

(iii) in the case of a minor, provides the name of a person present in South Africa who is, or has accepted to act, as such minor's guardian while in the Republic or certifies that such minor will be accompanied by a parent or guardian to the Republic;

(iv) undertakes to provide a prescribed periodic certification that such foreigner is under treatment; and

(v) undertakes to notify the Department when such foreigner has completed his or her treatment.

(2) When so requested by, and after consultation with, the Department of Health, the Department shall determine an ad hoc fee for the issuance of medical treatment permits in respect of institutions publicly funded or subsidised.

(3) A medical treatment permit does not entitle the holder to conduct work."

139 One wonders whether, from a constitutional point of view, this is a justifiable limitation of the right not to be unfairly discriminated against on the basis of disability.

140 Section 27 of the Refugees Act 130 of 1998 stipulates that: A refugee "enjoys full legal protection, which includes the rights set out in Chapter 2 of the Constitution and the right to remain in the Republic in accordance with the provisions of this Act". More specifically subsection 27 (g) provides that a refugee "is entitled to the same basic health services and basic primary education which the inhabitants of the Republic receive from time to time". It is curious that the legislature thought fit to include section 27(g) after stating in 27(b) that refugees are entitled to all of the rights in Chapter 2 of the Constitution which include the rights to health care services and to education. One of the objects of this Act is to "To give effect within the Republic of South Africa to the relevant international legal instruments, principles and standards relating to refugees". In terms of section 3 of the Act, "a person qualifies for refugee status for the purposes of this Act if that person-

(a) owing to a well-founded fear of being persecuted by reason of his or her race, tribe, religion, nationality, political opinion or membership of a particular social group, is outside the country of his or her nationality and is unable or unwilling to avail himself or herself of the protection of that country, or, not having a nationality and being outside the country of his or her former habitual residence is unable or, owing to such fear, unwilling to return to it; or

(b) owing to external aggression, occupation, foreign domination or events seriously disturbing or disrupting public order in either a part or the whole of his or her country of origin or nationality, is compelled to leave his or her place of habitual residence in order to seek refuge elsewhere; or

(c) is a dependant of a person contemplated in paragraph (a) or (b)".

a policy could be suicidal. For a developing country that cannot even afford to realize in full socio-economic rights for citizens, it is submitted that such an approach is inconceivable. Pieterse argues that though the Department of Home Affairs contends in its White paper on international migration that constitutional provisions relating to everyone cannot always apply equally to illegal aliens, legal residents and citizens alike, there is no constitutional indication why all aliens should not in principle be equally entitled to all constitutionally entrenched rights other than those reserved for citizens¹⁴¹. He notes with regard to emergency medical treatment that: “Commendably the Department of Home Affairs acknowledged in its *Green Paper on international migration* that all aliens, legal or illegal, should be afforded the right to emergency medical treatment, although no detailed provisions to this effect are contained in the Department’s subsequent White Paper on the same issue.”¹⁴² With particular regard to access rights such as those contemplated in section 26(1), 26(2) and 27(1) of the Constitution, Pieterse observes that the Department of Home Affairs apparently does not wish to extend any social welfare benefits (apart from emergency medical treatment and temporary schooling) to anyone other than citizens and

¹⁴¹ Pieterse fn 136 *supra*. He notes that: “Modern society is learning to accept that the benefits of citizenship are not limited to civil and political rights but include social and economic rights. Social resources like health and education are vital for the citizen’s economic efficiency and for furthering his and other citizens’ civil and political rights. It is argued that welfare rights are ‘conceived as a core element of citizenship in Western society’ and are ‘integral to the modern sense of citizenship’ Whether the entitlement to social and economic rights should extend to non-citizens is polemical. International human rights documents conferring such rights upon aliens are not widely ratified and many states are reluctant to include aliens in social assistance schemes. Because of the nature of socio-economic rights their availability is often dependent on the availability of state resources and they can therefore not always be guaranteed to the same extent as civil and political rights. Many countries are not in a position to provide adequately for the socio-economic needs of their citizens, let alone those of foreigners in their territory. Furthermore, aliens (especially those of the illegal variety) are often blamed for contributing to socio-economic hardship by taking away jobs and public benefits believed to be rightly due to citizens... South Africa’s Constitution differs significantly from that of the United States and most other countries of the world in that it expressly guarantees socio-economic rights...Both categories of socio-economic right are conferred on all people without any distinction between citizens and non-citizens...The extent to which aliens will succeed in relying on these rights is anything but clear.”

¹⁴² Pieterse fn 136 *supra* at p 57. Interestingly the Immigration Act No 13 of 2003, which is not yet operational, makes no express mention of the rendering of emergency medical treatment or any other kind of health services to foreigners illegally in the country. Section 42 simply says that save for “necessary humanitarian assistance” no person, shall aid, abet, assist, enable or in any manner help an illegal foreigner. The Promotion of Equality and Prevention of Unfair Discrimination Act No of 2000, which is not yet operational, prohibits unfair discrimination *per se*. It defines ‘prohibited grounds’ of discrimination as:

- “ (a) race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth; or
(b) any other ground where discrimination based on that other ground-
(i) causes or perpetuates systemic disadvantage;
(ii) undermines human dignity; or
(iii) adversely affects the equal enjoyment of a person’s rights and freedoms in a serious manner that is comparable to discrimination on a ground in paragraph (a);”

A person’s citizenship (i.e. of another country) is not listed expressly in the prohibited grounds but culture or birth could include citizenship by implication. In the Schedule, under section 3 it lists some unfair practices relating to health services and benefits as:

- 3 Health care services and benefits
(a) Subjecting persons to medical experiments without their informed consent.
(b) Unfairly denying or refusing any person access to health care facilities or failing to make health care facilities accessible to any person.
(c) Refusing to provide emergency medical treatment to persons of particular groups identified by one or more of the prohibited grounds.
(d) Refusing to provide reasonable health services to the elderly. “

permanent residents. He further observes that no authorities are cited for this stance and that it is doubtful whether this policy is in accordance with the Constitution. He does concede the possibility that the limitations clause in the Constitution may be used more vigorously against immigrants and that it is easily foreseeable that despite aliens' entitlement to socio-economic rights, the courts and the legislature will favour the socio-economic needs of citizens when deciding on policy in this regard, pointing to the dictum of Chaskalson P in *Soobramoney*¹⁴³ to the effect that:

“We live in a society in which there are great disparities in wealth. Millions of people are living in deplorable conditions and in great poverty. There is a high level of unemployment, inadequate social security and many do not have access to clean water or to adequate health services.”

It is submitted that the restriction of socio-economic benefits to, or discrimination in the area of socio-economic rights against, illegal foreigners is neither unfair nor unreasonable as long as there are limited resources available to the state for the fulfilment of socio-economic rights. South Africa is surrounded by countries that are much poorer than itself with literally millions of people who are in need of adequate health services and other socio-economic benefits. If there were no lawful way to ration health care services to illegal aliens in South Africa, it is submitted that the state would be unable to fulfil its constitutional obligations to progressively realize the fulfilment of socio-economic rights to anyone. If as fast as one illegal alien is deported, another enters the country and demands and receives health care services from the state, there will be a constant, very large rotating population of illegal aliens depleting the limited resources available for the rendering of those health care services and South African citizens and residents, with nowhere else to go for such services, are likely, contrary to the intention of the Constitution, to be progressively deprived of them. There is significant scope for argument that the obligation to protect, respect, promote and fulfil the rights in the Bill of Rights works in more than one direction and that it may also require the state to take reasonable measures to ensure that its capacity to progressively realize the socio-economic rights in the Bill of Rights is not eroded to the point where it no longer exists. The fact that the Constitution refers to citizens

¹⁴³ *Soobramoney* fn 23 *supra*

in some cases and “everyone” in others does not necessarily imply that “everyone” includes illegal aliens. There are two categories of persons on the spectrum between citizens and illegal aliens. These are temporary residents and permanent residents. It is conceivable that the ‘everyone’ referred to by the Constitution means everyone who is lawfully present in the country. There seems to be a logical disjunction in the argument that illegal aliens fall within the scope of the term ‘everyone’ used in the Constitution when they have defied the same legal system of which the Constitution is the grundnorm by their presence in the country. The Constitution does not award rights to persons in other countries- only to persons in South Africa. It could be argued that it does not contemplate or condone the illegal presence of citizens of other countries in South Africa since to do so would be to condone the violation of a part of the legal system of which it is the foundation. Illegal aliens are thus, for purposes of the South African legal system, in a sense not in South Africa since their entry took place without the sanction of the legal system. It thus seems incongruous to argue that they can claim rights in terms of that same legal system to all the benefits it confers upon those lawfully present. This is not to say that illegal aliens should not be accorded basic human rights in the process of their detention and deportation. Human rights are a concept of international law and therefore of much wider geographical application than the specific rights contained in the South African Constitution. It is of interest on this note, that Pieterse himself points out that international human-rights documents conferring social and economic rights upon aliens are not widely ratified. Furthermore, even the 1990 International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families which he cites as arguably the most progressive human-rights instrument in this regard, guaranteeing amongst other things that migrant worker shall be afforded equal treatment to nationals with regard to social security, the right to emergency health care, access to educational institutions, vocational training and housing schemes does not apparently include a right to health care services apart from emergency medical treatment. The other international legal instrument cited, the United Nations Declaration on the Human Rights of Individuals Who Are Not Nationals of The Country in Which They Live, determines that aliens *lawfully* residing in a state should enjoy rights to safe and healthy working conditions, health protection, medical care, social

security, social services and education.¹⁴⁴ This is logical because these people by following the legal procedures necessary to be lawfully present in the country have subjected themselves to the laws of that country and fall within the full scope of its legal system. The state in allowing them to enter has made a legal commitment to them. The court in *Larbi Odam* stressed not only the fact that the state had made a commitment to permanent residents by permitting them to enter the country¹⁴⁵ but also that the permanent residents had made a commitment to the country¹⁴⁶.

2.3.5.3 Health Tourists

The other question is whether, from a policy perspective, if the State wished to discourage so-called 'health tourism', it would be able to do so. Although this is predominantly a private health sector issue, people entering the country in significant numbers with the express purpose of undergoing surgery or some other form of medical treatment are likely to inadvertently affect the access to health care services of South African residents. The Immigration Act, which is not yet operational at the time of writing, does envisage such a possibility and makes express provision for permits for the purpose of medical treatment but only where such treatment is likely to be for longer than three months¹⁴⁷. In reality there are very few medical interventions which require even one month's stay in a hospital and generally speaking people who are treated for three months or longer are likely either to have a chronic health condition which cannot be cured by a single series of interventions or they have a terminal illness. The harsh economic reality is that either way, one would not want to see such patients in South Africa. If their medical insurance benefits run out or they suddenly take an unanticipated turn for the worse they may become a burden on the public health sector in which resources are already severely overstretched. Many health tourists come to South Africa for elective surgery in the private sector such as cosmetic surgery and

¹⁴⁴ Pieterse fn 136 *supra* at p55 and footnote 28

¹⁴⁵ *Larbi Odam* fn 130 *supra* at p759

¹⁴⁶ See *Larbi Odam* fn 130 *supra* at p758-749 where Mokgoro J stated that: "Permanent residents are generally entitled to citizenship within a few years of gaining permanent residency, and can be said to have made a conscious commitment to South Africa. Moreover, permanent residents are entitled to compete with South Africans in the employment market. As emphasised by the appellants, it makes little sense to permit people to stay permanently in a country, but then to exclude them from a job they are qualified to perform."

¹⁴⁷ Immigration Act fn 142 *supra*

surgery for less pressing health needs. Such treatment nonetheless requires the utilisation of human and other resources such as operating theatres which could be used in the treatment of South African residents. Such treatment rarely takes even one month. There is apparently no obligation in terms of the Immigration Act on people entering South Africa for the express purpose of receiving medical treatment for less than three months, which is likely to be the majority, to apply for a medical treatment permit or even declare the real reason for their entering the country.

Whilst at present most health tourists target the private health sector in South Africa, the question of whether the health care services are delivered in the public or the private sectors is largely irrelevant. Even where there is spare bed capacity in private hospitals, for instance, there are significant shortages of other resources used in the delivery of health care in South Africa, particularly human resources, at various levels within the health care system. If the private sector is doing a roaring trade in health tourism and is able to attract human resources away from the public sector and into the private sector to render health care services to tourists, this constitutes a significant loss for the public health sector and could severely impact upon its capacity to deliver health services to citizens and permanent residents. There is an opportunity cost in terms of the treatment of a South African citizen or permanent resident, in servicing a health tourist. Whilst there are not the long waiting lists for treatment in South Africa that there are in the British National Health Service, the question is whether, if such long waiting lists did develop as the result of an influx of health tourists, would there be a constitutional obligation upon the South African government to ensure that this does not happen? It is submitted that there would be such a constitutional obligation in view of the injunction not only to promote and fulfil the rights in the Bill of Rights but also to respect and protect them.

The other possibility is that health tourism could lead to a situation where private hospital treatment becomes so expensive for South African residents, due to the fact that a private hospital would rather treat a foreign patient paying in a strong foreign currency than a South African resident who cannot compete with weak rands, that the private sector becomes largely inaccessible to South African patients. They will then be forced to fall

back on the already overburdened public health sector for their health needs. In this way, valuable health resources located in South Africa could effectively be diverted away from South African residents for the benefit of foreign nationals who contribute very little to the economy in comparison to a tax paying local resident. The issue of health care services to foreigners also has a bearing on the question of the horizontal application of the Bill of Rights. If private health institutions are constitutionally obliged to provide health care services to South African residents as opposed to foreign nationals, they will be restricted in their capacity to deliver those same services to non-residents. Liebenberg¹⁴⁸ remarks with regard to the rights implicit in section 27(3) that this subsection is applicable horizontally and hence binds private hospitals, clinics, consulting rooms and ambulance services. Since emergency medical treatment is a specific, specialised subset of health care services it could be argued that the right to health care services contemplated in section 27(1) is not necessarily also horizontally applicable and that, in the present context, emergency medical services are in any event not the kind of services that are usually targeted by health tourists except unintentionally. The kind of health care services that health tourists are interested in are very often cosmetic surgery and other types of services that fall into the non-emergency category. Furthermore the private facility at which they are to undergo the treatment is likely to have made sure that they are in a financial position not only to pay for the contemplated treatment but also for other treatment in the event that something goes wrong. If private health facilities are not bound by a horizontal application of the rights in section 21(1) of the Constitution to deliver health care services to South African residents then from the current legal perspective they are under no obligation not to treat foreign patients. From a practical point of view, however, this may not be a desirable state of affairs given the potential indirect effects on the capacity of the health care system as a whole to deliver services to locals and, depending upon the magnitude of health tourism and its impact on the South African health system, it may have to be restricted in some way in order to protect the right of South African residents to access to health care services. The question of the horizontal application of the rights in the Bill of Rights is dealt with elsewhere in this chapter.

¹⁴⁸ Davis, Cheadle, Hayson (fn 124 *supra*) p 358

2.3.6 Available Resources

As discussed at length in chapter 1, the question of available resources is central, from a constitutional point of view, to the right of access to health care services. Liebenberg¹⁴⁹ observes that the critical question that arises is whether the ‘available resources’ of the state refers to its existing budgetary allocations, or whether it is a broader concept, incorporating the totality of the resources available to the state. She points out that Alston and other international law scholars are of the view that the phrase ‘to the maximum of its available resources’ in art 2 of the ICESCR refers to the overall resources of the country and is not confined to budgetary appropriations¹⁵⁰. Liebenberg notes further that the implication of the former interpretation is that the state would be in a position to determine the extent of its own obligations, by, for example, allocating minimal funds to the portfolios of housing, education, etc. The further question also arises whether the ‘available resources’ of a provincial government are to be determined only by reference to the budget of that provincial government or whether a court can enquire into the national government’s allocations to provincial levels in areas critical to the realisation of the rights. It is submitted that the views of Alston *P et al* on the level of international law are not necessarily appropriate or applicable to constitutional questions involving the availability of resources for the following reasons:

International law, as stated in chapter one, is essentially involved with the obligations of nation states to observe the provisions of various instruments of international law as opposed to the obligations of states towards their citizens and of citizens towards each other. Whilst these latter types of obligations clearly have an impact on the state’s fulfilment of its obligations in terms of such instruments of international law, in terms of the South African Constitution, international law does not automatically form part of the South African legal system. This is entirely consistent with the rule of law in terms of

¹⁴⁹ Chaakalson *et al*, fn 67 *supra* at p41-41

¹⁵⁰ Chaakalson *et al* fn 67 *supra* at p41-41 footnote 3

which the Constitution has been designated as the supreme law of the country and therefore even international law which is inconsistent with the Constitution cannot legitimately be applied by the courts. The Constitution itself is in some ways a moving target as a result of its emphasis on the values that underlie an open and democratic society and the fact that the constitutional court has emphasised the process approach to the Constitution.¹⁵¹

Due to the fact that international law is essentially involved with the obligations of nation states *inter se* and to the international community of nation states as a whole, its perspective must, of necessity, because it stands outside systems of national law, be different to the perspectives of national law. The perspective of international law is one of being on the outside looking in whereas the perspective of South African constitutional law is one of being on the inside looking out. Consequently the approach of international law in measuring the extent to which a nation state as a whole has met its obligations with regard to the available resources must be that suggested by Alston *et al*. It has to be a bird's eye view. However, from the point of view of the constitutional order within South Africa, recognising the doctrine of separation of powers, a system of fiscal federalism and imposing a complex matrix of obligations on national, provincial and local governments, one cannot afford to take the bird's eye view of international law if one wishes to preserve the supremacy of the Constitution within South Africa¹⁵². The weave of constitutional and

¹⁵¹ See for instance the words of Chaskalson P in *Van Rooyen And Others v The State And Others (General Council Of The Bar Of South Africa Intervening)* 2002 (5) SA 246 (CC) at para 34, p 273 "Bearing in mind the diversity of our society this cautionary injunction is of particular importance in assessing institutional independence. The well-informed, thoughtful and objective observer must be sensitive to the country's complex social realities, in touch with its evolving patterns of constitutional development, and guided by the Constitution, its values and the differentiation it makes between different levels of courts." The court in *Dawood*, fn 12 *supra*, at p 1043 comments: "Thus as this right has 'been crucial to our constitutional project', very compelling reasons would have to be advanced to justify its limitation." (writer's emphasis) See also Klare K "Legal culture and constitutionalism" (1998) 14 *SAJHR* 146 who speaks of transformative constitutionalism and notes that the Constitution as a transformative document requires continual reinvention to make sense of the changing world. The constitutional project becomes a long term project of constitutional enactment, interpretation and enforcement.

¹⁵² This question of differences in perspective is quite nicely illustrated in the observations of the court in *Mangope v Van Der Walt And Another NNO* 1994 (3) SA 850 (BG) where it said that: "I do not consider that the principles of international law, to which I was referred, are apposite to a case of the type now before me. I think it is a question of constitutional law. As Lord Reid observed in *Madzimbamuto v Lardner-Burke and Another* [1968] 3 All ER 561 (PC) at 573H-B: "With regard to the question whether the usurping government can now be regarded as a lawful government much was said about *de facto* and *de jure* governments. Those are conceptions of international law and in their Lordships' view they are quite inappropriate in dealing with the legal position of a usurper within the territory of which he has acquired control. As was explained in *Carl-Zeiss-Stiftung v Rayner and Keeler Ltd* (No 2) when a question arises as to the status of a new regime in a foreign country the court must ascertain the view of Her Majesty's Government and act on it as correct. In practice the government has regard to certain rules, but those are not rules of law. And it happens not infrequently that the government recognises a usurper as the *de facto* government of a territory while continuing to recognise the ousted Sovereign as the *de jure* government. But the position is quite different where a court sitting in a particular territory has to determine the status of a new regime which has usurped power and acquired control of that territory. It must decide. And it is not possible to decide that there are two lawful governments at the same time while each is seeking to prevail over the other. It is a historical fact that in many countries - and indeed in many countries which are or have been under British sovereignty - there are now regimes which are universally recognised as lawful



national law is much more dense and intricate than that of international law and for the national system to be internally consistent, one has to look to the Constitution, as opposed to international law, as the grundnorm. Provision has been made in the Constitution for courts and other tribunals to consider international law with a view no doubt *inter alia* to observing South Africa's international legal obligations but there is no obligation upon the courts to apply international law irrespective of whether or not it is consistent with the values enshrined in the Constitution. In *Grootboom* and *TAC*¹⁵³, for example, the constitutional court refused to apply the international law principle of minimum core obligations.

As pointed out in the previous chapter, taken to its logical extreme the question of a country's available resources could extend to implied obligations upon the international community to 'put its money where its mouth is'. If it seeks to impose obligations upon a country which require resources that country does not have and there are mechanisms for financial and other support at international level available to that country then those mechanisms must be mobilised to ensure that the resources are made available otherwise the pointing finger of accusation is simply turned back in the direction of the accusers. At a certain level international law seems inherently self-contradictory since on the one hand it seeks to deny national boundaries in terms of legal principles by insisting that international legal principles are applicable across national boundaries, regardless of the views of those nations on the subject, but on the other seeks to hold individual nations liable for their failure to observe those principles. It seems that the permeability of national boundaries for purposes of international law is, at times, unidirectional. If the courts themselves¹⁵⁴ do not believe that they have the necessary resources to make decisions concerning the allocation

but which derive their origins from revolutions or coups d'etat. The law must take account of that fact. So there may be a question how or at what stage the new regime became lawful.' The court emphasised that it is the consent or acceptance of the people of a new government established as the result of a revolution which is relevant rather than the principles of international law."

153

Grootboom fn 10 and *TAC* fn 57 *supra*

154

TAC fn 57 *supra* at para 37, p 740: "It should be borne in mind that in dealing with such matters the Courts are not institutionally equipped to make the wide-ranging factual and political enquiries necessary for determining what the minimum-core standards called for by the first and second amoi should be, nor for deciding how public revenues should most effectively be spent" and para 38: "Courts are ill-suited to adjudicate upon issues where Court orders could have multiple social and economic consequences for the community."

of resources at provincial level¹⁵⁵, the notion that they can even begin to contemplate the allocation of resources across provinces and take on the role of Parliament to provide for ‘the equitable division of revenue raised nationally among the national, provincial and local spheres of government’ is nothing short of mind boggling. It is submitted that the constitutional court has itself answered the question as to whether the court has the power to enquire into the national government’s allocations to provincial levels in areas critical to the realisation of the rights in *TAC* where it noted that:

“The Constitution contemplates rather a restrained and focused role for the Courts, namely, to require the State to take measures to meet its constitutional obligations and to subject the reasonableness of these measures to evaluation. Such determinations of reasonableness may in fact have budgetary implications, but are not in themselves directed at rearranging budgets. In this way the judicial, legislative and executive functions achieve appropriate constitutional balance.”¹⁵⁶

Viewed systemically, it is submitted that the role of the courts is not to rearrange the system in all its complex interrelationships but rather to exert acupressure at sensitive points within the system so as to encourage it to move or develop in a certain way.

Section 27(2) stipulates that the state must take reasonable legislative and other measures to achieve the progressive realisation of the right within available resources. In this regard, the constitutional court has pointed out that:

“The third defining aspect of the obligation to take the requisite measures is that the obligation does not require the State to do more than its available resources permit. This means that both the content of the obligation in relation to the rate at which it is achieved as well as the reasonableness of the measures employed to achieve the result are governed by the availability of resources. Section 26 does not expect more of the state than is achievable within its available resources. As Chaskalson P said in *Soobramoney*:

‘What is apparent from these provisions is that the obligations imposed on the state by ss 26 and 27 in regard to access to housing, health care, food, water, and social security are dependent upon the resources available for such purposes, and that the corresponding rights themselves are limited by reason of the lack of resources. Given this lack of resources and the significant demands on them that have already been referred to, an unqualified obligation to meet these needs would not presently be capable of being fulfilled.’

¹⁵⁵ *Soobramoney* fn 23 at p 776: “These choices involve difficult decisions to be taken at the political level in fixing the health budget, and at the functional level in deciding upon the priorities to be met. A court will be slow to interfere with rational decisions taken in good faith by the political organs and medical authorities whose responsibility it is to deal with such matters.”

¹⁵⁶ *TAC* fn 57 *supra* para 38 at p 740

There is a balance between goal and means. The measures must be calculated to attain the goal expeditiously and effectively but the availability of resources is an important factor in determining what is reasonable.”¹⁵⁷

Since the availability of resources is a variable which, by definition, is subject to fluctuation, and since what is reasonable in terms of the state’s efforts to fulfil its constitutional obligations must be seen in the context of the available resources, it follows that the state’s obligations can and do vary not only from one context to another but also across time. Admittedly, the Constitution requires “progressive” realisation which means that ideally the state’s obligations should not be permitted to regress in terms of its constitutional obligations but, in a situation where resources are greatly reduced from what they were previously and where the state finds itself in dire economic circumstances, it is submitted that in practical terms what it is constitutionally obliged to provide by way of access to health care services may well amount to less than what it was obliged to provide in more prosperous times. In a sense, the available resources limit or bound the right in a given set of circumstances. It is submitted that this is partly the reason that the court in *Grootboom* observed that deciding whether the state has fulfilled its obligations in a particular instance is very difficult and that every case has to be considered individually.¹⁵⁸

In keeping with this line of reasoning, the constitutional court in both the *Grootboom* and the *TAC*¹⁵⁹ cases rejected the argument that socio-economic rights have a minimum core to which every person in need is entitled. The concept of minimum core is discussed in considerable detail in chapter one and that discussion will therefore not be repeated here. However, it is important to point out that: “[t]his argument fails to have regard to the way ss (1) and (2) of both ss 26 and 27 are linked in the text of the Constitution itself, and to the way they have been interpreted by this court in *Soobramoney* and *Grootboom*.”¹⁶⁰

¹⁵⁷ *Grootboom* fn 10 *supra* p 70-71 para 46

¹⁵⁸ See *Grootboom* fn 10 *supra* para 20 p 61 where the court observed that: “The question is therefore not whether socio-economic rights are justiciable under our Constitution, but how to enforce them in a given case. This is a very difficult issue which must be carefully explored on a case-by-case basis.” (footnotes omitted)

¹⁵⁹ *Grootboom* fn 10 and *TAC* fn 57 *supra*

¹⁶⁰ *TAC* fn 57 *supra* p738 para 29

The manner in which sections 26 and 27 of the Constitution have been constructed defeats the argument in favour of a minimum core obligation as espoused in international law. The court in the *TAC* case observed that:

“Section 26(1) refers to the ‘right’ to have access to housing. Section 26(2), dealing with the state’s obligation in that regard, requires it to ‘take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of this right’. The reference to ‘this right’ is clearly a reference to the s 26(1) right. Similar language is used in s 27, which deals with health care services, including reproductive health care, sufficient food and water, and social security, including, if persons are unable to support themselves and their dependants, appropriate social assistance. Subsection (1) refers to the right everyone has to have ‘access’ to these services; and ss (2) obliges the state to take ‘reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights’. The rights requiring progressive realisation are those referred to in ss 27(1)(a), (b) and (c). In *Soooramoney* it was said: ‘What is apparent from these provisions is that the obligations imposed on the state by ss 26 and 27 in regard to access to housing, health care, food, water and social security are dependent upon the resources available for such purposes, that the corresponding rights themselves are limited by reason of the lack of resources.’

The obligations referred to in this passage are clearly the obligations referred to in ss 26(2) and 27(2), and the ‘corresponding rights’ are the rights referred to in ss 26(1) and 27(1). This passage is cited in *Grootboom*. It is made clear in that judgment that ss 26(1) and 26(2) ‘are related and must be read together’. Yacoob J said: ‘The section has been carefully crafted. It contains three subsections. The first confers a general right of access to adequate housing. The second establishes and delimits the scope of the positive obligation imposed upon the state. . . .’ It is also made clear that s 26 does not expect more of the state than is achievable within its available resources’ and does not confer an entitlement to ‘claim shelter or housing immediately upon demand’ and that as far as the rights of access to housing, health care, sufficient food and water, and social security for those unable to support themselves and their dependants are concerned, ‘the state is not obliged to go beyond available resources or to realise these rights immediately.’”¹⁶¹

There is only a single obligation upon the state, dependent upon the availability of resources, to provide access to health care services and not two: one based on the minimum core concept and one on the available resources concept. The court rejected the idea that a minimum core obligation was enforceable against the state irrespective of the resources that are available to fulfil that minimum core. It is submitted that, far from being a weakness in the right of access to health care services, the element of the availability of resources is its saving grace. It provides the mechanism for the translation of the right from the paper on which it is written into something that has practical meaning. Moreover the flexibility that it allows renders it possible to adapt and realistically apply the right to every possible permutation that could arise in relation to the need for health care services.

¹⁶¹ *TAC* fn 57 *supra*, p738-739 para 30-32 (footnotes omitted)

2.4 The Right of Children To Basic Health Care Services

The Constitution makes specific reference to a right of children to basic health care services in section 28(1)(c). It is thus necessary to consider this provision and its implications in the context of the broader right of everyone to health care services as provided for in section 27(1). Does this mean that children have a greater or more specific right to health care services than adults? Is the right of children to health care services a separate right from the rights conferred in section 27(1)? In other words do children have ‘two’ rights to health care services, one in terms of section 27(1) which refers simply to “health care services” and the other in terms of section 28(1)(c) which speaks of ‘basic health care services’? The answer has a bearing on the broader question of whether the right to health care services is a single right with many facets or whether there is in reality only a number of discrete rights, within different contexts, having no underlying systemic consistency.

2.4.1 Section 28 Rights v Section 26 and 27 Rights

One of the major differences between section 27 and section 28 is that the former stipulates that the state must take reasonable legislative and other measures to achieve the progressive realisation of the rights referred to in section 27. There is no similar qualification in section 28. It would in theory be possible to argue that the reason for the provision for basic health care services in paragraph 28(1)(c) is to ensure a minimum core of health services to children, available resource considerations aside¹⁶². However, the constitutional court in

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Haysom N in the chapter on children in *Davis et al*, fn 124 *supra*, lends support to this view in his submission at p 269, that the term ‘basic’ implies a ‘minimum level necessary to prevent malnutrition or disease must be provided.’ He further states at p 270 that: “Unlike the formulation of the rights in s 26 and 27, where a greater discretion is allowed to the state, the courts do not have to refer to the question of availability of resources in determining whether the state has met its obligation to provide these basic necessities to children (See generally de Vos P ‘The Economic and Social Rights of Children and South Africa’s Transitional Constitution’ 1995 (10) *South African Public Law* 233).” Haysom appears not to be entirely consistent in this view however because in discussing the right of children to basic nutrition, shelter, health care services and social services at p 269 he says “This provision will be subject to reasonable limitations arising out of the available resources of the state.” It is interesting that Haysom sees the right of children to basic health services as being preventive as opposed to curative. It is not clear whether he intended to refer to the more formal classification of different types of health care or whether the term “prevent” as applied to “disease” is intended to include curative health care as well as preventive in the sense that a cure prevents continuation in the diseased state. He states that the right conferred is intended to serve primarily as a safety net in cases of deprivation, neglect, starvation or abuse and observes that: “In comparison with the costs involved in the enforcement of civil rights (for example legal aid), the delivery of a minimum level of food and health services in areas enduring extreme deprivation should not be formidable.” It is submitted that unfortunately in health care terms, “the minimum necessary to prevent malnutrition and disease”

Grootboom and the *TAC*¹⁶³ cases rejected the minimum core concept¹⁶⁴ in principle, albeit primarily with reference to sections 26 and 27(1) which expressly require the state to take reasonable legislative and other measures to ensure the progressive realisation of this right within its available resources. In *Grootboom*¹⁶⁵ the court specifically considered the right of children to shelter as contained in section 28(1)(c). It observed with regard to *both* sections 26 and 28(1)(c) that: “[t]hese rights need to be considered in the context of the cluster of socio-economic rights enshrined in the Constitution.” The court in its judgement discussed the concept of minimum core obligations within the context of the obligations of the State in terms of section 26 and rejected that concept on the basis of the construction of the section in a manner which ties the rights therein contained to the issue of available resources. Some might be tempted to argue that the concept of minimum core could nonetheless be valid with regard to the rights of children expressed in section 28 which does not contain the same qualifications with regard to available resources as does section 26. However, in its discussion of the judgment of the high court as it pertained to section 28(1)(c), the constitutional court observed the following:

“The judgment of the High Court amounts to this: (a) s 28(1)(c) obliges the state to provide rudimentary shelter to children and their parents on demand if parents are unable to shelter their children; (b) this obligation exists independently of and in addition to the obligation to take reasonable legislative and other measures in terms of s 26; and (c) the state is bound to provide this rudimentary shelter irrespective of the availability of resources. On this reasoning, parents with their children have two distinct rights: the right of access to adequate housing in terms of s 26 as well as a right to claim shelter on demand in terms of s 28(1)(c). This reasoning produces an

in children does not necessarily mean that the funding of such health care services is as minimal as Haysom would have his readers believe. The prevention of disease in children is not necessarily either simple or straightforward and the phrase ‘minimum necessary to prevent’ can in itself be the subject of some debate. For example, in the context of the *TAC* case, the argument of the State was in a sense that that the provision of the drug Nevirapine to pregnant mothers and their newborn babies was not sufficient. It was not the minimum necessary to prevent malnutrition and disease in children since studies had shown that if the mother breastfed the child there was still a considerable risk of transmission of HIV from the mother to the child and that feeding substitutes were an important part of a programme that sought to prevent mother to child transmission of HIV. Furthermore, the State had concerns about potential adverse effects on long term management of the disease such as the development of large scale drug resistance in the face of only marginal success in the prevention of HIV transmission at birth. The court, of course, took the view that it is better to live now and die later than not to live at all and that even if only a few hundred lives were saved initially, the potential loss of life of thousands in the long term due to drug resistance was no argument for the State’s failure to provide the drug. In this case it is important to remember that the drug was available to the State free of charge but what if it had not been? What if there had been a significant price tag? Would the provision of Nevirapine still constitute basic health care services to children in the context of Haysom’s submission that it is the minimum level necessary to prevent malnutrition or disease? The numbers of antiretroviral drugs on the market are few and alternatives are even scarcer. This greatly reduces the options for HIV and AIDS prevention strategies generally. It is comparatively easy to run a vaccination programme for measles or rubella or smallpox in terms of which children can be immunized against these diseases and the vaccines are not prohibitively expensive but what are “basic health services” for children in the context of HIV and AIDS, hepatitis C and similar health conditions where no vaccines exist or where they are expensive and may carry significant adverse side effects that have cost implications for the health system in their own right?

163 *Grootboom* fn 10 and *TAC* fn 57 *supra*

164 *Minister of Health and Others v Treatment Action Campaign and Others*, fn 57 *supra*, see p 737 onwards

165 *Grootboom* fn 10 *supra*



anomalous result. People who have children have a direct and enforceable right to housing under s 28(1)(c), while others who have none or whose children are adult are not entitled to housing under that section, no matter how old, disabled or otherwise deserving they may be. The carefully constructed constitutional scheme for progressive realisation of socio-economic rights would make little sense if it could be trumped in every case by the rights of children to get shelter from the state on demand. Moreover, there is an obvious danger. Children could become stepping stones to housing for their parents instead of being valued for who they are.”¹⁶⁶

This reasoning, although it is aimed at defeating the inference drawn by the high court to the effect that because children have a right to shelter, so do their parents and that this is a right on demand, also implies that the rights of children in section 28(1)(c) must be seen in the context of available resources and as argument for the fact that one cannot regard this particular socio-economic right of children to shelter outside of the context of the available resources when the broader socio-economic right to housing contained in section 26 is part of a ‘carefully constructed constitutional scheme’ for the progressive realisation of socio-economic rights in general. In other words the implication is that the right of children to shelter in terms of section 28(1)(c) is no more a right on demand than is the right to housing expressed in section 26. In *Grootboom*¹⁶⁷, the respondents and the *amici* in supporting the judgment of the High Court drew a distinction between housing on the one hand and shelter on the other. They contended that shelter is an attenuated form of housing and that the state is obliged to provide shelter to all children on demand. The respondents and the *amici* emphasised that the right of children to shelter is unqualified and that, the ‘reasonable measures’ qualification embodied in ss 25(5) 26, 27 and 29 are markedly absent in relation to s 28(1)(c). The appellants disagreed and criticised the respondents’ definition of shelter on the basis that it conceives shelter in terms that limit it to a material object. They contended that shelter is more than just that, but defined it as an institution constructed by the state in which children are housed away from their parents.¹⁶⁸

The court did not accept the argument of the respondents that there is a distinction within the Constitution between housing on the one hand and shelter on the other. It argued that:

“Housing and shelter are related concepts and one of the aims of housing is to provide physical shelter. But shelter is not a commodity separate from housing. There is no doubt that all shelter

¹⁶⁶ *Grootboom* fn 10 *supra* p 80 para 70-71

¹⁶⁷ *Grootboom* fn 10 *supra*

¹⁶⁸ *Grootboom* fn 10 *supra* p 80 para 72



represents protection from the elements and possibly even from danger. There are a range of ways in which shelter may be constituted: shelter may be ineffective or rudimentary at the one extreme and very effective and even ideal at the other. The concept of shelter in s 28(1)(c) is not qualified by any requirement that it should be 'basic' shelter. It follows that the Constitution does not limit the concept of shelter to basic shelter alone. The concept of shelter in s 28(1)(c) embraces shelter in all its manifestations. However, it does not follow that the Constitution obliges the state to provide shelter at the most effective or the most rudimentary level to children in the company of their parents."¹⁶⁹

The differences in terminology between sections 26 and 28(1)(c) were not enough to convince the constitutional court that there were differences in the substance or content of the rights expressed in the two sections. The crux of the argument against seeing the rights of children to food, shelter and health care services as separate from those of other socio-economic rights, however, is contained in *Grootboom* where the constitutional court said:

"The obligation created by s 28(1)(c) can properly be ascertained only in the context of the rights and, in particular, the obligations created by ss 25(5), 26 and 27 of the Constitution. Each of these sections expressly obliges the State to take reasonable legislative and other measures, within its available resources, to achieve the rights with which they are concerned."¹⁷⁰

Again in its summary and conclusion the constitutional court noted that:

"Neither s 26 nor s 28 entitles the respondents to claim shelter or housing immediately upon demand."¹⁷¹

It is submitted that these findings and observations of the constitutional court conclusively preclude the argument that whilst minimum core obligations may not be a feature of the rights contained in sections 26 and 27 of the constitution they are applicable to those of children as expressed in section 28(1)(c) on the ground that the latter are not expressly subject to the requirement of progressive realisation within available resources.

The court in *Grootboom* observed that there is an overlap between the rights contained in sections 26 and 27 and those in 28(1)(c) in that the rights in section 26 and 27 are bestowed upon everyone whereas the rights in section 28(1)(c) are those of children only. It pointed out that:

¹⁶⁹ *Grootboom* fn 10 *supra* p 80-81

¹⁷⁰ *Grootboom* fn 10 *supra* para 74 p 81

¹⁷¹ *Grootboom* fn 10 *supra*, para 95 p 86

“Apart from this overlap, the s 26 and 27 rights are conferred on everyone including children while s 28, on its face, accords rights to children alone. This overlap is not consistent with the notion that s 28(1)(c) creates separate and independent rights for children and their parents.”¹⁷² [footnotes omitted]

The court went on to comment that 28(1)(c) does not create any primary state obligation to provide shelter on demand to parents and their children if children are being cared for by their parents or families. It further observed that this does not mean that the state incurs no obligation in relation to children who are being cared for by their parents or families and that in the first place, the state must provide the legal and administrative infrastructure necessary to ensure that children are accorded the protection contemplated by s 28¹⁷³.

From the foregoing it is thus clear that the right of children to basic health care services in terms of section 28(1)(c) is not a separate and independent right from that of their parents to access to health care services in terms of section 27(1) but rather a subset of the broader right. The right of children to health care services is primarily, but not exclusively, a right as against their parents or families¹⁷⁴. However, the state does have a responsibility, as the constitutional court pointed out in the *TAC* judgment¹⁷⁵ to create circumstances in which the

¹⁷² *Grootboom* fn 10 *supra* para 74 p 81

¹⁷³ *Grootboom* fn 10 *supra* para 78 p 82

¹⁷⁴ *Grootboom* fn 10 *supra*. The court said at p 81-82, para 76-77: “Section 28(1)(c) must be read in this context. Subsections 28(1)(b) and (c) provide: ‘Every child has the right -

(a) . . .

(b) to family care or parental care, or to appropriate alternative care when removed from the family environment;

(c) to basic nutrition, shelter, basic health care services and social services.’

They must be read together. They ensure that children are properly cared for by their parents or families, and that they receive appropriate alternative care in the absence of parental or family care. The section encapsulates the conception of the scope of care that children should receive in our society. Subsection (1)(b) defines those responsible for giving care while as (1)(c) lists various aspects of the care entitlement. It follows from ss 1(b) that the Constitution contemplates that a child has the right to parental or family care in the first place, and the right to alternative appropriate care only where that is lacking. Through legislation and the common law, the obligation to provide shelter in ss (1)(c) is imposed primarily on the parents or family and only alternatively on the State. The State thus incurs the obligation to provide shelter to those children, for example, who are removed from their families. It follows that s 28(1)(c) does not create any primary State obligation to provide shelter on demand to parents and their children if children are being cared for by their parents or families.”

See also *TAC* (fn 57 *supra* para 79 p 750) where the constitutional court observed that: “The state is obliged to ensure that children are accorded the protection contemplated by s 28 that arises when the implementation of the right to parental or family care is lacking” (footnotes omitted)

¹⁷⁵ *TAC* fn 57 *supra*, citing with approval *Grootboom* (fn 10 *supra*) in which the court said: “This does not mean, however, that the state incurs no obligation in relation to children who are being cared for by their parents or families. In the first place, the state must provide the legal and administrative infrastructure necessary to ensure that children are accorded the protection contemplated by s 28. This obligation would normally be fulfilled by passing laws and creating enforcement mechanisms for the maintenance of children, their protection from maltreatment, abuse, neglect or degradation, and the prevention of other forms of abuse of children mentioned in s 28. In addition, the state is required to fulfil its obligations to provide families with access to land in terms of s 25, access to adequate housing in terms of s 26 as well as access to health care, food, water and social security in terms of s 27. It follows from this judgment that ss 25 and 27 require the state to provide access on a programmatic and

right can be fulfilled. The right of children to basic health care services is therefore a facet of a single right of access to health care services rather than an additional and separate right to the one expressed in section 27(1) of the Constitution. In fact it would appear from the decision of the constitutional court in *Grootboom* that even a right to health care services is part of the larger bundle or system of socio-economic rights and as such, it should not be considered in isolation from these other rights. It remains to be explored whether the constitutional right of access to health care services is itself simply a facet of a larger right of access to such services or whether it in fact defines that single right in all of its facets as reflected in the various branches of South African law.

2.4.2 What is a child?

It is important to establish what is meant by the term 'child' for the purposes of the Constitution in order to establish who exactly holds the rights conferred on children in section 28 and how they may be exercised. A foetus is not a child for purposes of the Constitution¹⁷⁶. The Constitution provides that a child is a person under the age of 18 years but is silent on the subject of whether an unborn person is a child or not. Usually, in South African common law, personality is regarded as beginning at birth which means that a foetus or an unborn child cannot be the holder of legal rights except, in certain circumstances, by way of a fiction known as the *nasciturus* rule¹⁷⁷. In terms of this fiction, a

coordinated basis, subject to available resources. One of the ways in which the state would meet its s 27 obligations would be through a social welfare program providing maintenance grants and other material assistance to families in need in defined circumstances."

176

Chaakalson et al fn 67 *supra*, at 16.2 Reproductive Rights.

177

The rule was discussed in *Pinchin and Another v Santam Insurance Co Ltd* 1963 (2) SA 254 (W) in the context of a delictual claim. The full statement of the rule is '*nasciturus pro iam nato habetur quotiens de commodo eius agitur*' Hiemstra J observed that: "The legal question is crisply: Does a person have an action in respect of injury inflicted on him while he was still a foetus in his mother's womb? This looks like a philosophical conundrum as much as a legal one, but such philosophy as I have found on the question, seems to have come from the Delphic oracle. Professor Martin Verfeld tells us in *Acta Juridica*, 1960 p. 2: "St Thomas Aquinas drives things right back to the first fundamental truth that as justice presupposes right, so right presupposes that in the first place man should be there. Before you can have a right, you must be. 'It is through creation that the created being first comes to have rights.' He deduces from this, incidentally, that man had no right to creation and that God owed man nothing, since right and justice are a consequence of creation and do not merely precede it." The court then referred to Roman Law, D.1.5.7, where it is stated that "A child in its mother's womb is cared for just as if it were in existence, whenever its own advantage is concerned; but it cannot benefit anyone else before it is born." and D.1.5.96 in which it is stated that: "Those who are unborn are, by almost every provision of the Civil Law, understood to be already in existence, this is only true where his rights are in question, but no advantage accrues to others unless they are actually born." The court also referred to an American case, *Smith v Luckhardt* (1939) and a note in 13 *Tulane Law Review* (1939) provoked by the decision of the Illinois Appellate Court in this case. The facts were that a minor sued the defendant physicians for injuries sustained before birth. They had wrongfully diagnosed the pregnancy of the plaintiff's mother as a tumour of the uterus and tried to destroy it by X-ray treatment. As a result the plaintiff was born "a cripple and feeble-minded". The facts of *Smith v Luckhardt* offer an important reminder to

foetus is deemed to have the rights of a child if it is subsequently born alive. Initially it was applied only in the law of succession but the *Santam*¹⁷⁸ case extended it to the law of delict. The obvious question for anti-abortionists was whether the nasciturus rule could be applied to protect the life of an unborn child in a situation in which the mother desires to terminate the pregnancy. Could it be argued that a foetus has the right to life by virtue of an application of the nasciturus rule? This argument was tested in the first *Christian Lawyers* case discussed below¹⁷⁹.

2.4.2.1 *Christian Lawyers Association of South Africa v Minister of Health*¹⁸⁰

Facts

In *Christian Lawyers Association of South Africa and Others v Minister of Health and Others*¹⁸¹, the court had to consider whether the Choice on Termination of Pregnancy Act, 1996 (Act No 92 of 1996) was unconstitutional and should be struck down in its entirety on the basis that it infringed the right to life of a foetus¹⁸². The plaintiffs sought an order from the court declaring the Choice on Termination of Pregnancy Act¹⁸³ to be unconstitutional and striking it down in its entirety on the basis that section 11 of the Constitution, which provides that '(e)veryone has the right to life', applied also to unborn children from the

those in the health sector who may be tempted to draw the inference that because a foetus is not regarded as a child for purposes of the Constitution, it has no rights at common law. The application of the nasciturus rule in *Santam* so as to allow a claim in delict for wrongful injury sustained by a foetus while it was still in its mother's womb where it was subsequently born alive should not be discounted by those rendering health services to pregnant mothers.

178

Santam fn 177 *supra*

179

Christian Lawyers (No 1) fn 21 *supra*

180

Christian Lawyers (No 1) fn 21 *supra*

181

Christian Lawyers (No 1) fn 21 *supra*

182

Christian Lawyers (No 1) fn 21 *supra*. The court observed at 1118 that: "The plaintiffs' cause of action, founded, as it is, solely on s 11 of the Constitution, is therefore dependent for its validity on the question whether 'everyone' or 'every person' applies to an unborn child 'from the moment of the child's conception'. The answer hereto does not depend on medical or scientific evidence as to when the life of a human being commences and the subsequent development of the foetus up to date of birth. Nor is it the function of this Court to decide the issue on religious or philosophical grounds. The issue is a legal one to be decided on the proper legal interpretation to be given to s 11. I am in agreement with the dictum of the Canadian Supreme Court in *Tremblay v Daigle* (1989) 62 DLR (4th) 634 (SC) at 650a-c, where the following is said: "The respondent's argument is that a foetus is an "etre humain", in English "human being", and therefore has a right to life and a right to assistance when its life is in peril. In examining this argument it should be emphasised at the outset that the argument must be viewed in the context of the legislation in question. The Court is not required to enter the philosophical and theological debates about whether or not a foetus is a person but, rather, to answer the legal question of whether the Quebec Legislature has accorded the foetus personhood. Metaphysical arguments may be relevant but they are not the primary focus of enquiry. Nor are scientific arguments about the biological status of a foetus determinative in our enquiry. The task of properly classifying a foetus in law and in science are different pursuits. Ascribing personhood to a foetus in law is a fundamentally normative task. It results in the recognition of rights and duties - a matter which falls outside the concerns of scientific classification. In short, this Court's task is a legal one."

183

Choice on Termination of Pregnancy Act fn 35 *supra*

moment of conception. The defendants excepted to the plaintiffs' particulars of claim on the ground that they did not disclose a cause of action because section 11 conferred no rights on a foetus and did not preclude the termination of pregnancy in the circumstances and manner contemplated by the Act.

Judgment

With regard to the question of whether or not a foetus should be regarded as a person for the purposes of the Constitution, the court made some observations¹⁸⁴ which are quoted below because they conveniently encapsulate some of the prior jurisprudence on the subject of the legal personality of a foetus in South African law:

"I turn to consider the question whether the word 'everyone' in s 11 includes the unborn child. It is desirable that some consideration be given to the common-law status of the foetus. A word of caution should perhaps first be sounded. In the particulars of claim the plaintiffs allege that the foetus qualifies for protection under s 11 because 'the life of a human being starts at conception' and by implication therefore that human beings are from conception a person as envisaged by the said section. This is a *non sequitur*. As pointed out by Professor Glanville Williams in an article entitled 'The Foetus and the Right to Life' (1994) 33 *Cambridge Law Journal* 71 at 78 'the question is not whether the *conceptus* is human but whether it should be given the same legal protection as you and me'. In *Van Heerden and Another v Joubert NO and Others* 1994 (4) SA 793 (A) the Appellate Division of the Supreme Court (as it then was) considered various dictionary meanings of the word 'person' (*inter alia* 'an individual human being') and concluded (at 796F) that there is no suggestion in any of these meanings that the word 'person' can also connote a stillborn child, an unborn child, a viable unborn child, an unborn human being or a living foetus."¹⁸⁵

The court came to the conclusion that if section 28 of the Constitution, the section specifically designed to protect the rights of the child, does not include the foetus within the ambit of its protection then it can hardly be said that the other provisions of the bill of

¹⁸⁴ *Christian Lawyers*, (No 1) fn 21 *supra* at 1120 to 1121

¹⁸⁵ *Christian Lawyers*, (No 1) fn 21 *supra*. The constitutional court observed that: "The Court went on, however (at 797H–798B) to point out that there are a growing number of jurists who hold the view that the application of the *nasciturus pro iam nato habetur quotiens de commodo eius agitur* rule of the Roman law amounts to predating the legal subjectivity of the foetus. Thus, P J J Olivier *Legal Fictions: An Analysis and Evaluation* (Doctoral Thesis Leiden) and L M du Plessis 'Jurisprudential reflections on the status of unborn life' 1990 TSAR 44 maintain that the foetus is recognised as a legal persona and is protected as such. As pointed out by Professor Du Plessis, the decision in *Pinchin and Another NO v Santam Insurance Co Ltd* 1963 (2) SA 254 (W), in which a person's right to claim, after birth, compensation for injuries sustained in *ventre matris*, was recognised, makes sense only if it is assumed that that person was indeed in law a *persona* at the time when the injuries were sustained. The status of the foetus under our common law was left open in *Van Heerden's case supra*. The Appellate Division decided that, even if it is to be assumed that a stage has been reached in our legal development where the law recognises the foetus as a legal persona, the Legislature had no such legal persona in mind when it used the word 'person' in the legislation there under consideration, namely the Inquests Act 58 of 1959. There are South African decisions denying the foetus legal personality - see *Christian League of Southern Africa v Rall* 1981 (2) SA 821 (O) at 829 *in fin*; *Friedman v Glickman* 1996 (1) SA 1134 (W) at 1140G. It is not necessary for me to make any firm decision as to whether an unborn child is a legal persona under the common law. What is important for purposes of interpreting s 11 of the Constitution is that, at best for the plaintiffs, the status of the foetus under the common law may, as at present, be somewhat uncertain."

rights, including section 11, were intended to do so. This conclusion, said the court, finds further support in the fact that in all the provisions of the Bill of Rights, other than those in which a specific class of person is singled out for special protection, the rights are conferred on 'everyone'. Yet in many instances it is clear that the term 'everyone' could not have been intended to include the foetus within the scope of its protection. Thus, the right not to be deprived of one's freedom (section 12(1)(a)), not to be detained without trial (section 12(1)(b)), to make decisions concerning reproduction and to security in and control over one's body (section 12(2)(a) and (b)), not to be subjected to slavery, servitude or forced labour (section 13), rights relating to privacy and freedom of conscience, religion, thought, belief, opinion, expression, assembly, association and movement (sections 14, 15(1), 16(1), 17, 18 and 21) and other rights in regard to language, cultural life, arrest and detention (ss 30 and 35) are all afforded to 'everyone' and clearly do not include a foetus.

The court held that to include the foetus in the meaning of that term in section 11 would ascribe to it a meaning different from that which it bears everywhere else in the bill of rights and that, in the courts view was untenable¹⁸⁶.

Discussion

The statement of the court concerning the status of the foetus under the common law is being 'somewhat uncertain' is, it is submitted, somewhat unfortunate given the ruling in the *Santam*¹⁸⁷ case insofar as it may cast doubt upon the right of a child who is subsequently born alive to take legal action for delictual harm caused to it whilst *en ventre matris*. It appears, at least partly, to contradict the court's earlier statement that it is desirable that some consideration be given to the common-law status of the foetus and its observation that there is a growing number of jurists who hold the view that the application of the *nasciturus pro iam nato habetur quotiens de commodo eius agitur* rule of the Roman law amounts to precluding the legal subjectivity of the foetus. It is submitted that the positions of the common law and the Constitution on the subject of rights attributable to a child whilst still in its mother's womb are reconcilable in logical terms and that the *nasciturus* fiction is

¹⁸⁶ *Christian Lawyers (No 1)* fn 21 *supra* at p1122

¹⁸⁷ *Santam* fn 177 *supra*

a valuable part of South African jurisprudence which should not be undermined. The important point about the arguments in the *Christian Lawyers*¹⁸⁸ case was that the *nasciturus* rule did not and could not logically assist arguments regarding the constitutional right to life of a *conceptus* because it begged the question as to whether or not it would be born alive. The *nasciturus* rule, even if it does confer legal subjectivity on a foetus, contains a suspensive condition. The child must subsequently be born alive. If it is not born alive then no rights accrue. Questions of the termination of the pregnancy negate the possibility of fulfilment of this suspensive condition within the *nasciturus* rule. This does not mean that the *nasciturus* rule should be discarded or that the decision in the *Santam*¹⁸⁹ case was wrong. This would be throwing the baby out with the bathwater. Whilst it may not be logically possible to apply the *nasciturus* fiction to the right to life, what about the other rights in the Constitution? If the bodily integrity of a child is breached *in utero* so that she is subsequently born disabled should she have a right of action? If a pregnant mother presents at a hospital with foetal distress and the unborn baby is denied emergency medical treatment with the result that he is born with cerebral palsy should there be no right of recourse for the child?

The court in *Christian Lawyers*¹⁹⁰ observed that:

“There is no express provision affording the foetus (or embryo) legal personality or protection. It is improbable, in my view, that the drafters of the Constitution would not have made express provision therefor had they intended to enshrine the rights of the unborn child in the bill of rights, in order to cure any uncertainty in the common law and in the light of case law denying the foetus legal personality. One of the requirements of the protection afforded by the *nasciturus* rule is that the foetus be born alive. There is no provision in the Constitution to protect the foetus pending the fulfilment of that condition.”

Does this mean then, that for purposes of any of the rights contained in the Bill of Rights, the *nasciturus* rule cannot be applied? It is submitted that this question stands at the interface of constitutional and common law. It provokes a further question. If the *nasciturus* rule is inapplicable to rights conferred by the Constitution then why should it remain applicable to rights conferred at common law? In *Van Heerden and Another v Joubert NO*

¹⁸⁸ *Christian Lawyers* (No 1) fn 21 *supra*

¹⁸⁹ *Santam* fn 177 *supra*

¹⁹⁰ *Christian Lawyers* (No 1) fn 21 *supra* at p1122



*and Others*¹⁹¹, the Appellate Division had to consider the question of whether a stillborn baby was a person for the purpose of the Inquests Act, 1959 (Act No 58 of 1959). As the court pointed out in this case, the main objects of an inquest are to determine the cause of death, the circumstances surrounding the death, whether any person was responsible for such death, and whether the death can be attributed to the commission of any offence. It observed that:

“The State has an interest in the proper investigation of deaths due to other than natural causes. Even if nobody can be held responsible for a death in a particular case, it may still remain pertinent to determine the circumstances and cause of death in order that appropriate measures can be taken to prevent similar occurrences. There might therefore be reasons to proceed with an inquest in the present case. The question however remains whether the provisions of the Act are wide enough to confer jurisdiction upon the magistrate to do so. That in turn depends on the meaning of the word ‘person’ in the context of the Act.”¹⁹²

The court after studying dictionary definitions of the term “person” came to the conclusion that there was no suggestion in any of the dictionary meanings that the word ‘person’ can also connote a stillborn child, an unborn child, a viable unborn child, an unborn human being, or a living foetus. Significantly, the court then turned to the decision of the American Supreme Court in *Roe v Wade*¹⁹³. It also referred to *R v Tait*¹⁹⁴ in which the Court of Appeal held that a threat to a pregnant woman to kill her foetus was not a threat to kill a person under the Offences Against a Person Act, 1861. On the strength of these decisions the court came to the conclusion that the word ‘person’ in the context of the Inquests Act does not include an unborn child.

Counsel for the respondents relied on *Santam*¹⁹⁵ and its application of the *nasciturus* rule in the context of the law of delict. The court skirted the question of whether the application of the *nasciturus* rule in terms of the law of delict supported its conclusion that a stillborn child was not a person for purposes of the Inquests Act by saying that the issue was not whether a foetus should be regarded as a legal *persona* or to what extent life before birth should be protected, but whether the Act applies to the present case. It observed that had the

191 *Van Heerden and Another* 1994 (4) SA 793 (A)

192 *Van Heerden and Another* fn 191 *supra* at 795

193 *Roe* 410 US 113 (1973)

194 *Tait* [1990] 1 QB 290 (CA)

195 *Santam* fn 171 *supra*

drafters of the Constitution wished to protect the foetus in the bill of rights at all, one would have expected this to have been done in section 28, which specifically protects the rights of the child. The right of every child to family or parental care (28(1)(b)), to basic nutrition, health care and social services (28(1)(c)), to protection against maltreatment, neglect, abuse or degradation (28(1)(d)), and to legal representation (28(1)(h)), as well as the provision in ss (2) that a child's best interests are of paramount importance in every matter concerning the child, would have been particularly apposite to protect the foetus as well. Yet, said the court, there are clear indications that the safeguards in section 28 do not extend to protect the foetus. A 'child' for purposes of the section is defined in subsection (3) as a person under the age of eighteen years. In the court's view, age commences at birth. The protection afforded by subsections (1)(f)(i) and (1)(g)(ii) is dependent on the 'child's age'. A foetus is therefore not a 'child' of any 'age'. It said that the rights afforded by section 28(1) are in respect of 'every child' - i.e. all children. Yet certain of the rights could not have been intended to protect a foetus; para (f) relates to work, para (g) to detention and (i) to armed conflict. The protection afforded in the other paragraphs of subsection (1) must accordingly also exclude the foetus.

The Constitution itself is forward looking. Section 24(b) states that everyone has the right to have the environment protected, for the benefit of present and future generations, through reasonable legislative and other measures. Future generations are persons not yet conceived let alone not yet born. The question, in the light of the foregoing discussions is whether the as yet unborn generations would have the right, when they are subsequently born to take legal action against a previous generation for damage to the environment? The answer, it is submitted, lies in the wording of section 24(b) which says 'everyone' has the right. In accordance with the arguments above, an unborn generation would only have the right to take legal action after it was born in which case it would then be included in the category of 'everyone'. It could take action for the benefit of its own and future generations to protect the environment. Whether or not it could take action, on the basis of the *nasciturus* rule, in terms of the law of delict for damage to the environment whilst it was in its mother's womb is a matter which has still to come before the courts and which is beyond the scope of this chapter. Presumably the notion of 'environment' would have to be

the immediate environment of the pregnant mother and the damage to the environment would have to be such that the unborn child sustained some harm. If it was the environment, as opposed to the foetus, that sustained the harm so that the foetus, when subsequently born could no longer enjoy it because it has been rendered dangerous to health or well-being, the issue becomes interesting from a constitutional law point of view. Should the matter be treated as a constitutional violation or a constitutional delict? If the latter then the *nasciturus* rule might apply, if the former then possibly not, depending upon how uncertain the constitutional court perceives the *nasciturus* rule to be.

At a general level, one cannot help but feel a certain measure of unease with the judgement in *Christian Lawyers*¹⁹⁶. The logic seems devoid of the value considerations which are so central to constitutional issues generally and the rights in the Bill of Rights in particular. Human dignity, as noted before, is a not only a right but a constitutional value, and the court seems to have taken scant cognisance of this in its judgment. It is submitted that the question of whether or not a foetus is a person and therefore capable of being the holder of the right to life is only one aspect of abortion. Whilst it is not submitted that the court necessarily erred in its finding that a foetus cannot be the bearer of constitutional rights, its approach to the concept of balancing not only the rights of the mother and the foetus, but also the interests and values of an open and democratic society against those of the mother was possibly overly simplistic. The idea that because a foetus cannot logically hold some of the other rights in the Constitution which are conferred upon everyone, it cannot also hold the right to life does not bear scrutiny.¹⁹⁷ One cannot help but get the impression from the

¹⁹⁶*Christian Lawyers* (No 1) fn 21*supra*¹⁹⁷

The decision in *Christian Lawyers* (fn 21*supra*) has been criticised by Naudé T 'The Value of Life: A Note on Christian Lawyers Association of SA v Minister of Health' (1999) 15 *SAJHR* 541. The writer comments that: "Surprisingly, McCreath J did not commence his enquiry into the meaning of the word 'everyone' by considering relevant constitutional provisions. Instead he investigated the common law status of the foetus. He also asked whether a foetus would fall under the definition of 'person' in the Inquests Act 58 of 1959. Such an approach turns the proper enquiry on its head. The Constitution should be a yardstick against which the common law and legislation must be measured. The Constitution cannot serve as a yardstick if the interpreter's point of departure is to establish the meaning of constitutional provisions by reference to the common law and ordinary legislation...But it may be noted that instead of also asking whether the common law deems foetal life worthy of protection, McCreath J only focused on the question of whether the foetus is a 'person'. His discussion centred on the nasciturus fiction which protects the foetus's patrimonial interests. Criminal law, which does regard foetal life as worthy of protection, was not considered." In the view of Naudé, the central shortcoming in McCreath J's approach "was that he though he could resolve the dispute by consideration of the word 'everyone'. This probably flows from his predominantly text-based or 'literalist' and 'intentionalist' approach to constitutional interpretation. The limitations of a purely text-based approach, especially in the context of constitutional interpretation, have often been pointed out... These limitations are illustrated by the startling results flowing from the court's unritical application of the rule that the word 'everyone' should be given the same meaning wherever it appears in the legislative text." Commenting on McCreath J's reasoning that because 'everyone' in section 11 means the same as 'everyone' elsewhere in the Constitution, the foetus must be the bearer of all the other fundamental rights and because it clearly cannot be such a bearer of all the other rights, it is therefore excluded from the term 'everyone' in s 11, Naudé states that this is a

judgment of McCreath J that there is no wrongdoing in harming a foetus – even outside of the context of abortion - and that this is entirely consistent with constitutional values. In terms of even the common law the unfeeling message is if one negligently or intentionally harms a foetus, one should hope that it does not survive to sue for damages consequent upon such harm. It was possibly a weakness of the case made by the applicants that they seem to have based it purely upon the right to life of the foetus as a person as opposed to the some of the arguments cited by Naudé in the article referred to in footnote 226. Whilst it is not disputed that the question before the court had to be decided on the grounds of legal logic and law rather than philosophical or religious questions and that the decision of the court may well be correct in terms of its ultimate result, i.e. the constitutional validity of the Choice on Termination of Pregnancy Act, the logic by which the court reached its decision could still prove problematic in the future.

2.4.2.2 *Christian Lawyers Association vs Minister of Health (No 2)*¹⁹⁸

Facts

The plaintiff instituted an action in which it sought an order declaring sections 5(2) and 5(3) read with the definition of “woman” in sections 1 and 5(1) of the Choice On

startling argument. The writer states that a newborn baby is clearly not intended to be the bearer of rights such as freedom of conscience and the right to reproductive freedom yet no-one would suggest that it therefore cannot be the bearer of some of the other rights protected in a28 or of the right to life, and that legislation allowing termination of babies lives could never be unconstitutional. Naudé observes further that “Regardless of whether the foetus is the bearer of the right to life, permissive abortion legislation may be open to constitutional challenge. It could be attacked on the basis that the state has a positive duty to respect, protect, promote and fulfil the rights in the Bill of Rights...Provisions such as as 7(2),1,2 and 39 and the Constitutional Court’s approach to interpretation show that the entrenched rights do not function as negative-defensive rights guaranteeing protection against the state and others only, but also as objective norms expressing values that must be promoted by the state and the courts. A court does not have to find that a specific individual’s constitutional right has been infringed before declaring challenged legislation unconstitutional. The question is rather whether, objectively, the legislation conflicts with the value norms laid down by the Constitution. That these values function as objective norms implies that the formulation of constitutional provisions as ‘rights’ does not mean that these ‘rights’ function only as ‘subjective rights’ with a demonstrable bearer. They have a normative power in objective law...” According to Naudé, the “question whether abortion legislation may conflict with the Constitution on the basis that it does not adequately protect foetal life, even if the foetus is not a constitutional rights bearer, has not been much debated in South Africa. ‘Anti-abortionists’ usually insist that the foetus has the right to life. ‘Pro-choicers’ who conceded that the state has an ‘interest’ in regulating abortions which thus limits the woman’s rights usually do not consider the existence of a constitutional duty to do so. Naudé refers to the work of Meyerson in *Rights Limited* in which the latter argues that the wording of section 36 of the Constitution means that, when limitation of rights are considered, only arguments which would carry at least some weight with all reasonable people who relate to each other as possessors of equal status may be considered and that limitation of rights may only take place to avoid harms which all reasonable people would seek to avoid regardless of their conception of ‘the good’. Reference is also made to the fact that German courts and academics have used and debated the idea that the objective value order created by the Constitution may give rise to justiciable constitutional duties on the state and that it is this concept of Grundrechte as value-deciding norms creating an objective value order which lead to a recognition that permissive abortion legislation may be unconstitutional, even though the foetus is not a person. The Spanish constitutional court has also, according to Naudé followed this approach by recognising foetal life as a constitutionally protected legal interest, whilst conceding that the foetus is not a person and not the bearer of the right to life.

Termination of Pregnancy Act 92 of 1998 (“the Act”) to be unconstitutional and an order striking down sections 5(2) and 5(3) and the definition of “woman” in section 1 of the Act.

The provisions of the Act against which the plaintiff’s claim was directed are those that allow women under the age of 18 years to choose to have their pregnancies terminated without (a) the consent of the parents or guardians, (b) consulting the parents or guardians, (c) first undergoing counselling, and (d) reflecting on their decision or decisions for a prescribed period. The measures in (a) to (d) are collectively referred to as parental consent or control. In essence the plaintiff’s case was that young women or girls below that age are not capable on their own – without parental consent or control – to take an informed decision as to whether or not to have a termination of pregnancy which serves their best interests. In order to succeed the plaintiffs had to establish that the relevant provisions of the Act were in conflict with those of the Constitution.

The plaintiffs argued that a pregnant girl requires special protection by the state *inter alia* by ensuring that when enacting legislation which affects her she is not deprived in any way of the support, guidance and care of her parents/guardian and/or counsellor. Essentially the plaintiffs attacked the provisions of the Act on the grounds that there were unconstitutional because they permit a woman under the age of 18 years to choose to have her pregnancy terminated without parental consent or control. The defendants filed an exception to the plaintiff’s claims on the grounds that the conclusions in law with regard to the plaintiff’s claims and the overall conclusions that flow therefrom are not supported by the facts on which they are based.

Judgment

Mojapelo J in giving judgment noted that it was necessary when considering the issues raised to bear in mind the statutory provisions that came under attack in this case. The relevant sections of the Act provide as follows:

In section 1 of the Act the word “woman” is defined thus:

“ ‘woman’ means any female person of any age”.

Subsections 5(1) and 5(3) provide that:

- (1) Subject to the provisions of (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 (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: provided that the termination of the pregnancy shall not be denied because such minor chooses not to consult them.

Subsections (4) and (5) deal with exceptional cases and were irrelevant for the purposes of the judgment. They cover situations in which a woman is severely mentally disabled or in a state of continuous unconsciousness or where medical practitioners are of the opinion that continued pregnancy would pose the risk of injuries to the woman’s physical or mental health, where there exists a substantial risk that the foetus would suffer from severe physical or mental abnormality, where continued pregnancy would endanger the woman’s life, result in severe malformation of the foetus or pose a risk of serious injury to the foetus.

The court observed that the constitutional pegs on which the plaintiff hung its case were sections 28(1)(b), 28(1)(d) and 9(1) read with section 7(1) of the Constitution. Section 28(1) stipulates that -

“Every child has the right to family care or parent care”.

Section 28(1)(d) stipulates that -

“Every child has the right to be protected from maltreatment, neglect, abuse or degradation”.

Section 28(2) provides that “A child’s best interests are of paramount importance in every matter concerning the child.” Section 9 (1) provides that -

“Everyone is equal before the law and has the right to equal protection and benefit of the law.” Section 7(1) reads “This Bill of Rights is a cornerstone of democracy in South Africa. It enshrines the rights of all people in our country and affirms the democratic values of human dignity, equality and freedom.”

Mojapelo J remarked that the Act regulates the termination of pregnancy of women and that the principal rules by which it does so are as follows:

- (a) The termination of a pregnancy may only be done with the *informed consent* of the woman.
- (b) If she gives her informed consent to the termination of her pregnancy, no other consent is required (section 5(1) and 5(2)).
- (c) During the first twelve weeks of pregnancy, no more is required than the woman’s informed consent.
- (d) Thereafter a pregnancy may only be terminated in certain circumstances (section 2).
- (e) The termination may only be performed by a medical practitioner or, if it is performed during the first twelve weeks, by a registered midwife who has completed a prescribed training course (section 2(2)).
- (f) The termination may only be performed at a facility designated by the Minister (section 3(1)).
- (g) A pregnancy may not be terminated unless two medical practitioners or a medical practitioner and a registered midwife who has completed a prescribed course consent thereto (proviso to section 5)

The court pointed out that the Act also has the following ancillary provisions regulating the termination of the pregnancy: The state is obliged to promote the provision of counselling to women before and after the termination of the pregnancy. The counselling is, however, not mandatory or directive (section 4). Young women (below the age of 18 years) are

encouraged to consult with their parents, guardians, family members or friends before termination of their pregnancy. The medical practitioner or midwife who performs the termination must advise them to do so before their pregnancy is terminated. The actual final decision is, however, left to them as to whether or not to consult with their parents, guardians, family members and/or friends (section 5(3)). The medical practitioner or midwife who performs the termination must inform the woman of her rights under the Act (section 6). Mojapelo J stated that it is not therefore as if the legislature left the termination of pregnancy totally unregulated. He noted that the cornerstone of the regulation of termination of pregnancy of a girl and indeed any woman under the Act is the requirement of her “informed consent”. No woman, regardless of her age, may have her pregnancy terminated unless she is capable of giving her informed consent to the termination and in fact does so. The court therefore considered it necessary to consider the juridical meaning and effect of the requirement of informed consent.

After noting that the Act does not elaborate on what is meant by “informed consent” Mojapelo J pointed out that the concept is not alien to the common law. He stated that it forms the basis of the doctrine of *volenti non fit injuria* that justifies conduct that would otherwise have constituted a delict or crime. More particularly, he said, day to day invasive medical treatment, which would otherwise have constituted a violation of a patient’s right to privacy and personal integrity, is justified and lawful only because as a requirement of the law, it is performed with the patient’s informed consent.¹⁹⁹ Mojapelo J stated that it has come to be settled in South African law in this context that the informed consent requirement rests on the three independent legs of *knowledge, appreciation and consent*. He noted that the courts, in order to found a defence of consent, have often endorsed the statement by Innes CJ in *Waring & Gillow v Sherbourne*²⁰⁰ that:

“It must be clearly shown that the risk was known, that it was realised, that it was voluntarily undertaken. Knowledge, appreciation, consent – there are the essential elements; but knowledge does not invariably imply appreciation, and both together are not necessarily equivalent to consent.”

¹⁹⁹ The court referred in this regard to *Van Wyk v Lewis* 1924 AD 438 at 451; *Castell v de Greeff* 1994 (4) SA 408 (C) at 425; *C v Minister of Correctional Services* 1996 (4) SA 292 (T) at 300; Neethling J, Potgieter JM and Visser PJ: *Law of Delict*, 3rd ed p100-101; Neethling: *Persoonlikheidsreg*, 4th ed p 121-122.

²⁰⁰ *Waring* 1904 TS 340 at 344

The requirement of ‘knowledge’, said Mojapelo J, means that the woman who consents to the termination of a pregnancy must have full knowledge of the nature and extent of the harm or risk. The requirement of ‘appreciation’ implies more than mere knowledge. The woman who gives consent to the termination of her pregnancy “must also comprehend and understand the nature and extent of the harm or risk”. The last requirement of ‘consent’, said Mojapelo J, means that the woman must “in fact subjectively consent” to the harm or risk associated with the termination of her pregnancy and her consent “must be comprehensive” in that it must extend to the entire transaction inclusive of its consequences”.

The court then turned to the question of the capacity to consent and noted that in this context, valid consent can only be given by someone with the intellectual and emotional capacity for the required knowledge, appreciation and consent. Because consent is a manifestation of will “capacity to consent depends on the ability to form an intelligent will on the basis of an appreciation of the nature and consequences of the act consented to”²⁰¹. Mojapelo J said that young and immature children do not have the capacity for real knowledge, appreciation and consent. Such young and immature children therefore would not qualify under the Act to access the rights to termination of pregnancy because they are incapable of complying with the important jurisdictional requirement of giving informed consent. If such children are to be considered for termination of pregnancy, then in such a case, the normal common law rules that require the consent to be given by or with the assistance of the guardian must necessarily kick in²⁰². He noted that what the Act does not do is to fix a rigid age or number of years for the kicking in of such rules. Instead of using age as a measure of control or regulation, the legislature resorted/opted to use capacity to give informed consent as a yardstick. Where such capacity exists, said Mojapelo J, the Act recognises it in spite of the youthfulness or age of the person. Where it does not exist, then no such recognition is given, again in spite of youthfulness or age of the candidate for termination of pregnancy.

²⁰¹ The court referred to the case of *Van Heerden and Others* as cited in Boberg P *Law of Persons and the Family*, 2nd ed at p 849.

²⁰² Mojapelo J referred to *S v Marx* 1962 (1) SA 848 (N) at p 854 in this regard

A girl or any woman has the capacity to consent to the termination of her pregnancy and its concomitant invasion of her privacy and personal integrity only if she is “in fact mature enough to form an intelligent will” said the court. The court held that, within the context of the Act, actual capacity to give informed consent as determined in each and every case by the medical practitioner based on the emotional and intellectual maturity of the individual concerned and not on arbitrarily predetermined and inflexible age or fixed number of years is the distinguishing line between those who may access the option to terminate their pregnancies unassisted on the one hand and those who require assistance on the other. Following on from this conclusion, it found that it would be incorrect to approach the matter as if the Act is totally blind to the question of youth or minority. The court pointed out that the Act has specific provisions dealing with minors. In the case of a pregnancy minor, a medical practitioner or registered midwife is enjoined in peremptory language to advise the minor to consult with her parents, guardians, family members or friends before the pregnancy is terminated. The person performing the termination of pregnancy has no choice in this regard. This is a further regulatory measure of the Act but not a cornerstone of regulation under the Act said Mojapelo J. The injunction is thus subject to the proviso that the termination of pregnancy shall not be denied if such minor, having been duly advised, should choose not to consult with her parents, family members or friends. The court held that this was a useful provision that prevented frustration of a constitutional right when the minor is in fact emotionally and intellectually able to give informed consent to the procedure. A medical practitioner or registered midwife who is not satisfied that the pregnant minor has the capacity to give informed consent should therefore not perform the termination of pregnancy on such a minor. This of course applies equally to pregnancy minors and pregnancy adults, said Mojapelo J. If in such a case the medical practitioner or registered midwife performs the termination of pregnancy without the informed consent of his or her patient, his or her conduct will not be in accordance with the Act and will accordingly be unlawful. The court held that informed consent required by the Act is thus a consent that can be given by each and every person having the capacity to do so. It is a threshold with both intellectual and emotional attributes and those performing the termination of pregnancy operations have to satisfy themselves that it is met.



The court then went on to explore the *ratio* behind informed consent. It stated that an examination of the rationale behind the requirement of informed consent in medical procedures brings one to the very foundation principles of and from which the right to termination of pregnancy in itself arises. Referring to the case of *Castell v De Greef*²⁰³, Mojapelo J stated that Ackerman J on behalf of the full bench of the CPD made it clear that the ratio for that requirement was to give effect to the patient's fundamental right to self-determination. He quoted from the judgment at 420J where the court said that it was: "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" and at 426E where it stated that "it is in accord with the fundamental right of individual autonomy and self determination to which South African law is moving. This formulation also sets its face against paternalism, from many other species whereof South Africa is now turning away." Mojapelo J pointed out that the Transvaal Provincial Division recently endorses the approach in *Castell* on the basis of the patient's right to exercise her "fundamental right to self determination" in *C v Minister of Correctional Services*²⁰⁴. He held that the fundamental right to self determination itself lies as the very heart and base of the constitutional right to termination of pregnancy and pointed out that the recognition of the right of every individual to self determination has now become an imperative under the constitution and particularly in terms of the provisions of section 12(2)²⁰⁵, 27(1)(a)²⁰⁶, section 10²⁰⁷ and section 14²⁰⁸ of the Constitution. It is recognition of these rights, said Mojapelo J, that provides a foundation for the right to termination of pregnancy in South Africa. The Constitution recognises and protects the right to termination of pregnancy or abortion in two ways, firstly under section 12(2)(a), that is, the right to bodily and psychological integrity, and secondly, under section 12(2)(b), that is, the right to control over one's body. The court held that the closeness or commonality of the source of the right to termination of pregnancy with the *ratio* for informed consent make informed consent not only a viable and desirable principle for the regulation of the right but also the most

²⁰³ *Castell* fn 199 *supra*

²⁰⁴ *C v Minister of Correctional Services* fn 199 *supra* at p 300

²⁰⁵ Everyone has the right to bodily and psychological integrity which includes the right to make decisions concerning reproduction and the security and control over their body.

²⁰⁶ Everyone has the right to have access to reproductive health care.

²⁰⁷ Everyone has inherent dignity and the right to have their dignity respected and protected.

²⁰⁸ Everyone has the right to privacy

appropriate. It stated that the Constitution not only permits the Choice on Termination of Pregnancy Act to make a pregnant woman's informed consent the cornerstone of its regulation of the termination of her pregnancy, it requires the Act to do so. To provide otherwise would itself be unconstitutional.

Mojapelo J observed that the plaintiff alleged that a girl below the age of 18 years is not capable of giving informed consent as required by the Act, i.e. to make the decision whether or not to have a termination of her pregnancy which serves her best interests without the assistance and/or guidance of her parents, guardian or counsellor. He noted that the plaintiff argued that it is because such a person is not in a position to appreciate the need for and value of parental care and support. Mojapelo J stated that if indeed this were to be so then the very incapacity to give informed consent would disqualify such a girl from accessing the right to terminate her pregnancy. He found that the plaintiff's approach is a rigid approach to maturity which is blind to the fact of life that there will be women below the age of 18 years who are in fact mature, much as there will be those above that age (or any fixed age) who are in fact immature. He said that it failed to recognise and accommodate individual differences and that this was a major flaw or weak link in the plaintiff's case.

Mojapelo J said that when considering the validity of an exception to the particulars of claim on the basis that such particulars of claim do not disclose a cause of action, the proper judicial approach is that the allegations in such particulars of claim must be accepted as true. The plaintiff, the defendant and the *amicus curiae* all agreed on this point. He noted that what had to be accepted as true in the present case includes the allegation in paragraph 20.2 of the plaintiff's particulars of claim that a woman under the age of 18 "is not capable of giving informed consent" as required in section 5(1) of the Act. He stated that this approach is fatal to the plaintiff's claim as formulated as the allegations in this paragraph of the plaintiff's particulars of claim form part of the introductory portion of the particulars and therefore relate to the three claims which made up the entire claims of the plaintiff. He said that on the basis of the truth of the allegation in the plaintiff's particulars of claim that a girl under the age of 18 is incapable of giving informed consent then on the proper

interpretation of informed consent, such a girl will for that reason be excluded from accessing the termination of pregnancy right under the Act because such consent is the cornerstone of the regulation and a prerequisite for the exercise of the right. He stated that it is in this regard that the offending paragraph was fatal to the plaintiff's claim. The plaintiff and the amicus curiae, said the court, ostensibly did not agree with the generalised statement in the particulars of claim that a girl under the age of 19 is incapable of giving informed consent. However, as a matter of correct approach to the allegations in the particulars of claim they both argued that the allegations in the particulars of claim must be accepted as true. Save for that purpose, however, they expressly reserved for themselves the right to challenge the truth of the statement in paragraph 20.2 of the plaintiff's particulars of claim. He stated that the particulars of claim were only being considered for the purposes of the exception and for no other purpose and that for that direct purpose of determination of the issue in the present judgment, the court must accept that girls under the age of 18 years are incapable of giving informed consent. He further noted that section 5(1) of the Act provides that the termination of pregnancy may only take place with the "informed consent of the pregnant woman". The implications of paragraph 20.2 of the particulars of claim are therefore that girls who are less than 18 years old cannot (on their own) have their pregnancy terminated under the Act. For that reason they fall outside the ambit of section 5(1) of the Act which is under attack and have to be dealt with on some other basis since the subsection applies only to those who are capable of giving informed consent. Mojapelo J pointed out that the plaintiffs claims, A, B and C complain about the legislative failure to impose stricter or additional control on the termination of pregnancies of girls under 18. It should, however, never be permissible for a girl under 18 years to have her pregnancy terminated because, on the plaintiff's case, she is never capable of meeting the threshold required for termination imposed by section 5(1) of the Act, namely informed consent. The court observed that the plaintiff therefore complains about the failure of the Act to impose stricter regulation on something which the Act does not permit at all. The Act cannot possibly impose stricter control on something it prohibits altogether. Mojapelo J stated that he expressly invited counsel for the plaintiffs to address him on paragraph 20.2 because in his view it posed difficulties for the plaintiff if one accepts its truth, albeit for present purposes (exception stage) only. He still maintained, said Mojapelo J, that one must accept

its truth. He even argued further that the allegations in the paragraph must be read and understood in the context of the preceding allegations and that in the content the paragraph meant that such a girl is not capable of giving informed consent as required in the section without the assistance and/or guidance of parents, guardians and/or counsellors. The court held that this argument did not help the plaintiff since, if people who, in terms of paragraph 20.2 of the particulars of claim, incapable of giving informed consent, are unassisted girls under 18 years, then that becomes the category of persons in respect of whom the patient complains. It said that they are by virtue of their incapacity to give informed consent, excluded in the category of people for whom it is permissible to terminate pregnancy.

Mojapelo J held that for the particulars of claim to disclose a cause of action the allegations contained in them must support the conclusion of fact reached by operation of law as well as the remedy sought. Because a category of persons to whom the plaintiff's complaint relates are those excluded by incapacity to give informed consent, the allegations in the particulars of claim do not, said the court, support the conclusion. It pointed out that the claims of the plaintiff were excipiable because they assume that the Act permits girls under 18 years to have their pregnancies terminated when it in fact never permits them to do so (assuming the truth of paragraph 20.2). Thus said the court, on the basis that it is true that a girl under the age of 18 years is not capable of giving informed consent required by the Act, and if in practice the pregnancy of such girls is terminated on the basis of their purported consent, then the plaintiff's remedy is not to attack the Act but to stop medical practitioners and midwives who terminate the pregnancies of girls under the age of 18 because they are doing so unlawfully in violation of section 5(1) of the Act. Mojapelo J held that the constitutionality of the attack could not be sustained on the particulars of claim. The exception was upheld.

Perhaps because this was the second attack on the Choice on Termination of Pregnancy Act by the same plaintiffs²⁰⁹ on the grounds of constitutionality, Mojapelo J then went on to make some remarks and examined the matter from the perspective of the basis in law of the right of a woman to determine the fate of her pregnancy, or the right to termination of

²⁰⁹ They have to be admired for their persistence if not the ingenuity of their legal arguments.

pregnancy as he called it in the judgment. He considered the American case of *Roe v Wade*²¹⁰ in which the US Supreme Court founded the woman's constitutional right to determine the fate of her own pregnancy on the constitutional right to liberty entrenched in the Fourteenth Amendment to the US Constitution. He noted that it did so as follows:

1. In a line of previous cases the court recognised an implied constitutional guarantee of personal privacy derived from a variety of express constitutional guarantees, principally the guarantee of 'liberty' in the Fourteenth Amendment. In some of those cases the court struck down state prohibitions on the sale of contraceptives. In one of them Brennan J articulated the point of those decisions as follows:

"If the right of privacy means anything, it is the right of the individual, married or single, to be free from governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child"²¹¹

2. This right of personal privacy is "broad enough to encompass a woman's decision whether or not to terminate her pregnancy". Blackmun J in *Roe v Wade*²¹² explained at 177:

"The detriment that the state would impose upon the pregnant woman by denying this choice altogether, is apparent. Specific and direct harm medically diagnosable even in early pregnancy may be involved. Maternity or additional offspring, may force upon the woman a distressful life and future. Psychological harm may be imminent. Mental and physical health may be taxed by child care. There is also the distress, for all concerned, associated with the unwanted child and there is the problem of bringing a child into a family already unable, psychologically and otherwise, to care for it. In other cases, as in this one, the additional difficulties and continuing stigma of unwed motherhood may be involved."

3. The woman's right of privacy and her concomitant right to reproductive self-determination are, however not absolute. The state has an important and legitimate interest in the preservation and protection of the health and welfare of the woman herself and of the potential life of the foetus. When its interest in doing so becomes sufficiently compelling it warrants state intrusion upon the woman's privacy and self-determination²¹³.

210 *Roe v Wade* (1972) 35 L ed 147

211 *Eisenstadt v Baird* (1972) 31 L ed 2ed 349 at 364

212 *Roe* fn 210 *supra*

213 *Roe* fn 210 *supra*



4. During the first twelve weeks of the woman's pregnancy, the state's interest is not sufficiently compelling to warrant intrusion.
5. During the second period of twelve weeks, however, the state's interest in the protection of the health and welfare of the woman herself is sufficiently compelling to warrant regulation and control of that purpose. Its interest in the health and welfare of the foetus is however, not yet sufficiently compelling to warrant intrusion for its protection.
6. Only when the foetus becomes viable, which occurs more or less at the end of the second trimester, does the state's interest in the protection of the health and welfare of the foetus become sufficiently compelling to warrant intrusion for that purpose. The state may then regulate and even prohibit abortion to protect the life of the foetus provided that it does not preclude an abortion when necessary to preserve the life and health of the woman herself.

Mojapelo J pointed out that Professor Dworkin defends the court's conclusion that the Constitution protects the woman's freedom to determine the fate of her own pregnancy²¹⁴. He noted that in the later case of *Thornburg v American College of Obstetricians and Gynaecologists*²¹⁵ Blackmun J again explained the fundamental nature of the privacy of a woman's decision to terminate her pregnancy:

²¹⁴ He describes the impact of a prohibition on abortion as follows: "Laws that prohibit abortion or make it difficult or expensive to procure one, deprive a pregnant woman of a freedom or opportunity that is crucial to many of them. A woman who is forced to bear a child she does not want because she cannot have an early and safe abortion is no longer in charge of her own body: the law has imposed a kind of slavery on her. That is, however, only the beginning. For many women, bearing unwanted children means the destruction of their own lives, because they will no longer be able to work or study or live in ways important to them, or because they cannot support the children...Adoption even when it is available, does not remove the injury, for many women would suffer great emotional pain for many years if they turned a child over to others to raise and love." (Dworkin R, *Life's Dominion*). Mojapelo J notes that Dworkin concludes that once one accepts that the Constitution protects personal privacy then it follows that it also protects women's right to determine the fate of their own pregnancy: He quotes Dworkin as follows: "But once one accepts (the dictum of Brennan J quoted above) as good law, then it follows that women do have a constitutional right to privacy that in principle includes the decision not only whether to beget children but whether to bear them. (The line of privacy decisions referred to above) can be justified only on the presumption that decisions affecting marriage and childbirth are so intimate and personal that people must in principle be allowed to make these decisions for themselves, consulting their own preferences and convictions, rather than having society impose its collective decision on them. A decision about abortion is at least as private in that sense as any other decision the court has protected. In one way it is more so, because it involved a woman's control not just of her sexual relations but of changes within her own body, and the Supreme Court has recognized in various ways the importance of physical integrity."

²¹⁵ *Thornburg* (1986) 476 US 747 at 772

“Few decisions are more personal and intimate, more properly private, or more basic to individual dignity and autonomy, than a woman’s decision – with the guidance of her physician and within the limits specified in *Roe* – whether to end her pregnancy. A woman’s right to make that choice freely is fundamental. Any other result, in our view, would protect inadequately a central part of the sphere of liberty that our law guarantees equally to all.”

Mojapelo J also referred to dicta in *Casey v Planned Parenthood of Southeastern Pennsylvania*²¹⁶, the Canadian case of *R v Morgentaler*²¹⁷, *Rodriguez v British Columbia (Attorney General)*²¹⁸, and *Bruggeman and Scheuten v Federal Republic of Germany*²¹⁹.

²¹⁶ *Casey* (1992) 120 L ed 2d 674. Mojapelo J quoted the following dicta of O’Connor J in explanation of the conclusion of the US Supreme Court that women have a constitutional right to determine the fate of their own pregnancy: “It is settled now, as it was when the court heard arguments in *Roe v Wade* that the Constitution places limits on a state’s right to interfere with a person’s most basic decisions about family and parenthood.” (at 696-697) “Some of us as individuals find abortion offensive to our most basic principles of morality, but that cannot control our decision. Our obligation is to define the liberty of all, not to mandate our own moral code. The underlying constitutional issue is whether the state can resolve these philosophic questions in such a definitive way that a woman lacks all choice in the matter, except perhaps in those rare circumstances in which the pregnancy is itself a danger to her own life or health, or is the result of rape or incest.” (698-699) “Our law affords constitutional protection to those personal decisions relating to marriage, contraception, family relationships, child rearing and education...These matters involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment. At the heart of liberty is the right to define one’s own concept of existence, of meaning, of the universe and the mystery of human life. Beliefs about these matters could not define the attributes of personhood were they formed under compulsion by the state.” (at 698) “Abortion is a unique act. It is fraught with consequences for others: for the woman who must live with the implications of her decision; for the persons who perform and assist in the procedure; for the spouse, family and society which must confront the knowledge that these procedures exist, procedures some deem nothing short of an act of violence against innocent human life; and, depending on one’s beliefs, it does not follow that the state is entitled to proscribe it in all instances. That is because the liberty of the woman is at stake in a sense unique to the human condition and so unique to the law. The mother who carries a child to full term is subject to anxieties, to physical constraints, to pain that only she must bear. That these sacrifices have from the beginning of the human race been endured by woman with a pride that ennobles her in the eyes of others and gives to the infant a bond of love, cannot alone be grounds for the state to insist that she makes the sacrifice. Her suffering is too intimate and personal for the state to insist, without more, upon its own vision of the woman’s role, however dominant that vision has been in the course of our history and our culture. The destiny of the woman must be shaped to a large extent on her own conception of her spiritual imperatives and her place in society.” (at p 698-699). Mojapelo J noted that the same considerations as applied in the US would compel one to conclude that the South African Constitution protects a woman’s right to choose under its guarantees of dignity in section 10 and privacy in section 14. He stated that it is however, not necessary to resort to those general guarantees because section 12(2) specifically guarantees the woman’s right “to bodily and psychological integrity” including the right “to make decisions concerning reproduction” and “to security in and control over their body”. They were clearly designed, said Mojapelo J, specifically to protect the woman’s right to reproductive self-determination.

²¹⁷ *Morgentaler* (2) (1988) DLR (4th) 385. Mojapelo J noted that in Canada, section 7 of the Canadian Charter also protects the right to ‘liberty’ but goes further by providing express protection to the right to ‘security of the person’. In *Morgentaler* the Canadian Supreme Court held that the woman’s right to determine the fate of her own pregnancy enjoyed constitutional protection. He observed that the majority of the court founded that protection on the guarantee of ‘security of the person’ in section 7. Wilson J, who concurred with the majority, held that the protection could also be founded on the right to ‘liberty’ in section 7 and the concomitant implied guarantee of human dignity. At issue before the court was the constitutionality of section 251 of the Canadian Criminal Code which placed severe procedural restrictions on a woman’s freedom to obtain an abortion. Mojapelo J quoted the dicta of Dickson CJ explaining his conclusion that it violated that constitutional right to security of the person as follows: “At the most basic, physical and emotional level every pregnant woman is told by the section that she cannot submit a generally safe medical procedure that might be of clear benefit to her unless she meets criteria entirely unrelated to her own priorities and aspirations. Not only does the removal of decision-making power threaten women in a physical sense; the indecision of knowing whether an abortion will be granted inflicts emotional stress. Section 251 clearly interferes with a woman’s bodily integrity in both a physical and emotional sense. Forcing a woman, by threat of criminal sanction, to carry a foetus to term unless she meets certain criteria unrelated to her own priorities and aspirations is a profound interference with a woman’s body and thus a violation of security of the person.”

²¹⁸ *Rodriguez* (1993) 17 CRR (2ed) 193 at 203-204 and 107 DLR (4th) 342 at 391a-b. Mojapelo J noted that in the case of *Rodriguez* concerning the constitutionality of a criminal prosecution of assisted suicide, Sopinka J, who gave the judgment of the majority of the court, reviewed its jurisprudence on the right to security of the person and concluded as follows: “In my view then, the judgment of this court in *Morgentaler* [fn 205 *supra*] can be seen to encompass a notion of personal autonomy involving, at the very least, control over one’s bodily integrity free from state interference and freedom from state-imposed psychological and emotional stress...There is no question then, that personal autonomy, at least with respect to the right to make choices

Mojapelo J noted that section 12 (2)(a) and (b) of the Constitution provides that everyone has the right to bodily and psychological integrity which includes the right to make decisions concerning reproduction and to security in and over their body. He stated that compared to the foreign jurisdictions he had referred to previously, it is clear that the South African constitutional provisions are the most explicit concerning this right and that the provisions of section 12 guarantee the right of every woman to determine the fate of her pregnancy. A woman's freedom of choice, said Mojapelo J, is further reinforced by the right to equality and protection against discrimination on the grounds of gender, sex and pregnancy (section 9 of the Constitution), the inherent right to dignity and to have her dignity respected and protected (section 10 of the Constitution), the right to life (section 11), the right to privacy (section 14 of the Constitution) and 'more importantly' the right to have access to reproductive health care (section 27(1)(a) of the Constitution). He noted that some of these rights were themselves developed in the foreign jurisdictions previously cited by courts through judicial interpretation to found the right to termination of pregnancy. Cumulatively, therefore, the more explicit rights in section 12(2)(a) and (b) and all the other reinforcing rights provide a strong constitutional base for the right to termination of pregnancy in South African law. Mojapelo J points out in the judgment that like other constitutional rights the right to the termination of pregnancy is not absolute and that the state has a legitimate role in the protection of pre-natal life as an important value in South

concerning one's own body, control over one's physical and psychological integrity, and basic human dignity, are encompassed within security of the person, at least to the extent of freedom from criminal prohibitions which interfere with these." Mojapelo J stated that insofar as the South African Constitution also guarantees a right to 'security of the person' in section 12(1) it could similarly found a constitutional protection of a woman's right to determine the fate of her own pregnancy. He noted that it is, however, not necessary to resort to section 12(1) because section 12(2) (a) and (b) expressly guarantees a more specific right "to bodily and psychological integrity" including the right to make decisions concerning reproduction and to security in and control over one's body.

219

Bruggemann (1977) 3 EHRR 244. Mojapelo J noted that the German constitutional court has held that the right to life extends to the protection of pre-natal life but that it has also recognised a countervailing constitutional right which protects the woman's personal autonomy to determine the fate of her own pregnancy. He pointed out that the jurisprudence of the German constitutional court accordingly lends support to an alternative perspective that the right to freedom and security of the person affords constitutional protection to a woman's right to determine the fate of her own pregnancy albeit subject to limitation to protect the life of the foetus. He also noted that in Europe article 8 of the European Convention on Human Rights provides that "everyone has the right to respect for his private and family life". Mojapelo J quoted the following dicta of the European Commission in *Bruggemann* in holding that this right founded constitutional protection of a woman's right to self-determination: "The right to respect for private life is of such scope as to secure to the individual a sphere within which he can freely pursue the development and fulfilment of his personality. To this effect, he must also have the possibility of establishing relationships of various kinds, including sexual, with other persons. In principle, therefore, whenever the state sets up rules for the behaviour of the individual within this sphere, it interferes with the respect for private life..." (at 252 para 55). "However, pregnancy cannot be said to pertain uniquely, to the sphere of private life. Whenever a woman is pregnant, her private life becomes closely connected with the developing foetus." Mojapelo J notes that the Commission accordingly concluded that although the woman has a right of self-determination, it was permissible for the state to regulate abortion because the right to privacy cannot be interpreted solely as meaning that pregnancy and its termination are as a principle solely a matter of the private life of the mother. He states that the jurisprudence of the European Union accordingly recognises the woman's constitutional right to self-determination but also recognises that it is permissible for the state to regulate its exercise.

African society and may regulate and limit the woman's right to choose in this regard. However, he said, because the right itself is derived from the Constitution the regulation thereof by the state may not amount to the denial of that right. He stated that the provisions of section 36(1) of the Constitution would apply to any limitation of the right of a woman to terminate her pregnancy – in other words such limitation would be valid only to the extent that it is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom.

Mojapelo J noted that South African courts, unlike the US courts, have never had to address the impact of any state-imposed interference with the autonomy of a woman to determine the fate of her own pregnancy but have in different contexts recognised the potential for catastrophic consequences that might flow from the unwanted, but state-enforced birth of a child. He referred by way of example to *Administrator Natal v Edouard*²²⁰. Mojapelo J observes that if the state were to prohibit termination, its prohibition would force pregnant women to bear, give birth to and nurture unwanted children at the risk of suffering such “catastrophes” and with the associated impairment of their physical and psychological well-being. The state's interference would clearly constitute an impairment of women's right “to bodily and psychological integrity” and more particularly their right “to make decisions concerning reproduction” and “to security in and control over their body” said the court. It noted that the plaintiff recognised and acknowledged that the right in issue is a constitutional one and that it complained about the way the legislature, through the Act, allows girls to access the right. The plaintiff wanted restriction or regulation of access to the right based on age.

The court observed that the Act allows all women who have the intellectual and emotional capacity for informed consent, to choose whether to terminate their pregnancies or not, that it does not distinguish between them on the ground of age and that this is what the plaintiff complains of as being unconstitutional. Mojapelo J stated that this complaint is inconsistent with the Constitution because:

²²⁰ *Edouard* 1990 (3) SA 581 (A) at 591G where Van Heerden JA stated that: “There is no justification for holding, as a matter of law, that the birth of an ‘unwanted’ child is ‘a blessing’. The birth of such a child may be a catastrophe, not only for the parents and the child itself but also for previously born siblings.”

1. The right of every woman to choose whether to terminate her pregnancy or not is enshrined in sections 12(2)(a) and (b), 27(1)(a), 10 and 14 of the Constitution. All of these rights are afforded to 'everyone' including girls under the age of 18. They are accordingly also entitled to respect for and protection of their right to self-determination.
2. Section 9(1) provides that everyone is equal before the law and has the right to equal protection and benefit of the law. Section 9(3) goes further to prevent unfair discrimination against 'anyone' inter alia on the ground of "age". Any distinction between women on the ground of their age, would invade these rights.
3. It follows that any limitation upon the freedom of any woman, including any girl under the age of 18 years to have their pregnancy terminated constitutes a limitation of their fundamental rights. Such a limitation is valid only if justified in terms of section 36(1).

Mojapelo J stated that because the right is a constitutional one, one of the minimum requirements for justification is that the limitation must be rational. He said that the distinction made by the Act between those women who have the capacity for informed consent on the one hand and those who do not have the capacity on the other, is a rational distinction. It is for that reason capable of justification and is therefore constitutional. He noted that the argument that the provisions of the Act that were under attack are unconstitutional because they do not cater for the interest of the child is unsustainable. The legislative choice opted for in the Act, he said, serves the best interest of the pregnant girl child (section 28(2) of the Constitution) because it is flexible to recognised and accommodate the individual position of a girl child based on her intellectual, psychological and emotional make up and actual majority. It cannot be in the interest of the pregnant minor girl to adopt a rigid age based approach that take not account, little or inadequate account of her individual peculiarities. Mojapelo J stated that even if the plaintiff was to establish that the age based control or regulation was in the interest of the child, that would not be enough and that the plaintiff would have to go further and show that the legislative

choice adopted in the Act (based on informed consent) is in fact unjustifiable and unconstitutional.

The court observed that while the plaintiff had formulated its claim on the basis that girls or young women below the age of 18 are capable of giving informed consent, this is not necessarily so. The true position depends on the particular individual girl or woman and on her particular circumstances and must be determined for each and every woman in each case. In enacting the Act, the legislature assumed that there will be women below and above the age of 18 who will be incapable of giving informed consent and for this category the law requires parental or some other assistance in giving the informed consent. Mojapelo J pointed out that the legislature also recognised that there will be women above the age of 18 who are capable of giving informed consent and for this category the legislature requires no assistance when they give consent to termination of pregnancy. He said that as to whether a particular individual, irrespective of age, is capable of giving such consent, the legislature left the determination of the factual position to the medical professional or registered midwife who performs the act. Mojapelo J stated that he could not find that the exercise of this legislative choice was so unreasonable or otherwise flawed that judicial interference is called for in what is essentially a legislative function. Women or girls under the age of 18 are not unprotected for as long as they are incapable of giving informed consent. He noted that the legislature makes provision to ensure that all young women or girls below the age of 18 are encouraged to seek parental support and guidance when seeking to exercise the right to reproductive choice. The constitutional right, said the court, of a pregnant child to family or parental care (section 28(1)(b)) is therefore not denied. It is accommodated but not imposed. It is given effect under the Act in a manner that does not seek to negate other constitutional rights including the right to equality before the law, to equal protection and benefit of the law as well as the right to termination of pregnancy itself. Thus, said Mojapelo J, he could not find that the legislation is unconstitutional when it provides for what is constitutionally permissible and regulates it without affronting the Constitution. For this reason, he held, the plaintiff's particulars of claim did not disclose a cause of action. The exception was upheld, the plaintiff's claims were dismissed and no order was made in respect of costs.

Discussion

It is submitted with respect that the reasoning of the court in this case is a perfect example of the manner in which the logic within the Constitution itself must be applied to the determination of whether or not legislation is unconstitutional or not. The court interrogated the issue before it with regard not only to the most obvious and direct constitutional rights involved but also with regard to the rights that support and reinforce them. The judgment beautifully illustrates the interconnectedness and interrelatedness of the various rights in the Constitution and how they form part of a complex legal matrix that has to be considered as a whole that is more than the sum of its parts when adjudicating individual cases. The reasoning of the court also illustrates the wisdom of a bottom up approach to questions of human rights since the simple rights that are contained in the Bill of Rights can be used to construct other more complex rights that are no less constitutional. Just as the court was able to deduce a constitutional right to termination of pregnancy from the elemental rights contained in the Constitution, it is submitted, so can a constitutional right to health be deduced from the fundamental rights within the Bill of Rights. The need for such composite rights may or may not arise depending upon the facts of each case. The value of such a bottom up approach is that it is far more flexible and adaptable to the circumstances of each particular case than the top-down approach. The latter postulates composite rights which it then tries to populate with more detailed precepts. This is likely to lead to inconsistencies in practice since it requires that the basic legal principles (which may be indivisible unit rights) upon which the right rests are derived from the notion of the right itself rather than having those indivisible unit rights, or fundamental legal principles, describe and delineate the right. Unlike the situation in international law, in South African constitutional law, when dealing with rights issues one does not sit with the problem of trying to populate composite rights in terms of concepts such as minimum core and other subjective paradigms. The legal matrix of relevant rights is applied to the unique factual matrix in each case. It is submitted that the judgment of Mojapelo J neatly illustrates the logical elegance of this bottom-up approach.

At a more prosaic level, and from a different angle, it could be said that what is behind this case is an attempt by a group of religious fundamentalists to impose, by way of a court

judgment, their views concerning abortion on the rest of the population. In this sense, the case is once again a battle between a collective and the individual. It is seldom that an individual will be in any position to impose his or her religious views upon the collective and the balance of power, as history indicates, has generally not been in favour of the individual in such matters. The freedom of the individual to live his or her own life as he or she sees fit, the right to self-determination as it has sometimes been called, is fundamental to the South African constitutional system of law. In this case this principle, applied at a pragmatic, individual level trumped the abstract moralistic argument, cloaked as legal principle, of a particular religious grouping. The judgment of the court therefore supports not only the rights to bodily and psychological integrity, dignity and reproductive health care to which the court refers, but also the right to freedom of religion, thought, conscience, belief and opinion reflected in section 15 of the Constitution to which it does not expressly refer. The judgment itself is thus clearly consistent with, and integral to, a system of law that is larger than itself. At the most abstract level, sound court judgments will manifest such consistency and, due to the polycentricity of the Bill of Rights, will be justifiable at a number of different levels or from many different perspectives. The richness of such a system of law lies in its relevance to many different facets of life. It is multidimensional in its effect.

The decision of the court also emphasises the importance of flexibility in policy and legislation that impacts upon constitutional rights. It will be recalled that lack of flexibility was found to be a major failing in the government policy concerning access to Nevirapine for the purpose of the prevention of mother to child transmission of HIV²²¹. The age issue is one that often arises as a threshold in law. It is relevant as such in the health care context *inter alia* in terms of the Sterilisation Act²²² which is currently in the process of amendment²²³. Section 2 of the current Act provides somewhat awkwardly that -

- (1) No person is prohibited from having sterilisation performed on him or her if he or she is-
- (a) capable of consenting; and

²²¹ TAC fn 57 *supra*

²²² Sterilisation Act No 44 of 1998

²²³ The draft Sterilisation Amendment Bill was published for public comment on 04 September 2003 in Government Gazette No 25415, Notice No 2303 for public comment.

(b) 18 years or above.

(2) A person capable of consenting may not be sterilised without his or her consent.

(3) (a) Sterilisation may not be performed on a person who is under the age of 18 years except where failure to do so would jeopardize the person's life or seriously impair his or her physical health.

Subsection (2) is not entirely in keeping with subsection (1)(b) which, although it separates the capacity to consent from age, still imposes the age of 18 as a threshold. The peculiar phrasing of subsection (1) suggests that where a person is capable of consenting but is under the age of 18 years, sterilisation of that person is prohibited. However such prohibition must be inferred from section 2 (1) of the Act itself since there is no other legal prohibition or provision with regard to sterilisation either in the Act or outside of it. It is submitted that this subsection on its own could be in conflict with the constitutional right of a minor to bodily and psychological integrity given the arguments raised by the court in the second *Christian Lawyers* case²²⁴. According to the decision of the court in this case, it should be that where a person is capable of informed consent, this should be sufficient grounding for a right to be sterilised irrespective of the age of the person being sterilised. Sterilisation, like termination of pregnancy, is an exercise of a reproductive right and the right to security in and control over one's body in terms of section 12(2) of the Constitution. Subsection (2) of section 2 of the Act could be read as taking the principle in subsection (1) a step further in saying that a person capable of consenting may not be sterilised without his or her consent. Thus where a person is either over the age of 18 or under the age of 18, where he or she is capable of consenting, sterilisation may not take place without his or her consent. In this sense it is partially redemptive of subsection (1) because the latter gives everyone who is over 18 years of age and capable of consenting a right to be sterilised but does not address the converse which is the right of persons capable of consenting but under the age of 18 years *not* to be sterilised. It is only partially redemptive because the right to be sterilised in terms of subsection (1) is still age restricted even where a person is capable of consenting. It therefore limits the right to sterilisation for

²²⁴ *Christian Lawyers* (2) fn 199 *supra*



those persons who are under 18 years of age and capable of consenting. Since the right to make reproductive decisions and to security in and control over one's body are constitutional rights, it remains to be seen whether this provision constitutes a limitation of a constitutional right falling within the ambit of section 36(1) of the Constitution. There is an argument that sterilisation from the point of view of the right holder - especially in the case of women – is generally of a more permanent nature than the termination of a pregnancy. A person who terminates one pregnancy can usually still decide to have another pregnancy but a person who is sterilised cannot always be sure that the procedure can be reversed should he or she have a change of heart later on. Children and young people have the whole of their reproductive lives ahead of them and the question is whether, as a matter of policy, they should be allowed to be sterilised where they are capable of consenting but younger than 18 years of age. Whilst the inclination of many is likely to be that this should not be permitted, the question is if the person is capable of informed consent why should he or she be denied this choice simply on the basis of age? What is the difference between a mature 17 year old who wants to be sterilised and is fully capable of informed consent and a highly immature 18 year old who is barely capable of informed consent? Perhaps the distinction is that in terms of section 28(3) of the Constitution, a child is defined as a person under the age of 18 years and section 28(2) stipulates that a child's best interests are of paramount importance in every matter concerning the child. In such a situation it may possibly be argued that a person under the age of 18 is not capable of knowing what is in his or her best interests even if he or she is capable of giving informed consent. Informed consent involves knowledge and appreciation of the consequences as well as consent but does it necessarily encapsulate an understanding of the individual as to what is in his or her best interests? It is submitted, however, that this distinction between informed consent and what is in a person's best interests could be equally applied to decisions on choice of termination of pregnancy. The court in the second *Christian Lawyers* case²²⁵, although it did not discuss it directly, also did not identify it as a valid distinction. The problem with the concept of what is in a person's best interests is that it is highly subjective. This is well demonstrated in legal issues involving end of life decisions. For example, to accept high doses of painkillers may hasten death but will alleviate suffering. Which option is in the

²²⁵ *Christian Lawyers (2)* fn 199 *supra*

individual's best interests and who decides? Where a person is over the age of 21 the law is clear. Where a person is under the age of 21²²⁶, or 18 for that matter, the law is not so clear. Section 39 of the Child Care Act states that a person who is over the age of 14 can consent to medical treatment of himself or his child, but it is silent on the subject of the refusal of medical treatment by such a person. Many people would argue that a child of 14 is not in a good position to know what is in his best interests and should not be allowed to refuse essential medical treatment. The same section allows a medical superintendent to give treatment in the absence of the consent of the parents in certain circumstances but does not address the situation where a child is over the age of 14 and is refusing the proposed treatment. Whose decision prevails? It is submitted that given the provisions of section 28 of the Constitution that the interests of the child are paramount, as long as the medical practitioner acts in the best interests of the child, the courts are unlikely to decide against such practitioner in a claim for violation of the rights of the child in section 12(2) of the Constitution. It is submitted, however, there must be clear evidence that the decision was taken in the best interests of the child because in the absence of such evidence, it is likely

226

In terms of section 1 of the Age of Majority Act No 52 of 1972 all persons, whether males or females, attain the age of majority when they attain the age of twenty-one years. In terms of section 2 of this Act Any person who has attained the age of eighteen years may, subject to the provisions of this Act, apply to the provincial division of the Supreme Court of South Africa having jurisdiction in the area within which such person is ordinarily resident for an order declaring him to be a major. Despite the provisions of this Act many of the more recent statutes, possibly because they are following the Constitution, use the age of 18 as a threshold when it comes to taking certain decisions or performing certain actions. See for example the Explosives Act No 15 of 2003 which defines a "suitable person" as *inter alia* a person who is 18 years or older with regard to a licence which must be obtained by any person who wants to run a magazine for the storage of explosives; the Private Security Industry Regulation Act No 56 of 2001 which allows persons over the age of 18 years to be registered as a security service provider; the Electoral Act No 73 of 1998 which defines a voter as South African citizen who is 18 years old or older and whose name appears on the voters' roll; the Transport General Amendment Act 16 of 1995 which stipulates that a radio operator on a ship which is required by the International Convention for the Safety of Life at Sea, 1974, as amended, to have a radio installation, shall be not less than 18 years of age; the Basic Conditions Of Employment Act No 75 of 1997 which stipulates that 'child' means a person who is under 18 years of age as does the Social Assistance Act 59 of 1992, the Refugees Act No 130 of 1998, the Child Care Act No 74 of 1983, the Correctional Services Act No 111 of 1998; the Recognition Of Customary Marriages Act No 120 of 1998 which stipulates that for a customary marriage entered into after the commencement of this Act to be valid the prospective spouses must both be above the age of 18 years; the Liquor Act No 27 of 1989 which stipulates that the holder of a liquor licence shall not employ any person who is under the age of 18 years; the Births And Deaths Registration Act No 51 of 1992 which provides that a 'major' or 'person of age' means any person who has attained the age of 18 years or who has under the provisions of section 2 of the Age of Majority Act, 1972 (Act No 57 of 1972), been declared to be a major, and includes a person under the age of 18 years, who has contracted a legal marriage as does the South African Citizenship Act No 88 of 1995. It would seem that there is a widely held view that a child and a minor are not necessarily the same thing and that for purposes of the former, the age of 18 years is the cut off point whilst for the purposes of the latter, the out-off point is the age of 21 years. However this is not always the case. See for example the Liquor Act which defines a minor as a person who has not attained the age of 18 years. From a pragmatic perspective what is happening is that persons over the age of 18 years are increasingly being given legal capacity for various specific purposes without the amendment of the general legislation, namely the Age of Majority Act. For health purposes, the Medicines and Related Substances Act No 101 of 1965 provides that Schedule 1, 2,3,4,5 or 6 substance shall not be sold to any person apparently under the age of 14 years except upon a prescription issued by an authorised prescriber and dispensed by a pharmacist, pharmacist intern or pharmacist's assistant or by a veterinarian or a person who is the holder of a licence as contemplated in section 22C (1) (a), or on a written order disclosing the purpose for which such substance is to be used and bears a signature known to the seller as the signature of a person known to such seller and who is apparently over the age of 14 years. Section 39(4) of the Child Care Act stipulates that notwithstanding any rule of law to the contrary any person over the age of 18 years shall be competent to consent, without the assistance of his parent or guardian, to the performance of any operation upon himself and any person over the age of 14 years shall be competent to consent, without the assistance of his parent or guardian, to the performance of any medical treatment of himself or his child.

that the action taken in consequence thereof could well be a violation of section 12(2) rights and the provisions of section 39 will not avail the medical practitioner if his actions prove to be unconstitutional with regard to section 12(2) and section 28.

The judgment of the court in *Christian Lawyers*²²⁷ is clearly to the effect that the right to self-determination cannot be age restricted. It also suggests that the rights of children provided for in section 28 of the Constitution should not be imposed on them, for instance, by way of legislation that denies them the right to bodily and psychological integrity on the ground that their section 28 rights override all others. The implication is that these section 28 rights must be capable of being exercised and balanced against other possibly conflicting rights. In other words, there is still an element of choice involved on the part of the right holder as to whether or not to enforce the right. If the right is imposed then there is no question of its being exercised by the right holder. Generally, as far as children are concerned this issue does provoke some circuitous debates since children are often not in a position to exercise or enforce a right independently of an adult parent, guardian or caregiver. The younger the child the more this statement holds true. If the very rights designed to protect the child against *inter alia* an adult parent, guardian or caregiver must first be exercised by the child with the assistance of that parent, guardian or caregiver, this effectively weakens the protection that the right affords the child. It is this dilemma that the Choice on Termination of Pregnancy Act has to address - particularly in situations of sexual molestation of a minor woman by her parent, guardian or caregiver. The point of the judgment of the court in the *Christian Lawyers* case²²⁸ is that where a minor is capable of giving informed consent, the opposing will of a parent, guardian or caregiver should not be imposed upon the minor under the guise of section 28 of the Constitution simply because the minor is of a certain age. The capacity to give informed consent counts for more in such matters than an arbitrary threshold imposed in the abstract without reference to the individual who is most affected.

²²⁷ *Christian Lawyers* (2) fn 199 *supra*
²²⁸ *Christian Lawyers* (No 2) fn 199 *supra*

It is submitted that it is also not in keeping with the concept of administrative justice that rigid criteria such as age limits should be imposed where a large number of factual permutations can occur and not every one of them can be anticipated by legislation. It is a well-established principle of administrative law that each case must be decided on its merits and there is no reason why this principle should not be incorporated into legislation involving minors and the giving of informed consent by them - especially where the right to bodily and psychological integrity is involved.

Subsection (3)(a) of the Sterilisation Act does not take into account the right to psychological integrity referred to in section 12(2) of the Constitution in that it refers only to physical health.

Section 3 of the Act stipulates as follows –

- (1) Sterilisation may be performed on any person who is incapable of consenting or incompetent to consent-
 - (a) upon a request to the person in charge of a hospital and with the consent of a-
 - (i) parent;
 - (ii) spouse;
 - (iii) guardian; or
 - (iv) curator;
 - (b) if a panel contemplated in subsection (2) after considering all relevant information, including the fact that-
 - (i) the person is 18 years of age, unless the physical health of the person is threatened; and
 - (ii) there is no other safe and effective method of contraception except sterilisation, concurs that sterilisation may be performed; and
 - (c) if the person is mentally disabled to such an extent that such a person is incapable of-
 - (i) making his or her own decision about contraception or sterilisation;
 - (ii) developing mentally to a sufficient degree to make an informed judgement about contraception or sterilisation; and
 - (iii) fulfilling the parental responsibility associated with giving birth.
- (2) The person in charge of a hospital contemplated in subsection (1) must upon request, as prescribed for sterilisation, convene a panel which will consist of -
 - (a) a psychiatrist, or a medical practitioner if no psychiatrist is available;
 - (b) a psychologist or a social worker; and
 - (c) a nurse.
- (3) Where a person to be sterilised is in custodial care, no member of the panel may be an employee of the custodial institution.



- (4) If sterilisation is to be performed in a private health care facility, the members of the panel may not be employees of, or have a financial interest in, that facility.
- (5) The person performing the sterilisation must ensure that the method of sterilisation used holds the least health risk to the person on whom sterilisation is performed.
- (6) Sterilisation may not be performed in terms of subsection (1) unless the person suffers from a severe mental disability.
- (7) For the purposes of this section, 'severe mental disability' means a range of functioning extending from partial self-maintenance under close supervision, together with limited self-protection skills in a controlled environment through limited self care and requiring constant aid and supervision, to severely restrained sensory and motor functioning and requiring nursing care.

In this section, once again the question of 18 years of age is to be used as a threshold. In this instance, it is even more problematic because the section is dealing expressly with persons who are incapable of consenting. This incapacity is not linked in the Act to mental disability or lack of consciousness due to physical injury or illness. It can therefore also be applied to children who lack capacity simply because of their age. However section 2(3) deals with the sterilisation of mentally healthy minors and it is therefore unnecessary to regard this section as relevant to them. Age is only one factor that is an indicator of mental capacity. In the case of mentally disabled persons it may not be relevant at all since persons who are mentally disabled may never achieve legal capacity irrespective of their age. Mental capacity is often indicated or measured in terms of mental or developmental age. Thus an eighteen year old mentally disabled patient's cognitive functions may be pegged at the level of those of a healthy twelve year old. While the mind may not achieve full maturity the body of a mentally disabled person may well reach puberty and be capable of procreation. Indeed one of the primary concerns of the Sterilisation Act when it was first passed was to ensure that unnecessary sterilisation of mentally disabled persons was prohibited since mentally disabled persons also have reproductive rights. It was much easier in the past for parents and caregivers of such persons to have them sterilised than to worry about sexual activity leading to the birth of an unwanted child. However on one possible interpretation of section 3, the Act went too far in the direction of preventing sterilisation of mentally disabled persons under the age of 18 years insofar as the provisions of this section can be interpreted to mean that disabled persons younger than 18 years of

age may not be sterilised at all²²⁹. In the case of mentally disabled persons the age of 18 years is even more arbitrary for the purposes of sterilisation than it is for those who are not mentally disabled. In the context of sterilisation, the age of puberty is more relevant in the case of mentally disabled persons than the age of 18 years since the capacity of mentally disabled persons is unlikely to be related to their physical age. To apply the age of 18 years in this context as a reason for the refusal of sterilisation could have the effect of denying a mentally disabled person who is under the age of 18 years the right to dignity, to psychological integrity and to security in and control over his or her body. The proposed amendment to the Act seeks to preclude this.

The decision of the court in *Christian Lawyers (No 2)* has far reaching implications for legal capacity in general and is more in keeping with the Roman Law on the subject which attributed at least partial capacity to children over the age of seven and a significant degree of capacity to those over the age of fourteen years²³⁰. It is in keeping with more recent

229

It is submitted that it is possible to interpret section 3(1)(b) of the Act to mean that under certain circumstances a person may be sterilised even where he or she is under the age of 18 years and even though his or her physical health is not threatened because the section requires the panel to consider "all relevant information" of which the factors of age, physical health and availability of alternative methods of contraception are just a subset as indicated by the use of the word "including" in relation to these factors. However, practical experience has been that panels have been inclined to refuse sterilisations even in the face of very strong arguments in favour thereof where the person to be sterilised is under the age of 18 years and it was thus decided to amend the Sterilisation Act to ensure that the rights to dignity and psychological integrity of such persons are not compromised by such misinterpretation.

230

See Long G, 'Infans' *Lacus Curtius Roman Law (Smith's Dictionary, 1875)*. He notes that in the Roman law there were several distinctions of age which were made with reference to the capacity for doing legal acts:

1. The first period was from birth to the end of the seventh year during which time persons were called *Infantes* or *Qui fieri non possunt*.
2. The second period was from the end of seven years to the end of fourteen or twelve years, according as the person was a male or a female, during which persons were defined as *Qui fieri possunt*. The persons included in these first two classes were *Impuberes*.
3. The third was from the end of the twelfth or fourteenth to the end of the twenty-fifth year, during which period persons were *Adolescentes*, *Adulti*. The persons included in these three classes were *minores xxv annis* or *annorum*, and were often for brevity's sake, called *minores* only [CURATOR]; and the persons included in the third and fourth class were *puberes*.
4. The fourth period was from the age of twenty five during which persons were *Majores*.

He states: "The term *Impubes* comprehends *Infans*, as all *Infans* are *Impuberes*; but all *Impuberes* are not *Infantes*. Thus the *Impuberes* were divided into two classes; *Infantes* or thus under seven years of age, and those above seven, who are generally understood by the term *Impuberes*. *Pupillus* is a general name for all *Impuberes* not under the power of a father (Dig.50.tit.15a.239)."

See also Long G 'Impubes' *Lacus Curtius Roman Law (Smith's Dictionary, 1875)*. "An *infans* was incapable of doing any legal act. An *impubes*, who had passed the limits of *infantia*, could do any legal act with the *auctoritas* of his tutor, without such *auctoritas* he could only do those acts which were for his benefit. Accordingly such an *impubes* could stipulate (*stipulari*) but not promise (*promittere*); in other words, as Gaius (iii.107) expresses it, a *pupillus* could only be bound by the *auctoritas* of his tutor, but he could bind another without such *auctoritas*. But this remark as to *pupilli* only applies to those who had understanding enough to know what they were doing (*qui iam aliquem intellectum habent*), and not to those who were *infans* or *infanti proximi*, though in the case of the *infanti proximi* a liberal interpretation was given to the rule of law (*benignior juris interpretatio*), by virtue of which a *pupillus*, who was *infanti proximus*, was placed on the same footing as one who was *pubertati proximus*, but this was done for their benefit only (*propter utilitatem eorum*), and therefore could not apply to a case where the *pupillus* might be a loser (cf. Inst.iii.tit.19 s10 with Gaius, iii.108). An *impubes* was in the power of his father, for in the case of a *pupillus*, the *auctoritas* of the tutor was only allowed, in respect of the *pupillus* having property of his own, which a son in the power of his father could not have. In the case of obligations *ex delicto*, the notion of the *auctoritas* of a tutor was of course, excluded, as such *auctoritas* was only requisite for the purpose of giving effect to rightful acts. If the *impubes* was of sufficient

thinking on the subject of legal capacity and the medical treatment of children in particular.²³¹ For the purpose of medical treatment the question of the consent of a minor

capacity to understand the nature of his delict, he was bound by it; otherwise, he was not. In the case of a person who was *Pubertati proximus*, there was a legal presumption of such capacity; but still this presumption did not exclude a consideration of the degree of understanding of the impubes and the nature of the act, for the act might be such as either to be perfectly intelligible, as theft, or it might be an act which an impubes imperfectly understood, as when he was made the instrument of fraud. These principles were applicable to cases of *furtum*, *damnum injuria datum*, *injuria* and others; and also to crimes, in which the nature of the act mainly determined whether or not guilt should be imputed. An impubes could enter into a contract whereby he was released from a debt, but he could not release a debt without the auctoritas of his tutor. He could not pay money without his tutor; nor could he receive money without his tutor, at least it was not a valid payment because such payment was as a consequence, followed by a release to the debtor. But since the rule as to incapacity of an impubes was made only to save him from loss, he could not retain both the money and the claim. An impubes could not be a plaintiff or a defendant in a suit without his tutor... With the attainment of *pubertas*, a person obtained the full power of his property, and the *tutela* ceased: he could also dispose of his property by will; and he could contract marriage. According to the legislation of Justinian (*Inst. i tit. 22*), *pubertas*, in the case of a male, was attained with the completion of the fourteenth and, in a female, with the completion of the twelfth year. The Sabianini maintained that the age of *pubertas* was to be determined by physical capacity (*habitu corporis*), to ascertain which a personal examination might be necessary; the Proculiani fixed the age of fourteen complete, as that which absolutely determined the attainment of puberty (Gaius, i. 196; *Ulp. Frag. xi. 28*). It appears, therefore that under the earlier emperors there was some doubt as to the time when *pubertas* was attained, though there was no doubt that with the attainment of puberty, whatever that time might be, full legal capacity was acquired." http://www.ukans.edu/history/europe/ancient_rome.

231

See for instance the Children's Bill on <http://www.welfare.gov.za> which provides in section 13 that: "Every child has the right to: (a) have access to information on health promotion, sexuality, reproduction and the prevention of ill-health and disease; and (b) confidentiality regarding his or her health status and the health status of a parent, care-giver or family member, except when maintaining such confidentiality is not in the best interest of the child.

Section 17 of the Bill stipulates that a child, whether male or female, becomes a major upon reaching the age of 18 years. Boonstra H and Naah E 'Minors and the Right to Consent to Health Care' *The Guttmacher Report on Public Policy* notes: "The notion that many minors have the capacity and indeed the right to make important decisions about health care has been well established in federal and state policy. Many states specifically authorize minors to consent to contraceptive services, testing and treatment for HIV and other sexually transmitted diseases, prenatal care and delivery services, treatment for alcohol and drug abuse, and outpatient mental health care. With the exception of abortion, lawmakers have generally resisted attempts to impose parental consent or notification requirements on minors' access to reproductive health care and other sensitive services. Nevertheless the movement to "restore" parental rights and to legislate parental control over minors' reproductive health care decisions remains active." They point out that in the US, states have traditionally recognized the right of parents to make health care decisions on their children's behalf, on the presumption that before reaching the age of majority (18 in all but four states), young people lack the experience and judgment to make fully informed decisions. There have long been exceptions to this rule, however, such as medical emergencies when there is no time to obtain parental consent and in cases where a minor is emancipated by marriage or other circumstances and thus legally able to make decisions on his or her own behalf. In addition, courts in some states have adopted the so-called mature minor rule, which allows a minor who is sufficiently intelligent and mature to understand the nature and consequences of a proposed treatment to consent to medical treatment without consulting his or her parents or obtaining their permission. They state that: "Moreover, over the last 30 years, states have passed laws explicitly authorizing minors to consent to health care related to sexual activity, substance abuse and mental health care. Although some states give doctors the option of informing parents that their minor son or daughter has received or is seeking these services, these laws leave the decision of whether to inform the parents entirely to the discretion of the physician as to the best interests of the minor. This expansion of minors' authority over health care decisions was spurred in part by US Supreme Court rulings extending the constitutional right to privacy to a minor's decision to obtain contraceptives or to terminate an unwanted pregnancy. It also reflects a recognition on the part of lawmakers that while parental involvement is desirable, many minors will not seek services they need if they have to tell their parents." They observe that the Alan Guttmacher Institute has periodically reviewed state laws pertaining to minor's authority to consent to medical care and to make other important decisions without their parents' knowledge or permission. In 2004 its review was expanded to also take into account state court decisions and attorneys general opinions that affect young people's access to confidential services. The review conducted in July 2000, found the following:

Twenty-five states and the District of Columbia have laws or policies that explicitly give minors the authority to consent to contraceptive services.

Twenty-seven states and the District of Columbia have laws or policies that specifically authorize a pregnant minor to obtain prenatal care and delivery services without parental consent or notification.

All 50 states and the District of Columbia, specifically allow minors to consent to testing and treatment for STDs, including HIV (With respect to HIV, three states limit this authorization to testing only.) Forty-four states and the District of Columbia have laws or policies that authorized a minor who abuses drugs or alcohol to consent to confidential counseling and medical care. Laws in 20 states and the District of Columbia give minors the explicit authority to consent to outpatient mental health services.

No state explicitly requires parental consent or notification for any of these services. However two states - Texas and Utah - prohibit the use of state funds to provide contraceptive services to minors without parental consent. One state, Iowa, requires that parents be notified if their child receives a positive HIV test.

Boonstra and Naah note that in addition to laws and policies that permit minors to consent to specific services, 21 states have statutes that authorize minors to consent to general medical and surgical care, at least under some circumstances, such as having a child, being pregnant or having reached a certain age. In Alabama, for example, minors aged 14 and older may consent to general medical care; in South Carolina, they may do so at 16.

has proved problematic²³². The legal basis of the transaction is clearly of particular relevance in this context since minors do not usually have contractual capacity. If health services may only be rendered on the basis of the law of contract then a minor does not have the capacity to obtain such services without the assistance of his or her guardian. This is clearly, however, not in keeping with the provisions of section 39 of the Child Care Act discussed previously. The dicta of the court in *Christian Lawyers (No 2)*²³³ is in marked contrast to the legal position that prevailed even some five years ago²³⁴. The question is whether the judgment of the court should be restricted to the provisions of the Choice on Termination of Pregnancy Act concerning informed consent only in relation to terminations of pregnancy or whether it should logically be extended to other kinds of health care services. In principle it is difficult to see why the logic used by Mojapelo J in this judgment cannot be applied to most, if not all, other health care services for minors.

They point out that the one notable exception to the expansion of minors' decision-making authority on health care matters is abortion. Only two states – Connecticut and Maine – and the District of Columbia have laws that affirm a minor's ability to obtain an abortion on her own. Thirty one states have laws in effect that require the involvement of at least one parent in their daughter's abortion decision. In 16 of these states, a minor must have the consent of one or both parents; in the other 15 states, one or both parents must be notified prior to the abortion. They further note, however, that more than half of the states that require parental involvement for abortion permit a minor to make the decision to continue her pregnancy and to consent to prenatal care and delivery without consulting a parent. Furthermore states appear to consider a minor who is a parent to be fully competent to make major decisions affecting the health and future of his or her child even though many of these same states require a minor to involve her parents if she decides to terminate her pregnancy. In stark contrast to this restrictive approach to termination of pregnancy decisions, states allow minors to make other decisions that can have a lasting effect on their lives. For example, most states permit teenagers to drop out of high school without their parents' approval and despite the documented adverse effects associated with the lack of a diploma. Although all states require young people to stay in school at least to age 16 or 17, except in very limited circumstances, once that age threshold has been reached, the states generally impose no barriers to minors' deciding to leave. The most striking of all is that 34 states and the District of Columbia explicitly permit a minor mother to place her child for adoption without her own parents' permission or knowledge. In addition, 11 states make no distinction between minor and adult parents; in these states, it appears, the decision to relinquish her child for adoption rests with the young mother.

232 Boonstra and Naah fn 231 *supra* state that: "Establishing rules for minor's consent for medical care has been one of the more difficult issues to face policy makers. On the one hand it seems eminently reasonable that parents should have the right and responsibility to make healthcare decisions for their minor child. On the other it may be more important for a young person to have access to confidential medical services than it is to require that parents be informed of their child's condition. Minors who are sexually active, pregnant, or infected with a sexually transmitted disease (STD) and those who abuse drugs or alcohol or suffer from emotional or psychological problems may avoid seeking care if they must involve their parents. Recognizing this reality, many states explicitly authorize a minor to make decisions about their own medical care but balancing the rights of parents and the rights of minors remains a topic of debate."

233 *Christian Lawyers (No 2)* fn 199 *supra*

234 See for instance *S v Chipinge Rural Council* 1989 (2) SA 342 (ZS) the court stated that: "There is respectable authority for the proposition that majority is the criterion determining the existence of legal capacity in respect of consent or the voluntary assumption of risk. See Spiro *Law of Parent and Child* 4th ed at 192; Boberg *Delict: Principles and Cases* vol I at 731 - 2. But even if capacity to consent is not coextensive with capacity to contract, in the words of Professor Van der Walt in his work *Delict: Principles and Cases* para 34(h) at 54, the child must have '... the mental capability and maturity to evaluate responsibly the nature, and extent and implications of his consent or assumption of risk. The existence of legal capacity in this sense is therefore relative to the particular circumstances of the case and particularly to the nature of the interests involved and the seriousness of the harmful conduct involved. A child of 14 years may, eg, have the necessary legal capacity to consent to the destruction of her doll, but she would normally not have the necessary legal capacity to consent to medical treatment. Where the child does not have the necessary legal capacity, the guardian must act on behalf of the child.' See also Snyman *Criminal Law* at 101; Burchell and Hunt *South African Criminal Law and Procedure (General Principles)* 2nd ed vol 1 at 378.

The decision in *Christian Lawyers (No 2)*²³⁵ illustrates the importance of not taking longstanding legal principles for granted and the need to constantly re-examine the statutory and common law in the context of the Constitution. The capacity of a minor to enter into a contract, at least for health care services, must be construed not only in terms of the common and statutory law on legal capacity but also with regard to the right of access of 'everyone' to health care services including reproductive health care. It may be unconstitutional to take the view that a minor lacks contractual capacity and therefore cannot have access to health care services without the assistance of his or her parents. This is putting the cart before the horse since contractual capacity is subject to the constitutional right of access to health care services. This is not to say that in every situation a minor's contract for health care services has to be upheld. Clearly issues of informed consent are highly relevant as is evident from the judgment of Mojapelo J in *Christian Lawyers (No 2)*. It may be necessary in some instances to avoid the idea of contract altogether as a legal basis for the rendering of health care services to an unassisted minor. Presently this is possible on the basis of the provisions of the Child Care Act and in the case of terminations of pregnancy, the Choice on Termination of Pregnancy Act. The Children's Bill does not seem to have similar provisions but the National Health Bill does make some provision for informed consent in the context of health care services for minors. Due regard must also be had to the constitutional rights of 'everyone' to bodily and psychological integrity and to freedom and security of the person when considering the rendering of health care services to minors. Furthermore, it is the circumstances and capacity of the individual minor concerned, as opposed to minors as an amorphous group, that must be considered by those rendering health care services. Broad generalisations when dealing with specific patients on the basis of factors such as age, gender and health status are not only inadvisable, they may also be unconstitutional in a number of different aspects not least of which is unfair discrimination. The constitutional rights to dignity, to bodily and psychological integrity, to freedom and security of the person are powerful rights that cannot be ignored in the context of health service delivery and minors are entitled to these rights to no less a degree than anyone else.

²³⁵ *Christian Lawyers (No 2)* fn 199 *supra*

2.5 The Right of Prisoners to Medical Treatment

The right of prisoners to medical treatment is reflected in section 35(2) of the Constitution which states that:

”Everyone who is detained, including every sentenced prisoner, has the right-

.....

(e) to conditions of detention that are consistent with human dignity, including at least exercise and the provision, at state expense, of adequate accommodation, nutrition, reading material and medical treatment;

(f) to communicate with, and be visited by, that person's-

.....

(iv) chosen medical practitioner”.

The obvious question is whether this right of detained persons is yet another facet of the right of access to health care services or whether it is a discrete right which has no connection with the more general right expressed in section 27(1) of the Constitution. There are differences in the terminology used between the two sections. Section 35(2) refers to “medical treatment” whereas section 27(1) speaks of “health care services”. Section 27 refers to the progressive realisation of the rights within available resources. Section 35 contains no such qualification. What is the difference between these two sections, if any, for practical purposes? Section 35(2) makes specific mention of a choice of medical practitioner whereas section 27(1) does not make any reference to providers of health care services.

The Cape High Court considered some of these questions of the case of *Van Biljon and Others v Minister of Correctional Services and Others*²³⁶

2.5.1 *Van Biljon and Others v Minister of Correctional Services*²³⁷

Facts

²³⁶ *Van Biljon* 1997 (4) SA 441 (C) (*B and Others v Minister of Correctional Services and Others* 1997 (6) BCLR 789)

²³⁷ *Van Biljon* fn 236 *supra*

The applicants were HIV positive prisoners who sought orders declaring, *inter alia*, that 'the right to adequate medical treatment of the applicants and the prisoners infected with HIV, who have reached the symptomatic stage of the disease and whose CD4 counts are less than 500/ml, entitles them to have prescribed and to receive at state expense appropriate anti-viral medication'. Anti-viral medication had been prescribed for the first and second applicants but had not been provided to them by the prison authorities.²³⁸

It was argued for the respondents that convicted prisoners are entitled to the same standard of medical treatment as is provided for persons attending state institutions and that since ordinary persons attending provincial hospitals were not entitled to antiretroviral drugs for the treatment of HIV/AIDS due to budgetary constraints, neither were the prisoners. At the time, patients in provincial hospitals who were in the same condition as the applicants were not provided with antiretrovirals at state expense. Counsel for the applicants contended that, since the right to adequate medical treatment is guaranteed to prisoners in terms of the Constitution, prison authorities can never be heard to say that they are unable to provide such treatment as a result of budgetary constraints or lack of funds.

Judgment

The high court observed that:

“Once it is established that anything less than a particular form of medical treatment would not be adequate, the prisoner has a constitutional right to that form of medical treatment and it would be no defence for the prison authorities that they cannot afford to provide that form of medical treatment. I do not, however, agree with the proposition that financial conditions or budgetary constraints are irrelevant in the present context. What is ‘adequate medical treatment’ cannot be determined *in vacuo*. In determining what is ‘adequate’, regard must be had to, *inter alia*, what the state can afford. If the prison authorities should, therefore, make out a case that as a result of budgetary constraints they cannot afford a particular form of medical treatment or that the provision of such medical treatment would place an unwarranted burden on the state, the Court may very well decide that the less effective medical treatment which is affordable to the State must in the circumstances be accepted as ‘sufficient’ or ‘adequate medical treatment’. After all, as was pointed out by Mr Scholtz, s 35(2)(e) of the Constitution does not provide for ‘optimal medical treatment’ or ‘the best available medical treatment’, but only for ‘adequate medical treatment’.”

²³⁸

From headnote of *Van Biljon* fn 236 *supra*



Counsel argued, however, that the state owes a higher duty of care to HIV positive prisoners than to citizens who suffer from the same infection, in general. The court agreed with this argument on the basis that with reference to, *inter alia*, accommodation, nutrition and medical care, the Constitution itself draws a distinction between prisoners and people outside prison.²³⁹

The court held that the declarator sought by the applicants would compel medical doctors to prescribe some form of anti-viral medication and refused to make such order because it was not the function of the Court to make an order of that nature. It held that because anti-viral medication had in fact been prescribed for the first and second applicants on medical grounds, the question whether they were entitled to receive such therapy at state expense became an issue. The court said that although, in principle, lack of funds could not be an answer to a prisoner's constitutional claim to adequate medical treatment, and that therefore, once it was established that anything less than a particular form of medical treatment would not be adequate, the prisoner would have the constitutional right to that form of treatment, financial conditions and budgetary constraints were not irrelevant considerations: what amounted to 'adequate medical treatment' had to be determined with regard, *inter alia*, to what the state could afford. The court noted, with regard to the argument that the state owed a higher duty of care to HIV positive prisoners than to citizens outside prison suffering the same infection, that the Constitution itself drew a distinction between prisoners and those outside prison. It said that acceptance of the respondents'

²³⁹

See *Van Biljon* fn 236 *supra* para 53 p 457 onwards where the court observed that: "Unlike persons who are free, prisoners have no access to other resources to assist them in gaining access to medical treatment. It is true that some HIV positive prisoners will, upon release, be dependent on the state for medical treatment. On the other hand, there are prisoners, like first applicant, who may well be able, upon their release, to earn an income which will enable them to afford anti-viral treatment or who will receive charitable assistance from their employers. As far as the latter category of prisoners is concerned, an inroad would be made upon their personal liberties if they were to be refused access to anti-viral treatment. Since such inroad cannot be described as a necessary consequence of incarceration, I do not believe that the refusal to provide these prisoners with anti-viral medication is consistent with the principles of our common law. In saying that I obviously do not intend to suggest that the standard of medical treatment for any particular prisoner should be determined by what he or she could afford outside prison. What I am saying, is that the standard of medical treatment for prisoners in general cannot be determined by the lowest common denominator of the poorest prisoner on the basis that he or she could afford no better treatment outside. As far as HIV prisoners are concerned, there is another factor which should, in my view, be borne in mind, namely that they are more exposed to opportunistic viruses than HIV sufferers who are not in prison. It is applicants' case that tuberculosis and pneumonia are prevalent in prison. Although respondents deny the prevalence of these particular opportunistic infections, they do admit that the overcrowded conditions in which prisoners are accommodated exacerbates the vulnerability of HIV prisoners to opportunistic infections. Even if it is, therefore, accepted as a general principle that prisoners are entitled to no better medical treatment than that which is provided by the state for patients outside, this principle can, in my view, not apply to HIV infected prisoners. Since the state is keeping these prisoners in conditions where they are more vulnerable to opportunistic infections than HIV patients outside, the adequate medical treatment with which the state must provide them must be treatment which is better able to improve the immune systems than that which the state provides for HIV patients outside. The conclusion that the standard of adequate medical treatment for HIV infected prisoners is not *per se* determined by what the state provides outside for HIV patients is in effect a conclusive answer to respondents' contention."

argument would mean, for example, that the fundamental right of prisoners to adequate accommodation, also provided for in s 35(2)(e), would entitle them to no better accommodation than that provided for people outside prisons, whereas it was a fact of life that there were many people in the country whose accommodation could not by any standard be described as adequate. The court found that to refuse prisoners, some of whom might upon their release be able to earn an income which would enable them to afford anti-viral treatment, access to anti-viral treatment would be an inroad on their personal liberties, which inroad could not be described as a necessary consequence of incarceration. It noted that the standard of medical treatment for prisoners in general could not be determined by the lowest common denominator of the poorest prisoner on the basis that he or she could afford no better treatment outside than that offered at state institutions and pointed out that due to prison conditions the state could even be said to be exposing prisoners to a greater risk of opportunistic infection than they would encounter outside of prison. On this basis it could be argued that the state was obliged to afford HIV positive prisoners medical treatment that was able to boost their immune systems and protect them from this risk. The court found that the applicants had established that anti-viral therapy was the only prophylactic and that the benefits of such treatment, in the form of extended life expectancy and enhanced quality of life, were such that the treatment claimed by them had to be regarded as no more than the 'adequate medical treatment' to which they were entitled in terms of s 35(2)(e) of the Constitution. It ordered the first and second respondents to provide the first and second applicants with the anti-retroviral drugs that had been prescribed for them.

Discussion

At first glance it might appear that the finding of the court in *Van Biljon* is to the effect (a) that prisoners have greater rights to medical treatment than other persons in society and (b) that this right of prisoners does have a certain minimum core content. These conclusions might be founded (a) upon the fact that the court held that prisoners were entitled to antiretroviral medication for HIV whereas patients of provincial hospitals were not so entitled due to budgetary constraints and (b) upon the discussion in the judgment of what is meant by 'adequate' medical treatment. These conclusions might lead to the further

conclusion that the right of prisoners to medical treatment is separate from and different to the right of everyone to health care services in terms of section 27(1) of the Constitution. It is submitted, however that such conclusions would be erroneously drawn for the following reasons.

The court in *Van Biljon* stated expressly that if the prison authorities had argued a lack of resources for the provision of antiretroviral medication, its finding may have been different.²⁴⁰ This was recognised by the high court in *Soobramoney*²⁴¹ in a judgment which was subsequently upheld by the Constitutional Court, in the following terms:

“There remains for me to deal with one decision upon which the applicant’s counsel relied and that is the recent decision in *Van Biljon and Others v Minister of Correctional Services and Others* 1997 (4) SA 441 (C) (*B and Others v Minister of Correctional Services and Others* 1997 (6) BCLR 789). In that case Brandt J held that s 35(2)(e) of the Constitution obliged the state to provide prisoners suffering from HIV with certain very expensive drugs at state expense. If prisoners are entitled to enforce their right to adequate medical treatment the same should apply to the applicant who after all, is not a criminal (so counsel argued). A careful reading of the judgment, however, reveals that it does not provide support for the applicant's case. It is clear that the question of budget constraints was argued - see 454C (SA) (801E (BCLR)) where the following is said: ‘If HIV patients in provincial hospitals are to receive the combination therapy claimed by applicants, Mr Scholtz submitted, it would involve a prioritisation of resources in their favour. In view of the budget restrictions on the hospital services, such prioritisation would necessarily be at the expense of other patients dependent upon the provision of health care by the state. Such patients may include persons suffering from acute heart disease, cancer sufferers, children, the elderly, pregnant women and so on.’”

²⁴⁰

Van Biljon fn 236 *supra*. In fact what the court said at p 457 onwards was: [56] What respondents have shown through the affidavit of Dr Wood is that provincial hospitals cannot afford to provide all State patients who are HIV infected with the anti-viral treatment claimed by applicants. Dr Wood's motivation of this statement is - at least as far as Somerset Hospital is concerned - not disputed by applicants and, in fact, appears to be unanswerable. It appears from respondents' papers that the Department of Correctional Services is also subject to budgetary constraints. I agree with the submission by Mr Seligson, however, that no case is made out by respondents that, as a result of budgetary constraints, the Department of Correctional Services cannot afford to provide such anti-viral treatment for HIV positive prisoners who are eligible for this treatment. With regard to possible financial constraints, there is the further consideration of a cost-saving raised by applicants' experts to which respondents have, in my view, not given a conclusive answer. As appears from the foregoing, it is contended by applicants' experts, on the basis of international research, that the administration of anti-viral therapy at an early stage is cost-effective in that the treating of opportunistic infections is significantly reduced. It is true that respondents' medical expert, Dr Wood, does not agree with the results of the international research. It is also true, as was submitted by Mr Scholtz, that this dispute between medical experts cannot be determined on motion papers. It does, however, stand to reason that the postponement of the costly treatment for opportunistic infections must result in some cost-saving, even if such saving does not exceed the cost of prophylactic anti-viral treatment, as appears to be suggested by the results of international research. From respondents' papers, it appears that they have disregarded the possibility of any cost-saving through anti-viral treatment. In these circumstances, the polycentric issue referred to by Mr Scholtz does not arise. If a proper case was made out by respondents that, due to the constraints of its own budget, the Department of Correctional Services simply cannot afford the medical treatment claimed by applicants, I might have come to the same conclusion as the English Court of Appeal in *R v Cambridge Health Authorities* ([1995] 2 All ER 129 (CA)) or I might have found that 'adequate medical treatment' for applicants is dictated by such budgetary constraints. From what I have already stated, it appears, however, that on the facts of this case it is not necessary for me to make a definite finding on these difficult issues.”

²⁴¹

Soobramoney fn 23 *supra*

In dealing with this argument the learned Judge at 454C--D (SA) (802E (BCLR)) says the following:

“I do not, however, agree with the proposition that financial conditions or budgetary constraints are irrelevant in the present context. What is ‘adequate medical treatment’ cannot be determined *in vacuo*. In determining what is ‘adequate’, regard must be had to, *inter alia*, what the State can afford. If the prison authorities should, therefore, make out a case that as a result of budgetary constraints they cannot afford a particular form of medical treatment or that the provision of such medical treatment will place an unwarranted burden on the State, the Court may very well decide that the less effective medical treatment which is affordable to the State must in the circumstances be accepted as ‘sufficient’ or ‘adequate medical treatment’.”

The learned Judge then concludes that the prison authorities had not made out a case on the papers that as a result of budgetary constraints they could not afford to provide the anti-viral treatment for the prisoners.”

The court in *Van Biljon*²⁴² did not concede that the ambit of the right as it related to prisoners was greater than the right afforded to everyone else with regard to medical treatment. Rather it agreed that the state owed a *higher duty of care* to HIV positive prisoners and proceeded to give the reasons for this as being that the state itself, by incarcerating people, created a greater risk for them of exposure to opportunistic infections and at the same time nullified their ability or opportunity to work and earn enough money to obtain adequate treatment for their condition. Antiretroviral drugs are available in the private sector in which people can either belong to a medical scheme or can pay out of their own pockets for medical treatment. The approach of the court was that one could not say, in the absence of arguments around budgetary constraints, that prisoners must receive the same medical treatment as other people who are not incarcerated because other people who are not incarcerated are not necessarily exposed to the same risks of opportunistic infection and they have the further advantage of being free to work and pay for their medical treatment themselves. What the court was in effect saying is that the state cannot increase the risks to health of a certain sector of the population, whilst at the same time effectively restricting them in their ability to pay for their own medical treatment and then in the same breath argue that its obligations towards them are the same as for those members of the population to whom those risks and restrictions are inapplicable. It is not that the content of

²⁴² *Van Biljon* fn 236 *supra*

the right of prisoners to access to health care services is substantially different to those of non-prisoners but rather that the fact of incarceration materially restricts their access to health care services and moreover exposes them to the risk of opportunistic infections which would not necessarily have been characteristic of their lifestyle outside of prison and which they could take steps to avoid outside of prison²⁴³.

In view of the foregoing, it is submitted that it is not that the right of prisoners to adequate medical treatment that is materially different to the right of everyone to access to health care services. It is the context in which the right is exercised, or the circumstances in which the right holder finds himself, that results in a practical difference. *Van Biljon* highlights the fact that it is important to realise that the right to health care services is highly contextualised and always will be. Every judgment of the constitutional court on the subject of socio-economic rights and the wording of the rights in the Constitution itself points to this. In *Grootboom*²⁴⁴, for instance, the court said these matters have to be decided on a case-by-case basis. If one considers the wording of section 27(1) in relation to the situation of prisoners, the judgment in *Van Biljon* is entirely consistent with the right of everyone to access to health care services. Incarceration carries an opportunity cost which affects a prisoner's access to health care services. The state is required in some way to make good on that opportunity cost and if available resources permit it, this means affording to prisoners treatment which is reasonably necessary for their condition and which they would have been able to buy outside of prison. The court and the counsel for the applicants stressed in *Van Biljon* that the applicants were not entitled to optimal treatment or the best possible treatment – only adequate treatment²⁴⁵. If one looks at the judgment as whole, another description for “adequate” might be “... reasonable legislative and other measures within its available resources...”. The right of the poor with regard to access to health care services, when expressed in practical terms may seem different to those of the rich who can afford to pay for health care services or who do not have the same disease profiles. The rights of

²⁴³ *Van Biljon* fn 236 *supra*. The court observed, at p 457 that: “Even if it is, therefore, accepted as a general principle that prisoners are entitled to no better medical treatment than that which is provided by the state for patients outside, this principle can, in my view, not apply to HIV infected prisoners. Since the state is keeping these prisoners in conditions where they are more vulnerable to opportunistic infections than HIV patients outside, the adequate medical treatment with which the state must provide them must be treatment which is better able to improve the immune systems than that which the state provides for HIV patients outside.”

²⁴⁴ *Grootboom* fn 10 *supra*

²⁴⁵ *Van Biljon* fn 236 *supra*, p 455 para 49

those in desperate need; vulnerable groups such as old people, the disabled and children, may find expression in very different ways to those of healthy young adults. This does not change the nature of the right. Everyone has the right of access to health care services and legally speaking, there can be no discrimination between different groups. However, the effects of the exercise of the right, its expression in differing circumstances, may well be different due to the different levels of risk and the nature of the specific need²⁴⁶.

2.6 Conflicting Rights

The question of conflicting rights is a considerable subject in its own right and underpins many of the issues that have already been raised with regard to the unitary nature of the right of access to health care services and the interconnectedness of this right with other socio-economic rights. It is not proposed in this section to canvas the potential conflicts between various areas of the common law and the constitutional rights that relate to health care services but rather to examine more closely potential conflicts between other constitutional rights and the right of access to health care services *inter se*. A closer examination of the interface between the constitutional right of access to health care services and rights in other areas of law will be conducted at a later stage when these other areas of law as they relate to health care services are explored in more detail. The question for now is how does one reconcile conflicts between constitutional rights.

In *Van Zyl and Another v Jonathan Ball Publishers (Pty) Ltd and Others*,²⁴⁷ the court observed that:

“There is no hierarchy of rights set out in the Constitution. There is no precise formula for dealing with a tension between opposing rights. One right in chap 2 of the Constitution does not automatically trump another. At 17 of *Personality Rights* (op cit) Burchell states the following in dealing with the importance of the right to freedom of expression:

‘Self-esteem, respect and individual privacy are aspects of what makes up the totality of human dignity. Freedom of expression does not trump all other individual rights - it is, like these other rights, subject to reasonable and justifiable limits which, in turn, must also reflect the dictates of freedom, equality, democracy and dignity.’

²⁴⁶ This is consistent with the doctrine of transformative constitutionalism referred to elsewhere in this chapter.

²⁴⁷ *Van Zyl 1999 (4) SA 571 (W)* p591-592

When competing rights are asserted, one must view the assertions and the clashes in context and against the circumstances of each case. See *Holomisa v Argus Newspapers Ltd* 1996 (2) SA 588 (W) at 607B et seq. Opposing parties in cases like the present will respectively assert equally emphatically and with great enthusiasm that either the right to dignity is a primary right or that the role of the media in a democratic society cannot be overstated. At 18 of *Personality Rights* (op cit) Burchell states the following: ‘The balancing of rights and interests is the essence of the legal process and an adjudicator cannot avoid making difficult decisions. The appropriate balance between individual reputation, dignity and privacy and freedom of expression, for instance cannot be sidestepped.’”

The constitutional court recognised that there would be a need for the courts to balance competing rights as early as the *Certification* judgment²⁴⁸

In the health arena there is considerable scope for conflict. One example that the constitutional court has already resolved appears from the case of *Soobramoney*²⁴⁹. Sachs J observed with regard to the apparent conflict between the limitations imposed by the Constitution on the right to have access to health care services and the right to life that:

“However the right to life may come to be defined in South Africa, there is in reality no meaningful way in which it can constitutionally be extended to encompass the right indefinitely to evade death. As Stevens J put it: dying is part of life, its completion rather than its opposite. We can, however, influence the manner in which we come to terms with our mortality. It is precisely here, where scarce artificial life-prolonging resources have to be called upon, that tragic medical choices have to be made.”²⁵⁰

The constitutional right to life clearly does not imply an unqualified and unlimited right of access to health care services for the continued postponement of death.

2.6.1 Children’s Rights

Another highly emotive and controversial area is the interface between the right of children to have access to health care services and the child’s right to bodily and psychological

²⁴⁸ See *Ex Parte Chairperson Of The Constitutional Assembly: In Re Certification Of The Constitution Of The Republic Of South Africa*, 1996 (4) SA 744 (CC) p 792 para 55 where the court noted: “A further argument raised by the objectors was that NT 8(2) would bestow upon Courts the task of balancing competing rights which, they argued, is not a proper judicial role. This argument once again fails to recognise that even where a bill of rights binds only organs of State, Courts are often required to balance competing rights. For example, in a case concerning a challenge to legislation regulating the publication and distribution of sexually explicit material, the Court may have to balance freedom of speech with the rights of dignity and equality. It cannot be gainsaid that this is a difficult task, but it is one fully within the competence of Courts and within the contemplation of CP II.”

²⁴⁹ *Soobramoney* fn 23 *supra*

²⁵⁰ *Soobramoney* fn 23 *supra* p784 para 57

integrity contained in section 12 (2) of the Constitution. In South Africa there are children who live without an adult caregiver often as a result of the HIV and AIDS pandemic to which their parents and families have lost their lives. Older children take care of the younger ones in informal groups in outlying areas where there are no formal institutions in which these children can be accommodated. The question is what happens when these children require medical treatment? In circumstances where emergency medical treatment is required issues of consent are not usually problematic because the law caters specifically for emergency situations but consent does become a problem for routine medical attention such as all children require from time to time. A child's right to bodily and psychological integrity is no less than that of an adult and indeed children are more vulnerable to infringement of this right as evidenced by the high levels of child abuse in South Africa. This right would ordinarily be protected by means of the informed consent to treatment of the child by a parent or guardian. Where there is no parent or guardian what is the legal position? How does one implement the right to basic health care services of children in this situation? The obvious solution would be either to apply for a court order as the high court is the upper guardian of all minor children in South Africa or to request permission from the Minister of Health in terms of section 39 of the Child Care Act²⁵¹. At the time of writing the Department of Social Development is busy with a draft Children's Bill which deals more comprehensively with the subject of medical attention for children than does the current legislation.²⁵² It remains to be seen whether its provisions will be more workable

²⁵¹ Child Care Act fn 33 *supra*. According to this section -

"(1) 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.

(2) 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.

(3) The person whose duty it is to maintain the child concerned shall be liable for the cost of any treatment of, or operation upon, the child in terms of subsection (1) or (2) as if the treatment had been given or the operation had been performed on his instructions.

(4) Notwithstanding any rule of law to the contrary-

(a) any person over the age of 18 years shall be competent to consent, without the assistance of his parent or guardian, to the performance of any operation upon himself; and

(b) any person over the age of 14 years shall be competent to consent, without the assistance of his parent or guardian, to the performance of any medical treatment of himself or his child."

²⁵² Section 135 of the Bill deals with consent to medical treatment and surgical operations in the following terms -

(1) A child may be submitted to medical treatment or surgical operation only if consent for such treatment or operation has been given in terms of either subsection (2), (3), (4) or (5).

(2) (a) A child may consent, subject to paragraph (b), to medical treatment or a surgical operation, provided the child -



that those of the current legislation in addressing the needs of children. The draft Bill has not yet reached the stage where public hearings have been conducted by the relevant parliamentary portfolio committee. It is therefore likely to be considerably refined before it is finally passed. Consequently a detailed discussion of the Bill is not appropriate for present purposes.

Another aspect of this problem of protecting the rights of children is the issue of child abuse and choice on termination of pregnancy. There is evidence that due to the high levels of sexual abuse of children, many teenage pregnancies are the result of incest or rape by a guardian, parent or other family member who would, in normal circumstances be called upon to give consent for the medical treatment of that child. If the child is in a situation where she is pregnant with the parent's or guardian's or family member's child and wishes to terminate the pregnancy without the knowledge or involvement of that person, most people would argue that the child should have the right to do so – that the responsible person has demonstrated that he or she is not fit to take decisions concerning the welfare of the child. The Choice on Termination of Pregnancy Act does not define a woman as being of any particular age. This has been challenged at the time of writing by an interest group which maintains that the constitutional rights and interests of children are not being served by allowing them to undergo terminations of pregnancy in the absence of the support,

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- (i) is at least 12 years of age; and
 - (ii) is of sufficient maturity and has the mental capacity to understand the benefits, risks and social implications of the treatment or operation.
- (b) A child may not consent to a surgical operation in terms of paragraph (a) without the assistance of –
- (i) the parent of the child; or
 - (ii) the primary care-giver of the child.
- (3) The parent or primary care-giver of a child may subject to section 43 consent to the medical treatment of or a surgical operation on the child if the child is –
- (a) under the age of 12 years; or
 - (b) over that age but is of insufficient maturity or does not have the mental capacity to understand the benefits, risks and social implications of the treatment or operation.
- (4) The superintendent of a hospital or the person in charge of the hospital in the absence of the superintendent, may consent to the medical treatment of or a surgical operation on a child if –
- (a) the treatment or operation is necessary to preserve the life of the child or to save the child from serious or lasting physical injury or disability; and
 - (b) the need for the treatment or operation is so urgent that it cannot be deferred for the purpose of obtaining consent that would otherwise have been required.
- (5) A child and family court may consent to the medical treatment of or a surgical operation on a child if –
- (a) the child has been abandoned; or
 - (b) the parent or primary care-giver of the child –
 - (i) refuses to give consent or to assist the child in giving consent;
 - (ii) is physically or mentally incapable of giving consent or assisting the child in giving consent;
 - (iii) is deceased; or
 - (iv) cannot readily be traced.
- (6) No parent or primary care-giver of a child may refuse to assist a child in terms of subsection (2) (b) or withhold consent in terms of subsection (3) by reason only of religious or other beliefs, unless that parent or primary care-giver can show that there is a medically accepted alternative choice."

guidance and advice of their parents, guardians or adult family members. The matter has not yet been heard by the court.

2.6.2 HIV Positive Patients and Sexual Offenders

Another area of conflict of rights is that of health workers who deal with patients who are possibly HIV positive. Some patients know of their HIV positive status but many do not. If a health worker is accidentally exposed to HIV infection in an occupational incident he or she is in a similar position to a person who has been sexually assaulted by a person who is HIV positive. They have both been involuntarily exposed to the virus. The Department of Justice is busy with a draft Bill at present which makes provision for the compulsory HIV testing of alleged sexual offenders. This is a further instance of the legislative balancing of rights in favour of the victims of sexual assault to bodily and psychological integrity against the rights of alleged sexual offenders to privacy and bodily and psychological integrity. There seems to be growing recognition for the need to balance the rights of health care workers and victims of sexual assault against those of persons with whom they have been involved and who may have infected them with HIV. In the case of children, section 136 of the draft Children's Bill deals specifically with testing of children for HIV²⁵³. These

²⁵³ “(1) No child may be tested for HIV except when –

- (a) this is in the best interest of the child and consent has been given in terms of subsection (2); or
- (b) the test is necessary in order to establish whether –
 - (i) a health worker may have contracted HIV due to contact in the course of a medical procedure involving contact with any substance from the child's body that may transmit HIV; or
 - (ii) any other person may have contracted HIV due to contact with any substance from the child's body that may transmit HIV, provided the test has been authorised by a court.

(2) Consent for a HIV-test on a child may be given by –

- (a) the child, if the child is –
 - (i) 12 years of age or older; or
 - (ii) under the age of 12 years and is of sufficient maturity to understand the benefits, risks and social implications of such a test;
- (b) the parent or care-giver, if the child is under the age of 12 years and is not of sufficient maturity to understand the benefits, risks and social implications of such a test;
- (c) a designated child protection organisation arranging the placement of the child, if the child is under the age of 12 years and is not of sufficient maturity to understand the benefits, risks and social implications of such a test;
- (d) the head of a hospital, if –
 - (i) the child is under the age of 12 years and is not of sufficient maturity to understand the benefits, risks and social implications of such a test; and
 - (ii) the child has no parent or care-giver and there is no designated child protection organisation arranging the placement of the child; or
- (e) a child and family court, if –
 - (i) consent in terms of paragraph (a), (b), (c) or (d) is unreasonably withheld; or
 - (ii) the child or the parent or care-giver of the child is incapable of giving consent.”



provisions are likely to be controversial especially on the subject of testing in order to establish whether a health worker may have contracted HIV due to contact in the course of a medical procedure involving contact with any substance from the child's body that may transmit HIV. In effect this section is seeking to balance the constitutional rights of health workers to bodily and psychological integrity against those of the child to privacy. Those opposed to involuntary or compulsory testing for HIV argue that if universal precautions against infection are routinely undertaken then it should not be necessary to force a patient to undergo an HIV test. They also point out that if a health professional is accidentally exposed to HIV infection in a work related incident, he or she is likely to opt for HIV prophylaxis even if the patient in question tests negative for HIV due to the existence of a window period for sero-conversion in which a patient can still infect someone else with HIV but does not test positive for the virus. However it is not the intention to discuss the draft Children's Bill in this chapter but merely to highlight some of the issues concerning the balancing of the rights involved in the rendering health care services.

2.7 Rationing of Health Care Services and the Limitation of Rights

The rationing of health care services is a complex subject that embraces many more areas than just that of law. It is implicit in a world of limited resources and often explicit in decisions involving the allocation of resources. It involves questions not only of constitutional law but also of the law of contract, administrative law and even the law of delict. Since this chapter is dealing only with the constitutional law aspects of health services delivery, it is only in this context that the rationing of health care services will be discussed here. Rationing and access are two sides of the same coin. Rationing, properly applied, can improve access at a certain level since it can ensure more equitable distribution of resources so as to include people who previously had no access at all. However, it clearly has the potential to reduce access and whether or not this is a good thing depends a great deal upon the values and beliefs of the society in which it is effected. In the South African context, the term 'values' brings the discussion back to the Constitution. It is clear that

The Compulsory Testing of Alleged Sexual Offenders Bill (B10-2003) provides for the victim of an alleged sexual offence to apply to a magistrate for the compulsory testing for HIV of the alleged offender. If the offender is a minor, the Bill when it becomes law, will allow a magistrate to grant an order allowing him to be tested for HIV.

rationing decisions involving health will be judged against the rights in the Bill of Rights and the Constitution holds considerable potential for usefully informing rationing decisions. Since the Constitution awards a right of access to health care services, any limitation of this right would have to be in accordance with the provisions of the Constitution relating to the limitation of rights. Furthermore, because the right of access to health care services must be seen within the context of the other rights in the Bill of Rights, one must consider how the implementation of a right of access to health care services could restrict the other rights contemplated by the Constitution. It is necessary to establish whether there is any case law on this subject from which guidance may be obtained. It is also necessary to explore the entities which may either explicitly or implicitly ration access to health care services and on what basis. That rationing is implicit in the system itself is reflected by the observation of the court in *Soobramoney*²⁵⁴, subsequently quoted with approval in *Grootboom*²⁵⁵, that the content of the right is limited by the available resources. It is submitted, however, that this type of implicit rationing should rather be viewed in the context of the scope of a right rather than as a justifiable limitation of the right, i.e. rationing *per se*, since no right is absolute or unbounded²⁵⁶. They are all limited in their scope. It is submitted that the concept of the scope of a right is slightly different to the justifiable limitation of that right as contemplated in section 36 of the Constitution since 'scope' envisages an initial or original state of the right in a given set of circumstances whereas justifiable limitation implies a narrowing or restriction of the scope of the right so as to decrease the area included within

254 *Soobramoney* fn 23 *supra* para 11, p 771 "What is apparent from these provisions is that the obligations imposed on the state by ss 26 and 27 in regard to access to housing, health care, food, water, and social security are dependent upon the resources available for such purposes, and that the corresponding rights themselves are limited by reason of the lack of resources. Given this lack of resources and the significant demands on them that have already been referred to, an unqualified obligation to meet these needs would not presently be capable of being fulfilled."

255 *Grootboom* fn 10 *supra* at para 46, p 70

256 In *Soobramoney v Minister Of Health, Kwazulu-Natal* fn 82 *supra*, Combrinck J noted 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 does not infringe upon another person's right." In *Qozeleni v Minister Of Law And Order And Another* 1994 (3) SA 625 (E), the court noted at p 640 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)". See also *Rudolph And Another v Commissioner For Inland Revenue And Others* NNO 1994 (3) SA 771 (W) at p 74 in which Goldblatt J observed 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."

its original boundaries²⁵⁷. This argument would seem to be supported by the observations of Woolman²⁵⁸ in his criticism of the language of *Makwanyane*²⁵⁹ and the final Constitution with regard to limitation of rights.

2.7.1 Constitutional Aspects

The Constitution makes provision for situations in which it is necessary to limit the rights in the Bill of Rights in section 36²⁶⁰.

It has been observed that rights can be violated by administrative conduct on the part of the state and that legitimate reasons for depriving an individual or group of people access to a particular socio-economic right (for example non-compliance with a means test for social assistance) must be justified under the general limitation clause²⁶¹. It is important to note that the wording of section 36 stipulates that the rights may only be limited in terms of a *law* of general application. The question is whether administrative action itself can ever limit constitutional rights in terms of the wording of section 36. Although administrative action is taken in terms of a law of general application the question is whether the meaning of the phrase “in terms of” in section 36 encompass administrative action “in terms of” a law of general application or whether it was the intention that it could only be the “terms of” the law of general application that limit the right. It would seem that administrative

²⁵⁷ This distinction has been recognised by the constitutional court in *Bernstein And Others v Bester And Others NNO* (fn 43 *supra*) in which Ackermann J observed at p 792: “As will be seen in the following paragraphs, this echoes to some extent the approach of the United States Courts in determining the existence of a ‘reasonable expectation of privacy’, but it must of course be noted that the above comment was in regard to the limitation and not the scope of the right in question.”

²⁵⁸ See Woolman, fn 264 *infra*

²⁵⁹ *Makwanyane* fn 2 *supra*

²⁶⁰ Section 36 stipulates that:

(1) 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, taking into account all relevant factors, including -

(a) the nature of the right;
(b) the importance of the purpose of the limitation;
(c) the nature and extent of the limitation;
(d) the relation between the limitation and its purpose; and
(e) less restrictive means to achieve the purpose.

(2) Except as provided in as (1) or in any other provision of the Constitution, no law may limit any right entrenched in the Bill of Rights.

²⁶¹ Liebenberg in Chaskalson *et al* fn 67 *supra* at p41-29



action in terms of a law of general application is capable of limiting a right as contemplated in section 36 of the Constitution. The court in *Dawood*²⁶² stated that:

“It is an important principle of the rule of law that rules be stated in a clear and accessible manner. It is because of this principle that s 36 requires that limitations of rights may be justifiable only if they are authorised by a law of general application. Moreover, if broad discretionary powers contain no express constraints, those who are affected by the exercise of the broad discretionary powers will not know what is relevant to the exercise of those powers or in what circumstances they are entitled to seek relief from an adverse decision. In the absence of any clear statement to that effect in the legislation, it would not be obvious to a potential applicant that the exercise of the discretion conferred upon the immigration officials and the DG by ss 26(3) and (6) is constrained by the provisions of the Bill of Rights and, in particular, what factors are relevant to the decision to refuse to grant or extend a temporary permit. If rights are to be infringed without redress, the very purposes of the Constitution are defeated.”

From the foregoing it is clear that while the court did not raise the question of whether or not administrative decisions were capable of limiting rights in terms of the wording section 36 it dealt with the matter of the exercise of discretionary powers authorised in terms of the law of general application stating that there should be express constraints in the legislation so that those exercising the power know what is relevant to its exercise. The argument is clearly that where legislation gives an official discretionary powers the scope of which includes the power of limitation of a right then the discretionary powers must be exercised in accordance with section 36. Presumably the power to limit the right can be either express or implied in the legislation.

In *S v Makwanyane*²⁶³ the constitutional court observed that²⁶⁴:

“Our Constitution deals with the limitation of rights through a general limitation clause. As was pointed out by Kentridge AJ in Zuma's case, this calls for a ‘two-stage’ approach, in which a broad

²⁶² *Dawood* fn 12 *supra*

²⁶³ *Makwanyane* fn 2 *supra* at p435-436 (footnotes omitted)

²⁶⁴ Woolman S, ‘Out of Order? Out of Balance? The Limitation Clause of the Final Constitution’, (1997) 13 *SAJHR* 102 is critical of the language in both *Makwanyane* and the final Constitution saying that it seems to confuse the steps of fundamental rights analysis and fails to understand that not every limitation question involves questions of proportionality. He notes that: “The first question the Makwanyane court says we should ask is what is the nature of the right that is limited, and its importance to an open and democratic society based upon freedom and equality? The final Constitution rehearses this language with the more telegraphic injunction that we reflect upon the nature of the right. The problem is this. In two-stage fundamental rights analysis, the inquiry into the nature of the right limited and its importance in an open and democratic society based upon freedom and equality occurs at the first stage of analysis. The fundamental rights stage. Although I do not defend an absolutely rigid distinction between rights analysis and limitation analysis, the second distinction between rights analysis and limitation analysis – the limitation stage – directs our attention primarily, if not exclusively, to the reasonableness and justifiability of a limitation in an open and democratic society based upon human dignity, freedom and equality. Consideration of the nature and scope of the right is something that should already have taken place. To engage the question of a right's nature a second time would seem to invite analytical confusion.”

rather than a narrow interpretation is given to the fundamental rights enshrined in chap 3, and limitations have to be justified through the application of s 33. In this it differs from the Constitution of the United States, which does not contain a limitation clause, as a result of which courts in that country have been obliged to find limits to constitutional rights through a narrow interpretation of the rights themselves. Although the ‘two-stage’ approach may often produce the same result as the ‘one-stage’ approach, this will not always be the case...It is not whether the decision of the State has been shown to be clearly wrong; it is whether the decision of the State is justifiable according to the criteria prescribed by s 33. It is not whether the infliction of death as a punishment for murder ‘is not without justification’, it is whether the infliction of death as a punishment for murder has been shown to be both reasonable and necessary, and to be consistent with the other requirements of s 33. It is for the Legislature, or the party relying on the legislation, to establish this justification, and not for the party challenging it to show that it was not justified.”

The court further observed concerning the criteria for limitation of the right that:

“The criteria prescribed by s 33(1) for any limitation of the rights contained in s 11(2) are that the limitation must be justifiable in an open and democratic society based on freedom and equality, it must be both reasonable and necessary and it must not negate the essential content of the right.”²⁶⁵

It said that:

“the limitation of constitutional rights for a purpose that is reasonable and necessary in a democratic society involves the weighing up of competing values, and ultimately an assessment based on proportionality. This is implicit in the provisions of s 33(1). The fact that different rights have different implications for democracy and, in the case of our Constitution, for ‘an open and democratic society based on freedom and equality’, means that there is no absolute standard which can be laid down for determining reasonableness and necessity. Principles can be established, but the application of those principles to particular circumstances can only be done on a case-by-case basis. This is inherent in the requirement of proportionality, which calls for the balancing of different interests. In the balancing process the relevant considerations will include the nature of the right that is limited and its importance to an open and democratic society based on freedom and equality; the purpose for which the right is limited and the importance of that purpose to such a society; the extent of the limitation, its efficacy and, particularly where the limitation has to be necessary, whether the desired ends could reasonably be achieved through other means less damaging to the right in question. In the process regard must be had to the provisions of s 33(1) and the underlying values of the Constitution, bearing in mind that, as a Canadian Judge has said, ‘the role of the Court is not to second-guess the wisdom of policy choices made by legislators.’”²⁶⁶

²⁶⁵ *Makwanyane* fn 2 *supra* at p 436

²⁶⁶ *Makwanyane* fn 2 *supra* p 436. The court proceeds to an examination of Canadian law and points out that: “In a frequently cited passage, Dickson CJC described the components of proportionality as follows: “There are, in my view, three important components of a proportionality test. First, the measures adopted must be carefully designed to achieve the objective in question. They must not be arbitrary, unfair or based on irrational considerations. In short, they must be rationally connected to the objective. Secondly, the means, even if rationally connected to the objective in this first sense, should impair “as little as possible” the right or freedom in question: *R v Big M Drug Mart Ltd* at 352. Thirdly, there must be a proportionality between the effects of the measures which are responsible for limiting the Charter right or freedom, and the objective which has been identified as of “sufficient importance”. (*R v Oakes* 1986 19 CRR 308 ([1986] 1 SCR 103; (1986) 26 DLR (4th) 200 (SCC); [1987] LRC (Const) 477). In *S v Zuma* 1995 (4) BCLR 401 (CC) at para 35 the court cautioned against the attachment of overmuch importance to the test in the *Oakes* case saying that the *Oakes* criteria may well be of assistance to our courts in cases where a delicate balancing of individual rights against social interests is required. “But s33(1) itself sets out the criteria which we have to apply and I see no reason, in this case at least, to attempt to fit out analysis into the Canadian pattern.” The question of the role of the courts in altering or reviewing policy decisions of another branch of government arises in this context as well. Chaskalson P notes at p 437-438 that: “The second requirement of the *Oakes* test, that the limitation should impair the right ‘as little as possible’, raises a fundamental problem of judicial review. Can, and should, an unelected court substitute its own opinion of what is reasonable or necessary for that of an elected legislature? Since the judgment in *R v Oakes*,

Woolman²⁶⁷ notes that the limitation clause has a fourfold purpose. He says that firstly it functions as a reminder that the rights enshrined in the Constitution are not absolute. The rights may be limited where the restrictions can satisfy the test laid out in the limitation clause. Secondly, he says, the limitation clause indicates that rights may *only* be limited where and when the stated objective behind the restriction is designed to reinforce the values which animate this constitutional project. Those values include openness, democracy, freedom and equality, as well as the more specific values reflected in the individual rights themselves. Thirdly, say Woolman, the test set out in the limitation clause allows for open and candid consideration of competing government, public, private and constitutional interests. That is the limitation clause should provide a mechanism for weighing or balancing competing fundamental values against one another. Fourthly, he says, the limitation clause represents an attempt to solve the problem of judicial review by establishing a test which determines the extent to which the democratically elected branches of government may limit constitutionally protected rights and the extent to which an unelected judiciary may override the general will and write the law of the land. He observed that by making the guidelines for judicial nullification of majoritarian decisions reasonably precise the drafters hoped to provide at least a partial solution to the problem of judicial review.

Woolman²⁶⁸ has commented that the limitations clause in the final Constitution differs in two important respects from that in the interim Constitution. Firstly, it removes the justificatory requirement that a limitation be necessary for certain classes of rights and freedoms. He notes that all limitations on the rights and freedoms enshrined in the new Bill of Rights must simply be reasonable and justifiable in an open and democratic society based upon human dignity, equality and freedom in order to pass constitutional muster.

the Canadian Supreme Court has shown that it is sensitive to this tension, which is particularly acute where choices have to be made in respect of matters of policy. In *Irwin Toy Ltd v Quebec (Attorney-General)*, Dickson CJ cautioned that courts 'must be mindful of the legislature's representative function'. In *Reference Re ss 193 and 195.1(1)(c) of the Criminal Code (Man)*, it was said that 'the role of the Court is not to second-guess the wisdom of policy choices made by . . . legislators'; and in *R v Chaulk*, that the means must impair the right 'as little as is reasonably possible'. Where choices have to be made between 'differing reasonable policy options', the courts will allow the government the deference due to legislators, but '(will) not give them an unrestricted licence to disregard an individual's Charter Rights. Where the government cannot show that it had a reasonable basis for concluding that it has complied with the requirement of minimal impairment in seeking to attain its objectives, the legislation will be struck down.' (footnotes omitted)

267 See Chaakalson *et al* fn 67 at p12-1 to p12-2

268 Woolman fn 264 *supra*

Secondly, it removes the “shall not negate the essential content of the right requirement”. Woolman observes that this means that courts need no longer concern themselves with the apparently recondite determination of what constitutes the inviolable core of any given right.

In a discussion of the relevant factors in section 36(1) of the Constitution, Woolman complains that the order of these factors does not reflect accurately the proper order of factors for the purpose of limitation analysis. He says that the express ordering of the factors may lead the courts to ask the wrong questions at the wrong time and then observes that the first factors and second factors – the nature of the right which has been infringed and that importance of the purpose of the limitation – are both well placed. It is with the third factor, according to Woolman, that the problems begin. This factor is the nature and extent of the limitation. He asserts that this factor is misplaced and that it should be placed last, inviting as it does, cost-benefit analysis, arguing that the fourth factor – the relation between the limitation and its purpose – belongs after the second factor. Once the legitimacy of the objective is established, says Woolman, it makes sense to ask whether the means employed to achieve the objective are rationally related to achievement of the objective. Woolman alleges that it is not at all clear what the *Makwanyane* court or the drafters mean by the ‘nature... of the limitation’, saying that they seem to be concerned that an apparently justifiable limitation – one which serves a legitimate end, employs means rationally connected to that end and reflects one of the least restrictive means possible for achieving that end – does not impose costs or burdens upon the rights-holder(s) which far outweigh the benefits said to flow to other members of society. He says that this enquiry is the only one which compares directly the competing and often incommensurable values at stake and is also an enquiry bound to put the court under the greatest political pressure. It asks the court to revisit the compromise of social interests struck by the co-ordinate branches of government. It is submitted that this point is nicely illustrated by the situation facing the court in the *TAC* case although the question of justifiable limitation of rights was not expressly discussed in the judgement. Woolman observes that various constitutional goods are incommensurable with one another and that equality is not reducible to freedom and dignity is not the same thing as expression. He predicts that there will be situations in

which constitutional goods will urge independent and irreconcilable claims upon us: in such situations we will have to choose between incommensurable goods and then goes on to give some topical examples, illustrating that the balancing of rights and interests is very often a matter of personal preference depending upon one's ideological point of view.

2.7.2 Limitations of rights in the health care context

In the context of health there is a considerable potential need to limit the rights of persons in order to preserve and protect health and to protect the users of health care services. Thus there is legislation which –

- regulates the practice of various health professions including the qualifications people must have in order to practice as health professionals, compulsory community service upon qualifying as professionals including where such community service must be carried out, questions of how they may advertise and the manner in which they must conduct their practices;²⁶⁹
- regulates the donation, acquisition storage supply and use of human tissue for various purposes;²⁷⁰

²⁶⁹ Health Professions Act 1974 (Act No 56 of 1974), Nursing Act 1978 (Act No 50 of 1978), Pharmacy Act 1974 (Act No 53 of 1974), Allied Health Professions Act 1982 (Act No 63 of 1982), Dental Technicians Act 1979 (Act No 19 of 1979) There is soon to be a Traditional Health Practitioners Act as well. At the time of writing it is being processed through Parliament. It is clear from the dates of this legislation that it precedes the 1996 Constitution by many years and that its provisions have not been tested in terms of litigation against the Bill of Rights which illustrate the fact that the alignment of South African law with constitutional principles is an ongoing process. This legislation has been amended from time to time, in some cases after the Constitution came into effect but not all of these amendments have been substantially significant. The Pharmacy Act is probably a notable exception in that in 1997 certain amendments were proposed which would open up access to ownership of pharmacies by non-pharmacists. The other exception is the Health Professions Act which compels dispensing doctors to obtain a licence from the Director-General. Davis, Cheadle and Haysom (in 124 *supra*) after pointing out at p305 that the limitation provisions of the South African Constitution were drawn from the Canadian Charter of Rights and Freedoms refer at p313 to a Canadian case *Rocket v Royal College of Dental Surgeons of Ontario* (1990) 71 DLR (4th) 68 in which regulations governing the dental profession prohibited dentists from advertising. They observe that the Canadian Supreme Court had no difficulty in asserting the 'pressing and substantial' interest in regulating the profession and preventing irresponsible and misleading advertising on matters not susceptible to verification but found that the complete ban on advertising was a disproportionate means to effect this objective. It said that dentists should be able to 'advertise their hours of operation and the languages they speak, information which would be useful to the public and present no serious danger of misleading the public or undercutting professionalism...Moreover the value served by free expression in the case of professional advertising is not purely the enhancement of the advertiser's opportunity to profit...[t]he public has an interest in obtaining information as to dentist's office hours, the languages they speak and other objective facts relevant to their practice-information which [the law] prohibits dentists from conveying by advertising. Useful information is restricted without justification. The court held it was satisfied by these considerations that the adverse effect of infringement of the freedom of expression in this case outweighs the benefits conferred by the legislation.

²⁷⁰ Human Tissue Act No 65 of 1983



- restricts the freedom of people to smoke where they please and the ability of suppliers of tobacco products to sell tobacco products and advertise such products as they choose;²⁷¹
- restricts the location, nature and types of services of various kinds of health establishments;²⁷²
- how and by whom medicines may be sold;²⁷³
- who may own a pharmacy and under what conditions²⁷⁴.

Much of this legislation highlights the points made by Woolman about choices in the balancing of constitutional rights and interests. In view of Woolman's observations, the concept of balancing of rights and interests is possibly overly simplistic. In its regulation of health professionals and health care goods the legislation offsets the restriction of supply against the need for public safety, academic and professional freedom and freedom of expression and commercial activity against public health and freedom and security of the person. These constitute value choices which may or may not be constitutional, depending upon a wide variety of circumstances. It is precisely due to the idea of the balancing of rights that a potentially boundless number of possibilities for constitutionally based litigation exists with regard to each of these statutes. The concept of balance implies a situation centred approach. What constitutes a balance in one situation may not necessarily

²⁷¹ Tobacco Products Control Act No 83 of 1993

²⁷² The National Health Act, at the time of writing has not yet been proclaimed effective by the President. It contains provisions for certificates of need in terms of which the Director-General has the power to decide where a health establishment may be constructed as well as whether any modifications to existing health establishments may be made. The Health Act No 63 of 1977 which is currently in force also makes limited provision in terms of regulations, for a certificate of need type process in the issuing of licences for private hospitals and some of the provinces, such as KwaZulu-Natal, which have enacted their own legislation also makes provision for certificates of need to control health establishments.

²⁷³ The Medicines and Related Substances Control Act, 1965 (Act No 101 of 1965). An amendment to this Act in 1997 which becomes operational in May 2003 makes provision for the licensing of dispensing doctors and other health professionals who wish to sell medicines and restricts the power of such professionals to do so by compelling them to attend and pass a course to be established by the Pharmacy Council. Prior to this legislation dispensing doctors were able to dispense without such a licence. An amendment to the Health Professions Act which works in tandem with these provisions of Act 101 of 1965 and which compels dispensing doctors to obtain a licence to dispense medicines. The relevant section, 52 of the Health Professions Act, reads as follows:

"Dispensing of medicines

(1) A medical practitioner, dentist or other person registered in terms of this Act-

(a) may compound or dispense medicines only on the authority and subject to the conditions of a licence granted by the Director-General in terms of the Medicines and Related Substances Act, 1965 (Act 101 of 1965);

(b) shall not be entitled to keep an open shop or pharmacy.

(2) For the purposes of this section 'open shop' means a situation where the supply of medicines and scheduled substances to the public is not done by prescription by a person authorized to prescribe medicines." This is clearly a limitation of the right to pursue a trade, occupation or profession in terms of section 22 of the Constitution. The argument of the legislature is that it is justified. Whether or not it will be challenged on the basis of section 36 of the Constitution remains to be seen.

²⁷⁴ Pharmacy Act, 1974 (Act No 53 of 1974)

constitute a balance in another. The number of permutations of practical situations involving this legislation, the fact that cases of infringement of rights must usually be considered on their own merits and that generalisations are seldom possible, that one is often dealing with incommensurables, could lead to a situation in which, for a particular set of circumstances a particular law of general application does not constitute a justifiable limitation of rights but for another set of circumstances, it does. One cannot help but feel that within this paradigm, or lack thereof, the question of whether a limitation of rights is justifiable in terms of section 36 resembles a lottery. If the right combination of facts happens to proceed to litigation, the courts will decide that the limitation is unjustifiable despite numerous other factual combinations in which the limitation is uncontroversial and justified. In other words, if constitutional validity of a particular provision or enactment is relative, one can never state with absolute certainty that such a provision or enactment is constitutional. It is a question of constitutionality of the effect or result of the limitation in each individual case rather than the constitutionality of the limitation itself.

2.7.3 Case Law

Interestingly there have been relatively few instances of significant²⁷⁵ litigation against the state, challenging the legislation mentioned above, since the 1996 Constitution came into effect. The most pertinent case is that of *Minister of Health and Another v Maliszewski and Others* discussed below.

2.7.3.1 *Minister of Health and Another v Maliszewski and Others*²⁷⁶

Facts

²⁷⁵ In another case the Pharmaceutical Manufacturer's Association sought to challenge a perceived limitation of rights imposed by Act 90 of 1997, the Medicines and Related Substances Control Amendment Act, was settled out of court in favour of the state. The legislative principle that was contested remains unchanged. Another case, involving the 1993 Constitution, was against the state and the registrar of medicines who operates in terms of the Medicines and Related Substances Control Act No 101 of 1965. This case, *Reitzer Pharmaceuticals (Pty) Ltd v Registrar Of Medicines And Another* 1998 (4) SA 660 (T) is discussed further below.

²⁷⁶ *Maliszewski* 2000 (3) SA 1062 (SCA)



In this case, the Minister of Health appealed against a decision of the Transvaal division of the High Court in favour of 11 plaintiffs who had all obtained their medical qualifications outside South Africa and whose applications for full registration were denied on the ground that they had not written the Council's examination for full registration²⁷⁷. The plaintiffs argued that the Council's decision was unfair and unreasonable. In terms of the Medical, Dental and Supplementary Health Service Professions Act²⁷⁸ as it read on 29 October 1997 (the date on which proceedings had been instituted) a medical doctor who had qualified overseas and whose qualifications were not accredited as being on a par with those of South Africa could be granted limited registration in terms of s 26. Those who had been granted such limited registration could qualify for full registration if, having met the requirements prescribed by s 28(1)(b) and (c), they passed the examination for full registration (EFR), a practical, clinical and oral examination similar to that set for South African medical students at the end of their final year of training. In order to facilitate the return of South African exiles and their spouses who had studied and qualified as medical practitioners while abroad, a special dispensation, under which the normal requirements for the recognition of foreign qualifications was eased, operated between April 1991 and the end of 1991. The special dispensation was a once-off concession to returning exiles, there being no intention of introducing a lasting change to the normal rules governing the recognition of a foreign qualification or of introducing a general practice. As the class of intended beneficiaries did not lend itself to simple definition, the dispensation also applied to foreigners who were not spouses of South African citizens but who had acquired South African citizenship by naturalisation before the cut-off date. Those who sought registration under the special dispensation had to qualify and apply for it before the end of 1991. The special dispensation departed from the normal rules governing the recognition of foreign qualifications in a number of respects, including the careful assistance and monitoring of candidates during their period of practice under limited registration, their qualifying for full registration after one year's practice under limited registration, and, if their heads of department certified them to be sufficiently competent for full registration, their not being required to do the EFR. The respondents, all medical doctors who had passed their primary

²⁷⁷ When the case initially began the 1993 Constitution was applicable. By the time it reached the supreme court of appeal, the 1996 Constitution had come into effect and the court had to decide under which constitutional dispensation the case should be decided. It concluded that it had to be decided under the 1993 Constitution.

²⁷⁸ Health Professions Act *fn 269 supra*

medical examinations at certain overseas universities before emigrating to South Africa, had been granted limited registration by the second appellant council, which form of registration permitted them to work only in the public service. All had since become permanent residents and had acquired South African citizenship after 31 December 1991. They sought an order in a Provincial Division compelling the appellants to register them as medical practitioners without restrictions, without their being required to do the EFR, as it was only with full registration that they would be able to enter private practice as general practitioners. They contended that, on the basis of their qualifications and experience, they were entitled to equal treatment with South African-born citizens or foreigners who had acquired South African citizenship and who had been able to benefit from the special dispensation.

Judgment

In its judgment the Supreme Court of Appeal began by acknowledging that: “The appellants are entrusted with the function of administering the health services in the Republic of South Africa.”²⁷⁹ It observed that in terms of section 28 of the Medical and Dental and Supplementary Health Professions Act (now called simply ‘the Health Professions Act’), doctors like the respondents who had only limited registration could qualify for full registration provided they met the following requirements:

- (1) In terms of s 28(1)(b) they must have held limited registration for at least two years.
- (2) In terms of s 28(1)(c)(i) they must, while so registered, have practised in South Africa for at least two years, of which at least one year must have been at a public health facility approved by the Council.
- (3) In terms of s 28(1)(c)(ii) they must submit a certificate by the head of the health facility at which they practised certifying that they are ‘competent and of good character’.
- (4) In terms of s 28(1) they could then apply to the Council to sit for the EFR. In terms of s 28(2) the EFR had to be an examination designed to ascertain whether the practitioner –

²⁷⁹ *Maliszewski* see fn 276 *supra* at p 1066

- '(a) possesses professional knowledge and skill which is of a standard not lower than that prescribed in respect of medical practitioners . . . in the Republic;
- (b) has sufficient knowledge of the laws of the Republic applying to medical . . . practice . . . ; and
- (c) is proficient in at least one of the official languages of the Republic'.

The court noted further that the EFR could be taken at any South African medical school. Only after the practitioner passed the EFR and complied with all the other requirements was he or she entitled to full registration (s 28(4))²⁸⁰.

It acknowledged that in order to accommodate South African exiles returning home, the state and the council had introduced a temporary special dispensation for registration. Those who sought registration under the special dispensation had to qualify and apply for it before the end of 1991. The special dispensation was made subject to a cut-off date because it was intended to be a once-off concession to returning exiles. The court found that there was no intention to introduce a lasting change to the normal rules that govern the recognition of foreign qualifications, nor to introduce a policy to be followed in all future cases, nor to introduce a general practice²⁸¹.

The respondents abandoned their initial attack on the invalidity or unconstitutionality of any provision of the Act or the regulations. On their behalf it was also conceded that they were not entitled to full registration (and to the relief sought) merely by relying on the provisions of the Act and the regulations²⁸².

The court held²⁸³ that:

“There is no basis for extending the provisions of the special dispensation to the respondents. The special dispensation, by its very terms, is not applicable to them. They cannot rely on an extension of it because it created no entitlement on which to rely; it did not establish a policy or general practice binding the Council in respect of future cases, nor could it be said to have created a reasonable or legitimate expectation on the part of the respondents that they would be able to rely

²⁸⁰ *Maliszewski* fn 276 *supra* at p 1068

²⁸¹ *Maliszewski* fn 276 *supra* at p 1070

²⁸² *Maliszewski* fn 276 *supra* at p 1072

²⁸³ *Maliszewski* fn 276 *supra* at p 1073-1074



on it or benefit from it. The respondents always knew what the requirements for full registration, applicable to them, were. They had either to pass the EFR or to approach the Council under s 4(g) to recognise their qualifications as being equal, either wholly or in part, to any prescribed qualifications. For individuals in the position of the respondents these requirements are neither onerous nor unfair. It follows that the respondents have failed to prove a basis for the application of the equality principle and thus of compelling the Council to grant them full registration.”

It is important to note that the court commented that although the cut off date was somewhat arbitrarily chosen, as with all similar exemptions or exceptions or special dispensations, it was not done so unreasonably or unfairly and it was established and made known by the Council. When the special dispensation came to an end the full registration criteria became applicable. The court also observed²⁸⁴ that the special dispensation:

“did not establish a policy or general practice binding the Council in respect of future cases, nor could it be said to have created a reasonable or legitimate expectation on the part of the respondents that they would be able to rely on it or benefit from it. The respondents always knew what the requirements for full registration, applicable to them, were. They had either to pass the EFR or to approach the Council under s 4(g) to recognise their qualifications as being equal, either wholly or in part, to any prescribed qualifications. For individuals in the position of the respondents these requirements are neither onerous nor unfair.”

Discussion

In the last few observations of the court quoted above are some important guiding principles for setting policy, especially for once-off situations, in a way that avoids exploitation of the situation by the unscrupulous.

1. Arbitrariness does not necessarily equate to unfairness or unreasonableness where the circumstances are such that it is unavoidable to some degree.
2. Neither the dispensation nor the cut-off of the dispensation violated the principles of equality and there was no discrimination against the plaintiffs²⁸⁵. During and after the dispensation the same rules applied to everyone.

²⁸⁴ *Maliszewski* fn 276 *supra* at p 1073 - 1074

²⁸⁵ In *Maliszewski* (fn 276 *supra*) at p 1073 the court noted at that: “Against the foregoing it needs to be stated, as far as the equality argument is concerned, that the respondents have been treated on the same basis as all the other foreign doctors immigrating to South Africa who have acquired citizenship after December 1991. Thus viewed, there is no discrimination against the respondents. Nor is there discrimination against them *vis-à-vis* South African citizens by birth who qualified elsewhere but sought registration after December 1991 in South Africa: they have to pass the prescribed examination (unless they qualified in certain countries whose standards of training were by regulation accredited as being on a par with those of South Africa - which

3. The dispensation was communicated and established in such a way that it did not establish policy or general practice binding on the Council in respect of future cases.
4. The nature and limits of the dispensation²⁸⁶ were clearly defined, thus ensuring that the intention of the Council to create a once-off situation for a limited period of time was established.
5. No legitimate expectations were created in the minds of the plaintiffs that they would or could benefit from the dispensation.

It is submitted that the golden thread in *Maliszewski*, and the reason for the state's success, is the clarity of the Council's intentions and the fact that they were obviously communicated to relevant persons coupled with an absence of unfairness or unreasonableness.

Another case, *Reitser Pharmaceuticals*²⁸⁷ highlights the possibility that it is not only express, detailed and conscious limitations of rights that can be problematic but also the limitation of rights through the formulation of legislation that is either overbroad or too vague or both. The facts of the case are given below together with the main points of the judgment.

2.7.3.2 *Reitser Pharmaceuticals (Pty) Ltd v Registrar Of Medicines*²⁸⁸

Facts

is not the case with the respondents). The only basis for the reliance on the equality principle lies in a comparison of the respondents, who acquired citizenship after December 1991, and other foreign doctors in their position who acquired citizenship before that date."

286

The court in *Maliszewski* (fn 276 *supra*) at p 1073 pointed out that: "As explained above, the special dispensation was a relaxation of the normal requirements for full registration for a limited group of individuals and for a limited time with a clear out-off date. It amounted to a clearly defined exemption from the EFR. For the very reason that the Council did not wish to establish the special exemption as a general rule of practice or to create expectations, the out-off date was established and made known."

287

Reitser fn 275 *supra*

288

Reitser fn 275 *supra*



In this case, the applicant pharmaceutical company sought an order referring to the Constitutional Court the question of whether the definition of 'medicine' in s 1 of the Medicines and Related Substances Control Act 101 of 1965 (the Act), read with sections 14 and 19 of that Act, was in conflict with the provisions of s 26(1) of the Constitution of the Republic of South Africa Act 200 of 1993 which deals with the right to freely engage in economic activity. It also sought an order, pending the decision of the Constitutional Court, interdicting the respondents from preventing it from manufacturing, selling and distributing one of its products called Florex. This was a dried yeast product prescribed by doctors and used by patients as an anti-diarrhoeal as an adjunct to antibiotic therapy, the (as yet unproven) theory being that it would restore the flora in the intestines destroyed by the use of antibiotics. The product was sold in pharmaceutical dosages in capsule form. All anti-diarrhoeals which were not available for sale immediately before 5 July 1968 were called up for registration in terms of a resolution of the Medicine Control Council, approved by the second respondent, the Minister of Health, and published in the Government Gazette of 5 July 1968. Florex had not been available for sale before that date and had therefore been called up for registration. Sales of medicines subject to registration but which have not been registered are prohibited by s 14 of the Act. The applicant's case was that Florex was a dietary supplement, not a medicine, and would therefore not have been subject to registration under the Act save for the over-broad definition of 'medicine' in s 1. Although at the time of the application no medicinal claims were being made in the advertising and packaging material, at the time of its launch the Florex label had indicated that it was intended 'for concurrent use with antibiotic therapy . . . or as prescribed by your doctor'. Further indications that the applicant regarded Florex as an anti-diarrhoeal were, *inter alia*, that it regarded Inteflora, a product manufactured, sold and used for a similar purpose, as a competitor and the manner in which Florex had been marketed on the applicant's behalf. The applicant's attack on the definition of 'medicine' was primarily directed at the word 'used' in the introductory phrase on the grounds that, for example, even water would fall under the definition of 'medicine' if it were used to treat or cure thirst.²⁸⁹

289

From headnote *Reitzer* fn 275 *supra*

The respondents contended that the applicant itself conceded that the regulation and control of medicines, properly defined, is necessary and that its only complaint was that the definition of a medicine was too wide, so that the Act controls substances that are not really medicines. The respondents argued that Florex was so clearly and so obviously a medicine, whichever way one wished to define medicines, that it must and will fall within any reasonable definition of the word, and even the dictionary meaning thereof. Consequently, even if the Constitutional Court should declare the whole of the definition of medicine invalid Florex would still be a medicine - as understood in the ordinary grammatical sense of the word - and subject to registration, with the result that the declaratory order sought by the applicant would not be decisive of the real dispute between the applicant and the respondents, viz whether or not Florex should be registered as a medicine.

Judgment

The court did not accept the respondents' contention. It observed that the objection raised by the respondents was squarely dealt with in *Gooding v Wilson*²⁹⁰. That case concerned the constitutional validity of a Georgia statute making it a misdemeanor for any person, without provocation, to use to or of another, and in his presence, 'opprobrious words or abusive language, tending to cause a breach of the peace'. The conviction was based on the defendant's remarks to police officers while the defendant was participating in a picketing protest against the war in Vietnam. It quoted Mr Justice Brennan, delivering the opinion of the US Court as follows:

"It matters not that the words appellee used might have been constitutionally prohibited under a narrowly and precisely drawn statute. At least when statutes regulate or proscribe speech and when no readily apparent construction suggests itself as a vehicle for rehabilitating the statutes in a single prosecution . . . the transcendent (sic) value to all society of constitutionally protected expression is deemed to justify allowing "attacks on overly broad statutes with no requirement that the person making the attack demonstrate that his own conduct could not be regulated by a statute drawn with the requisite narrow specificity". . . . This is deemed necessary because persons whose expression is constitutionally protected may well refrain from exercising their rights for fear of criminal sanctions provided by a statute susceptible of application to protected expression.

'Although a statute may be neither vague, overbroad, nor otherwise invalid as applied to the conduct charged against a particular defendant, he is permitted to raise its vagueness or

²⁹⁰ *Gooding v Wilson* 405 US 518; 31 L Ed (2d) 408

unconstitutional overbreadth as applied to others. And if the law is found deficient in one of these respects, it may not be applied to him either, until and unless a satisfactory limiting construction is placed on the statute. The statute, in effect, is stricken down on its face. The result is deemed justified since the otherwise continued existence of the statute in un narrowed form would tend to suppress constitutionally protected rights.’ *Coates v City of Cincinnati*. . .”.

The court pointed out that the doctrine of over-breadth and vagueness are distinct but related concepts and quoted with approval from a judgement of the Canadian Supreme Court²⁹¹ which said that:

“Overbreadth and vagueness are different concepts, but are sometimes related in particular cases. As the Ontario Court of Appeal observed in *R v Zundel* (1987) 29 CRR 349 . . . cited with approval by Gonthier J in *R v Nova Scotia Pharmaceutical Society* . . . the meaning of a law may be unambiguous and thus the law will not be vague; however, it may still be overly broad. Where a law is vague, it may also be overly broad, to the extent that the ambit of its application is difficult to define. Overbreadth and vagueness are related in that both are the result of a lack of sufficient precision by a Legislature in the means used to accomplish an objective. In the case of vagueness, the means are not clearly defined. In the case of overbreadth the means are too sweeping in relation to the objective. Overbreadth analysis looks at the means chosen by the State in relation to its purpose. In considering whether a legislative provision is over broad, a court must ask the question: are those means necessary to achieve the State objective? If the State, in pursuing a legitimate objective, uses means which are broader than is necessary to accomplish that objective, the principles of fundamental justice will be violated because the individual’s rights will have been limited for no reason. The effect of overbreadth is that in some applications the law is arbitrary or disproportionate.”

At 209 Cory J said the following:

“In determining whether s 179(1)(b) is overly broad and not in accordance with the principles of fundamental justice, it must be determined whether the means chosen to accomplish this objective are reasonably tailored to effect this purpose. In those situations where legislation limits the liberty of an individual in order to protect the public, that limitation should not go beyond what is necessary to accomplish that goal.”

The court of appeal noted that a similar approach was adopted by the Constitutional Court in striking down the Indecent or Obscene Photographic Matter Act 37 of 1967 in which it was plainly recognised by the court that there were certain forms of obscenity which would justify a prohibition even on their possession. This did not prevent the Court from striking down the statute as a whole. The court quoted with approval the following words of Didcott J in *Case and Another v Minister of Safety and Security and Others; Curtis v Minister of Safety and Security and Others*²⁹²:

²⁹¹ *R v Heywood* 24 CRR (2d) 189 (SCC) at p 208

²⁹² *Case and Another* 1996 (3) SA 617 (CC)



“Such questions do not arise at present and are best left unanswered until some future case confronts us with them. But the trouble one now has with s 2(1) is that it hits the possession of other material too, material less obnoxious and sometimes quite innocuous which we cannot remove from its range while it lasts because the parts of s 1 giving it that effect are not satisfactorily severable from the rest.”

It then proceeded to consider the prospects of success and looked *inter alia* at the purpose of the Medicines and Related Substances Control Act²⁹³. In doing so it referred to the words of Kriegler AJA, as he then was, in *Administrator, Cape v Raats Röntgen and Vermeulen (Pty) Ltd*²⁹⁴:

“It would be advisable to pause for reflection lest the wood become obscured by the trees. Manifestly the Act was put on the statute book to protect the citizenry at large. Substances for the treatment of human ailments are as old as mankind itself; so are poisons and quacks. The technological explosion of the twentieth century brought in its wake a flood of pharmaceuticals unknown before and incomprehensible to most. The man in the street - and indeed many medical practitioners - could not cope with the cornucopian outpourings of the worldwide network of inventors and manufacturers of medicines. Moreover, the marvels of advertising, marketing and distribution brought such fruits within the grasp of the general public. Hence an Act designed, as the long title emphasizes, to register and control medicines. The enactment created a tightly meshed screening mechanism whereby the public was to be safeguarded: in general any medicine supplied to any person is, first, subject to stringent certification by experts; then it has to be clearly, correctly and comprehensively packaged and labelled and may only be sold by certain classes of persons and with proper explanatory information; to round it out detailed mechanisms for enforcement are created and ancillary measures are authorised.”

The court ruled that the limitation does not negate the essential content of the right in question and that it was reasonable and justifiable for ‘medicine’ to be defined widely.”²⁹⁵ On the strength of the foregoing, the temporary interdict sought by the applicant was refused.

Discussion

It is submitted that the interests of the public represented by the legislation and which were sought to be protected by the legislation were highly influential of the court’s decision not to grant the interdict and to tolerate an extremely broad definition of a medicine. Thus a provision which may be very broad in its scope, and might even be regarded as overbroad

²⁹³ Act No 101 of 1965

²⁹⁴ *Administrator, Cape v Raats Röntgen and Vermeulen (Pty) Ltd* 1992 (1) SA 245 (A) at 254B–E

²⁹⁵ *Reitzer* fn 275 *supra* at p 684

in other circumstances, can be saved by the weight and nature of the public interest it seeks to protect. The rigorous nature of the court's examination of both the definition of 'medicine' and the relevant constitutional principles is indicative, however, of the level of judicial caution that is applied to questions of over broadness and vagueness of legislative provisions that have an impact on constitutional rights. In this case the right in question was of freedom of economic activity because the definition of a medicine, when read in conjunction with another provision of the Medicines Control Act that prohibited the sale of medicines unless they were first registered in terms of the Act, had the effect of significantly restricting the freedom of economic activity in relation to medicines.

It is surprisingly difficult to define a medicine legislatively particularly when one starts looking at the question of whether a substance is a nutritional supplement and also given the fact that certain substances when applied or used in a certain way could constitute a medicine and at other times, not. For instance, common salt (sodium chloride) can be used as a medicine in certain circumstances. The natural element of the periodic table, iodine, is usually a solid and has many different applications only some of which are medicinal. It is when it is combined with certain other substances for use in the treatment of wounds, hyperthyroidism or medical diagnostics, that it becomes a medicine. In terms of the general regulations to the Medicines and Related Substances Act, a wound dressing is also a medicine despite the fact that when most people think of medicines they think of potions and pills. Certain chemicals that occur naturally within the human body are also classified as medicines for example, testosterone, oestrogens and prostaglandins since they are used as medicines in the treatment of illness. Vitamins can be either dietary supplements or medicines depending upon the purpose for which they are used and their dosage strengths. There is also the question of active pharmaceutical ingredients (APIs) and the 'packaging', in the form of the other inactive ingredients, with which they are sold for use by patients. A tablet for example consists of a combination of the API and the inactive ingredients. An API on its own, may or may not be a 'medicine' depending upon whether it is in a form that is suitable for use as such by a patient since a medicine is a substance that is "*used or purporting to be suitable for use* or manufactured or sold *for use in-*

- (a) the diagnosis, treatment, mitigation, modification or prevention of disease, abnormal physical or mental state or the symptoms thereof in man; or
- (b) restoring, correcting or modifying any somatic or psychic or organic function in man” [writer’s italics]

It is clear from the foregoing that the concept of a medicine is highly complex and technical matter that depends on the circumstances of its use and the purpose for which it is sold. The Act refers to medicines and scheduled substances the latter being defined as “any medicine or other substance prescribed by the Minister under section 22A”.

It is submitted with respect that the decision of the court was constitutionally correct in this case because it weighed up the interests concerned and came to the conclusion that the balance was in favour of a wide definition of a medicine. The constitutional right to freedom of economic activity in the interim constitution has been replaced in the Constitution with a right to *freely choose* a trade, occupation or profession. It is significant that the drafters of the Constitution saw fit to make such a change. One can no longer speak of a constitutional right to freedom of economic activity in the broad sense as one could when the interim constitution was still in place. The Constitution expressly states that the practice of a trade, occupation or profession may be regulated by law. Furthermore, the right to freely choose one’s trade occupation or profession in the Constitution is limited to citizens. Since only natural persons can become citizens the right does not available to juristic persons. In any event, it is submitted that given the existence and regular application and enforcement of legislation such as the Competition Act²⁹⁶, the Consumer Affairs, (Unfair Business Practices) Act²⁹⁷ and the various pieces of provincial legislation concerning consumer affairs²⁹⁸, not to mention the common law of contract, it is submitted that a broad right to freedom of economic activity is notional at best.

²⁹⁶ Competition Act No 89 of 1998

²⁹⁷ Consumer Affairs Act No 71 of 1998. In *Janse Van Rensburg No and Another v Minister Of Trade and Industry And Another* NVO 2001 (1) SA 29 (CC) the constitutional court held that section 8(5)(a) of the Act was unconstitutional but it the Act itself still stands. The court in this case suspended its order of constitutional invalidity for twelve months in order to give the legislature an opportunity to rectify the defect in the section.

²⁹⁸ See for instance Consumer Affairs (Unfair Business Practices) Act No 8 of 1996 (Limpopo Province); Consumer Affairs (Unfair Business Practices) Act No 5 of 1998 (Eastern Cape Province); Consumer Affairs (Unfair Business Practices) Act No 7 of 1996 (Gauteng Province); Consumer Affairs (Unfair Business Practices) Act No 14 of 1998 (Free State); Consumer Affairs (Unfair Business Practices) Act No 4 of 1996 (North West Province)

2.7.3.3 *Affordable Medicines Trust and Others v Minister of Health*²⁹⁹

Facts

The relief sought by the applicants initially entailed an extensive challenge to various sections of the Medicines and Related Substance Act³⁰⁰ as amended and regulation 18 of the General Regulations³⁰¹ to that Act on the basis of their constitutionality. At the core of the relief sought by the applicants was a ruling by the court that the legislative provisions that medical practitioners may not dispense medicines without a licence issued by the Director-General of Health was unconstitutional and thus invalid. At the hearing the relief sought by the Applicants was narrowed down to the following –

1. That section 22C(1)(a) of Act 101 of 1965 was unconstitutional and invalid inasmuch as it refers to “on the prescribed conditions”.
2. That Regulations 18(3)(b),(f),(g),(h) and (i), 18(4), 18(5), 18(6) and 20 of the General Regulations were unconstitutional and invalid.

Section 52 of the Health Professions Act³⁰² was amended by the Health Professions Amendment Act³⁰³ to the effect that a medical practitioner could only dispense medicines on the authority and subject to the conditions of a licence granted by the Director-General in terms of the Medicines and Related Substances Act. The applicants objected to the fact a medical practitioner’s dispensing licence is coupled to a particular premises arguing that doctors has for centuries held the right to dispense medicines as part of their practice. This was subject in principle to regulation by the Health Professions Council but in practice only a register was kept by the Council with no further regulatory requirements imposed. The applicants argued that section 22C(1) of the Medicines Act was silent on the question of

²⁹⁹ *Affordable Medicines Trust* unreported at the time of writing. Case number 1908/2004 in the Transvaal Provincial Division of the High Court. Judgment dated 02 July 2004.

³⁰⁰ Act No 101 of 1965

³⁰¹ General Regulations published in Government Gazette No 24727 on 10 April 2003.

³⁰² Health Professions Act No 56 of 1974

³⁰³ Health Professions Amendment Act No 89 of 1997



premises associated with the licence and that the Minister of Health was effectively making law which adversely affected the rights of health professionals and their patients. The respondents argued that the provisions of the Health Professions Act did not sufficiently regulate the 11 000 or so practitioners whose names were on the register as being dispensers of medicines. It argued that there were no standards, norms or guidelines to ensure that dispensing medical practitioners complied with or adhered to good dispensing and compounding practices and that a number of unacceptable practices, including bonussing, sampling of medicines and receipt of unacceptable incentives by dispensers of medicines occurred. This led to inappropriate prescribing, compounding and dispensing of medicines, increased costs of healthcare to the public and resulted in widespread bad dispensing practices. The applicants argued that if the legislature intended to limit a practitioner's right to dispense medicines to particular premises it should have said so in the relevant statutes. They argued that the regulatory provisions as they stood offended against the rule of law and the principle of legality. The stated government purpose of the licensing process is to increase access to medicines that are safe for use by the public.

Judgment

Kruger AJ observed that it is trite that one of the pillars on which the South African democratic dispensation is based is the principle of separation of powers and that as a general point of departure courts will be loath to enter into the fray of legitimate government policy. He stated that it is not for a court to adjudicate upon or apply value judgments with regard to the contents of government policy. At the same time, the principles of transparency and accountability constitute values which underpin the entire fabric of the Constitution. Herein, he said, lies a marked difference between the old order and the current dispensation. In the latter the formulation of policy is subject to public scrutiny and input and the end product is susceptible to assessment by the public. Public officials whether politicians or civil servants must be held responsible for their policies by the public. Kruger AJ noted that accountability in this sense forms part of the political process and it is not for the courts to interfere with policy matters under the guise of accountability. He observed that the respondents in their answering papers provided ample detail regarding the process which was followed and which resulted in the government

policy at issue and that the constitutional requirements of transparency and accountability had been complied with. The merits or de-merits of the policy that ensued were therefore immaterial, said Kruger AJ, for purposes of the constitutional challenges to be adjudicated upon. He stated that the remaining question was whether it could be said that the existence of a legitimate government purpose had been proven. In a nutshell the stated government purpose was to increase access to medicines that are safe for use by the public. Kruger AJ observed that this constitutes a legitimate government purpose³⁰⁴. The court noted that the applicants alleged in essence that the envisaged system of licensing with particular reference to the coupling of a licence to specific premises, is not rationally connected to the stated government purpose and that the licensing of premises was introduced for the first time by way of regulation 18, which the first respondent purportedly made in terms of section 22C(1). It noted further that the applicants alleged that regulations 18(3) and 18(4) where they refer to licensed premises are unconstitutional, that regulation 18 was unconstitutional inasmuch as the Minister had no power to make them and that substantial parts of the regulations are invalid on the grounds of vagueness or arbitrariness.

Kruger AJ pointed out that it was evident that the General Regulations were made in terms of the empowering section of the Medicines Act, namely section 35. The latter, *inter alia* makes provision for the making of regulations regarding storage, sale or use of medicines in respect of safety, quality and efficacy, the conditions under which medicines or scheduled substances may be sold and generally for the efficient carrying out of the objects and purposes of the Act. Hence, said the court, the Minister has comprehensive powers to make regulations on any aspect pertaining to the safety, quality and efficacy of medicines including their storage, keeping, use, sale, supply and the like. Kruger AJ stated that it is self-evidence that premises where medicines are kept or stored should adhere to certain minimum requirements and should be controllable as such. Even under the previous

304

Kruger AJ noted the reference by Chaskalson P in *S v Solberg; S v Negal; S v Lawrence* (in 137 *supra*) where he referred with approval to a passage from *Carmichael, Attorney General of Alabama v Southern Coal and Coke Co* 310 US 495 [1937] at 510, at [43]: "A State legislature, in the enactment of laws, has a widest possible latitude within the limits of the Constitution. In the nature of the case it cannot record a complete catalogue of the considerations which move its members to enact laws. In the nature of the case it cannot record a complete catalogue of the considerations which move its members to enact laws. In the absence of such a record courts cannot assume that its action is capricious or, that, with its informed acquaintance with local conditions to which the legislation is to be applied, it was not aware of facts which afford reasonable basis for its action. Only by faithful adherence to this guiding principle of judicial review of legislation is it possible to preserve to the legislative branch its rightful independence and its ability to function."

regulatory regime which only registered dispensing medical practitioners, they were required in terms of section 52(1)(a) of the Health Professions Act to confirm the address from which they would dispense. In their replying affidavit the applicants had also confirmed that the register kept in terms of section 52(1)(a) of the Health Professions Act regulates “technical aspects such as appropriate premises, adherence to statutory requirements, the storage of medicines etc.” Kruger AJ observed that the fact that the applicants concede that dispensing practices should be properly controlled appears from the statement made in the replying affidavit where the deponent states that issues such as the appropriate premises, adherence to statutory requirements and the storage of medicines are matters of which a patient would have no knowledge “but which would need to be regulated and controlled in the public interest”. He noted further that the applicants elsewhere made mention of the need for adequate dispensing controls and conditions and that they support the governments’ goals to ensure that high quality and appropriate medicines are safely distributed from clean and suitably equipped dispensing premises by properly trained dispensers. They also supported the regular inspection of premises to ensure that good dispensing practice is maintained. The court concluded that the principle of a known and identifiable address where medicines are kept is thus not foreign or new, even to the old dispensing, neither did the applicants contest that regular inspection and proper control go hand in hand with the safe supply of medicines from clean and suitably equipped dispensing premises. Thus, said the court, requirements regarding “licensed premises” are fully compatible with these facts in the context of section 35 of the Act.

Kruger AJ noted that the applicants relied heavily on what they referred to as “as symbiosis between section 22C(1)(a) and the regulations”. This “symbiosis” was allegedly borne out by way of the express reference in Regulation 18(1) to section 22C(1). He observed that section 22C(1) in essence deals with the empowerment of the Director-General to issue a licence to compound and dispense medicines. Regulation 18(1) does no more than confirm that an application for a licence to dispense or compound medicines should be directed at the Director-General. It is in that sense, said the court, that the reference to section 22C(1) as it appears in regulation 18(1) should be understood. Consequently, Kruger AJ found that he could not agree with the submission on behalf of the applicants that the relevant

regulations were not made in terms of section 35 of Act 101 of 1965 but as per regulation 18(1) they were made in terms of section 22C(1) of the Act. The court held that the regulations in general and regulation 19 in particular were made by the Minister in terms of section 35 of the Medicines Act. Thus the proximate cause of the alleged infringement did not lie in section 22C(1)³⁰⁵.

The court noted that it is within the power of parliament to determine what scheme should be adopted to attain the stated government purpose. The core issue is where the impugned provisions (which include the “prescribed conditions”) are rationally related to the stated government purpose. The latter includes the provision of medicines that are safe for use by the public. That in turn, by necessary implication implies the regulation of premises from which medicines are dispensed. That indeed, said the court, is what the legislation and the scheme brought about by it intend to address and achieve. It held that there was a clear rational relationship between the stated government purpose and the impugned legislation to the extent that the scheme brought about by the latter is clearly aimed at the provision of medicines that are safe for use by the public, and which will *inter alia* only be provided from identified premises which are controllable. The court noted that in terms of section 1 of the Medicines Act, “prescribed” is defined as “prescribed by or under the Act”. The term “this Act” is defined to include “any regulation”. The latter means “a regulation made and enforced under this Act”. The term “on the prescribed conditions” therefore means conditions made or enforced under the Medicines Act. Thus, said the court, the fact that regulation 18(3)(b) provides for that the exact location of the premises where compounding and/or dispensing will be carried out must form part of the application at the utmost differs only in degree from the former position in terms of section 52(1)(a) of the Health Professions Act. In terms of the latter the medical practitioner has to confirm the address from which he or she will dispense. Whether providing such an address could or could not be regarded as a “condition” said that court, is a matter of degree. At the very least, stated Kruger AJ, the higher threshold brought about by the new dispensation did not render the impugned provisions irrational vis-à-vis the legitimate government purpose. On the contrary, not only was the condition that the exact location of the premises (where

³⁰⁵ The court referred in this regard to *New National Party of South Africa v Government of the Republic of South Africa and Others* 1999 (3) SA 191 (CC) at 205C-E paragraph [21].

compounding and/or dispensing will be carried out) rationally related to the stated government purpose, it did not differ materially from the old dispensation to the extent that it did not introduce a wholly new and foreign element. Read with regulation 18(7), said the court, it made perfect sense. The court held that the words in section 22C(1)(a) “on the prescribed conditions” read with the contents of regulation 18 are rationally related to the stated government policy.

Kruger AJ noted that the regulations were made in terms of section 35 of the Medicine Act and not in terms of section 22C(1)(a). This section, he said, provides ample scope for the Minister to make regulations. He stated that the purpose of regulations is to spell out detail which, should it have been included in empowering legislation would render the alter cumbersome or which, by the very nature of the legislation itself could conveniently be dealt with by way of regulations without attempting to empower the relevant Minister to supersede Parliament’s legislative function or to assume legislative powers which due to their very nature reside with Parliament. In the current instance the court found that the Minister did not assume Parliament’s residual legislative powers, nor did she exceed the powers bestowed on her by section 35 to make regulations; the impugned parts of the regulations fall squarely, said the court, within the parameters imposed by section 35 regarding issues on which the Minister is empowered to make regulations. The court observed that the legislature probably appreciated that the conditions to be imposed might be of a specialised nature which required certain skills and expertise which would be more appropriately dealt with by those possessed of such skills and expertise. It held that the conditions imposed by the Minister, in consultation with the specialist body (the Medicines Control Council) were foreseen by the legislature to be of a nature which would not, in the ordinary course of events be conveniently dealt with by the Legislature itself. For this reason said the court it took the view that the Minister did not exceed her powers in making the regulations which couple the doctors’ right to dispense medicines to licensed premises.

With regard to regulation 19 the court observed that it required very little imagination to envisage that circumstances prevailing at different proposed dispensing premises may differ considerably. The circumstances of a busy city practice would be substantially different to

those in some far off corner in the Karoo or the Limpopo Province. It may be easier, said the court, for the dispensing doctor in a remote rural area to provide particulars with regard to the existence of other licensed health facilities in the vicinity of the premises from where the compounding and dispensing of medicines is intended to be carried out; to give a description of the geographic area to be served by the applicant; or to provide demographic considerations including disease patterns and health status of the users to be served. On the other hand, the city practitioner would find it relatively simple to describe the geographic area to be served by herself by naming the suburb/s served by the practice, but may experience some difficulties in estimating the number of health care users in that geographical area. The court stated that circumstances would dictate the particularity with which the requested information could be provided. Kruger AJ held that it did not follow that the information requested was necessarily arbitrary or capricious in nature. He observed that it is trite that words and expressions used in an enactment must be interpreted according to their ordinary meaning as well as in the light of their context. The latter is not limited to the language of the rest of the enactment but extends to the subject matter thereof, its apparent scope and purpose and within limits, its background. Where the language itself appears to admit of more than one meaning, one may from the beginning consider the context and the language to be interpreted together.³⁰⁶ The court said that taking into consideration the wide variety of circumstances that may prevail between different applicants from different cities, towns or parts of the country, the regulations must of necessity be phrased in a way in which, when responded to by the different “categories” of dispensing doctors, will provide the relevant decision-maker with sufficient material in order to be able to come to an informed decision. Kruger AJ said he found it hard to conceive that information which is to be supplied for the purposes envisaged by the regulations and in particular, Regulation 18(4), could be phrased in a more specific or normative way taking into consideration that the factors relevant to the decision to be made are so numerous and varied. He said it would have been extremely difficult (if not impossible) for the legislature as well as for the executive to have been more specific. To have attempted to identify potentially extreme variables in terms of narrow and specific criteria would not only have been impractical but well nigh impossible. He noted that the

³⁰⁶ The court referred to *Jaga v Dönges N.O. and Another* 1950 (4) SA 653 (A) at 662G-663A in this regard.



criteria in the regulations apply equally to all applicants and taking into consideration his or her prevailing circumstances each applicant could, to the best of his or her ability, provide the required information. The overarching objective is to increase access to medicines that are safe for use by the public. Kruger AJ then analysed in further detail the provisions of regulation 18(4)(a), 18(4)(b), 18(4)(c) and (d), 18(4)(e) and 18(4)(f), 18(5), 18(6) and 20. He observed with regard to the whole of Regulation 18(4) that it was evident that none of the factors referred to therein was decisive, of its own, of the decision to grant or refuse a licence and that clearly the objective was to attain an overall picture regarding the issues mentioned within the context of the overarching government purpose. He said that within the stated context the impugned provisions were clearly not intended to establish rigid norms or standards, nor to elicit rigid responses. They are phrased in a general way for reasons which are intended to elicit generalised responses with a view to enable the decision-maker to construe a general impression. Within that context, said the court, it did not regard any of the impugned provisions as arbitrary, vague or capricious or not objectively ascertainable with regard to the overall objective they were devised to attain. Kruger AJ said that it should further be borne in mind that should an applicant be aggrieved by the outcome of his or her application, the law provides for the means to address any alleged injustice. He said it was important to bear in mind that discretionary powers may be broad³⁰⁷

The court then went on to examine the alleged infringement of rights and noted that the constitutional challenge was narrowed down considerably compared to the initial attack on the licensing system *en bloc*. The main bone of contention was the coupling of a dispensing licence to particular premises. It noted that certain rights in the Bill of Rights had been relied upon by the applicants, namely the right to equality in terms of section 9, the right to practice their profession freely in terms of section 22, the right to dignity in terms of section 10, the right to freedom of movement in terms of section 21 and the right to property in

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The court referred in this regard to *Dawood and Others v Minister of Home Affairs* in 12 *supra* at 969 B-C para [53] where it was stated: "Discretion plays a crucial role in any legal system. It permits abstract and general rules to be applied to specific and particular circumstances in a fair manner. The scope of discretionary powers may vary. At times they will be broad, particularly when the factors relevant to a decision are so numerous and varied that it is inappropriate or impossible for the Legislature to identify them in advance. Discretionary powers may also be broadly formulated where the factors relevant to the exercise of the discretionary power are indisputably clear. A further situation may arise where the decision-maker is possessed of expertise relevant to the decisions to be made."

terms of section 25. The allegation was that the coupling of the licence to dispense medicines to licensed premises unjustifiably interferes with these rights in a manner that cannot be justified having regard to the provisions of section 36 of the Constitution. In addition the applicants contended that the coupling of a practitioner's licence to dispense to a particular premises constitutes an infringement of patients' rights, eg the right of choice from whom she wishes to receive medicine or will receive medicine in the future. The upshot was that the alleged infringement interfered with the patient's right to choose a particular practitioner and her right to enter into a private contractual relationship with such practitioner. The applicants alleged that this was an affront to the patient's dignity.

The court noted that section 22 of the Constitution provides that:

“Every citizen has the right to choose their trade, occupation or profession freely. The practice of a trade, occupation or profession may be regulated by law”

It stated that the content of the right in section 22 is the right to choose a trade, occupation or profession within the framework of any lawful regulation which controls its practice³⁰⁸. Kruger AJ pointed out that the government may control the practice of a trade, occupation or profession provided that any restrictions on the practice must be rational. He noted that the fact that section 22C of the Medicines Act introduces a licensing system for the dispensing of medicine by medical practitioners was not challenged per se and that the applicants aver that there is a conceptual difference between regulating and limiting. They argued that the impugned legislation goes beyond mere regulation and that it limits under the guise of regulation. The respondents contended that the impugned provisions did no more than regulate and that it is legitimate to regulate the practice of a profession so as to prevent harm to the general public, that public health is an important community interest

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The court referred to *Van Rensburg v South African Post Office Ltd* 1998 (10) BCLR 1307 (A) and *S v Solberg; S v Negal; S v Lawrence* (fn 137 *supra*). In *Solberg* the court held that: “Certain occupations call for particular qualifications prescribed by law and one of the constraints of the economic sphere is that persons who lack such qualifications may not engage in such occupations. For instance nobody is entitled to practise as a doctor or a lawyer unless he or she holds the prescribed qualifications and the right to engage ‘freely’ in economic activities should not be construed as conferring such a right on unqualified persons. Nor should it be construed as entitling persons to ignore legislation regulating the manner in which particular activities have to be conducted, provided always that such regulations are not arbitrary.” In *Van Rensburg* it was stated that: “The important point is that the Post Office Act does not place any absolute or unqualified barrier to the appellant's choice of a lawful trade, occupation or profession. It does not more than put reasonable controls into place on the conduct of the postal service, controls which have regard to the economic necessities of our times. This does not violate the appellant's section 22 rights”.

that calls for regulation and that the orderly dispensing of safe medicines is crucial for the health of those who receive and consume such medicines. The applicants contended that legal practitioners have a constitutionally protected right to dispense medicines, that such right had been historically established, that a medical practitioner has had a right to be registered as a dispensing doctor in terms of section 52(1)(a) since 1984, that the said section gave recognition to the right of medical practitioners to dispense (should they comply with the requirements for registration) so that the section merely gave that right a statutory context by requiring a name to be entered in the register. As such it merely constituted statutory confirmation of the right of doctors to dispense and the right of patients to receive medicine; none of the restrictions envisaged by the new system applied. The respondents argued that where the protection of public health is in issue, a more rigorous form of protection has been considered to be more appropriate by the legislature and given effect to by the executive. Although section 52(1)(a) of the Health Professions Act allowed a medical practitioner whose name was entered in a register to compound and dispense medicines such medical practitioners were not adequately regulated; there were no standards, norms or guidelines to ensure that they complied with or adhered to good dispensing and compounding practices. The coupling of the licence to dispense with a particular premises addresses those needs. The issue is not whether medical practitioners have a right to dispense for some or other reason but whether the impugned legislation in the first instance exceeds the boundaries of lawful regulation. Only if the answer to the latter question is in the affirmative, does the question regarding the possible curtailment of rights arise.

The court held that the issue was whether the impugned provisions limited the rights claimed by the applicants to the extent that they infringed any of these rights. In the view of the court the impugned provisions did no more than regulate the practice of dispensing and did not infringe the medical practitioner's rights to choose to practise as a medical practitioner or to choose to dispense medicines as part of his or her practice, albeit at an identified premises. The court stated that medical practitioners were not barred from applying for and being granted a licence entitling them to do so. It found that the overarching consideration is one of a legitimate government purpose regarding which a

particular scheme was devised by the legislature and to which the executive has given effect within lawful and valid bounds. It was the view of the court that issues regarding possible limitation of rights need not be considered at all as none of the rights relied on had been infringed upon. Consequently, said the court, whether the stated government purpose could have been achieved by less intrusive means fell outside of the ambit of its judgment. It held that it was not for the court to express an opinion regarding the state's preference for the scheme of licensing or to speculate with regard to better ways of attaining the stated government purpose.

The court found with regard to the alleged encroachment on patient's rights that no such encroachment had occurred. The fact that some patients may suffer a certain degree of inconvenience as a result of the way in which medical practitioner's rights to dispense are regulated does not result in the conclusion that a patient's dignity is being impaired on that his or her right to enter into a contractual relationship with a doctor of his or her choice is encroached upon to an extent which would render such encroachment unconstitutional. It said that to hold thus would be to extend the boundaries of patients' rights to an unrealistic Utopia.

The court concluded that the application should be dismissed on all grounds relied on by the applicants.

Discussion

The appellants in this case lost sight of a number of well established points of law with regard to the manner in which legislative requirements can and must be construed and applied. The law does not require the impossible of people³⁰⁹. Where it is objectively

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In *Gassner NO v Minister Of Law And Order And Others* 1995 (1) SA 322 (C) Van Zyl J observed that: "A substantial amount of academic discussion has been directed at the applicability of the maxim *lex non cogit ad impossibilia* in criminal law. See Joubert (ed) *The Law of South Africa* vol 6 para 55-9 at 45-6; van Oosten F F W 'Die Aard en Rol van die Stelreël *Lex non Cogit ad Impossibilia* in die Strafreë' in (1986) 49 *THRHR* 375-410 (an article containing an interesting discussion of the legal nature of the maxim as a defence and with a useful résumé of relevant comparative law); Burohell and Hunt *South African Criminal Law and Procedure* 2nd ed (1983) vol I at 351-4; De Wet and Swanepoel *Strafreë* 4th ed (1985) at 92-4; Visser and Vorster *General Principles of Criminal Law through the Cases* 3rd ed (1990) at 234-40; Snyman *Strafreë* 3rd ed (1992) at 62-5. See also Goldstein E L 'Onmoontlikheid in die Suid-Afrikaanse Strafreëstelsel' in (1966) 29 *THRHR* at 366-8 and the discussion by Ellis J of *S v Mxhosa* 1986 (1) SA 346 (C) in (1986) *De Jure* at 393-7. In his discussion of the maxim *lex non cogit ad impossibilia*, Broom *A Selection of Legal Maxims* 10th ed (1939) at 162 translates it as: 'The law does not compel a man to do

impossible for an applicant for a dispensing licence to supply certain information he or she cannot be expected to do so. Administrative officials are required to act reasonably in taking administrative decisions³¹⁰. They are also required to act reasonably in interpreting and implementing legislation. They are obliged to give reasons for their decisions both generally in terms of the Promotion of Administrative Justice Act³¹¹ and in terms of the Medicines And Related Substances Act³¹². There appeared to be an assumption or belief on the part of the applicants that the Director-General would act unreasonably in enforcing the relevant provisions of the Act and the regulations and that the intention was to refuse as many applications for dispensing licences as possible. The only alternative is that they were simply trying to attack the relevant legislative provisions on every possible front.

The Constitution itself recognises the power of the state to regulate the practice of a trade, occupation or profession. The argument of the appellant that regulation does not mean limitation is specious since it is an inherent quality of regulation that it sets boundaries or

that which he cannot possibly perform.' The word 'law' is used here in a general sense and is apparently not restricted to 'a law' in the sense of a statutory enactment. I do not believe that this is an accurate translation, since 'law' in a general sense would usually be rendered as *ius* rather than *lex*. That *lex* does in fact refer to a statute or a law appears from Broom's (*loc cit*) equating the said maxim with *impotentia excusat legem*, in the sense that the inability to perform or comply with an obligation imposed by a legal provision excuses such failure to perform or non-compliance. This is the meaning accorded to *impotentia excusat legem* in the English case of *Eager v Furnivall* (1881) 17 ChD 115 at 121 (per Jessel MR). A better approach than that of Broom may be found in Craies on Statute Law 7th ed (1971) at 268, where it is said: 'Under certain circumstances compliance with the provisions of statutes which prescribe how something is to be done will be excused. Thus, in accordance with the maxim of law, *Lex non cogit ad impossibilia*, if it appears that the performance of the formalities prescribed by a statute has been rendered impossible by circumstances over which the persons interested had no control, like the act of God or the King's enemies, these circumstances will be taken as a valid excuse.' This approach appears to have been acceptable in English law and has been applied in South African decisions from as early as 1880. I refer in this regard to *Hay v The Divisional Council of King William's Town* (1880) 1 EDC 97 at 100, where Smith J says: '. . . [W]hen a duty is imposed upon anyone by law, there must always be an implied condition that it is in his power to perform it. *Lex non cogit ad impossibilia* and *impotentia excusat legem* (Coke on Littleton), are very old maxims of law.'" The court noted further that: "In *John Roderick's Motors Ltd v Viljoen* 1958 (3) SA 575 (O) at 577H-578A the maxim is rendered as *lex non cogit ad impossibilia aut inutilia*, the *inutilia* presumably referring to 'unreasonable things' or, simply, 'unreasonableness'. In this context *inutilia* is certainly not synonymous with *impossibilia* in that unreasonableness need not give rise to or even suggest impossibility. Smit AJP appears to have relied on Maxwell on *The Interpretation of Statutes* 8th ed (1937) at 322 as a source for this rendition of the maxim. Counsel for the applicant referred the learned Judge to the ninth edition (1946) at 387. Neither of these editions was available to me but in the 12th edition by P St J Langan (1969) at 326 the maxim is cited without the addition of the words *aut inutilia*, in the context of intentions attributed to the Legislature when none is expressed."

See also *Montsisi v Minister Van Polisie* 1984 (1) SA 619 (A)

310 *Ampofo And Others v MEC For Education, Arts, Culture, Sports And Recreation, Northern Province, and Another* 2002 (2) SA 215 (T) Ngcobe JP, Hussain J and Basson J held that: "Reasonable administrative action in terms of s 33 of the Constitution has also been held to mean that a functionary (such as the department) is obliged to make decisions that are rationally justifiable (*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) (2000 (3) BCLR 241)). The Department cannot therefore be obliged to exercise its discretion in a particular manner merely because it has done so in the past. It is required to exercise its discretion in a rational and unfettered fashion. As stated earlier, a legitimate expectation cannot be relied upon to force a functionary to act unlawfully or contrary to its statutory duties."

See also *Mahabehlala v MEC for Welfare, Eastern Cape, and Another* 2002 (1) SA 342 (SE)

311 Act No 3 of 2000

312 Section 22C(4) of Act No 101 of 1965 specifically states that: "When the Director-General or the council, as the case may be, grants or refuses an application for a licence-

(a) written notice shall be given of that fact to the applicant; and

(b) in the event of the refusal of an application, the applicant shall be furnished with the reasons for such refusal."



parameters for the conduct or activity being regulated. A boundary is a limitation. Such boundaries may be set in a number of different ways, for instance by defining a particular term as inclusive of some aspects and exclusive of others, by outright prohibition of certain activities, by imposing conditions or defining the circumstances in which certain actions must or must not be taken. Regulations may not always limit constitutional rights as envisaged by section 36 of the Constitution since constitutional rights may not always be in issue. However, where the constitutional right itself includes a recognition that it may be regulated or controlled in some way, by implication this means that it is inherent to the right itself that its exercise can be limited and is subject to government control³¹³. If one wants to split hairs one can talk about the limitation of the power to exercise a right as opposed to the limitation of the right itself but such detailed analysis is seldom likely to take matters much further given that the courts have already said that the rights in the Bill of Rights are not absolute³¹⁴. One can have unlimited power to exercise a limited right or limited power to exercise a very broad right. To speak in such terms, is however to draw false distinctions as is illustrated when one takes the spectrum to its extremes – i.e. one can have so little power to exercise the widest possible right that it can seldom if ever be exercised or every power to exercise a right which is so devoid of content that it is meaningless. Either way one ends up with nothing. In any event section 36 of the Constitution refers to limitation of the rights in the Bill of rights while section 22 states that the practice of a trade occupation or profession may be regulated by law. If one looks at the wording of section 22 more closely the right is not to *practice* any trade, occupation or profession freely. This possibility is expressly excluded by the second sentence in section 22. The first sentence embodies a right to *choose* the trade occupation or profession freely. The right is thus a right to take a decision as to which trade, occupation or profession to

³¹³ See for instance *South African Post Office Ltd v Van Rensburg and Another* fn 308 *supra*

³¹⁴ *Saobramoney* fn 23 *supra*. In *De Reuck v Director Of Public Prosecutions, Witwatersrand Local Division, and Others* 2003 (3) SA 389 (W) the court noted that: "In *Hudson County Water Co v McCarter* (209 US 349 (1908) at 355) the following was stated: 'All rights tend to declare themselves absolute to their logical extreme. Yet all in fact are limited by the neighbourhood of principles of policy which are other than those on which the particular right is founded, and which become strong enough to hold their own when a certain point is reached.' The reason why all rights are not absolute is perfectly articulated in the judgment of Laws LJ in *Gough (Gough and Another v Chief Constable of the Derbyshire Constabulary* ([2001] 4 All ER 289 (QB) at 319e) in the following dictum: 'To give effect to the right's uttermost assertion - its logical extreme - would alike confound the right's moral credentials and its practical utility. The reason is, first, that the claim of moral authority for any right given by the general law rests upon the fact that the right belongs to every citizen, as do all other things thus given; so that in any particular case, where there is a clash of interests, it is inherent in the nature of the right itself that the individual who claims its benefit may have to give way to the supervening weight of other claims. And secondly, the right's practical utility rests upon the fact that there can be no tranquillity in the state without a plethora of unruly individual freedoms, which will be measured in the language of rights; anything else looks tyranny in the face without blinking, so that in any particular case, to crown the possessors of one such right and consign the others beneath the throne, will sooner or later undercut the community fabric.'"

follow. A limitation of this right, it is submitted would be one that interferes with that freedom of choice and not necessarily with the manner, place, or time or any other conditions in or under which, once that choice has been made, the trade, occupation or profession is practised³¹⁵. Interference with this right may be seen in the refusal of education authorities to allow a person to enrol for a particular course or an unreasonable

315

In *City Of Cape Town v Ad Outpost (Pty) Ltd And Others* 2000 (2) SA 733 (C) the court noted: "Section 22 appears to be modelled on § 4(1) of the German Basic Law, which provides that all Germans have the right freely to choose their occupation and profession, their place [of] work, study or training. The practice of an occupation or profession may be regulated by law. See De Waal *et al Bill of Rights Handbook* at 368–74. The German Courts have interpreted § 12 to provide a considerable amount of constitutional protection for commercial activities. See Currie D *The Constitution of the Federal Republic of Germany* at p 300 and Kommers D P *Constitutional Jurisprudence of the Federal Republic of Germany* (2nd ed) at 270 et seq. Thus in the Pharmacy Case 7 BVerfGE 3771 (Kommers at 274) art 12 (1) was interpreted to empower a legislature to regulate the practice as well as the choice of an occupation. Regulations dealing with the latter are greatly circumscribed by the article. The practice of an occupation which is the relevant issue in the present case may be 'restricted by reasonable regulations predicated on considerations of the common good'. Cited in Kommers at 277. See also the Chocolate Candy case 53 B VerfGE 135...."

Davis J distinguished German article 12 from the South African section 22 in these words: "There is always a great danger in the uncritical employment of foreign law in the process of domestic constitutional interpretation. Notwithstanding that art 12 and § 22 are similar in wording, the latter must be interpreted in the context of the South African constitutional text and its own pedigree. Thus, in my view, the interpretation of § 22 must take account of the difference of wording between § 22 of the Constitution and § 26 of the interim Constitution. The difference is manifest as follows:

(a) the right contained in § 22 is granted to citizens only;

(b) a more specific formulation of choice of trade, occupation, profession is replaced by a more general phrase, namely engagement in economic activity; [Writer's note: It is the other way around. In section 22 of the Constitution, the general provisions of the Interim Constitution are replaced the specific provisions of the Constitution]

(c) the use of every citizen requires that the provision is aimed at the individual rather than at the juristic body.

The purpose of § 22 would thus appear to be to ensure that regulations which control a citizen's right to choose a trade and occupation or profession should be implemented in a rational manner. As Jones J said in J R 1013 *Investments CC and Others v Minister of Safety and Security and Others* 1997 (7) BCLR 925 (E) at 930B–E: "We have a history of repression in the choice of a trade, occupation or profession. This resulted in disadvantage to a large number of South Africans in earning their daily bread. In the pre-Constitution era the implementation of the policies of apartheid directly and indirectly impacted upon the free choice of a trade, occupation or profession: unequal education, the prevention of free movement of people throughout the country, restrictions on where and how long they could reside in particular areas, the practice of making available structures to develop skills and training in the employment sphere to selected sections of the population only, and the statutory reservation of jobs for members of particular races, are examples of past unfairness which caused hardship. The result was that all citizens in the country did not have a free choice of trade, occupation and profession. Section 22 is designed to prevent a perpetuation of this state of affairs." In my view § 22 introduces a constitutional protection to be enjoyed by individual citizens as opposed to juristic bodies. The right ensures that each citizen will have the right to choose how to employ his or her labour and skills without irrational governmental restriction. It is not a provision which should be extended to the regulation of economic intercourse as undertaken by enterprises owned by juristic bodies which might otherwise fall within the description of economic activity." The important point to note is that section 22 cannot be construed as a right to freedom or economic activity - otherwise it could not have been restricted to private individuals as Davis J opined. It is a right to choose a trade, occupation or profession. Furthermore, Davis J held that it is a right to employ labour or skills without *irrational* governmental restriction.

See also *Röseman v General Council Of The Bar Of South Africa* 2004 (1) SA 568 (SCA) in which Streicher JA held: "Counsel submitted that the division of work between the professions was arbitrary and irrational and constituted an unreasonable limitation on his client's right to practise his profession now enshrined in § 22 of the Constitution. But that begs the question. The appellant has the right to become an attorney or an advocate but he has no right to redefine the limits of either profession. He cannot complain that he is not being permitted the free exercise of his right if he is unwilling to practise within the acknowledged or accepted scope of the profession." This case dealt with the issue of the so-called 'split bar' in legal practice in South Africa. In the context of dispensing doctors, the limits of the profession with regard to the dispensing of medicines were refined by section 22C(1) of the Medicines and Related Substances Act No 101 of 1965. The definition of the limits of a profession is clearly within the capacity of the legislature which may devolve certain of the details of this exercise to the executive or to a statutory professional body. The court referred in this case to the dicta of Cameron JA in *De Freitas and Another v Society of Advocates of Natal and Another* 2001 (3) SA 750 (SCA) at 763G where he said: '(I)t is in the public interest that there should be a vigorous and independent Bar serving the public, which, subject to judicial supervision, is self-regulated, whose members are in principle available to all, and who in general do not perform administrative and preparatory work in litigation but concentrate their skills on the craft of forensic practice. Streicher JA held: "There can, in my view, be no doubt that one of the objects of the referral practice is to ensure that administrative and preparatory work in litigation is handled by attorneys who are trained and organised to do so, thereby enabling advocates to concentrate their skills on the craft of forensic practice. It follows that a proper use of the referral practice serves the public interest. It follows, furthermore, on the other hand, that to allow advocates to accept instructions by attorneys to conduct litigation on behalf of a client from beginning to end, i.e. to do all the administrative and preparatory work in respect of litigation, would not serve the public interest and would constitute an abuse of the referral practice."

legislative or policy provision which restricts admission to a particular trade or profession – for example purely to keep the numbers down or to avoid competition for existing practitioners. In the present context, it is significant that the courts have held that agreements in restraint of trade, which impose all kinds of restrictions in terms of where a person may practice a trade occupation or profession, are not *per se* unconstitutional³¹⁶. It is submitted that if the courts are prepared to uphold contractual arrangements in which section 22 rights are restricted it is difficult to see why in principle, they should not uphold legislative provisions which have the same effect, provided of course that the tests of reasonableness and rationality are satisfied. The Harmful Business Practices Act³¹⁷ is a case in point. *De Waal et al*³¹⁸ point out that in *Janse van Rensburg NO v Minister van Handel en Nywerheid*³¹⁹ the applicants challenged the Act as a violation of the occupational freedom right. According to the court, the purpose of the Act was acceptable. The court held that: “It is a praiseworthy governmental objective to protect consumers from exploitation”. According to the court, the definition of ‘harmful business practice’ was not vague. The Act permitted a Committee to propose guidelines for definition of the term

³¹⁶ See *Fidelity Guards Holdings (Pty) Ltd T/A Fidelity Guards v Pearmain* 2001 (2) SA 853 (SE) in which Liebenberg J observed: “Whether a covenant in restraint of trade was unconstitutional in the light of the provisions of § 26 of the interim Constitution (the Constitution of the Republic of South Africa Act 200 of 1993) received the attention of the Courts. In *Waltons Stationery Co (Edms) Bpk v Fourie en 'n Ander* 1994 (4) SA 507 (O) it was held that covenants in restraint of trade were not excluded by § 26 and that the *Magna Alloys* case *infra* still reflected the positive law. The decision was subsequently followed in *Kotze en Genis (Edms) Bpk en 'n Ander v Potgieter en Andere* 1995 (3) SA 783 (C) and *Knox D'Arcy Ltd and Another v Shaw and Another* 1996 (2) SA 651 (W). The following remarks by Van Schalkwyk J in *Knox D'Arcy Ltd and Another v Shaw and Another* (*supra* at 660C - D/E) are, although he was then concerned with the provisions of § 26 of Act 200 of 1993, still apposite. ‘The Constitution does not take such a meddlesome interest in the private affairs of individuals that it would seek, as a matter of policy, to protect them against their own foolhardy or rash decisions. As long as there is no overriding principle of public policy which is isolated thereby, the freedom of the individual comprehends the freedom to pursue, as he chooses, his benefit or his disadvantage.’ And at 660I - 661A: ‘It is generally regarded as immoral and dishonourable for a promisor to breach his trust and, even if he does so to escape the consequences of a poorly considered bargain, there is no principle that inheres in an open and democratic society, based upon freedom and equality, which would justify his repudiation of his obligations. On the other hand, the enforcement of a bargain (even one which was ill-considered) gives recognition to the important constitutional principle of the autonomy of the individual.’ Insofar as a restraint is a limitation of the rights entrenched in § 22, the common law as developed by the Courts, in my view, complies with the requirements laid down in § 36(1). Any party to any agreement where a restraint clause is regarded as material is free to agree to include such a clause in the agreement and the common law in this regard is therefore of general application. In terms of the common law restraint clauses are only enforceable if they are not in conflict with public policy. In this regard the relevant principles were set out by Rabie CJ in *Magna Alloys and Research (SA) (Pty) Ltd v Ellis* 1984 (4) SA 874 (A) at 897I - 898A as follows: ‘(4) Dit is 'n beginsel van ons reg dat ooreenkomste wat teen die openbare belang is, nie afgedwing kan word nie, en 'n mens sou dus kon sê dat 'n ooreenkoms wat iemand se handelsvryheid inkort teen die openbare belang, en dus onafgedwingbaar is, indien die omstandighede van die betrokke geval sodanig is dat die Hof van oordeel is dat die afdwing van die ooreenkoms die openbare belang sou skaad. (5) Dit is in die openbare belang dat ooreenkomste wat vryelik aangegaan is, nagekom moet word. Dit is egter ook, in die algemeen gesê, in die openbare belang dat iedereen hom vir sover moontlik vryelik in die handels- en beroepswêreld moet kan laat geld. Dit kan aanvaar word dat in beperking van 'n persoon se handelsvryheid wat onredelik is, waarskynlik ook die openbare belang sou skaad indien die betrokke persoon daaraan gebonde gehou sou word.’ From the foregoing it seems to me that if a restraint clause is found to be enforceable after application of the principles laid down by the Courts, the requirements of § 36(1) will have been met.

³¹⁷ Consumer Affairs (Unfair Business Practices) Act No 71 of 1998

³¹⁸ *De Waal et al* fn 2 *supra*

³¹⁹ *Janse van Rensburg No v Minister van Handel en Nywerheid* 1999 (2) BCLR 204 (T)

which would be published by the Minister. This helped to concretise the abstract concept of a harmful business practice. The parallels with *Affordable Medicines Trust*³²⁰ are obvious. It is submitted that the purpose of the Unfair Business Practices Act is very much akin to that of the governmental purpose in requiring health professionals other than pharmacists to obtain a licence to dispense medicines.

De Waal *et al*³²¹ note that it is arguable that the second sentence applies only to measures that regulate occupational freedom without denying choice or access to an occupation. On this argument, they state, section 22 is a right freely to choose a trade, occupation or profession. This right to choose a trade, occupation or profession cannot be limited except by law of general application that is justifiable in terms of the criteria laid down in section 36. They note that the second sentence then adds little to the scope of the right by prohibiting regulation of the practice of an occupation other than by law and state that choice and practice of an occupation are not conceptually distinct, but rather 'constitute poles of a continuum'. It is submitted that De Waal *et al* do not accurately convey the content of the second sentence in interpreting it as prohibiting the regulation of the practice of an occupation other than by law. It is submitted that this is not the thrust of the second sentence. Prohibition does not feature in the second sentence. The object of the second sentence is to qualify the right that is awarded in the first. The first awards the right to freely choose and occupation, trade or profession. The second cautions that the practice of the occupation trade or profession chosen can be regulated by law. The first sentence should not therefore be interpreted to mean that people can choose to do anything they want by way of a trade, occupation or profession without limitation or reference to law. As it turns out the drafters of the Constitution were wise in inserting the second sentence because there is a large number of occupations that the law does not permit people to pursue at all – most notably those that fall within the realm of criminal activity. There are, however more subtle issues that manifest within the health service delivery context. It is submitted for instance that the right in section 22 cannot be exercised in the context of health service delivery without due regard for patient safety and wellbeing. They state that both are

320 *Affordable Medicines Trust* fn 299 *supra*

321 *De Waal et al* fn 2 *supra*



afforded protection from arbitrary regulation by section 22. By the same token, this would mean, they say, that both choice and practice are subject to the internal qualification and observe that it is implausible to argue that the internal qualification will not apply when regulation of the practice of an occupation also impacts on access to or choice of that occupation. This will almost always be the case. The better interpretation is therefore that the internal qualification in principle applies to restrictions on entry, choice and practice of an occupation. De Waal *et al* state in interpreting the internal qualification, emphasis should be placed on the term ‘regulation’ which refers to a rational ordering or organising of a certain trade, occupation or profession. A measure which attempts to close down a certain profession or trade cannot qualify as a regulation, but many measures that restrict access to a profession may qualify on this basis. For example the practice of certain professions (lawyers, doctors) is routinely regulated in order to protect the interests of the general public. It is submitted that this goes to the heart of the regulation versus limitation argument submitted by the applicants in *Affordable Medicines Trust*³²². De Waal *et al*³²³ refer to the dicta of Chaskalson P in *S v Lawrence*; *S v Negal*; *S v Solberg*³²⁴ that:

“Certain occupations call for particular qualifications prescribed by law and one of the constraints of the economic sphere is that persons who lack such qualifications may not engage in such occupations. For instance, nobody is entitled to practise as a doctor or as a lawyer unless he or she holds the prescribed qualifications, and the right to engage ‘freely’ in economic activity should not be construed as conferring such a right on unqualified persons; nor should it be construed as entitling persons to ignore legislation regulating the manner in which particular activities have to be conducted...”

They note that the meaning of ‘regulation’ may be illustrated with reference to the *South African Post Office* case³²⁵ in which the court accepted that section 7 of the Post Office Act *prima facie* violated the right to freedom of occupation but then concluded³²⁴ that the section merely regulated the ‘practice of the trade of running a postal service by law and therefore did not offend section 22. De Waal *et al* comment that the court was perhaps too eager to accept that the measure was a regulation in the true sense since protecting the Post Office against competition cannot qualify as regulation.

322 *Affordable Medicines* fn 299 *supra*

323 De Waal *et al* fn 2 *supra*

324 *S v Lawrence* fn 137 *supra*

325 *SA Post Office* fn 308 *supra*

The *Affordable Medicines Trust* case³²⁶ demonstrates a number of issues not least of which is the level of resistance by the health professions to change intended to benefit and protect the public. The fiduciary aspects of the provider-patient relationship have been demonstrated by the circumstances of this case, to be largely non-existent for many South Africa health professionals. They failed to do the necessary course and to apply for licences within the allotted time period in the full knowledge that this would be to the detriment of their patients, choosing instead to pinning their hopes on a court decision which they could not predict. The costs of compliance were not prohibitive, the course was available online in a self-study format and gave recognition to prior learning. Despite this many registered for the course too late to meet the deadline, even after extensions of time were effectively granted by the court. They found it convenient in their arguments in court to use patient interests to justify their failure to comply with the law, apparently refusing to appreciate that access to health care services is more than just mere availability and also entails safety and efficacy. They at first attempted to attack the government by way of a court action claiming that the Department of Health did not have the necessary infrastructure in place to implement the relevant legislative provisions. When it became apparent that this line of attack was not going to yield the desired results they produced a plethora of constitutional arguments that in the end boiled down to the very narrow issues outlined by Kruger AJ in his judgment. The legislation that imposed the dispensing licence requirement was passed by parliament in 1997 some six years before the initial litigation was instituted. It was only when government commenced with its implementation in 2003 that litigation commenced. The belatedness of the reaction by the applicants to legislative provisions which, in their view, were unconstitutional from inception is inexplicable. They also changed the direction of their arguments a few times during the course of the two sets of litigation, giving the distinct impression that what they wanted was a way out rather than confirmation of a point of legal principle. The arguments of the applicants as stated in the judgment of Kruger AJ were paper thin in the light of the other cases referred to in the discussion above. Pharmacists and pharmacy owners are subjected to similar regulations in terms of which they have to observe good pharmacy practice and the premises are inspected. In terms of

326

Affordable Medicines fn 288 *supra*

section 22(1) of the Pharmacy Act³²⁷, “A person authorised in terms of section 22A to own a pharmacy shall in the prescribed manner, specifying the prescribed particulars, apply to the Director-General for a licence for the premises wherein or from which such business shall be carried on and the Director-General may be entitled to issue or refuse such licence on such conditions as he or she may deem fit”. Section 22(4) stipulates that: “A pharmacy shall, subject to such conditions as may be prescribed, be conducted under the continuous personal supervision of a pharmacist, in accordance with good pharmacy practice as determined in the rules made by the council”. The Director-General issues the licence for the pharmacy which is tied to the premises. The competence of the pharmacist is established through training recognized by Pharmacy Council, the body within which the necessary expertise resides. The dispensing of medicines falls most specifically within the purview of the professional skill and knowledge of the pharmacy profession. It is for this reason that the course on dispensing for other health professionals in terms of the Medicines and Related Substances Act had to be approved by the Pharmacy Council. The licensing of dispensing doctors to dispense medicines is associated with the premises from which the medicine is to be dispensed for the same reasons that the licence to own a pharmacy is associated with the premises. The objection of the applicants to the licensing of dispensing of medicines in association with particular premises given the stated government purpose to ensure safety ignores the fact that medicines must be kept under certain very specific conditions if they are to retain their efficacy and safety. The applicants were also apparently oblivious of the difference between *bona fide* medical practitioners running established, hygienic medical practices and those itinerant purveyors of snake oil more commonly referred to as charlatans and mountebanks. Application for leave to appeal has been lodged in respect of both the constitutional court and the supreme court of appeal, the idea being that if the appeal is not heard in the former it will be heard in the latter. Whatever the appeal court decides, one thing is clear. The practice of medicine in South Africa appears to have lost its human face quite some time ago.

2.7.4 Rationing By Medical Schemes

³²⁷ Pharmacy Act No 53 of 1974

The Medical Schemes Act³²⁸ governs the manner in which medical schemes, which are not for profit entities, fund medical expenses. In the past, and to a large extent still currently, medical scheme expenditure is significantly concentrated within the private health sector although the situation is changing with certain relatively recent legislative and regulatory amendments which are designed to encourage explicit³²⁹ utilisation by medical scheme members of public health facilities. In terms of section 29 of the Act, medical schemes must provide in their rules for *inter alia* –

“The terms and conditions applicable to the admission of a person as a member and his or her dependants, which terms and conditions shall provide for the determination of contributions on the basis of income or the number of dependants or both the income and the number of dependants, and shall not provide for any other grounds, including age, sex, past or present state of health, of the applicant or one or more of the applicant's dependants, the frequency of rendering of relevant health services to an applicant or one or more of the applicant's dependants other than for the provisions as prescribed.”³³⁰

and

“the scope and level of minimum benefits that are to be available to beneficiaries as may be prescribed.”³³¹

Medical schemes may not ration prescribed minimum benefits that are obtained from a public hospital³³². They are required to pay the costs of such treatment in full and may not cancel or suspend a member's or his or her dependent's membership except on limited grounds that are unrelated to the health profile of the member or dependent.³³³ In terms of

³²⁸ Medical Schemes Act No 131 of 1998

³²⁹ The public health sector has operated for many years as a safety net for medical scheme members in the sense that when their benefits run out or the cost of a particular health care intervention is not covered by their medical scheme then they resort to the public health sector for treatment. This has resulted in adverse selection practices by medical schemes that has been referred to as ‘dumping’ of private patients onto the public sector for the high cost levels of care such as are typically required by the chronically ill and the elderly. The regulations to the Medical Schemes Act (dated 20 October 1999, Regulation Gazette No 6652, Notice No R 1262) contain an explanatory note to the prescribed minimum benefits package which states that one of the objectives of the package is “to avoid incidents where individuals lose their medical scheme cover in the event of serious illness and the consequent risk of unfounded utilisation of public hospitals.”

³³⁰ Section 29(1) (n) of Act No 131 of 1998

³³¹ Section 29(1) (o) of Act No 131 of 1998

³³² In terms of section 29(1)(p) of Act No 131 of 1998, “No limitation shall apply to the reimbursement of any relevant health service obtained by a member from a public hospital where this service complies with the general scope and level as contemplated in paragraph (o) and may not be different from the entitlement in terms of a service available to a public hospital patient.”

³³³ “In terms of section 29(2) of Act No 131 of 1998, medical scheme shall not cancel or suspend a member's membership or that of any of his or her dependants, except on the grounds of-

- (a) failure to pay, within the time allowed in the medical scheme's rules, the membership fees required in such rules;
- (b) failure to repay any debt due to the medical scheme;
- (c) submission of fraudulent claims;
- (d) committing any fraudulent act; or
- (e) the non-disclosure of material information.”

the regulations³³⁴ any benefit option that is offered by a medical scheme must reimburse in full, without co-payment or the use of deductibles, the diagnostic, treatment and care costs of the prescribed minimum benefit conditions specified in Annexure A of the regulations in at least one provider or provider network which must at all times include the public hospital system. The power of medical schemes to ration access to health care services by capping the amounts of expenditure on certain types of service is therefore only with regard to those services falling outside of the prescribed minimum benefits package. If they select the public hospital system as a preferred provider they may be able indirectly to ration to a limited extent, access to services by means of that choice since services which are not available in the public hospital system cannot, by definition form part of the benefit package. An example of this is the fact that in public hospitals premature babies weighing under one kilogram are not usually ventilated because their prognosis is poor and there is the usual scarcity of resources. In the private sector no such restrictions apply. The question is whether a medical scheme is obliged to pay for the ventilation of a premature neonate in terms of the minimum benefits package and the answer that is generally given is in the negative since the minimum benefits package follows public health sector treatment protocols and norms. If a prescribed minimum benefit is unavailable in the public hospital system, however, schemes are obliged to pay for that service in the private health sector regardless of the cost.

2.7.4.1 Constitutional Issues

The question of whether the rationing by a medical scheme of access to health care services is constitutional is dependent upon whether the right of access to health care services as set out in section 27(1) applies as between private persons. This subject is discussed elsewhere under the question of the horizontal application of constitutional rights. However it should be noted here that the answer to this question must, in practice depend upon the circumstances prevailing within the health system generally. For instance if one assumes that the state takes a decision to completely privatise the provision of health services so that it becomes purely a funder of health services rather than a supplier and that all health

³³⁴ Fn 329 *supra* Regulation 8

services must therefore be delivered within the private sector, the constitutional right of access to health care services and the obligation of the private sector to provide those services changes the focus and the obligations of the private sector dramatically. Admittedly it could be argued that the obligations of the private sector in such a model may be primarily contractual in terms of an agreement between a state owned funder and the private sector or even legislative if the model was implemented in terms of some form of enacted social health insurance system and that the primary constitutional obligation to provide access to health care services would rest with the state. If one accepts the system itself as legitimate, however, then the state can effectively transfer to the private sector at least some of its constitutional responsibility to provide the services to the private sector to the extent that there is funding within state coffers for the services in question. This is not to suggest that the state can contract out of its ultimate constitutional obligations as stated in section 27(2) but it is submitted that the wording of section 27(2) is sufficiently broad as not to impose upon the state a particular method for the fulfilment of its obligations as contemplated therein. The state is simply obliged to take reasonable legislative and other measures to achieve the realisation of the right within its available resources.

In terms of a different scenario, assume that for some reason the public health sector dwindles away to an almost insignificant level due to factors outside of the control of the state – for instance an unwillingness on the part of health professionals to work in the public sector for reasons that relate to more than just remuneration e.g. professional independence etc. The state has the funding for health care services but does not have the capacity to deliver them. It is submitted that it would be difficult for the private sector to refuse to negotiate with the state for the provision of health care services to persons who would under other circumstances have been public sector patients. This difficulty would rest on the basis of the constitutional right of access to health care services. As stated previously a right of access does not mean ‘free of charge to everyone’. It does not imply that the private sector has no right to charge for services rendered. In fact any other conclusion would make nonsense of the validity of the existence of the private sector. The private sector does not exist simply to be in business and to recover the costs of doing business. It exists to make profits. It competes for shareholding as much as it competes for

customers. If a private hospital group makes better profits than its competitors this is good for business because it is able to attract more interest in terms of shareholding. The value of its shares goes up which means it is attractive to investors and its survival in the longer term is assured.

2.7.5 Rationing By The State

Rationing by the state can take a number of different forms, not all of them obvious. In a system in which resources are limited there is always rationing of services whether implicit or explicit. The treatment protocols set and used by the state as considered in *Soobramoney*³³⁵ are an example of explicit rationing. Certificate of need systems such as that contained in the National Health Act³³⁶ and the restriction of the entry of foreign health professionals into South Africa in order to practice may constitute less obvious forms of rationing. Most decisions relating to rationing of health care services are likely to be controversial given the nature of the services. There is a worldwide shortage of organs for the purpose of organ transplantation. A policy that favours citizens and permanent residents on the list for organ transplantation is bound to come under the spotlight sooner or later as is a policy that favours HIV negative organ transplant candidates over HIV positive ones. The legally acceptable bases for rationing have been canvassed in the previous discussion of *Soobramoney*. However it is appropriate to consider some of the specific issues raised in the context of certificate of need and foreign health professionals since these two topics involve the interface of the constitutional right of freedom to pursue a trade, occupation or profession as contained in section 22 of the Constitution and so take the rationing debate further.

2.7.5.1 Certificate of Need

³³⁵ *Soobramoney* fn 23 *supra*

³³⁶ Act No 61 of 2003

The draft National Health Act³³⁷ makes provision for certificates of need to be issued to all health establishments. The considerations for the granting of a certificate of need, over and above the operational requirements and standards for a particular type of health establishment, relate to demographic issues such as the health needs of the population that is intended to be served by the proposed establishment, its geographical location, the proximity of existing health establishments offering the same services or services that are a substitute for the proposed service etc. Systems of certificate of need represent a form of rationing of health care services in the sense that they restrict the freedom of health care professionals and other persons in the business of the provision of health care services from setting up shop where they please. In South Africa there is a tendency for service providers to accumulate in heavily populated urban areas to the extent that there is maldistribution of health care services. This problem is not unique to South Africa as many countries which have large, relatively sparsely populated rural areas have to deal with the problem of ensuring the availability of health care services to people in these areas. Apart from inequitable distribution of health care services, an oversupply of service providers in urban areas creates its own problems in terms of overservicing of patients, perverse incentives and inappropriate provision of health care services, for example, based on the supplier's need to sell a certain quantity of a certain type of medicine rather than what would be the best and most suitable treatment for the patient's health condition.

In the sense that a certificate of need system attempts to redress problems relating to inequitable distribution of health care services it can be seen not as a system of rationing but rather an administrative tool to promote equitable distribution of health care services in order to ensure that people who may not previously have had access to certain health care services now do. From the foregoing it is clear that certificate of need issues cut across health economics at both macro and micro levels in that they require a balancing of the needs of a particular community with those of the larger population of a province or even the nation as a whole. The certificate of need concept comprises a form of health care market regulation in which the laws of supply and demand are only a part of the equation.

³³⁷ National Health Act fn 336 *supra*

It also has the potential to create competition between the private and public health sectors. Consider a situation in which a large privately owned hospital group decides to build a hospital in a particular area with a limited market for the services it proposes to provide at that hospital. Suppose that in the same area there is a public sector hospital which, for various reasons is not providing adequate health care services to the local population of the kind proposed by the private hospital group. If the public sector hospital, which is operating on a fee retention system, is not operating at full capacity due to poor management but has the potential to render most if not all of the services proposed by the new private sector hospital, what should the decision be concerning the private hospital group's application for a certificate of need for a new private hospital? The latter will be operating in direct competition with the existing public sector hospital which has for some years now enjoyed its own small monopoly in the delivery of these services. The issues raised by this question illustrate the potential impact of a system of certificate of need on competition within the health market generally whether between private and public sector or the private sector *inter se*. As such it may be argued that it constitutes unconstitutional interference in a person's right to pursue his or her chosen profession or occupation.

Whether or a system of certificate of need is constitutional can be dealt with on two fronts namely, the question as to whether it constitutes a justifiable limitation of the rights contained in section 22 of the Constitution but also whether the regulation by way of a certificate of need system is within the ambit of the provision in section 22 which allows for a trade, occupation or profession to be regulated by law. They are both likely to canvass the legitimacy of the concept of certificate of need in general rather than the validity of a particular decision not to grant a certificate of need which is likely to be in the arena of administrative rather than constitutional law³³⁸. The certificate of need process as it is envisaged in the National Health Act will cover not only hospitals and other large facilities but the consulting rooms of individual doctors, physiotherapists, dentists, psychologists and other health professionals. Depending upon the criteria on which certificate of need decisions are based, a dentist could find himself unable to practice in the small town where he grew up because there are already sufficient dentists practising there. The certificate of

³³⁸ Section 36 states that the rights in the Bill of Rights may only be limited by a law of general application to the extent that the limitation is reasonable and justifiable in an open and democratic society.

need rationale is intended to encourage this dentist to set up practice in a town where there is a shortage of dentists in order to improve the access of the population to health care services.

The question therefore arises as to whether a certificate of need system is justifiable in light of the government's obligation to ensure the progressive realisation of the right of access to health care services within available resources. The argument from the side of government would be that in order to ensure the progressive realisation of the right of access to health care services within available resources it cannot rely only on strategies to increase the available resources but must also look at methods for ensuring the more effective and efficient utilisation of the resources that are available. One can have sufficient numbers of general medical practitioners within the country but if they all set up practice in the major cities with the result that the rural towns and villages do not have access to their services, then it could be argued that the state is not fulfilling its constitutional obligations to ensure access to health care services within available resources. The tension is between the right of a private individual to practice his or her profession or occupation in the location of his or her choice and the obligation of government contained in section 27(2) of the Constitution. As stated previously section 22 of the Constitution gives a right of freedom to *choose* a trade, occupation or profession but allows for the regulation of the *practice* of such trade, occupation or profession.

Section 26 of the interim Constitution provided as follows:

- “(1) Every person shall have the right freely to engage in economic activity and to pursue a livelihood anywhere in the national territory.
- (2) Subsection (1) shall not preclude measures designed to promote the protection or the improvement of the quality of life, economic growth, human development, social justice, basic conditions of employment, fair labour practices or equal opportunity for all provided such measures are justifiable in an open and democratic society based on freedom and equality.”

In considering these provisions Chaskalson P observed in *S v Lawrence; S v Negal; S v Solberg*³³⁹ that:

“The requirement that the measures be justifiable in an open democratic society based on freedom and equality means that there must be a rational connection between means and ends. Otherwise the measure is arbitrary and arbitrariness is incompatible with such a society.”

(At para [41].) Chaskalson P then went on to say:

“Section 26 should not be construed as empowering a court to set aside legislation expressing social or economic policy as infringing "economic freedom" simply because it may consider the legislation to be ineffective or is of the opinion that there are other and better ways of dealing with the problems. If s 26(1) is given the broad meaning for which the appellants contend, of encompassing all forms of economic activity and all methods of pursuing a livelihood, then, if regard is had to the role of the courts in a democratic society, s 26(2) should also be given a broad meaning. To maintain the proper balance between the roles of the Legislature and the courts s 26(2) should be construed as requiring only that there be a rational connection between the legislation and the legislative purpose sanctioned by this section.”³⁴⁰

The differences between the Interim Constitution and the Constitution concerning the section 26 and section 22 rights have already been canvassed. The former refers more generally to economic freedom whereas the latter has been narrowed down to a right to freely choose a trade, occupation or profession.

The right contained in section 22 is a right only of natural persons³⁴¹. In the health care context this distinction is somewhat artificial given the fact that health care professionals can and in many cases do form juristic persons as a basis from which they pursue their professions. Pharmacy is a prime example. Many, if not most, pharmacists in South Africa practise under the umbrella of a close corporation or a company. In terms of the legislation on pharmacy, up until very recently³⁴², only pharmacists could have shares in a company that offers pharmacy services. Private hospitals invariably operate as companies. It is also open to other health professionals to create juristic persons from which to conduct their

³³⁹ *S v Lawrence* fn 137 *supra*

³⁴⁰ Quoted with approval in *City of Cape Town v Ad Outpost (Pty) Ltd and Others* (fn 315 *supra*)

³⁴¹ Although Section 8(4) of the Constitution states that a juristic person is entitled to the rights in the Bill of Rights to the extent required by the nature of the rights and the nature of that juristic person, section 22 refers specifically to 'citizens'. Juristic persons are not usually embraced by the term 'citizen'.

³⁴² Section 22A of the Pharmacy Act allows for the opening up of ownership of pharmacies to non-pharmacists. The regulations required to effect the principles in this section were promulgated in 2003.

practices. The upshot of the decision in *Ad Outpost*³⁴³ is apparently that if one wants to conduct a hospital business, which can most effectively be run as a company, then one must either forfeit the right to choose this trade or occupation freely as contained in section 22 or one must forfeit the benefits of operating as a juristic person rather than a sole trader. The alternative, if one is seeking to rely on the rights conferred by section 22, is to conduct the litigation in the name of the individual shareholders rather than in the name of the juristic person. A group of doctors wishing to own and run a hospital as a company cannot, in the name of the company, claim the right to freely choose this trade or occupation when, for instance, attacking a decision not to grant a certificate of need for the hospital, but these same *doctors* can, in their individual capacity, attack a decision not grant them a certificate of need for their consulting rooms on the basis of section 22. The only difference is the legal vehicle they have chosen for their business³⁴⁴.

2.7.5.2 Foreign Health Professionals

It is worth noting that the section 22 right is accorded only to citizens and not to 'everyone' as are so many of the other rights in the Constitution. This has the implication in the present context that foreign health care professionals, theoretically, may be legitimately prohibited from practising medicine in South Africa by South African law or in terms of a certificate of need process. This aspect of section 22 was discussed by the constitutional court in the

³⁴³ *Ad Outpost* fn 315 *supra*

³²² See however, De Waal, Currie and Erasmus, fn 2 *supra* in their discussion of the application of the Bill of Rights at p40-41 state that the constitutional court has rejected an all-or-nothing approach observing that it is prepared to extend the protection of fundamental rights such as the right to privacy, to juristic persons, but with a reduced level of protection on the basis that they are not capable of human dignity which forms the core of many of the fundamental rights. It would seem from their discussion of the issue that the test is the extent to which juristic persons are used by individuals for the collective exercise of their fundamental rights. They give the example that while it is difficult to see how some organs of state such as Parliament will ever be able to rely on the protection of the Bill of Rights, the South African Broadcasting Corporation or corporate entities such as universities which are set up by the State for the purpose of inter alia realising fundamental rights should be in a different position with regard to rights such as freedom of speech. They suggest that in the case of privately owned juristic persons it is not the size or the activities of the juristic person that are decisive but the relationship between the activities of the juristic person and the fundamental rights of the natural persons who stand behind the juristic person. Juristic persons thus become worthy of protection, they say, when they are used by natural persons for the collective exercise of their fundamental rights. Woolman in Chaskalson *et al* fn 67 *supra* at p 10-8 acknowledges that certain rights by their nature are simply inapplicable to juristic persons but at 10-9 states that: "Other rights must apply to corporations if their presence in the text is to be even partially vindicated." He comments that it is difficult to imagine the rights to property and economic activity belonging to natural persons and not to juristic persons and states that "Even in a regulated market economy, corporations must be able to form some strong expectations about what kind of property they can hold and transfer." This said he notes that giving equality rights to corporations so that they can pursue economic ends not only diminishes these values but could also lead to a weak equality jurisprudence and that the judicial deference paid to legislative restrictions on commercial concerns may 'infect' the closer judicial scrutiny accorded other equality concerns. Woolman argues that this restrictive approach should be rejected because it artificially suppresses questions worth asking such as: are some corporations discriminated against in some circumstances? (at p10-10).

certification judgment³⁴⁵. In subsequent judgments, however, the court has departed significantly from the more conservative position expressed in the certification judgment especially in respect of permanent residents³⁴⁶.

345

Ex Parte Chairperson Of The Constitutional Assembly: In Re Certification Of The 1997.(2) SA 97 (CC) at para 17 onwards where it noted that: "An objection, made by the Black Sash Trust, that was not raised before relates to AT 22 (a *verbatim* repetition of NT 22), the relevant part of which provides:

'Every citizen has the right to choose their trade, occupation or profession freely.'

The contention is that the right of occupational choice extended to citizens by AT 22 is a 'universally accepted fundamental right' which should be extended to everyone, i.e. irrespective of citizenship, in order to comply with CP II. The objection is foundationally flawed and it serves little purpose to cite, as the objector does, examples in international human rights instruments ostensibly extending the right of occupational choice to citizens and non-citizens alike. We say 'ostensibly' because the instruments cited do not upon proper analysis bear such an unqualified meaning.

The European Convention for the Protection of Human Rights and Fundamental Freedoms embodies no such right to occupational choice. Nor does the International Covenant on Civil and Political Rights ('ICCPR'). Article 12.4 of the ICCPR provides that '(n)o one shall be arbitrarily deprived of the right to enter his own country'. The right, in terms of the ICCPR, to enter a particular country is accordingly reserved for nationals only. This would reserve to States Parties the right to regulate nationality, citizenship or naturalisation. There does not appear to be anything in these instruments which would prohibit States Parties when regulating these matters from imposing suitable conditions, which would not otherwise conflict with the instruments, limiting the rights of non-nationals in respect of freedom of occupational choice.

Article 6.1 of the International Covenant on Economic, Social and Cultural Rights ('ICESCR') ostensibly recognises the right of 'everyone' to 'the opportunity to gain his living by work which he freely chooses or accepts'. But this right would be subject to what has been said in the preceding paragraph. Even more important is the fact that Article 2.3 of ICESCR itself allows developing countries 'with due regard to human rights and their national economy' to 'determine to what extent they would guarantee the economic rights recognised in the present Covenant to non-nationals'. It is subject to the even broader qualification in art 2.1 which makes it clear that the right in question is not fully enforceable immediately, each State Party only binding itself 'to the maximum of its available resources' to 'achieving progressively the full realisation of the rights recognised in the present Covenant'. In no way do we intend to denigrate the importance of advancing and securing such rights. We merely point out that their nature and enforceability differ materially from those of other rights.

The European Social Charter part I (1) which states that '(e)veryone shall have the opportunity to earn his living in an occupation freely entered upon' must be evaluated in the same light. The introduction to part I makes clear that the obligation on Contracting Parties in respect of this right goes no further than 'accept(ing) as the aim of their policy, to be pursued by all appropriate means, both national and international in character, the attainment of conditions in which the following rights and principles may be effectively realised'. The instruments discussed do not support the proposition that non-citizens are entitled to be treated on the same footing as citizens in regard to the freedom of occupational choice. [21] This distinction is in fact recognised in the United States of America and also in Canada. There are other acknowledged and exemplary constitutional democracies where the right to occupational choice is extended to citizens only, or is not guaranteed at all. One need do no more than refer to India, Ireland, Italy and Germany. CP II, as we made plain in the CJ, requires inclusion in a bill of rights of 'only those rights that have gained a wide measure of international acceptance as fundamental human rights'. The fact that a right, in the terms contended for by the objector, is not recognised in the international and regional instruments referred to and in a significant number of acknowledged constitutional democracies is fatal to any claim that its inclusion in the new South African Bill of Rights is demanded by CP II. It follows that the objection must be rejected."(Footnotes omitted)

346

See for instance *Labi-Odam And Others v Member Of The Executive Council For Education (North-West Province) And Another* fn 130 *supra*. Regulation 2(2) of the Regulations regarding the Terms and Conditions of Employment of Educators (GN R1743 of 13 November 1995) (the regulations) provide that no person shall be appointed as an educator in a State school in a permanent capacity, unless he or she is a South African citizen. The first respondent, as part of a rationalisation process, advertised posts held by foreign teachers temporarily employed in the North-West province, and issued such teachers with notices purporting to terminate their employment. The appellants (eight foreign teachers temporarily employed in the North-West Province, some of whom had permanent residence status) applied to the Bophuthatswana Provincial Division of the Supreme Court for an order declaring reg 2(2) invalid on the grounds that it constituted unfair discrimination in contravention of s 8(2) of the interim Constitution (the Constitution of the Republic of South Africa Act 2000 of 1993). The application was dismissed. The applicants appealed to the constitutional court which held that: "Because citizenship is an unspecified ground, the first leg of the enquiry requires considering whether differentiation on that ground constitutes discrimination. This involves an inquiry as to whether, in the words of Harksen, '... objectively, the ground is based on attributes and characteristics which have the potential to impair the fundamental human dignity of persons as human beings or to affect them adversely in a comparably serious manner'.

I have no doubt that the ground of citizenship does. First, foreign citizens are a minority in all countries, and have little political muscle. In this respect, I associate myself with the views expressed by Wilson J in the Canadian Supreme Court in *Andrews v Law Society of British Columbia* that: 'Relative to citizens, non-citizens are a group lacking in political power and as such vulnerable to having their interests overlooked and their rights to equal concern and respect violated. They are among "those groups in society to whose needs and wishes elected officials have no apparent interest in attending'.

(Citation omitted.)

Second, citizenship is a personal attribute which is difficult to change. In that regard, I would like to note the following views of La Forest J, from the same case: 'The characteristic of citizenship is one typically not within the control of the individual and, in

The effect of the decision of the constitutional court in *Larbi Odam*³⁴⁷ is that permanent residents must be treated in the same way as citizens for purposes of employment opportunities. Since “employment opportunities” is simply another translation for “trade, occupation of profession”, it would seem that the rights of permanent residents in this regard are the same as those ascribed to citizens in section 22 of the Constitution. Only temporary residents may not choose their trade, occupation or profession in South Africa and so presumably they might be capable of being legitimately excluded in terms of a certificate of need process from operating a health establishment. The problem with the present state of the law is that permanent residence status is relatively easier to obtain than citizenship but comes with most of the significant constitutional rights and benefits of citizenship. If there is little or no benefit in becoming a citizen (provided that one is not interested in a political career or in the right to vote) because most of the same rights can be enjoyed by permanent residents, and permanent residence status is relatively easy to come by, then it becomes very difficult to control or regulate an influx of foreigners all with an eye to making large amounts of money in an already crowded private health sector, often for transmission to their extended families in their countries of origin. At the same time, the public sector, where foreign doctors could be deployed to considerable advantage, must

this sense, is immutable. Citizenship is, at least temporarily, a characteristic of personhood not alterable by conscious action and in some cases not alterable except on the basis of unacceptable costs.’

This general lack of control over one's citizenship has particular resonance in the South African context, where individuals were deprived of rights or benefits, ostensibly on the basis of citizenship, but in reality in circumstances where citizenship was governed by race. Many became statutory foreigners in their own country under the Bantustan policy, and the Legislature even managed to create remarkable beings called ‘foreign natives’. Such people were treated as instruments of cheap labour to be discarded at will, with scant regard for their rights, or the rights of their families.” The constitutional court in *Larbi-Odam* does not seem to have considered the case before it in light of section 22 of the Constitution at all but rather decided it on the basis of unfair discrimination. Mokgoro J stated: “I hold that reg 2(2) constitutes unfair discrimination against permanent residents, because they are excluded from employment opportunities even though they have been permitted to enter the country permanently. The government has made a commitment to permanent residents by permitting them to so enter, and discriminating against them in this manner is a detraction from that commitment. Denying permanent residents security of tenure, notwithstanding their qualifications, competence and commitment is a harsh measure.” (at para 25 p 759) He also stated that: “Permanent residents should, in my view, be viewed no differently from South African citizens when it comes to reducing unemployment. In other words, the government's aim should be to reduce unemployment among South African citizens and permanent residents. As explained above, permanent residents have been invited to make their home in this country. After a few years, they become eligible for citizenship. In the interim, they merit the full concern of the government concerning the availability of employment opportunities. Unless posts require citizenship for some reason, for example due to the particular political sensitivity of such posts, employment should be available without discrimination between citizens and permanent residents. Thus it is simply illegitimate to attempt to reduce unemployment among South African citizens by increasing unemployment among permanent residents. Moreover, depriving permanent residents of posts they have held, in some cases for many years, is too high a price to pay in return for increasing jobs for citizens.” (at para 31 p760-761; footnotes omitted). This judgment could be seen as nullifying to an extent the express reference in section 22 of the Constitution to ‘citizens’. The constitutional court in *Larbi-Odam* (fn 130 *supra*), without reference to section 22 of the Constitution, seems itself to have taken the decision that it referred to in the certification judgment in its observation that Article 2.3 of ICESCR itself allows developing countries ‘with due regard to human rights and their national economy’ to ‘determine to what extent they would guarantee the economic rights recognised in the present Covenant to non-nationals’ and has paid scant attention to its comment that “The instruments discussed do not support the proposition that non-citizens are entitled to be treated on the same footing as citizens in regard to the freedom of occupational choice.” See also *Dawood* fn 12 *supra*

choose between employing health professionals who are temporary residents, and running the risk that they will often sooner rather than later attempt to obtain permanent residence status with a view to entering private practice, or not having sufficient numbers of health professionals to deliver services because many local health professionals do not wish to work in the public health sector at all. In reducing the already narrow legal gap between permanent residents and citizens the constitutional court has rendered South Africa a highly accessible and attractive location for the nationals of many less prosperous and less developed countries.

The *Dawood*³⁴⁸ case goes even a step further in that it essentially allows people who are temporary residents but who are married to South African permanent residents and citizens the right to apply for permanent residence from within South Africa on the understanding that such permanent resident status will be granted unless there is good reason not to. It is the experience of the national Department of Health that many foreign health professionals who enter the country marry South African permanent residents and citizens expressly with a view to obtaining permanent resident status. The result is that the public sector in employing foreign health professionals on a temporary basis is, in the long term creating a point of entry into the private health sector for these same professionals in an environment where in many instances there are already sufficient numbers of local professionals to render the services. With the introduction of certificate of need processes, South African citizens who are private sector health professionals will be competing with foreign health professionals for prime locations in which to pursue their chosen trade, occupation or profession.

2.8 Emergency Medical Treatment

The right not to be refused emergency medical treatment is specified in section 27(3) of the Constitution³⁴⁹. The elements of the right require closer examination. Questions also arise as to the structuring of section 27. Does the available resources restriction contemplated in

³⁴⁸ *Dawood* fn 12 *supra*

³⁴⁹ "No-one may be refused emergency medical treatment."

section 27(2) of the Constitution necessarily apply to this provision? The structuring of section 27 as a whole is such that section 27(2) is sandwiched between section 27(2) which expressly uses the word “right” and section 27(3) which does not. Section 27(2) refers to “these rights” Which rights are “these rights”? If section 27(2) had been intended to refer to the provision concerning medical treatment then why was the order not reversed? Why was section 27(2) not placed as the final provision in the section rather than the penultimate one if the intention was that it should apply to both health care services and emergency medical treatment? If one has to consider the question from a pragmatic perspective, however, then surely emergency medical treatment must also be limited by the availability of resources? If there are no resources for emergency medical treatment then how can the position be different to a situation in which there are no resources for the provision of health care services generally? In fact is not emergency medical treatment a subset of “health care services” or must the phrase “health care service” be read as excluding emergency medical treatment altogether? These questions will be explored in more detail below and in the discussion of the *Soobramoney* case³⁵⁰.

2.8.1 No-one may be refused

The right is couched in the negative. The high court pointed out in *Soobramoney*³⁵¹ that section 27(3) was not so much creating a right to emergency medical treatment as a right not to be refused emergency medical treatment³⁵². This does not necessarily mean, however, that there must be no balancing of the rights of one emergency victim with those of another. Even if *Soobramoney*’s condition had classified as a medical emergency, if there were other patients who stood a better chance of survival due to a general health status superior to that of *Soobramoney*, and there were limits as to how many patients could be treated, it is possible that *Soobramoney* would still not have been eligible for treatment since he was

³⁵⁰ *Soobramoney v Minister of Health, Kwazulu-Natal* fn 23 *supra*

³⁵¹ *Soobramoney* fn 23 *supra*

³⁵² See *Soobramoney* fn 23 *supra* where the court noted that: “The applicant contends that the same limitation does not apply to emergency medical treatment. As pointed out by counsel for the respondent s 27(3) does not create a right to emergency medical treatment. It prohibits anyone from refusing emergency medical treatment.” The constitutional court in *Soobramoney* fn 23 *supra*, at p 774 also emphasised that the right is stated in the negative. It said: “Section 27(3) itself is couched in negative terms - it is a right not to be refused emergency treatment. The purpose of the right seems to be to ensure that treatment be given in an emergency, and is not frustrated by reason of bureaucratic requirements or other formalities.”

not a candidate for a kidney transplant which was the main criteria used by the provincial health authorities to prioritise patients with chronic renal failure for dialysis. The legal principle that 'no-one' may be refused emergency medical treatment is qualified and must remain qualified³⁵³. It is no more absolute than the other rights in the Bill of Rights and is apparently just as affected by the availability of resources as the right to health care services in section 27(3)³⁵⁴.

As medical doctors are wont to point out, in real life, many of them, especially those working in trauma or emergency units in major hospitals are faced with situations every day in which they must prefer the interests of one patient over the other. A scientific method of prioritising medical attention to multiple injured known as triage is used in emergency medical departments throughout the world. Triage, a sorting or classification of patients based on their levels of medical urgency was first developed as a military term and used in wartime. The French used "triage" in the early 19th century to decide who would be taken from the battlefields to be treated and who would be left behind. Over the next century the practice was further developed in armies throughout the world and during World War 1 improved outcomes of some battle injuries were accredited to appropriate triage. It comprises a brief clinical assessment that determines the time and sequence in which patients should be seen in the emergency department or, if in the field, the speed of transport and choice of hospital destination. Triage in a disaster is neither perfect nor democratic. Patients who are severely injured and not expected to survive are the most difficult to categories³⁵⁵. The question as to where triage fits in the practice of South African medicine in the light of the constitutional directive that no one may be refused emergency medical treatment raises some interesting questions. Some practical examples of triage in emergency departments are:

³⁵³ See *Soobramoney* in 23 *supra* where Chaskalson P observed at 777 that: "But the state's resources are limited and the appellant does not meet the criteria for admission to the renal dialysis programme. Unfortunately, this is true not only of the appellant but of many others who need access to renal dialysis units or to other health services" and "There will be times when this requires it to adopt an holistic approach to the larger needs of society rather than to focus on the specific needs of particular individuals within society."

³⁵⁴ See further discussion below.

³⁵⁵ See Derlet RW 'Triage' <http://www.emedicine.com/emerg/topic670.htm>. The cardinal question which no-one seems comfortable in articulating is whether one utilises valuable time and resources on a critically injured patient who has less than a 20% chance of survival when that same time and those resources could be used to save another patient who is also likely to die in the interim but who stands an 80% chance of survival if attended to immediately. If one attends to the first patient first the chances are that two people will die whereas if one attends to the second first the chances are that only one will die.



A 55 year old man presented to the emergency department complaining of abdominal pain. He stated that he thought his condition was secondary to eating too much greasy fast food too rapidly. As the emergency department was busy the patient was sent to the waiting room after his blood pressure, pulse, respiration rates and temperature had been taken. Two hours later, the patient's friend complained that he looked pale and had increasing weakness. The patient's friend was told that the emergency department was overcrowded. Three hours after triage, the patient collapsed in the emergency department waiting room. He was brought into the emergency department hypotensive and was taken to surgery where he died of a ruptured aortic aneurysm.³⁵⁶

A 43 year old woman presented to the emergency department complaining of a headache. The patient had normal vital signs except for a temperature of 101.2F. The emergency department was very busy and overcrowded. Since this patient seemed no worse than the others, and the triage nurse has seen many patients that day whose symptoms included headache, she sent the patient to the waiting room. Four hours later another patient came to the triage desk stating that the woman, who was still in the waiting room, was having a seizure. A repeat temperature 5 hours after the initial presentation was 104.5 F and she was admitted to hospital with a diagnosis of meningitis.³⁵⁷

The above examples may not found a claim in terms of the law of delict as it is traditionally understood because it is quite possible that the triage nurse in each case did not act negligently. What about the patient's constitutional right not to be refused emergency medical treatment? Is making a patient wait in a busy crowded waiting room tantamount to a denial of his constitutional right? The answer to this question, it is submitted, is to be found in the judgment of the Durban High Court in *Soobramoney*³⁵⁸ in which Combrinck J observed that:

"I consider that the section must be interpreted in such a way that it is implicit in the words 'emergency medical treatment' that such treatment is possible and available. It could surely not have been the intention of the Legislature that irrespective of the costs and whether or not funds were available and irrespective of whether the treatment was available the persons requiring emergency medical treatment had to receive such treatment. So, for instance, if a hospital had an intensive care unit which was full and an emergency patient arrived would it be obliged to move one of its patients out so as to accommodate the emergency patient? Alternatively, is the state obliged to build additional intensive care units, procure additional dialysis machines, ventilators, heart-lung machines and other life-saving equipment to enable it to cater for all the patients requiring emergency medical treatment? It could surely not have been the intention of the Legislature that the right to access to health care was subject to the constraints of the state's resources and that a patient could be refused treatment but when his or her condition reached a critical stage and emergency treatment was required, the state then had to provide it irrespective of the cost."

³⁵⁶ Derlet fn 355 *supra*

³⁵⁷ Derlet fn 355 *supra*. These examples are from the United States.

³⁵⁸ *Soobramoney* fn 82 *supra* at p439-440

This said, perhaps there is scope for an argument that there could, in certain circumstances, be a responsibility on the hospital whose emergency unit is full to refer the patient to an alternative emergency facility and possibly even arrange for him to be transported there by ambulance if it such transport is available.

2.8.2 Emergency

How does one define a situation as one of ‘emergency’? If it is defined too broadly then the emergency department simply becomes more crowded and its resources more thinly stretched in treating people who could possibly afford to wait. Who decides when the patient is suffering from a condition requiring ‘emergency’ medical treatment, as opposed to just ‘medical treatment’? Laypersons may perceive a situation as an emergency when in fact, from a medically trained person’s point of view it is not. In the US there has been considerable debate on this subject and even, in some cases, legislation in an attempt to resolve the issue. In South Africa, it is submitted, the test is likely to be objective rather than subjective for purposes of determining whether a health facility has in fact violated a person’s constitutional rights in turning him away when he came seeking treatment or in rendering health care services but not with the urgency dictated by an emergency. Since a health facility in the public sector is unlikely to turn a patient away unless it is full to capacity or does not have the resources to render the services required, and since in terms of *Soobramoney*³⁵⁹ these are acceptable reasons for not rendering emergency medical treatment, the question is more likely to arise in the private health sector where a patient is turned away because he cannot demonstrate that he has the ability to pay.

2.8.2.1 Horizontal Application

It is submitted that in looking at whether a person’s constitutional rights were violated in this context, a court is likely first to consider the question of whether the right to emergency

³⁵⁹ *Soobramoney* fn 23 *supra*



medical treatment is of horizontal application or not. Liebenberg³⁶⁰ contends that the right is horizontally applicable when read with section 8(2) of the Constitution³⁶¹. It follows that if a private facility does have the right to claim payment for emergency treatment after the event then the logic of turning someone away because they are unable to pay at the time of the emergency is likely to constitute a violation of the right. In practice, however, the right to demand payment is not always capable of fulfilment due to the circumstances of the patient. Private hospitals and health care professionals are often obliged to write off significant amounts of money due to non-payment by patients for any number of reasons. Sometimes the cost of pursuing the debt is more than the debt itself. Debts also prescribed after three years so there is limited time in which to track the debtor and interrupt prescription. In a situation where an indigent person arrives on the doorstep of a private hospital requiring emergency medical treatment, the power of the hospital to demand payment is not likely to be of much assistance in aiding the hospital to recoup the costs of treatment. The only viable strategy, from a cost containment perspective, is to render sufficient treatment necessary to stabilise the patient and then transfer him or her to a public health facility as soon as possible³⁶².

It is submitted that the manner in which section 27 of the Constitution has been structured is also conducive to an interpretation that the right is horizontally applicable as is the fact that the right has been couched in the negative in section 27(3). Section 27(2) is sandwiched between section 27(1) which deals with the right of access to health care services and section 27(3) dealing with the right not to be refused emergency medical

³⁶⁰ Davis *et al* (fn 124 *supra*) at p 358. She states that "As health care services are not yet universally available and are subject to progressive realisation under section 27(2), the protection of this right extends only to situations in which a patient is 'refused' emergency medical treatment owing to a lack of money, race or other exclusionary practices. This subsection also does not confer a right to 'free' emergency medical treatment. Although a patient may not be turned away from a medical facility owing to a lack of funds, the costs of the treatment may be recovered later."

³⁶¹ Section 8(2) states that: "A provision of the Bill of Rights binds a natural or a 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." See also De Waal, Currie and Erasmus, fn 2 *supra* at 450 where they note that: "We have argued elsewhere that the right may be applied horizontally, entailing a duty for private hospitals. The right does not extend to routine medical treatment and it does not guarantee free services. Emergency treatment may not be refused because of lack of funds, but payment for treatment may be sought after the treatment has been provided."

³⁶² This does not always work well in practice as the public hospital in question argues that it does not have beds or some other resource necessary to treat the patient or simply refuses to take him or her for reasons that are not expressed at the time. It obviously pays private hospitals to have a healthy and co-operative relationship with the local public hospitals if they are to manage the problem of presented by a constitutional obligation to render what can amount to costly emergency medical treatment and still remain profitable. The other alternative is to negotiate with the state some kind of fee in respect of indigent patients which covers the costs of rendering the necessary services. It is only in an ideal world that private hospitals can survive on charity.

treatment. The reason for this was probably the intention on the part of the drafters that section 27(2) applies only to the rights contemplated in section 27(1) and not to those contemplated in section 27(3). If it had been intended that the phrase ‘these rights’ in section 27(2) must be applicable to section 27(3) rights then it would have been much more logical to place the wording contained in section 27(2) at the end of the section rather than in the middle. Liebenberg argues, presumably for this reason, that “Unlike the general right of access to health care services (sic) is not subject to the qualifications of progressive realisation and resource constraints.”³⁶³ It is submitted, with respect, that whilst this may have been true on the wording and structure of section 27(2) alone, it is not correct in light of the judgment in *Soobramoney*³⁶⁴.

In view of the judgment in *Soobramoney*, if a court concludes that the right is of horizontal application, it is likely to proceed to questions of reasonableness in deciding whether or not there was an infringement of the right by a private sector health care provider. Did the health care professional in turning the patient away do so because he could not pay? What kind of medical treatment would have been reasonably necessary under the circumstances? Could the patient have been stabilised at relatively low cost to the private provider before being transferred to a public health facility? Was the private provider already so busy that it could not cope with another patient? If the right is of horizontal application, it is submitted

³⁶³ *Davis et al* fn 124 *supra* at p 358

³⁶⁴ *Soobramoney* fn 23 *supra* at para 20, 774 Chaskalson P states that: “A person who suffers a sudden catastrophe which calls for immediate medical attention, such as the injured person in *Paschim Banga Khet Mazdoor Samity v State of West Bengal* (supra), should not be refused ambulance or other emergency services which are available and should not be turned away from a hospital which is able to provide the necessary treatment. * What the section requires is that remedial treatment that is necessary and available be given immediately to avert that harm.” (writer’s emphasis) See also the words of Combrinck J in the judgment of the court *a quo* where he comments at p 439 -440 that: “As pointed out by counsel for the respondent s 27(3) does not create a right to emergency medical treatment. It prohibits anyone from refusing emergency medical treatment. I consider that the section must be interpreted in such a way that it is implicit in the words ‘emergency medical treatment’ that such treatment is possible and available. It could surely not have been the intention of the Legislature that irrespective of the costs and whether or not funds were available and irrespective of whether the treatment was available the persons requiring emergency medical treatment had to receive such treatment. So, for instance, if a hospital had an intensive care unit which was full and an emergency patient arrived would it be obliged to move one of its patients out so as to accommodate the emergency patient? Alternatively, is the State obliged to build additional intensive care units, procure additional dialysis machines, ventilators, heart-lung machines and other life-saving equipment to enable it to cater for all the patients requiring emergency medical treatment? It could surely not have been the intention of the Legislature that the right to access to health care was subject to the constraints of the State’s resources and that a patient could be refused treatment but when his or her condition reached a critical stage and emergency treatment was required, the State then had to provide it irrespective of the cost.” See also the observations of De Waal, Currie and Erasmus, fn 2 *supra* at p 449 to 450 where they state that: “The state’s duty under s 27(3) is ‘not [to] refuse ambulance or other emergency services which are available’ and not to turn a person ‘away from a hospital which is able to provide the necessary treatment’. This available- and-able qualification makes it clear that s 27(3) does not create a positive constitutional obligation on the state to ensure that emergency medical facilities are made available so that no-one in an emergency situation can be turned away. Section 27(3) is therefore a right not to be arbitrarily excluded from that which already exists.” In this context, they refer to Scott C & Alston P ‘Adjudicating Constitutional Priorities in a Transnational Context: A Comment on *Soobramoney*’s Legacy and *Grootboom*’s Promise’ (2000) 16 *S&JHR* 206, at p 236.

that refusal to treat a patient on the grounds of his or her ability to pay is likely to constitute a violation of the patient's constitutional rights. Given the fact that private providers are unlikely to want to pay for emergency medical treatment for the indigent out of their own pockets and profits, they are likely to try and recoup these costs in a number of ways, the most obvious being from private patients who can afford to pay for private facilities. They may also attempt to conclude agreements with the state in terms of which they are remunerated a basic fee for the treatment of such cases. Either way, the horizontal application of the right not to be refused emergency medical treatment probably has significant cost implications for the state and private consumers of health care services alike. The impact on the private health sector of the horizontal application of the right not to be refused emergency medical treatment depends largely upon the scope of the right. If the court in *Soobramoney* had found that urgent treatment for chronic illnesses falls within the scope of emergency medical treatment it could potentially have put the private health sector out of business even with its ability to charge patients for its services. Billing is something quite unrelated to a patient's ability to pay. If the meaning of the phrase emergency medical treatment is too wide, it will impose an onerous burden on private providers of health care services such that they may not be able to remain in business.

2.8.2.2 Soobramoney

In the case of *Soobramoney*³⁶⁵ the constitutional court had reason to consider the nature of emergency medical treatment as opposed to health care services as contemplated in section 27(1) of the Constitution. The facts of *Soobramoney* have already been canvassed previously in this chapter. For present purposes it must be noted that the applicant argued that the renal dialysis treatment he required fell into the category of emergency medical treatment as envisaged in section 27(3) of the Constitution as opposed to health care services generally and that the respondent could therefore not refuse to give it to him. Chaskalson P stated that:

³⁶⁵ *Soobramoney* fn 23 *supra*

“The words ‘emergency medical treatment’ may possibly be open to a broad construction which would include ongoing treatment of chronic illnesses for the purpose of prolonging life. But this is not their ordinary meaning, and if this had been the purpose which s 27(3) was intended to serve, one would have expected that to have been expressed in positive and specific terms”

pointing out³⁶⁶ that:

“The purposive approach will often be one which calls for a generous interpretation to be given to a right to ensure that individuals secure the full protection of the bill of rights, but this is not always the case, and the context may indicate that in order to give effect to the purpose of a particular provision ‘a narrower or specific meaning’ should be given to it.”

The constitutional court, after considering foreign law with regard to the right to life in general and to emergency medical treatment in particular, made the important observation³⁶⁷ that:

“In our Constitution the right to medical treatment does not have to be inferred from the nature of the State established by the Constitution or from the right to life which it guarantees. It is dealt with directly in s 27. If s 27(3) were to be construed in accordance with the appellant’s contention it would make it substantially more difficult for the state to fulfil its primary obligations under ss 27(1) and (2) to provide health care services to ‘everyone’ within its available resources. It would also have the consequence of prioritising the treatment of terminal illnesses over other forms of medical care and would reduce the resources available to the State for purposes such as preventative health care and medical treatment for persons suffering from illnesses or bodily infirmities which are not life threatening. In my view, much clearer language than that used in s 27(3) would be required to justify such a conclusion.”

It was the view of the constitutional court that section 27(3) requires that remedial treatment that is necessary and available be given immediately to avert that harm³⁶⁸ and that the purpose of the right seems to be to ensure that treatment be given in an emergency, and is not frustrated by reason of bureaucratic requirements or other formalities. The court found that the applicant’s situation did not fall within the scope of section 27(3) and that it therefore had to be considered in the light of the resources available to the state in terms of section 27(1).

³⁶⁶ *Soobramoney* fn 23 *supra* at 772-773

³⁶⁷ *Soobramoney* fn 23 *supra* at 773-774

³⁶⁸ *Soobramoney* fn 23 *supra* p 774

The constitutional court, it is respectfully submitted, correctly refused in *Soobramoney* to blur the lines between ordinary health care services and emergency medical treatment.

Sachs J³⁶⁹ observed that:

“The special attention given by s 27(3) to non-refusal of emergency medical treatment relates to the particular sense of shock to our notions of human solidarity occasioned by the turning away from hospital of people battered and bleeding or of those who fall victim to sudden and unexpected collapse. It provides reassurance to all members of society that accident and emergency departments will be available to deal with the unforeseeable catastrophes which could befall any person, anywhere and at any time. The values protected by s 27(3) would, accordingly, be undermined rather than reinforced by any unwarranted conflation of emergency and non-emergency treatment such as that argued for by the appellant.”

The court was of the view that an emergency involves some sudden or unexpected catastrophe which calls for immediate medical attention³⁷⁰.

Even though the treatment required by the applicant in *Soobramoney*, was necessary for his survival this did not necessarily mean that it constituted emergency medical treatment. The Durban High Court took the view that:

“In any event, the applicant, in my view on the facts, cannot rely on the provisions of s 27(3). He has been suffering from the diseases mentioned for some years. He has not contracted a sudden illness or sustained unexpected trauma. It is true that if he does not receive the treatment he will die. Unfortunately, that is the position with all persons who suffer from long term disease. So, for instance, a person who has cancer may suffer from the disease for a number of years, but will eventually reach the stage where within days he will die. It is then an emergency situation for him but it is not the emergency that, in my view, the Legislature had in mind in s 27(3).”³⁷¹

There were really two issues in *Soobramoney*³⁷². The first related to the question of what constitutes emergency medical treatment as contemplated in section 27(3) of the Constitution. The second related to whether the state can be compelled to provide health care services, as contemplated in section 27(1) of the Constitution, to the terminally ill, regardless of the availability of resources or perhaps on the basis that the available resources should first be used to treat the terminally ill first and thereafter, any resources that are left can be used to render health services to everyone else.

369 *Soobramoney* fn 23 *supra* at p 781-782

370 *Soobramoney* fn 23 *supra*. Chaskalson P at para 20 p 774

371 *Soobramoney* fn 82 *supra* at p 439-440

372 *Soobramoney* fn 23 *supra*

It is submitted that unlike many of its critics³⁷³, the Constitutional court in a sound and highly rational judgment was able to take a clear sighted and unemotional approach to the harsh realities of the real world in which all resources are limited and come to a conclusion that difficult decisions regarding the allocation of resources are not always best made by the courts.³⁷⁴ It is submitted that if emergency medical treatment had been too widely construed by the constitutional court in this critically important judgment, not only would the obligations of the state have been skewed in favour of the treatment of terminal illness as suggested by Chaskalson P but the practical significance of the rights to both emergency medical treatment and health care services, as well as the distinction drawn in the Constitution between them, would have been undermined to the point where South Africa could have found itself in the same position as Venezuela – with court orders that impose upon the state impossible obligations and the content of the right to health care services has no meaning for those who need it most.³⁷⁵ In the words of Sachs J in *Soobramoney*,³⁷⁶ “The values protected by s 27(3) would, accordingly, be undermined rather than reinforced by any unwarranted conflation of emergency and non-emergency treatment such as that argued for by the appellant.”

³⁷³ See for instance the comments of Burchill R in ‘*Soobramoney v Minister of Health (Kwa-Zulu-Natal)*’ at <http://www.nottingham.ac.uk/law/iric/tnews/march98/SOBRAM.HTM> who states that the constitutional court judges in *Soobramoney* “have failed to provide any insight as to the circumstances which will allow for a right to health care to be ‘most fairly and effectively enjoyed’” and then proceeds to the usual debate on government spending on defence versus health care and stating that “Have decisions been made rationally and in good faith in determining the allocation of resources necessary to have a healthy society? It would be interesting to see what Chaskalson P had in mind concerning a holistic approach to government spending” It would appear that Burchill feels that the South African constitutional court’s role should have undertaken a review of the entire budget of the South African government in deciding *Soobramoney*’s case and that perhaps it should have directed that some of the expenditure devoted to defence matters should have been redirected by the court to save Mr *Soobramoney*. De Waal, Currie and Erasmus, fn 2 *supra* at p139 refer to the constitutional court’s “most controversial use of contextual interpretation to date in *Soobramoney v Minister of Health (Kwazulu-Natal)*”.

³⁷⁴ As Chaskalson P (fn 23 *supra*) observed at p776 onwards “Although the problem of scarce resources is particularly acute in South Africa this is not a peculiarly South African problem. It is a problem which hospital administrators and doctors have had to confront in other parts of the world, and in which they have had to take similar decisions. In his judgment in this case Combrinck J refers to decisions of the English Courts in which it has been held to be undesirable for a court to make an order as to how scarce medical resources should be applied, and to the danger of making any order that the resources be used for a particular patient, which might have the effect of denying those resources to other patients to whom they might more advantageously be devoted. The dilemma confronting health authorities faced with such cases was described by Sir Thomas Bingham MR in a passage cited by Combrinck J from the judgment in *R v Cambridge Health Authority, ex parte B*: ‘I have no doubt that in a perfect world any treatment which a patient, or a patient’s family, sought would be provided if doctors were willing to give it, no matter how much it cost, particularly when a life was potentially at stake. It would however, in my view, be shutting one’s eyes to the real world if the Court were to proceed on the basis that we do live in such a world. It is common knowledge that health authorities of all kinds are constantly pressed to make ends meet. They cannot pay their nurses as much as they would like; they cannot provide all the treatments they would like; they cannot purchase all the extremely expensive medical equipment they would like; they cannot carry out all the research they would like; they cannot build all the hospitals and specialist units they would like. Difficult and agonising judgments have to be made as to how a limited budget is best allocated to the maximum advantage of the maximum number of patients. That is not a judgment which the court can make.’” (footnotes omitted)

³⁷⁵ See the discussion of the case of *Cruz Bermudez, et al v Ministerio de Sanidad y Asistencia Social* in chapter 1 of this thesis.

³⁷⁶ *Soobramoney* fn 23 *supra* para 51 at p 782

2.8.2.3 EMTALA

Whilst it is not the intention within this thesis to conduct a comparative study of the law relating to emergency medical treatment of South African and foreign jurisdictions, it is worth reflecting on some of the issues concerning the concept of 'emergency' in relation to health care services that have arisen in the United States if only to anticipate some of the complications which may accompany questions concerning emergency medical treatment in South Africa. The Constitution moreover permits South African courts to consider foreign law in terms of section 39 (1)(c) when interpreting the Bill of Rights. The debate about what constitutes emergency medical treatment or an emergency medical condition is fraught with complexity if the American experience is anything to go by. Firstly there is the question of what is an emergency and who decides that it is and the nature of the treatment to be provided³⁷⁷. A further question is whether the provision of section 27(3) is in a sense not self-defeating because if left untreated for too long, many health conditions do become medical emergencies requiring emergency medical treatment? If the available resources limitation applies only to health care services and not to emergency medical treatment then

377

Combrink J in *Soobramoney* (fn 82 *supra*) gave at least a partial answer to this question when he noted at p 437 onwards that: "Insofar as the present case is concerned however, I am of the view that it is not the function of the Court to decide who shall and who shall not receive the required medical treatment. It is for the medical practitioners to make these decisions. They are qualified, whereas I am not, to decide on clinical grounds which patient will benefit the most from the treatment. The Court will only interfere if the doctors involved have exercised their judgment unreasonably, arbitrarily or have discriminated against a patient. In this regard I am in complete accord with the remarks of Balcombe LJ in the case of *Re J* (a minor) (wardship: medical treatment) a judgment of the Court of Appeal reported in [1992] 4 All ER 614 at 625g:

'I would also stress the absolute undesirability of the court making an order which may have the effect of compelling a doctor or health authority to make available scarce resources (both human and material) to a particular child, without knowing whether or not there are other patients to whom those resources might more advantageously be devoted. Lord Donaldson MR has set out in his reasons the condition of J and his very limited future prospects. The effect of the order of Waite J, had it not been immediately stayed by this court might have been to require the health authority to put J on a ventilator in an intensive care unit, and thereby possibly to deny the benefit of those limited resources to a child who is much more likely than J to benefit from them.' I find further support in the obiter remarks of Hoffmann LJ in *Airedale NHS Trust v Bland* a judgment of the Court of Appeal reported in [1993] 1 All ER 821 at 857b-d: 'I said that there were two distinctions between the prohibition on violating the person and the duty to provide care and assistance. So far I have mentioned only one. The second is that while the prohibition on violation is absolute, the duty to provide care is restricted to what one can reasonably provide. No-one is under a moral duty to do more than he can or to assist one patient at the cost of neglecting another. The resources of the national health service are not limitless and choices have to be made. This qualification on the moral duty to provide care did not enter into the argument in this case at all. The *Airedale NHS Trust* invited us to decide the case on the assumption that its resources were unlimited and we have to do so. But one is bound to observe that the cost of keeping a patient like Anthony Bland alive is very considerable and that in another case the health authorities might conclude that its resources were better devoted to other patients. We do not have to consider such a case, but in principle the allocation of resources between patients is a matter for the health authority and not for the courts.'

In that case the patient was a victim of the Hillsborough football ground disaster. He suffered a severe crushed chest injury which resulted in brain damage and left him in a persistent vegetative state. The issue was whether medical treatment could be withdrawn and the patient allowed to die." It is submitted that what the court was in effect saying was that even in emergency medical circumstances, the decision of medically trained staff to prioritise certain patients over others cannot be faulted except where they are acting unreasonably. It is submitted that a decision that a particular patient does not in fact require emergency medical treatment at all because the condition from which he or she is suffering is not an emergency is a similar one. It can only be faulted where the medical personnel in question acted unreasonably or arbitrarily or in a discriminatory fashion.



this is a way in which the available resources limitation can be circumvented?³⁷⁸ Another question is what is the bare minimum that should be done in the emergency? What is the nature of the emergency services that are required and is it the same irrespective of the nature of the facility involved in the situation?

The federal Emergency Medical Treatment and Active Labour Act, otherwise known as EMTALA, uses the term “emergency medical condition” and defines it as follows³⁷⁹:

“Emergency medical condition” means –

- A. a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances, and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in:
 - (i) Placing the health of the individual (or with respect to a pregnant woman, the health of a woman or her unborn child³⁸⁰) in serious jeopardy;
 - (ii) Serious impairment to bodily functions;
 - (iii) Serious dysfunction of any bodily organ of part;
- B. with respect to a pregnant woman who is having contractions:
 - (i) that there is inadequate time to effect a safe transfer to another hospital before delivery; or
 - (ii) that the transfer may pose a threat to the health or safety of the woman or the unborn child³⁸¹

³⁷⁸ The court pointed out in *Sobramoney* (fn 82 *supra*), however that “In the Constitution itself the Legislature recognises that the rights which it affords the citizen are not absolute and are limited by the funds available” and that “It could surely not have been the intention of the Legislature that the right to access to health care was subject to the constraints of the State’s resources and that a patient could be refused treatment but when his or her condition reached a critical stage and emergency treatment was required, the State then had to provide it irrespective of the cost.” It is further submitted that once the condition of a patient is stabilised and there is no longer an immediate threat to life or of serious impairment of bodily organs or functions, the medical treatment required can no longer be regarded as emergency medical treatment and that the person who has received the emergency treatment that was immediately necessary to save his life or health reverts to section 27(1) status in terms of his or her entitlement to health care services.

³⁷⁹ The definition seems to have changed relatively recently to include psychiatric disturbances and/or symptoms of substance abuse. Some sources still cite a previous wording which does not include these aspects – only severe pain.

³⁸⁰ In South African constitutional law the unborn child is not recognised as a person and therefore holds no constitutional rights (see discussion of what is a child elsewhere in this chapter).

³⁸¹ Examination and treatment for emergency medical conditions and women in labor 42 USC 1395dd (1986) <http://www.medlaw.com/statute.htm>; and <http://www.emedicine.com/emerg/topic860.htm>

EMTALA was enacted in 1986 as part of the Consolidated Omnibus Budget Reconciliation Act of 1985 primarily in response to concern that some emergency departments across the country refuse to treat indigent uninsured patients or inappropriately transferred them to other hospitals, a practice known as ‘patient dumping’.³⁸² The mischief it sought to address is thus similar in nature to the mischief that section 27(3) of the Constitution seeks to address. EMTALA requires hospitals that participate in Medicare to provide a medical screening examination to any person who comes to the emergency department, regardless of the individual’s ability to pay. Unlike the right in section 27(3) it apparently applies only to hospitals but there is a similarity in that it is likely that in terms of the Constitution, emergency medical treatment will have to be rendered regardless of the ability to pay. In terms of EMTALA if the medical screening reveals that the patient has an emergency medical condition as defined, then the hospital must provide treatment to stabilize the condition or provide for an appropriate transfer to another facility. If the hospital is unable to stabilize the condition, it must provide for transfer to another medical facility. The delaying of the medical screening examination and the stabilization of the patient in order to enquire into his or her ability to pay is prohibited. EMTALA obliges a hospital to accept a patient from a transferring hospital if it can provide the specialized care the patient needs and to report any inappropriate transfers. The regional offices of the Department of Health and Human Services’ (HHS) Centers for Medicare and Medicaid Services (CMS) are responsible for investigating complaints of alleged EMTALA violations and forwarding confirmed violations to HHS’ Office of Inspector General (OIG) for possible imposition of civil monetary fines³⁸³. The GAO commented in its report that the overall impact of EMTALA is difficult to measure because there are no data on the incidence of patient dumping before its enactment and the only measure of current incidence – the number of confirmed violations - is imprecise. Hospital and physician representatives told the GAO that more people were coming to emergency departments with non-urgent conditions as a result of EMTALA. The provider representatives said that patients who face financial or other barriers to care used emergency departments as their primary health provider because

³⁸² United States General Accounting Office Report to Congressional Committees “Emergency Care: EMTALA Implementation and Enforcement Issues” June 2001 available at <http://www.emtala.com>

³⁸³ United States General Accounting Office Report fn 382 *supra*

they know they will receive care there. EMTALA requires that a medical screening examination must be conducted on every patient who requests examination or treatment for a medical condition. This illustrates one of the problems of mandatory emergency medical treatment. One first has to establish that it is an emergency medical condition and the only way of doing this is usually to examine the patient. If the majority of seriously ill patients present to the emergency room of a hospital and the law requires that they must all be examined before they can be reclassified as non-emergencies, this has the potential to severely interfere with the delivery of emergency medical treatment to those patients that are in a genuine emergency situation. Even if the patient presents with medical records it is not safe to assume that his condition is as reflected in the records since some time may have elapsed between the compilation of the record and the examination to establish whether it is an emergency situation or not. Some emergencies are fairly obvious but there are others that are not. What is the position where a hospital turns a patient away without even seeing him or her for example it refuses to take transfer of the patient from another health facility?³⁸⁴ Yet another question is the extent to which secondary risks associated with emergency medical conditions are included in the term emergency medical treatment.³⁸⁵

³⁸⁴

In *St Anthony Hospital v United States Department of Health and Human Services* the US Court of Appeals (tenth circuit) had to consider such a situation. The judgment was handed down on 28 August 2002. St Anthony's Hospital had been fined for violation of EMTALA provisions against 'reverse-dumping' i.e. refusal to accept an appropriate transfer of a patient or to treat a patient who does not have medical insurance. The fine was imposed by the Department of Health and Human Services and the Departmental Appeals Board upheld the violation finding whereupon St Anthony's applied for review of the decision to the Court of Appeals. The facts were that a 65 year old male patient was involved in a motor vehicle accident on a highway outside of Oklahoma City in April 1995. He was taken that afternoon to the emergency room at Shawnee Regional Hospital, a small hospital about 35 miles outside of Oklahoma City that lacked the ability to perform many complex medical procedures. Almost two hours later, the patient was diagnosed with a neurological injury and his transfer was arranged to University Hospital in Oklahoma City. As he was boarded onto an ambulance another doctor arrived at the emergency room and was briefly informed of the patient's injury and that was being transferred to University Hospital because his back was broken. En route to the other hospital the patient's condition deteriorated and the ambulance was forced to return to Shawnee. In hindsight it was discovered that the patient had actually suffered from a life threatening traumatic injury to his abdominal aorta which shut off the flow of blood to his lower extremities. The doctor on duty examined the patient and immediately became concerned about his condition as he was extremely cyanotic from his umbilicus throughout his lower extremities and had no sensation from his umbilicus down. He had no pulse in his femoral arteries or feet. The doctor knew that the injury was life threatening and that the patient needed surgery. He also knew that Shawnee was not equipped to deal with that type of injury and so determined that he had to be transferred by airlifting him to University Hospital. He spoke to University Hospital over the telephone and was informed that it did not have the capacity to accommodate the patient because it already had two emergency surgeries to perform. A search for another hospital was conducted and the search included a call to St Anthony, a large modern hospital in Oklahoma City with state of the art surgical facilities. A thoracic and vascular surgeon working at St Anthony's refused to take the patient who was eventually transferred to Presbyterian Hospital in Oklahoma City. In an investigation, St Anthony was found to possess the specialized facilities, as well as the capacity, to treat the patient and that none of its operating rooms were in use that evening. St Anthony's was fined \$25 000. The Appeal Board affirmed the finding and increased the penalty to \$35 000. The court observed that given that the patient suffered from an unstabilized emergency medical condition and that Shawnee lacked the ability to perform the complex medical procedure needed, EMTALA imposed on Shawnee an obligation to effect an appropriate patient transfer to another medical facility. The court also said that it had considered the degree of culpability and found it to be substantial. St Anthony Hospital was aware of the critical condition of the patient and the need for his transfer. The hospital's on-call physician refused to come in to perform surgery on the multiple trauma patient despite the fact that the hospital had both the capacity and the capability to treat him and that the hospital inappropriately permitted the on-call physician to make the final decision for the hospital as to whether or not the hospital would accept the patient. The Court denied St Anthony hospital's request to have the agency's determination modified or set aside. (available at <http://www.kscourts.org.ca10.cases/2002/08/00->

In terms of EMTALA a pregnant woman who is having contractions is considered to be in an “emergency medical condition” if there is not enough time to safely transfer the woman

9529.htm) In the South African context, the liability of a private hospital for refusal of emergency medical treatment in the circumstances of the present case would be limited due to the fact that the surgeon in question is unlikely to be an employee of the hospital. In the private sector, medical specialists that use private hospital facilities are seldom if ever, employed by the hospital. This could have the result that a private hospital is unable to compel any doctor to perform the surgery including the doctor who initially refused to do it. The question is whether there would be a duty on the private hospital to attempt to find a doctor who is prepared to do the surgery or whether it should try to arrange for transfer of the patient to a public hospital which does employ doctors and can render the required services. The private hospital could not be held liable for the resident surgeon's refusal to operate on the grounds of vicarious liability because it is not his employer. It could not be held liable for failure to perform the surgery using other personnel because the personnel that private hospitals tend to employ in South Africa are nurses and administrative staff who are certainly not qualified to perform vascular surgery. In the public sector the situation would be considerably different because it does employ doctors and it can issue instructions to a doctor to perform an operation in appropriate circumstances if need be or locate another doctor who can do the surgery. As an employer it can be held vicariously liable for its employee's refusal to provide emergency medical treatment. The question is whether the obligation to provide emergency medical treatment extends to a juristic person, in view of the fact that in terms of the decision in *Ad Outpost* (fn 315 *supra*) juristic persons do not generally enjoy protection of the constitutional right to pursue a trade, occupation or profession. There seems to be some kind of incongruity in a situation where they do not enjoy such a right but are at the same time constitutionally obliged to perform the exact same services that would be protected by the right to follow a trade, occupation or profession. A complicating factor is that in the private sector, the persons who can provide the specialised surgical or other medical treatment are not the juristic persons owning the hospitals but rather the health professionals who use the facilities. Indeed some private hospitals do not even run their own trauma units (emergency rooms) but let out the trauma facility within the hospital to medical doctors who specialise in emergency medicine.

385

In *Reynolds and Another v MaineGeneral Health* the United States Court of Appeals (First Circuit) had to interpret the scope of coverage under EMTALA for secondary risks associated with emergency medical conditions. In that case, the deceased, William D Reynolds was driving a car that collided head-on with another vehicle. As a result of the accident Reynolds suffered various injuries including several fractures of bones in his lower right leg and left foot. He was taken immediately by ambulance from the accident scene to the emergency room in Kennebec Valley Medical Center (now known as the MaineGeneral Medical Center). After an emergency room nurse had triaged Reynolds he was examined by a doctor who took an oral medical history and ordered a series of laboratory tests, X-rays and an abdominal CT scan. After consideration this information the doctor determined that Reynolds suffered from multiple trauma to his lower right leg, including a probable open fracture of the right tibia and fibula and possible fracture of the left foot as well as a possible intra-abdominal injury. He requested consultations from a surgeon and an orthopaedic surgeon, the latter taking another oral medical history. Reynolds was transferred to the operating room where the orthopaedic surgeon performed a closed reduction and intramedullary rodding of the right tibia fracture and a closed reduction and percutaneous pinning of the left second, third and fourth metatarsal neck and head fractures. Following surgery Reynolds was admitted to the hospital floor where the hospital staff monitored his condition and he began receiving physical therapy. He was subsequently returned to the operating room for closure of his right lower leg wound and the next day he was discharged from hospital. Five days later he died of a massive pulmonary embolism that emanated from the deep venous thrombosis (DVT) at the fracture site of his right leg. A witness said that she had overheard Reynolds informing an employee of the hospital that his family had a blood clotting problem on his father's and brother's side of the family whenever they had a trauma. Several family members also said that they had told a MaineGeneral employee in the hospital room after Reynolds underwent surgery that he had a family history of hypercoagulability. His widow filed a complaint that MaineGeneral had failed to screen Reynolds appropriately for DVT and that they had failed to stabilise him for DVT before releasing him. The court had to determine the precise scope of the hospital's duty to screen for risks or related conditions associated with or aggravated by an emergency medical condition. The appellants argued *inter alia* that the DVT was a 'symptom' as contemplated in the definition of 'emergency medical condition' in EMTALA but the court did not accept this argument saying that it was not supported by statutory text or case law. It noted that in another case, *Correa v Hospital San Francisco* 69 F. 3d 1184, 1192 (1st Cir.1995), symptoms of nausea and dizziness which are not normally associated with an emergency medical condition might well herald an emergency medical condition in the case of a hypertensive diabetic. In such a case the symptoms were coupled with a history of hypertension and diabetes. The court distinguished *Correa's* case saying that at the time of the examination *Correa* was experiencing the symptoms of a pathological condition that were communicated to the staff of the emergency room whereas in *Reynolds's* case he was not experiencing any symptoms of DVT that he expressed to anyone at MaineGeneral. The court seems to be relying on the use of the wording 'manifesting' in the definition of medical emergency condition in EMTALA and saying that Reynolds was not manifesting the symptoms of DVT when he was being examined. The appellants also argued that the duty to screen did not stop after an initial screening but 'should be tolled, in effect, until after the traumatic injuries had been treated and clotting was more likely to have begun.' The court noted that EMTALA is a limited anti-dumping statute and not a federal malpractice statute and that the avowed purpose of EMTALA was not to guarantee that all patients are properly diagnosed, or even to ensure that they receive adequate care but instead to provide an 'adequate first response to a medical crisis for all patients and to send a clear signal to the hospital community that all Americans, regardless of wealth or status, should know that a hospital will provide what services it can when they are truly in physical distress. It is interesting to note that one of the key factors behind EMTALA is equality, a very prominent value in the South African Constitution and section 27(3) is aimed at supporting the principle of equality with regard to emergency medical treatment. Liebenberg in *Davis et al* fn 124 *supra* observes at p 358 that "As health care services are not yet universally available and are subject to progressive realisation under a 27(2), the protection of this right extends only to situations in which a patient is refused emergency medical treatment owing to a lack of money, race or other exclusionary practices." Available at <http://www.law.emory.edu/1circuit/jul2000/99-2153.01a.html>



prior to delivery or a transfer would pose a threat to the woman or her unborn child³⁸⁶. It is not clear at this point whether the same approach will be adopted with regard to the constitutional right to emergency medical treatment especially in view of the fact that in South Africa it is highly likely that hundreds of women still give birth outside of medical facilities in their cultural homes assisted by traditional birth attendants. It is likely that the circumstances of each case of a woman in labour will determine whether or not the situation does necessitate emergency medical treatment. It is submitted that even a woman living in an urban area attended to by a general practitioner or a gynaecologist and who always intended to have her baby in an urban hospital may not necessarily be considered to be a medical emergency simply because she goes into labour in a shopping mall and there are no anticipated or actual complications with the birth process. She might be in need of some assistance at the birth and a relatively quiet and private place to do so but the question of whether a normal birth is a condition which requires 'emergency medical treatment' as contemplated in the Constitution is a matter for debate. By the same token it seems illogical to treat a woman in labour in a rural village who is being attended to by a traditional birth attendant (midwife) as an emergency when it was planned that she would have the baby in this way and there are no complications. Onset of labour can be a sudden and unexpected event (although the extent to which it is unexpected is debatable) and some women do give birth after only short periods of labour but that it constitutes a medical emergency in every case is unlikely. Health care services of some kind may certainly be necessary but not necessarily emergency medical treatment. However, if a woman presents at a hospital and she is in labour and her medical records and attending doctor are not available, it may be wise to examine her in order to establish whether or not she is an emergency case because there can be complications which may well necessitate emergency medical treatment such as a Caesarean section. Giving birth is not always a life-threatening situation but it can be. The key question is whether the situation is in fact an emergency or simply requires health services that are available and necessary for the process to run smoothly and to watch for potential complications.

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Medical Staff Leader Handbook at www.cesepark.org/materials/2002.2003/dana.point/hadded.me.383.04.policyAnn.PDF

By contrast with EMTALA, the Constitution does not define 'emergency medical treatment' which does not make for a great deal of certainty for those who are obliged to provide it. The KwaZulu-Natal Health Act No 4 of 2000³⁸⁷ does not define emergency medical treatment but defines emergency medical services as follows:

"emergency medical services" means emergency medical services prescribed by regulation and included in the package of basic essential health services;"

Section 29(3) of that Act states that: "A person employed by a public health care establishment or private health care establishment who turns away a person requiring emergency medical services in terms of subsection(1) is guilty of an offence."

The use of the term 'emergency medical services', as opposed to 'emergency medical treatment', tends to get around the argument that any attempt to define emergency medical treatment as contemplated in the Constitution will end up being unconstitutional as the Constitution itself has left it open. The reference to the Constitutional concept of emergency medical treatment is oblique but nonetheless substantial as evidenced by the fact that failure to provide emergency medical services in KwaZulu-Natal is an offence. The approach to emergency medical treatment in the National Health Act is simply to restate the constitutional right. No regulations have yet been made on the subject of emergency medical treatment.

2.8.3 Medical Treatment

This phrase raises the question of who is liable to render the emergency medical treatment. For instance does it extend to first aid by persons who are not medically trained but have done a course in first aid? Does it extend to everyone in the crowd of people in the restaurant in which a patron is suffering a heart attack who know how to do cardio pulmonary resuscitation? Does it only apply to those who are medically trained and who are on duty at the time when the services are required? It thus also raises the question of an

³⁸⁷ Gazette KWN No 5560, Notice No 4, dated 13 September 2000

obligation to treat a person in an emergency irrespective of whether the medical professional concerned is on duty or not. The well-worn example is that of the general practitioner who is on his way to a concert one evening and who sees that a motor vehicle accident has just happened and emergency medical services are yet to arrive at the scene. Leibenberg³⁸⁸ argues that as the scope of the right is confined to 'medical' treatment it only binds those persons and institutions qualified to administer such treatment, including doctors, nurses and paramedics. A narrow interpretation is more in keeping with the traditional reluctance of the South African common law to impose upon the person in the street a positive duty to interfere in the affairs of another³⁸⁹. It must not be forgotten, however, that the values that are enshrined in the Constitution must inform the common law and not the other way around. Considerations of public policy even at common law have led to the imposition of liability for omissions in cases such as that of *Ewels*³⁹⁰. The fact that the Constitution stipulates that no one may be refused emergency medical treatment as opposed to conferring a right to emergency medical treatment does suggest that a general obligation to rescue was not intended. Refusal implies that there is some kind of request for assistance. The question is whether, in the event that a person is unable to

³⁸⁸Davis *et al* fn 124 *supra* at p358-359³⁸⁹

Strauss SA *Doctor, Patient and the Law* p 90 observes that there is no legal duty upon a person to rescue another, even if it could be expected of him, on purely moral grounds, to act positively to prevent the damage (he refers in footnote 5 to *Minister van Polisie v Ewels* 1975 (3) SA 590 (A) 596H). He notes that a duty to come to the rescue of another may arise from contract (eg in the case of the man who joins a municipal fire department as fireman, or the man who joins a hospital as ambulance driver or paramedic) or from statute (eg the duty imposed upon doctors, dentists and nurses who attend a child who has apparently been ill-treated or abused). He does state that, quite apart from these situations a duty to rescue may by common law arise from circumstances in which the parties, i.e. the person in distress and the would-be rescuer find themselves. He observes that in the case of *Minister van Polisie v Ewels* the Appellate Division gave recognition to this duty in the context of defining the limits of delictual liability for a non-feasance: in essence an omission is wrongful where the circumstances are such that the omission would not only evoke moral indignation but also that the convictions of society would require that the omission be regarded as wrongful. Applied to the medical situation, says Strauss, it is not difficult to conceive of circumstances in which there would clearly be a legal duty on the part of doctors, nurses and other medically qualified persons to come to the rescue of accident victims by means of medical aid. He submits that a duty to rescue someone by means of medical treatment will not arise where there is danger for the potential rescuer. However at p25 in a discussion of *Ewels* he points out that: "It is therefore clear that our law has evolved from its older, highly individualistic stance to a viewpoint reflecting a health social responsibility. A court may now well hold a doctor liable for harm suffered by an injured or ailing person, where the doctor was aware of his condition and unreasonably refused or failed to attend. The word 'unreasonably' must be emphasised." The facts of the case in *Ewels* were that the plaintiff was unlawfully assaulted by an off-duty policeman in the presence of other policemen who were on duty and failed to take any action to assist the plaintiff. The question was whether the Minister of Police could be held vicariously liable for this omission. It is submitted that the arguments in favour of the vicarious liability finding in *Ewels* are extremely strong because of the nature of a policeman's work – to protect the public and to prevent or stop crimes from being committed. The policeman who failed to act was on duty. They failed to perform an essential function of their work in failing to prevent an unlawful assault. Those employed for the purpose of protection of members of the public failed to protect a member of the public. In cases where medical practitioners, especially those in private practice, are on vacation or are attending a social function for recreational purposes the arguments that they should go to the assistance of a person who is ill or injured in their surroundings are not as strong as those in *Ewels*. This is not to say that no liability can be imposed on them for failing to assist – only that the chances of them being found liable for an omission are very much dependent upon the circumstances. If the same private medical practitioner is in his rooms on a lunch break before seeing the next patient and a person staggers in who has just been shot in a drive by shooting the chances are greater that such a medical practitioner would be held liable for an omission to assist the wounded person.

³⁹⁰*Ewels* fn 389 *supra*

make that request because they are unconscious or so badly injured that they are unable to speak, means that a failure to give them emergency medical treatment does not constitute a refusal and is thus not a violation of section 27(3). Clearly this cannot be the case. A request for assistance in an emergency could be tacit or implied in certain circumstances and it is likely that a refusal to assist a person in such circumstances will constitute a violation of the section 27(3) right - particularly if the refusal is unreasonable. In the example given previously of the general practitioner on his way to an evening function who sees a motor vehicle accident on the other side of a highway there is still a probability that if he drives on without offering assistance this will not necessarily constitute a violation of the section 27(3) right. Such examples are, in reality of limited value, however in that the only principle they really serve to illustrate is the importance of the circumstances of each particular case. If one changes just one detail of the story – for instance that the doctor is employed by the provincial emergency medical services to assist motor vehicle accident victims on roads within the province – the initial conclusion may be significantly revised.

2.8.4 Intellectual Property Rights and Access To Technology

There is significant potential for conflict of rights in the arena of intellectual property where an inventor of a new drug or a medical device or a similar health care invention wishes to commercially exploit the intellectual property rights in that invention. The more vital the invention is for the saving of life or the curing of a disease and the relative availability of other treatments for the same condition can contribute greatly to the tension between a right of access to health care services on the one hand and the right of a patentee to exploit an invention on the other. Such tension can assume international significance as it did when the Pharmaceutical Manufacturers Association challenged the provisions of the Medicines and Related Substances Control Amendment Act No 90 of 1997 concerning parallel importation. The United States of America put South Africa on its so-called Watch List of countries against which it considered imposing sanctions. The case was eventually settled out of court but it attracted considerable global attention.

2.8.4.1 Patents on Medicines

The question of patents on medicines will be dealt with in this chapter only from the perspective of the constitutional right of access to health care services and what this implies with regard to intellectual property rights in medicines. Many of the international debates in this area have centred around access to HIV/AIDS drugs for obvious reasons but the principles and issues involved relate to many different medicines used to treat various health conditions. As stated previously there is a tension between the law on intellectual property and society's interest in promoting and protecting the development of intellectual property on the one hand and the law on access to health care services and society's interest in ensuring the general health and well-being of the population on the other.

The Patents Act³⁹¹ is the relevant intellectual property legislation in South Africa insofar as the patenting of medicines is concerned. Section 4 of the Act stipulates that:

“A patent shall in all respects have the like effect against the State as it has against a person: Provided that a Minister of State may use an invention for public purposes on such conditions as may be agreed upon with the patentee, or in default of agreement on such conditions as are determined by the commissioner on application by or on behalf of such Minister and after hearing the patentee.”

Section 25 of the Patents Act governs what the subject matter of a patent³⁹². Generally speaking, a patent may be granted for any new invention which involves an inventive step and which is capable of being used or applied in trade or industry or agriculture.

Subsection (9) of section 25 affects patents for medicines in particular. It states that:

³⁹¹ Patents Act No 57 of 1978

³⁹² According to section 25 -

- (1) A patent may, subject to the provisions of this section, be granted for any new invention which involves an inventive step and which is capable of being used or applied in trade or industry or agriculture.
- (2) Anything which consists of-
 - (a) a discovery;
 - (b) a scientific theory;
 - (c) a mathematical method;
 - (d) a literary, dramatic, musical or artistic work or any other aesthetic creation;
 - (e) a scheme, rule or method for performing a mental act, playing a game or doing business;
 - (f) a program for a computer; or
 - (g) the presentation of information,shall not be an invention for the purposes of this Act.

“In the case of an invention consisting of a substance or composition for use in a method of treatment of the human or animal body by surgery or therapy or of diagnosis practised on the human or animal body, the fact that the substance or composition forms part of the state of the art immediately before the priority date of the invention shall not prevent a patent being granted for the invention if the use of the substance or composition in any such method does not form part of the state of the art at that date.”

Subsection (11) of section stipulates that an invention of a method of treatment of the human body by surgery or therapy or of diagnosis practised on the human or animal body shall be deemed not to be capable of being used or applied in trade or industry of agriculture.

The effect of these provisions is that medicines or therapeutic substances, which are capable of being used or applied in trade or industry or agriculture, are patentable but that methods of surgical, therapeutic or diagnostic treatment are not. The result is that a holder of patent rights in a medicine is entitled to exploit those rights for the duration of the period of the patent which is usually twenty years. In the case of a medicine, however, this period can be significantly reduced by the amount of time that it takes to have the registration of a medicine approved by the medicines regulatory authority which, in South Africa, is the Medicines Control Council (MCC) established in terms of the Medicines and Related Substances Act³⁹³. In terms of this Act a medicine may not be sold in South Africa unless it has been approved and registered by the MCC.

The effect of a patent is described in section 45(1) of the Patents Act³⁹⁴ as follows:

“The effect of a patent shall be to grant to the patentee in the Republic, subject to the provisions of this Act, for the duration of the patent, the right to exclude other persons from making, using, exercising, disposing or offering to dispose of, or importing the invention, so that he or she shall have and enjoy the whole profit and advantage accruing by reason of the invention.”

Section 56(1) of the Patents Act provides that any interested person who can show that the rights in a patent are being abused may apply to the commissioner in the prescribed manner

³⁹³ Fn 226 *supra*

³⁹⁴ Fn 319 *supra*

for a compulsory licence under the patent. What constitutes abuse is set out in section 56(2) of that Act.³⁹⁵

The subject of compulsory licensing in the context of intellectual property rights is often a contentious one since it usually allows the state in certain circumstances to override the intellectual property rights in goods needed for instance to deal with national crises or states of emergency. Compulsory licensing provisions usually attempt to achieve by means of legislation, an acceptable balance between society's real interest in encouraging inventors and its need for those inventions to be readily available to address matters of national interest. This subject will be canvassed in more detail in a subsequent chapter.

Questions as to the legitimacy of the interests of holders of intellectual property rights in medicines when weighed against the constitutional right of access to health care services will be discussed in more detail in another chapter as this is an area in which the interface between international law and international regulatory institutions on the one hand and national law and national regulatory institutions on the other is fairly extensive and needs to be explored in some depths. Intellectual property rights in medicines are very often a cost factor of the medicine since the patent holder is seeking to recover the costs of research and development on a particular drug within the limited lifespan of the patent while it still has the exclusive right to exploit its invention. Issues concerning the balancing³⁹⁶ of interests in

³⁹⁵ "(2) The rights in a patent shall be deemed to be abused if-

- (a) the patented invention is not being worked in the Republic on a commercial scale or to an adequate extent, after the expiry of a period of four years subsequent to the date of the application for the patent or three years subsequent to the date of the application for the patent or three years subsequent to the date on which that patent was sealed, whichever period last expires, and there is in the opinion of the commissioner no satisfactory reason for such non-working;
- (b)
- (c) the demand for the patented article in the Republic is not being met to an adequate extent and on reasonable terms;
- (d) by reason of the refusal of the patentee to grant a licence or licences upon reasonable terms, the trade or industry or agriculture of the Republic or the trade of any person or class of persons trading in the Republic, or the establishment of any new trade or industry in the Republic, is being prejudiced, and it is in the public interest that a licence or licences should be granted; or
- (e) the demand in the Republic for the patented article is being met by importation and the price charged by the patentee, his licensee or agent for the patented article is excessive in relation to the price charged therefor in countries where the patented article is manufactured by or under licence from the patentee or his predecessor or successor in title."

³⁹⁶ On the subject of balancing of constitutional rights, values or interests, Woolman 'Out of Order? Out of Balance?' in 256 *supra* points out somewhat pessimistically that balancing at its best often involves terminological confusion and its worst it is an impossible undertaking, pointing out that we value things in qualitatively different ways and each good is valued in our own and its own particular way. He says that we do not value things in quantitative terms: intensity or utility. Citing Walzer M, *Spheres of Justice* (1985) he observes that goods, like people, have shared meanings in a society, because goods, like people, are a product of social, political, economic, educational, religious and linguistic practices which generate meaning. It is the shared meaning or understanding of a good which determines or should determine, its movement and distribution. He says that according to Walzer, when the meanings of social goods are distinct, their distributions must be autonomous. That is, for each good there exists a set



this area can become acute, particularly with regard to lifesaving drugs that are effective in dealing with large scale public health problems such as HIV/AIDS and there has been extensive debate on a number of different levels at this place where public and private international law collide. They will be canvassed in due course in the chapter dealing with medicines regulation and control.

2.9 Reproductive Health Care

The phrase 'reproductive health care' is expressly included in the section 27(1) right of access to health care services. It is therefore necessary to consciously consider what implications it has for the rendering of health services and the constitutional obligations of the state and others in this regard. It is clearly important in this context to explore the subject of reproductive rights³⁹⁷ and the controversial issue of human cloning a topic upon which just about everyone who surfs the internet has written their views. There are at least two possible reasons for the express inclusion of reproductive health care in the section 27(1) right of access to health care services, depending on whether the reference to reproductive health care was intended to widen the concept of health care services to include services which would not ordinarily be regarded as such or whether it is a subset of health care services that was intentionally highlighted to emphasise health care for women in the area of reproduction. An example of the former is the artificial insemination of a fertile healthy woman with the sperm of a donor because her husband is infertile. This procedure is not designed to cure or remedy the husband's infertility and it is not really a health care service to the wife as there is nothing wrong with her. In human rights terms it is a procedure which is assisting the couple to exercise their reproductive rights. It may at first glance seem to be a highly contrived interpretation that the reference to reproductive rights was included in order to emphasise the health of women but when one takes into account the fact that as a concept, "reproductive rights was originally formulated by women activists, or better say, women's groups involved with health issues such as reproductive health, and that it contains a radical critique of patriarchal society and the dominant

of criteria and procedures deemed to be appropriate for their distribution. Woolman says that Walzer's view may need to be qualified and that the demands of justice are in fact more complex than Walzer's account allows.

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On this topic see further Albertyn C 'Reproductive health and the right to choose: Policy and law reform on abortion' in *Engendering the Political Agenda: a South African Case Study* C Albertyn et al (eds) CALS 1998

development model (Vuola 1998,11)³⁹⁸, such interpretation is not as contrived as it may sound. Women in male dominated societies, which includes just about all of the cultural groupings in South Africa, historically and even in many instances right up to the present day, have tended notoriously to get the short end of the stick when it comes to balancing the reproductive rights of men against theirs³⁹⁹. Aitken⁴⁰⁰ points out that in its 1993 *World Development Report*, the World Bank estimated that 34% of the burden of disease of reproductive age women in developing countries is due to reproductive health problems and that reproductive health problems account for 60% of the burden of disease for women in Africa. He states that it is hardly surprising therefore that prenatal delivery care, treatment of STDs and family planning are all included in the minimum essential package of clinical services recommended in the *World Development Report*.

It is submitted that the second interpretation, i.e., that the reference to reproductive health care is in acknowledgement of the prejudice suffered by women in this area and constitutes an express undertaking to remedy the situation is the more likely of the two possible reasons for it. This does not, of course, mean to say that men are not entitled to reproductive health care the same as women. Their right of access to reproductive health care is no less than that of women.

2.9.1 Reproductive Rights

The Constitution does not expressly refer to reproductive rights. Section 27(1) says that everyone has the right to have access to health care services including reproductive health care. The right to bodily and psychological integrity also has a bearing on reproductive

³⁹⁸ Ollila J in 'Womens Reproductive Rights' www.mv.helsinki.fi/home/jmollila/essay.htm notes that at least three types of reproductive rights can be distinguished: (1) the freedom to decide how many children to have and when to have them; (2) the right to have information and means to regulate one's fertility; and (3) the right to "control one's own body" (Dixon, Meuller, 1993, 12)".

³⁹⁹ Ollila, in 398 *supra*, notes that: "Male-gendered institutions of government, religion and the health professions have justified intervention in women's reproductive self-determination by invoking their own principles of public order, morality and public health. There are still laws against contraception and abortion in many countries; women lack control over their sexual and reproductive lives and the overall quality of reproductive health care is poor. Also the statistics show the interconnection between poverty, lack of reproductive rights and women's mortality."

⁴⁰⁰ Aitken IW 'Decentralization and Reproductive Health' Department of Population and International Health, Harvard School of Public Health, June 24 1998 www.reprohealth.org

issues since it is specifically recognised that this right includes the right to make decisions concerning reproduction⁴⁰¹. Significantly, there were objections to this section of the Bill of Rights on the grounds that it opens the way for abortion⁴⁰². The Choice on Termination of Pregnancy Act⁴⁰³ refers in its preamble to the promotion of reproductive rights. As with the right to health, reproductive rights are thus a derivative of other fundamental constitutional rights such as the right to privacy, the right to freedom and security of the person, and the rights to dignity, access to health care services and information⁴⁰⁴. This section concentrates on reproductive rights in the narrow sense in order to more closely examine that aspect of the right of access to health care services dealing with reproductive health care. It must be stressed that although discussions of reproductive rights usually focus on the reproductive rights of women⁴⁰⁵ and related issues, reproductive rights are not gender specific and are of fundamental importance to both men and women.

2.9.2 Reproductive health care in relation to reproductive rights

401 According to section 12 (2) of the Constitution "Everyone has the right to bodily and psychological integrity, which includes the right-

(a) to make decisions concerning reproduction; "

402 See *Ex Parte Chairperson of the Constitutional Assembly: In Re Certification of The Constitution of the Republic of South Africa, 1996* 1996 (4) SA 744 (CC) at para [59] where it was observed that:

"NT 12(2) provides that:

'Everyone has the right to bodily and psychological integrity, which includes the right -

(a) to make decisions concerning reproduction;

(b) to security in and control over their body; and

(c) not to be subjected to medical or scientific experiments without their informed consent.'

Objection was taken to this provision in the NT on the grounds that it opens the way to abortion. The objector argued that the proper interpretation of CP II permits the CA to increase the rights contained in the IC, but prohibits it from reformulating rights in a way that would detract from the protection conferred by the IC. The objector further argued that there are two provisions in the NT which effectively reduce the protection afforded the foetus by the IC. The first is NT 12(2) and the second is the omission of a provision equivalent to IC 33(1)(b). IC 33(1)(b) provides that any limitation of a right contained in the IC 'may not negate the essential content of the right'. The objector argued that the omission of this right may render it more probable that abortion will be held to be constitutional. It should be emphasised that this Court's current task is not to determine whether the NT permits abortion or not but to decide whether or not the NT complies with the CPs. The relevant CP in this case is CP II which requires the CA to include within the NT all 'universally accepted fundamental rights, freedoms and civil liberties'. Beyond that the CPs give the CA a wide discretion to determine which rights should be included in the NT and how they should be formulated."

403 Fn 35 *supra*

404 "In their narrowest sense reproductive rights demand respect for women's bodily integrity and decision-making in an environment that is free from abuse, violence and intimidation. They are also said to require access to voluntary, quality reproductive and sexual health information, education and services. Viewed more broadly reproductive rights may be linked to the provision of such social economic necessities as food shelter, childcare and education." O'Sullivan and Bailey in Chaakalson *et al*, fn 67 *supra*, p16-1 onwards.

405 Chaakalson *et al* (fn 67 *supra*) in discussing reproductive rights in Chapter 16 state at 16-1 that, "This chapter concentrates exclusively on abortion because it is at present the sole focus of the constitutional debate over reproductive rights. We would hope that as the rights interests and values underlying the debate are discussed in the context of women's lives in South Africa, the complex content of a right to reproductive health will not be overshadowed by the single issue of abortion."

It is submitted that the term “reproductive health care” refers to those health services connected with reproduction and the right to make decisions concerning reproduction. The term ‘health services’ not only means medical treatment but also relates to health education and information⁴⁰⁶. This is nowhere more true than in the context of reproductive rights. Since the decision to reproduce implies the right to decide not to reproduce, reproductive health care must include services concerning contraception and termination of pregnancy as much as it includes services relating to fertility, conception and giving birth. If “reproductive health care” is taken as referring to health services connected with reproduction and the right to make decisions concerning reproduction then the right to reproductive health care embraces a wide range of health care services relating to contraception, conception, fertility, infertility, pre-natal, perinatal and postnatal care, gynaecological services, advice on and treatment of sexually transmitted diseases, artificial insemination and other methods of artificial conception and fertilisation, and the extraction, storage and utilisation of human reproductive tissue such as oocytes and spermatozoa, human gonads etc.

The question of the right of access to reproductive health care may be most obvious in issues of termination of pregnancy but there are other areas of law in South Africa in which it does arise although perhaps not as noticeably. The Prescribed Minimum Benefits Package in the regulations to the Medical Schemes Act⁴⁰⁷ makes provision for the treatment of infertility as part of the mandatory services that medical schemes are required to provide as part of their benefit plans⁴⁰⁸. The Act defines a “relevant care service” as:

“any health care treatment of any person by a person registered in terms of any law, which treatment has as its object-

- (a) the physical or mental examination of that person;

⁴⁰⁶ Chaakalson et al fn 60 *supra* at 16-16 point out that :“Article 10 (h) of the Women’s Convention states that women have the right to ‘specific educational information to help to ensure the health and well-being of families, including information and advice on family planning’. Lack of access to information about reproductive health will prevent women from exercising their right to reproductive decision-making, which includes making informed choices, and this will consequently limit the control that they have over their bodies.”

⁴⁰⁷ Fn 328 *supra*

⁴⁰⁸ Code 902M of the Package (Diagnosis: Infertility) provides for surgical and medical treatment. Due to the high costs of certain fertility treatments there is at the time of writing a proposed amendment to the regulation which has been published for public comment and which restricts such treatment to: “ (a) hysterosalpingogram (b) the following blood tests: a. Day 3 FSH/LH b. Oestradiol c. Thyroid function (TSH) d. Prolactin e. Rubella f. HIV g. VDRL h. Chlamydia i. Day 21 Progesterone (o) laparoscopy (d) hysteroscopy (e) surgery (uterus and tubal) (f) manipulation of ovulation defects and deficiencies (g) semen analysis (volume; count; mobility; morphology; MAR-test) (h) basic counselling and advice on sexual behaviour, temperature charts etc. (i) treatment of local infections.” Gazette No 23379, Government Notice No 540, Regulation Gazette No 7344, 30/04/2002.



- (b) the diagnosis, treatment or prevention of any physical or mental defect, illness or deficiency;
 - (c) the giving of advice in relation to any such defect, illness or deficiency;
 - (d) the giving of advice in relation to, or treatment of, any condition arising out of a pregnancy, including the termination thereof;
 - (e) the prescribing or supplying of any medicine, appliance or apparatus in relation to any such defect, illness or deficiency or a pregnancy, including the termination thereof; or
 - (f) nursing or midwifery,
- and includes an ambulance service, and the supply of accommodation in an institution established or registered in terms of any law as a hospital, maternity home, nursing home or similar institution where nursing is practised, or any other institution where surgical or other medical activities are performed, and such accommodation is necessitated by any physical or mental defect, illness or deficiency or by a pregnancy;”

The term ‘relevant health service’ is used in the Act in the definition of the term “business of a medical scheme” and is central to this latter concept⁴⁰⁹. This definition indicates that the giving of advice in relation to a pregnancy as well as termination of a pregnancy is regarded as health care treatment for the purpose of coverage by medical schemes. Infertility also fits into this definition as it is a physical defect as contemplated in subparagraph (b) of the definition. Medical schemes are entitled to limit their benefits to the extent that they fall outside of the prescribed minimum benefits package. As pointed out previously even the prescribed minimum benefits package imposes some limitation on the nature and extent of fertility treatment. What about the obligations of government in the public sector? Are they greater than those of medical schemes, the same or less? Would the public health sector be obliged to provide the same levels of fertility treatment as those which medical schemes must provide or can it legitimately provide fewer or less technologically advanced reproductive health care services due to resource constraints? One would have to examine the rationale behind the prescribed minimum benefits package in order to answer such questions. If the rationale is to ensure the same level and nature of health care services to patients in the private sector as to those in the public sector then the answer is clearly “yes”. A similar answer would be given if it were a question of ensuring that the purpose was to ensure that private health sector patients have access to a basic package of services that are considered fundamental to health. However, if the reason is

⁴⁰⁹ According to section 1 of Act No 131 of 1998, “business of a medical scheme” means the business of undertaking liability in return for a premium or contribution-

- (a) to make provision for the obtaining of any relevant health service;
- (b) to grant assistance in defraying expenditure incurred in connection with the rendering of any relevant health service; and
- (c) where applicable, to render a relevant health service, either by the medical scheme itself, or by any supplier or group of suppliers of a relevant health service or by any person, in association with or in terms of an agreement with a medical scheme;”

rather to prevent the avoidance of liability for certain high risk conditions by medical schemes and to reduce the strain on public sector resources then the answer may not be as clear cut. Whilst equity arguments are strong it is a harsh economic reality that people who can afford to fund their own health care services are able to 'buy' more than those who cannot. These differentials are evident even within individual medical schemes which provide a range of options ranging from low cost offering the most basic health care benefits in the form of the prescribed minimum benefits package only to relatively high cost which includes a considerable number of benefits over and above those of the prescribed minimum benefits package. What is available in the private sector, especially in terms of advanced, and expensive health technology may not always be available in the public sector due to resource constraints. These issues serve to highlight interesting dichotomies within the public and private health sectors relating to rationing, the utilisation of available resources and equity in access to health care services.

2.9.3 The Ability to Reproduce

If reproductive rights are implicit in the constitutional Bill of Rights then the question arises as to what extent the inability to reproduce should be treated as a medical condition. This is an old question in a different context since it relates to the question of the rationing of access to health care services. Due to the fact, however, that infertility is usually not life-threatening and does not, except in extreme cases, affect an individual's ability to function in and contribute to society, combined with the fact that treatment of infertility can be extremely expensive, there is a tendency to downplay the right of access to health care services for infertility in favour of the more life threatening and physically disabling health conditions. To put it differently, decisions relating to the rationing of health care resources are likely to place treatment for infertility somewhere at the bottom of the hierarchy of health care services that must be provided. For this reason, techniques such as artificial insemination and *in vitro* fertilization are not often considered part of the standard package of health care services in either the public or the private health sectors although they are probably more easily available in the latter.

Reproductive rights raise some highly controversial issues with regard to not only the question of the right to life but also human dignity, access to technology and the extent to which rationing or denial of such access is legitimate. Should HIV positive people receive medical treatment aimed at promoting conception for instance? What about people with scientifically identified genetic abnormalities which can be passed on to their children and which cause severe disease or disability? Marriage laws often prohibit marriages between people whose degrees of consanguinity are too close in order to avoid genetic disorders caused by inbreeding. This could be said to be a justifiable limitation of the right to reproduce. The subject of reproductive rights is also likely to come to the fore in discussions around human cloning and the genetic manipulation of human tissue. Human cloning in its reproductive sense can be regarded as a kind of fertility treatment since it offers the opportunity of reproducing to someone who cannot do so in the usual way. It is simply a further step at the end of the spectrum of methods of assisted reproduction⁴¹⁰.

2.9.4 Assisted Reproduction

Fertility treatments which enhance the natural fertility of a person or cure their infertility is only one way of addressing difficulties with reproduction. There are other more extreme methods ranging from artificial insemination by husband (AIH), artificial insemination by donor (AID), in vitro fertilisation, freezing of human embryos and surrogate motherhood. Are these forms of treatment included in the right of access to health care services including reproductive health care? They are all relatively expensive procedures which very often have to be repeated a few times before being successful. Strauss⁴¹¹ points out that in South African law, of the two methods of artificial insemination (AID and AIH) the latter type particularly raises complex legal questions. It is not the intention to explore these legal questions in this chapter in any depths since it involves more than just constitutional law and the right to health care services, including as it does the question of contractual

⁴¹⁰ Andrews LB in 'Embryos Under the Knife' points out that "Each step along the way, from sperm donation to in vitro fertilisation to surrogate mothers to embryo research, we have gradually yet inexorably moved closer and closer towards engineering human life to fulfill individual desire." http://dir.eslon.com/health/feature/2000/08/21/stem_cell/index.html

⁴¹¹ Strauss, *Doctor, Patient and the Law: A Selection of Practical Issues*



arrangements, concepts of parenthood, the legal status of the child, the right of the child to support (which has already been previously discussed in relation to section 28 of the Constitution) and aspects of statutory law⁴¹².

At present artificial insemination is regulated in South Africa by the Human Tissue Act⁴¹³. The donation of gametes is strictly controlled, the term 'gamete' being defined in the Human Tissue Act as meaning either of the two generative cells essential for human reproduction. No one except a medical practitioner or someone acting under his or her supervision may remove or withdraw a gamete from the body of a living person for the purposes of artificial insemination. This does not adversely affect the constitutional right of access to reproductive care any more than does any other legislation restricting certain activities to health care professionals and regulating the qualifications and standards of services of those professionals.

As a result of an investigation into the legal position of illegitimate children in 1985 by the South African Law Commission the Children's Status Act⁴¹⁴ was enacted to provide *inter alia* for a situation in which children are the product of artificial fertilisation. Section 5 of that Act regulates the effect of artificial insemination.⁴¹⁵ Artificial insemination has thus been a legally and morally acceptable means of assisted reproduction in South Africa for some time. A more relevant question from the perspective of constitutional law involving the right of access to reproductive care and reproductive rights is whether a lesbian couple can insist on one partner being artificially inseminated so that they may have a child. This issue is complicated by the fact that the sperm donor must, in terms of the regulations to the

⁴¹² See Strauss *Doctor, Patient and the Law: A Selection of Practical Issues* at p181 onwards. See also Van Oosten *International Encyclopaedia of Laws*, Vol 3 Medical Law – South Africa

⁴¹³ Fn 270 *supra*

⁴¹⁴ Act No 92 of 1987

⁴¹⁵ It provides as follows: (1)(a) Whenever the gamete or gametes of any person other than a married woman or her husband have been used with the consent of both that woman and her husband for the artificial insemination of that woman, any child born of that woman as a result of such artificial insemination shall for all purposes be deemed to be the legitimate child of that woman and her husband as if the gamete or gametes of that woman or her husband were used for such artificial insemination."

The definition of artificial insemination is given in the Act as follows – "artificial insemination" in relation to a woman –

(a) means the introduction by other than natural means of a male gamete or gametes into the internal reproductive organs of that woman; or

(b) means the placing of the product of a union of a male and female gamete or gametes which have been brought together outside the human body in the womb of that woman, for the purposes of human reproduction."

Human Tissue Act⁴¹⁶ give a comprehensive written consent including consent to a physical examination and interview by a doctor; the taking of samples of gametes for the purpose of testing, analysing or processing; certain personal details (excluding his name, date of birth and ID number) being made available to the ultimate recipient; certain person details including his family history being made available to the doctor who will perform the artificial insemination; and certain confidential details regarding himself being made available to the Director-General, National Health and Population Development. The question is whether the donor must give consent to the use of his sperm in a situation in which the child will be raised by a same-sex couple. Is it necessary for him to know these details? In other words must the consent be specific and relate to use of the sperm by a named woman who is known to the sperm donor but who is not his wife? Strauss speaks of the “recipient and her husband” in his discussion of the provisions of the regulations to the Human Tissue Act. It is submitted that in the light of recent judgments in the constitutional court involving the constitutional rights of homosexual persons⁴¹⁷ a lesbian couple with a consenting sperm donor could not constitutionally speaking be refused artificial insemination on the basis of the homosexual nature of their relationship. Should the Human Tissue Act stipulate or imply otherwise then it will be necessary to amend that Act accordingly. Another potentially controversial area affecting reproductive rights is the right of a single woman to artificial insemination. Constitutionally speaking it is submitted that a single woman who wants to have a child without being involved in a sexual relationship, has a constitutional right to artificial insemination provided that she can afford the procedure and that the donation of the sperm is in conformity with legal provisions relating to the control of human tissue and gametes. The right to reproduce attaches to individuals and not only to pairs of individuals and is based on the constitutional right to freedom and security of the person - a very personal and private right in terms of its exercise.

The issue of surrogate motherhood and male homosexual couples is more problematic due to the legal complexities of surrogate motherhood *per se*. The South African Law

⁴¹⁶ Government Notice R1182 of 20 June 1986

⁴¹⁷ *National Coalition For Gay And Lesbian Equality And Others v Minister Of Home Affairs And Others* 2000 (2) SA 1 (CC) and *Satchwell v President of Republic of South Africa and Another* 2002 (6) SA 1 (CC); *National Coalition For Gay And Lesbian Equality And Another v Minister Of Justice And Others* 1999 (1) SA 6 (CC); *V v V* 1998 (4) SA 169 (C)

Commission produced a *Report on Surrogate Motherhood* in 1992⁴¹⁸ which describes surrogate motherhood as:

“an arrangement whereby one woman undertakes for financial or compassionate reasons to bear a child by means of artificial fertilisation for another person or persons with the intention of handing over the child born as a result thereof to such person or persons with the intention that the child become their legitimate child.”

According to the report, the term “surrogate mother” refers to the woman who bears the child rather than the woman who rears the child. Surrogate motherhood in constitutional terms, amounts to the exercise of the right to freedom and security of the person for the benefit of a third party. If surrogate motherhood were to be restricted or prohibited by law it is submitted that it would therefore have to be in accordance with section 36 of the Constitution in order to be valid since it would constitute a limitation of the right to freedom and security of the person. The Law Commission Report notes that it can probably be safely assumed that many surrogacy arrangements have been concluded and fulfilled without problems and publicity. It points out that surrogacy agreements only cause a public outcry when something goes wrong and the parties involved come before a court, for example when the parties want to contest custody, determine guardianship or establish the parentage of the child. According to the Commission, surrogacy arrangements gives rise to questions such as who is the child’s real mother; what is the legal status of the surrogate, the commissioning mother, the natural father or any donor; who has custody of the child; must the commissioning parents adopt the child even if it is biologically their child; can the surrogate consent to adoption; must the maxims *mater semper certa est* (the identity of the mother is always certain) and *pater est quem nuptiae demonstrant* (the father is he whom the marriage points out) apply to the surrogate and her husband; whose consent is required for a surrogacy agreement; and should the surrogate mother receive compensation? Most importantly, will a surrogacy agreement be recognised as a valid agreement and, if so, how will it be enforced?

From a constitutional perspective, to the extent that surrogate motherhood constitutes a waiver of the surrogate mother’s right to freedom and security of the person (depending

⁴¹⁸ *Report on Surrogate Motherhood Project 65, 1992*

upon the terms of the surrogacy agreement, she may agree to give up some of her rights to make decisions concerning her pregnancy) is a surrogacy agreement valid? This is a general question which relates to the possibility of waiver of constitutional rights rather than being related specifically surrogate motherhood. It is submitted that the question of whether a person can agree to waive, or more appropriately, limit their constitutional rights and freedoms depends very much on the values espoused by the Constitution and public policy. It also depends on the nature and extent of the limitation and the nature of the right. In the context of health care services, a right of access to health care services may be temporarily waived by a person insisting on being discharged from a particular hospital where he or she has been receiving treatment. This could also be argued simply as a choice not to exercise a particular right but it is submitted that a waiver is in many instances exactly that. A clause in restraint of trade in an employment contract is a choice on the part of the employee, in signing the contract, not to exercise his or her right to freedom of movement and freedom to pursue a chosen profession or trade. A professional boxer who steps into a boxing ring for a fight must inevitably, by implication, be accepting certain restrictions or limitations of his right to bodily and psychological integrity.

The South African Law Commission proposed a Bill on Surrogate Motherhood to regulate the consequences of human reproduction by artificial fertilisation of women acting as surrogate mothers⁴¹⁹. It appears not to have made it to the statute books which could be explained by the fact that it apparently runs contrary to the constitutional reproductive rights of unmarried and homosexual persons and persons who have never been married. Section 4 stipulates that no person except a husband and wife who are lawfully married to each other and who act jointly as a couple shall be competent to conclude a surrogate motherhood agreement. Section 3 is contrary to the reproductive rights of persons who have never been married since only women who are married, divorced or widowed may act as surrogate mothers. Generally speaking the draft Bill is highly restrictive of the constitutional right to freedom and security of the person and may not pass muster in terms of section 36 of the Constitution. The report of the South African Law Commission predates even the interim Constitution and it is therefore not surprising that there was no

⁴¹⁹ Government Gazette No 16479 of 14 June 1995.

discussion of constitutional legal principles. However the rights to freedom and security of the person, bodily integrity, autonomous moral agency and self-determination, which predate the Constitution⁴²⁰ and do have an impact on surrogacy appear not to have been canvassed in any detail by the Commission.

In the final analysis surrogate motherhood is about the deployment of existing technologies in a manner which impacts upon social values and public policy rather than the utilisation of developing technologies to artificially create a human being. In the comments of the Israel Medical Association to the South African Law Commission⁴²¹:

- Surrogacy is not a new science or technology. It merely entails the use of existing technology namely, gamete donation, in vitro fertilisation and embryo transplantation. Therefore the novelty of the method does not lie in the medical but in the legality and moral nature thereof.
- The ethical questions arising are –
 - The right of a woman over her own body;
 - The right of a couple to procreate;
 - The rights of the surrogate mother as though she may only be the hostess mother she has a right and responsibility to raise the child due to the greater biological and psychological involvement in the birth of the child;
 - The interests of a child who is not conceived in his own interests but to satisfy the needs of others; and
 - The potential exploitation of the woman

⁴²⁰ See for instance *Mabaso v Felix* 1981 (3) SA 865 (A); *Clarks v Hurst No And Others* 1992 (4) SA 630 (D); *Castell v De Greef* 1994 (4) SA 408 (C) at p 409 in which the court notes: "It is clearly for the patient, in the exercise of his or her fundamental right to self-determination, to decide whether he or she wishes to undergo an operation, and it is in principle wholly irrelevant that the patient's attitude is grossly unreasonable in the eyes of the medical profession: the patient's right to bodily integrity and autonomous moral agency entitles him or her to refuse medical treatment." *Duncan v Minister Of Law And Order* 1986 (2) SA 805 (A) in which the court observed at p806 that: "Policy requires that the defendant in an arrest case should bear a full onus, for the reasons set out in Mabaso's case at 873C - F and because the rights to bodily integrity and liberty are the most fundamental of a person's absolute natural rights (see Mabaso's case at 875D). See also *Brand v Minister of Justice and Another* 1959 (4) SA at 714G - H; *Newman v Prinsloo and Another* 1973 (1) SA at 126H - 127G and Mabaso's case *supra* at 873H." In *Maqungu And Another v Assistant Magistrate, Whittlesea, And Another* 1977 (2) SA 359 (E) the court observed at p 362: "The liberty of the individual, I must stress, is an important aspect of our civilisation and of our society and is not lightly to be interfered with. Where a court has deliberately accorded official recognition to an accused's right to liberty by the granting of bail, it should be reluctant thereafter to interfere unless convincing facts are placed before it to make it alter its views" and in *S v Barber* 1979 (4) SA 218 (D) at p 219 "It is well known, of course, that, when a court is required to exercise the discretion which it has to allow a detained person on bail, the court in effect has to balance the detainee's right to liberty against the interests of justice."

⁴²¹ See the SALC Report fn 399 *supra* at p116 to 117 as summarised by the SALC

It is submitted that the use of the word ‘ethical’ to describe the questions in the second bullet point above is somewhat misleading since most of these questions relate as much to points of law as they do to ethics. If it remains the view of the authorities that surrogate motherhood should be regulated, this will now have to be done with specific reference to the constitutional rights to freedom and security of the person. Whether surrogate motherhood falls into the category of reproductive care as envisaged in section 27(1) of the Constitution is irrelevant in the sense that surrogate motherhood *per se* is not about reproductive care but rather the extent of reproductive rights. In this sense it is located more appropriately in discussions around the constitutional right of freedom and security of the person contemplated in section 12 of the Constitution. As a legal topic, it falls largely outside of the scope of reproductive health care services since a pregnant mother whether she is a surrogate or not is entitled to reproductive care in terms of the Constitution. The techniques used in surrogate motherhood such as artificial insemination by donor and *in vitro* fertilisation are also it is submitted more suited to discussions of section 12 rights than section 27 rights since if they fall within the scope of section 12 rights – in other words they are based upon and supported by the rights in section 12 of the Constitution – no other logical conclusion can be reached but that they must in principle be included within the scope of the right of access to reproductive care bearing in mind the qualifications of section 27(2) of the Constitution with regard to progressive realisation and the availability of resources.

2.9.5 Sterilisation

The converse to the positive aspect of reproductive health care is contraception, sterilisation and ultimately abortion. The right to be sterilised like the right to be artificially inseminated is based rather more upon the right to freedom and security of the person as contemplated in section 12 of the Constitution than the section 27(1) right to reproductive care since if one accepts that a person has a right to security in and control over their own body as stated in section 12(2) (b) then the question of whether or not they have a right to medical

procedures for the purpose of sterilisation is in principle resolved and it becomes merely a question of the available resources of the state as to whether or not a person can undergo a sterilisation procedure. The right to human dignity can also have a bearing on the issue of sterilisation especially in the case of mentally disabled persons. The sterilisation of persons under the age of 18 years is a loaded topic and the issue of the sterilisation of the mentally disabled is even more so. When a mentally disabled person under the age of 18 years presents with a problem that can be resolved through sterilisation health professionals start to get uncomfortable. The Sterilisation Act, as stated previously is currently being amended so as to make it clear that while the reproductive rights of mentally disabled persons under the age of 28 years must be respected and protected, their other constitutional rights, such as the right to human dignity and psychological integrity must also be taken into consideration when the question of their sterilisation arises.

2.9.6 Human Cloning

Cloning is the controversial topic of the day for a number of reasons and the governments of many countries are at this stage opposed to it to a greater or lesser degree. It is much more of a reproductive rights and freedom and security of the person issue than a right to health services issue for the same reasons as in surrogate motherhood and artificial insemination. Unlike surrogate motherhood, however, it is a new technology that is developing at such speed that the law is unlikely to catch up for a while yet. It has the potential for the manipulation, utilisation and, ultimately, abuse of a person's genetic material without his or her consent or even knowledge. Since genetic makeup is in many ways as unique as a fingerprint, it can be seen as relating in a fundamental way to the identity and personality of a specific human being. As such it impacts upon the constitutional rights of dignity, privacy, and freedom and security of the person and by definition therefore, their reproductive rights⁴²². Generally speaking cloning for therapeutic

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Cloning is seen as diminishing the value of human individuality and as violating basic norms of respect for human life and the integrity of the human species. *Voluntary Moratorium on New Reproductive and Genetic Technologies*, pronounced by the Minister of Health at the National Press Theatre, Ottawa, July 27 1995, Government of Canada; *Projet de loi fédérale sur la procréation médicalement assistée (LPMA)* 1996, a. 2m and 36; Law No 94-653, 29 July 1994 on Respect for the Human Body, (1994) 45 (4) IDHL 498, a. 16-4

purposes is considered more acceptable than cloning for reproductive purposes. Article 1 of the *Resolution on Reproductive Technologies and the Protection of the Human Person* of the International Law Association states that “considering the dignity inherent in all human beings...any research or manipulation of human genetic material shall be for therapeutic purposes and shall be subject to the approval and control of an ethics committee.”⁴²³ Therapeutic cloning relates to the right of access to health care services since its purpose is not to create another human being but to grow organs and other tissue for use in the treatment of disease and for similar therapeutic purposes.

There are many different scientific techniques which fall under the broad generic term of “cloning” and in order to explore the legal aspects of cloning as it relates to the right of access to health care services including reproductive health care, one must first consider what is meant by ‘cloning’⁴²⁴. In the now famous case of Dolly the sheep a quiescent adult mammary cell was placed in the unfertilised ovum of a sheep in which the nucleus had been removed. The subsequent embryo was transferred into a surrogate mother sheep where it proceeded to divide as an embryo and was born genetically identical to the donor sheep except for the mitochondrial DNA which came from the ovum of the donor.⁴²⁵ This is a different technique to that used in embryo twinning or splitting.⁴²⁶ Due to the fact that there are a number of different scientific techniques which can apparently lead to the reproductive cloning of a human being it is difficult to regulate the issue at present⁴²⁷.

⁴²³ *Resolution on Reproductive Technologies and the Protection of the Human Person*, adopted at the 63rd Conference of the International Law Association (Warsaw, August 21-27, 1988, (1990) 41 (4) IDHL 723.

⁴²⁴ Jordaan DW ‘Human Reproductive Cloning: A Policy Framework for South Africa’ 119 *SALJ* 2002 p 294 describes two techniques associated with human cloning as being “cell mass division” and “nuclear substitution” and explains the difference between them. He observes that two distinctions can be drawn: in the first place between inter- and intra-generational cloning and secondly between reproductive and non-reproductive cloning. “Intra-generational cloning is when the individuals who share the same genetic identity are born in the same generation, while inter-generational cloning refers to the situation where such individuals are born in different generations. Reproductive cloning is cloning that is aimed at the birth of an individual who is genetically identical to someone in her or her own or in a previous generation. Non-reproductive cloning is cloning that is limited to the *in vitro* phase – ie the cloned embryos are not implanted in utero.”

⁴²⁵ *Nature*, 1997, v385, February 27, p 810-811

⁴²⁶ Knoppers BM *Cloning Human Beings – Cloning: An International Comparative Overview*, commissioned paper, University of Montreal. Available at www.georgetown.edu/research/nrcbl/nbac/pubs/cloning2/007.pdf

⁴²⁷ Knoppers (in 426 *supra*) points out at G-7 that often countries with an explicit prohibition on human cloning cover embryo splitting or twinning but not the technique that was used to create Dolly. She gives as an example the 1995 Infertility Treatment Act of the State of Victoria in Australia. It bans cloning as well as the attempt to clone with penal sanctions but defines cloning as “to form, outside the human body, an embryo that is genetically identical to another embryo or person” (article 3). According to Knoppers, the *German Embryo Protection Law* prohibits artificially causing a human embryo to develop with the same genetic information as another embryo, fetus, living person or deceased person and attaches penal sanctions. Knoppers notes that depending on how the phrase “causes a human embryo to develop” is interpreted, this definition “may or may not cover “Dolly”.” On the other hand, she observes that the highly specific 1990 Human Fertilization and Embryology Act of the United Kingdom, which proscribes “replacing a nucleus of a cell of an embryo with a nucleus taken from a cell of any embryo, person

The antipathy of many nations towards reproductive cloning does not necessarily extend to individual citizens of those states. It has been observed that if the federal government of the United States chooses to regulate or even ban cloning, that action might be challenged on a number of constitutional grounds – as violating scientists’ First Amendment freedom of inquiry or as violating a couple’s or individual’s constitution right of privacy or liberty to make reproductive decisions⁴²⁸. In the USA, the right to make decisions about whether to have children is constitutionally protected under the constitutional right to privacy and the constitutional right to liberty. This is a similar basis to the South African constitutional rights to privacy and freedom and security of the person. In *Eisenstadt v Baird*⁴²⁹ the US Supreme Court commented that “if the right to privacy means anything it is the right of the individual, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child.”⁴³⁰ The South African jurisprudence on the subject is not highly developed largely because the constitutional rights that found reproductive rights are relatively new but it is useful to consider the views of courts in other jurisdictions which recognise similar rights in order to get an idea of what the thinking is on the subject⁴³¹. Section 39 of the Constitution permits South African courts to consider foreign case law in interpreting the rights in the Bill of Rights and the constitutional court has referred to the decisions of

or subsequent development of an embryo” may also not be inclusive. The Canadian Bill on reproductive technologies seeks to make it a criminal offence to “manipulate an ovum, zygote or embryo for the purpose of producing a zygote or embryo that contains the same genetic information as a living or deceased human being, or, zygote, embryo or foetus”. Whilst this may cover the Dolly technique it does not allow for developments in technology that may render the use of embryonic and reproductive tissue as a source of tissue unnecessary if adult cells can be used for the same purpose.

428 Andrews LB *Cloning Human Beings: The Current and Future Legal Status of Cloning*, commissioned paper Chicago-Kent College of Law. Available at <http://www.georgetown.edu/research/nrobl/nbac/pubs/cloning2/cc6.pdf>

429 *Eisenstadt* 405 U.S. 438 (1972)

430 Quoted by Andrews (fn 428 *supra*) at F-6.

431 Jordaan (fn 424 *supra*) explores the ethical and legal considerations of human reproductive cloning. He observes that the Bill of Rights explicitly guarantees the right to reproductive freedom in terms of section 12(2) of the Constitution and notes that reproduction is neither synonymous with, nor dependent on sexual intercourse. On this basis he argues that a prospective parent has a prima facie right to decide to use cloning as a means of reproduction but acknowledges that the right can be limited if sufficient cause is shown in accordance with the limitation clause of the Bill of Rights. He lists the main objections that could be raised as identity, genetic diversity, human dignity, freedom and safety and discusses each of them in turn. He concludes by saying that all of the objections that relate to a permanent aspect of human reproductive cloning have been indicated as false: “human reproductive cloning in the context of the family will not *per se* compromise human dignity, freedom or the child’s development of a personal identity and will have an infinitesimally small effect on genetic diversity and might even enrich social diversity”. In Jordaan’s view the only valid objection to human reproductive cloning is the matter of safety which is not necessarily of a permanent nature and the safety objection does provide sufficient cause to place a moratorium on human reproductive cloning. He qualifies this by saying that research may within the near future invalidate the safety objection and that such a moratorium must therefore be only temporary. The safety objection, according to Jordaan is based on the fact that human reproductive cloning is still untested and animal experiments are still in their infancy. In accordance with the bio-ethical principle of beneficence, human reproductive cloning should not be attempted unless it is certain that the risk of birth defects associated with human cloning would not be greater than that associated with sexually conceived children.



American courts in a number of instances⁴³². According to Andrews, a federal district court has indicated that the right to make procreative decisions encompasses the right of an infertile couple to undergo medically assisted reproduction, including in vitro fertilization and the use of a donated embryo⁴³³. Some legal analysts have suggested that the constitutional right to make reproductive decisions free from unnecessary governmental intrusion covers the decision of a couple to undergo cloning. However other legal analysts have noted that the unprecedented step of creating a child with only one genetic progenitor would be such a fundamental change in the way humans “reproduce” that it would not be constitutionally protected⁴³⁴. Andrews points out that even if a restriction on cloning were found to infringe upon an individual’s or a couple’s right to make reproductive decisions, the government could justify the restriction if it had a compelling state interest and the restriction is imposed in the least restrictive manner possible. She argues that the potential physical and psychological risks of cloning an entire individual are sufficiently compelling to justify the banning procedure and comments that certain uses of cloning – such as the creation of a clone as a source of spare organs – would likely be banned by the Thirteenth Amendment prohibition of slavery and involuntary servitude. In South African law, a clone created in order to provide spare organs would have the same constitutional rights as any other human being and therefore could not be exploited for this purpose. Section 36 of the Constitution allows the limitation of rights by 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, taking into account all relevant factors including *inter alia* the importance of the purpose of the limitation, the nature and extent of the limitation and less restrictive means to achieve the purpose. The legal position in South Africa with regard to cloning for reproductive purposes is thus potentially the same as that in the United States although the views on cloning itself may differ between the two countries.

⁴³² In *Christian Lawyers Association of SA and Others v Minister of Health and Others* (fn 21 *supra*) for instance, the court applied the American decision of *Roe v Wade* (410 U.S. 113 (1973)). Examples of other cases in which the South African courts have made reference to American decisions are *S v Makwanyane and Another* (fn 2 *supra*); *Bernstein and Others v Bester and Others NNO* (fn 43 *supra*); *Soobramoney v Minister of Health, Kwazulu-Natal* (fn 23 *supra*); *Minister of Health and Others v Treatment Action Campaign and Others* (No 2) (fn 57 *supra*); *Friedman v Glicksman* (fn 185 *supra*).

⁴³³ Andrews fn 428 *supra* at F-6. The case referred to is that of *Lifchez v Hartigan* F. Supp. 1361 (N.D.Ill.) *aff’d* without opinion, sub nom., *Scholberg v Lifchez*, 914 F.2d 260 (7th Cir. 1990), cert. Denied, 498 U.S. 1069 (1991).

⁴³⁴ Andrews, fn 428 *supra*. Robertson J, *Statement to the National Bioethics Advisory Commission*, March 14, 1997, 83 and Annas G, *Testimony on Scientific Discoveries and Cloning: Challenges for Public Policy*, before the Subcommittee on Public Health and Safety, Committee on Labor and Human Resources, United States Senate, March 12, 1997, 4 respectively.

With regard to therapeutic cloning, particularly, the legal position in South Africa may be very different to that in the United States. Andrews observes that the use of cloned cells and tissue for research purposes other than the creation of a child would not be protected by the constitutional rights of privacy and liberty that protect reproductive decisions. Consequently a governmental regulation or ban of such research would not have to have such stringent justification. It would be constitutional so long as it was rationally related to an important governmental purpose. In South Africa, there is a constitutional right of access to health care services and this might well include aspects of cloning for therapeutic purposes, especially if it were the only treatment available and widely recognised as being appropriate for the purpose⁴³⁵. The view that therapeutic cloning *per se* is not necessarily a health care service any more than the activities around the research and development of a new drug constitute the drug itself could be of some relevance in constitutional questions involving cloning. It could, for instance, be argued that a health care service directly involves another human being as opposed to medical research activities which may or may not be of benefit to the health status of human beings. If one takes the view that unfettered medical research of all kinds must be permitted and encouraged by the state because medical research invariably carries the potential of improved access to health services or improved health services *per se*, this would not only lead to all kinds of human rights abuses in the field of medical research but would also present an unbalanced view of the rights and values contained in the Constitution. Cloning at this stage, as a collective term for the wide variety of scientific and laboratory activities that are involved in the artificial production of an embryo or embryonic cells or the scientifically forced evolution of stem cells into more specialised tissue, seems more of a precursor to health care services than a health service in its own right. It is a means to an end rather than an end in itself. Perhaps with time when cloning techniques are well established and the production of human tissue for various therapeutic purposes is the equivalent of having a dental technician make up a dental crown or bridge, one could regard therapeutic cloning as a health service with a greater degree of certainty.

In *van Biljon* (fn 228 *supra*) the court observed that “What has been established on the papers in this case is: (a) that although there is as yet no cure for the HIV virus, the internationally recognised ‘state of the art’ medical treatment for HIV infected patients is anti-viral medication.”

It is submitted that as far as a prohibition on cloning for reproductive purposes is concerned its legitimacy would have to be argued on the basis of a justifiable limitation of rights in terms of section 36 of the Constitution if cloning is within the scope of the right to reproduce. Whilst this may sound somewhat tautologous this is not necessarily the case since there may be scope for the argument that cloning process is so far removed from the process of human reproduction that it does not qualify as such in terms of any of the values of an open and democratic society. The central importance of the right to human dignity in the South African Constitution is also likely to have a strong bearing on any discussion of a prohibition on reproductive cloning since some of the objections to reproductive cloning referred to previously have been on the basis of the fact that it denies or adversely impacts upon human dignity.

It is submitted that with time questions of identity (or rather physical identification) would become of central importance in a society in which reproductive cloning took place on a significant and largely unregulated scale and that Jordaan's⁴³⁶ dismissal of the identity objection to cloning is overly simplistic. It deals with only one aspect of the highly complex subject of identity in a civilised society. There is a real sense in which society is functionally dependent upon physical identity as a marker or trigger for all kinds of controls, sanctions, privileges and purposes ranging through competence to drive a motor vehicle to criminal investigation processes and proof of guilt to personal security and banking systems to proof of parenthood and familial relationships. It is submitted that if reproductive cloning were to be permitted it would necessitate the introduction of powerful controls over human tissue so as to avoid the cloning of someone without his or her knowledge or consent. The physical identity of film stars, famous sportsmen and women and musicians is a jealously guarded aspect of their personality rights and may even in some cases constitute intellectual property. This is an aspect of reproductive cloning for future consideration. A child that is unwittingly saddled with a genetic identity that is the same as that of international terrorist or serial killer could be severely prejudiced

⁴³⁶ Jordaan (fn 424 *supra*) argues apparently on the basis that monozygotic twins are a natural phenomenon that is no more and no less desirable than non-twins that there is no right to genetic uniqueness and that indeed the concept of such a right would be offensive to monozygotic twins. He argues that monozygotic twins, although they share the same genetic structure clearly demonstrate that while people who share the same genetic structure may be very similar in many respects, they nevertheless differ sufficiently to leave no doubt about their individual identity.

throughout his or her life. It is not inconceivable that in a society that freely practises human reproductive cloning over a significant period of time, a criminal justice system might become virtually impossible because the moment that evidence is introduced to show that the accused is a clone or there are insufficient controls over human tissue in society such that the chances are high that he could be a clone, especially within the same generation, proof of guilt beyond reasonable doubt could become problematic. Even systems of ownership of property are often dependent upon the capacity to physically identify the owner. Jordaan in his dismissal of the identity argument against reproductive cloning fails to take into account the frequency of the occurrence of monozygotic twins relative to the frequency of births of non-identical persons. Monozygotic twins are not less desirable than non-twins because they are a comparatively rare occurrence. Furthermore, they are seldom if ever inter-generational. The identity objection rests on questions of balance and of degree. If the balance in society shifts in favour of individuals who have a genetic replica of themselves concurrently in existence, questions of identity would become problematic in just about every facet of human social and commercial life. The foregoing discussion may read like something from a science fiction novel but the power to generate identical human beings should not be underestimated in terms of its potential impact. With the passage of time the potential impact of the exercise of such power increases exponentially if it is allowed to be exercised indiscriminately and on a large scale.

It is not necessarily a valid assumption that many people would prefer sexual intercourse as a means of procreation given the choice between sexual reproductive means and non-sexual reproductive means. After all, they can enjoy sexual relations without reproducing. There may be considerable numbers of people who ardently desire to raise what they consider to be perfect offspring based upon notions of perfection as suggested or even dictated by mass media and personal idolisation of prominent politicians, actors, musicians and sportspeople and who have the means to make their dreams a reality. There are many people, reproductive cloning aside, who even now would like their children to resemble a famous sportsman or actor for financial reasons. The psychosocial implications of reproductive cloning alone have the potential to significantly alter the fabric of human society. It is submitted that human tissue is presently far too readily available in society as a whole to be

able to reassure individuals that they will not be reproductively cloned against their will or without their consent. Until such assurances can be given there is good reason for strict control, if not outright prohibition, of reproductive cloning. In principle cloning, whether for therapeutic or reproductive purposes, is simply a further step in the continual advancement of technology which will no doubt with time become a more acceptable concept to many people. In a controlled environment, which ensures that it is not abused, therapeutic cloning in particular has significant potential value for the health and wellbeing of humans generally.

2.10 National vs Provincial Government Obligations

The Constitution organises the responsibilities between the three spheres of government in terms of the Schedules⁴³⁷ and mandates co-operative government between them in section 41⁴³⁸. The three spheres of government are referred to in section 40 subsection (1) of which states that:

“In the Republic, government is constituted as national, provincial and local spheres of government which are distinctive, interdependent and interrelated.”⁴³⁹

⁴³⁷ Schedule 4 details functional areas of Concurrent National and Provincial Legislative Competence. Health services, housing, welfare services and education all fall into Part A of this Schedule. The conclusion to be drawn is that both the national government and the provincial governments have a responsibility for socio-economic rights. Municipal health services fall into Part B of Schedule 4. The national and provincial spheres have concurrent legislative competence over municipal health services to the extent set out in section 155(6)(a) and (7) of the Constitution. Schedule 5 details functional areas of exclusive provincial legislative competence.

⁴³⁸ In terms of subsection (1) of this section: “All spheres of government and all organs of state within each sphere must-

- (a) preserve the peace, national unity and the indivisibility of the Republic;
- (b) secure the well-being of the people of the Republic;
- (c) provide effective, transparent, accountable and coherent government for the Republic as a whole;
- (d) be loyal to the Constitution, the Republic and its people;
- (e) respect the constitutional status, institutions, powers and functions of government in the other spheres;
- (f) not assume any power or function except those conferred on them in terms of the Constitution;
- (g) exercise their powers and perform their functions in a manner that does not encroach on the geographical, functional or institutional integrity of government in another sphere; and
- (h) co-operate with one another in mutual trust and good faith by:
 - (i) fostering friendly relations;
 - (ii) assisting and supporting one another;
 - (iii) informing one another of, and consulting one another on, matters of common interest;
 - (iv) co-ordinating their actions and legislation with one another;
 - (v) adhering to agreed procedures; and
 - (vi) voiding legal proceedings against one another.”

⁴³⁹ De Waal, Currie and Erasmus in 2 *supra* note at p23 that: “Chapter 3 is aimed primarily at promoting a co-operative form of federalism instead of a competitive form of federalism... In co-operative forms of federalism the different levels of government share the same responsibilities. The Constitution usually allocates legislative and executive powers concurrently to the central and provincial government.” They observe that the practice is that the central legislature usually adopts framework legislation



The national executive is given the power in section 100⁴⁴⁰ to intervene when a province cannot or does not fulfil an executive obligation in terms of legislation or the Constitution, to ensure fulfilment of the obligation. It was perhaps in view of this section that the court observed in *Grootboom* that:

“The national government bears the overall responsibility for ensuring that the state complies with the obligations imposed upon it by s 26.”⁴⁴¹

It is submitted that this statement is equally true in respect of the obligations of the state in terms of section 27. Section 146 of the Constitution provides for the event of a conflict between national and provincial legislation in a functional area listed in Schedule 4⁴⁴² as follows:

- (2) National legislation that applies uniformly with regard to the country as a whole prevails over provincial legislation if any of the following conditions is met:
 - (a) The national legislation deals with a matter that cannot be regulated effectively by legislation enacted by the respective provinces individually.
 - (b) The national legislation deals with a matter that, to be dealt with effectively, requires uniformity across the nation, and the national legislation provides that uniformity by establishing-
 - (i) norms and standards;

and then leaves the details to be filled in by the provinces and the local governments to suit their own particular circumstances. They say that more often than not the sharing of responsibility translates into an arrangement in which framework laws and policies are made centrally and the laws are completed and executed at the provincial level. This arrangement has the advantage of securing uniformity across the country while allowing the provincial authorities to adapt the details to suit local implementation. The loss of the provinces own law making powers is then compensated for by providing them with opportunities to participate in the national legislative process. It is submitted that in the area of health services at least, although some provinces are more active and progressive than others, there is small doubt that they have not relinquished their legislative capacity.

- 440 “When a province cannot or does not fulfil an executive obligation in terms of legislation or the Constitution, the national executive may intervene by taking any appropriate steps to ensure fulfilment of that obligation, including-
- (a) issuing a directive to the provincial executive, describing the extent of the failure to fulfil its obligations and stating any steps required to meet its obligations; and
 - (b) assuming responsibility for the relevant obligation in that province to the extent necessary to-
 - (i) maintain essential national standards or meet established minimum standards for the rendering of a service;
 - (ii) maintain economic unity;
 - (iii) maintain national security; or
 - (iv) prevent that province from taking unreasonable action that is prejudicial to the interests of another province or to the country as a whole.”

441 *Grootboom* fn 10 *supra* para 66 p79

442 Cameron AJ has pointed out in *Ex Parte President Of The Republic Of South Africa: In Re Constitutionality Of The Liquor Bill* 2000 (1) SA 732 (CC) at para 48 p760 that: Whereas the Constitution makes provision for conflicts between national and provincial legislation falling within a functional area in Schedule 4, and between national legislation and a provincial constitution, the sole provision made for conflicts between national legislation and provincial legislation within the exclusive provincial terrain of Schedule 5 is in s 147(2), which provides that national legislation referred to in s 44(2) prevails over Schedule 5 provincial legislation. This suggests that the Constitution contemplates that Schedule 5 competences must be interpreted so as to be distinct from Schedule 4 competences and that conflict will ordinarily arise between Schedule 5 provincial legislation and national legislation only where the national Legislature is entitled to intervene under s 44(2).” (footnotes omitted)



- (ii) frameworks; or
- (iii) national policies.
- (c) The national legislation is necessary for-
 - (i) the maintenance of national security;
 - (ii) the maintenance of economic unity;
 - (iii) the protection of the common market in respect of the mobility of goods, services, capital and labour;
 - (iv) the promotion of economic activities across provincial boundaries;
 - (v) the promotion of equal opportunity or equal access to government services; or
 - (vi) the protection of the environment.
- (3) National legislation prevails over provincial legislation if the national legislation is aimed at preventing unreasonable action by a province that-
 - (a) is prejudicial to the economic, health or security interests of another province or the country as a whole; or
 - (b) impedes the implementation of national economic policy.
- (4) When there is a dispute concerning whether national legislation is necessary for a purpose set out in subsection (2) (c) and that dispute comes before a court for resolution, the court must have due regard to the approval or the rejection of the legislation by the National Council of Provinces.
- (5) Provincial legislation prevails over national legislation if subsection (2) or (3) does not apply.”

The Constitution does not define the term ‘health services’ and it does not define the term ‘municipal health services’ either. This creates something of a problem for the three spheres of government when it comes to budgeting. In order to be able to budget for health services, it is necessary to know where one’s responsibility begins and ends. In the case of municipal health services the national and provincial spheres of government have concurrent legislative competence to the extent set out in section 155(6)(a) and (7). These sections require that each province must establish municipalities in its province in a manner consistent with the legislation enacted in terms of subsections (2) and (3) and by legislative and other measures must –

- (a) provide for the monitoring and support of local government in the province; and
- (b) promote the development of local government capacity to enable municipalities to perform their functions and manage their own affairs.

They also state that the national government, subject to section 44 and the provincial governments have the legislative and executive authority to see to the effective performance by municipalities of their functions in respect of matters listed in schedules 4 and 5, by regulating the exercise by municipalities of their executive authority referred to in section 156(1).

The fact that municipal health services are mentioned separately in Part B of Schedule 4 and that the legislative power over them by the national and provincial spheres of government is restricted implies that they must be different from health service as listed in Part A of Schedule 4 in terms of which no restrictions are imposed⁴⁴³. However the matter is not as simple as this Cameron AJ points out in the *Liquor Bill* case⁴⁴⁴ that:

“The Constitution-makers’ allocation of powers to the national and provincial spheres appears to have proceeded from a functional vision of what was appropriate to each sphere and, accordingly, the competences itemised in Schedules 4 and 5 are referred to as being in respect of ‘functional areas’. The ambit of the provinces’ exclusive powers must, in my view, be determined in the light of that vision. It is significant that s 104(1)(b) confers power on each province to pass legislation ‘for its province’ within a ‘functional area’. It is thus clear from the outset that the Schedule 5 competences must be interpreted as conferring power on each province to legislate in the exclusive domain only ‘for its province’. From the provisions of s 44(2) it is evident that the national government is entrusted with overriding powers where necessary to maintain national security, economic unity and essential national standards; to establish minimum standards required for the rendering of services; and to prevent unreasonable action by provinces which is prejudicial to the interests of another province or to the country as a whole. From s 146 it is evident that national legislation within the concurrent terrain of Schedule 4 that applies uniformly to the country takes precedence over provincial legislation in the circumstances contemplated in s 44(2), as well as when it:

- (a) deals with a matter that cannot be regulated effectively by provincial legislation;
- (b) provides necessary uniformity by establishing norms and standards, frameworks or national policy;
- (c) is necessary for the protection of the common market in respect of the mobility of goods, services, capital and labour, for the promotion of economic activities across provincial boundaries, the promotion of equal opportunity or equal access to government services or the protection of the environment.

From this it is evident that where a matter requires regulation *inter-provincially*, as opposed to *intra-provincially*, the Constitution ensures that national government has been accorded the necessary power, whether exclusively or concurrently under Schedule 4, or through the powers of intervention accorded by s 44(2). The corollary is that where provinces are accorded exclusive powers these should be interpreted as applying primarily to matters which may appropriately be regulated *intra-provincially*.” (writer’s emphasis)

The trouble with health care services is that it can be extremely difficult to determine in practice which of them should be regulation inter-provincially as opposed to intra-

⁴⁴³ Cameron AJ noted in *In Re Constitutionality Of The Liquor Bill* (fn 442 *supra*) at para 50 p 760 that: “It follows that, in order to give effect to the constitutional scheme, which allows for exclusivity subject to the intervention justifiable under s 44(2), and possibly to incidental intrusion only under s 44(3), 87 the Schedule 4 functional competences should be interpreted as being distinct from, and as excluding, Schedule 5 competences. That the division could never have been contemplated as being absolute is a point to which I return in due course.”

⁴⁴⁴ *In Re Constitutionality Of The Liquor Bill* (fn 442 *supra*)



provincially due to their often polycentric nature⁴⁴⁵. As explained by the court in *van Biljon's* case:

“What is meant by polycentric decisions has also been described as follows with reference to the image of a spider's web:

‘A pull on one strand will distribute tensions after a complicated pattern throughout the web as a whole. Doubling the original pull will, in all likelihood, not simply double each of the resulting tensions. This would certainly occur, for example, if the double pull caused one or more of the weaker strands to snap. This is a “polycentric” situation because it is “many centred” - each crossing of the strands is a distinct centre for distributing tensions.’⁴⁴⁶

On the subject of the power of the legislative competence of provinces in respect of local government matters the constitutional court observed in the *Certification judgment* at paras 375 to 377 that:

“There is another respect in which provincial powers and functions in respect of LG have been altered. In IC sch 6 there is listed a broad functional area of legislative competence termed ‘Local Government, subject to the provisions of chap 10’. Within this broad sphere, and subject to national legislative overrides, provincial governments are free to legislate directly in relation to all LG matters. In the NT, however, specific functional areas of legislative competence in relation to LG are detailed in NT schs 4 and 5. Other legislative competences not dealt with in the NT may be assigned to the provinces by national legislation in terms of NT 104(1)(b)(iii). This restricted list-based provincial competence contained in the NT stands to be compared with the unenumerated potentially concurrent legislative powers afforded provinces under the IC. It is a difficult comparison to make. Notwithstanding that the lists of LG matters in parts B of NT schs 4 and 5, respectively, are extensive, it must be recognised that the enumerated list approach must, to some extent, be more restrictive than a loosely defined area of competence. This must mean that the NT attenuates the manner in which the legislative power is exercised. We conclude that to this extent provincial powers have been diminished in the NT. In respect of NT sch 5 matters, however, this diminution falls to be further gauged in the context of the measures safeguarding provincial power that are found in NT 76 read with NT 44(2). Under the latter, Parliament can intervene in NT sch 5 matters only when it is necessary to achieve the objectives set out in NT 44(2)(a)-(e). Such legislation is subject to the mechanism of NT 76(1), in terms of which the will of the NCOP, the institutional locus of provincial interests at national level, can be overborne only by a two-thirds majority of all the members of the NA. The greater constraint placed upon the national Legislature

⁴⁴⁵ Cameron AJ fn 442 *supra* highlights the nature of these difficulties in relation to Schedule 4 and Schedule 5 competences which are at least separated by a different Schedule whilst health care services appear in a single Schedule in terms of which provinces and national government have concurrent legislative competence: “That Schedule 4 legislation may impact on a Schedule 5 functional area finds recognition on one reading of s 44(3). Whatever its true reading this provision was not designed to undermine the Schedule 5 competences. They retain their full meaning and effect, except where encroachment by national legislation would in fact be ‘reasonably necessary for, or incidental to’ the effective exercise of a Schedule 4 power. Since, however, no national legislative scheme can ever be entirely water-tight in respecting the excluded provincial competences, and since the possibility of overlaps is inevitable, it will on occasion be necessary to determine the main substance of legislation and hence to ascertain in what field of competence its substance falls; and, this having been done, what it incidentally accomplishes. This entails that a Court determining compliance by a legislative scheme with the competences enumerated in Schedules 4 and 5 must at some stage determine the character of the legislation. It seems apparent that the substance of a particular piece of legislation may not be capable of a single characterisation only and that a single statute may have more than one substantial character. Different parts of the legislation may thus require different assessment in regard to a disputed question of legislative competence.” (footnotes omitted)

⁴⁴⁶ *Van Biljon* fn 236 at p 454

by the NT in respect of NT sch 5 matters has to be weighed against the attenuation of competences brought about by the listing of functions. A further relevant factor in the weighing process is to be found in NT 164. Pursuant to this provision all matters not dealt with under the NT may be prescribed by national or provincial legislation, the latter within the framework of national legislation. This power to prescribe residual LG matters may well be significant. Not only are provincial legislatures competent to so prescribe but the function of national legislation is restricted to regulation. It is adequate for present purposes to state that the term 'regulate' connotes a broad managing or controlling rather than a direct authorisation function. Thus Parliament is entitled, in relation to provincial legislative power under NT 164, to establish the general framework within which such power is to be exercised. This leaves room for provinces to determine details of LG matters within that framework and to legislate for them.⁴⁴⁷

It is worth noting that whilst Schedule 4 lists functional areas of concurrent national and provincial *legislative* competence, no mention is made of 'executive competence'. The court in *Executive Council, Western Cape Legislature, And Others v President Of The Republic Of South Africa And Others*⁴⁴⁸ pointed out that:

"The provinces are given executive competence by s 144(2) over:
'... all matters in respect of which such province has exercised its legislative competence, matters assigned to it by or under s 235 or any law, and matters delegated to it by or under any law'."

The constitutional court in *Ex Parte Chairperson Of The Constitutional Assembly: In Re Certification Of The Constitution*⁴⁴⁹ seems to regard executive competence as a concomitant of the legislative competence referred to in Schedule 4. It observed that:

"In the CJ we took into account that in terms of the IC the provinces have legislative and *executive* competence in respect of education" (writer's emphasis). Chaskalson *et al* point out that constitutionally, provincial executive authority is derived from three sources:

- (1) exercised provincial legislative competence;
- (2) powers delegated to the province by any law, and
- (3) powers assigned to the province⁴⁵⁰

The legislative competence of a province is only exercised when the province enacts legislation.

The legislative system for health care services as contemplated in the Constitution is itself polycentric in that municipalities have legislative and executive competence over municipal

⁴⁴⁷ *Certification judgment* fn 59 *supra* at p 882-883

⁴⁴⁸ *Executive Council, Western Cape Legislature* 1995 (4) SA 877 (CC)

⁴⁴⁹ *Ex Parte Chairperson Of The Constitutional Assembly* 1997 (2) SA 97 (CC) at para 170 p152

⁴⁵⁰ *Chaskalson et al* fn 67 *supra* at p 4-4



health services⁴⁵¹. Municipal health services are not defined but their boundaries will influence the scope of health care services since presumably whatever is not a municipal health service is a health service as contemplated in Part A of Schedule 4. Provinces and national government have concurrent legislative competence over health services. However, a province only has executive competence over health services if it has exercised its legislative competence over health services or powers have been assigned to it or delegated to it in terms of any law. One cannot therefore assume that all of the provinces have executive competence over all areas of health services within the province. Some provinces have enacted health legislation whilst others have not.⁴⁵² National government has a concurrent legislative competence with provinces over health services. The national government has not yet enacted framework legislation with respect to health services whereas quite a few of the provinces have done so intra-provincially. In terms of section 156(4) of the Constitution national and provincial governments must assign to a municipality “by agreement and subject to any conditions” the administration of a matter listed in Part A of Schedule 4 or Part A of Schedule 5 which necessarily relates to local government if that matter would be most effectively administered locally and the municipality has the capacity to administer it. So municipalities can actually be responsible, on a contractual basis for health services that are more than just municipal. The web becomes even more complicated when one considers that in terms of section 84(1)(i) of the Local Government: Municipal Structures Act⁴⁵³, district municipalities (Category C municipalities in terms of section 155 of the Constitution) are responsible for municipal health services but local municipalities (Category B municipalities in terms of section 155 of the Constitution) are the ones that are currently providing health services although they

⁴⁵¹ Section 151(2) of the Constitution states that the executive and legislative authority of a municipality is vested in its Municipal Council. Section 151(3) of the Constitution provides that a municipality has the right to govern, on its own initiative, the local government affairs of its community, subject to national and provincial legislation as provided for in the Constitution”. Section 151(4) stipulates that the national or provincial government may not compromise or impede a municipality’s ability or right to exercise its powers or perform its functions.

⁴⁵² See for instance the KwaZulu Natal Health Act No 4 of 2000; the Free State Hospitals Act No 13 of 1996; the Free State Provincial Health Act No 8 of 1999; the Eastern Cape Health Act No 10 of 1999; the Western Cape Health Facilities Boards Act No 7 of 2001; the Western Cape Health Act Amendment Act No 6 of 2002; the Eastern Cape Provincial Health Act No 10 of 1999; the Northern Province Health Services Act No 9 of 1999; the Health Laws Rationalisation Act No 11 of 1995 of the North West Province. See also the Assignment to the Provinces of the Health Act, 1977 under section 235(8) of the Constitution of the Republic of South Africa 1993 in terms of which the President assigned the administration of the Health Act 1977 (Act No 63 of 1977) excluding those provisions (if any) of the said Act which falls outside the functional areas specified in Schedule 6 to the Constitution or which relate to matter referred to in paragraphs (a) to (e) of section 126 (3) of the Constitution, to a competent authority within the jurisdiction of the government of a province mentioned in section 124 (1) of the Constitution designated by the Premier of the province concerned.

⁴⁵³ Act No 117 of 1998

have to be specifically empowered to do so in terms of section 84(3)(a) of the Local Government: Municipal Structures Act. Thus although the national government is ultimately responsible for ensuring that the constitutional obligations of the state with regard to section 27 of the Constitution are fulfilled, the provincial and municipal spheres of government have their own unique and original powers and responsibilities with regard to health services and it is not simply a matter of national government being able to enact legislation or go in and take control of the delivery of health services that fall within the scope of the powers awarded by the Constitution to provinces and municipalities. This makes for a complex dynamic in the area of health services between national, provincial and local spheres of government which renders it inevitable that the national Minister of Health is likely to be cited as a respondent in all litigation involving health care services irrespective of the level of involvement of the national department of health in the circumstances of the case.

Although the national department of health does not presently regard the direct provision health care services as its core function due to the fact that the provinces own the resources such a hospitals, clinics and pharmaceutical depots necessary to provide these services and that the provinces are providing them, it is submitted that if the national sphere of government is to be ultimately responsible for the fulfilment of the rights contemplated in section 27 of the Constitution, then it must, in the absence of a power to compel the provision of health care services by a province, retain the power to render those services at national level. Proclamation 152 of 1994 which assigned certain functions of the Health Act No 63 of 1977 to the provinces recognised this in its exclusion of section 14 of that Act from the assignment. In terms of section 14(1)(a) of the Health Act:

“(1)In addition to the functions entrusted to the Department of Health by any other law, the functions of the said Department shall, subject to the provisions of this Act, be-

- (a) with due regard to health services rendered by provincial administrations and local authorities, to co-ordinate health services rendered by the said Department and to provide such additional services as may be necessary to establish a comprehensive health service for the population of the Republic of South Africa;”

There is a mirror provision in section 16(1) of the Act which deals with the functions of the provinces which requires them to take into consideration the services rendered by the national department and other provinces and local authorities.

The National Health Bill which is intended to repeal the Health Act of 1977 is being processed at the time of writing and a detailed discussion of its provisions is thus not presently possible.

It is important to note with regard to section 100 that it is the national executive that must invoke its provisions. The national department of health or even the Minister of Health does not have the power to intervene directly in terms of this section if a province is failing to provide health care services. The national executive may issue a directive detailing the shortcomings of the province and how they can be addressed and may assume the functions of the province on limited grounds. The manner if any in terms of which the directive contemplated in section 100 may be enforced is a delicate subject. The fact that the constitution provides for the assumption of responsibility for the relevant obligation in the province by the national executive tends to suggest that this is the constitutionally acceptable method of enforcement of the directive. Section 41 stipulates specifically that the spheres of government must avoid legal proceedings against one another. It also requires them to assist and support one another. The section provides that national legislation may regulate the process established by this section but to date no such legislation has been forthcoming.

2.11 Horizontal Application of The Right To Health Care Services

The question of the horizontal application of the right to health care services has been touched on many times in the course of this chapter. Since the horizontal application of rights is a recurring theme involving private individuals and other entities within the private sector, it will arise as a topic in other chapters that relate to obligations between such parties. Consequently an attempt will be made in this section to identify only some of the key principles leaving more detailed and case specific discussions for later. The question of

the extent to which the constitutional rights involving health care services are enforceable against health care service providers in the private sector is clearly of vital interest to those providers. Unlike public health facilities and providers they are not funded by the fiscus and they must make sufficient profit from health care delivery to make it worth their while, and in the case of juristic persons, their investors' and potential investors' while, to continue to do so. If the contribution of the private health sector in South Africa to health service delivery is regarded as valuable and worthy of preservation, then the horizontal application of the right to health care services must be seen against this backdrop and in the context of the need for a balancing of the right to 'trade' in health care services and the rights of consumers of health care services.

The question of the horizontal application of rights has been the subject of some debate in the context of both the interim Constitution and the final Constitution and the section in the interim Constitution was changed in order to make more explicit the idea that the rights in the Bill of Rights are capable of horizontal application in certain circumstances⁴⁵⁴. Section 8(2) stipulates that a provision of the Bill of Rights binds a natural or a 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. In terms of section 8(3), when applying the provisions of the Bill of Rights to a natural or juristic person in terms of subsection (2) a court in order to give effect to a right in the Bill, must apply, or of necessary develop, the common law to the extent that legislation does not give effect to that right and may develop rules of the common law to limit the right, provided that the limitation is in accordance with section 36(1). De Waal *et al*⁴⁵⁵ note that there are five general considerations regarding the interpretation of section 8(2) that must be kept in mind from the outset.

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See the comments of Davis *et al* (fn 124 *supra*) at p 30 where they state that: " In the earlier work we stated what we thought was the obvious – Chap 3 applied to all law. We thought it uncontroversial and accordingly did no more than briefly describe the background debate and explain the mechanics of section 7(2) [of the interim Constitution] and why it was that we thought the Chapter applied to the common law and customary law. We were wrong on several counts. Our rendition of the debate was contested by Du Plessis LM and Corder H in *Understanding South Africa's Traditional Bill of Rights*, Juta & Co Ltd, Kenwyn 1994 at p 112 *seq*. The issue was hotly contested in the press and academic journals. The courts were evenly divided until the Constitutional Court decided the issue in *Du Plessis & others v De Klerk and Another* 1996(5) BCLR 658 (CC). The majority court took an opinion opposite the one advanced in this book" and at p 43 where they observe that: "The application provisions of the Chapter 2 of the Bill of Rights has been subjected to far more dramatic change than any other provision of Chapter 3 of the Interim Constitution. Whatever the interpretation placed on s8, it now will have some form of horizontal application." See also the observation of Liebenberg in Chaskalson *et al* (fn 43 *supra*) at 41-45 where she states that: " One of the profound changes introduced by the final Constitution is in respect of the application of the Bill of Rights to private parties."

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De Waal *et al* fn 2 *supra* at p 55



- “1. Section 8(2) states that a ‘provision’ may apply to private conduct⁴⁵⁶. It does not say that a ‘right’ may apply to private conduct. It is therefore possible, and quite reasonable that some of the provisions of the Bill of Rights may apply to the conduct of a private person or juristic persons while other provisions in the same section (and pertaining to the same right) will not apply to such conduct. For example, the right of access to health care services s27 (1) and (2)) probably does not apply horizontally.[For the reason that the duty imposed by the right is too burdensome to impose on private individuals] However, the right not to be refused emergency medical treatment (s27(3)) probably does apply horizontally...
2. Questions concerning the horizontal application of the Bill of Rights cannot be determined *a priori* and in the abstract. Although this is not explicitly stated, whether a provision in the Bill of Rights applies horizontally also depends on the nature of the private conduct in question and the circumstances of a particular case. This explains why section 8(2) states that a provision in the Bill of Rights binds a natural or juristic person if, and to the extent that, it is applicable. The extent to which a provision is applicable can only be determined by reference to the context within which it is sought to be relied upon.... However, a resort to context or the circumstances of a particular case should not be used to frustrate the clear intention of the drafters of the 1996 Constitution to extend the direct operation of the provisions of the Bill of Rights to private conduct. It is not permissible to argue, for example, that it is only when private persons find themselves in a position comparable to the powerful state that s 8(2) binds them to the Bill of Rights. It may be that most private or juristic persons do not have the capacity to infringe human rights in a manner and on a scale comparable to the state. But any interpretation of s 8(2) must avoid relying on such gross generalizations. The subsection was after all included to overcome the conventional assumption that human rights need only be protected in vertical relationships.
3. The purpose of a provision is an important consideration in determining whether it is applicable to private conduct or not... [T]he purpose of the right to human dignity does not necessarily demand differentiation between the state and private conduct.
4. The nature of any duty imposed by the right must be taken into account. This recognises that private or juristic persons are often primarily driven by a concern for themselves. On the other hand the state is supposed to be motivated by a concern for the well-being of society as a whole. The application of the Bill of Rights to private conduct should not undermine private autonomy to the same extent that it places restrictions on the sovereignty of government. This consideration is of particular importance when it comes to the

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Davis *et al* (fn 124 *supra*) observe at p 47 that: “Based on the inclusion of the word ‘judiciary’ in s (8)(1), and the significance given to that word by the Constitutional Court in the judgment of Kentridge AJ in the *Du Plessis* case, [*Du Plessis & Others v De Klerk & Another* 1996 (3) SA 850 (CC)] it can be argued that the conclusion reached by Mahomed DP with regard to horizontality, namely, that the horizontal application will apply to all private relationships is correct, even if Kriegler J could find liberal philosophical support for the conclusion that there are a range of relationships which should fall outside of the law. If the notion of judiciary in s 8(1) now implies that the Chapter applies to all law, the addition of section 8(2) appears to extend the ambit beyond the law to the conduct of private persons. Section 8(2) now asks of a court that it investigate all private relationships to ascertain whether a constitutional right is applicable to such a relationship. A person who previously had no right against another, might now enjoy such a right as the Constitution alters the nature of the private relationship.” This has far-reaching implications. In the case of the right of access to health care services for instance it might be possible to ground a constitutional claim of violation of this right in the absence of the negligence required to ground a claim in delict for the same omission or act and in the absence of the existence of a contract for those health services. The conduct of a private hospital in delivering health care services to a patient must not only be judged against the contract it has with that patient but must also be scrutinised to determine whether there was any violation of a constitutional right that came into play in the relationship. Davis *et al* comment that: In this way the relationship between s 8(1) which applies to all law and s 8(2) which applies to private relationships becomes coherent and consistent. There is a mandatory application of the Bill of Rights to all forms of law in terms of section 8(1) but a discretionary application to private relationships in terms of s 8(2), the discretion being bounded by the inquiry into the issue of suitability.”

imposition of duties which entail the spending of money.⁴⁵⁷ Since the conduct of private persons has to be funded from their own pockets, the same duties may not be imposed on them as can be imposed on an organ of state which relies on public funds. For example a private hospital cannot, unlike a state hospital, be saddled with the duty to provide every child with basic health care services (s 28(1)c)).

5. In some instances indications are found in the Bill of Rights itself as to whether a particular right may be applied to private conduct or not... Also it can be said that the nature of the duties imposed by the right to have legislative and other measures taken to protect that environment (s24(b)), to realize the right to housing (s26), the right to health care, food, water and social security (s27) and the right to education (s29) would normally result in them not being applicable to private conduct... ”

The judgment of the constitutional court in *Du Plessis v De Klerk*⁴⁵⁸, which will be considered in greater detail in a subsequent chapter caused quite a stir⁴⁵⁹ in legal academic circles when the court found that, for the purposes of the interim Constitution, the Bill of Rights applied only vertically. It set out some guidelines as follows:

- A private litigant may not invoke a right guaranteed in the Bill of Rights against another.
- A private litigant may, however, argue that a statute or executive act relied upon by the other private party is invalid because it is inconsistent with the Bill of Rights;
- Acts or omissions on the part of government may be attacked by a private litigant as being inconsistent with the Bill of Rights in any dispute with an organ of government due to the fact that the Bill of Rights also applies to common law.

The furor that this judgment caused in legal circles will be canvassed in a subsequent chapter when discussing the application of the Bill of Rights in the private sphere. It is

457

In the context of health services this is nowhere more apposite than in the situation of pharmaceutical research and development which is very much the domain of private enterprise. If it becomes apparent to pharmaceutical manufacturers that drugs for the treatment of HIV/AIDS are not profitable because of the pressure exerted by governments and activists or the application of the right of access to health care services to bring the prices down to the point where it is no longer feasible to research, develop or manufacture or supply such drugs, and they cease to do so the very aim that such activity seeks to achieve will be defeated at an inconceivable cost to society. The private sector cannot be compelled to invest money in unprofitable enterprises for the greater good.

458

Du Plessis fn 456 *supra*

459

Davis et al fn 124 *supra* at p 30 observe that “The issue was hotly contested in the press and in academic journals. The courts were evenly divided until the Constitutional Court decided the issue in *Du Plessis and Others v De Klerk and Another* 1996(5) BCLR 658 (CC). The majority of the court took an opinion opposite the one advanced in this book.” See also Cheadle H and Davis D ‘The Application of the 1996 Constitution In The Private Sphere’ (1997) *SAJHR* 44 who canvass the debates in some detail.

sufficient to note at this point that the application provisions of the interim Constitution in this regard were subject to significant alteration in the final Constitution⁴⁶⁰.

It is not inconceivable that in certain circumstances the right of access to health care services could be horizontally applicable. Previously, the picture was painted of a scenario in which the state decides that the best way to ensure access to health care services is to become a funder of health care services leaving the supply side to the private sector. In such a situation the patient has nowhere else to go but the private sector and even though this arrangement may have been established in terms of a contract between the state or relevant legislation, it is submitted that the patient's constitutional right of access to health care services in such an environment may well be enforceable against health establishments and professionals within the private sector as much as against the state. As a further example, it is likely that in a situation where a certain highly specialised form of treatment which has been shown to be successful, i.e. it is not in the experimental stages, is in limited supply due to a shortage of doctors skilled in the technique and the only physician in the country who is capable of administering the treatment to a particular patient refuses to do so on the grounds that as a private practitioner he can choose which patients he sees, it may be possible to argue on behalf of the rejected patient, that the latter has a constitutional right to those services. This would be particularly so if one assumes that the patient is prepared to pay, that he is unable to travel obtain the treatment elsewhere, that the physician's schedule is not such that he cannot accommodate another patient, and that his refusal is based purely on the fact that he does not have a good relationship with this particular patient. In the case of health services there is often an opportunity cost in choosing one particular health care provider over another because of time constraints in receiving a particular kind of treatment. It is also possible that certain types of treatment are only available in the private sector and that once a course of treatment has commenced it must be pursued to its full conclusion in order to avoid further jeopardy to the patient's health. A patient could effectively find himself 'locked in' to a particular course of treatment which is only available from a particular provider. In such situations, it is submitted that discontinuation of the treatment for no good reason could in certain circumstances ground a

⁴⁶⁰ See Davis *et al* in 124 *supra* at p 43 where the authors observe that the application provisions of the Chapter 2 of the Bill of Rights has been subjected to far more dramatic change than any other provision of Chapter 3 of the Interim Constitution.

constitutional claim in terms of the right of access to health care services. It is further submitted that there is scope for argument that, in much the same way as is contemplated in terms of the law of delict⁴⁶¹, once a particular health care provider assumes the responsibility of providing health care services to a particular patient, that patient acquires a constitutional right of access to health care services against the provider concerned, especially in circumstances where transfer of the patient to another facility or medical practitioner is not feasible for some reason. For example where the only hospital, which is a private hospital, in a relatively isolated small town serving a rural community takes into its care a chronically ill patient who is too ill to be transferred to another facility, it is submitted that the patient concerned may well have a constitutional right of access to health care services against that facility. This does not mean that the patient is not obliged to pay for those services but rather that in taking him in the facility has forfeited its power as a private operator to refuse to provide him with the health care services he needs. In summary, it is submitted that it more likely that a private entity will incur a constitutional obligation consistent with the right of access to health care services as contemplated in section 27(1) of the Constitution in relation to situations involving respecting or protecting the right as opposed to promoting and fulfilling it⁴⁶².

If one considers the composite right to health as opposed to the simple right to health care services then the argument is even stronger that the right is applicable horizontally since the rights to dignity, equality and freedom are not only rights but also human values central to the Bill of Rights and the Constitution⁴⁶³. As observed previously the right to dignity is

⁴⁶¹ See *Magware v Minister Of Health NO 1981 (4) SA 472 (Z)* in which the court held at p 477 that: "It is clear that there was a moral and professional duty to act reasonably towards the plaintiff. It seems to me that, on the facts, once the defendant's employees had undertaken treatment and had engaged in applying the plaster of Paris cast, there was set up a special relationship between defendant's employees, the casualty medical staff, and the plaintiff, different from the relationship between the plaintiff and a disinterested stranger. The plaintiff was in the care of the defendant's medical staff." Interestingly this was an application of the principles of *Ewels* (fn 376 *supra*) which was based significantly on considerations of public policy. Since the relationship between public policy and constitutional values is symbiotic in the sense that constitutional values must inform considerations of public policy and that considerations of public policy will undoubtedly have some influence on the way that constitutional values are interpreted and applied, the decision in *Magware* is of relevance in the South African legal context and within the new constitutional legal order despite the fact that it was decided in another country in terms of a different legal dispensation.

⁴⁶² This is supported by the observations of De Waal *et al* (fn 2 *supra*) at p 45 to the effect that the 1996 Bill of Rights recognises that private abuse of human rights may be as pernicious as violations perpetrated by the state. For this reason the Bill of Rights is not confined to protecting individuals against the state. In certain circumstances the Bill of Rights protects individuals against abuses of their rights by other individuals"

⁴⁶³ See section 1(a) which states that the Republic of South Africa is founded on the values of human dignity, the achievement of equality and the advancement of human rights and freedoms and also Section 7(1) of the Constitution which states that the Bill of Rights is a cornerstone of democracy in South Africa. It enshrines the rights of all people in our country and affirms the democratic values of human dignity, equality and freedom."



significant to a right to health and is one of the simple rights that contributes to the composite right to health. As de Waal *et al* point out⁴⁶⁴ the right to dignity protects an individual against assault on his or her dignity from any source, whether private or public. In similar vein the right to an environment that is not harmful to health or well-being in terms of section 24 of the Constitution and which is another of the simple rights that comprises the right to health cannot reasonably be said to be applicable only to the state. It would be senseless to prevent only the state from polluting the environment when the major sources of environmental pollution are likely to be located within private industry. The state in South Africa does not own a great many factories or industrial plants or mining operations in comparison to the private sector. Whilst it may be true that rights such as socio-economic rights, requiring legislative measures in order to realise them are likely to be primarily the responsibility of the state, as it is obvious that only the state can legislate, it is submitted that it would be a mistake to assume that this absolves the private sector from all responsibility in respect of those rights. The fact that section 24(b) encapsulates the right to have the environment protected through reasonable legislative and other measures does not detract from the fact that in section 24(a) everyone has the right to an environment that is not harmful to their health or well-being. Similarly, the right of everyone to have access to health care services in terms of section 27(1) sits in a separate subsection to the obligation of the state to realise the right through legislative and other measures within its available resources. It is submitted that obstruction by private persons of someone's right of access to health care services could well constitute a violation of the right. The question as to what kinds of behaviour could be viewed as obstructive is a question of the facts and circumstances of each case but, it is submitted, could include deliberate misinformation such that a patient does not seek required health care services, illegal strike action by health personnel that results in the unavailability of health services, the failure on the part of a private medical practitioner to refer an illiterate and seriously ill patient to a public health facility at which the required health services are available, the wilful and malicious destruction of the only road that leads to a rural hospital or even the failure on the part of a private contractor to adequately repair the road, failure on the part of a private hospital to maintain backup power supplies in the case of a power failure such that the ventilators in

⁴⁶⁴ De Waal *et al* fn 2 *supra* at p56

the intensive care unit suddenly fail etc. Although it is clear that in many cases the examples given above will found claims in terms of the law of delict or of contract it is submitted that the constitutional right of access adds another legal dimension to such claims. It remains to be seen how these and other situations will be dealt with by the courts and the litigants themselves in practice. It is submitted that, generally speaking, implicit in all rights of access is a freedom and that when that freedom is obstructed, curtailed or restricted in a material way there is usually the potential for recourse in terms of the law that granted that freedom. The Constitution, as the law that epitomises the protection of human rights and freedoms in South Africa, should be no different in this respect.

Liebenberg⁴⁶⁵ notes that: “In determining whether a right is ‘applicable’ regard must be had to (1) explicit textual references...; (2) horizontal applicability as a ‘necessary implication’ of the right...; and (3) whether the nature of the right and the duty it imposes is ‘capable’ and ‘suitable’ for horizontal application...”. In *Holomisa v Khumalo And Others*⁴⁶⁶ the court stated:

“However, I am of the view that s 8(2) does create space for an interpretation and a conclusion, at least in certain situations, that s 15 is horizontally applicable. When Kentridge AJ wrote the judgment in *Du Plessis and De Klerk*, there was nothing expressly stated in the interim Constitution about the direct horizontal application of rights. Therefore the general position had to be determined, and was found to be that chap 3 of the interim Constitution did not have a general direct horizontal application. Yet Kentridge AJ left the door open for an argument that certain provisions could be horizontally applicable. These would have to be in the nature of exceptions, however. Therefore the test is whether horizontal application is a necessary implication. Section 8(2) makes it quite clear that provisions of the Bill of Rights bind natural and juristic persons, as a general rule, if and to the extent that such a provision is applicable. Horizontal application is therefore wholly possible and plausible as far as the wording of the Constitution is concerned. ...As indicated earlier, the indirect horizontal application of rights in the Bill of Rights, or the development of the common law in accordance with the spirit, etc of the Bill of Rights, occurs in both Constitutions (in terms of s 35 of the interim Constitution and s 39 of the final Constitution). I earlier indicated that I do not regard the differences between s 35 and s 39 as sufficiently relevant to warrant a radically different result as far as the issue in this case is concerned. The relevant question is how significant the distinction is between the indirect horizontality of s 35 or s 39 and the direct horizontality allowed for by s 8 of the final Constitution.”

⁴⁶⁵ Chaskalson *et al* fn 67 *supra* at p 41-45

⁴⁶⁶ *Holomisa* 2002 (3) SA 38 (T) at p 59 and p 67

Liebenberg makes the point that the wording of section 8(2) makes it clear that a particular right may be only partially applicable to a dispute between private parties and that some of the duties imposed by the particular right may thus be capable of binding private parties while others may not be stating that:

“Cheadle and Davis oversimplify the matter by arguing that the socio-economic rights in ss 26 and 27 will not apply to private parties given the textual signals and ‘the potentially onerous nature of such a duty on private persons’. This argument may be persuasive to some extent in respect of the positive duties ‘to protect, promote and fulfill’ socio-economic rights. However, it does not persuade in respect of the negative duty ‘to respect’ socio-economic rights. It is eminently ‘suitable’ and indeed essential for the effective protection of socio-economic rights that private parties are bound to respect the negative duties flowing from the right.”⁴⁶⁷

She notes further that the possibility also exists that at least some of the positive duties imposed by the socio-economic rights may bind private parties.

“For example it may be argued that the recognition of children’s socio-economic rights in s28(1)(c) read with s28(1)(b) augments the common-law duty of support owed to children. Thus it could be extended, in appropriate circumstances, to parties that do not currently have this duty under the common law, for example the parents of the father of a child born out of wedlock... Section 27(3) requires that ‘no-one’ may be refused emergency medical treatment. This formulation strongly suggests a horizontal application. According to this interpretation private clinics, hospitals and ambulance services are under a duty to provide emergency medical treatment when this is requested from them. A failure to accord a horizontal interpretation to this right would undermine the substantive protection underpinning s28(3) and the right to life in s11.”

The present writer is in respectful agreement with the views of Liebenberg. They accord with the eminently logical approach of transformational constitutionalism and with the wording of section 8(2) of the Constitution itself. They are also in keeping with the observations of the constitutional court in the *Certification Judgement*⁴⁶⁸ to the effect that at the very least, socio-economic rights are capable of negative protection from improper invasion. It has been observed previously that the law does not operate in a vacuum and only acquires meaning when it is grounded in the facts of particular circumstances. This is equally true of the Bill of Rights. When this is combined with the fact that a provision of the Bill of Rights can apply to private conduct and then not necessarily completely but also partially it opens up an infinity of permutations in terms of the ways in which the Bill can

⁴⁶⁷ Chaskalson *et al* fn 67 *supra* at p41-45 to p41-46

⁴⁶⁸ *Certification judgment* fn 59 *supra*

affect and impact upon the relationships between private entities. It would be a very intrepid lawyer indeed who asserts that a particular category of rights, such as socio-economic rights, can never be horizontally applicable.

In *Amod v Multilateral Motor Vehicle Accidents Fund*⁴⁶⁹ the constitutional court makes the very important point that:

“Section 8(2) makes the Bill of Rights binding on natural and juristic persons ‘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’. Section 8(3) requires Courts in giving effect to s 8(2) to ‘apply, or if necessary develop, the common law to the extent that legislation does not give effect to that right’ and also empowers the Courts to develop ‘rules of the common law to limit the right, provided that the limitation is in accordance with s 36(1)’. The development of a coherent system of law may call for the development of the common law under s 35(3) of the interim Constitution and s 39(2) of the 1996 Constitution to be done in a manner consistent with the way in which the law will be developed under s 8(2) and (3) of the 1996 Constitution.”

It is submitted with respect that the statement of the constitutional court quoted above is illustrative of the vastness of the potential for legal development and transformation within the South African legal system that has been opened up by the Constitution.

2.12 Summary and Conclusions

It is evident from the size and scope of this chapter that the impact of the Constitution on the delivery of health services is far reaching and profound. The question of the existence of a right to health *per se* was explored in some depths. Whilst it is clear that a right to health could be inferred from the interconnectedness of such constitutional rights the right to bodily and psychological integrity, equality, freedom and security of the person, environmental rights, life etc, the value of such a right in the South African context is limited given the fact that one is required in terms of the Constitution to consider its individual elements which are expressly stated therein. Considerations of the elements of the various rights that relate to health care services as contained for instance in sections 27, 28 and 35 of the Constitution demonstrate the complexity of these rights and the importance of analysing them in both their constitutional and factual contexts when

⁴⁶⁹ *Amod* 1998 (4) SA 753 (CC) at para 31, p 765

applying them in practice. The jurisprudence on the subject of the right of access to health care services is still in its infancy but when viewed in the wider context of judgments on socio-economic rights still provides some extremely valuable and thoughtful guidelines and dicta that can be of assistance to policymakers and the executive branch of government in their attempts to fulfil their constitutional obligations with regard to such rights. The scope of this chapter emphasizes the fact that it is impossible not to take cognisance of the Constitution when making decisions involving the delivery of health care services whether in terms of rationing of health care, the nature and extent of the health care services to be provided, the rights of health care professionals to practice their professions or questions of intellectual property in health care goods. The manner in which the distinction between emergency medical treatment and health care services generally has been tentatively drawn by the constitutional court is encouraging and useful and whilst there will no doubt be further litigation involving questions of emergency medical treatment the foundations seem to be firmly in place for further constructive efforts on the part of the judiciary. All in all one gets the impression that South African constitutional law in the area of access to health care services is coming along nicely and that the project of transformative constitutionalism, although it still has a long way to go, is well under way. In the chapters that follow the importance and the significance of the Constitution to other areas of law involving the delivery of health care services will be an obvious leitmotif as is only fitting and proper for the foundation stone of a new legal order.

The discussions in the preceding chapters have covered the legal aspects of health service delivery from a largely theoretical perspective as opposed to that of the legal practicalities involved at the interface between the provider of health care services and the patient. The subsequent chapters will consider in more detail the latter aspect and the legal vehicles by means of which the delivery of health services takes place. Administrative law is a particularly important vehicle for the delivery of health services especially in the public health sector, given that administrative justice is a constitutional right. Consequently administrative law as it relates to health service delivery is the subject of the next chapter.



Chapter 3

Administrative Law and Health Service Delivery

| | |
|--|-----|
| Introduction | 353 |
| A PUBLIC SECTOR | 356 |
| 3.1 Introduction..... | 356 |
| 3.2 The Nature of Administrative Law | 357 |
| 3.3 Classifications of Administrative Action | 358 |
| 3.4 Administrative Agreements | 364 |
| 3.5 Private Law in The Public Health Sector | 368 |
| 3.6 The Right to Lawful, Reasonable and Fair Administrative Action | 377 |
| 3.6.1 Lawfulness | 379 |
| 3.6.2 Reasonableness | 384 |
| 3.6.3 Procedural Fairness | 388 |
| 3.7 Public Power and Judicial Review | 393 |
| 3.8 Value of Administrative Law in Health Service Decisions..... | 397 |
| 3.9 Administrative Law Theories | 400 |
| 3.9.1 Application in Case Law | 408 |
| 3.9.2 Administrative “Action” | 417 |
| 3.9.3 Summary..... | 418 |
| 3.10 Different Kinds of Power | 420 |
| 3.11 Decisions Involving Rationing | 431 |
| 3.12 The Right to Fair Administrative Action vs the Right to Health..... | 438 |
| 3.13 Manner of exercise of public power..... | 445 |
| 3.14 Case Law | 448 |
| 3.14.1 Applicant v Administrator, Transvaal, And Others | 448 |
| Facts..... | 448 |
| Judgment..... | 449 |
| Discussion..... | 451 |
| 3.15 Remedies..... | 454 |
| 3.16 Conclusions..... | 459 |
| B PRIVATE SECTOR..... | 463 |
| 3.17 Introduction..... | 463 |
| 3.18 Private Entities, Public Functions | 466 |
| 3.19 Public Private Entities | 469 |
| 3.20 Case Law | 478 |
| 3.20.1 Pennington v Friedgood And Others..... | 478 |
| Facts..... | 478 |
| Judgment..... | 481 |
| Discussion..... | 484 |
| 3.21 Summary and Conclusions | 488 |

Introduction

In the traditional view of the world the state holds all of the power and the individual must be protected from excesses in the exercise of that power. This is still evident in



some of the older Constitutions, such as that of the United States of America, in terms of which human rights were essentially seen as the protection of private individuals against inappropriate or unacceptable displays or abuses of public power by the state. The world has changed substantially since then. It has become a great deal more complex. Concentrations of power have shifted significantly away from the state into the hands of private sector groupings. The influence of non-governmental organisations that join forces globally on certain issues can no longer be ignored. The power of large trade unions and religious movements has been an important socio-economic factor in many parts of the world for some decades. Multinational corporations and their domination of world trade arenas spanning the borders of many different countries are a force that many governments now have to reckon with¹. It is against the backdrop of such a world that the dynamics involving the delivery of health care services must be considered. Cockrell points out that the focal points of power in society have changed considerably since the days when it resided primarily with the state². The significance of increasing globalisation and the concentration of power in the hands of the private and non-governmental sectors cannot be overstated. Individuals may not be in a contractual relationship with many such organisations and yet they have the power to take decisions which can seriously adversely affect those individuals' lives. In the context of health care services, for instance, a large multinational pharmaceutical manufacturer may decide not to sell a particular patented drug in a particular country or to price it in such a manner that renders it unaffordable to all but the extremely wealthy. A body such as the Medicines Control Council which is a juristic person in its own right can decide that a particular medicine is not effective for a particular indication and refuse to register it for that indication which means that it cannot lawfully be prescribed for such indication even

¹ Tushnet, M "The Issue of State Action/Horizontal Effect in Comparative Constitutional Law" *I.CON* Vol 1 No 1, 2003 p 79-88 observes at p 79 that: "Liberal constitutions identify human rights that ought not to be violated. But by whom? An important strand in liberalism focuses on creating political structures that simultaneously empower and limit governments. Put crudely, this strand leads constitutionalists to pay primary attention to the threats to human rights that government poses. Another strand takes the human rights themselves as a focus. It notes that corporations and non-governmental actors can threaten human rights too." He observes that governments and corporations can discriminate on the basis of race; governments and corporations can fire employees for speech with which the employer disagrees. The two strands come together when one observes that the people or corporations exercising "private" power are actually exercising power conferred on them by laws creating and regulating market behaviour. Thus government is always somehow implicated in private decisions. He then asks the crucial question: What are the constitutional implications of this? Is the way in which government is implicated in decisions by private employers to discriminate and the like sufficient to place some duties on either government or the private actors?

² Cockrell A "Private Law and the Bill of Rights: A Threshold Issue of Horizontality" *Private Law* P3 A-4 states that: "Whereas once it was only the state which might be considered to have had at its disposal instruments of authority and oppression, modern society has witnessed the emergence of new fragmented centres of power such as voluntary associations, trade unions, corporations, multinationals, universities, churches etcetera. The emergence of large, private institutions, wielding massive power over the lives of citizens is an integral part of modern life."

if it may be beneficial in certain circumstances. Health care services and products often fall into the same category as food and shelter. They are indispensable and essential to preserve life. Nevertheless they are economic goods, commercial commodities which are sold in multi billion dollar markets around the world. How does the man in the street engage them? In many ways the *raison d'être* for law is the existence of relationships and the need to define and regulate them. Some would no doubt argue that law is simply the external or societal manifestation and recognition of a relationship – whether it is between the individual and the executive, legislative or judicial branch of government, the national, provincial and municipal spheres of government, the minority and the majority, natural persons in the private capacity, juristic persons in their private capacity or the individual and society as a whole. The branch of law that is relevant depends upon the nature of the parties in relationship and the nature of the relationship.

The provider, in the provider-patient relationship, is not considered in this thesis only in the narrow sense of the doctor-patient relationship or hospital-patient relationship since providers of health care services come in many different forms and guises. Moreover, the distinction between funder and provider is often blurred. In the Medical Schemes Act, the definition of “business of a medical scheme” makes it clear that a medical scheme may itself render a ‘relevant health service’³. Similarly the state is both provider and funder of health care services in relation to most of the patients who are treated in the public sector⁴. The health professionals working in the public sector

³ Medical Schemes Act No 131 of 1998. In the Act the term “relevant health service” is defined as “any health care treatment of any person by a person registered in terms of any law, which treatment has as its object-

- (a) the physical or mental examination of that person;
- (b) the diagnosis, treatment or prevention of any physical or mental defect, illness or deficiency;
- (c) the giving of advice in relation to any such defect, illness or deficiency;
- (d) the giving of advice in relation to, or treatment of, any condition arising out of a pregnancy, including the termination thereof;
- (e) the prescribing or supplying of any medicine, appliance or apparatus in relation to any such defect, illness or deficiency or a pregnancy, including the termination thereof; or
- (f) nursing or midwifery,

and includes an ambulance service, and the supply of accommodation in an institution established or registered in terms of any law as a hospital, maternity home, nursing home or similar institution where nursing is practised, or any other institution where surgical or other medical activities are performed, and such accommodation is necessitated by any physical or mental defect, illness or deficiency or by a pregnancy;”.

⁴ Most state hospitals classify patients into different categories in order to determine whether or not there should be a co-payment and if so, on what basis. For example, in the Western Cape the Regulations Relating to the Uniform Patient Fee Schedule For Health Services Rendered by the Department of Health: Western Cape For Externally Funded Patients (Provincial Gazette No 5977 Notice No 21 of 29 January 2003) apply only to “externally funded patients”. An externally funded patient is defined as “a patient whose health services are funded or partly funded in terms of - (a) the Compensation for Occupational Injuries and Diseases Act, 1993 (Act No 130 of 1993), or (b) by the Road Accident Fund created in terms of the Road Accident Fund Act, 1996 (Act 56 of 1996) or (c) a medical scheme registered in terms of the Medical Schemes Act (Act 131 of 1998), or (d) another state department, local authority or foreign government or any other employer, or who exceeds the generally accepted income means test as implemented by the Provincial Government: Western Cape”. See for instance also the Regulations on Ambulance Fees in the Free State (Provincial Gazette No 64, Notice No 141 of 01

are, more often than not, employees rather than independent contractors as they are in the private sector.⁵ The employment relationship between the state and health professionals creates certain obligations for the health professionals that cast the provider-patient relationship in a different light to that in the private sector. The simple provider-patient relationship that is most often contemplated in many discussions of health law represents only a small percentage, in terms of volume of transactions, of the number of provider-patient relationships that exist in reality.

Since in South Africa a largely federal system of government prevails, especially in the arena of health services where, in terms of Schedule 4 of the Constitution, the national and provincial governments have concurrent legislative competence and since government as whole is in many respects different in legal terms to providers of health care services in the private sector, it is proposed to divide this chapter into two parts. The first will deal with the provider-patient relationship where the former is the state and the latter will deal with the relationship involving various types of private sector providers.

A PUBLIC SECTOR

3.1 Introduction

The government is a provider of health care services. In order to fulfil its role as such it is capable of exercising many different kinds of legal power. This fact renders an examination of the relationship between the patient and the state as provider of health care services fairly complex. For instance, is there ever a contractual relationship between them such as is most often inferred between the patient and the private sector provider or is this the exception rather than the norm? Are health service delivery decisions in the public sector based largely upon administrative law or are they 'business decisions' in terms of the law of contract? In the case of the former, a patient's legal relationship and the remedies available to him or her would differ significantly in form to those in terms of the law of contract. There is also the

October 2002) which states that a patient conveyed per ambulance shall be liable for the payment of the following fees in respect of every 50 kilometres, or part thereof, travelled: (a) An H1 hospital patient R30,00; (b) An H2 hospital patient R60,00; (c) An H3 hospital patient.

⁵ The private sector does employ health professionals but they are mainly nurses. General practitioners, dentists, physiotherapists, medical specialists, pharmacists and dieticians in the private sector are more likely to be self-employed than they are to be employees.

question of the state's constitutional obligations and the extent to which these must be seen as creating separate rights to those already contemplated in terms of the law of contract, delict and administrative law. It is proposed in this section to examine administrative law as it relates to the delivery of health care services within the public sector in order to establish the nature of the provider-patient relationships in various circumstances where the state is the provider.

3.2 The Nature of Administrative Law

According to Baxter, administrative law is:

“a set of common law principles which are designed to promote the effective use of administrative power, to protect individuals and organizations from its misuse, to preserve a balance of fairness between public authorities and those with whom they interact, and to ensure the maintenance of the balance of public interest.”⁶

It has been described by an American judge as including-

“the entire range of action by government with respect to citizen or by citizen with respect to the government, except for those matters dealt with by the criminal law, and those left to private civil litigation where the government's only participation is in furnishing an impartial tribunal with the power of enforcement”.⁷

It is not so easy in practice to define the concept of administrative action, despite the fact that this has been attempted in the Promotion of Access to Administrative Justice Act⁸. Klaaren⁹ observes that the administrative justice provision introduced by section 24 of the Interim Constitution, and continued in section 33 of the final Constitution, has had far-reaching consequences for South African administrative law. He states that both the structure of the Interim Constitution and the decisions of the constitutional court have nevertheless made it clear that this section is not “the single fount of administrative justice” and that work performed in comparable constitutional instruments has been divided and allocated to several distinct sections of the Constitution namely:

- the limitations clause;

⁶ Baxter *Administrative Law* (1984) p 3

⁷ Friendly H J, “The Federal Administrative Agencies: The Need For Better Definition of Standards, 75 *Harvard Law Review* 863(1962)

⁸ Act No 3 of 2000. See below for further discussion.

⁹ Klaaren J “Administrative Justice” Chaskalson *et al* (eds) *Constitutional Law of South Africa* 25-1

- the right of access to information;
- the right of access to court; and
- the right to freedom and security of the person

and that the right to administrative justice must be considered in relation to these other provisions.

3.3 Classifications of Administrative Action

To add to the confusion¹⁰ within administrative law, the courts at one stage used¹¹, and still today to some extent may have to use¹², a system of classification of administrative action that imitates the system of classification of different types of action of which administrative action itself forms a part. It is hardly surprising that this has the potential to cause considerable confusion for the courts and government officials alike¹³. The classification divides administrative acts into legislative, quasi-

¹⁰ Baxter (fn 6 *supra*) says at p 350: "The distinction between legislative and non-legislative administrative acts is often difficult or impossible to draw satisfactorily."

¹¹ Thus in *Premier, Eastern Cape, and Others v Cekeshe and Others* 1999 (3) SA 56 (TK) the court observed: "To some extent the learned Judge must have been influenced by the then existing classification of administrative acts into 'quasi-judicial' and 'purely administrative'. At 263F - G the learned Judge states: 'In the absence of a provision prescribing a quasi-judicial enquiry as a pre-requisite to the exercise of a power of expropriation, the act of expropriation is a purely administrative act. (Cf *Johnson & Co v Minister of Health* [1947] 2 All ER 395 at 398 - 9 and *Minister of the Interior and Another v Mariam* 1961 (4) SA 740 (A) at 751.)'... This classification has since been dealt a final blow. In the oft-cited case of *Administrator, Transvaal, and Others v Traub and Others* 1989 (4) SA 731 (A) Corbett CJ held at 759A - C: 'Another feature of the modern English administrative law which emerges from a study of the aforementioned cases, and others, is that the old classification of decisions into judicial, quasi-judicial and administrative no longer seems to have any relevance in this sphere. In *R v Gaming Board for Great Britain; ex parte Benaim and Another* [1970] 2 All ER 528 (CA) Lord Denning MR stated that "the "heresy" to the effect that the principles of natural justice apply only to judicial proceedings, and not to administrative proceedings, was "scotched" in *Ridge v Baldwin*. This was confirmed . . . by Lord Oliver in *Leech's case supra* at 505e where the latter stated that: ' . . . the susceptibility of a decision to the supervisory jurisdiction of the Court does not rest on some fancied distinction between decisions which are 'administrative' and decisions which are 'judicial' or 'quasi-judicial'.'"

¹² In *Shoprite Checkers (Pty) Ltd v Ramdau No And Others* 2001 (4) SA 1038 (LAC) the court notes: "I agree with the above approach by the Constitutional Court. In para [18] of the judgment in *Carephone Froneman DJP* does not seem to have appreciated that the administrative justice section could only apply if the action in question was an administrative action and that, because of this, a court would have no choice but to have to satisfy itself that such action was an administrative action before it could apply the provisions of the administrative justice section to it. This means that, however regrettable or even unpalatable it may be to have to classify actions according to whether they are administrative, judicial or quasi-judicial, courts have no choice but to classify actions according to such categories in certain circumstances under the new constitutional order in order to give effect to certain constitutional provisions.

¹³ The confusion is if anything compounded by the fact, for instance, that under the interim Constitution (and the 1996 Constitution) a local government is no longer a public body exercising delegated powers. Its council is a deliberative legislative assembly with legislative and executive powers recognised in the Constitution itself. Whilst it might not have served any useful purpose under the previous legal order to ask whether or not the action of a public authority was 'administrative', it is a question which must now be asked in order to give effect to s 24 of the interim Constitution and s 33 of the 1996 Constitution. One has a situation in which laws are made in terms of administrative action. See for instance *Fedure Life Assurance Ltd And Others v Greater Johannesburg Transitional Metropolitan Council And Others* 1999 (1) SA 374 (CC) where it was held that: "In addressing this question it is important to distinguish between the different processes by which laws are made. Laws are frequently made by functionaries in whom the power to do so has been vested by a competent legislature. Although the result of the action taken in such circumstances may be 'legislation', the process by which the legislation is made is in substance 'administrative'. The process by which such legislation is made is different in character to the process by which laws are made by deliberative legislative bodies such as elected municipal councils. Laws made by functionaries may well be classified as administrative; laws made by deliberative legislative bodies can seldom be so described." The constitutional court in this case explains how things worked under the previous legal order as follows: "Prior to the enactment of the interim Constitution, Courts adopted a more deferential attitude to laws made by elected legislatures than they did to laws made by administrative functionaries. Judicial review was developed and applied by South African Courts against the background of a legal order which

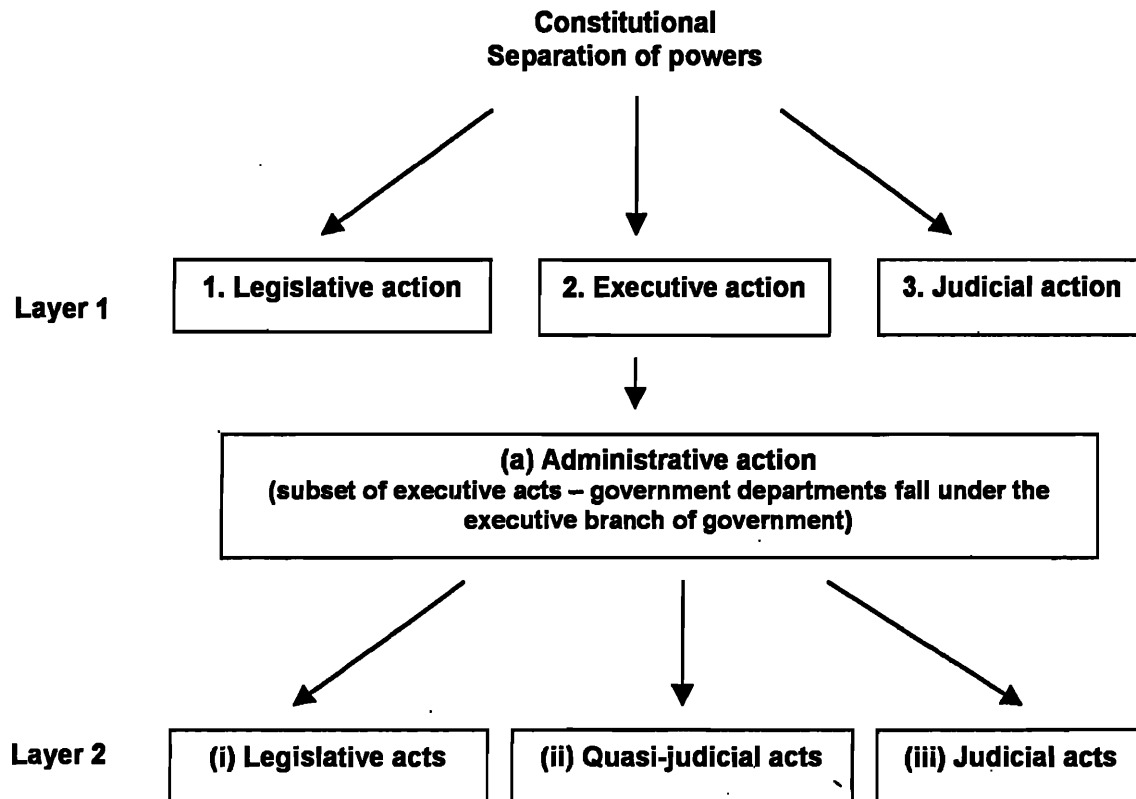
judicial and purely administrative. One has administrative action, that is essentially a sub-set of executive action¹⁴, which can be legislative, judicial or quasi-judicial in nature and which involves action neither the legislature nor the judiciary but by the executive. One thus has a hierarchy of classifications of different types of action in the diagram below using very similar nomenclature.

recognised the supremacy of Parliament. Legislation duly passed by Parliament in accordance with the then existing Constitution was not subject to judicial review, and the power of the Courts was confined to interpreting such laws and applying them to the facts of the particular case. However, a distinction was drawn between parliamentary legislation and other legislation enacted by 'subordinate legislatures' which was subject to judicial review. The true basis on which Courts were entitled to review subordinate legislation was a matter of some dispute. Some commentators saw it as implicit in the empowering legislation which was said to be subject to certain implied provisions applicable to the delegation of legislative powers unless expressly excluded by the empowering statute. Others, and this is the prevailing view, saw it as an inherent power of the Court, existing independently of the statute, which would be applied unless excluded by the empowering legislation... When there were elected provincial councils, their legislation (though in a sense legislation of a subordinate legislative body) was treated differently. The legislative power was characterised as original and not delegated, and the only question open on judicial review was whether the legislation fell within the scope of the powers vested in the councils. If so it could not be challenged on the ground of unreasonableness or on any of the other grounds on which the exercise of delegated legislative power could be reviewed by the Courts. " The court emphasises however, that the jurisdiction of the Courts to review legislation made by subordinate legislatures was not, however, a disputed issue. In broad terms the legislation was reviewed for 'legality'. The subordinate legislatures were not entitled to exceed their powers, nor to exercise them in a manner inconsistent with the limitations ordinarily attaching to the delegation of legislative power. If they did so, their laws would be struck down by the Courts as being invalid. It then goes on to explain the situation under the new legal order: "The introduction of the interim Constitution has radically changed the setting within which administrative law operates in South Africa. Parliament is no longer supreme. Its legislation, and the legislation of all organs of state, is now subject to constitutional control. It is within this context that consideration has to be given to the proper interpretation of the words 'administrative action' in s 24...The constitutional status of a local government is thus materially different to what it was when Parliament was supreme, when not only the powers but the very existence of local government depended entirely on superior legislatures. The institution of elected local government could then have been terminated at any time and its functions entrusted to administrators appointed by the central or provincial governments. That is no longer the position. Local governments have a place in the constitutional order, have to be established by the competent authority, and are entitled to certain powers, including the power to make by-laws and impose rates."

14

The court in *President of the Republic of South Africa and Others v South African Rugby Football Union and Others* 2000 (1) SA 1 (CC) stated as follows at para [142]: "As we have seen, one of the constitutional responsibilities of the President and Cabinet Members in the national sphere (and premiers and members of executive councils in the provincial sphere) is to ensure the implementation of legislation. This responsibility is an administrative one, which is justiciable, and will ordinarily constitute 'administrative action' within the meaning of s 33. Cabinet Members have other constitutional responsibilities as well. In particular, they have constitutional responsibilities to develop policy and to initiate legislation. Action taken in carrying out these responsibilities cannot be construed as being administrative action for the purposes of s 33. It follows that some acts of members of the executive, in both the national and provincial spheres of government will constitute 'administrative action' as contemplated by s 33, 108 but not all acts by such members will do so.

In *Premier, Eastern Cape, And Others v Cekeshe And Others* (fn 11 *supra*) the court observed that: "The general distinction between legislation and the execution of legislation is that legislation determines the content of the law as a rule of conduct, where executive authority applies the law in particular cases." *The Commonwealth v Grunseit and Others* (1943) 67 CLR 58. The enactment of primary legislation is not an administrative act but the implementation of such legislation is. (See definition of 'administrative action' in the PAJA section 1). Subordinate legislation is administrative action and therefore subject to judicial review. See Wiechers M *Administrative Law* who states: "Legislation does not appear out of the blue - first the authorised organ takes a decision to perform a legislative act, then the legislative measure goes through a process of consultation and drafting, then the measure is passed and finally promulgated. The initial decision to perform the administrative act will, in most cases, involve a legislative discretion and this discretion may be impugned on the same grounds as the exercise of a discretion in the performance of other legislative acts. The legislative act may also be challenged on the ground of other defects in the course of legislative process and on the strength of the ultimate effect of the act . . . even though a proclamation by the State President may be immune to judicial review in terms of an Act of Parliament, it remains subordinate legislation nevertheless and is subject to the rules relating to the creation, adoption, promulgation and interpretation of subordinate legislation."



Devenish *et al*¹⁵ note that there has in recent times been a strong inclination to avoid using the classification of administrative acts as legislative, quasi-judicial and purely administrative and that in *Du Preez v Truth and Reconciliation Commission*¹⁶, the Appellate Division held that for the purpose of applying the rules of natural justice, the classification of decisions as quasi-judicial or administrative has in effect been abandoned. They express the view, however, that the classification can nevertheless be beneficial in some circumstances and proceed to discuss the three types of administrative action on this basis. They note that legislative acts of the administration give rise to delegated legislation and that they are the most easily recognised. They note with regard to *Fedsure*¹⁷ that the resolutions taken by the municipality could not be classified as administrative action because the municipal council was exercising a power that was exclusively exercised by legislative bodies and that on this interpretation, other non-exclusive legislative decisions, as opposed to

¹⁵ Devenish GE, Govender K and Hulme D *Administrative Law and Justice in South Africa* at p 91

¹⁶ *Du Preez* 1997 (3) SA 204 (A) 11A-C

¹⁷ *Fedsure Life Assurance v Greater Johannesburg Transitional Metropolitan Council* fn 13 *supra*

legislative enactments, may still be subject to scrutiny under section 33 of the Constitution. Devenish *et al* point out that section 156(2) of the Constitution provides that a municipality may make and administer by-laws for the effective administration of matters which it has a right to administer and that therefore the Constitution empowers municipalities to administer by-laws. They observe that the implementation and administration of a by-law requires the exercise of a discretion in that decisions have to be taken and choices made between alternative courses of action. Such decisions required the exercise of delegated power and the application of the by-laws to a given set of circumstances. They are therefore subject to section 33 scrutiny.

In terms of Part B of Schedule 4 of the Constitution, municipalities are responsible for municipal health services, although these are not defined. Municipalities now have the power to make original, or primary, legislation on the subject of municipal health services. This has to be interpreted, however, within the broader constitutional context, particularly the concurrent legislative (and therefore executive) competence of the national and provincial spheres of government in the field of 'health services' as contemplated in Part A of Schedule 4 of the Constitution. In the National Health Act an attempt has been made to define municipal health services so as to be able to comply with and work within the fiscal federalism imposed by the Constitution and other legislation and avoid unfunded mandates as proscribed by the Public Finance Management Act¹⁸ for both municipalities and provinces with regard to the provision of health services. In order to know what funding must be made available to the three different spheres of government (national, provincial and executive) in respect of health services it is necessary to define for operational purposes the term "municipal health services". Naturally such a definition is not without its challenges given the fact that any attempt to define a constitutional term, no matter how well intentioned, is subject to constitutional challenge on the basis that it constitutes an attempt to amend the Constitution by stealth. In light of the foregoing discussion, however, it must be noted that the passing of by-laws by a municipality concerning municipal health services would be legislative as opposed to administrative action, in contrast to the position under the previous legal dispensation.

¹⁸ Act No 1 of 1999



Devenish *et al* note with regard to judicial acts that it is sometimes problematic to determine whether an administrative organ is carrying out purely judicial or curial functions and that there are only a few administrative authorities which perform judicial functions. Quoting *Garner*¹⁹, they identify the essential characteristics of judicial functions as:

- (1) There must be a *lis inter partes*, i.e. a dispute between two or more parties;
- (2) The proceedings in the disputed *lis* must have been initiated by one or more of the parties to the dispute, but not by the tribunal itself or some other governmental body not being a party to the dispute; and
- (3) As a general rule, the presiding officer or judge, having found the facts and applied the appropriate principles of law thereto, has little discretion in coming to his or her decision, he or she may not be influenced by preconceived principles of policy, but must apply prescribed rules so as to reach a decision.²⁰

Decisions involving the delivery of health care are in the main unlikely to be judicial administrative decisions. Under the old system of classification of administrative decisions they are more likely to be quasi-judicial or purely administrative decisions since except in the case of a dispute mechanism in terms of which a department of health must adjudicate between the interests of two or more parties (which is very unlikely in the health care context and is only necessary rarely, if at all).

Quasi-judicial acts are administrative acts in which an administrative body exercises a discretion²¹. A quasi-judicial function is an administrative function which the law requires to be exercised in certain respects as if it were judicial²². In *Hack v*

¹⁹ Jones BL and Thompson K *Garner's Administrative Law* p 344

²⁰ Devenish *et al* fn 15 *supra* at p 98

²¹ In *Administrator, Transvaal, And Others v Traub And Others* (fn 11 *supra*) the court held that whether the function be an 'administrative' function or whether it be 'purely administrative' or 'quasi-judicial' or 'judicial' the duty is to act 'fairly' and the *audi alteram partem* rule is simply a species of such duty. The courts have held that a public statutory body entrusted with administrative or quasi-judicial functions can be cited *eo nomine* in review proceedings, even if it is not a body corporate in the ordinary acceptance of that term (*M G Holmes (Pty) Ltd v National Transport Commission And Another* 1951 (4) SA 261 (T)). In *The Administrator, Transvaal And The Firs Investments (Pty) Ltd v Johannesburg City Council* 1971 (1) SA 56 (A), it was said that the court has jurisdiction under the common law to review a decision if an examination of the statute concerned reveals that the particular discretion or power involved is a quasi-judicial one. It is sufficient to show a "clear intention" of the legislature to negative and exclude the implication that the power so given is to be exercised in accordance with the fundamental principles of justice, rather than that this should be demonstrated as a "necessary implication". See *Publication Control Board v Central News Agency*, 1970 (3) SA at p. 489B - D. The first requirement is that the decision should prejudicially affect the property or liberty or rights of that individual who takes action to upset the decision. See *R. v Ngwevela*, 1954 (1) SA at p 127F; *Minister of Interior v Bechler and Others*, 1948 (3) SA 409. The prerequisites for deciding whether the function of a person statutorily authorised is quasi-judicial where that official's decision must be preceded by the recommendation of another body are dealt with in *Cassem v Oos-Kaapse Komitee van die Groepsgebiederaad*, 1959 (3) SA at pp. 659A - H; 661H - 662C; *South African Defence and Aid Fund v Minister of Justice*, 1967 (1) SA at pp. 270A - 271A.

²² Devenish *et al* fn 15 *supra*

*Venterspost Municipality And Others*²³ the court observed that as a general rule, a tribunal, or a body, even if administrative, must exercise its functions in a judicial or quasi-judicial way whenever it is empowered to make decisions, not in its own arbitrary discretion, but as a result of an enquiry into matters of fact, or of fact and law, and these decisions may affect the rights of, and involve civil consequences to, individuals. In the health-care context, quasi-judicial decisions are likely to consist primarily of licensing type decisions such as those contemplated in the National Health Bill in connection with the granting of certificates of need by the Director-General.

The Appellate Division in *Sugar Industry Central Board And Another v Hermannsburg Mission And Another*²⁴ stated that for the purpose of determining whether the *audi alteram partem* rule applies in relation to the exercise by the first appellant of the power, or duty, in terms of clause 37, depends on a determination of whether, in exercising such power or duty, the first appellant exercises a purely administrative function or acts in a quasi-judicial capacity. If the first appellant exercises a purely administrative function, the *audi alteram partem* rule has no application. If it acts in a quasi-judicial capacity the *audi alteram partem* rule applies unless it has been expressly or impliedly excluded. (*South African Defence and Aid Fund and Another v Minister of Justice*²⁵; *Publications Control Board v Central News Agency Ltd*²⁶; *Roberts v Chairman, Local Road Transportation Board, and Others*²⁷.) As to the tests to be applied in determining whether a statutory function being performed is quasi-judicial in nature or purely administrative, are to be found in *Hack v Venterspost Municipality and Others*²⁸, *Minister of the Interior and Another v Mariam*²⁹ and Roberts' case *supra*³⁰.

A professional act that is performed using professional skill and knowledge is apparently not an administrative act of any kind. In *S v Dobson*³¹ the court held that

23 *Hack* 1950 (1) SA 172 (W)

24 *Sugar Industry Central Board And Another* 1983 (3) SA 669 (A)

25 *South African Defence and Aid Fund and Another* 1967 (1) SA at p 270

26 *Central News Agency Ltd* 1970 (3) SA at p 488 - 489

27 *Roberts* 1980 (2) SA at p 489 - 490

28 *Hack* 1950 (1) SA at p 190

29 *Mariam* 1961 (4) SA at p 751

30 *Roberts* fn 26 *supra* at p 489 G - 490

31 *Dobson* 1993 (4) SA 55 (E)



the *audi alteram partem* rule is not applicable to the process of compiling of a report by a psychiatrist pursuant to an enquiry in terms of ss 77, 78 and 79 of the Criminal Procedure Act³²: the psychiatrists do not perform an administrative, judicial or quasi-judicial function but conduct their own enquiry in their own way to enable them to furnish an opinion concerning the mental capacity of the accused.

As stated previously the courts are presently inclined not to ascribe much value to these distinctions one of the reasons being that they are not particularly clear of useful³³.

Purely administrative acts are by definition neither judicial nor quasi-judicial. They are acts by which an administrative body creates, alters or terminates individual administrative law relationships. An administrative decision is one that is made according to administrative policy whereas a judicial one is made according to law³⁴.

3.4 Administrative Agreements

In *Transnet Ltd v Goodman Brothers (Pty) Ltd*³⁵ the court held that the reasoning employed in *Umfolozi Transport Bpk v Minister van Vervoer en Andere*³⁶, where it was held that the State Tender Board's handling of tenders for government transport services constituted administrative action and that the steps that had preceded the conclusion of the contract were purely administrative actions and decisions by officials, and that public money had been spent by a public body in the public interest, applied also to *Transnet*. In *Cape Metropolitan Council v Metro Inspection Services*

³² Criminal Procedure Act No 51 of 1977

³³ In *Knop v Johannesburg City Council* 1995 (2) SA 1 (A), the court stated that if the distinction between quasi-judicial and purely administrative decisions is of little use in solving problems in the context of the justiciability of a decision on the ground of failure to act fairly (see *Administrator, Transvaal, and Others v Traub and Others* fn 11 *supra* at 759A-C, 762F-H, 762H-763E, 763E-I and 763I-J), it is equally of little value in resolving the issue whether negligence in the making of the decision gives rise to liability for damages in delict. It found that in South African law there is no justification for treating the distinction between quasi-judicial and purely administrative functions as the touchstone for determining a public authority's liability for loss caused by the negligent exercise of statutory powers. It held that to determine the issue of wrongfulness, there was no point in straining to categorise the functions of the public authority as either quasi-judicial or purely administrative and quoted the remarks of the court in *Mutual Life & Citizens' Assurance Co Ltd and Another v Evatt* [1971] 1 All ER 150 (PC) as being particularly apposite: 'In our judgment it is not possible to lay down hard and fast rules as to when a duty of care arises in this or in any other class of case where negligence is alleged. When in the past Judges have attempted to lay down rigid rules or classifications or categories they have later had to be abandoned'.

³⁴ See *Devenish et al* fn 15 *supra* at p 103 onwards.

³⁵ *Transnet Ltd v Goodman Brothers* 2001 (1) SA 853 (SCA)

³⁶ *Umfolozi Transport Bpk* [1997] 2 B All SA 548 (SCA)

*(Western Cape) CC And Others*³⁷ the court found that different considerations applied where a contract between an organ of state and a private entity was preceded by purely administrative actions and decisions by officials in the sphere of the spending of public money by public bodies in the public interest. It held that these amounted to administrative actions because s 217(1) of the Constitution specifically provided that, when an organ of state in the national, provincial or local sphere of government contracted for goods or services, it had to do so in accordance with a system that was fair, equitable, transparent, competitive and cost-effective³⁸. The court in this case held that that it served little purpose to classify the agreement between the first respondent and the appellant as an 'administrative agreement' as the question remained whether the cancellation of the contract amounted to 'administrative action'.

It stated that that section 33 of the Constitution was not concerned with every act of administration performed by an organ of state, but was designed to control the conduct of the public administration when it exercised a public power, and that it followed that whether or not conduct amounted to 'administrative action' depended on the nature of the power being exercised. Other relevant considerations, said the court, are the source of the power, the subject matter, whether it involved the exercise of a public duty, and how closely it was related to the implementation of legislation. The court found that that it could not be said that the appellant had exercised a public power when it purported to cancel the contract. Although it derived its power to enter into the contract with the first respondent from statute, it derived its power to cancel the contract from the terms of the contract and the common law; when it had concluded the contract it did not act from a position of superiority or authority, nor did it, when cancelling, find itself in a stronger position than the position it would have been in had it been a private institution. When it purported to cancel the contract, it did not perform a public duty or implement legislation, but purported to exercise a contractual right founded on the consensus of the parties in respect of a commercial contract³⁹.

³⁷ *Cape Metropolitan* 2001 (3) SA 1013 (SCA)

³⁸ *Cape Metropolitan* fn 36 *supra* paragraph [19] at 1024B/C - F.)

³⁹ Pretorius DM 'The Defence of the Realm: Contract and Natural Justice' 2002 *South African Law Journal* 119 374 has criticised this judgment saying that the question as to the true nature of public power is not addressed adequately by the judgment and that the court did not provide a satisfactory analysis of the relationship between public power and contractual rights. He states that in addition, insufficient consideration was given to the fact that the appellant had, by means of its contract with the respondent, outsourced the performance of its own statutory and public functions and that it had done so by virtue of specific statutory authorisation. In other words, the contract (the conclusion of which was



Burns⁴⁰ notes that it has been said that although South African courts have recognised the administrative disposition and private law contract concluded by the state, they have not as yet, recognised the administrative law agreement⁴¹. She observes that it has also been said that these administrative agreements (in which the state acts in its capacity as an organ of state and exercises a measure of state authority) fall somewhere between the boundary of public law and private law. Public authorities are not empowered to conclude contracts which are incompatible with the proper exercise of their powers and duties: such contracts or actions are void because the authority has exceeded its power and has acted *ultra vires*. This is something that the general public and even members of the legal profession fail to understand when litigating or threatening litigation against organs of state and statutory bodies. The Medicines Control Council, for example, would be unable to conclude an out of court settlement agreement with a private company that is an importer of a medicinal product in respect of the seizure of those products which were being sold illegally because they were not registered. Such an agreement would be outside of the mandate of the Council whose primary task is to ensure the safety quality and efficacy of medicines sold in South Africa by means of a registration process.

Burns notes that the liability of the state for administrative agreements is anything but clear and that at this stage a delictual claim against the state for negligent action of independent contractors will in all probability also be unsuccessful. The state is usually unable to supervise or exercise control over the actions of a private agency while the latter is fulfilling its contractual obligations. Indeed one of the reasons for contracting in the first place is often the fact that the state lacks the resources to do the job itself. Burns comments that currently administrative agreements are governed in the main by rules of private law and courts are influenced by private law contracts when determining the rules which apply to administrative agreements. Thus, she says,

authorised by statute) had a public dimension in that it was intended to achieve a statutory objective, namely to collect levies imposed by statute for the benefit of the provincial fiscus. This fact, says Pretorius, was not accorded sufficient weight by the court, and militates against its assertion that the contract was of a commercial nature.

⁴⁰ Burns *Y Administrative Law Under the 1996 Constitution*

⁴¹ She refers to Floyd TB "Die onderskeid tussen die ooreenkoms en die administratiewe beskikking" 1995 SAPR/PL 282 at p 285

the liability of the state for private law contracts and administrative agreements is governed by the State Liability Act⁴².

It is submitted that the conceptual difficulties which Burns encounters in the failure of the courts to recognise “the true nature and extent of the administrative agreement” are caused largely by her own insistence on the conceptual framework that seeks to distinguish public and private law. The problem lies largely in this distinction. If the distinction is unimportant then what does it matter whether or not the courts recognise administrative agreements as a concept? The law of contract and the law of delict have served quite well for a number of centuries in righting the wrongs between contracting parties and members of society. Burns seems to be of the view that the state should be held liable for the actions of a private contractor that has been tasked by the state with the performance of a public function purely because it is a public function. It is submitted that this view is neither logical nor equitable in all instances since it absolves the private contractor of just about all relevant responsibility for its own incompetence or incapacity. Burns suggests that the state should be held liable for contracting negligently with contractors who are unable to perform the required function. Her view also demonstrates a superficial understanding of the practical realities of state contracting procedures which are usually in the form of tender processes and are heavily regulated by legislation such as the State Tender Board Act⁴³, the Public Finance Management Act⁴⁴, the Preferential Procurement Policy Framework Act⁴⁵, the National Supplies Procurement Act⁴⁶, the Broad-Based Black Economic Empowerment Act 53 of 2003 and last but not least the Constitution⁴⁷. The full scope of the concept of contractual freedom, it is submitted, is a privilege reserved to the private sector. Provided that public entities follow the rules and procedures contained in the legislation detailed above, it is submitted that the chances of success of a claim against the state for negligent contracting are negligible. She asks how the individual can be protected from the negligent acts of the contractor

⁴² Act No 20 of 1957. This may seem something of a contradiction as the State Liability Act can hardly be said to be private law but the point is that the Act serves as little more than an entry point for the private law of contract and of delict into public affairs.

⁴³ Act No 86 of 1998

⁴⁴ Act No 1 of 1999

⁴⁵ Act No 5 of 2000

⁴⁶ Act No 89 of 1970

⁴⁷ Act No 108 of 1996. Section 217(1) states: “When an organ of state in the national, provincial or local sphere of government, or any other institution identified in national legislation, contracts for goods or services, it must do so in accordance with a system which is fair, equitable, transparent, competitive and cost-effective.”



apparently on the understanding that the law of delict does not apply to private contractors who are performing public functions. It is submitted that the law of delict applies to private contractors performing public functions as much as it does to private contractors fulfilling private functions. It is not clear why, simply because it happens to be a public function that is performed, in Burns view the rules of delictual liability should work differently. As the courts have rightly stated it is not so much a classification of the agreement that is important as the nature of the action taken and whether it was in consequence of an ordinary contractual arrangement or some statutory provision which conferred the power to do so. Essentially administrative law is about the exercise of power that is granted not by the person over whom that power is exercised, as would be the case in a contract, but by some other agency, for example the state in terms of legislation. If one is not obsessed with distinctions between public and private law it becomes obvious that administrative law should be capable of regulating private entities where they are granted power over the general public or groups within the general public by way of processes over which the regulated group had little or no control. It is submitted that the concern of administrative law is not the nature of the authority that wields the power but rather that of the power itself.

3.5 Private Law in The Public Health Sector

In the healthcare context, the question of whether a nation or provincial government or municipality is exercising a public power or performing a public function is central to the question of whether the provider-patient relationship can be governed purely by private law, such as the law of contract, or whether it will always have an additional element of administrative law. Powers derived from statute are generally regarded as public powers and functions derived from statute are usually public functions. Unfortunately, life, as usual, is never that simple since it is possible to derive the power to enter into a contract from a statute in which case the conclusion of the contractual relationship in question is an administrative act⁴⁸. In the context of health

⁴⁸ See for instance *Metro Inspection Services (Western Cape) CC And Others v Cape Metropolitan Council* 1999 (4) SA 1184 (C) where it was observed that: "In *Cekeshe and Others v Premier, Eastern Cape, and Others* 1998 (4) SA 935 (Tk) at 956J - 957C (1997 (12) BCLR 1746 at 1766D - F) the Court emphasised that the substance and not the form of the action should be looked at in order to determine whether an action amounts to an administrative action or not. While this is undoubtedly so, one cannot disregard the fact that in the present case the contract is for the supply of services on behalf of an organ of state and that the authority of the respondent to conclude the contract is derived from statute. In *Goodman Bros (Pty) Ltd v Transnet Ltd* 1998 (4) SA 989 (W) at 996D (1998 CLR 405 at 411; [1998] 3 All SA 336 at



care, the concepts of public powers and functions are not particularly helpful. The question remains, in the context of a purported 'contract' for health care services between a public provider and a private patient, what is the source of the power or the public provider to enter into the contract? If the contract is expressly mandated by statute then the source of the power to contract is clearly statutory. However, if the statute is silent on the subject of whether or not services must or may be rendered on the basis of a contract and there is the possibility that they may be rendered on the basis of contract or administrative law, is a power on the part of a public provider to enter into a contract statutory in origin or does it derive merely from the fact that as a juristic person it has the power to enter into contracts in the same way as any other legal *persona*. Would a decision by a public entity to enter into a contract for health care services amount to an exercise of public power under these circumstances? Is it not too simplistic to say that when a public entity acts in terms of legislation it always exercises public power and that such action must always be classified as administrative action? The principle of legality and the rule of law require that a public entity must not overstep the bounds of its authority as conferred by legislation⁴⁹. If this is the case then the authority for every legitimate act of a public entity is based upon one piece of legislation or another and every act in terms of legislation constitutes the exercise of a public power or the performance of a public function in which case every such act is administrative in nature. This cannot be the case however, if one considers the dicta of the courts in judgments such as in *Cape Metropolitan Council v Metro Inspection Services (Western Cape) CC And Others*⁵⁰ which the court stated that:

343c; and 1998 (8) BCLR 1024 at 1031G) Blieden J expressed himself as follows: 'In my view, this argument overlooks the true meaning of an administrative act. It means any act relating to the management of the affairs of the respondent.' Applying this test, it could be said that the act of terminating the contract in terms of which the first applicant was carrying out the functions of the respondent in terms of the Regional Services Councils Act is an act relating to the management of the affairs of the respondent."

⁴⁹ In *Minister Of Public Works and Others v Kyalami Ridge Environmental Association and Another (Mukhwevho Intervening)* 2001 (3) SA 1151 (CC) it was noted at p 1166 that: "In *Fedsure Life Assurance Ltd and Others v Greater Johannesburg Transitional Metropolitan Council and Others* [fn 13 *supra*] this Court held: '(I)t is a fundamental principle of the rule of law, recognised widely, that the exercise of public power is only legitimate where lawful. The rule of law - to the extent at least that it expresses this principle of legality - is generally understood to be a fundamental principle of constitutional law.' Later in the same judgment it is said that: '(i)t seems central to the conception of our constitutional order that the Legislature and Executive in every sphere are constrained by the principle that they may exercise no power and perform no function beyond that conferred upon them by law. At least in this sense, then, the principle of legality is implied within the terms of the interim Constitution.' The Constitution now states explicitly that the rule of law is a foundational value of our legal order." See also *Fedsure Life Assurance Ltd and Others v Greater Johannesburg Transitional Metropolitan Council And Others* (fn 13 *supra*) where the court stated that: "It seems central to the conception of our constitutional order that the Legislature and Executive in every sphere are constrained by the principle that they may exercise no power and perform no function beyond that conferred upon them by law. At least in this sense, then, the principle of legality is implied within the terms of the interim Constitution."

⁵⁰ *Cape Metropolitan Council* fn 48 *supra*

“It follows that whether or not conduct is ‘administrative action’ would depend on the nature of the power being exercised. Other considerations which may be relevant are the source of the power, the subject-matter, whether it involves the exercise of a public duty and how closely related it is to the implementation of legislation.”

and in *President of the Republic Of South Africa and Others v South African Rugby Football Union and Others*⁵¹ where the court observed:

In s 33 the adjective ‘administrative’ not ‘executive’ is used to qualify ‘action’. This suggests that the test for determining whether conduct constitutes ‘administrative action’ is not the question whether the action concerned is performed by a member of the executive arm of government. What matters is not so much the functionary as the function. The question is whether the task itself is administrative or not. It may well be, as contemplated in *Fedsure*, that some acts of a legislature may constitute ‘administrative action’. Similarly, judicial officers may, from time to time, carry out administrative tasks. The focus of the enquiry as to whether conduct is ‘administrative action’ is not on the arm of government to which the relevant actor belongs, but on the nature of the power he or she is exercising.”⁵²

The general rules to be derived from these dicta are:

- 1 It is not so much the nature of the power bearer or functionary as the nature of the power or function that is relevant;
- 2 The nature of the power is only one of the considerations to be taken into account. Others are the source of the power, the subject-matter, whether it involves the exercise of a public duty and how closely related it is to the implementation of legislation;
- 3 The list of considerations referred to in 2 above is not exhaustive;
- 4 The source of the power is not apparently an overriding consideration but must be balanced in relation to other factors such as the nature of the power, how closely it is related to the implementation of legislation etc.
- 5 The nature of the task to be performed is an important factor;
- 6 The assessment must be made in light of the provisions of the Constitution and the overall constitutional purpose of an efficient, equitable and ethical public administration.

⁵¹ *South African Rugby Football Union 2000 (1) SA 1 (CC)* at para 141

⁵² See also para 143 of the same judgment: “Determining whether an action should be characterised as the implementation of legislation or the formulation of policy may be difficult. It will, as we have said above, depend primarily upon the nature of the power. A series of considerations may be relevant to deciding on which side of the line a particular action falls. The source of the power, though not necessarily decisive, is a relevant factor. So, too, is the nature of the power, its subject-matter, whether it involves the exercise of a public duty and how closely it is related on the one hand to policy matters, which are not administrative, and on the other to the implementation of legislation, which is. While the subject-matter of a power is not relevant to determine whether constitutional review is appropriate, it is relevant to determine whether the exercise of the power constitutes administrative action for the purposes of s 33. Difficult boundaries may have to be drawn in deciding what should and what should not be characterised as administrative action for the purposes of s 33. These will need to be drawn carefully in the light of the provisions of the Constitution and the overall constitutional purpose of an efficient, equitable and ethical public administration. This can best be done on a case by case basis.”

7 The assessment must ultimately be done on a case-by-case basis. This implies taking into account all of the relevant factors in each particular set of circumstances.

If it follows that a statute may confer and impose powers and functions other than public powers and functions. Public entities may enter into contracts and conduct business of a nature which does not mean that the power exercised in doing so is a public power or function. National, local and provincial governments are juristic *personae* with power to contract separately and individually from each other⁵³. What happens where there is a broad statutory obligation, as opposed to a power, to provide health care services? In terms of section 16 of the Health Act⁵⁴–

“(1) In addition to the functions entrusted to a provincial administration by any other law, the functions of a provincial administration with regard to health services in its province, shall, subject to the provisions of this Act, be-

- (a) to provide hospital facilities and services;
- (b) to provide ambulance services within its province and, with due regard to similar services provided by provincial administrations in adjacent provinces, to co-ordinate such services;
- (c) to provide facilities for the treatment of patients suffering from acute mental illness;
- (d) to provide facilities for the treatment of outpatients in hospitals or in other places where patients are treated for a period of less than twenty-four hours;
- (e) to provide and maintain maternity homes and services;
- (f) to provide personal health services, either on its own or in co-operation with any local authority;
- (g) with a view to the establishment of a comprehensive health service within its province, to co-ordinate the services referred to in paragraphs (a) to (f), inclusive, with due regard to similar services rendered by the Department of Health and Welfare, other provincial administrations and by local authorities;

⁵³ In *Lombard v Minister van Verdediging* 2002 (3) SA 242 (T) the court held: “Die Staat is ’n regspersoon maar sonder ’n geregistreerde kantoor of hoofbesigheidsplek en sonder ’n direkteur of beampte soos bedoel in die artikel.” See also *Minister Of Law and Order v Patterson* 1984 (2) SA 739 (A) where the court stated that: “Before proceeding to discuss the appeal, I should say that it was common cause between counsel in this Court that the state was the real defendant in the action instituted by the respondent, and, also, that the state is a legal persona.”

⁵⁴ Act No 63 of 1977



- (h) to promote family planning in the province concerned; and
- (i) to perform any other function as may be assigned to it by the Minister.”

There is nothing in this section that precludes the possibility of a province’s entering into a contract with a patient for the rendering of health services in fulfilment of its legal obligations as described in section 16. The fact that a province does not have to contract with a patient in order to create a legal relationship between itself and that patient does not mean that it cannot do so. In the case of contract law, however, intention is everything and in the case of the state in particular, one is only likely to encounter the question as to whether or not the necessary intention existed in pathological circumstances where a case has come before the court. In this situation, the state is likely to argue its case in the manner best calculated to win its case which may result in an argument based on the law of delict rather than that of contract since the onus of proof in the case of the former is possibly a harder one for the plaintiff to discharge⁵⁵. Thus in *Magware v Minister of Health No*⁵⁶ the defendant in his plea denied any contractual relationship between the parties choosing rather to admit negligence as averred in the declaration but pleading that such negligence consisted only of acts of omission not giving rise to delictual liability on the part of the defendant⁵⁷. In *Dube v Administrator, Transvaal*⁵⁸, *Buls and Another v Tsatsarolakis*⁵⁹, *Mtewa v Minister of Health*⁶⁰, *Pringle v Administrator, Transvaal*⁶¹, *Collins v Administrator, Cape*⁶² the basis of all of the claims was the law of delict and not the law of contract. The plaintiffs apparently did not even attempt to argue the existence of a contractual relationship between themselves and the public providers or that the terms thereof had been breached.

The fact that a contractual relationship is possible between a public provider of health care services and a patient is evidenced in *Shiels v Minister of Health*⁶³. In that case

⁵⁵ The onus of proving the intention of a complex and diffuse body such as the state which is comprised of many minds may possibly be even more difficult to discharge in the event that the state denies an intention to contract.

⁵⁶ *Magware* 1981 (4) SA 472 (Z)

⁵⁷ The facts of the case and the judgment of the court are discussed in more detail in the section on the law of delict

⁵⁸ *Dube* 1963 (4) SA 260 (W)

⁵⁹ *Buls* 1976 (2) SA 891 (T)

⁶⁰ *Mtewa* 1989 (3) SA 600 (D)

⁶¹ *Pringle* 1990 (2) SA 379 (W)

⁶² *Collins* 1995 (4) SA 73 (C)

⁶³ *Shiels* 1974 (3) SA 276 (RA)

the Minister of Health sued the appellant for the cost of manufacturing an artificial limb. The court quite clearly dealt with the relationship on the basis of the law of contract, stating at 279:

“Now clearly the principle established in those cases must apply to a contract such as this involving the highly technical task of constructing an artificial leg and making it fit, particularly in the case of the appellant who, on his own admission, is a difficult customer because, unfortunately, he has a very short stump.”

The case of *Administrator Natal v Edouard*⁶⁴ is a further example. In that case there was a contractual obligation to sterilise the respondent’s wife. The court refused to allow a claim for non-patrimonial loss on the ground that the South African law of contract does not allow a claim for intangible damages in the event of breach of contract.

Whilst there is strict and specific law relating to the situation in which the state is a purchaser of goods and services, the same does not hold true in a situation in which the state is the supplier of goods and services – in the health care context at least. The fact that there is a constitutional obligation upon the state to achieve the progressive realisation of the right of access to health care services within available resources also does not necessarily preclude the conclusion of a contract for the provision of these services. As stated in a previous chapter there is a significant difference between “a right of access to” and “a right to”, the former being less direct than the latter and creating the possibility that some action or effort is required on the part of the person exercising the right.

In practice, public providers differentiate between “externally funded patients” and others. They publish regulations, the promulgation of which is, in view of previous discussion, subject to administrative law, in terms of which fees are set for various categories of patients. For the most part the fees payable are determined on the basis of a means test. For instance in the “Regulations Relating To The Uniform Patient Fee Schedule For Health Care Services Rendered By The Department Of Health: Western Cape For Externally Funded Patients”⁶⁵ it is stipulation that “these regulations apply

⁶⁴ *Edouard* 1990 (3) SA 581 (A) the facts of the case and the judgement of the court are discussed in more detail in the section on the law of contract

⁶⁵ Provincial Gazette No 5977 of 29 January 2003, Notice No 21

to externally funded patients only.” The regulations define an externally funded patient as-

“a patient whose health services are funded or partly funded in terms of-

- (a) the Compensation for Occupational Injuries and Diseases Act, 1993 (Act 130 of 1993), or
- (b) by the Road Accident Fund created in terms of the Road Accident Fund Act, 1996 (Act 56 of 1996), or
- (c) a medical scheme registered in terms of the Medical Schemes Act, 1998 (Act 131 of 1998), or
- (d) another state department, local authority, foreign government or any other employer, or

who exceeds the generally accepted income means test as implemented by the Provincial Government: Western Cape.”

The Regulations set out a Uniform Patient Fee Schedule for various health care services provided to externally funded patients by the Western Cape Provincial government. Regulation 3 states that: “An externally funded patient who receives any medical treatment or any medical service, listed and categorised in Schedule 2, from a DOH facility, must pay the applicable tariff for such medical treatment or medical service received in accordance with the tariff of fees and charges as set out in Schedule P”. Technically speaking there is thus no need of a contract to create an obligation on the part of the patient to pay the applicable tariff.

Similarly in KwaZulu-Natal⁶⁶, the Regulations Relating To The Administration, Management And Control Of Provincial Hospitals, Services And Institutions Established In Terms Of Section 4 Of The Provincial Hospitals Ordinance⁶⁷ distinguish between “Private patients”, “full paying Hospital patients” and “part-paying hospital patients”.

The Regulations stipulate that -

⁶⁶ Notice No. 405 of 24 October 2002

⁶⁷ Ordinance No. 13 of 1961

“There shall be payable in respect of services rendered and supplies provided at, in or from provincial hospitals, community health centers and clinics the following charges which are defined by and subject to the 2002 KwaZulu-Natal Hospital Fees Manual which is available on request from any Provincial hospital in the Province:”
and then give the schedule of fees.

In the Free State the Regulations⁶⁸ entitled ‘Regulations On Fees For Health Services In The Free State’ provide for the classification of patients as follows–

- (1) Upon admission to a hospital, a patient shall be classified by the chief executive officer or delegated officials as a foreign patient, hospital patient or private patient.
- (2) A patient shall furnish such information and submit such proof as the chief executive officer or delegated officials may require of him or her, in order to be able to make a classification in terms of subregulation (1).

The regulations then go on to provide for a means test and methods of classification patients into the various categories.

The fact that the fees are prescribed by regulations means that they are not negotiable except within the scope of the regulations and as permitted by them. In practical terms, although they are subject to administrative law and therefore judicial review, unless they are excessive in the extreme, it would be difficult in practice to challenge them since the costs of operating a particular public hospital are not generally known either to the public at large or to the provincial government that owns it. Although the publication of tariffs of fees in regulations does not preclude a contractual relationship between the public provider and the patient it could be argued that the creation of a legal obligation by way of regulations to pay the fees and the specification and control of conditions of service by way of regulations is evidence of the absence of an intention to create a contractual obligation between the public provider and the private patient since it is difficult to conceive of a situation in which the state may wish to duplicate the terms of such relationship by way of a contract. In terms of the South African law of contract it is the intention of the parties to the transaction that is the

⁶⁸ Notice No 140 of 2002

deciding factor⁶⁹. Lately there has been development of some of the larger public hospitals in order to attract so-called “private” or “medical scheme patients” – the externally funded patients referred to in the Western Cape Regulations quoted above. Differentiated amenities, with more of a private sector flavour such as carpets on the floors, curtains on the windows and television sets in the ceiling, have in some cases been created with a view to attracting such patients and in contractual relationships have been entered into or are contemplated with medical schemes. However, not all of these contractual relationships apply to differentiated amenities within public hospitals. Relationships between schemes and provincial governments are presently contemplated in terms of which the public hospital becomes a designated provider in terms of the regulations to the Medical Schemes Act⁷⁰ and scheme beneficiaries are treated in the same facilities as other patients who are not beneficiaries of medical schemes. The mere fact that a contractual relationship exists between the medical scheme and the public provider does not necessarily mean that a contractual relationship is also created between the patient and the provider however. This topic will be discussed in more detail in the section on contracts with public providers. However it must be noted at this point that the type of contract is relevant in this context. These contracts are not necessarily for the benefit of a third party – which have the potential to make the patient a party to the contract – but more usually consist of arrangements between the scheme or scheme administrator and the provincial government in order to clarify payment methods and arrangements, to ensure treatment of the patient in accordance with the rules of the medical scheme and the exchange of information pertaining to the patient between the provider and the scheme, to balance the financial risks to which the scheme and the provider are both exposed between the parties, and to secure patient referrals to the provider by the medical scheme and its administrators and other contractors in order to ensure bed occupancy levels. It is submitted that despite what medical schemes and providers may claim to the contrary, contractual arrangements of this nature, especially where the scheme is represented by its administrator or a managed care contractor, are rarely intended for the exclusive or direct benefit of the patient. Although they are both likely to argue that the patient benefits in that public providers are cheaper and therefore he or she is less likely to exhaust medical scheme benefits, there are a

⁶⁹ This aspect of the relationship will be discussed in more detail in the section dealing with the law of contract.

⁷⁰ Medical Schemes Act fn 3 *supra*

number of fallacies behind this argument and it represents an oversimplification of the market forces and mechanisms that operate within health funding in the private sector. Further discussion of the medical schemes industry is not within the scope of this chapter. However it is worth noting that in terms of the Medical Schemes Act and Regulations regarding the mandatory package of minimum benefits which all schemes must provide, schemes are obliged to pay the costs of all of the treatments contemplated in that package in full regardless of in which sector treatment occurs and without co-payment unless the beneficiary uses a non-designated provider without good reason. Furthermore, due to differences in treatment protocols, operational procedures and sometimes staffing levels between public and private hospitals and the relative incapacity of the public sector to 'manage' inpatient stays in public hospitals so as to keep them to the minimum duration that is absolutely necessary, there is the distinct possibility that the costs of treatment in a public hospital may not be that much lower than those within a private one. Many medical schemes are battling for survival as they are too small, do not have significant market power to bargain effectively with providers, are unable to benefit from the legislatively mandated principles of community rating, their membership profiles are unfavourably skewed or they need to increase their reserves to levels mandated by the registrar without becoming so unaffordable to members that they start to leave for other more competitive schemes. The result is increasing pressure to keep the costs of the real, direct benefits to members as low as possible. Consequently arguments that these contracts between schemes and providers are for the benefit of scheme beneficiaries are overly simplistic. They are more often than not, arrangements of expedience for the scheme and the public provider. As is evident from the regulations referred to above, medical scheme members are in any event treated in public hospitals on the basis of the regulations and in the absence of contractual relationships between the provincial governments and the medical schemes concerned.

3.6 The Right to Lawful, Reasonable and Fair Administrative Action

In terms of section 33 of the Constitution:

“(1) Everyone has the right to administrative action that is lawful, reasonable and procedurally fair.



- (2) Everyone whose rights have been adversely affected by administrative action has the right to be given written reasons.
- (3) National legislation must be enacted to give effect to these rights, and must-
- (a) provide for the review of administrative action by a court or, where appropriate, an independent and impartial tribunal;
 - (b) impose a duty on the state to give effect to the rights in subsections (1) and (2); and
 - (c) promote an efficient administration.”

The legislation referred to in subsection (3) above is the Promotion of Administrative Justice Act⁷¹ (PAJA). It is against this constitutional and legislative backdrop that one must examine administrative law in relation to the delivery of health care services. As with all other areas of law in South Africa, administrative law is informed by and based upon constitutional principles⁷².

The implications of this for the state will be canvassed in more detail below. However it is important to note at this stage that the current status of administrative law as a branch of constitutional law as opposed to the common law, casts decisions by the state concerning the delivery of health care services in a whole new light. Decisions relating to the provision of health services based on administrative law are now subject to the provisions of the Constitution and the PAJA. The courts are no longer restricted, as they were when administrative law formed part of the common law, to trying the case only on the basis of principles of natural justice and rules of procedural fairness such as whether the official applied his or her mind, whether there was bias, whether the person affected by the decision was given an opportunity to be heard

⁷¹ Fn 8 *supra*

⁷² Chaskalson P has observed that: “Whilst there is no bright line between public and private law, administrative law, which forms the core of public law, occupies a special place in our jurisprudence. It is an incident of the separation of powers under which courts regulate and control the exercise of public powers by the other branches of government. It is built on constitutional principles which define the authority of each branch of government, their inter-relationship and the boundaries between them. Prior to the coming into force of the interim Constitution, the common law was ‘the main crucible’ for the development of these principles of constitutional law. The interim Constitution which came into force in April 1994 was a legal watershed. It shifted constitutionalism, and with it all aspects of public law, from the realm of common law to the prescripts of a written constitution which is the supreme law. That is not to say that the principles of common law have ceased to be material to the development of public law. These well-established principles will continue to inform the content of administrative law and other aspects of public law, and will contribute to their future development. But there has been a fundamental change. Courts no longer have to claim space and push boundaries to find means of controlling public power. That control is vested in them under the Constitution, which defines the role of the courts, their powers in relation to other arms of government and the constraints subject to which public power has to be exercised. Whereas previously constitutional law formed part of and was developed consistently with the common law, the roles have been reversed. The written Constitution articulates and gives effect to the governing principles of constitutional law.” (*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))

etc⁷³. They can now look into the merits of the case to a much greater extent. For instance the courts can look at the rationality of the exercise of a public power. It has been held that administrative action must be justifiable in relation to the reasons given for it and that value judgements have to be made by the courts to assess whether administrative action is justifiable in relation to those reasons. This inevitably involves consideration of the merits in some way or another⁷⁴.

Three aspects of the right to administrative justice are identified in section 33(1) – lawfulness, procedural fairness and reasonableness. These three elements are designed to ensure accountability, responsiveness and transparency in government. In *Kolbatschenko v King NO and Another*⁷⁵ the court held that as the requirement of accountable, responsive and transparent government was one of the founding values of constitutional democracy, it was only in highly exceptional cases that a court would adopt a hands-off approach where a discretion has been exercised or an executive or administrative decision made which directly affected the rights or interests of an individual applicant.

3.6.1 Lawfulness

⁷³ In *Van der Merwe v Slabbert No and Others* 1998(3) SA 613 (N), the court observed that the rules of natural justice described as the *audi* principles, came into play whenever a statute empowers a public official or body to perform an act or give a decision prejudicially affecting an individual in his liberty or property or existing rights or whenever such an individual had a legitimate expectation entitling him to a hearing. However, said the court, the *audi* principles were but one facet of the general requirement of natural justice that in the circumstances postulated that the public official or body concerned had to act fairly. In *Commissioner of Customs and Excise v Contained Logistics (Pty) Ltd* 1999 (3) SA 771 (SCA) the court observed that judicial review under the Constitution and the common law are different concepts. In the field of administrative law constitutional review is concerned with the constitutional legality of administrative action, the question in each case being whether or not it is consistent with the Constitution and the only criterion being that Constitution itself. While judicial review under the common law is essentially also concerned with the legality of administrative action, the question in each case is whether the action under consideration is in accordance with the behests of the empowering statute and the requirements of natural justice. The court noted that grounds for common law review developed over the years can never be regarded as a *numerus clausus* for the simple reason that administrative law is not static, particularly given the requirement of s35 (3) of the interim Constitution that any law be interpreted and that the common law be applied with due regard to the spirit, purport and objects of the Bill of Rights. It should be observed in this context that Chaskalson P rejected the idea that there were two separate systems of law saying that “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.” (*Pharmaceutical Manufacturers Association of SA and Another: In Re Ex Parte President of the Republic Of South Africa and Others* (fn 72 *supra*) para 44). It is submitted that with the further advent of the PAJA, any distinctions purists might wish between constitutional law and the common law as far as administrative law principles are concerned will become even more blurred. Chaskalson P’s assertion that there is only one system of law is reinforced by this Act. Section 6 of the Act provides for judicial review of administrative action on various grounds that are there listed including *ultra vires*, procedural unfairness, error of law, bad faith, bias etc.

⁷⁴ *Pharmaceutical Manufacturers of SA and Another: In Re Ex Parte President of the Republic of South Africa and Others* fn 72 *supra*

⁷⁵ *Kolbatschenko* 2001 (4) SA 336 (C) at 355I - 356D

The constitutional court in *Fedsure Life Assurance v Greater Johannesburg Transitional Metropolitan Council*⁷⁶ held that in relation to legislation and to executive acts that do not constitute 'administrative action', the principle of legality is necessarily implicit in the Constitution and that therefore the question whether local governments act *intra vires* in imposing rates and levies and paying subsidies remains a constitutional question. It held that it was fundamental to the principle of rule of law that local authorities act within the powers lawfully conferred upon them⁷⁷. In *De Lille and Another v Speaker of the National Assembly*⁷⁸ the court held that the rule of law did not countenance the administrative issue of a certificate to shield illegal and unconstitutional acts from judicial review. In *Minister of Correctional Services and Others v Kwakwa and Another*⁷⁹ the Appellate Division pointed out that the doctrine of legality, an incident of the rule of law, was an implied provision of the Constitution and that it was central to the conception of South African constitutional order that the Legislature and the Executive in every sphere was constrained by the principle that they could exercise no power and fulfil no function beyond that conferred upon them by law. In the same manner, said the court, the Commissioner of Correctional Services, in exercising public power, had to comply with the Constitution and had to act within the parameters of his statutory powers. In that case the court found that it was clear that the Commissioner had fundamentally misconceived his powers in terms of the Act and that in implementing the new system he had acted beyond his powers. He had disregarded the provisions of the Constitution and had fashioned a privilege system, in terms of which privileges were granted on a differential basis to prisoners in specified categories, that was inconsistent with its core values and not countenanced by the statutory regime from which he assumed his powers. For that reason the privilege system designed by him could not be allowed to stand.

Devenish *et al* point out that an administrative act has a specific and recognisable form. They note by way of example that a licence or permit has a stipulated form and

⁷⁶ *Fedsure* fn 13 *supra*

⁷⁷ See also *Pharmaceutical Manufacturers Association of SA and Another: In Re Ex Parte President of the Republic of South Africa and Others* (fn 72 *supra*) where the constitutional court held that the Court had previously held that the doctrine of legality, an incident of the rule of law, had been an implied provision of the Constitution of the Republic of South Africa Act 200 of 1993 (the interim Constitution) and that that decision was applicable to the exercise of a public power under the 1996 Constitution which, in s 1(c), specifically declared that the rule of law was one of the foundational values of the Constitution.

⁷⁸ *De Lille* 1998 (3) SA 430 (C)

⁷⁹ *Kwakwa* 2002 (4) SA 455 (SCA)

a letter by the licensing authority in question purporting to constitute a licence or permit will not constitute a valid certificate or permit because it does not comply with the stipulated form. The boundaries and requirements of an administrative act or decision are usually set out in the relevant statutes, regulations and proclamations⁸⁰. Administrative action which exceeds the limitations imposed by the empowering legislation or which does not meet the criteria set by that legislation is *ultra vires* and therefore unlawful⁸¹.

At common law, lawfulness is determined on the basis of public policy. As such it is fundamental not only to administrative law and administrative justice as contemplated in section 33 of the Constitution but also to the law of contract and of delict. The link between public policy and the values expressed in the Constitution was elucidated by the court in *Ryland v Edros*⁸². In this case the court held that if the spirit, purport and objects of Chapter 3 of the Constitution and the basic values underlying it were in conflict with the view as to public policy expressed and applied in the Ismail case then the values underlying chapter 3 had to prevail. The court said that the values of equality and tolerance of diversity and recognition of the plurality of South African society were among the values that underlie the Constitution and that those values “irradiate” the concepts of public policy and boni mores that the courts had to apply. The court held that courts should only brand a contract as offensive to public policy if it was offensive to those values which were shared by the community at large and not only by one section of it. In *Du Plessis and Others v De Klerk and Another*⁸³ Kriegler J stated that:

⁸⁰ Thus in *National Police Service Union and Others v Minister of Safety and Security* 2000 (3) SA 371 (SCA) the court held that the character of the scheme had not been of the kind which would normally call for promulgation: it had not amounted to a ‘by-law, regulation, rule or order’ within the purview of s 16 of the Interpretation Act and the proclamation itself had provided for the form of notification the administrative decision underlying the directive was to take, namely that members who might be affected thereby were to be informed, which had been done.

⁸¹ See for example *Munimed v Premier, Gauteng, an Andere* 1999 (4) SA 351 (T) in which the court said that that inasmuch as no other enabling provision existed in terms of which the Administrator was authorised to establish a medical aid fund (i.e. apart from s 79bis(1)) the result of the Administrator’s *ultra vires* act was that the applicant was not a juristic person at all. By establishing a medical aid scheme contrary to the provisions of s 79bis(1) the Administrator had acted beyond the scope of his powers, as a result of which the act of incorporation was a nullity. The fact that the applicant had been registered in terms of the Medical Schemes Act did not legitimise the *ultra vires* act (from headnote). See also *Pharmaceutical Manufacturers Association of SA and Another: In Re Ex Parte President of the Republic of South Africa and Others* (fn 72 *supra*) in which the constitutional court held that the exercise of all public power had to comply with the Constitution, which was the supreme law, and with the doctrine of legality, which was part of that law. The question whether the President had acted *ultra vires* or *intra vires* in bringing the 1998 Act into force when he had done so was, accordingly, a constitutional matter and the finding that he had acted *ultra vires* was a finding that he had acted in a manner inconsistent with the Constitution.

⁸² *Ryland* 1997 (2) SA 690 (C)

⁸³ *Du Plessis* 1996 (3) SA 850 (CC) at p 906 Mahomed JP stated in the majority judgment that: “ The common law is not to be trapped within the limitations of its past. It need not to be interpreted in conditions of social and constitutional ossification. It needs to be revisited and revitalised with the spirit of the constitutional values defined in chapter 3 of the

“What I am contending is that the law can deal effectively with these challenges through the very process envisaged by s 35(3), namely the indirect radiating effect of the chapter 3 rights on the post-constitutional development in the common law and statute law of concepts such as public policy, the boni mores, unlawfulness, reasonableness, fairness and the like, without any of the unsatisfactory consequences that direct application must inevitably cause. The common law of this country has, in the past, proved to be flexible and adaptable, and I am confident that it can also meet this new constitutional mandate.”

Mahomed JP referred with approval to the German legal system in which, he noted, the jurisprudence of the Federal Constitutional Court is consistently to the effect that the basic right norms contain not only defensive subjective rights for the individual but embody at the same time an objective value system which, as a fundamental constitutional value for all areas of the law, acts as a guiding principle and stimulus for the legislature, executive and judiciary⁸⁴.

This is reminiscent of the observations of Thirion J in *Edouard v Administrator, Natal*⁸⁵ which predated the Constitution.

Constitution and with full regard to the purport and objects of that chapter.” See also *Brisley v Drotosky* 2002 (4) SA 1 (SCA) in which Cameron AJ points out at para 91 p35 that: “The jurisprudence of this Court has already established that, in addition to the fraud exception, there may be circumstances in which an agreement, unobjectionable in itself, will not be enforced because the object it seeks to achieve is contrary to public policy. Public policy in any event nullifies agreements offensive in themselves - a doctrine of very considerable antiquity. In its modern guise, ‘public policy’ is now rooted in our Constitution and the fundamental values it enshrines. These include human dignity, the achievement of equality and the advancement of human rights and freedoms, non-racialism and non-sexism.” (footnotes omitted)

⁸⁴ See also p 902 of *Du Plessis* fn 83 *supra* where Mahomed JP observed: “There are some features, however, which bear on the construction of our own Constitution. The Federal Constitutional Court refers to the radiating effect (*Ausstrahlungswirkung*) of the basic rights on private law. In the Lüth case the Federal Constitutional Court held as follows: “The influence of the scale of values of the basic rights affects particularly those provisions of private law that contain mandatory rules of law and thus form part of the *ordre public* - in the broad sense of the term - that is, rules which for reasons of the general welfare also are binding on private legal relationships and are removed from the domination of private intent. Because of their purpose these provisions are closely related to the public law they supplement. Consequently, they are substantially exposed to the influence of constitutional law. In bringing this influence to bear, the courts may invoke the general clauses which, like article 826 of the Civil Code, refer to standards outside private law. “Good morals” is one such standard. In order to determine what is required by social norms such as these, one has to consider first the ensemble of value concepts that a nation has developed at a certain point in its intellectual history and laid down in its constitution. That is why the general clauses have rightly been called the points where basic rights have breached the (domain of) private law. . . .”

⁸⁵ *Edouard* 1989 (2) SA 368 (D). Thirion J stated, despite the fact that the Constitution had not yet been written at that time, that “Certain moral values and policy considerations have become generally accepted in the community and some of these have in their turn hardened into rules of law. By reasoning from settled principles in related fields and by striking a balance between competing consideration the Court tries to arrive at a result which will be fair to the individual and the community. In the process the Court must consider what interests legitimately require to be protected for the sake of the collective welfare and it must evaluate the probable consequences of adopting a public policy rule. The Court will only apply community attitudes and values in deciding cases if such attitudes and values have gained general acceptance in the community and are clear and if their application is necessary in the interests of sound social policy and the welfare of the community.”

There is no better evidence of the general acceptance of a value by a community than its enshrinement within its Constitution.

Clearly public policy and Constitutional values are inextricably intertwined. A court will not be able to justify a decision in which public policy as it perceives it, runs counter to constitutional values. Contracts that are contrary to public policy are unenforceable and unlawful⁸⁶. Similarly, it is submitted that administrative action that is contrary to public policy and therefore the underlying constitutional values is unlawful and subject to challenge in terms of section 33 of the Constitution and the PAJA. Lawfulness, in the context of section 33 of the Constitution, means more than just *intra vires*. The concept of lawfulness is based in South African law on constitutional values and considerations of public policy throughout the legal system⁸⁷. It is only the context that varies.

In terms of the law of delict, unlawfulness is also determined with reference to public policy and therefore to the underlying values of the Constitution. In *Mpongwana v Minister of Safety and Security* the court held that the test for whether an omission could be viewed as wrongful related to the existence or otherwise of a duty of care

⁸⁶ For instance in *Sasfin v Beukes* 1989 (1) SA 1 (A) the court held that agreements which are clearly inimical to the interests of the community, whether they are contrary to law or morality, or run counter to social or economic expedience will accordingly on grounds of public policy not be enforced. The court held that a further relevant and important consideration is that public policy should properly take into account the doing of 'simple justice between man and man'. It is submitted that the distinction between natural justice in the public law context and 'simple justice between man and man' in the private law context is merely contextual. The principle of the balancing of competing or conflicting interests is the same in both contexts. See the reference by Cameron J at p611-612 in *Holomisa v Argus Newspapers Ltd* 1996 (2) SA 588 (W) to balancing of fundamental rights as follows: "It is not clear, where a balance has to be struck between two fundamental values, why it should be done at a point which is so generous in its protection of the one and so meagre in its protection of the other." In *Holomisa*, the court states that: "The Constitution's structures and its values necessarily inform every aspect of legal reasoning and decision-making." In the same case Cameron J observes that: "A central consideration in South Africa is that the Constitution plants new values at the roots of our legal system. These include, as stated earlier, the values of equality, democracy, governmental openness and accountability."

⁸⁷ Traverso J acknowledges this in *Coetzee v Comitis And Others* 2001 (1) SA 1254 (C), stating: "We have moved from a very dark past into a democracy where the Constitution is the supreme law, and public policy should be considered against the background of the Constitution and the Bill of Rights." In *S v Lawrence; S v Negal; S v Solberg* 1997 (4) SA 1176 (CC), the constitutional court notes at para 33 that "Arbitrariness is inconsistent with 'values which underlie an open and democratic society based on freedom and equality', and arbitrary restrictions would not pass constitutional scrutiny." The fact that constitutional values underlie the entire legal system should not diminish the importance of context at a less abstract level. The court in *S v Lawrence supra* explained the need for context in the balancing of rights and values that: "The reason why context is so important in constitutional matters is well explained by Wilson J in *Edmonton Journal v Alberta AG*: '. . . (A) particular right or freedom may have a different value depending on the context. It may be, for example, that freedom of expression has greater value in a political context than it does in the context of disclosure of the details of a matrimonial dispute. The contextual approach attempts to bring into sharp relief the aspect of the right or freedom which is truly at stake in the case as well as the relevant aspects of any values in competition with it. It seems to be more sensitive to the reality of the dilemma posed by the particular facts and therefore more conducive to finding a fair and just compromise between the two competing values. . . .' It stated that "In deciding what is reasonable and necessary in the present case we should accordingly look to the actual dilemma triggered by its particular facts, and not deal with it in a formulaic way simply because s 14 has been infringed." (footnotes omitted). The golden thread of public policy and constitutional values operates at a broadly systemic level throughout South African law. This does not exclude the case- by-case approach. One should not make the mistake of adopting a 'one-size-fits-all' reasoning because that in itself would be unconstitutional.

owed to the claimant being part of the enquiry into lawfulness. In deciding whether a duty of care existed, the court said that, public policy played a role⁸⁸. In *Motor Industry Fund Administrators (Pty) Ltd and Another v Janit and Another*⁸⁹ the court held that not all invasions of privacy or publications of private facts are unlawful. It said that in demarcating the boundary between the lawfulness and unlawfulness of the intrusion or publication the court must have regard to the particular facts of the case and judge them in the light of contemporary *boni mores* or the genuine sense of justice of the community⁹⁰. Lawfulness is clearly a reflection of public policy and the latter in turn is underpinned and irradiated by the values of the Constitution. As such whether the concept occurs in administrative, delictual or contractual law, it is fundamentally that same golden thread that unifies them.

3.6.2 Reasonableness

An aspect of reasonableness is rationality. In *Durbsinvest (Pty) Ltd v Town and Regional Planning Commission, Kwazulu-Natal, and Others*⁹¹ the court observed that the principles of administrative law (as contemplated by the right to administrative justice entrenched in s 33 of the Constitution of the Republic of South Africa Act 108 of 1996 which are to be derived from the decision of the Constitutional Court in *Pharmaceutical Manufacturers Association of SA and Another: In re Ex parte President of the Republic of South Africa and Others*⁹²) are:

- (1) The review of an administrative decision of an organ of the Executive gives rise to a constitutional enquiry.

⁸⁸ *Mpongwana* 1999 (2) SA 794 (C). See also *Aucamp and Others v University of Stellenbosch* 2002 (4) SA 544 (C) in which Van Zyl J observed that: "It is trite that in order to succeed in a delictual claim for pure economic loss the plaintiff has to show, *inter alia*, that the conduct causing pure economic loss was wrongful in the sense that it infringed upon a subjective right of the plaintiff or breached a legal duty owed to the plaintiff. The legal duty as such must be directed at preventing reasonably foreseeable damage being caused to the plaintiff. In considering whether or not the conduct in question is wrongful the Court is required to make a value judgment. In doing so it must weigh up the interests of the parties and of the community at large against the background of the relevant facts and circumstances. In addition, it must strive, impartially and objectively, to apply the values of justice, fairness and reasonableness, while taking into account considerations of good faith (*bona fides*) and good morals (*boni mores*), otherwise known as public policy reflecting the legal convictions of the community." There is a detailed discussion of the concept of lawfulness in *Minister of Law and Order v Kadir* 1995 (1) SA 303 (A)

⁸⁹ *Motor Industry Fund Administrators* 1994(3) SA 56 (W)

⁹⁰ The court referred to *Financial Mail (Pty) Ltd and Others v Sage Holdings Ltd and Another* 1993 (2) SA 451 (A) at 462.

⁹¹ *Durbsinvest* 2001 (4) SA 103 (N)

⁹² *Pharmaceutical Manufacturers Association of SA* (fn 72 *supra*)



- (2) In any such enquiry the first question to be asked is whether the decision complained of is, objectively speaking, rationally related to the purpose for which the power was given.
- (3) If it was, and the decision was arrived at *bona fide* and within the authority and jurisdiction of the body whose decision is being enquired into, the Court cannot interfere with the decision merely because it disagrees with it⁹³.

In *Mafongosi And Others v United Democratic Movement And Others*⁹⁴ the court held that an administrative decision could be justified only by the reasons underpinning it. It was those reasons which showed whether decision was rational or not. If it was not, the decision could not be allowed to stand and had to be set aside even if the decision was reached in a manner that was *bona fides*. It said that administrative decisions had to be rationally related to the purpose for which the power was given, otherwise they would in effect be arbitrary and that the question of whether a decision was rationally related to the purpose for which the power was given called for an objective enquiry. Were this not so, a decision that, viewed objectively, was in fact irrational, may pass muster simply because the person who took it mistakenly and in good faith believed it to be rational. Such a conclusion would place form above substance and undermine the important constitutional principle.

Justifiability is an important criteria in establishing both the lawfulness and reasonableness of a decision. In *Roman v Williams NO*⁹⁵ the court held that justifiability as specified is to be objectively tested. It stated that the scope of this constitutional test is clearly much wider than that of the common-law test and it overrides the common-law review grounds as set out in *Johannesburg Stock Exchange v Witwatersrand Nigel Ltd*⁹⁶. The court held in *Roman* that administrative action, in order to prove justifiable in relation to the reasons given for it, must be objectively tested against the three requirements of suitability, necessity and proportionality which requirements involved a test of reasonableness. It said that gross unreasonableness is no longer a requirement for review. The constitutional test embodies the requirement of proportionality between the means and the end. The role

⁹³ *Durbsinvest* fn 91 *supra* at p 107F/G – H/I

⁹⁴ *Mafongosi* 2002 (5) SA 567 (TKH)

⁹⁵ *Roman* 1998 (1) SA 270 (C)

⁹⁶ *Johannesburg Stock Exchange* 1988 (3) SA 132 (A).

of the Courts in judicial reviews is no longer confined to the way in which an administrative decision was reached but extends to its substance and merits as well⁹⁷.

The concept of reasonableness permeates South African law. It is not unique or specific to administrative or constitutional law⁹⁸. The court in *S v Manamela and Another (Director-General of Justice Intervening)*⁹⁹ pointed out that:

“Reasonableness’ is a legal commonplace in the courts which are required to apply it daily in determining the standard of care exacted of persons in ordinary life.”

In *Holomisa v Argus Newspapers Ltd*¹⁰⁰ the court observed that:

“The reasonableness standard offers a powerful tool for resolving the difficulties inherent in protecting reputation while at the same time giving recognition to the role the Constitution accords free speech and expression. It will not be reasonable to publish most untrue statements of fact. Only due inquiry and the application of reasonable care will mark such conduct out for protection. A further valuable feature of the reasonableness standard is that, as

⁹⁷ *Roman* fn 95 *supra* at p 284F/G - 285A.

⁹⁸ In *Mafongosi and Others v United Democratic Movement and Others* fn 94 *supra* the court pointed out at p 576 that: “The reasonableness required for administrative actions taken by such functionaries is the same as the reasonableness required for decisions by organs of State. In other words there is a single set of standards for administrative justice.” In *De Beer NO v North-Central Local Council and South-Central Local Council and Others (Umhlatuzana Civic Association Intervening)* 2002 (1) SA 429 (CC) the court noted: “It is undesirable if not impossible to try to determine the requirements of reasonableness in the abstract. The reasonableness of notice provisions in any law must in the case of each provision be assessed on its own merits.” In *South African Commercial Catering and Allied Workers Union And Others v Irvin & Johnson Ltd (Seafoods Division Fish Processing)* 2000 (3) SA 705 (CC), a case involving allegations of bias on the part of labour appeal court judges, the constitutional court observed that: “The legal standard of reasonableness is that expected of a person in the circumstances of the individual whose conduct is being judged.” With regard to the test of reasonableness in the limitation of rights Sachs J noted in *Coetsee v Government Of The Republic Of South Africa; Matiso And Others v Commanding Officer, Port Elizabeth Prison, And Others* 1995 (4) SA 631 (CC) that: “The requirement that limitation be reasonable presupposes more than the existence of a rational connection between the purpose to be served and the invasion of the right. Thus a limitation logically connected to its objective could be unreasonable if it undermined a long-established and now entrenched right; imposed a penalty that was arbitrary, unfair or irrational; or, as in this case, used means that were unreasonable.” Referring to the judgement of Chaskalson P in *Makwanyane* where the latter stated *inter alia* that “The fact that different rights have different implications for democracy and, in the case of our Constitution, for ‘an open and democratic society based on freedom and equality’, means that there is no absolute standard which can be laid down for determining reasonableness and necessity. Principles can be established, but the application of those principles to particular circumstances can only be done on a case-by-case basis. This is inherent in the requirement of proportionality, which calls for the balancing of different interests” Sachs J added at p 655-656: “If I might put a personal gloss on these words, the actual manner in which they were applied in *Makwanyane* (the Capital Punishment case) shows that the two phases are strongly interlinked in several respects: firstly, by overt proportionality with regard to means, secondly, by underlying philosophy relating to values, and, thirdly, by a general contextual sensitivity in respect of the circumstances in which the legal issues present themselves.” Sachs J stated in *Coetsee supra* that “The notion of an open and democratic society is thus not merely aspirational or decorative, it is normative, furnishing the matrix of ideals within which we work, the source from which we derive the principles and rules we apply, and the final measure we use for testing the legitimacy of impugned norms and conduct.”

In *Govender v Minister of Safety and Security* 2000 (1) SA 959 (D) the court noted that Section 49(1) of the Criminal Procedure Act is a law of general application. It said: “Subsection (1) at present deals with the use of force in general and subjects its legality to the reasonableness test of the common law. In terms of the present authoritative interpretation, this reasonableness includes both a form of proportionality as well as a subsidiarity principle. The amount and method of force used must therefore be in proportional balance to the aim that is to be achieved and must be the minimum force that would be reasonably effective and feasible in the circumstances. It furthermore includes the weighing up of the nature and seriousness of the specific crime in question, as committed, against the amount and method of force used. In my view, s 49(1) is both necessary and justifiable in an open and democratic society based upon freedom and equality.”

⁹⁹ *Manamela* 2000 (3) SA 1 (CC)

¹⁰⁰ *Holomisa* fn 86 *supra* at p 617

the plurality pointed out in *Theophanous*' case, 'Reasonableness is a concept with which the law is familiar.'"¹⁰¹

There is a strong link between lawfulness and reasonableness as evidenced by the observation of the appeal court in *National Media Ltd and Others v Bogoshi*¹⁰¹ that:

"In our law the lawfulness of a harmful act or omission is determined by the application of a general criterion of reasonableness based on considerations of fairness, morality, policy and the Court's perception of the legal convictions of the community."

The case involved a claim for defamation. It is of some significance that the court further observed in this case that proof of reasonableness will usually (if not inevitably) be proof of lack of negligence¹⁰². It is also much in evidence in the law of contract especially with regard to covenants in restraint of trade where public policy plays an important role in determining whether or not the covenant should be upheld¹⁰³. Reasonableness is one of the conceptual pillars of the law of delict. In *Vogel v Crewe and Another*¹⁰⁴ the court held that the test of reasonableness should be applied taking into account the general norms acceptable to the particular society and that the test of reasonableness is an objective one and must happen in the light of prevailing circumstances. The link between values and reasonableness is evident *inter alia*¹⁰⁵ from *Botha And Another v Mthiyane And Another*¹⁰⁶ in which Claassen J stated that

¹⁰¹ *Bogoshi* 1998 (4) SA 1196 (SCA)

¹⁰² *Bogoshi* fn 101 *supra* at p 1215

¹⁰³ In *Roffey v Catterall, Edwards & Goudré (Pty) Ltd* 1977 (4) SA 494 (N) the court said that the reasonableness or unreasonableness of the covenant must be assessed with reference to all of the circumstances, and the essential enquiry is an objective one. Leon, *Jin S.A. Wire Co. (Pty.) Ltd. v Durban Wire & Plastics (Pty.) Ltd* 1968 (2) SA 777 (D) said at p. 787G - H: "I am not... by any means certain that the South African cases have been right in adopting the English view relating to onus. If it is correct to say that the doctrine of restraint of trade is applied in our law because of public policy, then it becomes relevant to enquire what that public policy is. What I think is contrary to public policy is a contract in unreasonable restraint of trade. If such view be correct then, applying the ordinary principles of onus relating to pleadings, it would seem that the onus would lie upon the party alleging it to show that the contract in question is in unreasonable restraint of trade." See also *National Chemsearch (SA) (Pty) Ltd v Borrowman And Another* 1979 (3) SA 1092 (A)

¹⁰⁴ *Vogel* 2003 (4) SA 509 (T)

¹⁰⁵ See also *Carmichele v Minister Of Safety And Security And Another* 2003 (2) SA 656 (C) in which Chetty J held as follows at p 671-672: "Reasonableness, on which the legal convictions of the community are based, is now to be found in the Constitution and not in some vague notion of public sentiment or opinion. In *Van Duivenboden v Minister of Safety and Security* [2001] 4 B All SA 127 (C), Davis J adopted this understanding where he stated at 132d: '(I)t would appear that the requirement of wrongfulness demands of the court that it determine whether society requires that the law classify the type of conduct concerned as impermissible, that is conduct of which a society disapproves. See Van Aswegen at 192 and Neethling, Potgieter and Visser *The Law of Delict* (1999) at 39 - 41. In turn the determination of "impermissibility" shaped by a society's vision of itself is contained within its legal system. In terms of the ultimate law in this country, the Constitution, South African society predicated upon foundational values of human dignity, liberty and equality. The newly established constitutional community is to be built upon those "common values and norms" and the added principle that public authority must be transparent and accountable to the public it serves.' Consequently, in the enquiry whether the State owed the public in general, and women in particular, a duty at private law to exercise reasonable care in the prevention of violent crime, the proper application of the test requires one to attach primary significance to these constitutional imperatives. On the application of that test, Klein, Hugo and Louw owed the plaintiff a legal duty to protect her against the risk of sexual violence perpetrated by Coetzee. The negligent failure to do so was, therefore, unlawful."

¹⁰⁶ *Botha* 2002 (1) SA 289 (W)

“In applying the test of reasonableness, the court is exercising a value judgment about whether a defendant in the circumstances of any particular case should be accorded legal protection.” See also *S v Manamela And Another (Director-General of Justice Intervening)*¹⁰⁷ in which the court held that although s 36(1) differs in various respects from s 33 of the interim Constitution, its application continues to involve the weighing up of competing values on a case-by-case basis to reach an assessment founded on proportionality. Each particular infringement of a right has different implications in an open and democratic society based on dignity, equality and freedom. There can accordingly be no absolute standard for determining reasonableness. This is inherent in the requirement of proportionality, which calls for the balancing of different interests. The proportionality of a limitation must be assessed in the context of its legislative and social setting. Also in *S v Makwanyane and Another*¹⁰⁸ Chaskalson P noted that ‘The limitation of constitutional rights for a purpose that is reasonable and necessary in a democratic society involves the weighing up of competing values, and ultimately an assessment based on proportionality. This is implicit in the provisions of s 33(1) [of the interim Constitution]. The fact that different rights have different implications for democracy and, in the case of our Constitution, for “an open and democratic society based on freedom and equality”, means that there is no absolute standard which can be laid down for determining reasonableness and necessity.’”

3.6.3 Procedural Fairness

The constitutional court has observed with regard to the right to administrative justice contained in section 33 of the Constitution that it enumerates four aspects of just administrative action and that the theme of fairness must be seen as governing the manner in which the four enumerated sections must be interpreted¹⁰⁹. It is thus a

¹⁰⁷ *S v Manamela* fn 99 *supra* at p 20

¹⁰⁸ *Makwanyane* 1995 (3) SA 391 (CC)

¹⁰⁹ In the minority judgment in *Bel Porto School Governing Body and Others v Premier, Western Cape, and Another* 2002 (3) SA 265 (CC). The court commented further at p309-310 that: “The words themselves have no fixed and self-evident meaning. Unless animated by a broad concept of fairness, their interpretation can result in a reversion to what has been criticised as the sterile, symptomatic and artificial classifications which bedevilled much of administrative law until recently. Undue technicality and artificiality should be kept out of interpretation as far as possible; the quality of fairness, like the quality of justice, should not be strained. There are at least three respects in which the concept of fairness should be seen as animating s 33. The first is to provide the link between the four enumerated aspects so that they are not viewed as separate elements to be dealt with mechanically and sequentially, but, rather, as part of a coherent, principled and interconnected scheme of administrative justice. Secondly, the interpretation of each of the individual subsections within the framework of the composite whole must be informed by the need to ensure basic fairness in

pervading principle of administrative justice rather than a single aspect of it. Conradie JA notes in *Modise and Others v Steve's Spar, Blackheath*¹¹⁰ that procedural fairness is a dominant theme in both administrative and labour law. Fairness is also relevant in the law of contract¹¹¹. Unconscionable contracts or contractual terms are fundamentally unfair¹¹². Although South African law has not yet progressed to the point where consumers are guaranteed protection from unfair or unconscionable terms as is the case in other jurisdictions such as the United States of America, Sweden, Germany, Israel, the Netherlands, Denmark and England¹¹³, South African courts will not uphold unconscionable terms or support unconscionable behaviour relating to a contract on the grounds that this would be *contra bonos mores*¹¹⁴.

dealings between the administration and members of the public. Thirdly, the appropriate remedy for infringement of the rights must itself be based on notions of fairness.”

110 *Modise* 2001 (2) SA 406 (LAC) at p450

111 In *Standard Bank of SA Ltd v Essop* 1997 (4) SA 569 (D) Meskin J stated: “ In my opinion, the applicant's conduct in having purported to stipulate for these rights was, and remains, unconscionable. It has purported to empower itself, in the event of any relevant default by the respondent, to deprive him of his status as a solvent person, and inevitably to subject him to all the onerous obligations and extensive restrictions which bind an insolvent in terms of the Act, without any notice to him and without his being able in any event to defend himself. This conduct offends my, and in my opinion it would offend any reasonable person's, sense of what is procedurally fair and it offends my, and in my opinion would offend any reasonable person's, sense of justice.

In *Janse Van Rensburg v Grieve Trust* CC 2000 (1) SA 315 (C) the court stated that “[I]n applying principles of logic and fairness in the *Wastie* decision *supra* [*Wastie v Security Motors (Pty) Ltd* 1972 (2) SA 129 (C)], Van Zijl J was, in my respectful view, doing just what the said Appellate Division decisions have been advocating over a long period of time. His concept of logic should, I believe, be understood to mean the reasonableness required by public policy to achieve justice and fairness between contracting parties. Together with the fundamental principle of good faith underlying the contractual relationship between such parties, public policy indeed requires a fine balance to be established between the relative rights, duties and interests of the parties, as held by Van Zijl J in his aforesaid judgment.

112 In *First National Bank of Southern Africa Ltd v Bophuthatswana Consumer Affairs Council* 1995 (2) SA 853 (BG) the court observed that: “The word ‘unconscionable’ has been judicially defined in the category of ‘unconscionable bargain’. ‘A bargain so one-sided and inequitable in its terms as to raise a presumption of fraud and oppression.’ See *Mozley and Whiteley's Law Dictionary* 10th ed by Hardy Ivamy E R. In England the subject of unconscionable bargains is dealt with in *Halsbury's Laws of England* 4th ed vol 18 para 344 at 157, and I quote: ‘Jurisdiction to grant relief: As part of the jurisdiction to grant relief against constructive fraud, Courts of equity have acted to protect persons in cases in which it was apparent, from the intrinsic nature and subject of the bargain itself, that it was one which no man in his senses and not under delusion would make on the one hand, and no honest and fair man would accept on the other; in fact, an inequitable and unconscionable bargain.’ It also noted that “The ordinary grammatical meaning of ‘unconscionable’ is ‘Having no conscience, unscrupulous, monstrously extortionate, harsh’, etc. See *The Shorter Oxford Dictionary* (*supra* vol II at 2405).”

113 See Discussion Paper of the South African Law Commission entitled ‘Unreasonable Stipulations in Contracts and the Rectification of Contracts’ (Project 47)

114 In *Mackay v Legal Aid Board* 2003 (1) SA 271 (SE) the court said: “But taxation does not override an enforceable contract between the parties, unless the agreed fee is so unreasonable as to be unconscionable and hence *contra bonos mores* (in which event the contract is not enforceable).” The Supreme Court of Appeal in *Eerste Nasionale Bank Van Suidelike Afrika Bpk v Saayman No* 1997 (4) SA 302 (SCA) noted that: “Die tendens word voortgesit in 1925 in *Weinerlein v Goch Buildings Ltd* 1925 AD 282 waar rektifikasie van ‘n kontrak op die bona fide-beginsel gebaseer word. Wessels AR verklaar op 292: The commentators put it thus: “As a general proposition your claim may be supported by a strict interpretation of the law, but it cannot be supported in this particular case against your particular adversary, because to do so would be inequitable and unjust, for it would allow you, under the cloak of the law, to put forward a fraudulent claim . . . It is therefore clear that under the civil law the Courts refused to allow a person to make an unconscionable claim even though his claim might be supported by a strict reading of the law. This inherent equitable jurisdiction of the Roman Courts (and of our Courts) to refuse to allow a particular plaintiff to enforce an unconscionable claim against a particular defendant where under the special circumstances it would be inequitable, dates back to remote antiquity and is embodied in the maxim ‘summum jus ab aequitate dissidens jus non est’.”

Davis J in an *obiter dictum* in *Mort NO v Henry Shields-Chiat* 2001 (1) SA 464 (C) op 474J-475F declared: “Like the concept of *boni mores* in our law of delict, the concept of good faith is shaped by the legal convictions of the community. While Roman-Dutch law may well supply the conceptual apparatus for our law, the content with which concepts are filled depends on an examination of the legal conviction of the community - a far more difficult task. This task requires that careful account be taken of the existence of our constitutional community, based as it is upon principles of freedom, equality and dignity. The principle of freedom does, to an extent, support the view that the contractual autonomy of the parties should be respected and that failure to recognise such autonomy could cause

The principles of procedural fairness are equally applicable to decisions of organs of state and other functionaries. In *Mafongosi and Others v United Democratic Movement and Others*¹¹⁵ the court stated that there were no separate principles applicable to the exercise of power by functionaries other than organs of State where the rights entrenched in s 33 of the Constitution were involved. It held that the reasonableness required for administrative actions taken by such functionaries was the same as the reasonableness required for decisions by organs of state and that there was a single set of standards for administrative justice. It also held that the requirement for procedural fairness was directed at the manner in which the administrative decision was concluded. This requirement, said the court, placed a duty upon the person taking the administrative decision to act fairly. The principles of natural justice formed the core content of procedural fairness¹¹⁶. The court found that what was required by procedural fairness differed from one case to the other and that it was the circumstances of the particular case which gave an indication of the procedural steps required for a proper decision¹¹⁷.

contractual litigation to mushroom and the expectations of contractual parties to be frustrated. See Glover G B [“Good faith and procedural unfairness in contract”] (1998) 61 *THRHR* 328 at p 334. But the principles of equality and dignity direct attention in another direction. Parties to a contract must adhere to a minimum threshold of mutual respect in which the “unreasonable and one-sided promotion of one’s own interest at the expense of the other infringes the principle of good faith to such a degree as to outweigh the public interest in the sanctity of contracts” Zimmermann (*supra* at 259 - 60). The task is not to disguise equity or principle but to develop contractual principles in the image of the Constitution. For an instructive insight into this approach, see van der Merwe D [“The Roman-Dutch law: from virtual reality to constitutional resource”] 1998 *TSAR* 1. In short, the constitutional state which was introduced in 1994 mandates that all law should be congruent with the fundamental values of the Constitution. Oppressive, unreasonable or unconscionable contracts can fall foul of the values of the Constitution. In accordance with its constitutional mandate the courts of our constitutional community can employ the concept of *boni mores* to infuse our law of contract with this concept of *bona fides*. See in this regard *Janse van Rensburg v Grieve Trust* CC 2000 (1) SA 315 (C) at 325 - 6.” Quoted with approval in *Brisley v Drotzky* 2002 (4) SA 1 (SCA). The court in this case also notes that: “Ook Hutchison lewer ’n sterk pleidooi dat die *bona fides*, geskraag deur die Grondwet, groter erkenning in ons kontraktereg verdien. In ’n hoofstuk getiteld ‘Good faith in the South African Law of Contract’ in Roger Brownsword, Norma J Hird and Geraint Howells *Good Faith in Contract: Concept and Context* (1999) 213 op 230 - 1 skryf hy: ‘What emerges quite clearly from recent academic writings, and from some of the leading cases, is that good faith may be regarded as an ethical value or controlling principle, based on community standards of decency and fairness, that underlies and informs the substantive law of contract. It finds expression in various technical rules and doctrines, defines their form, content and field of application and provides them with a moral and theoretical foundation. Good faith thus has a creative, a controlling and a legitimating or explanatory function. It is not, however, the only value or principle that underlies the law of contract nor perhaps, even the most important one. In the words of Lubbe and Murray: “It does not dominate contract law but operates in conjunction (and competition) with notions of individual autonomy and responsibility, the protection of reasonable reliance in commerce, and views of economic efficiency in determining the contours of contract doctrine. However, it will ensure just results only if Judges are alert to their task of testing existing doctrines and the operation of particular transactions against the constantly changing mix of values and policies of which *bona fides* is an expression.” On this view of things, which seems to be correct, the influence of good faith in the law of contract is merely of an indirect nature, in that the concept is usually if not always mediated by some other, more technical doctrinal device. Thus, for example, while good faith does not empower a court directly to supplement the terms of a contract, or to limit their operation, it might in appropriate cases enable the court to achieve these same results indirectly, through the use of devices such as implied terms and the public policy rule.”

115

Mafongosi fn 94 *supra*

116

Mafongosi fn 94 *supra* paragraph [17] at 576A/B - B/C

117

Mafongosi fn 94 *supra* paragraph [18] at 576G.

In *Du Preez and Another v Truth and Reconciliation Commission*¹¹⁸ the court observed that it was vital to consider the context of the inquiry and the fact that it is not a civil or criminal trial, or inquest, or other judicial proceeding, but a statutory inquiry. The claim to procedural fairness had to be considered in that context. It noted that in *Administrator, Transvaal v Traub*¹¹⁹, Corbett CJ - following *Ridge v Baldwin*¹²⁰ and subsequent decisions - held that the duty to act fairly 'is simply another, and preferable, way of saying that the decision-maker must observe the principles of natural justice'.

The requirement of procedural fairness does not imply the need in every case for interested parties to be heard before a decision is taken. In *Permanent Secretary, Department of Education and Welfare, Eastern Cape, and Another v Ed-U-College (PE) (Section 21) Inc*¹²¹ the court noted as to the nature of the requirements of procedural fairness and reasonableness that would arise in relation to the exercise of the particular power concerned, that a right of hearing would not accrue to all affected persons simply because a decision reducing the annual subsidy was to be taken. It said that schools and parents could not assume, in the absence of any undertaking by the Department of Education, that subsidies would always continue to be paid at the rate previously established or that they should be afforded a hearing should subsidies have to be reduced because the legislature had reduced the amount allocated for distribution.

With regard to the *audi alteram partem* rule, an element of procedural fairness, the court of appeal in *Nortje en 'n Ander v Minister van Korrektiewe Dienste en Andere*¹²² observed that despite the changing constitutional dispensation brought about by the Constitution, the principles of the common law still afford guidance as to what will be procedurally fair in a specific case. It said that according to the common-law principles in this regard the *audi alteram partem* rule is applicable where an administrative decision can prejudice a person to such extent that, in accordance with that person's legitimate expectation, the decision ought not to be taken unless he is

118 *Du Preez* 1997 (3) SA 204 (A)

119 *Traub* fn 11 *supra*

120 *Ridge* [1964] AC 40

121 *Ed-U College* 2001 (2) SA 1 (CC)

122 *Nortje* 2001 (3) SA 472 (SCA)

heard¹²³. The court held that there is no universally applicable set of requirements for compliance with the *audi alteram partem* rule and that because of the innumerable situations in which it may be applied, the rule is so flexible and adaptable that the requirements for compliance therewith cannot be separated from the context in which it is applied. The touchstone to be utilised in determining whether the rule was complied with in a specific case is intimately connected with the fundamental principle of the rule. The court found that the *audi alteram partem* principle is but one facet, albeit an important one, of the general requirement of natural justice that in the circumstances the public official or body concerned must act fairly. It noted that the duty to act fairly is concerned only with the manner in which the decisions are taken and does not relate to whether the decision itself is fair or not.

Accordingly, said the court, the question to be asked in every case in which the *audi alteram partem* rule is applicable is whether the person who is adversely affected by the decision had a just and fair opportunity to state his or her case. A closer definition of the requirements is neither feasible nor desirable, for the very reason that it would restrict the flexible application of the rule. It held that as a starting point for determining what constitutes a fair opportunity of being heard, the following guideline may be observed: Fairness will often require that a person who may be adversely affected by a decision should have an opportunity of making representations on his own behalf either before the decision is taken, with a view to producing a favourable result, or after it is taken, with a view to procuring its modification, or both. Since the person affected usually cannot make worthwhile representations without knowing what factors may weigh against his interests, fairness will often require that he is informed of the main points of the case which he has to answer.

The court said that depending on the circumstances, the *audi alteram partem* rule can also be complied with by allowing the affected person an opportunity of being heard after the decision has already been taken. It cautioned, however, that this should be the exception rather than the rule because a person who is heard only after a decision has been made is in a considerably weaker position than one who is given a hearing

¹²³ *Nortje* fn 122 *supra*, paragraph [14] at 479C - F

before the decision is taken. Therefore, as a rule, a hearing after the decision will suffice only if an earlier hearing was not possible.¹²⁴

Retroactive administrative decisions are particularly problematic because they tend to be subversive of the requirement of procedural fairness. In *Premier, Mpumalanga, and Another v Executive Committee, Association of State-Aided Schools, Eastern Transvaal*¹²⁵ the constitutional court held that though the courts should not as a rule impose obligations upon government that would inhibit its ability to make and implement policy effectively, the principle of procedural fairness was flouted where retroactive decisions were implemented without affording parties an effective opportunity to make representations.

3.7 Public Power and Judicial Review

Section 239 of the Constitution defines ‘organ of state’ as-

- (a) any department of state or administration in the national, provincial or local sphere of government; or
- (b) any other functionary or institution-
 - (i) exercising a power or performing a function in terms of the Constitution or a provincial constitution; or
 - (ii) exercising a public power or performing a public function in terms of any legislation.’

The term ‘public power’ is central to the concept of administrative law as indicated by the definition of “administrative action” in the PAJA. Administrative law involves the control of the exercise of public power. The nature of public power is not always easy to define. However it is clear that the exercise of public power is subject to judicial review.

In *Korf*¹²⁶ the court provided the following useful summary of jurisprudence concerning organs of state:

¹²⁴ *Nortje* fn 122 *supra*, paragraph [19] at 480G - I.

¹²⁵ *Executive Committee, Association of State-Aided Schools* 1999 (2) SA 91 (CC)

¹²⁶ *Korf v Health Professions Council of South Africa* 2000 (1) SA 1171 (T)

“It must further be noted that the ‘statutory body or functionary’ which previously could have been a component of an organ of State has now been given a much more precise content. In *Directory Advertising Cost Cutters v Minister for Posts, Telecommunications and Broadcasting and Others* 1996 (3) SA 800 (T) it was pointed out that an organ of state is not an agent of the State, it is part of government (at any of its levels). Section 233(1) of the interim Constitution included in the term ‘organ of state’ a statutory body or functionary. In that case I applied a narrower definition of the concept organ of state than that applied in *Baloro and Others v University of Bophuthatswana and Others* 1995 (4) SA 197 (B). The test laid down was whether the State had control. This approach was followed in *Mistry v Interim National Medical and Dental Council of South Africa and Others* 1997 (7) BCLR 933 (D) at 947B - 948C and *Wittmann v Deutscher Schulverein, Pretoria and Others* 1998 (4) SA 423 (T) at 454B in respect of the interim Constitution. *Directory Advertising Costs Cutters (supra)* was also followed in respect of the new Constitution in *ABBM Printing and Publishing (Pty) Ltd v Transnet Ltd* 1998 (2) SA 109 (W) at 113A - G and *Goodman Brothers (Pty) Ltd v Transnet Ltd* 1998 (4) SA 989 (W). In all these cases therefore the test applied in order to determine whether a body or functionary is an organ of state is whether that body or functionary is directly or indirectly controlled by the state.”

The court then considered whether the control test still applied to the meaning of the phrase “organ of state”. It also considered whether the difference in wording between the interim Constitution and the final Constitution constituted a material difference and came to the conclusion that it did not. It asked whether the description set out in subparagraph (b) had extended the meaning of organ of state. Subparagraph (i) limits it to a power or function in terms of the national and provincial constitutions and decided that “this does not bring about a difference”, noting that subsection (ii) limits it to a public power or public function in terms of any legislation but that it does not bring about a difference insofar as the reference to public power is concerned. It observed that the remaining question then is whether the reference to a public function in terms of legislation takes the concept ‘organ of state’ out of the control test and that the answer to this question depended on the meaning given to the words ‘public function’. The court came to the conclusion that the control test still applied to the definition of ‘organ of state’ even under the final Constitution, noting that the more precise definition of ‘organ of state’ in section 239 of the final Constitution was not intended to differ materially from the definition in the 1993 Constitution.

With regard to the definition of “public function”, the court observed¹²⁷ that:

“The three pillars of the state, legislative, executive and judicial, are referred to in s 239. The latter is expressly excluded. The executive arm is expressly mentioned in subpara (a) and the legislative one falls under subpara (b)(i) which can also encompass, for example, the auditor-general, public protector, etc. They are all part of the machinery of state. So is a functionary

¹²⁷

Korff fn 126 *supra* at p1177

(or institution) exercising a public power. There is no reason to give the word ‘public’ when used in conjunction with ‘function’ in para (b)(ii) a meaning that would take it outside the context of ‘engaged in the affairs or service of the public’ and give it the meaning of ‘open to or shared by all the people’. (Both these meanings are given in *The Concise Oxford Dictionary* for the word ‘public’.)”

The court in *Korf* decided on this basis that the Health Professions Council of South Africa was not an organ of state since the state did not control its activities¹²⁸.

In *Pennington v Friedgood and Others*¹²⁹ the court noted that judicial review under the Constitution and under the common law are not different concepts. Prior to the new constitutional dispensation the control of public power by the Courts by judicial review was exercised through the application of common-law constitutional principles. Under the new constitutional dispensation such control is regulated by the Constitution. 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. It is clear that whether such conduct

¹²⁸ See by way of contrast, however, *Association of Chartered Certified Accountants v Chairman, Public Accountants' and Auditors' Board* 2001 (2) SA 980 (W) in which the court held that the Public Accountants and Auditors Board which fulfils much the same role with regard to public accountants and auditors as does the Health Professions Council fulfils with regard to medical practitioners, dentists, psychologists and other health professionals, is an organ of state. The court then went on to consider whether the decision of the Board within the ambit of section 33 of the Constitution, constituting administrative action and came to the conclusion that it did and that it was therefore reviewable under the administrative justice provision in s 33 of the Constitution. In its judgment the court noted that: “The respondent argues that constitutional review is limited in its application to the review of legislative administrative acts or the exercise of legislative functions by public bodies” and then quoted from its heads of argument as follows: “It is vital to differentiate between two concepts - constitutional review and judicial review of administrative action. Judicial review of administrative action is a control mechanism applied by the High Court in the individual or concretised relationship between the State and the individual - the sphere of administrative law. For this purpose the validity of the enabling legislation is assumed. Constitutional review is similarly based on the need to limit and control governmental power, but challenges primarily legislation - it concerns constitutional law. Administrative review is exercised by the High Court on the basis of its inherent jurisdiction. In the sphere of public law it relates to irregularity or illegality in the performance of a statutory power or duty. Administrative review based upon formal legality puts limitations on the Executive, but does not restrain the Legislature... It is the introduction of constitutional review of legislation which in essence distinguished the new legal dispensation from the old legal order. . . It is submitted that the purpose of item 23 is to create criteria to be complied with by the Legislature and further to enrich the general body of legislation and the common law in terms of s39 of the Constitution. . . . Only if the legislative authority enabling the administrative action is challenged, would it be a matter for constitutional review...” The court went on to comment that the respondent’s argument was contrary to the present case law, noting that the law relating to judicial review had undergone a fundamental change by reason of the introduction of the Constitution. It said that the ambit of constitutional review is now significantly broader than the narrow confines referred to in the case of *South African Roads Board v Johannesburg City Council* 1991 (4) SA 1 (A). It decided that the Board clearly exercised a public power, that it was a creation of statute and the source of its power was to be found in the Public Accountants’ and Auditors’ Act 80 of 1991. The court found that the Board also appeared to fulfil a public function in terms of the said legislation in that it is a regulatory body entrusted with the task of ensuring that proper standards are maintained in the accounting and auditing profession. As such, the Board functions in close co-operation with structures of state authority, its members are appointed by the Minister and include persons selected among the persons holding office as state functionaries, it is also dependent upon the State for infrastructural support. The court did note that there was a dispute on the authorities as to whether these criteria are sufficient to characterise the Board as an institution which performs a ‘public function’, referring in this regard to *Baloro and Others v University of Bophuthatswana and Others* 1995 (4) SA 197 (B) and *Directory Advertising Cost Cutters v Minister for Posts, Telecommunications and Broadcasting and Others* 1996 (3) SA 800 (T). It said, however, that as the Board is an institution which exercises public power, it was unnecessary to decide whether it was an organ of state on the basis that it also performs a public function. The court does not seem to have referred to *Korf* at all.

¹²⁹ *Pennington* 2002 (1) SA 251 (C)

constitutes administrative action falls to be decided by reference to whether the action amounts to the exercise of public power or the performance of a public function¹³⁰. Whether that is so must be determined by reference, inter alia, to the source of the power exercised, the nature of such power, its subject-matter, whether it involves the exercise of a public duty and how closely it is related, on the one hand, to policy matters, which are not administrative, and, on the other, to the implementation of legislation, which is.

In *Metro Inspection Services (Western Cape) CC and Others v Cape Metropolitan Council*¹³¹ the court held that that where the act of the state or organ of state complained of (*in casu* the termination of the agreement) was derived from a public power, it amounted to an administrative act. It found that the respondent had appointed the first applicant to fulfil certain of the respondent's functions and duties in terms of the Act. Consequently the terms of the agreement were inextricably bound up with the statute. The decision to terminate the agreement was of the same nature as that which conferred on the respondent the right to contract with the first applicant. The respondent, and decision-maker in regard to the decision to terminate the agreement, was a public authority and, since its authority to appoint the first applicant derived from a public power, it followed that its authority to terminate the agreement with the first applicant similarly derived from a public power. The court held that the principles of administrative law applied to the decision by the respondent to terminate its agreement with the first applicant and that the agreement was thus an administrative agreement in law and the first applicant was entitled to procedural fairness with all that that entailed. The fact that the first applicant had not been given any notice of the case against it or of the decision-making process and had not been afforded any opportunity to be heard was clearly a fatal irregularity and invalidated the administrative act taken by the respondent.

It is thus of particular significance to the relationship between public providers and the patient in the health care context is the fact that apparently where the contract is

¹³⁰ See also *Cronje v United Cricket Board Of South Africa* 2001 (4) SA 1361 (T) in which the court observed with regard to the definition of administrative action in the PAJA that: "As I read this provision, read with the other provisions of the Act, a natural or juristic person will take administrative action only when exercising a public power or performing a public function in terms of an empowering provision. One may assume that this Act did not diminish the ambit of administrative action as it existed prior to its promulgation."

¹³¹ *Metro Inspection Services* 1999 (4) SA 1184 (C)

formulated in the exercise of a public power, it can never be governed solely by the private law of contract. In such circumstances administrative law will always have a bearing on the contract in question. The court said in *Toerien en 'n Ander v De Villiers No en 'n Ander*¹³², that it seemed clear that the administrative law principles of natural justice, including the *audi alteram partem* rule, should in South African law be applied in the termination of contracts of employment where the employer is a public authority whose decision to terminate the contract of employment amounts to the exercise of public power. Where these powers are conferred on the public authority by statute, and a decision is taken which affects the liberty, property or existing rights of another, then the *audi alteram partem* rule applies, unless the statute excludes it. A contract of employment which is partly governed by statute cannot therefore be regarded as merely civil. Similarly in *Van Der Merwe v Smith NO en 'n Ander*¹³³ the court held that the rules of natural justice were indeed applicable. The University was a creature of statute and the 'Service Conditions and Rules' were compiled in terms of s 13 of the Act. A contract of employment partly governed by a statute could not be treated as a contract governed merely by private law. Decisions of the employer in terms of such a contract of employment amounted to the exercise of public power and were necessarily subject to the principles of natural justice and subject to review by the Court. The decisions in these cases are apparently in keeping with the definition of administrative action in the PAJA. Sometimes it is as instructive to look at what is not there as it is to look at what is. In the case of the definition in the PAJA, the exclusions from what constitutes administrative action do not embrace section 82(2)(2) of the Constitution which reflects the power of the President to make any appointments that the Constitution or legislation requires the President to make other than as head of the national executive

3.8 Value of Administrative Law in Health Service Decisions

In a previous chapter it was observed that administrative law can be of considerable benefit to the state in taking decisions involving the delivery of health care services. This is because it is a valuable guide to procedural fairness in many situations

¹³² *Toerien* 1995 (2) SA 879 (C)

¹³³ *Van Der Merwe* 1999 (1) SA 926 (C)

requiring a decision to be taken¹³⁴. It is interesting that Baxter observes that the common law imposes much the same obligations as are imposed upon the state by administrative law upon private bodies who exercise power over individuals¹³⁵. This idea will be explored in more detail at a later stage when examining the law relating to private bodies. This point to note at present is that Baxter's observation is even more apposite within the context of the new constitutional order due to the fact that the

134 Hoexter C 'The Future of Judicial Review in Administrative Law' *SALJ* v117 2000 484 notes at p 485 "Administrative law on the other hand is a much bigger concept that encompasses various non-judicial safeguards against the abuse of administrative discretion, and is as much concerned with ways of generating good primary decisions as it is with detecting the abuse of power." She complains that in the South African context, the terms 'administrative law' and 'judicial review' have often been synonymous and that administrative law for many South Africans is and always has been about the judicial diagnosis of maladministration, about subjecting the actions of governmental bodies to judicial scrutiny and constraint. She observes that the reason is doubtless that South African law has never had much to offer except judicial review and that South Africans have never experienced an integrated system of administrative law in which judicial review is regarded as merely supplementary to the business of making good primary decisions and in which other forms of control and reconsideration – such as administrative adjudication – are taken seriously.

135 Baxter, *Administrative Law* p101: "Even if it is decided that an institution is private and not public the result might not be substantially different. As a general principle, any private institution which exercises powers over individuals is obliged to observe common law requirements which do not differ in principle from those applied to public bodies. Thus the courts have always been prepared to review the decisions of private or 'domestic' bodies such as the disciplinary tribunal of churches, trade unions or clubs and even the decisions of arbitrators. Although the basis upon which the powers of these bodies rest is contractual and not statutory, such bodies are often in a position to act just as coercively as public authorities and their decisions frequently have far reaching effects. Many of the principles of administrative law are designed to protect individuals from abuse of power. For this reason they are applied in almost identical form to private bodies and administrative law has itself drawn much from decisions involving 'domestic tribunals'. Cases involving the exercise of power by both public and private institutions are often cited interchangeably by the courts." In *Transnet Ltd v Goodman Brothers (Pty) Ltd* (fn 35 *supra*), the court held that the fact that Transnet, a state owned company, had recently been privatised and that it was no longer part of the state did not mean that it was not capable of administrative acts and that in providing a general service to the public it was performing a public function and exercising public powers. The state had ultimate control of the company and it was therefore subject to the law requiring lawful administrative action with regard to tender processes. See, however, *Cronje v United Cricket Board of South Africa* 2001 (4) SA 1361 (T) where Kirk-Cohen J observed at p 1374-1375 that: The rules of natural justice are, in the first place, rules of public law. They are part of the rules of administrative law that regulate the exercise of public power. That was so at common law and, in my view, remains so under the Constitution. Compare *Rose-Innes Judicial Review of Administrative Tribunals in SA* (1963) at 1, 89, 90, *Bushbuck Ridge Border Committee v Government of the Northern Province* 1999 (2) BCLR 193 (T) at 199F and *Pharmaceutical Manufacturers Association of SA and Another: In re Ex parte President of the Republic of South Africa and Others* (fn 72 *supra*) in paras [33], [37] - [40] and [45]. The *audi alteram partem* rule ordinarily applies only to public bodies in the exercise of their public powers. Thus in *South African Roads Board v Johannesburg City Council* 1991 (4) SA 1 (A) at 10G - I the Appellate Division stated: "(A) rule of natural justice . . . comes into play whenever a statute empowers a public official or body to do an act or give a decision prejudicially affecting an individual in his liberty or property or existing rights, or whenever such an individual has a legitimate expectation entitling him to a hearing, unless the statute expressly or by implication indicates to the contrary. . ."

and : "In exceptional cases private bodies are vested with public powers by statute. They are then subject to the rules of public law in the exercise of those powers. Those rules may expressly or by necessary implication prescribe the manner in which their powers must be exercised. If the repository of the power does not exercise them in the prescribed way, its conduct is subject to judicial review under public law. But these consequences flow, not from the nature of the body or the impact of its conduct, but from the underlying statute. In *Dawnlaan Beleggings (Edms) Bpk v Johannesburg Stock Exchange and Others* 1983 (3) SA 344 (W) at p 363 et seq, Goldstone J held that certain conduct of the Johannesburg Stock Exchange was subject to judicial review under public law, despite the fact that it was a private body. The learned Judge made it clear that this was so only because its empowering statute required the Johannesburg Stock Exchange to exercise its power in the public interest" and at p 1376, "The rules of natural justice are thus in the first place rules of public law, but they do sometimes apply in the sphere of private law, but then only when they are incorporated by contract. Contracts between private individuals and bodies are ordinarily not governed by the rules of natural justice but they may be incorporated expressly or by necessary implication, depending upon the terms of the contract. Such a right may even be granted to an outsider if a private body by contract extends such a right to an outsider. See, for example, *Marlin v Durban Turf Club and Others* 1942 AD 112 at 126 - 7, *Anschutz v Jockey Club of South Africa* 1955 (1) SA 77 (W) at p 80, *Jockey Club of SA v Transvaal Racing Club* 1959 (1) SA 441 (A) at p 450, *Turner v Jockey Club of South Africa* 1974 (3) SA 633 (A) at p 645 - 6, *Theron en Andere v Ring van Wellington van die NG Sendingkerk in Suid-Afrika en Andere* 1976 (2) SA 1 (A) at p 21D, *Carr v Jockey Club of South Africa* 1976 (2) SA 717 (W) at p 721 - 2, *Government of the Self-Governing Territory of KwaZulu v Mahlangu and Another* 1994 (1) SA 626 (T) at p 634 - 5 and *Lamprecht and Another v McNeillie* 1994 (3) SA 665 (A) at p 668. It is only where the constitution of a voluntary association incorporates the rules of natural justice that they then apply between the association and its members or those with whom it has privity of contract. The rules do not apply to a non-member who is not a party to the contract. See the cases of *Anschutz, Ricardo, Carr and Mahlangu* (at 634D - 635D) *supra*."

underlying values of administrative law, as informed by the Constitution, must of necessity be the same underlying values underpinning the various areas of law that affect the provider-patient relationship in the private sector. One would expect to find few fundamental differences between the legal rules governing the transactions between public and private sector if the underlying values are the same¹³⁶. In the time at which Baxter wrote, prior to the 1996 Constitution, these underlying values would have been reflected, possibly to a lesser degree, in public policy - hence the similarities in the law relating to private bodies and the administrative law governing public bodies. Under the present dispensation, the PAJA expressly throws the net wider than just public bodies to include in its ambit those private bodies exercising a public function. Underpinning even all of this, however, are the fundamental principles set out in the Constitution generally and the Bill of Rights in particular.

It is clearly necessary to consider health care delivery decisions in the light of administrative law both because of its Constitutional importance and because there are certain well established rules in terms of which administrative power must be exercised. Such an examination is of assistance in understanding the provider-patient relationship where the provider is the state because administrative law is very much the law of public administration and public health services are one of the many types of services that fall within the purview of public administration.¹³⁷ Administrative law is notoriously difficult to define. Baxter¹³⁸ writing in 1984 states that the basic format and principles of administrative law have been centuries in the making, yet its recognition as a distinct branch of law is a comparatively recent development. He

¹³⁶ Arguments about the horizontal application of the Constitution, especially the Bill of Rights, do have a bearing on this issue and will be canvassed at a later stage when looking at the provider-patient relationship in the private sector. However it is trite that the values of equality and human dignity, non-racialism and non-sexism upon which the South African Constitution is based are equally applicable within the public and private sectors.

¹³⁷ Stewart C "Tragic Choices and the Role of Administrative Law" *British Medical Journal* 2000 321 p 105-107 notes that: "The United Kingdom... is the only country in the Commonwealth where administrative law is having a major impact on medical decision making. The basic principles of administrative law are, however, shared by all common law jurisdictions and other countries (particularly Australia and New Zealand) are now seeing similar claims arise [in administrative law]. There is a pressing need for medical decision makers to familiarise themselves with the basic principles of administrative law." He comments further that "administrative law is having an increasingly important impact on medical decision making. There are two reasons for this: firstly the process of medical decision making is now indistinguishable from other types of bureaucratic administration. Treatments are dispensed according to clinical guidelines and policies. Decisionmaking is horizontally organised, from macrodecisions made by government departments through to misallocation by health authorities and ending with bedside decision making made collectively by groups of doctors. Secondly the question of whether particular patients should be treated is no longer solely about clinical factors specific to individual patients. The scarcity of resources means that treatment decisions concern questions of allocative efficiency, which include characteristics more properly described as "social". For example medical decision makers might take into account the sexual preference of a patient to determine whether infertility treatment should be provided. In such cases administrative law is able to examine the considerations of the decision maker to see if they have strayed into unlawful areas. Both factors mean that any disputes about treatment decisions are perfectly suited to administrative law and its focus on the legality of the decision making process."

¹³⁸ Baxter, fn 3 *supra* at p45

notes that throughout the world, and especially in Anglo-Saxon countries, the disciplined study of the subject began late and, until recently, progressed slowly. Disagreement as to its definition and proper areas of concern still remain. He comments that a factor retarding the development of administrative law as a significant discipline has been the lack of agreement as to what 'administrative law' is¹³⁹. This dilemma is nowadays possibly easier to resolve in some respects given the existence of the PAJA and the various definitions contained therein¹⁴⁰. The PAJA cannot, however, amend the Constitution. To the extent that the provisions of the Constitution relating to administrative justice are not contemplated or covered by the PAJA recourse must still be had to the Constitution directly. The right to just administrative action is only one aspect of the Constitution which involves administrative law. The right to equality before the law expressed in section nine of the Constitution is an example of another legal principles which is generally regarded as highly relevant to administrative law as is the right of access to information expressed in terms of section 32 of the Constitution.

3.9 Administrative Law Theories

There are a number of administrative law theories that have tended to be ranged along the spectrum of permutations possible on a traffic light. Thus the "red-light" approach to administrative law¹⁴¹ advocates a strong role for the courts to review administrative decisions and holds that the function of this branch of law is to control the excesses of the state. It has been said of this theory of administrative law:

"Behind the formalist tradition, we can often discern a preference for a minimalist state. It is not surprising, therefore, to find that many authors believing that the primary function of administrative law should be to control any excess of state power and subject it to legal and

¹³⁹ Baxter, fn 3 *supra* at p 49

¹⁴⁰ In *Schoonbee and Others v MEC for Education, Mpumalanga and Another* 2002 (4) SA 877 (T) the court observed at p 882 that: "The Act contains in great part what one may regard as partial codification of administrative law with specific reference to administrative actions." Hoexter, (fn 134 *supra*) however, is critical of the PAJA for its focus and emphasis, both directly and indirectly, on judicial review at the expense of other aspects of administrative law. She is of the view that the PAJA could have been used as an opportunity to develop a much more rounded and comprehensive body of administrative law in South Africa which, as a result of its history, has had an unfortunate tendency to regard judicial review as the central concept of administrative law.

¹⁴¹ Devenish, *et al* (fn 15 *supra*) p13 note that the extant protagonists of the 'red-light' theory are of the opinion that administrative power should be restricted to a limited range of social functions involving law and order, internal security and external defence. All the other activities that a community requires should be left to private initiative and the intrinsic forces of the market. The role, they observe, of administrative law is to provide effective legal controls over the exercise of state power and to confine it to its proper jurisdiction.

more especially judicial, control. It is this concept of administrative law that we have called 'red light theory'.¹⁴²

By contrast, the "green light" approach¹⁴³ holds that the function of administrative law is to facilitate the operations of the state and is based on the rationale that bureaucrats will function most efficiently on the absence of intervention. In this regard it has been observed that:

"Because they see their own function as the resolution of disputes and because they see the administrative function from the outside, lawyers traditionally emphasise external control through adjudication. To the lawyer, law is the policeman; it operates as an external control, often retrospectively. But a main concern of green light writers is to minimalise the influence of the courts. Courts with their legalistic values were seen as obstacles to progress, and the control which they exercise as unrepresentative and undemocratic. To emphasise this crucial point in green light theory, decision-making by an elite judiciary imbued with a legalistic, rights-based ideology and eccentric vision of the 'public interest'...was never a plausible counter to authoritarianism."¹⁴⁴

The "amber-light" theory as its name suggests lies between the red-light and green-light theories. Protagonists of this approach, while they favour the extensive use of state power for socio-economic purposes are not prepared to permit political institutions alone to control and monitor the exercise of such power. They maintain that a system of effective administrative law must be used to complement the political and parliamentary control of state power and to ensure accountability and transparency.

Whilst this somewhat linear spectrum of administrative law theory is likely in almost every instance to be an oversimplification, it would seem that the South African constitutional court¹⁴⁵ and indeed the Constitution itself could generally be said to

¹⁴² Harlow C and Rawlings R *Law and Administration* as quoted by Parish K "Administrative Law Theories" http://www.ntu.edu.au/faculties/lba/schools/Law/apl/Homepage/administrative_law_theories

¹⁴³ Devenish *et al* fn 15 *supra* note that the 'green-light' theory is a far more positive and ambitious approach to state power and that protagonists of this theory regard state power as a means of giving effect to beneficial social policies. Quoting from Leyland P, Woods T and Harden J *Administrative Law* p 6 they observe that this theory introduces a political and socio-economic context into the law 'which in essence derives from the utilitarian tradition (usually associated with Bentham and Mill; and the Fabian Society founded in 1884, particularly with the ideas of Sidney Webb), the moral imperative being to promote the greatest good for the greatest number, in this case by means of ameliorative social reform.' They comment that this theory favours accountability and greater democratic and public control over the exercise of power, rather than placing faith exclusively in law as a mechanism of control and accountability.

¹⁴⁴ Harlow and Rawlings fn 142 *supra*

¹⁴⁵ Thus the constitutional court in *Ex Parte Chairperson of the Constitutional Assembly: In Re Certification of the Constitution of the Republic of South Africa*, 1996, 1996 (4) SA 744 (CC) held that the fundamental structures and premises of a new constitutional text contemplated by the CPs were the following: (a) a constitutional democracy based on the supremacy of the Constitution protected by an independent judiciary; (b) a democratic system of government founded on openness, accountability and equality, with universal adult suffrage and regular elections; (c) a separation of powers between the Legislature, Executive and Judiciary with appropriate checks and balances to ensure accountability, responsiveness and openness; (d) the need for other appropriate checks on governmental power; (e) enjoyment of all

favour the amber light approach - particularly with regard to the realisation of the right of access to health care services. The fact that section 27(2) requires the state to take reasonable legislative and other measures within its available resources to progressively achieve the realisation of the right is indicative of an interventionist approach to socio-economic rights with a view to effecting extensive socio-economic and other reforms. At the same time there is a significant emphasis on accountability.¹⁴⁶ Rationality is an important aspect of accountability for decisions¹⁴⁷.

universally accepted fundamental rights, freedoms and civil liberties protected by justiciable provisions in the new text; (f) one sovereign state structured at national, provincial and local levels, each of such levels being allocated appropriate and adequate powers to function effectively; (g) the recognition and protection of the status, institution and role of traditional leadership; (h) a legal system which ensured equality of all persons before the law, which included laws, programmes or activities that had as their objective the amelioration of the conditions of the disadvantaged, including those disadvantaged on grounds of race, colour or creed; (i) representative government embracing multi-party democracy, a common voters' roll and, in general, proportional representation; (j) the protection of the new text against amendment save through special processes; (k) adequate provision for fiscal and financial allocations to the provincial and local levels of government from revenue collected nationally; (l) the right of employers and employees to engage in collective bargaining and the right of every person to fair labour practices; (m) a non-partisan public service broadly representative of the South African community, serving all the members of the public in a fair, unbiased and impartial manner; and (n) security forces required to perform their functions in the national interest and prohibited from furthering or prejudicing party political interests. Also in *Ex Parte Chairperson of the Constitutional Assembly: In Re Certification of the Amended text of Constitution of the Republic of South Africa 1996, 1997 (2) SA 97 (CC)* the court held that section 100, which permitted intervention by the national executive when a province could not or did not fulfil an executive obligation in terms of legislation or the Constitution, complied with CP VI (requiring a separation of powers between the Legislature, Executive and Judiciary, with appropriate checks and balances to ensure accountability, responsiveness and openness).

146

Sachs A, "The Constitution is Natural Justice Writ Large", *Controlling Public Power: Administrative Justice Through The Law*, p51 writing before the interim Constitution was finalised notes: "The texture of a constitution can in fact be measured by the richness of its systems of accountability". Mureinik, E "Reconsidering Review: Participation and Accountability", *Controlling Public Power: Administrative Justice Through The Law* p31-32 identifies accountability as a great principle of responsive democracy and states that in administrative law terms it means that the government must be able to justify its decisions. He says that this will also mean that decision-makers will be obliged to consider in advance, factors relevant to their decisions and that their decisions will as a result have better justifications and points out that the aspiration to better justified decisions translates into a demand for review for unreasonableness: "rationality review as we most commonly know it".

The Supreme Court of Appeal in *Minister of Safety and Security v Van Duivenboden* 2002 (6) SA 431 (SCA) held that what is called for when determining whether the law should recognise the existence of a legal duty in any particular circumstances is a balancing against one another of identifiable norms. While private citizens might be entitled to remain passive when the constitutional rights of other citizens are threatened, the State has a positive constitutional duty, imposed by s 7 of the Constitution, to act in protection of the rights in the Bill of Rights. The existence of that duty necessarily implies accountability and s 41(1) expressly demands, inter alia, that all spheres of government and all organs of State 'provide effective, transparent, accountable . . . government'. Where the State, as represented by the persons who perform functions on its behalf, acts in conflict with its constitutional duty to protect rights in the Bill of Rights, the norm of accountability must of necessity assume an important role in determining whether a legal duty ought to be recognised in any particular case. While the norm of accountability need not always translate constitutional duties into private law duties enforceable by an action for damages because there are other remedies available for holding the State to account, where the State's failure to fulfill its constitutional duties occurs in circumstances that offer no effective remedy other than an action for damages, the norm of accountability will ordinarily demand the recognition of a legal duty unless there are other considerations affecting the public interest outweighing that norm. (from headnote). The court held further that in this instance there was no effective way of holding the state accountable other than by way of an action for damages. In the absence of any norm or consideration of public policy outweighing it, the constitutional norm of accountability required that a legal duty be recognised.

Similarly in *Faircape Property Developers (Pty) Ltd v Premier, Western Cape* 2000 (2) SA 54 (C), the Cape High Court held that the determination of the legal convictions of the community on which the test for wrongfulness was based had to take account of the spirit, purport and objects of the Constitution of the Republic of South Africa Act 108 of 1996. The Constitution, it said, embraced the principle of accountability in that a public authority was accountable to the public it served when it acted negligently. Such accountability recognised legal responsibility for the consequences of such action. It thus held, given the absence of a mechanism for holding an authority accountable in terms of the Act and given that the principle of accountability was intrinsic to the legal convictions of the community, that it followed that a remedy should be available to a person wishing to hold an authority accountable for actions which could be shown to have been negligent, to have caused damage and which satisfied the requirements of legal causation. (from headnote)

In *Ngxuzo and Others v Permanent Secretary, Department of Welfare, Eastern Cape, and Another* 2001 (2) SA 609 (E) the court took the view that the Constitution specifically stated that the public administration had to be governed by democratic values and the principles of the Constitution and that it had to be accountable (s 195) and had appointed the Courts as the final instrument of ensuring the accountability of the exercise of public power. The court in this case

In *Pharmaceutical Manufacturers Association of SA and Another: In Re Ex Parte President of the Republic of South Africa and Others*¹⁴⁸, the constitutional court pointed out that that the setting of the rationality standard did not mean that the Courts could or should substitute their opinions as to what was appropriate for the opinions of those in whom the power had been vested. As long as the purpose sought to be achieved by the exercise of public power was within the authority of the functionary, and as long as the functionary's decision, viewed objectively, was rational, a Court could not interfere with the decision simply because it disagreed with it or considered the power to have been inappropriately exercised. Thus while there is a constitutional mandate for the state to fulfil in terms of measures to be taken to achieve the realisation of the right of access to health care services, its power to do so will not go unchecked by the judiciary in the sense that it is accountable for its decisions on the basis of principles such as rationality identified by the judiciary.

A more recent theory of administrative law is known as 'managerialism' and is based on the notion that administrative authorities should conduct their affairs and take decisions along such corporate business lines as are commonly encountered within the private sector. It grew from the increasing emphasis on efficiency, productivity and market forces which emerged in the late 1970's and eventually lead to the wholesale privatisation of traditional public sector functions. It has been described as "in many respects at odds with the traditional approach to administrative law". Managerialism treats public sector activities as though they were business enterprises and subjects them to private sector disciplines. It regards efficiency and productivity as central

observed that what was at stake was the accountability of an unelected administrative bureaucracy and a large-scale unlawful deprivation of social grants by way of administrative stealth and that the Courts had been appointed by the Constitution to prevent that from happening. (from headnote).

In *Qozalet v Minister of Law and Order and Another* 1994 (3) SA 625 (E) which involved the interim Constitution (Act 200 of 1993), the court said that the right of access to State information provided for in s 23 of the Constitution is something more than a mere constitutional right to discovery, it is also a necessary adjunct to an open democratic society committed to the principles of openness and accountability. Its application need therefore not be restricted to the exercise or protection of rights by way of litigation, but would extend also to non-judicial remedies aimed at the exercise or protection of such rights.

¹⁴⁷ Thus Murenik (fn 146 *supra*) notes that rationality review calls for far more specific scrutiny than the mere identification of gross error. It requires the reviewing body to ask whether:

- (a) the decision-maker has considered all the serious objections to the decision taken and has answers which plausibly meet them;
- (b) the decision-maker has considered all the serious alternatives to the decision taken and has discarded them for plausible reasons; and
- (c) there is a rational connection between premises and conclusion: between the information (evidence and argument) before the decision-maker and the decision that it has reached.

¹⁴⁸ *Pharmaceutical Manufacturers Association of SA* (fn 72 *supra*)

goals of public administration and assumes that their achievement equates with public interest¹⁴⁹

The nature of the health sector in South Africa, as in many other countries, is problematic when viewed in the context of a 'privatised' or managerialistic approach to the conduct of its business¹⁵⁰. The delivery of health care services does not easily translate into the world of commerce despite the existence of a relatively high profile private health sector in this country. It is complicated by human rights and constitutional issues which do not sit comfortably in a profit-driven, business environment. The main reason for the emphasis in the private sector on efficiency and productivity is profit and its maximisation. Whilst this approach may be perfectly legitimate and workable in the nuts and bolts market, the health care services environment is a different arena. This is evidenced within many forums at both local and international level. At international level one only has to look as far as the increasing pressure on the World Trade Organisation, the holders of and the exercise of intellectual property rights in medicines and other commodities essential to health service delivery to revise international intellectual property conventions and interpretations of patent law to take cognisance of internationally recognised rights to health and health care services¹⁵¹. At local level there are provisions in the Medicines

149 Parish K "Administrative Law Theories" Northern Territory University. But Parish questions the desirability of having the success of public entities with regard to service delivery measured by notions of efficiency and productivity. He observes that while many Australians would give an emphatic "No" to this question, the economist's balance of costs and benefits is "certainly not antithetical to traditional administrative law". He states that the pursuit of desirable ends ought not to be bought at a cost which exceeds their true benefit.
<http://www.ntu.edu.au/faculties/lba/schools/Law/apl/Homepage>

150 Burns Y 'Government Contracts and the Public/Private Law Divide' *South African Public Law* 1998 13 p 234 notes that the privatisation or sale of public assets has become a common occurrence in modern democratic states. She observes that South Africa is also moving in the direction of privatisation of certain services, notably electricity, transport and communication services. Burns also notes the increasing familiarity within South Africa of outsourcing and states: "If one accepts that an outsourcing contract, or service provision contract, is an administrative law agreement (in the sense that the administrative authority retains a measure of state authority with the result that the relationship between the state and the other party is one of inequality) it may be argued that the agreement should be subject to the principles of public law." She refers to the first National Performance Review published in the United States of America in September 1993, which outlined a plan to reinvent the government so that it might better serve its people and continue to lead the world in the new era of globalisation and notes that this new rhetoric involves significant changes in United States Administrative Law including:

- new blends of public and private sectors at all levels of government;
- a redefinition of what is public and what is private;
- greater reliance on bargaining and negotiation in the exercise of discretionary powers;
- increased reliance on privatisation and the delegation of public functions to private concerns;
- a market discourse which narrows the role of public interest values and replaces them with that of cost-benefit analysis.

151 See for instance Baker, 'The incredible shrinking Doha Declaration' *Health GAP* www.healthgap.org/press_releases/03/; Also Tayob R & Loewenson R 'Health Implications of the WTO 5th Ministerial Trade Talks' EQUINET September 2003 in Cancun, Mexico who explain as follows: "The Doha Ministerial Declaration from the 2001 WTO Ministerial Conference clarified the inherent rights countries enjoy under the Agreement on Trade-Related Aspects of Intellectual Property Rights, (TRIPs) to grant compulsory licenses that by-pass patents on medicines to secure public health. Compulsory licenses can be used for parallel importation or domestic production. Countries also enjoy the right under TRIPs to disregard patents on drugs for government use. As many developing countries have little or no drug production

and Related Substances Control Act¹⁵² which allow the Minister of Health, patent rights notwithstanding, to authorise the parallel importation of medicines into South Africa in order to promote access to more affordable medicines. Whilst the utilisation of available resources contemplated in section 27(2) of the Constitution should undoubtedly not be fruitless, wasteful or irregular (in the sense in which these terms are used in the Public Finance Management Act No 1 of 1999), and public officials should be held accountable for efficient and effective use of those resources, it is submitted that policy decisions involving health care will always have to take into account far more than just productivity and efficiency factors. As stated previously, the private sector is profit-driven. This does not necessarily result in effective or even cost-effective health care delivery¹⁵³ as demonstrated in the examples cited below.

capacity, they could only secure drugs from other countries producing compulsory licensed drugs. The catch was that TRIPs Paragraph 31(f) requires that a country produce drugs predominantly for domestic consumption and export a maximum of 49% of its production. This limited the amount of drugs available to developing countries who do not produce drugs. The WTO general council negotiated options for developing countries who lacked manufacturing capacity to access the benefits of the "TRIPs + Doha Declaration". On 30 August 2003 the general council agreed to waiver of TRIPs paragraph 31(f) under the following conditions:

1. The "solution" is not to be used for industrial or commercial policy objectives;
2. Drugs (and active ingredients) shall be specially packed, coloured or shaped and that members understand that this will not have a significant effect on price;
3. Countries shall notify the TRIPs Council of the basis upon which they have decided that do not have productive capacity and need to use the 'solution';
4. The TRIPs Council will be able to hear disputes on the implementation of the solution and take appropriate action.

Some southern governments and NGOs like the Consumer Project on Technology, Third World Network, Medicines Sans Frontiers were not happy with this 'solution'. They felt it compromised the ability of poor countries to provide pharmaceutical drugs. However other developing countries urged for its adoption as they feared that if an agreement was Ministerial Conference. This strategic course has given developing countries an agreement that has unresolved problems in relation to drug access, mainly in its efforts to avoid compulsory licensed drugs being diverted into markets where only patented drugs are available. It excludes "industrial and commercial policy objectives" but does not adequately define what these are, leaving uncertainty for developing countries as to what actions are illegal. The inclusion of active ingredients in the texts means that generic manufacturers may have difficulty in obtaining raw materials for production. It also places significant burdens on countries using the solution to somehow "objectively" show that they lack manufacturing capacity, particularly if they are challenged."

(<http://www.equinet africa.org/Resources/downloads/HealthimplicationsCancun0903.pdf>)

152

Act No 101 of 1965

153

In "Market Forces Are Bad For Hospital's Health" Kirschenbaum C and LeBow B note that: "We are told that the growth of for-profit hospitals will help contribute to the lower costs of health care and that competition is reducing excess administration. The standard market forces of supply and demand do not apply well to health care unless one gets sick. But free market advocates have repeatedly assured us that a market economy could reduce the spiralling cost of health care. Finally we have some strong data that indicate that the market at least as represented by for-profit hospitals is not so cost-effective as proponents have asserted." (<http://www.ibiblio.org/prism/Apr97/market.html>). They go on to quote from an article in the *New England Journal of Medicine* (March 13) entitled "Costs of Care and Administration at For-Profit and Other Hospitals in the United States" by Woolhandler S and Himmelstein D in which the authors report *inter alia* that:

- For -profit hospitals spent 23% more on administration than private not-for-profit hospitals and 34% more than public hospitals.
- Administrative costs accounted for an average of 26% of total hospital costs in fiscal 1994 which was up 1.2 percentage points from 1990
- Comparative 1994 administrative costs were 34% for for-profit private hospitals, 24.5% for private, not-for-profit hospitals and 22.9% for public hospitals
- There is a pattern of higher costs and reduced clinical staffing at for-profit hospitals.
- The percentage of costs devoted to administration increased between 1990 and 1994 for all three ownership categories resulting in less money for patient care.

South Africans in recent years have experienced a similar problem with regard to medical schemes administration. Although medical schemes are themselves not for profit entities they contract with companies who are to for administration. The Registrar of Medical Schemes has expressed concern at the increasing costs of administration of medical schemes since this is invariably at the expense of funding that could be more effectively and efficiently employed in providing health care services to scheme beneficiaries. The funding cake is limited in size. The bigger the slice that scheme administrators can secure for themselves, the smaller the remainder that is available for payment for

Example 1

The name of the United States of America is virtually synonymous with the phrase “free market”. It is regarded by many as the free market country of the world. The World Health Organisation has released an assessment of health systems throughout the world. Rankings are based on an overall index of performance. The US ranked 37th despite the fact that it ranks as number one in per capita health expenditure at \$2700 on average, per person. Furthermore it ranks 25th in male life expectancy and 19th in female life expectancy compared with 29 other industrialized countries. The Americans claim nevertheless to have some of the finest doctors and hospitals in the world¹⁵⁴.

Example 2

Singapore, in the period from 1984 to 1993 did all it could to encourage market forces in health care in the hope of lowering costs including the promotion of medical savings accounts, catastrophic insurance and competition amongst hospitals. The government offered inducements to its for-profit hospitals and clinics, which were given favoured status. After ten years Singapore’s health care costs had soared and a government white paper concluded that “market forces alone will not suffice to hold medical costs to the minimum. The health care system is an example of market failure. The government has to intervene to structure and regulate the health system.”¹⁵⁵ Robert G Evans, Professor of Economics at the University of British Columbia, writes that “The health status of an individual thus takes on a special importance to the community beyond that of her consumption in general, but similar to political or judicial status...Such special status derives from a general perception

health services. From a public health perspective, this is hardly an efficient or effective utilisation of resources for health care service delivery since it effectively reduces their availability for this purpose. According to a press release by Council for Medical Schemes dated September 04 2003 (available at <http://www.medicalschemes.com>) administration costs for medical schemes increased by 15.7% between 2003 and 2003 according to the Annual Report of the Council. This increase, according to the press release shows a “marked slowing” on the year before when the Registrar expressed concern over an annual increase of 41.7% in 2001. Even 15.7% is well above the Consumer Price Index for this period. Kirschenbaum and LeBow ask whether the market economy is so highly valued that for the sake of the “free market” people will tolerate even more injustice and lack of compassion in the health care system.

¹⁵⁴ *Vermont Health Care For All* <http://www.vthca.org/myths.htm>

¹⁵⁵ Hsiao W, “Marketization – The Illusory Magic Pill” *Health Economics* Vol.3 351-357, 1994 as referred to in *Vermont Health Care For All* fn 154 *supra*

that life, health and freedom are not ordinary commodities, but are prerequisites to the enjoyment of all others.”¹⁵⁶

Example 3

In New Zealand in 1993 the government implemented radical changes to the health services including splitting the “purchasing” role of the state from the “provision” of services. Under the new system, public money for health services was divided between four Regional Health Authorities (RHAs) whose job was to purchase health services for their populations. Having decided what services they would buy they then entered into negotiations with potential providers. The RHAs were expected to encourage competition between public and private hospitals and other service providers. Public hospitals which were previously owned by Area Health Boards became part of new state-owned institutions known as Crown Health Enterprises (CHEs). These latter were required to act in a business-like manner which included earning a return on their capital. The reforms created a “quasi-market environment” which implied that CHEs would have to be efficient and keep costs down in order to beat off competition from private hospitals and with contracts with the RHAs. The reasons for the reforms were perceived weaknesses in the old system such as the inefficiency of public hospitals. There had been a number of reports suggesting that private hospitals could provide the same services as public ones for about 30% less. Another weakness was that waiting lists for public hospital services were growing. Policy makers hoped that if public hospitals were forced to compete for their funding, public hospital management and efficiency would improve and savings from such efficiencies could be ploughed back into the system to shorten waiting lists and treat more people. After three years under the new system, waiting lists were higher than they had been to start with, 23 of the CHEs recorded persistent financial deficits and very few private hospitals won contracts off the RHAs since the latter mostly bought services from the CHEs closest to them with the result that there wasn’t even a great deal of competition between CHEs. The local CHEs ended up having a degree of monopoly power because the RHAs found that the only real option was to buy

¹⁵⁶ Evans R G *Strained Mercy: The Economics of Canadian Health Care*
http://frisch.ecn.uva.nl/ca.guy/11160/Manuel/Strained_Mercy/

services from CHEs closest to them. The costs of setting up the new system and writing and negotiating the purchaser-provider contracts were significant. As a result in 1996 the “experiment with competition” in the New Zealand health system came to an end. The word “competition” was replaced with “co-operation” “commercial profit objectives” became “principles of public service” and CHEs were renamed “hospitals”. Devlin, an economist specialising in health care at the University of Otago states that some would argue that this attempt to harness market forces in health care didn’t work because the competition was “too managed”. She says that the trick is to design a health care system with the right “mix” of “private” and “public” so that the result is a health care system that is both efficient and fair.¹⁵⁷ This statement tends to run counter to the managerialist theory of administrative law which effectively tries to diminish the differences between the way in which services are rendered in the public and private sector by seeking to encourage a more private sector type of approach to activities in the public sector.

Administrative law theories are of assistance in identifying the underlying policy frameworks or principles as to how administrative law should work in practice. The point about the examples given above in relation to administrative law and policy-making is that they illustrate the importance of the underlying assumptions of the system that is formulated and in particular the many different approaches that are embodied in that simple phrase “public interest”. Policy cannot in terms of South African law, be made in a vacuum. It has to be done with reference to certain reasonable and logical assumptions, established facts, and constitutionally recognized values. To the extent that policy informs legislation, the same applies to legislation whether of the principal or subordinate variety.

3.9.1 Application in Case Law

From the judgments in the two leading South African cases on the subject of the right of access to health care, *Soobramoney*¹⁵⁸ and *Treatment Action Campaign*¹⁵⁹, is that policy decisions that are either unreasonable or that are unreasonably taken can be

¹⁵⁷ Source of this example: Devlin N “The experiment with competition in health care: how come market forces didn’t work?” *Econz@Otago* July 1998 <http://www.otago.ac.nz>

¹⁵⁸ *Soobramoney v Minister of Health, Kwazulu-Natal* 1998 (1) SA 765 (CC)

¹⁵⁹ *Minister of Health and Others v Treatment Action Campaign and Others* (No 2) 2002 (5) SA 721 (CC)

challenged. These cases were not decided on the basis of administrative law no doubt because they involved policy decisions and policy implementation. The PAJA exempts development and implementation of national and provincial policy from its definition of administrative action. However, the reasons why the policy of the national government in the TAC case was declared unconstitutional and why the policy of the KwaZulu-Natal provincial government concerning renal dialysis was not, are remarkably similar to the principles of administrative law. In *Soobramoney*, because of the shortage of resources the hospital followed a set policy in regard to the use of the dialysis resources. Only patients who suffered from acute renal failure, which could be treated and remedied by renal dialysis were given automatic access to renal dialysis at the hospital. A set of guidelines had been drawn up and adopted to determine which applicants who have chronic renal failure will be given dialysis treatment. The court noted that due to the shortage of the available resources, notably dialysis machines, guidelines had to be developed to determine how best to use the existing ones. It observed that by using the available dialysis machines in accordance with the guidelines more patients are benefited than would be the case if they were used to keep alive persons with chronic renal failure, and the outcome of the treatment is also likely to be more beneficial because it is directed to curing patients, and not simply to maintaining them in a chronically ill condition. There was no suggestion that the guidelines were unreasonable or that they were not applied fairly and rationally when the decision was taken by the Addington Hospital that the appellant did not qualify for dialysis.

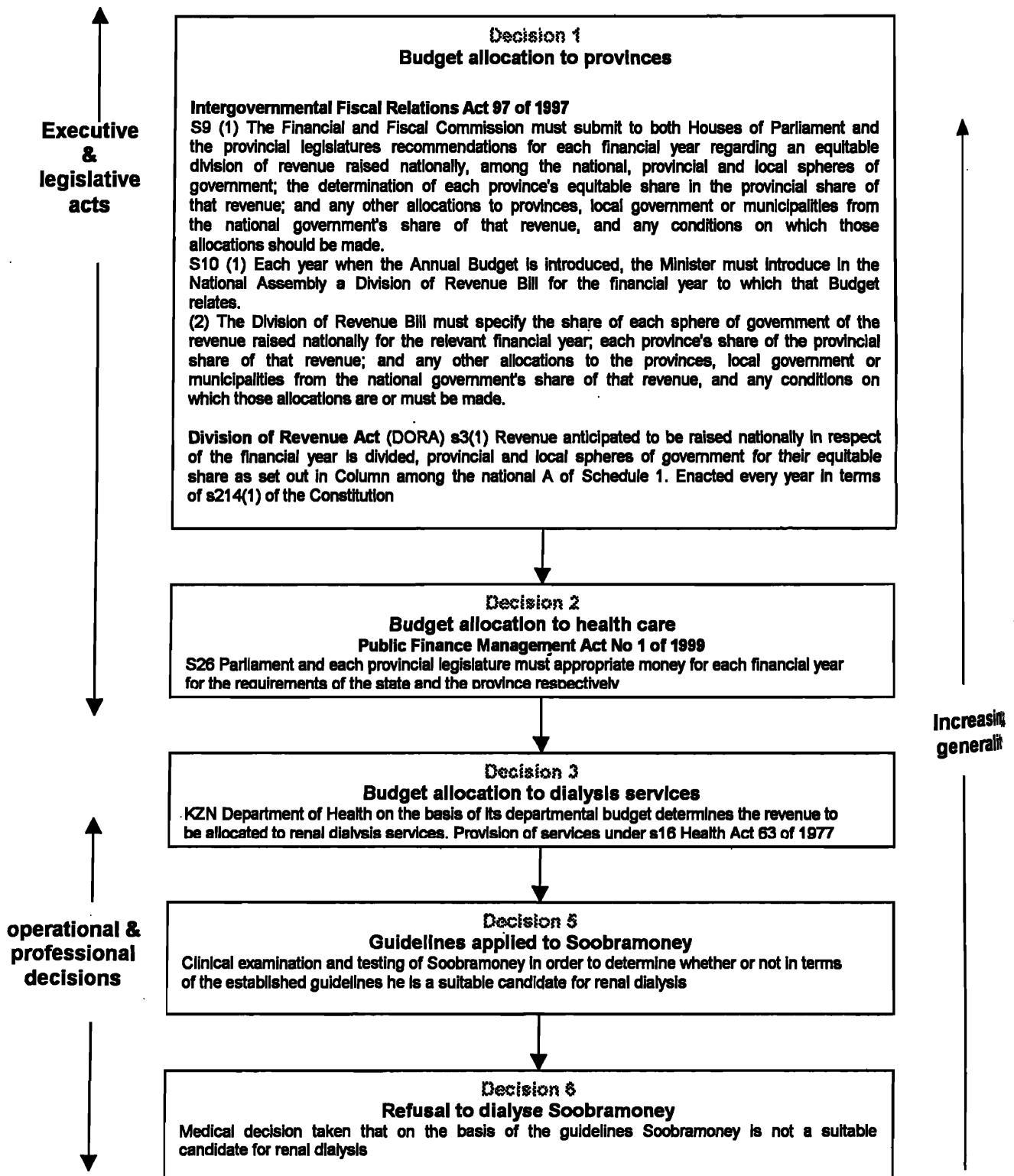
The court stated that the provincial administration which is responsible for health services in KwaZulu-Natal has to make decisions about the funding that should be made available for health care and how such funds should be spent. These choices involve difficult decisions to be taken at the *political level* in fixing the health budget, and at the *functional level* in deciding upon the priorities to be met. A court will be slow to interfere with rational decisions taken in good faith by the political organs and medical authorities whose responsibility it is to deal with such matters. The court here distinguished two different levels of decision making. The budgetary allocation decisions are not of an administrative nature but rather of a legislative or executive nature and therefore accountability is to the electorate rather than through a court of law by way of judicial review. The guidelines decision appears to have been

characterized as being at an operational level and therefore more appropriately taken by operational and other experts at that level. The only proviso appears to have been that such decisions were ‘rational’ and taken ‘in good faith’ by the political organs and medical authorities ‘whose responsibility it is to deal with such matters’. Thus the language used by the court to adjudicate a sequence of policy decisions which, technically speaking, fall outside the definition of ‘administrative action’ is clearly the language of administrative law. The lesson to be learned is that the same principles that underpin administrative decisions are applicable to other kinds of decisions – even if they are not administrative in nature. Put differently, whilst principles of reasonableness, fairness and good faith may be particular concerns of administrative law, they are not peculiar to the latter. It is submitted that the reason for this is that the basic values that underlie one area of a legal system cannot differ materially from those that support another if the system is to have any coherence and consistency at the macro-level. The Constitution as the grundnorm of the South African legal system, together with the values it espouses, is likely, if consistently applied, to lead to corresponding consistency across the boundaries of public and private law and the different legal disciplines within the broader legal system. Consequently one must adopt a system approach to law in which every part is seen as simply an element of the whole and must be interpreted consistently with it. In this view of law, the principles of administrative law in relation to the right of access to health care services must be regarded merely as a facet of a larger concept rather than as having an independent and isolated existence of its own.

The *Soobramoney* case illustrates the importance of seeing a particular decision as part of a system of decision-making rather than in isolation. Although this point is not highlighted in the judgment of the constitutional court, there were a number of different decisions that were taken which led up to the refusal to allow the plaintiff access to the provincial renal dialysis facilities. The first decision in the chain was a budgetary allocation decision in terms of which funding was allocated to KwaZulu-Natal province in terms of its equitable share. The second decision was by the provincial government of KwaZulu-Natal as to how much money should be allocated to expenditure on health care. The third decision was taken by the provincial health authorities as to how much of the funding allocated to health should be spent on the renal dialysis facilities and services provided by the province. The fourth decision to

be taken by the provincial health authorities was as to how best to use the renal dialysis facilities, given the available resources, in order to obtain the most benefit from them in terms of public health service delivery. The fifth decision was the application of the guidelines to Mr Soobramoney's particular and individual circumstances. The guidelines that were developed were created on the basis of current medical and scientific knowledge and practice. The sixth decision was not to grant him renal dialysis treatment at Addington Hospital. This decision was a combination of a professional medical decision as to the status of Mr Soobramoney's health and his prognosis, and a decision as to the applicability of the established guidelines to his situation (strictly speaking there may be circumstances where preconceived guidelines, no matter how well conceived, may not be applicable and the administrative process should take cognizance of this possibility if it is to be fair). The principles of rationality, good faith and reasonableness must run through all of them if the judgment of the court in *Soobramoney* is taken at more than just face value. The spectrum of the general to the specific, in terms of the impact of the policy decision taken by the provincial health authorities in *Soobramoney* was not specifically considered by the court in its judgment. However, it is implicit in the judgment that the values of reasonableness, rationality, fairness and good faith are applicable irrespective of the general or specific impact of the decision. Represented diagrammatically the decision chain would be as in Figure 1 below.

Figure1: Sequence Of Decisions Taken In Soobramoney vs The Minister Of Health (KwaZulu-Natal)



The court in refraining from interfering in both the political and operational decisions, and in recognizing the existence of these different levels and the fact that decisions were best left to persons working within those levels, effectively recognized the principle of subsidiarity which holds that decisions are best taken and powers best allocated to those levels of organisation which, by virtue of their nature, are most able and knowledgeable to take such decisions and exercise such powers and which are most directly affected by them¹⁶⁰. The principle of subsidiarity is of particular significance in the field of administrative law since it describes the rationale behind the doctrine of separation of powers. Like the concept of lawfulness, already discussed, subsidiarity implies the concept of a single, unified, underlying order for the distribution of power. Guerin¹⁶¹ describes it as about making sure that decisions are taken at the most appropriate level, for example by those most directly affected, by those best informed and those best placed to deal with the any consequences. In the context of separation of powers and the amber and green light theories of administrative law, the judiciary is the worst possible place to locate budgetary allocation decisions. By its own admission in *Soobramoney* and *TAC*, the constitutional court took the view that such decisions were best left to others¹⁶². What would happen in a situation in which a budgetary allocation decision is challenged as being unconstitutional? How would the constitutional court achieve or maintain the

¹⁶⁰ Subsidiarity has been described, but not mentioned by name, in a papal encyclical entitled "Quadragesimo Anno" (QA) of 1931 as a "weighty principle of social philosophy". The QA reads: "Just as it is gravely wrong to take from individuals what they can accomplish by their own initiative and industry and give it to the community, so also it is an injustice and at the same time a grave evil and disturbance of right order to assign to a greater and higher association what lesser and subordinate organizations can do. For every activity ought, of its very nature to furnish help to the members of the body social, and never destroy and absorb them." In the context of information systems, described in *The Principia Cybernetica Web* in its 'Dictionary of Cybernetics and Systems' as follows: "Problems are best solved in the subsystem where they arise. This is similar to the idea of management by exception. Subsystems are encouraged to resolve their conflicts themselves without referring them to higher authority. Whatever the solution is adopted, the subsystem will have to carry it out. Since their consent is essential, the optimum condition is for them to resolve their conflicts independently. If a solution is worked out by the subsystem, appeal to authority is not necessary. (Wheeler, 1970 p 133)".

¹⁶¹ Guerin K 'Subsidiarity: Implications For New Zealand Treasury Working Paper 02/03
<http://www.treasury.govt.nz/workingpapers/2002/>

¹⁶² In *TAC*, (fn 159 *supra*) the court observed that "it should be borne in mind that in dealing with such matters the courts are not institutionally equipped to make the wide-ranging factual and political enquiries necessary for determining what the maximum care standards called for by the first and second amici should be, nor for deciding how public revenues should most effectively be spent... Courts are ill-suited to adjudicate upon issues where court orders have multiple social and economic consequences for the community. The Constitution contemplates rather a restrained and focused role for the courts, namely to require the state to take measures to meet its constitutional obligations and to subject the reasonableness of these measures to evaluation. Such determinations of reasonableness may in fact have budgetary implications but are not in themselves directed at rearranging budgets. In this way the judicial, legislative and executive functions achieve appropriate constitutional balance." In *Soobramoney* (fn 158 *supra*) the court said "The provincial administration which is responsible for health services in KwaZulu-Natal has to make decisions about the funding that should be made available for health care and how such funds should be spent. These choices involve difficult decisions to be taken at the political level in fixing the health budget, and at the functional level in deciding upon the priorities to be met. A court will be slow to interfere with rational decisions taken in good faith by the political organs and medical authorities whose responsibility it is to deal with such matters."



appropriate constitutional balance between the 3 spheres of government – i.e. the legislature, the executive and the judiciary? It is submitted that the principle of subsidiarity supplied the most workable solution. As the constitutional court itself points out, the courts are ill-suited to this kind of decision. In keeping with the idea that the role of the courts is to require the state to take measures to meet its obligations and to subject the reasonableness of these measures to evaluation, it is submitted that the judiciary, when faced with a claim that a budgetary allocation decision is unconstitutional should approach the matter in much the same way as it did in *Soobramoney* when faced with a complaint that essentially involved decisions taken on the basis of expert knowledge in the field of medicine and public administration. It did not interfere with the substance of those decisions. In fact it could not legitimately do so since judges are, by definition, not health economists, politicians, public health administrators or medical doctors. Instead the court looked at the circumstances of the decisions taken and the needs they sought to address. It considered the rationality of the decisions, their reasonableness and fairness and the purpose for which they were taken. It addressed the framework or substructure of the decision rather than directly scrutinising and critiquing its substance. An analogy can be drawn between this situation and one in which a court is required to decide a claim for medical negligence on the basis of expert medical evidence. In such a situation the court determination will involve the examination of expert opinions and the analysis of their essential reasoning preparatory to the court's reaching its own decision on the issues raised¹⁶³. Carstens¹⁶⁴ points out that the court is faced with a problem in assessing conflicting schools of thought in medical practice. It has no idea what the reasonable, medically qualified person would have done in the circumstances because on the basis of the expert evidence available, there is not one reasonable medical practitioner but two or even more. The court itself lacks the expertise necessary to decide on the most appropriate medical decision that should have been taken under the circumstances which is why there is a need for expert medical evidence in the first place. Carstens postulated 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. He points out that logic refers to a process of

¹⁶³ See for example *Michael v Linksfield Park Clinic (Pty) Ltd* 2001 (3) SA 1188 (SCA). This case is discussed in detail in chapter 9 of this thesis dealing with cases in delict involving the private sector.

¹⁶⁴ Carstens P 'Setting the boundaries for expert evidence in support or defence of medical negligence – *Michael v Linksfield Park Clinic (Pty) Ltd*' *THRHR* 2002 p 430

reasoning/rationality based on scientific or deductive cause and effect whereas reasonableness is a value judgement indicative of or based on an accepted standard or norm. He notes that whilst it is true that logic more often than not is an integral part of reasonableness, it does not necessarily follow that logic can equate to reasonableness. Carstens submits that the true test for expert medical opinion is that the opinion should objectively and clinically reflect the standard or norms of accepted medical practice in the particular circumstances. In the same way, in the case of a budgetary allocation decision, it is submitted that the decision should objectively and clinically reflect constitutional and administrative law standards or norms in the particular circumstances. Carstens states that in the event of conflicting expert opinion or different schools of thought even a conflicting and minority school of thought or opinion will be acceptable provided that such opinion accords with what is reasonable by that branch of the medical profession. The thrust of the argument is that one cannot directly question the expertise or the knowledge base used to make a decision but one can interrogate the conclusions drawn and the actions taken in the light of that expertise or knowledge base. The decisions taken must be in line with or rationally connected to the knowledge base. It must be clear from the particular knowledge base that was used, what the reasons for the decision were. In *Michael* the court outlined an approach to expert evidence which includes-

- the examination of the opinions and the analysis of their essential reasoning;
- the evaluation of expert evidence to determine whether and to what extent the opinions advanced are founded on logical reasoning
- the fact that the logical basis of the opinion must be evident to the court i.e. that the expert has considered the comparative risks and benefits and reached a defensible conclusion.

In much the same way that expert decisions can be meaningfully evaluated by a court of law unversed in the subject matter of the relevant area of expertise, so too budgetary allocation decisions can be meaningfully evaluated by a court on the basis of an examination of the substructure of the decision. Generic evaluation criteria include internal comparisons whereby one aspect of a decision and the logic behind it as given by the decisionmaker is tested against another aspect of the same decision to ascertain whether there is internal consistency, the nature of the logic structures upon



which the decision is based including the quality of their construction in terms of the density and spread of the data upon which conclusions have been reached, the reasons why alternative conclusions or decisions have been rejected, the relationship of the variables involved in the decision to constitutional values and principles, the balancing of any conflicting rights and interests and the method or reasoning by which the perception of balance by the decision maker was achieved. The courts have observed that they may not substitute their own decisions for those of other organs of state simply because they don't like the decision that was taken¹⁶⁵. If the primary object is the preservation of the principle of separation of powers and recognition of the principle of subsidiarity then this is, with respect, correct. The courts may not usurp the powers of the legislature or the executive any more than the national, provincial and municipal spheres of government may encroach upon each other's jurisdictions. This would be contrary to subsidiarity and the constitutional order upon which the South African legal system is based. The distinction between the power of the judiciary and the power of the other branches of government may seem to be a fine one in principle but it is nonetheless important in practice and must be observed. The courts cannot and should not take policy decisions reserved for executive government and the legislature especially in situations involving polycentric spider webs¹⁶⁶ of cause and effect. They can and should pronounce on the constitutionality of the actions of the other branches of government at a level and in a manner which preserves and strengthens the credibility of all three branches.

3.9.2 Administrative "Action"

¹⁶⁵ See the words of Chaskalson P in *Pharmaceutical Manufacturers Association Of SA And Another: In Re Ex Parte President Of The Republic Of South Africa And Others* (fn 72 supra) para 90 "Rationality in this sense is a minimum threshold requirement applicable to the exercise of all public power by members of the Executive and other functionaries. Action that fails to pass this threshold is inconsistent with the requirements of our Constitution and therefore unlawful. The setting of this standard does not mean that the Courts can or should substitute their opinions as to what is appropriate for the opinions of those in whom the power has been vested. As long as the purpose sought to be achieved by the exercise of public power is within the authority of the functionary, and as long as the functionary's decision, viewed objectively, is rational, a Court cannot interfere with the decision simply because it disagrees with it or considers that the power was exercised inappropriately."

¹⁶⁶ Fuller, L "The Forms and Limits of Adjudication" (1978-9) 92, *Harvard Law Review* p 353. The concept of polycentricity as explained by Fuller has been incorporated into South African jurisprudence by way of the judgments in *Bel Porto School Governing Body and Others v Premier, Western Cape, and Another* 2002 (3) SA 265 (CC); *Van Biljon and Others v Minister of Correctional Services And Others* 1997 (4) SA 441 (C); *Kolbatschenko v King No and Another* 2001 (4) SA 336 (C).

It has been said that “at the very least ‘administrative action’ includes all action of an administrative nature taken by bodies exercising public power”¹⁶⁷. This begs the question: what is action of an administrative nature and is thus not particularly helpful. According to Klaaren, the exercise of a discretion is administrative action. The process of a government tender is administrative action and action taken by bodies such as parastatal corporations with the status of organs of state is administrative action. He observes that it should be interpreted to cover not only adjudicative administrative decisions but also delegated and subordinate legislation because to restrict the clause to adjudications only would be unthinkable, given the vast bulk of governmental administration undertaken by regulation¹⁶⁸. In *Fedsure Life Assurance Ltd and Others v Greater Johannesburg Transitional Metropolitan Council*¹⁶⁹ the constitutional court held that the right to administrative justice contemplated in section 24 of the Interim Constitution did not apply to by-laws made by a municipal council. The court said that the proper form of accountability for this type of governmental action was political to the electorate rather than judicial through the courts. In *Cekeshe & Others v Premier of the Eastern Cape & Others*¹⁷⁰ the court held that as a general rule ‘legislative action which has its source in the parliamentary process in the sense that there is a special opportunity for a motion and debate by a body with legislative powers will by definition not qualify as “administrative action”’.

3.9.3 Summary

In summary, it must be noted that the grounds rules that are emerging from court decisions involving administrative law are-

¹⁶⁷ Devenish *et al* (fn 15 *supra*) p 126. At footnote 71, they refer to *Jeeva v Receiver of Revenue, Port Elizabeth* 1995(2) SA 433 (SE) 441 in this regard where the court held that “a Commission of inquiry authorized by the Master of the Supreme Court and held under the machinery of the Companies Act is administrative action”. They also refer to Klaaren J “Administrative Justice” in the *Constitutional Law of South Africa* (original service 1996) (eds) Chaskalson *et al* 25-2.

¹⁶⁸ See Klaaren J (fn 9 *supra*). He notes that in *Fedsure Life Assurance Ltd & Others v Greater Johannesburg Transitional Metropolitan Council & Others* (fn 13 *supra*) the constitutional court clearly supported coverage by the administrative justice clause beyond administrative adjudications. The court, notes Klaaren, was willing to go beyond the bounds of *South African Roads Board v Johannesburg City Council* 1991 (4) SA 1 (A) where Milne JA elaborated upon a distinction between those government decisions applying generally (termed ‘legislative’) and those applying in a particular situation. The court in *Fedsure* commented that the cases referred to by Milne JA in exempting the impact of natural justice upon legislative decisions were of ‘little assistance’ in determining the content of administrative action in terms of the Constitution. Klaaren quotes from the judgment as follows: “Laws are frequently made by functionaries in whom the power to do so has been vested by a competent legislature. Although the result of the action taken in such circumstances may be ‘legislation’, the process by which the legislation is made is in substance ‘administrative.’” (para 27 of the judgment). He notes that the action of making delegated and subordinated legislation is thus administrative action. He notes further that “not only the decisions or rules promulgated under a statute but also the statutory regulatory framework itself falls within the substantive reach of section 33 of the Constitution. One does not only have a right to procedures laid down in legislation. Such procedures themselves will be scrutinized under s 33 (and s34).”

¹⁶⁹ *Fedsure Life* (fn 13 *supra*)

¹⁷⁰ *Cekeshe* 1999 (3) SA 56 (Tk)

- The source of the power though not necessarily decisive, is a relevant factor;¹⁷¹
- The nature of the holder of the power does not determine whether a decision is administrative or otherwise;¹⁷²
- The nature of the power is also an important factor;¹⁷³
- The subject-matter of the power is significant in determining whether the exercise of the power constitutes administrative action;¹⁷⁴
- whether it involves the exercise of a public duty; and
- how closely it is related on the one hand to policy matters, and on the other to the implementation of legislation .

In the sequence of decisions that led to *Soobramoney*, it is clear that not all of them could be categorised as administrative. The enactment of the Division of Revenue Act that applied in the year that Mr Soobramoney applied for renal dialysis to the provincial authorities, for instance, is not administrative action. The decision within the province to allocate a certain amount of funding to health is not administrative action and neither is the decision as to how the amount so allocated should be utilised in order to best deliver all of the health services for which the provincial department of health is responsible¹⁷⁵.

171 *President Of The Republic Of South Africa And Others v South African Rugby Football Union And Others* fn 51 *supra*

172 The focus of the enquiry as to whether conduct is 'administrative action' is not on the arm of government to which the relevant actor belongs, but on the nature of the power he or she is exercising (*President of the Republic of South Africa and Others v South African Rugby Football Union and Others* 2000 (1) SA 1 (CC)). In *Hayes and Another v Minister Of Finance and Development Planning, Western Cape, And Others* 2003 (4) SA 598 (C) the court said that what has to be taken into consideration is, inter alia, the source of the power, the nature of the power, its subject-matter, whether it involves the exercise of a public duty and "how closely it is related on the one hand to policy matters which are not administrative, and on the other hand to the implementation of legislation, which is."

173 Determining whether an action should be characterised as the implementation of legislation or the formulation of policy may be difficult. It will, as we have said above, depend primarily upon the nature of the power. See *President Of The Republic Of South Africa And Others v South African Rugby Football Union And Others* fn 51 *supra*. See also *Pennington v Friedgood And Others* (fn 129 *supra*) in which the court stated: "The question relevant to s 33 of the Constitution is not whether the action is performed by a member of the executive arm of Government, but whether the task itself is administrative or not and the answer to this is to be found by an analysis of the nature of the power being exercised."

174 "Determining whether an action should be characterised as the implementation of legislation or the formulation of policy may be difficult. It will, as we have said above, depend primarily upon the nature of the power. A series of considerations may be relevant to deciding on which side of the line a particular action falls.... While the subject-matter of a power is not relevant to determine whether constitutional review is appropriate, it is relevant to determine whether the exercise of the power constitutes administrative action for the purposes of s 33." *President Of The Republic Of South Africa And Others v South African Rugby Football Union And Others* fn 51 *supra*.

175 Section 1 of the PAJA exempts from the definition of administrative action the executive powers or functions of the Provincial Executive including the powers or functions referred to in section 125 (2) (d), (e) and (f) of the Constitution. This section states that the Premier exercises the executive authority together with the other members of the Executive Council, by (d) developing and implementing provincial policy; (e) co-ordinating the functions of the provincial administration and its departments; (f) preparing and initiating provincial legislation.

Each decision in the *Soobramoney* sequence, except the final one, has the potential effect of rendering Mr Soobramoney and others in his position eligible for renal dialysis. From a practical point of view, the underlying constitutional values and principles are the same irrespective of the level of the decision – the values of human dignity, equality, non-racialism and non-sexism and the constitutional rights to equality, life and access to health care services are relevant to every decision in the chain.

In *Premier, Mpumalanga & Another v Executive Committee of the Association of Governing Bodies of State-Aided Schools: Eastern Transvaal*¹⁷⁶ O'Regan J held as follows:

“In determining what constitutes procedural fairness in a given case, a court should be slow to impose obligations upon government which will inhibit its ability to make and implement policy effectively (a principle well recognised in our common law and that of other countries). As a young democracy facing immense challenges of transformation, we cannot deny the importance of the need to ensure the ability of the executive to act efficiently and promptly. On the other hand, to permit the implementation of retroactive decisions without, for example, affording parties an effective opportunity to make representations would flout another important principle, that of procedural fairness.”

The fact that there is in many instances a fine line within the current constitutional order, between an “administrative” decision and a “policy” decision, makes it advisable from the perspective of the policymaker for the same considerations of lawfulness, rationality, fairness, transparency, reasonableness, and the absence of arbitrariness and bias to apply in health policy decisions.

3.10 Different Kinds of Power

The question as to when the state is exercising a public power and when it is exercising some other power, for instance contractual power or political power, is of considerable importance in a consideration of the nature of the relationship of the provider of public health care services to the patient. When the state is providing health care services is it providing those services in terms of a purely constitutional obligation or does the patient contract with the state for the relevant services? Is the

¹⁷⁶ *Premier, Mpumalanga & Another* 1999 (2) SA 91 (CC)

state providing health services in fulfilment of a statutory obligation or in terms of the exercise of a function or power of government? If so does this preclude the existence of a contractual relationship between public provider and patient? Is the fact that in terms of section 27(1) people have a right of *access* to health care services rather than a right to health care services *per se* of significance in this context? The state has many different legal bases for its many and varied transactions and it is important to ascertain the nature of the legal basis upon which it provides health care services¹⁷⁷. There is the possibility that the provision of health care services is based upon more than just one particular area of law for example constitutional law, and that it is a mixture of constitutional, administrative, contractual and statutory law depending upon the circumstances of each case. Not every act by the state constitutes an administrative act¹⁷⁸. For instance it has been held that the cancellation of a contract

¹⁷⁷ See for instance *Shoprite Checkers (Pty) Ltd v Ramdau No And Others* 2001 (4) SA 1038 (LAC) where Zondo JP stated at p 1044 that: "In para [18] of the judgment in *Carephone Froneman DJP* does not seem to have appreciated that the administrative justice section could only apply if the action in question was an administrative action and that, because of this, a court would have no choice but to have to satisfy itself that such action was an administrative action before it could apply the provisions of the administrative justice section to it. This means that, however regrettable or even unpalatable it may be to have to classify actions according to whether they are administrative, judicial or quasi-judicial, courts have no choice but to classify actions according to such categories in certain circumstances under the new constitutional order in order to give effect to certain constitutional provisions."

¹⁷⁸ In *Permanent Secretary, Department of Education and Welfare, Eastern Cape, and Another v Ed-U-College (PE) (Section 21) Inc* 2001 (2) SA 1 (CC), the constitutional court noted that: "The applicants argued, in the alternative, that the exercise of the statutory power by the MEC involved a policy decision which either does not constitute administrative action or, if it does, was administrative action not subject to administrative review in this case. The applicants argued that the power conferred by s 48(2) of the Schools Act was political in nature and therefore its exercise does not constitute administrative action as contemplated by s 33 of the Constitution. In this regard, the applicants relied on the following dictum in the case of *Premier, Mpumalanga, and Another v Executive Committee, Association of State-Aided Schools, Eastern Transvaal*: 'In my view, the learned Judge did not consider sufficiently the fact that s 32 of the Act reserves the decision as to what grants should be made to state-aided schools to the second applicant, a duly elected politician, who is a member of the executive council of the province. By definition, therefore, the decision to be made by the second applicant was not a judicial decision but a political decision to be taken in the light of a range of considerations... (A) Court should generally be reluctant to assume the responsibility of exercising a discretion which the legislature has conferred expressly upon an elected member of the executive branch of government.'

To the extent that the applicants relied upon this case to establish that a decision to allocate subsidies is not reviewable as administrative action in terms of the Constitution, they were mistaken. The case is authority for the contrary proposition. This *dictum* is concerned not with the question of the character of the power exercised by the official and whether it was administrative action or not but with the question of when it is appropriate for a court to substitute its decision for that of an administrative official." The constitutional court continued at para 18 to observe that: "In *President of the Republic of South Africa and Others v South African Rugby Football Union and Others* this Court held that, in order to determine whether a particular act constitutes administrative action, the focus of the enquiry should be the nature of the power exercised, not the identity of the actor. The Court noted that senior elected members of the Executive (such as the President, Cabinet Ministers in the national sphere and members of executive councils in the provincial sphere) exercise different functions according to the Constitution. For example, they implement legislation, they develop and implement policy and they prepare and initiate legislation. At times the exercise of their functions will involve administrative action and at other times it will not. In particular, the Court held that when such a senior member of the Executive is engaged upon the implementation of legislation, this will ordinarily constitute administrative action. However, senior members of the Executive also have constitutional responsibilities to develop policy and initiate legislation and the performance of these tasks will generally not constitute administrative action. The Court continued as follows: "Determining whether an action should be characterised as the implementation of legislation or the formulation of policy may be difficult. It will, as we have said above, depend primarily upon the nature of the power. A series of considerations may be relevant to deciding on which side of the line a particular action falls. The source of the power, though not necessarily decisive, is a relevant factor. So, too, is the nature of the power, its subject-matter, whether it involves the exercise of a public duty and how closely it is related on the one hand to policy matters, which are not administrative, and on the other to the implementation of legislation, which is. While the subject-matter of a power is not relevant to determine whether constitutional review is appropriate, it is relevant to determine whether the exercise of the power constitutes administrative action for the purposes of s 33. Difficult boundaries may have to be drawn in deciding what should and what should not be characterised as administrative action for the purposes of s 33. These will need to be drawn carefully in the light of the provisions of the Constitution and the overall constitutional purpose of an efficient, equitable and

by an organ of state was not an administrative act¹⁷⁹. Decisions which are made in fulfilment of statutory obligations have been held not to be administrative acts.¹⁸⁰ A decision to issue summons for recovery of arrear payments for services rendered was held as not falling within ambit of administrative action as contemplated in s 33 of Constitution¹⁸¹. The Supreme Court of Appeal has observed that:

“It is patently clear that the fundamental right created by s 33(1) and (2) of the Constitution is that of lawful and procedurally fair administrative action. I emphasise the words ‘administrative action’, because they emphasise the very first question to be asked and answered in any review proceeding: what is the administrative act which is sought to be reviewed and set aside? Absent such an act, the application for review is stillborn.”¹⁸²

ethical public administration. This can best be done on a case by case basis.”(Footnotes omitted.) It should be noted that the distinction drawn in this passage is between the implementation of legislation, on the one hand, and the formulation of policy on the other. Policy may be formulated by the Executive outside of a legislative framework. For example, the Executive may determine a policy on road and rail transportation or on tertiary education. The formulation of such policy involves a political decision and will generally not constitute administrative action. However, policy may also be formulated in a narrower sense where a member of the Executive is implementing legislation. The formulation of policy in the exercise of such powers may often constitute administrative action.” O’Regan J at para 19 pointed out that: “If it is decided that the exercise of the statutory power does constitute administrative action, the enquiry is not ended. It is necessary then to determine what the Constitution requires. For example, it will be necessary to decide whether the action has been conducted in a procedurally fair manner, whether it is reasonable and lawful. Determining what procedural fairness and reasonableness require in a given case will depend, amongst other things, on the nature of the power.” (Footnotes omitted)

179 *Cape Metropolitan Council v Metro Inspection Services (Western Cape) CC And Others* (fn 48 *supra*). The court noted at para 18 p 1023 - 1024 that: “The appellant is a public authority and, although it derived its power to enter into the contract with the first respondent from statute, it derived its power to cancel the contract from the terms of the contract and the common law. Those terms were not prescribed by statute and could not be dictated by the appellant by virtue of its position as a public authority. They were agreed to by the first respondent, a very substantial commercial undertaking. The appellant, when it concluded the contract, was therefore not acting from a position of superiority or authority by virtue of its being a public authority and, in respect of the cancellation, did not, by virtue of its being a public authority, find itself in a stronger position than the position it would have been in had it been a private institution. When it purported to cancel the contract it was not performing a public duty or implementing legislation; it was purporting to exercise a contractual right founded on the consensus of the parties in respect of a commercial contract. In all these circumstances it cannot be said that the appellant was exercising a public power. Section 33 of the Constitution is concerned with the public administration acting as an administrative authority exercising public powers, not with the public administration acting as a contracting party from a position no different from what it would have been in had it been a private individual or institution.” At para 19 p 1024, it distinguished the situation termination of the contract from the conclusion of a contract on the following basis: “In support of the contention that the appellant’s cancellation of the contract constituted ‘administrative action’ the first respondent’s counsel, in argument before us, referred to the decision in *Umfolozu Transport (Edms) Bpk v Minister van Vervoer en Andere* [1997] 2 B All SA 548 (SCA) at 552j - 553a, in which this Court held that the State Tender Board’s handling of tenders for transport for the government constituted administrative action. They also referred to the decision in *Transnet Ltd v Goodman Brothers (Pty) Ltd* (fn 35 *supra*) at 870D - F, in which this Court held that the actions of Transnet in calling for and adjudicating tenders constituted administrative action. In those cases the Court reasoned that the conclusion of a contract was preceded by purely administrative actions and decisions by officials in the sphere of the spending of public money by public bodies in the public interest. Different considerations apply in those circumstances. Section 217(1) of the Constitution specifically provides that when an organ of state in the national, provincial or local sphere of government, or any other institution identified in national legislation, contracts for goods or services, it must do so in accordance with a system which is fair, equitable, transparent, competitive and cost-effective.”

180 In *Steele And Others v South Peninsula Municipal Council And Another* 2001 (3) SA 640 (C) it was held that a decision of a municipality to remove half of the speed bumps constructed in certain suburban roads was not a legislative or an administrative act but rather the exercise of the municipal council’s constitutional authority and right to govern the local government affairs of its community. The resolution was not an implementation of any law but rather fulfilment of council’s statutory obligation to see to traffic control and road safety. This decision seems to make a fairly fine distinction between implementation of law versus fulfilment of a statutory obligation. In many circumstances the distinction may be difficult to draw at all since the distinction between a power and an obligation is not necessarily always clear-cut.

181 *Eastern Metropolitan Substructure v Peter Klein Investments (Pty) Ltd* 2001 (4) SA 661 (W)

182 *Gamevest (Pty) Ltd v Regional Land Claims Commissioner, Northern Province and Mpumalanga, and Others* 2003 (1) SA 373 (SCA) at p 382

Only administrative action is subject to the Promotion of Administrative Justice Act¹⁸³ and the remedies laid down in that Act are only available therefore, in respect of administrative action as defined therein. In terms of s 1 of the PAJA, the phrase ‘administrative action’ is defined as meaning-

“any decision taken, or any failure to take a decision by –

- (a) an organ of state, when –
 - (i) exercising a power in terms of the Constitution or a provincial constitution; or
 - (ii) exercising a public power or performing a public function in terms of any legislation; or
- (b) a natural or juristic person, other than an organ of state, when exercising a public power or performing a public function in terms of an empowering provision, which adversely affects the rights of any person and which has a direct, external legal effect, but does not include –
 - (aa) the executive powers or functions of the National Executive, including the powers or functions referred to in ss 79(1) and (4), 84(2)(a), (b), (c), (d), (f), (g), (h), (i) and (k), 85(2)(b), (c), (d) and (e), 91(2), (3), (4) and (5), 92(3), 93, 97, 98, 99, and 100 of the Constitution;”¹⁸⁴

183

Fn 8 *supra*

184

The intention behind some of these exclusions is not altogether clear. Closer analysis yields some anomalous results. In some of the sections of the Constitution referred to there are two basic types of powers and functions as opposed to just one. It is not clear whether the PAJA intends both types in every case. For example in terms of section 91(2) the President appoints the Deputy President and Ministers, assigning their powers and functions, and may dismiss them. The first type of power and function in this provision is the powers and functions that are assigned to the Deputy President and the Ministers by the President. The second type is the power and function of the President in this section to appoint the Deputy President and the Ministers and dismiss them and to assign to them their powers and functions. Which are the powers and functions “referred to” in section 91(2)? Is it only the former? Only the latter? Or both types? If the act of the President in assigning to the Deputy President and the Ministers their powers and functions is an administrative act then it falls within the definition of “administrative action” in the PAJA and the same rules apply to it. Section 84(2)(i) which relates to the appointment of ambassadors, plenipotentiaries, and diplomatic and consular representatives by the President is excluded from the definition of “administrative action” in the PAJA but section 84(1)(e) referring to the making of any appointments that the Constitution or legislation requires the President to make, other than as head of the national executive, is not. In view of the fact that section 91(3) and (4) are included in the PAJA’s list of exclusions it would seem that the President’s appointment of the Deputy President and the Minister’s does not constitute administrative action in terms of the PAJA. The question then returns the focus to the first type of powers and functions in section 91(2), i.e. those assigned to the Deputy President and the Ministers by the President. Do they also fall outside of the definition of administrative action given in the PAJA or not? The fact that section 91(3) and (4) of the Constitution are part of the exclusions to the definition inclines one to the interpretation that they do not fall outside of the definition. This conclusion is strengthened by the fact that the PAJA excludes from the definition of administrative action those powers and functions referred to in section 92(2) of the Constitution but not sections 92(1) and 92(3). These subsections refer respectively to the responsibility of the Deputy President and the Ministers for the powers and functions of the executive assigned to them by the President and the requirement that members of Cabinet must act in accordance with the Constitution and provide Parliament with full and regular reports concerning matters under their control. However an obvious counterargument is that the reason the powers and functions in section 92(1) are not excluded from the definition of administrative action in the PAJA is simply that it would constitute unnecessary repetition of what was already excluded by way of the reference to section 91(2). The confusion is further compounded by the fact that section 93 is excluded from the PAJA’s definition of administrative action. This section confers upon the President the power to appoint Deputy Ministers from among the members of the National Assembly. If the appointment of Deputy Ministers is not an administrative action in terms of the PAJA then how can the appointment of Ministers and the Deputy President be otherwise? Section 99 of the Constitution, also excluded by the PAJA definition of administrative action, is another section that refers to two kinds of powers and functions. It refers to the power of a Cabinet Minister to assign any power



- (bb) the executive powers or functions of the Provincial Executive, including the powers or functions referred to in ss 121(1) and (2), 125(2)(d), (e) and (f), 126, 127(2), 132(2), 133(3)(b), 137, 138, 139 and 145(1) of the Constitution;
- (cc) the executive powers or functions of a municipal council;
- (dd) the legislative functions of Parliament, a provincial legislature or a municipal council;

or function that is to be exercised or performed in terms of an Act of Parliament to a member of a provincial Executive Council or to a Municipal Council. It also refers to the powers and functions assigned. If one looks at section 100 (another exclusion in the PAJA definition of administrative action) the confusion deepens. In terms of subsection (1)(b) of section 100, when a province cannot or does not fulfil an executive obligation in terms of legislation or the Constitution, the national executive may intervene by taking any appropriate steps to ensure fulfilment of that obligation including assuming responsibility for the relevant obligation in that province to the extent necessary to *inter alia* maintain essential standards or meet established minimum standards for the rendering of a service. Must one come to the conclusion in the light of the PAJA definition of administrative action and the exclusion of section 100 that all executive action whether in terms of the Constitution or other legislation is not administrative action? If this is indeed the intention of the PAJA then the question becomes: how one distinguishes administrative action from executive action? Section 101 of the Constitution is headed 'Executive Decisions'. It refers to decisions taken by the President and requires them to be in writing if taken in terms of legislation or if they have 'legal consequences'. The section also requires that proclamations, regulations and other instruments of subordinate legislation must be accessible to the public. This discussion may seem overly technical but it is important to establish whether decisions of the state involving the provision of health care services are executive decisions or administrative ones. The decision of the court in *Steele's case* (fn 13 *supra*) suggests that decisions taken in the course of the exercise of a constitutional or statutory obligation are not administrative decisions. If decisions involving health care service delivery are not administrative decisions they cannot be challenged on the grounds of administrative law. Two concrete examples may help to illustrate the point. Cabinet takes a decision in principle that a programme involving the use of antiretroviral drugs in the treatment of AIDS must be developed and implemented. The decision is not taken in terms of any specific law except that it is within the parameters of the Constitution, more particularly section 27(2). The programme is duly developed by the National Department of Health, with the Minister of Health approving the various steps and aspects of the programme proposed by the Department. The provincial departments of health are tasked by Cabinet with implementing the programme in their respective provinces which means they will have to decide on human resources issues, at which facilities the programme can begin immediately as opposed to others to whom it must later be extended and how much funding to request from the central fund established for the purpose of the programme. In terms of the programme, doctors and medical superintendents of state hospitals employed by the provincial departments of health are empowered to take decisions concerning the stocks of the drugs they will maintain within their facility, the number of patients they will be able to treat effectively, whether or not a particular patient is eligible for the antiretroviral programme etc. Which of the various decisions taken at the different levels is executive and which, if any, are administrative? The decision by Cabinet is likely to be classified as an executive decision due to the nature of Cabinet itself but also due to the fact that Cabinet is acting in fulfilment of a constitutional obligation to achieve the progressive realisation of the right of access to health care services. The decisions by the Minister of Health in approving the various steps and aspects of the programme developed by the national Department of Health are likely to be executive for the same reason that those of Cabinet are executive. They are taken in the execution of the constitutional obligation expressed in section 27(2). In terms of section 85(2) of the Constitution the President exercises executive authority, together with other members of the Cabinet by *inter alia* developing and implementing national policy. The Cabinet decision to provide antiretroviral drugs is very much a national policy decision. What about the decisions taken by various officials of the provincial health departments, for instance in deciding how much funding to apply for, at which facilities the programme will be offered immediately and the redeployment of human resources for purposes of the programme? It is clear that at least some of these decisions will verge on administrative as opposed to executive ones. The decisions of the medical superintendents and medical doctors at each public health facility may be administrative where they involve questions of logistics but not necessarily where they are based on professional medical opinions or judgments in relation to individual patients. The irony is that were Cabinet to have legislated the programme into being rather than left it at the level of a policy decision, the implementation of the relevant national legislation is included under administrative action in terms of the PAJA definition since section 85(2)(a) is not one of the exclusions in the definition of administrative action in that Act. It would seem that the were the programme itself to be legislated, even though it was developed by the National Department of Health in exactly the same way, its implementation by the provinces would become administrative action on their part as might even the professional decisions of the medical practitioners attending the AIDS patients depending upon the level of detail to which the programme is legislated. The fact that the legislation itself is in terms of a constitutional obligation just as much as is the policy decision taken by Cabinet, does not, apparently, make a difference. Decisions taken in the implementation of legislation fall under the heading of administrative action while decisions taken in the implementation of a documented policy directive of Cabinet apparently do not necessarily. In the latter case one would have to examine the particular decision in question, the level at which it is taken, the nature of the knowledge base and circumstances informing it and its legal basis. The importance of the distinction between law and policy will further emerge in subsequent discussion.



- (ee) the judicial functions of a judicial officer of a court referred to in s 166 of the Constitution or a Special Tribunal established under s 2 of the Special Investigation Units and Special Tribunals Act¹⁸⁵, and the judicial functions of a traditional leader under customary law or any other law;
- (ff) decision to institute or continue a prosecution;
- (gg) a decision relating to any aspect regarding the appointment of a judicial officer, by the Judicial Service Commission;
- (hh) any decision taken, or failure to take a decision, in terms of any provision of the Promotion of Access to Information Act¹⁸⁶; or
- (ii) any decision taken, or failure to take a decision, in terms of s 4(1)'.

It is clear from this definition that administrative action is not confined to the state but can also be taken by private bodies¹⁸⁷. It is also clear that not all action by organs of state constitute administrative action or the exercise of administrative power¹⁸⁸. The Constitution gives a very broad definition of the term 'organ of state'¹⁸⁹. It is

¹⁸⁵ Act No 74 of 1996

¹⁸⁶ Act No 2 of 2000 .It is somewhat ironic that decisions taken in terms of the Promotion of Access to Information Act are not administrative action as defined in the PAJA given that access to information – especially state held information - is one of the primary concerns of administrative law. (See for instance Hoexter (fn 134 *supra*) at p 498 where in criticising the PAJA she observes that “the statute contains no duty on administrators to communicate their rules and standards in an appropriate manner to those likely to be affected by them.” It is, however, logical if one takes the view that the fulfilment of a statutory obligation does not amount to administrative action as the court did in *Steele* (fn 180 *supra*)

¹⁸⁷ *Devenish et al* (fn 15 *supra*) observe at p 25 that: ““Administrative action” is the conduct of public authorities and indeed private entities when they exercise public powers, perform public functions or are obliged to exercise authority in the public interest. This means that common law review no only applies in a very narrow field in relation to private entities that are required in their domestic arrangements to observe the common law principles of administrative law. This applies in relation to voluntary associations, such as sporting clubs and religious organisations.”

¹⁸⁸ *Devenish et al* (fn 15 *supra*) note that administrative acts are neither legislative nor judicial. They state that an administrative decision is one made according to administrative policy whereas a judicial one is made according to the law.

¹⁸⁹ Act 108 of 1996, section 239 states: ““organ of state’ means-

- (a) any department of state or administration in the national, provincial or local sphere of government; or
- (b) any other functionary or institution-

- (i) exercising a power or performing a function in terms of the Constitution or a provincial constitution; or
- (ii) exercising a public power or performing a public function in terms of any legislation,

but does not include a court or a judicial officer;”. In fact the vagueness of this language in the interim Constitution (Act 200 of 1993) has been criticised. See Woolman S, Chaskalson M, Kentridge J, Klaaren, Marcus G, Spitz D and Woolman S *Constitutional Law of South Africa* p10-35 who points out that: “The text also fails to make clear when the state is present in other guises. According to s7(1), the ‘Chapter binds all legislative or executive organs of state’. But what counts as organs of state? According to the definition in s 233(1)(ix), organs of state are understood to include ‘any statutory body of functionary’. While this definition of an organ of state prevents too unduly narrow an interpretation of those state actors bound by the Chapter, it still begs two questions. First, what counts as a statutory body? Is it enough that the institution has been created by statute for it to be a statutory body? Or must it possess additional special properties to deserve subjection to constitutional scrutiny? Secondly, what counts as a functionary? Is it enough that such functionary exercise what are generally recognised as state powers and prerogatives without any further imprimatur of the state? Or must the state be present in some other tangible way?” In passing it must be noted that the courts seem to prefer the secondary view. In *Nextcom (Pty) Ltd v Funde No And Others* 2000 (4) SA 491 (T), Bertelsmann J observed that: “In *Directory Advertising Cost Cutters v Minister of Posts Telecommunications and Broadcasting and Others* 1996 (3) SA 800 (T) ([1996] 2 All SA 83) Van Dijkhorst J investigated the circumstances which determine whether a body or functionary is an organ of State or not. In holding that Telkom, a statutory body, had to be qualified as such, he stated that an organ of State includes an institution which is ‘. . . an intrinsic part of government - i.e. part of the public service or consisting of government appointees at all levels of government - national, provincial, regional, and local - and those

important to note that it does not mean only public sector entities but includes other entities that exercise a public power or perform a public function. Other types of powers identified in the definition are judicial powers, legislative powers and executive powers. The decision of the Cape High Court in *Steele's case*¹⁹⁰ to the effect that a decision of a municipality to remove speed bumps was not a legislative or an administrative act but rather the exercise of the municipal council's constitutional authority and right to govern the local government affairs of its community and that the resolution was not an implementation of any law but rather fulfilment of council's statutory obligation to see to traffic control and road safety would appear at first glance to be at odds with the definition of "administrative action" in the PAJA quoted above until one refers to paragraph (cc) of the exclusions section of the definition

institutions outside the public service which are controlled by the state - i.e. where the majority of the members of the controlling body are appointed by the State or where the functions of that body and their exercise is prescribed by the state to such an extent that it is effectively in control. In short, the test is whether the state is in control.' (At 810F - H.) This test has been repeatedly applied since, compare *Korf v Health Professions Council of South Africa* 2000 (1) SA 1171 (T) and authorities there cited, as well as *Mistry v Interim National Medical and Dental Council of South Africa and Others* 1999 (7) BCLR 933 (D) and *ABBM Printing & Publishing (Pty) Ltd v Transnet Ltd* 1998 (2) SA 109 (W)."

In *Korf*, (fn 126 *supra*) the court had to decide whether the Health Professions Council was an organ of state for the purposes of the Constitution. It is a statutory body created by the Health Professions Act No 54 of 1973. Van Dijkhorst J made the following important observations at p 1177 to 1178: "Judgment in *Directory Advertising Cost Cutters (supra)* was delivered on 29 February 1996. The Constitution was promulgated on 18 December 1996 after having been adopted by the Constitutional Assembly on 8 May 1996. It must therefore be accepted that the drafters were aware of the different interpretations placed upon the predecessor of item 23(2) of Schedule 6 by the Courts in *Directory Advertising Cost Cutters* on the one hand and *Baloro* on the other. One is therefore enjoined to ascertain whether the Constitutional Assembly made a choice between the wider test of *Baloro* and the narrower one of *Direct Advertising Cost Cutters*. There is no evidence of such a choice for the interim period pending legislation in the mere re-enactment of item 23 of Schedule 6 to the interim Constitution. But even item 3(2) of Schedule 6 with its limited lifespan has to be interpreted in the light of the definition of organ of state in s 239 of the Constitution. It is more precise than the previous one, but is it wider? The 1993 definition 'statutory body or institution' has now become 'any other functionary or institution'. I do not think that therein lies a material difference. The latter phrase is further limited in the definition, whereas the 1993 definition was limited by the nature of an organ of State as explained in *Direct Advertising Cost Cutters*. Has the description set out in subpara (b) now extended the meaning of organ of state? Subparagraph (i) limits it to a power or function in terms of the national and provincial constitutions. This does not bring about a difference. Subsection (ii) limits it to a public power or public function in terms of any legislation. It does not bring about a difference insofar as the reference to public power is concerned. The remaining question then is whether the reference to a public function in terms of legislation takes the concept 'organ of state' out of the control test. The answer depends on the meaning given to the words 'public function'. The three pillars of the state, legislative, executive and judicial, are referred to in s 239. The latter is expressly excluded. The executive arm is expressly mentioned in subpara (a) and the legislative one falls under subpara (b)(i) which can also encompass, for example, the auditor-general, public protector, etc. They are all part of the machinery of state. So is a functionary (or institution) exercising a public power. There is no reason to give the word 'public' when used in conjunction with 'function' in para (b)(ii) a meaning that would take it outside the context of 'engaged in the affairs or service of the public' and give it the meaning of 'open to or shared by all the people'. (Both these meanings are given in *The Concise Oxford Dictionary* for the word 'public'.) It follows that the more precise definition of 'organ of state' in s 239 of the Constitution was not intended to differ materially from the 1993 definition. That definition was interpreted in *Direct Advertising Cost Cutters* to include the element of control. I adhere to that decision. The Supreme Court of Appeal also appears to favour the control test (in a different context) in the unreported judgment in *Umfolozai Transport (Edms) Bpk v Die Minister van Vervoer en Andere*, case No 231/95 in which judgment was delivered on 13 March 1997 (p 16). As stated, the decision in *Direct Advertising Cost Cutters* was followed and the control test was applied by other Courts in respect of both the interim Constitution and item 23(2)(a) of Schedule 6 to the Constitution. It was not argued that *Direct Advertising Cost Cutters* or these other cases are either inapplicable or wrong. It follows that the control test has to be applied in this case. The issue whether or not the respondent is an organ of state arose squarely in *Mistry v Interim National Medical and Dental Council of South Africa and Others (supra)*. In that case both Booysen J, who dismissed the applicant's claim for interim relief, and McLaren J, who dismissed the applicant's claim for final relief, applied the control test and concluded that the respondent's predecessor was not an organ of state. It will serve no purpose to repeat the facts set out at 947 - 8 of the judgment which led the Court to come to this conclusion. There has been no material change. The state is not in control of the respondent. The respondent is not an organ of state."

Korf was also applied in *Van Rooyen and Others v the State and Others* 2001 (4) SA 396 (T) and *Lebowa Mineral Trust v Lebowa Granite (Pty) Ltd* 2002 (3) SA 30 (T).

190

Steele fn 180 *supra*



which mentions the executive power or functions of a municipal council. The court in *Steele* apparently decided that the decision of the municipal council in question was not an administrative one because it constituted the exercise of the municipal council's executive powers or functions. Where then does this leave decisions involving the delivery of health care services? The definition in the PAJA excludes the executive powers or functions of the National Executive, including the powers or functions referred to in various sections of the Constitution. Some of the powers and functions reflected in section 85(2) of the Constitution are excluded from the definition of "administrative action". These are the exercise of executive authority by the President together with other members of the Cabinet by -

- (b) developing and implementing national policy;
- (c) co-ordinating the functions of state departments and administrations;
- (d) preparing and initiating legislation; and
- (e) performing any other executive function provided for in the Constitution or in national legislation.

Subparagraph (a) of section 85(2) refers to the implementation of national legislation except where the Constitution or an Act of Parliament provides otherwise. Significantly, the PAJA omits this section from its exclusion of what constitutes administrative action. This creates something of a problem in legal logic with regard to the provision of health care services. In terms of section 27(2) of the Constitution the state is required to take reasonable *legislative and other measures* to achieve the progressive realisation of the right of access to health care services within its available resources. Implementation of the legislative measures comprises administrative action whereas implementation of policy and other measures may or may not constitute administrative action depending upon the nature of the decision. It is important to note that it is only decisions taken by organs of state when exercising a *power* in terms of the Constitution or exercising a public *power* or performing a public *function* in terms of any legislation that fall within the definition of administrative action in the PAJA. Where the decision is taken in fulfilment of a constitutional *obligation* or in the fulfilment of an *obligation* in terms of legislation, it does not apparently constitute administrative action. The logic behind the fact that the fulfilment of a statutory obligation does not constitute an administrative action where the obligation in question is so specific that it leaves no room for discretion on the part of the official concerned is fairly obvious. One cannot subject to judicial review an act by a state

official which is done in the fulfilment of a clear and unambiguous instruction by the Legislature expressed in terms of law. Where, however there is room for discretion on the part of the official, for instance, as to the manner in which the obligation is fulfilled, it is submitted that there is scope for argument that the decision of the official in exercising that discretion could and in certain circumstances should be reviewable administrative action. For example a legislative obligation that a National Consultative Health Forum consisting of “relevant stakeholders” must be convened “at least once a year” in order to promote transparency and to involve the private sector and other interested parties in issues affecting health service delivery leaves a fair amount of discretion. Who are the relevant stakeholders? How are they identified and issued with invitations? When and in what circumstances should the minimum of one meeting a year be exceeded given the stated purpose of the Forum?

Since there is a constitutional *obligation* upon the state with regard to access to health care services in terms of section 27(2), it may well be argued that decisions taken in fulfilment of this obligation fall outside of the scope of the definition of administrative action and outside of the scope of the PAJA. A macroscopic consideration of the definition of administrative action in the PAJA reveals that it does not consist of the exercise of all types of power. It excludes certain types of power notably, executive, legislative and judicial in relation to the activities of the three spheres of government in exercising these types of power and functions. Thus the legislative functions and the executive powers or functions of a municipal council are excluded.

In terms of Part A of Schedule 4 of the Constitution, the national and provincial governments have concurrent legislative competence in the functional area of health services. Decisions taken in the exercise of this competence would therefore be excluded from the definition of administrative action. Since executive power follows legislative power it is logical that the executive powers of national and provincial governments are also excluded from the definition of administrative action. It is nevertheless not a simple matter to determine whether or not a particular action or decision amounts to an administrative rather than an executive action or decision. In the health context decisions are taken at many different levels and on many different bases. The injunction from the courts is not to look at the nature of the decision maker

but rather at the nature and impact of the decision itself in trying to decide whether or not it is an administrative decision. There is a further problem with the review of administrative decisions in the health context especially. Review tends to focus on irregularities in procedure albeit with a view at times to the substance of the case, depending on the circumstances. As long as the distinction between review and appeal remains, there will be an inevitable focus in review proceedings on procedural fairness. In the context of health care the setting aside of a decision on grounds of a procedural regularity can literally be hazardous to health. For example, the Medicines Control Council has the power to register medicines in South Africa in order for them to be sold here. The general rule is that unlicensed medicines may not be sold in South Africa. In deciding whether or not to register a medicine, the Council must look at the safety, efficacy and quality of the medicine. These criteria are scientific in nature. Should a decision of the Medicines Control Council not to register a medicine be set aside because although the Council acted incorrectly with regard to some procedural rule, the medicine is patently dangerous and it would not be in the public interest to have it registered here? Usually the court will refer the matter back to the decision making body when reviewing a decision of a public body. In this present example the outcome will inevitably be the same if the medicine is defective with regard to its safety, efficacy or quality. The only difference will be the procedural correctness in taking the decision. A court is not itself competent to decide on the safety, efficacy or quality of a medicine. For it to even attempt to interfere with the substance of a decision of the Medicines Control Council could be harmful to public health. In the case of a province deciding not to purchase a particular piece of expensive but highly effective emergency medical equipment for a major provincial hospital that deals regularly with road accident victims, the power of a court to refer the matter back to the provincial authorities once the victim has died is of little assistance to the victim. Is such a decision an administrative decision in any event given the Constitutional obligation to achieve the progressive realisation of the right of access to health care services?

A unilateral administrative act is referred to as a disposition.¹⁹¹ Wiechers¹⁹² defines a disposition as a unilateral act (other than a legislative or judicial act) whereby, in

¹⁹¹ Devenish *et al* (fn 15 *supra*) p 104.

given circumstances, an individual legal relationship is created, fixed, varied or terminated or whereby such creation, determination, variation or termination of a legal relationship is refused. It takes place by virtue of authoritative power vested in the administrative body. It is a rule of administrative law that an administrative organ may not regulate a general relationship by way of a disposition.¹⁹³ An example of a unilateral administrative act is the grant or refusal of a licence. The granting of a licence does not constitute a contract between the administrative body and the applicant. A licensing decision must take into account broader issues than just the benefit of the licence to the applicant. The public interest and the constitutional rights and obligations of both the applicant and of those who will be affected by the licensing decision must be taken into account. The relationship between the applicant for a licence and the licensing body is one founded upon administrative law and bounded by the particular statute granting the administrator the power to grant licences.

Where an administrative body enters into a contractual relationship, the contract is governed by principles of the private law of contract. However, Devenish *et al* point out that apart from a private law contract, the state can contract with private persons using an “authoritative contract”, the distinction between this type of contract and a private law contract being that the former contains an element of authoritative power whereas the latter is based on the principle of equality between contracting parties. The consent of the private party determines the extent and scope of the authoritative power. They observe that a bilateral administrative contract arises in a situation where the state renders an essential service such as the provision of electricity. A further example of a bilateral agreement is that of a collective labour agreement concluded by organised employers and employees organisations and then approved by the administrative authority and published in the form of subordinate legislation. According to Devenish *et al*, Wiechers is of the view that this type of contract provides the state with one of the best and most democratic methods of entering into the trade, labour and social life of the individual and so provides clear evidence of the fact that the functions performed by the administration are not only regulatory. They point out that such agreements must not be prohibited whether expressly or by

¹⁹² Wiechers *M. Administrative Law* p 122

¹⁹³ Devenish *et al* (fn 15 *supra*) p 104

necessary implication by common law or statute. They must also not amount to an obstruction of the authoritative function since an administrative authority may not fetter its powers of discretion or restrict its authoritative function. Such contracts may also not conflict with general peremptory provisions of the empowering Act or any other statute and in the absence of statutory authority they may not automatically impose coercive duties on third parties. They can however, confer rights and privileges on third parties. Finally they must be concluded in the general interest for a public purpose.¹⁹⁴

The term “public interest” is commonly found in administrative law but its meaning is not always easily determined or ascertained¹⁹⁵.

3.11 Decisions Involving Rationing

Health care service delivery often requires decisions involving rationing. South African examples include a decision to implement a clinical protocol that prohibits the ventilation of neonates weighing less than one kilogram or a decision that HIV/AIDS positive persons are not suitable candidates for organ transplantation.

The case of *Child B* in the United Kingdom is an example of an administrative decision involving the rationing of health care. In the United Kingdom the possibility of a contractual relationship between the patient and the provider of public health care is excluded¹⁹⁶. The National Health Service (NHS) introduced a full and

¹⁹⁴ See generally Devenish *et al* (fn 15 *supra*) at p105-106

¹⁹⁵ The court in *Asko Beleggings v Voorsitter Van Die Drankraad No En Anders* 1997 (2) SA 57 (NC) held that the meaning of the term ‘public interest’ was a wide and uncertain term. The term ‘public interest’ in s 22(2)(d)(i)(ee) had to be interpreted in this case to mean that the granting of the licence had to be in the interest of the community. In *Ex Parte North Central And South Central Metropolitan Substructure Councils Of The Durban Metropolitan Area And Another* 1998 (1) SA 78 (LCC) the court held that that in deciding whether the agreement complied with ss (6) of s 34 it was necessary to investigate the concept of ‘public interest’. It found that though the Courts had never defined the concept it was clear that in arriving at what was in the public interest they compared the deprivation of some private convenience with the benefit that was likely to result therefrom for the general public or part thereof. The constitutional court in *President Of The Republic Of South Africa And Others v South African Rugby Football Union And Others* 2000 (1) SA 1 (CC) distinguished between “public concern” and “public interest”. It held that a matter of public concern was, therefore, not a matter in which the public merely had an interest, it was a matter about which the public was also concerned. ‘Public concern’ in this context aid the court was therefore a more restricted notion than that of public interest.

¹⁹⁶ Kennedy I and Grubb *A Medical Law* p272 state that “The conventional understanding of the doctor-patient relationship within the NHS is that it is not contractual. However the orthodoxy has been challenged.” They note that until the NHS was created in 1948, treatment was either provided privately or on a charitable basis...”Within the NHS today it is generally accepted that there is no contractual relationship between a doctor (whether general practitioner or hospital doctor) and the patient (*Pfizer Corp v Ministry of Health* [1965] AC 512 (HL)). Equally, there is no contractual relationship between the patient and the hospital such as the NHS Trust, where the patient is cared for. Any claim for damages based upon a breach of duty lies only in tort and, in particular, in action for negligence.” They observe that the basis for the orthodoxy is two-fold. First, medical services within the NHS are provided to the patient pursuant to a



comprehensive public service of healthcare provision free at the point of consumption.¹⁹⁷ There is a legal duty upon every Health Authority in the NHS to arrange with regard to their area, personal medical services for all persons wishing to take advantage of the arrangements¹⁹⁸. The Health Authority contracts with general practitioners and other providers of health care services for the provision of services to patients. In terms of the British National Health Service Act every person is entitled to have a general practitioner as their doctor. The mechanism by which the relationship is created between a general practitioner and a patient is through an individual applying by delivery of his medical card or making an application for inclusion on the general practitioner's list of patients¹⁹⁹. It is largely governed by statute and the obligations of the general practitioners towards their patients are themselves defined by statute or subordinate legislation²⁰⁰. This means that the relationship between the patient and a public provider of health care services is based on administrative law as opposed to the law of contract which renders it of particular interest in the present context.

The case of *Child B* illustrates the relatively unique issues involving administrative decisions in this field. Child B was diagnosed with non-Hodgkin's lymphoma in 1990 for which she was treated at Addenbrooke's Hospital in Cambridge. In 1993 she was diagnosed with a second cancer, acute myeloid leukaemia. She underwent treatment at the Royal Marsden Hospital in London. Nine months later she relapsed and the paediatricians treating her advised that she had a further six to eight weeks to live. They expressed the view that a child with her medical history was unlikely to benefit from further intensive treatment and should be placed on palliative care only. Her

statutory obligation. Such compulsion to provide a service is considered to be inconsistent with a contractual arrangement. Secondly, the patient fails to provide the necessary consideration in return for the doctor (or other's) promise to treat which is necessary if a contract is to exist. However the statutory context within which a general practitioner functions is not necessarily inconsistent with a contractual arrangement. The authors cite the arguments in favour of a contractual relationship but then go on to point out that there are two factors which tell against them. They state that there is in truth no real reason for an English court to "divine a contract" between the parties. The structure of health care provision within the internal market of the NHS is antithetical to contractual arrangements. As an example, they give the fact that the National Health Service and Community Care Act 1990 specifically states that agreements between 'purchasers' and 'providers' are not legally enforceable contracts. Secondly the statutory and regulatory context in which health services are provided may lead a court to infer that the parties had no intention to create legal relations in the form of a contract. The South African law of contract does not subscribe to the doctrine of consideration and so the absence of a system of payment in the public sector would not be an obstacle to the formation of a contract. In any event in South Africa, public sector patients are classified on the basis of a means test and charged accordingly so except for the indigent, there is likely to be some form of 'consideration'.

197 Kennedy and Grubb (fn 196 *supra*) p53

198 British National Health Service Act 1977

199 Kennedy and Grubb, (fn 184 *supra*) p77.

200 E.g. National Health Service (General Medical Services) Regulations 1992 (SI 1992 No 635) and National Health Service (Pharmaceutical Services) Regulations 1992 (SI 1992 No 662)



father was not willing to accept this advice. He found two doctors in California who were willing to recommend that Child B should receive a second bone marrow transplant. The advice from the American doctors was far more optimistic than that of the British paediatricians and the latter were surprised by it. They did not accept the American view and reiterated their opinion that only palliative care should be given. The father then approached a leukaemia specialist at Hammersmith Hospital who also gave more positive advice than that of the paediatricians. The health authorities, when approached for permission for Child B to be treated at Hammersmith Hospital declined, arguing that the paediatricians caring for the child were in the best position to assess treatment options and that the authorities were not prepared to use resources on experimental procedures with only limited chances of success. The father consulted his solicitors who sought leave for judicial review to challenge the decision of the health authorities. This was granted. The High Court took the view that the health authority should reconsider its decision because the right to life was precious even though the chances of success were acknowledged to be low. The judgment was overturned on appeal. The judges in the Court of Appeals reaffirmed the reluctance of English courts to challenge health authority decisions on the funding of treatment and ruled that the authority had weighed the advice it had been given and there was no basis for its decision to be referred back for reconsideration. In response to the media coverage of the court case, an anonymous donor offered to provide funds for the treatment. The offer was accepted and treatment started in the private sector. The specialist who took over the treatment of the child decided not to undertake a second transplant but instead used an experimental form of treatment known as donor lymphocyte infusion. The treatment enabled the child to enjoy a few extra months of life. She eventually became ill again and died in May 1996²⁰¹. In discussing this case Ham notes that it demonstrates the tension between a concern to use resources for the benefit of the population as a whole and the urge to respond to the needs of individuals faced with the prospect of death.

In South African constitutional terms this case would be balancing the right to life of one individual against that of many others. The constitutional court in *Soobramoney v*

²⁰¹ Ham C "Tragic Choices in health care: Lessons form the *Child B Case*" *British Medical Journal* 1999; 319 p1258-1261 (6 November).

*Minister Of Health, Kwazulu-Natal*²⁰² was faced with a similar issue. It was a question of allowing one man who was essentially terminally ill due to a number of reasons to have renal dialysis at the expense of others who were likely to recover. The facts of this case and the judgement of the court have already been discussed in a previous chapter and so will not be repeated here. However it is worth considering from an administrative law point of view the circumstances of Soobramoney's case and that of *Child B* since in both cases the administrative authority successfully met the challenge to its decision. In both cases the ethical challenge was to meet the needs of all individuals within the available resources. As Ham points out, although health authorities have a particular responsibility to ensure justice in the allocation of these resources, they are also expected to respect each individual as a person in his or her own right. The Cambridge and Huntingdon Health Authority in the case of *Child B* was in a somewhat different position to the provincial health authority in KwaZulu-Natal in *Soobramoney* because in the former, the adult cancer specialists viewed the balance between the harm and benefit of the treatment differently from the paediatricians. In other words there was a dispute between the experts as to the efficacy of the treatment and the benefit Child B would derive from it. In *Soobramoney* there was no question that the patient would benefit from the renal dialysis. It was whether or not to give him preference over other patients who were undoubtedly likely to benefit more from it in terms of both quality of life and longevity. Ham makes reference to the "rule of rescue" which effectively states that when individuals are suffering from life-threatening conditions there is an obligation to intervene even when this may run counter to the concerns of the community as a whole²⁰³. This is apparently not in direct alignment with the views of Sachs J in

²⁰² *Soobramoney* fn 158 *supra*

²⁰³ Richardson J and McKie J "The Rule of Rescue" *Centre for Health Program Evaluation Working Paper 112* express the rule of reason concept as follows: "Why do we mount expensive searches – for sailors lost at sea, for example – when the likelihood of finding those missing is slim? (Creadon, 1997). Why do we offer critically ill patients intensive care, when the likelihood of it being effective is negligible? (Osborne and Evans 1994 p779). Why do some patients receive a second or third heart or liver transplant, when first-time recipients have a higher one-year survival rate? (Ubel *et al*, 1998 p 276–9). Is it possible to justify such practices when there are better uses for our resources? One consequence is that these practices manifest a psychological imperative that is hard to resist: namely, the urge to rescue identifiable individuals facing avoidable death, without giving too much thought to the opportunity cost of doing so. Jonsen dubbed this the 'Rule of Rescue' (Jonsen, 1986, pp172–4)." They explain that rule of rescue is not consistent with putting available resources to the best alternative use as follows "Whatever the explanation for the counter-intuitive ordering of Oregon's initial list, the Rule of Rescue (RR) is clearly at odds with CEA as ordinarily understood, and in particular with that form of CEA which uses the quality-adjusted life year or QALY as the measure of effectiveness. In its simplest form the QALY represents a year of life that has been weighted, or discounted, by an index of the quality of life. By convention, full health has a weighting of 1 and death has a weighting of zero. So, for example, if a year of life on hospital dialysis is considered to be worth only 60 per cent as much as a year of normal health, other things being equal, then 20 years of life on dialysis would be equivalent to 20 * 0.60 = 12 QALYs. In conventional CEA it is only the change in the length and quality of life that are of importance and QALYs combine these two dimensions of outcome. QALYs therefore provide a (conceptually) simple method for prioritizing health care: all else equal, the lower the cost of a



*Soobramoney*²⁰⁴ where he stated that health care rights by their very nature have to be considered not only in a traditional legal context structured around the ideas of human autonomy but in a new analytical framework based on the notion of human interdependence. Sachs J observed that a healthy life depends upon social interdependence: the quality of air, water and sanitation which the state maintains for the public good; the quality of one's caring relationships which are highly correlated to health; as well as the quality of health care and support furnished officially by medical institutions and provided informally by family, friends and the community. He pointed out that "When rights by their very nature are shared and inter-dependent, striking appropriate balances between the equally valid entitlements of expectations of a multitude of claimants should not be seen as imposing limitations on those rights (which would then have to be justified in terms of section 36) but as defining the circumstances in which the rights may most fairly and effectively be enjoyed. The rule of rescue approach apparently favours the right to life of an individual above the broader rights and interests of the community but it seems overly simplistic in the light of Sachs J's observations which suggest that one cannot entirely extricate the rights of an individual from the rights and interests of the community. A single individual's right to life or health cannot be seen independently of that of others in the context of limited, shared resources produced by the community as a whole. The rule of rescue approach, by contrast, states that there comes a point at which the rights and interests of the individual must be considered in isolation from the community in which he or she lives and functions. It is unhelpful in situations where the right to life of one person must be balanced against the same right to life of another such as was the case in *Soobramoney*."

QALY the greater the value for money offered by a programme or treatment, and thus the higher a priority it should be. But the RR conflicts with this logic. Decisions influenced by the RR show a strong tendency to disregard CEA when this is necessary to save an identifiable individual facing avoidable death. Allocative efficiency – maximizing utility per unit cost – is simply not the only, or even the major, factor when someone's life is visibly endangered." This illustrates the complexity of health rationing decisions and the importance of the sometimes emotionally laden values of the community (in the case of South Africa community values are reflected to a significant extent in the Constitution) as well as the more utilitarian approaches of economics theory. They make an important point in observing that: "If the total social utility gained from the Rule of Rescue, including the utility gained from having reinforced within the community the belief that life is valuable and worth great effort to preserve, outweighs the utility sacrificed by not putting resources to the best alternative use, then the Rule of Rescue would be justifiable from a utilitarian point of view. On the other hand, fairness requires that we do not discriminate between individuals on morally irrelevant grounds, and being 'identifiable' – being in a context that evokes the 'Rule of Rescue' response in others – does not seem to be a morally relevant ground for discrimination. We conclude by observing that utilitarians can make their case stronger by distinguishing between cases where the societal demand for rescue measures is contrived by media coverage, and cases where it is not. Discrimination against anonymous individuals is more objectionable in the former cases than in the latter."

In language reminiscent of the South African Constitution, Ham observes that decision-makers have to ensure “accountability for reasonableness” in taking decisions on healthcare coverage. He notes that Daniels and Sabin²⁰⁵ proposed four conditions that need to be met in order to ensure accountability for reasonableness:

- (1) **Publicity condition:** decisions regarding coverage for new technologies (and other limit setting decisions) and their rationales must be publicly accessible;
- (2) **Relevance condition:** these rationales must rest on evidence, reasons and principles that all fair minded parties (managers, clinicians, patients and consumers in general) can agree are relevant to deciding how to meet the diverse needs of a covered population under necessary resource constraints;
- (3) **Appeals condition:** there is a mechanism for challenge and dispute resolution regarding limit setting decisions, including the opportunity for revising decisions in light of further evidence or arguments;
- (4) **Enforcement condition:** there is either voluntary or public regulation of the process to ensure that the first three conditions are met.

With reference to the decision taken by the Cambridge and Huntingdon Health Authority in the case of *Child B*, Ham notes that not all of these conditions were met. For example, the application of a set of values to the *Child B* case met the relevance condition but the manner in which the authority’s decision was communicated only partly fulfilled the publicity condition. He points out that more effort could have been made to explain the basis of the decision not to fund intensive treatment in advance of media attention. Similarly he points out that the appeals condition was not met in that there was no mechanism for challenge and dispute resolution other than a request to the health authority to reconsider its decision. The absence of such a mechanism meant that legal action was the only formal recourse available to the family of Child B. The enforcement condition, says Ham, was met through judicial review of the health authority’s decision but the restrictive scope of such reviews in the English legal system means that only some aspects of the process proposed by Daniels and Sabin were scrutinised by the courts. In particular, notes Ham, the courts looked only at the health authority’s decision-making process and did not require an explanation

²⁰⁵ Daniels N and Sabin J, “The ethics of accountability in managed care reform”, *Health Affairs* 1998; 17 p 50-64 [Medline]



or justification of the decision or an assessment of the evidence on which it was based. According to Daniels and Sabin a commitment to transparency that case law requires improves the quality of decision-making. An organisation whose practice requires it to articulate explicit reasons for its decisions becomes focused in its decision-making²⁰⁶.

Ham goes on to observe that Hadorn has drawn parallels between decision making processes in health care and in the legal system saying that “the need to make relatively consistent case-by-case decisions amidst profound complexity is clearly one of the forces that has driven the health care system to adopt quasi-judicial features.” He notes that Hadorn argues that consistent procedures need to be adopted in health care, and he contends that these procedures should be centred on the consideration of economic evidence concerning the outcomes of care and the formulation of judgements based on this evidence. Hadorn maintains that judgements should be based on a standard of proof that might be more or less stringent depending on the availability of resources and the views of policy makers. He makes the point that “in the selection of a standard of proof...the fundamental balance between individual claims of need (that is, pursuit of individual good) and the greater public good is achieved.

Many of the principles and points identified above are inherent in the South African constitutional order and have been re-enforced and expounded by the constitutional court and constitutionally mandated legislation.²⁰⁷ The PAJA requires reasons for decisions to be given in writing for instance. It takes a conscious and sustained effort, however, on the part of administrative entities such as government departments to maintain a body of knowledge relevant to the decisions that must be taken, to keep record of decisions in order to ensure consistency with previous decisions, to formulate rules for the setting of policy and for the taking of decisions in such as

²⁰⁶ Daniels N and Sabin J, “Limits to health care: fair procedures, democratic deliberation and the legitimacy problem for insurers. *Philosophy of Public Affairs* 1997; 26 p 327-328 as quoted in Ham “Tragic Choices in Health Care: lessons from the Child B case” fn 201 *supra*.

²⁰⁷ See for instance the constitutional court’s emphasis on relevance (the court held that although the concerns raised on behalf of the appellants were relevant to the ability of government to make a ‘full package’ available throughout the public health sector, they were not relevant to the question whether Nevirapine should be used to reduce mother-to-child transmission of HIV at those public hospitals and clinics outside the research sites where facilities in fact existed for testing and counselling) and transparency in *Minister of Health and Others v Treatment Action Campaign and Others* fn 159 *supra*.

manner as to ensure consistency in the future and to foster a culture in which decisions are taken on the basis of and in accordance with all of the foregoing.

3.12 The Right to Fair Administrative Action vs the Right to Health

Should a decision by an inspector acting in terms of the Medicines and Related Substances Act to confiscate a shipment of hair product containing dangerously high quantities of lead be reversed by a court on the grounds that the decision was not taken in accordance with the prescribed procedures? This question essentially juxtaposes the constitutional right to fair administrative action and the constitutional rights to life, freedom and security of the person, including the right to bodily and psychological integrity, and to an environment that is not harmful to their health or well-being and requires a balancing of rights exercise. It seems fairly obvious which rights should win in this example. The problem arises in that the decision to confiscate the goods, even if it means that this constitutes a violation of the right to fair administrative action is not one that is initially made by a court of law the members of which are well trained and hopefully versed in these delicate balancing exercises. It must be taken by an administrative official often “on the spot”. An obvious solution to the problem is to give the administrative official sufficient power in subordinate or even principal legislation, containing the necessary guidelines and parameters for the exercise of that power, so as to protect the right and interests of both the public and the importer of the hair products. Unfortunately, even if such legislative provisions overcame all of the hurdles of lawmaking, it is not always possible to anticipate in law every permutation of practical life. Legislation is not necessarily an ideal remedy in every instance. The fact remains that “[C]omplex policy decisions should be made by accountable decision makers...Citizens must accept that the state should have the power to affect their interests, and that it makes decisions through rational processes.”²⁰⁸

Is a decision taken by the provincial government of a province not to supply antiretroviral drugs to pregnant mothers and their children an administrative or an executive decision? Is a decision by a medical superintendent to allow a non-governmental organisation access to the premises of the public hospital he runs in

²⁰⁸ O'Regan C “Rules for Rule-Making” *Controlling Public Power: Administrative Justice Through The Law* at p 106



order to assist rape victims an administrative decision or is it a business decision based on the fact that they are leasing some of the space in the hospital? Is a decision by a National Blood Transfusion service to screen blood for diseases using a much more expensive but also much more reliable laboratory test an administrative decision?

To the extent that the Constitution itself protects and recognises the right to just administrative action, a legislative classification of certain decisions as falling outside of the definition of administrative action has the power to subvert the right. Furthermore, the exclusion from the definition of decisions involving the implementation of policy, while at the same time including in the definition decisions involving the implementation of legislation, is potentially an undesirable discouragement of legislative action on the part of government entrenching in law critical policy initiatives derogation from which should be actionable by affected persons and possible even criminalized in certain instances. The doctrine of legitimate expectation cannot fill such a gap. It is important to note that the Constitution itself does not define the term 'administrative action' either in section 33, which declares that everyone has the right to administrative action that is lawful, reasonable and procedurally fair, or elsewhere. While it is clearly not feasible that all forms of public action should be regarded as administrative action, there is inherent within any legislative attempt at definition of the term 'administrative action', the potential for legal challenge to that definition on constitutional grounds.

A decision by the state to give priority to certain health services or to shut down a particular public health establishment or to provide certain health services at the level of a rural clinic rather than a regional hospital could be seen as an administrative decision or exercise of public power. There is however, a significant difference between an administrative act and other acts on the part of the state.²⁰⁹ Not all acts of

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In *Cape Metropolitan Council v Metro Inspection Services (Western Cape) CC And Others* (fn 48 *supra*), Streicher JA noted at p 1023 to 1024: "The section [33] is not concerned with every act of administration performed by an organ of State. It is designed to control the conduct of the public administration when it performs an act of public administration ie when it exercises public power (see *President of the Republic of South Africa and Others v South African Rugby Football Union and Others* 2000 (1) SA 1 (CC) ('SARFU') at para [136] and *Pharmaceutical Manufacturers Association of SA and Another: In re Ex parte President of the Republic of South Africa and Others* [fn 72 *supra*] at paras [20], [33], [38] - [40]). In paras [41] and [45] of the *Pharmaceutical Manufacturers Association* case Chaskalson P said: '[41] Powers that were previously regulated by 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. . . .' '[45] Whilst there is no bright line between public and private law, administrative law, which forms the core of public law, occupies a special place in our jurisprudence. It is an incident of the separation of powers under which courts regulate and control the exercise of public power by the other branches of government. It is built on constitutional principles which define the authority of each branch of government, their interrelationship and the boundaries between them. . . . Courts no longer



administration constitute the exercise of public power. Consequently the circumstances of each decision in the chain must be carefully considered in order to establish whether or not the exercise of a public power was involved and also whether it was taken in the course of the implementation of legislation as opposed to government policy. A practical example is the legislative provisions with regard to certificate of need in the National Health Act. The policy objective behind this licensing system is to achieve a better distribution of health service providers and facilities throughout the country with a view to improving access to health care services in underserved areas. As such, is it directly aligned with the state's section 27(2) obligations. The Act requires all providers and would be providers of health care services to apply to the Director-General for a certificate of need in order to be able to provide health care services. Persons not in possession of a certificate of need may not provide health care services. Few would argue that the decision of the Director-General as to whether or not to grant a certificate of need is an administrative decision. There is a considerable body of administrative law around the granting of various kinds of licenses. By contrast, a policy decision of the Minister of Health to establish a chain of community health clinics in deep rural areas where there are no other health facilities is unlikely to be a decision of an administrative nature.

It would seem that professionals or experts who are required to give an expert or professional opinion in terms of a statute may not be engaged in administrative action²¹⁰. If one looks more closely at the activities of a health professional employed

have to claim space and push boundaries to find means of controlling public power. That control is vested in them under the Constitution, which defines the role of the courts, their powers in relation to other arms of government and the constraints subject to which public power has to be exercised. . . .'

It follows that whether or not conduct is 'administrative action' would depend on the nature of the power being exercised (SARFU at para [141]). Other considerations which may be relevant are the source of the power, the subject-matter, whether it involves the exercise of a public duty and how closely related it is to the implementation of legislation (SARFU at para [143]). The appellant is a public authority and, although it derived its power to enter into the contract with the first respondent from statute, it derived its power to cancel the contract from the terms of the contract and the common law. Those terms were not prescribed by statute and could not be dictated by the appellant by virtue of its position as a public authority. They were agreed to by the first respondent, a very substantial commercial undertaking. The appellant, when it concluded the contract, was therefore not acting from a position of superiority or authority by virtue of its being a public authority and, in respect of the cancellation, did not, by virtue of its being a public authority, find itself in a stronger position than the position it would have been in had it been a private institution. When it purported to cancel the contract it was not performing a public duty or implementing legislation; it was purporting to exercise a contractual right founded on the consensus of the parties in respect of a commercial contract. In all these circumstances it cannot be said that the appellant was exercising a public power. Section 33 of the Constitution is concerned with the public administration acting as an administrative authority exercising public powers, not with the public administration acting as a contracting party from a position no different from what it would have been in had it been a private individual or institution."

210

S v Dobson (fn 31 *supra*). This case involved the question of whether the actions of psychiatrists performing an evaluation in terms of sections 77,78 and 79 of the Criminal Procedure Act were administrative in nature. Zietsman JP observed at p61 that: "In this case the psychiatrists in question were not performing an administrative, a judicial or a quasi-judicial function. They were conducting their own enquiry in their own way to enable them to furnish an opinion concerning the mental capacity of the accused. They were also not furnishing advice based on information received to an

by the state, one must ask in what way his or her functions differ from those of a government official who is qualified as an accountant and must assess the tax payable by a member of the public or whether someone qualifies for a welfare grant or a Director-General who must bring his or her expertise in public health administration to bear on a decision involving the granting of a certificate of need? The state employs professionals of different kinds to perform its functions. These functions are generally speaking public functions in terms of legislation as contemplated in the definition of administrative action in section 1 of the PAJA. Why should health professionals making treatment decisions in their capacity as public sector employees be different to accountants, lawyers and public health administrators employed by the state making decisions based on their professional skill and knowledge? The rationale for granting a public official an administrative discretion and assigning to such person the power and responsibility to make the relevant decision is tied up in the fact that such official has or has access to the requisite expert knowledge and skill.

The rendering of health services by the state is mandated by legislation – not necessarily the Constitution which only obliges the state to ensure the progressive realisation of the right rather than to deliver health care services itself – but the Health Act²¹¹ and the soon to be proclaimed National Health Act²¹² which is to be replace the former. The question before the court in *Dobson*²¹³ was whether the psychiatrists performing the evaluation were obliged to observe the *audi alteram partem* rule and there seems to be the underlying assumption that if the psychologists were engaged in administrative action they would have to do so. It is not true, however, that every administrative act must be subject to the *audi alteram partem* rule and that someone is always entitled to a hearing when an administrative power is exercised²¹⁴. When a

administrative body about to take an administrative decision. To enable them to perform their functions it was necessary that they obtain information from various sources and the information they could obtain from the prosecutor was important to them. They did not then accept the information as being correct, and act upon it. It was information they put to the accused to assess his reactions thereto, and they then had to form their own opinion regarding his mental condition. In such a case what the psychiatrists are required to do is to form an opinion and to advise the Court of their opinion and findings and, if their findings are disputed, the Act gives the accused the right to have the psychiatrists subpoenaed and submitted to cross-examination. I do not believe that the *audi alteram partem* principle, to be applied in the manner submitted by Mr Bursey, is applicable in such a case.

211 Act No 63 of 1977

212 Act No 61 of 2003

213 *Dobson* fn 31 *supra*

214 In *Gardener v East London Transitional Local Council and Others* 1996 (3) SA 99 (E) the court held that: "Fairness is a relative concept. The meaning to be attached to 'procedurally fair administrative action' must therefore be determined within the particular framework of the act in question viewed in the light of the relevant circumstances. The procedure must be fair not only to the holder of the right affected by the administrative act, but also to the executive or administration acting in the public interest. I do not understand s 24(b) to mean that the audi-principle is absolutely applicable to every administrative act. Such an interpretation would make possible the misuse of the Constitution to hold



person is exercising professional skill and judgment in taking a decision, it could, in certain circumstances, be argued that laypersons should not be included in the decision-making process because by definition they have nothing to add to the debate. Thus in *Dobson*²¹⁵, it was not for the prisoner to state whether or not he was mentally unfit for trial as his opinion was neither of a professional nature nor objective. This said, in the case of the provision of health care services by a health professional, the patient would as a general rule in any event have to be consulted and his or her consent obtained to treatment that was proposed due to the requirements of informed consent and the constitutional right to bodily and psychological integrity. Admittedly in a situation where treatment is withheld, the informed consent requirement may not necessarily assist the patient unless treatment had already commenced²¹⁶. It must be borne in mind, however, that this case pre-dates the Constitution. People now have a constitutional right of access to health care services. They also have a constitutional right to administrative justice. A decision not to administer medical treatment of a particular kind to a particular patient could well constitute a decision 'which adversely affects the rights of any person and which has a direct, external legal effect' in the words of the PAJA. In its definition of administrative action the PAJA includes any decision or failure to take a decision by 'a natural or juristic person, other than an organ of state, when exercising a public power or performing a public function in terms of an empowering provision'. Thus even where a health professional was not an employee but was contracted to the state to provide health care services, a decision to refuse treatment could constitute administrative action in terms of the PAJA.

up necessary social reform measures, or for that matter any executive or administrative act. In deciding whether the principle applies to an administrator acting in terms of s 7(2)(b) of the Act, one must have regard to the objects of the Act, as well as to the fact that application of the audi-principle to the administrator's acts could delay the proclamation of the agreement and possibly frustrate the implementation of the transitional local council." This is affirmed by section 3(2)(a) of the PAJA which states that "A fair administrative procedure depends on the circumstances of each case." The Appellate Division has observed that: "There is a presumption that the *audi alteram partem* rule applies to the exercise of judicial and quasi-judicial power to affect prejudicially the interests of the individual. It will be held to have been implicitly excluded if that implication is 'necessary' or emerges from the 'clear intention' of Parliament. *Omar and Others v Minister of Law and Order and Others; Fani and Others v Minister Of Law and Order and Others; State President and Others v Bill* 1987 (3) SA 859 (A). In *Cekeshe* the court said: "I accept, for present purposes, that in an appropriate case the audi alteram partem rule may not find application (see *Gardener v East London Transitional Local Council and Others* 1996 (3) SA 99 (E) at 116E - F. The fact that in that case Erasmus J was dealing with the position in terms of s 24(b) of the interim Constitution (the Constitution of the Republic of South Africa Act 200 of 1993) does not, in my view, affect the position: *South African Roads Board v Johannesburg City Council* (supra at 13D); *Van Zyl J's judgment in the Court a quo*)." *Premier, Eastern Cape, and Others v Cekeshe and Others* 1999 (3) SA 56 (TK)

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Dobson (fn 31 supra)

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Technically speaking the patient should, in the course of the process of being informed with a view to obtaining his or her consent, also be told of reasonable and treatment alternatives so that he or she is given the opportunity to question or even challenge the health professional recommendation of a particular method of treatment and opt for an alternative where this is reasonable and available. In the National Health Act provision is made in Chapter 2 for the user to be informed of "the range of diagnostic procedures and treatment options generally available to the user".



The formulation of policy by an official is generally unlikely to constitute administrative action although the formulation of policy may in the narrower sense amount to administrative action if the policy is formulated within a legislative framework²¹⁷. There is a National Policy for Health Act²¹⁸ which empowers the Minister to “determine the national policy to be applied in respect of any matter which in his opinion will promote the health of the inhabitants of the Republic”. It is unlikely that this type of policymaking could be regarded as an administrative act due to the broad and general nature of the power that is conferred by the Act. The Act provides an example of a situation in which the implementation of legislation will not constitute administrative action under the PAJA because the legislation is in fact mandating the exercise of executive, rather than administrative, powers. This kind of legislation is generally speaking not only unnecessary because the executive powers of the state derive fundamentally from the Constitution and any attempt to further describe them in legislation could unintentionally but unconstitutionally result in a fettering of such powers, but also because of the confusion that can result from the power to set policy in terms of legislation. A case in point is that of *Minister of Education v Harris*²¹⁹. In that case the National Education Policy Act²²⁰ empowered the Minister of Education to determine national policy for education, including, in s 3(4)(i), national policy for ‘the admission of students to education institutions which shall include the determination of the age of admission to schools’. Sections 6 and 7 of the Act make it clear that national legislation, as opposed to national policy, can be introduced only after a process of extensive consultation and publication has been completed. On 18 February 2000 the Minister of Education published a notice 1 under s 3(4) of the National Education Policy Act (the National Policy Act) stating that a

²¹⁷ *Permanent Secretary, Department of Education and Welfare, Eastern Cape, and Another v Ed-U-College (PE) (Section 21) Inc* 2001 (2) SA 1 (CC)

²¹⁸ Act No 116 of 1990 to be repealed by the National Health Act. The Act in section 2 sets out guidelines for the policy to be made by the Minister in the following terms:

Provided that such policy shall be determined within the framework of the following guidelines:

- (i) That an inhabitant of the Republic, if he is capable of doing so, shall primarily be responsible for his own and his family's physical, mental and social well-being, but that the state and local authorities shall share responsibility in this regard by providing an efficient and comprehensive health service;
- (ii) that such inhabitant shall pay the costs incidental to his medical treatment, but that the financial circumstances of a patient shall not take precedence over the necessity for treatment, and that indigent persons shall be accommodated;
- (iii) that the provision of a comprehensive health service by the state and local authorities shall be directed in a responsible manner at the needs of the individual and those of society, but that the available financing sources, natural resources and manpower of the Republic shall be taken into account;
- (iv) that the private sector shall be encouraged to provide health services in the Republic, but that the provision of such services shall be in the public interest.

²¹⁹ *Minister Of Education v Harris* 2001 (4) SA 1297 (CC)

²²⁰ Act No 27 of 1996

learner may not be enrolled in grade one in an independent school if he or she does not reach the age of seven in the same calendar year. Talya Harris was part of a group of children who had enrolled at the age of three in the King David pre-primary school, and had spent three years being prepared for entry to the primary school in the year 2001. Her sixth birthday was due to fall on 11 January 2001, a short while before the school year would begin. Challenging the validity of the notice, her parents sought an order of court permitting her to be enrolled in grade one in the year she turned six. The constitutional court noted that policy made by the Minister in terms of the National Policy Act does not create obligations of law that bind provinces, or for that matter parents or independent schools. It said that the effect of such policy on schools and teachers within the public sector is a different matter. For the purposes of present case, the court said it was necessary only to determine the extent to which policy formulated by the Minister may be binding upon independent schools. It then went on to point out that there was nothing in the Act which suggested that the power to determine policy in this regard conferred a power to impose binding obligations. The court observed that in the light of the division of powers contemplated by the Constitution and the relationship between the Schools Act and the National Policy Act, the Minister's powers under s 3(4) are limited to making a policy determination and he has no power to issue an edict enforceable against schools and learners. It held that in issuing the notice the Minister exceeded the powers conferred upon him by s 3(4) of the National Policy Act and accordingly infringed the constitutional principle of legality. The appeal failed.

The distinction between policy and law seems to have escaped the notice of the Minister and officials of the Department of Education in this instance. It is submitted that the fact that legislation empowered the Minister to make policy had something to do with this. There is unfortunately no clear definition of what policy is. In *Harris* the court referred to the dicta of Harms JA in *Akani Garden Route (Pty) Ltd v Pinnacle Point Casino (Pty) Ltd*²²¹ noting that the word 'policy' is inherently vague and may

²²¹ *Akani* 2001 (4) SA 501 (SCA). The court stated: "As Harms JA pointed out in *Akani Garden Route (Pty) Ltd v Pinnacle Point Casino (Pty) Ltd*, the word 'policy' is inherently vague and may bear different meanings: 'It appears . . . to serve little purpose to quote dictionaries defining the word. To draw the distinction between what is policy and what is not with reference to specificity is, in my view, not always very helpful or necessarily correct. For example, a decision that children below the age of six are ineligible for admission to a school can fairly be called a "policy" and merely because the age is fixed does not make it less of a policy than a decision that young children are ineligible, even though the word "young" has a measure of elasticity in it. Any course or program of action adopted by a government may consist of general or specific provisions. Because of this I do not consider it prudent to define the word either in general or in the

bear different meanings. One thing is clear, however, and that is that policy is not law and as such is not applicable within or binding upon the private sector. The court in Harris did suggest that policy may be 'binding' upon public schools and teachers within the public sector but held that it could not bind the provinces or independent schools. If the same operational situation holds for schools as it does for hospitals however, then this suggestion is something of an illusion because in the health sector the provinces 'own' and run public hospitals and health facilities. The national Department of Health does not as a rule provide health care services although it does have the power to do so in terms of the Health Act²²². Any policy decision that was not binding on the provinces would thus effectively not be implemented unless the provinces chose to do so. This further diminishes the need for and significance of legislation empowering a Minister to make policy especially in areas of concurrent legislative competence on Schedule 4 of the Constitution such as health services and education.

3.13 Manner of exercise of public power

There have been a number of important judicial pronouncements upon the manner in which public power must be exercised.²²³ The emphasis of the constitutional court

context of the Act. I prefer to begin by stating the obvious, namely that laws, regulations and rules are legislative instruments whereas policy determinations are not. As a matter of sound government, in order to bind the public, policy should normally be reflected in such instruments. Policy determinations cannot override, amend or be in conflict with laws (including subordinate legislation). Otherwise the separation between Legislature and Executive will disappear. In this case, however, it seems that the provincial legislature intended to elevate policy determinations to the level of subordinate legislation, but leaving its position in the hierarchy unclear. . . .'

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Fn 211 *supra*

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In *Shoprite Checkers (Pty) Ltd v Ramdau NO and Others* 2001 (4) SA 1038 (LAC) at p1045-1047, Zondo JP made the following observations: "It is a requirement of the rule of law that the exercise of public power by the Executive and other functionaries should not be arbitrary. Decisions must be rationally related to the purpose for which the power was given, otherwise they are in effect arbitrary and inconsistent with this requirement. It follows that in order to pass constitutional scrutiny the exercise of public power by the Executive and other functionaries must, at least, comply with this requirement. If it does not, it falls short of the standards demanded by our Constitution for such action. The question whether a decision is rationally related to the purpose for which the power was given calls for an objective enquiry. Otherwise a decision that, viewed objectively, is in fact irrational, might pass muster simply because the person who took it mistakenly and in good faith believed it to be rational. Such a conclusion would place form above substance and undermine an important constitutional principle.' In the course of para [89] of his judgment [in *Pharmaceutical Manufacturers of SA and Another: In re Ex parte President of the Republic of South Africa and Others* [fn 72 *supra*]] Chaskalson P also said: 'What the Constitution requires is that public power vested in the Executive and other functionaries be exercised in an objectively rational manner.'

He continued thus in para [90]: '[90] Rationality in this sense is a minimum threshold requirement applicable to the exercise of all public power by members of the Executive and other functionaries. Action that fails to pass this threshold is inconsistent with the requirements of our Constitution and therefore unlawful. The setting of this standard does not mean that the Courts can or should substitute their opinions as to what is appropriate for the opinions of those in whom the power has been vested. As long as the purpose sought to be achieved by the exercise of public power is within the authority of the functionary, and as long as the functionary's decision, viewed objectively, is rational, a Court cannot interfere with the decision simply because it disagrees with it or considers that the power was exercised inappropriately. A decision that is objectively irrational is likely to be made only rarely but, if this does occur, a Court has the power to intervene and set aside the irrational decision.' What is clear from the judgment of the Constitutional Court is that:

(1) as long as a particular decision is the result of an exercise of public power, such a decision can be set aside by a court if it is irrational;

referred to in the previous chapter on the reasonableness of decisions taken by the state is echoed strongly by the emphasis on rationality in the exercise of public power in cases such as *Pharmaceutical Manufacturers of SA and Another: In re Ex parte President of the Republic of South Africa and Others*²²⁴.

It has been observed that -

“[T]he problem with subordinate legislation in a democracy is easy to state, but difficult to resolve... To date the key legal mechanism for the control of bureaucracy has been judicial review, but judicial review, even if well-developed, is not all that the law should do to structure and control bureaucracy.”²²⁵

O'Regan distinguishes between rule-making and decision-making by quoting Schwartz²²⁶ who observes that rule-making is normally general and looks only to the future; adjudication is particular and looks also to the past. She notes that administrative rule-making is not comprehensively regulated in South Africa but its extent cannot be understated and points out that bureaucratic power must not only be subject to the will of parliament but its exercise must also be fair, efficient and accountable. According to O'Regan, these are the three normative requirements which should guide the development of administrative law.

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- (2) the *bona fides* of the person who made the decision do not by themselves put such a person's decision beyond the scrutiny of the Court;
 - (3) the rationality of a decision made in the exercise of public power must be determined objectively;
 - (4) a court cannot interfere with a decision simply because it disagrees with it or it considers that the power was exercised inappropriately;
 - (5) a decision that is objectively irrational is likely to be made only rarely;
 - (6) decisions (of the Executive and other functionaries) must be rationally related to the purpose for which the power was given, otherwise they are in effect arbitrary and inconsistent with (the requirement of the rule of law that the exercise of public power by the Executive and other functionaries should not be arbitrary).

[20] Having set out above part of what was made clear by the Constitutional Court in the *Pharmaceutical Manufacturers'* case about the reviewability of decisions made in the exercise of public power on grounds of irrationality, it seems to me that it would also be useful to have regard to what was made clear by this Court in *Carephone* about the reviewability of CCMA awards on grounds of unjustifiability. In this regard this Court made it clear that:

- (a) the constitutional provision that administrative action must be justifiable in relation to the reasons given for it 'introduces a requirement of rationality in the merit or outcome of the administrative decision . . . [which] goes beyond mere procedural impropriety as a ground for review, or irrationality only as evidence of procedural impropriety'(at para [31] at 1434);
- (b) 'it would be wrong to read into the administrative justice section an attempt to abolish the distinction between review and appeal' (at para [32] at 1434);
- (c) 'whether administrative action is justifiable in terms of the reasons given for it, value judgments will have to be made which will, almost inevitably, involve the consideration of the "merits" of the matter in some way or another but, as long as the Judge determining this issue is aware that he or she enters the "merits" not in order to substitute his or her own opinion on the correctness thereof, [but] to determine whether the outcome is rationally justifiable, the process will be in order' (at para [36]);
- (d) the question to be asked in order to determine whether or not a decision is justifiable or rational is: 'is there a rational objective basis justifying the connection made by the administrative decision-maker between the material properly available to him and the conclusion he or she eventually arrived at?'"

224 *Pharmaceutical Manufacturers* fn 72 *supra*

225 O'Regan C fn 206 *supra*

226 *Administrative Law* p 190

Subsequently, the constitutional court, of which O'Regan was a member, decided 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*²²⁷ that there was a difference between requiring a court or tribunal in exercising a discretion to interpret legislation in a manner that was consistent with the Constitution and conferring a broad discretion upon an official, who may have been quite untrained in law and constitutional interpretation, and expecting that official, in the absence of direct guidance, to have exercised the discretion in a manner consistent with the provisions of the Bill of Rights. It observed that officials were often extremely busy and had to respond quickly and efficiently to many requests or applications. The nature of their work did not permit considered reflection on the scope of constitutional rights or the circumstances in which a limitation of such rights was justifiable. The court said that it was true that as employees of the state they bore a constitutional obligation to seek to promote the Bill of Rights as well but it was important to interpret that obligation within the context of the role that administrative officials played in the framework of government, which was different from that played by judicial officers. According to the judgment of the court, the fact that the exercise of a discretionary power might have been challenged subsequently and successfully on administrative grounds, for example, that it was not reasonable, did not relieve the Legislature of its constitutional obligation to promote, protect and fulfil the rights entrenched in the Bill of Rights. The court held that in a constitutional democracy the responsibility to protect constitutional rights in practice was imposed both on the Legislature and on the Executive and its officials. It said the Legislature had to take care when legislation was drafted to limit the risk of an unconstitutional exercise of the discretionary powers it conferred and that guidance would often be required to ensure that the Constitution took root in the daily practice of governance. Where necessary, said the court, such guidance had to be given. Guidance could be provided either in the legislation itself or, where appropriate, by a legislative requirement that delegated legislation be enacted properly by a competent authority. It was for the Legislature, in the first place, to identify the policy considerations that would render a refusal of a temporary permit justifiable.

²²⁷ *Dawood* 2000 (3) SA 936 (CC)

In *Schoonbee and Others v MEC for Education, Mpumalanga and Another*²²⁸ the court observed that an administrative action should not be taken on account of bias or a reasonable suspicion of bias. The action has to fall within the parameters of the law, in other words, where there is a material procedure or condition which the law prescribes, the wielder of power is obliged to have regard to that. Administrative action has to be procedurally fair and it should not be undermined by an error of law or, put otherwise, an error of understanding or application of the law. The official who takes the administrative action should not be persuaded by matters other than those which are relevant for purposes of the decision before it; he or she should not have regard to or be persuaded or moved by some ulterior purpose or motive or make considerations which are irrelevant. He or she must act honestly and rationally and not arbitrarily, or capriciously.

In *President of the Republic of South Africa and Others v South African Rugby Football Union and Others*²²⁹ the court observed that -

“The requirement of procedural fairness, which is an incident of natural justice, though relevant to hearings before tribunals, is not necessarily relevant to every exercise of public power. *Du Preez's* case is no authority for such a proposition, nor is it authority for the proposition that, whenever prejudice may be anticipated, a functionary exercising public power must give a hearing to the person or persons likely to be affected by the decision. What procedural fairness requires depends on the circumstances of each particular case.”

3.14 Case Law

In the context of administrative law and access to health care services the case of *Applicant v Administrator, Transvaal, and Others*²³⁰ is of relevance although it predates the Constitution.

3.14.1 *Applicant v Administrator, Transvaal, And Others*

Facts

The applicant was a patient at a provincial hospital (“the hospital”) operated by the first, second and third respondents. The second respondent was the Director of

²²⁸ *Schoonbee* 2002 (4) SA 877 (T) at 882

²²⁹ *President of the Republic of South Africa* fn 51 *supra* at para 219 p 97

²³⁰ *Applicant v Administrator, Transvaal, and Others* 1993 (4) SA 733 (W)

Hospital Services, Transvaal, and the third respondent the Chief Medical Superintendent at the hospital. The applicant, who was a non-paying patient at the hospital's HIV clinic, had been diagnosed as having CMV-retinitis and given a prescription for a drug called Ganciclovir on 28 January 1992. After having been fitted with a special catheter to facilitate the administration of the drug, he was informed that the Provincial Administration had decided not to supply him with it. Ganciclovir was the only effective treatment for CMV-retinitis which, if untreated, inevitably results in blindness. Despite its not having been approved by the Medicines' Control Council and accordingly not registered in terms of the Medicines and Related Substances Control Act 101 of 1965, five other AIDS patients had been treated with Ganciclovir at the hospital's HIV clinic. This treatment had subsequently been approved by the second respondent *inter alia* because the drug was at the time being supplied free of charge by the manufacturer. (An unregistered drug for which *ad hoc* approval from the Medicines' Control Council had been obtained could be administered at the hospital with the approval of the second or third respondent.) The free supply of the drug ended in October 1991 and in February 1992 the second respondent had taken a policy decision that Ganciclovir would no longer be supplied to AIDS patients. This decision led to the refusal to provide the applicant with the drug and had been motivated on the grounds, *inter alia*, that it (1) was not a registered drug; (2) was toxic and had severe side-effects; and (3) was expensive and the costs of supplying it to an increasing number of AIDS patients would drain available funds. The applicant applied for an order (1) setting aside the decision of the respondents not to supply him with Ganciclovir, a drug used to treat CMV-retinitis, an eye disease relatively common in AIDS patients; and (2) directing the respondents to make the drug available to him as soon as reasonably possible.

Judgment

The court made the following observations as to the reasons for the decision taken by the respondents:

1. The fact that the drug was not registered was not *per se* decisive. Firstly, the drug was the first anti-viral drug to be licensed in the United States of America for the treatment of the disease caused by CMV infection. Ganciclovir therapy

has been approved by the Food and Drug Administration in the United States for the treatment of CMV-retinitis. Secondly, the drug, which was obtainable from Pharmatex Pharmaceuticals, was in the process of being registered. According to that company the drug was registered in most countries in the world, where it was available. Thirdly, the second respondent permitted the use of the drug on an *ad hoc* basis.

2. The fact that the drug was toxic and had severe side-effects was not per se decisive. The doctors who recommended it, Drs Miller and Spencer, were aware of the risk of using it, as was the applicant, who had been informed of that risk and those doctors and the applicant were willing to take the risk. While the drug was available to the TPA at no cost to the TPA, the second respondent permitted its use. The drug did not undergo a metamorphosis when a price was attached to it.
3. The cost of the drug was relevant, particularly if regard was had to the potential number of AIDS patients who would have to be treated in the years to come. The court said that it was proper that the second respondent weigh up that cost in relation inter alia to a budget, the drug's efficacy and the needs of other patients. Yet, said the court, the cost of the drug could not be said to be unacceptable if it was to be administered only to the applicant.

The court considered the question as to whether, when the second respondent took the policy decision that the drug was not to be administered to AIDS patients, he should have taken into account factors peculiar to the applicant and the history of the use of the drug at the HIV clinic at the Johannesburg Hospital. It identified these factors as follows:

1. The applicant was terminally ill. He had a few months to live. While the drug might not prolong or save the life of the applicant, it would improve the quality of his life by retarding the progression of the CMV-retinitis.
2. The applicant had an expectation that he would be treated with the drug. Five other patients were so treated. That treatment was ratified by the second

respondent. The applicant was not to know that that treatment was administered at a time when the Transvaal Provincial Administration was not paying for the drug. It did not lie in the mouth of the respondents to say that the applicant's expectation was irrelevant. One of the considerations the second respondent took into account when he decided to ratify the use of the drug on the five patients was the expectation of the five patients.

3. The Hickman-line was surgically implanted into the applicant's left sub-clavian vein by a surgical registrar at the Johannesburg Hospital. The applicant remained in hospital for a week. The catheter was removed as it had become infected. Treatment of a particular kind - the administration of the drug - was commenced at a provincial hospital to a terminally ill patient, creating in his mind the expectation that the treatment would be continued until completion.

The court gave the order sought by the applicant.

Discussion

Even though this judgment predates the Constitution, it is still of considerable significance for a number of reasons. Although the court did not expressly say as much, the applicant seems to have succeeded at least partially on the basis of the doctrine of legitimate expectation²³¹. In practice the two forms of expectation may be interrelated and even tend to merge. Thus, the person concerned may have a legitimate expectation that the decision by the public authority will be favourable, or at least that before an adverse decision is taken he will be given a fair hearing.' Corbett CJ went on to explain that the doctrine of legitimate expectation is an offshoot of the obligation on the part of a decision-maker to 'act fairly'.²³²

²³¹ This concept of a legitimate expectation is summed up by Corbett CJ at 758D as follows: "As these cases and the quoted extracts from the judgments indicate, the legitimate expectation doctrine is sometimes expressed in terms of some substantive benefit or advantage or privilege which the person concerned could reasonably expect to acquire or retain and which it would be unfair to deny such person without prior consultation or a prior hearing; and at other times in terms of a legitimate expectation to be accorded a hearing before some decision adverse to the interests of the person concerned is taken. As Prof Riggs puts it in the article to which I have referred (at 404): 'The doctrine of legitimate expectation is construed broadly to protect both substantive and procedural expectations.'" *Administrator, Transvaal, and Others v Traub and Others* fn 11 *supra*

²³² At 758G-759A of *Traub* (fn 11 *supra*) Corbett CJ observed that: "A frequently recurring theme in these English cases concerning legitimate expectation is the duty on the part of the decision-maker to 'act fairly'. As has been pointed out, this is simply another, and preferable, way of saying that the decision-maker must observe the principles of natural justice (see O'Reilly's case *supra* at 1126j-1127a; *Attorney-General of Hong Kong* case *supra* at 350g-h; *Council of Civil Service Unions* case *supra* at 954a-b). Furthermore, as Lord Roskill explained in the last quoted case, the phrase, "a



The fact that the medicine was not registered, the fact that the free supplies ended and the fact that the drug in question would not save the life of the patient were not relevant. This case contains a number of important lessons for those involved in health care delivery and illustrates the caution with which delivery of services should be approached. Donations of free drugs for a limited period, for instance in the context of HIV/AIDS, by drug companies wishing to establish a foothold in the market in circumstances where the treatment or the nature of the drug is such that it is lifelong and once commenced should not be withdrawn can be problematic for the public health sector since once it starts using the treatment or drug on patients, it cannot necessarily use the fact that the free supply has dried up as a basis for discontinuing the treatment. The creation in the minds of patients of an expectation that they will now receive antiretroviral drugs or other medication for a chronic health condition, eg asthma, diabetes, cardiovascular disease etc, is likely to preclude the possibility of suddenly discontinuing the treatment for those particular patients for funding reasons. The court in the Ganciclovir case²³³ took the view that for the particular patient in whose mind the expectation of receiving the drug had been created, there were different considerations than for other patients in whose minds no such expectation had been created²³⁴. If one creates an expectation in the minds of a multitude of patients suffering from a particular condition that they will be treated for that condition in a certain way or using a particular intervention, for instance by way of media announcements and publicity campaigns, then from a public health point of view one could be obliged, on the basis of the doctrine of legitimate expectation, to put one's money where one's mouth is and ensure that the treatment is made available. Health administration is logistically speaking a complex and difficult task and it is conceivable that in isolated instances a patient may present at a health facility where stocks have run out. This kind of administrative glitch need not have legal

duty to act fairly", must not be misunderstood or misused. It is not for the Courts to judge whether a particular decision is fair. The Courts are only concerned with the manner in which the decisions were taken and the extent of the duty to act fairly will vary greatly from case to case. Many features will come into play including the nature of the decision and the relationship of those involved before the decision was taken (see at 954b-c); and a relevant factor might be the observance by the decision-maker in the past of some established procedure or practice. It is in this context that the existence of a legitimate expectation may impose on the decision-maker a duty to hear the person affected by his decision as part of his obligation to act fairly. (See at 954e; cf *Lloyd and Others v McMahon* [1987] 1 All ER 1118 (HL) at 1170f-g)"

²³³ *Applicant v Administrator, Transvaal, And Others* fn 230 *supra*

²³⁴ The court said at p 741 (fn 230 *supra*): "I must make it clear that I do not say that the policy decision was wrong, nor must this judgment be read to create a right for all AIDS sufferers with CMV-retinitis to receive the drug. My finding is that, on the facts of this case and this case only, the second respondent was obliged to continue with the treatment that had commenced with the insertion of the Hickman-line and which the applicant was led to believe he would continue to receive from the Johannesburg Hospital."

consequences if there are adequate referral mechanisms in place to send the patient to other centres or to ensure that restocking will take place within a short period of time. However, large-scale failure to make good on public promises, could well have legal implications for the promisor. It is much easier not to make those promises than to make them. An example would be free cataract operations for people whose vision is impaired as a result of cataracts. It is not reasonable for people to expect that they will all have their cataracts surgically removed immediately. They may have to join long waiting lists and be prepared to travel to other facilities over which the caseload has been spread in order to have their operations. These kind of logistical problems are unavoidable and cannot be challenged legally unless the delays are unnecessary and unjustified. However, a decision to stop the free cataract surgery program halfway through the waiting list may well attract litigation. This is in effect what happened in microcosm to the HIV/AIDS patient in the Ganciclovir case²³⁵.

A further lesson to be learned from this case is that quality of life is as material an issue to the patient as length of life. The drug Ganciclovir would not have extended the patient's life or cured his condition. However it was crucial to the quality of the remaining length of life left to him. The court regarded this factor as significant in its judgement. One cannot hide behind an argument that states because the treatment or medication does not serve a particular narrow purpose such as the preservation or prolongation of life, a purpose for which it was never in any event designed, that there is no obligation to provide the treatment. In the case of medication in particular, it is usually registered for each specific indication for which it may lawfully be used. Even if a medicine is registered in South Africa this does not mean that it can be used for the treatment of just any health condition²³⁶. If one starts using the drug in the treatment of a patient for an indication for which it is registered and creates the expectation of further treatment with that drug in the mind of the patient health provider cannot argue that the patient must no longer be treated with the drug because

²³⁵ *Applicant v Administrator, Transvaal, And Others* fn 230 *supra*

²³⁶ For example, Misoprostol (Cytotec) is a synthetic prostaglandin analogue registered in many countries for the prevention of peptic ulceration in patients taking non-steroidal anti-inflammatories. According to Rees, 'Misoprostol - Benefit or Caution', *IPPF Medical Bulletin* p5 www.ippf.org, the medication has received much attention in recent years because of its widespread unregistered use in obstetrics and gynaecology for various conditions and interventions. She says that while the manufacturer (Searle) is uncomfortable about this aspect of its use, clinicians all over the world are researching the drug's potential for revolutionizing the management of several common conditions in women and that it has many characteristics that make it an attractive prospect for use in obstetrics and gynaecology, particularly for developing countries. If it is not registered for terminations of pregnancy then prescribing and dispensing it for such purpose is illegal.

it does not serve a different purpose for which it was never registered as an indication. Ganciclovir would never have been registered for the treatment of HIV/AIDS because it was never developed for that purpose. The indication for which it would have been registered was CMV-retinitis, an opportunistic infection common in AIDS sufferers. In the *Administrator Transvaal* case²³⁷ the fact that it had not been registered with the Medicines Control Council was irrelevant because the law permitted its use upon *ad hoc* approval by the Council.

An additional lesson to be learned is that although there is a general rule, in the words of Denning LJ, “(t)he hospital authorities are under a duty to take reasonable care of him. Whenever they accept a patient for treatment, they must use reasonable care and skill to cure him of his ailment.”²³⁸ It did not follow, however, that if the court was of the view that it would be reasonable for the applicant to receive the drug, the respondents could be compelled to supply it to the applicant. The discretion to allow the use of a non-registered, non-coded, drug in a provincial hospital, said the court, rests on the second respondent, not on the court. It is submitted that in each case what constitutes ‘reasonable care’ will depend on the particular circumstances but that it is important to note that where an official has a discretionary power the court may not simply substitute its own decision for that made by the official in the exercise of that discretionary power.

3.15 Remedies

The remedy for bilateral administrative acts may be based either on private law or administrative law depending upon the nature of the act²³⁹. If the state is given the power to unilaterally alter the content of an agreement then the remedy becomes an administrative one rather than one based on contract. The authority or power of the state cannot be fettered by a contract and so a contractual term purporting to do so is unlikely to be upheld by a court.²⁴⁰ Administrative action may be challenged on the

²³⁷ *Administrator Transvaal* fn 230 *supra*

²³⁸ *Cassidy v Minister of Health* [1951] 2 KB 343 (CA) at 360. See too *Mtetwa v Minister of Health* 1989 (3) SA 600 (N) at 606E.

²³⁹ *Devenish et al* (fn 15 *supra*) p 514

²⁴⁰ Thus in *Southern Metropolitan Substructure v Thompson And Others* 1997 (2) SA 799 (W) the court held that the Johannesburg City Council and its successors in title would not be empowered to bind themselves by contract to the moratorium alleged as such a contract would clearly be incompatible with the proper exercise of the applicant's statutory power to allocate housing to those who qualified or had already qualified for it: such a contract would be an unreasonable and incompetent fetter on its powers and duties. The constitutional court in *President Of The Republic Of*

grounds of unreasonableness²⁴¹. Section 33 of the Constitution states that everyone has the right to administrative action that is, *inter alia*, reasonable. An action for damages flowing as a consequence of an administrative decision will not, however, always be permitted by the courts. In *Knop v Johannesburg City Council*²⁴² the court held that the fact that the legislature had in section 139 of the Town-Planning and Townships Ordinance 15 of 1986 (T) prescribed a particular form of procedure by which an aggrieved applicant, in an application under s 92 of the ordinance for the subdivision of an erf in a township, could obtain relief against the refusal of his application showed by necessary implication that it did not intend a negligently incorrect refusal to give rise to an action for damages. As to the broader considerations of policy, it held that on the one hand an aggrieved applicant did not need an action for damages to protect his interests since he had readily at hand the appeal procedure provided within the legislative framework. On the other hand, said the court, considerations of convenience militated strongly against allowing an action for damages as the threat of such an action would unduly hamper the expeditious consideration and disposal of applications by the local authority in the first instance. It cautioned that this was not to say that the local authority need not exercise due care in dealing with applications. It had to exercise such care but the point was that it would be contrary to the objective criterion of reasonableness to hold the local authority liable for damages if it should turn out that it acted negligently in refusing an application, when the applicant had a convenient remedy at hand to obtain the approval he was seeking. It was the view of the court that to allow an action for damages in those circumstances would offend the legal convictions of the community. Consequently, it held that the refusal of an

South Africa And Others v South African Rugby Football Union And Others 2000 (1) SA 1 (CC) held that, although there was some uncertainty as to the precise ambit of the principle that a public authority could fetter, by contract, the exercise of its own discretion, there was little doubt that a public authority could not enter into a contract which was wholly incompatible with the discretion conferred upon it. More conclusively, one member of the Cabinet could not of her or his own accord enter into a contract with a third party which would have precluded or constrained the President from exercising powers conferred upon her or him directly by the Constitution.

In *Durban Add-Ventures Ltd v Premier, Kwazulu-Natal, And Others* (No 2) 2001 (1) SA 389 (N) the court held that that, if the applicant enjoyed a legitimate expectation, at best this would have afforded it a right to be heard before the regulations were promulgated. The doctrine of legitimate expectation could not be employed so as to place substantive constraints on the power of a lawmaker to enact delegated legislation and, in particular, could not operate in the present circumstances so as to inhibit the formation of government policy. For good reasons the Courts were reluctant to fetter government from implementing changes to policy. The doctrine of legitimate expectation could not be applied to hinder the formation of government policy in circumstances where a change of direction was in the public interest. (from headnote)

²⁴¹ The constitutional court in *Minister Of Health And Others v Treatment Action Campaign And Others* (No 2) (fn 159 *supra*) observed that the Constitution contemplates rather a restrained and focused role for the Courts, namely to require the State to take measures to meet its constitutional obligations and to subject the reasonableness of these measures to evaluation. In *Govender v Minister Of Safety And Security* 2001 (4) SA 273 (SCA) the Supreme Court of Appeal held that it was the requirement of reasonableness that required interpretation in the light of constitutional values. It held that conduct unreasonable in the light of the Constitution could never be 'reasonably necessary' to achieve a statutory purpose.

²⁴² *Knop* fn 33 *supra*

application for the subdivision of an erf in a township, through an error due to negligence, was not a wrongful act giving rise to a delictual claim for damages²⁴³.

Judicial review is the most obvious remedy. In terms of section 6(1) of the PAJA any person may institute proceedings in a court or a tribunal for the judicial review of an administrative action. In terms of subsection (2) of section 6 –

A court or tribunal has the power to judicially review an administrative action if-

- (a) the administrator who took it-
 - (i) was not authorised to do so by the empowering provision;
 - (ii) acted under a delegation of power which was not authorised by the empowering provision; or
 - (iii) was biased or reasonably suspected of bias;
- (b) a mandatory and material procedure or condition prescribed by an empowering provision was not complied with;
- (c) the action was procedurally unfair;
- (d) the action was materially influenced by an error of law;
- (e) the action was taken-
 - (i) for a reason not authorised by the empowering provision;
 - (ii) for an ulterior purpose or motive;
 - (iii) because irrelevant considerations were taken into account or relevant considerations were not considered;
 - (iv) because of the unauthorised or unwarranted dictates of another person or body;
 - (v) in bad faith; or
 - (vi) arbitrarily or capriciously;
- (f) the action itself-
 - (i) contravenes a law or is not authorised by the empowering provision; or

²⁴³

See also *Oltzki Property Holdings v State Tender Board and Another* 2001 (3) SA 1247 (SCA) in which the court observed that where the legal duty to prevent loss sought to be invoked by a plaintiff derives from the breach of a statutory provision, the question whether the statute imposed such a duty must be assessed not on broad or even abstract questions of liability, but on a general criterion of reasonableness, based on considerations of morality and policy, and taking into account the legal convictions of the community and constitutional norms, values and principles. The focal question, said the court, remains one of statutory interpretation, since the statute may on a proper construction thereof itself confer a right of action, or alternatively provide the basis for inferring that a legal duty exists at common law. The process in either case requires the consideration of the statute as a whole, its objects and provisions, the circumstances in which it was enacted, and the kind of mischief it was designed to prevent. But where a common-law duty is at issue, the answer depends less on the application of formulaic approaches to statutory construction than on a broad assessment of whether it is 'just and reasonable' that a civil claim for damages should be granted. The determination of reasonableness here in turn depends on whether affording the plaintiff a remedy is congruent with the Court's appreciation of the sense of justice of the community (from headnote).

- (ii) is not rationally connected to-
 - (aa) the purpose for which it was taken;
 - (bb) the purpose of the empowering provision;
 - (cc) the information before the administrator; or
 - (dd) the reasons given for it by the administrator;
- (g) the action concerned consists of a failure to take a decision;
- (h) the exercise of the power or the performance of the function authorised by the empowering provision, in pursuance of which the administrative action was purportedly taken, is so unreasonable that no reasonable person could have so exercised the power or performed the function; or
- (i) the action is otherwise unconstitutional or unlawful.

Section 8 of the PAJA describes the remedies that are available under judicial review proceedings as follows –

- (1) The court or tribunal, in proceedings for judicial review in terms of section 6 (1), may grant any order that is just and equitable, including orders-
 - (a) directing the administrator-
 - (i) to give reasons; or
 - (ii) to act in the manner the court or tribunal requires;
 - (b) prohibiting the administrator from acting in a particular manner;
 - (c) setting aside the administrative action and-
 - (i) remitting the matter for reconsideration by the administrator, with or without directions; or
 - (ii) in exceptional cases-
 - (aa) substituting or varying the administrative action or correcting a defect resulting from the administrative action; or
 - (bb) directing the administrator or any other party to the proceedings to pay compensation;
 - (d) declaring the rights of the parties in respect of any matter to which the administrative action relates;
 - (e) granting a temporary interdict or other temporary relief; or
 - (f) as to costs.

- (2) The court or tribunal, in proceedings for judicial review in terms of section 6 (3), may grant any order that is just and equitable, including orders-
- (a) directing the taking of the decision;
 - (b) declaring the rights of the parties in relation to the taking of the decision;
 - (c) directing any of the parties to do, or to refrain from doing, any act or thing the doing, or the refraining from the doing, of which the court or tribunal considers necessary to do justice between the parties; or
 - (d) as to costs.

It is clear from this section that the remedy is dependent for its appropriateness on the context of the claim. Only in exceptional cases may the court substitute its own decision for that of the administrator. In view of the dicta of the courts on this subject discussed previously it is submitted that the courts will be extremely reluctant to use section 8(1)(c)(ii). It is questionable whether this provision is even constitutional in view of the doctrine of separation of powers. Even in *TAC*²⁴⁴ the court acknowledged that whilst it had the authority to pronounce upon the constitutionality of an executive decision and even make an order that would have a budgetary implication, the courts are ill-equipped to make decisions of an executive or administrative nature. It is also noteworthy that it is only in exceptional cases that the administrator or any other party to the proceedings can be ordered to pay compensation. In the context of the provision of health care services, this may mean that if a plaintiff chooses to base his or her claim on provider-patient relationship founded in administrative law, he or she should not be looking for compensation but rather an order of court instructing the administrator to revisit its decision, prohibiting the administrator from acting in a particular manner, eg closing down a hospital etc. In practice a claim is unlikely to be brought only on the basis of administrative law given the fact that access to health care services is a constitutional right²⁴⁵.

²⁴⁴ *TAC* fn 159 *supra*

²⁴⁵ Liebenberg, in Chaskalson *et al* (eds) *Constitutional Law of South Africa*, points out at 41-28 to 41-29 that "administrative conduct under a statute may amount to the deprivation of a substantive constitutional guarantee and that legitimate reasons for depriving an individual to a particular socio-economic right must be justified under the general limitations clause. In the absence of justification, administrative action that deprives people of their access to socio-economic rights is unconstitutional." She notes further that unreasonable administrative action and procedural unfairness also infringe the right to just administrative action, and will require independent justification under the limitations clause. This illustrates the interrelationship between socio-economic rights and the right to just administrative action." She points out, however that not every scaling down or even abolition of a programme of state support will amount to a negative infringement of the rights in sections 26(1) and 27(1) of the Constitution and that a violation will not arise if

There may be remedies provided by statute in specific instances. Apart from this it seems that the administrative law relationship will in many instances give rise to a duty of care on the part of the public provider and that failure to observe such duty will ground a claim on the basis of the law of delict. This aspect will be discussed in more detail in the section on the law of delict.

3.16 Conclusions

A relationship between public providers of health care services and patients based on administrative law as opposed to the law of contract would therefore have the following elements:

At the general level –

It must be borne in mind that although policy decisions are not within the scope of administrative law, decisions involving the implementation of legislation are and so the nature of the decision taken would have to be ascertained before it could be challenged. It is important to remember, however, that in the context of health care access to health care services is a constitutional right. Even if the relationship between public provider and patient were only administrative one cannot see it in isolation from the Constitution which will always be present in and relevant to such a relationship. Constitutional principles suffuse every branch of law.

- (1) An administrative decision to close down a public health care establishment, or to remove health care services from a particular area, especially when there is no reasonably accessible alternative, would have to be taken on the basis of the administrative law principles of procedural fairness, reasonableness and legality or lawfulness. This may mean that there will have to be adequate notice of the proposal to do so and also that a reasonable opportunity must be given to make representations. It will be subject to constitutional and administrative law review.

suitable alternative programmes exist or if the beneficiary can gain access to the right through his or her private resources.

- (2) Reasons for an administrative decision to remove health care services or close down a health establishment would have to be given.
- (3) Treatment protocols and guidelines must be developed in a manner that is lawful, procedurally fair and reasonable and that adequately takes into account the rights and interests of all patients.
- (4) Where of necessity the interests of some patients must be preferred over those of others, the basis for the preference must be fair, rational and reasonable under the circumstances.
- (5) Cognisance must be taken of any legitimate expectations that may have been created in the minds of the community when taking an administrative decision to provide or withdraw health care services.
- (6) Treatment programmes should not be unfairly discriminatory either in terms of the nature of the treatment administered to patients or groups of patients or in terms of the procedure in which the treatment is administered
- (7) Where an administrative decision involves the granting of a licence to deliver health care services or sell health care goods, this must done with regard to the rules of administrative justice, the applicant must have an opportunity to make representations, the decision must be unbiased and all applicants must be treated equally. There may not be undue delays in the communication of the licensing decision.

At the specific level-

- (1) Where treatment guidelines exist, these must be applied to each patient fairly and rationally.
- (2) The constitutional rights of the patient to bodily and psychological integrity must be respected when treating him or her. This implies that the patient's

informed consent will be obtained in every instance where this is reasonably possible.

- (3) Payment may be claimed from the patient in accordance with regulations or other subordinate legislation determining such fees and their applicability to various categories of patient.
- (4) Administrative procedures for the delivery of health care services must be efficient and avoid undue or unnecessary delays²⁴⁶.
- (5) Treatment may not suddenly and without sound medical reasons be withdrawn or discontinued once it has commenced especially where a legitimate expectation of continuing treatment has been created in the mind of the patient or where the treatment or health condition of the patient is itself of an ongoing or continuous nature.
- (6) Deviation from recognised and accepted treatment guidelines and protocols must be lawful, procedurally fair and reasonable under the circumstances. Where a patient has already commenced a different course of treatment and has come to expect a certain kind of treatment, informed consent considerations aside, he or she must be informed of any decision to deviate from the accepted course of treatment and the reasons therefor.

Decisions of health professionals working in the public sector could constitute administrative action especially in circumstances where treatment standards, guidelines and protocols are promulgated in subordinate legislation. The implementation of legislation is one determining factor for administrative action. To the extent that the delivery of health services is mandated by legislation and public sector health professionals are implementing said legislation, their activities are likely to fall within the definition of administrative action. The fact that fees are determined by way of regulations, that the nature of the services to be rendered in respect of such fees is also determined by regulation, that the delivery of various kinds of health

²⁴⁶ *Mahabehlala v MEC For Welfare, Eastern Cape, And Another* 2002 (1) SA 342 (SE)

services is mandated by legislation such as the Health Act No 63 of 1977 and that in the delivery of such services, a discretion is often exercised all strongly suggest that the relationship between public providers and patients are largely of an administrative nature. Even if it could be argued that in certain circumstances a contract existed between the provider and the patient, it is highly unlikely that administrative law considerations will ever be completely excluded from the relationship.

B PRIVATE SECTOR

3.17 Introduction

It has already been pointed out that the traditional divisions between public and private sector are no longer as well defined as they once were. Private entities in some cases have more power relative to the individual than do government agencies and their activities can have an equal or greater impact than those of government agencies on constitutional rights²⁴⁷.

The Public Finance Management Act and more specifically its regulations make express provision for public private partnerships (PPPs) with a view to fulfilling public functions²⁴⁸. Although a private party may be contracted to perform a public function in terms of a public-private partnership, the regulations²⁴⁹ stipulate that a PPP agreement involving the performance of an institutional function does not divest the accounting officer or accounting authority of the institution concerned of the responsibility for ensuring that such institutional function is effectively and efficiently performed in the public interest or on behalf of the public service. In terms of the regulations, PPP agreements have to be approved by the relevant treasury with regard

²⁴⁷ Freeman J 'Private Parties, Public Functions and the New Administrative Law' <http://ssrn.com> notes: "In fact many private actors participate in governance in ways that are rarely recognized by the public, acknowledged by politicians or carefully analysed by legal scholars. The contributions of private individuals, private firms, financial institutions, public interest organizations, domestic and international standard-setting bodies, professional associations, labour unions, business networks, advisory boards, expert panels, self-regulating organizations and non-profit groups belie administrative law's pre-occupation with agency discretion. Private individuals serve on influential government boards; "expert" private committees exercise important powers on accreditation; private producer groups may directly negotiate regulations together with other interested parties and the agency; non-profit and for-profit organizations contract to provide a variety of government services and perform public functions ranging from garbage collection to prison operation; individuals...private standard setting organisations generate health and safety standards that agencies automatically adopt. Contemporary governance might best be described as a regime of "mixed administration" in which private and public actors share responsibility for both regulation and service provision."

²⁴⁸ Act No 1 of 1999. The Treasury Regulations For Departments, Trading Entities, Constitutional Institutions And Public Entities as published in Government Notice R740 in Government Gazette No23463 of 25 May 2002 as amended by General Notice 37 in Government Gazette No 25915 of 16 January 2004 define 'public-private partnership' as follows: 'public-private partnership' or 'PPP' means a commercial transaction between an institution and a private party in terms of which the private party-

- (a) performs an institutional function on behalf of the institution; and/or
- (b) acquires the use of state property for its own commercial purposes; and
- (c) assumes substantial financial, technical and operational risks in connection with the performance of the institutional function and/or use of state property; and
- (d) receives a benefit for performing the institutional function or from utilising the state property, either by way of:
 - (i) consideration to be paid by the institution which derives from a revenue fund or, where the institution is a national government business enterprise or a provincial government business enterprise, from the revenues of such institution; or
 - (ii) charges or fees to be collected by the private party from users or customers of a service provided to them; or
 - (iii) a combination of such consideration and such charges or fees;

²⁴⁹ Treasury Regulations fn 233 *supra*, reg 16.7.2

to value for money, affordability and substantial technical, operational and financial risk transfer to the private party²⁵⁰.

There is an increasing statutory emphasis on the activities of a particular entity or person in terms of the nature of their functions i.e. public functions as opposed to private functions, rather than their identity or the method of their origination. Thus a statutory body can enter into private contracts as can a government department while private companies can perform public functions.

In terms of section 28 (3) (a) of the Promotion of Equality and Prevention of Unfair Discrimination Act²⁵¹ the state, institutions performing public functions *and all persons* have a duty and responsibility, in particular to-

- (i) eliminate discrimination on the grounds of race, gender and disability;
- (iii) promote equality in respect of race, gender and disability.

Section 239 of the Constitution defines an organ of state as –

- (a) any department of state or administration in the national, provincial or local sphere of government; or
- (b) any other functionary or institution-
 - (i) exercising a power or performing a function in terms of the Constitution or a provincial constitution; or
 - (ii) exercising a public power or performing a public function in terms of any legislation,

In terms of the Promotion of Access to Information Act²⁵² -

‘public body’ means-

- (a) any department of state or administration in the national or provincial sphere of government or any municipality in the local sphere of government; or
- (b) *any other functionary or institution when-*

²⁵⁰ Treasury Regulations fn 248 *supra*

²⁵¹ Promotion of Equality and Prevention of Unfair Discrimination Act No 4 of 2000

²⁵² Promotion of Access to Information Act No 2 of 2000

- (i) exercising a power or performing a duty in terms of the Constitution or a provincial constitution; or
- (ii) *exercising a public power or performing a public function in terms of any legislation.*

The Public Protector is competent *inter alia* to investigate, on his or her own initiative or on receipt of a complaint, any alleged -

- abuse or unjustifiable exercise of power or unfair, capricious, discourteous or other improper conduct or undue delay *by a person performing a public function;*
- improper or unlawful enrichment, or receipt of any improper advantage, or promise of such enrichment or advantage, by a person as a result of an act or omission in the public administration or in connection with the affairs of government at any level *or of a person performing a public function;*
- act or omission by a person in the employ of government at any level, *or a person performing a public function*, which results in unlawful or improper prejudice to any other person.²⁵³

In terms of the Promotion of Administrative Justice Act, 'administrative action' means any decision taken, or any failure to take a decision, by-

- (a) an organ of state, when-
 - (i) exercising a power in terms of the Constitution or a provincial constitution; or
 - (ii) exercising a public power or performing a public function in terms of any legislation; or
- (b) 'a natural or juristic person, other than an organ of state, *when exercising a public power or performing a public function in terms of an empowering provision,*

which adversely affects the rights of any person and which has a direct, external legal effect.

²⁵³ Section 6 (4) of Act No 23 of 1994

3.18 Private Entities, Public Functions

It is submitted that whilst organs of state perform public functions this does not necessarily mean that if the function is a public one it is an organ of state that is performing it. The Promotion of Administrative Justice Act and the other legislation referred to above makes it clear that persons other than organs of state can also perform public functions. It must also be inferred from the Promotion of Administrative Justice Act that administrative action and public functions are not, at least for the purposes of this Act, mutually interchangeable concepts.

There are considerable legal concerns around the performance of public functions by entities and persons within the private sector not least of which is the problem of accountability and the threat posed by delegation to the doctrine of the separation of powers²⁵⁴. There are also problems, however with the creation of for profit public entities that have objectives more comparable to those of the private sector than those the public sector.

The creation of public entities such as the National Health Laboratory Service (NHLS), the Medical Research Council (MRC) and the Council for Medical Schemes (CFMS) has the effect of removing the areas in which they operate from direct state control in many instances. For example provided that the MRC remains within the boundaries of its statutory mandate, it is free to decide which business to take on and which to reject in terms of research projects. This is problematic for government because public health research has always been something of a cinderella in the worlds of academic and, particularly, commercial medical research yet it is vital for informing policy making, health resources planning and the fulfilment of the state's constitutional mandate to achieve the progressive realisation of the right to health care within available resources. In the implementation of an HIV and AIDS management and treatment programme a large and reliable laboratory facility is required in order to ensure that essential blood and other tests are conducted as part of the treatment regimen. The NHLS as an independent body over which the state has no direct control

²⁵⁴ Freeman J fn 247 *supra* states that: "In legal theory this degree of private delegation raises concerns about both the accountability of private groups and the threat delegation poses to separation of powers principles." She refers to Krent H J, 'Legal Theory: Fragmenting the Unitary Executive: Congressional Delegations of Administrative Authority Outside the Federal Government' (1980) 85 *Nw U. L. Rev.* 62

is essential to the delivery of the programme countrywide yet it is technically free to take its own business decisions.

In South Africa there are shortages of health research personnel, trained laboratory technicians and other human resources that are necessary for medical research. Those resources that are available to the state for these activities should thus be carefully husbanded rather than given away.

It is submitted that delegations of public functions to private sector entities and the creation of public entities that are not under the control of the state to perform essential public functions could in some instances even be unconstitutional given the fact that section 27(2) of the Constitution requires the state to achieve the progressive realisation of socio-economic rights within *its* available resources. If it alienates its resources or fragments them to the extent that it has largely abdicated its powers and responsibilities in terms of section 27(2), it is submitted that this could be seen as a subversion of its constitutional role. The danger is that this subversion is likely to take place gradually and in a piecemeal fashion so that a government that is not alert to the bigger picture could one day find that it has castrated itself without realising it. The private sector is not as stable as the public sector in many respects. It is income driven, if not profit driven. It is subject to the whims and fancies of shareholders, fluctuations in foreign exchange rates, competition and other market forces.

Even certain non-governmental organisations (NGOs) are hungry for power and control over their area of interest. Whilst the needs of other groupings may be just as significant, the more powerful NGOs have the resources to make themselves heard and are thus likely to receive more attention for themselves and the interests they represent. Individuals within private entities seek personal power, aggrandisement and the furtherance of their personal interests and there are no guarantees that in five years time they will be answerable to their constituencies in a general election.²⁵⁵ It is

²⁵⁵ Freeman J in 247 *supra* notes that: "Private actors remain relatively insulated from legislative, executive and judicial oversight. To the extent that private actors perform traditionally public functions unfettered by the scrutiny that normally accompanies the exercise of public power, private participation may indeed raise accountability concerns that dwarf the problem of unchecked agency discretion. In this view private actors do not raise a new democracy problem; they simply make the traditional one even worse because they are considerably more unaccountable than agencies. In addition private agencies threaten other public law values that are arguably as important as accountability. Their participation in governance may undermine features of decision making that administrative law demands of public actors, such as openness, fairness, participation, consistency, rationality and impartiality."



submitted that there is a fundamental and inescapable conflict of interest in the delegation of public functions to private entities. Since funding must follow the function such delegation means putting public money into private hands that are seeking to make a profit and to serve, not the public interest, but self interest²⁵⁶. Health care services are a public good and access to them, a constitutional right. To place responsibility for the delivery of health care services solely in the realm of the private sector would be problematic unless, there was some assurance of funding for those services. This is often the case in other countries with strong social or national health insurance systems for example France and Australia. The state retains the financial and purchasing power which assures access to health services sourced from the private sector as well as state owned institutions. In South Africa at present no such powerful state funding mechanism exists to balance the scales of power in a scenario where health care is provided largely by the private sector. However if such a scenario could come into play, it is submitted that the question of whether the delivery of health care services was a public or a private function would become very real indeed. Rationing and resource allocation decisions taken by providers in such a scenario could not be dictated purely by private sector motives. They would either have to be managed by way of contractual relationships between a state funder and the providers or by administrative law principles. Health care goods and services are not ordinary commodities the distribution of which can be adequately ensured and regulated by commercial law and common market forces.

It would seem that the US offers significant opportunities for fruitful study of when and how not to give away public power²⁵⁷ although it is submitted that the South

²⁵⁶ Merusak K argues in 'Limitations to the transfer of public functions to persons in private law: aspects of constitutional law and administrative law' 2000 *Juridica* VIII 499-507 that on the basis of the Constitution of Estonia, the state must perform its essential functions itself and that the transfer of public functions related to the exercise of authority to persons in private law is only possible to a certain extent. However, Merusak states that social functions need not, as a rule be performed by the state or local governments, who may transfer such functions to persons in private law although they must ensure their performance. It is submitted that there are similar arguments that can be raised with the regard to the South African Constitution and the outsourcing of public functions to the private sector in South Africa. The fact of the matter is that the Constitution unequivocally imposes certain obligations on the state with regard to its powers and functions and that the statutory assignment of such powers and functions to the private sector in an attempt to transfer the risk or obligation imposed by the Constitution is likely to be unconstitutional. Furthermore contractual arrangements which outsource public functions, whilst not necessarily unconstitutional, cannot succeed in absolving the state of its ultimate responsibility, for instance in terms of section 27(2) to take reasonable legislative and other measures to progressively achieve the realisation of the rights in section 27(1).

²⁵⁷ Freeman J, in 247 *supra* observes: "Beyond the familiar literature on agency capture, one struggles to find careful analyses of how traditional command and control regulation depends so heavily upon private self-reporting, negotiation and industry co-operation in enforcement...while my illustrations are mostly federal or state, one can find public-private arrangements functioning at every level of government. Indeed the blending of public-private actors is likely to be especially complex at the state and local level." Freeman points out that economists and policy makers usually justify privatisation on the theory that private control will provide efficiency gains but that John D. Donahue in *The*

African Constitution is much stronger in terms of its potential for curbing this trend than is the older US Constitution.

3.19 Public Private Entities

There are a number of permutations that arise within the public-private interface. At one end of the spectrum one finds public entities that operate rather more in the private sector than they do in the public sector - what one might call, public private companies. These are entities that have usually been converted into private entities from their previous status as government entities. The State Information Technology Agency is an example of such an entity. At the other end of the spectrum one finds essentially private entities that are fulfilling mostly public functions. An example of these would be private waste disposal companies that are contracted to various municipalities to remove waste. The question arises what the position would be of a private provider of health care services that is contracted by the state to operate a state owned health establishment that is serving non-paying public sector patients. Conversely what would be the position of a state owned and operated facility that is contracted to a medical scheme to service its beneficiaries. Would administrative law apply to the former? Would it apply to the latter? If the answers are different in each instance then what is the reason for such difference?

Freeman²⁵⁸ observes that the most common example of public-private cooperation in governance takes the form of agencies contracting with private non-profit and for profit firms to provide social services or perform public functions. She states that in most cases public agencies engaged in contracting out believe that they are surrendering only policy *implementation* while retaining authority over policy *making* but that this distinction is tenuous at best. Freeman uses the example of private management of prisons but it is just as apposite in the context of public health service delivery by private contractors. She points out that private prison guards exercise discretion that affects prisoner's most fundamental liberty interests (over meals, showers, exercise time, cell conditions, transportation, work assignments, visitation).

Privatization Decision argues that the presence of competition is more important than the public or private nature of the decision maker. She notes that privatisation proponents also argue that the capital market and the company meeting provide more direct accountability than public agencies. She states that privatisation does not guarantee accountability, however. It often enables secrecy

258

Freeman fn 247 *supra*

Prison officials judge when infractions occur, impose punishments and make recommendations to parole boards. Even where an agency retains the authority to accept or reject rules by the private provider, the latter interprets and puts those rules into operation, giving them practical meaning and blurring the line between policy making and implementing functions. She notes that authority over day to day operation confers upon the private manager a “governmental” power to both legislate and adjudicate. Freeman states that a contractual system relies on judicial enforcement of the private law of contract rather than judicial enforcement of administrative law principles at the behest of private citizens. There is thus a possibility that a contractual regime might undermine public participation in decision making and impede public access to relief for injuries suffered by the intended beneficiaries of the contract. The private contractor may provide poor service, injure consumers or engage in anti-competitive behaviour, for example, with little fear of reprisal.

In the private health sector, which in South Africa, is largely profit driven, private contractors to the state may provide health care services that offer the highest returns rather than those that give the best health outcomes or that address the most urgent needs of the communities served. They would also have many different kinds of perverse incentives which revolve largely around the promotion of self-interest. In the absence of highly specific service level agreements that are closely managed by the public sector, public-private arrangements that, in the interests of the promotion of efficiency, provide for financial rewards that are directly related to under expenditure by the contractor are likely in the long run to end up short changing patients in terms of quality of care. Price fixing has been a feature of the private health sector for many years. It is a relic of a previous legal dispensation that actively promoted it in the form of gazetted tariffs for various health services but despite the change in legislation some years ago, the Competition Commissioner ruled as recently as last year that private hospitals, medical practitioners and medical schemes were guilty of anti-competitive practices and fined them substantial amounts of money. The Supreme Court has held that a private hospital could freely insert the most exclusionary indemnity clauses in patient admission documentation which constitutes a record of the contract between a patient and a hospital in order to avoid claims of even gross



negligence on the part of its staff²⁵⁹. The court expressly upheld and preferred the principle of freedom of contract over the constitutional right of access to health care services and despite the obvious imbalance of bargaining power between the contracting parties. If the private sector is entitled to enter into such contracts why should a private contractor managing a government owned health establishment not do the same? If such a contractor refuses to provide a drug in circumstances similar to those in *Applicant v Administrator, Transvaal, And Others*²⁶⁰ what recourse does the patient have? Against the state he would be able to invoke the provisions of the Promotion of Administrative Justice Act. Against the private contractor he would only be able to do so if the provision of health care services was found to be a public function. Since the provision of health services within the public and private sectors is not materially different in terms of the needs served, the nature of the services provided and the circumstances in which they are provided, it is difficult to find justifications for distinctions between the one as being a public function and the other not. One could argue that private patients have a choice that public patients do not, but the realities of the situation of private patients indicate that such choices are often notional rather than real.

In the health care context patient choices are generally limited whether they are private or public sector patients. Many medical schemes restrict patient choice in the private sector when it comes to high cost health interventions such as hospitalisations and there are some that even indirectly compel their members to use public sector facilities. Schemes also restrict, directly or indirectly, the number of visits to medical and dental practitioners per year and access to medication in terms of benefit ceilings. The patient can go to a private provider if he or she is able and prepared to pay the difference in rates. Many medical scheme members cannot afford to do so. Many medical scheme contributions are based on earnings levels as are the fees payable to public hospitals by employed patients who have an income. Those who earn more pay more in both instances. The consumption of health care goods and services entails very little choice on the part of consumers whether they are public or private sector patients. They are not experts trained in the relative merits of the many different brands of medication on the market or the effective use of medical devices. They

²⁵⁹ *Afrox Healthcare Bpk v Strydom* 2002 (6) SA 21 (SCA)

²⁶⁰ *Applicant v Administrator, Transvaal, And Others* fn 230 *supra*

cannot, in the majority of cases, assess for themselves whether they are being led up the garden path or whether what they are being told about their health needs and the management of their health condition is true. They are not in a position to know about alternative therapies that may be just as effective but less costly unless they are told by the provider of health care services. These are vulnerabilities of public and private sector patients alike. Second opinions in the private sector are dependent on the availability of funding and are not necessarily easily obtained. If one obtains conflicting medical opinions then a second opinion can yield more questions than answers for the unfortunate, and medically illiterate, patient.

A contractual regime in the health care context tends to the assumption that there is equal bargaining power between the contracting parties when, particularly in this context, this is the exception rather than the norm. The distinction between the largely administrative law relationship between patients in the public sector and public sector providers on the one hand, and the contractual relationships between private patients and private providers on the other, in respect of services that are essentially the same, throws into stark relief the dilemma created by classifying health services rendered in the private sector as a private function rather than a public one. It is submitted that there are useful analogies that can be drawn between waste disposal and health service delivery. Waste disposal is essentially a public function in the sense that it is necessary not only for the good of the individual who generates the waste but also for the broader community that is likely to suffer the hazards that an accumulation of such waste would create. Health services are also essentially a public function since they are necessary not only for the good of the individual but also for the society in which that individual functions. There are a variety of reasons apart from the obvious ones that relate to contagious diseases. Sick parents cannot support their children. Children in poor health cannot be properly educated. Adults in poor health cannot attend at work or when they do cannot perform to the full capacity. The HIV and AIDS pandemic has brought these truths to light in a way that few other health conditions can. Like waste disposal, health care services are in many senses a 'grudge' purchase generated by a need for the opposite of one's current situation. One has to purchase health services because one is in poor health – an undesirable state of affairs. In the case of both waste disposal and health care services, people are usually not in a position to perform these services for themselves. They are dependant upon

broader societal structures for these arrangements. In short they are public goods. The idea of health care services as a public good is explored more fully in a subsequent chapter.

What then are the arguments for not regarding all health services as a public function regardless of where they are rendered? Why should administrative law, which is after all preoccupied with procedural fairness not apply equally in the public and private health sectors? This is a particularly relevant question in the light of the constitutional values of equality and freedom upon which the legal system must be structured.

Freeman states that an emerging literature in administrative law suggests that the pressing challenge for the field is to determine when and how to extend legal requirements to private actors performing public functions²⁶¹. She states that the trend away from government shifts the administrative law terrain so much that failure to constrain discretion is not the crucial problem in the field. Instead the challenge is ensuring that privatisation, contracting out and other measures designed to yield authority to private parties do not eviscerate the public law norms of accountability, procedural regularity and substantive rationality that administrative law has laboured so hard to provide.²⁶² She states that although laudable for its focus on private actors and its bold assertion that discretion is no longer the central issue in the field, the emerging privatisation literature does not go far enough. According to Freeman the new privatisation literature in administrative law is marked by debates over whether judicial review will subside or intensify as the private role in administration increases. Some scholars argue, she says, that a proliferation of private activity will weaken the executive and legislative capacity to exert control over public decisions which will invite greater judicial oversight.²⁶³ Courts may then choose to regulate private actors either by expanding the state action doctrine or by infusing common law doctrines with public norms, such as good faith obligations in contract. Indeed, she says, there

²⁶¹ Freeman fn 247 *supra*

²⁶² Freeman observes that viewed in this light, a continued emphasis on constraining agency discretion is like shuffling the deck chairs on the Titanic and notes that it is not surprising that such concerns have arisen first and most forcefully in the United Kingdom, Australia and New Zealand, countries that already impose far fewer legal and procedural constraints on ministerial discretion, and which have witnessed very significant degrees of public sector re-structuring in the last two decades.

²⁶³ Freeman, fn 247 *supra*, refers to Mullan D 'Administrative Law at the Margins' in *The Province of Administrative Law*, M Taggart ed in this regard.

is ample precedent for imposing procedural requirements on private parties performing public functions when they act in derogation of the public interest.

Freeman points out that the task for administrative law is more complicated than delineating a threshold test to determine when a private actor is performing a sufficiently public function to justify the imposition of public law constraints. Other questions are –

- Do private actors have any obligation to be “public-regarding” in setting standards that are then incorporated by reference by a government agency or is the agency’s stamp of approval an adequate guarantee of accountability?
- Should courts review the exercise of enforcement discretion to approve voluntary self-regulation more carefully than when it is exercised for other purposes?

Significantly she observes that the necessary inquiry will require highly specific analyses of the dangers (self-dealing, conflicts of interest, secrecy, irrationality, lack of representation, and procedural irregularity, to name some) posed by different regulatory arrangements. Freeman states that before imposing traditional (administrative law) constraints on private actors one should look at whether other actors or different mechanisms might play a role in providing accountability and ensuring compliance with public law norms. In other words, she says, the impulse to respond to private activity by constraining private actors merely shifts the focus to the private side of the equation rather than re-orienting the administrative law enquiry to the public-private regime as a new entity. She points out that the public acceptability or legitimacy of a decision making regime turns in part upon the expectations of how the actors in that regime ought to behave when they play certain kinds of roles. For example when they function in an advisory capacity in which they purport to be neutral, one might rightly expect disinterested decision making. Freeman suggests that a mixed administrative regime might rely on numerous informal accountability mechanisms and non-governmental actors to control the dangers posed by public-private arrangements and that public-private arrangements can be more accountable because of the presence of powerful independent professionals within private

organizations or because the agency's threat of regulation provides the necessary motivation for effective and credible self-regulation which involves non-government actors. She says that informal regulatory regimes can emerge in a context where there is no formal government participation. Freeman proposes a concept of mixed administration but points out that there are some significant obstacles not least of which is the fact that the public-private distinction is central to constitutional law. Whilst this may be true of the US Constitution it is submitted that it is less true of the South African Constitution which expressly acknowledges for instance the possibility of the horizontal application of the rights in the Bill of Rights. However the South African Constitution does make it clear that certain actions are the exclusive domain of government whose role, after all is to govern. Freeman does note that in a handful of cases both American and Commonwealth courts have imposed procedural requirements on public actors by reasoning that they are in effect behaving as private actors and points out that doctrinal mechanisms like "the source of power" or "public function" tests enable courts to characterize traditionally private actors as public whenever they exercise a sufficiently important and traditionally public regulatory function. She points out that such doctrinal innovations continue to rely heavily on the formalistic and conceptually dubious characterization of activity as essentially public or private and that this divide remains resilient in the face of withering attacks from critical legal studies, feminist legal theory, legal postmodernism and outsider legal scholarship. Freeman states that no matter how blurred the line between public and private and no matter how difficult to design an intellectually defensible test to distinguish them, most scholars agree that there ought to be a meaningful difference between the two and that constitutional constraints should apply *only* to the former. She observes that one finds a similar commitment to the public-private distinction in administrative law.

Freeman's approach to the extent that it supports regulation by private entities is not supported in this thesis not only because of the problems that seem to accompany over privatisation given the American experience but because of the approach of the South African Constitution itself²⁶⁴. Moreover, the imposition of specific obligations such as

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Thus section 43 stipulates that -

In the Republic, the legislative authority-

(a) of the national sphere of government is vested in Parliament, as set out in section 44;

(b) of the provincial sphere of government is vested in the provincial legislatures, as set out in section 104; and

is contained in section 27(2) upon the state renders it unconstitutional for the state to privatise to the point where it is incapable of fulfilling those obligations because it has given away the mechanisms and resources necessary to do so. This is not to suggest that the state must provide all health care services itself. However, if the state gives away even the power to regulate health service delivery, the power to set standards for quality, safety and efficacy and to legislate mechanisms which can counteract the negative impact on access by market forces and other social factors then it is submitted that it will effectively have undermined its capacity to fulfil its constitutional obligations. What is interesting about Freeman's views is that the line between public and private function is not as clear as might first appear and that she provides some useful arguments for the application of certain principles of administrative law in the health care sector. In South Africa, fairness is a constitutional and legislative preoccupation due to largely to its history. Fairness is also a preoccupation of administrative law. Equality is a constitutional value that supports and underlies fairness. In South Africa there is legislation such as the Promotion of Equality and Prevention of Unfair Discrimination Act²⁶⁵ for instance which states in section 24 that (1) The State has a duty and responsibility to promote and achieve equality and (2) All persons have a duty and responsibility to promote equality. In terms of this Act, limiting women's access to social services or benefits, such as health, education and social security constitutes unfair discrimination on the ground of gender. It is submitted that where the activities of the private sector impact or have the potential to negatively impact upon constitutional values and the capacity of persons to realise their constitutional rights there are strong arguments in favour of the principles of administrative law in those situations. In fact this is one of the key identifiers of administrative action in terms of the Promotion of Administrative Justice Act²⁶⁶ which states in the definition of this term it is any decision taken, or any failure to take a decision...which adversely affects the rights of any person and which

(c) of the local sphere of government is vested in the Municipal Councils, as set out in section 156.
In terms of section 85 -

(1) The executive authority of the Republic is vested in the President.

(2) The President exercises the executive authority, together with the other members of the Cabinet, by-

- (a) implementing national legislation except where the Constitution or an Act of Parliament provides otherwise;
- (b) developing and implementing national policy;
- (c) co-ordinating the functions of state departments and administrations;
- (d) preparing and initiating legislation; and
- (e) performing any other executive function provided for in the Constitution or in national legislation.

²⁶⁵ Promotion of Equality Act fn 251 *supra*

²⁶⁶ Promotion of Administrative Justice Act fn 8 *supra*

has a direct, external legal effect. This section of the Act also introduces the public function test as discussed previously.

In the Netherlands administrative law, as in South Africa, is applicable to any action with regard to the execution of public law power. Public law power is defined in that country as authority to decide on the behaviour of another person²⁶⁷. In the Netherlands privatised organisations are largely regulated by administrative law and the process of conversion from a state organisation to a privatised company is governed by administrative law in all stages.

What is interesting is that van der Vlies *et al* observe with regard to methods of safeguarding public interest that the latter may be served by competition but only under specific conditions. They state that even if the competition is real, the public interest might need more guarantees, noting that if privatisation leads to competition *for* the market only and not to competition *in* an open market, competition is in fact void. It is widely acknowledged that in the health sector, competition does not work very well due to the captive nature of the consumer and the high levels of necessary regulation of health professionals and products. The Research Council for Government Policies (WRR) in the Netherlands developed five main checkpoints for good governance in privatisation namely democratic legitimisation; equity before the law; legal certainty; efficiency and efficacy. Democratic legitimisation requires democratic steering and democratic accountability. The authors note that competition and equity before the law are not entirely compatible concepts and that competition may cause companies to infringe the principle of equity before the law. Thus an insurance company may exclude certain high risk groupings (as happened in the South African medical schemes industry prior to the introduction of the Medical Schemes Act in 1998) although such behaviour does not observe the principle of equity before the law. Legal certainty, they state, is partly connected to predictability of actions of the administration. However, they say, public law does not have the monopoly on certainty and is itself limited in this regard in that rules are open to interpretation and officials are awarded certain discretionary powers.

²⁶⁷ Van der Vlies IC, Stoter S W and Lubach DA 'Application of Administrative Law to Privatization In The Netherlands' *European Journal of Comparative Law* <http://www.ejcl.org/64/art64-24.html>

Van der Vlies *et al*²⁶⁸ comment that whether a public or a private organisation of a service is effective or efficient depends mainly on the character of the service. Thus electricity was traditionally traded in a monopoly market because the infrastructure required to provide it was too technically sophisticated to allow competition. Nowadays, infrastructure is less complex and allows competition without the risk of losing the availability of electricity to everyone. This observation is very interesting in the context of the South African health sector in which the infrastructure is not such that health care services are available to everyone. It seems that where there is a well established infrastructure that is readily accessible, competition is feasible but where the infrastructure is insufficient competition will have the effect of excluding from access to resources altogether those who are less able to compete for them. This usually means the poor. In other words, infrastructure needs to reach a certain critical mass before competition becomes a positive factor.

3.20 Case Law

3.20.1 *Pennington v Friedgood And Others*²⁶⁹

Facts

During 1999 Fedsure Health (Pty) Ltd (Fedsure) became the administrator of the Erica medical scheme; the board of trustees of the scheme (the board) became dissatisfied with the service that the scheme was receiving from Fedsure and in due course cancelled its administration agreement with Fedsure and transferred its administration to Old Mutual Healthcare (Pty) Ltd, the fifth respondent, although no formal administration agreement was concluded with the fifth respondent. The board was not satisfied with the manner in which the scheme was being administered under this arrangement and on 8 May 2001 it resolved to terminate its administration agreement with the fifth respondent with effect from 30 June 2001 and to appoint Bensure Management Services (Pty) Ltd, the sixth respondent, as administrator of the scheme with effect from 1 July 2001. The annual general meeting of the scheme was held on 29 June 2001; the first respondent chaired the meeting and the second, third and fourth respondents and representatives of the fifth and sixth respondents were also

²⁶⁸ *Van der Vlies et al* fn 267 *supra*

²⁶⁹ *Pennington* fn 129 *supra*

present, as was the applicant; the first to fourth respondents were elected as the trustees of the scheme at the meeting. The applicant was unhappy with the manner in which the annual general meeting was conducted on 29 June, and on 3 July 2001 he launched an application as a matter of urgency to be heard the next day, 4 July 2001. He claimed the following relief:

“2 That a rule *nisi* be issued calling upon the first through the fourth respondents, in their capacity as trustees of the Erica Medical Aid Society (the scheme) and all interested parties, to appear at 10:00 on Tuesday, 31 July 2001, alternatively at a date to be determined by the above honourable Court, to show cause, if any, why the decision set out in para 2.1 through 2.10 herein below, exercised at the annual general meeting (the AGM) of the scheme, held on 29 June 2001, should not be reviewed and set aside and why an order should not be given in terms of para 2.11 and 2.12 herein below.

- 2.1 The refusal of the first respondent to stand the meeting down to allow arrangements to be made to electronically record the minutes of the meeting.
- 2.2 The refusal of the first respondent to stand the meeting down pending an application to the High Court for an order to compel the electronic recording of the minutes of the meeting.
- 2.3 The appointing of an agent or servant of the consulting firm Jacques Malan & Associates to take the minutes of the meeting.
- 2.4 The refusal of the first respondent to recuse himself as chairperson of the meeting.
- 2.5 The refusal of the first respondent to stand the meeting down pending an application to the High Court for an order to recuse himself from the meeting.
- 2.6 The refusal of the first and second respondents to recuse themselves from participating or voting at the meeting.
- 2.7 The ruling by the first respondent that the eight motions tabled by the applicant in terms of the scheme rules were out of order and therefore would not be dealt with at the meeting.

- 2.8 The stated action by the first respondent that he had disqualified two nominations for trustees because they had not been completed properly.
 - 2.9 The refusal of the first respondent to call for a poll of the members present or by proxy for the election of trustees of the scheme.
 - 2.10 The refusal of the first through fourth respondents to give an undertaking that the administration of the scheme would not be transferred from the fifth respondent to the sixth respondent pending the lodging of this application.
 - 2.11 Why an order should not be given directing that the costs of this application be paid jointly and severally by the first through the fourth respondents in their personal capacity and by the fifth and sixth respondents only in the event that said respondents oppose this application.
 - 2.12 Declaring that, because of the aforesaid irregularities, the continuation of the meeting and any decisions made and resolutions passed at the meeting are invalid.
3. That pending a decision of this honourable Court for the review and setting aside of the aforementioned decisions, the respondents be interdicted and restrained from transferring the administration of the scheme from the fifth respondent to the sixth respondent.
 4. Ordering that any and all records of the members of the scheme in the possession of the sixth respondent be returned to the scheme immediately and that the sixth respondent be restrained and interdicted from contacting the members of the scheme or in any way interfering with the business of the scheme.”

The matter came before Van Zyl J on 4 July 2001. He granted no relief, but postponed the matter for hearing on the semi-urgent roll on 3 September 2001 and gave directions for the filing of answering and replying affidavits and heads of argument by all the parties bar the fifth respondent, and ordered that costs would stand over for later determination. He specifically stated that no order was made in respect of the fifth respondent. Van Zyl J did not grant the interim interdict sought in para 3 of the notice of motion.

The fifth respondent abided the decision of the Court. During the first morning of the hearing, the applicant and the sixth respondent, represented by Mr Sholto-Douglas, reached an agreement in terms of which the former withdrew his application against the sixth respondent and tendered to pay its costs. At a far later stage of the argument, it was also agreed between the applicant and the first to fourth respondents that the applicant would withdraw his claim for interdictory relief against the first to fourth respondents as contained in paragraph 3 of the notice of motion. The following issues accordingly arose for decision: whether the first respondent's rulings and the other conduct referred to in paragraph 2 of the notice of motion fell to be reviewed, viz whether such conduct was indeed reviewable as a matter of law; whether on the facts a case was made out for the review and the setting aside of the conduct complained of; a striking out application; and the appropriate relief.

Judgment

The court referred to *Pharmaceutical Manufacturers Association of SA and Another: In re Ex parte President of the Republic of South Africa and Others*²⁷⁰ as being of great importance. It observed that since the advent of the Constitution and, pursuant thereto, the PAJA, a requisite jurisdictional fact for success on judicial review is that the impeached conduct must constitute administrative action and said that from the dicta from *Pharmaceutical Manufacturers* and from the PAJA, it was clear that whether such conduct constitutes administrative action falls to be decided by reference to whether such action amounts to the exercise of public power or the performance of a public function. Referring to the decision in *Transnet Ltd v*

²⁷⁰ *Pharmaceutical Manufacturers Association of SA* (fn 72 *supra*) in which Chaskalson P, speaking for the Full Constitutional Court, 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" and

"The exercise of public power was regulated by the Court through the judicial review of legislative and executive action. This was done by applying constitutional principles of the common law, including the supremacy of Parliament and the rule of law. The latter had a substantive as well as a procedural content that gave rise to what Courts referred to as fundamental rights, but because of the countervailing constitutional principle of the supremacy of Parliament, the fundamental rights could be, and frequently were, eroded or excluded by legislation. Judicial review served the purpose of enabling Courts, whilst recognising the supremacy of Parliament, to place constraints upon the exercise of public power."

*Goodman Brothers (Pty) Ltd*²⁷¹ Hodes AJ noted that what falls to be considered is, *inter alia*, the source of the power exercised, the nature of such power, its subject-matter, whether it involves the exercise of a public duty, and how closely it is related on the one hand to policy matters which are not administrative, and on the other to the implementation of legislation, which is. The court also referred to the cases of *Dawnlaan Beleggings (Edms) Bpk v Johannesburg Stock Exchange and Others*²⁷², *Johannesburg Stock Exchange and Another v Witwatersrand Nigel Ltd and Another*²⁷³, *Herbert Porter & Co Ltd and Another v Johannesburg Stock Exchange*²⁷⁴ and *Cape Metropolitan Council v Metro Inspection Services (Western Cape) CC and Others*²⁷⁵ and compared the first two decisions with the last two.

Hodes AJ observed that a medical scheme is a body corporate. In terms of the Medical Schemes Act it acquires such status upon registration. It is governed by the Act, the regulations and the scheme rules. Such rules constitute the contract between the scheme and its members.²⁷⁶ A meeting of the members of a scheme is thus similar to a meeting of the members of a company. Both acquire status in terms of an Act of Parliament. In this case, the Act and, in the case of a company, the Companies Act.

In the instant case, as in *Herbert Porter*, the relationship between the trustees (the first to fourth respondents) and the members of the scheme is governed by the Act, the regulations and the rules. In the case of a company the relationship between members and the company is governed by the Companies Act and the articles of association of that company. The court said that just as a meeting of shareholders of a company is not subject to the review of the High Court (*Dawnlaan Beleggings; R v Disciplinary Committee of the Jockey Club, ex parte Massingberd-Mundy*²⁷⁷), so too the proceedings of an annual general meeting of a medical scheme are also not subject to the review of the High Court, for they do not constitute administrative action. The court stated that judicial review is a remedy to curb improper or inappropriate exercise of public power.

271 *Transnet* fn 35 *supra*

272 *Dawnlaan* fn 135 *supra*

273 *Johannesburg Stock Exchange* 1988 (3) SA 132 (A)

274 *Herbert Porter* 1974 (4) SA 781 (T)

275 *Cape Metropolitan* fn 48 *supra*

276 *Meaker NO v Roup, Wacks, Kaminer & Kriger and Another* 1987 (2) SA 54 (C) at 61G - 62C.

277 *Ex parte Massingberd-Mundy* [1993] 2 All ER 207 (QB) at 221b - e

Hodes AJ noted that in *Transnet Ltd v Goodman Brothers (Pty) Ltd*²⁷⁸ in a concurring judgment, Olivier JA gleaned the following from decisions of the Constitutional Court:

- (a) Administrative law is an incident of the separation of powers under which courts regulate and control the exercise of public power by the other branches of Government.
- (b) The question relevant to section 33 of the Constitution is not whether the action is performed by a member of the executive arm of Government, but whether the task itself is administrative or not and the answer to this is to be found by an analysis of the nature of the power being exercised.
- (c) What falls to be considered is, *inter alia*, the source of the power exercised, the nature of such power, its subject-matter, whether it involves the exercise of a public duty, and how closely it is related on the one hand to policy matters which are not administrative, and on the other to the implementation of legislation, which is.

He quoted the following words of Devenish, Govender and Hulme²⁷⁹ :

““Administrative action” is the conduct of public authorities and indeed private entities when they exercise public powers, perform public functions or are obliged to exercise authority in the public interest. This means that common-law review now only applies in a very narrow field in relation to private entities that are required in their domestic arrangements to observe the common-law principles of administrative law. This applies in relation to voluntary associations, such as sporting clubs and religious organisations.”

and stated that he was in agreement with them.

The court concluded that nothing contained in the Act, the regulations or the scheme rules imports a requirement by the trustees to observe the common-law principles of administrative law. Accordingly, it held that the conduct of the first to fourth respondents which the applicant sought to impeach by way of review was not in law susceptible to this Court’s review jurisdiction and that the application for review falls to be dismissed.

²⁷⁸ *Transnet* (fn 35 *supra*) para [34] at 865A - J

²⁷⁹ *Devenish et al* fn 15 at p 25

Discussion

Although the finding of the court in this particular case is, it is submitted, correct, it cannot necessarily be used as a precedent to show that medical schemes do not perform public functions and are thus not subject to considerations of administrative law. The court did recognise the possibility of the performance of a public function by a private entity.

With regard to medical schemes and their more day to day activities involving the funding of medical expenses and the enrolment of members the following should be born in mind-

- (1) Medical schemes are creatures of statute in the sense that they have to be registered in terms of procedures required by the Medical Schemes Act²⁸⁰ and that only when registered are they lawfully able to conduct the business of a medical scheme as defined.
- (2) The content of the rules of medical schemes are closely regulated. Not only are they largely dictated by section 29 of the Medical Schemes Act²⁸¹ but they are

²⁸⁰ Medical Schemes Act No 131 of 1998 section 22 and 24

²⁸¹ According to section 29: (1) The Registrar shall not register a medical scheme under section 24, and no medical scheme shall carry on any business, unless provision is made in its rules for the following matters:

- (a) The appointment or election of a board of trustees consisting of persons who are fit and proper to manage the business contemplated by the medical scheme.
- (b) The appointment of a principal officer by the board of trustees who is a fit and proper person to hold such office.
- (c) The appointment, removal from office, powers and remuneration of officers of a medical scheme.
- (d) The manner in which contracts and other documents binding the medical scheme shall be executed.
- (e) The custody of the securities, books, documents and other effects of the medical scheme.
- (f) The appointment of the auditor of a medical scheme and the duration of such appointment.
- (g) The power to invest funds.
- (h) Subject to the provisions of this Act, the manner in which and the circumstances under which a medical scheme shall be terminated or dissolved.
 - (i) The appointment of a liquidator in the case of a voluntary dissolution.
 - (j) The settlement of any complaint or dispute.
 - (k) The amendment of the rules in accordance with the provisions of section 31.
 - (l) The giving of advance written notice to members of any change in contributions, membership fees or subscriptions and benefits or any other condition affecting their membership.
 - (m) The manner of calling the annual general meeting and special general meetings of members, the quorum necessary for the transaction of business at such meetings and the manner of voting thereat.
 - (n) The terms and conditions applicable to the admission of a person as a member and his or her dependants, which terms and conditions shall provide for the determination of contributions on the basis of income or the number of dependants or both the income and the number of dependants, and shall not provide for any other grounds, including age, sex, past or present state of health, of the applicant or one or more of the applicant's dependants, the frequency of rendering of relevant health services to an applicant or one or more of the applicant's dependants other than for the provisions as prescribed.
- (o) The scope and level of minimum benefits that are to be available to beneficiaries as may be prescribed.



also subject to the approval of the Registrar of Medical Schemes and may not be amended without his sanction.

- (3) The choices of a member of a medical scheme are to leave or to continue as a member under the rules made in accordance with the Act and as approved and registered by the Registrar. There is no scope for the negotiation of benefits on an individual basis. Members can, in terms of the rules of some schemes apply for so-called *ex gratia* benefits but the decision as to whether or not such benefits are granted or not lies with the trustees of the scheme.
- (4) Generally speaking anyone who subscribes to a particular benefit option is entitled to exactly the same benefits as other subscribers. The Medical Schemes Act actively discourages the practice of risk rating individuals according to their health profiles and other individual risk related characteristics such as gender and age. The notion that these rules embody the terms of the contractual arrangement between the member and the scheme does not sit comfortably in the law of contract. One could almost see an argument here for the concept of an

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- (p) No limitation shall apply to the reimbursement of any relevant health service obtained by a member from a public hospital where this service complies with the general scope and level as contemplated in paragraph (o) and may not be different from the entitlement in terms of a service available to a public hospital patient.
- (q) The payment of any benefits according to-
- (i) a scale, tariff or recommended guide; or
 - (ii) specific directives prescribed in the rules of the medical scheme.
- (r) The dependants of a member are entitled to participate in the same benefit option as the member.
- (s) The continuation, subject to such conditions as may be prescribed, of the membership of a member, who retires from the service of his or her employer or whose employment is terminated by his or her employer on account of age, ill-health or other disability and his or her dependants.
- (t) For continued membership of a member's dependants, subject to such conditions as may be prescribed, after the death of that member, until such dependant becomes a member of, or is admitted as a dependant of a member of another medical scheme.
- (u) If the members of a medical scheme who are members of that medical scheme by virtue of their employment by a particular employer terminate their membership of the said medical scheme with the object of obtaining membership of another medical scheme or of establishing a new medical scheme, such other or new medical scheme shall admit to membership, without a waiting period or the imposition of new restrictions on account of the state of his or her health or the health of any of his or her dependants, any member or a dependant of such first mentioned medical scheme who-
- (i) is a person or persons contemplated in paragraph (s); or
 - (ii) is a person or persons contemplated in paragraph (t).
- (2) A medical scheme shall not cancel or suspend a member's membership or that of any of his or her dependants, except on the grounds of-
- (a) failure to pay, within the time allowed in the medical scheme's rules, the membership fees required in such rules;
 - (b) failure to repay any debt due to the medical scheme;
 - (c) submission of fraudulent claims;
 - (d) committing any fraudulent act; or
 - (e) the non-disclosure of material information.
- (3) A medical scheme shall not provide in its rules-
- (a) for the exclusion of any applicant or a dependant of an applicant, subject to the conditions as may be prescribed, from membership except for a restricted membership scheme as provided for in this Act;
 - (b) for the exclusion of any applicant or a dependant of an applicant who would otherwise be eligible for membership to a restricted membership scheme; and
 - (c) for the imposition of waiting periods other than as provided for in section 29 (A).

administrative contract since the only variable subject to negotiation is whether or not a person wishes to become a member or resigns from membership. Membership of a medical scheme is presently voluntary. However social health insurance legislation in the not too distant future may render it mandatory to belong either to a private medical scheme or a public fund that serves essentially the same purpose.

- (5) The Act requires at least 50% of the trustees to be elected from amongst scheme members. This means that the remaining 50% can be appointed by someone else. Power over the scheme is thus not necessarily exclusively in the hands of its members.
- (6) Membership of closed or restricted membership schemes is often a condition of employment. With the current high levels of unemployment one could argue that membership of such schemes for employees of the relevant employer is thus mandatory. This is a further erosion of the contractual nature of the relationship between scheme and member.
- (7) The duties of the trustees are set out in section 57 of the Act and the Council for Medical Schemes may, in terms of section 46, by notice in writing, remove from office a member of the board of trustees of a medical scheme if it has sufficient reason to believe that the person concerned is not a fit and proper person to hold the office concerned. Directors of companies are generally removed by way of a resolution of the relevant company in terms of section 22 of the Companies Act.²⁸²
- (8) Provisions very similar to the principles of administrative law are imposed on trustees of medical schemes. In terms of section 57(6) of the Act the board of trustees shall-
 - (a) take all reasonable steps to ensure that the interests of beneficiaries in terms of the rules of the medical scheme and the provisions of this Act are protected at all times;

²⁸² Companies Act No 61 of 1973

- (b) act with due care, diligence, skill and good faith;
- (c) take all reasonable steps to avoid conflicts of interest; and
- (c) act with impartiality in respect of all beneficiaries.

It is submitted that in view of the foregoing it may be difficult to argue that a decision of a board of trustees is not subject to administrative review, especially where the complaint relates to a failure to act in good faith or with impartiality in respect of a beneficiary. When one considers the definition of 'administrative action' in the Promotion of Administrative Justice Act, it is submitted that in certain circumstances there may well be scope for argument that the business of a medical scheme as defined in the Medical Schemes Act is a public function. Medical schemes in South Africa are not for profit entities that exist solely for the benefit of their members. Procedural fairness, equality and reasonableness are extremely important factors in an environment in which the continued existence of a medical scheme is heavily dependent upon its credibility with its members. Access to health care services is a constitutional right that is very much dependent on the availability of funding. If a medical scheme unreasonably withholds funding for a health care intervention that is within the scope of the benefits provided by the scheme, it is unlikely, however that administrative review will be the weapon of choice for the member since the Act itself provides for a system for dealing with complaints and disputes which allows for appeals to the Council for Medical Schemes and an Appeal Board established under the Act.

The meaning of the expression "public function" will largely determine whether or not the activities of a private entity fall within the definition of "administrative action" in terms of the PAJA. It is submitted, however, that

- (1) where the individual affected by the activity concerned is one out of a group of persons,
- (2) the group has been selected or created by some agency external to itself, the individual in question did not actively or directly choose to be a part of that particular group and may not even be aware of the extent or nature of the group in question (in other words membership of the group was a result of external circumstances, default or the dictates of law),

- (3) the activity concerned was not directed specifically at that particular individual but rather more generally at the group of which he forms a part, and
- (4) the circumstances and parameters of the activity in question are defined, mandated or dictated by legislation

such factors would present a strong argument that the activity in question is a public function and where the rights are directly affected thereby (i.e. the definition of 'administrative action' in the PAJA is satisfied) this activity would also constitute administrative action.

3.21 Summary and Conclusions

Administrative law clearly has an important role to play in the delivery of health services by the public sector in particular. The delivery of health services is in fact more likely to take place in terms of a relationship between provider and patient that is governed by administrative law than one governed by the law of contract. This is due to a number of reasons not least of which is that the *essentials* of what would ordinarily have been a contractual relationship are usually specified in legislation or regulations. The transaction within the public sector has little or no commercial value given that many patients are not required to pay for health care services as they are indigent. Those that do earn an income are charged for services on the basis of their income as opposed to the true cost of rendering those services and there is no profit motive involved. This position is changing to some degree within the public health sector with some of the larger hospitals trying to attract medical scheme patients to differentiated amenities in order to obtain a greater income for the establishment concerned. However, revenue retention by public health establishments is still a problematic area and the motive behind revenue retention is in any event not a profit one.

The principles of administrative law are in many ways better suited to regulate a relationship between patients and providers of health care services because of the emphasis on procedural fairness and the growing view that health services are a public good. If access to health care services should be based on criteria other than relative wealth or income and that the right to health should be enjoyed by everyone

irrespective of their socio-economic status then the provision of health care services starts to look much less of a commercial transaction as contemplated by the law of contract and much more of a resource allocation and distribution process the procedural aspects of which are governed by administrative law. The problem with the law of contract, as will be explained in a subsequent chapter, is that it is not only still very commercially oriented, an orientation which does not sit comfortably with the concept of health care services as a public good, but it is also in South Africa at least, rooted in the Victorian era where multinational corporations and similar legal entities did not exist and power rested very much in the hands of governments. The law of contract in South Africa has not yet absorbed the realities of the imbalances of power created by current global markets and organisations whose wealth exceeds the Gross Domestic Product of many countries.

Administrative law and its preoccupation with fairness is uniquely positioned to be of great assistance and benefit to both patients and providers of health care services in terms of regulating their relationships. It is therefore unfortunate that it is unlikely that South African courts will in the near future be prepared to construe the delivery of health care services as a transaction that should be governed by administrative law rather than the law of contract. There is too strong a predilection to take into account the needs of private sector health service providers from a commercial perspective as will be demonstrated in the discussion of the relevant cases in the chapter of this thesis that deals with the law of contract. Perhaps as South Africa moves towards a social health insurance system, more and more of health service delivery transactions, even in the private sector, will come to be governed by legislation to the point where administrative law will be able to play a meaningful role in the delivery of health services in both public and private sectors.

Chapter 4

Law of Contract: Health Service Delivery

| | | |
|-------|--|-----|
| 4.1 | Introduction..... | 489 |
| 4.2 | Fundamental Concepts | 495 |
| 4.2.1 | Public Interest | 495 |
| 4.2.2 | Bona Fides or Good Faith..... | 499 |
| 4.2.3 | Public Policy (Boni Mores) | 502 |
| 4.2.4 | Reasonableness | 508 |
| 4.2.5 | Fairness..... | 511 |
| 4.2 | Formation of a Contract..... | 513 |
| 4.3 | Informed Consent in the Context of Contract..... | 519 |
| 4.4 | Freedom of Contract..... | 527 |
| 4.5 | Emergency Medical Treatment..... | 533 |
| 4.6 | Damages | 542 |
| 4.7 | Statutory Considerations..... | 549 |
| 4.8 | Tacit Contracts | 551 |
| 4.9 | Implied Terms..... | 554 |
| 4.10 | Tacit or Implied Terms in Health Care Contracts..... | 570 |
| 4.11 | Issues Involving Contracts for Health Care Services..... | 575 |
| 4.13 | Summary and Conclusions | 585 |

4.1 Introduction

This chapter, together with chapters five and six, deals with the subject of the law of contract as it relates to health service delivery. The fundamental legal concepts relating to health service delivery in the law of contract are dealt with in this chapter four while chapter five deals with the case law involving contracts for health service delivery in the public sector and chapter six deals with the case law involving such contracts in the private sector. The material was too voluminous to include it all in a single chapter and in any event it was felt that it might be useful to structure the case law in this way so that the cases involving the two different sectors are grouped together for ease of reference and comparison.

The law of contract as it relates to the delivery of health care services is not very well informed in South Africa due largely to the fact that, of the few cases that have been decided with regard to health care services, most of the later ones have been decided on the basis of the law of delict even where the claim was couched in terms of the law of contract and only in the alternative, in terms of the law of delict. The public sector

is capable of entering into contractual relationships for the delivery of health care services, as evidenced by some of the cases discussed in this chapter, but whether or not it in fact does so as a matter of course is far from clear. *Administrator Natal v Edouard*¹, discussed below, a relatively recent case involving a contractual claim for health services against the state, was decided on the basis of the law of contract because it was not open to the plaintiffs to claim in delict rather than because the law of contract was the preferred basis of the claim. Furthermore, the contract was for a sterilisation – an elective procedure which centres around a highly specific result or outcome – and is therefore in many ways distinguishable from most other contracts for the delivery of health care services in terms of which a ‘cure’ or a particular outcome is seldom guaranteed. Some of the reasons for the lack of clarity as to whether health care services are delivered by public sector providers in terms of a contract as opposed to some other basis are:

- the fact that payment of fees is often required in terms of regulations which prescribe the terms and conditions of payment;
- that the state provides health services to the indigent from whom no payment is required;
- that there is a constitutional obligation upon the state to ensure the progressive realisation of the right of access to health care services that is not shared by private sector providers; and
- that the intention of a body such as the state to contract is often very difficult to establish in the absence of hard evidence to this effect.

The private sector, by contrast generally delivers health care services on a contractual basis as evidenced by the standard documentation that is used by medical practitioners and other health professionals and private hospitals. However even in the private sector, issues can become complicated by the fact that:

- many patients are funded by medical schemes which themselves may have entered into contracts with providers for the delivery of health care services to scheme members;

¹ *Administrator Natal v Edouard* 1990 (3) SA 581 (A) discussed below

- the fees charged by large providers such as private hospitals are usually negotiated between medical schemes and such hospitals as opposed to the hospitals and their individual patients;
- the patient often does not have much of a say in which private hospital he is treated if he desires to have the services of a particular medical specialist since the specialists tend to restrict their practices to one or two private hospitals;
- the medicines prescribed for patients by doctors are usually priced in terms of industry based standards such as Maximum Medical Aid Price (MMAP) which is the maximum price that medical schemes are generally prepared to pay for a particular medicine or the 'Blue Book Price' which is the maximum price that retail pharmacists are prepared to pay for medicines; and
- the patient generally has no say in the price or the nature of the medicines that are prescribed for him or her.

From the point of view of the patient in the private sector, the market for health services is anything but free. It is dominated in the hospital sector by three large hospital groups, it is dominated in the medical schemes sector by an industry association called the Board of Healthcare Funders, as well as a few large scheme administrators, and more and more medical practitioners are joining so-called independent practitioners associations which are collectives designed to even the balance of power between individual medical practitioners and their suppliers and also between medical practitioners and medical schemes. Late in 2003 and at the beginning of 2004, the Competition Commissioner conducted an investigation and found the South African Medical Association, the Hospital Association and the Board of Healthcare Funders guilty of restrictive horizontal practices. At the time of writing the former two have paid settlement orders whilst the latter wanted to contest the matter in the Competition Tribunal.

Historically, the law of contract developed in the context of commerce and trade. In such an environment, competition for goods and resources is the norm. Parties can capitalise on superior knowledge, inside information, expertise and skill and use these attributes to gain a competitive advantage over others with whom they contract and compete. Suppliers and their customers have competing interests. The former wishes



to sell their services and products for the highest possible prices whilst the latter wishes to purchase them at the lowest possible prices. In the course of the bargaining process, all other things being equal, they tend to meet somewhere in the middle. In the commercial environment, one party is generally not obliged to place the interests of the other party before its own. Although there are contracts in which the parties stand in fiduciary relationships to one another, such as contracts of insurance, these are the exception rather than the norm. All contracts in South Africa must be in good faith but this does not mean that the contractants always stand in a fiduciary relationship towards one another. The law of contract protects contracting parties against clauses which are contrary to public policy but it does not expect a party to give away any advantages he may have in terms of superior or more comprehensive knowledge about the circumstances or context in which the contract will operate². Business people are allowed to have trade secrets and a competitive edge. They are permitted to protect and claim exclusive rights to relevant trade and other knowledge especially to the exclusion of those with whom they contract and their competitors. These broad principles, it is submitted, do not sit well in the health care context for a number of different reasons not least of which is that the market for health care services is widely recognised as economically abnormal in terms of the manner in which the laws of supply and demand operate³. The health care provider is obliged, in

² Christie RH *The Law of Contract* 4th ed observes at p 321 that in contracts of sale there is a duty on the seller to disclose latent defects of which he is aware, the extent of the duty having been settled by the Appellate Division in *Van der Merwe v Meades* 1991(2) SA 1 (A) but what little authority there is indicates that a buyer is entitled to remain silent when he, not the seller is aware of facts that substantially increase the value of the merx. After referring to the cases of *Van Niekerk and Van der Westhuizen v Weps and Morris* 1937 SWA 99 where a seller who knew that water on the farm was unwholesome but did not inform the buyers that the tests they carried out were insufficient to reveal its unwholesome nature was held liable and *Joseph v Parkes* 1906 EDC 138 where a buyer of a farm knew there were diamonds on it was held entitled to remain silent, Christie states: "The reason for thus distinguishing between buyers and sellers may perhaps be that the seller's silence in *Van Niekerk* caused the buyers to suffer a loss, whereas the buyer's silence in *Joseph* merely deprived the seller of the opportunity of making a fortuitous profit."

³ *Clement D 'Beyond Supply and Demand: The reasons for increased health care costs go beyond simply supply and demand and solutions are tougher than they seem' Fedgazette May 2002* notes that even the Economist magazine, a free market advocate if ever there was one, conceded that "there remain some genuine problems that limit the ability of unfettered markets to deal well with health care." These problems, he says, stem from market imperfections or failures that result in a less than socially optimal allocation of resources. He noted that the problems fall into several categories: those inherent to insurance, those resulting from imperfect information, those due to too few players buying or selling health care services and those caused by unequal access to healthcare. It has been observed that: "Health care is replete with widespread, systematic market failure (Plain R, Professor of economics at the University of Alberta quoted by McMaster G in the article referred to below) and that: "The crucial distinction between health care and other markets is that the consumer is not adequately informed and must rely on professionals to diagnose problems and advise treatment, all the while acting ethically and with the patient's best interests at heart." McMaster G 'Critics Wary of Health Care Recommendations' *ExpressNews* January 9 2002. (<http://www.expressnews.ualberta.ca>)
Rice T, Professor of Health Services, University of California, Los Angeles School of Public Health, states in 'Market Failure in Health Care: Still Common After All These Years' that: "Regrettably there is no real solution to market failure in health care. Consumers would need to know as much as physicians or physicians would have to act as perfect "agents" for their customers. Neither is likely to happen. Rather, one needs to recognize that these failures are part of what makes health care different from most other goods and services. Thus, rather than trying to push government out, we need use government – perhaps even more than we do now- to obtain efficient and equitable outcomes. Admittedly, governments are subject to failure just as are markets. According to Charles Wolf government faces a number of challenges. Some of these include: it is often hard to define and measure outputs; by its nature, government is monopolistic and doesn't face the discipline of having to adhere to a "bottom line" of profits and losses; and it is

terms of the standards of disclosure for informed consent, to disclose the information that the reasonable patient would require as opposed to what he or she thinks the patient should know. This allows very limited scope for the existence of trade secrets and other competitive information, as would usually be the case between two contracting parties in the commercial context. Ethically and legally, the healthcare provider is not permitted to exploit superior knowledge for its own advantage at the patient's expense. The reason why a patient consults a health care provider in the first place is to gain access to the expertise of the latter in order to benefit therefrom. Secondly in relation to competing health professionals there are limits imposed by their ethical and professional rules as regards competitive behaviour⁴. The position is somewhat different in the case of private hospitals and similar institutions. They do tend to compete against each other both in terms of the 'hotel' services they provide and in terms of the technology they use or make available to the medical specialists operating within their facilities. However, they are still subject to the same standards for informed consent as are medical practitioners and other health professionals. In the private sector, the professional health services rendered by hospitals centre almost exclusively around nursing care by nurse employees. In the public sector most if not

overseen by politicians who tend to prefer quick fixes rather than long-term solutions. As a result, one often sees government operate inefficiently and, in addition, inequitably since it is often beholden to special interests who contribute in one way or another to the politicians and political parties. Nevertheless when one looks at outcomes from health care systems – quality, access and satisfaction weighted against costs – it is difficult to conclude that the more market-like system emblematic of the United States is indeed superior. Government and markets can and should work together since each is subject to its own particular failures, but there is little evidence to indicate that there should be a sea-change towards greater reliance on markets. So long as market failure permeates the health care sector, market-based solutions will be inadequate." (http://worldbank.org/hnp/hsd/ViewPoint_RiceFebruary2003)

In 'Strained Mercy: The Economics of Canadian Health Care' Evans RG, Professor of Economics at the University of British Columbia notes that: "The general theme of the story is that the nature of health care as a commodity, its intrinsic peculiarities discussed above, leads to certain distinctive forms of "market failure." Such "failure" means that the organization of health care production and distribution through unregulated private markets – purely voluntary exchange processes – governed by the price mechanism, leads to unsatisfactory outcomes. Resources are not allocated to or used in health care production, and/or the care produced is not distributed among users, in a way which most of the members of society find acceptable. Accordingly various forms of intervention, institutional responses, arise in both the public and the private sectors, which either supplement or supplant private market relationships. These interventions – regulation, public subsidy, insurance, private charity, etc. – are anticipated to lead to patterns of resource allocation and/or output distribution in the health care sector which are more generally acceptable to the wider society. But these responses have the problems common to therapy in other fields – they have harmful side effects. Furthermore, multiple therapies for multiple problems result in interactions which often accentuate these side effects. Side effects give rise, in turn, to further institutional responses which have their own strengths and weaknesses, and thus the system evolves through time... What does seem clear, however, is that the market failure problem and the process of institutional evolution are an interactive totality. Theoretically optimal "solutions" to the specific problems of uncertainty, externalities, or asymmetry of information, analysed in isolation from other sources of market failure whether intrinsic or derivative, provide few useful guides to policy. There is little point in controlling the patient's arthritis with a therapy which induces a bleeding stomach ulcer, or even of controlling that by contributing to kidney failure." (http://frisch.ecn.ulaval.ca/guy/11160/Manuel/Strained_Mercy/)

⁴ The Ethical Rules of the Health Professions Council state for instance that disciplinary steps can be taken for-
"Supercession

(17) In cases where he or she is or should be aware that a patient is under treatment by another practitioner, superseding such other practitioner without taking reasonable steps to inform the practitioner originally in charge of the case.

(18) Impeding a patient, or someone acting on behalf of a patient, from obtaining the opinion of another practitioner or from being treated by another practitioner.

Professional reputation of colleagues

(19) Unjustifiably casting reflection on the probity or professional reputation or skill of a person registered under the Act."



all health professionals are usually employees⁵. However, the public sector is not nearly as competitive as the private sector as the former does not have the same profit motives as the latter and there are many other significant drivers for the delivery of health care in the public sector not least of which is the state's constitutional obligation to ensure access to health services – particularly for the indigent. Although the Supreme Court of Appeal does seem to have allowed a private hospital to exploit its position of power relative to that of the patient in the *Afrox* case⁶ discussed elsewhere in this chapter, it will be argued, however, that this decision was constitutionally, and for other reasons, incorrect. Patients are not ordinary consumers. They cannot be treated in the same manner, legally speaking, as other consumers. Health professionals may not use secret remedies⁷. Treatment methods used by health professionals must have some level of general acceptance and recognition within their profession if they are to successfully defend claims of professional negligence. Furthermore in the health care context, innovation is a highly complex topic that raises a number of problems for ordinary health professionals and medical researchers alike. In other sectors, innovative products, methods of doing business and services often give a supplier a competitive edge. In many cases, secrecy is a critical factor since not every innovation can be the subject of legally recognised intellectual property rights. A health professional who is too innovative could fall foul of a number of legal, ethical and professional rules⁸. Medicines have to be registered before they may be sold in South Africa. They have to be tested in clinical trials that follow accepted and recognised scientific and ethical methodologies before they can be registered. There is provision in the National Health Bill, currently awaiting signature by the President, for the regulation of health technology and equipment and

⁵ Some health professionals in the private sector do session work in the public sector.

⁶ *Afrox Healthcare v Strydom* 2002 (6) SA 21 (SCA)

⁷ See the Ethical Rules made in terms of section 49(2) of the Health Professions Act which state in Rule 25 that disciplinary steps can be taken against a professional for making use in the conduct of his or her practice of (a) any form of treatment, apparatus or technical process which is secret or is claimed to be secret (b) any apparatus which proves upon investigation to be incapable of fulfilling the claims made in regard to it; and

Rule (33) "Subject to the provisions of section 52 of the Act –

- (a) participating in the manufacture for commercial purposes, or the sale, advertising or promotion of any medicine as defined in the Medicines and Related Substances Control Act, 1965 (Act No. 101 of 1965), or any other activity which amounts to trading in medicines;
- (b) engaging in or advocating the preferential use or prescription of any medicine, if any valuable consideration is derived from such preferential use or prescription: Provided that the provisions of this subparagraph shall not prohibit a practitioner from owning shares in a listed public company manufacturing or marketing medicines, or, subject to the provisions of the Pharmacy Act, 1974, from being the owner or part-owner of a pharmacy, or, whilst employed by a pharmaceutical concern in any particular capacity, from performing such duties as are normally in accordance with such employment."

(The rules are available on the Council's website at www.hpcs.co.za) See also the Health Professions Council's Policy Document on Undesirable Business Practices.

⁸ See footnote 7 *supra*

there is also provision in the Medicines and Related Substances Control Act⁹ for the regulation of medical devices. A complete regulatory system for health technology is likely to be developed consistently with the implementation of the certificate of need provisions of the National Health Act¹⁰. Health professionals can patent medical devices of their own invention and use them on or in their patients but the regulatory authorities are taking an increasingly proactive stance against perverse incentives and, for example an orthopaedic surgeon who sells to colleagues an artificial hip of his own devising for use in their patients may run the risk of being called to account, if not legally then in terms of the professional and ethical rules¹¹.

4.2 Fundamental Concepts

It is necessary to discuss in more detail certain concepts that impact directly on the law of contract as it relates to health care services. These concepts are cross cutting and have relevance in other areas of law such as the law of delict, constitutional law and administrative law as well as the law of contract. They illustrate the importance of a synergistic as well as an analytical approach to law and the importance of underlying commonalities that promote and create consistency and cogency within the legal system as a whole.

4.2.1 Public Interest

The term ‘public interest’ takes on a new meaning for the state in the light of the obligation imposed upon the state by section 7 (2) of the Constitution which requires that the State must “respect, protect, promote and fulfil the rights in the Bill of Rights”. It is submitted that this provision brings within the scope of the phrase ‘public interest’ the Bill of Rights and its application in all of its diversity and complexity. In *Ex Parte North Central and South Central Metropolitan Substructure*

⁹ Medicines Control Act No 101 of 1965

¹⁰ National Health Act No 61 of 2003

¹¹ For instance, the professional and ethical rules of the HPCSA referred to in fn 7 *supra* state *inter alia* that disciplinary steps can be taken against a health professional for accepting commission from a person or another practitioner in return for the purchase, sale or supply of any goods, substances or materials used by him or her in the conduct of his or her professional practice (Rule 6)

*Councils of the Durban Metropolitan Area and Another*¹² Moloto J canvassed the meaning of the phrase 'public interest' in some depths¹³ observing that "this is a very elusive concept which is used to mean many differing (and sometimes conflicting) things but is rarely the subject of any attempt at clear definition." He said that in arriving at what is in the public interest, the courts compare the deprivation of some private convenience with the benefit that is likely to result therefrom for the general public or part thereof. It is submitted that the public interest is a concept that straddles the public/private law boundary¹⁴ as it is a feature of constitutional, administrative and

¹² *Ex parte North Central and South Central Metropolitan Substructure Councils* 1998 (1) SA 78 (LCC)

¹³ The *dicta* of Moloto J in *Ex Parte North Central* (fn 12 *supra*) are quoted here in full as they canvass some of the jurisprudence on the subject as at that date. "In examining whether the settlement agreement complies with the requirements of ss (6) of s 34, it is necessary to investigate the concept 'public interest'. This is a very elusive concept which is used to mean many differing (and sometimes conflicting) things but is rarely the subject of any attempt at clear definition. It is assumed to be generally understood and is not defined in the Act. No argument was placed before the Court on the concept of public interest because the matter was settled. However, the Court conducted independent research into the meaning of the concept. A number of interpretations have been gleaned from various authorities, amongst which a few are mentioned hereunder: The *New Shorter Oxford English Dictionary* vol 2 (1993) defines 'public interest' simply as 'the common welfare', which phrase is itself just as wide and situational as the phrase 'public interest'. The phrase is used in a number of cases in South African law without being defined. What is clear, however, is that in arriving at what is in the public interest, the Courts compare the deprivation of some private convenience with the benefit that is likely to result therefrom for the general public or part thereof. In this regard the Court said the following in the *Clinical Centre* case: 'Looking at the subsection broadly, the intention seems to be that the Court shall consider the whole matter objectively, deciding in that way whether the requirements of the premises can be said to be "reasonably necessary in the interest of the public", and then considering whether the private hardship which will be caused to the lessee is so severe as to outweigh the considerations of public interest.' In a more recent case involving a review of the refusal by the liquor board to grant a liquor licence in a township of some 1939 inhabitants served by no other licensed bottle store, on the grounds, *inter alia*, that there were three bottle stores in the town centre 2-3 kilometres away, Nicholson J said the following about the meaning of 'public interest':

- (a) It does not mean that the public whose interest is to be served is necessarily to be widely representative of the general public.
- (b) It means that the public would be better served if the applicant were granted the licence than that the existing state of affairs was to continue.
- (c) It is not the national interest that is intended but that of the inhabitants in the areas for which the licence is sought or visitors to that area.'

The learned author W du Plessis also refers to a weighing of interests in determining the public interest, and adds that there is an objective as well as a subjective side to the test. She then continues: 'Die belange van die een individu word teenoor dié van 'n ander afgeweg om te bepaal of enige regte aangetas is (subjektiewe sy). Hiermee word egter nie volstaan nie, want daar moet ook 'n objektiewe oordeel gevel word om te bepaal of die skending van die betrokke belange met die gemeenskap se oordeel strook of nie.'

The learned author then proceeds to state that it is not always possible to define the concept. She refers to Flathman's definition of 'the public interest' which is as follows: 'a general commendatory concept used in selecting and justifying public policy. It has no general or descriptive meaning applicable to all policy decisions, but can be determined for particular cases.' She then mentions some special aspects which she uses to define the concept. These aspects are (i) State security; (ii) economic interests; (iii) individual interests as collective interests; (iv) legal interests; (v) administrative interests and (vi) strategic interests. After discussing each of these aspects the learned author offers the following definition of the 'public interest': 'Die versamelnaam vir 'n aantal histories uitgekristalliseerde, beskermingswaardige Staatsveiligheids-, ekonomiese, strategiese, administratiewe, sosiale and regsbelange wat op 'n gegewe moment subjektief en objektief bepaalbaar is en in 'n gemeenskap die balans tussen die botsende belange van individue onderling en individue in verhouding tot die Staat handhaaf.'...

Finally, I reiterate that the meaning to be given to the concept of the public interest in s 34 was not argued before us. Whilst I was satisfied that the settlement in this matter was, in the particular circumstances, in the public interest, this judgment is not intended to be conclusive as to the meaning to be ascribed to the term."

¹⁴ For examples in the law of contract see *Afrax Healthcare Bpk v Strydom* (fn 6 *supra*). It was held that the elementary and basic general principle was that it was in the public interest that contracts entered into freely and seriously by parties having the necessary capacity should be enforced. The respondent's contention that a contractual term in terms of which a hospital could exclude liability for the negligent conduct of its nursing staff was not in the public interest could accordingly not be supported; *Shoprite Checkers (Pty) Ltd v Bumpers Schwarmas CC And Others* 2002 (6) SA 202 (C): "An examination of the content of the consensus prompts a consideration of the concept of *bona fides* which underpins contractual relationships. The concept of *bona fides* has proved to be somewhat elusive with regard to its definition and scope. See in particular Lubbe GF 'Bona Fides, Billikheid en die Openbare Belang in die Suid Afrikaanse Kontrakte Reg' 1990 *Stellenbosch Law Review* 7. Whatever the uncertainty, the principle of good faith must require that the parties act honestly in their commercial dealings. Where one party promotes its own interests at the expense of another in so unreasonable a manner as to destroy the very basis of consensus between the two parties, the principle of good faith can



contract law as well as the law of delict. The public interest is a flexible concept that changes with changing conditions and circumstances. The question as to who is the final arbiter of what is in the public interest, e.g. the executive or the judiciary, is a matter of statutory interpretation and the application of administrative and constitutional law principles to the particular circumstances under discussion. In the broad sense, health legislation *is* public interest legislation. The many different statutes administered by the national department of health regulate:

- the manner in which various health professionals are trained and conduct their professions in order to protect the public interest;¹⁵
- the manner in which foodstuffs, cosmetics and disinfectants are stored sold, handled and processed in order to protect the public interest;¹⁶
- the importation, sale, storage, composition, efficacy and marketing of medicines in order to protect the public interest;¹⁷
- the location and establishment of hospitals, clinics and other kinds of health establishment, the manner of their construction and their staffing requirements in order to protect the public interest¹⁸;

be employed to trump the public interest inherent in the principle of the enforcement of a contract.”; *Oos-Transvaalse Kodoperasie Bpk v Heyns* 1986 (4) SA 1059 (O): An agreement not to report a crime to the appropriate authorities in consideration for compensation is contrary to the public interest, irrespective of whether or not it is an offence to conclude such an agreement; *Sibex Engineering Services (Pty) Ltd v Van Wyk and Another* 1991 (2) SA 482 (T): In general it is contrary to public interest to enforce unreasonable restriction on person’s freedom to trade; *Basson v Chilwan and Others* 1993 (3) SA 742 (A): “The public interest must be the touchstone for deciding whether the Courts will enforce the restraint clause or not.... Where public interest is the touchstone, and where public interest may change from time to time, there can be no *numerus clausus* of the circumstances in which a Court would consider a restraint on the freedom to trade as being unreasonable.”; See also *Magna Alloys and Research (SA) (Pty) Ltd v Ellis* 1984 (4) SA 874 (A); *Roffey v Catterall, Edwards & Goudre (Pty) Ltd* 1977 (4) SA 494 (N); *National Chemsearch (SA) (Pty) Ltd v Borrowman and Another* 1979 (3) SA 1092 (T); *Barnard v Barnard* 2000 (3) SA 741 (C); *Kleyenstrüber v Barr and Another* 2001 (3) SA 672 (W); *Coin Sekerheidsgroep (Edms) Bpk v Kruger en ’n Ander* 1993 (3) SA 564 (T). For examples in the law of delict see *Benson v Robinson & Co (Pty) Ltd and Another* 1967 (1) SA 420 (A): The immunity accorded to the use of defamatory words on so-called privileged occasions, rests on a foundation of public interest; *Neethling v Du Preez and Others*; *Neethling v The Weekly Mail and Others* 1994 (1) SA 708 (A): “...reference may usefully be made at this stage to the observations to be found (albeit in a different context) in regard to the concept of ‘the public interest’ in the recent judgment of this Court in *Financial Mail (Pty) Ltd and Others v Sage Holdings Ltd and Another* 1993 (2) SA 451 (A). In delivering the majority judgment Corbett CJ said (at 464C-D): ‘(1) There is a wide difference between what is interesting to the public and what it is in the public interest to make known...The media have a private interest of their own in publishing what appeals to the public and may increase their circulation or the numbers of their viewers or listeners; and they are peculiarly vulnerable to the error of confusing the public interest with their own interest....’”; See also *Kemp and Another v Republican Press (Pty) Ltd* 1994 (4) SA 261 (E); *Financial Mail (Pty) Ltd and Others v Sage Holdings Ltd and Another* 1993 (2) SA 451 (A). For examples in administrative law see *Maharaj v Chairman, Liquor Board* 1997 (1) SA 273 (N); *Bulk Deals Six CC and Another v Chairperson, Western Cape Liquor Board, and Others* 2002 (2) SA 99 (C); *Reitzer Pharmaceuticals (Pty) Ltd v Registrar Of Medicines and Another* 1998 (4) SA 660 (T): In all these circumstances any alleged harm the applicant may suffer as a result of the enforcement of the provisions of the Act is outweighed by the public interest and the interest of the respondents; *Financial Services Board and Another v De Wet NO and Others* 2002 (3) SA 525 (C): “I have little doubt that it was thought by the Legislature to be in the public interest that such supervisory powers and duties should be conferred on the Registrar. Many members of the public would belong at some stage or another to pension funds and the security of their pensions would be of vital importance to most of them. It is in the public interest that the administration of pension funds should ensure that members are fairly dealt with and that the receipt of their pensions is not placed in jeopardy.”

¹⁵ Health Professions Act No 56 of 1974, the Allied Health Professions Act No 63 of 1982, the Nursing Act No 50 of 1978, the Dental Technicians Act No 19 of 1979, the Pharmacy Act No 53 of 1974

¹⁶ The Foodstuffs, Cosmetics and Disinfectants Act No 54 of 1972

¹⁷ The Medicines and Related Substances Control Act fn 9 *supra*



- the places in which tobacco products may be used in order to protect the public interest;¹⁹
- the handling, storage and disposal of hazardous substances such as radioactive and biological materials in a manner that seeks to ensure the health and wellbeing of the general public;²⁰
- the payment of compensation for occupational diseases in mines and works²¹.

It is submitted that acts performed in terms of this legislation must generally be done in a manner that best serves the public interest since this is the basis for the legislation itself.

Actions that are contrary to the interests of the community are contrary to public policy and an agreement is contrary to public policy if it is opposed to the interests of the state, or of justice, or of the public²². Agreements which are clearly inimical to the interests of the community, whether they are contrary to law or morality or run counter to social or economic expedience, will accordingly on the grounds of public policy not be enforced²³. Christie²⁴ notes that since the Constitution came into

18 The Health Act No 63 of 1977 soon to be repealed by the National Health Act which is presently not yet operational.

19 The Tobacco Products Control Act No 83 of 1993

20 The Hazardous Substances Act No 15 of 1973

21 The Occupational Diseases in Mines and Works Act No 78 of 1973

22 See generally Christie *fn 2 supra* p 398-417

23 See *Magna Alloys and Research (SA) (Pty) Ltd v Ellis* 1984 (4) SA 874; *Sasfin v Beukes* 1989 (1) SA 1 (A); *Aquilius* 1941 SALJ p 346 states: "A contract against public policy is one stipulating a performance which is not *per se* illegal or immoral but which the Courts, on grounds of expedience, will not enforce, because performance will detrimentally affect the interests of the community." Kerr AJ *The Principles of the Law of Contract* p 175. Lubbe GF and Murray C *Farlam & Hathaway Contract – Cases Materials & Commentary*, Van der Merwe S, Van Huyssteen LF, Reinecke MFB, Lubbe GF and Lotz JG, *Contract: General Principles*, state at p 139 that: "Often agreements will be said to be illegal because they are contrary to good morals (*contra bonos mores* in the strict sense) or public interest or policy...Such an expression does not introduce an additional criterion which takes the notion of illegality outside the realm of the law: the *boni mores*, public interest and public policy are only relevant in this context in so far as they provide the basis upon which a decision on the question of illegality is made *in law*. The law does not enforce morals simply because they are morals, but it does to some extent absorb moral content into legal doctrine and even specific rules...The distinction between *boni mores*, public interest and public policy is not at all clear. In practice the expression *boni mores* as it is employed with regard to illegality is mostly reserved for agreements which relate to the everyday morals or standards of conduct set by society, such as the norms governing sexual morals and honest and proper conduct. On the other hand, agreements which are to the detriment of the state, which obstruct or defeat the administration of justice, or which restrict the freedom to act or to be economically active, are usually said to be contrary to public interest. In the final instance that which is in the public interest would include that which is in accordance with good morals, although an agreement which is not immoral as such may for reasons of economic or other expedience nevertheless be against the public interest. An appraisal of the public interest is not limited to the wider interest of society in general but may include the individual interests of the parties to a particular agreement. So, for instance, a contractual term which restricts freedom to trade may seem acceptable when only the general interest of society is considered but may be so unreasonable when the relative interests of the contractants are taken into account that it is against the public interest after all. Determining the public interest is particularly difficult in a heterogeneous society: should one have regard (only) to the interests and customs of a particular section of that society or (only) to the interests of the society as a whole? The guiding principle should be that sectional title interests must be evaluated within the context of the wider interests of the society as a whole: sections of a society have an interest in upholding the general interests of the society whilst society itself has an interest in maintaining sectional interests. In a given case it may therefore be in the public interest to place the main emphasis on specific section interests and customs before the interests and customs of the wider community. By the same token the public interest will often be determined by individual interests."

operation it has affected the enforceability of contracts. He states that the Bill of Rights defines the constitutional rights and that a contract that infringes any of these rights will generally be unenforceable. Christie uses the word 'generally' because the Constitution does not simply order the courts to condemn outright any act such as a contract which infringes a provision of the Bill of Rights. Instead it requires the courts to proceed with more care by first investigating whether the constitutional right is applicable to the situation, taking into account the nature of the right and the nature of any duty imposed by the right. Christie states that by accepting the Constitution as a reliable statement of public policy, a court would have no difficulty in declaring a contract which infringed a provision of the Bill of Rights to be contrary to public policy and therefore unenforceable²⁵.

4.2.2 Bona Fides or Good Faith

Good faith is a central principle of the South African law of contract²⁶. In *Eerste Nasionale Bank van Suidelike Afrika Bpk v Saayman NO*²⁷, Olivier JA held in a

²⁴ Christie fn 2 *supra* p 402-403

²⁵ Christie fn 2 *supra* points out at p 411-412 that the law would be hopelessly self-contradictory if it treated a contract to commit an unlawful act as enforceable, as it would be approbating and reprobating the same act, blowing hot and cold. He notes that contracts while not purporting to bind the parties to the commission of an unlawful act, might encourage them to do so, may also fall foul of the law on grounds of public policy but here it is very necessary to maintain a sense of balance. An unadorned rule that a contract tends to encourage the commission of an unlawful act is void, or any rule expressed in similar general terms, would lead to endless trouble because the tendency could not be discerned in many contracts that have been found in practice to be not only harmless but actively beneficial in the business world. The courts have therefore tended to look at a number of types of contract in which the tendency to encourage the commission of an unlawful act can be traced and when the tendency rises to a dangerous level say "Thus far and no further". He points out that exemption clauses raise the same question of public policy as insurance contracts: knowledge of the protection given by an exemption clause may encourage the unlawful behaviour from liability for which it gives protection. A limit has therefore had to be placed on the extent of such protection. At p 210-211 he explores the permissible limits of exemption clauses with reference to the dicta of the courts in *Morrison v Angelo Deep Gold Mines Ltd* 1905 TS 775, *Wells v Alumentite Co* 1927 AD 69; *Goodman Brothers (Pty) Ltd v Rennies Group Ltd* 1997 (4) SA 91 (W) and *Republic of South Africa v Fibre Spinners & Weavers (Pty) Ltd* 1978 (2) SA 794 (A). Christie observes that the basis on which the courts decide what is and is not permissible is public policy (Grotius 3 1 42; Voet 2 14 16). Innes CJ stated in *Morrison supra*: "Now it is a general principle that a man contracting without duress, without fraud and understanding what he does, may freely waive any of his rights. There are certain exceptions to that rule and certainly the law will not recognise any arrangement which is contrary to public policy." Mason J in the same case stated at 784-785: "Now in our law it is a principle that agreements *contra bonos mores* will not be enforced and that is in reality the same as the English maxim as to contracts against public policy. It is a wide reading and not well-defined principle, and the courts always recognize the difficulties and dangers of the doctrine. For this argument to succeed on the ground of public policy, it must be shown that the arrangement necessarily contravenes or tends to induce contravention of some fundamental principle of justice or of general statutory law, or that it is necessarily to the prejudice of the interests of the public."

²⁶ See for instance *Shoprite Checkers (Pty) Ltd v Bumpers Schwarmas CC and Others*, fn 14 *supra*, where Davis J observed at p 215-216: "The concept of *bona fides* has proved to be somewhat elusive with regard to its definition and scope. See in particular Lubbe G 'Bona Fides, Billikheid en die Openbare Belang in die Suid Afrikaanse Kontrakte Reg' 1990 *Stellenbosch Law Review*. Whatever the uncertainty, the principle of good faith must require that the parties act honestly in their commercial dealings. Where one party promotes its own interests at the expense of another in so unreasonable a manner as to destroy the very basis of consensus between the two parties, the principle of good faith can be employed to trump the public interest inherent in the principle of the enforcement of a contract. This concept of good faith is congruent with the underlying vision of our Constitution (the Constitution of the Republic of South Africa Act 108 of 1996) to the extent that our Constitution seeks to transform our society from its past, it is self-evident that apartheid represented the very opposite of good faith. Concepts which were employed during apartheid lacked any form of integrity. Our Constitution seeks to develop a community where each will have respect for the other and in which

minority judgment for the respondent that *bona fides* was an aspect of the broader principle of public interest²⁸. Christie²⁹ states that there is every reason to hope that when the opportunity arises the Supreme Court of Appeal will apply Olivier JA's reasoning, harnessed to the concept of public policy in the context of the unfair enforcement of a contract. He notes that the foundation has long since been laid by the Appellate Division's recognition that in South African law the concept of good faith is applicable to all contracts and its acceptance of the principle that in deciding whether public policy forbids the enforcement of a contract the circumstances existing at the time enforcement is sought must be taken into account. In *Brisley v Drotzky*³⁰ Olivier J referred with approval to an article by Hutchison D entitled 'Good faith in the South African Law of Contract'³¹ and then went on to lament the fact that the operation of the principle good faith has for a long time not been completely explored and given content and that it will take much time and many judgments before this is achieved. Christie expresses the hope that when this task is finally complete a new framework and thought pattern will exist in the law of contract. Davis J in *Mort No v Henry Shields-Chiat*³² observed that like the concept of *boni mores* in the South African law of delict, the concept of good faith is shaped by the legal convictions of the community. He noted that while Roman-Dutch law may well supply the conceptual apparatus for South African law, the content with which concepts are filled depends on an examination of the legal convictions of the community - a far more difficult task. He said that this task requires that careful account be taken of the

integrity in government as well as in the exercise of power will be of paramount concern. To rely on the strict written words of a contract and to ignore an underlying oral agreement which not only shaped the written agreement but which forms part of the essential consensus would be to enforce the very antithesis of integrity and good faith in contractual arrangements."

27 *Saayman* 1997 (4) SA 302 (SCA)

28 See discussion under public policy below.

29 Christie fn 2 *supra* at p19

30 *Brisley* 2002 (4) SA 1 (SCA)

31 Brownsword R, Hird NJ and Howells G, *Good Faith in Contract: Concept and Context* 213 p 230 - 1. The article states: "What emerges quite clearly from recent academic writings, and from some of the leading cases, is that good faith may be regarded as an ethical value or controlling principle, based on community standards of decency and fairness, that underlies and informs the substantive law of contract. It finds expression in various technical rules and doctrines, defines their form, content and field of application and provides them with a moral and theoretical foundation. Good faith thus has a creative, a controlling and a legitimating or explanatory function. It is not, however, the only value or principle that underlies the law of contract nor perhaps, even the most important one. In the words of Lubbe and Murray: "It does not dominate contract law but operates in conjunction (and competition) with notions of individual autonomy and responsibility, the protection of reasonable reliance in commerce, and views of economic efficiency in determining the contours of contract doctrine. However, it will ensure just results only if Judges are alert to their task of testing existing doctrines and the operation of particular transactions against the constantly changing mix of values and policies of which *bona fides* is an expression." On this view of things, which seems to be correct, the influence of good faith in the law of contract is merely of an indirect nature, in that the concept is usually if not always mediated by some other, more technical doctrinal device. Thus, for example, while good faith does not empower a court directly to supplement the terms of a contract, or to limit their operation, it might in appropriate cases enable the court to achieve these same results indirectly, through the use of devices such as implied terms and the public policy rule."

32 *Mort* 2001 (1) SA 464 (C) at p 474-475



existence of the constitutional community, based as it is upon principles of freedom, equality and dignity and that the principle of freedom does, to an extent, support the view that the contractual autonomy of the parties should be respected and that failure to recognise such autonomy could cause contractual litigation to mushroom and the expectations of contractual parties to be frustrated. Davis J comments, however that the principles of equality and dignity direct attention in another direction. Parties to a contract must adhere to a minimum threshold of mutual respect in which the unreasonable and one-sided promotion of one's own interest at the expense of the other infringes the principle of good faith to such a degree as to outweigh the public interest in the sanctity of contracts. He says that the task is not to disguise equity or principle but to develop contractual principles in the image of the Constitution and that the constitutional state introduced in 1994 mandates that all law should be congruent with the fundamental values of the Constitution. Consequently, says Davis J, oppressive, unreasonable or unconscionable contracts can fall foul of the values of the Constitution. In accordance with its constitutional mandate the courts of the South African constitutional community can employ the concept of *boni mores* to infuse the law of contract with this concept of *bona fides*³³. In terms of the law of delict the principle of *bona fides* relates to the state of mind of the person who caused the harm³⁴. It is related to the principle of reasonableness³⁵. A reasonable person does not act in bad faith.

³³ Davis J in *Mort* (fn 32 *supra*) referred in this regard to *Janse van Rensburg v Grievs Trust* CC 2000 (1) SA 315 (C) at 325 - 6. Davis J notes at p 475 of the judgment: "It appears that the South African Law Commission, in its report dated April 1998, sought to solve this difficulty through legislation. Howsoever these developments are implemented it is clear that our highest Court has given the green light in the direction of the development of a concept of good faith in our law of contract which would render the body of contract law congruent with the values of our constitutional community. Nevertheless, an important development of our law must be grounded upon the appropriate factual matrix. To trump the principle of the enforceability of a contract, the offending clauses require more than a treatment which seeks ambiguity where none exists. The very content of the contract and the manner in which the parties created their contractual relationship and hence their legitimate expectations viewed within the context of the enforcement of the contractual provisions must be carefully scrutinised. From this inquiry the question of the unreasonable promotion can be evaluated and hence trumping the principle of enforceability can be appropriately considered."

³⁴ In *Frankel Pollak Vinderine Inc v Stanton* NO 2000 (1) SA 425 (W), Wunsh J referred to the dicta of Ogilvie-Thompson JA in *Grant and Another v Stonestreet and Others* 1968 (4) SA 1 (A) in which he stated: "In general, the Act insists on the holder's honesty. The measure of a holder's good faith is therefore whether he had a certain subjective state of mind when he acquired the instrument. The question is not whether he should have had knowledge of a certain fact but whether he did in fact have such knowledge. The doctrine of constructive knowledge, which attributes knowledge of certain facts to a holder in circumstances where a reasonable man would have made enquiries, does not apply to negotiable instruments. This measure of good faith, it is said, would impair the rapid negotiation of bills and would be detrimental to commerce. Consequently, it is accepted that a holder who has acquired a bill through carelessness, negligence or ignorance cannot by reason only of his state of mind be disqualified as a holder in due course. A holder can be dishonest without having knowledge of specific defects of title. His acquisition might be in bad faith if he merely suspects that something is wrong. He would also be in bad faith should he suspect something untoward about the bill. It has been said: "Notice and knowledge" means not merely express notice, but knowledge, or the means of knowledge to which the party wilfully shuts his eyes - a suspicion in the mind of the party, and the means of knowledge in his power wilfully disregarded." The word "suspicion" is not entirely apt, because a suspicion may exist that is not based on specific facts. The distinction to be made here is between honest ignorance and a dishonest state of mind - a reluctance to ascertain the true facts. If the holder suspects that something is wrong but chooses to remain ignorant of the true state of affairs, he is not in good faith. To determine the holder's state of mind one has to consider the facts known to him, and

Public entities are obliged to act in good faith³⁶ and in some cases the relevant statute goes so far as to confer immunity upon them for acts done in good faith in the exercise of their statutory obligations³⁷.

4.2.3 Public Policy (Boni Mores)

Contracts that are contrary to public policy are generally not enforceable³⁸. In *Friedman v Glicksman*³⁹, the facts of which will be more fully canvassed below, the

evaluate those apparently suspicious circumstances that call for enquiry. These facts and circumstances help to determine whether the holder did, subjectively, act in good faith.”

Wunsh J observed: “A person who is a *bona fide* possessor or occupier because he or she believes that he or she is lawfully entitled to possession or occupation does not lose that status because there are not ‘reasonable or probable grounds’ for his or her belief (*Banjo v Sungrown (Pty) Ltd* 1969 (1) SA 401 (N) at 406A - G). As pointed out by Milne JP in that case: ‘That an alleged belief is based on a mistaken view of the law may possibly, in certain circumstances, be a reason for doubting the existence of the belief, but that is, I suggest, another matter: and the absence, otherwise, of reasonable grounds for belief may, indeed, provide cogent evidence that the belief did not exist. *Grant and Another v Stonestreet and Others* 1968 (4) SA 1 (A) at 21H. But the existence or otherwise of an honest belief remains a question of fact.’ A person who is doubtful as to his or her right to possess because of fear of an adverse claim is not a bona fide possessor or occupier (*George v Shimwell Bros* 1910 TPD 890 at 894; *BC v Commissioner of Taxes* 1958 (1) SA 172 (SR) at 179A - E; *Grobler NO v Baikhutsong Business Undertaking (Pty) Ltd and Others* 1987 (2) SA 547 (B) at 569G - H). Scholtens says in this regard: ‘Actual knowledge will also be denied to exist when on the facts known to the possessor no reasonable man could continue to consider himself to be entitled to the thing.’ (1958) 75 SALJ 282 at 291”.

35 Wunsh J noted in *Frankel* (fn 34 *supra*): “If it looks to you that advice given to you could possibly be wrong, your professed belief that you are acting lawfully because it is on the strength thereof will not be *bona fide* if you refrain from questioning it (*S v Waglines (Pty) Ltd and Another* 1986 (4) SA 1135 (N) at 1146F - G). But the question is one of the accused’s state of mind. In all the examples I have given, where knowledge is essential, there is a common thread. What is required is actual knowledge. Where a person has a real suspicion and deliberately refrains from making inquiries to determine whether it is groundless, where he or she sees red (or perhaps amber) lights flashing but chooses to ignore them, it cannot be said that there is an absence of knowledge of what is suspected or warned against. In the absence of direct evidence, a court has to determine the existence of knowledge as an inference from the established facts and circumstances. If a person’s professed ignorance is so unreasonable that it cannot be accepted that he or she laboured under it, evidence of the ignorance will not be believed in the absence of some acceptable explanation. But this amounts to a finding of actual, subjective knowledge made when a person wilfully precludes himself or herself from acquiring it.”

36 *Premier, Eastern Cape, and Others v Cekeshe and Others* 1999 (3) SA 56 (TK); *Dews And Another v Simon’s Town Municipality* 1991 (4) SA 479 (C). See also the Promotion of Administrative Justice Act No 3 of 2000.

37 Thus section 25 of the Medicines and Related Substances Act, fn 9 *supra*, states: “The council or a committee appointed under section 9 (1), 22G (1) or 24 (1) or any member of the council or of any such committee shall not be liable in respect of anything done in good faith under this Act.” Section 62 of the Medical Schemes Act No 131 of 1998 states that: “The Minister, the Council, a member of the Council or of the Appeal Board, the Registrar, Deputy Registrar or other staff member of the Council shall not be liable in respect of any bona fide exercise of a discretion in the performance of any function under this Act. See also *Inkatha Freedom Party and Another v Truth and Reconciliation Commission and Others* 2000 (3) SA 119 (C); In *Soobramoney v Minister of Health, KwaZulu-Natal* 1998 (1) SA 765 (CC) the court said that “The provincial administration which is responsible for health services in KwaZulu-Natal has to make decisions about the funding that should be made available for health care and how such funds should be spent. These choices involve difficult decisions to be taken at the political level in fixing the health budget, and at the functional level in deciding upon the priorities to be met. A court will be slow to interfere with rational decisions taken in good faith by the political organs and medical authorities whose responsibility it is to deal with such matters.”

38 *Administrator, Natal v Edouard* fn 1 *supra*; *Ryland v Edros* 1997 (2) SA 690 (C); *Coetzee v Comitits And Others* 2001 (1) SA 1254 (C); *ABSA Bank H/A Bankfin v Louw en Andere* 1997 (3) SA 1085 (C): An agreement whereby a party waives beforehand and in its entirety the protection of the Prescription Act 68 of 1969 is contrary to public policy and thus invalid; *Nuclear Fuels Corporation of SA (Pty) Ltd v Orda AG* 1996 (4) SA 1190 (A); *Miller and Another NNO v Dannecker* 2001 (1) SA 928 (C); *De Beer v Keyser and Others* 2002 (1) SA 827 (SCA); *Citibank NA, South Africa Branch v Paul NO and Another* 2003 (4) SA 180 (T); In *Maseko v Maseko* 1992 (3) SA 190 (W) the court held: “While there is no *fraudem creditorum* without proof of actual prejudice (see *Hockey v Rixom & Smith* 1939 SR 107), it is my view that an agreement designed to mislead creditors is immoral and against public policy even if it has not yet served its purpose (cf *Schuster v Guether* 1933 SR 19).”; *De Klerk v Old Mutual Insurance Co Ltd* 1990 (3) SA 34 (E): The fact that the clause in question sought to limit the plaintiff’s entitlement to commission which had fallen due by the date of termination of his employment where the latter was terminated before the plaintiff had completed five years’ continuous service, did not render the provisions of that clause plainly improper and unconscionable, or inimical to the interests of the community, and that it was therefore not contrary to public policy; See also *Mufamadi and Others v Dorbyl Finance*

court held that an agreement between a pregnant woman and a doctor that he would advise her whether there was a greater risk than normal that she might have a potentially abnormal or disabled child so that she might make an informed decision on whether or not to terminate the pregnancy is not *contra bonos mores* but sensible, moral and in accordance with modern medical practice.

The role of public policy and bona fides was canvassed by the court in *Eerste Nasionale Bank van Suidelike Afrika Bpk v Saayman NO*⁴⁰. The case is of particular relevance to the field of health care services not because it dealt directly with a contract for health care services but because of the question of the contractual capacity of one of the parties and the relevance of bona fides and the public interest to the law of contract. In that case, Mrs Malherbe had been 85 years old, hard of hearing and almost blind when she was asked to sign the documents in question. At the time she had often been confused and disoriented⁴¹. The court founds that she had clearly been persuaded by her son to sign one utterly prejudicial document after the other while under the impression that she was merely making the shares available to him, without any prejudice to her rights, and that she needed only to ask for their return in order to get them back. She had signed the documents without having their import explained to her and without having read them. The court referred to the requirements for contractual capacity⁴² and came to the conclusion that Mrs Malherbe did not have

(Pty) Ltd 1996 (1) SA 799 (A); *Standard Bank of SA Ltd v Essop* 1997 (4) SA 569 (D); *Goodman Brothers (Pty) Ltd v Rennies Group Ltd* 1997 (4) SA 91 (W); *Berlesell (Edms) Bpk v Lehae Development Corporation BK en Anders* 1998 (3) SA 220 (O); *Traco Marketing (Pty) Ltd v Commissioner for the South African Revenue Service: In re Commissioner for the South African Revenue Service v Traco Marketing (Pty) Ltd* 1998 (4) SA 1002 (SE); *Theron v Phoenix Marketing (Pty) Ltd (Heyman Intervening)* 1998 (4) SA 287 (W); *Venter and Others v Credit Guarantee Insurance Corporation of Africa Ltd and Another* 1996 (3) SA 966 (A)

³⁹ *Friedman* 1996 (1) SA 1134 (W)

⁴⁰ *Saayman* fn 27 *supra*

⁴¹ The court observed at p 313 of the judgment: "Dr Von Delft het getuig dat, oor die 20 jaar wat hy mev Malherbe ken, daar 'n verswakking in begripsvermoë, oordeel en insig ingetree het. Na sy mening is dit 'hoogs onwaarskynlik dat sy op haar hoë ouderdom en met inagneming van haar kroniese serebrale siektetoestand rasioneel opgetree het toe sy onder invloed van ander partye sekere borgskappe en sekuriteite vir banklenings gegee of gelewer het' Dr Quail het met mev Malherbe gekonsulteer op twee geleenthede, naamlik op 29 Maart en 29 April 1993. Op nie een van die geleenthede kon hy betekenisvolle besonderhede van haar bekom ten aansien van die dokumente wat sy geteken het nie. Hy is van mening dat mev Malherbe aan pseudo-demensie ly. 'n Persoon wat aan pseudo-demensie ly, toon as gevolg van depressie die simptome van 'n persoon wat aan demensie ly. Sy mening het hy onder andere gebaseer op die feit dat haar kognitiewe funksionering wesenlik verskil het op die twee geleenthede wat hy haar gesien het. Hy het getuig dat, met die inligting tot sy beskikking, dit onmoontlik was om te sê of dit ook die geval was toe sy die gewraakte dokumente onderteken het. Hy het wel ook getuig dat sy moontlik reeds in 1989 aan demensie gely het maar het dit betwyfel."

⁴² See p 314 of the judgment where it stated: "Die regsposisie is soos volg uiteengesit deur Innes AR in *Pheasant v Warne* 1922 AD 481 op 488: '(A)nimus is an essential element in contractual obligations. In ordinary cases the *animus* is deduced, and can only be deduced, from the outward manifestation of intention whether spoken or written. But once it is clear that the necessary intelligence is wanting then there can be no *animus* or consenting mind. . . . (I)t is now recognised that persons may be of such mentality as to require special protection and control, even though they might not be accurately described as *mente capti* in the sense in which that term is used in the books. . . . And a court of law called upon to decide a question of contractual liability depending upon mental capacity must determine whether the person concerned was or was not at the time capable of managing the particular affair in question - that is to say whether his mind was such that he could understand and appreciate the transaction into which he purported to enter.'"

the contractual capacity to enter into the contract at the time. In his minority judgment Olivier JA stated that he disagreed with the majority of the court that it had been shown that Mrs Malherbe had not had the capacity to contract at the relevant time. He then went on to consider the role of the public interest and bona fides in the law of contract and noted that:

“Die funksie van die bona fide-begrip (ook genoem die goeie trou) was eenvoudig om gemeenskaps opvattinge ten aansien van behoortlikheid, redelikheid en billikheid in die kontraktereg te verwesenlik.”

Olivier JA then canvassed some of the history of the application of the *bona fides* concept⁴³ and stated that the problem with the assertion of the court in McDuff’s case that equitable principles are only of force insofar as they have become authoritatively incorporated and recognised as rules of positive law was that it apparently originates from a static, closed system and so if fairness is not already a rule of positive law then *caedit questio*. Referring to the dictum of Innes J in *Blower v Van Noorden*⁴⁴ where he said:

“There come times in the growth of every living system of law when old practice and ancient formulae must be modified in order to keep in touch with the expansion of legal ideas, and to keep pace with the requirements of changing conditions”

⁴³ At p 319 of the judgment he noted: “Reeds vroeg in hierdie eeu het juis hierdie Hof die voortou geneem om die bona fide-beginsel te erken en te verwesenlik. *Neugebauer & Co Ltd v Hermann* 1923 AD 564 is ’n vroeë voorbeeld. Daar is beslis dat ’n afslaer nie verplig is om ’n bod, wat gemaak is deur een van ’n groep bidders wat saamgespan het om nie teen mekaar te bieder, te aanvaar nie. Volgens die Engelse reg sou die afslaer die bod moes aanvaar het; volgens die Amerikaanse reg egter nie. Innes HR verklaar op 573: ‘Our law accords, in my opinion, more with the American than with the English view. It is not so much a question of public policy as of the requirements of good faith. The principle is fundamental that bona fides is required from both parties to a contract of sale.’ Net in die volgende jaar het hierdie Hof weer van die beginsel gebruik gemaak om ’n grondslag vir die leerstuk van fiktiewe vervulling van ’n voorwaarde te identifiseer en wel in *MacDuff & Co Ltd (in Liquidation) v Johannesburg Consolidated Investment Co Ltd* 1924 AD 573. Beide Innes HR (op 589) en Kotzé AR (op 610) beroep hulle op die bona fide-beginsel. Die tendens word voortgesit in 1925 in *Weinerlein v Goch Buildings Ltd* 1925 AD 282 waar rektifikasie van ’n kontrak op die bona fide-beginsel gebaseer word. Wessels AR verklaar op 292: ‘The commentators put it thus: As a general proposition your claim may be supported by a strict interpretation of the law, but it cannot be supported in this particular case against your particular adversary, because to do so would be inequitable and unjust, for it would allow you, under the cloak of the law, to put forward a fraudulent claim . . . It is therefore clear that under the civil law the Courts refused to allow a person to make an unconscionable claim even though his claim might be supported by a strict reading of the law. This inherent equitable jurisdiction of the Roman Courts (and of our Courts) to refuse to allow a particular plaintiff to enforce an unconscionable claim against a particular defendant where under the special circumstances it would be inequitable, dates back to remote antiquity and is embodied in the maxim “*summum jus ab aequitate dissidens jus non est*”. Die eerste klanke van ’n enger siening tref mens juis in bogenoemde uitspraak aan en wel by Kotzé AR. Alhoewel hy die ‘doctrine of equity’ in ons gemenerereg erken, verklaar hy op 295: ‘Our common law, based to a great extent on the civil law, contains many an equitable principle; but equity, as distinct from and opposed to the law, does not prevail with us. Equitable principles are only of force insofar as they have become authoritatively incorporated and recognised as rules of positive law.’”

⁴⁴ *Blower* 1909 TS 890 at p 905

Olivier JA noted that it was echoed in the judgment of the court in *Bank of Lisbon and South Africa Ltd v De Ornelas and Another*⁴⁵. He also referred to the case of *Meskin NO v Anglo-American Corporation of SA Ltd and Another*⁴⁶ where it was held that:

“It is now accepted that all contracts are *bonae fidei* (some are even said to be *uberrimae fidei*). This involves good faith (*bona fides*) as a criterion in interpreting a contract (Wessels (op cit para 1976)) and in evaluating the conduct of the parties both in respect of its performance (Wessels para 1997) and its antecedent negotiation. Where a contract is concluded the law expressly invokes the dictates of good faith, and conduct inconsistent with those dictates may in appropriate circumstances be considered to be fraud;”

and

“It may, perhaps be questioned whether these criteria do not go further in applying ethical considerations in *contrahendo* than our authorities recognise. On the other hand there can be no doubt that in *contrahendo* our law expressly requires *bona fides*, a concept of variable content in the light of changing mores and circumstances. On the assumption (without deciding) that the ultimate test suggested by Millner correctly reflects the present state of our law, there is a striking resemblance between that test and eg ‘die algemene regsgevoel van die gemeenskap’ mentioned above in regard to *delict generally*.”

After considering a few other cases⁴⁷, Olivier J went on to hold that in his opinion it could rightly be said that the *bona fides* concept is a part of the generally applicable

⁴⁵ *Bank of Lisbon* 1988 (3) SA 580 (A)

⁴⁶ *Meskin* 1968 (4) SA 793 (W)

⁴⁷ See page 321-323 of Saayman's case (fn 25 *supra*) in which Olivier observed: “In ander uitsprake van hierdie Hof is die grondliggende waardes van die goeie trou, billikheid en openbare belang in die kontraktereg ook beklemtoon; veral wat betref die afdwing van kontrakte wanneer dit teen die regsgevoel skrei. So, bv het Hefer AR in *Benson v SA Mutual Life Assurance Society* 1986 (1) SA 776 (A) gekonstateer dat 'n hof die diskresie het om nie spesifieke nakoming van 'n kontrak te gelas nie. Hierdie diskresie, so is verklaar op 783C-E: ‘. . . is aimed at preventing an injustice - for cases do arise where justice demands that a plaintiff be denied his right to performance - and the basic principle thus is that the order which the Court makes should not produce an unjust result which will be the case, eg, if, in the particular circumstances, the order will operate unduly harshly on the defendant. Another principle is that the remedy of specific performance should always be granted or withheld in accordance with legal and public policy. . . .’ In verband met die afdwing van ooreenkomste wat die handelsvryheid beperk, het die Howe self 'n verreikende bevoegdheid om beperkinge op sodanige ooreenkomste te plaas, ontwikkel en wel op grond van openbare belang. In *Magna Alloys and Research (SA) (Pty) Ltd v Ellis* 1984 (4) SA 874 (A) het Rabie HR op 891H-I gesê: ‘Omdat opvatting oor wat in die openbare belang is, of wat die openbare belang vereis, nie altyd dieselfde is nie en van tyd tot tyd kan verander, kan daar ook geen numerus clausus wees van soorte ooreenkomste wat as strydig met die openbare belang beskou kan word nie. Dit sou dus volgens die beginsels van ons reg moontlik wees om te sê dat 'n ooreenkoms wat iemand se handelsvryheid inkort teen die openbare belang is indien die omstandighede van die betrokke geval sodanig is dat die Hof daarvan oortuig is dat die afdwing van die betrokke ooreenkoms die openbare belang sou skaad.’ En op 893G: ‘i.e. opvatting dat 'n persoon wat 'n beperking wil afdwing nie die las dra om te bewys dat dit redelik inter partes is nie, bring nie mee dat oorwegings van die redelikheid of onredelikheid van 'n beperking nie van belang is of kan wees nie.’ En op 895D-E: ‘Die belangrike vraag is dus nie of 'n ooreenkoms van so 'n aard is dat dit *ab initio* ongeldig is nie, maar of dit 'n ooreenkoms is wat die Hof, gesien die vereistes van die openbare belang, nie behoort af te dwing nie.’ D ie opvatting dat alle kontrakte in ons reg *bonae fidei* is, dws deur die goeie trou beginsel beheers word, is ook deur hierdie Hof erken onder andere in *Paddock Motors (Pty) Ltd v Igesund* 1976 (3) SA 16 (A) op 28; *Magna Alloys and Research (SA) (Pty) Ltd v Ellis* (*supra* op 893C ev); *Mutual and Federal Insurance Co Ltd v Oudtshoorn Municipality* 1985 (1) SA 419 (A) op 433B-C; *LTA Construction Bpk v Administrateur, Transvaal* 1992 (1) SA 473 (A) op 480D-E; *Sasfin (Pty) Ltd v Beukes* 1989 (1) SA 1 (A) op 71 ev en weer 8C-D; *Botha (now Griessel) and Another v Financredit (Pty) Ltd* 1989 (3) SA 773 (A) op 782J ev. ie *bona fides*, wat weer gebaseer is op die redelikeheidsopvattinge van die gemeenskap, speel dus 'n wye en onmiskenbare rol in die kontraktereg. Zimmermann in sy bydrae ‘Good Faith and Equity’ in Zimmermann en Visser (reds) *Southern Cross - Civil Law and Common Law in South Africa* (1996) op 217-60 toon oortuigend aan dat gemelde beginselkompleks onderliggend is aan bekende regsinstellings soos estoppel, rektifikasie, onskuldige wanvoorstelling, die kennisleer, onbehoorlike beïnvloeding en dat dit 'n belangrike rol speel by die uitleg van kontrakte, die inlees van stilswyende en geïmpliseerde bedings, die openbaringsplig by kontraksluiting, fiktiewe vervulling van 'n voorwaarde en die erkenning van repudiëring as 'n vorm van kontrakbreuk. Dit blyk ook dat daar 'n innige verband bestaan tussen die begrippe *bona fides*, openbare belang, openbare beleid en *justa causa*. Dit blyk uit die analise van Smalberger AR in *Sasfin (Pty) Ltd v Beukes* (*supra* op 71-8G); uit die woorde van Hoexter AR in *Botha (now Griessel)*

public interest principle. The *bona fides* principle is applied, he said, because the public interest requires it⁴⁸ and observed at page 326 of the judgment that:

“Ek hou dit as my oortuiging na dat die beginsels van die goeie trou, gegrond op openbare beleid, steeds in ons kontraktereg ‘n belangrike rol speel en moet speel, soos in enige regstelsel wat gevoelig is vir die opvattinge van die gemeenskap, wat die uiteindelijke skepper en gebruiker van die reg is, met betrekking tot die morele en sedelike waardes van regverdigheid, billikheid en behoortlikheid.”

The interconnections between public interest, *bona fides* (good faith), public policy, the *boni mores* and reasonableness, fairness and propriety or due process, are clear in this statement.

Despite such enlightened judgments such as those in *Sasfin* and *Saayman* in which the courts were prepared to apply the concepts of public policy and *bona fides* in such a way as to achieve a just result, it is unfortunate that this is not an approach which South African courts apparently universally adopt. Not all judges appear to be ready to embrace such a progressive approach to the development of the common law. There are still some judges who apparently prefer to compartmentalize the law within concrete, leadlined pigeonholes that prevent any form of ‘contamination’ of one branch of law by the other⁴⁹. A case in point is that of *Afrox HealthCare Limited v*

and Another v Financscredit (Pty) Ltd (supra op 783A–B) dat openbare belang gerig is op die noodsaaklikheid dat simple justice between man and man gedoen moet word, en uit wat gesê is in Magna Alloys and Research (SA) (Pty) Ltd v Ellis (supra). (Sien ook Zimmermann Southern Cross op 259 voetnoot 326.)”

⁴⁸ See *Saayman* fn 27 *supra* at p322. Olivier JA dismissed the idea that the court in *Bank of Lisbon and South Africa Ltd v De Ornelas and Another* intended that the *bona fides* principle, along with the *exceptio doli generalis*, no longer played a role in practical terms although acknowledging that the judgment in *Bank of Lisbon* could be read this way. He said it was apparent that the court itself, without always using the term *bona fides*, still applied the underlying principle. In view of this, Olivier JA observed: “Ek voel myself dus vry om die beginsels van openbare belang, wat die *bona fide*-beginsel insluit op die onderhawige feitestelsel toe te pas net soos wat dit in *Sasfin (Pty) Ltd v Beukes (supra)* en *Botha (now Griessel) v Financscredit (Pty) Ltd (supra)* en die ander genoemde uitsprake gedoen is. Ek hou in gedagte die vermaning dat daardie beginsel oordeelkundig en versigtig toegepas moet word. Dit is belangrik om weer die woorde van Smalberger AR in *Sasfin (Pty) Ltd v Beukes (supra op 9B–C)* te herhaal: “No court should therefore shrink from the duty of declaring a contract contrary to public policy when the occasion so demands. The power to declare contracts contrary to public policy should, however, be exercised sparingly and only in the clearest of cases, lest uncertainty as to the validity of contracts result from an arbitrary and indiscriminate use of the power. One must be careful not to conclude that a contract is contrary to public policy merely because its terms (or some of them) offend one’s individual sense of propriety and fairness. In the words of Lord Atkin in *Fender v St John-Mildmay* 1938 AC 1 (HL) at 12 ([1937] 3 All ER 402 at 407B–C), “the doctrine should only be invoked in clear cases in which the harm to the public is substantially incontestable, and does not depend upon the idiosyncratic inferences of a few judicial minds” (see also *Olsen v Standaloff* 1983 (2) SA 668 (ZS) at 673G). Williston on Contracts 3rd ed para 1630 expresses the position thus: “Although the power of courts to invalidate bargains of parties on grounds of public policy is unquestioned and is clearly necessary, the impropriety of the transaction should be convincingly established in order to justify the exercise of the power. Dit sê iets van die instinkiewe gevoel van versigtigheid waarmee borgkontrakte bejeën word, dat die uitsprake wat in die meer moderne tye die *bona fide*-beginsel die sterkste beklemtoon en toegepas het, juis met borgkontrakte en die beweerde aanspreeklikheid van borge handel.”

⁴⁹ Pretorius DM “The Defence of the Realm: Contract and Natural Justice” 2002 *SALJ* 119 p 374 notes that “...it is surprising that it is still asserted in some decisions that the rules of natural justice have no application in the field of contract. Oblivious to the subtle nuances of the principles set out above, and blinded by their single-minded and tenacious faith in the idea that *pacta sunt servanda*, come hell or high water, these decisions seek to defend the realm of contract against invasion by principles of judicial review and – heavens forbid! – notions of fairness. It is gratifying to know that South African law is more sophisticated than these decisions suggest is the case.” (footnotes omitted. See cases and articles cited in footnotes 45 and 46 on p 381)

*Strydom*⁵⁰, the facts of which are discussed in the section relating to the private sector. In that case the court refused to allow a patient to escape the consequences of a disclaimer he had signed absolving the hospital from all liability and indemnifying it from any claim instituted by any person (including a dependant of the patient) for damages or loss of whatever nature (including consequential damages or special damages of any nature) flowing directly or indirectly from any injury (including fatal injury) suffered by or damage caused to the patient or any illness (including terminal illness) contracted by the patient whatever the cause/causes, except only with the exclusion of intentional omission by the hospital, its employees or agents. The respondent contended that the relevant clause was contrary to the public interest, that it was in conflict with the principles of good faith or *bona fides* and that the admission clerk had had a legal duty to draw his attention to the relevant clause, which he had not done. The grounds upon which the respondent based his reliance on the public interest were the alleged unequal bargaining positions of the parties at the conclusion of the contract, as well as the nature and ambit of the conduct of the hospital personnel for which liability on the part of the appellant was excluded and the fact that the appellant was the provider of medical services. The respondent alleged that, while it was the appellant's duty as a hospital to provide medical treatment in a professional and caring manner, the relevant clause went so far as to protect the appellant from even gross negligence on the part of its nursing staff. He said that this was contrary to the public interest. The court refused to accept the respondent's argument that s 39(2) of the Constitution obliged every court, when developing the common law, to promote the spirit, purport and object of the Bill of Rights and that the relevant clause conflicted with the spirit, purport and object of section 27(1)(a) of the Constitution, which guaranteed each person's right to medical care, and as such was accordingly in conflict with the public interest. As an alternative, the respondent argued that, even if the clause did not conflict with the public interest, it was still unenforceable as it was unreasonable, unfair and in conflict with the principle of *bona fides* or good faith. The court nonetheless ruled in favour of the applicant.

⁵⁰ *Afox* fn 6 *supra*

In *BOE Bank Bpk v Van Zyl*⁵¹ the court had to consider the question of proper consent to suretyship agreement concluded between a Bank and the father of a principal party to the main agreement whose husband, to whom she was married in community of property, had entered into the agreement. In giving judgment for the applicant the court held that an overarching ground of avoidance based on the absence of *bona fides* or the improper procurement of consensus was not recognised. It said that there was no authority for it in the decisions of the Supreme Court of Appeal, and that it was not for the court to depart from settled rules without proper direction from that source. It also stated that there was also no authority for the statement that the distinctions between duress, misrepresentation and undue influence as well as the recognised requirements for these concepts had to be dispensed with. The court held that, even if the existence of a single overarching ground for avoidance based on equity were to be accepted, it was nevertheless clear that the respondent's invocation thereof had to fail. His pleadings did not leave room for it, and it was in any event not open to him, in circumstances in which he had 'nailed an unsuccessful defence to the mast of duress', to argue on the same pleadings that the requirements of that defence had to be altered on grounds of equity.

4.2.4 Reasonableness

The concept of reasonableness in South African law is deserving of a thesis of its own and only the basic elements will be canvassed here sufficiently for the purpose of showing that it is another core element of the legal system that is not confined to a particular branch or area of law.

Reasonableness is a key principle in the law of contract. It is used to assess the legality of restraint of trade agreements⁵², the time allowed for performance⁵³ and evidence of misrepresentations inducing contract⁵⁴.

⁵¹ *BOE* 2002 (5) SA 165 (C)

⁵² *Nursing Services of South Africa (Pty) Ltd v Clarke* 1954 (3) SA 394 (N); *Savage and Pugh v Knox* 1955 (3) SA 149 (N); *Hermer v Fisher and Others* 1960 (2) SA 650 (T); *Super Safes (Pty) Ltd and Others v Voulgarides and Others* 1975 (2) SA 783 (W); *Roffey v Catterall, Edwards & Goudré (Pty) Ltd* 1977 (4) SA 494 (N); *National Chemsearch (SA) (Pty) Ltd v Borrowman And Another* 1979 (3) SA 1092 (T); *David Wuhl (Pty) Ltd and Others v Badler and Another* 1984 (3) SA 427 (W); *Drewtons (Pty) Ltd v Carlie* 1981 (4) SA 305 (C); *Bonnet and Another v Schofield* 1989 (2) SA 156 (D); *Humphrys v Laser Transport Holdings Ltd and Another* 1994 (4) SA 388 (C); *CTP Ltd and Others v Independent Newspapers Holdings Ltd* 1999 (1) SA 452 (W); *Kleyenstrüber v Barr and Another* 2001 (3) SA 672 (W)

⁵³ *Nel v Cloete* 1972 (2) SA 150 (A)

It is also a concept that is central to the law of delict⁵⁵. The standard test for negligence is that of the reasonable person, what he or she would have done in the circumstances in which the defendant found him or herself and how the defendant's actions measure up against this standard⁵⁶. The conduct of the reasonable man is in

⁵⁴ *Orville Investments (Pty) Ltd v Sandfontein Motors* 2000 (2) SA 886 (T). The court held that even though the objective test need not have been applied in determining materiality where the misrepresentation had been made fraudulently, the test of reasonableness did not fall away altogether. A further element to be established was inducement - had the misrepresentation induced the contract? This was a question of fact. But, in determining whether the plaintiff had been so induced to enter into the contract, a court would, at least to some extent, base its decision on what a reasonable person in the position of the misrepresentee would have done. Thus the reasonableness of the misrepresentee's behaviour in relying on the misrepresentation was of evidential value.

⁵⁵ In *Zysset and Others v Santam Ltd* 1996 (1) SA 273 (C) Scott J held that it was doubtful whether the distinction between benefits received by a plaintiff from a third party which must be deducted from the plaintiff's damages for patrimonial loss and those which may not be on the grounds that they are *res inter alios acta* can be justified on the basis of a single jurisprudential principle. In the past the distinction has been determined by adopting an essentially casuistic approach. He noted that whatever the true rationale may be, if indeed there is one, the enquiry must inevitably involve, to some extent, at least, considerations of public policy, reasonableness and justice. In *Van Wyk v Santam Bpk* 1998 (4) SA 731 (C) the court held that the distinction between deductible and non-deductible benefits could not be justified on the basis of a single jurisprudential principle. The inquiry inevitably involved considerations of public policy, reasonableness and justice. In *McNally v M & G Media (Pty) Ltd and Others* 1997 (4) SA 267 (W) the court held, with regard to a second possibility in terms of which the exception sought to place the onus of proving unlawfulness on the plaintiff and that it entailed the acceptance of a general standard of reasonableness as the test for unlawfulness where the plaintiff was a public official and the published matter constituted 'free and fair political activity', that these propositions were contrary to what had been held in *Neethling v Du Preez and Others; Neethling v The Weekly Mail and Others* 1994 (1) SA 708 (A), and that the Court was similarly bound by that judgment. In *Road Accident Fund v Sauls* 2002 (2) SA 55 (SCA) the court said that there is no general 'public policy' limitation to the claim of a plaintiff for damages for the negligent causation of emotional shock and resultant detectable psychiatric injury, other than a correct and careful application of the well-known requirements of delictual liability and of the onus of proof. It is not justifiable to limit such a claim, as has been offered as one solution, to a defined relationship between the primary and secondary victims, such as parent and child, husband and wife, etc. In determining limitations a court will take into consideration the relationship between the primary and secondary victims. The question is one of legal policy, reasonableness, fairness and justice, ie was the relationship between the primary and secondary victims such that the claim should be allowed, taking all the facts into consideration. As regards the class of persons to whom a duty may be owed to take reasonable care to avoid inflicting psychiatric illness through nervous shock sustained by reason of physical injury or peril to another, it is sufficient that reasonable foreseeability should be the guide.

⁵⁶ See *McMurray v H L & H (Pty) Ltd* 2000 (4) SA 887 (N) in which the court canvassed the characteristics of the reasonable man as follows: "What qualities and characteristics does the notional reasonable man have? One knows that the reasonable man generally expects and is entitled to expect reasonableness rather than unreasonableness, legality rather than illegality, from others. (*Solomon and Another v Musset and Bright Ltd* 1926 AD 427 at 433; *Moore v Minister of Posts and Telegraphs* 1949 (1) SA 815 (A) at 826.) The reasonable man certainly does not in general regard himself as obliged to take steps to guard against recklessness or the gross negligence of others. (*South African Railways and Harbours v Reed* 1965 (3) SA 439 (A).) Obviously this also applies to the criminal conduct of others. It goes without saying that this notional reasonable man generally complies with the law and always acts reasonably. We know that the reasonable man is not a timorous faintheart, always in trepidation lest he or others suffer some injury; on the contrary, he ventures out into the world, engages in affairs and takes reasonable chances." He takes reasonable precautions to protect his person and property and expects others to do likewise (per Van den Heever JA in *Herschel v Mrups* 1954 (3) SA 464 (A) at 490F). A further characteristic of the reasonable man is that he is conservative in his approach to a situation which *Herschel v Mrups* 1954 (3) SA 464 (A) could be described as *res nova*. He does not readily consider that he is in such a situation obliged to prevent harm to others and thus acts wrongfully if he does not. (*Natal Fresh Produce Growers' Association and Others v Agroserve (Pty) Ltd and Others* 1990 (4) SA 749 (N) at 754B - C.) The reasonable man generally minds his own business. He does not in general regard it as his duty to behave as the good Samaritan or to be his brother's keeper. (*Minister van Polisie v Ewels* 1975 (3) SA 590 (A) at 596H; *Herschel v Mrups* (*supra*) at 490E.) Where the reasonable man owns property he, as a general rule, considers that he is entitled to use his property as he sees fit in the process of advancing his own reasonable interest (cf *Vanston v Frost* 1930 NPD 121; *Neethling*, *Potgieter JM* and *Visser PJ Law of Delict* 3rd ed at p 17). The reasonable man does not consider himself to be under a general duty to prevent loss to others by positive conduct, nor to prevent pure economic loss. He would consider that such duties would probably place too heavy a burden on the community. (*Law of Delict* (*op cit* at 55).) The reasonable man does, however, recognise that he is sometimes under a duty to prevent loss to others by positive conduct or to prevent pure economic loss. In deciding when such a duty arises, he is guided by the legal convictions of the community. Sometimes, for example, where the reasonable man happens to be a policeman who sees a person being assaulted, he would recognise that according to the legal convictions of the community he is under a legal duty to take reasonable steps to prevent the assault. (*Ewel's case supra* at 597H.) The reasonable man would also realise that he is according to the legal convictions of the community obliged to regulate his conduct so as to prevent pure economic loss which he foresees as a likely result of his conduct if he could reasonably do so. (Compare *Coronation Brick (Pty) Ltd v Strachan Construction Co (Pty) Ltd* 1982 (4) SA 371 (N).) Where the reasonable man is a landowner or occupier upon whose land a source of danger exists which is reasonably foreseeable could result in harm to his neighbour, he would

turn informed by the legal convictions of the community⁵⁷. The legal convictions of the community, the *boni mores*, are informed by the Constitution⁵⁸ and are a part⁵⁹ of public policy. This last is ultimately informed by the Constitution as previously stated. Reasonableness is also a well-established principle of administrative law. In *Mafongosi and Others v United Democratic Movement and Others*⁶⁰ the court held that the reasonableness required for administrative actions taken by such functionaries

recognise that there is a duty upon him to take reasonable steps to avoid the harm. (*Regal v African Superslate (Pty) Ltd* 1963 (1) SA 102 (A) (slate waste); *Moubray v Syfret* 1935 AD 199 at p 203 (ferocious animal); *Minister of Forestry v Quathlamba (Pty) Ltd* 1973 (3) SA 69 (A) at 82E - F (fire).) Where the reasonable man has himself, either personally or through employees, created the danger, for example lit a fire, he would accept that the duty to take reasonable steps to prevent the fire from spreading to his neighbours is a high one. (*Van Wyk v Hermanus Municipality* 1963 (4) SA 285 (C) at 330D; *Steenberg v De Kaap Timber (Pty) Ltd* 1992 (2) SA 169 (A) at 181A.) Even where he is not responsible for lighting the fire, the reasonable landowner would accept that he is obliged to take such steps once he becomes aware of the fire on his property. (Quathlamba's case *supra* at 82E - F.; See also *Government Of The Republic Of South Africa v Basdeo And Another* 1996 (1) SA 355 (A); *Kritzinger v Steyn En Andere* 1997 (3) SA 686 (C); *Barnard v Santam Bank Bpk* 1997 (4) SA 1032 (T); *Grootboom v Graaff-Reinet Municipality* 2001 (3) SA 373 (E)

57 In *McMurray* fin 54 *supra* Booysen J observed: "As I have pointed out, the reasonable man is guided by the legal convictions of the community. The learned authors of *Law of Delict* (op cit at 37 and 38) state: "The general norm or criterion to be employed in determining whether a particular infringement of interests is unlawful, is the legal convictions of the community: the *boni mores*. The *boni mores* test is an objective test based on the criterion of reasonableness. The basic question is whether, according to the legal convictions of the community and in light of all the circumstances of the case, the defendant infringed the interests of the plaintiff in a reasonable or an unreasonable manner."

(Authors' emphasis.) This statement is fully supported by the decisions quoted by the learned authors in support of it, *inter alia* the Ewel's case *supra* at 597; *Universiteit van Pretoria v Tommy Meyer Films (Edms) Bpk* 1977 (4) SA 376 (T) at 387; *Coronation Brick* case *supra* at 380; *Natal Fresh Produce* case *supra* at 753 - 4; *Clarke v Hurst NO and Others* 1992 (4) SA 630 (D) at 651 - 3; *Administrateur, Transvaal v Van der Merwe* 1994 (4) SA 347 (A) at 358 and 364. The learned authors of *Law of Delict* (op cit) state at 46: ". . . (The general *boni mores* test is seldom applied directly to establish wrongfulness because more precise methods have been developed to determine the legal convictions of the community. In other words, the determination of wrongfulness - the investigation into the legal convictions of the community - finds practical application or expression in specific legal norms and doctrines with the result that it is necessary to investigate the legal convictions of the community directly only in exceptional cases. Two examples of the practical application of the *boni mores* yardstick are to be found in the view that wrongfulness amounts to the infringement of a subjective right or the non-compliance with a legal duty to act.' (Authors' emphasis.) The learned authors of *Law of Delict* point out further that the *boni mores* test for wrongfulness functions 'at most at a supplementary level, because the convictions of the community concerning what good conduct should be regarded as reasonable or unreasonable for the purposes of the law of delict, have over time found expression in many common law and statutory norms, grounds of justification and certain theoretical legal methods whereby wrongfulness may be established. Consequently it is seldom necessary to apply the general *boni mores* test directly.' They state further that there are two main ways in which the general *boni mores* or reasonableness criterion is applied as a supplementary test for wrongfulness: 'Firstly, the *boni mores* test is applied as a test for wrongfulness in cases where either the wrongfulness of the defendant's conduct does not appear from the violation of an existing delictual norm, or the lawfulness thereof does not appear from the presence of a recognised ground of justification' (at 47) and, secondly, 'recourse to the general reasonableness test becomes imperative for purposes of refinement, especially in assessing wrongfulness in borderline cases (at 49). This is a case in which the wrongfulness of the defendant's conduct does not appear from the violation of an existing norm, nor is it clear that the lawfulness of the conduct appears from the presence of a recognised ground of justification. It is thus a case in which the *boni mores* criterion represented by the convictions or feelings of the community has to be applied."

58 *Minister Of Safety and Security v Van Duivenboden* 2002 (6) SA 431 (SCA) at p 444 where Nugent JA stated: "In applying the test that was formulated in *Minister van Polisie v Ewels* the 'convictions of the community' must necessarily now be informed by the norms and values of our society as they have been embodied in the 1996 Constitution. The Constitution is the supreme law, and no norms or values that are inconsistent with it can have legal validity - which has the effect of making the Constitution a system of objective, normative values for legal purposes."

59 See *Dersley v Minister van Veiligheid En Sekuriteit* 2001 (1) SA 1047 (T) where van Dyk J stated at p1055 "Met die deurlaes van hierdie artikel en latere beslissings wat ek nagegaan het, het dit my getref dat die basiese toets verander het en dat dit vandag daarin geleë is dat 'n judisiële waarde-oordeel uitgespreek moet word of die eiser se betrokke aangetaste belang in die omstandighede en tipe situasie wat voor die hof op die feite sou dien, ooreenkomstig die *boni mores* (dit wil sê, die regsopvatting van die gemeenskap) beskermingswaardig is al dan nie; en indien wel, is daar inderdaad 'n regsplig op sodanige persoon wat hy nie mag nalaat nie. Andersins is daar geen regsplig op 'n verweerder om die regte van die eiser te beskerm nie. In 'n verdere uiteensetting het mnr Havenga daarop gewys dat wanneer die *boni mores* maatstaf aanvaar word dit bestaan uit die regsdoelstelling van die gemeenskap en nie noodwendig 'n sedelik, of 'n sosiale, of 'n moderne morele maatstaf is nie. Hy verwys na onder andere die saak van *Minister van Polisie v Ewels* 1975 (3) SA 590 (A) op 596 waarna mnr Bolt, wat namens die verweerder verskyn het, inderdaad ook die Hof verwys het."

60 *Mafongosi* 2002 (5) SA 567 (TKH)

is the same as the reasonableness required for decisions by organs of state. In other words there is a single set of standards for administrative justice. In terms of section 33 of the Constitution everyone has the right to administrative action that is lawful, reasonable and procedurally fair.

4.2.5 Fairness

The concept of fairness, like that of reasonableness, is too complex to explore fully in this thesis. It is sufficient for present purposes to note that it is a well-recognised principle of contract law, the law of delict and administrative law⁶¹ in South Africa. That fairness is a concern of the law of contract is evidenced by the decisions of the courts in cases such as *Standard Bank of SA Ltd v Essop*⁶² *Lubbe v Volkskas Bpk*⁶³ *Thompson v Scholtz*⁶⁴ and *Bouygues Offshore and Another v Owner of the MT Tigr and Another*⁶⁵. The courts in the context of the law of contract speak of “simple justice between man and man”. It is submitted that this phrase is just another way to express the need for fairness in contract⁶⁶. The phrase was used in *Jajbhay v Cassim*⁶⁷ and

⁶¹ “With regard to the concept of fairness in relation to section 33 of the Constitution Mokgoro J and Sachs J in their minority judgment commented in *Bel Porto School Governing Body And Others v Premier, Western Cape, And Another* 2002 (3) SA 265 (CC): “The theme of fairness must be seen as governing the manner in which the four enumerated sections must be interpreted. The words themselves have no fixed and self-evident meaning. Unless animated by a broad concept of fairness, their interpretation can result in a reversion to what has been criticised as the sterile, symptomatic and artificial classifications which bedevilled much of administrative law until recently. Undue technicality and artificiality should be kept out of interpretation as far as possible; the quality of fairness, like the quality of justice, should not be strained. There are at least three respects in which the concept of fairness should be seen as animating s 33. The first is to provide the link between the four enumerated aspects so that they are not viewed as separate elements to be dealt with mechanically and sequentially, but, rather, as part of a coherent, principled and interconnected scheme of administrative justice. Secondly, the interpretation of each of the individual subsections within the framework of the composite whole must be informed by the need to ensure basic fairness in dealings between the administration and members of the public. Thirdly, the appropriate remedy for infringement of the rights must itself be based on notions of fairness. [153] The jurisprudence of transition is not unproblematic. This Court has emphasised the need to eradicate patterns of racial discrimination and to address the consequences of past discrimination which persist in our society. This relates to substantive fairness, which focuses on the effect or impact of government action on people. This Court has also emphasised the obligation upon the government to exhibit procedural fairness in decision-making. A characteristic of our transition has been the common understanding that both need to be honoured. The present case highlights a particular aspect of that complex process, in which a Court may be called upon to examine both the procedural fairness of the decision and substantive fairness, or fairness of the effect or impact, and in that examination these two aspects may to some extent become intertwined. It is necessary to determine the circumstances in which a Court, looking at a scheme that as a whole passes the test of constitutional fairness, can and should detach a detail which, viewed on its own would be constitutionally unfair.” (footnotes omitted)

⁶² *Essop* 1997 (4) SA 569 (D)

⁶³ *Lubbe* 1991 (1) SA 398 (O)

⁶⁴ *Thompson* 1999 (1) SA 232 (SCA)

⁶⁵ *Bouygues* 1995 (4) SA 49 (C)

⁶⁶ In *Henry v Branfield* 1996 (1) SA 244 (D), Levinsohn J observed: “For the purposes of this alternative claim the plaintiff accepts that the contract in question was illegal and unenforceable and therefore the rule in *pari delicto potior est conditio defendentis* applies. The strict application of this rule prevents a party from recovering any money or property delivered pursuant to such illegal contract. However, the plaintiff contends that the *pari delicto* rule ought to be relaxed in this case in accordance with the principles set forth in the leading case of *Jajbhay v Cassim* 1939 AD 537. Stratford CJ at 544 put it as follows: “Thus I reach my third conclusion, which is that Courts of law are free to reject or grant a prayer for restoration of something given under an illegal contract, being guided in each case by the principle which underlies and inspired the maxim. And in this last connection I think a Court should not disregard the various degrees of turpitude in delictual contracts. And when the delict falls within the category of crimes, a civil court can reasonably

subsequently in *Sasfin (Pty) Ltd v Beukes*⁶⁸ and *Botha (Now Griessel) and Another v Finanscredit (Pty) Ltd*⁶⁹ in which the court stated that, while public policy generally favours the utmost freedom of contract, it nevertheless properly takes into account the necessity for doing simple justice between man and man⁷⁰. The phrase 'simple justice between man and man' has also been used in the context of the law of delict⁷¹.

The application of the principle of fairness in the law of delict is evidenced in the law of defamation in particular in which fair comment is a defence. Significantly, what is fair is in general ascertained by reference to the convictions of the community (*boni mores*)⁷². In *Southern Insurance Association Ltd v Bailey No*⁷³ the Appellate Division noted that it had never attempted to lay down rules as to the way in which the problem

suppose that the criminal law has provided an adequate deterring punishment and therefore, ordinarily speaking, should not by its order increase the punishment of the one delinquent and lessen it of the other by enriching one to the detriment of the other. And it follows from what I have said above, in cases where public policy is not foreseeably affected by a grant or a refusal of the relief claimed, that a Court of law might well decide in favour of doing justice between the individuals concerned and so prevent unjust enrichment.' Earlier in this judgment the learned Chief Justice dealt with the case of *Brandt v Bergstedt* 1917 CPD 344 and said in relation to that case at 543: 'In the first the reasoning implies that the learned Judge considered himself bound by the authorities he quoted to refuse relief to the plaintiff, whereas I respectfully suggest that he should have approached the matter from the more fundamental point of view as to whether public policy was best served by granting or refusing the plaintiff's claim. If the learned Judge had so approached the case and had considered that as an equitable Judge he was free (as I think he was) to order the restoration of the cow, I cannot doubt that he would have granted the relief prayed. Indeed the facts of that case afford a typical example which called for a decision on which side public policy is best served. It may be said that contracts of that nature are more discouraged by leaving the bereft plaintiff unhelped and the doubly delinquent defendant in possession of his ill-gotten gains. I cannot agree with this view, which I think would not so much discourage such transactions but would tend to promote a more reprehensible form of trickery by scoundrels without such honour as even thieves are sometimes supposed to possess, and public policy should properly take into account the doing of simple justice between man and man.' In the same case *Watermeyer JA* (as he then was) at 550 said: 'The principle underlying the general rule is that the Courts will discourage illegal transactions, but the exceptions show that where it is necessary to prevent injustice or to promote public policy, it will not rigidly enforce the general rule. The real difficulty lies in defining with any degree of certainty the exceptions to the general rule which it will recognise.'"

67 *Jajbhay* 1939 AD 537 at 544

68 *Sasfin* 1989 (1) SA 1 (A)

69 *Botha* 1989 (3) SA 773 (A)

70 See also *Pangbourne Properties Ltd v Nitor Construction (Pty) Ltd And Others* 1993 (4) SA 206 (W); *Mufamadi And Others v Dorbyl Finance (Pty) Ltd* 1996 (1) SA 799 (A); *Brisley v Drotzky* 2002 (4) SA 1 (SCA) and *Mccain Frozen Foods (Pty) Ltd v Beestepan Boerdery (Pty) Ltd* 2003 (3) SA 605 (T) in which the court said: "It seems that, if the matter cannot be sorted out by the parties, which I might add I believe could have been done, simple justice between man and man and the preservation of the situation in order to cause the least damage is called for. ...if one would have to accede to the argument as presented by Mr Bergenthuin that *ante omnia* the principles must apply irrespective of what the surrounding circumstances might indicate (as I understand his argument) then I am afraid it would be to sacrifice substance, common sense and simple justice between man and man on the altar of formalism. I believe I cannot ignore the surrounding circumstances of the case when considering whether there was a duty to communicate acceptance of the offer to the respondent or not." In *Eerste Nasionale Bank Van Suidelike Afrika Bpk v Saayman No* (fn 27 *supra*) Olivier J stated that: "Dit blyk ook dat daar 'n innige verband bestaan tussen die begrippe bona fides, openbare belang, openbare beleid en *justa causa*. Dit blyk uit die analise van Smalberger AR in *Sasfin (Pty) Ltd v Beukes* (*supra* op 71-8G); uit die woorde van Hoexter AR in *Botha (now Griessel) and Another v Finanscredit (Pty) Ltd* (*supra* op 783A-B) dat openbare belang gerig is op die noodsaaklikheid dat simple justice between man and man gedoen moet word, en uit wat gesê is in *Magna Alloys and Research (SA) (Pty) Ltd v Ellis* (*supra*). (Sien ook D Zimmermann *Southern Cross* op 259 voetnoot 326.)"

71 In *Rousseau and Others NNO v Visser and Another* 1989 (2) SA 289 (C) the court held: "In the present case the parties are not in *pari delicto* but, even if they are, the principles enunciated in *Jajbhay v Cassim* 1939 AD 537 lead one to the conclusion that the requirements of justice and the interests of public policy demand that the question as to whether those who bought activators from the company have a valid claim for the refund of the purchase price the matter based on the *condictio ob turpim vel justam causam* be answered in their favour."

72 See Neethling, Potgieter *Visser Law of Delict* p 347. Also *Yazbek v Seymour* 2001 (3) SA 695 (E); *Neethling v The Weekly Mail and Others* 1994 (1) SA 708 (A)

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



of an award of general damages should be approached. It said that the accepted approach is the flexible one described in *Sandler v Wholesale Coal Suppliers Ltd*⁷⁴, namely: “The amount to be awarded as compensation can only be determined by the broadest general considerations and the figure arrived at must necessarily be uncertain, depending upon the Judge's view of what is fair in all the circumstances of the case.”⁷⁵

Concerning administrative law, in *Bel Porto*⁷⁶ the minority judgement held that there are circumstances where fairness in implementation must outtop policy and that fairness in dealings by the government with ordinary citizens is part and parcel of human dignity. Mokgoro J and Sachs J in their minority judgment observed that the objective of judicial intervention under section 33 of the Constitution is to secure compatibility with fundamental notions of fairness in relation to the exercise of administrative power. They said that in some circumstances fairness may require a setting aside of a whole scheme so as to enable a significant part to be revisited, in others the scheme can go ahead in general with a part being re-examined and necessary adaptations made and noted that if this were not so the interest of minority groups could always be overridden by invoking the principle that what matters is the greatest good for the greatest number. Alternatively and conversely, they said, it could mean that the majority could be made to suffer unfairly in order to accommodate the interest of the minority. It is particularly important when a proposed measure is likely to have a disproportionate impact on a certain group that such group be given a meaningful opportunity to intervene and have its interests considered in a balanced way. The majority of the court in this case held, however that substantive unfairness has never been a ground for judicial review. The unfairness has to be of such degree that an inference can be drawn from it that person who made decision erred in respect that would provide grounds for review. This inference, said the court, was not easily drawn.

4.2 Formation of a Contract

⁷⁴ *Sandler* 1941 AD 194 at 199

⁷⁵ *Carstens NO v Southern Insurance Association Ltd* 1985 (3) SA 1010 (C); *Reyneke v Mutual and Federal Insurance Co Ltd* 1991 (3) SA 412 (W); *Van der Berg v Coopers & Lybrand Trust (Pty) Ltd and Others* 2001 (2) SA 242 (SCA)

⁷⁶ *Bel Porto School Governing Body and Others* fn 61 *supra*



If the relationship between a public provider and a patient is contractual in nature then it is necessary to establish the manner and grounds upon which such contract is formed. In the South African public health sector at present, although indigent patients, or patients who fulfil certain criteria in terms of a means test are treated free of charge in state owned health facilities, this does not apply to everyone. There are tariffs in place in terms of which people who do not meet the criteria set by the means test are obliged to make some payment for the health services they receive⁷⁷. Whilst this tariff may not necessarily cover the cost of the treatment, it constitutes some form payment for services rendered. In South African law, however, consideration is not in any event an essential requirement for the existence of a contract as it is in English law⁷⁸. It is the intention of the parties that is paramount. In the context of public health service delivery it is not easy to establish the nature of the parties' intentions. If there is a constitutional or other legislative obligation to provide health care services, the existence of an intention to contract becomes questionable.

The fact that no-one may be refused emergency medical services in terms of section 27(3) of the Constitution by implication tends to suggest that other health care services may be refused. The ability to refuse to treat a patient could be evidence of the fact that the state has a choice as to whether or not to enter into a relationship with a patient which in its turn suggests that the relationship could be contractual in nature. However the apparent distinction in the Constitution between emergency health care services and other types of health care services seems not to be as broad as the structuring of section 27 might at first sight suggest. As the Durban High Court

⁷⁷ See for instance Regulations on Fees for Health Services in the Free State, Free State Provincial Gazette No 64 of 01 October 2002 Notice No 140 of 2002; Regulations on Ambulance Fees in the Free State, Free State Provincial Gazette No 64 of 01 October 2002, Notice No 141 of 2002; Regulations Relating To The Administration, Management and Control of Provincial Hospitals, Services and Institutions, Established in Terms of Section 4 of the Provincial Hospitals Ordinance, 1961 (Ordinance No 13 of 1961): Amendment KwaZulu-Natal Provincial Gazette No 6134, Notice No 405 of 24 October 2002; Hospitals Ordinance No 14 of 1958 :Amendment Regulations Relating To The Classification of And Fees Payable By Patients At Provincial Hospitals, 2003 Gauteng Provincial Gazette No 659 Notice No 659 of 05 March 2003; Regulations Relating To The Uniform Patient Fee Schedule For Health Care Services Rendered By The Department of Health: Western Cape For Externally Funded Patients, Western Cape Provincial Gazette No 5977 Notice No 21 of 29 January 2003;

⁷⁸ In *Conradie v Roussouw* 1919 AD 279 the Appellate Division unanimously rejected the idea that the English doctrine of consideration forms part of South African law. De Villiers, AJA, concluded at p320 that "According to our law, if two or more persons, of sound mind and capable of contracting enter into a lawful agreement, a valid contract arises between them enforceable by action. The agreement may be for the benefit of one of them or both (Grotius 3.6.2). The promise must have been made with the intention that it should be accepted (Grotius 3.1.48); according to Voet the agreement must have been entered into *serio ac deliberato animo*. And this is what is meant by saying that the only element that our law requires for a valid contract is consensus, naturally within proper limits – it should be *in* or *de re licita ac honesta*." See Christie fn 2 *supra*, p10 to12 for further discussion. Although the doctrine had subsequently been discussed in South African cases this position remains unchanged. See for instance *Adams v SA Motor Industry Employers Association* 1981(3) SA 1189 (A) where the court stated at p1198 "We are not encumbered by the technicalities of the doctrine of consideration and in our law a novation is not presumed: the intention of the parties is the decisive factor (cf *Smit v Rondalia Versekeringsskorporasie van SA Bpk* (*supra* at 346H))."

pointed out in *Soobramoney*⁷⁹ the state cannot be expected to provide even emergency medical services beyond its available resources. This would not be reasonable or feasible and the state, can only be required to do what is reasonable. The section 27(3) prohibition does not distinguish between the private and public sectors.

Christie states that the most common and normally helpful technique for ascertaining whether there has been agreement is to look for an offer and an acceptance of that offer⁸⁰. However, he immediately sounds a warning in the words of Caney J in *Godfrey v Paruk*⁸¹ that the phrase 'offer and acceptance' is not to be applied as a talisman revealing by a species of esoteric art, the presence of a contract. Contracts can be entered into without offer and acceptance. It is submitted that a statutory requirement, whether express or implied, to enter into a contract does not necessarily negate the contractual nature of a transaction or a relationship. It merely restricts or specifies the legal mechanism in terms of which that relationship arises or the transaction is effected⁸². If an express statutory requirement that a contract is entered into does not alter the nature of the transaction as being contractual despite the fact that the intentions of the parties to contract are in such situations largely replaced by a legal requirement to contract then it is submitted that the absence of full freedom to contract also does not *per se* negate the possibility of a contract's arising. Thus even if a public sector provider is constitutionally obliged to provide health care services to a

⁷⁹ *Soobramoney v Minister of Health, Kwazulu-Natal* 1998 (1) SA 430 (D)

⁸⁰ Christie, fn 2 *supra* at p31. He refers to *Reid Bros (SA) Ltd v Fischer Bearings Co Ltd* 1943 AD 232 where the court stated at p 241 that "a binding contract is as a rule constituted by the acceptance of an offer" and *Estate Breat v Peri-Urban Areas Health Board* 1955 3 SA 523 (A) at 532E where it was stated that: "Consensus is normally evidenced by offer and acceptance. But a contract may be concluded without offer and acceptance other than pure fictions imported into the transaction for doctrinal reasons. Nor does every accepted offer constitute a contract." At 88 Christie observes, however, that in exceptional cases offer and acceptance can either not be identified at all, or only with the most artificial reasoning and that the point is that it is not necessarily correct to argue that because there is no offer and acceptance, there is no contract. He gives a number of examples of circumstances in which a contract unquestionably comes into being without any offer and acceptance except 'sheer fictions'. These include the imposition of territorial limits on distributors or 'sole agents'; the restriction of tenants in a block of shops from carrying on businesses similar to those of other tenants; the imposition of restrictive covenants in a township. He notes that the common characteristics of all these situations are that a scheme is set up and a number of participants enter into contracts with the originator of the scheme and although not expressly contracting with each other, they participate in the expectation that all other participants will obey the rules of the scheme. He points out at p90 that another type of contract without offer and acceptance that should not be overlooked is a contract created by statute and cites section 65(2) of the Companies Act 61 of 1973 as an example.

⁸¹ *Godfrey* 1965 (2) SA 738 (D) at 743C

⁸² For example section 20 of the State Information Technology Agency Act No 88 of 1998 requires that "A business agreement to regulate the relationship between individual participating departments or organs of state and the Agency must be concluded." Section 42 (1)(b) of the National Heritage Resources Act No 25 of 1999 with reference to heritage agreements states: "Such a heritage agreement must be in the form of a binding contract." National Student Financial Aid Scheme Act No 56 of 1999 section 19(3) states that: "A written agreement must be entered into between the NSFAS and every borrower or bursar." It may also introduce an element of administrative law as stated in section 2 of this chapter.

patient, this does not preclude the possibility of a contractual relationship between them.

If health services are provided by way of a contractual relationship that is not restricted or specifically addressed by any other law then can a public provider refuse to treat a patient? If so, in what circumstances? It is submitted that the nature of the provider is relevant in determining how it must behave in this regard since the state is obliged in terms of the Constitution to respect, protect, promote and fulfil the rights in the Bill of Rights. A public provider will not be able to arbitrarily refuse to treat a patient. There will have to be a reason for such refusal which is in accordance with constitutional principles and values. Section 27 gives the answer as to what kinds of reasons for refusal might be acceptable. They relate largely to the availability of resources.

The private sector is in a somewhat different position to the public sector in that it does not share the obligation imposed upon the state by section 27(2) of the Constitution. It is, however, important to bear in mind that the right of access to health care services is specified in section 27(1) and there is no express indication in this subsection that the right of access to health care services is one that is enforceable only against the state. The question of the horizontal application of the Bill of Rights has proven to be a vexed one and is canvassed in more detail elsewhere. However it is important to note that in terms of sections 8(2) and 8(3) of the Constitution -

“A provision of the Bill of Rights binds a natural or a 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.

When applying a provision of the Bill of Rights to a natural or juristic person in terms of subsection (2), a court-

- (a) in order to give effect to a right in the Bill, must apply, or if necessary develop, the common law to the extent that legislation does not give effect to that right; and
- (b) may develop rules of the common law to limit the right, provided that the limitation is in accordance with section 36 (1).”

In *Jooste v Botha*⁸³ van Dijkhorst J stated that in determining whether a horizontal right is intended, one has to have regard to the nature of the proposed right, its enforceability, the practicalities of the human relationships involved and whether public policy or public *mores* require such moral obligation to be converted into a legal obligation. He said that it is important to bear in mind that the proposed horizontal right will not operate in a void. It will invariably infringe upon and curtail the rights of others. According to van Dijkhorst J, the horizontal application of the Bill of Rights is not mechanical or unqualified, but is to be done with circumspection. It is submitted that if one considers the right of access to health care services applied horizontally and juxtaposed against the right to refuse to provide those services, one must ask on what basis the latter should outweigh the former in the balancing exercise which would confront a court should this issue arise in litigation⁸⁴. The latter could be described as the right of free trade but not necessarily the right embodied in terms of section 22 on its own as this right is in the words of the Constitution: “the right to *choose* their trade, occupation or profession. The practice of a trade, occupation or profession may be regulated by law”[writer’s italics]. Thus the right is not to *practice* a trade, occupation or profession freely, because this can be regulated by law, but to freely *choose* such trade occupation or profession. The right to freedom of association is granted but not elaborated upon in section 18 in the Bill of Rights. The right to refuse to treat a patient could possibly be based on this right.

It is quite possible that in certain circumstances there is no contractual relationship between a patient and a provider of health care services because the provider has

⁸³ *Jooste* 2000 (2) SA 199 (T)

⁸⁴ Sachs J in *Prince v President, Cape Law Society, And Others* 2002 (2) SA 794 (CC) stated that:” In *Christian Education South Africa v Minister of Education* 2000 (4) SA 757 (CC)] and *Prince [Prince v President, Cape Law Society, and Others* 2000 (3) SA 845 (SCA)] this Court emphasised the importance of contextualising the balancing exercise required by s 36 of the Constitution. Such contextualisation reminds us that although notional and conceptual in character, the weighing of the respective interests at stake does not take place on weightless scales of pure logic pivoted on a friction-free fulcrum of abstract rationality. The balancing has always to be done in the context of a lived and experienced historical, sociological and imaginative reality. Even if for purposes of making its judgment the Court is obliged to classify issues in conceptual terms and abstract itself from such reality, it functions with materials drawn from that reality and has to take account of the impact of its judgments on persons living within that reality. Moreover, the Court itself is part of that reality and must engage in a complex process of simultaneously detaching itself from and engaging with it. I believe that in the present matter, history, imagination and mind-set play a particularly significant role, especially with regard to the weight to be given to the various factors in the scales.”
The court in *Van Zyl and Another v Jonathan Ball Publishers (Pty) Ltd and Others* 1999 (4) SA 571 (W) quoted Burchell J *Personality Rights*: “The balancing of rights and interests is the essence of the legal process and an adjudicator cannot avoid making difficult decisions. The appropriate balance between individual reputation, dignity and privacy and freedom of expression, for instance cannot be sidestepped.”

contracted⁸⁵ with a medical scheme or managed care organisation to treat the patient. Health maintenance organisations are not as common in South Africa as they are in the United States and the model in terms of which a private provider of health care services employs various kinds of health professionals to fulfil its contractual obligations to render services to the employees of a particular employer or some other collective does not feature significantly in the South African context. There are many different models of managed health care⁸⁶ but those that seem to be the most common in South Africa are essentially an extension of medical schemes administration, often contracted out to specialised consultants⁸⁷ who offer services relating to pharmacy benefit management, management of hospital services utilisation etc. Large providers such as private hospitals appoint their own case managers largely to deal with those medical schemes that are applying managed care principles to benefit utilisation by beneficiaries. Depending on the nature of the contract between the hospital and the scheme there is sometimes a contractual provision which precludes the service provider from recourse to the patient for payment for treatment rendered in terms of the contract. Chapter five of the regulations to the Medical Schemes Act⁸⁸ deals expressly with the provision of managed health care. Managed health care tends to use generally accepted and highly specific treatment protocols⁸⁹ not only so that

⁸⁵ One kind of agreement that can be entered into is a capitation agreement. This term is defined in the regulations to the Medical Schemes Act No 131 of 1998 as follows - “‘capitation agreement’ means an arrangement entered into between a medical scheme and a person whereby the medical scheme pays to such person a pre-negotiated fixed fee in return for the delivery or arrangement for the delivery of specified benefits to some or all of the members of the medical scheme”

⁸⁶ The regulations to the Medical Schemes Act No 131 of 1998 define managed health care as follows - “‘managed health care’ means clinical and financial risk assessment and management of health care, with a view to facilitating appropriateness and cost-effectiveness of relevant health services within the constraints of what is affordable, through the use of rules-based and clinical management-based programmes;

⁸⁷ The regulations to the Medical Schemes Act No 131 of 1998 define a managed care organisation as follows – “‘managed health care organisation’ means a person who has contracted with a medical scheme in terms of regulation 15A to provide a managed health care service;”

⁸⁸ Fn 37 *supra*

⁸⁹ The regulations to the Medical Schemes Act No 131 of 1998 define a protocol as follows – “‘protocol’ means a set of guidelines in relation to the optimal sequence of diagnostic testing and treatments for specific conditions and includes, but is not limited to, clinical practice guidelines, standard treatment guidelines, disease management guidelines, treatment algorithms and clinical pathways;” Regulation 15D stipulates standards for managed health care as follows -

“If any managed health care is undertaken by the medical scheme itself or by a managed health care organisation, the medical scheme must ensure that:

- (a) a written protocol is in place (which forms part of any contract with a managed health care organisation) that describes all utilisation review activities, including a description of the following:
- (i) procedures to evaluate the clinical necessity, appropriateness, efficiency and affordability of relevant health services, and to intervene where necessary, as well as the methods to inform beneficiaries and health care providers acting on their behalf, as well as the medical scheme trustees, of the outcome of these procedures;
 - (ii) data sources and clinical review criteria used in decision-making;
 - (iii) the process for conducting appeals of any decision which may adversely affect the entitlements of a beneficiary in terms of the rules of the medical scheme concerned;
 - (iv) mechanisms to ensure consistent application of clinical review criteria and compatible decisions;
 - (v) data collection processes and analytical methods used in assessing utilisation and price of health care services;
 - (vi) provisions for ensuring confidentiality of clinical and proprietary information;

funders can be sure that their beneficiaries are receiving treatment which is recognised within the health profession as being appropriate for a particular condition but more specifically so that they can predict the expenses associated with the treatment of that condition and manage the financial risks accordingly. Medical schemes who use a managed care regime will usually not fund treatment which deviates from the accepted and preset treatment protocols except in emergency situations.

4.3 Informed Consent in the Context of Contract

The role of informed consent in the formation and conclusion of a contract is of particular importance in the context of contracts for health care services. Informed consent can be a precursor to the contract for health care services in the same way as can a misrepresentation inducing a contract but it can also form a part of the terms of the contract itself⁹⁰. In the contractual context in particular, the role of the concept of therapeutic privilege, it is submitted, can be problematic. In order for a contract to arise there must be an intention to contract⁹¹. The intention to contract must in its turn arise from the exercise of the free will of the parties in the circumstances in which the

-
- (vii) the organisational structure (e.g. ethics committee, managed health care review committees, quality assurance or other committee) that periodically assesses managed health care activities and reports to the medical scheme; and
 - (viii) the staff position functionally responsible for day-to-day management of the relevant managed health care programmes;
 - (b) the managed health care programmes use documented clinical review criteria that are based upon evidence-based medicine, taking into account considerations of cost- effectiveness and affordability, and are evaluated periodically to ensure relevance for funding decisions;
 - (c) the managed health care programmes use transparent and verifiable criteria for any other decision-making factor affecting funding decisions and are evaluated periodically to ensure relevance for funding decisions;
 - (d) qualified health care professionals administer the managed health care programmes and oversee funding decisions, and that the appropriateness of such decisions are evaluated periodically by clinical peers;
 - (e) health care providers, any beneficiary of the relevant medical scheme or any member of the public are provided on demand with a document setting out-
 - (i) a clear and comprehensive description of the managed health care programmes and procedures; and
 - (ii) the procedures and timing limitations for appeal against utilisation review decisions adversely affecting the rights or entitlements of a beneficiary; and
 - (iii) any limitations on rights or entitlements of beneficiaries, including but not limited to restrictions on coverage of disease states; protocol requirements and formulary inclusions or exclusions.

⁹⁰ Van der Merwe *et al* (fn 23 *supra*) state at p 74 that: "A representation which occurs during precontractual negotiations can be made a part of the consensus between the parties and as such becomes a term of the ensuing contract. For example, a representation may be warranted to be true. Should the representation then turn out to be false the contract will have been breached and the normal consequences of breach of contract by way of breach of warranty will follow. Whether a representation amounts to a contractual term of whether it merely causes an error in motive without becoming a part of the contract (although it may influence one party's decision to enter into the contract) must be decided according to the intention of the parties."

⁹¹ It is therefore all the more interesting that Claassen NJB and Verschoor *Medical Negligence in South Africa* at p 69 identify four exceptions to the physician's duty to inform, only one of which can be seen in a contractual context (in cases where the patient indicates that he does not wish to be informed of the nature of the proposed treatment, the risks involved or the probably consequences). The other three are situations in which the patient either specifically lacks contractual capacity – i.e. where the patient is brought into hospital in a critical, unconscious condition, or where the patient's state of mind is such that his capacity to contract (in the sense of being able to take rational decisions for his own benefit) could potentially be impaired or diminished by the disclosure i.e. where the disclosure of the full extent of his illness will influence him to such a degree that his recovery will be prejudiced or presents a threat to the patient's well-being or where the patient specifically does not consent to the treatment - i.e. in the event of an emergency where a patient's interests are sacrificed in favour of, e.g. the protection of society such as where the patient is suffering from a contagious disease or is inoculated to prevent its outbreak.



contract is to be concluded. They must therefore be aware of those circumstances in order to make a decision to be bound by a contract. Misrepresentations inducing a contract can vitiate the consent requirement and invalidate the contract. This is a fundamental and inherent conflict that arises within the law of contract in the context of health services delivery. It also serves to illustrate one aspect of the uncomfortable fit of the law of contract within this context. It is no small irony that the fact that non-disclosure of material facts on the basis of therapeutic privilege can be pleaded as a defence in the context of the law of delict while that same non-disclosure in the context of the law of the subsequent contract for health care services could vitiate the agreement between the parties⁹². Welz⁹³ explores the boundaries of medical therapeutic privilege by noting that decisions dealing with the therapeutic privilege defence are notably absent in South African law. He notes that in *SA Medical and Dental Council v McLoughlin*⁹⁴ Watermeyer CJ commented that: "It may sometimes even be advisable for a medical man to keep secret from his patient the form of treatment which he is giving him and for a medical man to disclose to anyone, other than the patient, the form of treatment which he is carrying out, may amount to a gross breach of confidence between doctor and patient." Welz observes that this statement is in no way conclusive, however. It alludes to the issue of confidentiality in the context of the doctor-patient relationship and hardly even contains the rudiments of the therapeutic privilege defence. He notes that what Watermeyer J had to say in *Richter & Another v Estate Hamman*⁹⁵ when referring to the problems surrounding the so-called therapeutic privilege of the medical profession is more to the point. He described the doctor's dilemma in a way that clearly contributed to the wider debate concerning the existence and the desirability or otherwise of this defence when he

⁹² Christie fn 2 *supra* notes at p 313 that: "In our modern law in which all contracts are *bona fidei*, it is not necessary to prove that a misrepresentation was fraudulent in order to invalidate the contract and the innocent party is equally entitled to rescind whether the representation was fraudulent or innocent". The reason is that, once it has been discovered that the representation was incorrect it is against good faith for the party who made it to continue to hold the innocent party to a contract so obtained. *Parke v Hamman* 1907 TH 47 p52; *Lamb v Walters* 1926 AD 358 at p 364; *Sampson v Union and Rhodesia Wholesale Ltd* 1929 AD 469 at p 480; *Harper v Webster* 1956 (2) SA 495 (FC) 501; *Pretorius v Natal South Sea Investment Trust Ltd* 1965 (3) SA 410 (W) 415H. It is submitted that in the case of the patient in the health services context, the power to rescind the contract may be cold comfort indeed.

⁹³ Welz D 'The Boundaries of Medical-Therapeutic Privilege' (1999) 116 *South African Law Journal (SALJ)* p 299. See also Van Oosten FFW 'The Doctrine of Informed Consent in Medical Law' (unpublished doctoral thesis University of South Africa 1989); Van Oosten FFW 'Informed consent: patient rights and the doctor's duty of disclosure in South Africa.' Paper read at a conference at Sun City in August 1987 (1989 *Medical Law*, 7(5) p443-56); Van Oosten FFW 'The so-called "therapeutic privilege" or "contra-indication": Its nature and role in non-disclosure cases' 1991 *Medicine and Law* 10 (1) p 31; Van Oosten FFW 'Castell v De Greef and the doctrine of informed consent: Medical paternalism ousted in favour of patient autonomy' 1995 *De Jure* 164; Welz D 'The parameters of medical-therapeutic privilege' (unpublished masters dissertation University of South Africa 1998; Coetzee LC 'Medical Therapeutic Privilege' (unpublished masters dissertation University of South Africa 2001)

⁹⁴ *McLoughlin* 1948 (2) SA 355 (A) at p 366

⁹⁵ *Richter* 1976 (3) SA 226 (C) at 232 G-H



explained: “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 best interests to have it. In *Castell v De Greeff*⁹⁶ Ackermann J expressly acknowledged the therapeutic privilege defence in South Africa law but left open the question what the ‘ambit of the so-called “privilege” may today still be’. Welz notes that while not rejecting the defence out of hand, Ackermann J appears to hold the view that it does not fully accord with the present day developments of South African law which clearly promote patient autonomy and self-determination. He adds that South African legal opinion, scant as it may be, appears to be unanimous in its acceptance in principle of the notion that in special circumstances the duty to disclose may be suspended⁹⁷. Welz states that this is an exception to the general rule that ordinarily a patient in a non-emergency case must be informed of the nature of the treatment and the substantial risks it holds for him or her.⁹⁸ He notes that such a withholding of information must be in the best interests of the patient him- or herself but may also be justified where full disclosure may create a substantial danger to a third party⁹⁹. Welz observes that this common sense view is widely supported in medico-legal literature and may predictably be upheld in suitable cases brought before South African courts. He then states that in order to explore the limits of medical-therapeutic privilege, 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

⁹⁶ *Castell* 1994 (4) SA 408 (C) at 426H

⁹⁷ Welz , fn 93 *supra*, refers to Van den Heever P ‘The Patient’s Right to Know: Informed Consent in South African Medical Law’ 1995 *De Rebus* 53

⁹⁸ Welz , fn 93 *supra*, refers to Strauss SA *Doctor Patient and The Law* p10

⁹⁹ Welz, fn 93 *supra*, refers to Giesen D *International Medical Malpractice Law* at p 382. See also Claassen and Verschoor fn 91 *supra* at p 69-71 who refer to the English case of *Sidaway v Board of Governors of the Bethlehem Royal Hospital and the Maudsley Hospital* [1985] 1 All ER 643 653 F in which the scope of therapeutic privilege is described as: “ This exception enables a doctor to withhold from his patient information as to risk if it can be shown that a reasonable assessment of the patient would have indicated to the doctor that disclosure would have posed a serious threat of psychological detriment to the patient.” They also refer to the American case of *Canterbury v Spence* 464 F 2d 772 CA SC 1972 at 789 where the court stated: “The critical enquiry is whether the physician responded to a sound medical judgment that a communication of the risk information would present a threat to the patient’s well-being. The physician’s privilege to withhold information for therapeutic reasons must be carefully circumscribed, however, for otherwise it might devour the disclosure rule itself. The privilege does not accept the paternalistic notion that the physician may remain silent simply because divulgence might prompt the patient to forego therapy the physicians feels the patient really needs. That attitude presumes instability or perversity for even the normal patient and runs counter to the foundation principle that the patient should and ordinarily can make the choice for himself.” Claassen and Verschoor point out that in *Hatcher v Black* (*The Times*, July 2, 1954 as cited by Jackson RM and Powell JL 1982 *Professional Negligence* 1 ed at p 238) it was decided that not only may a practitioner withhold information from a patient, he is even entitled to tell a lie in connection with the proposed treatment if he is of the opinion that the patient’s chances of recovery will be improved thereby. It is hardly necessary to point out that the latter situation is anathema to the creation of a contract between the parties since it precludes consensus.

determine the meaning of reasonable disclosure¹⁰⁰. It is submitted that in the context of the traditional, common law of contract in particular, the concept of therapeutic privilege is a paternalistic and patronising view that gives the power to decide what is in the best interests of the one contracting party to the other contracting party and could constitute anathema rather than common-sense¹⁰¹ especially in the private sector environment in which health professionals and health institutions are out to make a profit from the delivery of health care services. Christie explores whether a general test can be propounded for deciding whether in any particular case silence amounts to a misrepresentation and notes that a big step in this direction was taken by Vieyra J in *Pretorius v Natal South Sea Investment Trust Ltd*¹⁰² Christie observes that the test of involuntary reliance here applied is in accordance with the principle underlying the requirement of disclosure of material facts in contracts of insurance. The insured must disclose all the material facts in contracts of insurance. The insured must disclose all such facts because the insurer involuntarily relies on him for information on such facts: it might theoretically be possible to ascertain these facts by other means but it

¹⁰⁰ Welz fn 93 *supra* goes on to investigate in his paper the nature and scope of therapeutic privilege with reference to American, Canadian, Anglo-Australian and German law. He concludes that the duty to disclose is not absolute but relative and that various instances can be identified in which the duty of disclosure is restricted or does not exist at all. He notes that these exceptions to the general disclosure rule have been conveniently categorized in the form of instances where the defence of therapeutic privilege is applicable in certain jurisdictions. These are the following:

- (1) Where disclosure would be detrimental to the patient's health (physical or mental) or endanger his or her life.
- (2) Where it might interfere with the patient's rational decisionmaking.
- (3) Where it might detrimentally affect the patient's therapy.
- (4) Where it would be inhuman.
- (5) Where the risks attached to it are as grave as those attached to the treatment or even outweigh them.
- (6) Where it will present a threat to a third party.

¹⁰¹ Christie (fn 2 *supra*) at p 320 notes that silence may amount to a misrepresentation in some cases. There is no general rule that all material fact must be disclosed and that non-disclosure therefore amounts to misrepresentation by silence but in certain circumstances this is undoubtedly the rule. (*McCann v Goodall Group Operations (Pty) Ltd* 1995 (2) SA 718 (C) 723E-F) He notes that in *Iscor Pension Fund v Marine and General Trade Insurance Co Ltd* 1961 (1) SA 178 (T), Roberts AJ at p185 softened the previous hard line between contracts of insurance and other contracts in these words: "In some contracts parties are required to place their cards on the table to a greater extent than in others, but the determination of the extent of the disclosure does not depend on the label we choose to stick on a contract. The principles applicable to contracts of insurance do not differ in essence from those applicable to other kinds of contracts, but where one party has means of knowledge not accessible to the other party, and where from the nature of the contract the latter (as in the case of insurance) binds himself on the basis that all material facts have been communicated to him, the non-disclosure of any such fact is fatal...The contract is void because the risk run is in fact different from the risk understood and intended to be run at the time of the agreement (*Carter v Boehm*, 97 ER 1162). These principles apply to suretyship though there is no universal obligation to make disclosure but 'very little said which ought not to have been said, and very little not said which ought to have been said would be sufficient to prevent the contract being valid' (*Davies v London Provincial Marine Insurance Co* (1878) 8 Ch D 469 at p 475)" Christie notes at p321 that other circumstances in which there can be no doubt that silence may amount to a misrepresentation are: where part of the truth has been told but the omission of the remainder gives a misleading impression (*Marais v Edelman* 1934 CPD 212); where a true representation has been made but before the making of the contract the facts have changed (*Viljoen v Hillier* 1904 TS 312 p 315-316; *Cloete v Smithfield Hotel (Pty) Ltd* 1955 (2) SA 622 (O) p 626-627); where a party, not necessarily with a dishonest motive, has done something which has had the effect of concealing facts which would otherwise have been apparent to the other party *Dibley v Furter* 1951 (4) SA 73(C); *Knight v Hemming* 1959 (1) SA 288 (FC); where a party presents for signature a standard form contract without drawing attention to an unusually onerous clause, in circumstances where he must have known that the signatory would not read the contract and discover the clause (*Kempston Hire (Pty) Ltd v Snyman* 1988 (4) SA 371 (SE))

¹⁰² *Pretorius* 1965 (3) SA 410 (W) in which the court said there was "an involuntary reliance of the one party on the frank disclosure of certain facts necessarily lying within the exclusive knowledge of the other such that in fair dealing the former's right to have such information communicated to him would be mutually recognised by honest men in the circumstances." Vieyra J based his judgment on an article by MA Millner (1957) 'Fraudulent Non-Disclosure' 74 SALJ 177.

would not be practical in the business sense. Christie states that it is difficult to imagine any other basis for the rule that partners and agents must make full disclosure than that their co-partners and principals are, by the vary nature of their relationship, in a position of involuntary reliance on them - it would not be practical in the business sense for them to obtain information on material facts known to their partners or agents by making inquiries elsewhere. It is submitted that the same is true, if not more so, for the patient with regard to the information concerning his health and medical treatment in the possession of the health care provider. The patient is involuntarily reliant on the health care provider to disclose information which, practically speaking, it would be impractical to obtain elsewhere. Christie notes that -

“...we require disclosure of material facts in insurance and other contracts not because they are contracts *uberrimae fidei* but because they are contracts in which a situation of involuntary reliance necessarily exists, and we came to attach the *uberrimae fides* label to them as a reminder that, in them, this situation always exists.”¹⁰³

It is submitted that Christie’s reasoning is particularly apposite and elucidating in the context of contracts for health care services since the latter perfectly fit the paradigm he proposes with regard to duties of disclosure and so-called fiduciary relationships. It is submitted that much of the tension between the South African government and the private health sector in South Africa at present, ostensibly in relation to law reforms contained in the National Health Act¹⁰⁴ concerning certificate of need and in the Medicines and Related Substances Act¹⁰⁵ concerning the licensing of doctors to dispense medicines, essentially stems from the fact that the state perceives health care providers to have fiduciary responsibilities of an order close to which Birks identifies

¹⁰³ Christie fn 2 *supra* at p 322. See also Kerr (fn 21 *supra*) who states at p 279 that a non-disclosure is similar in many respects to a misrepresentation. At p291 he points out that non-disclosure leaves the other party with an incomplete picture of the situation which leads to a different decision from that which would have been taken had the situation been fully understood. Kerr points out at p 295 that if each party to negotiations leading up to a contract had always to mention all he knew that might conceivably influence the other party most transactions would take an unreasonably long time and/or involve an unreasonable amount of paper work. He states: “Further, some facts are considered in law to be irrelevant to particular transactions. In addition to a certain extent each party is expected to inform himself of available facts.” Kerr notes at p 75 that classes of misrepresentation are often distinguished by virtue of the presence or absence of fault or of a particular type of fault. Hence, he says, one encounters distinctions between misrepresentations which are accompanied by fault and those which are not so accompanied. He states that none of these distinctions is truly fundamental. They simply serve to indicate the presence or absence of (a particular type of) fault as but one of the elements of misrepresentation. He states that the distinctions do serve a practical purpose inasmuch as they affect the nature and scope of the applicable remedies and notes that an analysis and systematisation of the requirements of misrepresentation indicate that in the present context misrepresentation is regarded as nothing more than a particular delict. Kerr states that neither logic nor policy appears to necessitate such an approach. It is quite possible – and perhaps even preferable, to focus on the quality of the conduct involved as being improper(whether in the sense of being wrongful or even having a wider meaning) without resorting to a more technical concept such as delict.

¹⁰⁴ National Health Act fn 10 *supra*

¹⁰⁵ Medicines Act fn 9 *supra*

as the third degree of obligatory altruism¹⁰⁶, whilst the health professionals and providers themselves have come to perceive the relationship to be at most at the

106

Birks P 'The content of fiduciary obligation' 2000 *Israel Law Review* 34 p 3 explores this subject in some detail and argues that the word 'fiduciary' fails to identify either the content or the causative event of the obligation of which we generally mean to speak. He notes that since Justice Paul Finn published his prize-winning book in 1977 (Finn PD *Fiduciary Obligations*) fiduciary obligations have achieved a new prominence in the common law world. "They have become, as the saying goes, all the rage. Breach of fiduciary duty bids to become a new civil wrong which can be committed by a wide range of people who find themselves concerned with the welfare of others. Professional advisors, governmental agencies, even parents, have had to take account of this new kind of liability." Although Birks is not in favour of overuse of the fiduciary concept which seems to have been created by its rise to fashion, he continues to state that "Abuse of confidence is one genuine addition to the list. Abuse of confidence is now a well established civil wrong, despite the reluctance of 'tort' to welcome wrongs with no common law pedigree. Breach of fiduciary duty will turn out to be another, but much more closely confined than counsel have tried to make it. The name must change. The word 'fiduciary' signally fails to identify either the content or the causative event of which we generally mean to speak." Birks notes that: "All primary obligations recognised by law require some degree of altruism. In general it requires in the interest of others only that we inhibit our own conduct so that it does not cause harm to them. In special circumstances it requires us to take positive action to improve another's position. In even more special circumstances it requires us to take positive action to improve another's position disinterestedly – that is, uninfluenced by any competing interest of our own. These are the three degrees of legally obligatory altruism." With regard to this last he states that: "The third degree requires not only positive action in the interest of another but also disinterestedness, the elimination of the pursuit of any conflicting interest of the actor himself. The difference between the two degrees is easy to illustrate from contract cases. A contractor, say a builder, who is obliged to use skill and care to implement the client's wishes, is ex hypothesi constrained to act positively in the interest of the other, the client. He is not thereby obliged to forego discounts and commissions which he knows that he can get from particular suppliers. Similarly a shopkeeper who accepts the burden of advising a buyer as to the suitability of goods for a particular purpose is not bound to exclude from consideration a brand of his own making or in which he has a material interest. The limit of the obligation in these cases is to advance the other's interest according to an objective standard. If the contractor's concurrent pursuit of its own interest brings the performance below that standard it will be in breach, as where materials on which he was able to obtain a discount prove unsatisfactory. But the mere fact that the contractor takes a secret commission or other collateral economic advantage is not in itself a wrong. Only the third degree of altruism requires self-denial of that kind. This line between the second and third degree of obligatory altruism was drawn in *Hospital Products Ltd v US Surgical Corporation* (1984) 156 CLR 41 (HCA). An American company which manufactured surgical equipment had sent a senior executive, Blackman, to Australia to develop its sales there. In Australia, Blackman, finding that his employers had no patent there, set about copying their products and marketing them through companies which he himself created, in this way he made huge profits in competition with his employers. There was no doubt that he had been under a contractual obligation to use his best efforts in their behalf. He was, therefore, in breach of contract and he had to pay massive compensatory damages for that breach. However, it would have been even better from the point of view of his employers if they had been able to take the profits that he and his companies had made. They failed to establish any secondary obligation to pay over those profits. The majority of the High Court thought that the only way that the American company could establish an obligation to pay over the profits was for them to show that Blackman was their fiduciary (Deane J took the view that this was an unnecessary detour and preferred to ask directly whether this was such a breach of contract as made him liable for his profits. This is the preferable approach); they thought he was not. Deane J's view is arguably preferable. He thought that in such a case in which the lining of the defendant's own pocket was achieved through breach of contract, it was open to the courts to award by way of damages the profits which he had made, without any need to find that the defendant was in breach of a fiduciary obligation... For the purpose of the present exercise of differentiation, we only need to see that, rightly or wrongly, the High Court of Australia thought Mr Blackman was under an obligation to promote the interests of his employer but not under any obligation to promote those interests disinterestedly. That is, he was not bound to abstain from the pursuit of any interest of his own that might possibly have led him to sacrifice the interests of those relying on him. His was, in their view, an obligation of altruism in the second degree. His liability, whatever its measure should have been, could only be bad for management, not pursuing interests of his own."

<http://shelburne.butterworths.co.uk/truststaxestates/articles/>

The lack of recognition of the fiduciary nature of the provider patient relationship is not confined to South Africa. See Choudhry S, Choudhry NK and Brown AD 'Unregulated private markets for health care in Canada? Rules of Professional Misconduct, Physician Kickbacks and Physician Self-referral' 2004 *CMAJ* 170(7) p 1115 who observe that IHF's [privately owned independent health facilities] depend on physician referrals for patients. This raises 2 important issues. First, IHFs can compensate physicians for patient referrals (a kickback), a practice that can potentially distort clinical judgment. Second, physicians can make referrals to IHFs that they themselves own, raising similar concerns. Both problems have occurred in the United States and have prompted regulation... Financial conflicts of interest involving physicians are regulated by common law which imposes a fiduciary duty on physicians towards patients. [*McInerny v MacDonald* (1992) 93 D.L.R. (4th) 415] Canadian courts have stated that physicians fulfill this duty by disclosing conflicting interests to patients. [*Henderson v Johnston* (1956) 5 D.L.R. (2d) 524 (Ont HC)] Unfortunately in most clinical settings disclosure provides inadequate protection for patients." They note that the US data suggests that physician ownership of IHFs increases the number of referrals and leads to higher costs. Physicians who owned and operated diagnostic imaging equipment in their offices were up to 7 times more likely to obtain radiologic examinations than were physicians who always referred patients to radiologists. In addition, the charges per episode of care were significantly higher for self-referring physicians. Moreover the authors note that the existing data on quality suggest that the purported benefits of self-referral for quality may not exist. For example, licensed physiotherapists spent significantly less time per visit treating patients in physician-owned facilities than in other facilities. Choudhry *et al* point out that some physicians are deftly dodging the body of law that imposes a fiduciary duty on physicians. <http://www.cmaj.ca/cgi/content/full/170/7/1115> It is worth noting that in South Africa, the vast majority of private hospitals and clinics are IHFs. Litman M 'Self-referral and Kickbacks: Fiduciary Law and the Regulation of "trafficking

second degree of obligatory altruism. Unfortunately, the Supreme Court of Appeal has recently reinforced this view in *Afrox Healthcare v Strydom*¹⁰⁷, being unable to see private hospitals as any different from suppliers of other goods and services. The former requires a certain level of disinterestedness on the part of health professionals and other providers of health care services while the latter only recognises primary duties to act positively for the benefit of another both in contract and, outside of a contract. Birks points out that under the latter head every tort is the breach of a primary duty imposed in the absence of contract. Sometimes the primary duty is to take positive action in the interests of another¹⁰⁸. This could be seen as a point of fundamental difference between the delivery of health care services in the public sector and that in the private sector. The former is likely to have a higher degree of personal disinterestedness in the delivery of health care services than the latter due largely to the fact that the latter is profit driven unlike the former. It is submitted, however the public health sector is not entirely disinterested in the sense contemplated by Birks but rather that its interests are largely different to those of the private sector. The public health sector although not interested in making profits for profit's sake does have a very real interest in increasing the scope and size of its income given the enormous financial pressures it faces to meet the ever increasing health care needs of the population in general. However it is interesting that Birks, comes close to using the language of the South African constitution in pointing out that the obligation of disinterestedness cannot be severed from the obligation to *promote and preserve*. He

in patients” 2004 *CMAJ* 170 (7) p 1119 notes: “Fiduciaries are ‘obligatory altruists’. They must selflessly, although not without remuneration, attend to their patients interests with single-minded attention. In law, physicians are fiduciaries because they undertake to dedicate themselves to their patients, who have a reasonable expectation of such dedication, and patients rely on it implicitly. Factors which give rise to the fiduciary duty of physicians include the power and influence of physicians, the vulnerability and dependence of patients and the solemn pledge of physicians to act only in their patients’ interests. Fiduciary duty mandates exemplary relational behaviour and unlike malpractice law, is not concerned with standard-of-care issues. As fiduciaries, physicians must discharge their responsibilities to patients with loyalty, honesty, candour and good faith, all the while avoiding conflict of interest. Material interests that compete with the interests of patients, including benefits of self-referrals and kickbacks, must be avoided for they give rise to a ‘reasonable possibility of mischief.’”[footnotes omitted]. Fiduciary law in South Africa with regard to health professionals in particular appears to be largely undeveloped compared to the Canadian situation. Given that, despite this, the Canadians still experience problems with flagrant disregard of these legally imposed duties, it is hardly surprising that there are problems of this nature in South Africa where the law on this subject is not developed. Given the approach of the South African courts to health care contracts, it is likely to remain so unless the Legislature steps in.

107

Afrox fn 6 *supra* discussed in Chapter 6

108

Birks fn 106 *supra*. The first degree of obligatory altruism he identifies is framed in the negative and is illustrated by Birk with reference to the case of *Donoghue v Stevenson* ([1932] AC 562 (HL) 580) in which the plaintiff was made ill by the remains of a snail in a ginger beer bottle and in which Lord Atkin famously stated: “The liability for negligence, whether you style it such or treat it as in other systems as a species of “culpa” is no doubt based upon a general public statement of moral wrongdoing for which the offender must pay. But acts or omissions which any moral code would censure cannot in a practical world be treated so as to give a right to every person injured by them to demand relief. In this way that rules of law arise which limit the range of complainants and the extent of their remedy. The rule that you are to love your neighbour becomes in law, you must not injure your neighbour; and the lawyer’s question, who is my neighbour? receives a restricted reply. You must take reasonable care to avoid acts or omissions which you can reasonably foresee would be likely to injure your neighbour. Who then in law is my neighbour? The answer seems to be – persons who are so closely and directly affected by my act that I ought reasonably to have them in contemplation as being so affected when I am directing my mind to the acts or omissions which are called in question”.

notes that an independent obligation to abstain from pursuing interests of one's own is unintelligible, certainly unworkable and states that the very formulation of the chief restatement of this obligation shows that it is an obligation of disinterestedness in the course of doing something: the trustee shall not pursue any interest of his own which might possibly conflict with his duty to the beneficiary, *scilicet* his duty to promote and preserve the interest of the beneficiary. So, says Birks, these two are bound together. The core obligation of the trustee is a compound obligation and it is indivisible at least in the sense that while the positive obligation of care can exist on its own, the obligation of disinterestedness cannot. The trustee, says Birks, must promote and preserve the interests of the beneficiary with the care and skill of a prudent person of business and to abstain from the pursuit of all interests which might conflict with that duty. In the constitutional context in South Africa, the beneficiary for the public health sector is the person who holds the right of access to health care services including reproductive health care in terms of section 27(1) of the Constitution and the state's obligation is to protect, respect, promote and fulfil that right. It is not too difficult to draw an analogy between the position of a trustee and that of the state. That there is an added dimension to contractual relationships between health service providers and patients is widely recognised¹⁰⁹. In fact a fiduciary relationship can even arise between providers of services to health practitioners in some instances due to the nature of the contractual relationship in terms of which support services are provided to the practitioner¹¹⁰.

¹⁰⁹ For instance in Report C: 'Fiduciary Duty of a MSO On Behalf of a Physicians Contractee' it is noted that in Black's Law Dictionary a contract is defined as an agreement between two or more persons which creates an obligation to do or not to do a particular thing. Black's defines a fiduciary as a person having duty, created by his undertaking, to act primarily for another's benefit in matters connected with such undertaking. A fiduciary invokes a higher level of trust that is born out of dependency. The Report notes that a fiduciary duty as defined by Black's is "a duty to act for someone else's benefit while subordinating one's personal interests to that of the other person. It is the highest standard of duty implied by law." The Report points out that patients generally depend upon and trust the knowledge, professionalism and skill of physicians for their health needs, thus creating a fiduciary responsibility on the part of physicians. Consequently patients are entitled to certain rights as the result of that relationship. AMA Policy 140.975 "Fundamental Elements of the Patient-Physician Relationship" states that these rights include the following: "From ancient times physicians have recognised that the health and well-being of patients depends upon a collaborative effort between physician and patient. Patients share with physicians the responsibility for their own health care. The patient-physician relationship is of the greatest benefit to patients when they bring medical problems to the attention of their physicians in a timely fashion and work with their physicians in a mutually respectful alliance. Physicians can best contribute to this alliance by serving as their patients' advocate and fostering these rights: (1) The patient has the right to receive information from physicians and to discuss the benefits, risks and costs of appropriate treatment alternatives. Patients should receive guidance from their physicians as to the optimal course of action. Patients are also entitled to obtain copies of summaries of their medical records, to have their questions answered, and to be advised of potential conflicts of interest that their physicians might have, and to receive independent professional opinions...." Thus, says the Report, it can be concluded that a fiduciary duty is more than a contract duty, and also that there are certain rights that of patients that physicians should respect. (http://www.ama-assn.org/ama1/pub/upload/mm/21/reportc_i97.doc)

¹¹⁰ In Report C (fn 109 *supra*) it is noted that at the 1997 Annual Meeting, the American Medical Association Organized Medical Staff Section (AMA-OMSS) adopted Substitute Resolution A12, "Fiduciary Duty of a MSO on Behalf of a Physician Contractee". This resolution asked that the AMA-OMSS study the legal duties and responsibilities that flow from management services contracts with individual physicians and physician groups. Testimony heard during the OMSS reference committee hearing reflected not only confusion in understanding the legal rights and responsibilities of

Informed consent from a contractual point of view is important to ensure consensus and that the parties are bound by the terms of their agreement.

4.4 Freedom of Contract

Freedom to contract and freedom of contract have been identified as principles that are fundamental to the law of contract in South Africa. This freedom is based on public policy¹¹¹. Since constitutional values and principles now infuse and inform public policy, the principle of freedom of contract must similarly acknowledge and be shaped in accordance with constitutional values and principles. Even before the Constitution came into being, the freedom of contract and the logically allied principle of *pacta servanda sunt* were defined and limited by considerations of public policy¹¹².

a Management Services Organisation (MSO) but also its relationship and fiduciary responsibility to physicians and other contracting entities. The Assembly agreed that it would be helpful for the OMSS Governing Council to investigate the issue to determine if it is simply a contractual matter that can be rectified through review of the contract by appropriate legal counsel. The focus of Report C was the distinction between a contract relationship that an MSO may have with a physician and the MSO's possible fiduciary relationship to the physician. The Report notes with regard to MSOs that while there is no commonly accepted definition of such an organisation the following description could be used for the purposes of a study on MSOs: "An entity that is owned by physicians, hospitals, private investors, or a combination thereof, which provides contract management and/pr practice management services to physicians and medical groups."

The study indicated that in some cases MSOs purchase the hard assets of medical practices (e.g. medical equipment, office furniture and supplies) and the physicians and other office staff become employees of the MSO (or of a foundation in states like California that prohibit the corporate practice of medicine). In other cases MSOs offer services to networks of independent physicians. In most cases MSOs use a combination of these approaches. It is observed in the Report that in an article by Mark F. Weiss, private attorney specializing in the representation of physicians and physician groups, published in the September 18, 1995 issue of LACMA Physician, he suggests that some MSOs may have created a fiduciary duty to the physician – the highest duty imposed by law – owed by the MSO to the physician. In the article he states: "An agent must act with the utmost good faith in its dealings with the principal. The relationship obligates the agent to perform its services in accordance with the highest degree of loyalty, integrity and honesty. The agent's failure to perform to such standards will result in tort liability (including punitive damages) for breach of fiduciary duty and fraud as well as liability for breach of contract. Therefore even though the MSO has profit motives different and apart from those of the physician, it is still possible that it is the physician's agent. The existence of an agency relationship is determined by the terms of the agreement between the parties, interpreted in light of the circumstances in which the agreement was made.

111 See *Standard Bank of SA Ltd v Wilkinson* 1993 (3) SA 822 (C) in which the court stated: "Which brings us to the third aspect that must be borne in mind, viz that public policy favours the utmost freedom of contract and requires that commercial transactions should not be unduly trammelled by restrictions on that freedom (see *Sasfin* at 9E-F). As Innes CJ said in the *Law Union Rock* case *supra* at 598: 'Public policy demands in general full freedom of contract; the right of men freely to bind themselves in respect of all legitimate subject-matters.'

One is further reminded of the much-quoted aphorism of Jessel MR in *Printing and Numerical Registering Co v Sampson* (1875) LR 19 Eq 462 at 465: 'If there is one thing which more than another public policy requires, it is that men of full age and competent understanding shall have the utmost liberty of contracting and that their contracts, when entered into freely and voluntarily, shall be held sacred and shall be enforced by courts of justice.'

(See also *Wells v South African Aluminite Company* 1927 AD 69 at p 73) In *SA Sentrale Ko-op Graanmaatskappy Bpk v Shifren en Andere* 1964 (4) SA 760 (A) at 767A, Steyn CJ emphasised 'die elementêre en grondliggende algemene beginsel dat kontrakte wat vryelik en in alle erns deur bevoegde partye aangegaan is, in die openbare belang afgedwing word'. It is this freedom of contract and the voluntary acceptance by a surety of the burdens of suretyship that bring us to the conclusion that it is only when a suretyship agreement or some of its terms are clearly inimical to the interests of the community as a whole that it or they should be declared to be objectionable."

112 In *Bank Of Lisbon and South Africa Ltd v De Ornelas and Another* fn 45 *supra* Jansen JA stated: Apart from statutory innovations, there are in any event a number of well-recognised instances in our law of contract where freedom of contract and the principle of *pacta servanda sunt* and the ideal of certainty give way to other considerations. A few examples may be mentioned. A creditor has a right to specific performance but a Court may in the exercise of its discretion refuse to make such an order. The discretion 'is aimed at preventing an injustice - for cases do arise where

Strauss¹¹³ in discussing the doctor-patient relationship in the private sector context points out that a doctor is, with a few exceptions, at liberty to select or refuse patients at will. Continuing he observes that “There being no legal duty in general upon a doctor to accept a patient, it is also true that the doctor has no general right to treat any person”¹¹⁴. At first glance, this statement does not seem to be true of a situation in which the state is constitutionally obliged to provide access to health care services as discussed in chapter two. If one assumes for the moment that there is an obligation on the state to provide health care services, this does not necessarily mean that the state has a general right to treat a person. It is a well-established principle that people cannot as a general rule¹¹⁵ be treated against their will even if there is an obligation to treat. The patient’s rights to bodily and psychological integrity in terms of section 12 of the Constitution cannot be taken lightly. As far as the state’s obligation to treat a patient, if any, is concerned, this must also be qualified by the fact that the Constitution itself recognises that the realisation of the right to health care services is limited by available resources and that it requires a series of progressive steps towards achievement of the right.¹¹⁶ In view of this there can only be at best a qualified obligation on a public provider to treat a patient. It is submitted, however that even so, the matter is not as simple as this for a number of reasons. Firstly, as has been

justice demands that a plaintiff be denied his right to performance - and the basic principle thus is that the order which the Court makes should not produce an unjust result which will be the case, eg if, in the particular circumstances, the order will operate unduly harshly on the defendant. Another principle is that the remedy of specific performance should always be granted or withheld in accordance with legal and public policy....’ (Per Hefer JA in *Benson v SA Mutual Life Assurance Society* 1986 (1) SA 776 (A) at 783D - E.) A restraint of trade is not per se invalid or unenforceable - but it is so if it offends against the public interest (*Magna Alloys and Research (SA) (Pty) Ltd v Ellis* 1984 (4) SA 874 (A)). In delivering the judgment of the Court, Rabie CJ points out: ‘Omdat opvatting oor wat in die openbare belang is, of wat die openbare belang vereis, nie altyd dieselfde is nie en van tyd tot tyd kan verander, kan daar ook geen numerus clausus wees van soorte ooreenkomste wat as strydig met die openbare belang beskou kan word nie. Dit sou dus volgens die beginsels van ons reg moontlik wees om te sê dat ’n ooreenkoms wat iemand se handelsvryheid inkort teen die openbare belang is indien die omstandighede van die betrokke geval sodanig is dat die Hof daarvan oortuig is dat die afdwing van die betrokke ooreenkoms die openbare belang sou skaad.’

‘Die opvatting dat ’n persoon wat ’n beperking wil afdwing nie die las dra om te bewys dat dit redelik inter partes is nie, bring nie mee dat oorwegings van die redelikheid of onredelikheid van ’n beperking nie van belang is of kan wees nie.’ (At 893H.) ‘Die belangrike vraag is dus nie of ’n ooreenkoms van so ’n aard is dat dit *ab initio* ongeldig is nie, maar of dit ’n ooreenkoms is wat die Hof, gesien die vereistes van die openbare belang, nie behoort af te dwing nie.’ (At 895D - E.) The Court may reduce a stipulated penalty to such an extent as it may consider equitable in the circumstances’ (Act 15 of 1962, s 3 - reinstating the common law). Not only contracts against public interest or public policy are subject to control by the Court, but also those offending the boni mores. In this field reference must be made to the sense of justice (regsgevoel) of the community, as is the case in *delict*, where it is now recognised that there is no numerus clausus of actionable wrongs.

113 Strauss fn 98 *supra* at p3

114 Strauss fn 98 *supra*

115 Where there is a serious risk to public health or safety from highly contagious diseases or mental illness the position is somewhat different but these situations are exceptions to the general rule and are strictly controlled by legislation for example the Health Act No 63 of 1977 and Regulations thereto and the Mental Health Act No 18 of 1973 soon to be replaced by the Mental Health Care Act No 17 of 2002.

116 In reality, if one regards the right of access to health services in its purest form as being unrestricted access to health services of all types and levels necessary and appropriate for the treatment of any health condition then the right of access to health care is unlikely ever to be realised but will always consist of an endless progression towards it.



stated in chapter two of this thesis, section 27(1)(a) of the Constitution states simply that everyone has the right of access to health care services including reproductive health care. It does not suggest that the state alone bears the concomitant obligation of this right. Section 27(2) imposes an obligation upon the state to take reasonable legislative and other measures within its available resources to achieve the progressive realisation of the right. The wording of section 27(2) does not require the state to provide health care services. It imposes a much less direct obligation – to take reasonable legislative and other measures within its available resources to achieve the progressive realisation of the right. The obligation that is imposed upon the state by section 27(2) allows a fair degree of flexibility to the state in achieving the progressive realisation of the right. Furthermore, the right awarded in section 27(1)(a) is a right of *access* as has been pointed out in chapter two. It is submitted that the wording of section 27 of the Constitution allows sufficient latitude for the state not to provide health care services at all but rather to contract with private sector providers for the provision of those services. Such a step would still be fulfilling its constitutional obligation to take reasonable legislative and other measures to achieve the progressive realisation of the right within available resources. Strictly speaking there is thus no explicit constitutional obligation upon the state to provide health care services itself. Whether or not such an obligation exists would depend upon the circumstances governing the availability of health care services in South Africa. In a situation such as the present, the private sector does not have the capacity to provide health care services to the general population. As long as such a situation exists, it could probably successfully be argued that the state does have a constitutional obligation to provide health care services itself. However, if the state contracted out the management of public health care facilities to the private sector - in other words placed at its disposal the remaining health care facilities in the country - and entered into contractual arrangements with the private sector whereby the latter provided health care services to all residents of South Africa in fulfilment of the state's constitutional obligations, and the state became essentially a funder of health care services rather than a provider, it could not be argued that the state was legally obliged to treat anyone. In a situation in which the state had contracted out the delivery of health services to the private sector, the constitutional right of access to health care services would be enforceable against both the state and the private sector since while the state could never escape its constitutional obligation to achieve the

realisation of the right of access to health care services, the private sector would be contractually or even statutorily¹¹⁷ obliged to provide those services. The other qualifier is that even if the state is obliged to provide health care services itself, it does not necessarily follow that it must provide them to everyone. People who have access to health care services because they are able to pay for them would not necessarily be entitled to health care services from the state in the absence of express arrangements to the contrary.

The privatisation scenario painted above, although it is not, to the knowledge of the writer, currently contemplated by the South African government, is a useful illustration of the notion that a private sector provider's right to refuse to treat a patient may not be much different to that of a public sector provider and of the further logical step that the freedom to choose with whom to contract is not necessarily proof, or a *sine qua non*, of the contractual nature of the provider-patient relationship. Even in the private sector, it is doubtful whether a private provider would have the right to refuse, without good reason, to treat anyone who came to him or her for health care services. Strauss observes that a doctor who arbitrarily and unreasonably refuses to attend a seriously ill or injured person may be held liable if the patient cannot manage to get another doctor and suffers harm¹¹⁸. He refers to Voet who states that a doctor who refuses to attend a patient cannot be held liable under the Aquilian law (i.e. for damages), although, Voet adds that "it would suit the duty of a good man to come to help the imperilled fortunes of his neighbour, if he can do it without hurt to himself."¹¹⁹ He notes that Voet hastens to add that a doctor who performs a good operation but then abandons the curative treatment will not escape liability. Strauss then discusses the question of liability for omissions with reference to the duty to rescue with reference to the case of *Minister van Polisie v Ewels*. Whilst this is straying into the area of the law of delict, which will be the subject of further discussion in another section of this chapter, it must be noted here, as it was noted in section 2 of this chapter dealing with administrative law, that questions of public policy, especially as identified in the values espoused by the Constitution, are

¹¹⁷ For instance in terms of a statute creating a social health insurance system in which private providers must provide certain health services if the state enters into a contract with them

¹¹⁸ Strauss (fn 98 *supra*) is writing primarily in the context of the private sector but does not specify whether he regards this statement as applicable to both public and private sectors or only one of them.

¹¹⁹ Strauss fn 98 *supra* p 23 quoting at footnote 2, *Commentarius ad Pandectas* 9.2.3 (Gane's translation).

common to the law of both delict and contract. Policy considerations in the law of delict which impose an obligation upon a health services provider to provide such services to a particular patient may be the same policy considerations that effectively compel a provider to contract with that patient for the provision of health care services.

If the power of the state to refuse to treat a patient is different from that of a public sector provider it is likely to be not so much as a result of the Constitutional obligations of the state to achieve the progressive realization of the right of access to health care services in section 27(2) but rather due to the fact that the state as a provider of health care services is regulated in terms of a number of statutes, for example the Health Act¹²⁰, and is bound by administrative law considerations. It could be that the state contracts with certain categories of patients for the rendering of health services and not others. In this scenario, the patients with whom the state contracts would be the so-called 'externally funded' patients, for example patients who are members of medical schemes or who are covered by the Road Accident Fund and who have a choice of whether or not to obtain health services in the public sector, whilst those who are not externally funded and who literally have no choice but to obtain health services in the public sector have a relationship with the state based on administrative law. The reasons for this distinction would be based on the different intentions of the two types of patients and the state with respect to each of them – provided that such intentions are in fact different. This might be indicated in different admission procedures for the two types of patient, procedures for instance in terms of which the externally funded patients are required to sign forms on admission that indicate a contractual intent such as an undertaking to pay for the services rendered in the event of the failure of their medical schemes to pay, the application of different rates and terms of payment to the externally funded patients, their utilisation of specific facilities within a health establishment reserved only for externally funded patients, consent to be bound by the undertaking in their personal capacity etc. In the case of patients who are not externally funded, the inherent nature of health care services is such that the intention of such patients in a contractual context would play a relatively minor role compared to the intention of the state. Whilst this may seem

¹²⁰ Health Act fn 18 *supra*

unpalatable it is the hard truth of the matter. Such patients have no bargaining power. They have no choice but to accept the services offered by the state or remain ill or injured, and possibly even die. They have no option but to use state facilities, no power to demand particular drugs or services in preference to others that achieve the same result, no real power to refuse to enter into a contractual relationship if the state decides that this is its preferred legal basis for the public provider relationship. The situation strikes at the heart of the general, free market contractual assumption that the parties are on a relatively equal footing. Where public policy recognises that they are not on an equal footing there is usually significant legislative or judicial 'interference' in the relationship such as happens, for instance in the case of employment contracts or restraint of trade agreements.¹²¹ In the health care sector contracts generally and in the public health care sector in particular contracts are very often not expressed in writing and are not even in express terms. If they exist, they are very often implied. They are inferred from the circumstances. As such they are often conceptual frameworks retrospectively superimposed upon a particular set of factual circumstances so as to come to a particular conclusion on the basis of a pre-selected process of logic. As such they are elegant, often ethereally grey, legal fictions after the fact as opposed to the present intentions of the parties baldly stated in black and

121

Diemont J observed at p762-763 in *Wohlman v Buron* 1970 (2) SA 760 (C): "It is trite law that a distinction must be drawn between contracts entered into between masters and servants and contracts for the sale of a goodwill where the parties contract on an equal footing. This has been stated many times. I need refer only to the oft-cited judgment of Greenberg, J.A., in *Van de Pol v Silbermann and Another*, 1952 (2) SA 561 (AD) at p. 571. In that case the learned Judge said that in agreements in restraint of trade where the parties are contracting on an equal footing the fact that they have agreed on terms is not conclusive evidence that such terms are reasonable, nevertheless such agreement is weighty evidence pointing to the conclusion that the restraint imposed was no more than was necessary to protect the interests of the parties concerned." The link between freedom of trade, sanctity of contract and the power balance between the parties is evident from *Drewtons (Pty) Ltd v Carlis* 1981 (4) SA 305 (C) in which Watermeyer JP stated: "In *Crimpers Salon (Pty) Ltd v Thomas* 1981 CPD unreported I had occasion to say: 'I am also of the firm conviction that while there is, of course, the need for the Court to preserve the right of freedom of trade, it is equally necessary, if not more so, to maintain the sanctity of contract and the Court should be slow to decline to enforce the terms of an agreement, including those of a restraint clause, voluntarily entered into by adults of contractual capacity who contract on an equal footing.'" Claassen J observed in *Filmer And Another v Van Straaten* 1965 (2) SA 575 (W): "In the case of *Hepworth Ltd v Snelling*, 1962 (2) P.H. A.48, I mentioned the well-known legal principles applicable in a case like the present. For the sake of convenience I repeat here substantially what was said on that occasion: 'The law appertaining to a matter of this nature has been stated in many cases in this country and in England. The law could be considered from three aspects:

- A. The general rule applicable in all trade-restricting contracts.
- B. The general rule applicable where parties contract on equal terms - such as where two general dealers or two auctioneers enter into a trade restricting contract.
- C. The rules applicable where parties do not contract on equal terms, as, for example, in the cases of master and servant or teacher and pupil...

As to 'B' it is the general tendency of the Court not to interfere between parties contracting on equal terms, provided the public interests are not affected detrimentally. The parties are considered the best judges of what is a reasonable contract between themselves. The doctrine *pacta sunt servanda* is applicable, and the Courts look with disfavour on a party attempting to escape from a contract into which he has entered with his eyes open, and then alleging afterwards that it was unreasonable. See *New United Yeast Distributors (Pty.) Limited v Brooks*, 1935 W.L.D. 75 at p. 83.

In *Shacklock Phillips-Page (Pvt) Ltd v Johnson* 1977 (3) SA 85 (R), Goldin J commented at p89: The Court will regard with more favour and abstain from interfering in contracts between parties contracting on equal terms than in disputes between persons of unequal bargaining power, because equal contracting parties may often be regarded as the best judges as to what protection is reasonable in their own interests (*Spa Food Products Ltd.*, *supra* at p. 718; *Ackermann-Göggingen Aktiengesellschaft v Marshing*, 1973 (4) SA 62 (C) at pp. 72 - 73; *Esso's Case*, *supra* at p. 712).

white¹²². In a situation where one party has no real choice but to enter into a contract, no choice in reality as to the terms and conditions thereof and no bargaining power with which to negotiate contractual terms and conditions with the other party, the inference of a contractual relationship between them would, it is submitted, be highly artificial to say the least.

At a constitutional level there is no prohibition on either the public or private sector either contracting or charging for health care services. The requirement is not 'free' health services but "access" to health services. As has been pointed out in a previous chapter, 'access' means different things to different people depending on their personal means and resources. In the case of the indigent, 'access' may well imply that health services must be rendered free of charge but in the case of patients who can afford to pay even if it is only a small amount, towards the costs of the health care services they receive, 'access' does not mean free of charge. The state has the power to legislate tariffs and fees for services it renders in order to cover the costs or partial costs thereof. In such circumstances, it has no need of a contractual relationship upon which to base its right to payment. This state of affairs may mitigate against the inference of a contractual relationship between provider and patient.

4.5 Emergency Medical Treatment

122

In *J De Moor (Edms) Bpk v Beheerliggaam Van Outeniqua* 75/80 1985 (3) SA 997 (T) the court observed: "In *Roberts Construction Co Ltd v Dominion Earthworks (Pty) Ltd and Another* 1968 (3) SA 255 (A) het die Appellhof beslis dat: "An implied contract cannot be pleaded baldly and left, as it were, in the air without any indication from what it is to be inferred. It is necessary to plead the circumstances giving rise to the implied contract." Op 261F in fine- 262A - C sê Jansen WN AR: "The general principle would require a statement of the facts or circumstances constituting any implied contract relied upon, or, put in another way, the facts or circumstances from which such contract is inferred". In *Spes Bona Bank v Portals Water Treatment* 1981 (1) SA 618 (W) Nestadt J pointed out: Wessels *Law of Contract in South Africa* 2nd ed vol 1 para 261, quoting an old English case, says that the only difference between an express and an implied contract is as to the mode of proof. An express contract is proved by direct evidence, an implied contract by circumstantial evidence. The nature of such evidence was referred to by Van Zyl J in *Frame v Palmer* 1950 (3) SA 340 (C) at 345 in the following terms: "... An implied or tacit contract differs from an express contract only in the manner in which the offer or acceptance is made, namely it is not expressed in words, gesture or writing but is implied from all the circumstances and the actions of the parties: Voet 2.14.15. From these circumstances and actions the Court, in order to establish such a contract, must come to the conclusion that there was an implied offer and implied acceptance and that the parties intended to contract with each other; in other words that from the circumstances and by their actions the parties in fact intended that a binding contract should come into being. With the exception that the contract is entered into tacitly or by implication all the other essentials which must be present when an ordinary express contract is entered into must also be present in an implied contract. (See too *Fiat SA v Kolbe Motors* 1975 (2) SA 129 (O); Wessels vol 2 para H 4426.) The person whom it is proposed to fix with a tacit contract must be fully aware of the circumstances referred to and his conduct must be unequivocal. (*Blaikie-Johnstone v Holliman* 1971 (4) SA 108 (D) at 119; *Big Dutchman (SA) (Pty) Ltd v Barclays National Bank Ltd* 1979 (3) SA 267 (W) at 281; Wessels paras 259, 266) In the latter regard, Wessels, quoting *Maasdorp Institutes of SA Law* vol 3 4th ed at 64, states (in para 256): "In order to constitute a valid tacit contract, the conduct of the parties must not only be such as to be consistent with consent, but such as will allow of no other interpretation according to the rule of common sense." This paragraph was referred to with approval in *Bristow v Lycett* 1971 (4) SA 223 (RA). The legal effect, therefore, of a person's conduct depends largely upon what a court of law thinks a reasonable man would consider his intention to have been. If the court has any doubt, the presumption will be against the person who asserts that there has been a tacit contract."

At the outset a distinction must be made between health care services generally and emergency medical treatment, given that the Constitution itself draws such a distinction. However, even the right not to be refused emergency medical treatment is not without its limitations. These limitations are essentially the available resources of the state¹²³. The KwaZulu-Natal Health Act¹²⁴ refers to ‘emergency medical services’ rather than ‘emergency medical treatment’. It states at section 29(1) that a health care user is entitled, “as a matter of right, to emergency medical services for any life threatening condition at any public health care establishment or private health care establishment”. Subsection (3) of section 29 stipulates that a person employed in a public health care establishment or private health care establishment who turns away a person requiring emergency medical services in terms of subsection (1) commits an offence. This is an extreme view of the right of not to be refused emergency medical treatment since it criminalizes (at least in the province of KwaZulu-Natal) the act of turning away a person requiring emergency medical services. The other provinces do not share this view. The Mpumalanga Hospitals Bill of 1997¹²⁵ states in section 18 concerning admission and discharge of patients: “The head of clinical services of a provincial hospital shall, subject to any regulations, determine the order in which persons shall be admitted to such hospital having regard to the urgency of their need for treatment: provided that admission to a provincial hospital may not be denied in the case of an emergency. The Bill does not make this an offence. The Mpumalanga Health Facilities and Services Bill of 2000, which seems to have superseded the Mpumalanga Hospitals Bill of 1997, also makes no mention of a refusal of emergency treatment as being a criminal offence. Section 4 is the same as section 18 of the 1997 Bill. The Eastern Cape Provincial Health Act¹²⁶ merely stipulates at section 12(b) with

¹²³ Thus Combrinck J in *Soobramoney v Minister Of Health, Kwazulu-Natal* (fn 76 *supra*) observed as follows at 439-440: “As pointed out by counsel for the respondent a 27(3) does not create a right to emergency medical treatment. It prohibits anyone from refusing emergency medical treatment. I consider that the section must be interpreted in such a way that it is implicit in the words ‘emergency medical treatment’ that such treatment is possible and available. It could surely not have been the intention of the Legislature that irrespective of the costs and whether or not funds were available and irrespective of whether the treatment was available the persons requiring emergency medical treatment had to receive such treatment. So, for instance, if a hospital had an intensive care unit which was full and an emergency patient arrived would it be obliged to move one of its patients out so as to accommodate the emergency patient? Alternatively, is the State obliged to build additional intensive care units, procure additional dialysis machines, ventilators, heart-lung machines and other life-saving equipment to enable it to cater for all the patients requiring emergency medical treatment? It could surely not have been the intention of the Legislature that the right to access to health care was subject to the constraints of the State’s resources and that a patient could be refused treatment but when his or her condition reached a critical stage and emergency treatment was required, the State then had to provide it irrespective of the cost.”

¹²⁴ KwaZulu-Natal Health Act No 4 of 2000

¹²⁵ Provincial Gazette No 282 of 25 October 1997, Notice No 356 of 1997. As far as the writer has been able to ascertain, this Bill has not yet been passed into law in Mpumalanga

¹²⁶ Eastern Cape Provincial Health Act No 10 of 1999

regard to emergency medical treatment for any life threatening condition that users are entitled to it “through ambulance services and at any public or private health care establishment.” The National Health Act¹²⁷ does not criminalize a refusal to render emergency medical treatment. This discrepancy between the law of KwaZulu-Natal and the other provinces illustrates the need for framework legislation such as the National Health Act. The KwaZulu-Natal Health Act¹²⁸, in criminalizing the constitutional prohibition of a refusal to render emergency medical services does not specify any exceptions to the rule. No matter how busy or incapable a health facility may be of attending to a particular patient, no matter how many other emergency patients it may also have to attend to, no matter how few health professionals may be physically available to give the patient immediate attention, it is a criminal offence, in KwaZulu-Natal, to turn away someone requiring emergency medical services. It could even be argued that the criminalizing of such a provision is counterproductive since instead of quickly referring a person requiring emergency medical treatment to another facility where he or she can be attended to immediately, such person may have to wait for a while at the facility he or she first went to for assistance because the personnel there might be afraid of committing a criminal offence in sending him or her to another health care institution. In genuine circumstances of emergency such delays can be fatal. Whilst it could be argued that emergency medical services could be seen as including the act of sending a person to another health care facility that is better equipped to render the emergency services required, this is not at all clear from the definition in the KwaZulu-Natal Health Act¹²⁹.

If a person is entitled to emergency medical services ‘as of right’ this does not necessarily mean that a contractual relationship cannot arise between the patient and the provider. However, the reasons for inferring such a relationship may be thin on the ground. The fact that a person is entitled to emergency medical services also does not preclude the provider from subsequently seeking payment from the patient or other responsible person for the emergency medical treatment that was rendered.

The terms ‘emergency medical services’ and ‘emergency medical treatment’ are not necessarily synonyms. Firstly the term ‘emergency medical services’ in the health

¹²⁷ National Health Act fn 10 *supra*

¹²⁸ KwaZulu-Natal Health Act fn 124 *supra*

¹²⁹ KwaZulu-Natal Health Act fn 124 *supra*

care environment tends to focus attention on health care service infrastructure such as trauma units and the manner in which such units are equipped, ambulance services and who may operate them, other specialised forms of transportation of critically ill or injured persons, and disaster management and containment systems. The term ‘emergency medical treatment’, on the other hand is rather more indicative of the direct and immediate application of recognised medical techniques to the person of one requiring such treatment. It is more personalised and less diffuse than the term “emergency medical services” and conveys a sense of application of medical skill and knowledge to an individual who is seriously ill or injured. It is the term used by the Constitution in section 27(3).

Attempts to define the term ‘emergency medical treatment’ are problematic from the point of view of constitutional law since there is no definition of the term in the Constitution itself. An attempt to define it in other legislation for the purpose of giving effect to the right embodied in section 27(3) of the Constitution could be regarded as an attempt to indirectly amend the Constitution. At the same time, the Constitution is what might be called framework legislation *par excellence* in the sense that the detailed mechanics relating to the Bill of Rights are not contained therein. The question of what constitutes an emergency has apparently plagued other jurisdictions to the extent that they have seen fit to define it fairly specifically.¹³⁰ Although the constitutional court has very usefully given an idea of the nature of emergency medical treatment in *Soobramoney*¹³¹, it too did not give a precise definition but rather expressed a general sense of what emergency medical treatment does not include – notably chronic conditions in respect of which ongoing, long-term medical treatment is required and designed to indefinitely postpone death rather than to immediately save a life. This creates something of a certainty problem for people generally and the law relating to the delivery of health care services in particular. Whilst the court in *Soobramoney*¹³² seems to have ruled out the possibility of a subjective interpretation

¹³⁰ See discussions of emergency medical treatment in Chapter Two – especially with regard to the American Emergency Medical Treatment and Labor Act.

¹³¹ *Soobramoney v Minister of Health, KwaZulu-Natal* (fn 37 *supra*)

¹³² *Soobramoney* fn 79 *supra*. Combrinck J observed in *Soobramoney* at p 440: “In any event, the applicant, in my view on the facts, cannot rely on the provisions of s 27(3). He has been suffering from the diseases mentioned for some years. He has not contracted a sudden illness or sustained unexpected trauma. It is true that if he does not receive the treatment he will die. Unfortunately, that is the position with all persons who suffer from long term disease. So, for instance, a person who has cancer may suffer from the disease for a number of years, but will eventually reach the stage where within days he will die. *It is then an emergency situation for him but it is not the emergency that, in my view, the Legislature had in mind in s 27(3).*” (writer’s italics).



of the term 'emergency' so that the patient's perceptions of his or her health status are not the material factor in ascertaining whether or not a particular situation does constitute an emergency, one is still left with the possibility of a large number of grey areas which will presumably ultimately have to be decided by the courts. For instance is it only situations in which a person's life is materially threatened that are envisaged by section 27(3) of the Constitution or does it include situations in which a person's health, as opposed to life, is threatened? Take for instance a situation where a worker loses a finger in an industrial accident and is rushed to the nearest health facility where he urgently requires surgery to have the finger re-attached to his hand if he is to regain full use of it or the situation of a person who sustains a chemical injury to her eyes which, if treated immediately will save her sight although her life is not in any danger. What about a woman who is in labour and about to give birth? Does her situation constitute a medical emergency or does it only become an emergency when it becomes necessary for her to have a Caesarian section because the child is positioned incorrectly and becomes stuck in the birth canal? As stated previously the question of what constitutes emergency medical treatment as opposed to ordinary health care services has considerable financial implications given the Constitutional prohibition on refusal of medical treatment. It is logical, given this state of legal affairs, that the nature of emergency medical treatment will have to be determined with regard to each particular case and possibly, in terms of the principle of subsidiarity, the decision as to whether or not treatment does constitute emergency medical treatment is ultimately a medical decision rather than a legal one¹³³. This does not, however, solve the potential problem of variations in practice due to the subjectivity of the health professionals involved. It is conceivable that one health professional may quite reasonably classify certain medical treatment as ordinary health care services whilst another could justifiably argue that the same treatment

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In *Soobramoney* fn 79 *supra* Combrinck J observed: "Where there is a conflict such as this, the Court would normally weigh up the interests of the respective parties and based on equity decide which party's right should take precedence over the other. Insofar as the present case is concerned however, I am of the view that it is not the function of the Court to decide who shall and who shall not receive the required medical treatment. It is for the medical practitioners to make these decisions. They are qualified, whereas I am not, to decide on clinical grounds which patient will benefit the most from the treatment. The Court will only interfere if the doctors involved have exercised their judgment unreasonably, arbitrarily or have discriminated against a patient. In this regard I am in complete accord with the remarks of Balcombe LJ in the case of *Re J (a minor)* (wardship: medical treatment) a judgment of the Court of Appeal reported in [1992] 4 All ER 614 at 625g: 'I would also stress the absolute undesirability of the court making an order which may have the effect of compelling a doctor or health authority to make available scarce resources (both human and material) to a particular child, without knowing whether or not there are other patients to whom those resources might more advantageously be devoted. Lord Donaldson MR has set out in his reasons the condition of J and his very limited future prospects. The effect of the order of Waite J, had it not been immediately stayed by this court might have been to require the health authority to put J on a ventilator in an intensive care unit, and thereby possibly to deny the benefit of those limited resources to a child who is much more likely than J to benefit from them.'"

constitutes emergency medical treatment. The reason for this is that there is usually an element of subjectivity in any expert opinion whether of a legal or medical or other technical nature. As stated previously, attempts to define the term ‘emergency medical treatment’ in legislation, are constitutionally problematic because the Constitution itself does not define the term. There is also a practical difficulty which runs alongside the legal one. Attempts at definition of this kind of term are complicated by the fact that a definition is a generic description of a concept based upon an appreciation of most, if not all of the foreseen or anticipated variations that can occur within such a concept whilst emergency situations are often difficult to foresee or anticipate (adjectives such as ‘sudden’ and ‘unexpected’ are often used in relation to the word ‘emergency’¹³⁴) and the number of possible permutations is considerable and unpredictable. What constitutes an emergency with regard to one set of facts may not constitute an emergency in respect of another. A case in point is that of a person stung by a bee. The bee sting itself may or may not be an emergency depending on whether or not the person stung is allergic to bee stings. An allergy to bee stings can be life threatening for a person who is allergic since he or she may suffer from anaphylactic shock brought on by the venom but such a sting would be a completely minor event for someone who is not allergic.

The question is where does emergency medical treatment begin and end. From the point of view of the provider patient relationship, this distinction may depend upon whether the relationship has a basis in contract or not. It may be that emergency medical treatment is not based upon the law of contract but other health services are. It could be argued that the rendering of emergency medical treatment is a public function - because in terms of the Constitution, no-one may be refused emergency medical treatment - whereas the rendering of other health services may or may not be a public function depending upon whether it is a public or private provider that is rendering the services. This point will be explored in more detail in the section on the private sector. In practical terms one must ask for example, whether the emergency

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In *Soobramoney* (fn 37 *supra*) the court noted with regard to the experience of the patient in *Paschim Banga Khet Mazdoor Samity and Others v State of West Bengal and Another* that “the occurrence was sudden, the patient had no opportunity of making arrangements in advance for the treatment that was required, and there was urgency in securing the treatment in order to stabilise his condition.” See for example also *Samson v Winn* 1977 (1) SA 761 (C) in which the court held: “This is, to my mind, almost a classical case of a sudden or unexpected emergency, and the conduct of the defendant must be judged according to the standards of a reasonable man placed in similar circumstances” and *Epol (Pty) Ltd v Bezuidenhout* 1980 (3) SA 624 (T) where the court observed that: “He drove a vehicle in such a manner so as to place the said Moloi in a position of imminent danger and thereby caused the said Moloi to be faced with a sudden and unexpected emergency.”

transportation of a patient to the nearest facility constitute emergency medical treatment (a) if it is not in an ambulance and (b) if it is? When a patient has been attended to within a hospital's trauma unit and is then transferred to the intensive care unit, does the treatment in intensive care remain emergency medical treatment or does it become a critical health care service? As stated previously, questions such as these are important because of the constitutional distinction between emergency medical treatment and health services of a more general nature. The obligations of the provider to the patient may be different depending upon whether or not it is emergency medical treatment. Whilst a provider may in certain circumstances have no option but to refuse a patient emergency medical treatment, the provider may be obliged to refer the patient to another provider who can. The same is not necessarily true in the case of ordinary health services.

In *Soobramoney* the question was whether the required treatment constituted emergency medical treatment at all. The courts have not yet addressed the question of when medical treatment ceases to be emergency medical treatment for purposes of the Constitution. In practical terms it is likely that this question will have to be resolved on a case-by-case basis. However, for operational and financial reasons, there is a need for health legislation to define the nature of emergency medical care or emergency medical services.

The draft regulations¹³⁵ to the KwaZulu-Natal Health Act define "emergency medical care" as "the on-site evaluation, treatment and care of an ill or injured public health care user by an emergency care practitioner in an emergency medical incident and the continuation of evaluation, treatment and care of the public health care user during the transportation of the public health care user to or between public health care establishments". What is meant by "on-site" is not clear. Does it include the treatment of the user in a trauma unit by a medical practitioner who specialises in emergency medical treatment or does it mean only treatment by a paramedic at the site where a person first succumbs to the illness or sustains the injury or does it include both?

¹³⁵ Notice No 23 of 2002 in Gazette No 6120 of 15 August 2002 (published for public comment)

The Free State regulations¹³⁶ define “emergency medical care” as “the evaluation, treatment and care of an ill or injured person in an emergency care situation and the continuation of treatment and care during the transportation of such person to or between medical facilities. The care begins at the site where the emergency occurred, until the patient is discharged/transferred out of an emergency care facility.” These regulations are for the purpose of controlling and regulating the delivery of emergency medical services in the Free State rather than fleshing out the rights of users to emergency medical treatment. However they at least specify when the emergency situation ends – i.e. when a person is transferred out of the emergency care facility.

The Gauteng Ambulance Services Bill¹³⁷ defines “emergency medical care” as “the rescue, evaluation, treatment and care of an ill or injured person in an emergency care situation and the continuation of treatment and care during the transportation of such patients to or between medical facilities in order to prevent loss of life aggravation of illness or injury.” This definition envisages only rescue and evacuation type situations as opposed to treatment once the patient has reached an emergency care facility but then the Bill is primarily concerned with ambulance services as opposed to health services of a broader nature.

A finding of a contractual relationship between a patient and a provider in an emergency situation is likely to be fairly synthetic given the nature of the circumstances in which emergency medical treatment is usually required. The patient is sometimes not even conscious and even if he is, he is usually in no fit state to formulate an intention to contract. The constitutional right to life and the constitutional prohibition on the refusal of emergency medical treatment are consistent. The basis of the relationship is more likely to be in constitutional law than in the law of contract as far as emergency medical treatment is concerned. The fact

¹³⁶ Provincial Notice No. 65 of 2003 ‘Regulations Governing Emergency Medical Services In The Free State Province’, Provincial Gazette No 22 of 28 March 2003. The regulations define: “Emergency Medical Care Incident” as “an event threatening or causing acute injury and/or illness, which requires immediate preventative and/or remedial medical intervention” and “Emergency Medical Service” as “a private or state organization operating on a twenty-four hour basis, which is solely dedicated, staffed and equipped to offer:

- (i) pre-hospital medical treatment and the transport of the ill and/or injured;
- (ii) inter-hospital emergency medical treatment and transport of referred patients;
- (iii) where appropriate, the medical rescue of patients from a medical rescue situation detrimental to the health of an individual or community”

¹³⁷ Gauteng Ambulance Services Bill Notice No 2229 in Provincial Gazette No 124 of 08 May 2002

that payment may be required of a person who has received emergency medical treatment does not necessarily render the relationship contractual. South African law recognises a number of possibilities for the recovery of expenses or fees such as actions on the basis of unjust enrichment or *negotiorum gestio*¹³⁸ where a person has acted for the benefit of another at his own expense. The relationship of in the case of *negotiorum gestio* has been described as quasi-contractual¹³⁹.

It is submitted that the constitutional stipulation that no one may be refused emergency medical treatment is not confined to the public health sector. It applies to the private health sector as well. A private provider may charge for services with respect to emergency medical treatment but this does not detract from the fact that such treatment may not be refused. In such circumstances, the constitutional basis of any contract that may arise between the provider and the patient for such services is

138

In *Maritime Motors (Pty) Ltd v Von Steiger And Another* 2001 (2) SA 584 (SE) the concept of *negotiorum gestio* was explained by Janser J as follows: "It appears from the same work that the term *negotiorum gestor* was originally used to describe the person who acts on behalf of another and solely for the latter's benefit in circumstances of urgency, knowing that he had no such authority to act. There was and could be no question of any relationship arising between the parties by consent. It was further emphasised by the learned authors that the *negotiorum gestor* plays a constantly shrinking role in the world of ever-improving communications because it is quite clear that an unauthorised person should not interfere in another's affairs if it is possible to get in touch with that other. In *Standard Bank Financial Services v Taylam* 1979 (2) SA 383 (C) at 387 in fin - 388C Van Zijl JP set out the law in regard to *negotiorum gestorum* as follows: 'Our law in regard to *negotiorum gestorum* is based firmly, with but minor divergencies, upon the Roman law. In Roman law the payment of the debt of another without a mandate to do so gives rise to the *actio negotiorum gestorum contraria* and the *gestor* could recover the amount of such payment together with the interest thereon unless the debtor had some interest in the payment not being made. (See *Digest* 3.5.43 and 22.1.37.) This quasi-contractual relationship was brought about where the *gestor*, acting without a mandate, rendered a service to the *dominus* - in this instance the debtor - and in doing so acted reasonably and in the interest of the *dominus* with the intention not only of administering the affairs of the *dominus* but also of being compensated for such administration. This action fell away if the *gestor* did not intend to serve the *dominus*, i.e. the *gestor* mistakenly thought he was administering his own affairs or made payment of a debt *sui lucri causa*. There is a basic difference between the *gestores* in these two instances. In the first the *gestor* acted *bona fide*, but in the mistaken belief that he was serving the *dominus*. In the latter instance he acted *mala fide* in his own interest. These two classes of *gestor* can be described respectively as the *bona fide gestor* and the *mala fide gestor*. Neither of them could sue as *negotiorum gestor* as neither had the intention to serve the *dominus*. If, however, the *dominus* had been enriched at their expense they were each given the right to recover from the *dominus* on the grounds of unjust enrichment.' The distinction between *negotiorum gestio* and unjust enrichment was explored by the court in *Couws v Jester Pools (Pty) Ltd* 1968 (3) SA 563 (T) where it noted that "Rubin, *Unauthorised Administration in South Africa*, pp. 72 - 73, also emphasises the distinction between the true action based on *negotiorum gestio* and an action based on enrichment: 'There can be little doubt that in most cases a *negotiorum gestio* results in actual enrichment of the *dominus*. The destruction of the beneficial service rendered by the *gestor* before the *dominus* could enjoy it may safely be regarded as a rare occurrence. It is clear, also, that in some cases the same result would be achieved whether the person rendering the service claimed as a *gestor* or relied on the principle of unjust enrichment; furthermore, that in such cases, the latter course must be recommended because the intention of the plaintiff would be irrelevant, and to that extent the proceedings would be simplified. It must be borne in mind, however, that in the one case the claim is for all the useful and necessary expenses incurred; in the other, it is based upon an entirely different criterion, namely, the extent to which the *dominus* has been enriched. In the first case the question is whether they are expenses which the *dominus* would, himself, have incurred, whether the amount thereof represents his actual enrichment or not; in the second case all considerations other than the actual enrichment of the *dominus* fall away. It follows, therefore, that there are circumstances in which a plaintiff who, able to base his claim on *negotiorum gestio*, nevertheless chose to rely on the principle of unjust enrichment, would, thereby, deprive himself of the right to recover part of the amount which he had expended in the course of the *gestio*. In fact, such a plaintiff would be ill advised to base his claim on the principle of unjust enrichment, unless he had first satisfied himself that he would be entitled to recover no less on that basis than on the basis of *negotiorum gestio*.' See also *Absa Bank Ltd T/A Bankfin v Stander T/A Caw Paneelkloppers* 1998 (1) SA 939 (C) at p944 where van Zyl J observed: "Hence the basic prerequisite for an action arising from *negotiorum gestio*, namely the intention to manage the affairs of another (*animus negotia aliena gerendi*), was absent. I have dealt fully with this prerequisite in my study on *Negotiorum Gestio in South African Law* (1985) at 31-40, where the relevant authorities are set forth."

139

Standard Bank Financial Services Ltd v Taylam (Pty) Ltd 1979 (2) SA 383 (C)

very much apparent. It is submitted that the private provider does not have a choice as to whether or not to render emergency medical treatment. There may be objectively ascertainable circumstances in which such provider is unable to render the required services, for instance because of lack of capacity due to the demands of other patients in a similar situation, or because the technology required to perform certain procedures is unavailable etc but these are objective circumstances that exist irrespective of the inclination, or lack thereof, of the provider to render the emergency medical treatment. If the relationship between a provider of emergency medical services and a person requiring them is contractual, then, it is submitted, it is a contract mandated by the Constitution. The usual rules of freedom to contract do not apply in the sense of that the provider has the power to choose with whom to contract.

4.6 Damages

The damages payable for breach of contract, unlike those in respect of a delict, are usually calculated to place the plaintiff in the position in which he or she would have been but for the breach. A plaintiff who wishes to claim damages must prove –

- (a) Breach of contract committed by the other contractant;
- (b) Damage;
- (c) A factual causal connection between the breach and the damage;
- (d) That for the purposes of the law the damage is close enough to the breach in that it was reasonably foreseeable or agreed to by the contractants.¹⁴⁰

There are clearly many areas of commonality between the factors listed above and those required to succeed in a claim in delict.

Christie¹⁴¹ notes that any the investigation of damages for breach of contract must logically start with an inquiry into whether the damages were caused by breach. It so happens, he says, that this inquiry has engaged the courts more frequently in the law of delict than in the law of contract but in both types of case the inquiry is basically the same and Corbett CJ's restatement of the relevant principles in *International*

¹⁴⁰ Van der Merwe, Van Huyssteen, Reinecke, Lubbe Lotz fn 23 *supra* p296

¹⁴¹ Christie fn 2 *supra* at p629

*Shipping Co (Pty) Ltd v Bentley*¹⁴² is as authoritative in contract as in delict. Christie points out that these principles call for a two-stage inquiry first into factual causation and then into legal causation. To establish factual causation it must be shown that the breach was the *causa sine qua non* of the loss. This is the same test that is most often applied to establish factual causation in delict and is discussed in more detail in the chapter on the law of delict¹⁴³.

A contractant who claims damages must prove that he actually suffered damage or loss as a result of the breach of contract. South African courts are not prepared to award nominal damages where actual damage cannot be proven.¹⁴⁴ In the health care context, the harm suffered in respect breach of contract is in effect very similar to that in terms of the law of delict given the nature of the services that are rendered. There is often pain and suffering, loss of amenities of life, loss of expectation of life and disfigurement as well as patrimonial loss. The law of contract, however, only

¹⁴² *Bentley* 1990 (1) SA 680 (A) 700E-701A

¹⁴³ See also Kerr, fn 21 *supra* 648, who states that normally a number of factors, each of which is a *conditio sine qua non*, contribute to bringing about the loss. He quotes the dicta of Corbett CJ in *Bentley* (fn 131 *supra*) to which Christie also refers. At 700E of the judgment Corbett CJ stated: 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'. (See generally *Minister of Police v Skosana* 1977 (1) SA 31 (A) at 34E - 35A, 43E - 44B; *Standard Bank of South Africa Ltd v Coetsee* 1981 (1) SA 1131 (A) at 1138H - 1139C; *S v Daniels en 'n Ander* 1983 (3) SA 275 (A) at 331B - 332A; *J Siman & Co (Pty) Ltd v Barclays National Bank Ltd* 1984 (2) SA 888 (A) at 914F - 915H; *S v Mokgethi en Anders*, [1990 (1) SA 32 (A)] a recent and hitherto unreported judgment of this Court, at pp 18 - 24.) Fleming JG *The Law of Torts* 7th ed at 173 sums up this second enquiry as follows: 'The second problem involves the question whether, or to what extent, the defendant should have to answer for the consequences which his conduct has actually helped to produce. As a matter of practical politics, some limitation must be placed upon legal responsibility, because the consequences of an act theoretically stretch into infinity. There must be a reasonable connection between the harm threatened and the harm done. This inquiry, unlike the first, presents a much larger area of choice in which legal policy and accepted value judgments must be the final arbiter of what balance to strike between the claim to full reparation for the loss suffered by an innocent victim of another's culpable conduct and the excessive burden that would be imposed on human activity if a wrongdoer were held to answer for all the consequences of his default.' In *Mokgethi's* case *supra*, Van Heerden JA referred to the various criteria stated in judicial decisions and legal literature for the determination of legal causation, such as the absence of a *novus actus interveniens*, proximate cause, direct cause, foreseeability and sufficient causation ('adekwate veroorsaking'). He concluded, however, as follows: '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 beleidsorewegings 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 regs aanspreeklikheid, as 'n meer konkrete afgrensingsmaatstaf gebruik kan word nie.'

It must further be borne in mind that the delictual wrong of negligent misstatement is relatively novel in our law and that in the case which in effect brought it into the world, *Administrateur, Natal v Trust Bank van Afrika Bpk* 1979 (3) SA 824 (A), Rumpff CJ emphasised, with reference to the fear of the so-called 'limitless liability', that this new cause of action could be kept within reasonable bounds by giving proper attention to, *inter alia*, the problem of causation (see at 833B).

¹⁴⁴ 7 LAWSA 'Damages para 12 and Van der Merwe *et al* fn 21 *supra*



recognises patrimonial damages. In *Edouard v Administrator, Natal*¹⁴⁵ the court observed that it may be that the needs of modern society require that damages should be recoverable on contract for non-pecuniary loss for injured feelings, pain and suffering etc but that if there is a need to extend the rules of our law relating to the recoverability of non-pecuniary loss flowing from breach of contract, such need best be accommodated in the law of delict where the concepts of wrongfulness and fault (in the form of *culpa* and *dolus*) and the defences germane to delict can be used to define the limits of the relief. This reluctance of the courts to depart from the compartmentalisation of law at the expense of justice is unfortunate. The courts use the same considerations to limit liability for damages in contract as they do in the law of delict. To say then, that such forms of damages are best confined to delictual claims is illogical and irrational. Public policy considerations play as strong a role in the law of contract as they do in the law of delict when questions of the limitation of damages arise. The consequences 'wrong' that is done to the plaintiff upon breach of contract in the health care context is no different in effect to that same wrong when couched in delictual terms. The pain and suffering is the same, the loss of expectation of life etc are all the same irrespective of the nature of the cause – i.e. breach of contract or breach of a duty in delict. The failure of the courts to appreciate the difference between contracts for the supply of health care services and those for the supply of other services leads to decisions in this specific context that are difficult to justify on rational grounds and without the use of legal sophistries such as the need to define the limits of relief. Legal causation is used to avoid awards of damages based on causes that are too remote. Christie points out that damages for breach of certain types of contract, such as sales, leases and contracts of employment are frequently assessed according to principles that have been evolved to meet the special requirements of those contracts¹⁴⁶. It is a great pity that they show no inclination to do the same in respect of contracts for health services when there are so many policy reasons for doing so notably that health services are increasingly being regarded as a public rather than a private good, that they are the subject of constitutional rights and that the provider patient relationship is and should remain, fiduciary in nature despite the fact that health professionals in this country seem to have lost sight of this fact

¹⁴⁵ *Edouard* 1989 (2) SA 368 (D)

¹⁴⁶ *Christie* fn 2 *supra* at p 630

some time ago¹⁴⁷. It is submitted that these factors present powerful arguments for regarding contracts for health services differently to those for other goods and services.

The courts' refusal in South Africa to award non-pecuniary damages for breach of contract on the ground that such claims should be restricted to the law of delict starts to encounter logical difficulties when one enters the realm of damages for mental distress or psychological harm, as opposed to physical harm, for breach of contract unless one asserts, as did the court in *Clinton-Parker v Administrator, Transvaal Dawkins v Administrator, Transvaal*¹⁴⁸ that the mind and the body do not exist in two separate dimensions but that both exist in the physical dimension and that the nervous system is just as much a part of the body as any other physical structure. Even this argument does not help to justify the failure to recognise the possibility of damages for non-pecuniary loss in the law of contract – especially in the context of contracts for health care services. Pain and suffering, like psychological harm, are experienced through the nervous system – a physical structure. The loss of amenities of life is experienced through the physical organism. There is no other way to experience the realities of the physical world including loss, pain and suffering, except via the physical structures of the body. Mental or psychological stress is accompanied by well-recognised and documented physical reactions and strains on the body.

¹⁴⁷ The fierce resistance by dispensing doctors in South Africa to the legislative introduction of a system of licensing of dispensing doctors and other health professionals who wish to dispense medicine in a series of litigation against the government is a case in point. Judge President Ngoepe, in the Transvaal Provincial Division, recently accused the doctors of using their patients as a human shield against the state to assist their attempts to circumvent the legislation. At the time of writing, the litigation is still ongoing. The licensing system is designed to ensure that health professionals are properly qualified to dispense medicine in a manner that is not prejudicial to patients. The dispensing doctors have a conflict of interest in the dispensing of medicine that has been internationally recognised *inter alia* by the World Health Organisation since in no other 'market' environment is it possible for a vendor to instruct a customer to purchase an item with such persuasive force and from such a position of power relative to the customer. The chances of a patient refusing to purchase medicine prescribed for him or her by a doctor are very low.

¹⁴⁸ *Clinton-Parker* 1996 (2) SA 37 (W). In that case at p54 the court stated that: "The Appellate Division in Bester's case [*Bester v Commercial Union Versekeringsmaatskappy van SA Bpk* 1973 (1) SA 769 (A)] made it clear that general principles of delict apply to cases where nervous shock or psychiatric damage are the consequence of a negligent act. The crucial question to be asked, according to Bester's case, is whether the consequence was in all the circumstances of a specific case reasonably foreseeable. Jonathan Burchell in *Principles of Delict* at 59 points out that the Courts 'here and in other countries have been cautious about extending liability for negligently caused nervous shock'. The learned author deals with developments in South African law in this regard. He reminds us that in the early cases in South Africa liability for negligently inflicted nervous shock was restricted by two factors, viz the nervous shock had to result in physical injury and the plaintiff must have feared for his or her own safety. Burchell states: 'The first of these restrictions was based on the outdated distinction between mind and matter and based on the view that injury to the physical body was the subject of Aquilian liability and that damage to the individual's nervous system on its own was not sufficient for such liability. The second factor was a way of limiting the scope of potential liability to someone who in fact ran the risk of being physically injured. 'With reference to Bester's case, Burchell correctly concludes that the above approach has now been regarded as too restrictive. He points out that Bester's case held that the brain and the nervous system is just as much part of the physical body as an arm or a leg. The learned author states at 60: 'The Appellate Division in this case looked at certain limiting factors. The nervous shock in order to give rise to a claim for damages under the Aquilian action must be substantial and not of short duration and such shock must be reasonably foreseeable before the defendant can be held liable for causing such injury.'"



Therefore to state that damages for loss of a 'physical' kind are recognised while damages that are not of a 'physical' kind are not is to make a specious distinction. Why should a plaintiff suing for breach of contract have to prove that one kind of loss, (non-pecuniary) was caused through the fault of the defendant whilst there is no similar restriction with regard to pecuniary loss? In the context of a breach of contract for health care services why should different legal standards apply to different types of damages flowing from the same series of events? The argument that non-pecuniary damages are best decided in terms of the law of delict because this is more likely to limit claims in damages for non-pecuniary loss is not valid if the observations of Christie referred to earlier with regard to *International Shipping Co (Pty) Ltd v Bentley* are correct. It is submitted that the problem with contract law in certain contexts is that it is essentially commerce based and commercially driven. In light of such a backdrop it is easy to see why damages for non-pecuniary loss do not form part of this area of the law. The law of contract when seen in this light is about business transactions between two or more parties in a situation that involves trade or a bargain of some sort. It is about the creation of wealth for the parties or the improvement in some way of their worldly estates and is therefore concerned with issues of patrimony. The world has changed subtly and in many ways, however, since this view of the law of contract was first conceived¹⁴⁹. We have public utilities such as

149

In European contractual law, Article 9:501: Right to Damages provides that-

(1) The aggrieved party is entitled to damages for loss caused by the other party's non-performance which is not excused under Article 8:108.

(2) The loss for which damages are recoverable includes:

(a) non-pecuniary loss; and

(b) future loss which is reasonably likely to occur.

In terms of Article 9:502: General Measure of Damages -

The general measure of damages is such sum as will put the aggrieved party as nearly as possible into the position in which it would have been if the contract had been duly performed. Such damages cover the loss which the aggrieved party has suffered and the gain of which it has been deprived.

Whilst Article 9:503: Foreseeability provides that -

The non-performing party is liable only for loss which it foresaw or could reasonably have foreseen at the time of conclusion of the contract as a likely result of its non-performance, unless the non-performance was intentional or grossly negligent. <http://www.cisg.law.pace.edu/cisg/text/textef.html#a9501>. The increasing standardisation of commercial law due to globalisation is a trend which South African courts will not be able to ignore for much longer. In South Africa, in the health care context, health tourism is a growing industry and it is only a matter of time before a foreign national sues a South African health care institution for breach of a contract for health care services. Legal principles that are more prejudicial to the locals than their foreign counterparts are likely to be subjected to considerable criticism and review as globalisation continues. By way of example of the potential for an area of law to take on different contexts and purposes, in accordance with the changing needs of society one need look no further than the law of delict. It has been observed by Gallo P 'Punitive Damages in Italy?', that in ancient Roman Law the main function of tort law was punishment and deterrence. In the field of tortious liability Roman law was characterised by a plurality of remedies, such as *actio furti*, *rapina*, *injuria*, *damnum injuria datum* whose main function was punishment and deterrence rather than compensation. The wrongdoer was compelled to pay up to four times as much compensatory damages. The penalties were paid directly to the victim of the tort. Roman law also knew public penal action especially in the field of tortuous conduct against the state, the public order, the king's peace etc. Subsequently law started to develop and expanded its field of application to that of protection of the person, theft, robbery, injury to the person etc. In this way the main function of the penal law became punishment and deterrence while the main function of tort law became compensation. Gallo observes that in modern times civil lawyers usually say that the only function of tort law is compensation. Punishment and deterrence can only be achieved by means of penal law. Also in common law countries, he states, one can notice a similar evolution and a growing tendency to differentiate the main functions of tort law and

electricity supplies, public transport systems, telecommunication systems and postal systems that until recently were state run and owned and without which it was difficult if not impossible to conduct business, and water and sewerage systems

penal law. Having said this however it is important to note that in Anglo-American law, the function of punishment and deterrence has never been completely eliminated from the field of tort law. Gallo notes that in England, starting from the 13th century, statutes introduced private penalties and subsequently punitive damages were also contemplated by case law. More recently the House of Lords limited the applicability of exemplary damages to three situations:

- (1) Where the public administration deprives a citizen of his fundamental rights;
- (2) Whenever someone aims at obtaining enrichment as a consequence of his wrongful conduct;
- (3) When punitive damages are especially provided by statute.

He points out that punitive damages have greatly expanded their field of application in the United States and in the field of product liability. Gallo states that in Italy and more generally in Europe, there are no applications of private sanctions comparable to the American ones especially in the field of product liability but that starting from the eighties, Italian case law is showing a growing tendency to rediscover exemplary damages as a consequence of the expansion of tort law in the field of the protection of the person, his reputation, honour and privacy.

<http://www.ius.unifr.it/cardoza/Review/Torts/Gallo-1997/gallo.htm>

It is submitted that the significant point to note here is that rigid compartmentalisation of principles of common law into particular areas is not only artificial but can also lead to a situation in which a branch of the common law no longer meets the needs of the society it is supposed to serve and fails to fulfil its perceptions of justice. Such areas of law are likely to find themselves in danger of extinction (often by way of legislative intervention) when such a situation prevails. It is hardly insignificant that the South African Law Commission was called upon some time ago to consider the question of unconscionable contracts and that it lamented the unseemly demise of the *exceptio doli* from the common law in no uncertain terms.

In the Netherlands, the main source of the law of damages which governs personal injury cases is to be found in legislation, mainly the Dutch Civil Code. Articles 6:95-6:110 lay down specific provisions on damages. They provide rules in relation to the heads of loss and the method of assessment of the amount of damages to be awarded. Significantly the articles apply, in principle, whether the cause of action is in tort or for breach of contract. In accordance with articles 6:95 and 6:96, all pecuniary losses caused by a tort or breach of contract must be compensated, irrespective of whether such losses for instance arise from harm to the person, to goods or to other interests. The right to compensation for non-pecuniary damage is limited to certain categories. Article 6:95 states: "The damage which must be repaired pursuant to a legal obligation to make reparation consists of patrimonial damage and other harm, the latter to the extent that the law grants a right to reparation thereof". Dutch law provides a limited right to non-pecuniary damages in personal injury cases. Article 6:106 states: "(1) The victim has the right to an equitably determined reparation of harm other than patrimonial damage: (a) if the person liable had the intention to inflict such harm; (b) if the victim has suffered physical injury, injury to honour or reputation or if his person has been otherwise afflicted; (c) if the harm consists of injury to the memory of a deceased person inflicted upon the non-separated spouse, upon the registered partner or upon a blood relative up to the second degree, provided that the injury took place in a fashion which would have given the deceased, had he still been alive, the right to reparation of injury to honour or reputation. (2) The right to reparation in the preceding paragraph cannot be transferred or seized, unless agreed upon by contract or unless an action for such reparation has been instituted. For transfer by general title it is sufficient that the title-holder has notified the other party that he claims reparation." The phrase in paragraph 1(b) which refers to a person who has been otherwise afflicted ('of op andere wijze in zijn persoon is aangetast') is open to judicial interpretation, allowing for further development in this area. The amount of non-pecuniary damages is determined according to equity ('naar billijkheid'). Source: Lindenberg S D and Verburg R 'Personal Injury Compensation in the Netherlands'

<http://www.peopil.com/downloads/netherlands-web.doc>

In the United Kingdom Lord Bingham stated in *Watts v Morrow* [1991] 4 All ER 937 CA that: "A contract breaker is not in general liable for distress, frustration, anxiety, displeasure, vexation, tension or aggravation which his breach of contract may cause to the innocent party. This rule is not, I think, founded on the assumption that such reactions are not foreseeable, which they surely are or may be, but on considerations of policy. But the rule is not absolute..." Lord Bingham went on to note the exceptions to the 'mental distress' rule: "Where the very object of the contract is to provide pleasure, relaxation, peace of mind or freedom from molestation, damages will be awarded if the fruit of the contract is not provided or if the contrary result is procured instead." Palfreyman D notes that this exceptional category of cases is not the product of Victorian contract theory but the result of evolutionary developments in case law from the 1970s, and that in practice in real life in the lower courts non-pecuniary damages are regularly awarded on the basis that the defendant's breach of contract deprived the plaintiff of the very object of the contract, viz, pleasure, relaxation and peace of mind. <http://oxcheps.new.ox.ac.uk>

In *Farley v Skinner* [2001] 3 WLR 899 the House of Lords allowed an amount of £10 000 for non pecuniary damages for the diminished enjoyment of a property due to aircraft noise. The house that Mr Farley had bought was not far from a navigation beacon and the impact of aircraft noise on the property was marked. Mr Farley had specifically asked about aircraft noise and told the agent that he did not want a property on a flight path. He was a successful businessman who wanted to retire to the country. When he moved in to the property he discovered the noise problem but decided not to sell. He sued Mr Skinner for damages for non-pecuniary loss in the form of diminished enjoyment of the property. See also Lawlor Rochester of Glaholt and Associates 'Case Comment: Non-Pecuniary Damages for Breach of a Construction Contract [(1986) 13 C.L.R. 63]' and the Canadian cases of *Pilon v Peugeot Canada Ltd* (1980), 29 O.R. (2d) 711, 114 D.L.R. (3d) 378, 12 B.L.R. 227; *A.G. Ont. v Tiberius Productions Inc* (1984) 46 O.R. (2d) 152, 44 C.P.C. 14, 8 D.L.R.(4th) 479, 25 A.C.W.S. (2d) 163 (Ont. H. C.); *Vorvis v Ins. Corp of B.C.* (1984), 53 B.C.L.R. 63, 4 C.C.E.L. 237, 9 D.L.R.(4th) 43, 28 A.C.W.S. (2d) 111 (B.C. C. A.); *Fanstone v Fensom* (1979), 1 A.C.W.S. 59 (B.C.S.C.); *Edwards v Boulderwood Dev Co.* (1983), 1 C.L.R.73 (N.S.T.D.), reversed (1984), 64 N.S.R. (2d) 395, 9 C.L.R. 253, 30 C.C.L.T. 223, 34 R.P.R. 171, 143 A.P.R. 395, 21 A.C.W.S. (2d) 181 (N.S. C.A.) there discussed.

<http://www.glaholt.com/Articles/Non-Pecuniary.htm>



without which urban and suburban life would be intolerable.¹⁵⁰ At the risk of sounding repetitive, it must be acknowledged that access to health care services is now a constitutional right and therefore much more than just the subject matter of a commercial contract in the ordinary context of trade. The Constitution does not distinguish between the rights to bodily and psychological integrity. They are, if anything, interrelated and largely inseparable. A contract for health care services is by and large not concerned with the patrimony of the patient and any claim that a patient is patrimonially 'enriched' by health care services is likely to end up in tautologous and meaningless arguments to the effect that the extent to which he or she is enriched is measurable in terms the cost of those services. To put it another way, good health is not something to which a price tag can be readily attached. It is submitted that if public goods such as health services are to be dealt with in terms of the law of contract then the backdrop against which the law of contract has traditionally been considered and construed must take on a richer and more meaningful texture if it is to remain a credible and rational tool for the resolution of disputes in this area. Contracts can be useful vehicles for securing a wide variety of goods and services that have many different social values both for the individual consumer and for society as a collective. It is clear from the socio-economic rights reflected in the Bill of Rights that the interests of society in the access of individuals to some kinds of goods and services is much greater than in the case of others. It is to be hoped in future, at least with respect to contracts for health care services, that South African courts will use such considerations to justify a move away from the dicta in cases such as *Edouard v Administrator, Natal*¹⁵¹ in which the court observed with regard to *Jockie v Meyer*¹⁵² that this case was clear authority that, even where the loss flows from a breach of contract, damages are only recoverable for non-pecuniary loss suffered as a result of contumelia, if the pleadings allege and the evidence proves the essentials of the *actio*

¹⁵⁰ The Romans, it is true also had municipal water systems but it is doubtful that these were a central focus of their law of contract and in any event the legal system in South Africa is not Roman in origin but Roman-Dutch with a strong British flavour in some areas.

¹⁵¹ *Edouard* fn 145 *supra*

¹⁵² *Jockie* 1945 AD 354. See the discussion of this case in Christie (fn 2 *supra*) at p 633-634 where he notes that: "The non-patrimonial damages claimed in *Edouard* could have been refused without going so far as this, and the result is not a happy one as legislation is unlikely and would be difficult to draft. Our law will therefore remain incapable of awarding realistic damages against a party who is in breach of a contractual undertaking to provide convenience, comfort, entertainment or enjoyment unless the Supreme Court of Appeal can be persuaded to step out of the corner into which the Appellate Division painted itself." It is submitted that contracts for health care services are a case in point. Their objective is generally the alleviation of pain and suffering and loss of amenities. Where the actions or omissions of the provider effectively cause more of same it is difficult to see why damages for breach of contract should not be awarded. A rigid logic whose main aim seems to be to promote some notion of legal conceptual elegance and compartmentalisation of legal principles is cold comfort for the suffering patient.

injuriarum, i.e. the claim has to be laid in delict and more particularly under the *actio injuriarum* and that in South Africa law damages for injured feelings are not as a general rule recoverable in a claim on contract.

4.7 Statutory Considerations

The Consumer Affairs (Unfair Business Practices) Act¹⁵³ states that -

“‘unfair business practice’ means any business practice which, directly or indirectly, has or is likely to have the effect of-

- (a) harming the relations between businesses and consumers;
- (b) unreasonably prejudicing any consumer;
- (c) deceiving any consumer; or
- (e) unfairly affecting any consumer.”¹⁵⁴

It seems that the facts of the Afrox case fall squarely within the unfair business practice jurisdiction of the Consumer Affairs Act.

The Act provides for the establishment of a Consumer Affairs Committee whose functions are to-

- (a) from time to time make known information on current policy in relation to business practices in general and unfair business practices in particular, to serve as general guidelines for persons affected thereby;
- (b) receive and dispose of representations in relation to any matter with which it may deal in terms of the Act;
- (c) receive and dispose of particulars of the result of any investigation made by a competent authority in relation to any matter with which the committee may deal in terms of the Act;
- (d) may make such preliminary investigation as it may consider necessary into, or confer with any interested party in connection with, any unfair business practice which allegedly exists or may come into existence;

¹⁵³ Consumer Affairs Act No 71 of 1988

¹⁵⁴ In the Consumer Affairs Act, ‘business practice includes-

- (a) any agreement, accord, arrangement, understanding or undertaking, whether legally enforceable or not, between two or more persons;
- (b) any scheme, practice or method of trading, including any method of marketing or distribution;
- (c) any advertising, type of advertising or any other manner of soliciting business;
- (d) any act or omission on the part of any person, whether acting independently or in concert with any other person;
- (e) any situation arising out of the activities of any person or class or group of persons, but does not include a practice regulated by competition law;” The Act defines a consumer as follows-

“‘consumer’ means -

 - (a) any natural person to whom any commodity is offered, supplied or made available;
 - (b) any natural person from whom any investment is solicited or who supplies or makes available any investment;
 - (c) any other person who the Minister with the concurrence of the committee declares to be a consumer by notice in the Gazette;
 - (d) any person who is a consumer for the purposes of this Act in terms of any other law;”

- (e) perform any other function assigned to it by the Act.
- (f) if it chooses assign any preliminary investigation or investigation in terms of the Act to a competent authority.

Consumers are defined in the Free State legislation as natural persons to whom any commodity is offered, supplied or made available where that person does not intend to apply the commodity for the purposes of resale, lease, the provision of services or the manufacture of goods for gain, any natural person from whom is solicited or who supplies or makes available any investment and any other person whom the responsible Member of the Executive Council declares to be a consumer.

Consumer Affairs Courts exist in the various provinces¹⁵⁵. Their powers are extensive. Generally speaking, they have the power to hear, consider and make a decision on any matter before the court, award costs on a prescribed scale against any person found to have conducted the unfair business practice concerned and who is found to have acted fraudulently or grossly unreasonably. The Free State legislation makes provision for the appointment of a consumer protector to receive and investigate complaints of alleged harmful business practices. They can issue urgent temporary orders including attachment orders, prohibitory interdicts and authorising an investigating officer to take any action that may be necessary to prevent the unfair business practice in question. They can also make orders such as may be necessary to ensure the discontinuance or prevention of an unfair business practice and may direct the dissolution of any body or the severance of any connection or form of association between two or more persons or bodies. They can make orders relating to advertising, business schemes, practices or methods of trading, marketing and distribution and business interests. They can appoint curators *inter alia* to realize the assets of the person involved in an unfair business practice and distribute them among the consumers concerned.

¹⁵⁵

In terms of various provincial statutes. See the Consumer Affairs Act No. 14 of 1998 of the Free State; the Consumer Affairs (Unfair Business Practices) Act No. 8 of 1996 of Limpopo Province; Consumer Affairs (Harmful Business Practices) Amendment Act, 2003 (Act No. 2 of 2003) of Limpopo Province; Western Cape Consumer Affairs (Unfair Business Practices) Act, No 10 of 2002; Consumer Affairs Unfair Business Practice Act 5 of 1998 of the Eastern Cape; Consumer Affairs (Harmful Business Practices), Act 1996 (Act No. 4 of 1996) of the North West Province; the Gauteng Consumer Affairs (Unfair Business Practices) Act 7 of 1996; The Mpumalanga Consumer Affairs Act, 1998 (Act No. 6 of 1998); Northern Cape Consumer Affairs (Unfair Business Practices) Act, 1996 (Act No 7 of 1996)

It is of interest to note that in European Contract Law¹⁵⁶, Article 4:110 entitled 'Unfair Terms not Individually Negotiated' provides that -

- (1) A party may avoid a term which has not been individually negotiated if, contrary to the requirements of good faith and fair dealing, it causes a significant imbalance in the parties' rights and obligations arising under the contract to the detriment of that party, taking into account the nature of the performance to be rendered under the contract, all the other terms of the contract and the circumstances at the time the contract was concluded.
- (2) This Article does not apply to:
 - (a) a term which defines the main subject matter of the contract, provided the term is in plain and intelligible language; or to
 - (b) the adequacy in value of one party's obligations compared to the value of the obligations of the other party.

Perhaps one solution for patients wishing to claim in terms of the law of contract in respect of unsatisfactory contracts for health care services is to approach, not the ordinary courts which seem incapable of moving away from antiquated ideas about the 'market' for such services, but the Consumer Affairs Courts instead. They may be more likely to have an understanding of the need to protect consumers and of the nature and extent of the imbalances in bargaining power between consumers and suppliers that in reality pervade the health services sector.

4.8 Tacit Contracts

The courts appear to differ on the test to be used in order to determine the existence of an implied or tacit contract¹⁵⁷. The one test has been dubbed the "no other reasonable

¹⁵⁶ Principles Of European Contract Law Text of articles in English: Parts I and II (complete and revised version 1998)
<http://www.cisg.law.pace.edu/cisg/text/textef.html#9s5>

¹⁵⁷ The Appellate Division in *Joel Melamed and Hurwitz v Cleveland Estates (Pty) Ltd; Joel Melamed and Hurwitz v Vorner Investments (Pty) Ltd* 1984 (3) SA 155 (A) observed: "As to tacit contracts in general, in *Standard Bank of South Africa Ltd and Another v Ocean Commodities Inc and Others* 1983 (1) SA 276 (A) it was stated (at p 292B - C): "In order to establish a tacit contract it is necessary to show, by a preponderance of probabilities, unequivocal conduct which is capable of no other reasonable interpretation than that the parties intended to, and did in fact, contract on the terms alleged. It must be proved that there was in fact *consensus ad idem*. (See generally *Festus v Worcester Municipality* 1945 CPD 186 at p 192 - 3; *City of Cape Town v Abelsohn's Estate* 1947 (3) SA 315 (C) at p 327 - 8; *Parsons v Langemann and Others* 1948 (4) SA 258 (C) at p 263; *Bremer Meulens (Edms) Bpk v Floros and Another*, a decision of this Court

interpretation test” and the other the “preponderance of probabilities test”.¹⁵⁸ Christie points out that on the face of it these two tests are irreconcilable and the courts are in some difficulty choosing which to employ. He suggests that it is not necessary to abandon each test entirely as it is possible to synthesise them into a test which incorporates the best of both and states that the best approach to a synthesis seems to be to recognise that in deciding whether a tacit contract or tacit term has been proved the court is undertaking an inquiry that involves three stages instead of the usual two. Christie states that the first stage is to decide on the preponderance of probabilities, what facts have been established. The second stage is to decide, also on a preponderance of probabilities, what conclusion consistent with those facts is most likely to be correct. However, when deciding whether a tacit contract has been proved a third stage must be interposed. This, says Christie, is to decide how the proved facts, i.e. the conduct of each party and the surrounding circumstances, must have been interpreted by the other¹⁵⁹. He continues to state that his analysis is no more than an explanation of the words ‘unequivocal conduct’ that are included in most if not all formulations of the no other reasonable interpretation test. The one party’s conduct must be unequivocal in the sense that the other party could have no reasonable doubt of his intention to contract but in deciding whether agreement is the proper inference to draw from such conduct the court, suggests Christie may be satisfied on the preponderance of probabilities. He restates his proposed synthesis of the two tests as follows:

reported only in Prentice Hall, 1966 (1) A36; *Blaikie-Johnstone v Holliman* 1971 (4) SA 108 (D) at p 119B - E; *Big Dutchman (South Africa) (Pty) Ltd v Barclays National Bank Ltd* 1979 (3) SA 267 (W) at p 281E - F; *Muhlmann v Muhlmann* 1981 (4) SA 632 (W) at p 635B - D.)”

This is the traditional statement of the principle, as is borne out by the cases cited; and it was accepted as being correct by appellants’ counsel. The correctness of this general formulation has nevertheless been questioned on the ground that it would appear to indicate a higher standard of proof than that of preponderance of probability as regards the drawing of inferences from proven facts (see Christie *The Law of Contract in South Africa* at p 58 - 61; cf also *Flat SA v Kolbe Motors* 1975 (2) SA 129 (O) at p 140; *Plum v Mazista Ltd* 1981 (3) SA 152 (A) at p 163 - 4; *Spes Bona Bank Ltd v Portals Water Treatment South Africa (Pty) Ltd* 1983 (1) SA 978 (A) at p 981A - D). In this connection it is stated that a court may hold that a tacit contract has been established where, by a process of inference, it concludes that the most plausible probable conclusion from all the relevant proved facts and circumstances is that a contract came into existence (see Plum’s case *supra* at p 163 - 4). It may be that in the light of this the principle as quoted above from *Standard Bank of SA Ltd v Ocean Commodities Inc (supra)* requires reformulation. In this regard, however, there is this point to be borne in mind. While it is perfectly true that in finding facts or making inferences of fact in a civil case the court may, by balancing probabilities, select a conclusion which seems to be the more natural or plausible one from several conceivable ones, even though that conclusion is not the only reasonable one, nevertheless it may be argued that the inference as to the conclusion of a tacit contract is partly, at any rate, a matter of law, involving questions of legal policy. It appears to be generally accepted that a term may not be tacitly imported into a contract unless the implication is a necessary one in the business sense to give efficacy to the contract (see *Van den Berg v Tenner* 1975 (2) SA 268 (A) at p 276H - 277B and the cases there cited). By analogy it could be said that a tacit contract should not be inferred unless there was proved unequivocal conduct capable of no other reasonable interpretation than that the parties intended to, and did in fact, contract on the terms alleged.

¹⁵⁸

Christie fn 2 p 93.

¹⁵⁹

Christie fn 2 *supra* p 94-95

“In order to establish a tacit contract it is necessary to prove, by the preponderance of probabilities, conduct and circumstances which are so unequivocal that the parties must have been satisfied beyond reasonable doubt that they were in agreement. If the court is satisfied on the preponderance of probabilities that the parties reached agreement in that manner it may find the tacit contract established.”¹⁶⁰

Christie’s proposed synthesis of the two tests has not met with universal approval.¹⁶¹

In *Edouard*¹⁶² the plaintiffs did not need to prove a tacit contract because the court *a quo* took the written consent form as being part of the contract. Furthermore the parties had in any event agreed in advance on the facts, including the existence of the contract between them, and the matters upon which the court should decide. The existence of a tacit contract between them was thus not one of them.

In the context of health care services many contracts are not in express terms either written or verbal. The patient presents at a health facility and is treated. In the case of a public-provider the patient undergoes a means test in order to establish into which financial category he or she falls and to determine what if any fee is payable as determined by the provincial government by way of fee regulations. The documentation may at most consist of a consent form but in some cases this is not even available as consent can be obtained verbally from the patient. If a contractual relationship is to be found to exist between the public provider and the patient it will often have to be inferred from the circumstances. It is therefore of importance to ascertain under what circumstances the courts are likely to infer a contract between the parties. In *Joel Melamed and Hurwitz v Cleveland Estates (Pty) Ltd; Joel Melamed and Hurwitz v Vornier Investments (Pty) Ltd*¹⁶³ Corbett JA noted that in the cases concerning tacit contracts which had previously come before the courts, there had always been at least two persons involved. He said that in order to decide whether

¹⁶⁰ Christie fn 2 *supra* p 96. The test proposed by Christie was apparently cited with approval in *Landmark Real Estate (Pty) Ltd v Brand* 1992 (3) SA 983 (W)

¹⁶¹ See *Muller v Pam Snyman Eiendomskonsultante (Pty) Ltd* 2001 (1) SA 313 (C) in which the court discussed the two tests and stated a preference for the ‘no other reasonable interpretation test’. Comrie J said: “It seems to me, with respect, that proof of the primary facts on a balance of probabilities is required by either test, and that the main difference between them lies in the strength of the inferences to be drawn from the facts so proven. As Corbett JA observed, that would at least in part be influenced by considerations of legal policy. My own preference, writing as a single Judge of first instance, is for the so-called traditional test, the only reasonable interpretation test, provided that the test is applied in a common sense and businesslike way. I respectfully disagree with the ‘synthesis’ solution proposed by Christie (loc cit). I fear that to borrow notions from the criminal law will tend to obfuscate rather than clarify the position. The idea of a compelling inference appeals to me: a compelling inference derived from proof on a balance of probabilities of unequivocal conduct usually in a business setting. Perhaps it is the word ‘plausible’ which disturbs me.”

¹⁶² *Edouard* fn 1 *supra*

¹⁶³ *Joel Melamed* see fn 157 *supra*

a tacit contract arose the courts have had regard to the conduct of both parties and the circumstances of the case generally and that the general approach was an objective one. He observed that the subjective views of one or other of the persons involved as to the effect of his actions would not normally be relevant. Corbett JA said that where there is only one person involved a tacit contract may be inferred from conduct and the general circumstances, but in such a case the court should carefully scrutinize the evidence in order to distinguish between statements of fact capable of objective assessment and subjective views as to the matter in issue.

4.9 Implied Terms

The doctrine of legitimate expectation is one that is traditionally regarded as applicable to public entities rather than private persons. Pretorius¹⁶⁴ notes that the twin pillars that buttress natural justice are statute and contract and that the statutory pillar of natural justice has been renovated and fortified as a result of the introduction of the legitimate expectation. He then asks whether this doctrine also reinforces the contractual pillar of natural justice in other words whether the doctrine of legitimate expectation finds application outside of the field of administrative law. This question will be explored in more detail in the section on the private sector later in this chapter with regard to private provider-patient relationships but it is also relevant to an exploration of the public provider –patient relationship and will be discussed here from this latter perspective.

It may seem strange at first to start a discussion of implied terms in contracts with an consideration of the administrative law doctrine of legitimate expectation but, as will be seen from what follows, and in support of the central theme of this thesis, the various branches of law are simply facets of a larger, internally consistent, whole. The relationship between administrative law and the law of contract in the context of health services delivery is an important one both from an underlying public policy perspective and because at least one of the parties to the contractual relationship presently under consideration cannot escape the dictates of administrative justice as enshrined in the Constitution. The question to be answered with regard to public provider-patient contracts must always be whether such contracts must be seen purely

¹⁶⁴ Pretorius D M "Letting the Unruly Horse Gallop In the Field of private Law: The Doctrine of Legitimate Expectation in 'Purely Contractual' Relations" 2001 *SALJ* 118 p 473

in the light of the law of contract or whether they must always be regarded against a backdrop of relevant administrative law principles? In other words can the approach to the public provider-patient relationship ever be based on just one legal 'layer' or will it always be multi-layered? This question is of considerable significance for courts of law in considering questions of claims for damages but it is equally relevant for legal practitioners drawing up the particulars of claim. Traditionally the plaintiff chooses the battleground¹⁶⁵, casting it as widely as possible so as to include all of the potential and legally viable bases for relief. Thus in the context of claims relating to health care services there is often the question of whether one proceeds on the basis of the law of contract or delict or whether one can use both. Very often the lines between them are not as distinct as they at first glance appear¹⁶⁶. In fact one of the more controversial decisions¹⁶⁷ of the Appellate Division in the field of the law of delict was apparently based upon a desire to preserve the increasing blurring of distinctions between the law of contract and the law of delict¹⁶⁸. Where the provider operates

¹⁶⁵ See for instance *Martin v Martin* 1997 (1) SA 491 (N) in which the court held: "And, in any event, if the respondent had a choice of remedies she was perfectly entitled to choose the one which she considered the more efficacious, regardless of any supposed advantages which the other may have had for the appellant."

¹⁶⁶ See *Friedman v Glicksman* 1996 (1) SA 1134 (W) and *Mukheiber v Raath And Another* 1999 (3) SA 1065 (SCA) in which the court observed: "In *Edouard Van Heerden JA* (at 590F), 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. I consider 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. 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 (see the remarks in *Lillicrap, Wassenaar and Partners v Pilkington Brothers* (supra at 499A-1)). The duty of care in either case seems inevitably to be measurable by the same yardstick and I am of the view that the same policy considerations that underlie the *Edouard* judgment are applicable in the appeal now under consideration. These considerations do not stand in the way of allowing the Raath's action." See also for examples of alternative causes of action *Pinshaw v Nexus Securities (Pty) Ltd And Another* 2002 (2) SA 510 (C); *Rens v Colman* 1996 (1) SA 452 (A); *Esterhuizen v Administrator, Transvaal* 1957 (3) SA 710 (T); *Van Der Walt Business Brokers (Pty) Ltd v Budget Kilometers CC And Another* 1999 (3) SA 1149 (W) A.

¹⁶⁷ *Boberg PQR The Law of Delict Vol I: Aquilian Liability* in his discussion of *Lillicrap* lists the many criticisms of the judgment in a footnote.

¹⁶⁸ In *Lillicrap, Wassenaar And Partners v Pilkington Brothers (Sa) (Pty) Ltd* 1985 (1) SA 475 (A) the court noted: "There is clear authority that in certain situations negligence in performing a contractual obligation may give rise to liability in both contract and delict. The case of the negligent surgeon is the clearest example. *Van Wyk v Lewis* 1924 AD 443 - 444. But this was a case of physical injury and of a duty which, while co-existent with the contractual duty, was not dependent on the existence of the contract. There is no general rule in our law (as there may be in England - see *Esso Petroleum Co Ltd v Mardon* [1976] 1 QB at 820) that a professional man's breach of his contractual duty, causing economic loss, is per se a delict. On the contrary, the weight of South African authority is against that approach. In the first place, there is the strong dictum in *Hamman v Moolman* 1968 (4) SA at 348E - G which indicates that it is unnecessary and undesirable to extend delictual liability for negligent statements where well-established contractual remedies exist. Cf the *Administrateur, Natal* case supra at 834F. The Cape Provincial Division has not followed this dictum: *Kern Trust (Edms) Bpk v Hurter* 1981 (3) SA at 607. But it has, correctly, been adopted in the Transvaal. *Latham v Sher* 1974 (4) SA at 695H - 696A; *Du Plessis v Semmelink* 1976 (2) SA at 503A - F. More particularly, where a professional man is negligent in carrying out his contractual duty (absent physical damage), there is much authority that only an action in contract lies. This was for many years accepted law in England. *Steljes v Ingram* [1903] 19 TLR 534 (architect); *Groom v Crocker* [1939] 1 KB 194 (solicitor). This view of the law survived the decision in *Hedley Byrne & Co Ltd v Heller & Partners Ltd* 1964 AC 465. See *Bagot v Stevens Scanlan & Co* [1966] 1 QB 197 (architect); *Clark v Kirby-Smith* 1964 Ch 506 (solicitor); *Cook v Swinfen* [1967] 1 WLR 457 (solicitor). However, tortious liability for negligent statements in England has now been extended holus-bolus into the field of contract. *Esso Petroleum Co Ltd v Mardon* [1976] 1 QB 801; *Midland Bank Trust Co v Hett, Stubbs & Kemp* 1979 Ch 384. Natal has followed suit - *Rampal (Pty) Ltd and Another v Brett, Wills & Partners* 1981 (4) SA at 365E - 366E. In the Transvaal, however, there is Full Bench authority that the action lies only in contract. *Bruce NO v Berman* 1963 (3) SA at 23F - H. See also *Honey & Blanckenberg v Law* 1966 (2) SA at 46; *Mouton v Die Mynwerkersunie* 1977 (1) SA at 142H. (In *Tonkwane Sawmill Co*

within the public sector, does this range of options become extended to include administrative and constitutional law? It is the nature of the parties that complicates matters when dealing with a private law relationship between two parties where at least one of them is an organ of state¹⁶⁹. Put another way, the question with regard to

Ltd v Filmalter 1975 (2) SA at 453 and in *Broderick Properties (Pty) Ltd v Rood* 1964 (2) SA at 310 this point was not raised.) For the reasons which follow, there is no reason of need, convenience or policy to extend the liability of a professional into the delictual field, and policy and convenience in fact point the other way. See also Van der Walt (op cit at 8 para 5); McKerron (1973) 90 SALJ at p 1. The recognition of a duty of care (during the period of their contractual relationship) in the terms alleged by the respondent would impose upon the appellant no substantive obligation which it did not owe to the respondent under the contract between them. The two sets of obligations, as has been seen, would be co-extensive. This would constitute an invasion by the law of delict of an area which is already fully and satisfactorily occupied by other legal rules. There is no ground of legal policy which calls for or justifies such an invasion. *Herschel v Mrupe* (supra at p 478C). *Hamman v Moolman* 1968 (4) SA at 348E. If liability in delict were allowed in principle in such a situation, the distinction between contract and delict would be unnecessarily undermined where the delictual duty of care arises exclusively by virtue of the contractual relationship between the parties (as was the position here) and is precisely co-extensive with the contractual duty. Further, for the reasons given below, the type of damages sought by the respondent are appropriate only to a contractual claim and are alien to our principles of delictual liability. It is wrong in principle to allow a contracting party, whose rights and obligations have been determined by his agreement and that of the other contracting party, to circumvent the consensual definition of the parties' rights and obligations by proceeding in delict. This is particularly so in the present case where the appellant's contractual duties have been set out in detail in the agreement. In such a situation it is implicit that the parties intended the contractual definition of their rights and obligations to be exclusive of any other liabilities. See W J Hosten 'Concursus Actionum of Keuse van Aksies' 1960 THRHR at 267 - 269. *Bagot v Stevens, Scanlan & Co* [1966] 1 QB 197. Justice and practical convenience do not call for the additional remedy. In some cases it is resorted to because of more favourable prescription provisions. But this is not in law or policy a good ground for granting a remedy in delict where a contractual remedy was previously available. The ruling that the various contractual considerations and in particular the question of a frustration of the contract by allowing a claim in delict are matters for pleading, not exception, is incorrect: they are matters of policy and therefore relevant to the existence of the duty of care. Other authorities which caution against an undue extension of delictual liability grounded on negligence into an area covered by contract are *Alliance Building Society v Deretich* 1941 TPD at 206; *Atkinson Oates Motors Ltd v Trust Bank of Africa Ltd* 1977 (3) SA at 198. See also the Canadian cases of *J Nunes Diamonds Ltd v Dominion Electric Protection Co* (1972) 26 DLR (3d) (Canadian Sup Ct) at 727 - 8. (Cf 723); *Sealand of the Pacific v Robert McHaffie Ltd* 1974) 51 DLR (3d) 792 (British Columbia CA). The Judge *a quo* incorrectly held that the minority judgment of SPENCE J in the *J Nunes Diamonds* case accords with the overwhelming weight of authority in our law: it is rather the majority judgment of Pigeon J which accords with the weight of South African authority and in particular the approach to the question of extending delictual liability in the cases cited above. For the same reason the minority judgment of Wilson JA in *Dominion Chain Co Ltd v Eastern Construction Co Ltd* (1976) 68 DLR (3d) at 394 and 395 is preferable to that of the majority."

169

Viljoen JA observed in *East London Western Districts Farmers' Association And Others v Minister Of Education And Development Aid And Others* 1989 (2) SA 63 (A): "The state may, of course, in appropriate circumstances, also be a party to a private law dispute pertaining to contract or delict, or one governed by s 1 of Act 20 of 1957, but in my view the present is not such a case. It is purely a matter of administrative law. In this respect Wiechers *Administrative Law* (2nd ed) deals at 306 H (see at 345 - 6 of the Afrikaans second edition of *Administratiefreg*) with the relationship between State and private liability as follows: 'Many of the problems arising in the determination of the ambit of state liability for administrative acts may be ascribed to the fact that private law is regarded as the basis for such liability. If, on the other hand, it is accepted that the relationship of State liability is an administrative law relationship which is governed by the rules of administrative law, the application of private law within this relationship acquires due significance. According to this approach the relationship of State liability is an unequal relationship insofar as the state is able to regulate its own liability, primarily in accordance with private law, but sometimes in a manner peculiar to administrative law. Because the relationship within which the aggrieved individual and the administrative organ find themselves is in many aspects analogous to the private law relationship of obligation, it is understandable that the rules of private law are particularly suited to the governing of this relationship. However, the application of private law should not obscure the fact that the relationship of state liability is one of inequality.' He proceeds to enumerate the differences between the relationship of state and private liability, among which the following two are, in my view, apposite: '1. In the private law relationship of obligation private law interests and powers are weighed up against one another while in the state liability relationship powers of Government and the general interest on the one hand, and the general interest and private interests and rights on the other, are weighed up against one another. The determination of the nature and scope of Government, or more specifically, administrative powers, is primarily a question of administrative law...3. In the state's relationship of liability the state may unilaterally determine the content and ambit of its own liability, but in the private law relationship one party cannot determine its own powers and duties without the other's consent, whether express or tacit.' Our law seems to be well settled insofar as statutory authority conferred on lower-tiered public bodies is concerned. This is so both as regards the onus to be discharged as well as the substantive law. The principles applicable are set out, *inter alia*, in the case of *Johannesburg Municipality v African Realty Trust Ltd* 1927 AD 163, the headnote of which reads: 'Where the exercise of statutory powers is alleged to have resulted in an injury to another the enquiry in each instance is whether an interference with private rights is justified. If it is not there is an end to the matter. If it is then the exercise of the statutory power is limited by another consideration, namely that it must be carried out without negligence - *Geddes v Ban Reservoir* 3 AC 430; *Tobiansky's case* (1907 TS 134); *New Heriot Mining Co v Union Government* 1916 AD 421 applied. If the nature of the work authorised is such that it may or may not interfere with private rights according to circumstances then the person entrusted with statutory authority is entitled to show that under the circumstances of the case it is impossible to carry out the work without such interference in which case an

public provider-patient relationships in the contractual setting is whether the state can ever escape its nature and, like the prince in the fairy-tale, assume the role of a pauper so as to be able to contract on an equal footing with the patient. If the answer to this question is in the negative¹⁷⁰, then the further question arises as to the applicability of the doctrine of legitimate expectation to the contractual relationship between the public provider and the patient. As indeed the question also arises as to whether there would be certain terms implied by law within this contractual relationship that are grounded in administrative law. The question of the applicability of the doctrine of legitimate expectation in a contractual context is not on quite the same footing as other terms implied in the contract on the basis of administrative law because a legitimate expectation, in the context of administrative law stands outside of the concept of a right conferred by law. In administrative law, a legitimate expectation is an interest as opposed to a right¹⁷¹. The objection to the importation of a legitimate expectation into a contract as an implied or tacit term is that it would confer upon it

inference that an infringement of private rights was sanctioned would be justified. For otherwise the grant of statutory authority would be nugatory. As to what amounts to negligence in such circumstances, if by a reasonable exercise of the powers given by statute or common law the damage could be prevented, it is negligence not to make such reasonable exercise of such powers.' At 172 Innes CJ distinguishes between directory and permissive powers conferred upon a local authority as follows: 'Where express provision is made on the point there is no difficulty: and even where the contemplation of the Legislature is not expressed it may be very clearly implied. If, for instance, the statutory powers are directory, then their exercise in the manner authorised cannot create liability at the suit of an injured party. For the doing of what the Legislature has ordered in the way which it has indicated cannot found an action at the instance of a person prejudiced thereby. The implication is clear that the lawgiver intended to legalise an infringement of his rights. (*Metropolitan Asylum Dist v Hill* 6 AC at 203.) Cases where the statutory powers are permissive and not directory present greater difficulty. But the test is the same - can an intention to interfere with the common law rights of others be implied? Certain general considerations may be useful, but are not necessarily decisive.'"

170

This question of the distinction between private law and public law relationships, which is in essence what is under discussion here, ties in to an even more complex and yet relevant constitutional debate concerning the vertical as opposed to horizontal application of the rights in the Bill of Rights in the Constitution. There are four basic permutations that are relevant within this chapter dealing with the relationships between provider and patient. They are as follows: public entity vs private entity under public law; public entity vs private entity under private law; private entity vs private entity under public law and private entity vs private entity under private law. The validity of the distinctions between public and private law lie at the heart of the debate. In *Du Plessis And Others v De Klark And Another* 1996 (3) SA 850 (CC) Krieger J observed as follows in this regard: "My reading of chapter 3 gives to the Constitution a simple integrity. It says what it means and means what it says. There is no room for the subtleties and nice distinction so dear to the hearts of medieval theologians and modern constitutional lawyers. The Constitution promises an 'open and democratic society based on freedom and equality', a radical break with the 'untold suffering and injustice' of the past. It then lists and judicially safeguards the fundamental rights and freedoms necessary to render those benefits attainable by all. No one familiar with the stark reality of South Africa and the power relationships in its society can believe that protection of the individual only against the State can possibly bring those benefits. The fine line drawn by the Canadian Supreme Court in the *Dolphin Delivery* case and by the US Supreme Court in *Shelley v Kraemer* between private relationships involving organs of State and those which do not have no place in our constitutional jurisprudence. Nor are we consigned to the hypocrisy so trenchantly excoriated by the authors of the two Canadian articles quoted in *Baloro and Others v University of Bophuthatswana and Others*. What is more, my reading of the Constitution avoids jurisprudential and practical conundrums inherent in the vertical-but-indirectly-horizontally-irradiating interpretation. One does not need to ascertain whether a question is one of public or private law (wherever the boundary may lie in our legal system); one is not confronted with knotty problems where a private relationship is, wholly or partially, governed by statute; nor where an organ of State is a party to a manifestly private law dispute, for example flowing from contract or delict. There are no anomalies where one sues a policeman and his Minister in delict or when an organ of State and a private person are co-plaintiffs or co-defendants. Nor is it of any consequence that a rule of the common law derives from an ancient statute of a former government or from the writings of a legal sage of old. The law is the law; where the chapter fits, it is applied; where it does not, its spirit, purport and objects are duly regarded."(footnotes omitted).

171

The PAJA distinguishes between a right and a legitimate expectation by using them in the alternative in section 3(1) "Administrative action which materially and adversely affects the rights or legitimate expectations of any person must be procedurally fair." Devenish GE, Govender K and Hulme D *Administrative Law and Justice in South Africa* note at p311 "Obviously where existing rights are affected there is no need to rely on the doctrine" [of legitimate expectation]. However a degree of overlapping may occur."



the status of a right as opposed to an interest. The question is whether in the context of the law of contract, this objection is a valid one. The answer hinges upon the peculiar nature of a legitimate expectation. In terms of the law of contract a tacit term can be implied from the facts, from trade usage or by law. Legitimate expectation according to Devenish *et al* may arise either from an express promise given on behalf of a public authority or from the existence of a regular practice which the claimant can reasonably expect to continue¹⁷². It is submitted that there are significant similarities between tacit terms in the law of contract and legitimate expectations in administrative law. Like a tacit term in contract law, a legitimate expectation, in its preliminary form, generally sits outside of the formally recognised boundaries of the relationship between the parties. In the case of contract it sits outside of the written document in which the parties have described their agreement. In the case of administrative law it sits outside of the statutorily defined relationship of a public entity to ordinary citizens. Like a tacit term, a legitimate expectation may arise from the facts or from 'trade usage' in the sense of a longstanding practice of a public authority, or by law. In the case of the last mentioned, the existence of a right, could give rise to a legitimate expectation that a power to take a decision affecting the ability to freely exercise that right would require that those affected are given an opportunity to be heard¹⁷³. Devenish *et al*¹⁷⁴ note that the application of the doctrine of legitimate expectation usually but not necessarily requires a promise or the existence of a regular practice and that in at least one case the court refused to extend the doctrine by finding a legitimate expectation in their absence.¹⁷⁵ Although they cite two cases in which the courts have been prepared to recognise a legitimate expectation in the absence of a promise or practice they state that it is problematic whether mere considerations of fairness in the absence of a promise or the existence of a regular practice should give rise to application of the doctrine of legitimate expectation. The moral of the story is that there must be an objective, rational basis and legal for a

172 Devenish *et al* fn 171 *supra* at p308-309

173 Thus in *Public Servants Association of SA v Minister of Justice* 1997(3) SA 925 (T) the court found that the applicants not only had a right to be considered for the posts concerned but they had a legitimate expectation to be appointed to such posts. They therefore had a right to be heard in relation to the formulation of the affirmative action policy. In this case the applicants were all white male state attorneys who contended that they had not even been interviewed for positions for which they were well qualified, on the grounds of their race and gender. The Department of Justice had introduced an affirmative action policy to the effect that no white males would be considered eligible for certain posts.

174 Devenish *et al* fn 171 *supra* at p315

175 *Ngema v Minister of Justice, KwaZulu* 1992(4) SA 349 (N)

legitimate expectation¹⁷⁶. One cannot have a legitimate expectation contrary to a law, or, it is submitted, public policy¹⁷⁷, which stipulates differently¹⁷⁸. The same is true of tacit or implied terms in a contract. In order to decide whether a tacit term is to be imported into a contract one must first examine the express terms of the contract.¹⁷⁹ The express terms, as Christie points out, may deliberately exclude the possibility of importing tacit terms of a particular type. The same is true for a legitimate expectation. It may be excluded by the terms of a statute or subordinate legislation. No tacit term may be imported in contradiction of an express term.¹⁸⁰ A legitimate expectation may not be entertained in the face of contrary statutory provisions. The express terms may also exclude the possibility of importing tacit terms even when the express terms do not expressly cover the question but give rise to the inference that the parties do not wish to include the term in question. It is submitted that the same is true with regard to statutory interpretation and the doctrine of legitimate expectation.

¹⁷⁶ The court said in *Administrator, Transvaal, and Others v Traub and Others* 1989 (4) SA 731 (A): "It is clear from these cases that in this context legitimate expectations' are capable of including expectations which go beyond enforceable legal rights, provided they have some reasonable basis."

¹⁷⁷ The doctrine of legitimate expectation is recognised on the grounds of public policy. It would not therefore make sense to permit a legitimate expectation to fly in the face of the basis for its acceptance into law. The court in *Traub* (fn 164 *supra*) noted that: "A useful and comprehensive overview and analysis of the relevant decisions is to be found in an article by Prof Robert E Riggs, published in (1988) 36 *American Journal of Comparative Law* at 395ff. In an epitomical first paragraph to his article Prof Riggs states: "Since the landmark decision of *Ridge v Baldwin*, handed down by the House of Lords in 1963, English Courts have been in the process of imposing upon administrative decision-makers a general duty to act fairly. One result of this process is a body of case law holding that private interests of a status less than legal rights may be accorded procedural protections against administrative abuse and unfairness. As these cases teach, a person whose claim falls short of legal right may nevertheless be entitled to some kind of hearing if the interest at stake rises to the level of a "legitimate expectation". The emerging doctrine of legitimate expectation is but one aspect of the "duty to act fairly", but its origin and development reflect many of the concerns and difficulties accompanying the broader judicial effort to promote administrative fairness. As such, it provides a useful window through which to view judicial attempts to mediate between individual interests and collective demands in the modern administrative state." Devenish *et al* (fn 159 *supra*) state at p 318 that "Legitimate expectation is intrinsically merely a manifestation of the seminal principle of fairness which is so fundamental to the manner in which the courts must interpret and apply the norms and principles of contemporary administrative law". This appears to be a fair summing up of the situation."

¹⁷⁸ In *University Of The Western Cape and Others v Member of Executive Committee for Health and Social Services and Others* 1998 (3) SA 124 (C) the court held: "Without dwelling much on the doctrine of legitimate expectation, it should be pointed out that no one can have a legitimate expectation of doing something contrary to the law, or of preventing a functionary from discharging his statutory duty. See *Attorney-General of Hong Kong v Ng Yuen Shiu*, above at 351. See also *R v Ministry of Agriculture, Fisheries and Food, ex parte Hamble (Offshore) Fisheries Ltd* [1995] 2 All ER 714 (QB) at 723-4; *Union of Teachers' Associations of South Africa and Another v Minister of Education and Culture, House of Representatives, and Another*, *Isaacs and Others v Minister of Education and Culture, House of Representatives, and Another* 1993 (2) SA 828 (C) at 841H-I. In my view it is in the interests of good administration that a public body should act fairly and should implement whatever promise it may have made so long as the implementation thereof does not interfere with its statutory duty. In *casu* the first respondent is under a statutory duty in terms of s 11 of the Act to make appointments to the public service. Therefore any promise or undertaking which conflicts with its statutory duty to make appointments cannot be enforced by the courts. The contrary is clearly untenable. It would lead to an absurd situation whereby public bodies could simply ignore their statutory duties by making promises which conflict with them. Surely it would be unfair to enforce promises which fly in the face of statutory duties. Thus whatever the source of a 'legitimate expectation' might have been in *casu*, I am satisfied that it was not legitimate because the applicants knew that the first respondent was under a statutory duty to make appointments to posts which had to be advertised.

¹⁷⁹ See Christie fn 2 *supra* p 191. He refers to the words of Rumpff JA in *Pan American World Airways Inc v SA Fire and Accident Insurance Co Ltd* 1965 3 SA 150 (A) 175C: "When dealing with the problem of an implied term the first enquiry is, of course, whether, regard being had to the express terms of the agreement, there is any room for importing the alleged implied term."

¹⁸⁰ Authorities cited by Christie (fn 2 *supra*) in this regard at p 191 are *FJ Hawkes & Co Ltd v Nagel* 1957 (3) SA 126(W) 132 C; *Springvale Ltd v Edwards* 1969 1 SA 464 (RA) 472C; *Neuhoff v York Timbers Ltd* 1981(4) SA 666 (T) 679; *Robin v Guarantes Life Assurance Co Ltd* 1984(4) SA 558 (A) 567A-F

An implied term that is not derived from trade usage or law is derived not only from the common intention of the parties but also their imputed intention¹⁸¹. In the law of contract, terms can be implied by trade usage just as a legitimate expectation can arise from a regular practice on the part of an administrator.¹⁸² With regard to terms imposed by law Corbett AJA pointed out in *Alfred McAlpine*¹⁸³ that such terms are imposed by law from without¹⁸⁴. He observes that in a sense ‘implied term’ is, in this context a misnomer in that in content it simply represents a legal duty (giving rise to a correlative right) imposed by law, unless excluded by the parties, in the case of certain contracts. Christie notes that this observation of Corbett AJA raises ‘the vexed question’ of nomenclature. He says that the point is that a contract is an agreement and one would therefore expect all its terms to be agreed between the parties. Like a tacit term, somewhat paradoxically, a legitimate expectation in fact takes on the flavour of a right once it has been recognised by a court of law in the sense that legal consequences flow from it. The distinction between a tacit term and a legitimate expectation on the basis that the one effectively confers rights and obligations once it is recognised and the other does not is thus largely notional rather than practical.

181 In *Alfred McAlpine & Son (Pty) Ltd v Transvaal Provincial Administration* 1974 (3) SA 506 (A), Corbett AJA observed: “In the second place, “implied term” is used to denote an unexpressed provision of the contract which derives from the common intention of the parties, as inferred by the Court from the express terms of the contract and the surrounding circumstances. In supplying such an implied term the Court, in truth, declares the whole contract entered into by the parties. In this connection the concept, common intention of the parties, comprehends, it would seem, not only the actual intention but also an imputed intention. In other words, the Court implies not only terms which the parties must actually have had in mind but did not trouble to express but also terms which the parties, whether or not they actually had them in mind, would have expressed if the question, or the situation requiring the term, had been drawn to their attention (see *Dahl v Nelson, Donkin and Co.* (1881) 6 App. Cas. 38 at p. 59; *Techni-Pak Sales (Pty.) Ltd. v Hall*, 1968 (3) SA 231 (W) at pp. 236 - 7; Chitty, *Contracts*, 23rd ed., p. 313; B Weeramantry, *The Law of Contracts*, p. 573; but cf. *Trollope & Colls v N.W. Hospital Board*, (1973) 2 All E.R. 260 at pp. 267 - 8).”

182 See the discussion in Christie (fn 2 *supra*) from p184-190. See also Kerr AJ fn 21 *supra* at p 355 who states “Where a usage is actually known to the contracting parties, and the court can feel confident that they intended to adopt it, it is probable that the requirement of reasonableness means little more than that the usage must not be so opposed to public policy that if the parties had expressly stated it as part of their contract, the law would not have enforced it.”

183 *Alfred McAlpine* fn 181 *supra*

184 In legal parlance the expression “implied term” is an ambiguous one in that it is often used, without discrimination, to denote two, possibly three, distinct concepts. In the first place, it is used to describe an unexpressed provision of the contract which the law imports therein, generally as a matter of course, without reference to the actual intention of the parties. The intention of the parties is not totally ignored. Such a term is not normally implied if it is in conflict with the express provisions of the contract. On the other hand, it does not originate in the contractual consensus: it is imposed by the law from without. Indeed, terms are often implied by law in cases where it is by no means clear that the parties would have agreed to incorporate them in their contract. Ready examples of such terms implied by law are to be found in the law of sale, e.g. the seller’s implied guarantee or warranty against defects; in the law of lease the similar implied undertakings by the lessor as to quiet enjoyment and absence of defects; and in the law of negotiable instruments the engagements of drawer, acceptor and endorser, as imported by secs 52 and 53 of the Bills of Exchange Act, 34 of 1964. Such implied terms may derive from the common law, trade usage or custom, or from statute. In a sense “implied term” is, in this context, a misnomer in that in content it simply represents a legal duty (giving rise to a correlative right) imposed by law, unless excluded by the parties, in the case of certain classes of contracts. It is a naturalium of the contract in question.

The debates around non-variation clauses in the law of contract highlight the question of legitimate expectation in the field of administrative law¹⁸⁵. In *Brisley v Drotzky*¹⁸⁶ Olivier JA conceded that Hutchison was correct where he said the following concerning *SA Sentrale Ko-op A Graanmaatskappy Bpk v Shifren en Andere*¹⁸⁷:

“The principle in Shifren’s case has consistently been reaffirmed, albeit with the rider in a recent case that non-variation clauses are to be restrictively interpreted since they curtail freedom of contract. It is therefore still good law, despite the fact that the courts have frequently felt uncomfortable about applying the principle, and have resorted to all sorts of ingenious stratagems to avoid doing so. The reason is quite simply that, no matter how logical its theoretical justification, in practice the principle would be productive of injustice if applied without a good deal of discretion and qualification. For, on the face of it, Shifren appears to allow a party to go back on his or her word, even when another has in good faith relied thereon. Take the all too common situation represented by Shifren itself: a contract of lease containing a non-variation clause requires the written consent of the landlord for any cession by the tenant of its rights under the contract; the landlord orally consents to such a cession but later, after the cession has taken place, purports to cancel for breach, averring that the oral agreement is of no force or effect in view of the non-variation clause. To permit the landlord to cancel the contract in such circumstances seems not merely unjust but a violation of the principle that parties to a contract are expected to behave in accordance with the dictates of good faith.”¹⁸⁸

In the context of legitimate expectation there is a similar feeling that an administrator should not be allowed to go back on his or her word when another has in good faith relied thereon at least without observing some form of procedural fairness¹⁸⁹. The debate concerning substantive as opposed to procedural fairness in the context of the doctrine of legitimate expectation as canvassed in *Meyer v Iscor Pension Fund*¹⁹⁰ is unnecessary for the purposes of this discussion since the intention here is simply to demonstrate the commonalities between the law of contract and administrative law without going too far into the complexities of either of them.

It is submitted that the question of whether the state can exclude the principles of administrative justice by way of contractual terms from its relationship with a patient

¹⁸⁵ In *Randcoal Services Ltd And Others v Randgold And Exploration Co Ltd* 1998 (4) SA 825 (SCA) van Heerden DCJ stated: “However, in my view, a non-variation clause curtails common law freedom to contract and must hence be restrictively interpreted.

¹⁸⁶ *Brisley* 2002 (4) SA 1 (SCA)

¹⁸⁷ *Shifren* 1964 (4) SA 760 (A)

¹⁸⁸ Hutchison D ‘Non variation clauses in contract: any escape from the Shifren straitjacket?’ (2001) 118 *SALJ* 720 at 721

¹⁸⁹ Brand JA observed in *Meyer v Iscor Pension Fund* 2003 (2) SA 715 (SCA): “At the end of his argument in this Court, Meyer relied on the doctrine of legitimate expectation, not only to reinforce his objection based on unfair discrimination but as the mainstay of his whole case. He was, however, immediately confronted with the fundamental difficulty that, in administrative law, the doctrine of legitimate expectation has traditionally been utilised as a vehicle to introduce the requirements of procedural fairness and not as a basis to compel a substantive result. According to the traditional approach, it matters not whether the expectation of a procedural benefit is induced by a promise of procedural benefit itself or by a promise that some substantive benefit will be acquired or retained. The expectation remains a procedural one.”

¹⁹⁰ *Meyer* 2003 (2) SA 715 (SCA)



must be answered on a similar basis to the approach of the courts to non-variation clauses in the law of contract¹⁹¹. Non-variation clauses are inimical to the concept of contract since they effectively restrict the rights or powers of the parties to contract. They undermine their own foundations in law. As such they represent something of a legal paradox. In the same way, purported waivers of constitutional rights undermine the founding principles of the legal system. As such they should not, as a general rule, be permitted. This view is supported by the judgment in *ABBM Printing & Publishing (Pty) Ltd v Transnet Ltd*¹⁹², the applicant had for a number of years published and printed an in-flight magazine for the respondent which was wholly controlled and owned by the state. The respondent called for new tenders for the printing and production of the magazine and awarded the tender to someone else. The applicant asked for reasons for its decision from the respondent which referred the applicant to clause 10.1 of the conditions of tender, which provided that the respondent would not 'bind itself to accept the lowest or any tender, nor . . . assign any reason for the rejection of a tender'. The applicant responded that it was nevertheless entitled to establish that the tender process did not infringe its right to just administrative action guaranteed by s 33 of the Constitution of the Republic of South Africa Act 108 of 1996. The court found on the facts that there was no evidence of that the applicant had waived its constitutional right to administrative justice and said that it did not therefore have to look at the 'considerable weight of authority that doubts that a person can be held to a statutory or constitutional waiver of his constitutional rights'. The court did say that if it had not been able to find on the facts as it had done, however, then it would that there was no estoppel and no waiver of the applicant's

¹⁹¹ See *Miller and Another NNO v Dannecker* 2001 (1) SA 928 (C) where the court observed: "Finally, good faith or *bona fides* has deep roots in South Africa's mixed legal system. In *Eerste Nasionale Bank van Suidelike Afrika Bpk v Saayman NO*, fn 25 *supra* at 321 - 2 ([1997] 3 All SA 391 at 406) Olivier JA held that there is a close link between the concepts of good faith, public policy and the public interest in contracting. This is because the function of good faith has always been to give expression in the law of contract to the community's sense of what is fair, just and reasonable. The principle of good faith is then a wider notion of public policy; the courts invoke and apply the principle because the public interest so demands. Good faith accordingly has a dynamic role to play in ensuring that the law remains sensitive to and in tune with the views of the community. (See generally Dale Hutchison *Good Faith in the South African Law of Contract* SA Law Commission, Draft 199, of which Judge Olivier JA is chairperson). In *casu*, we would have to assume that good faith lay at the root of the oral agreement constituting the pactum. The plaintiffs would thus hardly be heard to seek to rely on strict compliance with the provisions of clauses 15.1 and 15.2 of the franchise agreement if, indeed, there had been a pactum as alleged by the defendant. The dictates of public policy and the views of the community would never be served by a slavish adherence to a non-variation clause in the face of an agreement in the form of the pactum. It is my view, that if nothing else, the defendant in *casu* would successfully hold the plaintiffs to the pactum on the grounds that the agreement must be taken to have been entered into in good faith. The good faith basis of contract, after all, imposes an obligation on contractors not to exercise powers in ways which run counter to the concept of *bona fides*. Jansen JA put it in *Tuckers Land and Development Corporation (Pty) Ltd v Hovis* 1980 (1) SA 645 (A) as follows (at 625D - G): 'It could be said that it is now, and has been for some time, felt . . . that in all fairness, there should be a duty upon a promisor, not to commit an anticipatory breach of contract, and such a duty has always been enforced by our Courts. . . . It should therefore be accepted that in our law an anticipatory breach is constituted by the violation of an obligation *ex lege*, flowing from the requirement of *bona fides* which underlies our law of contract.'"

¹⁹² *ABBM Printing* 1998 (2) SA 109 (W)

constitutional right to reasons for the respondent's decision.¹⁹³ In *Transnet Ltd v Goodman Brothers (Pty) Ltd*¹⁹⁴ the court succinctly held that:

"In my view, the correct approach to the question of waiver of fundamental rights is to adhere strictly to the provisions of s 36(1) of the Constitution. It provides that: 'The rights in the Bill of Rights may be limited only in terms of law of general application to the extent. . . .' A waiver of a right is a limitation thereof. One must be careful not to allow all forms of waiver, estoppel, acquiescence, etc to undermine the fundamental rights guaranteed in the Bill of Rights. In my view, a strict interpretation of s 36(1) is indicated. Transnet has not made out a case that the waiver it relies upon is warranted by a law of general application."

It is submitted that the concerns of administrative law and principles of administrative justice are not so far removed from the concerns of the law of contract under the South African constitutional order¹⁹⁵ as the conceptual distinctions between them as

193

See p118 of the *ABBM* judgment (fn 192 *supra*) where the court stated: "The respondent bears the onus of proving the applicant's waiver of its constitutional rights. Although para 10.1 of the respondent's invitation to tender records that it will not assign any reasons for rejecting a tender, there is on the affidavits before me, no evidence on which I can find that at the time it submitted its tender the applicant was aware of its constitutional rights and that it either expressly or impliedly waived its constitutional rights. On the facts before me I can find no basis on which it could be found that there is an estoppel. By reason of these findings it is unnecessary to deal with the considerable weight of authority which doubts that a person can be held to a statutory or constitutional waiver of his constitutional rights. In this regard I refer to *Community Development Board v Revision Court, Durban Central, and Another* 1971 (1) SA 557 (N) at 565B; *Tellis and Others v Bombay Municipal Corporation and Others*; *Kuppusami and Others v State of Maharashtra and Others* 1987 LRC (Const) 351 (SC), a decision of the Supreme Court of India at 366E-I; *S v Frames (Cape Town) (Pty) Ltd* 1995 (8) BCLR 981 (C) at 989E-J; *Maharaj v Chairman, Liquor Board* 1997 (1) SA 273 (N) at 276J-277B; *Hogg Constitutional Law of Canada* (Carswell, 1991) at 34-1. Had I been unable to decide the issue of waiver and estoppel on the facts I would, on the above authorities have found that there was no estoppel and that there had been no waiver by the applicant of its constitutional rights and that the respondent cannot rely on clause 10.1 of the conditions of tender to frustrate the applicant's constitutional right to reasons for the respondent's decision."

194

Transnet 2001 (1) SA 853 (SCA)

195

In *Brisley v Drotzky* fn 186 *supra* the court noted: "Ook Hutchison lewer 'n sterk pleidooi dat die *bona fides*, geskraag deur die Grondwet, groter erkenning in ons kontraktereg verdien. In 'n hoofstuk getiteld 'Good faith in the South African Law of Contract' in Roger Brownsword, Norma J Hird and Geraint Howells *Good Faith in Contract: Concept and Context* (1999) 213 op 230 - 1 skryf hy: 'What emerges quite clearly from recent academic writings, and from some of the leading cases, is that good faith may be regarded as an ethical value or controlling principle, based on community standards of decency and fairness, that underlies and informs the substantive law of contract. It finds expression in various technical rules and doctrines, defines their form, content and field of application and provides them with a moral and theoretical foundation. Good faith thus has a creative, a controlling and a legitimating or explanatory function. It is not, however, the only value or principle that underlies the law of contract nor perhaps, even the most important one. In the words of Lubbe and Murray: "It does not dominate contract law but operates in conjunction (and competition) with notions of individual autonomy and responsibility, the protection of reasonable reliance in commerce, and views of economic efficiency in determining the contours of contract doctrine. However, it will ensure just results only if Judges are alert to their task of testing existing doctrines and the operation of particular transactions against the constantly changing mix of values and policies of which *bona fides* is an expression." On this view of things, which seems to be correct, the influence of good faith in the law of contract is merely of an indirect nature, in that the concept is usually if not always mediated by some other, more technical doctrinal device. Thus, for example, while good faith does not empower a court directly to supplement the terms of a contract, or to limit their operation, it might in appropriate cases enable the court to achieve these same results indirectly, through the use of devices such as implied terms and the public policy rule.' Terwyl bogemelde perspektiewe onderskryf moet word, is die moeilike vraag hoe die *bona fides* op kontraktuele geskille toegepas moet word. Die werking van die *bona fides* in ons kontraktereg is nog lank nie volledig verken en inhoud gegee nie. Dit sal oor jare en aan die hand van baie uitsprake moet geskied. Uiteindelik sal, hopelik, 'n nuwe raamwerk en denkpatroon in ons kontaktereg ontstaan. Teen 1988 het die meerderheid van hierdie Hof by monde van Joubert AR nie gehuiwer om 'n grafrede oor die *exceptio doli generalis* uit te spreek nie, soos blyk uit *Bank of Lisbon and South Africa Ltd v De Ornelas and Another* 1988 (3) SA 580 (A). Dié *exceptio* was 'n belangrike regs-middel wat aan die redelikheid en billikheid 'n sterk derogerende werking verleen het, dws dit is gebruik om die gestrengte reg in bepaalde gevalle te versag. Maar slegs 'n jaar later het hierdie Hof nie teruggedeeins om kontrakteervryheid en regsekerheid op te weeg nie teen 'the doing of simple justice between man and man' - (*Sasfin (Pty) Ltd v Beukes* 1989 (1) SA 1 (A) op 9A - C). Sedertdien, soos reeds genoem, het die redelikheid en billikheid in die vorm van die *bona fides* al hoe meer op die voorgrond getree. Dit is duidelik dat ons reg in 'n ontwikkelingsfase is waar kontraktuele geregtigheid meer as ooit tevore as 'n morele en juridiese norm van groot belang op die voorgrond tree. Hierdie tendens sal na alle waarskynlikheid, soos akademië soos Neels tereg aantoon, deur grondwetlike waardes versterk word. (Sien Jan Neels 'Regsekerheid en die Korrigerende Werking van Redelikheid en Billikheid' (deel 3) in (1999) 3 *TSAR* 477 op

public and private law at first glance suggest. In *Brisley v Drotzky* the Supreme Court of Appeal noted the importance of the constitutional values in the law of contract and the increased significance of concepts such as *bona fides* as one expression of the values and policies underlying the South African legal system. The concept of *bona fides* is common to both the law of contract and administrative law. In *Eerste Nasionale Bank Van Suidelike Afrika Bpk v Saayman No*¹⁹⁶ the court reviewed the long history of *bona fides* or good faith in the South African law of contract.¹⁹⁷ It is a

489; sien ook A van Aswegen 'The Future of South African Contract Law' in *Die Toekoms van die Suid-Afrikaanse Privaatreg*, (1994) 44 op 46 - 51; A van Aswegen 'The Implications of a Bill of Rights for the Law of Contract and Delict' 1995 *SAJHR* op 50 ev.) Daar kan veral gewys word op hoofstuk 2 van die Grondwet wat waardes soos vryheid, gelykheid en waardigheid beskerm; art 39(2) wat vereis dat die houe die gees, strekking en oogmerke van die handves moet bevorder wanneer die gemenerereg ontwikkel word, en op art 173 wat bepaal dat die hoër Howe die inherente bevoegdheid het om die gemenerereg te ontwikkel met inagneming van die belang van geregtigheid. Dit word ook al hoe meer duidelik dat kontemporêre gemeenskapsbehoefes, onder andere die beskerming van swakkere kontraktante, van die houe vereis om meer aktief op te tree. Ek vereenselwig my dus met Prof C F C van der Walt se pleidooi in 'Beheer oor Onbillike Kontraksbedinge - Quo Vadis vanaf 15 Mei 1999' 2000 *TSAR* 33 op 41): 'Bykans jaar na die uitspraak in *Neugebauer & Co Ltd v Hermann* en ten spyte van die "lyn van beslissings" wat daarop gevolg het, moet gekonkludeer word dat die houe waarskynlik nie self die punt sal bereik waar hulle relevante waardes regstreeks op kontraksbedinge sal toepas nie. Vir sover die houe aan hulleself en die presedentestelsel oorgelaat word om te onderskei tussen bedinge wat afdwing sal word of nie, en tussen bedinge wat nêg is of nie, sal hulle nie daarby uitkom nie. Intussen sal die houe waarskynlik steeds voortgaan om "grondliggende waarde" van goeie trou onregstreeks, agter die mom van allerlei ander regsfigure, remedies en diskresies toe te pas. Laasgenoemde werkswyse moet uit die oogpunt van judisiële optrede teen onbillike kontraktuele situasies uiteraard nie geringgeskat word nie. Tensy daar egter snel vordering met die regstreekse benadering kom, sal 'n aanvaarbare ewewig van regte en verpligtinge op die kontrakteregsterrein (dit wat as billik en regverdig bestempel word) nie deur die houe bereik kan word nie.'

196

Saayman fn 27 *supra*

197

The court in *Saayman* (fn 27 *supra*) stated: "In *Meskin NO v Anglo-American Corporation of SA Ltd and Another* 1968 (4) SA 793 (W) het Jansen R, toe nog 'n Regter van 'n Provinsiale Afdeling van die Hooggeregshof, sterk na vore getree as kampvegter vir die praktiese verwesenliking van die bona fide-beginsel in ons kontraktereg. Op 802A het hy verklaar: 'It is now accepted that all contracts are bonae fidei (some are even said to be uberrimae fidei). This involves good faith (bona fides) as a criterion in interpreting a contract (Wessels (op cit para 1976)) and in evaluating the conduct of the parties both in respect of its performance (Wessels para 1997) and its antecedent negotiation. Where a contract is concluded the law expressly invokes the dictates of good faith, and conduct inconsistent with those dictates may in appropriate circumstances be considered to be fraud; . . .'. En weer, na aanleiding van die plig om inligting te openbaar by die kontraksluiting, het hy gesê op 804D: 'It may, perhaps be questioned whether these criteria do not go further in applying ethical considerations in contrahendo than our authorities recognise. On the other hand there can be no doubt that in contrahendo our law expressly requires bona fides, a concept of variable content in the light of changing mores and circumstances. On the assumption (without deciding) that the ultimate test suggested by Millner correctly reflects the present state of our law, there is a striking resemblance between that test and eg "die algemene regsgevoel van die gemeenskap"' mentioned above in regard to delict generally.' Toe Jansen R na hierdie Bank verhef is, het hy dieselfde benadering konsekwent gehandhaaf, veral in *Tuckers Land and Development Corporation (Pty) Ltd v Hovis* 1980 (1) SA 645 (A) op 651B-652G en *Bank of Lisbon and South Africa Ltd v De Ornelas and Another* (*supra* op 611G-617H ev), in 'n minderheidsuitspraak. (Sien oor Jansen AR se bydrae, Carole Lewis in (1991) 108 *SALJ* op 249-64.) In ander uitsprake van hierdie Hof is die grondliggende waardes van die goeie trou, billikheid en openbare belang in die kontraktereg ook beklemtoon; veral wat betref die afdwing van kontrakte wanneer dit teen die regsgevoel skrei. So, bv het Hefer AR in *Benson v SA Mutual Life Assurance Society* 1986 (1) SA 776 (A) gekonstateer dat 'n hof die diskresie het om nie spesifieke nakoming van 'n kontrak te gelas nie. Hierdie diskresie, so is verklaar op 783C-E: '. . . is aimed at preventing an injustice - for cases do arise where justice demands that a plaintiff be denied his right to performance - and the basic principle thus is that the order which the Court makes should not produce an unjust result which will be the case, eg, if, in the particular circumstances, the order will operate unduly harshly on the defendant. Another principle is that the remedy of specific performance should always be granted or withheld in accordance with legal and public policy. . . .'. In verband met die afdwing van ooreenkomste wat die handelsvryheid beperk, het die Howe self 'n verreikende bevoegdheid om beperkinge op sodanige ooreenkomste te plaas, ontwikkel en wel op grond van openbare belang. In *Magna Alloys and Research (SA) (Pty) Ltd v Ellis* 1984 (4) SA 874 (A) het Rabie HR op 891H-I gesê: 'Omdat opvattinge oor wat in die openbare belang is, of wat die openbare belang vereis, nie altyd dieselfde is nie en van tyd tot tyd kan verander, kan daar ook geen numerus clausus wees van soorte ooreenkomste wat as strydig met die openbare belang beskou kan word nie. Dit sou dus volgens die beginsels van ons reg moontlik wees om te sê dat 'n ooreenkoms wat iemand se handelsvryheid inkort teen die openbare belang is indien die omstandighede van die betrokke geval sodanig is dat die Hof daarvan oortuig is dat die afdwing van die betrokke ooreenkoms die openbare belang sou skaad.' En op 893G: 'Die opvatting dat 'n persoon wat 'n beperking wil afdwing nie die las dra om te bewys dat dit redelik inter partes is nie, bring nie mee dat oorwegings van die redelikheid of onredelikheid van 'n beperking nie van belang is of kan wees nie.' En op 895D-E: 'Die belangrike vraag is dus nie of 'n ooreenkoms van so 'n aard is dat dit ab initio ongeldig is nie, maar of dit 'n ooreenkoms is wat die Hof, gesien die vereistes van die openbare belang, nie behoort af te dwing nie.' Die opvatting dat alle kontrakte in ons reg bonae fidei is, dws deur die goeie trou beginsel beheers word, is ook deur hierdie Hof erken onder andere in *Paddock Motors (Pty) Ltd v Igesund* 1976 (3) SA 16 (A) op 28;

similarly recurring theme in administrative law¹⁹⁸. Unfortunately the courts do not always express themselves in language that acknowledges the legal reality that the values and public policy principles underlying different branches of law are fundamentally the same or where different constitutional principles and values are applicable, that they are internally consistent with each other. This is due in part to a persistent distinction drawn by the courts between different branches of law, such as contract and delict, in a manner that implies that there is no fundamental relationship between them. Thus for instance in *Wagener v Pharmacare Ltd; Cuttings v Pharmacare Ltd*¹⁹⁹ the court observed:

“It is nevertheless necessary to say that the submission advanced on the appellants' behalf that the principle in the Kroonstad case should be extended to encompass strict product liability is untenable. That matter was concerned with a warranty imposed on a seller by the law of sale which can be excluded by contract. *Contract and delict, being quite separate branches of the law, have their own principles, remedies and defences*. One cannot, because of the absence of contractual privity between the injured party and the manufacturer, simply graft warranty liability onto a situation patently governed by the law of delict.”(writer's italics).

Magna Alloys and Research (SA) (Pty) Ltd v Ellis (supra op 893C ev); *Mutual and Federal Insurance Co Ltd v Oudtshoorn Municipality* 1985 (1) SA 419 (A) op 433B–C; *LTA Construction Bpk v Administrateur, Transvaal* 1992 (1) SA 473 (A) op 480D–E; *Sasfin (Pty) Ltd v Beukes* 1989 (1) SA 1 (A) op 71 ev en weer 8C–D; *Botha (now Griessel) and Another v Finanscredit (Pty) Ltd* 1989 (3) SA 773 (A) op 782J ev. Die bona fides, wat weer gebaseer is op die redelikeheidsopvattinge van die gemeenskap, speel dus 'n wye en onmiskenbare rol in die kontraktereg. Zimmermann in sy bydrae ‘Good Faith and Equity’ in Zimmermann en Visser (reds) *Southern Cross - Civil Law and Common Law in South Africa* (1996) op 217–60 toon oortuigend aan dat gemelde beginselkompleks onderliggend is aan bekende regsinstellings soos estoppel, rektifikasie, onskuldige wanvoorstelling, die kennisleer, onbehoorlike beïnvloeding en dat dit 'n belangrike rol speel by die uitleg van kontrakte, die inlees van stilswyende en geïmpliseerde bedinge, die openbaringsplig by kontraksluiting, fiktiewe vervulling van 'n voorwaarde en die erkenning van repudiëring as 'n vorm van kontrakbreuk. Dit blyk ook dat daar 'n innige verband bestaan tussen die begrippe bona fides, openbare belang, openbare beleid en *justa causa*. Dit blyk uit die analise van Smalberger AR in *Sasfin (Pty) Ltd v Beukes* (supra op 71–8G); uit die woorde van Hoexter AR in *Botha (now Griessel) and Another v Finanscredit (Pty) Ltd* (supra op 783A–B) dat openbare belang gerig is op die noodsaaklikheid dat simple justice between man and man gedoen moet word, en uit wat gesê is in *Magna Alloys and Research (SA) (Pty) Ltd v Ellis* (supra). (Sien ook D Zimmermann *Southern Cross* op 259 voetnoot 326.) Dit kan na my mening tereg gesê word dat die bona fide-begrip in die kontraktereg 'n onderdeel van die algemeen-geldende openbare belangbeginsel is. Die bona fides word toegepas omdat die openbare belang dit vereis.”

198

In *Simon's Town Municipality v Dews And Another* 1993 (1) SA 191 (A) the Appellate Division observed that “‘Good faith’ here relates to the subjective state of mind of the repository of the power and, broadly-speaking, requires that in exercising the power he should have acted bona fide, honestly and without ulterior motive. (Cf *Oude Meester Groep Bpk and Another v SA Breweries Ltd; SA Breweries Ltd and Another v Distillers Corporation (SA) Ltd and Another* 1973 (4) SA 145 (W) at 150G–151D; *Bloems Timber Kilns (Pty) Ltd v Volkskas Bpk* 1976 (4) SA 677 (A) at 689A–E.) In *Premier, Eastern Cape, And Others v Cekeshe And Others* 1999 (3) SA 56 (TK) the court noted: “Parliament can never be taken to have intended to give an official or an administrative body the power to act in bad faith or the power to abuse his or its powers. Such powers are conferred on an official or administrative body to promote the policy and/or objects of the Act. When the Court says it will intervene if a particular body acted in bad faith it is but another way of saying that such power was not being exercised within the scope of the statutory authority given by Parliament. (See *R v Commission for Racial Equality, ex parte Hillingdon London Borough Council* [1982] QB 276 ([1981] 3 WLR 520).) Dealing with the discretionary powers conferred on an administrative official or body, Wade (op cit) states as follows: ‘(W)here Parliament confers power upon some Minister or other authority to be used in discretion, it is obvious that the discretion ought to be that of the designated authority and not that of the Court. Whether the discretion is exercised prudently or imprudently, the authority's word is to be law and the remedy is to be political only. On the other hand, Parliament cannot be supposed to have intended that the power should be open to serious abuse. It must have assumed that the designated authority would act properly and responsibly . . . with a view to doing what was best in the public interests and most consistent with the policy of the statute. It is from this presumption that the Courts take their warrant to impose legal bounds on even the most extensive discretion.’” In terms of section 6(2) of the PAJA, a court or tribunal has the power to judicially review an administrative action if the action was taken in bad faith.

199

Wagener 2003 (4) SA 285 (SCA)

It is submitted with respect that it is not so much the decision of the court that is problematic as it is the manner of its justification. The existence of two separate branches of law should not be used in itself as justification for the refusal or granting of a particular remedy for a number of reasons. The most obvious reason is that the Constitution requires the courts to develop the common law in accordance with constitutional values and principles. These are common to all law in South Africa. One cannot therefore take the view that the one particular branch of law is totally separate to another and that on this basis alone a particular remedy should not be extended in the one, because it might constitute an intrusion into the other branch of law.²⁰⁰ A less obvious, but no less important and related, reason is that such an approach has the potential to lead the courts into the trap of using pre-constitutional legal reasoning to arrive at post-constitutional decisions without questioning or examining the basis for such pre-constitutional reasoning to establish whether or not it is consistent with constitutional principles and values²⁰¹. This in turn leads to a failure on the part of the courts to develop the common law as they are constitutionally mandated to do²⁰². Another reason not to be too insistent upon drawing clear distinctions between the different branches of law as an end in itself is exemplified by

²⁰⁰ The real question is whether the extension of the remedy is constitutionally required or justified.

²⁰¹ Thus in *Carmichele v Minister Of Safety And Security And Another (Centre For Applied Legal Studies Intervening)* 2001 (4) SA 938 (CC) the constitutional court observed: "The proceedings in the High Court and the SCA took place after 4 February 1997 when the Constitution became operative. It follows that both the High Court and the SCA were obliged to have regard to the provisions of s 39(2) of the Constitution when developing the common law. However, both Courts assumed that the pre-constitutional test for determining the wrongfulness of omissions in delictual actions of this kind should be applied. In our respectful opinion, they overlooked the demands of s 39(2). In the High Court and the SCA the applicant relied only on the common-law understanding of wrongfulness which has been developed by our Courts over many years. Save in one respect referred to in the applicant's heads of argument in the SCA, no reliance was placed on the provisions of the IC or the Constitution as having in any way affected the common-law duty to act owed by police officers or prosecutors to members of the public. With regard to the 'interests of the community' imposing a legal liability on the authorities, it was submitted by the applicant's counsel that it would 'encourage the police and prosecuting authorities to act positively to prevent violent attacks on women'. In support of that submission counsel referred to authorities in this Court and the SCA devoted to patterns of discrimination against women. It does not appear to have been suggested that there was any obligation on the High Court or the SCA to develop the common law of delict in terms of s 39(2) of the Constitution." (Footnotes omitted)

²⁰² Thus in *Carmichele* (fn 201 *supra*) the court noted: "It needs to be stressed that the obligation of Courts to develop the common law, in the context of the s 39(2) objectives, is not purely discretionary. On the contrary, it is implicit in s 39(2) read with s 173 that where the common law as it stands is deficient in promoting the s 39(2) objectives, the Courts are under a general obligation to develop it appropriately. We say a 'general obligation' because we do not mean to suggest that a court must, in each and every case where the common law is involved, embark on an independent exercise as to whether the common law is in need of development and, if so, how it is to be developed under s 39(2). At the same time there might be circumstances where a court is obliged to raise the matter on its own and require full argument from the parties. It was implicit in the applicant's case that the common law had to be developed beyond existing precedent. In such a situation there are two stages to the inquiry a court is obliged to undertake. They cannot be hermetically separated from one another. The first stage is to consider whether the existing common law, having regard to the s 39(2) objectives, requires development in accordance with these objectives. This inquiry requires a reconsideration of the common law in the light of s 39(2). If this inquiry leads to a positive answer, the second stage concerns itself with how such development is to take place in order to meet the s 39(2) objectives. Possibly because of the way the case was argued before them, neither the High Court nor the SCA embarked on either stage of the above inquiry.

the words of the Supreme Court of Appeal in *Transnet Ltd v Goodman Brothers (Pty) Ltd*²⁰³:

“The identification of an administrative action, in contrast to an act regulated by private law, has become more difficult with the increasing use by the State of private law institutions, notably contract, to perform its duties. This takes place by privatisation, delegation, outsourcing, etc (see A Cockrell ‘Can you Paradigm? - Another Perspective on the Public Law/Private Law Divide’ 1993 *Acta Juridica* 227; Yvonne Burns ‘Government Contracts and the Public/Private Law Divide’ (1998) 13 SA Public Law at 234 et seq).”

It seems that a number of conclusions can be drawn from the foregoing discussions with regard to contractual relationships between public providers and patients:

1. It is unlikely that a contractual term will be interpreted as constituting a waiver of a constitutional right or as estopping a patient from enforcing his or her constitutional rights. The right of access to health care services is a constitutional right as is the right to administrative justice;
2. A public provider-patient contractual relationship is rarely likely to be one dimensional due to the fact that the public provider will be subject, in addition to purely contractual obligations, to the relevant provisions of administrative law. Since public providers derive their powers largely from legislation and since the implementation of legislation is regarded as administrative action, to the extent that the delivery of health care services constitutes the implementation of legislation, administrative law will be a factor in any contractual public provider-patient relationship²⁰⁴;

²⁰³ *Transnet* fn 194 *supra*

²⁰⁴ See in which Cameron JA observed: “Even if the conditions constituted a contract (a finding not in issue before us, and on which I express no opinion), its provisions did not exhaust the province's duties toward the tenderers. Principles of administrative justice continued to govern that relationship, and the province in exercising its contractual rights in the tender process was obliged to act lawfully, procedurally and fairly. In consequence, some of its contractual rights - such as the entitlement to give no reasons - would necessarily yield before its public duties under the Constitution and any applicable legislation. This is not to say that the conditions for which the province stipulated in putting out the tender were irrelevant to its subsequent powers. As will appear, such stipulations might bear on the exact ambit of the ever-flexible duty to act fairly that rested on the province. The principles of administrative justice nevertheless framed the parties' contractual relationship, and continued in particular to govern the province's exercise of the rights it derived from the contract. Counsel's invocation of the *Cape Metropolitan* case as authority to the contrary is mistaken. There it was held that a local authority's cancellation of an agreement was not ‘administrative action’ under the Constitution entitling the other contractant to procedural fairness before termination. Although the public authority derived its power to conclude the contract from statute, it was held that the same could not necessarily be said about its power to cancel. But the *Cape Metropolitan* case turned on its own facts, and this Court was careful to delineate them. In the first place, the tender cases were expressly distinguished. Second, the employment cases (where a public authority's express statutory power to dismiss public sector workers was held bound by public duties of fairness notwithstanding that a corresponding right existed at common law or that such a right might also have been contained in a contract) were also distinguished. Third and most importantly, the Court in *Cape Metropolitan* did not purport to provide a general answer to the question whether a public authority in exercising powers derived from a contract is in all circumstances subject to a public duty to act fairly. That question was left open. Instead, the Court's judgment makes it plain that the answer depends on all the circumstances. The critical passage in the reasoning of Streicher JA is this: ‘Those terms [ie entitling the public authority to cancel the contract] were not prescribed by statute and could not be dictated by the [public authority] by virtue of its



3. The considerations of public policy that underlie the law of contract must be interpreted as consistent with, if not the same as those that underlie administrative law since both are founded upon the principles and values established by the Constitution;
4. Due to the apparent restriction of the administrative law doctrine of legitimate expectation by the courts to procedural relief only, the doctrine of legitimate expectation does not at present provide an alternative remedy for substantive relief equivalent to that which can potentially be provided by an implied term in the context of the law of contract. It is thus likely that in practice there will still be separate causes of action cited for procedural relief as opposed to substantive relief on the basis of administrative law and the law of contract respectively;
5. The fact that the provider is a public body is likely to impact upon its contractual relationships in the sense that a number of terms may be implied by law that would not necessarily be implied had the provider been a private body. Such implied terms may, depending upon the context, include a duty to act reasonably, a duty to act fairly in terms of procedures envisaged under the contract, a duty to give written reasons for decisions and actions taken under the contract, a duty to give adequate notice of intended actions under the contract. The implied terms may be by virtue of section 3 of the PAJA which relates to procedurally fair administrative action affecting any person.²⁰⁵

This conclusion may meet with objections on the basis that the incorporation of implied terms of this nature in contracts with public providers is unnecessary because such providers cannot in any event escape the provisions of administrative law. The

position as a public authority. They were agreed to by the first respondent, a very substantial commercial undertaking. The [public authority], when it concluded the contract, was therefore not acting from a position of superiority or authority by virtue of its being a public authority and, in respect of the cancellation, did not, by virtue of its being a public authority, find itself in a stronger position than the position would have been had it been a private institution. When it purported to cancel the contract it was not performing a public duty or implementing legislation; it was purporting to exercise a contractual right founded on the consensus of the parties in respect of a commercial contract. In all these circumstances it cannot be said that the [public authority] was exercising a public power.'

The case is thus not authority for the general proposition that a public authority empowered by statute to contract may exercise its contractual rights without regard to public duties of fairness. On the contrary: the case establishes the proposition that a public authority's invocation of a power of cancellation in a contract concluded on equal terms with a major commercial undertaking, without any element of superiority or authority deriving from its public position, does not amount to an exercise of public power." (footnotes omitted)

205

"Such implied terms may derive from the common law, trade usage or custom, or from statute." (*Alfred McAlpine & Son* fn 181 *supra*)

purists would argue that there may be separate and specific remedies for violations of statutory provisions that exclude other remedies and that the provisions of administrative law and the law of contract are separate branches of law with their own principles, remedies and defences. It is submitted that it is precisely for this reason that in certain circumstances it may be appropriate to allow terms implied by administrative law in a contract. When a person contracts with the government there is seldom a question as to in whose favour the power balance usually lies. In the context of health services, the patient is particularly vulnerable. He or she is in the majority of cases totally dependent upon the public provider for the services required and does not have the choice of obtaining them elsewhere. The consequences of a breach of contract for health services are often irreversible and sometimes fatal in which case purely procedural remedies may well amount to no remedy at all. The expectations of a patient contracting with the state may be quite different from those of a person contracting with a private provider and may even in some circumstances predispose the patient to being less careful in dealing with the public provider than the private provider – for example the same levels of self-interest would not be expected of a public provider as of a private provider, a certain respect and regard for public policy considerations and the interests of the community would feature higher on a patient's list of expectations of a public provider than of a private provider, the accountability of the public provider to the patient is not only in its capacity as provider of health care services but in its capacity as the state, the executive branch of government of the country, the custodian of the public interest, the respecter, protector, promoter, and fulfiller of the rights in the Bill of Rights.

Where the state dishonours such expectations in the context of health care services, the harm to the patient has the potential to be considerable. Moreover the harm flowing from a violation of such an implied term is likely to be quantifiable in much the same way that contractual damages arising from private provider-patient contracts are quantifiable. It is difficult to see a reason why, in the absence of any statutory provisions to the contrary and where appropriate in the circumstances, certain terms based in administrative law should not be implied in the public provider-patient contract where such a contract is found to exist.

4.10 Tacit or Implied Terms in Health Care Contracts

If one looks at the case law dealing with the delivery of health care services and those involving other forms expert skill and advice, it is submitted that there are a number of terms which may be inferred in a health care contract on the grounds of public policy, fairness and reasonableness. It is submitted that the following terms are relevant in the context of contracts for health the public health sector and the courts should be prepared to read them into contracts for health care services between public providers and patients in the appropriate circumstances. The terms are derived on the basis of the legal principles listed below, not necessarily in order of appearance and not necessarily only one principle at a time:

- 1 A term which is sought to be implied in a contract must be capable of clear and precise formulation;²⁰⁶
- 2 The terms below would in most instances satisfy the ‘officious bystander test’²⁰⁷
- 3 The court in *Standard Bank of SA Ltd v Durban Security Glazing (Pty) Ltd and Another*²⁰⁸ identified the following principles and guidelines for tacit terms. It is submitted that the tacit terms proposed below satisfy these requirements –
 - (a) A Court is slow to import a tacit term in a written agreement²⁰⁹. It is submitted that the public provider-patient contract is rarely if ever written;
 - (b) The Court has no power to supplement the bargain between the parties by adding a term which they would have been wise to agree upon, although they did not. The fact that the suggested term would have been a reasonable one for

²⁰⁶ *Rapp and Maister v Aronovsky* 1943 WLD 68 at 75; *Desai and Others v Greyridge Investments (Pty) Ltd* 1974 (1) SA 509 (A) at 522H - 523A; *Hamilton-Browning v Denis Barker Trust* 2001 (4) SA 1131 (N) at 1137

²⁰⁷ *Reigate v Union Manufacturing Co (Ramsbottom)* [1918] 1 KB 592 ([1918] 118 LT 483) referred to in *Hamilton-Browning v Denis Barker Trust* 2001 (4) SA 1131 (N); In *The MV Prosperous; Aegean Petroleum (UK) Ltd v Pan Bulk Shipping Ltd Cobam NV Intervening*; *Cobam NV v Pacific Northern Oil Corporation And Others* 1995 (3) SA 595 (D) the court observed that: “The ‘officious bystander test’ is expressed thus by MacKinnon LJ in *Shirlaw v Southern Foundries (1926) Ltd* [1939] 2 KB 206 at 227: ‘Prima facie that which in any contract is left to be implied need not be expressed as something so obvious that it goes without saying; so that if, while all the parties were making their bargain, an officious bystander were to suggest some express provision for it in their agreement, they would testily suppress him with a common zeal. At least it is true, I think, that, if a term were never implied by a Judge unless it could pass that test, he could not be held to be wrong.’” The court stated that “That test, to my mind, simply underlines and highlights the point that the term sought to be implied must be an obvious one.”

²⁰⁸ *Standard Bank of SA Ltd v Durban Security Glazing (Pty) Ltd and Another* 2000 (1) SA 146 (D)

²⁰⁹ *Sweets from Heaven (Pty) Ltd and Another v Ster Kinekor Films (Pty) Ltd and Another* 1999 (1) SA 796 (W)

them to adopt or that its incorporation would avoid an inequity or a hardship to one of the parties, is not enough. The suggested term must, in the first place, be one which was necessary as opposed to merely desirable, to give business efficacy to the contract; and, what is more, the Court must be satisfied that it is a term which the parties themselves intended to operate if the occasion for such operation arose, although they did not express it. . . . That does not mean, in my view, that the parties must consciously have visualised the situation in which the term would come into operation. . . . It does not matter, therefore, if the negotiating parties fail to think of the situation in which the term would be required, provided that their common intention was such that a reference to such a possible situation would have evoked from them a prompt and unanimous assertion of the terms which was to govern it ²¹⁰.

- (c) The question to be asked is based always upon an hypothesis: what would the parties have done if confronted with the situation that has arisen? The situation must, of course, be one necessarily and obviously arising out of the contract which the contract in express terms has not provided for²¹¹.
- (d) In order to determine whether a tacit term has been proved on a balance of probabilities regard must be had to the evidence, the conduct of the parties and the surrounding circumstances²¹².
- (e) The Court is to determine from all the circumstances what a reasonable and honest person who enters into such a transaction would have done, not what a crafty person might have done who had an *arrière pensée* to trick the other party into an omission of the term. The transaction must be regarded as a normal business transaction between two parties both acting as reasonable businessmen²¹³.

210 Per Colman J in *Techni-Pak Sales (Pty) Ltd v Hall* 1968 (3) SA 231 (W) at 236E - 237A (emphasis supplied).

211 Per Stratford JA in *Administrator (Transvaal) v Industrial & Commercial Timber & Supply Co Ltd* 1932 AD 25 at p 38 (emphasis supplied).

212 *Minister van Landbou-Tegniese Dienste v Scholtz* 1971 (3) SA 188 (A) at 196H-197A.

213 Per Wessels ACJ in *Administrator (Transvaal) v Industrial & Commercial Timber & Supply Co Ltd* 1932 AD 25 at p 33.

The tacit terms suggested below are derived as much from the law of delict and constitutional and administrative law as from the law of contract. Purists may object to such cross-pollination of the law of contract by these other areas of law. It is submitted, however, that given that the judgments of the courts are public knowledge and that public policy does not in principle distinguish between areas of law but is concerned in the main with constitutional values and principles, the public interest, fairness and reasonableness, there is no reason why principles from the law of delict, constitutional and administrative law should not inform the law of contract.

- 1 The public provider must take all reasonable steps to ensure that the health professional, eg the nurse, doctor or physiotherapist, in the employ of the public provider is qualified to perform the services the patient is receiving and such professional meets with the licensing requirements of any law with respect to his or her profession²¹⁴.
- 2 The patient will be treated with a reasonable degree of professional skill and care and to a standard required by the professional and ethical rules of the profession to which the relevant health practitioner belongs²¹⁵.
- 3 Decisions concerning the patient's treatment will be taken by the public provider in a manner that is lawful, reasonable and procedurally fair²¹⁶. In practice this

²¹⁴ See *Mtsetwa v Minister of Health* 1989 (3) SA 600 (D) in which the court said "The two Transvaal cases, as well as *Buls and Another v Tsatsarolakis* 1976 (2) SA 891 (T), neither mention nor support the distinction, which is pivotal to the decision in the Lower Umfolosi case, between professional work over which the hospital is said to have no control and for which it is accordingly not liable, and managerial or administrative duties performed by an employee, for which it is responsible. In the Transvaal cases the issue was simply whether the particular member of staff was negligent in the exercise of his duties, regardless of whether he was part of a professional team or not." See also *Buls and Another v Tsatsarolakis* 1976 (2) SA 891 (T); *Minister van Polisie en 'n Ander v Gamble en 'n Ander* 1979 (4) SA 759 (A); *Minister of Police v Rabie* 1986 (1) SA 117 (A).

²¹⁵ In *Van Wyk v Lewis* 1924 AD 438 at p 444 and p 448, it was held that "in deciding what is reasonable the Court will have regard to the general level of skill and diligence possessed and exercised at the time by the members of the branch of the profession to which the practitioner belongs". See also *Blyth v Van Den Heever* 1980 (1) SA 191 (A) and *Durr v Absa Bank Ltd And Another* 1997 (3) SA 448 (SCA) in which the court observed: "Not only did the Judge below adopt the 'typical broker' test, but he held that Mrs Durr tendered no evidence as to the duties and functions of bankers under circumstances such as exist in this case. That is not entirely correct. Mr Goldhawk had said: 'If a person holds himself out as an expert and there is support, such as a financial institution confirming that he's an expert, then any person dealing with him should be entitled to expert advice. There's the analogy of if you get into a taxi and the taxi driver is a bad driver, does that remove any negligence claim you may have against him?' Mr Goldhawk is a chartered accountant and a specialist investigating accountant. He was appointed as such by the liquidators of 'Supreme' and gained a deep insight into the group and its penumbra. In *Jansen Van Vuuren and Another NNO v Kruger* 1993 (4) SA 842 (A) the court said "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." See also *Dube v Administrator, Transvaal* 1963 (4) SA 260 (W)

²¹⁶ *Janse Van Rensburg NO and Another v Minister Of Trade and Industry and Another NNO* 2001 (1) SA 29 (CC); *Winckler and Others v Minister of Correctional Services and Others* 2001 (2) SA 747 (C) Section 33(1) guarantees everyone the right to administrative action that is lawful, reasonable and procedurally fair. See also *South African Veterinary Council and Another v Veterinary Defence Association* 2003 (4) SA 546 (SCA)

means that the patient will be consulted before such decisions are taken and that he or she will be informed of the decision before it is taken.

- 4 The patient's consent will be obtained with regard to treatment that is administered to him or her prior to the administration of such treatment²¹⁷.
- 5 The provider undertakes to render the health services in accordance with the patient's consent and on the basis of the information supplied to the patient in order to obtain that consent²¹⁸.
- 6 The patient will be informed of the fact that treatment is of an experimental nature or is being conducted in the course of research and will be given the opportunity to refuse such treatment before it is administered²¹⁹.
- 7 The patient's health information will be kept confidential and will not be used in a way that will cause harm to the patient. It will not be disclosed to anyone without the patient's prior consent²²⁰.
- 8 The patient is entitled to rely on and act in accordance with the advice of the health professionals treating him or her in their capacity as experts²²¹.
- 9 Unless specifically stated otherwise in express and unambiguous terms the provider does not undertake to cure the patient²²².

²¹⁷ *Lybery v Jeffries*, 1925 AD 236; *Esterhuizen v Administrator, Transvaal* 1957 (3) SA 710 (T); *Richter And Another v Estate Hammann* 1976 (3) SA 226 (C); *Castell v De Greef* 1994 (4) SA 408 (C); *Broude v McIntosh And Others* 1998 (3) SA 60 (SCA)

²¹⁸ *Esterhuizen v Administrator, Transvaal* 1957 (3) SA 710 (T)

²¹⁹ Section 12(2)(c) of the Constitution

²²⁰ *Jansen Van Vuuren And Another NNO v Kruger* 1993 (4) SA 842 (A)

²²¹ *In Pinshaw v Nexus Securities (Pty) Ltd And Another* 2002 (2) SA 510 (C) the court said that "Clients are wont to place their trust not just in the company, but also in the individuals within the company with whom they deal. Clients tend to expect, and in my view are entitled to expect, the exercise of skill and care from the individual advisers and managers. A failure to exercise appropriate skill and care can have devastating consequences, as Durr's case *supra* illustrated. Furthermore, financial advisers and managers can vis-à-vis their immediate clients contract out of or limit liability, and as I see the position, they can for delictual purposes do the same for their employees. To fix Van Zyl with a duty to Mrs Pinshaw, in the circumstances pleaded, strikes me as being fair and in accord with the legal convictions of the community. It seems to me, therefore, that policy considerations favour upholding the duty rather than negating it."

²²² *In Buls and Another v Tsatsarolakis* 1976 (2) SA 891 (T) the court commented: "Every man has a legal right not to be harmed; but is there, apart from a contract, a legal right to be healed? It is no doubt the professional duty of a medical practitioner to treat his patient with due care and skill, but does he, merely by undertaking a case, become subject to a legal duty, a breach of which founds an action for damages, to take due and proper steps to heal the patient? It is an interesting question but, because it was not argued and because it is not necessary for the purposes of the present decision to answer it, I shall not discuss it further." See Strauss *fn* 98 *supra* at p40-41 at which he respectfully submits that where a patient consults a doctor who undertakes to treat him, the doctor assumes no greater duty than to treat the



- 10 The provider will always act in the best interests of the patient and will only administer treatment that is medically necessary²²³.
- 11 The patient will not be abandoned by the provider. Alternative health services will be provided where the provider can no longer provide the health care services previously supplied to the patient. The provider ensure that where a course of treatment has commenced it will be completed²²⁴.
- 12 The provider is entitled to payment for health care services where this is provided for by law and the patient or other person responsible for the patient is liable to pay the costs of such services²²⁵.
- 13 In the absence of provisions in law to the contrary, the patient will not be detained against his or her will by the public provider²²⁶.
- 14 The provider will take reasonable measures to ensure the health and safety of the patient while he or she is receiving health services at its premises²²⁷.
- 15 The goods supplied to the patient in the course of medical treatment are fit for the purpose for which they were supplied and are free of latent defects²²⁸.

patient with due care and skill, unless the doctor has expressly guaranteed that the patient will be healed by his treatment – something which the prudent doctor will not generally do.

223 See *The State v Sikunyana and Others* 1961 (3) SA 549 (E) in which the court stated: “The medical practitioner who performs a dangerous operation with his patient’s consent incurs no criminal responsibility if just cause for the operation exists, for, the law does not regard his conduct as improper: but if ‘there is no just cause or excuse for an operation, it is unlawful even though the man consents to it’- vide *Bravery v Bravery*, 1954 (3) A.E.R. 59 at p. 67, per Denning, L.J. Any intentional act which involves the likelihood of bodily harm to another and which is not recognised by modern usage as a normal and accepted practice of society is forbidden by law and is in no way dependent upon the absence of consent on the part of the victim.”

224 *Applicant v Administrator, Transvaal, and Others* 1993 (4) SA 733 (W)

225 See the previous discussions of the legislation in the different provinces and their fee regulations.

226 Section 12(1) of the Constitution

227 *Beaven v Lansdown Hotel (Pty), Ltd* 1961 (4) SA 8 (N) *Regal v African Superslate (Pty.) Ltd* 1963 (1) SA 102 (AD); *Quathlamba (Pty) Ltd v Minister Of Forestry* 1972 (2) SA 783 (N); *Bronte Hotel (Pvt) Ltd v Low* 1974 (2) SA 353 (R); *Kritzinger v Steyn En Andere* 1997 (3) SA 686 (C). See also section 9(1) of the Occupational Health and Safety Act No 85 of 1993 which states that “Every employer shall conduct his undertaking in such a manner as to ensure, as far as is reasonably practicable, that persons other than those in his employment who may be directly affected by his activities are not thereby exposed to hazards to their health or safety.” The definition of ‘employer’ in the Act is wide enough to include the state.

228 In *Curtaincrafts (Pty) Ltd v Wilson* 1969 (4) SA 221 (E), the court said that a purchaser of an article is entitled to expect is that the article shall be free from such latent defects as are not to be expected in an article of that quality, price and type, unless he obtains a warranty in expressly wider terms. *Kroonstad Westelike Boere-Ko-Operatiewe Vereniging Bpk v Botha and Another* 1964 (3) SA 561 (A) Liability for consequential damage caused by latent defect attaches to a merchant seller, who was unaware of the defect, where he publicly professes to have attributes of skill and expert knowledge in relation to the kind of goods sold.

16 The patient's constitutional rights to life, bodily and psychological integrity, human dignity, privacy, freedom and security of the person, freedom of religion, belief and opinion, and access to health care services will be respected, protected, promoted and upheld by the public provider²²⁹.

It is submitted that most of these terms would be the same for private sector providers.

4.11 Issues Involving Contracts for Health Care Services

If the question of whether or not the provision of ordinary health care services is based on the law of contract is rather murky, it is submitted that the same question when applied to emergency medical treatment is murkier still. Provinces do charge for emergency medical services, including ambulance services, and they also charge for various kinds of emergency medical treatment rendered at health establishments. As stated previously the English law doctrine of consideration forms no part of the South African law of contract and the fact that a payment for services is required does not automatically imply the existence of a contract either. The fact of the matter is that even in the private sector, the inference of a contractual relationship between provider and patient tends to take place after the event at a time when a need arises to scrutinise the nature of the relationship more closely. It is submitted that there is a different dimension to 'trade' in health services compared to other non-essential or more commercial commodities, access to which is not so strictly regulated or controlled by law both in terms of who may supply them and the conditions for

See also *Crawley v Frank Pepper (Pty) Ltd* 1970 (1) SA 29 (N) A seller is obliged to disclose all material latent defects which unfit or partially unfit the *res vendita* for the purpose for which it was intended to be used. By operation of the Aedilitian Edicts, as expounded and adopted in our law, into every contract of sale there is imported a warranty by the seller against such latent defects. Although a seller may contract out of his obligations to disclose and out of the statutorily imported warranty against latent defects, the existence of which he does not know at the time of the sale, if he purports to contract out of his obligation to disclose and of the implied warranty against material latent defects unfitting, or partially unfitting, the *res vendita* for the purpose for which it is sold, and those defects are present to his mind at the time of the sale, but he remains silent about them although he must know that to disclose their existence would cause a prospective buyer either not to purchase at all or to insist on a lower price than he otherwise would pay, he will be given the 'replication of fraud' (*de dolo replicationem*).

See also *Holmdene Brickworks (Pty) Ltd v Roberts Construction Co Ltd* 1977 (3) SA 670 (A) where it was held that a merchant who sells goods of his own manufacture or goods in relation to which he publicly professes to have attributes of skill and expert knowledge is liable to the purchaser for consequential damages caused to the latter by reason of any latent defect in the goods. Ignorance of the defect does not excuse the seller. Once it is established that he falls into one of the above-mentioned categories, the law irrebuttably attaches this liability to him, unless he has expressly or impliedly contracted out of it. The liability is additional to, and different from, the liability to redhibitorian relief which is incurred by any seller of goods found to contain a latent defect. Broadly speaking, a defect may be described as an abnormal quality or attribute which destroys or substantially impairs the utility or effectiveness of the *res vendita* for the purpose for which it has been sold or for which it is commonly used. Such a defect is latent when it is one which is not visible or discoverable upon an inspection of the *res vendita*.

229

This is an obligation imposed upon the state by section 7(2) of the Constitution.

supply, which are not so immediately necessary for the continued or improved health or wellbeing of the person requiring them.

In the case of an emergency, it would not usually be feasible to argue a contractual intention on the part of the patient or the provinces sufficient for the establishment of a contractual relationship because even the patient is very often incapable of forming such an intention before the services are rendered. *Ex post facto* ratification and consent to a contractual relationship is a possibility but even in the private health context it is not a comfortable fit. The nature of the services rendered and the goods supplied²³⁰ in health care services are for the most part such that they cannot be returned should a patient decide after the event, not to accept them or ratify the relationship with the provider. It could be argued that a contract could arise in a situation where the patient is not the contracting party but is for instance a child or an old person for whom the contracting party is responsible, but there is the possibility of counterarguments of duress²³¹ or even undue influence, which may have a fair chance of success in emergency situations. Even in non-emergency situations providers of health care services are often in a position of considerable power relative to the consumer. A person who requires surgery for instance usually does feel strong and well and could in many instances not be in a position to act as rationally or reasonably as would a healthy person. He or she is quite often literally at the mercy of the health care provider who is attending to them and may, depending upon the circumstances, be mentally and physically incapacitated to a considerable extent²³². In

²³⁰ Many of the goods used in the delivery of healthcare services are consumables such as medicines and disinfectants, swabs, dressings and bandages, sutures, needles and syringes, X-Ray film etc.

²³¹ The court in *Paragon Business Forms (Pty) Ltd v Du Preez* 1994 (1) SA 434 (SE) noted that “In *Arend and Another v Astra Furnishers (Pty) Ltd* 1974 (1) SA 298 (C) at 305 *in fine*-306B Corbett J (as he then was) dealt with the requirements of duress as follows: ‘Reverting to the defence raised by first defendant, it is clear that a contract may be vitiated by duress (*metus*), the *raison d’être* of the rule apparently being that intimidation or improper pressure renders the consent of the parties subject to duress no true consent . . . Duress may take the form of inflicting physical violence upon the person of a contracting party or of inducing in him a fear by means of threats. Where a person seeks to set aside a contract, or resist the enforcement of a contract, on the ground of duress based upon fear, the following elements must be established:

- (i) The fear must be a reasonable one.
- (ii) It must be caused by the threat of some considerable evil to the person concerned or his family.
- (iii) It must be the threat of an imminent or inevitable evil.
- (iv) The threat or intimidation must be unlawful or *contra bonos mores*.
- (v) The moral pressure used must have caused damage.’

has been pointed out by, amongst others, Christie in his work *The Law of Contract* 2nd ed at 368, it is impossible to produce a precise and exact formula to be applied to determine when a contract will be set aside or not enforced on grounds of duress (compare, for example, the requirements of duress set out in Joubert (ed) *Law of South Africa* vol 5 para 138 with those as laid down in the Arend’s case *supra* and quoted above).”

²³² One of the earliest cases involving undue influence in South African law is *Preller And Others v Jordaan* 1956 (1) SA 483 (A) in which an elderly farmer in his declaration against his former medical practitioner and the latter’s son and daughter averred that at a time when he was old and sick and bodily, spiritually and mentally weak and exhausted, he had been influenced in an improper and unlawful manner by his doctor, who was also his adviser, to give and transfer to him four farms to be administered by him for the benefit of the farmer’s wife and the labourers on the farm, and that he

*BOE Bank Bpk v Van Zyl*²³³ the court discussed the difference between duress and undue influence²³⁴ and commented that although there was no absolute boundary between these concepts, South African law had not yet developed to the extent that a single overarching defence such as 'misuse of circumstances' was generally recognised.

Another aspect of contracts for health services is that the consumer is not in a position to evaluate the quality of the services he or she receives or the correctness or accuracy of the health advice given. Health economists call it information asymmetry²³⁵. By far

would never have done so had he not been so weak and exhausted and totally under the influence of the doctor. The court held that the grounds of *restitutio in integrum* in the Roman-Dutch Law are wide enough to cover the case where one person obtains an influence over another which weakens the latter's resistance and makes his will pliable, and where such a person then brings his influence to bear in an unprincipled (gewetelose) manner in order to prevail upon the other to agree to a prejudicial (skadelike) transaction which he would not normally have entered into of his own free will. It said that the words 'undue influence', or such words as 'onbehoorlike beïnvloeding' ('improper influence'), constitute an altogether suitable name for the ground of action which exists in these circumstances. The court held that the exception taken by the doctor had rightly been dismissed.

233

BOE Bank Bpk v Van Zyl 1999 (3) SA 813 (C)

234

The court observed at p 824-825: "Daar bestaan egter geen waterdigte skeiding tussen die verskillende kontraktuele aanvegtingsgronde, en veral tussen dwang en onbehoorlike beïnvloeding, nie. (Sien by *Savvides v Savvides and Others* 1986 (2) SA 325 (T) op 329F-G; Wessels *The Law of Contract in South Africa* 2de uitg band 1 /s 1209); Van der Merwe, Van Huyssteen *et al Kontraktereg - Algemene Beginsels* (Juta & Kie, 1994) op 72; Lubbe G 'Voidable Contracts' in Zimmerman en Visser *Southern Cross - Civil Law and Common Law in South Africa* op 261 ev). Lubbe (op cit op 293-4) beskryf die situasie treffend as 'the collapse of conceptual barriers between undue influence and *metus*'.

Meerdere skrywers staan dan ook 'n enkele oorkoepelende aanvegtingsgrond voor, te wete 'die onbehoorlike verkryging van wilsooreenstemming' of 'misbruik van omstandighede'. (Sien Van der Merwe, Van Huyssteen *et al* (op cit op 72-3 en 96 ev) en vgl ook Van Huyssteen 'Onbehoorlike Beïnvloeding en Misbruik van Omstandighede in die Suid-Afrikaanse Verbintenisreg' op 127 ev). Ons regsontwikkeling het egter nog nie die stadium bereik waar 'n enkele oorkoepelende aanvegtingsgrond algemeen erken word nie. Hierdie is ook nie die geleentheid of die plek om enige verdere stukrag aan hierdie moontlike ontwikkeling in ons reg te verleen nie. Vir doeleindes hiervan aanvaar ek dat die regsfiguur van dwang en onbehoorlike beïnvloeding in die huidige stand van ons reg steeds afsonderlike en selfstandige aanvegtingsgronde daarstel. Wat die fundamentele onderskeid tussen die twee gronde betref, is daar 'n skaarste aan gesag by ons. Die verskillende vereistes vir die onderskeie aanvegtingsgronde word egter wel gereeld geformuleer. (Sien by Wessels (op cit /s 1167); *Broodryk v Smuts NO* 1942 TPD 47 op 51-2; *Arend v Astra Furnishers* (*supra* op 306A-B); *Christie Law of Contract in South Africa* 3de uitg op 343-4 in verband met dwang; en *Patel v Grobbelaar* (*supra*) en *Hofer and Others v Kevitt NO and Others* (*supra*) in verband met onbehoorlike beïnvloeding.) Die verskil tussen dwang en onbehoorlike beïnvloeding word kernagtig soos volg gestel deur Kerr *The Principles of the Law of Contract* 4de uitg op 245: 'Undue influence differs from *metus* in that it may be exercised without any threat being issued or menace being present.' Meer volledig en diepgaande is die bespreking deur H Lubbe (op cit te 289), wat daarop wys dat daar dikwels in ons regspraak op hierdie regsfiguur van onbehoorlike beïnvloeding teruggeval is 'where contracts were concluded in response to threats and pressure below the level of *metus* as traditionally understood by the courts'. Die tipe van gevalle waar hierdie verweer normaalweg aanwending vind, word dan soos volg deur die geleerde skrywer geklassifiseer (*ibid*): 'It has often been resorted to in cases involving persons of limited intellectual capacity who, physically and psychologically isolated from the outside world, fall prey to shady and unscrupulous characters. The former often face evidential difficulties when seeking relief from oppressive transactions on grounds such as mental incompetence, misrepresentation, duress, or other traditional defences. As far as both the memory of past events and the ability to communicate these to the court is concerned, the traditional defences often demand too much of the disadvantaged party. The doctrine of undue influence was resorted to in a number of cases in order to counter such evidential difficulties.'"

235

It has been defined as a "Condition in which at least some relevant information is known to some but not all parties involved. Information asymmetry causes markets to become inefficient, since all the market participants do not have access to the information they need for their decision making processes." <http://www.investorwords.com/cgi-bin/getword.cgi?2461> See also generally *Journal of Health Politics, Policy and Law: Special Issue Kenneth Arrow and the Changing Economics of Health Care* http://www.ihcpar.rutgers.edu/rwjf/downloads/research_in_profiles_iss03_apr2002.pdf and Atlas S 'Diagnosis Critical' <http://www-hoover.stanford.edu/publications/digest/033/atlas.html> who states that the patient-doctor relationship is uniquely important to medical care because of the extreme nature of the information gap between patient and physician (i.e. the buyer and the seller. No other industry has such asymmetry of information, and perhaps no other information asymmetry is so permanent...As medical care becomes even more technologically advanced, highly complex diagnostic and therapeutic algorithms will become commonplace. This asymmetry of information makes it crucial that physicians have an established relationship with their patients. This will help ensure that appropriate medical care is offered and accepted, while minimizing concerns for profit that are standard in other industries." Naci Mocan H and the National



the majority of patients are given no choice as to the medication prescribed for them or the nature of the health services that are rendered to them even in the private sector. They are in any event not always in a position to make informed choices in a rational and objective manner. They are not therefore by any means on an equal footing with the expert provider of health care services in the negotiation of a contract. Yet South African law, unlike many other jurisdictions, is curiously slow to regulate any aspect of the relationship so as to ensure a better balance between the parties.

It may be argued that contract is not the best legal mechanism for the delivery of public health services in any event and that particularly in the context of public health services, contractual relationships should not generally be inferred in the absence of clear evidence to the contrary²³⁶. A sound reason for this might be that contract is essentially a mechanism of the free market which promotes competition and operates on the principle that suppliers who deliver bad or substandard service will not last long because consumers will vote with their feet. In the context of health care services, due to information asymmetry and the vulnerability of consumers of health care services, the markets do not operate in the same way as they do in respect of other goods and services. Unfortunately this logic is not in keeping with the case-by-case approach to contracts used in our law. The courts are unlikely to make a general inference about contracts for health services in the public sector but are more likely to prefer to consider only the particular facts of the case before them although obviously a similar case in the same province and governed by the same statutory terms and conditions is likely in practice to yield the same result.

A third issue is that contracts for health services do not generally undertake to cure the patient or even relieve symptoms except where this is stated expressly in clear and unambiguous terms but the expectation or belief of the patient in receiving or consenting to the services is likely to be some kind of relief of even a cure – otherwise

Bureau of Economic Research observe in a paper entitled 'Can Consumers Detect Lemons? Information Asymmetry in the Market for Child Care': "In his seminal paper, Akerlof (1970) shows that in a market with asymmetric information between buyers and sellers, adverse selection is likely to result. If it is difficult for buyers to assess the quality of the product, and if quality is costly to produce, sellers of high quality products will not be able to command higher prices for higher quality. As a result, high quality products will withdraw from the market, leaving the 'lemons' behind."
<http://econ.cudenver.edu/mocan/papers/InformationAsymJuly2003.pdf>

236

Courts in any event are unlikely to infer a contractual relationship unless there is some fairly firm evidence to the contrary. Furthermore if there is clear evidence to the contrary then contract is by definition not to be implied. It is express. Implied contracts must therefore exist in the absence of firm evidence of the existence of a contract. They are apparently creatures of public policy as perceived by the courts in combination with their assessment of the evidence on a balance of probabilities.

why would he bother?²³⁷ The South African law of contract espouses the principle of the 'reasonable man' in much the same way as does the English law²³⁸. Despite this

237

Steyn J 'Contract Law: Fulfilling the Reasonable Expectations of Honest Men' 113 (1997) *The Law Quarterly Review* p 433 notes that a thread runs through English contract law that effect must be given to the reasonable expectations of honest men. He observes that while it is a defensible position for a legal system to give predominance to the subjective intentions of the parties, this is not the English way. English law adopts the external standard which is that of the reasonable man. He notes that the proposition can be restated so as to say that the law must respect the reasonable expectations of contracting parties. In considering what these are he observes that the expectations that will be protected are those that are, in an objective sense common to both parties and that the law of contract is generally not concerned with the subjective expectations of a party. In the case of a contract for health services it would seem from the case law that the reasonable expectations of the patient do not usually include the promise of a cure on the part of the provider. Strauss (fn 94 *supra*) discusses this question at p 40 and refers to the English case of *Thake and Another v Maurice* [1986] 1 All ER 497 (CA) in which the English Court of Appeal refused to come to the conclusion that there had been a guarantee of success where a doctor had performed an unsuccessful vasectomy on a married man. It must be noted, however, that the husband and wife in this case succeeded in contract and in tort because the defendant surgeon had failed to warn of the slight risk that the husband's vasectomy might not leave him permanently sterile. The facts in this case were that the first plaintiff signed a form stating that he consent to undergo a vasectomy operation which was duly carried out. The second plaintiff subsequently became pregnant and gave birth to a baby girl. The plaintiffs brought an action against the defendant claiming that their contract with the defendant was a contract to sterilise the first plaintiff and that the contract had been breached when he became fertile again, alternatively that they were induced to enter into the contract by a false warranty or innocent misrepresentation that the operation would render the first plaintiff permanently sterile or in the further alternative that the defendant had failed to warn them that there was a small risk that the first plaintiff might become fertile again. There was no suggestion that the defendant had not performed the operation properly and at the time of the operation it was known in medical circles that in rare cases the effect of the operation could be reversed naturally. Neill LJ gave judgment as follows: "It is common ground that the defendant contracted to perform a vasectomy operation on Mr Thake and that in the performance of that contract he was subject to the duty implied by law to take reasonable skill and care. The question for consideration is whether in the circumstances of the instant case the defendant further undertook that he would render Mr Thake permanently sterile by means of this operation... It is not in dispute that the task of the court is to seek to determine objectively what conclusion a reasonable person would have reached having regard to (a) to the words used by the defendant, (b) the demonstration which he gave and (c) the form which Mr and Mrs Thake were asked to sign. Counsel for the plaintiffs placed particular reliance on the following matters (1) that on more than one occasion the defendant explained to the plaintiffs that the effect of the operation was 'irreversible', subject to the remote possibility of later surgical intervention, and counsel pointed out that this explanation was reinforced by the statement in the form 'I understand that the effect of the operation is irreversible'... For my part, however, I remain unpersuaded... It is the common experience of mankind that the results of medical treatment are to some extent unpredictable and that any treatment may be affected by the special characteristics of the particular patient. It has been well said that 'the dynamics of the human body of each individual are themselves individual.' I accept that there may be cases where, because of the claims made by a surgeon or physician for his method of treatment the court is driven to the conclusion that the result of the treatment is guaranteed or warranted. But in the present case I do not regard the statements made by the defendant to the effect of his treatment as passing beyond the realm of expectation and assumption. It seems to me that what he said was spoken partly by way of warning and partly by way of what is sometimes called 'therapeutic reassurance'. (As quoted in Kennedy and Grubb *Medical Law* 3rd ed p1556.) Strauss also refers to the South African case of *Behrmann and Another v Klugman* 1988 WLD unreported in which the South African court said it found the reasoning by the English judges 'very persuasive'. This case also involved an unsuccessful vasectomy. The court held that even if the doctor used the phrase 'end of the road' or 'you will not have another child', it was not intended in the context as irreversible other than to describe the nature of the operation and was not intended to give a guarantee as to the permanent success of the operation. The court found that no breach of contract by the doctor was established. Strauss also cites the English case of *Eyre v Measday*, [1986] 1 All ER 488 (CA) an unsuccessful sterilisation operation in which a court rejected the female patient's claim for damages even if the doctor had told the woman that the operation "must be regarded as a permanent procedure". In the case of *Greaves & Co (Contractors) Ltd v Baynham Mickle and Partners* [1975] 3 All ER 99 CA, Lord Denning stated that "The law does not usually imply a warranty that he will achieve the desired result, but only a terms that he will use reasonable care and skill. The surgeon does not warrant that he will cure the patient. Nor does the solicitor warrant that he will win the case." (Quoted by Strauss at p41)

238

In *Ridon v Van der Spuy and Partners (Wes-Kaap) Inc* 2002 (2) SA 121 (C) the court held as follows at p138-139: "... even in the absence of subjective consensus, the so-called 'reliance theory' (the theory of quasi-mutual assent) may in appropriate circumstances form an alternative basis for contractual liability. In the case of *Sonap Petroleum (SA) (Pty) Ltd (formerly known as Sonarep (SA) (Pty) Ltd) v Pappadogianis* 1992 (3) SA 234 (A), Harms AJA considered the leading cases and the opinions of academic writers on the reliance theory (at 238I - 241D) and came to the following conclusion (at 239I - J): 'In my view, therefore, the decisive question in a case like the present is this: did the party whose actual intention did not conform to the common intention expressed, lead the other party, as a reasonable man, to believe that his declared intention represented his actual intention? . . . To answer this question, a three-fold enquiry is usually necessary, namely, firstly, was there a misrepresentation as to one party's intention; secondly, who made that misrepresentation; and thirdly, was the other party misled thereby?' In *Steyn v LS4 Motors Ltd* 1994 (1) SA 49 (A), the Appellate Division again confirmed its adherence to the reliance theory of contractual liability, while at the same time emphasising that, consensus being the essence of contract, subjective intention cannot be ignored: 'Where it is shown that the offeror's true intention differed from his expressed intention, the outward appearance of agreement flowing from the offeree's acceptance of the offer as it stands does not in itself or necessarily result in contractual liability. Nor is it in itself decisive that the offeree accepted the offer in reliance upon the offeror's implicit representation that the offer correctly reflected his intention. Remaining for consideration is the further and crucial question whether a reasonable man in the position of the offeree would have accepted the offer in

discrepancy between the expectations of the patient and the undertaking of the provider, the patient usually has little or no choice in seeking the services of the provider. In the public sector, patients classified as ‘public patients’ in terms of the various regulations cited above do not even have a choice as to which particular provider renders the services. In many instances, their opportunities to ‘shop around’ if they are dissatisfied with the advice or treatment they have been given are significantly restricted if they exist at all. Since the nature of the services rendered at a public health establishment are predetermined and there are often clinical protocols and guidelines which are uniformly implemented across all public health establishments, the power of the patient to ‘negotiate’ the terms of a contract for services falling outside of the predetermined services and clinical guidelines and protocols is virtually non-existent. The position is: these are the services on offer – take them or leave them. In reality in most cases involving health care services, the element of choice reflected in the second half of this statement is no choice at all. The constitutional court in *TAC*²³⁹ reflected these sentiments in the following words:

“Here we are concerned with children born in public hospitals and clinics to mothers who are for the most part indigent and unable to gain access to private medical treatment which is beyond their means. They and their children are in the main dependent upon the State to make health care services available to them.”

It is submitted that the tendency of the English courts to interpret contracts for health services as not including guarantees of a cure or the achievement of the object of the treatment is not always reconcilable with either South African public policy or the law of contract as it applies to other suppliers of goods and services²⁴⁰. In *Edouard v Administrator Natal*²⁴¹ Thirion J observed:

the belief that it represented the true intention of the offeror, in accordance with the objective criterion formulated long ago in the classic dictum of Blackburn J in *Smith v Hughes* (1871) LR 6 QB 597 at 607. Only if this test is satisfied can the offeror be held contractually liable’ (per Botha JA at 61C - E). (See further the discussion of the Steyn case by Lewis in 1994 *Annual Survey of South African Law* at 127 - 9, and of Lewis in 1998 *Annual Survey of South African Law* at p 176 - 9.)” See also *Sonap Petroleum (SA) (Pty) Ltd (formerly known as Sonarep (SA) (Pty) Ltd) v Pappadogianis* 1992 (3) SA 234 (A); *Fourie NO v Hansen and Another* 2001 (2) SA 823 (W); *Nasionale Behuisingskommissie v Greyling* 1986 (4) SA 917 (T); *Multilateral Motor Vehicle Accidents Fund v Meyerowitz* 1995 (1) SA 23 (C); *Road Accident Fund v Mothupi* 2000 (4) SA 38 (SCA); *Maritime Motors (Pty) Ltd v Von Steiger and Another* 2001 (2) SA 584 (SE); *Steyn v LSA Motors Ltd* 1994 (1) SA 49 (A); *Horty Investments (Pty) Ltd v Interior Acoustics (Pty) Ltd* 1984 (3) SA 537 (W); *Distillers Corp Ltd v Modise* 2001 (4) SA 1071 (O)

239 *Minister of Health and Others v Treatment Action Campaign* (No 2) 2002 (5) SA 721 (CC) see para 79 page 750

240 Thirion J in *Edouard v Administrator, Natal* fn 145 *supra* observed at p 384-385: “There is every reason why a party, who, when he enters into a contract, foresees the likelihood that his breach of the contract would result in loss of a particular kind to the other party, should be held liable for such loss when it does eventuate as a consequence of his breach. In this connection the following remarks of Innes CJ in *McCullough & Whitehead v Whiteaway & Co* 1914 AD 599 at 625 are in point: ‘Now, that the document was one-sided and harsh admits of no doubt, but I am not aware of any principle of our law by which, on that ground alone, an undertaking deliberately and knowingly entered into could be repudiated.’ It is furthermore a principle of general application to contracts that, if the kind or type of loss likely to be caused by the breach of the contract was within the reasonable contemplation of the parties when the contract was made



“Where sterilisation was sought to prevent the birth of a handicapped child and a normal and healthy child is born, the parents’ claim for damages in respect of the maintenance of the child might fail on the ground that such loss was not in contemplation of the contracting parties. Considering the ease with which doctors would be able to protect themselves against liability by warning the woman of the danger that the operation might not result in sterility, *there seems to be no reason why the Court should extend to them a special protection against their own negligence; be it in a delictual or contractual context. Pharmacists or manufacturers who make extravagant claims as to the effectiveness of the products they sell would have only themselves to blame.*”(writer’s italics).

There seems to be a degree of logical dissonance about the fact that where the sterilisation operation was not performed the person upon whom it should have been performed has a legally recognisable claim but where it was performed on the understanding that it is ‘irreversible’ only to fail one or two years later there can be no such claim because in ‘rare cases’ the sterilisation has been known to fail. From a layperson’s, i.e. the patient’s point of view, the reason for a healthy person seeking to be sterilised is so that he or she can no longer participate in the conception of a child. There are, however, other ways of contraception which may be generally regarded as less reliable than sterilisation. Presumably one of the considerations in the mind of someone who has opted to be sterilised is not only that he or she no longer wants to be able to conceive a child but also that he or she no longer wants to have to use other forms of contraception. A person who has undergone surgery for sterilisation would not be expecting to have to continue to use other forms of contraception – otherwise there would be little point in being sterilised. The patient who is under anaesthetic in an operating theatre is in no position to appreciate what is happening or see to it that a particular procedure has been done or done correctly. Even when he or she regains consciousness very often the only evidence available is a surgical wound and the information supplied by the surgeon as to what was done.

and therefore not too remote, it is immaterial that the magnitude or extent of the loss is such that it was not within the reasonable contemplation of the parties. *Wroth and Another v C Tyler* [1973] 1 All ER 897 (Ch) at 922. For the position in delict see *Botes v Van Deventer* 1966 (3) SA 182 (A)... The argument that liability in wrongful birth actions might have an adverse influence on professional standards or might limit the number of practitioners willing to undertake sterilisation operations is nothing but a make-weight. The sterilisation operation is a fairly simple surgical procedure and it would be a simple matter for the doctor to explain to the patient that there is, despite the operation, a possibility that she might still fall pregnant. It would be easy for the doctor to contract out of liability. Fears that recognition of wrongful birth claims lead to an unmanageable extension of liability or difficulties in the field of assessment of damages have not withheld the Courts in England from recognising such claims. See *Thake and Another v Maurice* [1986] 2 WLR 337 (CA) ([1986] 1 All ER 497); *Emeh v Kensington and Chelsea and Westminster Health Authority* [1984] 3 All ER 1044 (CA).



The question of whether or not a person should be liable for damages whether in contract or in delict is often a question of public policy as to where the risk should lie. In the case of a sterilisation operation the question is whether it should lie with the patient or the surgeon. The English court in *Thake* in refusing to accept that the surgeon would have guaranteed a successful outcome effectively concluded that the risk should lie with the patient. Neill LJ in that case observed that –

“it is the common experience of mankind that the results of medical treatment are to some extent unpredictable and that any kind of treatment may be affected by the special characteristics of the particular patient.”

Neill LJ seemed to be drawing a very fine distinction in observing that while both plaintiffs and the defendant expected that sterility would be the result of the operation and the defendant appreciated that that was the plaintiffs’ expectation, this did not mean that a reasonable person would have understood the defendant to be giving a binding promise that the operation would achieve its purpose or that the defendant was going further than to give an assurance that he expected and believed it would have the desired result. If the nature of the contractual undertaking is sterilisation it is difficult to see how this differs in principle from a guarantee of sterilisation. The court seems to be saying that the nature of the undertaking was not sterilisation *per se* but a surgical operation designed to effect sterilisation which seems to be splitting hairs in favour of the surgeon²⁴². Neill LJ did find for the plaintiffs in the end but the arguments in his judgment concerning the court’s construction of the contractual relationship between a provider and patient unduly favour the provider. The fact that in rare cases the effect of a vasectomy could be reversed naturally should not be a

²⁴² The dissenting judgment of Kerr LJ seems to pick up on this point in the following observations: “On this appeal it was common ground that the court’s task was to determine objectively the terms of the contract whereby the defendant offered and agreed to operate on the male plaintiff. What would a reasonable person in the position of Mr and Mrs Thake have concluded in that regard? Was it merely that the defendant would perform a vasectomy operation subject to the duty implied by law that would do so with reasonable skill and care? Or was it that the defendant would perform this operation so as to render Mr Thake permanently sterile? Counsel for the defendant submitted that, even if the latter was the correct objective construction of the terms of the offer made by the defendant, it was nevertheless not so understood by Mr and Mrs Thake. He said that this was merely what they believed would be the result of the operation, not what they believed the defendant had undertaken to do...But in my view no such further question arises here, since it is plain on the evidence that Mr and Mrs Thake intended that Mr Thake should be rendered permanently sterile and believed that this is what the defendant had agreed to do.” (As quoted in Kennedy and Grubb *Medical Law* 3rd ed). Kerr LJ also found in favour of the plaintiffs. Kerr LJ distinguished between different kinds of medical treatment as follows: “The considerations which lead me to this conclusion can be summarised as follows. First, we are here dealing within something in the nature of an amputation, not treatment of an injury or disease with inevitably uncertain results. The nature of the operation was he removal of parts of the channels through which sperm had to pass to the outside in such a way that the channels could not reunite... On the evidence in this case the position is quite different, in my view, from what was in the mind of Lord Denning MR in *Greaves & Co (Contractors) Ltd v Baynham Meikle & Partners* [1975] 3 All ER 99 at 103-104, [1975] 1 WLR 1095 when he said: ‘The surgeon does not warrant that he will cure the patient.’ That was said in the context of treatment or an operation designed to cure, not in the context of anything in the nature of an amputation.”

factor which weighs in on the side of the surgeon. It should rather be seen as supportive of the patient's claim. Such cases are *rare*. One cannot help but ask why the patient as the layperson should carry the risk of this rare occurrence when it is the doctor, the expert, who is in the business of sterilisations and is profiting on the basis of his alleged expertise and skill? If the fact that such cases are rare counts in favour of the doctor who is an expert, who has held himself out as an expert to the patient, a layperson, and who is the only person who is likely to know what he actually did or failed to do in relation to a sterilisation operation, the chances of the patient's ever being able to prove that the doctor acted in breach of contract are slim to non-existent. If the fact that such cases are rare counts in the patient's favour, however, then the doctor must discharge an onus. He must have adequate records of what he did that day. He must be able to show that he used a surgical procedure that is generally accepted as being suitable for its intended purpose. If the doctor has not acted in breach of contract in such a situation it should not be difficult for him to show this on a balance of probabilities. In *Thake* the court observed that if the defendant had given his usual warning the objective analysis of what he conveyed would have been quite different.

In another context, the South African law of contract does not hesitate to impose the risk upon the person who is skilled or an expert and is trading on or in that skill or expertise. In *Jaffe & Co (Pty) Ltd v Bocchi And Another*²⁴³ the court observed at p 363:

"The seller who is an *artifex* is placed in a special category. See Voet, 21.1.10. He is fully liable for consequential damages even though ignorant of the latent defects. The South African Provincial Divisions have gone further. They have followed Pothier where he says in his treatise on the contract of sale:

'There is one case in which the seller, even if he is absolutely ignorant of the defect in the thing sold is nevertheless liable to a reparation of the wrong which the defect causes the buyer in his other goods; and this is the case where the seller is an artisan or a tradesman who sells the manufacture of his own trade, or of the kind of dealing of which he makes a business.'

Then he quotes certain examples and proceeds:

'It is the same in regard to a dealer whether he is or is not the maker of the articles which he sells. By the public profession which he makes of his trade he renders himself responsible for the goodness of the merchandise which he sells for the use to which it is destined. If he is the manufacturer he ought to employ in his business none but good workmen for whom he is responsible. If he is not the manufacturer he ought to expose for sale none but good articles. He ought to have knowledge of his wares, and ought to sell none but good.'"

²⁴³ *Jaffe & Co 1961 (4) SA 358 (T)*

The basis for this rule of contract law is clearly public policy²⁴⁴. Hiemstra J states at p 364:

“With humble respect I agree with the statement of Schreiner, J.A., in *Hackett's* case at p. 692 where he said:

‘The decisions in the Provincial Divisions . . . broadly speaking recognise the justice of the generalisation that a seller who manufactures or deals in a kind of goods should be treated as having given the buyer of such goods from him his expert assurance that the goods are free from latent defects. It seems to me that this recognition accords with the present day needs of the community.’

In *Ciba-Geigy (Pty) Ltd v Lushof Farms (Pty) Ltd En 'n Ander*²⁴⁵ the court held that a merchant-dealer who publicly professes to have expert knowledge in respect of the type of product that he sells is liable to the purchaser under the *actio empti* if the latter should suffer consequential damage as a result of a latent defect in the *res vendita*. It said that a latent defect is defined as an abnormal quality or attribute which destroys or substantially impairs the utility or effectiveness of the *res vendita* for the purpose for which it has been sold or for which it is commonly used²⁴⁶.

Consequential damages are greater in extent than ordinary damages. Under the aedilician remedies it is contrasted with redhibitorian relief which is relief for the return of the purchase price paid for the defective goods²⁴⁷.

²⁴⁴ In *Holmdene Brickworks (Pty) Ltd v Roberts Construction Co Ltd* 1977 (3) SA 670 (A), Corbett JA observed at p 682: “The legal foundation of respondent's claim is the principle that a merchant who sells goods of his own manufacture or goods in relation to which he publicly professes to have attributes of skill and expert knowledge is liable to the purchaser for consequential damages caused to the latter by reason of any latent defect in the goods. Ignorance of the defect does not excuse the seller. Once it is established that he falls into one of the above-mentioned categories, the law irrefutably attaches this liability to him, unless he has expressly or impliedly contracted out of it. (See Voet, 21.1.10; Pothier, *Contrat de Vente*, para. 214; *Kroonstad Westelike Boere Ko-op. Vereniging v Botha*, 1964 (3) SA 561 (AD); also *Bower v Sparks, Young and Farmers Meat Industries Ltd.*, 1936 NPD 1; *Odendaal v Bethlehem Romery Bpk.*, 1954 (3) SA 370 (O).) The liability is additional to, and different from, the liability to redhibitorian relief which is incurred by any seller of goods found to contain a latent defect (see *Botha's* case, *supra* at p. 572).”

He then went on to question whether the legal foundation of the claim was in fact the law of contract or the law of delict in the following words at p686-687: Counsel for both parties argued the matter on the basis that the liability of the manufacturer/seller for consequential damages arising from a latent defect in the *res vendita* is founded upon breach of contract. It is by no means clear that this is so. If the liability be regarded as one flowing from an implied warranty or undertaking, imported by law, that goods sold by a manufacturer are free of latent defects (see *Hackett v G. & G. Radio and Refrigerator Corporation*, 1949 (3) SA 664 (AD) at pp. 691 - 2; *Jaffe & Co. (Pty.) Ltd. v Bocchi and Another*, 1961 (4) SA 358 (T) at pp. 364, 368; cf. *Minister van Landbou-Tegniese Dienste v Scholtz*, 1971 (3) SA 188 (AD) at pp. 196 - 7), then the remedy is contractual. If, on the other hand, the manufacturer/seller is held liable on the ground that he is taken to have knowledge of the defect (see *Erasmus v Russell's Executor*, 1904 T.S. 365 at pp. 373 - 4; *Seggie v Philip Bros.*, 1915 CPD 292 at p. 306; *Marais v Commercial General Agency Ltd.*, 1922 T.P.D. 440 at pp. 444 - 5) and that the sale of defective goods with such imputed knowledge is treated as being a case of implied fraud or something cognate to fraudulent misrepresentation (see Mackeurtan, *Sale of Goods*, 4th ed., p. 265; De Wet and Yeats, *Kontraktereg*, 3rd ed., p. 235), or if the ground of liability be the fault, or *culpa*, of the seller in that, being the manufacturer of the goods, he ought to have knowledge of his wares (*Hackett's* case, *supra*, judgment of Court a quo, cited in *Kroonstad Westelike Boere Ko-op. Vereniging v Botha*, *supra* at p. 570; also *Button v Bickford, Smith & Co.*, 1910 W.L.D. 52; *Evans and Plows v Willis & Co.*, 1923 CPD 496 at pp. 503 - A 5), then the remedy would seem to be delictual rather than contractual. The question whether it be breach of contract or delict would affect the basis upon which damages are computed and in practice might lead to different results.

²⁴⁵ *Ciba-Geigy* 2002 (2) SA 447 (SCA)

²⁴⁶ Paragraph [48] at E 465G - J.)

²⁴⁷ *Consol Ltd v/a Consol Glass v Twee Jonge Gezellen (Pty) Ltd And Another* 2002 (6) SA 256 (C), Bignault J commented: “Mr Duminy (for plaintiff) submitted that, in the context of the clause in question, liability for consequential loss or

The question of the applicability of section 27(1) of the Constitution to the private health sector seems to be fairly clear in the sense that, if the services are available in the private health sector anyone should have access thereto. It is not even necessary to consider the provisions of section 8 of the Constitution in this regard and the vexed question of the horizontal application of the Bill of Rights. The state does not have the capacity to provide the health service needs of the entire population and the private sector is therefore an essential component of the health system in South Africa. The fact that the private sector can impose conditions upon such access, such as payment, does not detract from a general right of access and is perfectly acceptable up to a point. That point, it is submitted, is where the conditions imposed are so onerous upon the patient, or so biased in favour of the provider, that they effectively deny access without protecting any legally recognisable interest²⁴⁸ of the provider (or where the interest of the provider, when weighed against that of the patient does not justify, on constitutional and public policy terms, the undue preference given in the contract to the provider's interest) or where the conditions themselves are unconstitutional in the sense that they unjustifiably infringe or limit other constitutional rights of the patient such as the right to equality, the right to human dignity, the right to bodily and psychological integrity or the right to freedom and security of the person.

4.13 Summary and Conclusions

The law of contract, from the point of view of the patient in particular, is not an ideal vehicle for relationships involving health service delivery as the case discussions that follow in chapters five (public sector) and 6 (private sector) will demonstrate. The power of a patient to bargain is greatly diminished both as a result of the nature of the services involved and the patient's physical and mental status as well as the expert and economic power that health professionals and health establishments respectively hold to a much greater extent by comparison. It will be seen in the two subsequent

damage is anything which goes beyond the replacement of defective goods. As presently framed, he submitted, the entire counterclaim (as amended) is a claim for consequential loss. This is borne out by the formulation of the alternative claim, in para 3.8 of the counterclaim (as amended), where the full amount of the damages are described as consequential damages. In my view plaintiff's submission on this issue is correct. The meaning of the term consequential loss or damage is unfortunately not precise. In one sense it is contrasted with direct damage. Visser and Potgieter *Law of Damages* at 55 refers to a view that direct loss means the immediate or direct consequence(s) of a damage-causing event, while consequential loss is damage that flows from such direct loss. In the context of relief under the aedilician remedies, however, a claim for consequential damages is contrasted with redhibitorian relief, ie relief for the return of the purchase price paid for the defective goods."

248

As determined by public policy and the legal convictions of the community



chapters that concepts such as contractual fairness and public policy considerations with regard to contracts are issues that South African courts flirt with but show less convincing signs of espousing in a clear and systematic way especially in the area of health service delivery within the private sector. The Constitution it is submitted adds a distinct gloss on the law of contract concerning health care services generally and access to emergency medical treatment in particular. If the law of contract is to be the legal vehicle by means of which people exercise their rights of access to health care services, including reproductive health care, and emergency medical treatment, the courts are going to have to change their tendency to view such contracts as purely commercial transactions that are no different to contracts for any other kind of service. The Constitution does not preclude the horizontal application of the rights in the Bill of Rights and the fact that the language of section 27(1) refers to a right of *access* as opposed to a direct right to health care services suggests that private sector providers of health care services may well find themselves faced with fairly convincing arguments in the future that this right in particular has a horizontal application especially in circumstances where the state simply does not have the capacity to accommodate everyone who is in need of health care. The Constitution, it is submitted, strongly supports the inclusion of certain implied terms in contracts for the delivery of health care services that relate for instance, to quality of care as a feature of access and a patient's right to be treated with due respect for his or her dignity and privacy. These points and others will be highlighted in the following two chapters as the relevant case law is discussed in more detail.

Chapter 5

Law Of Contract In Health Service Delivery -Public Sector

| | | |
|-------|---|-----|
| 5.1 | Introduction..... | 587 |
| 5.2 | Case Law | 595 |
| 5.2.1 | Behr v Minister of Health | 595 |
| | Facts..... | 595 |
| | Judgment..... | 596 |
| | Discussion..... | 597 |
| 5.2.2 | Shiels v Minister of Health | 598 |
| | Facts..... | 598 |
| | Judgment..... | 599 |
| | Discussion..... | 599 |
| 5.2.3 | Administrator, Natal v Edouard | 600 |
| | Facts..... | 600 |
| | Judgment..... | 601 |
| | Discussion..... | 604 |
| 5.2.4 | Pizani v Minister of Defence | 607 |
| | Facts..... | 607 |
| | Judgment..... | 608 |
| | Discussion..... | 610 |
| 5.3 | Provincial Health Legislation and the Intention of the State..... | 611 |
| 5.4 | Arguments in Favour of Contractual Relationship | 623 |
| 5.5 | Arguments Against Contractual Relationship | 625 |
| 5.6 | Conclusions Regarding Health Care Relationships | 627 |
| 5.7 | Summary and Conclusions | 629 |

5.1 Introduction

In the previous chapter the fundamental principles of the law of contract relating to the delivery of health care services were discussed in some detail. This chapter covers the relevant case law insofar as it involves public sector providers. In the following chapter the same exercise will be conducted with regard to private sector providers.

The question of whether a person enters into a contract with the state in seeking medical services from a public sector health facility is not one that is easily resolved with regard to both policy and law. The nature of the relationship between the patient and the state as a provider of health care services is complicated by the constitutional obligation of the state to achieve the progressive realisation of the right of access to health care services within the available resources. In South Africa, public health services are traditionally the safety net into which all patients can fall, including those

within the private sector who have exhausted their medical scheme benefits or whose membership of a scheme has been terminated for some reason or another. In recent years attempts, such as the introduction of a compulsory package of minimum benefits to be provided by medical schemes, have been made to avoid adverse selection practices by schemes by means of which the risks posed by high cost, high risk health problems such as those suffered by the elderly or the chronically ill, are effectively transferred to public health facilities. Private funders previously were able to risk rate members and thereby secure for themselves the luxury of dealing only with the comparatively manageable funding risks presented by the relatively young and healthy. There is still, however, the problem of the increasing unaffordability of medical schemes for the significant majority of the population coupled with the hard fact that most people who retire from employment are unable to pay medical scheme contributions from their retirement income despite the fact that this is when they are most in need of funding for medical expenses. From a constitutional perspective the state cannot refuse access to health care services to a person who has no alternatives available to them. This is a baseline which materially alters the position of public providers of health care services in relation to their private counterparts. Private health care providers, unlike the state, are not tasked by the Constitution with the progressive realisation of the right of access to health care services within available resources. If there is an obligation upon the state to provide health care services to those who have nowhere else to go the next policy question is whether it should do so also for those who have. In other words should the state with its limited resources also provide medical treatment to medical scheme patients and others who are 'externally funded' and if so, on what basis? Since it is difficult in practice for the state to distinguish between medical scheme patients and other externally funded patients from those who are obliged to use public health services, most provinces have adopted a means test as a way of identifying different categories of patients according to their financial status. Many provinces are desirous of attracting externally funded patients as they see them as generators of much needed income for public health establishments. Of late there have been increased moves, including regulations to the Medical Schemes Act¹, to allow medical schemes to designate state facilities as preferred providers of health care services to members so as to increase the numbers

¹ Medical Schemes Act No 131 of 1998



of scheme members that are using state health facilities. The wisdom of this remains to be seen due to certain infrastructural problems of constitutional origin relating to financial management in government. There is also the problem of limited capacity in the public sector. If the latter treats private patients in such volumes that access for the indigent is compromised, then the constitutionality of treating private patients who can afford to go elsewhere could become questionable. Although there are many potential problems with the running of public hospitals as businesses the question of whether public hospitals owned by provincial governments may make a 'profit' and retain the revenue they generate to improve their services, resources and facilities rather than paying it into the provincial revenue fund is one of the most obvious at this stage. Legislation such as the Public Finance Management Act, read in conjunction with the Constitution,² is problematic when it comes to the creation of trading

² Act No 1 of 1999 read with Section 213 of the Constitution which stipulates:

- (1) There is a National Revenue Fund into which all money received by the national government must be paid, except money reasonably excluded by an Act of Parliament.
- (2) Money may be withdrawn from the National Revenue Fund only-
 - (a) in terms of an appropriation by an Act of Parliament; or
 - (b) as a direct charge against the National Revenue Fund, when it is provided for in the Constitution or an Act of Parliament.
- (3) A province's equitable share of revenue raised nationally is a direct charge against the National Revenue Fund.

Section 226 stipulates:

- (1) There is a Provincial Revenue Fund for each province into which all money received by the provincial government must be paid, except money reasonably excluded by an Act of Parliament.
- (2) Money may be withdrawn from a Provincial Revenue Fund only-
 - (a) in terms of an appropriation by a provincial Act; or
 - (b) as a direct charge against the Provincial Revenue Fund, when it is provided for in the Constitution or a provincial Act.
- (3) Revenue allocated through a province to local government in that province in terms of section 214 (1), is a direct charge against that province's Revenue Fund.
- (4) National legislation may determine a framework within which-
 - (a) a provincial Act may in terms of subsection (2) (b) authorise the withdrawal of money as a direct charge against a Provincial Revenue Fund; and
 - (b) revenue allocated through a province to local government in that province in terms of subsection (3) must be paid to municipalities in the province.

The Public Finance Management Act No 1 of 1999 provision for and regulates various kinds of state or stated owned entities and further elaborates on the principles of government finances laid down in the Constitution. Thus it allows for the creation of national and provincial government business enterprises. The Act defines 'national government business enterprise' as an entity which (a) is a juristic person under the ownership control of the national executive; (b) has been assigned financial and operational authority to carry on a business activity; (c) as its principal business, provides goods or services in accordance with ordinary business principles; and (d) is financed fully or substantially from sources other than (i) the National Revenue Fund; or (ii) by way of a tax, levy or other statutory money". The definition of a provincial government business enterprise is similar. There is also provision for national and provincial public entities. 'Provincial public entity' is defined in the Act as (a) a provincial government business enterprise; or (b) a board, commission, company, corporation, fund or other entity (other than a provincial government business enterprise) which is (i) established in terms of legislation or a provincial constitution; (ii) fully or substantially funded either from a Provincial Revenue Fund or by way of a tax, levy or other money imposed in terms of legislation; and (iii) accountable to a provincial legislature. Under section 13 of the Public Finance Management Act, with relatively few exceptions none of which are relevant to the present discussion, all money received by the national government must be paid into the National Revenue Fund. Section 22 of the Act contains a similar stipulation with respect to provincial governments and Provincial Revenue Funds. Regulation 15.5 of the Treasury regulations under the Public Finance Management Act stipulate that all revenue received by a department must be paid daily into its Paymaster-General account or, for amounts less than R500, as soon as practicable, but at least by the last working day of the month. No provincial department may receive a transfer payment from a national department or public entity directly; such funds must be deposited into the nominated banking account of the province as required by paragraph 15.2.3. Money collected by a department, which is not classified as revenue, must be paid into the department's Paymaster-General account and accounted for in its ledger. This includes money received for agency services provided to another department. Regulation 15.3.2 stipulates that

accounts and other mechanisms whereby health departments of provincial governments can generate and use funds that do not form part of their equitable share raised nationally to fulfil their constitutional obligations³. Although these obstacles are not peculiar to a contractual relationship between public provider and patient since they would be applicable to funds generated in other ways as well, the contractual relationship more than any other is associated with the idea of trade and commerce and what in administrative law might be termed the managerialistic approach to public health administration. The existence of a *contractual* relationship between patient and public provider, more than any other would promote the notion that the state is 'selling' health care goods and services and patients are 'purchasing' them creating a wealth of completely different legal and social implications for and perceptions of the relationship between the public provider and the patient and possibly even casting the public provider in the same light as the private provider of health care services to a much greater extent.⁴ It must be stated at the outset, however, that a contractual relationship does not necessarily imply a commercial objective. This would depend upon the government policy behind the promotion of a specifically contractual relationship as opposed to any other kind (i.e. the intention of the parties). There may be many reasons for preferring a contractual relationship as the basis for a public provider-patient relationship that are not related to revenue generation or profit. One of these might be to empower consumers to play a more active role in ensuring

money deposited into the Paymaster-General account must immediately be available to the relevant treasury for funding expenditure or investment according to its central cash management responsibilities.

3

According to section 227 of the Constitution -

(1) Local government and each province-

(a) is entitled to an equitable share of revenue raised nationally to enable it to provide basic services and perform the functions allocated to it; and

(b) may receive other allocations from national government revenue, either conditionally or unconditionally.

(2) Additional revenue raised by provinces or municipalities may not be deducted from their share of revenue raised nationally, or from other allocations made to them out of national government revenue. Equally, there is no obligation on the national government to compensate provinces or municipalities that do not raise revenue commensurate with their fiscal capacity and tax base.

(3) A province's equitable share of revenue raised nationally must be transferred to the province promptly and without deduction, except when the transfer has been stopped in terms of section 216.

(4) A province must provide for itself any resources that it requires, in terms of a provision of its provincial constitution, that are additional to its requirements envisaged in the Constitution.

4

See Burns Y 'Government Contracts and the Public/Private Law Divide' 1998 *SA Public Law* 13 p 234 where she observes that one of the significant changes to American administrative law as a result of the increasing privatisation of state functions is a market discourse which narrows the role of public interest values and replaces them with that of cost-benefit analysis. She notes that the cumulative effect of a market approach to regulation, regulatory structure and procedures is to introduce a new mix of public and private power. In South African law this would have considerable implications for state operations in ways that are not at obvious at first - for instance in the context of competition law. The Competition Act No 89 of 1998 applies to all economic activity within, or having an effect within, the Republic except collective bargaining in the labour relations context and significantly for purposes of the present discussion "concerted conduct designed to achieve a non-commercial socio-economic objective or similar purpose." The State is not per se exempt from the provisions of the Competition Act. The national government and the provincial governments and municipalities are not a single entity but may well be seen under the Competition Act as 'firms' in their own right. The definition of 'firm' in the Competition Act is disturbingly vague. In terms of section 1'firm' "includes a person, partnership or a trust."

they receive services of an appropriate and acceptable standard, another may be to foster a culture of competitive service provision between public health establishments for the benefit of patients. When a public provider provides health care services in its capacity as part of the executive branch of government as opposed to a capacity which is much closer to that of an ordinary private sector supplier of the same services, the dynamic has the potential to change quite considerably as illustrated later on in this section by experience in New Zealand.

As the dynamics of state operations change so too do the legal considerations governing them. Burns⁵ points out that if one accepts that an outsourcing contract, or service provision contract, is an administrative law agreement in the sense that the administrative authority retains a measure of state authority with the result that the relationship between the state and the other party is one of inequality), it may be argued that the agreement should be subject to principles of public law. The same is true of a contractual relationship in terms of which the state provides services such as health care. As was noted in the previous section on administrative law, the stage is already set, at least to some extent, in South African law for the application of administrative law to contractual relationships even where both parties to the contract are private entities. In terms of section 3 of the Promotion of Administrative Justice Act (PAJA)⁶, “administrative action” means any decision taken, or any failure to take a decision, by *inter alia* a natural or juristic person, other than an organ of state, when exercising a public power or performing a public function in terms of an empowering provision which adversely affects the rights of any person and which has a direct, external legal effect. It is submitted that the careful boundaries that were previously drawn between public and private law, and different areas of law under the previous legal order are becoming transparently thin⁷. This is as much the result of changing

⁵ Burns fn 4 *supra*

⁶ Promotion of Administrative Justice Act No 3 of 2000

⁷ Cockrell A ‘Can you paradigm? – Another perspective on the public/private law divide 1993 *Acta Juridica* p 227 points out that “...the rules of ‘private law’ are doctrinal artefacts by means of which the state regulates and coerces all civil society and as such might equally qualify to be categorized as a matter of ‘public law’. That is to say, the community as a whole has a legitimate interest in the matter in which ‘private’ transactions are regulated, and this interest goes far beyond the minimalist enforcement of rules to which individuals have given their prior consent. The law of contract provides (ironically enough), the best example of this shift in emphasis. A long tradition in legal scholarship has sought to portray the rules of contract as being no more than the natural expression of the wills of the contracting parties. But this idea was subjected to a process of corrosive critique in the early part of the century by American Realists who sought to show that the real concern of contract law centred on the circumstances in which the sovereign power of the state would be put at the disposal of one party in order to coerce another. Seen in this light, the rules governing contractual liability begin to look remarkably like part of public law” See also Pretorius DM (‘The Defence of the Realm: Contract and Natural Justice’ 2002 *South African Law Journal* 119 p 374). He notes: “The *audi alteram partem* principle applies

views on how governments and the private sector should operate and interact as it is on the Constitutional legal order. Some of the changes are worldwide. Burns⁸ notes that the emphasis on global competition and economic growth coupled with the general weakness of any single individual state in the face of globalization processes encourages more negotiation on the part of the state as well as regulatory approaches more sympathetic to the cost conscious demands of multinational businesses and government as well. It is not so much the nature of the powerbearer as the nature of the power that is to determine which legal principles apply⁹. Burns¹⁰ observes that South African law has not as yet fully recognised the administrative agreement, despite the conclusion of a large number of these agreements. She states that the question is whether these administrative agreements are ordinary commercial contracts, which are subject to the principles of private law and the provisions of the State Liability Act¹¹ or whether they are subject to separate public law rules. The public sector is increasingly taking on every appearance of private sector style operations while the degree and nature of power that is being increasingly wielded by

whenever a statute empowers a public body of official to perform an act or to give a decision prejudicially affecting a person in his liberty or property or existing rights, or whenever he has a legitimate expectation that he will be heard before that act is performed or that decision given. It is sometimes asserted that the application of the rules of natural justice is confined to the field of administrative law and, more specifically that the audi principle is not applicable to the exercise of 'purely contractual rights'. However this assertion is fallacious: the twin pillars of natural justice, as Sir William Wade famously declared, are statute and contract" (footnotes omitted). Pretorius observes that: "There is another difficulty with the public power/contractual rights dichotomy. It fails to draw an adequate jurisprudential distinction between powers and rights. It has been suggested that public authorities, like natural and juristic persons, may 'acquire' powers by contract. It has also been said that the act of a public body would be subject to judicial review if the source of the power concerned is statutory but not if the relevant power is derived from contract. Statements of this nature are dogmatically unsound. Public bodies cannot 'acquire' powers from contracts. Public powers are derived from statute, and, in England, also from the prerogative and, in the case of certain incorporated bodies, from their charters. A public body may have a contractual or common-law right to cancel a contract. A distinction must be drawn between a right and the antecedent powers that inhere in the body concerned by virtue of its constituent statute or charter or, in some cases, by virtue of the prerogative. If the body concerned were to exercise its contractual or common-law right to cancel a contract, it would ultimately be acting by virtue of some pre-existing power in much the same way as a company's contractual or common-law right to cancel a contract can only be exercised by virtue of the fact that its incorporation clothed it with juristic personality and conferred upon it the power or capacity to enter into contracts within the scope of its legal capacity, as determined by its memorandum of association. Thus, in Hohfeldian terms, the ability or capacity to conclude contracts is a 'power'; the legally enforceable claims that are derived from contracts are rights" (footnotes omitted)

⁸ Burns fn 4 *supra*

⁹ But see Pretorius (fn 7 *supra*) who observes that: "There is another difficulty with the public power/contractual rights dichotomy. It fails to draw an adequate jurisprudential distinction between powers and rights. It has been suggested that public authorities, like natural and juristic persons, may 'acquire' powers by contract. It has also been said that the act of a public body would be subject to judicial review if the source of the power concerned is statutory but not if the relevant power is derived from contract. Statements of this nature are dogmatically unsound. Public bodies cannot 'acquire' powers from contracts. Public powers are derived from statute, and, in England, also from the prerogative and, in the case of certain incorporated bodies, from their charters. A public body may have a contractual or common-law right to cancel a contract. A distinction must be drawn between a right and the antecedent powers that inhere in the body concerned by virtue of its constituent statute or charter or, in some cases, by virtue of the prerogative. If the body concerned were to exercise its contractual or common-law right to cancel a contract, it would ultimately be acting by virtue of some pre-existing power in much the same way as a company's contractual or common-law right to cancel a contract can only be exercised by virtue of the fact that its incorporation clothed it with juristic personality and conferred upon it the power or capacity to enter into contracts within the scope of its legal capacity, as determined by its memorandum of association. Thus, in Hohfeldian terms, the ability or capacity to conclude contracts is a 'power'; the legally enforceable claims that are derived from contracts are rights" (footnotes omitted)

¹⁰ Burns fn 4 *supra*

¹¹ State Liability Act No 20 of 1957

major multinational private sector corporations is in many cases greater than that of governments. It is submitted that the boundaries between state and private sector are becoming less distinct in South Africa where there is a comprehensive set of Treasury regulations governing public private partnerships¹². There are increasing numbers of these partnerships in the area of health services delivery¹³. If the rigid split between public and private law is to be maintained, which branch of law will govern the relationship between a public-private partnership delivering health care services and its patients? One could argue that the definition of public-private partnership is such that the private provider is performing the functions of the public entity – i.e. a public function - and that therefore public law should apply even when it is a private provider that is performing it but this argument loses much of its logical impetus when that same private sector provider, operating outside of the public-private partnership, is delivering exactly the same health care services in a purely private capacity. The nature of the function of health care services delivery is not such that it is a uniquely or even routinely public function as opposed to a private one. The problems that arise with the classification of law into categories of public and private are demonstrated by the judgment of the court in *Cape Metropolitan Council v Metro Inspection Services (Western Cape) CC*¹⁴. The criticism of this judgment by Pretorius has already been referred to earlier¹⁵. To briefly recap, Pretorius argues that the court did not take sufficient cognisance of the fact that the contract effected the outsourcing of a public function to a private entity in terms of a statutory authorisation to do so

¹² See Treasury Regulations For Departments, Trading Entities, Constitutional Institutions And Public Entities Government Notice R740 in GG 23463 of 25 May 2002 which define 'public-private partnership' as a commercial transaction between an institution and a private party in terms of which-

- (a) the private party either performs an institutional function on behalf of the institution for a specified or indefinite period; or acquires the use of state property for its own commercial purposes for a specified or indefinite period;
- (b) the private party receives a benefit for performing the function or by utilising state property, either by way of:
 - (i) compensation from a revenue fund;
 - (ii) charges or fees collected by the private party from users or customers of a service provided to them; or
 - (iii) a combination of such compensation and such charges or fees.

¹³ A public-private partnership in healthcare, the first of its kind in South Africa, was launched on November 2002 when the Free State health department signed an agreement with Network Healthcare Holdings Limited (Netcare) and its empowerment partner Community Healthcare Holdings for the Pelonomi and Universitas hospitals in Bloemfontein. The partnership involves the use of spare space between the two institutions. In terms of the agreement the Netcare/Community Healthcare Joint Venture consortium manage over 200 private beds and five operating theatres at the two hospitals, which are the largest public hospitals within the Free State. The consortium and its partners will invest R80-million in the project over the next two years. In terms of the agreement, Community Healthcare holds 40% shares of the consortium, Netcare holds 25% and the remaining 35% is held by black empowerment companies and groups consisting of healthcare practitioners, women's groups and other investors.

http://www.safica.info/ess_info/sa_glance/health/pelonomi.htm. There is also a public-private partnership involving the Inkosi Albert Luthuli Hospital, the R3 billion, 846 bed public hospital in KwaZulu-Natal, where a range of non-clinical functions has been outsourced. The underlying objective is to achieve better service especially in fields where the public sector has not been particularly effective. These include the provision and maintenance of medical technology and information technology (<http://www.doh.gov.za/docs/sp/2003/sp0610a.html>). See also Thomas A and Hensley M 'Public-Private Partnerships in Healthcare' (http://www.ip3.org/publication2002_013.htm)

¹⁴ *Cape Metropolitan Council v Metro Inspection Services (Western Cape)CC and Others* 2001 (3) SA 1013 (SCA)

¹⁵ Pretorius fn 7 *supra*

and that the purely commercial flavour of the contract was questionable. It is submitted that if one thinks about the law not in terms of compartments of public and private but in terms of the underlying constitutional principles and values upon which it rests then many of these problems can be avoided. Concepts of fairness, reasonableness, *bona fides*, public interest and due process are not unique to public law and the power wielded by some private entities these days exceeds that of the state so it seems illogical to argue that the principles of natural justice, for instance, are applicable only in the public sector because the parties are not on an equal footing and there is a need to recognise this and avoid abuses of power by the state. In many instances in the private sector the parties are also not on an equal footing and there are significant power imbalances against consumers. The courts have used exactly the same arguments when dealing with restraint of trade clauses in employment contracts where the employer and the employee are both private entities. Questions of power imbalances are not unique to the public sector and should therefore be a concern of the law in general as opposed to just 'public law'. The distinctions between administrative action and other kinds of activity are valuable not so much because they seek to categorise actions into areas of public law as opposed to private law but because they identify acts and decisions in a context which significantly weights the power balance in favour of a particular entity and there is thus the potential for equally significant prejudice to those affected by its acts. A statutory power to act in a way that adversely affects the rights of others and which has a 'direct, external legal effect'¹⁶ must therefore be balanced out by considerations of fairness and reasonableness if it is not to be exercised in a way that is offensive to constitutional principles and values and detrimental to the public interest. This is why administrative law has a tendency to be more visible in the public sphere of operation as opposed to the private sphere. Most of the powers exercised in the former are statutory and peculiar to the entity upon whom they are conferred. There is no equivalent or balancing power held by those against whom it is exercised or those who are affected by its exercise. It is submitted that the definition of 'administrative action' in the PAJA supports this argument.

¹⁶ See the definition of administrative action in section 1 of the PAJA referred to previously.

Significantly, whether they are dealing with public or private sector issues, the language of the courts and the considerations they apply to public and private sector relationships are becoming increasingly similar. By way of example, there are a number of fundamental concepts which are being progressively applied within both the private and public spheres in keeping, it is submitted, with the South African constitutional order. They are canvassed briefly below but also come up for discussion elsewhere in this section.

5.2 Case Law

The relevant cases will be canvassed and discussed in this section in order to ground further discussion on the subject of the contractual relationship between public provider and patient in the sections that follow.

The case of *Behr v The Minister of Health*¹⁷ is of relevance to the question of whether the state can contract with a patient for the delivery of health care services although it does not directly deal with the question of the legal basis of the relationship between a public sector provider of health care services and the patient but rather a husband's obligation to maintain his wife.

5.2.1 Behr v Minister of Health

Facts

Behr's wife deserted him after some marital problems. When a reconciliation attempt went awry he shot her. She was admitted to a government hospital in Bulawayo suffering from a severe gunshot wound to the abdomen. The question was whether the husband or wife was responsible for the charges for the medical treatment in view of the fact that she had deserted him previously. As Murray CJ put it, "The present case

¹⁷ *Behr* 1976 (2) SA 891 (T)

concerns a husband's obligation to pay for what is conceded to be a necessary services supplied to his wife.”

Judgment

The court remarked that there was a difference between the English law and the Roman-Dutch law as followed in South Africa and Southern Rhodesia in regard to the basis on which a husband's liability to pay for such household necessities as have been supplied to his wife is founded. It noted that the *Du Preez v Cohen Bros*¹⁸ Wessels J expressed the view that the wife's capacity to bind her husband's credit for necessities was not a result of the relationship of principal and agent but was an incident necessarily flowing from the mere fact of marriage. After considering other cases the court observed that-

“this legal obligation appears to be clearly established as existing while there is a common household and presumably also where the parties are living apart by mutual consent.”

At p 631 of the judgment Murray CJ said that he shared the view that the plaintiff must be held to his particulars as pleaded which placed the claim on the restricted basis that the defendant was liable *qua* husband for the cost of necessary medical attention supplied to his wife. In consequence, it would not be proper, he said, to base the court's decision on various points discussed during the hearing relating to implied authority from Behr, ratification of the supply of services to the wife, whether it was obligatory on the defendant in order to escape liability, to have given notice of desertion prior to the supply of services, to the hospital authorities who had previously in 1958 rendered her hospital treatment for which he had paid them, and whether there was any obligation on him, not as husband, but as the person who had inflicted a serious injury upon her to recompense the hospital authorities for the medical treatment necessary to save her life. The court said rather than the ground for upholding the claim of the Minister of Health was based on the fact that though the wife had been a deserting party until the infliction of the injury upon her, this feature merely suspended the husband's obligation of maintenance as long as the desertion continued. Thereafter if by reason of his wrongful action he either made it impossible

¹⁸ *Du Preez* 1904 T.S. 157



for her to return to the household, or gave her just cause for refusing to do so, his obligation revived. The court said that this was the immediate effect of his infliction of this serious injury upon her.

In his judgment Young J noted that on the hospital admission form the person responsible for the fee was given as Behr and that he at no time disputed liability until a letter of demand was sent to him, whereupon he referred the plaintiff to the wife for payment.

Discussion

As stated previously this case did not revolve so much around the nature of the relationship between the government hospital in Bulawayo and the patient as it did around the relationship of the husband and wife. However, a reading of the judgement indicates that there was a general assumption that the relationship was at least quasi contractual¹⁹ and that the government hospital was regarded in the same light as any other supplier of household necessities. There was talk of the wife's being authorised by her husband to obtain the necessary medical treatment, alternatively, ratification (of the contract for) the supply of services to the wife. There was also some discussion as to whether the husband should have placed a notice in the paper warning potential contractants of his wife's desertion so that they would know she no longer had the power to bind his credit. A husband's duty to provide his wife with the necessaries of life is usually exercised by contracting with the suppliers of those necessaries – hence the debate about the basis of the wife's authority to bind the husband contractually to pay for those necessaries. The fact that the court found that the husband was obliged to pay for the costs of the medical treatment his wife had received on the basis of the duty of maintenance he owed her rather than on the basis of the delictual claim which

¹⁹ Murray CJ observed at p 630: "This legal obligation appears to be clearly established as existing while there is a common household, and presumably also where the parties are living apart by mutual consent. Where, however, the wife has left the home without the husband's consent, the right of a third party to recover from the husband the cost of necessaries supplied to her depends on whether the wife had or had not just cause for leaving the home. If she had such cause, the husband's legal duty to support his wife and provide her with necessaries continues despite the cessation of the joint household, and the tradesman who supplies her with necessaries such as food or clothing, the landlord who lets her a lodging, the professional man who renders her necessary service, are entitled to recover from the husband. As it is put by Dr. Ruben in his handbook on *Unauthorised Administration (negotiorum gestio)* at p 62, the tradesman or landlord or professional man is discharging a legal duty resting upon the husband; he is a *gestor* who has administered the affairs of the *dominus*, i.e., the husband, and is therefore entitled to compensation from him. This is the basis upon which the judgment of Benjamin, J., in *Gammon v McClure*, 1925 CPD 137 at p. 139, is based, and the husband's liability to pay compensation to the *gestor* was enforced in *Coetzee v Higgins*, 5 E.D.C. 352, a case which has subsequently been referred to with approval (see e.g., *Excell v Douglas*, 1924 CPD 472 at p. 481)."

she clearly had against him is also of relevance since it indirectly supports the notion that the wife bound the husband contractually in exercising her right to obtain necessary medical treatment at his expense. The approach of the government hospital itself seemed to be in the usual contractual context. The admission form required the wife to state who would be responsible for payment of the hospital's fee and when the husband subsequently failed to make such payment, it sent him a letter of demand. The government had clearly regarded the husband as directly contractually obliged to it for the fees for his wife's medical treatment.

The case of *Shiels v Minister of Health* is also supportive of the notion that the public health sector can contract for the delivery of health care services to patients. In this case however, the health services also involved the sale of goods.

5.2.2 *Shiels v Minister of Health*²⁰

Facts

The respondent had obtained judgement in a magistrate's court for the price of an artificial leg which has been manufactured for the appellant at a government institution. The appellant denied liability saying that while he admitted that the respondent had done certain work and manufactured an artificial limb for him it was a specific term of the contract that the limb to be manufactured by the appellant was to be a copy of a limb which had been previously manufactured for him in Glasgow and that it had to be double-articulated at the hip. He said that the limb which had been manufactured by the respondent was not a copy of the limb that had been made in Glasgow because it was not double articulated at the hip. The evidence showed that the making of an artificial leg is a highly skilled task involving a lengthy process of fitting and adaptation on the patient before it is finally completed. There was no question of the patient being able to obtain a ready-made leg to fit him. It emerged that the leg made by the respondent was in fact designed to be an improvement on the leg that had been made in Glasgow. The accounts department of the central hospital sent the appellant an account for the leg once it had been made and adjusted to fit him.

²⁰ *Shiels* 1974 (3) SA 276 (RAD)

Judgment

The court found that the contract which had eventuated between the appellant and the respondent had not been for a leg the same as the one made in Glasgow. It considered whether the appellant was entitled to summarily reject the leg after a trial of a day or two and refuse to pay the account without affording the respondent the opportunity of adjusting the leg so as to make it fit. The court referred to the case of *Theunissen v Burns*²¹ dealing with 'almost identical facts' in which it was held that where a person had ordered three suits from a tailor and had been fitted by the tailor but had complained that they did not fit and refused to pay the bill, the tailor was entitled to a reasonable opportunity to take the suits back and make them fit. As the appellant in that case failed to afford the tailor that opportunity, he could not escape liability for the tailor's account and accordingly his appeal was dismissed. The court also referred to the case of *Kruger v Boltman*²² involving a contract for the fitting and supply of a set of artificial teeth. The teeth were finished off and sent to the customer who refused to pay the bill because they did not fit properly. In its judgment in that case the court said that unless and until the respondent had been given an opportunity of remodelling the set, his claim for payment on the contract could not be resisted. The court in *Shiels*' case concluded that the principle established in those cases must apply to a contract such the present one involving the highly technical task of constructing an artificial leg and making it fit, particularly in the case of the appellant who, by his own admission was a difficult customer because he had a very short stump. It held that a reasonable opportunity must be afforded after the completed article has been despatched to the customer and that the appellant had not afforded the respondent that reasonable opportunity and that the appeal should be dismissed with costs.

Discussion

The important points to note about this case are that the court made no distinction between suppliers of goods in the private sector and the government as a supplier of goods. The same rules applied to both. It did not question the fact that a contractual

²¹ *Theunissen* 21 S.C 421

²² *Kruger* 1933 (1) PH A3

relationship had arisen between the Minister of Health and Shiels. In fact it enforced the contract that it found to have arisen between them. The contract could be said to have been for a combination of sale of goods and for work²³ because it was not only for the manufacture of the leg but also for the fitting of the leg to the appellant. It is therefore not only health care services which may be the subject of a contract between the state and the patient but also goods. This would embrace not only artificial limbs but also *inter alia* medicines, dressings and other consumables, wheelchairs, dentures, spectacles and other assistive devices.

The most recent case to recognise a contractual relationship between a public provider and a patient is that of *Administrator Natal v Edouard*²⁴. It is a South African case as opposed to the two that were previously cited which were decided by then Rhodesian courts with reference to South African legal principles.

5.2.3 Administrator, Natal v Edouard²⁵

Facts

The respondent's wife was admitted to a provincial hospital for a Caesarian section in order to give birth to their third child. The respondent and his wife requested that a tubal ligation be performed on the wife at the same time as they could not afford to have any more children and the wife wished to be sterilised. The tubal ligation was not in fact performed and one year later the wife gave birth to a fourth child. The respondent sued for damages on the basis of breach of contract including the cost of supporting and maintaining the child born as result of the failure to perform the sterilisation operation, and general damages for the discomfort, pain and suffering and loss of amenities of life suffered by his wife.

²³ In *Smit v Workmen's Compensation Commissioner* 1979 (1) SA 51 (A) the test for the difference between a contract for services (*locatio conductio operarum*) and a contract of work (*locatio conductio operis*) was discussed at length. For further discussion of contracts of sale and contracts of work see *Sifris en 'n Ander, NNO v Vermeulen Broers* 1974 (2) SA 218 (T) (in which the court considered the dividing line between a contract of sale and a contract of work); *BK Tooling (Edms) Bpk v Scope Precision Engineering (Edms) Bpk* 1979 (1) SA 391 (A); *Wed (Pty) Ltd v Pretoria City Council And Others* 1988 (1) SA 746 (A); *Scholtz v Thompson* 1996 (2) SA 409 (C); *Klopper En Andere NNO v Engelbrecht En Andere NNO* 1998 (4) SA 788 (W). See also Van Oosten FFW 'Medical Law – South Africa' *International Encyclopaedia of Laws* Vol 3 Blanpain R (ed)

²⁴ *Administrator Natal v Edouard* 1990 (3) SA 581 (A)

²⁵ *Edouard* fn 24 *supra*

The two issues submitted to the Court for adjudication were whether the Administration was in law obliged, because of its breach of contract, to pay (i) a sum representing the cost to the respondent and Andrae of maintaining and supporting Nicole, and (ii) general damages for the non-patrimonial loss suffered by Andrae. It was agreed that, should the Court find for the respondent on the first issue, an amount of R22 500 was to be awarded, and that an affirmative finding on the second issue would carry an award of R2 500.

Judgment

The court noted that the respondent's claim under consideration was unique only in the sense that it is based upon a complete failure to perform a sterilisation operation. It said that in the wealth of foreign case law of which the court was aware, the plaintiff's action was invariably based upon a failed sterilisation procedure (including a vasectomy), or a failure to warn that the procedure might not be 100% successful or that its effect might be reversible, and, on occasion, the incorrect dispensing of a prescription for birth-control pills. The court stated that in principle the precise nature of the breach of contract or neglect giving rise to the birth of an unwanted child is immaterial. Thus it can make no difference whether the breach of contract consists of a complete failure to carry out the agreed procedure, or of an ineffective surgical intervention. Van Heerden JA then canvassed in detail the various public policy issues surrounding claims for wrongful pregnancy in foreign jurisdictions. They are not canvassed here because they are not relevant in the present context as they are not peculiar to the law of contract but can also be based on the law of delict. The court observed that the claim in *Edouard*²⁶ was based on the law of contract. Van Heerden JA stated that because of the facts set out in the stated case, as amplified, it was common cause that:

- the respondent suffered damages in the form of child-raising expenses as a result of the breach,
- that such damages were a direct and natural consequence thereof, and
- that the loss was contemplated by the parties as a likely consequence of failure to perform the agreed sterilisation operation, more particularly

²⁶ *Edouard* fn 24 *supra*

because, to the knowledge of the Administration, the respondent and Andrae could not afford to support any more children.

He pointed out that the claim therefore satisfied all of the requirements of South African law for the recovery of damages flowing from breach of contract. Van Heerden JA noted that in the court *a quo* it was nonetheless contended that the claim should be disallowed because of considerations of policy and expediency but that in the appeal court, counsel for the appellant, correctly, in van Heerden JA's view, did not rely on considerations of expediency. Van Heerden JA expressed agreement with the views of Thirion J in the court *a quo* on this subject saying that there was in any event in South African law no authority for denying a claim for the recovery of contractual damages merely because it may be expedient to do so²⁷. In the appeal against the judgment of Thirion J, however, counsel for the appellant did persist with the contention that the respondent's claim should have been rejected by reason of the dictates of public policy. Van Heerden JA was not as ready as Thirion J to accept the idea that in appropriate circumstances public policy may stand in the way of the recovery of damages for breach of contract where the contract itself is valid. He assumed for the purposes of the case in question that in South African law public policy may require the disallowance of a claim for damages founded upon a breach of a valid and enforceable agreement. The appeal court then proceeded to examine more closely the public policy objections to a claim for wrongful pregnancy which it identified as running along two broad themes - 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 child²⁸. The court observed with regard to damages that in South African law intangible loss is in principle awarded only in delict and then, apart from infringements of rights of personality, only in the case of a bodily injury. It said that if patrimonial loss is claimed, the tangible benefits accruing as a result of a breach of contract or the commission of a delict (other than those excluded by an application of the maxim *res inter alios acta*) must be brought into account and that the monetary value of those benefits must be set off against the gross loss. Van

²⁷ *Edouard fn 24 supra* at p 588

²⁸ *Edouard fn 24 supra* at p 589



Heerden JA noted that it has, however, never been suggested that benefits of a non-pecuniary nature must also be 'subtracted' from a patrimonial loss nor is there any foundation for such a suggestion in South African law. The court held that 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. It referred with approval to the Bundesgerichtshof which states 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. The court quoted from a number of American cases in stating its view that public policy did not preclude a claim for contractual damages for an unwanted pregnancy²⁹. Counsel for the appellant argued that an inevitable incident of birth is the creation of a legal duty obliging a parent to support the child and that statute law serves to reinforce the duty, eg s 6 of the Divorce Act³⁰. He stated that while the pregnancy claim of the respondent was not one by which he sought to be relieved from his obligation to support the child, he did seek to have the Court determine the cost of that support and to obtain an order for recovery of that amount from the appellant. In the result the judgment of the court *a quo* served to transfer from the respondent to the appellant the obligation to maintain the child. He argued that this runs counter to public policy which demands that there be no interference with the sanctity accorded by law to the relationship between parent and child. Van den Heever JA expressed the view that there was a basic fallacy in this submission in that it in no way relieved the respondent (or his wife) from the

²⁹ *Edouard* fn 24 *supra* at p591-592: In concluding my discussion of the two themes I can do no better than quote the following judicial pronouncements: 'It is not at all that human life or the state of parenthood are inherently injurious; rather it is an unplanned parenthood and an unwanted birth, the cause of which is directly attributable to a physician's negligence, for which the plaintiff seek compensation. Certainly there are positive aspects to child rearing and enduring benefits to parenthood, but that does not mean, to me, that parents who take measures to prevent the conception of a child should be burdened with all of the expenses that go along with raising that child - expenses that they would not have incurred had it not been for the negligence of another.' [*Cockrum v Baumgartner* 447 NE 2d 385 (1983) at 392-3 (dissent of Clark J)] And: 'I see no reason for departing from the rule that a negligent person is liable for the foreseeable consequences of his negligence. There is no justification for holding, as a matter of law, that the birth of an "unwanted" child is a "blessing". The birth of such a child may be a catastrophe not only for the parents and the child itself, but also for previously born siblings. The doctor whose negligence brings about such an undesired birth should not be allowed to say, "I did you a favour", secure in the knowledge that the Courts will give to this claim the effect of an irrebuttable presumption.' [*Terrell v Garcia* 496 SW 2d 124 1973 at 131 (dissent of Cadena J)] And: 'We reject the proposition that as a matter of law and public policy no legally cognisable claim for child rearing damages can ever arise in such cases where the unplanned child is born normal and healthy. That... public policy... may foster the development and preservation of the family relationship does not, in our view, compel the adoption of a *per se* rule denying recovery by parents of child rearing costs from the physician whose negligence has caused their expenditure. In other words, it is not to disparage the value of human life and the societal need for harmonious family units to protect the parents' choice not to have children by recognising child rearing costs as a compensable element of damages in negligent sterilisation cases. We, therefore, decline to follow the majority rule of those jurisdictions which have held that in all cases, without regard to the circumstances, the benefits to the parents from the birth of a healthy child always outweigh child rearing costs and thus result in no injury or damage to the parents.' [*Jones v Malinowski* 473 A 2d 429 at 435 (1984)]

³⁰ Divorce Act 70 of 1979

obligation to support the child. He said that at most it enabled the respondent to fulfil that obligation and that there could thus be no question that the obligation had in law been transferred from the respondent to the appellant.

The court did not allow the respondent's claim for the discomfort, pain and suffering and loss of amenities of life suffered by the child's mother in consequence of her pregnancy and the subsequent birth of the child on the basis of an absence of evidence of any such claim in the old authorities and that South African courts have in later years consistently indicated that only patrimonial loss may be recovered in contract³¹.

Discussion

The court *a quo* found that the agreement between the respondent and the appellant was partially in writing in that the respondent and his wife had signed a consent form which stated:

"I, Andrae Edouard, request and hereby consent to the performance of a surgical operation by tubal ligation on myself for the purpose of producing incapability of procreation.... I acknowledge that I am fully aware of and understand the purpose and consequence of the said operation including the fact that permanent sterility in all cases may not result."

It is interesting that the court used the consent form as evidence of the existence of a contractual relationship between the parties because even in the absence of a contractual relationship, it would still be necessary in order to show that the operation had been performed with the informed consent of the patient and in order to preclude

³¹ See *Edouard* fn 24 *supra* at p 596. The court noted: "An alternative contention put forward by counsel for the respondent is that there should be an extension of liability for breach of contract so that the innocent party may recover intangible damages, and in any event damages for pain and suffering. On the assumption that a Court has the power, in exceptional cases, to modify or alter our common law, it is hardly necessary to say that there must be compelling reasons for doing so."

It appears that since the middle of the present century English Courts have awarded an innocent party damages even in cases where he did not suffer physical inconvenience as a result of breach of contract. A striking example is to be found in the so-called holiday cases. In these the plaintiff had booked, through a travel agent, a holiday at a hotel. To his chagrin he discovered on arrival that the facilities available at the hotel were significantly inferior to the promised facilities. In consequence he claimed damages from the travel agent. It was held that he could recover an amount in respect of *inter alia* vexation and mental distress. In my view there is no sufficient reason of policy or convenience for importing into our law such an extension of contractual liability. To do so would be to graft onto a contractual setting elements of the *actio injuriarum*. Moreover, the party guilty of breach of contract would be liable to compensate the innocent party for loss which is not even recoverable by the Aquilian action. In any event, in most instances the principles of our law relating to liability for breach of contract appear to be adequate to afford the innocent party sufficient satisfaction. Take the holiday cases. The plaintiff would be entitled to claim the difference between the value of the promised facilities and those actually available to him. It is also conceivable that the latter facilities might have been virtually worthless, in which case the plaintiff could recover the full contract price. *Holmdene Brickworks (Pty) Ltd v Roberts Construction Co Ltd* 1977 (3) SA 670 (A) at p 687; *Novick v Benjamin* 1972 (2) SA 842 (A) at p 860; *Ranger v Wykerd and Another* 1977 (2) SA 976 (A) at p 987; *Dippenaar v Shield Insurance Co Ltd* 1979 (2) SA 904 (A) at p 917.

a claim in delict based on lack of consent. The fact that a person requests treatment and consents thereto does not necessarily mean that there is a contractual intention. Written evidence of consent to treatment such as that in a consent form is primarily to ensure that the patient gives proper consent and to protect the provider from allegations of violation of the right to bodily and psychological integrity. In Edouard's case the plaintiff in the court *a quo* had no choice but to proceed on the law of contract because the plaintiff had failed to comply with the requirements of the Limitation of Legal Proceedings (Provincial and Local Authorities) Act³² in that he failed to give notice of his intention to institute legal proceedings for the recovery of delictual damages. This demonstrates the advantage to the patient in having both contract law and the law of delict to choose from when formulating a claim. It may be that in some cases a court for reasons of public policy, especially in circumstances where a delictual claim was precluded on a technicality such as the one in *Edouard*, would want to infer the existence of a contractual relationship if possible in order to afford the patient some relief.

Edouard's case falls into a particular category in that it involved a request that a particular elective procedure – namely sterilisation of the plaintiff's wife, be carried out and an undertaking on the part of the provider to do so. The provider failed to carry out this undertaking. This is a situation which is different in some respects to others in which health services are rendered for a number of reasons. Firstly, it is the health professional who usually proposes and recommends a particular course of treatment to the patient who then either accepts it or rejects it or asks for alternatives. This is not the case with sterilisation. Secondly, a sterilisation procedure is not a medical necessity. It falls into the same category as a limited number of other treatments such as cosmetic surgery. Thirdly, the patient's power to choose to have the treatment or not is not impaired by physical or mental suffering or threat of death or disability. The nature of the procedure is such that it implies and indeed contemplates a particular result or outcome and that the permutations, in terms of outcome, are much more limited than for other kinds of health services. Fourthly the procedure and its intended result is not what one would call therapeutic in the

³² Act No 94 of 1970

dictionary sense of “of or relating to the healing of disease.”³³ Sterilisation is not a cure for an abnormal or pathological condition. It is submitted that these differences, when considered overall distinguish the dynamics of the provider-patient relationship in this context from the more common therapeutically based relationship. In Edouard’s case, unlike the cases in which sterilisation operations were performed and failed, the procedure was not even carried out. The question was not therefore the guarantee of a cure which the courts are so reluctant to impute to a medical practitioner, but rather an undertaking to perform a particular procedure which was never fulfilled.

In the context of run of the mill health care services, one of the ironies of health care contracts generally is that they are seldom read to guarantee to cure a patient but at the same time the sole purpose for entering into them is usually the hope, and even the intention, to be cured on the part of the patient and the hope, and even intention, to cure the patient on the part of the provider. The fact that this does not always materialise is irrelevant. The reasons for failure of medical treatment are many and varied ranging from the sheer negligence of a provider to the individual manner in which different patients react to treatment. Why would one undergo the hardships of chemotherapy or cardiothoracic surgery unless it was in the hope or even belief that they are likely to be effective? Surely contracts for medical services should not be considered in quite the same light as the purchase of a lottery ticket? Allopathic medical treatment in particular can sometimes cause more damage than the health condition from which the patient initially suffers. It is generally not without a price not only in financial terms but also in terms of physical and mental pain and stress. The stakes for the patient are usually much higher than the few rands it costs to purchase a lottery ticket. The question of whether a provider is in breach of a contract for health services should depend upon the reasons for treatment failure. If the reasons are outside of the control of the provider then they should be regarded in the same light as acts of God in insurance contracts. If the reasons are within the control of the provider and such control was not adequately or sufficiently exercised so as to ensure the expected outcome then it is difficult to see why the patient should not succeed in a claim for breach of contract. The obvious problem with this approach is that it is

³³ Concise Oxford Dictionary

paralleled too closely by the requirements of a claim on the basis of the law of delict. Those who prefer to compartmentalise the law are likely to oppose such an approach.

5.2.4 **Pizani v Minister of Defence**³⁴

This case does not involve a contractual relationship between the provider and the patient but it does explore the relationship between a public provider and a patient based upon legislation. For this reason it is presented here in counterpoint to the previous cases referred to in order to more closely examine the alternative to the law of contract as the basis of a public provider-patient relationship.

Facts

The appellant, had instituted action against the respondent for damages arising out of alleged negligent medical treatment performed upon him whilst he was a member of the Defence Force, the treatment having been performed by military doctors in the Defence Force. The respondent had raised a special plea that the action was barred, in respect of part of the relief claimed, by the provisions of s 113(1) of the Defence Act in that the action had been instituted more than six months after the cause of action in respect of that part of the action covered by the special plea had arisen. The appellant replicated that it was impossible for him to have become aware of the facts giving rise to that part of the cause of action referred to in the special plea by reason of the fact that he was under regulation 11 of chapter XV of the General Regulations for the SA Defence Force and the Reserve and the Military Discipline Code obliged to accept the arrangements made by the Surgeon-General of the Defence Force for the provision and administration of any treatment to him and that he was not in law entitled to seek any treatment for his injury other than that arranged for him by the Surgeon-General. It was alleged that the appellant was not aware of the negligence of the military doctors before a date six months prior to the institution of the action and that it was therefore impossible for him to comply with the provisions of s 113(1) of the Defence Act before that date. It was alleged in the alternative that it would be unconscionable conduct for the respondent to raise the special plea based on s 113(1) of the Act. A Provincial Division had upheld the special plea.

³⁴ *Pizani* 1987 (4) SA 592 (A)

Judgment

In its judgment the court made the following observations:

Regulation 7 imposes upon the Surgeon-General a general duty to arrange for the provision to a patient of, *inter alia*, the medical and hospital treatment which is required in respect of an injury from which the patient is suffering in order to effect his recovery. It provides that the Surgeon-General, or a medical officer designated by him for the purpose, shall from time to time determine the nature and extent of the treatment required by the patient and may authorise the provision or administration of such treatment.

Regulation 11 deals generally with the manner in which the Surgeon-General must provide treatment for a patient. Subparagraph (1) places on the Surgeon-General a general duty to provide treatment and to exercise control thereover. To this end he is required, as far as it is professionally and administratively possible, to make use of the facilities of the military medical service and such other state medical facilities as may be at his disposal. Treatment may be administered at the patient's residence, a hospital, a clinic, an outpatients' department of a hospital, the medical officer's consulting rooms or any other designated place. In certain instances where military facilities are not available or suitable the Surgeon-General may authorise the treatment of the patient at any other designated hospital or institution. In addition, whenever the Surgeon-General considers that the treatment of a patient cannot be undertaken by a medical officer of the South African Medical Corps or a district surgeon or where a second opinion is required, he may designate a medical officer not employed on a full-time basis by the state for the treatment of the patient (subpara 2(g)). He may also accept liability on behalf of the state for the cost of any treatment provided to a patient by any practitioner or hospital in a case of emergency.

Regulation 12 deals with the provision of medical appliances, such as artificial limbs, dentures etc. In terms of the regulation, the Surgeon-General determines the specification, type or pattern of medical appliance to be provided for a patient, subject to the proviso that a patient may at his own request be provided with an article of a different specification, etc on condition (i) that this is approved by the Surgeon-

General or officer acting on his authority and (ii) that any additional expenses arising from this special provision are recovered from the patient concerned.

Regulation 13 deals with the defrayment of the cost of any authorised treatment or medical appliance and provides generally that such cost is to be met by the state. Provision is made for the payment of fees to practitioners not in the full-time service of the state who treat patients. It is also provided that where a patient is treated at a non-military hospital or institution he must be accommodated in a general ward, provided that in certain circumstances a medical officer may authorise at state expense accommodation in a ward other than a general ward and that

“this regulation shall not be construed as prohibiting a member from arranging, in terms of a private agreement between him and the hospital concerned, for the use of such other ward by him or his dependent on condition that such member shall pay any additional expenses arising from such agreement directly to the hospital concerned and that the State shall not be liable therefor.”

The court noted that the appellant’s argument was that it is implicit in the regulations referred to above that it would be unlawful and a breach of the MDC for a member of the Permanent Force who suffered an injury to consult a private medical practitioner in order to get a second opinion or to check on the correctness of a diagnosis made by an army doctor.

It stated, however, that it was unable to discern such a necessary implication in the regulations in question and that the regulations make it obligatory for the Surgeon-General to provide at state expense medical treatment for an injured member of the Permanent Force and prescribe that the treatment shall be given by military doctors at military hospitals, etc. The court held that it was probably correct to say that it was implicit in the regulations that the patient concerned is in general obliged to accept treatment by military doctors and at military institutions. But this does not preclude him from seeking at his own expense a second opinion from a private medical practitioner. The court pointed out that the denial of the right of a member of the Permanent Force to consult a private doctor would constitute a serious derogation from his ordinary rights as an individual, especially where he suspected that the

treatment given to him by the army doctor might have been incorrect or even negligent, and it would require either an express provision in the regulations or a clear implication to establish the denial of this right. It found that there was no express provision and no such implication.

Discussion

Where regulations such as those applicable in *Pizani* impose a specific and detailed obligation upon the state to provide health care services at its own cost, it is submitted that this is highly likely preclude an inference of a contractual relationship between the public provider and the patient where the circumstances and scope of the services fall within the ambit of the regulations. Any attempt by the parties in such a situation to allege a contractual relationship between them would not only be unlikely but also superfluous since there is no need for such a contractual relationship in light of the existence of another legal basis for the provision of the health care services. It is difficult to conceive of a reason why the parties would wish to enter into a contractual relationship in circumstances where the law already imposes a specific obligation upon the provider to supply the relevant health care goods and services. The court was even prepared to accept a general obligation on the part of the patient to accept treatment by military doctors at military institutions. In this sense the military doctors and military institutions could almost be seen as having a right to treat the patient. The court refused, however, to accept the argument that this right was exclusive.

It is significant that the court refused to read into the regulations an interpretation which precludes the patient from entering into a contract at his own expense with a private doctor since such a provision would constitute a serious derogation from his ordinary rights. The case was decided prior to the advent of the Constitution in terms of which everyone has a right to have access to health care services. It would have been interesting to see the view of the court had the Constitution been applicable at the time. It may nevertheless be argued that the judgment contains the kernel of a notion that even where someone has access to health care services, he is not precluded from questioning or rejecting them, especially where there is a reasonable belief that they may be defective or inadequate, although there may be a general positive legal obligation upon him to receive such services. In the language of the Constitution one

might say that the right to bodily and psychological integrity will not easily be taken to have been restricted by way of a purported narrowing of a person's choices concerning health services.

5.3 Provincial Health Legislation and the Intention of the State

Since health care services are rendered largely by the provinces, it will be instructive to examine more closely some of the provincial legislation that governs the rendering of health services in order to establish whether or not a contractual relationship is intended. It is not sufficient to assume that if one province excludes the possibility of a contractual relationship with a patient that they all do. However, as will appear from the more detailed consideration below it would seem that even the provinces with the most comprehensive legislative provisions on the delivery of health care services have not consciously contemplated the possibility of a contractual relationship with patients but seem to base the relationship rather on administrative law and regulatory provisions.

The Eastern Cape Provincial Health Act³⁵ states that health service users are entitled, within provincial government, financial and human resources, to right of access to available comprehensive provincial health care services (section 12(c)). Section 13 stipulates that "Except to the extent limited by financial and human resources, health service users shall be entitled, as health service users, to access to comprehensive provincial health care services offered by designated provincial and district health care establishments" and that all health service users entering the comprehensive provincial health care system shall, subject to regulations promulgated in terms of the Act be entitled on the basis of need and subject to available provincial, financial and human resources to comprehensive provincial health care services including, but not limited to primary health care and secondary and tertiary health services on the terms and conditions specified in the regulations.

It would seem that although the possibility of contracting is left open by the use of terminology such as 'access', a contractual relationship is probably not contemplated

³⁵ Act No 10 of 1999

between the public provider and the patient because the access is to be “on the terms and conditions specified in the regulations”. The regulations are likely, practically speaking, to preclude the need for contractual terms and conditions to govern the provider patient relationship and their existence would tend to support an inference or conclusion that a contractual relationship is not intended by the private provider. In the absence of evidence of an intention to contract, one would not usually infer that a contract has been entered into³⁶. The health services in this instance are comprehensive and include services at primary, secondary and tertiary level. A restriction is represented by the fact that the services are only available at designated facilities but this is likely in practice to mean that not every level of service is available at every facility simple because certain facilities may be designated purely as tertiary services providers while others are designated as purely primary services providers for obvious reasons. Not every rural clinic can have a magnetic resonance imaging scanner or a laminar flow operating theatre.

The KwaZulu-Natal Health Act³⁷ states in section 29(2) that “a health care user is entitled to the progressive realization, within the Province’s available resources, to the right –

- (a)
- (b) of access to available primary health care services.”

The Act defines “primary health care services” as “accessible first level health services included as part of the package of basic essential health services as prescribed by the Minister in regulations.” Section 30(1) states that “[E]veryone is entitled within the Province’s available resources and funds allocated to the Department and as a matter of right, to the progressive realization of access to primary health care services offered by designated public health care establishments.” To the extent that these provisions seek to narrow the constitutional right of access to health care services to purely primary health care services they are probably unconstitutional. If only primary health care services were available in the province due to a lack of resources this might not be the case but the KwaZulu-Natal Department of Health in fact provides as a matter of course, secondary and tertiary

³⁶ Although see the later discussion on tacit contracts.

³⁷ Act No 40 of 2000



level services in many of its hospitals. The manner in which this legislation is worded could give rise to the understanding that while a contractual relationship is not intended with regard to primary health care services because these are available as of right in terms of the legislation, this is not necessarily true for secondary and tertiary health care services which are not apparently governed by the legislation. In other words while a contractual relationship is not envisaged with regard to primary healthy care services it is a possibility with regard to secondary and tertiary services. In terms of the regulations to the KwaZulu-Natal Health Act, a “free public health care user” means a public health care user who is deemed a free public health care user in terms of Departmental guidelines and does not pay for public health care services on the basis of a means test as determined by the Department. The regulations define a “full-paying public health care user” as “a public health care user who by virtue of his or her financial circumstances, is neither a free nor a part paying public health care user and is treated as a full-paying public health care user in terms of Departmental policy.” There is no mention of the level of health care, i.e. primary, tertiary or secondary, in this context. Regulation 3 of the regulations to the KwaZulu-Natal Health Act makes provision for the classification of public health care users by the head of the public health care establishment³⁸. If one examines the provisions of

³⁸

3. (1) The head of the public health care establishment or his or her designee must, at the time of the public health care user's admission to or treatment in a public health care establishment or as soon thereafter as possible, classify the public health care user as a -
 - (a) free public health care user;
 - (b) part-paying public health care user;
 - (c) full-paying public health care user; or
 - (d) private health care user.
- (2) A person is deemed to be a full-paying public health care user until he or she proves that he or she qualifies as a free or part-paying public health care user.
- (3) A part-paying public health care user, full-paying public health care user or private health care user treated at public health care establishment must sign an acknowledgement of debt for fees incurred in the course of receiving health care services at the public health care establishment.
- (4) The head of a public health care establishment or his or her designee may, where necessary, make an assessment of the financial circumstances of the person responsible for the payment of the fees of the person to be admitted or treated.
- (5) For purposes of subregulation (4), the head of the public health care establishment or his or her designee may require the person responsible for payment of public health care establishment fees to furnish relevant information or documentation which the head of the public health care establishment may deem necessary.
- (6) A person who is required to furnish any information or document contemplated in subregulation (5) and a dependent of that person may not be admitted to or treated in a public health care establishment unless the information or documentation has been furnished: Provided that, a person may be treated where, in the opinion of the head of the public health care establishment or his or her designee, refusal to admit or treat a person could have dangerous or detrimental consequences to the person seeking admission or treatment.
- (7) The head of a public health care establishment or his or her designee may, at any time, reassess the financial circumstances of a person responsible for fees of a public health care user.
- (8) The head of a public health care establishment or his or her designee may, after reassessing the ability of a person to pay fees as contemplated in subregulation (7), determine that a public health care user should be treated as a full-paying public health care user where the public health care user -
 - (a) fails to provide the necessary documentation of his or her financial circumstances within the period stipulated by the head of the public health care establishment or his or her designee; or

regulation 3 in detail the following is noteworthy in terms of the question of whether or not there is an intention to contract –

- (1) Patients who in terms of the regulations are required to pay fees must sign an acknowledgement of debt for such fees in respect of health services received;
- (2) The head of a public health establishment can require certain documentation of a patient's financial circumstances in order to classify the patient as a free public health care user, a part-paying public health care user, a full paying public health care user or a private health care user and may reassess such classification at any time;
- (3) The patient can be refused admission to a public health establishment unless the financial information required for the purposes of the assessment and classification of the patient is furnished;
- (4) The head of a public health establishment can determine that the fees must be paid at a higher rate but not exceeding the prescribed rate;

-
- (b) has been classified or reclassified as a free or part-paying public health care user where the health care user or person liable for the payment of fees is a member of a medical aid scheme: Provided that -
- (i) the public health care user must be reclassified as a part-paying public health care user when the benefits enjoyed under the health care user's medical aid scheme are depleted;
 - (ii) no charge other than that applicable to part-paying public health care users may be charged for any service, treatment, appliance or prosthesis not covered by the health care user's medical aid scheme; and
 - (iii) the charge, other than the charge applicable to part-paying public health care users, for any service, treatment, appliance or prosthesis not fully covered by the health care user's medical aid scheme, must not exceed the amount covered by the health care user's medical aid.
- (9) Subject to subregulation (10), the head of a public health care establishment or his or her designee may determine that the fees be paid at a higher rate not exceeding the prescribed rate.
 - (10) The head of the public health care establishment or his or her designee must satisfy himself or herself that owing to any change in the financial circumstances of the person responsible for fees, the person is able to pay fees at a rate higher than the rate previously assessed.
 - (11) A head of a public health care establishment or his or her designee may not reassess fees when the person responsible for payment is deceased.
 - (12) A person who is aggrieved by an assessment or re-assessment made by a designee of the head of a public health care establishment may appeal to the head of the public health care establishment.
 - (13) A person who is aggrieved by an assessment or re-assessment made by the head of a public health care establishment may appeal to the Head of Department.
 - (14) An appeal to the Head of Department contemplated in subregulation (13) must be accompanied by the recommendations of the head of a public health care establishment.
 - (15) The decision of the Head of Department on the appeal contemplated in subregulation (13) is final.
 - (16) The Head of Department may bring an action against a person for damages incurred by the Department as a result of the person knowingly or wilfully furnishing any information or documentation which is false, incorrect or misleading.

- (5) A person who is aggrieved by an assessment or re-assessment made by the head of the public health establishment may appeal to the Head of the provincial health Department whose decision is final;
- (6) The Head of Department can bring an action against a person for damages incurred by the Department as a result of the person knowingly or willfully furnishing any information or documentation which is false, incorrect or misleading.

It is submitted that the fact that signature of an acknowledgement of debt for fees by the patient or other person responsible for payment is a regulatory requirement is not necessarily indicative of an intention to contract with regard to the delivery of health services on the side of the public provider or the patient since the patient is apparently bound by law to sign it. It is more likely an attempt to ensure that the patient or other person responsible for payment is aware of his or her obligation to pay the fees and to shift the risk of the costs of the collection of such fees from the province to the person responsible for payment. This is borne out by the fact that the patient cannot negotiate the fees payable. They are determined on the basis of objective evidence as assessed by the head of the health establishment. The head of the health establishment can unilaterally decide to alter the level of fees payable within the limits of the prescribed rate and the remedy provided for a decision of the head of the health establishment is an administrative one as opposed to a contractual one. The legal basis for the debt, in the absence of a contract, would be the regulations themselves since regulation 5 lists the circumstances in which a person is *not* required to pay for treatment and services at a public health care establishment.

The nature of the damages for which the Head of Department can bring an action is not specified but if one looks at the basis of the damages they tend to suggest civil wrongdoing rather than breach of contract³⁹. Although deliberate misrepresentation is a ground for damages in the law of contract, the fact that the regulations do not allow

³⁹ The wording of the regulation suggested that an element of culpability is required. By contrast, in certain circumstances under the law of contract even an innocent misrepresentation is grounds for a claim for damages. See *Phams (Pty) Ltd v Palzes* 1973 (3) SA 397 (A). See also *Labuschagne v Fedgen Insurance Ltd* 1994 (2) SA 228 (W). This is not true of the law of delict. In *Ericson v Germie Motors (Edms) Bpk* 1986 (4) SA 67 (A) the court stated: "There is in our law no basis for an action for damages in delict founded upon an innocent (ie non-fraudulent or non-negligent) misrepresentation."

a contractual remedy to a patient who is aggrieved by a decision as to what fees he should pay suggests that the damages contemplated might be in terms of the law of delict. It would be administratively unjust to allow a contractual remedy to one party to the contract – i.e. the provincial government, while denying a remedy of the same nature to a patient. Of course one would have to consider the circumstances of each case before ruling out the possibility of a contractual relationship.

The Gauteng District Health Services Act⁴⁰ defines ‘primary health care services’ as “comprehensive health care services that includes preventative, promotive, curative and rehabilitative health care within the context of community participation, inter-sectoral collaboration and an adequate referral system”. The Act seeks to transfer the responsibility for the delivery of primary health care services to municipalities in terms of section 19. Such assignments of functions are contemplated in section 156 of the Constitution. This raises the question, however, that if a municipality is liable for the rendering of primary health care services, does this mean that a provincial health facility that offers secondary and tertiary level health care services is lawfully entitled to refuse to treat a person requiring primary health care services who has not availed themselves of those services at the local municipal health clinic? If the answer is that such a patient may not be refused such primary health care services by the provincial facility this would render the delivery of appropriate levels of health care by facilities at a level that can most appropriately, efficiently and effectively deliver those services highly problematic from the point of view of the practical organization of health services delivery. Primary health care services delivered at facilities that are designed for the rendering of more complex secondary and tertiary levels of health care are much more expensive than those same services rendered at their proper level within the health care system such as community based clinics and health care facilities. Gauteng appears not to have enacted any legislation resembling that of KwaZulu-Natal that specifically grants a patient a right to a particular level of health service. In terms of the Hospitals Ordinance Amendment Act⁴¹, Gauteng legislation provides for a similar system of classification of patients into part paying and private as does the KwaZulu-Natal legislation. Section 31(2) of Ordinance 14 of 1958 as amended by the

⁴⁰ Act No 8 of 2000

⁴¹ Act No 4 of 1999

1999 Act stipulates that the superintendent, chief executive officer or his or her designee may call for such information or documents as he or she may deem necessary or as may be prescribed in any regulation and no person shall be admitted into any provincial hospital or receive treatment thereat unless such information or documents have been furnished by or on behalf of such person. The Gauteng legislation contains the same exception as the KwaZulu-Natal legislation to the effect that a patient can be admitted where in the opinion of the superintendent, treatment cannot be deferred without danger or detrimental consequences to the patient. In General Notice 7867 of 2000 entitled: “Amendment To The Regulations Relating To The Classification Of And Fees Payable By Patients At Gauteng Provincial Hospitals, Mortuary Fees, And Fee Pertaining To Ambulances And The Amendment Of Hospital Tariffs, Mortuary And Ambulance Tariffs With Effect From 1 November 2000”⁴² the statement is made with regard to financial principles that:

“All health services rendered by the state are chargeable. However, no emergency service may be refused if a patient cannot pay for it and no patient, including an externally funded patient, will be required to meet all costs of essential medical services should such costs place an excessive financial burden on her/him.”

The liability of an externally funded patient is stated as follows:

“Externally funded patients will pay the full rate prescribed by the UPFS. In cases where services are rendered to patients by a private health care practitioner, the patient or her/his funder will be liable for the facility fee component of the UPFS tariff to the public health facility concerned. It is the responsibility of the private practitioner to render an account to the patient or her/his funder for any professional fee due to the private practitioner.”

The proposed regulations also state the following “Administrative Principles”:

- Patients who are not externally funded are eligible to pay reduced fees for services received. The onus rests on the patient to prove her/his eligibility to be categorized as a subsidized patient. If a patient refuses to do this, then he/she must be regarded as a full paying patient.

⁴² Provincial Gazette No 174 Part.1 13 November 2000

- The eligibility of a patient to pay reduced fees will be based on a standard means test or the membership of the patient to certain groups exempted from paying for public health services.
- Patients paying reduced fees will be encouraged to pay cash. In such cases a payment receipt but not an invoice will be produced. In cases where the reduced fee cannot be paid in full and the patient is not reclassified into a group exempt from payment, a credit agreement must be entered into with the patient or her/his guardian.
- Patients funded by a medical scheme registered in terms of the Medical Schemes Act⁴³, are governed by the provisions of that Act with regards to the minimum benefits for which the funder is liable. For the purposes of charging for services not covered by the funder, the patient will be classified as provided for in principle 7 and will be liable for the payment of the applicable fees.
- A facility fee plus a professional fee will be charged for each procedure group. The professional fee will not be charged where a patient utilizes the services of his/ her private clinician.

It seems in view of these similarities that the position is much the same for Gauteng as it is for KwaZulu-Natal and that there is apparently no intention to contract with patients on the part of the provincial government of Gauteng. The fact that a credit agreement, which is undoubtedly a contract, must be entered into where the patient cannot pay the fee in full and is not reclassified, does not necessarily mean that initial relationship involving the rendering of health services by the provincial government is contractual. It could be argued that the requirement of the credit agreement is based upon the need to establish the amount and frequency of the payments that must be made by the patient over time and also to facilitate debt collection procedures by the province should the patient fail to pay. The need for the contract in other words arises not so much in order to facilitate the delivery of and payment for health services but to ensure payment as required by regulations. The health services themselves may

⁴³ Medical Schemes Act fn 1 *supra*

already have been rendered by the time that the credit agreement becomes necessary. If the credit agreement is as a matter of routine practice entered into in advance of the rendering of the health services, for instance as part of the admission procedures to the hospital, then it could be argued that the relationship between the patient is of a contractual nature. However, in this instance there would still be a strong administrative law element in the relationship given the imbalance of power between the contracting parties and the fact that many of the essential terms of the ‘contract’ are determined by regulations.

As far as the Western Cape is concerned the Health Act⁴⁴ still applies. It effected some minor amendments to the provisions of this Act insofar as they affect the Western Cape Province in 2002⁴⁵. The Western Cape has made entitled ‘Regulations Relating To The Uniform Patient Fee Schedule For Health Care Services Rendered By The Department Of Health: Western Cape For Externally Funded Patients,’⁴⁶ primarily concerning public sector patients who are members or beneficiaries of medical schemes and other funds that pay for health services. The Regulations apply only to ‘externally funded patients’ and define this phrase as follows:

“externally funded patient’ means a patient whose health services are funded or partly funded in terms of-

- (a) the Compensation for Occupational Injuries and Diseases Act, 1993 (Act 130 of 1993), or
- (b) by the Road Accident Fund created in terms of the Road Accident Fund Act, 1996 (Act 56 of 1996), or
- (c) a medical scheme registered in terms of the Medical Schemes Act, 1998 (Act 131 of 1998), or
- (d) another state department, local authority, foreign government or any other employer, or who exceeds the generally accepted income means test as implemented by the Provincial Government: Western Cape;”

They set tariffs for various categories of health facilities and health services delivered by the public health sector in the Western Cape to persons who are externally funded patients. Regulation 3 states that an externally funded patient who receives any medical treatment or any medical service, listed and categorised in Schedule 2, from a department of health facility, must pay the applicable tariff for such medical treatment

⁴⁴ Act No 63 of 1977

⁴⁵ Western Cape Health Act Amendment Act No 6 of June 2002. Notice No 164 in Provincial Gazette No 5891 of 18 June 2002

⁴⁶ Provincial Gazette No 5977 Notice No 21 of 29 January 2003

or medical service received in accordance with the tariff of fees and charges as set out in Schedule I of the regulations

The Northern Province Health Services Act⁴⁷ states in section 34 that subject to the provisions of section 36 every manager must admit for treatment in or at any health service or facility in his or her charge so far as adequate and appropriate accommodation is therein available, persons suffering from or subject to any of the diseases, injuries or conditions for the treatment of which such health service or facility is established. Section 36 deals with classification of patients and contains similar provisions relating to documentary proof of financial status as the legislation of KwaZulu-Natal and Gauteng. In terms of section 35, the remedies for a person who is aggrieved at the classification are administrative. The Member of the Executive Council for Health of the province is given the power to prescribe fees for the treatment of a person in a health service or facility in section 41 of the Act.

The North West Health Bill, which seems not to have been passed into law at the time of writing simply states in section 24 that the medical administrator or head of clinical services of a provincial hospital shall, subject to any regulations, determine the order in which persons shall be admitted to such hospitals having regard to the urgency of their need for treatment as far as adequate and appropriate accommodation is available. The Mpumalanga Hospitals Bill⁴⁸, which also seems not to have been passed into law, leaves matters such as fees for health services to regulations. It contains provisions that are similar to the North West Health Bill. The Free State Provincial Health Act⁴⁹ provides in section 36 that the MEC shall by notice in the Provincial Gazette regulate the package of health care to be provided. It stipulates that the health care package at each level of care shall be accessible, acceptable, affordable, efficient, comprehensive and integrated with promotive, preventative, curative and rehabilitative services. It requires the Department of Health in the province to ensure progressive implementation of health services at all levels of care in order to avoid and remove duplication and fragmentation of health services,

⁴⁷ Act No 5 of 1998 Provincial Gazette No 4 of 1999

⁴⁸ A 1997 Bill

⁴⁹ Act No 8 of 1999

improve and maintain the quality of health services within the available resources and remove all barriers to access to health services where possible. The Department is also tasked with reviewing and monitoring the efficiency of the respective health packages on a regular basis. The user is not expressly given any specific rights relating to access to health services in this Act although there are rights to information, informed consent, confidentiality and to complain. Section 35 states that health care providers shall fulfil every duty owed to each patient including the duty inter alia to “provide the best quality care appropriate”. There is no suggestion of a contractual relationship between the province and the patient for the provision of health care services to the patient.

In view of the foregoing it seems that whilst provincial governments may be free to contract with patients for the provision of health services they generally seem to prefer the expression the public provider patient relationship in terms of regulations, thereby bringing it within the scope of administrative law. This said, one must bear in mind the distinctions made between paying and non-paying patients and between the different levels of services in some of the provincial legislation and regulations. It may well be that in particular circumstances the facts may indicate that there is sufficient evidence of a contractual relationship with the patient and the existence of such a relationship can thus never be completely discounted. The fact that provinces enter into contracts with medical schemes to treat medical scheme patients on certain terms and conditions may lead to a conclusion that a patient is a party to the contract because it is a contract for the benefit of the patient. However this would depend on the nature of the terms of the particular contract between the scheme and the provincial government in question.

Even if provincial governments had indicated more strongly a preference for a contractual basis for the provider- patient relationship, if one considers the circumstances, with the Constitution as backdrop, in which a private health care provider may legitimately refuse to treat a person, they are no different in principle to the circumstances in which a public health care provider may refuse to treat one. The freedom of a private provider of health care services to refuse treatment is not as wide, in legal terms, as it may first appear. The Constitution prohibits unfair



discrimination in general and upon a number of specific bases. A health care provider who turns away a patient on the grounds of his or her race, age, gender, disability sex, sexual orientation, culture, religion, language, belief, birth, marital status, ethnic or social origin or pregnancy is likely to be in violation of that patient's constitutional right to equality as well as his or her right of access to health care services. If a private health care provider cannot supply a good reason on legal or ethical grounds for turning a patient away, such as the provider's own ill health, disability, lack of competence in a specialised area, non-compliance with licensing requirements or lack of capacity, it is submitted that unfair discrimination is likely to be raised as a possibility or even a probability⁵⁰ for the private provider's refusal to treat the patient on the premise that if there is no good reason why the provider does not wish to treat the patient and there must be a reason for the provider's refusal, one must start looking to other kinds of reasons as possibilities. It is submitted that the range of acceptable reasons, other than those based on legal and ethical principles, for a private provider's turning away a person needing health care services given the foregoing is likely to be fairly narrow. It is also submitted that the same holds true for public health care service providers except that, to the extent that their decision constitutes an administrative one, they will be obliged to give reasons in terms of the PAJA and these are open to interrogation in terms of administrative law. It is important to remember, however, that this Act also applies to private persons, natural and juristic, when exercising a public power or performing a public function in terms of an

⁵⁰ The Promotion of Equality and Prevention of Unfair Discrimination Act No 4 of 2000 (which is not yet in operation as at the time of writing" states in section 13 concerning burden of proof:

- "(1) If the complainant makes out a prima facie case of discrimination-
- (a) the respondent must prove, on the facts before the court, that the discrimination did not take place as alleged; or
 - (b) the respondent must prove that the conduct is not based on one or more of the prohibited grounds.
- (2) If the discrimination did take place-
- (a) on a ground in paragraph (a) of the definition of 'prohibited grounds', then it is unfair, unless the respondent proves that the discrimination is fair;
 - (b) on a ground in paragraph (b) of the definition of 'prohibited grounds', then it is unfair-

- (i) if one or more of the conditions set out in paragraph (b) of the definition of 'prohibited grounds' is established; and
 - (ii) unless the respondent proves that the discrimination is fair."
- The Schedule to this Act stipulates unfair practices in the health sector in section 3 as follows:
- "3 Health care services and benefits
- (a) Subjecting persons to medical experiments without their informed consent.
 - (b) Unfairly denying or refusing any person access to health care facilities or failing to make health care facilities accessible to any person.
 - (c) Refusing to provide emergency medical treatment to persons of particular groups identified by one or more of the prohibited grounds.
 - (d) Refusing to provide reasonable health services to the elderly."

Section 8, dealing with discrimination on the grounds of gender states that subject to section 6, no person may unfairly discriminate against any person on the ground of gender, including limiting women's access to social services or benefits, such as health, education and social security.

empowering provision which adversely affects the rights of any person and which has a direct, external legal effect.

5.4 Arguments in Favour of Contractual Relationship

It is submitted that there are a number of aspects about the public provider-patient relationship that support the idea that it is contractual. The concept of informed consent, for instance, tends to strengthen the idea of a contractual relationship rather than diminish it even though informed consent is traditionally discussed rather more in the context of the law of delict than of the law of contract. Informed consent requires that the patient is fully informed of the nature of the proposed treatment, its consequences and the consequences of not having it, the risks associated with it and alternatives to it.⁵¹ In this sense it is very much akin to the contractual principles of meeting of minds⁵², contractual capacity⁵³ and of involuntary reliance⁵⁴. The

⁵¹ See generally *Castell v De Greef* 1994 (4) SA 408 (C) A; *C v Minister Of Correctional Services* 1996 (4) SA 292 (T); *Broude v McIntosh and Others* 1998 (3) SA 60 (SCA); *Minister of Health And Others v Treatment Action Campaign and Others* (No 2) 2002 (5) SA 721 (CC)

⁵² In *Seeff Commercial And Industrial Properties (Pty) Ltd v Silberman* 2001 (3) SA 952 (SCA) at p958 the court notes that: "A basic rule is that - 'an acceptance of an offer made ought to be notified to the person who makes the offer, in order that the two minds may come together'. (Per Bowen LJ in *Carlill v Carbolic Smoke Ball Co* [1893] 1 QB 256 (CA) at 268. See also *R v Nel* 1921 AD 339 at 344; *Reid Bros (South Africa) Ltd v Fischer Bearings Co Ltd* 1943 AD 232 at 241.) If the patient does not understand what it is that the health care provider is proposing in terms of treatment then any consent given will not be properly informed. The health care provider and the patient must be *ad idem* as to what it is that the health care provider is permitted by the patient to do to him or her.

⁵³ Minors are generally not recognised as being capable of giving informed consent in much the same way that they are not recognised as having contractual capacity until they have reached a certain age. Strauss SA, *Doctor, Patient and the Law: A Selection of Practical Issues* at p 5 observes that "Obtaining a legally 'safe' consent where the patient is a minor, i.e. an unmarried persons below the age of 21 years, is a matter of general concern to medical practitioners. Where a parent or guardian is available to give consent there are no problems". In terms of section 39(4) of the Child Care Act, No 74 of 1983 "Notwithstanding any rule of law to the contrary-

(a) any person over the age of 18 years shall be competent to consent, without the assistance of his parent or guardian, to the performance of any operation upon himself; and

(b) any person over the age of 14 years shall be competent to consent, without the assistance of his parent or guardian, to the performance of any medical treatment of himself or his child."

In terms of the law of contract, "In Roman Dutch law the judgment of a minor is considered immature throughout his minority and he is consequently not bound by his contracts" (*Edelstein v Edelstein* 1952 (3) SA 1 (A)). In *Dhanabaktium v Subramanian* 1943 AD p 160 the court stated at p 167 that: "According to the common law a minor cannot bind himself by contract without the assistance of his guardian subject to certain qualifications."

⁵⁴ Christie *The Law of Contract* 4th ed at p 322, referring to *Pretorius v Natal South Sea Investment Trust Ltd* 1965 (3) SA 410 (W) where the court observes that: "There is an 'involuntary reliance of the one party on the frank disclosure of certain facts necessarily lying within the exclusive knowledge of the other such that, in fair dealing, the former's right to have such information communicated to him would be mutually recognised by honest men in the circumstances'" states as follows: "The test of involuntary reliance here applied is in accordance with the principle underlying the requirement of disclosure of material facts in contracts of insurance. The insured must disclose all material facts because the insurer involuntarily relies on him for information on such facts: it might theoretically be possible to ascertain these facts by other means but it would not be practical in the business sense". It is submitted that the patient is in the same position more or less as the insurance company. He or she is involuntarily reliant upon the health care professional who knows his or her unique situation as well as being in possession of expert medical knowledge that may not be readily available elsewhere, to disclose the material facts. Whilst it may be possible to obtain the relevant information from other sources or health care providers it is not always practically or financially possible for the patient to do so. See also *Absa Bank Ltd v Fouche* 2003 (1) SA 176 (SCA) where the court observes that: "I am prepared to assume, though not without some hesitation, that the information about the alarm and the guards can be classed as falling within the exclusive knowledge of the branch officials. My hesitation stems from the fact that information which is, if desired, as readily ascertainable as this was, should not be categorised as exclusive knowledge. 'Exclusive knowledge' in this sense is knowledge which is



classification of patients into various categories and the requirement that they must pay a certain amount for such services could be indicative of an intention to contract, especially where there is a requirement that if the fee cannot be paid in a single cash amount, the person responsible for the payment must enter into a credit agreement with the provider. Although it is not necessarily sufficient to ground the inference of a contract on its own since the doctrine of consideration is not part of the South African law of contract, it is submitted that in certain circumstances the requirement of payment for health services may be an indicator of a contractual intention. Other circumstances which may be indicative of a contractual relationship are where the patient has requested a specific procedure for a particular reason such as those in *Edouard*⁵⁵. The fact that the procedure is elective as opposed to essential to the health or wellbeing of the patient may also have a bearing. In practice a court is unlikely to refuse to acknowledge a contractual relationship between a public provider and a patient where this can be demonstrated on a balance of probabilities where the provider itself asserts that there was no intention on its part to contract. Clearly the inference of a contract between the parties will depend upon the circumstances of each case and also public policy considerations. The question of the existence of a contractual relationship between a public provider and a patient is rarely likely to arise outside of the context of litigation in any event given the nature of the delivery of health care services in the public sector and the absence of any form of negotiation between the parties in most instances. It is, however, of some significance that in the South African cases many of the parties seem to have chosen to base their claims on the law of delict as opposed to that of contract. Of the four cases discussed in this section only one South African case, that of *Edouard*⁵⁶, is based squarely upon the law of contract. If a court should find that there is a constitutional obligation upon the state specifically to deliver health care services, especially if this obligation is reinforced by national health legislation, then the likelihood in the abstract, of the existence of a contractual relationship between the patient and the public provider is diminished since there may be no logical need for it – particularly in circumstances where the patient has no choice but to use the public health system and is not obliged to pay for health care services in terms of a means test.

inaccessible to the point where its inaccessibility produces an involuntary reliance on the party possessing the information (Christie RH *The Law of Contract* 4th ed at 322).”

55 *Edouard* fn 24 *supra*

56 *Edouard* fn 24 *supra*

5.5 Arguments Against Contractual Relationship

Since the existence of a contract is fundamentally dependent upon the intention of the parties to enter into a contract, however, it does not necessarily follow that a contract arises in every instance in which a public provider of health care services renders such services to a patient. In *Magware's* case⁵⁷ the Minister of Health when faced with a claim for damages arising from the negligent application of a plaster cast by hospital staff, in his plea denied the existence of a contractual relationship between the parties. The court decided the case in the absence of a contractual relationship on the basis of the law of delict.

In *Dube v Administrator, Transvaal*⁵⁸ (W) Trollip J noted that the plaintiff's action was founded on negligence and not on contract. This does not necessarily mean, however, that a contract did not exist between them. The fact is that a plaintiff can choose the legal basis of an action for damages when the circumstances support both a claim in terms of the law of contract and one in terms of the law of delict. Similarly the Administrator Transvaal may have chosen to deny the existence of a contract with the patient for strategic reasons in order to make it more difficult for the plaintiff to prove his claim, placing upon him the onus of proving the existence of a contract if this was the route that he chose to go. The plaintiff's claim in *Mtetwa v Minister of Health*⁵⁹ was based upon three alternative causes of action, namely:

- (a) an implied contractual agreement between the parties, with a breach of a material term of that agreement by one of the defendant's employees and the resultant liability of the defendant on the basis of the actions of a servant conducted within the course and scope of his employment with his principal; alternatively

⁵⁷ *Magware v Minister of Health NNO* 1981 (4) SA 472 (Z) (see later for detailed discussion of the facts and the judgement).

⁵⁸ *Dube* 1963 (4) SA 260 (W)

⁵⁹ *Mtetwa* 1989 (3) SA 600 (D) at p601-602

- (b) a claim in delict arising from the failure by the defendant's employees to employ reasonable skill and care in their treatment of the plaintiff, by treating her negligently, with the resultant liability of the defendant being based upon the actions of a servant acting within the course and scope of his employment with his principal; alternatively
- (c) a wrongful, unlawful and intentional assault on the plaintiff by one or more servants of the defendant, the liability of the defendant being based upon the actions of an employee-servant acting within the course and scope of his employment with his principal.

The case is discussed in more detail under the section on the law of delict due to the fact that it essentially revolved around the question of vicarious liability. It is clear from this, however, that the basis of a claim for damages in the health care context can range from contractual to delictual and even criminal law. The fact that a contract arises between a provider and a patient does not by any means preclude a delictually based duty of care. Neither does it preclude the possibility of a criminal action for assault, in the absence of the informed consent of the patient although this point will be discussed in more detail at a later stage. As stated previously the existence of obligations on the basis of constitutional and administrative law, to render health care services to a patient may preclude an inference that a contractual relationship arose between them. The question of the administrative contract, which is something of a hybrid straddling administrative law and the law of contract, appears not to have found total recognition in South African law at present judging from the statements of the writers referred to previously. It is submitted that this is a prime example of the reluctance of some South African courts to allow cross-pollination of one area of law by another. In fact it is even more than that since it constitutes a failure to recognise that constitutional principles and values are fundamental to all areas of law and that there is a positive constitutional obligation upon the courts to develop the common law in accordance with these. There may be circumstances in which a contract is implicitly precluded as the basis of the relationship between a public provider and a patient. The case of *Pizani v Minister Of Defence*⁶⁰ offers an example of this.

⁶⁰ *Pizani* fn 34 *supra*

5.6 Conclusions Regarding Health Care Relationships

In the context of health services delivery, one must consider the law holistically whilst at the same time retaining an awareness of its different facets. It would be a mistake to think only in terms of the law of contract or only in terms of the law of delict or administrative law when considering the provider-patient relationship. This is demonstrated by a series of cases in which relationships which began essentially by way of a contract between the parties gave rise to obligations based upon the law of delict⁶¹. The boundaries between these different areas of law are permeable because

61

Beginning with *Van Wyk v Lewis* 1924 AD 438 and ending most recently with *Pinshaw v Nexus Securities (Pty) Ltd and Another* 2002 (2) SA 510 (C). In *Van Wyk v Lewis* the defendant performed an emergency operation on the plaintiff but accidentally left a swab in her body. Some twelve months later, the plaintiff evacuated the swab through her bowel into which it had found its way. The plaintiff alleged that the defendant had acted negligently and unskillfully in failing to remove the swab and sued him for two thousand pounds. The Appellate Division confirmed the judgment for the defendant of the trial court and held that the action was based on tort, the defendant had been obliged to act with reasonable skill, having regard to the general level of skill and diligence possessed and exercised at the time by members of the branch of his profession to which he belonged. It held further that the onus of establishing negligence lay with the plaintiff and that the latter could not, in the circumstances of the case, rely on the maxim *res ipsa loquitur*. The Appellate Division found that the defendant had acted reasonably and had therefore not been negligent, in relying upon the theatre sister to count the swabs used in the surgery and that if the theatre sister had been negligent, her negligence could not be attributed to the defendant in any way. Innes CJ in discussing the basis of the plaintiff's claim observed that the line of division where negligence is alleged is not always easy to draw, "for negligence underlies the field both of contract and of tort. Cases are conceivable where it may be important to decide on which side of that line the cause of action lies. But the present is not such a case..." Wessels JA stated in his judgement at 455 that "...The case... is one of those... where the relationship between the parties arises out of a contract but where the act complained of is an injury or delict done in consequence of carrying out the contract. The delict grows out of a breach of duty which the law implies from the contract between the parties – the duty of the surgeon who contracts to operate not to do so negligently..."

In *Pinshaw*, the plaintiff was an elderly widow who had taken up permanent residence with her family in Australia. Exchange control regulations did not permit her to remit sufficient funds and assets to that country and she therefore entered into a contract with the first defendant, dealing in this context with the second defendant, who signed on behalf of the first defendant. In terms of the contract the plaintiff agreed to invest R1 million in stock market equities to be managed and controlled by the first respondent. The funds were placed under the control of the second defendant, who was the director of the first defendant in charge of private client portfolio management. The contract included a clause which indemnified the first defendant or any of its directors or employees against any losses and liability or damage for claims brought by the client by reason of the operation of his or her account unless the claims were attributable to fraud, bad faith, dishonesty or gross negligence on the part of the first defendant, its directors or its employees. The plaintiff's entire portfolio was invested in one stock (C Ltd), of which the second defendant was the senior manager. The portfolio dropped in value to approximately R343 000 as a result of the investment. The plaintiff instituted action for pure economic loss and alleged that the trading in such a high-risk investment had been to her detriment and not in furtherance of her interest. She proceeded against the first defendant based on contract, alleging breach of fiduciary duty and grossly negligent action. She also claimed against the first and second defendant in delict, averring that, in dealing with the portfolio on behalf of the first defendant, the second defendant had acted fraudulently or recklessly or grossly negligently in the course of the first defendant's business and within the scope of his authority, and held the first defendant liable for the conduct of the second defendant. The second defendant took exception to the plaintiff's particulars of claim insofar as they related to the alternative cause of action based on alleged recklessness or gross negligence, claiming them to be vague and embarrassing, lacking averments necessary to sustain the cause of action. The basis of the exception was that the second defendant alleged that he did not owe the plaintiff a legal duty to act with care and, without this duty of care being established, the cause of action could not succeed. The second defendant alleged that it was the first defendant, not himself, which was contractually bound and obligated to the plaintiff and that she should seek redress there. The court stated that it was apparent that the pleading has been so framed in order to meet the exclusionary clause, clause 16, of the contract. This clause excluded the liability of Nexus and its directors and employees (of whom Van Zyl was one) 'unless the claims are attributable to fraud, dishonesty or gross negligence' or unless the losses are attributable to 'fraud, bad faith, or gross negligence'. The existence of clause 16, said the court, may have an impact on the substantive question of unlawfulness. In deciding whether Van Zyl owed Mrs Pinshaw a legal duty, the court said that it must have regard to all the circumstances, including the existence and terms of the contract with Nexus and including clause 16 itself. If in all the circumstances Van Zyl owed Mrs Pinshaw some duty, there were two ways of looking at the position. The duty might be a duty qualified by clause 16. Alternatively, it might be a wider duty to exercise reasonable care in the management of the portfolio. In that case it would be for Van Zyl, who was not a party to the contract, to show that he was entitled to the benefit of clause 16. Mrs Pinshaw, however, had impliedly conceded the entitlement and so the court did not take this aspect further. Comrie J then went on to discuss the case of

they are based upon the same grundnorm – the Constitution. There should be general recognition by the courts of the substantive and fundamental objects and purposes behind the legal principles to be found in the various areas of South African law so as to facilitate the development of the common law by the courts in a manner which will ensure a single totally internally consistent and coherent system of law. Whilst the division of the law into different branches and legal disciplines facilitates complex analyses of legal principles within those branches and disciplines it does not further the development of the common law by the courts as envisaged by the Constitution and does not promote consistency, justice, reasonableness or fairness within the South African legal system as a whole. A certain level of legal synthesis, as opposed to analysis, is necessary in order to achieve this. In the real world, people do not operate businesses or fulfil public functions in terms of only one particular area of law. Health

Lillicrap, Wassenaar and Partners v Pilkington Brothers (SA) (Pty) Ltd 1985 (1) SA 475 (A) as follows at p 518-519: "Lawyers will know that this case was preceded by *Administrator, Natal v Trust Bank van Afrika Bpk* 1979 (3) SA 824 (A) which held that in our law Aquilian liability could in principle arise from negligent misstatements which caused pure financial loss, but cautioned against an extension which was either too wide or too rapid. In 1985 Lillicrap's case came before the same Court on exception. It was a claim for pure economic loss arising out of a contract by a firm of consulting and structural engineers to render professional services to Pilkington Brothers. There were two complications: first, at some stage Salanc had been interposed as the contracting party, and the engineers had become in effect sub-contractors to Salanc; second, any claim against the engineers in contract had apparently become prescribed. So Pilkington Brothers sued the engineers in delict for damages for alleged negligent performance of their duties undertaken initially in terms of the direct contract and later in terms of the sub-contract. Two principal questions arose for decision. The first was the question of concurrency. Given the antecedent contract, could the claim for pure economic loss be brought in delict? The Court answered affirmatively at 496F: '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. See *Van Wyk v Lewis* 1924 AD 438; Hosten (op cit at 262); R G McKerron *Law of Delict* 7th ed at 3; J C Van der Walt in Joubert *The Law of South Africa* vol 8 para 5 at 7 - 11. The mere fact that the respondent might have framed his action in contract therefore does not per se debar him from claiming in delict. All that he need show is that the facts pleaded establish a cause of action in delict.'

That this conclusion applied also to a claim for pure economic loss appears from the very next sentence of the judgment of Grosskopf AJA: 'In the present case we are concerned with a delictual claim for pecuniary loss....' Given that concurrency was in principle permissible, the second question which arose was whether in the circumstances of Lillicrap's case (as alleged, the case having been decided on exception) the engineers owed Pilkington Brothers a legal duty of care in delict over and above their contractual duties. This depended on whether the engineers had acted wrongfully, as distinct from culpably. The Court of Appeal, by a majority, held against Pilkington Brothers for what were essentially reasons of policy. The Court was being invited to extend Aquilian liability, and should react cautiously; there was no need for delictual liability as the position was governed by the contractual arrangements; the parties reasonably expected that such arrangements would apply, and not be circumvented by action in delict; and (distinguishing *Van Wyk v Lewis* 1924 AD 438) there was no infringement of rights of property or person. Grosskopf AJA said at 501G: 'To sum up, I do not consider that policy considerations, require that delictual liability be imposed for the negligent breach of a contract of professional employment of the sort with which we are here concerned.'" Comrie J then went on to make a statement which it is submitted is of considerable significance in the context of the delivery of health care services. He said at 519-520: "It may be noted that Lillicrap was, by the terms of the majority judgment, confined to the case of the negligent performance of a contract to render professional services. It was not put so widely as to refer to persons professing skill in a calling. While many persons financial services have excellent qualifications, I am not aware that they are required to undergo graduate study and rigorous training of the kind which are a *sine qua non* of the right to practise as a professional engineer. It seems to me that on this ground too, Lillicrap's case is technically distinguishable from the present matter."

It must be borne in mind that the judicial debate embodied in these cases centred around Aquilian liability for pure economic loss flowing from a contractual relationship. However, as Comrie J pointed out at the start of his review of the cases that had been decided on this subject since *Lillicrap*: "As far as possible I shall confine the review to cases of pure economic loss, actual or inferred, though it will be seen that such a neat compartmentalisation is not readily achievable." For the sake of convenience, further discussion of the judgment in *Pinshaw* is to be found later on in this chapter in the context of the law of delict. It must be noted however, that the decision in *Lillicrap* came in for significant criticism (See Boberg, *The Law of Delict Vol I: Aquilian Liability* p 15-16 and the critics there listed) much of it for precisely the reason that the approach of the court assumed that compartmentalisation of the law at any level is not only possible but also necessary for reasons which, in distillation, seem to amount to little more than a predilection for purism.

services delivery is a good example of this because it contains elements of constitutional, statutory and common law - this last most notably in the areas of contract and delict. When a public provider is considering its obligations and options in any given situation it needs to know what these are across all of the relevant legal disciplines. The same applies for the patient. Since one particular area of law impacts upon another and may even modify a particular conclusion drawn on the basis of only one legal discipline it is logical to view the issue from a global perspective. Before one can identify the point of law upon which a particular unique situation hinges, one has to examine all of the possibilities. The law of contract is particularly versatile and flexible in terms of relationships *inter partes*. They can exclude the operation of certain legislative provisions by agreement, they can also expressly include them by agreement, they can exclude or include certain legal consequences arising not only from the law of contract but the law of delict and other areas of the common law, the nature of the relationship in contractual terms is very much dependent on the power balance between them and the dynamics of the situation in which they come together which raises all kinds of public policy issues. They may agree on things that are impermissible in terms of public policy or the Constitution or contrary to certain overriding statutory provisions. It would be overly simplistic to consider their relationship only in terms of the law of contract - especially in the context of health services delivery which is so essential to the wellbeing of both the individual and the collective.

5.7 Summary and Conclusions

It seems that while the state undoubtedly has the capacity to enter into contracts with patients for the delivery of health care services it is not often that it does so and indeed, it is likely, as for instance in the case of *Edouard*⁶², that conscious thought was only given to the existence of a contractual relationship once it became apparent that there was a need to litigate against the state in this matter. The intention to contract is central to the question of whether or not a contract in fact came into being and whilst it may be relatively simple to establish that intention on the part of the patient it is not nearly as simple to do so in respect of the state. Generally speaking,

⁶² *Edouard* fn 24 *supra*

from the point of view of the state, only officials having a sufficient degree of seniority and who have been delegated the power to do so can bind the state contractually.

Medical officers and nurses employed within public hospitals to render health services to patients generally do not occupy sufficiently high ranks within the public service to have the delegated authority to bind the state contractually. They would have no need, as employees of the state, to enter into contracts with patients themselves and it is unlikely that in the normal course of their daily activities that they would apply their minds to entering into contracts with patients on behalf of the state. Hospital superintendents, who may well have the power to enter into contracts on behalf of the state in terms of delegations from the head of the relevant provincial department of health, do not consult with patients for this purpose and indeed do not have much direct dealings with patients except possibly where there is a problem.

In terms of the Public Finance Management Act⁶³ the head of department is the accounting officer of a government department and his or her responsibilities are set out in section 36 of this Act. One of the obligations of an accounting officer is to must settle all contractual obligations and pay all money owing, including intergovernmental claims, within the prescribed or agreed period. In terms of the Act, an accounting officer may not commit a department, trading entity or constitutional institution to any liability for which money has not been appropriated.

There are strict rules with regard to contracts entered into by the state. For instance in terms of section 86(3) of the Public Finance Management Act:

“any person, other than a person mentioned in section 66 (2) or (3), who purports to borrow money or to issue a guarantee, indemnity or security for or on behalf of a department, public entity or constitutional institution, or who enters into any other contract which purports to bind a department, public entity or constitutional institution to any future financial commitment, is guilty of an offence and liable on conviction to a fine or to imprisonment for a period not exceeding five years”. [writer’s italics].

The nature of the responsibilities of an accounting officer in terms of the Public Finance Management Act are such that the accounting officer is unlikely to want to

⁶³ Fn 2 *supra*

delegate the power to bind the state contractually to a large number of much lower ranking officials such as those who are employed at the ‘coal face’ in the delivery of health care services. For this reason it is submitted that it is largely a legal fiction to say that a patient contracts with the state for health care services.

The most likely legal scenario is that there is no contractual relationship at all and that patients receive health care services from the state in terms of empowering statutes such as the Health Act⁶⁴ and the National Health Act⁶⁵ read in conjunction with legislation such as the PAJA. There is legally speaking no need for a contract to govern the relationship between provider and patient since there is sufficient legislation governing the situation already. For instance patients are obliged to pay fees to public hospitals in terms of regulations and they are entitled to health care services in terms of the Constitution and other relevant national and provincial legislation. They would have a claim in delict for damages suffered in consequence of medical malpractice by the state. This said, it is submitted that to the extent that the contractual fiction within the public health sector serves its purpose, as it did in the case of *Edouard*, it is a useful one whose demise is not likely in the foreseeable future.

The position with regard to the private sector is very different as will be shown in the following chapter. The law of contract is alive and well, although flourishing in a somewhat Victorian fashion, with regard to health service delivery in the private sector. Contractual relationships are perhaps more necessary in a milieu in which, in contrast to the public sector, few if any functions and powers regarding health service delivery are derived directly from specific empowering legislation. There is no law that requires private entities to provide health care services. They do so of their own volition. Similarly there is no law which states the nature of the services they must provide. It is largely only the ‘how’ that is regulated within the private sector as opposed to the ‘what’ and the ‘why’.

⁶⁴ Act No 63 of 1977

⁶⁵ Act No 61 of 2003. It is not yet effective.



Chapter 6

Law Of Contract: Health Service Delivery in the Private Sector

| | | |
|-------|--|-----|
| 6.1 | Introduction..... | 631 |
| 6.2 | Case Law..... | 637 |
| 6.2.1 | Argus Printing and Publishing Co v Dr Van Niekerk..... | 637 |
| | Facts | 637 |
| | Judgment..... | 638 |
| | Discussion..... | 638 |
| 6.2.2 | Tulloch v Marsh | 639 |
| | Facts | 639 |
| | Judgment..... | 640 |
| | Discussion | 642 |
| 6.2.3 | Sutherland v White | 648 |
| | Facts | 648 |
| | Judgment..... | 648 |
| | Discussion..... | 650 |
| 6.2.4 | Oates v Niland | 653 |
| | Facts | 653 |
| | Judgment..... | 654 |
| | Discussion..... | 654 |
| 6.2.5 | Hewatt v Rendel | 654 |
| | Facts | 655 |
| | Judgment..... | 655 |
| | Discussion..... | 658 |
| 6.2.6 | Recsei's Estate v Meine | 660 |
| | Facts | 660 |
| | Judgment..... | 660 |
| | Discussion..... | 664 |
| 6.2.7 | Friedman v Glicksman..... | 668 |
| | Facts | 668 |
| | Judgment..... | 670 |
| | Discussion..... | 677 |
| 6.2.8 | Afrox Healthcare Bpk v Strydom..... | 690 |
| | Facts | 690 |
| | Judgment..... | 692 |
| | Discussion..... | 702 |
| 6.2.9 | Oldwage v Louwrens | 714 |
| | Facts | 714 |
| | Judgment..... | 721 |
| | Discussion..... | 736 |
| 6.3 | Summary and Conclusions | 738 |

6.1 Introduction

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

Contract is generally regarded in the private health care sector as the usual legal basis on which a patient obtains services from a provider. This is despite the fact that in the context of the relationship between a medical practitioner and a patient, documentation reflecting the agreement is seldom created and there is usually no negotiation of the terms between the contracting parties. The contract between provider and patient are therefore often verbal. This obviously does not detract from the validity of such contracts but it does make their terms harder to prove. Where the provider is a health care institution such as a private hospital, the agreement is more likely than not to be reduced to writing, but again there is precious little negotiation between the patient and the provider concerning its terms, even the essential terms. The question of how the constitutional rights of access to health care services and the right not to be refused emergency medical services apply in the context of the law of contract and to private sector providers of health care services has so far not been canvassed in much significance except in the case of *Strydom v Afrox Healthcare*¹ in which the arguments of the court in finding for the plaintiff were, with respect, not particularly well constructed although its finding, it is submitted, was just and effectively correct. The law of contract in South Africa seems still to be premised on business concepts, perceptions of the manner in which markets operate and the kinds of goods and services within those markets that were relevant a hundred years or more ago. At that time, people could afford to enter into litigation at the level of the High Court for non-payment of an account for dentures². There are few dentists in the present day who would litigate at High Court level for non-payment for a set of false teeth since the cost of the litigation exponentially exceeds that of the teeth. One hundred years ago, the primitive ancestors of what we know as medical schemes were just beginning to take shape. One hundred years ago, organ transplants were a dream of the future and there was no such thing as renal dialysis. X-ray machines were a

¹ *Strydom* (2001) 4 All SA 618 (T)

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



radical new technology and some people still believed that the brain was made up of thirty-seven organs, each controlling a different part of the personality³. One hundred years ago aspirin was formulated from salicylic and acetic acids. It was the first drug to be synthesised and its formulation is regarded as the foundation of the modern pharmaceutical industry⁴. One hundred years ago, patent medicine men roamed the countryside selling all kinds of concoctions that were supposed to cure nearly any ailment. The claims made were fantastic and the sales pitch excellent; so, naturally, people bought the concoctions. The medicine man was careful to tell people that the effect was not immediate so as not to arouse suspicion while he was still in town⁵. Faughnan and Lagace write that it is easy to forget that we have had scientific medicine only for a short time. Biomedical sciences began their great surge only sixty years ago, and the clinical sciences have gained strength only in the past twenty or thirty years. Those who would turn away from science now should first review a medical textbook from only one hundred years ago. It is filled with as many worthless remedies as any medieval text, or modern herbal⁶. One hundred years ago it was thought that a physiological basis for female insanity existed in the reproductive organs and that the obvious solution was surgery. For example, women underwent hysterectomies for “calming” purposes; the word “hysteria” is derived from the Greek word for uterus⁷. The medical world has changed considerably in the last hundred years and so, it is submitted, has the nature of health care services, their capacity to prolong or sustain life and the central role they play in our society. Diseases that were fatal to one’s ancestors one hundred years ago are now little more than inconveniences thanks to the enormous advances in medical technology, skill and knowledge over the last century⁸.

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

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

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

⁵ Stump II RC ‘Magnetic Water Treatment Attracts Gullible’ *Newsplash* <http://www.h2otest.com/newsplash/magnet.html>

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

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

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

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

It is submitted that health care services these days are about a lot more than just a private bargain between a purveyor of medical goods or services and a consumer of those goods or services. There is a very real public interest in the manner in which health care services are delivered, in the nature of those services and in the extent to which they are available to those who cannot afford to pay for them. Notions of social responsibility are central to the philosophies of many large corporates including the need to uplift the poor, protect the environment and promote the health of the communities within which they operate. In legal philosophical terms it is no longer 'every man for himself' but the need to balance the interests of the individual (which includes not only men, but also women and children in these enlightened times) against those of society as a whole that is important. It is not so much 'bargains' that should be the concern of contracts between provider and patient in the health care context but quality, safety and efficacy and a fair price to the consumer for something that is starting to be regarded by economists and other disciplines as a public good⁹.

⁹ Merson M in 'SARS Proved Health is Global Public Good' *YaleGlobal Online* states that globalization facilitated both the spread and the containment of SARS causing coronavirus. He points out that modern travel and labour migration patterns helped spread the disease, and global links amplified its political and economic impact. Simultaneously, modern communication and science alerted the world to the disease and facilitated a strong public health response. SARS thus imparted a fundamental reality: health is a global public good. It demonstrated that domestic and global health policy can no longer be divided because local health problems can have global repercussions.

The IHPN in 'Health – a Global Public Good' Bulletin Number 10: January 2002 notes that the World Health Organization is calling for a massive investment by the rich governments of the world into the health of the world's poor. This was the conclusion of a report by the Commission on Macroeconomics and Health launched in London on 20 December 2001. It observes that this argument has strong similarities with calls from the United Nations Development Programme (UNDP) for health to be considered a public good. The Commission itself refers to global public goods and defines them as "goods whose characteristics of publicness (nonrivalry in consumption and nonexcludability of benefits) extend to more than one set of countries or more than one geographic region". The article considers the nature of public goods as follows –

"The concept of dividing goods into 'public' and 'private' goods arises from classical economics and can be dated back to the 18th century. According to this concept, characteristics of public goods include:

- Non-rivalry in consumption which means that one person's use of a good does not prevent another person from using it... This is termed by some as non-divisibility'
- Non-excludability, i.e. use of item is available to all people/groups of people...
- Non-rejectability, individuals are unable to choose to forego consumption...

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

Research and development of medicines that is purely profit driven leads to the marginalization of diseases and conditions that, should they break out on a global scale, could seriously impact upon the world economy. The comparatively recent SARS scare is a good example of how a relatively obscure disease can suddenly become of global significance¹⁰. Taking all this into account it is submitted that one cannot justifiably conclude that health care goods and services are no different to any other goods and services. This in turn carries the implication that contracts in the private health sector should be regulated to reflect these differences as should those who provide health care services and goods within this sector. The South African government has in recent years started to give legislative recognition to these same

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

10

Pablos Mendez A, of the Rockefeller Foundation Centre for the Management of Intellectual Property in Health Research and Development has pointed out that globally from 1975 to 1997 although 1233 new chemical entities were registered only 11 were products for tropical diseases of poverty and half of these were for veterinary purposes.

<http://www.mrc.ac.za/conference/IP/pablosmendez.pdf>

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

perspectives on health service delivery. The amendment¹¹ to the Medicines and Related Substances Act¹², made express provision in section 22G for a transparent system for the pricing of medicines including a single exit price which is the only price at which medicines may be sold to persons other than the state. The intention behind the section is evidenced by other sections of the Act as amended notably sections 18B and section 18A. The regulations envisaged by this section have been written relatively recently and it is clear that the idea of trading in medicines is no longer supported by government policy or legislation. Those who supply medicines are entitled to a professional fee for services rather than a mark-up on the cost price of the medicine. In legal terms this means that the provider-patient contract where the former is a dispensing doctor or retail pharmacist will be a mixed one – for goods and services in the majority of cases - in which both elements are clearly visible to the consumer in terms of what he is paying for. Systems of bonusing, rebates and volume or bulk discounts and sampling that are common trade practices in other sectors have been outlawed by the Medicines and Related Substances Act, emphasising the idea that medicines are no ordinary commodity. Over and above this, however, provision is made for the prescription by the Minister of Health of the fees that wholesalers, distributors, retail pharmacists and dispensing doctors may charge with regard to the activities that surround the supply of medicines, once again making the point that health services are also different to services in other sectors.

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

¹¹ Act No 90 of 1997

¹² Act No 101 of 1965

It is submitted that it is against these legislative and policy backdrops that one must construe the delivery of health care services within the private sector. Socio-economic rights have been recognized by the constitutional court as being justiciable¹³. The subject matter of these rights in South Africa can never again be seen as mere commodities in trade.

6.2 Case Law

6.2.1 *Argus Printing and Publishing Co v Dr Van Niekerk*¹⁴

Facts

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

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

¹⁴ *Argus* (1895) 2 OR 40

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

Judgment

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

Discussion

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

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

6.2.2

*Tulloch v Marsh*¹⁵

Facts

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

¹⁵ *Tulloch* 1910 TPD 453

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

Judgment

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

¹⁶ *Lowle* [1907] TS 1069

¹⁷ *Lee* 30 L.J. Q.B. p254



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

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

¹⁸ *Lee* fn 17 *supra*

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

Discussion

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

Strauss²⁴ comments with regard to *Tulloch* that legally speaking the contract between a doctor and a patient would be for the letting and hiring of work (*locatio conductio operis*) but that the court decided that with regard to dental services in this case that the transaction legally amounts to a sale and not one of letting and hiring of services. He notes that one of the interesting implications of this ruling is that the equitable relief of the dentist claiming a reduced amount for the work done by him, irrespective of its shortcomings, does not apply in respect of dentures and points out that the patient who complains of a patently defective denture would be entitled to reject it, cancel the contract with the dentist and claim damages for breach. In the case of latent defect, says Strauss, the patient would be able either to claim rescission of the contract or retain the denture and claim a reduction on its price. He states that these legal remedies are available to the patient even if the dentist did not expressly guarantee satisfaction. Contracts for the sale of goods therefore have somewhat different implications to contracts for the letting and hiring of services in the health care context. Whilst generally speaking contracts for the letting and hiring of services in relation to health care come with no guarantee of a cure or undertaking as to the end result of those services, contracts for goods must meet the reasonable expectations of the purchaser and the seller can be held liable for latent defects. It has previously been

¹⁹ *SA Wood Turning* 1962 (4) SA 263 (T)

²⁰ *Progress Dental Laboratory* 1965 (3) SA 192 (T)

²¹ *Carpet Contracts* 1975 (2) SA 436 (T)

²² *Forsyth* 1982 (2) SA 164 (N)

²³ *Polpark* 1978 (2) SA 816 (A).

²⁴ Strauss *Doctor Patient and The Law: A Selection of Practical Issues* at p 69

observed that where the seller professes expertise in the good sold he can also be held liable for consequential damages²⁵.

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

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

In *Polpark Dispensary (Pty) Ltd v SA Pharmacy Board*²⁶ the crisp question was whether the business that the appellant, a body corporate, wanted to conduct on certain premises in Springs was that of “a retail pharmacist” within the meaning of s 22 (1) (e) of the Pharmacy Act²⁷ (“the Act”). If it was, it could not be carried on, for appellant would then not be entitled to be registered as a pharmacist under the Act and hence could not practise as such. It then followed too that the respondent, the South African Pharmacy Board (“the Board”), would have correctly declined appellant’s application for registration under the Act; that the Transvaal Provincial Division rightly dismissed the appellant’s appeal to it under section 24 and that appellant’s present appeal must be dismissed. The converse would apply if the answer to the above question was in the negative: appellant’s present appeal must then succeed and its registration as a pharmacist be ordered.

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

²⁶ *Polpark* fn 23 *supra*

²⁷ Pharmacy Act No 53 of 1974

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

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

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

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

²⁸ *Medicaments* (1970) 1 WLR 1339



the contrary, they are private premises and not accessible to the public at all. Counsel also relied on *Turpin v Middlesborough Assessment Committee*²⁹ and other similar cases that all deal with the expression “a retail shop” in an English rating statute. This argument said the court, is also untenable for these reasons. Selling to the public is not an essential ingredient of a retail trade. In any event, the patients in the clinic, to whom the appellant sells the medicines prescribed for them all come from the public; while in the clinic they can thus be regarded as members of the public, albeit only an exclusive or limited section thereof; so this particular point made by the appellant’s counsel, said the court, loses its force. Moreover while retail trade is usually conducted from a shop on a street or in a place open to the public, that too is not essential in respect of a retail pharmacist or pharmacy. According to s 1 of the Act, “pharmacy” means “any place where is performed any act specially pertaining to the profession of a pharmacist”. A retail pharmacist can therefore carry on his business at any place or premises and not necessarily in a shop. Turpin’s and the other cases referred to *supra* were therefore all inapplicable to the problem in hand. In Turpin’s case the question was whether for rating purposes under the English Rating and Valuation (Apportionment) Act³⁰, certain premises were primarily occupied and used for the purposes of a “retail shop”. That expression was defined as including “any premises of a similar character” (i.e. similar to the character of a retail shop) “where retail trade or business... is carried on”. The premises in question were held to be “a retail shop”, *inter alia*, because “the public can resort (to them) for the purpose of having - particular wants supplied therein”. The court noted that on the other hand in *Toogood and Sons Ltd v Green*³¹, the premises were held not to be “a retail shop” because the premises were not such that the public could resort to them for that purpose if they wanted to. It observed that in *Dolton Bournes and Dolton Ltd v Osmond*³² a similar conclusion was reached. But, said the court, in these and other like cases that were quoted, an entirely different statutory provision was being construed and applied. There the inquiry wits into both the character of the premises and the nature of the trade or business conducted on it. It referred especially to *Ritz Cleaners*

²⁹ *Turpin* 1931 AC 452 at 470 *et seq*

³⁰ 1928

³¹ *Toogood* 1932 AC 663

³² *Dolton Bournes* (1955) 1 WLR 61 (CA)

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

The intention of the government as evidence from the provisions of section 22G of the Medicines and Related Substances Act³⁴ as amended is to change the emphasis within pharmacies and wholesalers from of trade in medicines to professional services in respect of which fees are payable. In such an environment the pharmacist will be in much the same position as the dentist selling dentures constructed by a dental technician and, it is submitted, the contract will be a mixed one for the sale of goods and the letting and hiring of services.

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

³⁴ *Medicines Act fn 12 supra*

6.2.3

*Sutherland v White*³⁵

Facts

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

Judgment

³⁵ *Sutherland* 1911 EDL 407



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

³⁶ *Le Roux* [1911] EDL 381

³⁷ *Thurston* [1908] TH 79

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

Discussion

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

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

- (i) in the building industry where the conductor operis undertook to erect a house or building with his own materials on a building site provided by the locator operis;
- (ii) in the manufacturing industry where the conductor operis undertook to manufacture or construct some object from material supplied to him for the purpose by the *locator operis*, eg the building of a ship; the commissioning of a goldsmith to fashion rings from gold delivered to him for the purpose;
- (iii) where articles were handed to craftsmen to work on, or to repair or to clean, eg jewels sent to a jeweller to be set or engraved, clothes handed to a fuller to be cleaned;

³⁸ *Smit* 1979 (1) SA 51 (A)

- (iv) in the transportation of goods or passengers;
- (v) in the training of slaves.

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

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

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

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

6.2.4 *Oates v Niland*³⁹

Facts

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

³⁹ *Oates* 1914 CPD 976

Judgment

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

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

Discussion

In this case the contract was also essentially one of sale. The patient was, however, using the teeth and made no effort to pay the dentist despite the fact that they were clearly serviceable. If the patient accepts the goods and uses them, it does not lie within his mouth to say that he should not be obliged to pay for them. This case is clearly different from that of *Sutherland v White* due to the fact that the teeth in the latter case were unsuitable. Where the product is of such a nature that it is required to be fitted or adjusted to suit the patient, a proper opportunity to do so must be given to the supplier⁴⁰.

6.2.5

***Hewatt v Rendel*⁴¹**

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

⁴¹ *Hewatt* 1925 TPD 679

Facts

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

Judgment

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

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

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

⁴² *Perionowsky* (4 F & F 977)



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

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

⁴³ *Van Wyk* 1924 AD 438

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

Discussion

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



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

6.2.6

*Recsei's Estate v Meine*⁴⁴

Facts

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

Judgment

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

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

⁴⁴ *Recsei's Estate* 1943 EDL 277

importance to the form and contended that the object of obtaining the signature of the patient to this form was not only to cover the doctor performing the operation but to bind the patient to the doctor whose name appears on the case sheet i.e. in this case the plaintiff. The evidence of Drs Ziervogel and Phillips, however, disposed of this contention. Their evidence was to the effect that the signature of the patient on the consent form does not bind the patient to any particular doctor whose name appears on the case sheet and that the primary purpose of obtaining the signature of the patient to such a form is to protect the hospital authorities by procuring in advance the consent of the patient to submit to an operation; the very wording of the form shows that the patient agrees “to leave the nature and extent of the operation to the discretion of the surgeons.” Lewis AJ stated that in his reply to the request for particulars the plaintiff had relied on the “form of consent to operation” in so far only as the date thereof enabled him to fix the date when the deceased had given his express consent to the plaintiff operating upon him; that express consent was there stated to be a verbal consent only. It was alleged that the deceased made no stipulation as to who should consent to the operation when it was discussed with him and that when the plaintiff advised him that he would perform the operation the deceased raised no objection. Lewis AJ said that it did not necessarily follow that because the evidence of the plaintiff on this point was uncontradicted, it should necessarily be accepted. There was only the plaintiff’s evidence in support of his allegations. The plaintiff’s evidence stood alone and though there was no rule of law that a claim against a deceased estate must be corroborated, it is a sound rule of practice that when such a claim depends on the oral and uncorroborated testimony of the claimant it should be very strictly scrutinised⁴⁵. It was not necessary, said Lewis AJ to decide where this evidence should be accepted because even assuming that it was accepted, this did not conclude the case in his favour. Lewis AJ said it was true that ordinarily the consent of an adult in full possession of his mental faculties (as was admitted to be the case of the deceased) would be sufficient authority for the performance of a surgical operation upon him. But there were some very special features of this case which took it out of the ordinary run of cases and a perusal of the evidence of the plaintiff as a whole satisfied the court that on his own admission he was well aware that in order to perfect his mandate to operate upon the deceased, he required not only the consent of the

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

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

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

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

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

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

Discussion

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

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

In any event the decision of the court seems to have been a just one since it appears that Dr Meine deliberately and unethically prevailed upon a weak and ailing old man, in the absence of his son's protective presence and in the full knowledge that the son had requested other doctors to perform the operation, to allow him to perform it instead. Ordinarily, in the absence of a duty of support owed by a child to its aged parent⁴⁶, there would be no liability on the part of the child for the medical expenses of the parent due to the legal requirements of privity of contract and the fact that one adult person cannot in the absence of a legal duty of support be held liable for the debts of another⁴⁷. However, in this particular case the son had clearly taken it upon himself to contract for his father's medical treatment as evidenced by the fact that invoices had previously been sent to the son in respect of such treatment of the father by Dr Meine.

The Medical Schemes Act⁴⁸ defines a dependant as follows:

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

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

⁴⁸ Medical Schemes Act No 131 of 1998

‘dependant’ means-

- (a) the spouse or partner, dependent children or other members of the member's immediate family in respect of whom the member is liable for family care and support; or**
- (b) any other person who, under the rules of a medical scheme, is recognised as a dependant of a member;**

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



claim against him by the hospital merely because his mother is registered as his dependant with his medical scheme. The duty of support of a child to a parent is very much dependent both for its nature and content on the circumstances of each case and is generally quite different to the duty of support owed by a parent to a child. Furthermore, paragraph (b) of the definition of a dependant in the Medical Schemes Act tends to suggest that a person can be registered as a dependant of a member in the absence of a legal duty of support owed by the member to that dependant. Thus the registration of a person as a dependant of a member of a medical scheme is not necessarily proof of a legal duty of support owed by the member to the dependant. A hospital or health professional who tries to hold an adult child liable for medical costs incurred by his mentally competent parent would have to show in the circumstances of the particular case that there was a legal duty of support owed to the parent by that child⁴⁹. If there is more than one child, as is often the case, then technically the duty of support may have to be proven against all of the children and not necessarily just the member of the medical scheme who had registered his mother as a dependant since the duty to support a parent cannot rest on the shoulders of only one child and not those of other siblings⁵⁰. There is a reciprocal duty of support between spouses.⁵¹ In certain circumstances there may even be a duty of support owed by a grandchild to a

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

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

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



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

6.2.7

*Friedman v Glicksman*⁵³

Facts

The allegations made by the plaintiff were:

1. That when pregnant, she consulted the defendant, a specialist gynaecologist, to advise her apropos of the risk that she might have been pregnant with a potentially abnormal and/or disabled infant.
2. It was understood between the plaintiff and the defendant that the plaintiff wished to terminate her pregnancy if there was any risk greater than the normal risks of the infant being born in an abnormal and/or disabled condition.
3. An agreement was concluded in terms of which the defendant would provide such advice in order that the plaintiff might make an informed decision on her

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

In *Miller v Miller*, 1940 CPD 466 at p 469, Jones, J, said: "In my view the duty to support which falls upon parents, grandparents, children and brothers and sisters only becomes operative so as to give rise to a claim at law when it is proved that the husband is dead or unable to afford support. Primarily the duty falls upon the husband, and it is only when he is dead or unable to provide support that a right to claim support from a parent or child or brother or sister arises. The whole trend of the treatment of the matter by Voet and Huber indicates that a legal right to claim support from a grandparent or brother or sister does not exist unless the parents fail."

⁵³ *Friedman v Glicksman* 1996 (1) SA 1134 (W); *Manousakis and Another v Rempal Entertainment CC* 1997 (4) SA 552 (C)

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

4. In the alternative the defendant, by virtue of his professional status, was under a duty to provide the advice to the plaintiff both in her personal capacity and on behalf of Alexandra for the purpose set out in 3 above. In this regard he had to act with the skill, knowledge and diligence normally exercised by other members of his profession.
5. The defendant, having carried out certain tests, advised the plaintiff that there was no greater risk than the normal risk of having an abnormal and/or disabled child and that it was quite safe for her to proceed to full term to give birth.
6. The defendant's advice was erroneous and Alexandra was born disabled on 5 March 1991.
7. The defendant in giving his advice had acted negligently in a number of respects. Had he not acted in this negligent manner he would have concluded that there was a greater than normal risk of the child being born disabled and would have advised the plaintiff of this fact.
8. Had she received the correct advice the plaintiff would have terminated her pregnancy forthwith.
9. The defendant's negligence was a breach of his duty of care as well as a breach of the agreement concluded.

Based on these facts plaintiff brought two claims:

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

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

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

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

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

Judgment

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

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

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

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

Thus, said Goldblatt J, different considerations apply to the claims instituted by the plaintiff in that the one claim is a ‘wrongful birth’ claim and the other a ‘wrongful life’ claim. The defendant argued that it would be against public policy to enforce the contract entered into between the plaintiff and the defendant because it would encourage abortion and thus be inimical to the right to life enshrined in section 9 of the Constitution of the Republic of South Africa Act⁵⁴ as well as to the generally recognised sanctity accorded by society to life and the process by which it is brought about.

Goldblatt J stated that in his view there was no substance in this submission, which flew directly in the face of the Abortion and Sterilisation Act⁵⁵. In terms of s 3(c) an abortion may be procured ‘where there exists a serious risk that the child to be born will suffer from a physical or mental defect of such a nature that he will be irreparably seriously handicapped’. Thus, he said, the Legislature has recognised, as do most reasonable people, that cases exist where it is in the interests of the parents, family and possibly society that it is better not to allow a foetus to develop into a seriously defective person causing serious financial and emotional problems to those who are

⁵⁴ Interim Constitution (Act No 200 of 1993)

⁵⁵ Act No 2 of 1975

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

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

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

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

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

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

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

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

⁵⁷ *Berman* 404 A.2d 8 (1979)

⁵⁸ *Edouard* fn 56 *supra*

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

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

⁵⁹ *Pinchin* 1963 (2) SA 254 (W)

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

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

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

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

⁶⁰ *Speck* Pa 268 Super 342 (1979); 408 A 2d 496

⁶¹ *Philips* 508 F Supp 537 (1980)

⁶² *Curlender* App 65 Cal Rptr 477

⁶³ *McKay* [1982] 2 All ER 771 (CA)

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

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

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

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

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

⁶⁴ Per Stephenson LJ at 781e

⁶⁵ Per Ackner LJ at 787h

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

Discussion

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



it is not, then a contract contemplating such termination is lawful and there is a concomitant legal duty in delict to provide medical advice with a view to determining the necessity of the termination. It is submitted that in the context of health care service in particular, this kind of indivisibility between the law of contract and the law of delict is particularly evident due to the nature of the services provided. The court used the limitation of liability argument to preclude a claim for wrongful life in terms of the law of delict. Strauss⁶⁶ writing in 1991 observes that it is still an open question whether South African courts will uphold a claim for wrongful life and that different policy considerations may apply in respect of such a claim. He notes that liability for wrongful life is a completely different story to claims for wrongful conception and refers to Giesen⁶⁷ who has pointed out that claims by the infants themselves have been regarded almost universally with disfavour. Giesen comments that the child is not claiming that the physician's negligence caused its defects but that had he informed its parents properly, it would never have seen the light of day at all. And the courts have refused on policy grounds to hold that life, even if experienced with severe handicaps, is or can be preferable to non-existence. The unarticulated conundrum in these cases, it is submitted, rests in the fact that the purpose of a contractual award of damages is to place the victim in the position in which he or she would have been but for the breach. In the present context, taken to its logical conclusion it means to compensate a person for the fact that he or she did not die. Effectively, therefore, it means awarding damages for a death that did not occur and is rather more an attempt to quantify the value of death, or non-existence, than it is to quantify the 'loss' arising from a disabled life. Similarly, in terms of the law of delict, the object is to place the plaintiff in the position in which she would have been but for the wrongful act or omission of the defendant. In this instance, it would mean killing the plaintiff. This goes contrary to public values and the legal convictions of the community with regard to life. It is mirrored in the attitude of the South African law to euthanasia. A plaintiff would not be able to bring an action in delict against a doctor who failed to euthanase him as requested, either on the basis of a contract or in terms of the law of delict, since to cause or hasten the death of another, even if he or she is in any event dying, is wrongful in terms of the legal convictions of the community. Any legal developments

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

⁶⁷ Giesen D, *International Medical Malpractice Law*

in favour of euthanasia would of logical necessity have to give rise to a review of the legal position in the case of wrongful life claims since in principle there is no difference between the two except that they usually occur at two different ends of the human lifespan. Strauss⁶⁸ comments that judging by the views expressed by South African jurists, it is highly unlikely that 'wrongful life' claims will be upheld by South African courts as a cause of action. It turns out that this view was validated by the judgment in Friedman's case. Claassen and Verschoor⁶⁹, also writing prior to *Friedman*, note that in *Gleitman v Cosgrove*⁷⁰ the first wrongful life claim was instituted by a disabled child. The mother contracted rubella during the first three months of pregnancy and she was assured by the defendant paediatrician that the illness would have no prejudicial effect on her unborn child. On the strength of this advice she decided not to have an abortion. The child was subsequently born with brain damage and seriously defective sight, speech and hearing. Both the parents' and the child's unlawful life claims were rejected by the court. The court contended that no parallel could be drawn between human life and a state of non-existence and further that any life in any form whatsoever, was to be preferred to non-life. They also refer to *Stewart v Long Island College Hospital*⁷¹ and to the case referred to by Goldblatt J in *Friedman, Berman v Allen*⁷². Claassen and Verschoor canvass the reasons for rejecting a claim for damages on the basis of wrongful life⁷³ and note that Brownlie⁷⁴ disagreed with Strauss that South African courts were likely to reject a claim for wrongful life.

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

⁶⁸ Strauss fn 24 *supra* at p 197

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

⁷⁰ *Gleitman* 227 A.2d 689, NJ 1967

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

⁷² *Berman* fn 57 *supra*

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

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

something he could have prevented except by killing the foetus and there is insufficient evidence that this last is any kind of solution in any event. There is a certain symmetry between the wrongful birth situation and the situation in *S v Williams*⁷⁵ where the accused tried to argue that the act of taking the patient off the life-support system was a *novus actus interveniens* that caused her death and as opposed to the assault on the deceased by the accused. In the wrongful life situation the birth was inevitable according to the natural course of events just as the death in *S v Williams*⁷⁶ was inevitable due to the natural course of events. In both situations the medical intervention that was required was supposed to avoid the anticipated outcome and divert the natural course of events from its logical conclusion. The difference is that in wrongful birth cases that logical conclusion is birth whereas in *S v Williams*⁷⁷ it was death. The two cases are consistent in terms of their logical symmetry in that the courts in both cases rejected the idea that the failure to divert the natural course of events from its logical conclusion was unlawful. However these two cases are at the two extreme ends of a health care spectrum. In the middle of the spectrum and, in all likelihood to the majority of cases involving health care delivery, the opposite rule applies as illustrated by the Volkmann's contracture cases⁷⁸ and the sterilisation cases⁷⁹. In these cases the judgments of the court went against medical practitioners who failed to reasonably avert the consequences of the natural course of events. This apparent logical inconsistency need not necessarily be a problem since there are other examples of logical systems in which the rules that apply generally start to break down or have a different effect at extreme ends of a spectrum.⁸⁰ It can also be argued that at the extreme ends of the spectrum the rights of the health professionals themselves and boundaries of reasonableness are more prominent features of the logical system. For example in cases involving the termination of pregnancy, the constitutional right of the health professional to freedom of conscience, religion, thought, belief and opinion starts to weigh in against the right to have a pregnancy

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

⁷⁶ *Williams* fn 75 *supra*

⁷⁷ *Williams* fn 75 *supra*

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

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

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

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

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

In the health care context, the right of the a newborn dependant of a member of a medical scheme to benefit from that medical scheme is a more common example of similar boundary issues in the law of contract as it applies to health care services. A person is a member of a medical scheme and as such is entitled to certain benefits not only for him- or herself but also her registered dependants. The basis of the member's relationship with the medical scheme lies in the law of contract⁸². Maternity benefits in respect of confinement costs for the pregnant mother and any medical treatment that may be necessitated by the birth process and attendant complications are usually offered by medical schemes. The baby is not yet born. It is not yet a dependent in its own right independent of its mother. Nonetheless, while the unborn child is in the mother's womb, it can be given medical treatment that is specifically intended to address the health problems of the child and not the mother. An extreme example of such treatment is *in utero* surgery on the unborn child to correct conditions such as spina bifida, congenital diaphragmatic hernia and heart defects⁸³. Since in South African law a foetus is not a person⁸⁴ and only persons have contractual capacity, any

⁸¹ *Williams* fn 75 *supra*

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

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

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

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

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

85

In *Ex Parte Oppel And Another* 2002 (5) SA 125 (C) the court referring to *Wolman and Others v Wolman* 1963 (2) SA 452 (A), observed that generally, a minor cannot conclude legally binding contracts unassisted. Likewise, the minor cannot institute legal proceedings without the assistance of his guardian. A parent can contract on behalf of a minor child in certain circumstances. Christie *The Law of Contract* at p 264-265 notes that a person is a minor, in terms of the Age of Majority Act No 57 of 1972, until he or she reaches the age of 21 or marries or is emancipated either under the 1972 Act or tacitly. A child under the age of 7 years has no contractual capacity at all so the only contracts that can be binding on him are those made by his guardian on his behalf. (See Voet 26 8 9). The court in *Ten Brink No and Another v Motala and Others* 2001 (1) SA 1011 (D) the court stated that: "Counsel for the applicants contends, however, that where a person such as the second respondent signs in a representative capacity, that fact must appear *ex facie* the document itself. The contention cannot be sustained because in *Cook v Alured* 1909 TS 150, Innes CJ had said (at 151): "Though a contract purport to be entered into in the name of the agent, parol evidence may be led to show that it was entered into on the principal's behalf. Such evidence does not in truth vary the written contract, because the liability of the other party to the contract remains. It simply informs the Court that some other person is entitled to sue upon it, and that the principal desires to enforce his rights under it."

If such evidence is permissible in the case of an agent, then the same must *a fortiori* apply to the case of a father and natural guardian signing on behalf of his minor child. Counsel's contention is in any event in conflict with the decision in *Van der Merwe v Kenkes (Edms) Bpk* 1983 (3) SA 909 (T), where a woman married out of community of property had sued on a contract for the purchase of fixed property. Her husband had signed the contract on her behalf without qualifying his signature, and it was held that extrinsic evidence would be admissible to prove that in signing the contract her husband had acted on her behalf. Counsel submits that the matter is otherwise in the case of a father signing on behalf of his minor child, but in my judgment there is no difference in principle."

In *Visser v Van Tonder* 1986 (2) SA 500 (T) the court observed that a contract with a minor is an example of a limping contract with reference to *Edelstein v Edelstein NO and Others* 1952 (3) SA 1 (A). However, Christie RH *The Law of Contract* at p270 points out that minor's unassisted contracts which call for performance only from the other party and not from the minor are also enforceable. Christie quotes the dicta of Van den Heever JA in *Edelstein* as follows: "It will be observed that Grotius does not say that in the exceptional cases mentioned by him the contract of a minor is valid. He approaches the matter from the point of view of obligations. In general, he states, a minor cannot assume an obligation; if he purports to do so, the obligation is not enforceable. Grotius mentions two relevant exceptions: (1) a minor may validly stipulate for an advantage and (2) ...What is meant by the former is perfectly clear from our authorities: an unassisted minor cannot validly make a promise to perform; he may, however, stipulate for a performance by the other party to the transaction. The type of stipulation appears from van der Keessel (*Dictata ad Grot.* 1.1.8): an unassisted minor may validly accept a donation or stipulate that a valid claim against himself be not enforced." Christie says that that only quibble one can have with that passage is that it makes Grotius state the general rule in the form "a minor cannot assume an obligation; if he purports to do so the contract is not enforceable." Why then, one might well ask, is Grotius' first exception an exception since it does not involve the assumption of an obligation by the minor? The answer is that that is not how Grotius states the general rule, so his first exception is a true exception to the rule as stated by him. What Grotius says (1 8 5) according to Christie is: "any contract entered into by minors unassisted, even though confirmed by oath, has no binding force (*buiten rechts-dwanck*) as unknown to the civil law: except that they may stipulate for something to their advantage". A contract in terms of which a medical scheme is obliged to fund within the scope of its registered rules, the health care expenses of a minor child could arguably be seen as creating a contractual obligation between the scheme and that minor child because it is not the minor child that is obliged to pay the contributions but the principal member. There is no obligation on the minor child as such but there is an obligation upon

membership it may be argued that the relationship between a scheme and its members is not contractual but it is submitted that this argument is likely to succeed only in the most limited of circumstances⁸⁶. A member is entitled to register dependants with his medical scheme so that they too may receive benefits in terms of the scheme rules.

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

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

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

room for this kind of surgery on fetuses as they cannot give consent. Development of fetal surgery promises to be a major source of new therapy and to increase pressure on policymakers and ethicists to define the difference between responsibilities to women and to future children⁸⁷. American courts have encountered some problems with the question of the legal basis on which to protect a foetus both from its own mother and from third parties. Prosecutors and judges in numerous states have begun to apply child abuse, neglect, support, endangerment and homicide statutes in an attempt to deter, punish or remedy maternal conduct during pregnancy deemed harmful to the unborn child. Many prosecutors and judges have relied on statutory authority when requiring pregnant women to undergo medical procedures thought “necessary to preserve fetal life or health”⁸⁸. It is clear that the closer the law comes to attributing a duty upon a mother, or to other persons, to act in a certain way towards an unborn child, the more significant become the contractual obligations between a parent and a third party for the benefit of that unborn child⁸⁹. From there it is a small logical step to recognising certain obligations to an unborn child directly. This chain of legal development however, is on a collision course with the notion that the unborn child is not a person. In South African law, the nasciturus rule at this stage applies only in the law of delict and the law of succession. It has not been extended to other areas of law. The question is whether, in the context of the law of contract, there is any substantial logical reason not to. The court in *Friedman v Glicksmann*⁹⁰ used the possibility of a child’s suing its parents as one argument in favour of precluding a claim for wrongful

87 McGee G ‘Bioethics At The End Of The 1990s’ *MSNBC Breaking Bioethics* Bioethics.net
<http://www.bioethics.net/msnbc>

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

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

90 *Friedman* in 53 *supra*

life. Whilst the writer is not arguing in favour of claims for wrongful life, whether based in delict or on a contract, the question is whether a child's capacity to sue its parents is problematic in terms of the legal convictions of the community? Child abuse is a delict as much as it is a crime. In South Africa in particular, children unfortunately need all the legal protection against abuse that they can get. Cook⁹¹ notes that courts have increasingly grappled with the subject of whether a woman has a maternal duty to guarantee the health of her foetus. As a result of these decisions prenatal tort liability has not developed primarily during the last few decades to the point where children may now bring personal injury actions against their mothers for harmful prenatal conduct. Cook points out that at the core of these personal injury actions is the belief that a child has "a legal right to begin life unimpaired by physical or mental defects caused by another's negligence. From the cold logical perspective, an unborn child that is dead as the result of an abortion cannot bring a delictual claim for harmful prenatal conduct because it is dead and it never became a person in the eyes of the law. The conundrum is that if the abortion fails and the child is born injured, it can. The writer has already pointed out the thinness of the boundaries between contractual and delictual obligations in the context of health care. It is submitted that in the context of the law of contract, to state that a foetus is not entitled to benefit from contractual obligations in its favour imposed upon a third party by its parents is no different to saying that a neonate is not entitled so to benefit. A contract for health care services is not enforceable on behalf of a foetus but it is enforceable on behalf of the neonate. The American system also recognises a rule similar to the nasciturus rule in South Africa. In general when an injured foetus is born alive, the child or those acting on behalf of the child may maintain an action to recover damages for negligently inflicted prenatal injuries caused by third parties⁹². There seems to be no major differences in principle on this subject between the American legal system and our own. The writer has already pointed out that South African courts tend not to be too pedantic when faced with claims in delict and in contract in situations involving health care services where the cause of action is fundamentally the same. They have a tendency to end up resolving the case on the basis of the law of delict

⁹¹ Cook *fn 88 supra*

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



rather than the law of contract but seem not to be unduly concerned with the finer distinctions between the law of contract and the law of delict. It is submitted that these finer distinctions are in any event becoming increasingly still finer over time. The question of contractual capacity when one is dealing with health service delivery to minors is no big hook upon which an analytical lawyer should get hung up when considering health services to children in view of the provisions of section 28(1)(c) section 28(2) and section 27(1) of the Constitution. The law of contract holds an agreement with an unassisted minor binding when it is purely to the advantage of that minor and when no reciprocal obligations are imposed on the minor him- or herself. Similarly a parent can assist a child to enter in to a contract which is then also binding upon both the minor and the third party. In other words, contracts with minors are legally, technically possible despite the fact that they have no contractual capacity. In this sense, therefore, it is difficult to distinguish between a minor and a foetus. When it comes to the legal position of the unborn child, despite the fact that is not yet a person in the eyes of the law, the position is not as clear cut as it would first appear. The law does recognise, albeit in roundabout ways, the need to protect an unborn child. The application of the nasciturus rule in the law of delict and the law of succession is an example of this. Cook notes that the question of whether courts may convict the slayer of a foetus under homicide statutes has been the subject of controversy for many years. He states that at common law and in the absence of a statute, there is no crime of a child dies before birth. However, under many state statutes today, if the child is born alive and later dies, the culpability is the same as that incurred in the killing of any other human being. The rationale is that a child who has an “independent existence” separate from his or her mother is a human being. Cook⁹³ observes that recently courts have provided that damage inflicted in a foetus *in utero* is sufficient to support a homicide charge even without a live birth. At the federal level, feticide statutes are receiving growing attention. Under the Unborn Victims of Violence⁹⁴, United States attorneys can charge individuals who commit an already defined federal crime of violence against a pregnant woman with a second offence on behalf of the second victim, the unborn child. Currently the majority of states already have “unborn victim laws”. It would seem that of late the American

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

⁹⁴ Unborn Victims of Violence Act of 2001

legal position with regard to an unborn child, to which Grosskopff JA referred in *Van Heerden and Another v Joubert No and Others*⁹⁵ has changed and continues to do so⁹⁶ without necessarily conferring personhood on a foetus. In the context of health care services to a foetus Cook notes that the federal government has calculated that the average healthcare costs of a drug-exposed foetus total about one million dollars.

⁹⁵ *Van Heerden* 1994 (4) SA 793 (A)

⁹⁶ Grosskopff JA noted: "In the case of *Roe v Wade* 410 US 113 (1973) the Supreme Court was called upon to decide on the constitutionality of the Texas criminal abortion laws. In the course of the argument it was submitted that a foetus was a 'person' within the language and meaning of the Fourteenth Amendment, but the majority of the Court (at 156-8) was not persuaded that the word 'person' also included the unborn. In *R v Tait* [1990] 1 QB 290 (CA) the Court of Appeal held that a threat to a pregnant woman to kill her foetus was not a threat to kill a 'person' under the Offences against the Person Act 1861. I am likewise of the view that the word 'person' in the context of the present Act does not include an unborn child. Cook (fn 88 *supra*) notes that subsequent to the Roe decision, state courts have upheld convictions under general homicide statutes for the death of an unborn, viable foetus. In other jurisdictions, however, the courts have held that prosecutors may maintain a conviction under general homicide statutes only if the legislature defines a foetus as a "person" or "human being" under the terms of the statute. Not surprisingly, says Cook, courts continue to debate over a parent's legal obligation to protect fetal health. In 1931 the court in *People v Yates* [298 P. 961 (Cal. Dist. Ct. App. 1931)] resolved the issue of whether prosecutors could successfully charge a father with neglect of his unborn child. The father in *Yates* failed to furnish food, clothing, shelter and other medical attendance to his unborn child's mother. The court held that the father had a duty to provide these necessary things to ensure the health of his unborn child by providing them for the mother. Almost seventy years later, the South Carolina Supreme Court in *Whitner v South Carolina* [492 S.E. 2d at 777] addressed whether the state could prosecute a mother for neglecting her unborn child. The unborn child's mother ingested crack cocaine during her pregnancy and the state brought criminal neglect charges against her for her conduct. The Whitner court became the first high court of any state to hold that a viable foetus is a person within the meaning of its state child abuse laws. As a result of this decision, some commentators have argued that health and social services professionals must guess whether a pregnant woman's failure to obtain prenatal care, to quit smoking or drinking, to stop taking over-the-counter medicine, or to refrain from playing rigorous sports constitutes unlawful behaviour.

There is a clearly a contrary view to the subject of 'foetal rights' that largely favours the interests of the mother over the unborn child. Martin S and Coleman M in 'Judicial Intervention in Pregnancy' *McGill Law Journal* Vol 40 p 947 for instance postulate that judicial intervention in pregnancy is one of the means by which control is legally exercised on women's bodies and lives. They note that despite the recommendations of the Royal Commission on New Reproductive Technologies which rejected proposals for intervention, and the fact that the movement to recognize foetal 'rights' has been stronger in the United States than in Canada, these proposals nevertheless pose a subsisting threat to women and that women's right to equality in particular, is compromised. They observe that in the United States there have been many cases of women forced to undergo Caesarian sections or subjected to criminal sanctions or civil liability for their conduct during pregnancy. They also caution against being overconfident that this is purely an American problem since judicial intervention, legislation, mental health considerations and academic literature in Canada all mirror the American position albeit to a lesser extent. The recommendations of the Commission with regard to judicial intervention in pregnancy and birth are interesting. They read: "273. Judicial intervention in pregnancy and birth not be permissible. Specifically, the Commission recommends that (a) medical treatment never be imposed upon a pregnant woman against her wishes; (b) the criminal law, or any other law, never be used to confine or imprison a woman in the interests of her foetus; (c) the conduct of a pregnant woman in relation to her foetus not be criminalized; (d) child welfare or other legislation never be used to control a woman's behaviour during pregnancy or birth; and (e) civil liability never be imposed upon a woman for harm done to her foetus during pregnancy. 274. Unwanted medical treatment and other interferences, or threatened interferences with the physical autonomy of pregnant women be recognized explicitly under the *Criminal Code* as criminal assault." The authors point out that the majority of the Commissioners expressly rejected claims to assimilate the position of an unborn foetus to that of a born child and refused to create and impose special legal obligations on pregnant women. They stated that medical treatment should "never" be imposed upon a pregnant woman against her wishes and that child welfare or other legislation should "never" be used to control a woman's behaviour during pregnancy or birth. It is submitted that in South Africa, in constitutional terms, there is no such thing as a fetal right. Although the constitutional rights of a pregnant woman to bodily and psychological integrity are unquestionable and would in the majority of cases take precedence over the interests of her foetus, they are also not absolute and can be limited in terms of section 36 of the Constitution by a law of general application. It is submitted that there are instances where the law should protect the foetus in the interests of the constitutional values of human dignity, equality and freedom. These instances may be narrowly restricted for instance to acts and omissions which, were they in relation to a child, would be unlawful in the criminal sense. For example it may be argued a pregnant woman who seeks to terminate her pregnancy outside of the provisions of the Choice on Termination of Pregnancy Act, her actions should be subjected to some form of legal sanction if there are no good grounds for her failure to make use of the facilities provided for in the Act and as a result of her actions, a disabled child is born subsequently. It is further submitted that a pregnant woman stands in unique relation to her unborn child and that it is reasonable to justify on this basis, a distinction between the manner in which the law treats her acts and omissions in relation to her unborn child and how it treats those of third parties in relation to that unborn child. In other words the 'rights' of a foetus, if such they be, should not be regarded as the same in relation to its mother as they are in relation to others. This is because the foetus and its mother effectively share the same physical body and their interests are thus uniquely and inseparably intertwined.



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

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

Contracts for the benefit of a third person are possible in law but they generally have the result that when the third person accepts the benefit, he or she becomes a party to the contract⁹⁷. Thus the court in *Friedman*⁹⁸ held that a mother cannot claim, as mother and natural guardian of her abnormal or disabled child, general damages and loss of future earnings from the doctor who agreed to advise the mother, when pregnant, whether she was at greater risk than normal of having an abnormal or disabled child, so that she could make an informed decision whether or not to terminate her

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

⁹⁸ *Friedman* fn 53 *supra*

pregnancy, and who incorrectly informed her that she was at no greater risk than normal. There can be no claim in contract because the child's legal personality only commences at birth and a principal cannot claim on behalf of a non-existent principal and also because the agreement cannot be a contract for the benefit of a third party since the third party could only accept the alleged benefit, i.e. the termination of pregnancy, when it was no longer possible⁹⁹. Similarly there could be no claim in delict because the doctor owed no duty to the child to give the child's mother an opportunity to terminate the pregnancy, and it was impossible to calculate damages, being the difference between an impaired life and no life.

6.2.8 *Afrox Healthcare Bpk v Strydom*¹⁰⁰

Facts

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

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

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

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

¹⁰⁰ *Afrox* 2002 (6) SA 21 (SCA)

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

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

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

Judgment

The court *a quo* took as its point of departure that the onus was on the appellant to show that the provisions of clause 2.2 were enforceable against the respondent. As authority for this position it cited *Durban's Water Wonderland (Pty) Ltd v Botha and Another*¹⁰¹. The Supreme Court of Appeal (SCA) in *Strydom* stated that this case was, however, authority for the complete opposite as appeared from the dictum of Scott JA at 991C-D¹⁰²

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

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

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

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

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

“The power to declare contracts contrary to public policy should, however, be exercised sparingly and only in the clearest of cases, lest uncertainty as to the validity of contracts result from an arbitrary and indiscriminate use of the power. One must be careful not to conclude that a contract is contrary to public policy merely because its terms (or some of them) offend one’s individual sense of propriety and fairness. In the words of Lord Atkin in *Fender v St John-Mildmay* 1938 AC 1 (HL) at 12: . . .

‘the doctrine should only be invoked in clear cases in which the harm to the public is substantially incontestable, and does not depend upon the idiosyncratic inferences of a few judicial minds...’

In grappling with this often difficult problem it must be borne in mind that public policy generally favours the utmost freedom of contract, and requires that commercial transactions should not be unduly trammelled by restrictions on that freedom.”

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

¹⁰³ *Sasfin* 1989 (1) SA 1 (A)

¹⁰⁴ *Botha (now Griessel)* 1989 (3) SA 773 (A)

¹⁰⁵ *Brummer* 1999 (3) SA 389 (SCA) at 420F

¹⁰⁶ *De Beer* 2002 (1) SA 827 (SCA) op 837C - E

¹⁰⁷ *Brisley* 2002 (4) SA (1)

¹⁰⁸ *Government of the Republic of South Africa v Fibre Spinners & Weavers (Pty) Ltd* 1978 (2) SA 794 (A) at 804C - 806D and *Durban's Water Wonderland (Pty) Ltd v Botha and Another* (supra op 989G - I.)

considerations of public interest, to be unenforceable¹⁰⁹. The three grounds upon which the respondent based his arguments concerning the public interest were:

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

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

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

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

¹¹⁰ Strauss third edition at p305

public interest, it must be born in mind in the adjudication of the subjective ground of objection that the respondent did not in his pleadings rely upon gross negligence on the part of the appellant's nursing staff. He alleged nothing more than negligence. The question whether the contractual exclusion of a hospital's liability for damages caused by the gross negligence of its nursing staff would be contrary to the public interest, said Brand JA, was thus not the issue in the present case. Brand JA stated that even if one accepted the submission that it is indeed the case, this would not automatically invalidate clause 2.2. Apparently the provisions of the clause in this case would rather be interpreted so as to exclude gross negligence. Brand JA quoted the dictum of Innes CJ in *Wells v South African Alumenite Company (supra)* where he stated¹¹¹:

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

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

¹¹¹ *Wells* fn 109 *supra* at p72-73

Conditions on the provision of such services. The question said Brand J, still remains whether clause 2.2. is such a legally enforceable provision or not. According to the respondent's submission, the role of section 27(1)(a) is implied by the provisions of section 39(2) of the Constitution according to which each court is obliged in the development of the common law, to promote the spirit, purport and objects of the Bill of Rights. The effect of section 39(2), it was argued for the respondent, is that in the consideration of the question of whether a particular contractual provision is in conflict with the public interest, regard must be had to the fundamental rights which are set out in the Constitution. It was submitted with regard to the argument that clause 2.2 was enforceable prior to the Constitution, that it is now in conflict with the spirit, purport and object of section 27(1)(a) and is consequently contrary to the public interest. Brand JA stated that seeing that the Constitution first came into effect on 04 February 1997 while the agreement between the parties arose on 15 August 1995, the first question in considering this argument is whether section 39(2) empowers and obliges the court to rely on constitutional provisions which were not in operation when the contractual relationship between the parties existed. Concerning direct breach, said Brand JA, the constitutional has no retrospective power. Transactions which were valid when it commenced are thus not rendered invalid retrospectively with regard to the direct application of the Constitution¹¹². Brand JA noted that the question concerning the possible retrospective influence of the Constitution in an indirect manner as envisaged in section 39(2) had not yet been expressly decided. He noted that the fact that this is not a simple question is evident from *Ryland v Edros*¹¹³ and *Amod v Multilateral Motor Vehicle Accidents Fund (Commission for Gender Equality Intervening)*¹¹⁴. Brand JA said he found it unnecessary to give attempt to provide a conclusive answer to this question. In the light of his opinion concerning the effect of section 27(1)(a) on the validity of clause 2.2, he was prepared to accept in favour of the respondent that the provisions of section 27(1)(a) should be taken into account although the relevant agreement was concluded on 15 August 1995 and there was also no matching provision in the interim Constitution. He noted that in *Carmichele v Minister of Safety and Security and*

¹¹² *Du Plessis and Others v De Klerk and Another* 1996 (3) SA 830 (CC) (1996 (5) BCLR 658) para [14]; *Gardener v Whitaker* 1996 (4) SA 337 (CC) (1996 (6) BCLR 775) para [13].

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

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

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

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

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

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

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

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

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

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

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

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

and in para [61]

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

¹¹⁷ *Shifren* 1964 (4) SA 760 (A)

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

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

1. The situation in which the High Court is convinced that the relevant rule of the common law is in conflict with the constitutional provision. In this instance the High Court is obliged to depart from the common law. The fact that the relevant rule of the common law was laid down pre-constitutionally by the SCA makes no difference. The Constitution is the supreme law and where a rule of common law is in conflict with it, the latter must give way.
2. The situation in which the pre-constitutional decision of the SCA was based on considerations such as *boni mores* or public interest. If the High Court is of the opinion that such decision, with regard to constitutional values, no longer reflects that *boni mores* or considerations of public interest, then the High Court is obliged to depart therefrom. Such a departure said Brand JA is not in conflict with *stare decisis* because in any event it is accepted that the *boni mores* and considerations of public interest do not remain static.
3. A situation in which a rule of common law which was laid down in a pre constitutional decision of the SCA, is not directly in conflict with any specific provision of the Constitution and is also not dependent on changing considerations such as *boni mores* or public interest. Nevertheless the High Court is convinced that the relevant rule, upon the application of section 39(2), should be changed in order to promote the spirit, purport and objects of the Constitution. Is the High Court in such a situation empowered to give effect to its convictions or is it still obliged to apply the common law as it was preconstitutionally in terms of the principles of *stare decisis*? The answer, said Brand JA is that the principles of *stare decisis* still apply and that the High Court is not empowered by section 39(2) to depart from the decisions of the SCA whether they are pre- or post- constitutional. He noted that section 39(2) of the Constitution must be read in conjunction with section 173. According to the latter recognition is given to the inherent competence of the High Court –

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

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

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

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

With regard to misrepresentation and mistake Brand JA stated that consideration of this alternative required that the factual background be set out in more detail. He noted that the respondent's evidence was that he signed the admission document without reading it in the place indicated with a cross. The respondent's attention was not drawn to clause 2.2. In the absence of any evidence to the contrary it must be accepted, said the court, that the respondent was not aware of the contents of clause 2.2 when he entered into the agreement. Nonetheless the respondent conceded that he knew that the admission document contained the terms of the contract between himself and the appellant and he did not dispute that he had full opportunity to read the document. In these circumstances the fact that the respondent signed the document without reading it does not lead, as a rule to the result that he is not bound by its contents. Brand JA then referred to the case of *Burger v Central South African Railways*¹²⁰ in which it was held that a person who signs an agreement without reading it does so at his own risk and is consequently bound thereby as though he were aware of its provisions and expressly consented thereto¹²¹. Brand JA conceded that there were certain exceptions to this general rule and referred in this regard to Christie¹²². The exception relied upon by the respondent was that the admissions clerk had a duty to inform him of the contents of clause 2.2 and that he failed to do so. The respondent conceded that as a general principles there is no legal duty upon a contracting party to inform the other of the contents of their agreement. The reason why the respondent alleged that such a duty existed on the admissions clerk was that he, the respondent, did not expect such a clause in an agreement with a hospital. Seeing that a hospital is supposed to supply medical and professional services in a professional manner, the respondent argued that he did not expect that the applicant would try to indemnify itself against the negligence of its own nursing personnel. The answer to this, said Brand JA, is that the respondent's subjective expectations concerning the contract between himself and the appellant play no role in the question of whether there was a duty on the admissions clerk to point out clause 2.2. to him. What is of relevance to

¹²⁰ *Burger* 1903 TS 571

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

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

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

Discussion

It is submitted, with respect, that the decision of the Supreme Court of Appeal in this case is both unfortunate and regrettable for the reasons set out below - not least of which is the fact that the court saw fit not to distinguish between suppliers of health care services and any other kind of supplier. The most obvious way to demonstrate the problems with this decision is to apply it within the public sector. On this basis of this decision would and should an exclusion clause of the nature used by Afrox Healthcare be applicable by government hospitals in respect of the people to whom they deliver health care services? If suppliers of health care services are the same as any other, then the government, as a supplier of health care services, should be able to include such a clause in its admission documentation. The fact that patients, as non-lawyers, may not understand the nature or import of such a clause, clearly does not make a difference to the Supreme Court of Appeal. The fact that health care professionals are ethically obliged by their professional rules to take due and proper care and exercise their professions with diligence was used by the Supreme Court of Appeal to justify the presence of such a clause, when it is submitted, it should have been used to strike it down. The professional rules and standards which are applied to health professionals are an indication of what it means to be a professional in the first place. Members of the public expect to be treated in a professional manner and up to a certain standard when they seek out the services of a registered professional because if they did not, they might as well go to Joe Public for those same services. What

would be the reason for seeking out professional help if it meant that the professional in question was not bound to follow certain ethical rules and standards of practice associated with his profession? The Medical Protection Society has different rates for different types of indemnity cover depending on whether a health professional is self-employed or employed by a third party. The rates for the latter are much lower on the assumption that the employer either self insures (in the case of the state) or takes out some form of public liability insurance¹²³. If a nurse's professional indemnity cover

123

In fact some years ago Dr John Hickey of the Medical Protection Society and actuary Tony Mason wrote a paper entitled 'Funding of Clinical Negligence Liabilities in the Public Sector' (obtained from Dr John Hickey, Medical Protection Society 33 Cavendish Square, London W1G 0PS, UK) in they argue why doctors in public sector employment should not be required to purchase professional indemnity protection. Insurance in the public sector is particularly problematic due to the fact that government self insures. A number of provincial governments in South Africa were considering legislation to compel publicly employed doctors to purchase professional indemnity cover against claims of clinical negligence. The current position is that other than in cases of gross negligence, the hospital will assume vicarious liability for the acts or omissions of its employees and will indemnify those employees against such claims. The paper was prepared at the request of the South African Medical Association and sets out to show that by implementing such a change the costs to the public purse of clinical negligence would be greater than is currently the case. It further seeks to show that there is also a significant risk that the cost of professional indemnity protection for individuals employed in the public sector will be prohibitive, particularly for high risk specialities and is likely to reduce the recruitment of those specialities. In fact, it is submitted, the same arguments are applicable to professionals in the private sector although in the case of medical practitioners, these are generally self-employed. The authors stated that medical negligence probably has one of the longest 'tails' of all types of insurance (another contextual difference of which Brand JA was clearly unaware) and most insurance companies refuse to underwrite this type of business or will only offer the more limited claims made coverage. The 'tail' refers to the delays that occur between the occurrence of an adverse incident (that will probably give rise to a claim) and the time it is first reported and the further delay until that claim is eventually settled. The average delay between incident and settlement may be as long as 6 or 7 years and increases for the larger more complex claims which, in some cases, take decades. When it is appreciated that the rate of claims inflation (particularly in the cost of settling large claims) may be 1-2% higher than earnings inflation, it is perhaps not surprising that so few insurers are interested in this business and that the cost to purchasing cover is so high. Apart from claims inflation, the other noticeable trend over the last 15 years has been the steep increase in the number of claims and it is clear that the general public has become more consumerist and litigious. Because of the average delay of several years between an incident and the time it is reported as a claim, the underlying claims frequency can often be masked so that the experience appears more favourable than it actually is. The authors point out that there are many disadvantages to compelling publicly employed staff to purchase their own indemnity protection and these have been recognised in recent years by governments around the world. State indemnity schemes are now in place in England, Wales, Scotland, Australia, Malaysia, Hong Kong and in many European and American States. The reasons they give are:

Cost of cover: This can be substantial, particularly for high-risk specialities such as obstetrics, gynaecology, orthopaedic surgery, neurosurgery and plastic surgery. The authors give the example of a submission by the MPS to the Irish Department of Health in which it was reflected that specialist obstetricians in Ireland comprised 5% of MPS membership, contributed 9% of income and were responsible for 20% of reported claims by number and 33.3% of liabilities. They state that similar ratios are likely to exist in South Africa. Claims experience in South Africa is deteriorating i.e. increasing although not as dramatically as elsewhere in the world. Therefore in all likelihood rates will rise year on year.

Demands by staff for reimbursement of subscriptions: Staff tend to demand reimbursement from the employers for subscriptions. Reimbursement, say the authors, means that effectively the public hospitals move from a pay as you go basis (as is currently the case) to claims made or occurrence based funding, diverting public funds from the provision of care to the indemnifying company.

Affordability in certain specialities: If there is no reimbursement of subscriptions, then the paradox occurs that doctors in different specialities who are paid the same will have to pay significantly different subscription rates, leading to demands for differing salary levels for different specialities. For junior staff in the very high-risk specialities their subscription rates may be higher than their salaries.

Adverse effect on recruitment into specialities: If the cost of protection is so very much higher in certain specialities and there is no reimbursement, it will be increasingly difficult to recruit those specialities.

Risk of no cover and complexity: If staff choose to purchase cover on a claims made basis, there is a very real risk of gaps in cover if they change indemnifiers or choose for any reason not to purchase run off cover when they leave the hospital's employ. This leads to exposure of the hospital to clinical negligence liability and the possibility of uncompensated patients.

Administration and claims management costs: In the experience of the MPS claims arise from a sequence of systems failures or errors some of which are the responsibility of the employing hospitals rather than the individual staff member, for example equipment failures. In circumstances such as these the hospital feels compelled to instruct its own lawyers leading to arguments over apportionment of responsibility. The increased expenditure on legal fees is one of the reasons cited by the Irish government for introducing a State indemnity scheme.

It is submitted that for present purposes there is likely to be no difference between the public and private health sectors in South Africa with regard to nurses since in both sectors they tend to be employees rather than self-employed.

takes into account the vicarious liability of her employer and is lower than would have been the case had she been self-employed, then this judgment of the Supreme Court of Appeal may effectively have left patients who are the victims of negligence of nurses without recourse to compensation. A disciplinary hearing by a professional council even assuming any sanction is imposed, is cold comfort to a patient that has lost the ability to work or to function in society or that has experienced considerable pain and suffering and become liable for extra medical expenses as a result of professional negligence. It is submitted with respect that the confidence of the Supreme Court of Appeal that the existence of professional bodies to discipline professionals who do not practise their professions according to acceptable standards is a sufficient deterrent of professional negligence and adequately reduces the attendant risks to patients is naïve to say the least. It is tantamount to saying that the criminal law sufficiently addresses the risks of crime for the man in the street and that one should not expect, or take measures to protect oneself against, criminal behaviour because a system exists for the prosecution of crime. The court as long ago as 1957 refused to accept the view that the delicts of health professionals who are employed by a hospital should not attract vicarious liability for their employer¹²⁴. It is not being

124

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

See *Esterhuizen v Administrator, Transvaal* 1957 (3) SA 710 (T) and *Dube v Administrator, Transvaal* fn 78 *supra*. See also the discussion of this subject in *Mtetwa v Minister of Health* 1989 (3) SA 600 (D) and the discussion there of *Lower Umfolosi District War Memorial Hospital v Lowe* 1937 NP 31 and *St Augustine's Hospital (Pty) Ltd v Le Breton* 1975 (2) SA 530 (D). In *Mtetwa* the court expressly refused to follow the approach of Feetham J in *Lower Umfolosi* that: "I accept the proposition that in the performance of their professional duties nurses are not under the control of the hospital authority so as to become its servants, and that the obligation of the hospital authority in regard to the professional work of its nurses is limited to taking reasonable care to assure itself of the professional competence of the nurses whom it employs. No question as to the competence of the nurses employed arises in this case, because there is an admission on the record to the following effect: 'Mr Lowe, attorney for plaintiff, admits that there was no negligence on the part of the Board in the appointment of the nurses, and that he is satisfied that the nurses are all duly qualified.'"

And again, at p 42: "Now I differ from the conclusion at which he arrives. It seems to me that, on his own showing, it is perfectly clear that the placing of this hot bottle in the patient's bed, and the subsequent supervision of the patient while recovering from the anaesthetic with the hot water bottle in his bed, were professional duties on the part of the nurse or nurses concerned. It is irrelevant to say that, when the patient is in a normal condition and not disabled, he can place the hot water bottle where he likes. The dominating fact in regard to this case is that the patient was recovering from an anaesthetic after an operation. For that purpose he required a hot water bottle in his bed in order to provide conditions necessary for his proper recovery. He was not in a condition to protect himself from the hot water bottle, or to judge the heat of the hot water bottle; he was entirely in the hands of the nurse or nurses, and they were in charge of him, not as domestic servants, but as nurses responsible for seeing that proper conditions were provided in which he could recover from the effects of the anaesthetic; and in regard to the whole of this business in connection with the placing of the bottle in the bed, the heating of the bottle, the wrapping of the bottle and the supervision of the patient, they were bound to use their professional skill; their professional training taught them that it was necessary for the patient to have a hot water bottle, that he was incapable of protecting himself from the bottle, and that, owing to possible movements on the part of the patient in the condition in which he was, supervision was necessary. They were acting, therefore, in a professional manner and not as domestic servants insofar as they dealt with the hot water bottle, and, that being so, they failed in the carrying out of professional duties for the discharge of which the hospital authority was not responsible."

Nienaber J noted in *Mtetwa* that because *Lower Umfolosi* was a judgment of two Judges, Fannin J, in a later Natal case, *St Augustine's Hospital (Pty) Ltd v Le Breton* 1975 (2) SA 530 (D), regarded himself as bound by it, notwithstanding some strong misgivings he expressed about its correctness. That case also involved negligence on the part of the nursing staff. A 92-year-old patient fractured her leg when, in the middle of the night, she fell out of a hospital cot. The Court stated, apropos of the earlier judgment and the English cases cited in it, at 536H - 537A: "The effect of these cases is to render liable a hospital authority for the negligence of doctors, surgeons and nurses, employed by them on a full- or part-time basis, in the performance of the professional duties they are employed to perform. The later view now adopted in



argued here that the court in *Afrox* was even suggesting that a hospital employer cannot be held vicariously liable for the delicts of its employees. The point being made is rather that the statement of Brand AJ to the effect that the entire argument that clause 2.2 would promote negligent and unprofessional conduct on the part of the nursing staff is built on a *non sequitur*, firstly because the nursing staff are still bound to observe their professional code of conduct and secondly because action against an employee of the applicant for negligent acts would adversely impact on its reputation and competitiveness, does not take into account the practical realities of the situation. Real life, it is submitted, is far more complicated than this. Brand JA has seized only upon those factual elements within a larger factual matrix, which suit his particular viewpoint irrespective of how they impact in reality upon the other elements of the matrix to produce a result which Brand JA could not anticipate without more in-depth knowledge of the business of health service delivery than he apparently has¹²⁵. The

England seems to me to be the more correct one, and McKerron *The Law of Delict* 7th ed at 92, expresses the view that "there can be no doubt as to the correctness of these decisions".

It seems probable that, had this Court in 1937 had before it the 1942 and later English decisions, the result of the *Lower Umfolosi* case might well have gone the other way.'

And again, at 537H - 538: 'That being so, I must apply the law as stated in the *Lower Umfolosi* case and hold that as in that case, so in the present case, in the absence of any special term in the contract between the hospital and the patient, the ordinary contract between patient and hospital does not cast upon the hospital an obligation to do more than take reasonable steps to assure itself of the professional competence of the nurses it employs to attend to the patient.'

And, finally, at 538D: 'I think I should add that, had I been free to do so, I would have been disposed to accept as more in accordance with our law the later English decisions, and to have applied the law as there applied and as applied in *Esterhuizen v Administrator, Transvaal* 1957 (3) SA 710 (T), and *Dube v Administrator, Transvaal* 1963 (4) SA 260 (T), in neither of which, incidentally, do I find any reference to the *Lower Umfolosi* case.'

Nienaber J observed that the two Transvaal cases, as well as *Buls and Another v Tsatsarolakis* 1976 (2) SA 891 (T), neither mention nor support the distinction, which is pivotal to the decision in the *Lower Umfolosi* case, between professional work over which the hospital is said to have no control and for which it is accordingly not liable, and managerial or administrative duties performed by an employee, for which it is responsible. In the Transvaal cases the issue was simply whether the particular member of staff was negligent in the exercise of his duties, regardless of whether he was part of a professional team or not. As long as the decision in the *Lower Umfolosi* case stands, that is not, however, the prevailing view in Natal. It was that consideration that prompted the defendant's exception.

Nienaber J found in *Mtsetwa* that: "The point on which the decisions in the *Lower Umfolosi* case hinged was that a member of the professional staff of a hospital was not a servant proper for whose misdeeds the hospital was accordingly responsible. At the time that was perceived to be a principle of law. Nowadays, I venture to suggest, the question is purely one of fact. The degree of supervision and control which is exercised by the person in authority over him is no longer regarded as the sole criterion to determine whether someone is a servant or something else. The deciding factor is the intention of the parties to the contract, which is to be gathered from a variety of facts and factors. Control is merely one of the indicia to determine whether or not a person is a servant or an independent worker." He held that: "To the extent that the judgment in the *Lower Umfolosi* case purported to enunciate a universal principle of law, namely that a hospital assumes no responsibility for the negligence of any member of its staff engaged in professional work, it has thus been overtaken by more recent authority, not only by the South African cases referred to but indeed by English ones as well. (See, for instance: *Gold v Essex County Council* [1942] 2 KB 293; *Collins v Hertfordshire County Council* [1947] KB 598; *Cassidy v Ministry of Health* [1951] 2 KB 343 (CA); *Roe v Minister of Health* [1954] 2 QB 66.) Professor J C van der Walt suggests (1976 THRHR 399 at 405) that the later English cases have undermined the foundation on which the judgment in the *Lower Umfolosi* case was based. I agree. The *ratio decidendi* of that judgment, in my respectful view, is outmoded and accordingly no longer authoritative."

125

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

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

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

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

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

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

judgment almost gives the impression that nurses and other professional staff employed by a private hospital operate fairly independently, almost as contractors, of their employer and that the hospital itself has no authority to supervise them nor does it have any responsibility to control them in the same way that other employers control their employees. The impression is created that the fact that these employees are professionals and therefore subject to the disciplinary powers of their professional body somehow reduces the weight of the public policy considerations that the employer should be held vicariously liable. The employer should be permitted to reduce its insurance burden by shifting the risk onto the professional in question – an individual employee. From a professional indemnity cover perspective this idea has been rejected by many different countries around the world¹²⁶.

With regard to the former argument, it is submitted that the frequency with which nurses are disciplined by the South African nursing council and even the relatively lower frequency with which they are found guilty and struck off the roll or their names removed from the register, is such that it gives the lie to this argument. Furthermore, an employer who is not vicariously liable for the negligence of its employees may be less concerned about taking preventive action to preclude professional negligence - even if it takes action to discipline the nurse as an employee after the event. Once a nurse is subject to a disciplinary proceeding by her professional body it is too late. The negligent act has already harmed a patient. Given the nature of the services rendered by nurses, such harm can include death and permanent disablement. As to the latter argument, when the nursing council disciplines a nurse and removes his or her name from the roll the name of his or her employer is not mentioned when the relevant notice is published in the Government Gazette¹²⁷. It is submitted that this argument, whilst it may have some attraction in the

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

<http://www.parliament.vic.gov.au/lawreform/hea/list.html>

126

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

127

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

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

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

¹²⁸

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

professionalism of its staff when touting for business¹²⁹. This kind of information is very much publicly available. The company even boasts about its college of nursing¹³⁰. It is submitted that the publication of this kind of information by private

129

Presently on the website (<http://www.afroxhealth.co.za/>) is a document entitled "Core Values". It reads:

Core values

Organisational values are principles or qualities considered worthwhile by an organisation. At Afrox Healthcare there is a fundamental commitment to these values throughout the entire organisation - merely posting them on a bulletin board and paying them lip service is not tolerated! 'Living' these values in our day-to-day business activities provides us with the foundation of what is important to us - namely, providing world-class patient care.

Accountability

We ensure employees know what they are responsible for and are empowered to deliver.

Collaboration

We maximise our achievements as a group, not as individuals.

Transparency

We believe that visible problems can be solved and that informed people make better decisions.

Stretch

We continuously push the boundaries of performance."

Another entry on the website reads:

"Quality

Afrox Healthcare's quest is to maintain world-class quality standards at all its hospital facilities - to the benefit of its patients, employees, supporting medical practitioners and funders. A world-class quality management process

We believe that our unique process of managing quality standards in our hospitals matches and probably exceeds the best to be found anywhere in the world today.

The Afrox total quality management (TQM) process was launched throughout the company in 1993, exposing each and every employee to the company's vision for quality management. The Healthcare division then adapted the programme to satisfy the unique demands of the healthcare industry.

The programme incorporates a vision, policies and procedures, critical success factors with supporting key performance indicators and specified activities. It is reviewed and upgraded on an ongoing basis. Continued adherence to these standards has been maintained by encouraging each and every employee to participate fully in the process and contribute to the decision-making processes. All new employees are exposed to the process as part of their induction training.

Today, Afrox Healthcare and its member hospitals are reaping the rewards of this visionary approach to quality management. A culture of service excellence, a spirit of teamwork amongst all levels of staff and a continuous quest for improvement are now firmly entrenched. This, in turn, means that patients, funders and supporting medical practitioners can rely on our consistently high standards in all disciplines associated with hospital management, particularly nursing care. We also embarked on a scientific quality improvement programme at the Eugene Marais Hospital during 1997. This ward resource management program has now been implemented in most Afrox Healthcare hospitals with both input and output measures based on quality improvement. This program ensures quality care through resource and standards management."

130

An article from the website (see fn above) states: "The Afrox College of Nursing has invested millions in the training of world-class nurses and the establishment of learner centres countrywide. After four years of offering accredited diploma courses and supplying Afrox Healthcare's hospitals with highly skilled nurses, the college has now opened its doors to external students.

"Undoubtedly, the most serious challenge to the healthcare industry is the drain on specialized and experienced nursing skills. As a member of the private healthcare sector, we accept responsibility to implement initiatives to develop and train nurses, which will contribute to the skills development and empowerment of our people, and to create an environment in our hospitals which will attract, support and retain quality nurses," said Michael Flemming, managing director of Afrox Healthcare Limited.

One such initiative is the Afrox College of Nursing, which entered into a groundbreaking partnership with the University of Port Elizabeth four years ago to ensure that the high nursing standards, which are a hallmark within the Afrox Healthcare group, are continued into the new millennium. Outcomes-based learning and training and the development of skills and competencies is a priority within the group's hospitals.

"The college has gone from strength to strength and we have taken up the challenge to ensure the ongoing provision of highly qualified nursing staff to the more than sixty Afrox Healthcare hospitals across the country. We want to pay tribute to our nurses for their exceptional level of professionalism and unwavering commitment towards quality patient care," said Sharon Vasuthevan, training manager, at a nursing diploma ceremony held in Johannesburg.

"Student numbers have increased dramatically. More than 1 000 nurses have graduated from the college by 2002, and 488 are enrolled at present. In the last week, 150 students graduated from the college, and for the first time, 30 external students have enrolled this year for the four-year diploma in nursing. We are now the largest private nursing training institution in South Africa with nine learner centres in Johannesburg, Pretoria, Bloemfontein, Durban, Witbank, Klerksdorp, East London, Port Elizabeth and Cape Town. All practical nursing training takes place in the Afrox Healthcare hospitals, which ensures that learners are exposed to new technologies and the highest standards of quality care."

"Our numerous successes last year include training more than double the number of critical care and theatre nurses than the previous year. We offer basic and post-basic diploma courses in areas such as critical care, operating theatre, emergency, orthopaedic and general nursing," Sharon said. "Community involvement is very important for us, and the group's community involvement projects will be extended to all nine learner centres this year. This fits in with Afrox Healthcare's philosophy of building sincere and meaningful partnerships with the communities in which we operate," Sharon said. Students at the learner centres are also actively involved with local organisations and regional initiatives.

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

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

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

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

Court of Appeal demonstrates not only in this case but also in others such as *Carmichele*¹³¹ a surprising and unfortunate reluctance to take opportunities to align the more traditional common law principles with the Constitution¹³² and that within this court, judicial inertia is the order of the day.

Section 9 of the Occupational Health and Safety Act¹³³ provides for general duties of employers and self-employed persons to persons other than their employees as follows-

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

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

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

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

¹³³ Act No 85 of 1993

Every employer must conduct his undertaking in a particular manner. That manner is to ensure as far as is reasonably practicable that persons other than employees who may be directly affected by his activities are protected. The protection in question relates *expressly* to hazards to their *health* or safety. This Act provides expressly for the vicarious liability of employers for acts of their employees in certain circumstances in section 37¹³⁴. It is submitted that to the extent that legislation can be regarded as indicative of public policy concerns and the legal convictions of the community, the Supreme Court of Appeal erred in taking the opposite view that the employer could contract out of liability in these particular circumstances, relating as they did to the health and safety of persons directly affected by the employer's activity of running a private hospital and offering health care services to the general public therein. In terms of section 38(1) of this Act any person who contravenes or fails to comply with *inter alia* a provision of section 9 is guilty of an offence and on conviction is liable to a fine not exceeding R50 000 or to imprisonment for a period not exceeding one year or to both such fine and such imprisonment¹³⁵. It is pointed out in the chapter on the law of delict that the test for wrongfulness is the same for both

134

“37 Acts or omissions by employees or mandataries

- (1) Whenever an employee does or omits to do any act which it would be an offence in terms of this Act for the employer of such employee or a user to do or omit to do, then, unless it is proved that-
 - (a) in doing or omitting to do that act the employee was acting without the connivance or permission of the employer or any such user;
 - (b) it was not under any condition or in any circumstance within the scope of the authority of the employee to do or omit to do an act, whether lawful or unlawful, of the character of the act or omission charged; and
 - (c) all reasonable steps were taken by the employer or any such user to prevent any act or omission of the kind in question,
 the employer or any such user himself shall be presumed to have done or omitted to do that act, and shall be liable to be convicted and sentenced in respect thereof; and the fact that he issued instructions forbidding any act or omission of the kind in question shall not, in itself, be accepted as sufficient proof that he took all reasonable steps to prevent the act or omission.
- (2) The provisions of subsection (1) shall *mutatis mutandis* apply in the case of a mandatory of any employer or user, except if the parties have agreed in writing to the arrangements and procedures between them to ensure compliance by the mandatory with the provisions of this Act.
- (3) Whenever any employee or mandatory of any employer or user does or omits to do an act which it would be an offence in terms of this Act for the employer or any such user to do or omit to do, he shall be liable to be convicted and sentenced in respect thereof as if he were the employer or user.
- (4) Whenever any employee or mandatory of the State commits or omits to do an act which would be an offence in terms of this Act, had he been the employee or mandatory of an employer other than the State and had such employer committed or omitted to do that act, he shall be liable to be convicted and sentenced in respect thereof as if he were such an employer.
- (5) Any employee or mandatory referred to in subsection (3) may be so convicted and sentenced in addition to the employer or user.
- (6) Whenever the employee or mandatory of an employer is convicted of an offence consisting of a contravention of section 23, the court shall, when making an order under section 38 (4), make such an order against the employer and not against such employee or mandatory.”

135

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

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

6.2.9 *Oldwage v Louwrens*¹³⁶

Facts

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

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

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

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

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

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



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

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

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

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

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

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

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

Alternatively the plaintiff averred that:

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

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

2. The said representation was false in that the aforesaid procedure was not essential and in that the plaintiff did not require the said procedure in order to recover from the medical complaints that the plaintiff was suffering from;
3. The said representation was material and made with the intention of inducing the Plaintiff to agree to the aforesaid procedure. Relying on the truth thereof, the plaintiff did so agree;
4. The said representation was negligently made by the defendant, having regard to the defendant's professional skill and expertise and the information which could, upon a reasonable enquiry, have been obtained by the defendant which would have shown that the said representation was untrue;

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

Judgment

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

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

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

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

and that at p526, the learned judge further observed -

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

138 *Mitchell* 1914 AD 519 at 525

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

Yekiso J observed that as Strauss correctly points out, this *dictum* still holds good today although medical science has made tremendous strides since 1914 and today’s technological aids being vastly superior to those in 1914, that despite such technological advances of our century, medicine still is not - and probably never will be – an exact science comparable to mathematics. Much depends on the skill and experience of the individual practitioner¹³⁹.

He noted that the principle enunciated in *Mitchell v Dixon* supra was followed in a number of subsequent decisions, notably *Buls and Another v Tsatsarolakis*¹⁴⁰; *Correira v Berwind*¹⁴¹; *Castell v De Greeff*¹⁴² amongst others. Foreign case law, in particular judgments of the English courts, although generally do not constitute a binding precedent to our courts, have always had considerable persuade force and are often referred to by our courts¹⁴³. In *Whitehouse v Jordan* the English Appeal Court held that a “mere error of judgment” on the part of a medical practitioner does not constitute negligence. In this regard Ackerman J in *Castell v De Greeff*¹⁴⁴ said the following:

“It has on occasions been suggested that a ‘mere error of judgment’ on the part of a medical practitioner does not constitute negligence. In *Whitehouse v Jordan and Another* (1981) 1 All ER 267(HL) the House of Lords, *inter alia*, considered the correctness of the statement by Denning MR in the Court of Appeal that:

‘We must say, and say firmly, that, in a professional man an error of judgment is not negligence.’

The House of Lords held this to be an inaccurate statement of the law. At 281a Lord Fraser of Tullybelton expressed the view that: “*I think Lord Denning MR must have meant to say that an error judgment ‘is not necessarily negligent’.*”

¹³⁹ Strauss SA *Doctor Patient and the Law* 3rd edition 1999 at p 252

¹⁴⁰ *Buls* 1976 (2) SA 891(T)

¹⁴¹ *Correira* 1986 (4) SA 60(ZHC);

¹⁴² *Castell* 1994 (1) SA 408(C)

¹⁴³ See *Castell v De Greeff* fn 142 *supra* at p 416 and a reference therein to the judgment of the English Appeal Court and the House of Lords in *Whitehouse v Jordan and Another* (1981) 1 All ER 267(HL)

¹⁴⁴ *Castell* fn 142 *supra* at p416 E-H

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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



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

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

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

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

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

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

¹⁴⁶ *Chester* (2002) 3 All ER 552 at 572E

¹⁴⁷ *Richter* 1976(3) SA 226(C)

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

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

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

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

The plaintiff's version was that in the discussion he had with the defendant, in the presence of Mrs Cloete, only one procedure was suggested to him and no other procedure was discussed with him other than the one the defendant offered. Yekiso J observed that if consent to the alternative procedure was offered and accepted in this discussion, it would have been accepted and, therefore, procured in the presence of Mrs Cloete. Mrs Cloete who could have corroborated the defendant's version was not called to testify nor was she amenable to be subpoenaed by the plaintiff. The judge said that the inference was thus irresistible that either her evidence would have supported the plaintiff's version or would not have supported the defendant's version. But if she would have supported the defendant's version it was inconceivable why she was not called. Yekiso J found that on the evidence he could not find that the plaintiff was properly counselled before the vascular operation was performed, that other options, other than the procedure performed, were properly discussed with him, in particular that he did not need to undergo the vascular operation immediately, that he was advised of the material risks attendant to such operation and that he had given an informed consent to such operation. He then turned to the question of whether the defendant's failure to obtain the informed consent of the plaintiff amounted to an assault. In this regard Yekiso J noted that in a number of decisions the courts have always held that in instances where a medical practitioner administers treatment to a patient without the patient's informed consent, such conduct constitutes assault¹⁴⁸. The judge then noted that there is a school of thought that such conduct on the part of a medical practitioner, if it falls short of assault, it nonetheless could amount to a violation of a right to privacy. The court noted that in *Broude v McIntosh & Others*¹⁴⁹ Marais JA considered it a strange notion that this type of conduct should be juristically characterised as an assault. He made the following remarks:

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

¹⁴⁹ *Broude* 1998(3) SA 60 (SCA)

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

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

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

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

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

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

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

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

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

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

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

¹⁵⁰ Rutherford RB (5th ed) at p 983

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

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

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

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

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

Discussion

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

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

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

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

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

6.3 Summary and Conclusions

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

of health care services. There is widespread international recognition of the need to protect consumers from unconscionable, unfair clauses in contracts. There is also considerable international debate and discussion concerning contract theory and the directions in which the law of contract, and indeed the concept of contract, needs to evolve in order to remain meaningful to society¹⁵². It is fairly obvious to anyone prepared to devote even a little thought to the subject of contracts and the environment in which they operate to appreciate that the world has changed

152

See generally Harker, 'The role of contract and the object of remedies for breach of contract in contemporary Western society' 1984 *SALJ* 121; Hillman, R A 'The Crisis in Modern Contract Theory' 67 *Texas Law Review* (1998) p 103; Macneil I, "Contracts: Adjustment of Long-Term Economic Relations Under Classical, Neoclassical and Relational Contract Law" 72 *Northwestern University Law Review* 1 p 19.

Heffey P, Paterson J and Robertson A *Principles of Contract Law* point out that recent research on contracts "shows that parties to commercial contracts are not the hard-bargaining individuals engaged in discrete, one-off transactions that classical contract theory and neo-classical economics would have us believe. Parties to contracts are often engaged in long-term relationships with one another, or as part of a close-knit industry, and that has a significant impact on the way in which they deal with one another. These empirical insights have given rise to a whole new way of looking at contracts. Rather than viewing contracts as discrete exchanges between utility-maximising individuals, relational contract theory views contract as a more complex social interaction. Macaulay identified the need to view contracts in a different way which took into account the relations between the parties. Ian Mcneil then explore what it mean to look at a contract from a relational perspective." They observe that Mcneil's analysis of contracts is based on recognition of the fact that contractual relations are conducted within a social matrix. Exchange is only possible within a society that provides: firstly a means of communication (so that the parties can understand one another) secondly: a system of order so that the parties use exchange rather than force to get what they want); thirdly, a payment mechanism for the enforcement of promises. Since a contract can only be made against such a social background, all contracts are relational, in the sense of involving social relations and being embedded in a much broader social web. Some contracts are, however, more relational than others in the sense that they are more deeply embedded in social relations. Mcneil has suggested that there exists a spectrum of contractual behaviour with highly relational contracts at one end and discrete transactions at the other. A relational contract is one in which social relations play a significant role. This may be because the performance of the contract is so closely integrated with the parties' other activities, because parties are relying heavily on social conventions or because the parties are involved in a long-term relationship. In a highly relational contract the parties are less likely to be able to predict and deal with future contingencies. The more relational the exchange, the less the parties will plan and allocate risks. Thus more flexibility will be required during the course of the relationship...Social relations may play a significant role in an exchange because the parties expect each other to behave in accordance with social customs and conventions which define their respective roles. The role of a medical doctor for example, is defined by social convention. A patient consulting a doctor about a particular medical problem would find it very difficult to spell out in advance the doctor's obligations in respect of diagnosis, treatment and referral. Instead of attempting to define the doctor's obligations in advance, the patient relies on the doctor to operate within and fulfil the doctor's socially understood role."

It is submitted that where the role of the doctor as socially understood, has in fact departed from that social understanding, for example with regard to the fiduciary relationship of a doctor to a patient where the doctor himself no longer considers the relationship to be fiduciary, this is evidence of a need for the legislative, judicial or regulatory protection of the patient. The arguments of the patient in *Afrox* (fn 100 *supra*) in terms of his perceptions of the manner in which a private hospital is supposed to behave towards its patients as opposed to the approach of the hospital itself to its patients is a case in point. The patient had a relational perception of his contract with the hospital whereas the hospital itself perceived the transaction as discrete and structured it that way. It is submitted that to permit contracts structured on the basis of discrete transactions that more appropriately belong in the relational setting, as the court did in *Afrox*, can lead to the unfair application of the rules of the law of contract and an unacceptable disregard for clear principles of public policy.

Heffey *et al* note that: "At the discrete end of the contractual spectrum are transactions that are more isolated from the social context in which they are made. A relatively discrete transaction does not involve any significant co-ordination between performance of the contract and the parties' other activities, requires less flexibility and co-operation between the parties and does not draw so heavily on social conventions and understandings. A one-off exchange will usually be relatively discrete, but this will not always be the case. A single visit to a doctor is likely to be highly relational, for the reasons discussed above, even if the patient has not seen the doctor before and never does again. Mcneil's example of a highly discrete transaction is a motorist making a cash purchase of petrol at a service station on a highway on which the motorist rarely travels. This transaction involves the simultaneous (or almost simultaneous) exchange of goods and money, and does not involve any ongoing obligations. Even this transaction is deeply embedded in a broad, complex social web consisting of such things as social conventions regarding behaviour, brand loyalty (possibly involving loyalty reward schemes) and credit card or electronic payment mechanisms." The authors point out that the relational perspective identifies a deficiency in classical and economic approaches to contract law because the discrete exchange is at the heart of both understandings of a contract. They note that Gudel ('Relational Contract Theory and the Concept of Exchange') (1998) 46 *Buffalo Law Review* p 763 has observed: "Contract law was and is relatively well adapted to dealing with discrete transactions. However, it was and is ill-equipped to deal with problems arising out of contract relations. To put it another way, contract law has had a powerful bias in favour of discreteness, and discrete legal doctrines applied to relational contracts often produced results that were intuitively unfair."

considerably since Roman times and that contracts are instruments used to regulate highly complex, socio-economic, as opposed to purely economic, relationships between parties. The interests of broader society in contracts between two parties have intensified in many instances to the point where legislation governs the standard terms and dictates whether or not terms introduced by the parties themselves are socially and legally acceptable. Fuller and Perdue¹⁵³ observe that the proposition that legal rules can be understood only with reference to the purposes they serve would today scarcely be regarded as an exciting truth. The notion that law exists as a means to an end has been commonplace for at least half a century. They point out, however, that there is no justification for assuming that because this attitude has now achieved respectability, and even triteness, that it enjoys a pervasive application in practice. We are still all too willing, they say, to embrace the conceit that it is possible to manipulate legal concepts without the orientation which comes from the simple inquiry: toward what end is this activity directed? It is submitted that nowhere in South African law is the truth of this statement more evident than in the judgment of the Supreme Court of Appeal in *Afrox Healthcare v Strydom*¹⁵⁴. Relational contract theory contests the idea that promise is at the heart of contract. In more relational exchanges, since the parties do not plan in a comprehensive way, their promises are likely to be incomplete (which is exactly the case in most health care settings) and so their association will be governed by relational norms¹⁵⁵.

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

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

154 *Afrox* fn 100 *supra*

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

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

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

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

It is clear that unless South African courts are prepared to depart from antiquated views of the contexts in which the law of contract operates and to accept modern socio-economic and relational realities, the law of contract in the health sector at least, has a very limited future as between provider and patient. Contracts between corporate funders of health care services and providers of those services may serve to largely replace the need for contracts between the individual patient and the provider in many instances as the South African government is presently considering a system of Social Health Insurance which will operate as much within the private sector as in the public sector. Legislation tends increasingly to govern relationships between providers and patients in such environments. The beginnings of such legislation, in the form of the provisions of the Medicines and Related Substances Act¹⁵⁶ concerning the licensing of dispensing doctors and the pricing of medicines are concrete examples of such a trend. More advanced approaches to the law of contract clearly indicate that contracts still have much to offer in the regulation of relationships between private individuals and entities even in the context of health service delivery. If the South African law of contract was capable of embracing such advanced approaches and developing in a way that effectively and realistically meets the needs of South African society there is no doubt that it could still be a useful way of understanding and upholding various kinds of relationships in civil law. Unfortunately there seems to be little promise of such developments locally.

¹⁵⁶ Fn 12 *supra*

Chapter 7

Law Of Delict: Health Service Delivery

| | | |
|---------|---|-----|
| 7.1 | Introduction | 742 |
| 7.2 | Fundamental Concepts | 750 |
| 7.2.1 | Conduct | 751 |
| 7.2.1.2 | Assault | 754 |
| 7.2.1.3 | Liability for Omissions..... | 762 |
| 7.2.2 | Causation | 763 |
| 7.2.3 | Wrongfulness (Unlawfulness)..... | 772 |
| 7.2.4 | Fault..... | 783 |
| 7.2.5 | Loss | 785 |
| 7.3 | Necessity | 801 |
| 7.4 | Vicarious Liability..... | 809 |
| 7.5 | Medicines | 818 |
| 7.6 | Constitutional Delicts? | 825 |
| 7.7 | Res Ipsa Loquitur and Strict Product Liability..... | 837 |
| 7.8 | Imperitia Culpae Admumeratur..... | 865 |
| 7.9 | Class Actions..... | 875 |

7.1 Introduction

Civil wrongdoing in the context of the law relating to health services delivery introduces the question of the balance of power between provider and patient and whether the fact that the provider usually has a considerable advantage over the latter should have any bearing on the manner in which the law addresses claims in delict. The patient is often in a position of vulnerability in relation to the health care provider similar to very few consumers of other goods and services. It is obvious that health services are of such a nature that they are extremely personal to the consumer. The vulnerability of the patient as consumer of health care goods and services manifests on a number of fronts –

- The knowledge of the service provider usually far exceeds that of the patient. The latter is, most of the time, in no position to disagree with the service provider on technical points such as the likelihood of success of a particular form of treatment vis-à-vis other treatment options and the relative levels of risk involved;

- The quality and efficacy of service provided is often dependent as much upon the level of personal skill and expertise of the service provider, which the patient is usually incapable of assessing in any meaningful way, as it is upon the selected treatment modality;
- In the case of surgical procedures, services are delivered while the patient is unconscious and therefore completely oblivious of what is happening to him or her;
- The services are usually rendered in circumstances where the patient is already weakened either physically or psychologically, or both, by a health condition;
- The service provider is often party to the most intimate details of the patient's life and may know more about him than even his spouse;
- The patient often has no option but to trust the service provider, especially in the public sector where choice of providers is usually extremely limited, if it exists at all.
- The consequences of failure by the service provider to perform in accordance with acceptable and recognised standards can be extremely costly to the patient in the sense that no amount of money can compensate for what is lost.¹ In some instances, the negligence of the service provider can command the highest price of all – the life of a patient.

There are a number of rights in the constitutional Bill of Rights that are impacted by this relationship. They are the rights to life² and human dignity³, the

¹ *Collins v Administrator Cape* 1995 (4) SA 73 (C)
² Constitution section 11
³ Constitution section 10

right to privacy⁴, the right to freedom and security of the person⁵, the right to bodily and psychological integrity⁶, the right of access to health care services⁷ and the right to equality⁸ - to name those rights most directly involved.

The manner in which the provider relates to the patient is itself a part of the services the former is rendering and can influence the outcome of the treatment. Patients are therefore uniquely vulnerable in the provider-patient relationship. In an obvious example, that of psychiatry, the manner in which the psychiatrist relates to her patients could literally mean the difference between whether they commit suicide or commit to long term therapy for depression⁹. In a less obvious example, a doctor may have to convince a patient that it is in the patient's best interests to undergo an HIV test. The patient is unlikely to consent to this if the doctor comes across as being critical of HIV positive people as immoral or inferior to others or more concerned for his own safety in treating the patient than in the patient's wellbeing. In other provider-purchaser relationships, the relationship itself is not necessarily a material factor influencing the quality and efficacy of the services. An evil tempered plumber is capable of fixing a broken pipe as well as an even tempered one and apart from some extra unpleasantness for the customer in the case of the former, the

4 Constitution section 14

5 Constitution section 12

6 Constitution section 12 (2)

7 Constitution section 27(1) and section 27(3)

8 Constitution section 9

9 The Royal College of Psychiatrists in 'Vulnerable Patients, Vulnerable Doctors: Good Practice in Our Clinical Relationships' <http://www.rcpsych.ac.uk/publications/cr/council/cr101/pdf> dated April 2001 recommends that the clinician should develop self awareness – the ability to monitor and understand his or her own feelings and actions within the therapeutic relationship. They state that the clinician is in a particularly powerful position in any relationship with a patient and that the patient trusts the clinician to handle that power with sensitivity. It notes that in certain circumstances the clinician is charged with taking over responsibility for deciding what is in the patient's best interests, sometimes against the will of the patient. Such action should be taken only when there is no alternative, in the least restrictive manner possible with reciprocal benefit to the patient, strictly within the law and with due consultation. It observes that it is not in the patient's best interest for the clinician to hold on to knowledge about the patient's condition or to 'invent' certainty where there is none, for the clinician's own comfort. The Society states that the ability to decide how to impart difficult information sensitively – both the certainty and uncertainty of diagnosis and prognosis – is a skill that the clinician must acquire and observes that therapeutic relationships are founded on mutual respect and that respect breaks down when the expectations of the patient exceed the capabilities of the therapist and *vice versa*. In the document it is recognized that all patients are vulnerable by virtue of being patients needing help. See also Strauss SA 'Geneesheer Patiënt en Reg: 'n Delikate Driehoek' 1987 TSAR 1

outcome is still the same and the pipe is fixed. The area of clinical trials is another one in which patient vulnerability has been recognised¹⁰.

In other contexts the law does take cognisance of such imbalances between suppliers and purchasers and attempts to redress them. For instance in *Consol Ltd T/A Consol Glass v Twee Jonge Gezellen (Pty) Ltd And Another*¹¹ the court had the following to say on the subject of consequential damages:

“In my view plaintiff’s submission on this issue is correct. The meaning of the term consequential loss or damage is unfortunately not precise. In one sense it is contrasted with direct damage. Visser and Potgieter *Law of Damages* at 55 refers to a view that direct loss means the immediate or direct consequence(s) of a damage-causing event, while consequential loss is damage that flows from such direct loss. In the context of relief under the aedilician remedies, however, a claim for consequential damages is contrasted with redhibitorian relief, ie relief for the return of the purchase price paid for the defective goods. See *Holmdene Brickworks (Pty) Ltd v Roberts Construction Co Ltd 1977 (3) SA 670 (A)* at 682 in fine - 683C: ‘The legal foundation of respondent’s claim is the principle that a merchant who sells goods of his own manufacture or goods

¹⁰ See for example Perkins H S ‘Balancing Self and Patient in the Physician-Patient Relationship’ *Chest* April 2002 (<http://www.findarticles.com>) in which he observes that: “Certain sensitive relationships involving unequal parties demand a higher motivation than self-interest. The stronger party has a special duty to ignore self-interest and serve the interests of the weaker party. Such relationships are called fiduciary because the weaker party must trust the stronger. Physician power and patient vulnerability make the physician-patient relationship necessarily a fiduciary one. The physician must promote the patient’s legitimate medical interests, sometimes at a cost to the physician’s own interests. The rationale for such a fiduciary duty is clear: a patient will not come for care without trusting the physician to promote the patient’s interests.” Perkins refers to the issue of clinical trials funded by pharmaceutical companies and performed by practising physicians and a specific trial comparing a new inhaled corticosteroid, a proven inhaled corticosteroid and a placebo for treating moderate persistent asthma. He notes that there is convincing argument that by withdrawing patients with stable asthma from proven treatment and randomising some to the placebo, the trial risks patients’ serious clinical deterioration. In response to the question as to why the trial was approved he notes the speculation that self-interest was the driving force – that the sponsoring company may have expected marketing advantages from the results and the participating physicians their fees for subject recruitment. Perkins makes the point that if physicians received bounties for recruiting patients to the study then this creates a serious conflict of interest since the profit motive may have tempted physicians to recruit their patients despite the medical risks involved. He also points out that there were consistent references in the trial report to subjects as ‘patients’ and to research interventions as ‘treatments’. He says that this blurred the critical distinction between research and therapy. Research subjects should expect no benefit and possibly some harm from research interventions. Furthermore, he says, research physicians owe subjects only the few services detailed in consent forms. In contrast, patients can expect benefit from therapy and treating physicians owe them extensive, often unwritten, fiduciary services. Not grasping this distinction, says Perkins, many patients mistakenly expect therapeutic benefit from research and physicians often do not think to correct the misunderstanding.

See also Puttagunta PS, Caulfield, TA, Griener G, ‘Conflict of Interest in Clinical Research: Direct Payment to the Investigators for finding Human Subjects and Health Information’ *Health Law Review* Vol 10 no 2 p30 (www.law.ualberta.ca) who note that the recent death of a teenager in a drug therapy trial has drawn attention to how financial conflicts of interest may compromise patient protection. They state that while research institutions throughout the world have instituted a variety of conflict of interest guidelines, the potential conflicts associated with investigators receiving direct payment from private companies for both recruitment of patients and the running of clinical trials in pharmaceutical research remains a relatively unexplored area. They note that more and more doctors in private practice are being recruited to run industry sponsored trials and that this trend arose in the last twenty years when government funding for clinical drug trials declined and industry funding increased. They note that the conflicts include erosion of informed consent, compromise of patient confidentiality and enrolment of ineligible subjects in clinical trials.

¹¹ *Consol Ltd 2002 (6) SA 256 (C)*

in relation to which he publicly professes to have attributes of skill and expert knowledge is liable to the purchaser for consequential damages caused to the latter by reason of any latent defect in the goods. Ignorance of the defect does not excuse the seller. Once it is established that he falls into one of the abovementioned categories, the law irrebuttably attaches this liability to him, unless he has expressly or impliedly contracted out of it. (See Voet 21.1.10; Pothier *Contrat de Vente*, para 214; *Kroonstad Westelike Boere Ko-op Vereniging v Botha* 1964 (3) SA 561 (A); also *Bower v Sparks, Young and Farmers Meat Industries Ltd* 1936 NPD 1; *Odendaal v Bethlehem Romery Bpk* 1954 (3) SA 370 (O).) The liability is additional to, and different from the liability to redhibitorian relief which is incurred by any seller of goods found to contain a latent defect.”

Whether the law of delict takes sufficient cognisance of the peculiarities of the health services context is a matter for discussion in the pages that follow.

Another question that arises with regard to the law of delict, especially in the context of health services delivery, is whether the scope and ambit of the obligations of the provider in terms of the law of delict are similar to those imposed in terms of the law of contract or whether they are different and if so, in what way. Contracts for health services are in some respects different from contracts for other goods and services. Medicines, for example, often come with no guarantees of efficacy and no promises of a cure despite the fact that one of the criteria for the registration of a medicine in South Africa in terms of the Medicines and Related Substances Control Act¹² is efficacy. Consequently damages for breach of a contract for health services tend in many instances to resemble quite closely those that are payable in terms of the law of delict in the same context. It has been argued elsewhere in this thesis that one of the most obvious tacit or implied terms of a health care services contract is that the provider will take due and proper care not to harm or injure the patient's person since this is one of the usual risks of medical treatment. If such a term is breached then the nature of the damages should it is submitted, be very similar to those for a delict in the same circumstances. This issue is discussed in more detail below.

¹² Medicines Control Act No 101 of 1965

From a public sector perspective one must ask about the delictual liability of the Medicines Control Council if it negligently approves the registration of a medicine which subsequently proves to be ineffective, unsafe or of low quality. What also would be the liability of the retailer of the medicine or the prescriber of the medicine in these circumstances? Would they be protected by the argument that because the medicine is registered with the Medicines Control Council they are entitled to assume that it is safe, effective and of a suitable quality for the purpose or indication for which it was registered? If one medicine is prescribed in the public sector in preference to another because the former medicine has been donated and is therefore supplied at no cost to the state, what is the liability of the state in a situation in which the donated medicine turns out to be defective or where it is effective but less so than the other medicine? Where logistics in the public health sector break down to the point where persons requiring chronic, life-sustaining medication, such as insulin for diabetes, are unable to obtain their medication would such a failure constitute a delict on the part of the state? In a factual situation such as that in *Minister of Health and Others v Treatment Action Campaign and Others (No 2)*¹³ could the state be held liable in delict for the infection with HIV of a neonate who together with her HIV positive mother was not given Nevirapine as prophylaxis for mother to child transmission of the disease? Could the state be held liable in delict for its refusal in principle to supply a certain drug to patients in the public health sector or to allow the transplantation of organs into HIV positive patients? In other words, does the law of delict extend to policy decisions that are taken by the government in the public health care context? Organs of state are explicitly bound by the Constitution and the Bill of Rights whilst this is not necessarily the case for private persons. If the state's actions in violating a constitutional right fit the legal framework for the law of delict then technically speaking, a violation of constitutional rights can constitute a delict in certain circumstances.

¹³ TAC 2002 (5) SA 721 (CC)



From a private sector perspective, is the right of access to health care services in the Bill of Rights horizontally applicable and if so, would a violation of that right by a service provider in that sector give rise to a claim in the law of delict? Is there a different duty of care implied in this right for the public provider as opposed to the private provider or is it the same for both? If defective health care services are rendered by a private provider can this constitute a violation of the patient's right of access to health care services? This question relates to the meaning of the term 'access' in that context of section 27(1) of the Constitution.

Section 38 of the Constitution recognises the possibility of class actions¹⁴. The decisions and actions of organs of state can affect large numbers of people whereas those of private entities tend, on the whole to affect smaller numbers. There are, of course, exceptions to this general feature in that the decision of a pharmaceutical company to discontinue the production of a medicine can have a significant effect on millions of people but on the whole individual transactions within the private sector tend to be limited in the risk they pose for the participants. For example a decision by the state to use a particular medicine for a particular health condition will impact on large numbers of patients treated by the state for that condition whereas in the private sector, whilst the use of drug formularies is on the increase, health professionals, and to a lesser degree their patients, still have a fair degree of choice in the medicines that are used and prescribed.

In *Carmichele v Minister of Safety and Security*¹⁵, the constitutional court said that where the common law is deficient, courts have an obligation, not a discretion, to develop the common law and that while this does not mean that

¹⁴ The section provides: Anyone listed in this section has the right to approach a competent court, alleging that a right in the Bill of Rights has been infringed or threatened, and the court may grant appropriate relief, including a declaration of rights. The persons who may approach a court are-

- (a) anyone acting in their own interest;
- (b) anyone acting on behalf of another person who cannot act in their own name;
- (c) anyone acting as a member of, or in the interest of, a group or class of persons;
- (d) anyone acting in the public interest; and
- (e) an association acting in the interest of its members.

¹⁵ *Carmichele* 2001 (4) SA 938 (CC)



courts must in each and every case embark on an independent exercise as to whether the common law is in need of development, instances may arise where a court is obliged to raise the matter on its own and require full argument from the parties¹⁶.

In this chapter the fundamental aspects of the law of delict are discussed in relation to health service delivery. These aspects are conduct, causation,

¹⁶ Leinius and Midgley JR 'The Impact of the Constitution on the Law of Delict' (2002) 119 *SALJ* p17 point out that the obligation imposed upon the courts is the following: first they have to consider whether the common law is deficient when measured against the constitutional objectives; if it is then courts have to determine what ought to be done to ensure that the common law reflects the proper values. They argue that while agreeing that the courts have an obligation to develop the law, the rationale therefore does not lie in either of the sections 39(2) or 173 of the Constitution –that section 39(2) obliges all courts (including magistrate's courts), tribunals or forums to promote the spirit, purport and objects of the Bill of Rights *when* they develop the common law, but under the section, there is no directive as to when any development should be undertaken. Similarly, they say, section 173 confirms that the constitutional court, the Supreme Court of Appeal and the High Courts have inherent power to develop the common law, but there is no indication that they must do so. They question whether, in the light of the fact that magistrate's courts, tribunals and forums do not have such inherent power, the constitutional court considers them to have an obligation similar to that of the higher courts and then go on to suggest that the obligation to develop the common law can be found in section 8 of the Constitution which states that the Bill of Rights applies to all law and binds the judiciary (section 8(1)) and in order to give effect to the Bill, courts must develop the common law (section 8(3)). They state that in their view, this section contains the implicit obligation on courts to ensure that the common law reflects constitutional values. The writer submits that whilst there is merit in the views of Leinius and Midgley on this point, the obligation of the courts to amend the common law should be drawn from a holistic view of the Constitution rather than piecemeal debates about which particular section contains this obligation. For instance section 2 of the Constitution states that it is the supreme law of the Republic and that law or conduct inconsistent with it is invalid and the obligations imposed by it must be fulfilled. It is submitted that the inconsistencies to which it refers are not necessarily only positive contradictions, express or implied, of the Constitution but also negative contradictions in terms of which the common law does not recognise or affords insufficient recognition to constitutional principles and values. If a negative inconsistency is just as invalid as a positive one, the obvious solution in the former case is to develop the common law in such a manner as to eliminate the inconsistency. The injunction at the end of section 2 that obligations imposed by the Constitution must be fulfilled reinforces this argument particularly with regard to negative inconsistencies. To the extent that the judiciary can be regarded as being a part of 'the state' and it is submitted that there is no reason why it should not, section 7 (2) which requires the state to respect, protect, promote and fulfil the rights in the Bill of Rights also carries a clear implication of an obligation upon the judiciary to develop the common law where it is not in keeping with constitutional values and principles. If this section had stopped at respect and protect this argument might not have been as strong but it is submitted that the obligation to promote and fulfil in the context of the judiciary can only mean that the courts may not sit back and wait for the legislature and the executive to introduce statutory reforms but must themselves play an active, creative and positive role in ensuring that the rights in the Bill of Rights are realised. Given the context in which they operate this means, *inter alia*, developing the common law. Similarly, there is a rationale for this obligation of the courts, and indeed forums and tribunals, in section 9 which deals with the right to equality. Section 9(2) states that equality includes the full and equal enjoyment of all rights and freedoms – "to promote the achievement of equality, legislative *and other measures* designed to protect or advance persons, or categories of persons disadvantaged by unfair discrimination may be taken"(writer's italics). It is submitted that these 'other measures' in the context of the judiciary, can mean the development of the common law. Feminists in particular may say that, with respect to *Carmichele* (fn 15 *supra*) this argument is of particular significance given that rape is presently a crime against women in the South African legal system and that in the past the rights of women, a group disadvantaged by unfair discrimination, have not been high on society's list of priorities. Feminist arguments aside, however, section 9(1) is the real weight behind this particular point since it states that everyone is equal before the law and has the right to equal protection and benefit of the law. In *Carmichele*, the common law of delict was not offering that 'equal protection and benefit'. It favoured the authorities who had not taken sufficient steps in the circumstances to ensure that the appellant's rights to bodily and psychological integrity would be protected. 'Equal' does not, it is submitted, mean that 'all cats are grey in the dark' and that a 'one size fits all' approach is appropriate but rather that there must be balance in the law such that one party is not unduly favoured over another. The appellant in *Carmichele*, because of her circumstances, did not have 'equal enjoyment' of all rights and freedoms and the common law of delict failed to recognise this.

unlawfulness, fault and loss. Other relevant concepts such as vicarious liability, the maxims *imperitia culpa adnumeratur* and *res ipsa loquitur* and necessity are also covered. Specific attention is given to delicts involving medicines and the prospect of class actions is considered.

7.2 Fundamental Concepts

The State Liability Act¹⁷ recognises the liability of the state for delictual acts including its vicarious liability for the wrongful acts of state employees.

In terms of section 1 of the Act, any claim against the state which would, if that claim had arisen against a person, be the ground of an action in any competent court, shall be cognizable by such court, whether the claim arises out of any contract lawfully entered into on behalf of the state or out of any wrong committed by any servant of the state acting in his capacity and within the scope of his authority as such servant.

Unlike the private health sector in South Africa, the state employs not only nurses, physiotherapists, and pharmacists but also general practitioners and medical specialists. The private sector employs nurses but physiotherapists, pharmacists, general practitioners and medical specialists tend to be in independent practice in the private sector. Consequently the scope of the risk of vicarious liability to which a private hospital is exposed could be significantly smaller than the scope of the same risk for a public hospital owned by a provincial government. It might be possible, however, to hold a private provider liable for its own negligence in allowing an incompetent surgeon to continue to operate within its premises since such provider has the power to refuse admission privileges or other forms of access to its facilities. In this instance, it would be not so much a question of vicarious liability for the delicts of an

¹⁷ State Liability Act No 20 of 1957

independent third party as much as direct liability for the provider's own negligence.

The fundamental elements to establish a claim in delict in South African law are causation, wrongfulness, fault (consisting of negligence [*culpa*] and intention [*dolus*] but more commonly negligence), voluntariness (conduct)¹⁸ and loss¹⁹. Both acts and omissions may found a claim in delict. Delictual actions are generally regarded as private law actions. The principal difference between private law and public law is that private law is directed at the protection of the individual or private interest, whilst public law aims to preserve the public interest. Delictual remedies are compensatory in nature, compensating the prejudiced person for the harm the wrongdoer has caused²⁰.

7.2.1 Conduct

Only an act of a human being, in contrast to that of an animal or a force of nature, is accepted as conduct. A juristic person may act through its organs (humans) and may thus be held delictually liable for its actions. Conduct only qualifies as such for the purposes of the law of delict if it is voluntary i.e. subject to the control of the will of the person engaged in the conduct. The person concerned must not be acting under some form of compulsion and must be able to exercise his or her own will in acting or refraining from action.

¹⁸ The term 'conduct' includes both a positive act and an omission. See Neethling, Potgieter and Visser, *The Law of Delict* 3rd ed p 2 who state that for the purposes of the law of delict, conduct may be defined as a voluntary human act or omission. See also the discussion on the subject in Boberg PQR *The Law of Delict: Aquilian Liability Vol I*; Burchell J *Principles of Delict*; Mckerron RG *The Law of Delict*; Van der Walt JC and Midgley JR *Delict: Principles and Cases*.

¹⁹ These are expressed in different ways. For instance the South African Law Commission (Discussion Paper 97, Project 82, 'A Compensation System for Victims of Crime in South Africa') has observed that: "There are five elements of a delict: namely an act, wrongfulness, fault, harm and causation. If one of these elements is missing, no delict exists and, accordingly, no liability. In South African law, a distinction is made between delicts that cause patrimonial financial damage and those of an intentional nature, which cause injury to personality. The South African law of delict allows a third action for pain and suffering in terms of which compensation for injury of personality is allowed as a result of the wrongful and negligent (or intentional) impairment of the bodily or physical-mental integrity (Neethling *et al.*, 1990, p. 5)." See also *Geldenhuys v Minister of Safety and Security and Another* 2002 (4) SA 719 (C) in which the Davis J said "It is perhaps trite to set out the well-known elements of the modern Aquilian action, but for the purposes of analysis, a recapitulation assists to promote the internal coherence of this judgment. The six elements are (i) voluntary conduct; (ii) unlawful or wrongful; (iii) capacity; (iv) fault either in the form of *dolus* or *culpa*; (v) causation; (vi) loss." [Footnotes omitted]

²⁰ SA Law Commission Discussion Paper 97, Footnote 427 at fn 9 *supra*

Although an act may be separate in time and space from its consequences, this does not mean that one can say that a delict arises in the absence of voluntary conduct²¹. In the healthcare context the thalidomide disaster is a good example of conduct, in this case the release of the drug into the market, remote in time and space from the damage it caused. Thalidomide is a drug with anti-inflammatory and antiangiogenic properties that was sold mainly in 1962. Its use by pregnant women resulted in thousands of cases of serious birth defects and it was withdrawn from the market. In *S v Shivute*²², the court had to consider the issue of voluntariness in relation to a charge of culpable homicide against a nurse who administered an intramuscular injection of chloroquine into a four year old child as opposed to the prescribed chloroquine syrup which was to be administered orally. The child died. The nurse who worked in a busy camp under apparently stressful conditions that dealt with returnees to Namibia, said that she knew that the administration of an injection of chloroquine would kill a child and that she was not consciously aware that she was administering the wrong prescription. She never raised the defence of mental illness or defect in her defence. The court noted that the law presumes that an accused is of sound mental health and is criminally responsible. It held that when the issue is whether the accused was not criminally responsible because of a mental illness or defect, the onus of proof rests on the accused and such onus must be discharged on a balance of probabilities. It stated that when the issue is raised in the absence of criminal responsibility which is not the result of mental illness or defect and if a proper basis is laid in the evidence for the absence of criminal responsibility, then the accused must be given the benefit of the doubt on the issue of criminal responsibility if a reasonable doubt exists at the close of the case for the defence in regard to the cause of the absence of criminal responsibility. The court said with regard to negligence that the requirement is that the accused ought reasonably to have foreseen the possibility of death resulting from his or her conduct and failed to take reasonable steps to avoid

²¹ See Neethling, Potgieter and Visser fn 18 *supra* at p 27-34 for a detailed discussion of the element of conduct.
²² *S v Shivute* 1991 (1) SACR 656 (Nm)



this eventuality. It found that in view of the fact that the accused was a qualified and experienced nurse taken together with the fact that she said she knew that to administer that quantity of chloroquine to that child would have been fatal the only reasonable inference to draw was that any reasonable person with the qualifications and experience of the accused and in the position of the accused would have known at the time of the injection at least that such a course could have been fatal and therefore would have taken reasonable care to pursue a course of conduct which would have prevented such a result. The accused, it found, had failed to act like a reasonable person and was thus either reckless or negligent. O'Linn J observed that at the end of the day the only defence raised on behalf of the accused was whether or not the accused was criminally responsible at the time of the alleged crime based on the possibility that she suffered some form of non-pathological mental aberration or defect at the time of the commission of the crime. There was expert evidence to the effect that the appellant suffered from a 'non-pathological mental disintegration of a temporary nature'. It was submitted by counsel for the appellant that she was 'momentarily impaired'. It was not expressly suggested that the accused acted in a state of automatism which would have eliminated the element of voluntariness from her action. The court considered all of the evidence and came to the conclusion that the decision of the court *a quo* in convicting the accused of culpable homicide was correct and that there was insufficient evidence that she had not acted out of her own volition in administering the lethal dose to the child. It would seem from some aspects of the judgment, that the nurse may have made an error due to stress and tiredness. At one stage, 400 returnees a day entered the camp where she was working and the day of the child's death had been busy. She said that she did not know what happened to her at the stage that she administered the drug to the child incorrectly. However, the court noted that the excuse was nowhere made that she could not cope with the pressure of her work or that she was too tired to give proper attention to the patients or that she was suffering from some illness or defect affecting her physical and mental resources.



People may act involuntarily for a number of reasons. Those that have been recognised by the courts in the past include sleep, unconsciousness, a fainting fit, an epileptic fit, serious intoxication, a blackout, compulsion by human agency (*vis absoluta*), mental illness, hypnosis, strong emotional pressure, low blood sugar and heart attack²³. Automatism, i.e. that fact that a person acts mechanically and not of his or her own free will is recognised as a defence but it will not succeed if the defendant intentionally created the state of automatism in which he or she acted involuntarily in order to harm another²⁴. In the health care context the defence of compulsion can become fairly complex. It is closely related to the defence of necessity sometimes referred to as 'duress of circumstance'²⁵.

7.2.1.2 Assault

Medical treatment without consent can attract a criminal charge of assault²⁶. The court in *The State v Marx* noted that the definition of assault is as follows:

²³ Cases of relevance in this regard are *S v Goliath* 1972 (3) SA 1 (A); *S v Johnson* 1969 (1) SA 204 (A); *R v Dhlamini* 1955 (1) SA 120 (T); *R v Du Plessis* 1950 (1) SA 297 (O); *R v Rossouw* 1960 (3), SA 326 (T); *R v Victor* 1943 TPD 77; *R v Schoonwinkel* 1953 (3) SA 136 (C); *S v Ramagaga* 1965 (4) SA 254 (O); *S v Bezuidenhout* 1964 (2) SA 651 (A); *S v van Rensburg* 1987 (3) SA 35 (T) and *S v Stellmacher* 1983 (2) SA 181 (SWA). They are discussed in more detail in Neethling, Potgieter and Visser (fn 18 *supra*)

²⁴ Neethling, Potgieter and Visser (fn 18 *supra*). Burchell, fn 18 *supra*, notes at p 75 that for an act to be justified on the ground of necessity, (a) a legal interest of the defendant must have been endangered (b) by a threat which had commenced or was imminent but which was (c) not caused by the defendant's fault, and, in addition, it must have been necessary for the defendant to avert the danger, and (e) the means used for this purpose must have been reasonable in the circumstances.

²⁵ Compulsion or duress is a form of necessity and is recognized as a general defence. *S v Goliath* (fn 23 *supra*); *S v Mietwa* 1977 (3) SA 628; *S v Kibi* 1978 (4) SA 173; *S v Alfeus* 1979 (3) SA 145; *S v Petersen* 1980 (1) SA 938.

²⁶ This seems to be the situation in other jurisdictions as well. In Canada, for instance (Somerville MA 'Medical Interventions and the Criminal Law: Lawful or Excusable Wounding' (1980) *McGill Law Journal* vol 26 p82-96) section 45 of the Criminal Code specifically exempts surgical operations from criminal sanction stating that everyone is protected from criminal responsibility for performing a surgical operation upon any person for the benefit of that person if (a) the operation is performed with reasonable care and skill and (b) it is reasonable to perform the operation having regard to the state of health of the person at the time the operation is performed and to all the circumstances of the case. The Canadian Criminal Code is based on the common law which enforced a prohibition against maiming oneself or another. The word 'maim' was defined in *Stephen's Digest* as follows: "A maim is a bodily harm whereby a man is deprived of the use of any member of his body, or of any sense in which he can use in fighting, or by the loss of which he is generally and permanently weakened; but a bodily injury is not a maim merely because it is a disfigurement". Therefore any more than *de minimis* wounding was *prima facie* illegal, but some woundings could be justified. Section 198 of the Canadian Criminal Code provides that "Everyone who undertakes to administer surgical or medical treatment to another person or to do any other lawful acts that may endanger the life of another person or to do any other lawful acts that may endanger the life of another person, is except in cases of necessity, under a legal duty to have and to use

reasonable knowledge, skill and care in so doing." Somerville points out that in the Criminal Code if the phrase 'surgical or medical treatment' is intended to be qualified by the phrase 'lawful act' i.e. that medical or surgical treatment is just one example of lawful acts dangerous to life, the *prima facie* assumption would be one of legality. She notes, however, that the difficulty with such an interpretation is that the forerunners of section 198 were first *Stephen's Digest* and then section 212 in the first Canadian Criminal Code and there is no indication that these provisions were meant to alter the substantive law as it then stood. Rather, in all probability, they merely formulated the standard of care required in order to avoid criminal liability where persons undertook acts requiring special skill or knowledge which were of a dangerous character. Thus, she says, it may be argued that the *prima facie* legality or illegality of any such act was not contemplated by these provisions and remained to be determined by a separate enquiry. She discusses the section in more detail and in doing so mentions the case of *Re "Eve"* P.E.I Family Court No FDS-37, June 14, 1979 (The Supreme Court of Canada made a later decision on this matter in *E (Mrs) v Eve* 2 S.C.R. 388 (1986)) in which Justice McQuaid held that: "the benefit referred to in section 45 was thereby extended to include not only the health of the patient but as well the socio-economic and other considerations with the result that the surgery might be employed not only to preserve and protect health, but as well to preserve the quality of life in a broader medical sense." Despite the use of the wide criterion, however, the judge refused to authorize the particular sterilisation procedure. There are similar issues that impact on questions of sterilisation in South African law and the National Department of Health is busy at the time of writing processing an amendment to the South African Sterilisation Act No 44 of 1998. Section 2 (3) (a) provides that: 'Sterilisation may not be performed on a person who is under the age of 18 years except where failure to do so would jeopardize the person's life or seriously impair his or her physical health.' No mention is made of the person's mental health or human dignity, both of which are protected by the Constitution, the former in section 12(2) of the Constitution in the form of psychological integrity and the latter in section 10 of the Constitution. The amendment of this section of the Act is therefore necessary to align it with the recognition by the Constitution of these rights.

Somerville goes on to explore the practical realities and the question of whether non-therapeutic medical interventions are lawful. She says it has become a matter of increasing importance as such procedures have been more frequently undertaken and are even regarded as commonplace. She notes that the question of their legality first arose with the increasing availability and effectiveness of cosmetic surgery. The courts, she says, stretched the law a little by asserting that these operations were within the traditional concept of therapeutic benefit because there was psychological benefit present. The problem became even more acute, however, with live donor organ transplants and after initial use of the psychological benefit test, most courts faced the reality that in many cases there was no therapeutic benefit to the donors. She says that even before the enactment of legislation authorising such donation, the operation was not in practice considered illegal, at least when performed on a competent consenting adult. Similarly non-therapeutic sterilization of consenting adults and non-therapeutic medical experimentation are frequent events in society that do not foment court actions by the mere fact of their performance. With respect to the latter practice Somerville says it is worth noting that in *Hlushka v University of Saskatchewan* (1996) 53 D.L.R. (2d) 436 (Sask. C. A.), one of the earliest cases involving non-therapeutic medical research, the question of the illegality of the intervention itself was not raised. She asks how this *de facto* legalisation of non-therapeutic interventions can be reconciled with the legal precedents which have been outlined? She states that a solution depends on determining how public policy and section 45 act and interact to legitimise medical interventions.

In the United Kingdom the starting point is also that intentionally touching a person is unlawful – the civil wrong of battery or even the crime of assault – unless that person has consented or there is other lawful authority (Oates L, 'The court's role in decisions about medical treatment' *British Medical Journal* Nov 18 2000). Oates states that each year there are about 20 cases in the family division of the High Court in England and Wales concerning whether medical procedures should be carried out on people who are unable, or refuse, to consent to such treatment. Oates acts as a state funded lawyer brought in to represent those who need a guardian *ad litem* or litigation friend (primarily children and mentally incapacitated people) or as an *amicus* at the request of the court. He notes that there is a legal doctrine of necessity that provides lawful authority for emergency medical treatment that is both necessary and reasonable and designed to save life, assist recovery or ease suffering. According to Oates, the House of Lords in the case of *R v Bournemouth* [1999] 1 AC 458 extended the doctrine of necessity to cover treatment for mental disorder when there has been an informal admission to hospital. Oates states that most instances where medical treatment is given to save life or to enhance the quality of life take place without the need for any reference to the court and that there is in fact a duty of care upon medical practitioners to treat the patient according to a judgment of his or her best interests. Once lack of capacity is shown, the test is one of best interests. This has been judicially defined, says Oates, to encompass medical, emotional, and all other welfare issues. He says that a court should draw up a checklist of the actual benefits and disadvantages and potential gains and losses, including physical and psychological risks and consequences, and should reach a balanced conclusion as to what is right from the point of view of the individual who is the subject of the proceedings.

It is submitted that the difficulties in the Canadian experience in even attempting (under one interpretation) to exclude medical interventions from the definition of assault and render them *prima facie* lawful demonstrate the value of the current approach of South African law that they are *prima facie* unlawful violations of well established and long recognised rights. If one starts from the premise that they are lawful it starts to become extremely difficult to define just what it is that is lawful and where that lawfulness begins and ends. In South African law this problem does not arise because the intervention is *prima facie* unlawful. The maxim *volenti non fit injuria* provides a key element of this system of legal principle in that it both recognises and supports the fundamental importance of such 'absolute' human rights as the rights to life, to human dignity, to freedom and



“an assault is the act of intentionally and unlawfully applying force to another directly or indirectly or attempting or threatening by any act or gesture to apply such force to the person of another if the person making the threat has, or causes the other to believe upon reasonable grounds that he has, the present ability to effect his purpose”.²⁷

In *Stoffberg v Elliot*²⁸ Watermeyer J observed that a man by entering a hospital does not submit himself to such surgical treatment as the doctors in attendance upon him might think necessary. He said that by going into hospital a person does not ‘waive or give up his right of absolute security of the person’. He still has the right to say what operation he will submit to, and unless his consent to an operation is expressly obtained, any operation performed upon him without his consent is an unlawful interference with his right of security and control of his own body.

In *Esterhuizen v Administrator Transvaal*²⁹ the question of medical assault and the difference between South African and English law in this regard was canvassed by counsel for the plaintiff³⁰. Bekker J held in *Esterhuizen* that:

security of the person and to bodily and psychological integrity. It also places squarely in the hands of the individual the right to self-determination. The pivotal importance of the principle of consent in the South African system can therefore not be overstated and should be bolstered rather than undermined. If one adopts this approach that medical interventions are *prima facie* lawful then the importance of consent becomes greatly diminished since the consent of the individual is presently the primary legalising factor in South African law. To the extent that the *obiter dictum* of Marais JA in *Broude v McIntosh and Others* 1998 (3) SA 60 (SCA) that it is not appropriate for a doctor to be accused of assault, with all its perjorative connotations, for mere lack of patient consent can be interpreted as meaning that South African law should convert to the idea that medical interventions are *prima facie* lawful, the writer submits that it this is not supported by constitutional principles. Given the history of the South African people and the past disregard for the rights of human dignity, bodily and psychological integrity and freedom and security of the person it is submitted that to diminish the value of consent in this context would be wholly inappropriate and could potentially undermine the realisation of the fundamental rights in the Bill of Rights for South Africans. The current system of dealing with medical interventions on an exception or justification basis and on the circumstances of each individual case is far preferable - especially in view of the imbalance of power in favour of the health professional as discussed elsewhere in this thesis. It is submitted that the evidentiary difficulties and challenges to patients in discharging the burden of proof which are currently at undesirable levels due to the courts’ persistent unwillingness to apply the maxim of *res ipsa loquitur* to medical negligence cases can only be exacerbated by a shift in legal thinking to the effect that medical interventions of *prima facie* lawful - despite the best intentions of health professionals. The application of public policy considerations to determine the outer limits of wrongfulness are a sufficient safeguard to ensure adequate protection of health professionals in South Africa at this stage given the fact that litigation in South Africa is far from accessible to the person in the street.

²⁷ *Marx* 1962 (1) SA 848 (N). The definition was taken from Gardiner and Lansdown, *S.A. Criminal Law and Procedure*, 6th. ed. vol. 11 at p 1570. Williamson JP observed that “This definition, as pointed out by Innes, C.J, in *Rex v Jolly and Others*, 1923 AD 176 at p. 179, is substantially taken from the Transkeian Penal Code. ‘This definition,’ said Sir James Rose-Innes, ‘would appear to be satisfactory for all practical purposes. It recognises that the application of force may be indirect as well as direct - a conclusion which is logically unassailable, for it is evident that a person may cause force to be applied to the body of another without himself touching that other.’”

²⁸ *Stoffberg* 1923 CPD 148

²⁹ *Esterhuizen* 1957 (3) SA 710 (T)

“a therapist, not called upon to act in an emergency involving a matter of life or death, who decides to administer a dosage of such an order and to employ a particular technique for that purpose, which he knows beforehand will cause disfigurement, cosmetic changes and result in severe irradiation of the tissues to an extent that the possibility of necrosis and a risk of amputation of the limbs cannot be excluded, must explain the situation and resultant dangers to the patient - no matter how laudable his

³⁰ Counsel's argument contains a useful survey of the case law and relevant authorities and is thus reflected below for the sake of convenience. "Plaintiff's claim for assault is based on the *actio injuriarum*. Any aggression upon the person of another is *prima facie* an *injuria*. By an *injuria* is meant an act committed in contempt of another's personality. See McKerron *Law of Delict*, 4th ed. pp. 66 and 67. See also *Stoffberg v. Elliot*, (fn 28 *supra*). All the plaintiff needs show in order to establish the existence of *animus injuriandi* is that the act complained of constituted an aggression upon his person, his dignity or his reputation and that the act was intentional. See *Whittaker v Roos*, 1912 AD 131. See also the aspect of defamation. McKerron, *supra* at p 203. Defendant may, however, rebut the presumption by proving that he was unaware that his act would constitute an impairment of the plaintiff's personality. English Law with its categories of torts is no guide. In English law assault is dealt with under the broad heading of the trespass to the person. In SA law assault is dealt with under the *actio injuriarum*. In this case the onus is on the defendant to prove that the act complained of was not wrongful. There is a distinction between South African law and English law in regard to assault. As far as South African law is concerned the definition of assault in Criminal Law contains no reference to the words 'without consent'. See the definition of assault in Gardiner & Lansdown *Criminal Law & Procedure*, vol. II, p. 1432. In English law the words 'without consent' are introduced. Therefore, in English law there can only be an assault if there is no consent, whereas in South African law 'the act of intentionally and unlawfully applying force to the person of another' constitutes an assault. The word 'unlawful' presents no difficulty as it is always unlawful to invade the right of bodily safety of another. In South African law assault is an 'injuria' together with a large number of other acts which infringe the personal rights of safety, dignity, privacy or reputation. See Gardiner & Lansdown, *supra*, secs. 1 and 2. English law in this respect differs greatly from South African law. In South African law there is no onus on the plaintiff to prove that the assault was committed without the plaintiff's consent. The onus is on the defendant to prove that the plaintiff consented to the assault. See de Villiers *Roman & Roman Dutch Law of Injuries* pp. 24, 25, 27, 144, 145 and 146. See also Manfred Nathan *Common Law of South Africa*, vol. III, p. 1662 and vol. IV, p. 2584. See also *Cohen Lazar & Co v Gibbs*, 1922 T.P.D. 145. The defendant may rebut the presumption of *injuria* by establishing the defence of *volenti non fit injuria*. Consent to a surgical operation is treated on the basis of *volenti non fit injuria*. See McKerron, *supra* pp. 95, 96. See also *Stoffberg v Elliot*, *supra*; *Ex parte Dixie* 1950 (4) SA 748. English and American authorities also treat consent to an injury on the basis of *volenti non fit injuria*. See Halsbury *Laws of England*, 2nd ed. vol. 23 pp. 715 to 719. See also Re-statement of the Law of Torts American Law Institute, vol. I, p. 96, sec. 49. There cannot be consent by a person to a surgical operation unless the risks are explained. See *Botha v Rompel*, 1955 T.P.D. case 501/1953, unreported. When one speaks of consent to an intentional harm it is on the basis of *volenti non fit injuria*. See *Lampert v Hefer, N.O.*, 1955 (2) SA 507. In order to establish the defence of *volenti non fit injuria* the defendant must establish knowledge of the danger, appreciation thereof, and consent thereto. See *Waring & Gillow Ltd v Sherborne*, 1904 T.S. 340. See also *Union Government v Mathee*, 1917 AD 703. The Courts will not find the existence of an implied agreement unless the person who is alleged to have made it had full knowledge of the nature and extent of the risk to be run. See McKerron, *supra* pp. 96, 97. See *Stern v Podfrey*, 1947 (1) SA 350; *Osborn v L & N. W. Railway*, 1888 (2) Q.B.D. 220. See also *Canadian Pacific Railway Co v Fr chet*, 1915 A.C. 871."

In *The State v Marx* fn 27 *supra*, counsel for the state observed that according to the definition of assault in Gardiner & Lansdown, vol. 11 at p. 1570, the application of direct or indirect force is a requisite. He submitted that the administration of a noxious substance amounts to the applying of indirect force to the victims. He argued that if it were held that the present case was not an assault then *injuria* is a competent verdict noting that where the offence charged includes the commission of any other offence, the accused may be convicted of any offence so included although the whole offence charged is not proved. Assault is frequently a constituent part of a more serious crime. Assault is also a constituent part of any indictment alleging the unlawful infliction of bodily harm. The unlawful infliction of bodily harm is in itself a common law offence namely that of *injuria* (Gardiner & Lansdown, vol. 11 pp. 1579 – 81). Counsel for the state argued that although the crime of *injuria* in South African law has popularly been applied to injury to dignity and reputation, it has also in instances been applied to cases of physical injuries; *Rex v Jack*, 1908 T.S. 131; *Rex v Kelamon*, 14 S.C. 329 at p. 333. He noted that the present indictment alleges injuries to the children and it would therefore be competent in the circumstances of this case to substitute the verdict of guilty of *injuria*. This case is interesting because it involved a charge of assault for the administration of alcohol to children. Alcohol is a toxic substance as are most medicines. The court held that the deliberate administration of alcohol to children is an assault on them. It is submitted that the administration of a medicine to a child under circumstances in which there has been no proper consent obtained could therefore also constitute assault in certain circumstances. See further the discussion of *R v Van Schoor* 1948 (4) SA 349 (C), *S v Mkweshana* 1965 (2) SA 493 (N) and *S v Shivute* 1991 (1) SACR 656 (Nm) below which involved charges of culpable homicide as a result of the incorrect administration of medicines.



motives might be - and should he act without having done so and without having secured the patient's consent, he does so at his own peril".

In *Broude v McIntosh and Others*³¹ Marais JA questioned whether cases involving medical negligence and lack of patient consent should be pleaded as assault³². His view is that it is a strange notion to suggest that the actions of a medical practitioner whose intention is to heal a patient should be labelled perjoratively in this way simply because he or she omitted to explain one or other material fact to a patient concerning the proposed treatment. It is submitted with respect that while the arguments of Marais JA have merit, they are based on somewhat emotional grounds rather than the importance of the right to bodily and psychological integrity. In South African law the term 'assault' includes a wide variety of activities that do not all suggest criminal violence. Whilst it may well have taken on such a connotation in the minds of laymen, to a lawyer, 'assault' is a technical term in law which for sound reason covers a range of activities which on the violence scale range from zero to infinity. The point is that the criminal law upholds what the court in *Stoffberg v Elliot* called 'absolute security of the person'. It is a right that is fundamental to the state of being human and is akin to the right to life itself. Any suggestion

³¹ *Broude* fn 26 *supra*

³² At pages 67-68 of the judgment in *Broude supra* Marais JA stated: "Pleading a cause of action such as this as an assault to which the patient did not give informed consent is of course a familiar and time-honoured method of doing so. However, I venture to suggest with respect that its conceptual soundness is open to serious question and merits reconsideration by this Court when an appropriate case arises. To the average person, and I suspect to many a lawyer, it is a strange notion that the surgical intervention of a medical practitioner whose sole object is to alleviate the pain or discomfort of the patient, and who has explained to the patient what is intended to be done and obtained the patient's consent to it being done, should be pejoratively described and juristically characterised as an assault simply because the practitioner omitted to mention the existence of a risk considered to be material enough to have warranted disclosure and which, if disclosed, might have resulted in the patient withholding consent. It seems to me to be inherent in the notion that, even if the risk does not eventuate and the surgical intervention is successful, the practitioner's conduct would nonetheless have constituted an assault. That strikes me as a bizarre result which suggests that there is something about the approach which is unsound. There is no principle of law of which I am aware by which the characterisation as lawful or unlawful of an intentional act objectively involving the doing of bodily harm to another can be postponed until its consequences are known. Either it was an assault at the time of its commission or it was not. Events occurring *ex post facto* can logically have no bearing on the question. It is no answer to say that if the undisclosed risk does not eventuate, no damage will have been caused. That has nothing to do with the characterisation of the medical practitioner's act in intervening surgically as lawful or unlawful. I mention this merely by way of example to explain why I consider that the validity of causes of action framed in this manner in circumstances similar to those which are said to exist in this case requires re-examination. (I emphasise the latter qualification; I leave aside cases in which *mala fides* is involved such as cases of deliberate fraud and deliberate misrepresentation of what is entailed in order to obtain consent which would otherwise not be forthcoming.) However, re-examination would be inappropriate in the present case. The matter was not argued and even if it be assumed in favour of appellant that the cause of action based upon an allegation of assault is conceptually sound in law, I agree with the trial Judge's conclusion that the evidence does not bear it out." See also Strauss SA 'Bodily Injury and the Defence of Consent' 1964 *SALJ* 179; Strauss SA 'Toestemming tot Benadeling As Verweer In Die Strafreë en Die Deliktereg' (doctoral thesis) (1961)



that an unjustified interference with such a right is something less than criminal needs extremely careful consideration. In South Africa it is well known to anyone who works in the health sector that health professionals do not take the question of informed consent seriously in their daily practice. Health professionals still tend to have a highly paternalistic approach to their patients, especially, but not solely, to those who may be illiterate or have a low level of education. In the public sector they raise arguments about spending ‘unnecessary’ time talking to patients about their condition while in the private sector, informed consent if any, is relegated to the signature of a form on admission to a hospital which the patient may feel he or she has little or no choice in signing, or in the case of a private medical practice, a blanket consent which is signed when a person first visits the doctor’s rooms with the intention of becoming his patient. None of this is legally acceptable but it happens every day. All of this is with the threat of criminal assault in the event of failure to obtain consent hanging over the heads of providers. South African society, unlike American society, is largely non-litigious – a fact which is undoubtedly attributable to the fact that litigation is still an extremely expensive business and mostly beyond the means of the ordinary person and justice is a commodity that has to be purchased. The National Health Act³³ specific provision for informed consent on the part of patients largely because of the failure by the health professions to adequately address this issue. It is noteworthy that the Bill contains an express requirement that the patient must be informed that he or she can refuse the proposed treatment³⁴. Strauss states that in the absence of an

³³ National Health Act No 61 of 2003

³⁴ Strauss *SA Doctor Patient and the Law: A Selection of Practical Issues* notes that to perform a medical operation upon or to administer treatment to a person against his will or even without his consent amounts to assault, for which the doctor may be held liable in a civil action for damages and be criminally prosecuted. He states that as far as a claim for damages is concerned a South African court will probably not award more than a nominal amount where it appears that the doctor has in fact saved the patient’s life. Where there has been *injuria* associated with the unauthorised treatment, damages may well be awarded in respect of such *injuria*. Strauss does state that if, however, a patient has suffered harm, for instance in consequence of a blood transfusion such as an infection with a serious disease on account of the blood having been contaminated, substantial damages may conceivably be awarded. The writer submits that where no damages can be proved, none will be awarded since damages in terms of the law of delict are not generally punitive but compensatory in nature. This subject was canvassed in detail by the constitutional court in *Fose v Minister Of Safety And Security* 1997 (3) SA 786 (CC). In *G Q v Yedwa And Others* 1996 (2) SA 437 (TK) the plaintiff claimed damages for shock, pain and suffering, as well as *injuria*, arising out of his wrongful assault and circumcision by the defendants. The plaintiff was a

captain in the Defence Force. He had already gone through the Xhosa initiation rites, including circumcision, several years before the attack by the defendants, who were also members of the Defence Force. White J stated that "I have therefore turned to those cases in which the plaintiffs were assaulted, but did not suffer serious injury, for guidance in determining the quantum of damages. When doing so, it once again struck me how small, and often insignificant, are the awards made by our courts for damages arising from personal injury and contumelia arising from an assault. I can only add my voice to the suggestion, which has been made from time to time, that such awards be increased substantially." In this case the plaintiff did not suffer serious or lasting physical injuries. He did not require hospitalisation and the only medical treatment he received was the cleaning of the wound to his foreskin, and the application of ointment thereto. The pain he suffered was also not excessive. The removal of the remainder of his foreskin was undoubtedly painful and, as stated above, he thereafter suffered pain, which appeared to the court to be no more than discomfort, for a period of two weeks. In all the circumstances an equitable award for shock, pain and suffering, which will be fair to both the plaintiff and the defendants, will be an amount of R5 000. White J observed that: "By far the most serious aspect of the assault, vis-à-vis damages, is the contumelia (insult) suffered by the plaintiff. Three aspects of the case exacerbated his humiliation. They were the nature of the assault, the imputation against his manhood, and the effect of that imputation on his subordinates. The first aggravating feature was the very nature of the assault. To have his trousers removed, his legs forced open and then to be circumcised, was manifestly an extremely degrading experience. The second aggravating feature was the symbolic imputation of the assault. Circumcision has great significance in Xhosa culture - it signifies the passing from boyhood to manhood, and the conferring on the recipient of the rights and privileges, and more particularly responsibilities, of manhood. A man who has not been circumcised has no standing in, and is denigrated by, their society. Circumcision is therefore a very emotive issue, especially when an uncircumcised man professes to have been circumcised and to be entitled to the privileges of manhood, and from time to time uncircumcised men, who act in this manner, are forcibly circumcised. Against this background it is clear that when the defendants assaulted the plaintiff they implied that he was not a man, but a charlatan and impostor who had not been circumcised. It is therefore not surprising that the plaintiff testified that he found this imputation against his manhood extremely offensive, degrading and humiliating. The third aggravating circumstance was that the imputation that the plaintiff had not been circumcised resulted in his being held in contempt by his subordinates, which caused him further degradation and humiliation. For the reasons set out above the Court must award a substantial amount as damages for contumelia, and I am of opinion that the amount claimed by the plaintiff under this heading is not excessive." The Court granted damages in the amount of R15 000. Of this amount R10 000 was for contumelia and R5000 was for shock, pain and suffering.

In *Minister Of Justice v Hofmeyr* 1993 (3) SA 131 (A), Hoexter JA held that: "One of an individual's absolute rights of personality is his right to bodily integrity. The interest concerned is sometimes described as being one in corpus, but it has several facets. It embraces not merely the right of protection against direct or indirect physical aggression or the right against false imprisonment. It comprehends also a mental element."

It is submitted that this is consistent with the manner in which the right to bodily and psychological integrity has subsequently been framed in section 12(2) of the Constitution.

Hoexter J stated that: "The general principles of the modern South African law of delict are essentially derived from Roman law. See Joubert (ed) *Law of South Africa* vol 8 at 11 para 6. *Injuria* is the wrongful and intentional infringement of an interest of personality. In an action for damages based on *injuria* the plaintiff must prove intent (*dolus, animus injuriandi*) on the part of the defendant. Intent and motive, however, are discrete concepts. As pointed out by Stratford JA in *Gluckman v Schneider* 1936 AD 151 at 159: 'Motive . . . is the actuating impulse preceding intention.' Intention is a reflection of the will rather than desire. The pertinent difference between the two concepts was stressed in the Whittaker case *supra*. At 131 of his judgment Solomon J stated: 'It is not necessary in order to find that there was an *animus injuriandi* to prove any ill-will or spite on the part of the defendants towards the plaintiffs . . .'. It is clear that without *dolus* the action for an *injuria* would lie neither in Roman law nor in Roman-Dutch law. See the remarks of Davis J in *Wade & Co v Union Government* 1938 CPD 84 at 86. It is equally clear, however, that in a limited class of *injuria* the current of precedent has in modern times flowed strongly in a different direction. In this limited class of delicts *dolus* remains an ingredient of the cause of action, but in a somewhat attenuated form, in the sense that it is no longer necessary for the plaintiff to establish consciousness on the part of the wrongdoer of the wrongful character of his act. Included in this limited class are cases involving false imprisonment and the wrongful attachment of goods. The possibility that in the case of certain forms of *injuria* involving constraints on personal liberty the wrongdoer's legal liability might exist even in the absence of his appreciation of the wrongful nature of his injurious act, has been explicitly recognised by this Court. In *Ramsay v Minister van Polisie en Andere* 1981 (4) SA 802 (A) Botha AJA (with whom the remaining members of the Court concurred) agreed with the order appearing at the end of the judgment of Jansen JA but was at pains to dissociate himself from certain observations in regard to *animus injuriandi* in the judgment of Jansen JA. At 818E-H Botha AJA said the following: 'Hy aanvaar, na aanleiding van die posisie by laster, dat *animus injuriandi*, wat onregmatigheidsbewussyn verg, in die algemeen 'n element is van alle inbreuke op die persoonlikheid wat as *injuria* aangemerkt word. Ek aanvaar dit nie. Ek laat die moontlikheid oop dat daar by bepaalde vorme van *injuria* na die eise van regsbeleid aanspreeklikheid kan bestaan in die afwesigheid van onregmatigheidsbewussyn by die dader. In der waarheid word my benadering onderskraag deur die huidige stand van die regspraak. Dit val nie te betwyfel nie dat daar in die regspraak, veral in die Transvaal, oor 'n tydperk van jare met betrekking tot sekere vorms van *injuria* 'n standpunt ingeburger is wat beteken dat by sekere *injuria* onregmatigheidsbewussyn by die dader geen voorvereiste vir aanspreeklikheid is nie. Ek hoef nie daaroor op besonderhede in te gaan nie. By wyse van enkele voorbeelde verwys ek slegs na *Birch v Ring*

1914 TPD 106; *Cohen Lazar & Co v Gibbs* 1922 TPD 142; *Smit v Meyerton Outfitters* 1971 (1) SA 137 (T).¹ In the *Cohen Lazar* case *supra* a court messenger, on the instructions of a creditor who had no judgment, seized property of the debtor. A Full Court (Wessels JP and Gregorowski J) held that the seizure was an *injuria*. In the course of his judgment Wessels JP said at 144: 'The mere illegal and intentional interference with the liberty of a free man by seizing him or his property is a delict which will support an action for damages.' and later in his judgment at 145: 'It is revolting to one's common sense to think that a person unsupported by any judgment could induce a clerk to issue to him a writ, seize a person's property, and escape liability merely because he acted without malice and under the impression that no judgment was required. If a person by his own unauthorised act intentionally injures an innocent person in his property, the latter is *prima facie* entitled to damages for loss caused to him.'... I have cited the majority judgment in the *Ramsay* case *supra* as an example of recognition by this Court of the fact that in cases involving the liberty of the citizen there may be liability for an *injuria* despite the wrongdoer's unawareness of the wrongful character of his act. No less significant, however, is the line of reasoning adopted by this Court more than 80 years ago in the *Whittaker* case *supra*. The same recognition, although not roundly expressed, is, I think, implied in the decision in the *Whittaker* case. It is clear from the judgments delivered therein that *dolus* was predicated as an essential element of the *injuria* with which the Court was concerned. Innes J in the course of his judgment (at 122) put the matter thus: 'I agree with Wessels J (who delivered the judgment of the Court below) in holding that the illegal treatment to which the plaintiffs were subjected amounted to a delict on the part of those responsible for it. And I think the delict was of the class dependent upon intent (*dolus*); in other words, that it constituted an *injuria*. The action of the Governor was a wrongful and intentional interference with those absolute natural rights relating to personality, to which every man is entitled.' And again at 124: 'I have already pointed out that the infringement of the rights of these persons amounted to an *injuria*; a necessary feature of which is the existence of *dolus*, or intent. But when an unlawful aggression of this nature has been proved, the law presumes that the aggressor had in view the necessary consequence of his conduct; that is, that he had the intention to injure, the *animus injuriandi* (De Villiers *Injuries* 145). That does not mean that he was actuated by malice or ill-will, but that he deliberately intended that the operation of this unlawful act should have effect upon the plaintiff.'

Turning to the judgment of Solomon J one finds the following remarks at 130-1: 'It seems to me that we have present here all the requisites which are necessary to found an action of *injuria*. Those requisites are well laid down by De Villiers in his work on the law of injuries as follows: First: "An intention on the part of the offender to produce the effect of his act"; in other words, the *animus injuriandi*. It is not necessary in order to find that there was an *animus injuriandi* to prove any ill-will or spite on the part of the defendants towards the plaintiffs; and it is quite immaterial what the motive was or that the object which the defendants had in view was a laudable one. It is sufficient that the injuries suffered by the plaintiffs were inflicted by the defendants, not accidentally or negligently, but with deliberate intention.' Neethling *Persoonlikheidsreg* 2nd ed (1985) says at 116: 'Alhoewel onregmatige vryheidsberowing 'n *injuria* is waarvoor *animus injuriandi* 'n aanspreeklikheidsvereiste behoort te wees, het die regspraak onder invloed van die Engelse reg hierdie vereiste feitlik geheel en al negeer.' In amplification of the above statement the learned author in footnote 11 on the same page points out that in the *Whittaker* case *supra* at 122 and 130-1 '... *dolus* of *animus injuriandi* onomwonde as vereiste vir onregmatige vryheidsberowing gestel word. Nietemin is die verweerders aanspreeklik gehou niestandaande die feit dat hulle bona fide geglo het dat hulle optrede geregverdig was (vgl op 129) en opset weens gebrek aan onregmatigheidsbewussyn bygevolg by hulle ontbreek het' Having referred to the decision in *Smit v Meyerton Outfitters* (*supra*) Prof Neethling comments: 'Die opsetselement, onregmatigheidsbewussyn, en by gevolg dwaling as 'n verweer word dus uitdruklik verwerp. Mens kan gevolglik konkludeer dat aanspreeklikheid op grond van onregmatige vryheidsberowing skuldloos is.' To which he adds (by way of footnote no 16 on the same page): 'Agesien daarvan dat hierdie negering van die skuldvereiste aan die invloed van die Engelse reg toe te skryf is, kom spesiale oorwegings wat sodanige afwyking regverdig nietemin hier te pas' In my opinion the succinct dictum in *Smit v Meyerton Outfitters* (*supra*) quoted earlier in this judgment embodies a correct statement of our modern law. The application of the principle therein stated furthermore entails practical consequences which seem to me to be both sensible and just. The principles of our law of delict which govern the legal liability of a wrongdoer for the infliction of unlawful bodily restraint, touching as they do the liberty of the subject, are principles of vital importance. I do not think that this Court should try to reverse the direction along which our law has developed as reflected in the line of judicial precedents examined in this judgment. To upset an established and satisfactory principle because it is not in accordance with the Roman or Roman-Dutch law would be to deny development to our law. Law is not a static thing. It is forever changing and being adapted to novel conditions.' In *Peter v Peter And Others* 1958 (4) SA 361 (N) Caney J observed that "The word 'injury' or 'injuries' can be used in a wide sense, as meaning any infraction of right or wrongful act. But the ordinary meaning is injury to property or to person (*R v Hutcheons and Another*, 1912 T.P.D. 705 at p. 710), although it seems that, in relation to property, the more appropriate term is 'damage to property', whilst 'injury' is employed in relation to persons, whether as to bodily or physical injury (embraced in the Aquilian action) or injury to 'absolute rights of personality', as to dignity or reputation. For this the *actio injuriarum* is given. De Villiers on *Injuries*, pp. 21, 22; *Wille's Principles*, p. 465 (3rd ed.).... In our country, also, damages or compensation for 'personal injuries' has an established meaning, that is to say relief in consequence of bodily hurt obtainable primarily under the aquilian action, though there may also be an element of *contumelia*."

It is submitted that the in the health services context this line of legal precedent is consistent with and supportive of the idea that damages for unauthorised medical treatment can and should be awarded in appropriate circumstances not only in respect of physical or bodily injury in the Aquilian sense, but also in respect of *injuria*. The nature of medical treatment is such that it affects the patient's 'personhood'. It affects

overriding social interest, or an interests such as that of a minor child who is dependent upon the person concerned, the mentally competent individual's right to control his own destiny in accordance with his own value system must be rated higher than even his health and life. He says that if there is a conflict between the desire of a person to go his own way, forego medical treatment and to expire in his own manner, on the one hand, and the desire of the doctor to cure him of his disease or to secure his health on the other, the former should be accorded preference. There is neither a general right nor a general duty on the part of a person to protect another against himself³⁵.

7.2.1.3 Liability for Omissions

Generally speaking liability for omissions is more restricted than liability for commissions due to the fact that the courts are reluctant to make individuals within society responsible for the welfare of others to whom they have no relationship.³⁶ One is generally speaking entitled in law to mind one's own business.³⁷ In the context of health care the Constitution has to some extent

much more than just his life or physical wellbeing. Strauss (fn 34 *supra*) comments that if the treatment saves the patient's life then the award of damages is likely to be minimal but this should not be the case in all circumstances. If a patient who is suffering from an incurable disease is forcibly treated against his will in order to save his life and this objective is achieved but in the process his suffering is prolonged and his rights to human dignity and to bodily and psychological integrity have been violated it is submitted that there may well be arguments on the basis of public policy that clearly favour the wrongfulness of such an act and that would support a significant award of damages. Life is not everything. It is rather the lowest common denominator in being human as the matrix of other rights in the constitutional Bill of Rights indicates.

35 Strauss fn 28 *supra* at p31

36 Neethling, Potgieter and Visser (fn 18 *supra*)

37 In *Sea Harvest Corporation (Pty) Ltd and Another v Duncan Dock Cold Storage (Pty) Ltd and Another* 2000 (1) SA 827 (SCA), Scott JA observed that "In the course of the past 20 years or more this Court has repeatedly emphasised that wrongfulness is a requirement of the modern Aquilian action which is distinct from the requirement of fault and that the inquiry into the existence of the one is discrete from the inquiry into the existence of the other. Nonetheless, in many if not most delicts the issue of wrongfulness is uncontentious as the action is founded upon conduct which, if held to be culpable, would be prima facie wrongful. (Compare *Lillicrap, Wassenaar and Partners v Pilkington Brothers (SA) (Pty) Ltd* 1985 (1) SA 475 (A) at 497B - C.) It is essentially in relation to liability for omissions and pure economic loss that the element of wrongfulness gains importance. Liability for omissions has been a source of judicial uncertainty since Roman times. The underlying difficulty arises from the notion that, while one must not cause harm to another, one is generally speaking entitled in law to mind one's own business. Since the decision in *Minister van Polisie v Ewels* 1975 (3) SA 590 (A) the Courts have employed the element of wrongfulness as a means of regulating liability in the case of omissions. If the omission which causes the damage or harm is without fault, that is the end of the matter. If there is fault, whether in the form of *dolus* or *culpa*, the question that has to be answered is whether in all the circumstances the omission can be said to have been wrongful or, as it is sometimes stated, whether there existed a legal duty to act. (The expression "duty of care" derived from English law can be ambiguous and is less appropriate in this context. See *Knop v Johannesburg City Council* 1995 (2) SA 1 (A) at 27D - E.) To find the answer the Court is obliged to make what in effect is a value judgment based, *inter alia* on its perceptions of the legal convictions of the community and on considerations of policy. The nature of the enquiry has been

introduced an exception to this rule in the form of the right in section 27(3) not to be refused emergency medical treatment. This right has been discussed elsewhere in this thesis in greater detail. The point to note is that it, like the other constitutional rights is not absolute, but it nonetheless comes closer so far than any other legal principle in compelling certain persons to act in certain circumstances. A health professional or health establishment that refuses to provide emergency medical treatment, whether in the private or public sectors, without solid grounds for doing so is likely to be faced with a claim for violation of this constitutional right. The claim will in all likelihood be based in delict since the harm caused by the refusal to give emergency medical treatment is likely to be construed as a civil wrongdoing involving *dolus* rather than *culpa*. Obviously the claim would have to be considered in the light of the relevant circumstances. It is noteworthy that although the language of the Constitution seems to be couched in terms of a positive act, i.e. a refusal to provide medical treatment, rather than an omission, the wrongful 'act' in question is likely to be an omission – the failure to provide medical treatment – rather than a positive act.

7.2.2 Causation

In *Muller v Mutual And Federal Insurance Co Ltd And Another*³⁸ the court observed that "...the problem of causation in delict involves two distinct enquiries. The first is whether the defendant's wrongful act was a cause of the plaintiff's loss ('factual causation'); the second is whether the wrongful act is

formulated in various ways. See, for instance, *Minister van Polisie v Ewels* (*supra* at 597A - B); *Minister of Law and Order v Kadir* 1995 (1) SA 303 (A) at 318 E - H and the recent formulation, albeit in a different context, in *National Media Ltd and Others v Bogoshi* 1998 (4) SA 1196 (A) at 1204D. It is clear that the same facts may give rise to a claim for damages both *ex delicto* and *ex contractu* so that the plaintiff may choose which to pursue. But a breach of a contractual duty is not per se wrongful for the purposes of Aquilian liability. (See the Lillcrap case *supra* at 496D - I and 499D - G.) Whether the requirement of wrongfulness has been fulfilled or not will be determined in each case by the proper application of the test referred to above." This passage was quoted with approval by Comrie J in *Pinshaw v Nexus Securities (Pty) Ltd And Another* 2002 (2) SA 510 (C)

³⁸ *Muller* 1994 (2) SA 425 (C)

linked sufficiently closely to the loss for legal liability to ensue ('legal causation' or remoteness)."³⁹

In *Minister of Police v Skosana*⁴⁰, the court observed that causation in the law of delict gives rise to two 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 see the harm giving rise to the claim⁴¹. If it did not, then no legal liability can arise and *caedit 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 part⁴². Therefore the test for factual causation is, except in the most unusual of circumstances, the *causa (conditio) sine qua non*. The plaintiff must show that the harm would not have arisen but for the actions or omissions of the defendant. The courts decide the question of legal causation on the basis of a number of factors that relate essentially to public policy. The importance of public policy in the constitutional legal order that prevails in South Africa has already been discussed in some detail elsewhere. Public policy is informed by the values and principles of the Constitution. Thus decisions as to legal causation must also be informed by constitutional values and principles.

³⁹ See also *Minister of Police v Skosana* 1977 (1) SA 31 (A) at p 34E-35D and *Siman & Co (Pty) Ltd v Barclays National Bank Ltd* 1984 (2) SA 888 (A) at p 914F-915A; *International Shipping Co (Pty) Ltd v Bentley* 1990 (1) SA 680 (A) at p 700E-701F and *S v Mokgethi en Andere* 1990 (1) SA 32 (A)

⁴⁰ *Skosana* 1977 (1) SA 31 (A) at 34E-35D

⁴¹ *Silva's Fishing Corporation (Pty) Ltd v Maweza* 1957 (2) SA 256 (A) at 264; *Kakamas Bestuursraad v Louw* 1960 (2) SA 202 (A) at 222

⁴² Farlam AJ in this case quoted *Prosser Law of Torts* 4th ed at p 237, where it is stated: "A cause is a necessary antecedent; in a very real and practical sense, the term embraces all things which have so far contributed to the result that without them it would not have occurred. It covers not only positive acts and active physical forces, but also pre-existing passive conditions which have played a material part in bringing about the event. In particular it covers the defendant's omissions as well as his acts." And then observed that: "The test is thus whether but for the negligent act or omission of the defendant the event giving rise to the harm in question would have occurred. This test is otherwise known as that of the *causa (conditio) sine qua non* and I agree with my Brother Viljoen that generally speaking there may be exceptions- (see *Portwood v Svamvur* 1970 (4) SA 8 (RA) at 14) no act, condition or omission can be regarded as a cause in fact unless it passes this test (see *Da Silva and Another v Coutinho* 1971 (3) SA 123 (A) at 147)."



Questions of legal causation involve the limits of legal liability.⁴³ The appropriate test for legal causation has been a matter for some debate both in foreign jurisdictions and in South African law⁴⁴. In *Smit v Abrahams*⁴⁵ the court identified two tests from the literature: the direct consequences test and the reasonable foresight test. The former has been explained as follows:

“The presence or absence of reasonable anticipation of damage determines the legal quality of the act as negligent or innocent. If it be thus determined to be negligent, then the question whether particular damages are recoverable depends only on the answer to the question whether they are the direct consequence of the act.”⁴⁶

The second test is derived from the judgment of Lord Simonds in *Overseas Tankship (UK) Ltd v Morts Dock & Engineering Co Ltd*⁴⁷ where he stated:

“... (I)t does not seem consonant with current ideas of justice or morality that for an act of negligence, however slight or venial, which results in some trivial foreseeable damage, the actor should be liable for all consequences however unforeseeable and however grave, so long as they can be said to be “direct”. It is a principle of civil liability, subject only to qualifications which have no present relevance, that a man must be considered to be responsible for the probable consequences of his act. To demand more of him is too harsh a rule, to demand less is to ignore that civilised order requires the observance of a minimum standard of behaviour.”

In, Farlam AJ points out that the principle upheld in *Overseas Tankship* is subject to at least two qualifications: (a) as long as the ‘kind of damage’ is foreseeable the extent need not be and (b) the precise manner of occurrence need not be foreseeable.

Farlam AJ states in *Smit* that it is his view that the direct consequence test is not really a rival which ousts the test of reasonable foresight observing that where it applied it operated as an extension to the reasonable foresight test so that, in

⁴³ “The use of the expression ‘legal causation’ to describe the concept underlying the second enquiry, namely the enquiry as to the remoteness of damage, may be a convenient label, but it must not be allowed to distract one’s attention from the important consideration that the second enquiry does not really raise a question of causation but relates to the fixing of the outward limit of legal liability.”

⁴⁴ See the discussion in *Smit v Abrahams* (fn 45 *infra*) at p162-174

⁴⁵ *Smit* 1992 (3) SA 158 (C)

⁴⁶ *In re Polemis and Furness, Withy & Co* [1921] 3 KB 560 (CA)

⁴⁷ *Overseas Tankship* [1961] AC 388 (PC) ([1961] 1 All ER 404)

effect, the two were combined with the result that a defendant will be held liable for (i) the reasonably foreseeable consequences of his culpable conduct, plus (ii) any direct consequences thereof, even if they were not foreseeable.

This view was subsequently accepted in *Gibson v Berkowitz*⁴⁸ along with the dicta in *S v Mokgethi an Andere*⁴⁹.

In *Silver v Premier, Gauteng Provincial Government*⁵⁰, the court quoted from the minority judgment of Corbett JA (as he then was) in *Siman & Co (Pty) Ltd v Barclays National Bank Ltd*⁵¹ and especially at 915E where he said:

“In many instances, however, the enquiry requires the substitution of a hypothetical course of lawful conduct for the unlawful conduct of the defendant and the posing of the question as to whether in such case the event causing harm to the plaintiff would have occurred or not; a positive answer to this question establishing that the defendant's unlawful conduct was not a factual cause and a negative one that it was a factual cause. This is so in particular where the unlawful conduct of the defendant takes the form of a negligent omission. In *The Law of South Africa* (ibid para 48) it is suggested that the elimination process must be applied in the case of a positive act and the substitution process in the case of an omission. This should not be regarded as an inflexible rule. It is not always easy to draw the line between a positive act and an omission, but in any event there are cases involving a positive act where the application of the but-for rule requires the hypothetical substitution of a lawful course of conduct (cf Prof A M Honoré in *International Encyclopaedia of Comparative Law* c 7 at 74–6). A straightforward example of this would be where the driver of a vehicle is alleged to have negligently driven at an excessive speed and thereby caused a collision. In order to determine whether there was factually a causal connection between the driving of the vehicle at an excessive speed and the collision it would be necessary to ask the question whether the collision would have been avoided if the driver had been driving at a speed which was reasonable in the circumstances. In other words, in order to apply the but-for test one would have to substitute a hypothetical positive course of conduct for the actual positive course of conduct.”

⁴⁸ *Gibson v Berkowitz And Another* 1996 (4) SA 1029 (W). The court noted as follows: “In South Africa the matter has become settled in that the Appellate Division has now laid down a ‘flexible norm’ (‘soepele maatstaf’) whereby considerations of policy, reasonableness, equity and justice are applied to the facts of the case. Van Heerden JA in *S v Mokgethi en Andere* 1990 (1) SA 32 (A) at 40I–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 subsidiër 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 regspraakspreeklikheid, as ‘n meer konkrete afgrensingsmaatstaf gebruik kan word nie.”

⁴⁹ *Mokgethi* 1990 (1) SA 32 (A). See also *Carmichele v Minister of Safety and Security and Another* 2003 (2) SA 656 (C)

⁵⁰ *Silver* 1998 (4) SA 569 (W). See chapter 8 for a discussion of the facts and judgment of this case.

⁵¹ *Siman* fn 39 *supra* at p 914C–918A



The potential for convergence of the principles of the law of contract and of delict is evident from the judgement in *Silver* where the court refused to distinguish between the test for causation in considering the contractual as opposed to the delictual claim of the patient⁵². It is submitted that this is particularly relevant in the context of claims involving health care services since the facts upon which the claim is based, whether in contract or in delict, are likely to be the same in many instances. In other contexts where contractual claims are based rather more on the anticipated outcome or results of performance than on a failure to perform to some reasonably required minimum standard, there may be argument for a different test of causation to that contemplated in the law of delict. The latter attempts to put the plaintiff in the position in which he would have been but for the wrong that was done him whereas the law of contract attempts to put the plaintiff into the position in which he would have been had the obligations of the defendant under the contract been fulfilled. In the context of the law relating to health services delivery in particular, it has already been pointed out that it is very seldom that results of treatment are contractually guaranteed by those rendering it and the courts are unlikely to infer any kind of assurance of an outcome in a health services contract due to the unpredictability in many instances of health outcomes following treatment. The conflation of delictual and contractual

⁵² *Silver v Premier, Gauteng Provincial Government* fn 50 *supra*. On the subject of the *sine qua non* test the court observed at p 574-575 of the judgement that: "I am aware that the plaintiff's claim is founded in contract and, in the alternative, in delict. But I see no reason why the *sine qua non* test should not apply equally to the contractual claim in casu. The loss sustained by the plaintiff is said to have been caused by the breach of an implied term of an agreement that the hospital through its staff and employees would exercise due care, skill and diligence in providing nursing care. Precisely the same facts are relied upon as constituting a breach of the implied term as are relied upon as constituting a breach of the duty of care owed to the plaintiff. It would be anomalous if the same result did not follow irrespective of the cause of action. Furthermore, although the question of remoteness of damage for breach of contract is approached (in the absence of a contractual stipulation as to the basis on which compensation is to be made) by determining whether the damage flowed naturally and directly from the defendant's breach or is such a loss as the parties contemplated might occur as a result of such breach (*Victoria Falls & Transvaal Power Co Ltd v Consolidated Langlaagte Mines Ltd* 1915 AD 1 at 22 and 54), it must, in my view, follow as a matter of logic that as a general rule, the test for factual causation would first have to be satisfied. There will, of course, be exceptions, such as that cited by Visser and Potgieter in *Law of Damages* (1993) para 6.3.2 at 80-1: '(W)here a building contractor X is not able to build because Y, who has to deliver cement, and Z, who has to supply bricks, both fail to honour their contractual obligations on the same day and thus cause damage to X (eg he loses profit). According to the *conditio sine qua non* "test", neither Y nor Z has caused damage since, if the breach of contract of each is notionally eliminated, the damage does not fall away!' The learned authors express the view that common sense must be employed in such cases - an approach emphasised by Corbett JA in Siman's case at p 917 in fine-918A and employed by Lord Wright in *Yorkshire Dale Steamship Co Ltd v Minister of War Transport* [1942] AC 691 (HL) at 706 [1942] 2 All ER 6) and by Beadle CJ in *Portwood v Svanvur* 1970 (4) SA 8 (RA) at 15F-G."

principles in this context is thus logical and justifiable because it is the harm that is done to the patient in the 'delictual' sense, that grounds the claim in contract on the basis of a breach of an implied or express term to take reasonable care. Put another way, the law of contract tends to presuppose that the basis for the contract is an intended positive change in the circumstances of the contracting parties – an arrangement for their mutual benefit that contemplates an improvement in both their situations. To the extent that contracts for health care services do not tend towards such legally recognised presuppositions, the obligations of the parties to the contract are not squarely within the contractual paradigm but lean to some extent towards the delictual paradigm.

The spirit of contractual arrangements from the patient's perspective in the health services context could generally be summed up as: "If you won't say that you can cure me, at least promise to take due care not to harm me in the process of trying". This is a 'contractualisation' of the principles of the law of delict which is why it is entirely apposite to treat the two kinds of claims similarly. There is technically speaking no need to incorporate such a term in the contract except, possibly, for the purpose of mitigating the burden of proof for the patient which he or she would carry in terms of the law of delict. However, the balance of power between patient and provider is such that there is unlikely to be an express term in the contract between them which renders the provider strictly liable for any harm the patient may suffer as a result of the former's ministrations. Consequently the parties are most likely to contemplate an element of fault in their contract as being the reasonable 'trigger' for the liability of the provider. As far as implied terms are concerned, a court is unlikely to accept argument that an implied term of such a contract disposed of the requirement of fault on the part of the provider as a trigger for a claim by the patient. This is likely to be contrary to the norms of society in the majority of cases. Fault is a prominent feature of the law of delict which is why there is in

some respects no practical difference between the contractual and delictual claims in such a situation.

Lines of cause and effect are a preoccupation of the *sine qua non* test for causation⁵³. It is important to distinguish, however, between factual causation and legal causation. Even if the *conditio sine qua non* test is satisfied on the basis of the facts there is still the question of whether, legally speaking, the causal link should be recognised⁵⁴. The question of causation, viewed holistically, is therefore as much one of policy as it is one of fact⁵⁵. In *S v*

⁵³ The court quoted from an unreported case in discussing the applicability of the 'but for' test for causation as follows: "In conclusion, on the applicability of the 'but for' test for causation, I would refer to the following passage in the unreported judgment (which I feel obliged to say I gave but in which Labuschagne J concurred) in *Aalwyn J Bezuidenhout and Another v Willie J Jacobus Rossouw h/a Riviera Eiendomme* (WLD, case No A3010/97, delivered on 15 May 1997): 'Gewoonlik waar daar bepaal moet word of 'n sekere gevolg deur die optrede of versuim van een van die partye regtens veroorsaak is, moet daar gekyk word na 'n verskeidenheid van faktore wat 'n waardebeoordeling deur die Hof verg. Die vraag of die eerste bekendstelling van die eiendom die eintlike verkooptransaksie veroorsaak het, is geen uitsondering nie. In *Aida Real Estate Ltd v Lipschitz* 1971 (3) SA 871 (W) te 873H-874D het Marais R die volgende gesê: "The law with regard to a matter of this kind is usually stated in the following form: The duty of the estate agent, if he is to earn remuneration by way of commission for selling property, is to introduce to his principal (the seller) a purchaser who is willing and financially able to buy the property, and he earns the commission if a sale is concluded with that purchaser at the stipulated price or a price ultimately proved to have been acceptable to the seller. A proviso has been added to the effect that the introduction of the able and willing buyer must have been the effective cause or *causa causans* of the sale. If a new factor intervenes causing or contributing to the conclusion of the sale and the new factor is not of the making of the agent, the final decision depends on the result of a further enquiry - viz, did the new factor outweigh the effect of the introduction by being more than or equally conducive to the bringing about of the sale as the introduction was, or was the introduction still overridingly operative? Only in the latter instance is commission said to have been earned. This enquiry is not a metaphysical speculation in the result of cause and effect. It requires, as is said in *Webranchek v L K Jacobs and Co Ltd* 1948 (4) SA 671 (A), a commonsense approach to the question of what really caused the sale to be concluded, or, to put it differently, as it is said in a restatement of the law in America, whether it is 'just' that the agent should receive credit and compensation for the work he has done for the seller. In regard to this latter version, it may be said in passing that this question has nothing to do with the amount of work the agent put into it. The mere furnishing to the prospective buyer of the principal's address or the location of the property offered may be sufficient to entitle him to claim commission from the seller, provided a line of cause and effect can reasonably be traced from the introduction to the conclusion of the sale." Die woorde wat ek gekursiveer het, is belangrik. Dit moet nooit uit die oog verloor word nie dat voordat die gewone vraag (soos in *Aida Real Estate v Lipschitz* (*supra*) uiteengesit) ontstaan, daar hier - soos in enige ander situasie waar oorsaaklikheid bepaal moet word - eers aan die *sine qua non* (ofte wel "but for") toets voldoen moet word. Met ander woorde, as daar nie gesê kan word dat, was dit nie vir die agent se optrede nie, die gevolg (verkoop van die eiendom) nie sou ingetree het nie, kan die optrede van die agent nooit as oorsaak van die verkooptransaksie bestempel word nie. Andersom gestel, as die verkooptransaksie sou plaasgevind het afgesien van enigiets wat die agent gedoen het, is die agent nie (ingevolge die gewone kontrak tussen 'n agent en die eienaar) op kommissie geregtig nie.'

⁵⁴ Thus in *Standard Chartered Bank of Canada v Nedperm Bank Ltd* 1994 (4) SA 747 (A) the court stated: "My conclusion is that the untrue report issued by Nedbank was a factual cause of Stanchart's loss. In other words, it was a *conditio sine qua non* of such loss. That, however, does not conclude the enquiry. It is still necessary to determine legal causation, i.e. whether the furnishing of the untrue report was linked sufficiently closely or directly to the loss for legal liability to ensue, or whether the loss is too remote. The principles applied in such an inquiry have recently been expounded by this Court in the cases of *S v Mokgethi en Andere* 1990 (1) SA 32 (A) at 39D-41B; *International Shipping Co (Pty) Ltd v Bentley* (*supra* at 700E-701G); and *Smit v Abrahams*, as yet unreported, dated 16 May 1994, at pp 22-5, 32-3, 36-7, 39-40 of the typescript. As appears from these judgments, the test to be applied is a flexible one in which factors such as reasonable foreseeability, directness, the absence or presence of a *novus actus interveniens*, legal policy, reasonability, fairness and justice all play their part."

⁵⁵ In *Smit v Abrahams* 1994 (4) SA 1 (A) the court held that there can be no doubt that in South African law the *ratio* of *Owners of Dredger Liesbosch v Owners of Steamship Edison; The Edison* [1933] AC 449 (HL) ([1933]



*Williams*⁵⁶ the court was faced with a situation in which a person was wounded so seriously that the injuries, in the absence of prompt medical intervention, would very soon lead to death. The victim of the crime was kept alive artificially by means of a respirator. She was subsequently taken off the respirator once it had been established that her brainstem was no longer functioning. Her heart and lungs ceased functioning some ten minutes after the ventilator was disconnected. The appellant was sentenced to death for her murder. He appealed on the grounds that the real cause of the victim's death was the disconnection of the respirator. In other words a *novus actus interveniens* had occurred to cause her death. The court held that it was not necessary to decide the case on the basis of whether the medical definition of death as being brainstem death must be accepted in law since it was possible to deal with the matter on the more traditional view of the community that death occurred when there was no longer a heartbeat or respiration. It held that the appellant's allegation of a *novus actus interveniens* was unreasonable and unacceptable in that he had given the deceased a wound which, had she not received medical assistance, would have lead rapidly to her death. Medical practitioners had done their best to save her. In the process her life was artificially maintained. When the ventilator was finally disconnected this action

All ER Rep 144), i.e. that damages consisting of expenses incurred as a result of the plaintiff's impecuniosity, has no right of existence. The rigidity of the rule is inconsistent with the flexible approach followed in South African law, as explained in *S v Mokgethi en Andere* 1990 (1) SA 32 (A) at 39J-41B, in particular the flexible criterion whereby the Court considers on the basis of policy considerations whether there is a sufficiently close connection between act and consequence (at 40I-I). There is no room for the employment of the *ratio* of *The Edison* in a system where legal causality is determined by asking the question whether there is a sufficiently close connection between act and consequence, and that question has to be answered on the basis of policy considerations and the limits of reasonableness, fairness and justice. The impecuniosity of the plaintiff as a joint cause of the damage is merely one of the facts which, together with all the other facts of each particular case, has to be taken into consideration in the application of the predominating flexible criterion (the 'oorheersende elastiese maatstaf') (Mokgethi's case at 40D) in terms of which the Court determines whether the defendant should be held liable for the damages in question. (At 14E-F, 15E-G.) The court took the view that the importance and efficacy of the predominating criterion in resolving questions of legal causality lies in its flexibility. Any attempt to detract from its flexibility should be resisted. Comparisons between the facts of the case which has to be resolved and the facts of other cases in which a solution has already been found, or which might hypothetically arise, can obviously be useful and of value, and sometimes even decisive, but one should be careful not to attempt to distil fixed or generally applicable rules or principles from the process of comparison. The argument that the plaintiff's claim should 'in principle' be rejected is misplaced. There is only one principle: in order to determine whether the plaintiff's damages are too remote from the defendant's act to hold the defendant liable therefor, considerations of policy, reasonableness, fairness and justice should be applied to the particular facts of the case. (at p 18E-H). (From headnote)

56

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

was not the cause of her death but rather the termination of a fruitless attempt to save her life.⁵⁷

Medical treatment does not necessarily have the effect of breaking the line of causation between the original injury and the death of a person. Even from the point of view of factual causation the withdrawal of medical treatment from a person who has suffered mortal injury cannot be said to constitute a new intervening cause of the ultimate result. From the point of view of legal causation the argument of a *novus actus interveniens* in these circumstances is clearly wrong since it would be contrary to the legal convictions of the community and the values of the Constitution to allow a wrongdoer to escape the consequences of such a heinous crime on the basis that medical practitioners tried to save the victim's life but failed. The argument of a *novus actus interveniens* in the context of medical treatment could only succeed if there was convincing evidence that the medical treatment itself precipitated the person's death and that the initial injury would not have had the same result.

With specific regard to the health care context, it has been observed that the general causation requirement in toxic torts encourages both corporate self-deception and disregard for the public interest. It encourages industry not to investigate harm resulting from its product. By predicating liability on the plaintiff's proof of causation, the tort system builds in disincentives for corporations to know and disclose information about harm. Legal scholar Margaret Berger argues that it is time to create a new toxic tort that would condition culpability on the 'failure to develop and disseminate significant

⁵⁷ The court in *Williams* (fn 56 *supra*) referred to the observations of the English court in the case of *R v Malcherek; R v Steel* [1981] 2 All ER 422 in which Lord Lane stated as follows: "There is no evidence in the present case here that at the time of conventional death, after the life support machinery was disconnected, the original wound or injury was other than a continuing, operating and indeed substantial cause of the death of the victim, although it need hardly be added that it need not be substantial to render the assailant guilty..." and "Where a medical practitioner adopting methods which are generally accepted comes *bona fide* and conscientiously to the conclusion that the patient is for practical purposes dead, and that such vital functions as exist (for example, circulation) are being maintained solely by mechanical means, and therefore discontinues treatment, that does not prevent the person who inflicted the initial injury from being responsible for the victim's death. Putting it in another way, the discontinuance of treatment in those circumstances does not break the chain of causation between the initial injury and the death."



data'⁵⁸. She says that agent orange, asbestos, the Dalkon Shield, thalidomide and tobacco are all instances where companies failed to test their products initially, failed to report problems as they emerged and failed to do research to investigate those problems. A system that encourages a 'don't ask, don't tell' policy decouples liability from moral responsibility and thus threatens the basic underpinning of corrective justice. It has been observed that some might argue that current regulations which require premarket testing for drugs and chemicals deemed to be potential hazards are sufficient. However, the regulations have loopholes that the tort system, in placing the burden of proof on the plaintiff, fails to close.

7.2.3 Wrongfulness (Unlawfulness)

Wrongfulness is a question of public policy as informed by the values and principles of the Constitution.⁵⁹ It is remarkable that both the Cape High Court and the Supreme Court of Appeal had to be reminded of this fact by the Constitutional Court in a judgment handed down in 2001⁶⁰ despite the fact that in other judgments, in some cases in the same division of the High Court, the courts were taking express cognizance of this central legal principle.⁶¹

⁵⁸ She is quoted by Raffensberger C in 'Toxic Tort System Fails the Basic Test' *Science for Lawyers The Environmental Forum*, May 2002 www.sehn.org/pdf/may-june_02.pdf

⁵⁹ In *Van Duivenboden v Minister of Safety and Security* [2001] 4 B All SA 127 (C), Davis J stated at 132d: "(I)t would appear that the requirement of wrongfulness demands of the court that it determine whether society requires that the law classify the type of conduct concerned as impermissible, that is conduct of which a society disapproves. See Van Aswegen at 192 and Neethling, Potgieter and Visser *The Law of Delict* (1999) at 39 - 41. In turn the determination of "impermissibility" shaped by a society's vision of itself is contained within its legal system. In terms of the ultimate law in this country, the Constitution, South African society is predicated upon foundational values of human dignity, liberty and equality. The newly established constitutional community is to be built upon those "common values and norms" and the added principle that public authority must be transparent and accountable to the public it serves."

⁶⁰ *Carmichele v Minister of Safety and Security and Another (Centre for Applied Legal Studies Intervening)* fn 15 *supra*.

⁶¹ See *Faircape Property Developers (Pty) Ltd v Premier, Western Cape* 2000 (2) SA 54 (C) where Davis J stated: "In my view, the determination of the legal convictions of the community on which the test for wrongfulness is based must take account of the spirit, purport and object of the Constitution. As Prof Mureinik wrote, the new Constitution 'must lead to a culture of justification' - a culture in which every exercise of power is expected to be justified' ((1994) 10 *SAJHR* 31 at 32). This principle of justification includes the concept of accountability, namely that a public authority is accountable to the public it serves when it acts negligently and without due care. Accountability includes the recognition of legal responsibility for the consequences of such action."



The case of *Carmichele v Minister Of Safety And Security And Another*⁶² is a classic example of the importance of the role of the Constitution in the decisions of the courts and of the need to take into account the values and principles contained in the Constitution when considering matters that were previously solely the domain of the common law. In an earlier judgment granting absolution, the Cape High Court held that the pleaded omissions, on which the plaintiff relied, were not wrongful in that the defendants did not owe the plaintiff a legal duty to take positive steps to prevent the harm occasioned to the plaintiff. The court's finding was based on the application of the common-law position as expounded in the decisions of the then Appellate Division in *Minister van Polisie v Ewels*⁶³; *Minister of Law and Order v Kadir*⁶⁴; *Knop v Johannesburg City Council*⁶⁵. The matter then went to the Supreme Court of Appeal and from there to the Constitutional Court.

On appeal, the Constitutional Court (*Carmichele v Minister of Safety and Security and Another (Centre for Applied Legal Studies Intervening)*)⁶⁶ referred to the aforementioned common-law test, and, with particular reference to the dictum of Hefer JA (in *Minister of Law and Order v Kadir*), concluded that in the exercise of determining whether a legal duty exists, the weighing and striking of a balance between the interests of the parties and the conflicting interests of the community amount to “a proportionality exercise with liability dependant upon the interplay of various factors”. It held further that “proportionality is consistent with the Bill of Rights, but that exercise must now be carried out in accordance with the “spirit, purport and objects of the Bill of Rights” and the relevant factors must be weighed in the context of a constitutional state founded on dignity, equality and freedom and in which government has positive duties to promote and uphold such values”.

⁶² *Carmichele* fn 49 *supra*

⁶³ *Ewels* 1975 (3) SA 590 (A)

⁶⁴ *Kadir* 1995 (1) SA 303 (A)

⁶⁵ *Knop* 1995 (2) SA 1 (A)

⁶⁶ *Carmichele* fn 15 *supra*

In upholding the appeal, the Constitutional Court refrained from itself deciding whether the law of delict should be developed on the basis contended for on behalf of the plaintiff. What it did hold was that where the common law deviates from the spirit, purport and objects of the Bill of Rights, the courts have an obligation to develop it by removing that deviation. It furthermore held that under the Constitution, courts are obliged to develop the common law under section 39(2) of the Constitution and that both the Cape High Court and the Supreme Court of Appeal assumed that the pre-constitutional test for determining the wrongfulness of omissions in delictual actions of this kind should be applied and in so doing “overlooked the demands of s 39(2)” of the Constitution. The Cape High Court in its reconsideration of the matter admitted that in handing down its initial judgment it did not have regard to the provisions of section 39(2). It noted that counsel for the applicant submitted that in the light of this constitutional duty imposed on the state, and in particular the duty on the State to protect women against violent crime in general, it is necessary to revisit the conventional test for wrongfulness to determine whether the state owed the plaintiff a legal duty to protect her against attacks of the sort perpetrated against her by the rapist: Reasonableness, on which the legal convictions of the community are based, is now to be found in the Constitution and not in some vague notion of public sentiment or opinion. In agreeing with him, Chetty J referred to the words of Davis J in *van Duivenboden* to the effect that the requirement of wrongfulness demands of the court that it determine whether society requires that the law classify the type of conduct concerned as impermissible, that is conduct of which a society disapproves and that in terms of the ultimate law in South Africa, the Constitution, South African society is predicated upon foundational values of human dignity, liberty and equality⁶⁷. Leinius and Midgely⁶⁸ note that the criterion for assessing wrongfulness or unlawfulness is said to be one of objective reasonableness, requiring careful

⁶⁷ *Van Duivenboden* fn 59 *supra*

⁶⁸ Leinius and Midgely fn 16 *supra*



balancing, amongst others, of the parties' interests and the circumstances of the particular case. Public policy plays an important role: courts are required to render value judgments as to what society's notions of justice demand and such judgments should reflect the community's perception of justice, equity, good faith and reasonableness⁶⁹. They note further that the constitutional court suggested in *Carmichele*⁷⁰ that in applying section 39(2), concepts such as 'policy decisions and value judgments' might have to be replaced, supplemented or enriched by constitutional norms (paragraph 56). Noting that they agree with this view, they observe that the Constitution sets out criteria for determining society's notions of justice and equity and articulates values and norms which must underpin society's rules and their application. They state that if the common law does not reflect these notions and values, some development will be necessary to ensure that it does so from now on. Leinius and Midgley caution, however, that the view of the constitutional court that development should take place within the common law's paradigm should be heeded so that whilst the Bill of Rights is now an important factor in assessing wrongfulness, it is not the exclusive embodiment of public policy in delictual matters. They point out that the *boni mores*, the legal convictions of the community, reflect wider concerns and encompass additional policy considerations – particular factors relevant to omissions, or pure economic loss (for example indeterminate liability), being some of them⁷¹. It is submitted that whilst Leinius and Midgely

⁶⁹ Leinius and Midgley, fn 16 *supra* at p 19. They cite *Minister of Law and Order v Kadir* 1995(1) SA 303 (A) at 318F-G; J C van der Walt & R Midgley *Delict: Principles and Cases vol 1 'Principles'* 2ed (1997) para 56; J Neethling, JM Potgieter & PJ Visser *Law of Delict* 3 ed (1999) at p 38 and p 43.

⁷⁰ *Carmichele* fn 15 *supra*

⁷¹ Leinius and Midgley, fn 16 *supra*, note that according to the constitutional court, it remains unclear as to how constitutional obligations on the state translate into private-law duties towards individuals. On the one hand it might be easier, they say, to accentuate the objective nature of unlawfulness and 'to cast the net of unlawfulness wider because constitutional obligations are now placed on the state to respect protect promote and fulfil the rights in the Bill of Rights and, in particular, the right of women to have their safety and security protected.' On the other hand the elements of fault and remoteness (legal causation) might play a greater role. They do acknowledge that in some instances constitutional values might point to more restricted liability. In their view, while there are instances where constitutional imperatives must be taken into account in assessing fault or legal causation, the wrongfulness criterion is the correct locus for enquiring whether constitutional obligations have delictual equivalents. They note that an infringement of a fundamental right or breach of a constitutional duty will not necessarily entitle one to sue in delict. To do so, fundamental rights and obligations which flow therefrom must establish a subjective right or a corresponding legal duty, or at least fit into one of the established categories. The duty upon the state to ensure that one can freely exercise the right to vote, they say, is an example of a constitutional duty which does not have a delictual equivalent, whereas the right to dignity clearly has. They state that at another level, the more common one, the Constitution will have an 'indirect radiating effect' on existing concepts, as suggested in *Du Plessis v De Klerk* 1996 (3) SA 850 (CC) at paragraph



may be correct in saying that constitutional values and principles are a subset of those to be found at common law, where the latter are inconsistent with the former, section 2 of the Constitution is relevant and applicable and the latter must be discarded. In this sense therefore, only to the extent that common law policy considerations can be regarded as logically and legally consistent extensions of the constitutional values and principles, can they legitimately be applied in deciding claims in the law of delict. It is further submitted that lawyers should guard against being overly legalistic, in the sense of looking at the letter of the Constitution, rather than its spirit, when engaging in legal analysis of public policy principles since policy in itself is not a legal concept that fits easily into moulds of black and white or this and that. Policy is polycentric. Values are relative. The focus in policy consideration is not so much upon the words which express it as the spirit behind it. For this reason, legal thinking from a previous era which tends to focus more or less exclusively on an analytical, almost scientific, approach to legal interpretation and argument is likely to sit uncomfortably in policy debates, constitutional or otherwise.

In *Dersley v Minister Van Veiligheid En Sekuriteit*⁷² the court held that the test for wrongfulness required that a judicial value judgment had to be pronounced upon whether or not the infringement of the particular interest of the plaintiff was, in the circumstances, in accordance with the *boni mores* (i.e. the legal

110 but that it seems to them that in these instances courts are not concerned with establishing principles or legal norms which apply across the board to all similar instances. Rather, as the Supreme Court of Appeal pointed out in *Cape Town Municipality v Bakkerud* 2000 (3) SA 1049 (SCA) paragraph 27 "In applying the test of what the legal convictions of the community demand and reaching a particular conclusion the courts... are making value judgments *ad hoc*". They note that in the *Bakkerud* case it was noted that the imposition of a duty on one municipality to repair pavements would not lead to a blanket duty on all municipalities to do so and in the context of *Carmichele* (fn 15 *supra*) the imposition of a duty on either the police or the prosecutor would not create a legal principle that liability would exist in all similar cases. Each case depends on its own facts. Thus when the Constitution is used in this way – to permeate and enrich the common law, Leinius and Midgely, argue that it is not the common law rule that is tested but the result of its application in the circumstances of the case. A court's conclusion as to whether or not a legal duty exists in the circumstances must be compatible with the constitutional norms and values. They state that in both instances thus far the enquiry focuses on whether or not the defendant's *conduct* adhered to constitutional standards. According to Leinius and Midgely, a third way in which the Constitution could be used is in determining whether or not the *law* applicable to the parties is constitutional. They note that in *Carmichele* the constitutional court did exactly that when it noted that the issue of wrongfulness involves 'weighing and the striking of a balance between the interests of the parties and the conflicting interests of the community' and commented that such a proportionality exercise is consistent with the Bill of Rights. In saying so, they maintain that the court in fact declared the standard test for determining wrongfulness to be constitutional.

72

Dersley 2001 (1) SA 1047 (T)

convictions of the community). If so, there was a legal duty upon a defendant to protect the rights of the plaintiff, which he could not neglect. If not, there was no such legal duty upon a defendant. It stated that the *boni mores* standard consisted of the legal convictions of the community and was not necessarily an ethical, social or contemporary moral standard. Rather it was directed at weighing, in the light of the particular circumstances, the reasonableness or otherwise of the defendant's conduct against the infringement of the plaintiff's interests. If reasonableness lay on the side of the defendant, he was not burdened by any legal duty. If, on the other hand, reasonableness lay on the side of the plaintiff, the defendant was indeed subject to a legal duty⁷³.

73

At 10541/J - 1055E/F. Scott J in 'Deliktuele Aanspreeklikheid Vir Veroorsaking Van Suiwer Ekonomiese Verlies: Die Deur Word Wier Oopgemaak' 2001 *Tydskrif vir Hedendaagse Romeins-Hollandse Reg* 64 p681-689 critically examines the judgment in *Dersley*. He says that van Dyk J did not once in this case expressly refer to the fact that he was dealing with the question of delictual liability for pure economic loss. Van Dyk J, he says, found the core of the problem that stared him in the face in the process of the application of the relevant legal principles to the facts before him in the legal rules of delict applicable to omissions as a manifestation of human behaviour. Accordingly he devoted his attention exclusively to capturing the modern South African dispensation concerning the test for unlawfulness in the case of an omission. He observes with regard to the aspect of unlawfulness as dealt with in this case that Van Dyk J attached great value to the contribution of J C van der Walt who points to the basis of unlawfulness as being located in either a violation of the claimant's subjective right or the non-compliance with a legal duty owed to the claimant. He notes that these sentiments have been shared since the sixties through the writings of academic heavyweights such as WA Joubert and NJ van der Merwe and further notes that the acceptance of van der Walt's opinion regarding the more sophisticated present day nature of the *boni mores* test does not exactly indicate something which would be regarded in academic circles as revolutionary. In fact, says Scott, it should rather be disturbing for academics working in the field of delict that concepts such as those expressed by Van der Walt are accepted as noteworthy by the bench. Van Dyk J came to the conclusion that: "Dit het my getref dat die basiese toets verander het en dat dit vandag daarin geleë is dat 'n judisiële waarde-oordeel uitgespreek moet word of die eiser se betrokke aangetaste belang in die omstandighede en tipe situasie wat voor die hof op die feite sou dien, ooreenkomstig die *boni mores* (dit will sê, die regsopvatting van die gemeenskap) beskermingswaardig is al dan nie; en indien wel, is darr inderdaad 'n regsplig op sodanige persoon wat hy nie mag nalaat nie. Andersins is daar geen regsplig op 'n verweerder om die regte van die eiser te beskerm nie." Scott states that the court's conclusion unfortunately paints a skewed picture of the *boni mores* test. Firstly, he says, it is clear that van Dyk J was setting out the application of the test for unlawfulness in the adjudication of an omission as the cause of pure economic loss while he gave the impression that he was defining the test for unlawfulness in general. Unlawfulness as the violation of a legal duty, the existence and scope of which is determined by the *boni mores*, is the model of choice for the adjudication of omissions. Secondly, says Scott, it should be noted that it is simplistic to hint that the *boni mores* are only relevant in the determination of the worthiness of protection, or not, of an interest. It is obvious that a legally protected interest may in other circumstances be violated, such as in the case of justification. Scott says that van Dyk J's formulation does not allow the function of the *boni mores* to be fulfilled in the process of the demarcation of the scope of the legally protected interest. He observes that there is a great difference between a case such as that of *Dersley* and that of *Ewels* which revolved around the fact that policemen had failed to intervene in the plaintiff's cause. In *Dersley* the employee of the defendant had gone out of his way to be helpful to the plaintiff. He engaged in positive action which led to harm to the plaintiff. The mere fact that this conduct was a failure to fulfil his role as a police official in conflict with specific and general legislation ought not to magically transform his act into an omission says Scott. He refers to Van der Walt and Midgley *Delict: Principles and Cases* who issue a warning with regard to this type of situation in the following words: "The failure (omission) to stop at a stop street indicates negligent or deficient positive conduct – *culpa in faciendo*. The mere fact that linguistic alternatives enable us to describe the positive occurrence in a negative way (for example, 'the driver failed or omitted to stop at the stop street') is legally irrelevant in the determination of the nature of the conduct."



In *Aucamp And Others v University Of Stellenbosch*⁷⁴ it was held that in considering whether or not the conduct in question is wrongful, the Court is required to make a value judgment. In doing so it must weigh up the interests of the parties and of the community at large against the background of the relevant facts and circumstances. In addition, it must strive, impartially and objectively, to apply the values of justice, fairness and reasonableness, while taking into account considerations of good faith (*bona fides*) and good morals (*boni mores*), otherwise known as public policy reflecting the legal convictions of the community⁷⁵. The court in this case set out the factors that should be taken into account in considerations of wrongfulness, i.e. whether the defendant was able to avoid reasonably foreseeable harm by taking reasonable steps to do so, as follows:

- (a) whether the defendant had known or had subjectively foreseen that his or her negligent conduct would cause harm to the plaintiff;
- (b) whether the defendant could have taken reasonably practical steps to prevent such harm;
- (c) whether the defendant possessed or had professed to possess special skill, competence or knowledge;
- (d) whether special protection against economic loss had been required;
- (e) whether a finding in favour of the plaintiff would lead to a multiplicity of actions or indeterminate liability which would have severe social consequences;
- (f) whether a statutory provision required the prevention of economic loss;
- (g) whether the plaintiff had been able to protect him- or herself against potential economic loss; and
- (h) whether the defendant had been able to protect him- or herself against such loss, for example by arranging adequate insurance cover⁷⁶.

⁷⁴ *Aucamp* 2002 (4) SA 544 (C)

⁷⁵ *Aucamp* fn 74 *supra* paragraph [68] at 5671 - 568B/C.

⁷⁶ *Aucamp* fn 75 *supra* paragraph [69] at 568F - I/J.

The court stressed, however, that there was no *numerus clausus* of such factors. It stated that in the case of negligent misrepresentation, wrongfulness is determined by establishing whether or not the defendant had breached a legal duty to furnish correct information to the person entitled to such information. Similar principles to those applicable with regard to wrongfulness in a general delictual context apply, as do similar guidelines as to whether or not the defendant had a legal duty in a particular case. It listed the factors to be taken into consideration in considering a claim for negligent misrepresentation as follows:

- (a) whether the parties had a contractual or fiduciary relationship requiring that correct information concerning any matter arising from such relationship be supplied
- (b) whether the defendant had certain exclusive information which was not readily accessible to the plaintiff or other parties;
- (c) whether the defendant had furnished information by virtue of his or her professional knowledge and competence;
- (d) whether the defendant had been aware, or ought by the exercise of reasonable care to have been aware, of the existence and identity of persons who would rely on his or her negligent misrepresentation; and
- (e) whether the defendant had been aware, or ought by the exercise of reasonable care to have been aware, of the existence and identity of persons who would suffer damage should the misrepresentation not be corrected, and would benefit should it be corrected⁷⁷.

In *Geldenhuis v Minister Of Safety And Security And Another*⁷⁸ Davis J referred to an article by Francois du Bois⁷⁹ which sets out four themes that are illustrative of the key considerations taken into account by courts in investigating wrongfulness. Davis J notes that briefly stated, these themes can be set out thus:

⁷⁷ *Aucamp* fn 74 *supra* at paragraph [70] at 568J - 569E

⁷⁸ *Geldenhuis* 2002 (4) SA 719 (C)

⁷⁹ Du Bois F "Getting wrongfulness right: A Ciceronian attempt" 2000 *Acta Juridica* 1 at p 33ff

1. Courts are reluctant to impose delictual liability in cases where the enforcement of a duty in delict may disrupt a contractual allocation of rights and duties.
2. A finding of wrongfulness may be excluded where the law of delict lacks jurisdiction because the event complained of is of such a nature that the legal determination of the defendant's duty to the plaintiff, being the application of the element of fault, cannot be expected to reflect that person's obligations correctly. Of particular relevance to this issue is the recognition by the law of a sphere of decision-making autonomy, which makes the context of the dispute unsuitable for a judicial determination.
3. The extension of wrongfulness will not be easily undertaken where the rights and duties that are at issue have economic and the market provides a mechanism for distributing these in circumstances that could function as an alternative to adjudication.
4. The consideration that an extension of wrongfulness would open the "floodgates" of litigation; a point made by Toon van den Heever as follows: "If every individual were liable for failure to protect others against loss, each would be compelled in order to avoid liability, to run around and busy himself with the affairs of his neighbours, to the neglect of his own, which would lead to chaos." (*Aquilian Damages in South African Law* (1944) at 37.)

Questions of wrongfulness in the context of health care can become particularly complicated. Reference has already been made to the thalidomide disaster in the 1960s and the fact that the drug was withdrawn from the market. In 1987 the Hansen's Disease Centre contracted with the manufacturer of the drug to manufacture clinical grade thalidomide for the treatment of erythema nodosum leprosum. Over 50 kilograms of 99.5%-plus pure drug was delivered and used. Thalidomide clinical trial planning commenced in 1989 with the submission of the drug master file, inspection by FDA and planned orphan drug designation



submissions. The first pilot clinical trial against Crohn's disease was begun in 1991. In 1992, working with the Division of AIDS of the National Institute of Allergy and Infectious Diseases and an AIDS Clinical Trials Group principal investigator, planning began for a trial against recurrent aphthous ulcers in HIV-positive patients, a previously untreatable and incurable condition that severely degraded the quality of life. Study interim analysis in October of 1995 showed that 61 percent of treated patients had complete healing of all their ulcers versus the 5 percent of placebo patients and 91 percent of treated patients had partial or complete healing of all of their ulcers as compared to 18% of placebo patients. From 1993 to 1997 pilot trials were started against three AIDS-related conditions – Kaposi's sarcoma, prurigo nodularis, a severe dermatological condition and immuno deficiency in AIDS patients. The drug clearly has benefits in the treatment of otherwise untreatable conditions. The problem is how to maximise the availability of thalidomide to patients for whom nothing else works while inhibiting its routine availability so as to ensure a pregnant woman can protect her foetus. Thalidomide must therefore be safe and effective not only in the regulatory sense, but safe and effective for everyday use. It was noted in 1997 that the political pendulum in the US was swinging from a paradigm of government as protector and as agent of its citizens to one of less regulation and more consumer and independent citizen decision making. The point was made that if there are fewer government resources to provide comprehensive knowledge and regulatory balancing of risk and reward as they pertain to thalidomide, the patient's ability to make a fully informed and objective use decision can only be adversely affected. When cost-effectiveness constraints and time constraint pressures on providers are added, risk to the patient can only increase further. The result of all this increases the chance of accidents and therefore the threat of litigation. Such a series of events would be nothing short of catastrophic, not only to the victim, but to all others then benefiting from thalidomide and all who might benefit from it. Investment and development initiatives would be chilled or halted, probably irrevocably.⁸⁰

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Andrulic Corporation "Thalidomide: Potential Benefits and Risks" transcript Open Public Scientific Workshop

Wrongfulness in the health care context can be a question of balancing the interests of various groupings in society. It can be a question of calculated risks. The question is who takes these decisions and on what basis? These are important questions because if the risk is demonstrably worth it, and the courts sanction those who take it on the basis of a single case that goes wrong, what are the consequences for the many who benefit from the risk? The courts do not necessarily have the means to make policy decisions at these levels. The logical tools at their disposal do not necessarily allow for consideration of all of the public interest issues. Cases that are argued before them are most likely to be about the interests of individuals and not the interests of society as a whole.

The South African Law Commission has observed that professionals traditionally operate in spheres in which success is not always feasible and that even where important factors are within the professional's control, he cannot always guarantee success.⁸¹ The Commission notes that the courts face a particular difficulty in establishing a rational approach to professional liability. On the one hand provision has to be made for adequate protection of the consumer, client or patient and on the other hand human fallibility has to be taken into account. The Commission noted that South African medical practitioners have traditionally received "soft treatment" from the courts and that there have been several cases in which medical practitioners have been held liable for malpractices but in the majority of cases they have been absolved of blame. It also noted that an interesting phenomenon in the USA is that the greatest increase in litigation is experienced in those fields of medicine where the most progress has been made with the development of methods of treatment. The development of sophisticated technology has apparently created higher expectations among patients.

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⁸¹ Working Paper 51 'Limitation of Professional Liability' Project 70 1989

7.2.4 Fault

Negligence (*culpa*) is the most commonly encountered form of fault in the context of health service delivery. Although intention (*dolus*) is another recognized form of fault, it tends to play a more significant role in the criminal law than in the law of delict. For this reason, the discussion that follows will focus on fault in the form of negligence. The test for negligence in the South African law of delict has for a long time been accepted as the one enunciated by Holmes JA in *Kruger v Coetzee*⁸²: “For the purposes of liability *culpa* arises if -

- (a) a *diligens paterfamilias* in the position of the defendant -
 - (i) would foresee the reasonable possibility of his conduct injuring another in his person or property and causing him patrimonial loss; and
 - (ii) would take reasonable steps to guard against such occurrence; and
- (b) the defendant failed to take such steps.”⁸³

In *Mukheiber v Raath and Another*⁸⁴ the Supreme Court of Appeal apparently seems to have favoured the relative theory of negligence posed by Boberg⁸⁵ and stated as follows:

“For the purposes of liability *culpa* arises if -

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

⁸² *Kruger* 1966 (2) SA 428 (A) at p 430E - F.

⁸³ Holmes J states in *Kruger*, fn 82 *supra*, that: “This has been constantly stated for the last 50 years. Requirement (a)(ii) is sometimes overlooked. Whether a *diligens paterfamilias* in the position of the person concerned would take any guarding steps at all and, if so, what steps would be reasonable, must always depend on the particular circumstances of each case. No hard and fast rules can be laid down. Neethling J and Potgieter JM in ‘Die Toets vir Nalatigheid Onder Die Soeklig: *Sea Harvest Corporation (Pty) Ltd v Duncan Dock Cold Storage (Pty) Ltd* 2000 (1) SA 827 (SCA); *Mkatshwa v Minister of Defence* 2000 (1) SA 1004 (SCA)’ note that in *Mukheiber v Raath* 1999 (3) SA 1065 (SCA) 1077 Olivier JA chose to follow Boberg’s reformulation of the test. They criticise this departure from precedent as being without explanation and as supportive of the legal impossibility that even a completely lawful act could be construed as negligent. They say that these decisions create a climate of uncertainty and are thus regrettable. See further the discussion under *Mukheiber v Raath* in chapter nine of this thesis

⁸⁴ *Mukheiber* fn 83 *supra*

⁸⁵ Boberg PQR, *The Law of Delict : Aquilian Liability*. Vol I at p 390

- (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.”

Scott JA comments in his judgement in *Sea Harvest Corporation (Pty) Ltd And Another v Duncan Dock Cold Storage (Pty) Ltd And Another*⁸⁶ that, broadly speaking, the former involves a narrower test for foreseeability, relating it to the consequences which the conduct in question produces, and serves in effect to conflate the test for negligence and what has been called “legal causation” (cf *Siman & Co (Pty) Ltd v Barclays National Bank Ltd*⁸⁷ so as, it is contended, to eliminate the problems associated with remoteness.

Scott JA does not read the judgment in *Mukheiber* to have unequivocally embraced the relative theory of negligence. He points out that elsewhere in the judgment and when dealing with the issue of causation the court appears to have applied the test of “legal causation” which the strict application of the relative theory would have rendered unnecessary. He then goes on to state that, having said this, it should not be overlooked that in the ultimate analysis the true criterion for determining negligence is whether in the particular circumstances the conduct complained of falls short of the standard of the reasonable person⁸⁸.

In *Mkhatswa v Minister of Defence*⁸⁹ the court emphasised that what is required to satisfy any test for negligence is foresight of the reasonable possibility of harm. Foresight of a mere possibility of harm will not suffice. The Supreme Court of Appeal in this case refused to follow the judgement in *Mukheiber* on

⁸⁶ *Sea Harvest* 2000 (1) SA 827 (SCA)

⁸⁷ *Siman* fn 39 *supra* at p 914F - H

⁸⁸ *Sea Harvest Corporation (Pty) Ltd And Another v Duncan Dock Cold Storage (Pty) Ltd And Another* fn 86 *supra* at p 839

⁸⁹ *Mkatskwa v Minister of Defence* 2000 (1) SA 1104 (SCA)

the ground that it “might give rise to some uncertainty as to what was sought to be conveyed”⁹⁰.

In *Van Duivenboden*⁹¹ the court observed that negligence is not inherently unlawful. It is unlawful, and thus actionable, only if it occurs in circumstances that the law recognises as making it unlawful. Unlike the case of a positive act causing physical harm, which is presumed to be unlawful, a negligent omission is unlawful only if it occurs in circumstances that the law regards as sufficient to give rise to a legal duty to avoid negligently causing harm. The value of synthesis as opposed to analysis is clear from this statement. Although it is useful to identify the various elements of a delict in order to contemplate them in greater detail, there is a danger in considering them in isolation since they must be considered in a systemic context in terms of which each has a bearing on or relationship to the other. In the same vein, where a legal duty is recognised by the law, an omission will attract liability only if the omission was also culpable according to the test of whether a reasonable person in the position of the defendant would not only have foreseen the harm but would also have then acted to avert it⁹². The academic debate that was provoked by *Mukheiber v Raath* is canvassed in more detail in the discussion of that case below.

7.2.5 Loss

As stated previously, loss in the law of delict is calculated differently to loss in the law of contract. Under the law of contract the loss is calculated with regard to the position in which the plaintiff would have been but for the breach of contract. Generally speaking this position is a positive improvement on the position of the plaintiff prior to the contract. In terms of the law of delict, loss is calculated with regard to the position that the wronged party would have been in

⁹⁰ *Mukheiber* fn 83 *supra* at p1111

⁹¹ *Van Duivenboden* fn 59 *supra*

⁹² *Van Duivenboden* 2002 (6) SA 431 (SCA) paragraph [12] at p 441E - 442A.



but for the wrongdoing. It therefore attempts to restore the plaintiff as far as possible to the position he was in before the wrong occurred. In delict, both non-pecuniary and pecuniary loss is recognised whereas in the law of contract, only pecuniary loss is recognised⁹³. With regard to non-pecuniary loss, however, South African courts have apparently decided that it must be viewed subjectively⁹⁴ as opposed to objectively in that, the victim of the delict must be in a position to be able to appreciate and experience the wrong that has been done in order for it to be compensable. In *Collins v Administrator, Cape*⁹⁵, the facts of which are given in more detail below, the court held that where a defendant's negligence has resulted in the plaintiff becoming permanently unconscious for the remainder of her life, there is no basis in South African law for awarding her non-pecuniary damages in respect of pain and suffering, shock, discomfort, loss of amenities or shortened expectation of life because the delictual action for damages is compensatory, not punitive. In other words where the non-pecuniary loss is so great that the plaintiff is unable to comprehend it, no damages will be awarded. Where the degree of non-pecuniary loss is not such that the loss itself has robbed the plaintiff of the capacity to experience the loss, however, non-pecuniary damages will be awarded. The court in *Collins* said that where the plaintiff is unconscious and all her physical needs have been taken care of, it is not possible to compensate her

⁹³ *Administrator Natal v Edouard* 1990 (3) SA 581 (A)

⁹⁴ Although in *Collins v Administrator, Cape* fn 1 *supra* the Cape court held that there is no basis for accepting in South African law the distinction drawn in English law between a subjective and an objective element in the loss of amenities of life, a distinction which owes its existence to the Law Reform (Miscellaneous Provisions) Act of 1934 which made a claim for loss of expectation of life transmissible to a deceased's estate. As such a claim is not transmissible in South Africa the occasion for such distinction does not arise and, without such need, there is no logical basis for the drawing of such a distinction, it is submitted that in essence this is what the 'functional' approach of the court amounts to.

Neethling, Potgieter and Visser (fn 18 *supra*) at p 249 that in *Gerke v Parity Insurance Co Ltd* 1966 3 SA 484 (W) the court researched the English law and came to the conclusion that in that system a predominantly abstract (objective) approach is followed but that subjective considerations do play a role in determining the quantum of damages. They quote the observations of Ludorf J to the effect that the test is (a) objective in that something falls to be awarded for what has been called loss of happiness even in a case where the victim has been reduced to a state in which he has never realised and will never realise that he has suffered this loss; (b) is, however, subjective, in the sense that the court in fixing quantum, will have regard to any relevant data about the individual characteristics and circumstances of the plaintiff which tend to show the extent and degree of the deprivation; (c) is subjective, also, in the sense that any realisation which the plaintiff has, or did have or will have, of what he has lost, is most material and important. The authors observe that although the case has been strongly criticised and correctly so in some instances, it has generally been followed in other cases such as *Reyneke v Mutual and Federal Insurance Co Ltd* 1991 3 SA 412 (W) and in *Southern Insurance Association Ltd v Bailey* 1984 (1) SA 98 (A). They point out that the Appellate Division did not condemn the approach in the *Gerke* case in *Bailey*.

⁹⁵ *Collins* fn 1 *supra*

for her loss. It would be like paying a dead person money in order to compensate him for the loss of his life. In *Collins*, the court held that the so-called 'functional' approach is consistent with the principles of South African law and involves the award of non-pecuniary damages only to the extent that such damages can fulfil a useful function in making up for what has been lost in the sense of providing for physical arrangements which can make the victim's life more endurable. It cited *Southern Insurance Association Ltd v Bailey NO*⁹⁶ in support of the principle that the function to be served by an award of damages is a relevant consideration in determining what damages should be awarded. The effect of the judgment is that where an award of non-pecuniary damages to the unconscious plaintiff will not serve any purpose for the plaintiff at all, there is no basis for making any award.

The decision in *Collins* has been criticised as a failure on the part of the court to take into account the high value accorded to human life and dignity by the Bill of Rights⁹⁷. Neethling *et al*⁹⁸ argue that in analysing the problem under discussion it is important to note that the existence of injury to personality should not be confused with its compensability. They state that there is clear agreement that injury to the personality of a person whose consciousness has been reduced to such a level that he has little or no insight into his own condition cannot be compensated by an award of damages and point out that the solution under German law in such a case is to make an award of objective satisfaction which signifies a symbolic redress of the harm by effecting retribution for the wrong done to the plaintiff⁹⁹. Neethling *et al* observe that

⁹⁶ *Bailey* fn 94 *supra*

⁹⁷ Visser PJ 'Geen Vergoeding vire Bewustelose Eiseres' 1996 *THRHR* p 179

⁹⁸ Neethling *et al* fn 18 *supra*

⁹⁹ Neethling *et al* (fn 18 *supra*) note that Boberg *Delict* p 570 also seems to favour the German approach. Boberg states that "It is believed that our courts will and should continue to award a nucleus of damages for loss of amenities of life to the unconscious plaintiff a la Gerke, though any actual evidence of awareness should greatly increase the award. Compromise this solution may be, but it offers the necessary flexibility to deal justly with individual circumstances, and enables the law to express society's sympathy with the victim and its sense of outrage at this grievous loss". See the criticism by Neethling *et al* in fn 338 on p 250 of the views of van der Merwe and Olivier (*Die Onregmatige Daad in die Suid-Afrikaanse Reg*) p 192 fn 51 on this subject and also their exploration of the opinions of Luntz H 'Damages In Cases of Brain Injury' 1965 *SALJ* p 10 and Erasmus HJ 'Genoegdoening vir Verlies aan Lewensgenietinge' 1976 *TSAR* p 238. The court in *Reymeke* (fn 94 *supra*) stated as follows with regard to the criticism of Luntz H in an article entitled 'Damages in cases of brain injury -

injury to personality in cases of interests which are directly related to consciousness consists only of an injury to feelings. The operation of the conscious mind is thus a prerequisite, they say, for the existence of harm such as pain and physical suffering. They note that other forms of personal loss are only

Some developments' SALJ 1967 at 6 (Luntz disagreed with the conclusion reached by Ludorf J in the *Gerke* case. He seemed to favour the functional approach, i.e. the subjective approach and relied heavily on the Australian case of *Skelton v Collins* (1966) 39 ALJR p 480 wherein the High Court of Australia dissented from the views expressed in the *Wise v Kaye* and *West v Shephard* cases.): "His criticism seems to have lost much force in view of the House of Lords decision in the *Lim Poh Choo* case [*Lim Poh Choo v Camden and Islington Health Authority* [1979] 2 All ER 910 (HL)] ... It seems to me that the criticism of Luntz is also rendered ineffective by the judgment of Nicholas JA in the *Bailey* case [*Southern Insurance Association Ltd v Bailey NO* 1984 (1) SA 98 (A)] ... when the learned Judge referred to Lord Scarman's judgment aforesaid with apparent approval and then continued at 119F as follows: 'As I read the judgment in the *Katz* case, however, it did not lay down that the "functional" approach was the one to be followed: all that was said was that on the facts of the *Katz* case, an approach of that kind would not call for an interference with the damages awarded by the trial Court.' Classen J said: "I respectfully read the judgment of Nicholas JA as expressly refraining from laying down a principle of law that the Court is obliged to apply the functional approach where the patient is unconscious of any loss suffered or where the award would most probably not be employed to alleviate his lot. As I understood his judgment the Courts, when making an assessment for general damages, may take into account as one of the factors influencing the amount of the award the fact that such an award cannot be utilised by the patient to alleviate any loss of amenities of life. He did not prohibit the award of general damages for loss of amenities of life or reduced expectation of life to a patient in a 'cabbage' case." With regard to the criticism of *Gerke* by Erasmus, ('Genoegdoening vir verlies van lewensgenietinge' (1976) 2 TSAR 238) the court in *Reyneke* observed that: "The learned author argues that damages for pain and suffering and loss of amenities of life are in the nature of a solatium analogous to that awarded under the *actio injuriarum*. He cites *Government of The Republic of South Africa v Ngubane* 1972 (2) SA 601 (A) at 607B - C where Holmes JA held as follows: "Third, claims for bodily injury involving pain and suffering and the like have this in common with claims under the *actio injuriarum* - namely that both relate to non-pecuniary loss and the amount awarded is regarded in the nature of a solatium. As Van Winsen J observed in *Hoffa's* case *supra* at 955A: "(T)he damages awarded therefore bear a direct relationship to the personal suffering of the injured party and are intended for his personal benefit. The damages awarded to him are in a certain sense analogous to the *solatium* which is awarded under the *actio injuriarum* to someone as a salve for his wounded feelings."

Professor Erasmus then proceeds to conclude that the *Gerke* decision [*Gerke NO v Parity Insurance Co Ltd* fn 94 *supra*] is wrong and in conflict with the *Ngubane* decision: "Die huidige posisie is dus dat by die enigste geleentheid waarop die vraag pertinent ter sprake gekom het, vergoeding vir verlies van lewensgenietinge toegestaan is aan 'n persoon wat sodanig breinbeskadig was dat hy nie bewus was van sy eie toestand nie. Intussen het die Appèlhof, in navolging van verskeie Provinsiale Afdelings, 'n uitleg gegee van die aard van die aksie wat onversoenbaar is met enige toekenning onder hierdie hoof aan die breinbeskadigde slagoffer. Daar word derhalwe met eerbied aan die hand gedoen dat in die lig van die beslissing van die Appèlhof van die *Ngubane* -saak, daar nou sonder twyfel aanvaar moet word dat die *Gerke* -saak verkeerd beslis is. As die vergoeding vir verlies van lewensgenietinge die vorm aanneem van 'n troosgeld, 'n *solatium*, dan is dit genoegdoening vir die leed wat die slagoffer persoonlik ervaar. As die benadeelde persoon as gevolg van die aard van sy beserings geen leed ervaar nie, is hy a fortiori nie geregtig op genoegdoening vir dit wat hy nie ervaar nie."

Classen J then states: "With respect to the learned author, I cannot agree with his conclusions. The *Ngubane* case decided that a claim for damages for pain and suffering and loss of amenities of life is incapable of cession prior to *litis contestatio*. The Court did not decide, nor was it called upon to decide, whether a patient in a vegetative state, and thus still alive, is entitled to general damages for pain and suffering and loss of amenities of life. As indicated in the *Sandler v Wholesale Coal Suppliers Limited* case *supra*, completely different considerations apply as to whether damages are claimable or not. These were described as 'the broadest general considerations' and 'what is fair in all the circumstances'. These considerations do not apply when considering the question whether or not a claim for pain and suffering and loss of amenities of life is cedable or not. It goes without saying that a *solatium* is not capable of cession. However that is not the enquiry I am concerned with. I have to decide whether a *solatium* is payable to a person in a vegetative state. The question which is relevant here is whether an objective or subjective standard is to be applied in assessing such damages. The merits or demerits of these tests were never considered nor relevant in either the *Ngubane* case or the case of *Hoffa NO v SA Mutual Fire & General Insurance Co Ltd* 1965 (2) SA 944 (C). As such the criticism of Prof Erasmus seems unjustified. Furthermore, in awarding damages for loss of amenities of life to a person in a vegetative state, one is not awarding such damages to anyone else but the patient. It is not an award to the heirs. The fact that it may eventually redound to the benefit of the heirs because the patient cannot utilize it for his own benefit, does not make the award any less an award of damages to the patient. In any event it seems to me that the criticism of Prof Erasmus falls by the wayside in view of the stamp of approval given by the House of Lords and the South African Appellate Division in the *Lim Poh Choo* and *Bailey* cases respectively."



indirectly related to consciousness. Thus where there is an impairment of reputation or a loss of the amenities of life, the loss is not only to be found in the feelings or consciousness of the plaintiff. In cases of defamation and loss of amenities, it is possible to ascertain objectively without reference to the feelings of the plaintiff whether his esteem in society has been lowered or to what extent his capacity to enjoy a normal life has been negatively influenced. They state that the connection with consciousness is only created through affective (sentimental) loss, that is the reaction of the injured person to his loss, or in other words, his personal unhappiness. In such case an injury to personality has both a subjective and an objective element. According to Neethling *et al* unconsciousness excludes only the subjective element. They observe that an unconscious person with brain injuries does not have a normal life and does not take part in normal activities and ask how it can then be correct to say that there is no loss? They take the view that the fact that the loss cannot be compensated does not mean that it is non-existent or that the law should ignore it and point out that in such cases the objective function of satisfaction becomes relevant in German, Australian and South African law. They state that the common mistake which is made in the evaluation of personal loss where the plaintiff is unconscious is to equate the existence of loss with its compensability.

In *Reyneke v Mutual and Federal Insurance Co Ltd*¹⁰⁰ the court stated that in making an award the courts adopt an objective approach in determining the

¹⁰⁰ *Reyneke* fn 94 *supra*. The facts of the case were that the plaintiff, the father of a minor daughter, Suzette Analine Reyneke, who was born on 8 July 1970 sued the defendant company both in his personal capacity and in his capacity as father and natural guardian of Suzette. The claim arose out of a collision which occurred on 9 October 1986. Suzette was on roller skates in Lombard Street, Klerksdorp when the vehicle, which was insured by the defendant company, collided with her. Since the injury, Suzette lay in the surgical ward No 6 at the Klerksdorp hospital. She sustained various minor injuries, viz a fractured jaw, a fracture of the metacarpal of her hand, multiple rib fractures and fractures of both knees. For all practical purposes these minor injuries were not relevant to the dispute. However, as a result of a major head injury, Suzette was in a permanent vegetative state, i.e. she fell into the class of cases known as 'cabbage' cases. She was unaware of all bodily functions, blind, mute, deaf and there was no prognosis of recovery of any of these faculties. The brain injury caused prolonged loss of consciousness and haemorrhage in the deep seated ganglial areas of the brain. As a result of this head injury she was 100% disabled. She was fed by a naso-gastric tube and her urine was drained by an indwelling catheter. She responded to pain only by decerebration posturing. There was a well-marked cough reflex on tracheal pressure. Her pupils were large and did not respond to light. She was blind. Her primary reflexes were still present but she had no spontaneous movement. She could not speak but breathed spontaneously. Her bowels were evacuated either spontaneously or with digital help two or three times a week in bed. There had been episodic chest and bladder infections but these usually clear up within two to three days and in a few instances after approximately nine days. Suzette was emaciated and had lost approximately 16

amount of damages, that is, it awards damages for loss whether the victim is aware of such loss or not. In awarding damages for loss in this category, the court may, but is not obliged to, take into as one of the factors influencing the award, the so-called 'functional approach' whereby the amount of damages may be increased or decreased depending on (a) the extent to which the money so

kilograms in weight since the date of the collision. At that time she weighed approximately 55 kilograms, whereas her weight had reduced to 39 kilograms. At the time of the collision she was 16 years of age and she was 20 years when case was heard. She would be bedridden for the rest of her life. In medical terms her condition is described as being a Persistent Vegetative State or PVS after a definition by Jennett and Plum made in 1972. A brain scan showed extensive loss of cortex and diffuse atrophy. She had been in a coma since the collision. The Persistent Vegetative State described patients with irreversible brain damage who, on recovery from a deep coma, pass into a state of seeming wakefulness and reflex responses but never return to a cognitive sapient state. It is the result of destruction of the cerebral cortex of the brain but with sufficient preservation of the brainstem to sustain the vegetative functions - respiration, circulation, gag-reflex etc. The PVS is distinguishable from brainstem death where the patient is kept alive by mechanical respiratory support which, if withdrawn, will result in death. The claim was for (1) Suzette's remaining life expectation; (2) general damages; (3) past and future loss of earnings. With regard to the claim for general damages, Classen J stated at p419 onwards as follows: I now turn to the difficult task of making an award under the heading of 'general damages'. Normally this head of claim will include items such as pain and suffering, loss of expectation of life, loss of amenities of life, disfigurement etc. I may just in passing mention that 'loss of amenities of life' has been defined as 'a diminution in the full pleasure of living'. See *H West & Son Ltd and Another v Shephard* [1963] 2 All ER 625 (HL) at 636G - H. The amenities of life flow from the blessings of an unclouded mind, a healthy body, sound limbs and the ability to conduct unaided the basic functions of life such as running, eating, reading, dressing and controlling one's bladder and bowels. Per Hoexter JA in *Administrator-General, South West Africa and Others v Kriel* 1988 (3) SA 275 (A) at 288E - G. It is common cause that Suzette has lost all these amenities of life. The problem with which I am faced is the difficult question of whether Suzette is aware of the fact that she has suffered any loss of this nature. Suzette's case is to be distinguished from other cases known as the 'twilight' cases where some communication with the patient is sometimes possible. Examples of the so-called 'twilight cases' are *Roberts NO v Northern Assurance Co Ltd* 1964 (4) SA 531 (D); *Lim Poh Choo v Camden and Islington Health Authority* [1979] 2 All ER 910 (HL); *Marine & Trade Insurance Co Ltd v F Katz* NO 1979 (4) SA 961 (A) at 983A; and *Southern Insurance Association Ltd v Bailey* NO 1984 (1) SA 98 (A) at 120A. The 'cabbage' cases which are on all fours to the present instance are *Wise v Kaye and Another* [1962] 1 All ER 257 (CA) and *Gerke NO v Parity Insurance Co Ltd* 1966 (3) SA 484 (W). e problem which arises in the 'cabbage' cases is whether a Court should award any general damages in circumstances where the patient is not aware of any suffered loss and where any awarded amount will only redound to the benefit of the patient's heirs, i.e. the patient will not be able to make use of the money to alleviate his/her condition. In dealing with this vexed question the Courts in England and in South Africa have developed a twofold approach, namely a subjective and an objective approach: (i) A subjective approach is adopted in the sense of recognising that certain losses can only be compensated if they are consciously experienced by the patient. Conjoined to this subjective approach is the additional consideration that the money should be employable to alleviate the victim's condition in some manner. This approach has sometimes been called the 'functional' approach, according to which damages for non-pecuniary loss may be awarded only to the extent that they can be employed to provide the patient with reasonable solace ('solatium') for his misfortunes. See Bailey's case *supra* at 118A where Nicholas JA indicates that the Supreme Court of Canada has favoured the functional approach. In South Africa the functional approach was adopted by Roberts AJ in *Steenkamp v Minister of Justice* 1961 (1) PH J9. This case was approved by Rosenow J in *Geldentuys v SAR & H* 1964 (2) SA 230 (C) but dissented from by Burne J in *Roberts NO v Northern Assurance Co Ltd* 1964 (4) SA 531 (D) at 540D - G. (ii) An objective approach is adopted in the sense that certain losses are experienced by a patient whether he is conscious thereof or not. The aforesaid divided approach has been applied in Gerke's case *supra* at 494F - H, *Wise v Kaye* (*supra* at 263C - F and 265C - E) and in *T Marsden v National Employers General Insurance Company Limited*, an unreported decision by Swart J in case No 7992/88, delivered in the WLD on 24 September 1990 where Swart J held: "And, as to the distinction to be drawn between damages for pain and suffering and damages for loss of amenities: "The former depend on the plaintiff's personal awareness of pain, her capacity for suffering. But the latter are awarded for the fact of deprivation - a substantial loss, whether the plaintiff is aware of it or not." The effect of this divided approach is that the head of claim 'loss of amenities' is divided into two categories of loss, viz

- (1) pain and suffering, shock, mental anguish, anxiety, distress or fear etc; and
- (2) loss of amenities of life, loss of expectation of life, disfigurement etc.

It is then said that category 1 requires a subjective approach, i.e. if the patient does not consciously experience pain, distress, fear etc, there can be no compensation. As for category 2, it is said that these amenities are objectively lost whether the patient is aware of such loss or not."



awarded can be utilised to benefit the victim in alleviating his/her lot in life; and/or (b) the extent to which such money will exclusively benefit the victim's heirs. The court in *Reyneke* followed the decision in *Gerke* while the court in *Collins* refused to follow these two decisions and the precedent on which they were based. Since the *Reyneke* and *Gerke* decisions are those of Witwatersrand Provincial Division of the then Supreme Court and the decision in *Collins* is that of the Cape Provincial Division of the then Supreme Court, one is in effect faced with a bifurcated approach to a single question of law by South African courts who on a par in terms of the authoritative levels of their respective judgments. (See Neethling *et al*)

One of the arguments used by the court in *Collins* to justify its decision is that the object of an award of damages under the law of delict is compensatory and not punitive. Potentially there is another basis for damages which lies between these two polarities and which falls within the realm of constitutional law rather than common law. This possibility is, however, dependent upon the view that the Constitution creates rights that are over and above those recognised by the common law of delict. If one takes for example the Constitutional right to bodily and psychological integrity as expressed in section 12 (2) of the Constitution, one must ask, in order to justify an award of constitutional damages for violation of this right, whether the parameters of this right are wider than those traditionally recognised by the law of delict in respect of bodily and mental injury. Even if the answer is in the affirmative, one is then faced with the question of the extent to which the common law right and the constitutional right overlap. It is only to the extent that the common law right is a subset of the constitutional right, i.e. that the constitutional right is broader than the common law right, that there is scope for the recognition of purely 'constitutional damages' i.e. those falling outside of the scope of the law of delict. Where the two rights overlap, there is no logic in awarding what effectively could amount to double damages as this would place the plaintiff in a better position than that in which he found himself prior to the wrong done to



him. Furthermore, one must bear in mind the constitutional injunction to the courts to develop the common law. According to section 8(3) of the Constitution¹⁰¹, when applying a provision of the Bill of Rights to a natural or juristic person in terms of subsection (2), a court-

- (a) in order to give effect to a right in the Bill, must apply, or if necessary develop, the common law to the extent that legislation does not give effect to that right; and
- (b) may develop rules of the common law to limit the right, provided that the limitation is in accordance with section 36 (1)¹⁰².

Traditionally, damages are awarded in terms of the common law of delict to *compensate* the plaintiff. The court in *Collins* did not refer to the Constitution. Would the Constitution require one to take a different view to the judgments in *Reyneke* or *Collins* or is it supportive of the judgments in either of these cases? Due to the fact that the court in *Collins* saw fit to depart from the decision in *Reyneke*, one is now faced with a choice as to how similar matters should in

¹⁰¹ Act No 108 of 1996

¹⁰² The constitutional court in *Carmichele v Minister Of Safety And Security And Another (Centre For Applied Legal Studies Intervening)*(fn 15 *supra*) was critical of both the High Court and the Supreme Court in their failure to take into consideration the provisions of section 39(2) of the Constitution holding that where, as in the present case, it was clear that the common law had to be developed beyond existing precedent, there were two stages to the enquiry the Court was obliged to undertake: it had to consider, first, whether the existing common law required development in accordance with the objectives of s 39(2) and, if so, how this development was to take place in order to meet the objectives of s 39(2). It said that in the present case neither the High Court nor the SCA had embarked on either stage of this enquiry, with the result that the CC did not have the benefit of any assistance from either Court on either stage of the above enquiry. Ackermann and Goldstone JJ commented at p 961-962 that: "The influence of the fundamental constitutional values on the common law is mandated by s 39(2) of the Constitution. It is within the matrix of this objective normative value system that the common law must be developed. This requires not only a proper appreciation of the Constitution and its objective, normative value system, but also a proper understanding of the common law. We have previously cautioned against overzealous judicial reform. The proper development of the common law under s 39(2) requires close and sensitive interaction between, on the one hand, the High Courts and the Supreme Court of Appeal which have particular expertise and experience in this area of the law and, on the other hand, this Court. Not only must the common law be developed in a way which meets the s 39(2) objectives, but it must be done in a way most appropriate for the development of the common law within its own paradigm. There are notionally different ways to develop the common law under s 39(2) of the Constitution, all of which might be consistent with its provisions. Not all would necessarily be equally beneficial for the common law. Before the advent of the IC, the refashioning of the common law in this area entailed 'policy decisions and value judgments' which had to 'reflect the wishes, often unspoken, and the perceptions, often but dimly discerned, of the people'. A balance had to be struck between the interests of the parties and the conflicting interests of the community according to what 'the (c)ourt conceives to be society's notions of what justice demands'. Under s 39(2) of the Constitution concepts such as 'policy decisions and value judgments' reflecting 'the wishes . . . and the perceptions . . . of the people' and 'society's notions of what justice demands' might well have to be replaced, or supplemented and enriched by the appropriate norms of the objective value system embodied in the Constitution."

future be decided. There is furthermore the public policy concern that in situations such as those in *Reyneke* and *Collins*, how does one give recognition to the weight of the harm that has been done in the light of constitutional rights to human dignity, the right to life and the right to bodily and psychological integrity? Assuming that wrongfulness has been clearly established in terms of the law of delict and in view of the extreme nature of the plaintiff's loss, how does one recognize or admit such a gross violation of these constitutional rights? Is the compensation that is and was traditionally available under the common law of delict sufficient for this purpose or is something more required? While compensation is the main object of the law of delict it is not necessarily the main object of the Bill of Rights. The objects of the latter embrace the possibly broader concerns of the protection of human dignity and freedom, the enforcement of respect for the human condition and for human life and the recognition of the individual worth of every member of society as a human being. The Constitution is expressly concerned with fundamental values. The question is, if society has recognised the innate worth of an individual human being, then surely it has as much of an interest in the observation of the constitutional rights of individuals as do the individuals themselves?¹⁰³ This is one sense in which the Constitution may be said to be broader in scope than the law of delict which, falling as it does within the scope of private law, is more concerned with the rights and interests of individuals rather than the collective. The vital interests of society in the observation of the provisions of the Constitution generally and the Bill of Rights in particular could be said to be more prominently recognised in constitutional law than in the law of delict. However, a powerful counterargument to this is that the Bill of Rights in the particular context of the right to bodily and psychological integrity is merely a

¹⁰³ This is clearly expressed in the minority judgment of Didcott J in *Fose v Minister of Safety and Security* (1996 (2) BCLR 232 (W)) where he stated: "Deterrence speaks for itself as an object. But the idea of vindication, used in the sense that it conveys at present, calls for some elaboration. One of the ordinary meanings which 'to vindicate' bears, the aptest now so it seems to me, is 'to defend against encroachment or interference'. Society has an interest in the defence that is required here. Violations of constitutionally protected rights harm not only their particular victims, but it as a whole too. That is so because, unless they are adequately remedied, they will impair public confidence and diminish public faith in the efficacy of the protection, and for a good reason too since one invasion discounted may well lead to another. The importance of the two goals is obvious and does not need to be laboured. How they are best attained is the question."

codification of the common law right and the fact that the law of delict recognises the importance of public policy in the concept of wrongfulness is comparable to, and in fact no different from, the constitutional expression of the interests of society in the observation of the right in question. The Constitution merely spells out the values of society in a more definite way so that there is now no doubt as to the nature of the public policy that must be taken into consideration in questions of wrongfulness for the purposes of the law of delict.

It has been argued that the objectives of the law of delict differ fundamentally from those of constitutional law. The primary purpose of the former is to regulate relationships between private parties whereas the latter, to a large extent, aims at protecting the chapter 3 rights of individuals from state intrusion. Similarly, the purpose of a delictual remedy differs fundamentally from that of a constitutional remedy. The former seeks to provide compensation for harm caused to one private party by the wrongful action of another private party whereas the latter has as its objective (a) the vindication of the fundamental right itself so as to promote the values of an open and democratic society based on freedom and equality and respect for human rights; (b) the deterrence and prevention of future infringements of fundamental rights by the legislative and executive organs of state at all levels of government; (c) the punishment of those organs of state whose officials have infringed fundamental rights in a particularly egregious fashion; and (d) compensation for harm caused to the plaintiff in consequence of the infringement of one or more of the plaintiff's rights entrenched in chapter 3 of the Constitution. The common-law remedies are not directed to the achievement of the first three of these objectives and the common law should not be distorted by requiring it to perform these functions and fulfil the purposes of constitutional law. Hence the necessity for a specific and separate public-law constitutional damages remedy¹⁰⁴.

¹⁰⁴ These were the arguments of counsel for the plaintiff in *Fose v Minister Of Safety And Security*, fn 34 *supra*, as summarised by Ackermann J at p 798.



The court in *Collins* was of the opinion that the concepts of loss and damages are two distinct elements which should not be confused. They are separate concepts. This sharp distinction, although logical when considered with regard to the idea of compensation for personal injury as subjectively experienced, is somewhat counter-intuitive and paradoxical from an holistic and more value based approach. It creates a certain unease, possibly because the message seems to be that if one is going to injure someone, it may be cheaper to do it to such a degree that he is unable to appreciate certain elements of his loss. In fact, as the courts have pointed out, it could be argued that it is cheaper to kill a person than to maim him. Although the degree of loss in the *Collins* case was possibly the greatest that could be sustained by a human being, damages could not be awarded because the loss was so great that nothing would compensate for it. There is also the argument that the criminal law exists to express society's displeasure at wrongful actions causing such loss and that such displeasure should not be expressed through the law of delict in the private sphere¹⁰⁵. It is argued that the defendant must be entitled to the full protection of the higher standard of proof that is placed upon the state in a criminal case in which he runs the risk of punishment. It could be argued that this sense of unease arises only from the point of view of the compensation payable in terms of the law of delict and because it does not take into account the possible criminal penalties that may also be involved. A counter to this is that not all delicts are crimes but this does not diminish the wrongfulness of the delictual action in the public mind. The courts have indeed observed with regard to the concept of wrongfulness in criminal law that it is the same as the concept of wrongfulness in terms of the

105

Van der Walt, *Delict: Principles and Cases* states: "The historical anomaly of awarding additional sentimental damages as a penalty for outrageous conduct on the part of the defendant is not justifiable in a modern system of law. The basic purpose of a civil action in delict is to compensate the victim for the actual harm done. In the case of impairment of personality by wrongful conduct it may be difficult to determine the amount of the solatium which will confer personal satisfaction or compensation for the injury, but in principle all factors and circumstances tending to introduce penal features should be rigorously excluded from such an assessment. The aim of discouraging evil and high-handed conduct is foreign to the basic purposes of the law of delict. It is for criminal law to punish and thereby discourage such conduct. The policy of awarding punitive damages unduly enriches the plaintiff who is entitled only to compensation for loss suffered. This policy has the added disadvantage of putting a wrongdoer in jeopardy of being punished twice - in the civil proceedings and in the criminal proceedings which could conceivably follow or which have preceded the civil action."

law of delict.¹⁰⁶ There seems to be a view that the only distinguishing factor between a delict and a crime is that the one is compensatory and the other, punitive and that consequently this distinction should not be blurred because it would be prejudicial to defendants in delictual claims and would obviate the compensatory principle of the law of delict by rewarding the plaintiff for claiming¹⁰⁷. It is submitted that this view requires considerable legal

¹⁰⁶ In *Clarke v Hurst No And Others* 1992 (4) SA 630 (D) at p 652, Thirion J said: "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. If it is accepted, as I think it should, 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. I can see no reason why the concept of wrongfulness in criminal law should have a content different from what it has in delict. For the purposes of this case I accept the following formulation of wrongfulness in criminal law by Snyman *Strafreg* 2nd ed at 100: 'Om vas te stel of 'n handeling wederregtelik is, moet dus gekyk word of dit in stryd is met die goeie sedes of die regsdoelstelling van die gemeenskap. Die regverdigingsgronde moet gesien word as praktiese hulpmiddels om die wederregtelikheid vas te stel. Hulle verteenwoordig maar net die situasies wat meestal in die praktyk voorkom en wat daarom al uitgekristalliseer het as maklik herkenbare gronde vir die uitsluiting van wederregtelikheid. Hulle dek egter nie die hele terrein van die onderwerp waarom dit hier gaan nie, te wete die afbakening van wederregtelike en regmatige gedrag.' However, see the statement of the constitutional court in *Khumalo And Others v Holomisa* 2002 (5) SA 401 (CC) that: "It should be emphasised that the Court's perception of the legal convictions of the community as a test for determining wrongfulness in delict might well have to be reconsidered in the context of our new constitutional order. See *Carmichele v Minister of Safety and Security and Another (Centre for Applied Legal Studies Intervening)* 2001 (4) SA 839 CC". It is submitted that this observation of the court in *Khumalo* concerning the dicta of the court in *Carmichele* should not be seen as an expression of the need to do away with the test of the legal convictions of the community so much as it is the need to see the values expressed in the Constitution as the basis for the legal convictions of the community. This is borne out by the emphasis of the court in *Carmichele* of the need for sensitivity to the common law at p 961 to 962 of the judgment and its statement that: "Under s 39(2) of the Constitution concepts such as 'policy decisions and value judgments 'reflecting 'the wishes . . . and the perceptions . . . of the people' and 'society's notions of what justice demands' might well have to be replaced, or supplemented and enriched by the appropriate norms of the objective value system embodied in the Constitution." [writer's italics]

¹⁰⁷ The court in *Fose* (fn 34 *supra*) stated that: "Serious judicial doubts have been expressed concerning, and considerable academic criticism levelled against, the award of punitive damages in delictual claims. . . Professor Van der Walt, whose views are broadly representative of academic criticism generally, expresses his misgivings succinctly as follows: 'The historical anomaly of awarding additional sentimental damages as a penalty for outrageous conduct on the part of the defendant is not justifiable in a modern system of law. The basic purpose of a civil action in delict is to compensate the victim for the actual harm done. In the case of impairment of personality by wrongful conduct it may be difficult to determine the amount of the *solatium* which will confer personal satisfaction or compensation for the injury, but in principle all factors and circumstances tending to introduce penal features should be rigorously excluded from such an assessment. The aim of discouraging evil and high-handed conduct is foreign to the basic purposes of the law of delict. It is for criminal law to punish and thereby discourage such conduct. The policy of awarding punitive damages unduly enriches the plaintiff who is entitled only to compensation for loss suffered. This policy has the added disadvantage of putting a wrongdoer in jeopardy of being punished twice - in the civil proceedings and in the criminal proceedings which could conceivably follow or which have preceded the civil action.'" [Footnotes omitted] Ackermann J did state however that: "The question whether, in addition to compensatory damages, 'penal' or 'punitive' or 'exemplary' damages (expressions often used interchangeably and confusingly) are (or ought to be) awarded in delictual claims is a matter of some debate in South Africa. It appears to be accepted that in the Aquilian action and in the action for pain and suffering an award of punitive damages has no place. The Appellate Division has, however, recognised that in the case of defamation punitive damages may in appropriate cases be awarded. In the case of damages for adultery it has been accepted that a penal component is still appropriate. It must of course be borne in mind that it is not always easy to draw the line between an award of aggravated but still basically compensatory damages, where the particular circumstances of or surrounding the infliction of the *injuria* have justified a substantial award, and the award of punitive damages in the strict and narrow sense of the word. There appears to be scant authority for the award of punitive damages in the case of assault, over and above the damages awarded for patrimonial loss, pain and suffering and for the contumelia suffered, which can itself be aggravated by the circumstances of and surrounding the assault." See *Dippenaar v Shield Insurance Co Ltd* 1979 (2)-SA 904 (A) at p 908 where the court stated: When damage for personal injuries has to be assessed, a person's patrimony includes, *inter alia*, the capacity to earn money

philosophical debate and discussion which is beyond the scope of this thesis. It is however, worth noting that in his minority judgment in *Fose*¹⁰⁸ Kriegler J makes the following cautionary comments on the judgments of the majority of the court and the minority judgment of Didcott J in that case:

“On one point, I respectfully suggest, Ackermann J is uncharacteristically ambivalent. As I understand the reasoning in paras`[69]–[73] of his judgment, my learned Colleague in principle condemns punitive damages as a potential remedy for infringements of constitutional rights but at the same time seeks to found the current rejection on the particular facts of this case. For reasons that I hope to make plain shortly, I agree that we should unequivocally reject punitive damages as a remedy in this case. I do believe, however, that we should refrain from any broad rejection of any particular remedies in other circumstances. On that same point my Colleague Didcott J holds that punitive or exemplary damages are not claimable from the State, the defendant in the present case, for breaches of constitutional rights. He, however, leaves open the case of other infringers of such rights. *Notwithstanding the circumscribed ambit of the rejection of punitive/exemplary damages, I believe that we need not and should not go as far as Didcott J in rejecting for all time the possibility that a case may arise where punitive or exemplary damages are ‘appropriate’ redress for infringement of constitutionally protected rights.*[writer’s italics]

It is important to note that in the context of the law relating to the delivery of health care services, violations of the constitutional rights to bodily and psychological integrity and other aspects of the right to freedom and security of the person will almost inevitably underlie claims in delict. Whether the converse is true is arguable¹⁰⁹.

through his work and skill, i.e. his mental and physical efforts. The loss or impairment of this capacity is therefore also an element of Aquilian damages, if it has in fact led to a diminution of the plaintiff's patrimony. Reinecke (op cit at 29, 34); Byleveldt's case *supra* at 150C. In dealing with this particular head of damage, it is therefore more correct to talk of loss or impairment of earning capacity than of loss of income (whether of past income or future income). Equally, there is in principle no distinction between "loss of past income" and "loss of future income"; the lapse of time between the injury and the trial is purely incidental. In theory the loss was caused immediately when the personal injury was sustained and in theory (perhaps also in practice) the claim for damages could be heard on the day after the accident. In theory there is only one, indivisible cause of action for Aquilian damages and the passage of time only helps to bring greater clarity about the facts regarding the sequelae of the injury. Byleveldt's case at 174G. There has been discussion in the common law whether the correct concept in "loss of earnings" or "loss of earning capacity", the underlying notion being that in the latter event there should be an award of damages for this item of loss even if it has not in fact led to any actual patrimonial loss at all (i.e. the test is then what could the plaintiff have earned, not what would he have earned); Luntz *Assessment of Damages for Personal Injury and Death* (1974) at 131 - 6; *Winfield & Jolowicz on Tort* 10th ed (1975) at 572 note 55. Fleming (op cit at 218). Whilst such an approach would be quite wrong for our law, it appears to have found some adherents in the Australian Courts; however, it appears from the *dictum* in the leading Australian case of *Graham v Baker* (quoted by Luntz (op cit at 134)) that the correct approach has now also been adopted there."

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Fose fn 103 *supra*

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See for instance the judgment of Cameron JA in *Ojitzki Property Holdings v State Tender Board And Another* 2001 (3) SA 1247 (SCA) in which he observes that: "It is well established that in general terms the question whether there is a legal duty to prevent loss depends on a value judgment by the court as to whether the

plaintiff's invaded interest is worthy of protection against interference by culpable conduct of the kind perpetrated by the defendant. The imposition of delictual liability (as Prof Honoré has pointed out) thus requires the court to assess not broad or even abstract questions of responsibility, but the defendant's liability for conduct 'described in categories fixed by the law'. This process involves the court applying a general criterion of reasonableness, based on considerations of morality and policy, and taking into account its assessment of the legal convictions of the community and now also taking into account the norms, values and principles contained in the Constitution. Overall, the existence of the legal duty to prevent loss 'is a conclusion of law depending on a consideration of all the circumstances of the case'.

Where the legal duty to the plaintiff invokes derives from breach of a statutory provision, the jurisprudence of this Court has developed a supple test. The focal question remains one of statutory interpretation, since the statute may on a proper construction by implication itself confer a right of action, or alternatively provide the basis for inferring that a legal duty exists at common law. The process in either case requires a consideration of the statute as a whole, its objects and provisions, the circumstances in which it was enacted, and the kind of mischief it was designed to prevent. But where a common-law duty is at issue, the answer now depends less on the application of formulaic approaches to statutory construction than on a broad assessment by the court whether it is 'just and reasonable' that a civil claim for damages should be accorded. 'The conduct is wrongful, not because of the breach of the statutory duty *per se*, but because it is reasonable in the circumstances to compensate the plaintiff for the infringement of his legal right.' The determination of reasonableness here in turn depends on whether affording the plaintiff a remedy is congruent with the court's appreciation of the sense of justice of the community. This appreciation must unavoidably include the application of broad considerations of public policy determined also in the light of the Constitution and the impact upon them that the grant or refusal of the remedy the plaintiff seeks will entail.

Though this Court's broad-based approach to determining whether in such circumstances a legal duty exists has attracted criticism, it seems generally to accord with trends in other jurisdictions grappling with related issues. More importantly, it seems to me to be especially apposite to constitutional interpretation, which involves the application of just such standards of public principle and policy. Section 187 does not appear in an ordinary statute. It is part of a Constitution, and within the limits of linguistic meaning 16 constitutional principles must infuse our understanding of its effect. The enactment of the interim Constitution marked the transition from the old order to a new society - one avowedly open and democratic and based on freedom and equality, in which courts were not only enjoined in interpreting fundamental rights provisions to promote the values underlying such a society (s 35(1)), but in interpreting 'any law' to have due regard to the spirit, purport and objects of the fundamental rights chapter (s 35(3)). Though the provisions of the interim Constitution do indeed deal with many mundane questions of governmental structure and organisation not requiring the application of lofty principle, 'any law' in s 35(3) in my view includes where appropriate the other provisions of the interim Constitution itself. 18 Specifically, therefore, in interpreting 'any law' to have due regard to the spirit, purport and objects of the fundamental rights chapter (s 35(3)). Though the provisions of the interim Constitution do indeed deal with many mundane questions of governmental structure and organisation not requiring the application of lofty principle, 'any law' in s 35(3) in my view includes where appropriate the other provisions of the interim Constitution itself. 18 Specifically, therefore, in interpreting such provisions s 35(3) applies, and '... when a court is confronted with a problem of unenumerated rights it should seek to answer the question as to whether the development [scil: recognition] of a right which is unenumerated in the Constitution would foster or promote those values which underlie an open and democratic society based on freedom and equality'.

To these considerations may be added that in determining whether a delictual claim arises from breach of a statute the fact that the provision is embodied in the Constitution may (depending on the nature of the provision) attract a duty more readily than if it had been in an ordinary statute."

In this case the plaintiff pleaded its claim on two alternative bases. Claim A alleged that its entitlement to damages arose from the defendants' breach of the plaintiff's right to a fair, public and competitive system of tendering embodied in s 187(2) of the interim Constitution. Claim B alleged in the alternative that the defendants' conduct constituted an infringement, entitling the plaintiff to damages, of the fundamental right to administrative justice enshrined in s 24(a), (b) and (d) of the interim Constitution. In 1995, the provincial government of Gauteng began to make arrangements to relocate from Pretoria to Johannesburg. It invited tenders for office accommodation to house various departments in an inner-city precinct. The appellant ('the plaintiff') obtained an option to purchase a building in the precinct, and tendered to provide office space in it to the provincial government. Its tender was not accepted. Thereafter it instituted a claim for damages against the first and second respondents, respectively the State Tender Board which awarded the tender, and the Province of Gauteng which the plaintiff alleged had miscondacted itself during the tender process in specified ways with which the Tender Board has associated itself. The damages the plaintiff claimed allegedly arose from the defendants' unlawful conduct in managing the tender process and in awarding the tender. They consisted in the profit the plaintiff asserted it would have made from rentals if it had been awarded the tender. The claim failed. Cameron J observed that: "The plaintiff, which seeks to evoke a delictual remedy from the interstices of the interim Constitution, aspires to recover through it a loss measured not in delictual but in contractual terms. That is a far-reaching assertion. While it is not impossible that a statutory provision, constitutional or otherwise, could be held to accord such recompense for its breach, it seems to me quite inappropriate for this to occur by judicial interpretation of a provision whose primary injunction is for legislative action to occur in that very area. Certainly the contention that it is just and reasonable, or in accord with the community's sense of justice, or assertive of the interim Constitution's fundamental values, to award an unsuccessful tenderer who can prove misfeasance in the actual award its lost profit does not strike me in this context as persuasive... I agree with the observations of Davis J in *Faircape Property Developers (Pty) Ltd v Premier, Western Cape* that in deciding whether a statutory provision grounds a claim in damages the determination of the legal convictions of the community must take account of the spirit, purport and objects of the Constitution, and that the constitutional principle of justification embraces the concept of accountability. This in turn must of course weigh in the balance when determining legal responsibility for the consequences of public malfeasance." [Footnotes omitted]

The conflation of the concept of constitutional damages with that of punitive damages may not necessarily be theoretically correct. Punishment in the criminal law is expressed as much in terms of imprisonment as it is expressed in money. Indeed, in the case of more serious criminal actions, punishment sounding in money is not an option. The idea in delict that money is adequate compensation for the violation of the rights of personality is illusory¹¹⁰. This is nowhere more clearly demonstrated than in the law of defamation. A reputation, once lost, can seldom if ever be recovered¹¹¹ in the same way that the capacity to enjoy life, or to be happy, can in certain circumstances never be recovered - irrespective of the amount of damages awarded. Damages sounding in money are, nonetheless awarded in the case of the former¹¹².

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- 110 In *Chetcuti v Van Der Wilt* 1993 (4) SA 397 (TK) the court observed that: "Assessment of such damages is always a difficult matter, involving as it does 'the placing of a money value upon abstractions' (Amerasinghe 'Defamation and Aspects of Actio Injuriarum in Roman Dutch Law' at 178) and the damages cannot be gauged with precision or nicety. In dealing with the difficulty of assessing such damages Lord Atkin in *Ley v Hamilton* [1935] TLR 384 stated at 386: 'They are not arrived at as the Lord Justice seems to assume by determining the "real" damage and adding to that a sum by way of vindictive or punitive damages. It is precisely because the "real" damage cannot be ascertained and established that the damages are at large. It is impossible to track the scandal, to know what quarters the poison may reach; it is impossible to weigh at all closely the compensation which will recompense a man or a woman for the insult offered or the pain of a false accusation . . . The "punitive" element is not something which is or can be added to some unknown factor which is non-punitive.' In *Muller v South African Associated Newspapers Ltd and Others* 1972 (2) SA 589 (C) Watermeyer J stated as follows at 595A: "In estimating the amount of damages to be awarded the Court must have regard to all the circumstances of the case. It must, *inter alia*, have regard to the character and the status of the plaintiff, the nature of the words used, the effect that they are calculated to have upon him, the extent of the publication, the subsequent conduct of the defendant and, in particular, his attempts, and the effectiveness thereof, to rectify the harm done." In *Buthlezi v Poorter and Others* 1975 (4) SA 608 (W) at 613H-I Williamson AJ added the rider that the Court "is also entitled to take into account the conduct of the defamer from the time the libel was published until judgment to the extent that such conduct is directly connected with the wrong sued on". See also *Khan v Khan* 1971 (2) SA 499 (RAD) at 500C where Lewis AJP stated that: "In English law and in South African law, it is well recognised that the Court is justified in awarding exemplary damages in an appropriate case. The circumstances which have been held to justify such an award of exemplary damages are the wantonness of the allegation and the conduct of the defendant in regard to the allegations right up to the time of judgment . . ."
- 111 In *Afrika v Metzler And Another* 1997 (4) SA 531 (NM) the Namibian court put it graphically thus: "It is, in my view, humanly speaking virtually impossible for one to restore another's good name and reputation to its former glory by a mere, at times invariably predestinated, retraction and/or apology. Similarly no one who empties an eiderdown quilt in the wind is able again to gather the eiderdown and restuff the quilt to its previous format with same." The court stated that: "With the new democratic dispensation heralded by the Namibian Constitution entrenching fundamental human rights and fundamental freedoms and the premium to be attached to one's good name and reputation in instances of flagrant violation thereof, the time has come to have a liberal approach in the determination of the quantum and award much higher damages, especially instances where aggravating circumstances are present as in the present case. Only then will persons, especially newspaper editors/reporters, publishers/printers and/or owners, be more on their qui vive and be mindful of the strict/absolute liability applicable to members of the press and hopefully act in accordance with the special duty of care that rests upon their shoulders and subject to law pursuant to the reasonable restrictions on the exercise of the fundamental freedoms imposed by art 21(2) of the Namibian Constitution, if they know that substantive exemplary/punitive damages could be visited upon them if they defame another *animus iniuriandi*."
- 112 In *SA Associated Newspapers Ltd en 'n Ander v Samuels* 1980 (1) SA 24 (A) the Appellate Division observed that: "The elements to be taken into account in estimating the amount to be awarded are thus the contumelia suffered, the loss of reputation and the penalty. See *Gelb v Hawkins* 1960 (3) SA at 693H; *Salzmann v Holmes* 1914 AD at 480." See also with regard to punitive damages *Pont v Geysen en 'n Ander* 1968 (2) SA 545; SA

It is conceivable, especially in circumstances where the defendant health care provider is guilty of persistent and repeated violations of such constitutional rights, that exemplary damages, or at least vindicatory damages in the form of a heavier award of damages than would normally be the case, would be justified in terms of the law of delict on constitutional grounds.

In *Fose v Minister Of Safety And Security*¹¹³ the court canvassed the subject of constitutional damages in other jurisdictions in some detail. It summarised the position in foreign jurisdictions as follows:

“The foregoing survey of the remedies granted in other jurisdictions for the breach of a constitutional right indicates that in most cases they are ‘public law’ remedies (to employ for the moment the nomenclature used in certain of the foreign jurisdictions). My understanding of the United States jurisprudence is that both the s 1983 relief as well as the award of constitutional damages based directly on the Constitution should be seen as legislative and judicial responses to the perceived inadequacy of the common-law tort remedies. This inadequacy arises from the limitations placed on relief in tort by various manifestations of the principle of sovereign immunity and vicarious liability and by the vagaries and inconsistencies of tort law, which falls within the jurisdiction of state courts. The responses differ, however. The s 1983 response is basically a statutory extension of a remedy which still is fundamentally a common-law tort remedy. On the other hand the remedy developed in the *Bivens* and similar cases discussed above appears to have a marked ‘public law’ character. The plaintiff is not limited to a remedy under ordinary tort law. The remedy is a completely independent remedy. It differs from that granted between two private citizens and it is one particularly intended to ‘vindicate the interests of the individual in the face of the popular will as expressed in legislative majorities’. The ‘public law’ nature of the remedy under the Canadian Charter is clearly, albeit perhaps implicitly, recognised and express recognition of the ‘public law’ nature of similar remedies has been given under the New Zealand Bill of Rights and the Constitutions of Trinidad and Tobago, India and Sri Lanka.”

The court in *Fose* was asked to award constitutional damages in order to vindicate the constitutional rights of the plaintiff and was asked for punitive damages for violation of the plaintiff’s constitutional rights in order to deter similar future violations of such rights. The interim Constitution was in force at

Associated Newspapers Ltd and Another v Yutar 1969 (2) SA 442; *Buthelezi v Poorter and Others* 1975 (4) SA 608.

113 *Fose* fn 34 *supra*

the time of this case. The only requirement of the interim Constitution was that the relief given by a competent court in any particular case should be ‘appropriate relief’ (in terms of section 7(4)(a)). It was left to the courts to decide what would be appropriate relief in any particular case. There was much discussion on the subject of a ‘public law’ remedy as opposed to the ‘private law’ remedy that was available to the plaintiff in terms of the law of delict. Significantly, Ackermann J refused to deal with the issue on the basis of the divisions between public and private law recognising that the validity of such artificial distinctions is becoming increasingly questionable and that it could be dangerous to infer solutions in terms of such an analytical framework¹¹⁴.

7.3 Necessity

This defence¹¹⁵ is often raised in controversial contexts such as the need to smoke cannabis for medical reasons, euthanasia, abortion, sterilisation of mentally disabled persons and surgical removal of organs from donors¹¹⁶.

¹¹⁴ In this regard Ackerman J observed at p818-819 that: “While the foreign jurisprudence referred to emphasises that the proper protection of entrenched fundamental rights requires a ‘public law’ remedy, it is preferable, for the present, to refer to the ‘appropriate relief’ envisaged by s 7(4) merely as a ‘constitutional remedy’. It is both undesirable and unnecessary, for purposes of this case, to attempt to do that which has seemingly eluded scholars in the past and given rise to wide differences of opinion among them, namely the drawing of a clear and permanent line between the domains of private law and public law and the utility of any such efforts. Much of this interesting debate is concerned with an analysis of power relations in society; the shift which has taken place in the demarcations between ‘private law’ and ‘public law’; how functions traditionally associated with the state are increasingly exercised by institutions with tenuous or no links with the state; how remedies such as judicial review are being applied in an ever widening field and how legal principles previously only associated with private legal relations are being applied to State institutions. Suffice it to say that it could be dangerous to attach consequences to or infer solutions from concepts such as ‘public law’ and ‘private law’ when the validity of such concepts and the distinctions which they imply are being seriously questioned.”

¹¹⁵ Necessity is in fact one of a number of grounds of justification. See for instance the discussion of grounds of justification in Neethling *et al* fn 18 *supra* at p73-111. Burchell, fn 18 *supra*, comments at p 70 that if a medical practitioner performs an operation upon or treatment of a patient without informed consent being given by the patient (or legally approved representative) the medical procedure will be unlawful (i.e. an assault). However in an emergency situation (where for instance the patient is unconscious, cannot give the required consent and there is no time to contact relatives) then the doctor may be justified by necessity in performing an operation to save the patient’s life.

¹¹⁶ In an English case in September 2000 the Court of Appeal gave judgment in the case of *Re: A (Children)* 2000 (www.courtservice.gov.uk) on the question of whether the proposed surgical separation of ischiopagus twins (joined at the pelvis), which would result in the death of one of them, would constitute murder. At the heart of the legal debate in this case was the question of whether decisions about the relative worth of the life of individuals could be legally made when those decisions result in the loss of the life considered less worthy. The twins, Jodie and Mary were born to parents who were devout Catholics. Mary was the weaker of the two and had she been born alone, would not have survived. She was kept alive by virtue of Jody’s circulatory system. Although Jodie was considered capable of surviving a separation procedure, Mary was not. If no separation took place, both would die in a matter of months due to the added strain on Jodie’s circulatory system. The medical team looking after the twins wished to separate them but the parents would not sanction the operation. The latter could not sanction the shortening of Mary’s life in order to extend Jodie’s. They felt that if it was God’s will that both should die then so be it. The medical team at St Mary’s Hospital, Manchester sought a



ruling from the High Court that surgery to separate the twins, knowing that such a procedure would kill Mary, would not be unlawful. Johnson J ruled that the operation would not be unlawful because in his view the proposed operation represented a withdrawal of blood - a situation analogous to the withdrawal of feeding and hydration in *Airedale NHS Trust v Bland* (1993). The parents appealed on the grounds that Johnson J was wrong in finding that the proposed operation was in either Mary's or Jodie's best interests and that it should have been held that the operation was not legal. Ward LJ, Brook LJ and Walker LJ of the Court of Appeal considered submissions from all interested parties and came to the same conclusion – that Johnson J was correct and that the operation to separate the twins was not unlawful. However, they came to this decision via differing routes. The Court of Appeal held that:

- (1) The clinical judgment is that Jodie and Mary are both alive and therefore separate human beings for the purposes of civil and criminal law;
- (2) It is fundamental that every person's body is inviolate and that every person's life is of equal inherent value and the judge in the court a quo had therefore been wrong to conclude that Mary's life would be worth nothing to her. It said that life was of value in itself whatever the diminution in one's capacity to enjoy it. Furthermore, apart from the fact that the distinction between an act and an omission was of doubtful ethical or legal importance in the context of a doctor's duty to preserve life, it was utterly fanciful to characterise the contemplated operation as an omission rather than an act. The operation would involve a substantial invasion of Mary's bodily integrity and would, in the absence of justification, involve an unlawful assault upon her. The correct question is whether it was in Mary's best interests that an operation which would cause Mary to die, should be carried out. It followed that, looking at Mary's position in isolation and ignoring the equally clear benefit to Jodie, the court would not be able to sanction the operation.
- (3) The question was whether the court could balance Jodie's and Mary's conflicting interests where the right to life is at stake. Ordinarily in family law the interests of the child are paramount but this must be qualified where the interests of two children, each with an entitlement to have their interest treated as 'paramount' were in conflict. It would be an abdication of the court's duty to refuse to undertake such a balancing act and the least detrimental alternative must be found.
- (4) Whilst the parents have the right to make a decision on the future of the twins and their wishes command the greatest respect such rights are subservient to the paramount duty of the court to consider the welfare of the child. Where its view of the child's welfare was inconsistent with the view of the parents, it must give effect to its own judgment. The matter should be decided afresh, albeit with due weight attached to the wishes of the parents rather than reviewing the reasonableness of the parental decision.
- (5) The interests of the two children must be balanced, weighing the advantages and disadvantages to each of the proposed course of action rather than comparing the worth of one life against another. As such it was legitimate to consider the actual quality of life that each may experience. The prospect of a full life for Jodie was counterbalanced by the acceleration of certain death for Mary but the fact that Mary's capacity to live was in any event fatally compromised meant that the balance of interest was heavily in Jodie's favour. Furthermore, it was relevant that Mary was only alive at all because she was supported by her stronger sibling and that she was constitutionally incapable of being self-supporting. It followed that, subject to the question of the lawfulness of the proposed operation in terms of the criminal law, permission should be granted.
- (6) The proposed operation would unquestionably and foreseeably cause Mary's death so that the doctors have the required murderous intent. The lawfulness of the operation therefore turns on the availability of a defence to murder. Two important principles could be discerned. The doctors have a duty to Mary not to operate because it would kill her and a duty to Jodie to operate because it would save her life. The doctors cannot be denied a right of choice where they were under a duty to choose. In the face of such a conflict of duty, the law must allow an escape route by allowing the doctors to choose the lesser of two evils and they should be placed in exactly the same position as that in which the court found itself and allowed to make the decision along the same lines as the court has done.
- (7) The proposed operation does not offend against the sanctity of life principles. The reality of the situation was that Mary was killing Jodie by draining her lifeblood, albeit such an action on her part could not be described as unlawful. The doctors would therefore be justified in coming to Jodie's aid in legitimate defence of her life. The plea of quasi self-defence is applicable in the unique circumstances of this case;
- (8) The three requirements for the application of the defence of necessity, that the act was needed to avoid the inevitable and irreparable evil, that no more should be done than was reasonably necessary for the purpose to be achieved and that the evil inflicted was not disproportionate to the evil avoided, were satisfied in this case.
- (9) The Human Rights Act, 1998, incorporating the European Convention on Human Rights into domestic law, is due to come into force before any operation could be carried out and is therefore applicable. Article 2 of the Convention provides that no one should be deprived of their life intentionally save in circumstances not relevant to this appeal. However, the ECHR does not import any prohibition on the proposed operation not already found in pre-existing domestic law.

(<http://www.worldjii.org/int/cases/ICHRL2000/67.html>)

The case sparked quite a bit of controversy and as one writer put it 'brought into focus so many difficult and far-reaching issues in family and criminal law that the debate is likely to go on for years'. (Fitzpatrick J 'Jodie and Mary: whose choice was it anyway?' *Spiked Liberties* 19 June 2001 (<http://www.spiked-online.com>)).

Fitzpatrick, a director at the Kent Law Clinic and co-author of *Criminal Justice and the Human Rights Act 1998*, 2nd edition 2001, observes that the law protects human life in different ways at different stages. The law protects the embryo from experimentation once the primitive streak has appeared or 14 days have passed, but not before. The law protects the foetus from a termination but not during the first 24 weeks of pregnancy if medical opinion considers there to be a health risk (very broadly defined) to the mother or any of her children. Furthermore, he says, the law allows a mother to have a termination at any time before birth if medical opinion confirms a substantial risk of a seriously handicapped child being born. A mother suffering from post-natal depression who kills her child in its first year will face an infanticide rather than a murder charge and be treated as if she had committed manslaughter. Beyond that, the laws of assault, homicide etc, protect all legal persons, adult and child alike. Fitzpatrick points out that one situation that raises similar principles to the conjoined twins case is that of the pregnant woman who can seek a termination right up to term in cases where serious handicap is expected. The interests of the woman, as future parent with the extra burdens of caring for a seriously handicapped child, are simply given priority over those of the foetus - either because the foetus (handicapped or not) is not recognised as a person who can be wronged by a termination, or because a greater value is placed upon the self-determination of an adult than on the life of a seriously handicapped unborn baby. In either case, he says, it is not clear what the difference is between a seriously handicapped foetus a few days before birth and a seriously handicapped neonate a few days after birth. Nor is it clear how the physical event of birth transforms a foetus into a person or confers a value on the handicapped neonate equal to that of a healthy adult human being. He points out that the law, however, confers personhood at birth, drawing a crucial line at this point for understandable reasons, not least the fact of separation and entry into the world. He notes that it is necessary to draw a line as to when life begins at some point and it may be necessary to apply it rigidly for the purpose of upholding its integrity and says that once the law recognised Jodie and Mary as legal persons who were children, there was only one decision to which the courts could come. Under British law if the jurisdiction of the court is invoked to protect a legal person who is a child, then the court must give 'first and paramount consideration' to the interests of that child. There is little flexibility, the interests of the parents must come second. Fitzpatrick states that there is a limited analogy between the position of these parents and that of the pregnant woman seeking a very late termination of the pregnancy on account of the risk of a seriously handicapped child. In both cases the parents are prepared to sanction the death of their severely handicapped babies, one by termination, the other by refusing to consent to an operation that could save one of the twins. One difference, however, is that the respect and mercy shown by the law to the pregnant mother is not available to the twins' parents because their children have actually been born. He says that whilst human beings must have the protection of the law, the question as to whether that protection has to be both full and immediate is less clear as the law on infanticide indirectly indicates. Fitzpatrick refers to a case in 1997 in which the Court of Appeal had reversed a High Court order that the transplant operation take place on a child a few weeks old against the mother's wishes. Medical opinion was that the child would die within two and a half years without the surgery, the prospects of a successful transplant were good and in the patient's best interests. In determining the interests of the child the court gave special weight to the strong and reasoned parental objections – based on risk of failure, knowledge of pain and suffering involved and the effect on the mother's future care of the child were she made to bring him up against her wishes. He says that this case was mentioned in the case of Jodie and Mary but not followed and notes that the law can be a blunt instrument and that it is foolish to make use of it at every opportunity. The parents were faced with the gross abnormalities of conjoined children, the prospect of certain early death of one and the survival of the other with a risk she was seriously handicapped. Worse still, the survival of that child depended upon their sanctioning the immediate death of the other. Fitzpatrick states that the striking feature of the case is that the hospital authorities insisted on invoking the law. They were not prepared to let the parents have their way but sought to impose their own view as to what should happen to the children. He says their action bespeaks boldness among healthcare professionals about the propriety of interfering in the private lives of their patients and a readiness to resort to law rather than to accommodate the judgment of others. Fitzpatrick notes that in his judgment Lord Justice Ward said that the hospital authorities were entitled to seek the court's ruling. He went out of his way, however, not to endorse the view that the hospital authorities were under a duty to refer the matter to the court and he also said that other medical teams may well have accepted the parent's decision. Had St Mary's done so, there could not have been the slightest criticism of the hospital for letting nature take its course in accordance with the parents' wishes. Later in his judgment he said, however, that if the court were to give permission for the operation to take place, then a legal duty would be imposed on the doctors to treat their patient in her best interests, i.e. to operate upon her. Fitzpatrick reflects that this is an interesting position: it would have been lawful for the doctors to have accepted the parent's decision and let the twins die; the doctors were entitled, but not bound, to seek a court ruling; having done so they were bound in law to accept the court's decision – which was contrary to that of the parents. He notes that the judge seemed to be saying that not everything has to be referred to the courts, even those matters of life and death that the court would be constrained to decide differently. Fitzpatrick states that something of the judge's own diffidence on this topic is contained in his opening comment: 'There has been some public concern as to why the court is involved at all. We do not ask for work but we have a duty to decide what parties with a proper interest ask us to decide.'

Necessity is a defence against unlawfulness or wrongfulness. In *S v Adams*¹¹⁷ the court considered the doctrine of necessity in the context of the criminal law and noted that for an act to be justified on the grounds of necessity:

- (a) a legal interest of the accused must have been endangered;
- (b) by a threat which had commenced and was imminent;
- (c) which was not caused by the accused's fault and
- (d) in addition it must have been necessary for the accused to avert the danger; and
- (e) the means used for this purpose must have been reasonable in the circumstances.

In *Adams*¹¹⁸ King J referred to *R v Bourne*¹¹⁹ where a surgeon carried out an operative procedure on a girl of 15 in order to procure an abortion. She had conceived in consequence of a rape. It was held that the defence of necessity had succeeded – apparently because it was held that the operation was necessary to preserve the life of the girl which the accused genuinely believed to be in danger. There was considerable argument in *Bourne* as to the distinction between danger to life and danger to health. The statements by McNaghten J are contained in his direction to the jury and, said King J, it appeared therefrom that if the danger had been to health alone the accused would have been convicted.¹²⁰ King J stated that there was no reason why threats to the interests of a third party, particularly one under the protection of an accused, should not justify an act in necessity to the same extent as threats in respect of an accused himself. The principle *nemo tenetur ad impossibilia* can only be applied to a prohibitory provision by holding that an accused could not help doing the act prohibited by law, in the sense of impossibility of performance. King J said he did not intend,

117 *Adams* 1979 (4) SA 793 (T)

118 *Adams* fn 117 *supra*

119 *R v Bourne* (1938) 3 All ER 615 (CCC)

120 In *R v Bourne* (fn 119 *supra*) at p 617 and 618, in dealing with the distinction between danger to life and danger to health, McNaghten J said: "... As I say, you have heard a great deal of discussion as to the difference between danger to life and danger to health... but is there a perfectly clear line of distinction between danger to life and danger to health? I should have thought not. I should have thought that impairment of health might reach a stage where it was a danger to life... it may be that you will accept the view that Mr Oliver put forward when he invited you to give to the words 'for the purpose of preserving the life of the mother' a wide and liberal view of their meaning. I would prefer the word 'reasonable' to the words 'wide and liberal'... He is not only entitled, but it is his duty to perform the operation with a view to saving her life..."

in saying this, to confuse the defence of necessity with the defence of impossibility, the two being distinguishable legal concepts.

He said he agreed with the statement by Glanville Williams¹²¹ that a criminal statute need make no mention of the doctrine of necessity as a statute can be regarded as being impliedly subject to the doctrine, just as a statute is impliedly subject to the defence of infancy, insanity or self-defence. This, in turn, would, of course, be subject to an express provision in the statute excluding the doctrine of necessity or an implied exclusion because of some express language in the statute. In regard to the legal interest, there is no clear statement of law as to what can be embraced by a legal interest to justify a defence of necessity. An interest connotes objective concern in something. The difficulty arises in endeavouring to define a legal objective concerning something. It was submitted on behalf of the appellant that the legal interest need only be a legitimate one, which the ordinary man has in our society, to protect the life or good health of himself and the persons to whom he stands in a protective relationship. King J held that a legal interest must involve a fear of injury to person or damage to property saying he found it unnecessary to decide whether the legal interest must be one which is capable of protection in law or need only be legitimate, but not necessarily one capable of protection in law¹²².

Rumpff J held in *S v Adams; S v Werner*¹²³ that “Wanneer ‘n toestand regtens as noodtoestand beskou moet word, sal ahang van die feite van elke geval. Of die optrede van ’n persoon wat in noodtoestand handel as redelik beskou kan word of nie, hang ook van die feite van elke geval af.”¹²⁴ South African law

¹²¹ Glanville Williams 1965 *Current Law Problems* at p 224

¹²² King J in *Adams* fn 117 *supra* also referred to the American Penal Code, Tentative Draft No 853, which stated: “Conduct which an actor believes to be necessary to avoid an evil to himself or to another is justifiable, provided that: (a) The evil sought to be avoided by such conduct is greater than that sought to be prevented by the law defining the offence charged...”

¹²³ *S v Adams; S v Werner* 1981 (1) SA 187 (A)

¹²⁴ Du Toit, one of the Counsel for the state set out the principles and precedents as follows: “In die Suid-Afrikaanse reg is die volgende vereistes vir die verweer van noodtoestand aangestip: (1) daar moet, objektief gesien, ’n reeds begonne toestand van nood wees, of, ook objektief gesien, ’n onmiddellik dreigende noodtoestand; (2) die persoon in beweerde nood moes nie regtens verplig gewees het om die nood te verduur

recognizes a general defence of necessity. In Roman law there was no systematic discussion of the defence of necessity but there are isolated instances in which such a defence was recognized¹²⁵. Several Roman-Dutch writers considered necessity as a general defence¹²⁶. Necessity has been recognized as a general defence in modern South African law¹²⁷. The legally protected interest may be threatened by force of surrounding circumstances¹²⁸.

Strauss¹²⁹ submits that there are only three possible grounds of justification for a medical intervention namely –

- The patient's consent (or the consent of someone legally capable of consenting on his behalf);
- *Negotiorum gestio* which entitles a doctor to administer emergency medical treatment in those cases where on account of the patient's condition he is unable to consent;
- Necessity, i.e. where the interests of society are at stake (which would entitle a doctor to treat the patient even against his will) for example where medical intervention is necessary to prevent the spreading of a contagious disease¹³⁰.

nie; (3) die persoon moes nie self die toestand van nood geskep het nie; (4) sy gewraakte optrede moet die enigste manier van redding uit die nood wees; en (5) die belange wat hy opoffer moet nie groter wees as die bedreigde belange nie. Kyk De Wet en Swanepoel *Strafreg* 3de uitg te 87 - 89; Burchell en Hunt *South African Criminal Law and Procedure* band 1 te 283 et seq; *R v Yermaak* (1900) 21 NLR te 211; *R v Garnsworthy* 1923 WLD te 21; *R v Mahomed* (supra te 34, 36); *R v Werner* 1947 (2) SA 823; *R v Baxter* 1929 EDL 189; *R v Damascus* 1965 (4) SA te 600 - 601, 603; *S v Bradbury* 1967 (1) SA te 393, 394, 399 - 400, 404; *R v Mneke* 1961 (2) SA te 243; *R v Canestra* (1951 (2) SA te 324); *R v Van der Merwe* 1950 (4) SA te 126; *R v Samuel* 1960 (4) SA te 703; *United States v Holmes* 1 Wall Jr 1,26 Fed Cas 360; *R v Chipesa* 1964 (4) SA te 474; *S v Mletwa* 1977 (3) SA te 631; *S v Pretorius* 1975 (2) SA te 90; *S v Goliath* 1972 (3) SA 1; *S v Alfeus* 1979 (3) SA 145."

¹²⁵ D 47.9.3.7; D 9.2.49.1; D 43.24.7.4; D 9.2.29.3; D 19.5.14

¹²⁶ Grotius *De Jure Belli ac Pacis* 2.2.6 - 9; Puffendorf *De Jure Naturae et Gentium* 2.6.4 and 5; Van der Keessel *Praelectiones* 47.2.8.

¹²⁷ *S v Mahomed and Another* 1938 AD at 34 - 35; *S v Rabodila* 1974 (3) SA 324; *S v Pretorius* 1975 (2) SA 85; *Chetty v Minister of Police* 1976 (2) SA at 452 - 3; *Minister of Police v Chetty* 1977 (2) SA 885; *S v Adams* 1979 (4) SA at 796A - C; Burchell and Hunt *South African Criminal Law and Procedure vol I General Principles* at 283 et seq; De Wet and Swanepoel *Strafreg* 3rd ed at 87 - 88; J V van der Westhuizen *Noodtoestand as Regverdigingsgrond in die Strafreg* (1979) LLD dissertation (Pretoria) 730.

¹²⁸ *S v Pretorius* 1975 (2) SA 85 at 89 - 90; *Stoffberg v Elliott* 1923 CPD 148 at p 150.

¹²⁹ Strauss fn 34 *supra*

¹³⁰ Strauss (fn 34 *supra*) at p31. In "Murder, The Defence of 'Necessity' and Medical Practice after the case of the conjoined twins Jodie and Mary" (http://www.forensicmed.co.uk/siamese_twins.htm) Jones R examines the legal basis for the type of decision that was made in this case and considers whether this decision will have any impact on other areas of medical practice where 'value of life' decisions are made. He notes that Ward LJ made the point in his judgment that the prohibition of intentional killing was recognised as the cornerstone of law and



He points out that in *Stoffberg v Elliot*¹³¹ it was held that in the eyes of the law every person has certain absolute rights which the law protects. They are not dependent on statute or upon contract but they are rights to be respected and one of the rights is absolute security to the person. Any bodily interference with or restraint of a man's person which is not justified, or excused or consented to is wrong. A man by entering a hospital does not submit himself to such surgical treatment as the doctors in attendance upon him may think necessary. He remains a human being and retains his rights of control and disposal of his own body. He still has the right to say what operation he will submit to and 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. More recently, in *Minister of Safety and Security and Another v Xaba*¹³², Southwood J in the Durban and Coast Local Division of the High Court refused to follow a decision of the Cape High Court in *Minister of Safety and Security and Another v Gaqa*¹³³ in which an order was granted to allow police officials to use necessary violence to obtain the surgical removal of a bullet from an accused in circumstances where it was required as evidence in the criminal prosecution of the accused. In *Xaba* the applicants applied for the confirmation of a rule *nisi* which would declare the second

social relationships and is of supreme moral value. It reflects the sanctity of life doctrine which is essentially a religious concept. He points out, however, that Ward LJ noted that the principle does not represent an absolute rule – life must be protected from unjust attack, and the deliberate taking of life is prohibited except in self-defence or in the legitimate defence of others. All of the judges considered the possibility of the proposed operation on Jodie and Mary as falling within the realm of the doctrine of necessity although it was Brook LJ who provided a detailed examination of the application of this 'obscure aspect of the common law' as Jones puts it. He notes that in essence the defence of the doctrine of necessity is of a similar species to that of duress and has been termed "duress of circumstances" and that it embodies the concept of utilitarianism. He quotes Sir James Stephens who stated in the Digest of Criminal Law (1887) that the doctrine of necessity could be described as follows: "An act which would otherwise be a crime may in some cases be excused if the person accused can show that it was done only in order to avoid consequences which could not otherwise be avoided, and which, if they had followed, would have inflicted upon him or others whom he was bound to protect inevitable and irreparable evil, that no more was done that was reasonably necessary for that purpose and that the evil inflicted by it was not disproportionate to the evil avoided."

Jones notes the defence of duress itself has been disapproved where the charge is murder (*Abbott v R* (1976)) and historically, the case of *R v Dudley & Stephens* (1884) suggested that necessity was not a defence that would be successful either. It was reaffirmed in the more recent cases of *R v Howe* (1987) and *R v Pommell* (1995) but Brook LJ considered the facts of these cases to be very different to the case of Jodie and Mary. Brook LJ found that the component parts of necessity had been fulfilled in *Re: A (Children)*. Ward LJ agreed and stated that the doctors were in an impossible position.

131 Stoffberg fn 28 *supra*

132 *Xaba* 2003 (2) SA 703

133 *Gaqa* 2002 (1) SACR 654 (C)



applicant, a police officer, to be entitled to ‘use reasonable force, including any necessary surgical procedure performed by . . . medical doctors’ to remove a bullet lodged in the respondent’s thigh, and directing the respondent to subject himself to the procedure, failing which the Sheriff was to furnish the necessary consent on his behalf. The respondent was a suspect in a motor-vehicle hijacking case and the police believed the bullet would connect him with the crime. Not surprisingly, the respondent refused to undergo the procedure. The applicants relied on section 27 of the Criminal Procedure Act¹³⁴ which deals with legitimate use of force by police in the event of resistance against search or seizure, and section 37, which deals with police powers in respect of prints and bodily features of the accused. Section 27 of the Criminal Procedure Act authorises a ‘police official’ to ‘use such force as may be reasonably necessary to overcome any resistance’ against a lawful search of any person or premises. Section 37(1)(c) authorises a ‘police official’ to ‘take such steps as he may deem necessary in order to ascertain whether the body of a person . . . has any mark, characteristic or distinguishing feature or shows any condition or appearance; provided that no police official shall take any blood sample’. Section 37(2)(a) allows ‘any medical officer of any prison or any district surgeon or, if requested thereto by any police official, any registered medical practitioner or registered nurse to ‘take such steps, including the taking of a blood sample, as may be deemed necessary to ascertain whether the body of any person ... has any mark, characteristic, or distinguishing feature or shows any condition or appearance’. The applicable section of the Constitution, section 12, guarantees the right to freedom and security of the person, including the right ‘to be free from all forms of violence from either public or private sources’, and the right to bodily and psychological integrity, including the right to ‘security and control [one’s] body’. Section 36 of the Constitution provides that fundamental rights such as those in section 12 may be limited by a law of general application in certain circumstances.

¹³⁴ Criminal Procedure Act No 51 of 1977

In the cases of *Xaba* and *Gaga* the court had to balance the rights of the suspects to bodily and psychological integrity against the rights of society as a whole to safety and security. It is interesting that in the one the court came down in favour of the individual and in the other in favour of the collective. Generally speaking the courts seem to favour the rights of the individual over those of the collective. The obvious question in these two cases is why, if the suspects were innocent, they would object to having the bullets removed since this would have proved their innocence if it in fact existed. In the context of the doctrine of necessity it is possible that the decision of the court in *Xaba* was correct provided that the court could draw an adverse inference from the suspect's unwillingness to have the bullet removed. In other words there may be less drastic ways of proving the suspect's guilt than the forced removal of the bullet. However, it could be argued that in South Africa the rights of society to safety and security are under siege and that the interests of the collective should weigh more heavily in these circumstances than those of the individual since the harm to the individual, should he be guilty or innocent, of minor surgery is not nearly as significant as the potential harm to society, should he be guilty, of releasing him to continue his hijacking activities which cost people their lives.

7.4 Vicarious Liability

The liability of public providers of health care services is likely to be vicarious in most if not all instances. As noted previously the State Liability Act specifically recognizes the possibility of such liability. According to Neethling *et al*, vicarious liability may in general terms be described as the strict liability of one person for the delict of another. In other words it the delict of the tortfeasor is imputed to another person who has a particular relationship of authority over the tortfeasor in the absence of fault on the part of that other person. The important relationships in this regard are employer and employee and principal and agent. Neethling *et al* observe that the rationale for the vicarious liability of an employer for the delicts of an employee is controversial. They state that the best-known explanation is that the employer's liability is

founded on his own fault (*culpa in eligendo*). However, fault in the choice of employee has been referred to in *Feldman (Pty) Ltd v Mall*¹³⁵ as a “hoary explanation” and Neethling *et al* agree. They point out that this explanation is based on a fiction since according to this theory there is an irrebuttable presumption that the master has been negligent if he servant commits a delict. It is not open to him to prove the opposite. Other theories put forward are the interest or profit theory, the identification theory, the solvency theory and the risk or danger theory¹³⁶ Neethling *et al* observe that Scott¹³⁷ argues convincingly that the risk or danger theory furnishes the true rationale for the employer’s liability. The theory assumes that the work entrusted to the employee creates a certain risk of harm for which the employer should be held liable on the grounds of fairness and justice as against injured third parties¹³⁸. Scott¹³⁹ maintains that the employer should only be held liable if the conduct of the employee was reasonably foreseeable¹⁴⁰.

In *Masuku and Another v Mdlalose and Others*¹⁴¹ the Supreme Court of Appeal observed that despite various nuances in expression, the common-law test of vicarious liability, i e whether the employee in question was acting in the course and scope of his employment or, put differently, whether he was engaged in the affairs or business of the employer, had been applied consistently since 1958 to the liability of the state for the wrongful acts of police officers.¹⁴² It stated that

¹³⁵ *Feldman* 1945 AD 733

¹³⁶ See Neethling *et al* fn 18 *supra* at p 373 for a more detail as to the substance of these theories.

¹³⁷ Scott WE, *Middellike Aanspreeklikheid in die Suid-Afrikaanse Reg* p 30

¹³⁸ In *Minister Of Law And Order v Ngobo* 1992 (4) SA 822 (A) the court held, however, that in the circumstances of that case, there could be no doubt that, on the basis of the standard test, the appellant ought not to have been held vicariously liable for the employee’s wrongful act because the constables had not been on duty; they had at no stage purported to be carrying out any police function, they had unnecessarily resorted to the use of firearms in the course of an equally unnecessary altercation with strangers; and they had in no sense been engaged in the affairs of the appellant (despite the fact that they had used the revolvers they had been authorised to retain, which factor, though relevant, was not in itself enough to satisfy the standard test).

¹³⁹ Scott fn 137 *supra*

¹⁴⁰ This conclusion was not supported by the minority judgment of Viljoen JA in *Minister of Police v Mbilini* 1983 (3) SA 705 (A)

¹⁴¹ *Masuku* 1998 (1) SA 1 (SCA)

¹⁴² See *African Guarantee & Indemnity Co Ltd v Minister of Justice* 1959 (2) SA 437 (A) at p 445; *Mhlongo and Another NO v Minister of Police* 1978 (2) SA 551 (A) especially at 567 para (3); *Macala v Maokeng Town Council* 1993 (1) SA 434 (A); *Minister of Law and Order v Ngobo* 1992 (4) SA 822 (A) at 826F–828A;

the previous cases, on analysis, all confirmed that, in order to establish the vicarious liability of the state, the plaintiff must prove that the person who did the wrong was (a) an employee of the state acting in that capacity, and (b) that he or she performed the wrongful act in the course or scope of his or her employment. It said that the tests for state liability for the wrongful acts of police officers and the test for an employer's vicarious liability were stated explicitly to be the same in *Mhlongo and Another NO v Minister of Police*¹⁴³.

The terms 'within the scope of his authority' and 'within the scope of employment', said the court, were treated as being synonymous. Reference was made to the notional difference between the two last-mentioned concepts that were mentioned, but not explained or used, in *Feldman (Pty) Ltd v Mall* but doubt was expressed as to the tenability of this difference when Corbett JA stated at 567D:

"Nevertheless, it has never been suggested that the state escapes liability for a wrongful act committed by a servant in his capacity as such simply because the act fell outside the 'scope of his authority', when it was clearly within the 'scope of his employment'."

In *Minister of Safety and Security v Jordaan T/A Andre Jordaan Transport*¹⁴⁴ it was noted that the standard test for vicarious liability is whether the delict in question was committed by an employee while acting in the course and scope of his employment. The inquiry is frequently said to be whether at the time the employee was about the affairs or business, or doing the work, of the employer. The court said that while this was no doubt true, it should not be overlooked that the affairs or business or work of the employer in question must relate to what the employee was generally or specifically instructed to do. It held that provided the employee was engaged in activity reasonably necessary to achieve either objective, the employer would be liable. The court observed that the difficulty is that, while the general approach to be adopted may be easy enough to formulate,

Tshabalala v Lekoa City Council 1992 (3) SA 21 (A) at 28B–29B; *Minister of Police v Rabie* 1986 (1) SA 117 (A) at 132G–H, 134D–135C; *Minister of Police v Mbilini* 1983 (3) SA 705 (A) especially at p 710B–712B.

143

Mhlongo fn 142 *supra*

144

Jordaan 2000 (4) SA 21 (SCA)

its lack of exactitude is such that problems inevitably arise in its application. This is particularly so in the so-called deviation cases. Not every act of an employee committed during the time of his employment which is in the advancement of his personal interests or for the achievement of his own goals, necessarily falls outside the course and scope of his employment. In each case, whether the employer is held to be liable or not must depend on the nature and extent of the deviation. Once the deviation is such that it cannot reasonably be held that the employee is still exercising the functions to which he was appointed, or still carrying out some instruction of his employer, the latter will cease to be liable. The court found that whether that stage has been reached is essentially a question of degree and said that answer to each case will depend upon a close consideration of the facts. The same is true of the inquiry as to whether the deviation has ceased and the employee has resumed the business of his employer.

In *Minister van Veiligheid vn Sekuriteit v Phoebus Apollo Aviation Bk*¹⁴⁵ it was held that the actions of three dishonest policemen who were involved in a robbery had not, considered objectively or subjectively, fallen within the course and scope of their duties and that they had embarked on an unauthorised jaunt for their own benefit with the intention of stealing from their own employer. It was held, further, that the three policemen had, by their theft and fraudulent conduct, not caused vicarious liability to devolve upon their employer.

In *Minister van Veiligheid en Sekuriteit v Japmoco Bk H/A Status Motors*¹⁴⁶ the respondent claimed that members of the vehicle theft unit of the South African Police Service, in the service of the State, had intentionally and for private gain, co-operated with a syndicate of car thieves and made it possible for the latter to sell cars stolen by its members. The relevant policemen prepared and issued motor vehicle clearance certificates, without which the vehicles could not be B

¹⁴⁵ *Phoebus Apollo* 2002 (5) SA 475 (SCA)

¹⁴⁶ *Japmoco* 2002 (5) SA 649 (SCA)



registered and resold. Eight of the vehicles for which false documentation was provided were sold to a second-hand motor vehicle dealer, Pro-fit, which in turn sold the vehicles to the respondent. The respondent sold seven of the vehicles at a profit to various members of the public. All eight vehicles were later seized by the police. Six of the seven purchasers held the respondent liable in terms of his common-law implied warranty against eviction and the respondent was forced to compensate each of them by repaying the purchase price or value of the motor vehicle. The respondent lost the eighth vehicle. The respondent based his claim in delict. It was argued that the relevant policemen, acting within the course and scope of their employment as employees of the state, had made it possible for the thieves to trick unsuspecting purchasers with false documentation. Without the relevant documents, the respondent alleged that he would never have purchased the relevant vehicles and would therefore have suffered no damages. During the trial it was admitted that the relevant clearance certificates were issued while the relevant policemen were aware of the fact that the clearance certificates were being issued in respect of stolen vehicles. The Court had to answer three questions: (1) Had the respondent proved a causal link between the actions of the relevant policemen and the purchase of the eight vehicles by the respondent; (2) had the policemen been acting within the course and scope of their duties; and (3) had the respondent proved the fact that he had suffered damages as well as the quantum thereof. Nienaber JA held that an employer was legally liable for the damage caused to third parties by the unlawful actions of his employee within the course of his duty. He said that whether the unlawful action occurred within the course of the employee's duty was a factual enquiry and that sometimes it was a question of degree whether the relevant action fell just within or without the scope of the employment. It could fall within the scope of employment even where it conflicted with an emphatic ban from the employer and even where the employee acted intentionally and not negligently. The employee's purpose had to be examined and in this respect, the test was subjective. Where there was, however, a close connection between the employee's action for his own interests and purposes

and the business of the employer, the employer might still be liable. Nienaber JA held that this was an objective test. He held further that the unlawful conduct of the relevant policemen consisted of the intentional issue of false clearance certificates, knowing that innocent third parties could be misled to their detriment thereby. Such actions were in conflict with the prescriptions of their employer, the appellant. Subjectively speaking, their prime objective was not to serve the interests of their employer but to favour their own pockets. On the other hand, each of them was, objectively speaking, performing the exact task assigned to them. This was accordingly not a matter where the employees, in the manner in which they performed the task, had totally distanced themselves from their assigned duties. The court said that that, while the clearance certificates were false, they were not forged. There was therefore a close connection between the employees' actions for their own interests and purposes and the business of the employer. The appellant was accordingly, in principle, responsible for the actions of his officers. It said that such action contained an element of fraud was not in itself conclusive. The fraud was not so much aimed at the employer as at third parties and did not necessarily reside in the action but the purpose with which the action was executed. However, the respondent failed in his claim because he had not proved the quantum of his damages.

In *Minister of Safety and Security v Van Duivenboden*¹⁴⁷ the court had to consider the question of liability for an omission as well as vicarious liability of the state for the omissions of its employees. In this case it held that there was no effective way of holding the state accountable other than by way of an action for damages. The court stated that in the absence of any norm or consideration of public policy outweighing it, the constitutional norm of accountability required that a legal duty be recognised. The negligent conduct of police officers in those circumstances was accordingly actionable and the state was vicariously liable for the consequences of any such negligence¹⁴⁸.

¹⁴⁷ *Van Duivenboden* fn 92 *supra*

¹⁴⁸ Paragraph [22] at 448C/D - E.

Strauss¹⁴⁹ points out that the general principle is that there must be a relationship of employment whereby one person stands in a position of authority in relation to another in terms of which the former is legally capable of exercising control over the latter's actions¹⁵⁰.

The question in the health care context is whether employees who are registered health professionals can incur liability on the part of their employers by their negligent actions in the course and scope of their duties. After all they can be punished by their own professional boards for such acts and the employer does not necessarily itself have the expertise to know when for instance an employee surgeon is being negligent in the operating theatre. The earlier cases did at first subscribe to the view that an employer cannot be held vicariously liable for the 'professional' negligence of employees. Thus it was held in the case of *Lower Umfolosi District War Memorial Hospital v Lowe*¹⁵¹ that the placing by a nurse of a hot water bottle in the bed of a patient who had been under the effects of an anaesthetic, causing the patient to be badly burnt, was a professional act of negligence and that the hospital could thus not be held liable.¹⁵² In *St*

¹⁴⁹ Strauss fn 34 *supra*

¹⁵⁰ In *Stein v Rising Tide Productions CC* 2002 (5) SA 199 (C) it was held that the Courts had drawn a clear distinction, for the purposes of vicarious liability, between an 'independent contractor' and an employee (or 'servant'). As a general rule, an employer was vicariously liable for the delicts of his employee acting in the course and scope of his employment, while he was not vicariously liable for the negligence of an independent contractor employed by him - the exception being where the employer himself had in some way been personally at fault (usually negligent) in regard to the conduct of the independent contractor that had caused harm to a third party. The main distinction between the two was that the employee (servant) undertook to render personal services to the employer, while the independent contractor undertook to perform a certain specified piece of work or to produce a certain specified result for the employer. Unlike an employee, an independent contractor was generally not subject to the control or the instructions of the employer as to how he performed the work or produced the result. In the past the Courts had generally relied on the so-called 'control test' to determine whether the employment relationship was one of 'master and servant' or one of employer/independent contractor. The court further held that problems experienced with the control test had led the Courts to rely, particularly in marginal cases, on the 'dominant impression' test, viz whether or not the dominant impression was that of a contract of employment. This required a typological approach in which the right of control was not an indispensable requirement of the contract of service, but only one of a number of indicia, the combination of which might be decisive. Other indicia were: the nature of the work; the existence of a right of supervision; the manner of payment (fixed rate or commission); the relative independence of the employee; the employer's power of dismissal; whether the employee was precluded from working for another; whether the employee was required to devote a particular amount of time to his work; whether the employee was required to perform his duties personally; the ownership of the working facilities and whether the employee provided his own tools and equipment; the intention of the parties; the period of employment, etc. (From headnote)

¹⁵¹ *Lower Umfolosi* 1937 TPD 31

¹⁵² Other South African cases that followed the same logic are *Hartl v Pretoria Hospital Board* 1915 TPD 336 and *Byrne v East London Hospital Board* 1926 EDL 128



*Augustine's Hospital (Pty) Ltd v Le Breton*¹⁵³ a 92-year-old patient fractured her leg when, in the middle of the night, she fell out of a hospital cot due to the negligence of the nursing staff in failing to erect the sides of the cot at night. The single judge was constrained to hold that in the absence of any special term in the contract between the hospital and that patient, the ordinary contract between patient and hospital does not cast upon the hospital an obligation to do more than take reasonable steps to assure itself of the professional competence of the nurses it employs to attend to the patient. The patient could thus not hold the hospital liable for the negligence of its nursing staff. The court in this case made the point that it was obliged by the principle of *stare decisis* and the fact that the decision of the Natal court in the *Lower Umfolosi Memorial Hospital* case had been one of a Full Bench to make the judgment that it had but that it would have preferred to come to a different finding had it been free to do so. In *Mtewa v Minister Of Health*¹⁵⁴ the plaintiff was a patient at the King George V Hospital. She was being treated for suspected tuberculosis. The physician treating her was a certain Dr Pala, an employee of the defendant. The plaintiff alleged that Dr Pala acted carelessly in prescribing and administering a particular medication for her, in consequence of which she suffered a series of unpleasant and harmful after- and side-effects. She accordingly claimed R7 000 for pain, suffering, discomfort and inconvenience and R3 000 for loss of amenities. The respondent excepted to the plaintiff's claim on the basis of the decision of the court in *Lower Umfolosi District War Memorial Hospital v Lowe*. The court in *Mtewa* observed that in the Transvaal the cases of *Esterhuizen v Administrator Transvaal*¹⁵⁵; *Dube v Administrator Transvaal*¹⁵⁶ and *Buls and Another v Tsatsarolakis*¹⁵⁷ do not mention nor support the distinction, which is pivotal to the decision in the *Lower Umfolosi* case, between professional work over which the hospital is said to have no control and for

¹⁵³ *St Augustine's* 1975 (2) SA 188 (D); 1975 (2) SA 530 (D)

¹⁵⁴ *Mtewa* 1989 (3) SA 600 (D)

¹⁵⁵ *Esterhuizen* fn 29 *supra*

¹⁵⁶ *Dube* 1963 (4) SA 260 (T)

¹⁵⁷ *Buls* 1976 (2) SA 891 (T)



which it is accordingly not liable, and managerial or administrative duties performed by an employee, for which it is responsible. In the Transvaal cases the issue was simply whether the particular member of staff was negligent in the exercise of his duties, regardless of whether he was part of a professional team or not. However, said the court, as long as the decision in the *Lower Umfolosi* case stands, that is not the prevailing view in Natal. Because of the divergence of judicial views, and because the plaintiff was anxious to avoid the predicament which compelled Fannin J in the *St Augustine's Hospital (Pty) Ltd case* to follow the one view while preferring the other, the plaintiff, as the respondent to the exception, initiated an application in terms of s 13(1)(b) of the Supreme Court Act¹⁵⁸ to have the hearing of the exception referred to the Full Court of the Natal Provincial Division. That application, which was not opposed, was duly granted. The court observed that the point on which the decision in the *Lower Umfolosi* case hinged was that a member of the professional staff of a hospital was not a servant proper for whose misdeeds the hospital was accordingly responsible. At the time that was perceived to be a principle of law. Nowadays, the question is purely one of fact. The degree of supervision and control which is exercised by the person in authority over him is no longer regarded as the sole criterion to determine whether someone is a servant or something else. The deciding factor is the intention of the parties to the contract, which is to be gathered from a variety of facts and factors. Control is merely one of the *indicia* to determine whether or not a person is a servant or an independent worker. Nienaber J stated that just as the Minister of Law and Order can be held accountable for the peccadilloes of a policeman even when the latter exercised a discretion of his own¹⁵⁹ and indeed, even when he was not on duty¹⁶⁰, so too, it might be argued by analogy, the Minister of Health is at risk if a member of the staff of a hospital under his command is negligent in the exercise of any of his duties, be they professional and not subject to dictation

¹⁵⁸ Supreme Court Act No 59 of 1959

¹⁵⁹ *Minister van Polisie en 'n Ander v Gamble en 'n Ander* 1979 (4) SA 759 (A)

¹⁶⁰ *Minister of Police v Rabie* 1986 (1) SA 117 (A)



from others. The court held that to the extent that the judgment in the *Lower Umfolosi* case purported to enunciate a universal principle of law, namely that a hospital assumes no responsibility for the negligence of any member of its staff engaged in professional work, it has been overtaken by more recent authority, not only by the South African cases referred to but by English ones as well.¹⁶¹

7.5 Medicines

Medicines are of particular interest in the delictual sphere because they are the product or goods aspect of health services delivery. Consequently issues such as product liability and the liability of the manufacturer as opposed to that of the health services provider who supplies the medicine are of relevance. Whilst issues of the administration of medicines by health care providers are also important, the context in which medicines are marketed, developed and supplied by manufacturers adds a new dimension to the discussion. The efficacy of a medicine is a quality that can only be generally, as opposed to specifically, established in the sense that different individuals react and respond differently to the same medicine¹⁶². They may experience different side-effects, they may

¹⁶¹ See, for instance: *Gold v Essex County Council* [1942] 2 KB 293; *Collins v Hertfordshire County Council* [1947] KB 598; *Cassidy v Ministry of Health* [1951] 2 KB 343 (CA); *Roe v Minister of Health* [1954] 2 QB 66

¹⁶² The Nuffield Council on 'Bioethics Pharmacogenetics: Ethical Issues' has stated that: "People vary in their response to the same medicine. Few medicines are effective for everyone; all may cause adverse reactions or occasionally death. Some of the variation between individuals in response to medicines is due to differences in their genetic make-up. There are many different reasons why medicines may be dangerous or ineffective, such as inaccurate prescribing, poor compliance by the patient and interaction between a particular medicine and other substances, including other medication. However, advances in genetic knowledge may enable us to take better account of differences between individuals. Pharmacogenetics is the study of genetic variation that affects response to medicines. It has the potential to play an important role in improving safety and efficacy. Adverse reactions to medicines have significant costs, in both human and monetary terms. In addition, considerable resources are wasted on prescribing medicines that have little or no effect in particular patients." http://www.nuffieldbioethics.org/filelibrary/pdf/pharmacogenetics_report.pdf. They proceed to point out that the most common reason for medicines to be withdrawn from the market once they have been licensed is the subsequent occurrence in patients of serious adverse reactions which were either unsuspected at the time of marketing authorisation or occur more frequently than was expected at the time of the grant of marketing authorisation. They also make the point that both public and private providers of healthcare operate on limited budgets. In addition to the traditional requirements of quality, efficacy and safety for the regulatory approval of new medicines, public policy in many countries is developing the requirement to assess medicines for their cost-effectiveness.

Abraham J, Sheppard J and Reed T "Rethinking Transparency and Accountability in Medicines Regulation in the United Kingdom" *British Medical Journal* Jan 2 1999 observe that: "The marketing of a number of drugs that would have been withdrawn because their risks outweighed their benefit would probably have been challenged earlier if there had been greater transparency and public accountability... In the case of Opren, the lack of experimental testing for photosensitivity before approval in the United Kingdom and the omission of clear estimates of risks of photosensitivity from the United Kingdom product data sheet might well have been questioned. Hundreds of patients who had taken Opren subsequently complained of persistent photosensitivity. Similarly, Zomax was approved in the United Kingdom for the chronic treatment of arthritis without any

experience widely varying levels of efficacy, in some cases they may even experience an allergic reaction to the medicine. Furthermore, the efficacy of a medicine from the point of view of the patient is dependent upon a number of external factors such as the accuracy of the diagnosis, the manner and the environment in which it is administered or taken, the overall state of health of the patient, whether the patient has an allergy to the medicine¹⁶³, whether it is taken in combination with other drugs or an appropriate dietary regimen etc.

Laypersons are sometimes of the view, in relation to medicines, that even if the medicine is not effective surely there can be no harm in taking it. This can be a dangerous misperception. Many medicines are toxic substances, some more so than others¹⁶⁴. They can themselves induce illness if used incorrectly. There can

warning on the product data sheet, despite positive carcinogenicity findings in animal tests before marketing. After the drug had been withdrawn, the Medicines Commission described the findings on carcinogenicity as a cause for concern when justifying its recommendation that Zomax should be returned to the market. Had those findings been public before the drug had been approved fewer patients would probably have been prescribed Zomax. More recently, Halcion was finally banned in the United Kingdom in 1993. It had been approved in 1978 but suspended since 1991. On banning Halcion the British regulatory authorities said that if they had known in 1978 what they knew in 1991, they would never have approved the drug in the first place."

Brazell C, Freeman A and Mosteller, M "Maximizing the value of medicines by including pharmacogenetic research in drug development and surveillance" *British Journal of Clinical Pharmacology* March 2002 state that "Genetics provides significant opportunities to maximize the safety and efficacy of medicines...The ability to develop drugs with a predictable response will allow clinicians to provide targeted treatment for patients with greater confidence of safety and efficacy. Patients will therefore receive more efficacious, timely and well-tolerated medicines."

¹⁶³ Penicillin for example is an effective antibiotic in many instances but some individuals are allergic to it and therefore cannot use it.

¹⁶⁴ Anti-retroviral drugs are highly toxic substances that can in some cases result in death. By way of example the drug profile of Abacavir (ABC): *Ziagen* (GlaxoSmithKline); related: *Trizivir* (TZV) CLASS: reads as follows – NRTI INDICATIONS: Most potent NRTI. FORMS AND PRICE: Tabs: 300 mg at \$6.41. As TZV: AZT 300 mg/3TC 150 mg/ ABC 300 mg at \$16.75 PATIENT ASSISTANCE: 800-722-9294

REGIMEN: 300 mg bid. Renal failure: Standard. PATIENT INSTRUCTIONS: No food restrictions. Warn about hypersensitivity reactions expressed as fever (usually 39° to 40°C), rash (maculopapular, often subtle), fatigue, nausea, vomiting, diarrhea, abdominal pain, muscle/joint pain, paresthesias, cough and/or dyspnoea. The highest risk is in the first 6 weeks but can occur at any time. A common concern is that every cold or side effect from a drug taken concurrently is interpreted as a side effect of ABC. Fever is nearly always present with ABC hypersensitivity. Patients should be advised to contact provider with questions prior to d/c. Warn of lipodystrophy and fat redistribution. WARNINGS: HSR, may be severe, resulting in hypotension and possible death. Warning card is available from pharmacists. Next dose will illicit same or worse Sx, may wish to administer next dose under observation. Remember that once this drug is stopped for suspected hypersensitivity it is often lost forever. SIDE EFFECTS: HSR with above Sx; complications include anaphylaxis, renal failure, hepatic failure, hypotension and death. Rechallenge has resulted in 3 deaths. GI intolerance. Class ADR: Lactic acidosis and hepatic steatosis.... DRUG INTERACTIONS: ETOH increases ABC AUC 41% (clinical significance unknown); ABC may \uparrow methadone Cl; \uparrow methadone dose may be required. PREGNANCY: Category C.

Efavirenz, EFV: *Sustiva* (Bristol-Myers Squibb)

CLASS: NNRTI

INDICATIONS: Potent anti-HIV agent; one of few triple agent regimens with comparable antiviral activity with baseline VL above or below 100,000 c/mL in treatment naive patients.

FORMS AND PRICE: Caps: 50 mg, 100 mg, 200 mg at \$4.39

REGIMENS: 600 mg (three 100 mg tabs) hs. Renal failure or hepatic failure: Standard PATIENT INSTRUCTIONS: Take without regard to meals except that high fat meals should be avoided because they increase absorption. If switching from PI to EFV, some experts suggest an overlap of 1 week to achieve

also be significant consequences for general public health if they are used inappropriately. Multi-drug resistant tuberculosis (MDR-TB)¹⁶⁵ is a real example of the dangers for patients of widespread resistance to antibiotics. MDR-TB can only be treated with a limited number of extremely expensive antibiotics. If resistance to these antibiotics develops, there is no other effective treatment for the disease. Malaria is another example of a disease that has beaten what was once its standard treatment.¹⁶⁶ The World Health Organisation has warned that many infectious diseases which can be controlled now may be untreatable within 10 years¹⁶⁷. The same principles are applicable to

therapeutic EFV levels. Avoid in pregnancy and in women contemplating pregnancy. Warn of potential side effects of bad dreams and “disconnected” feeling, with the anticipation that if these occur, they will occur with the first dose and will usually resolve in 2 to 4 weeks. Women cannot depend on oral contraceptives when taking EFV. Warn of lipodystrophy, fat redistribution, and rash. **WARNINGS:** Avoid in 1st trimester of pregnancy and in women contemplating pregnancy; birth control pills may be unreliable due to interaction with EFV. CNS side effects in >50% in first 2 to 3 weeks and may be profound with confusion, vivid dreams, depersonalization, etc. Impact of ETOH, prior mental illness, or psychoactive drugs not well characterized. May need to avoid driving and other potentially dangerous activities during first 2 to 4 weeks. May cause false positive cannabinoid test (confirmatory tests are negative). Drug interactions, see below. **SIDE EFFECTS:** Rash—15% to 27%, sufficiently serious to d/c drug in 1% to 2%; d/c if rash is associated with fever, blistering, desquamation, mucous membrane involvement, arthritis or Stevens-Johnson syndrome (rare). CNS effects, see above. Hepatitis with ALT >5 x ULN in 2% to 3%. **Class ADRs:** Rash, lipodystrophy (not well characterized), cholesterol and HDL increase. **DRUG INTERACTIONS:** Contraindicated: Astemizole, terfenadine, midazolam, triazolam, cisapride, clarithromycin and ergot. EFV reduces levels of RBT, increase RFB dose to 450–600 mg/day or 600 mg 2x/week. Minimal RIF interaction, use standard doses of each. EFV reduces methadone levels, monitor for withdrawal Sx. Possibly significant interactions: Ethinyl estradiol (use alternative method of birth control) and warfarin (monitor pro-time). Pls: see Table 6–10, p. 34.
Source: <http://www.hopkins-aids.edu/publications/abbrevgd/abbrevgd.pdf>.

165 Biotec Tuberculosis <http://www.biotec.com/ftpbrapid.html>. “Multi-drug resistant tuberculosis (MDR-TB) refers to drug resistance to at least two key TB drugs, isoniazid and rifampicin... Treatment of MDR-TB requires use of less effective, more toxic and expensive drugs for longer periods. Patients with MDR-TB are less likely to be cured, giving the potential opportunity of spreading MRD-TB to the community.”

166 Radio Netherlands ‘Drug Resistance’ <http://www.rnw.nl/health/html/drug-resistance.html> reports that chloroquine as frontline treatment for malaria is now nearly useless. Since its synthesis in 1934, chloroquine has been used all over the world as a cheap and effective front-line treatment for malaria. In the later 1950’s the first cases of chloroquine resistance were detected and today, chloroquine is no longer an effective anti-malarial drug in many countries of South America and Asia and Africa where 90% of malaria cases occur. Drug Information – News <http://pharmnet.co.za/druginfo/news/news02.htm> informs travellers that current malaria prophylaxis is being recognised globally as becoming less effective due to parasitic resistance. Chloroquine has been the mainstay of antimalarial drugs treatment for the past 40 years but resistance is now widespread and few countries are unaffected. Resistance to mefloquine is also developing rapidly, particularly in areas of South East Asia.

167 BBC News ‘Antibiotics could soon be useless’ 13 June 2000 <http://news.bbc.co.uk/1/hi/health/789591.stm>. According to the report, new strains of ‘old’ diseases, such as tuberculosis (TB), which are immune to existing treatments have been reported across the world in recent years. In Russia and China, 10% of TB patients have strains resistant to the two most powerful treatments. Last year, New York City spent almost US\$1bn to control an outbreak of multi-drug resistant TB. In Thailand, drug resistance has meant the doctors can no longer prescribe the three most common drugs to treat malaria. Dr David Heymann, executive director of the WHO’s communicable diseases programme said there was an urgent need to reduce infection levels before the diseases wear the drugs down. He is quoted as saying, “The world may only have a decade or two to make optimal use of many of the medicines presently available to stop infectious diseases. We are literally in a race against time to bring levels of infectious disease down world-wide.” The WHO says that drug resistance has occurred as a result of haphazard use of drugs. In wealthy countries resistance has occurred because of unnecessary demand and overuse of drugs. In poorer countries drug resistance is often blamed on underuse of drugs because many people fail, often because of lack of money, to finish drug treatment courses.



antiretroviral drugs (ARVs). The dangers of resistance are real¹⁶⁸. Apart from mutation of the virus within individuals which can lead to individual resistance to ARVs, there is the danger of global resistance to ARVs as the ARV resistant strains spread and become dominant. The HI virus mutates periodically to a point at which the prevailing recommended drug regimens have to be changed or new drugs, where possible, introduced¹⁶⁹. Given that there is only a limited number (approximately 20) different ARVs available worldwide and most of them are currently used in 3 or 4 drug combinations¹⁷⁰, mass resistance to ARVs

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- 168 According to the Rutger Hauer Starfish Foundation, a global surveillance system for tracking HIV drug resistance has been launched by the World Health Organization and the International AIDS Society. They believe that the programme will be crucial to prevent important HIV drugs, called antiretrovirals, from being “wasted” as they start to be used in the developing world. Their use has been made possible as a result of price cuts by drug companies, cheaper generic versions of the drugs and foreign aid funding. The surveillance network will also help western countries use antiretrovirals more intelligently. (www.rutgerhauer.org/rutgerhauerstarfish.info/2/info/newstories) See also WHO Global Strategy for Containment of Antimicrobial Resistance (WHO/CDS/CSR/DRS/2001.2) in which it is stated that deaths from acute respiratory infections, diarrhoeal diseases, measles, AIDS, malaria and tuberculosis account for more than 85% of the mortality from infection worldwide. Resistance to first-line drugs in most of the pathogens causing these diseases ranges from zero to almost 100%. In some instances resistance to second- and third-line agents is seriously compromising treatment outcome. Added to this is the significant global burden of resistance hospital-acquired infections, the emerging problems of antiviral resistance and the increasing problems of drug resistance in the neglected parasitic diseases of poor and marginalized populations. According to the WHO, resistance has recently been described as a threat to global stability and national security. In 1998 the World Health Assembly urged member states to develop measures to encourage appropriate and cost-effective use of antimicrobials, to prohibit the dispensing of antimicrobials without the prescription of a qualified health professional, to improve practices to prevent the spread of infection and thereby the spread of resistant pathogens, to strengthen legislation to prevent the manufacture, sale and distribution of counterfeit antimicrobials and the sale of antimicrobials on the informal market and to reduce the use of antimicrobials in food-animal production.
http://www.who.int/csr/resources/publications/drugresist/EGlobal_Strat.pdf. In another publication in 2000, entitled ‘Overcoming Antimicrobial Resistance’ the World Health Organisation stated that recent studies it had undertaken indicated that for every 100 respiratory infections, only 20% required antibiotic treatment. This meant that 80% of patients are treated with unnecessary medications thereby leading drugs directly into the sight lines of resistance. It commented that while bacterial infections can kill, treating viral illness with antibiotics is not only ineffective but contributes to the development of resistance. (<http://www.who.int/infectious-disease-report/2000/ch4.htm>).
- 169 Gillim L, Gusella GL, Vargas J Jr, Marras D, Klotman ME and Cara A ‘Development of a Novel Screen for Protease Inhibitors’ *Clinical and Diagnostic Laboratory Immunology* <http://cdli.asm.org/cgi/content/full/8/2/437> note that “Since the onset of the AIDS epidemic, a number of antiretroviral drugs have been developed for the treatment of human immunodeficiency virus type 1(HIV-1) infection. While the initial target for therapy was reverse viral transcriptase, inhibitors targeting the viral protease (PR) enzyme have become a mainstay of antiretroviral therapy. Although use of these compounds in multidrug regimens has dramatically reduced viral load as well as morbidity and mortality, their long term benefit in HIV-1 infected patients has dramatically reduced viral load as well as morbidity and mortality, their long-term benefit in HIV-1 infected patients has been limited by the emergence of drug-resistant viral strains. The high rate of mutation of HIV-1 coupled with incomplete viral suppression and widespread use of this class of drugs will continue to contribute to this problem. For this reason it is essential that new drugs targeting PR, as well as new viral targets be developed.”
- 170 See ‘Quadruple Therapy With A Protease Inhibitor and NNRTI Achieves Highest Rate of Viral Suppression in Nucleoside Analogue Experienced Patients’ (Montaner/Mellors, *NEJM* 8/9) *HIVdent Drug & Medications News Update*. It has now been observed, for example, that quadruple therapy consisting of two nucleoside reverse transcriptase inhibitors (one of which is new), a protease inhibitor and a non-nucleoside reverse transcriptase inhibitor achieves a higher rate of viral suppression in patients who have already been treated with NRTIs (antiretroviral drugs) than treatment regimens consisting of NRTIs and either a NNRTI or a protease inhibitor, according to a study published in the August 9 (2001) edition of the *New England Journal of Medicine*. The study was conducted by Dr Mary Albrecht and colleagues of the AIDS Clinical Trials Group. The findings indicated that quadruple therapy offers “significantly more durable suppression” than either



can rapidly become a serious and global public health problem. Negligent or irresponsible prescription and use of certain drugs can therefore in itself be harmful not only to individual patients but to society as a whole. What has all this to do with the law of delict, one might ask. It is submitted that there is potential for claims in delict, based on the circumstances discussed above, at a number of different levels within the health system. Take for example the case of a family doctor who negligently, unnecessarily and repeatedly prescribes a drug for a particular patient. The drug is a lifesaver for a particular condition (eg myocardial infarct) when taken appropriately but if used too frequently results in a rapid build up of resistance within the patient which nullifies its efficacy for the life threatening condition. In certain circumstances the doctor could be held liable for a claim in delict if the patient's capacity to benefit from the drug was nullified by the doctor's unnecessary prescription of it and it was reasonably foreseeable that the patient could suffer from the life threatening condition at some stage. Obviously much would depend on the facts of the particular case but delictual liability within these circumstances is not impossible. Within the public sector, overuse or misuse of certain medicines on the prescription of doctors who are employees of the state and who create a public health risk because of an increase in drug resistance due to the overuse or misuse of the medicine, could conceivably lead to claims in delict in certain circumstances. At a constitutional level the irresponsible and irrational prescription of a drug within the public health sector could result in reduced access to health care services for large numbers of patients – especially if any alternative therapies were considerably more expensive and therefore unaffordable for the majority of patients that previously had access to the now defunct drug. Class actions could conceivably arise against drug manufacturers in consequence of marketing practices which actively encourage health professionals to 'push'

version of triple therapy. Extensive previous treatment with NRTIs that has lead to zidovudine resistance may result in hypersusceptibility to NRTIs. They stated that although conserving some classes of treatment for later use is an important consideration, the benefits of using additional classes of potent agents with the goal of suppressing viral replication must be weighed against the potential risks of incurring new or long term toxic effects and limiting future treatment options.
(<http://www.hivdent.org/drugs/drugs1/drugqtwap082001.htm>)

their products when treating patients in terms of prescriptions and medical advice if it can be shown that such marketing is irresponsible and does not warn doctors and other prescribers of the dangers of resistance with the result that the drug becomes useless to those who need it. There has of late been a major shift in advertising with more and more funds being spent on direct to consumer promotion of drugs.

One of the major problems with responsible use of pharmaceutical products in order to avoid mass resistance and one that does not seem to be linked very often in the literature to problems of resistance are the commercial practices surrounding the sale and marketing of medicines. Pharmaceutical manufacturers and others in the medicines supply chain incentivise healthcare professionals to prescribe and administer their particular products and also specific volumes of those products. The primary motivation is commercial – to ‘move’ as much product as possible. The results of unethical marketing of medicines are *inter alia* unethical, unnecessary and irresponsible prescription of medicines.¹⁷¹ Furthermore, at the extreme end of the spectrum, it could even be said that drug resistance is a beneficial aspect of the system from the point of view of the manufacturer since as long as it can continue, by means of research and development to stay ahead of the resistance game it is guaranteed of a market for new drugs as the older ones become obsolete. Drug companies are likely to argue that drug resistance is not beneficial for them because they would like to continue to sell both old and new products. However the maximum duration of a patent is usually twenty years in principle and less in practice. Once the drug goes off patent, the fact is that its price drops dramatically as generic manufacturers climb onto the bandwagon. The theory of planned

¹⁷¹ Fresle DA and Wolfheim C ‘Public Education in Rational Drug Use: A Global Survey’ WHO Geneva March 1997 Pharmaceutical marketing to prescribers, dispensers and consumers may contribute to irrational use. Unethical marketing of drugs is widespread in developing countries and although standards have improved in developed countries, recent studies have found continuing problems, such as false and misleading claims, switch campaigns and commercial promotion disguised as scientific trials.
www.who.int/medicines/library/dap/who-dap-97-5/WHODAP975.pdf

obsolescence¹⁷² describes a way of maintaining control of a particular market in other industries¹⁷³. Manufacturers who make drugs for the communicable diseases market do not have to worry about planned obsolescence – nature has built it into the system for them in the form of drug resistance. However, this does not mean to say that they cannot profit significantly from drug resistance and that there is no inherent perverse incentive sufficiently present within the system for them to focus on and actively promote widespread, high-volume use of a drug without being overly concerned about the appropriacy of that use. Furthermore, all drugs have expiry dates beyond which they may not lawfully be sold. It is clear that just around medicines alone, which are only one aspect of health services delivery, there are a number of complex issues upon which the law of delict has relevance.

The question of the liability of a medicines regulatory authority to cancel or suspend the registration of a medicine on receipt of information subsequent to its registration that its efficacy is dubious is also of interest in the context of delicts committed by the state¹⁷⁴. Section 16 of the Medicines and Related Substances Control Act¹⁷⁵ states that:

1) If the council-

¹⁷² The *New Dictionary of Cultural Literacy*, Third Edition 2002, defines 'planned obsolescence' as "Incorporating into a product features that will almost certainly go out of favour in a short time, thereby inducing the consumer to purchase a new model of the product. Placing sweeping tail fins on an automobile was an example of planned obsolescence." <http://www.bartleby.com/59/18/plannedobsol.html>

¹⁷³ Bulow J 'An Economic Theory Of Planned Obsolescence' states that "Except under unusual conditions, a monopolist will produce goods with inefficiently short useful lives. The result is closely linked to the observation that a durable goods monopolist will prefer to rent, rather than sell, its output. An oligopolist, or equivalently a monopolist facing certain entry in a subsequent period, also has a countervailing incentive to extend durability. As a corollary, such firms have an incentive to steer customers to purchase rather than rental contracts. This same result also holds if future competition is to be over a related but not identical substitute product. Therefore, while monopolists will opt for inefficiently short useful lives, oligopolists may choose either uneconomically short or long lives, depending on their technologies and market conditions. There is also an incentive to increase durability to deter entry."
<https://faculty-gsb.stanford.edu/bulow/articles/An%20Economic%20Theory%20of%20Planned%20Obsolescence.pdf>

¹⁷⁴ In terms of section (3) (a) of the Medicines and Related Substances Act No 101 of 1965: If after consideration of any such application and after any investigation or enquiry which it may consider necessary the council is satisfied that the medicine in question is suitable for the purpose for which it is intended and complies with the prescribed requirements and that registration of that medicine is in the public interest, it shall approve of the registration thereof. In terms of section 1(3) of the Act: In determining whether or not the registration or availability of a medicine is in the public interest, regard shall be had only to the safety, quality and therapeutic efficacy thereof in relation to its effect on the health of man or any animal, as the case may be.

¹⁷⁵ Medicines Act fn 12 *supra*

- (a) is of the opinion that any person has failed to comply with any condition subject to which any medicine has been registered; or
- (b) is of the opinion that any medicine does not comply with any prescribed requirement; or
- (c) is of the opinion that it is not in the public interest that any medicine shall be available to the public,

the council shall cause notice in writing to be given accordingly by the registrar to the holder of the certificate of registration issued in respect of that medicine.

(2) Any such notice shall specify the grounds on which the council's opinion is based, and shall indicate that the person to whom it is directed may within one month after receipt thereof submit to the registrar any comments he may wish to put forward in connection with the matter.

(3) If no such comments are so submitted, or if after consideration of any comments so submitted the council is of the opinion that the registration of the medicine in question should be cancelled, the council may direct the registrar to cancel the registration thereof.

The Act does not state what happens if the council fails to comply with section 16. Furthermore subsection (3) states that the council *may* direct the registrar to cancel the registration of the medicine if it is of the opinion that the registration of the medicine in question should be cancelled. Since for the purposes of the Act, registration of a medicine is based upon its quality, efficacy and safety, it is difficult to envisage a situation in which the Council would be justified in failing to cancel the registration of a medicine where it is of the opinion that such registration should be cancelled.

7.6 Constitutional Delicts?

To some extent this topic has already been touched upon in the earlier discussion under the section on loss. However, it is important to explore this

issue specifically from the constitutional perspective of the State's obligation to achieve the progressive realisation of the right of access to health care services. If the State, or some organ of state, fails in some obvious respect to do so, does this constitute a delict against the affected persons? A pertinent example of this is the present state of affairs concerning municipal health services. Section 84 of the Local Government: Municipal Structures Act¹⁷⁶ assigns certain functions to district municipalities including municipal health services.¹⁷⁷ There are two problems associated with this. The first is that health services being rendered by municipalities are for the most part funded and rendered by metropolitan municipalities and local municipalities. These latter levy rates and taxes within their areas of jurisdiction and fund such services from these rates and taxes. District municipalities do not have the power to raise money in this way. Essentially, therefore, the Municipal Structures: Local Government Act has created an unfunded mandate for district municipalities. This in itself is not problematic in view of the fact that the Minister of Provincial and Local Government can authorise a local municipality to render municipal health services in its area.¹⁷⁸ The Minister did issue such authorisations to most, if not all, local municipalities by way of a series of notices issued in November 2000. Subsequently, in 2003, the Minister decided to revoke the authorisation to the extent that it covered municipal health services with effect from 01 July 2004 and did so by way of a series of notices published in the Gazette. Since the funding issues for district municipalities will not have been resolved at that time, since estimates are that the current value of municipal health services rendered by local municipalities is close to one billion rands and since the provincial governments do not have this kind of funding available to enable them to step into the breach, the Minister's actions in revoking the authorisations are highly problematic and quite possibly unconstitutional.

¹⁷⁶ Municipal Structures Act No 117 of 1998

¹⁷⁷ Fn 176 *supra* Section 84(1)(i)

¹⁷⁸ Fn 176 *supra* Section 84(3)(a)



It is conceivable that a situation could arise in which a person seeking health care services, especially emergency medical treatment, suffers loss due to the fact that the required health care services were not available or were not available within a specific time. Reference has already been made to the case of *Olitzki* and the concurrence of the Supreme Court of Appeal in that case with the observations of Davis J in *Faircape Property Developers (Pty) Ltd v Premier, Western Cape*¹⁷⁹ that in deciding whether a statutory provision grounds a claim in damages the determination of the legal convictions of the community must take account of the spirit, purport and objects of the Constitution, and that the constitutional principle of justification embraces the concept of accountability. What is the position when the statute in question is the Constitution itself? In *NAPTOSA and Others v Minister of Education, Western Cape, and Others*¹⁸⁰ the court observed that:

“The complexities of remedies for a violation of a fundamental right were, in the context of a claim for ‘constitutional damages’, discussed in *Fose v Minister of Safety and Security* 1997 (3) SA 786 (CC) (1997 (7) BCLR 851). It is clear from this decision of the Constitutional Court that there may be circumstances where a litigant against the state would be entitled to rely directly on a breach of a fundamental right. Whether this would be permissible would depend, however, on the availability of ‘appropriate relief’. The majority judgment written by Ackermann J explains that ‘appropriate relief’ will in essence be relief that is required to protect and enforce the Constitution. In deciding what is appropriate relief, the interests not only of the complainant but of society as a whole, he holds, ought to be served.

In *Gerber v Voorsitter: Komitee Oor Amnestie van Die Kommissie vir Waarheid en Versoening*¹⁸¹ it was held that it was of paramount importance that the rights set out in the Bill of Rights had to be protected and accordingly the Court had to be prepared to determine whether the constitutional rights of the applicant had been infringed or threatened and to apply the appropriate legal remedy and that neither the procedure nor the investigation nor the legal remedy should be hamstrung if the Constitution and the Bill of Rights were to be given their fullest meaning. The court held further that in applying section 38 of the

¹⁷⁹ *Faircape* fn 61 *supra*
¹⁸⁰ *NAPTOSA* 2001 (2) SA 112 (C)
¹⁸¹ *Gerber* 1998 (2) SA 559 (T)

Constitution, the nature of the remedy or what it was called was not important. Where the rights set out in the Bill of Rights were infringed by the conduct or decision of a lower court or a tribunal, council or official which exercised judicial, quasi-judicial or administrative functions, the person affected thereby could seek relief in terms of Rule 53 of the Uniform Rules of Court. In the event that the Court found that the applicant's rights in terms of the Constitution had been infringed, it could grant the appropriate relief.

Clearly the courts construe their power to grant appropriate relief as being wide and flexible. In *Bel Porto School Governing Body and Others v Premier, Western Cape, and Another*¹⁸² the constitutional court observed that:

“There are several provisions in the Constitution which are important to bear in mind when considering constitutional remedies, in particular ss 38, 172(1), 8(3), and 39(2). Section 172 provides that if a court finds law or conduct inconsistent with the Constitution, it must declare that law or conduct to be invalid to the extent of its inconsistency. In addition to the declaration, the court may proceed to provide additional appropriate relief. Sometimes a declaration of invalidity may not be sufficient, or appropriate on its own. The constitutional defect might lie in the incapacity of the common law or legislation to respond to the demands of the Bill of Rights. Section 8(3) then requires that the Court should develop a suitable remedy. No particular remedy, apart from the declaration of invalidity, is dictated for any particular violation of a fundamental right. Because the provision of remedies is open-ended and therefore inherently flexible, Courts may come up with a variety of remedies in addition to a declaration of constitutional invalidity. An ‘all-or-nothing’ decision is therefore not the only option...The flexibility in the provision of constitutional remedies means that there is no constitutional straightjacket such as suggested in the High Court or in argument in this Court. The appropriateness of the remedy would be determined by the facts of the particular case. In a constitutional state with a comprehensive Bill of Rights protected by a Judiciary with the power and duty to do what is just, equitable and appropriate to enforce its provisions, it is not hard cases that make bad law, but bad cases that make hard law.”

It is submitted that probably the most likely situation in which a constitutional delict will be recognised in future is that described by the court in *Soobramoney v Minister of Health, Kwazulu-Natal*¹⁸³ in reviewing the facts of the Indian case of *Paschim Banga Khet Mazdoor Samity and Others v State of West Bengal and*

¹⁸² *Bel Porto* 2002 (3) SA 265 (CC)

¹⁸³ *Soobramoney* 1998 (1) SA 765 (CC)

*Another*¹⁸⁴. It was a case in which constitutional damages were claimed. The claimant had suffered serious head injuries and brain haemorrhage as a result of having fallen off a train. He was taken to various hospitals and turned away, either because the hospital did not have the necessary facilities for treatment, or on the grounds that it did not have room to accommodate him. As a result he had been obliged to secure the necessary treatment at a private hospital. It appeared from the judgment that the claimant could in fact have been accommodated in more than one of the hospitals which turned him away and that the persons responsible for that decision had been guilty of misconduct. This is precisely the sort of case which would fall within s 27(3). It is one in which emergency treatment was clearly necessary. The occurrence was sudden, the patient had no opportunity of making arrangements in advance for the treatment that was required, and there was urgency in securing the treatment in order to stabilise his condition. The treatment was available but denied. In the South African context, however, it is most likely to occur in the context of the refusal by a private sector hospital of emergency medical treatment if the patient is unable to pay the exorbitant deposit which such hospitals tend to require in advance of treatment. The public sector is likely to turn away a patient requiring medical treatment only in circumstances where the particular facility is not equipped to give adequate assistance or where it is already at running at full capacity with regard to emergency medical services. In this latter scenario it will be a question of whether the facts sufficiently justify the refusal to provide emergency medical treatment, i.e. whether the resources were being adequately utilised, whether there were attempts to refer the patient to an alternative facility where treatment could be obtained, the availability of such alternatives etc, whereas in the former scenario the refusal is likely to be unconstitutional in the absence of arguments of lack of capacity.

The constitutional obligation to provide emergency medical treatment is a particularly good example because in terms of the common law of delict as it

¹⁸⁴ *Paschim* 1996 (AIR) SC 2426.

stands currently, there is no generally recognised obligation to render emergency medical treatment¹⁸⁵.

A further question of some importance in the context of health services delivery is whether a provider can contract out of delictual liability, whether this is in accordance with public policy and how this issue is dealt with by the courts. The Appellate Division, in the case of *Afrox Healthcare Bpk v Strydom*¹⁸⁶ answered this question in the affirmative for the private sector at least. The facts of this case are canvassed in detail in the section of the thesis that covers contracts within the private sector. The question is whether, in the light of the constitutional obligations of the state to provide access to health care services, the state could also contract out of delictual liability to patients in its care. In the *Afrox* case, the High Court tried, in what is, with respect, an ineptly reasoned judgment, to bring the matter within constitutional values and decided in favour of the plaintiff. The Supreme Court of Appeal, in what is with respect, a highly regressive judgment, chose to reverse the decision of the High Court and – notwithstanding the constitutional rights of the patient to bodily and psychological integrity, and human dignity – followed the well worn argument of the sanctity of contract under just about all circumstances except those that are essentially criminal. It is a great pity that this case never got as far as the constitutional court. The High Court and the Supreme Court of Appeal have been criticised by the Constitutional court on at least one occasion¹⁸⁷ for failing

¹⁸⁵ In the common law of delict the existence of a duty to rescue is a question of fact as much as it is of law since the duty to rescue can be inferred in certain circumstances. See *Minister of Police v Ewels* (fn 43 *supra*) The relevant passages (in translation) from the interpretation in *Ewels*' case at p 684 which provide assistance are the following (at p 597E): 'Just as a duty to rescue can sometimes be a legal duty, so a duty to protect may be a legal duty, and it would depend on all the facts whether such duty is a legal duty or not. *Clearly it is impossible to determine in general when such a legal duty would arise.*' [Writer's italics] The Constitution, it is submitted, imposes that general duty at least upon health care providers, to 'rescue' persons in need of emergency medical treatment. See also *Silva's Fishing Corporation (Pty) Ltd v Maweza* 1957 (2) SA 256 (A). Strauss, *Doctor, Patient and the Law* p 24 points out that the traditional view that no liability will lie for mere omission came under attack in our law in the middle of this century (the 20th century). He states that a court may now well hold a doctor liable for harm suffered by an injured or ailing person where the doctor, aware of his condition, unreasonably refused or failed to attend. It is quite possible that even in the absence of the Constitution, the courts would infer on a case by case basis, a duty upon a health care provider to attend to a patient but, it is submitted that the Constitution still goes further in that it actively prohibits a refusal of emergency medical treatment.

¹⁸⁶ *Afrox* 2002 (6) SA 21 (SCA)

¹⁸⁷ *Carmichele* fn 15 *supra*



to take into account the provisions of section 39(2) of the Constitution and it is submitted that *Afrox* is another case in point. In *Afrox*, the admission document signed by the respondent during his admission to the hospital contained an exemption clause, providing that the respondent ‘absolved the hospital and/or its employees and/or agents from all liability and indemnified them from any claim instituted by any person (including a dependant of the patient) for damages or loss of whatever nature (including consequential damages or special damages of any nature) flowing directly or indirectly from any injury (including fatal injury) suffered by or damage caused to the patient or any illness (including terminal illness) contracted by the patient whatever the cause/causes are, except only with the exclusion of intentional omission by the hospital, its employees or agents’. The appellant relied on such clause to avoid liability. The clause was extremely wide in its scope,¹⁸⁸ the applicant even apparently foregoing his constitutional right to life and waives a claim based on negligence and even, it would seem, intentional commission since the only exception is intentional omission. The judgment is discussed in detail elsewhere in this thesis. A study of the indemnity clause in *Afrox* reveals that the constitutional rights that the patient waived were those to life, bodily and psychological integrity and human dignity. As stated previously, it is not only the individual who has an interest in the observation of, and respect for, his constitutional rights but society as a whole. Individuals can find themselves in desperate circumstances, and in the health services context in particular their judgment is likely to be impaired in many instances. Their ability to resist inroads into their fundamental rights is not what it usually is due to physical and mental stress, they may believe that they have no choice but to sign the indemnity clauses if they want to receive treatment. It is submitted that the arguments of the Supreme Court of Appeal in its judgment in this case took none of the bargaining equalities between patient

¹⁸⁸ *Afrox* fn 186 *supra*. “Ek onthef die hospitaal en/of sy werknemers en/of agente van alle aanspreeklikheid en ek vrywaar hulle hiermee teen enige eis wat ingestel word deur enige persoon (insluitende 'n afhanklike van die pasiënt) weens skade of verlies van watter aard ookal (insluitende gevolgskaide of spesiale skade van enige aard) wat direk of indirek spruit uit enige besering (insluitende noodlottige besering) opgedoen deur of skade berokken aan die pasiënt of enige siekte (insluitende terminale siekte) opgedoen deur die pasiënt wat ook al die oorsaak/oorsake is, net met die uitsluiting van opsetlike versuim deur die hospitaal, werknemers of agente.”



and provider into account in *Afrox*. It saw a contract for health services as no different to any other contract for goods and services - despite the fact that it has been widely and repeatedly recognised that such contracts are not just like any other.¹⁸⁹ If the values and the rights recognized by the Constitution are a reflection of public policy then it would surely be contrary to public policy to allow a waiver of those rights since such waiver would in effect be an attempt to sanction behaviour that is contrary to public policy. In the delictual context, behaviour that is contrary to public policy is wrongful or unlawful and, as has already been observed in the contractual context, provisions that are contrary to public policy are unlawful and therefore unenforceable. Agreements contrary to statutory provisions or purporting to exclude such provisions from the relationship are unlawful as they are contrary to public policy¹⁹⁰. It is important to point out in this context that a decision not to exercise a particular constitutional right on the part of the right holder should not be equated with a waiver of that right. It is part of the concept of a right that the holder is free to choose whether or not to exercise it in certain circumstances. Thus in the health care context, a patient who has been the victim of the negligence of a doctor in treating him or her has the power to decide whether or not to claim damages, i.e. to exercise the right to go to court to enforce the right to bodily and psychological integrity. A waiver is a contractual undertaking not to exercise a

¹⁸⁹ For the latest expression of this issue see *Redefinition of Negligence/Liability A Summary Paper prepared by the Australian Medical Association Queensland* 20 August 2002 in which it is stated: "The doctor-patient relationship cannot be seen as a normal commercial interaction even though a fee is paid. The service provided by a doctor has a readily visible and assessable component and a less tangible but nevertheless essential second component. The obvious first component consists of the basic facts of the patient's disorder conveyed in the consultation and the treatment parameters proscribed including measurable factors such as a discussion of potential adverse effects and compilations of the treatment recommended. Similarly a procedure or surgical operation falls into this first component and likewise is readily assessable and open to outside scrutiny. However, there is a second less measurable component to the doctor patient interaction that is just as important to the therapeutic outcome for the patient. In a consultation this consists of the ability of the medical practitioner to achieve a beneficial outcome for the patient and always involves several less measurable components such as

- persuading the patient to follow a prescribed course of treatment;
- persuading the patient to desist from other self-prescribed remedies which interfere with recovery;
- altering behaviour patterns which, although not immediately obvious to the present specific complaint will nevertheless significantly benefit that person in the longer term (losing weight, lifestyle changes)
- with medical procedures or surgical operations the preparation and post-operative management is often as important to the eventual outcome as the technical exactitude of the surgery itself."

¹⁹⁰ See for instance *ABSA Bank H/A Bankfin v Louw En Andere* 1997 (3) SA 1085 (C) in which it was held that an agreement whereby a party waives beforehand and in its entirety the protection of the Prescription Act 68 of 1969 is contrary to public policy and thus invalid. In *Sasfin (Pty) Ltd v Beukes* 1989 (1) SA 1 (A) the court said that "Agreements which are clearly inimical to the interests of the community, whether they are contrary to law or morality, or run counter to social or economic expedience, will accordingly, on the grounds of public policy, not be enforced." [writer's italics]



right in the event that it is contravened by someone else. In this sense it is almost a license to someone to contravene the right since in the event that he does so, no action will be taken against him¹⁹¹. In *Goodman Bros (Pty) Ltd v Transnet Ltd*¹⁹² the court stated that it is contrary to the spirit of the Constitution for the respondent to require anyone with whom it deals to waive his constitutional rights. It is submitted with respect that this is logically correct because in terms of section 2 of the Constitution it is the supreme law of the Republic, law or conduct inconsistent with it is invalid and the obligations imposed by it must be fulfilled. If ordinary legislation cannot lawfully contradict or restrict the rights in the Constitution¹⁹³, even indirectly, then it is difficult to see why contractual provisions, at least as between the contracting parties, should be able to achieve this¹⁹⁴. A waiver of a constitutional right in a

¹⁹¹ The cases of *Community Development Board v Revision Court, Durban Central, And Another* 1971 (1) SA 557 (N) *Frames (Cape Town) (Pty) Ltd* 1995 (8) BCLR 981 (C) *Maharaj v Chairman, Liquor Board* 1997 (1) SA 273 (N); *ABBM Printing & Publishing (Pty) Ltd v Transnet Ltd* 1998 (2) SA 109 (W) are authority for the argument that waivers of constitutional rights are themselves unconstitutional and thus contrary to public policy.

¹⁹² *Transnet* 1998 (4) SA 989 (W) at p 997

¹⁹³ In terms of section 8 of the Constitution the Bill of Rights applies to all law and binds the legislature, the executive, the judiciary and all organs of state. It also 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. In terms of section 36(1) of the Constitution 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... Except as provided in subsection (1) or any other constitutional provision no law may limit any right entrenched in the Bill of Rights.

¹⁹⁴ See however, Hopkins K. *Constitutional Rights and Waiver* (2001) 16 *SAPR* 122 who comments that the view of Olivier JA that the correct approach to the question of waiver of fundamental rights is to adhere strictly to the provisions of section 36(1) of the Constitution is an 'oversimplification of what is in reality an extremely complicated issue'. Hopkins says that Olivier JA has seemingly attached equal importance to all of the fundamental rights. He says that he finds this reasoning untenable because it implied that all rights in the bill of rights are destined to receive the same treatment in issues of waiver. He argues that a more careful analysis reveals that a hierarchy of rights is prevalent within the Bill of Rights and that for this reason each right needs to be assessed on its own before assigning a weight of significance to it. Hopkins says that it makes no sense to attach the same weight of significance to all rights. He notes that Olivier JA states that a waiver is a limitation of a right and that, for this reason, strict adherence to the provisions of section 36(1) is warranted. Surely, says Hopkins, this cannot be correct because a waiver cannot be a limitation in the section 36 sense of the term because it is not a law of general application. A waiver is simply the operation of the law of contract that agreements must be upheld. Having said this it is true that enforcement of a waiver might constitute an infringement of a constitutional right in which case the courts ought not to be entitled to uphold them unless there is good reason to do so. With respect to Hopkins he is oversimplifying both the context in which constitutional rights operate and the law of contract since he does not pursue the logic further to state the essential principle of the law of contract that where a provision is contrary to public policy or the moral values of the community, it will not be enforced. Since the Constitution is the embodiment of these values it follows that a contractual provision that is contrary to the Constitution cannot be enforced. Hopkins also fails to appreciate that one cannot sit in the abstract and assign a hierarchy to the rights in the Bill of Rights since they only have real meaning in the various contexts in which they are played out in society. Their relative weights and significance, it is submitted, are dependent upon the context in which they are exercised and any attempt to state that one right has more weight than another ignores the polycentric structure of the Bill of Rights itself. Hopkins observes that Currie in the 1999 *Annual Survey of South African Law* p 54 -55, commenting on the case of *Garden Cities Incorporated Association Not For Gain v Northpine Islamic Society* 1999 (2) SA 268 (C) suggests that freedom rights such as the right to freedom of religion can be waived by a contractual undertaking. He explains this by saying: "This is because freedom rights can be positively or negatively exercised. Just as

one can exercise the right to freedom of expression by choosing to remain silent, one is free to practise one's religion and equally free to choose not to. A waiver therefore amounts as it were to an undertaking to exercise the right negatively. The undertaking in clause 20(b) [of the contract of sale] not to make calls to prayer would be similar to a contractual undertaking not to disclose certain information, or not to work in one's chosen profession, or to perform nude on stage or to attend religious instruction in a private school. These are respectively waivers of rights to freedom of expression, to occupational freedom, to privacy and to freedom of religion. There should in principle be no objection to enforcing contractual undertakings such as these since they are not violations of a constitutional right." Hopkins notes that in addition to the distinction that Currie makes, it seems that there are also other factors that make it necessary to consider the content of the right in the debate as to whether or not such right is capable of being waived. He says that whenever one speaks of a waiver of fundamental rights, one is in effect referring to two concepts – 'waiver' and 'fundamental rights capable of being waived'. This complex issue is best understood, says Hopkins, in the context of an appreciation for both of these concepts. He goes on to define 'waiver' as 'in essence a unilateral decision made by one of the parties to a contract not to avail oneself of a right or power or benefit or opportunity'. This definition, he says, seems to be compatible with the Supreme Court of Appeal's consistent tendency to equate waiver with election – in other words when one waives then one is in effect electing not to enforce a remedy, for example, or not to claim a right. But a distinction needs to be maintained between two 'categories' of waiver argues Hopkins. He says that the first is a waiver of contractual rights and the second is a waiver of rights conferred by law. Hopkins notes that it may at first seem that waiver of constitutional rights is concerned with the second category of waiver only. However, he says, this is not necessarily the case. The second category applies to situations where the rightholder may for example choose not to rescind a contract for misrepresentation or elect not to cancel a contract for breach. In these examples the right being waived is one conferred by law and the waiver is by choice – the consent of the other party is not required in order to waive these rights. But, says Hopkins, where the waiver is of a constitutional right in terms of a contract then there is no longer a choice. There is no possibility of election to resort to a right that is ordinarily conferred by law. There is an agreement with the other contracting party that the constitutional right will not be claimed and the constitutional remedy will not be enforced. For this reason, says Hopkins, it seems that one is concerned with more than simply the second category of waiver identified earlier. However, he says, one is not strictly speaking dealing only with the first category either because the first category involves the waiver of a right conferred by a term in the contract. He gives as an example the landlord who despite the fact that the lease requires payment of the rent on the first day of every month, waives the right to be promptly paid by accepting late payment. He says that it seems as though the waiving of a constitutional right does not fall squarely into this category unless the provisions of the bill of rights are implied into all contracts as terms. The problem with this, notes Hopkins, is that terms can only be implied into contracts where they do not conflict with express terms that already exist. He says that this is problematic because all contracts that seek to waive the constitutional rights of one party do so with an express term. It is the inclusion of this express term that effectively disqualifies one from later trying to include, by implication, the very term expressly excluded. Thus it is difficult to slot constitutional waiver into the first category identified above.

It is submitted that this reasoning of Hopkins is guilty of a number of errors in logic. The first is that he conflates the concept of contractual waiver of a contractual or other right with the concept of waiver of a contractual or other right. Thus he says waiver of constitutional rights is not concerned with the second category of waiver only – i.e. the waiver of rights conferred by law, because even in the law of contract it is possible to waive the right to rescind a contract for misrepresentation, a right conferred not by the contract, but by law. This is a *non sequitur*. He is conflating the origin of the right with the 'origin' or basis of the waiver. It is submitted that there are four possible elements in this logical system. These are (a) a non-contractual waiver of a right conferred by law – whether by the common law, a statute or the Constitution (b) a non-contractual waiver of a right conferred by contract eg a unilateral decision, despite provision for breach in the contract itself, not to act upon that contractual provision and invoke the remedies for breach (c) a contractual waiver of a right conferred by contract for example an undertaking in the contract that if a certain event transpires, the party will waive a right conferred by that same contract (d) a contractual waiver of a right conferred by law i.e. the common law, a statute or the Constitution. It is category (d) with which one is most concerned in the question of contractual waivers of constitutional rights since contractual waivers of constitutional rights are binding. The person who waives the right is bound by that waiver, depending on the nature and terms of the contract either indefinitely or for a specific and identifiable period of time eg the term of the contract or a period identified by a term within the contract. It is submitted that even in terms of the two categories imposed by Hopkins upon himself, the waiver of a constitutional right falls clearly into the second category, whether it is contractual or non-contractual. The first and second categories are defined with reference to the source of the right and not with reference to the source or basis of the waiver. A constitutional right, logically speaking, should not be regarded as a contractual right because it is not a right conferred by the contract. Any attempt to include a constitutional right as a contractual right would be largely superfluous. At most, it may give the rightholder in question a platform from which to launch a claim for contractual (as opposed to delictual) damages for violation of a constitutional right. However it may be that, depending upon the nature of the contract in question, a particular constitutional right could be regarded as an implied term of the contract in any event. The second is that he is crossing the thread of a waiver of a contractual right, with the thread of an act of waiver of a right external to a contract. Thus he says, in speaking of a waiver of constitutional rights one is not dealing only with the first category – i.e. waiver of contractual rights because not every constitutional right is an implied term of the contract. There is in any event a tautology, which Hopkins himself points out, since potential implied terms are ousted by express terms to the contrary. It is submitted that this latter argument is not useful in that it simply

begs the question and ignores the fact that the Constitution is the substratum or grundnorm of all law in South Africa, including the law that upholds contractual arrangements. A contractual term could only oust an implied constitutional right if the law recognises that a contractual arrangement can oust or exclude a constitutional right from the relationship. If the law did so it would be conceding that contracts can be structured such that they are not subject to the Constitution which is a legal impossibility since all law (and a contract constitutes law between its parties) is subject to the Constitution and to the extent that it is inconsistent with it – invalid. Hopkins then draws another distinction which, it is submitted, is on firmer ground. There is a distinction he notes between the waiver of a fundamental right and a mere decision not to exercise it. Waivers are undertakings given to another person not to exercise a right at a future time. He notes further that if waivers are simply undertakings then waivers are themselves contracts and that it thus stands to reason that the enforceability of a waiver must be determined in the same way as it would be for any other type of contract. Considerations of public policy, says Hopkins, thus play a crucial role. He states that there can be no general rule on the validity of a contractual waiver of constitutional rights per se since each must be scrutinised to determine whether or not the waiver is contrary to public policy. He goes on to point out that public policy is not informed by the Constitution generally and the Bill of Rights in particular. This means, says Hopkins that the resourceful body of public policy doctrine will play a crucial role in determining the validity and enforceability of contracts. He observes that prior to the Constitution, the sanctity of contract was regarded as the pillar of public policy stating that it nevertheless remains to be discussed how public policy will treat agreements that expressly seek to waive the fundamental rights of one of the parties thereto. Hopkins states that this is an interesting question because of the apparent tension between the traditional pre-constitutional idea that sanctity of contract is public policy epitomised on the one hand and the new post-constitutional idea that the Bill of Rights represents a reliable statement of what public policy is on the other.

The writer submits that there is no question as to which is the correct view since the Constitution ushered in a new legal order for South Africa and to the extent that the common law, within which the notion of sanctity of contract is rooted, is in conflict or inconsistent with the Constitution, or constitutional values, it must be modified or adapted to the extent necessary to remedy that conflict or inconsistency. To suggest otherwise is to undermine the rule of law and the concept of the Constitution as the supreme law. The writer further submits that one must decide carefully what is meant by waiver and whether it is a concept that is grounded only in the law of contract and must therefore always be regarded as a contractual undertaking or whether it is wider than the law of contract and includes for instance a unilateral, non-binding decision of a person with no intention to contract, not to act upon or exercise a particular right. Hopkins seems not to appreciate the importance of this distinction consistently throughout the course of his article. Hopkins states that it is easily conceived that some of the fundamental rights can be waived without too much controversy and gives the example of an accused person in a criminal action waiving her right to silence. It is to be noted in passing that, in contradistinction to what Hopkins said earlier, such waiver is not contractual. (In fact it may not even be waiver in the technical sense at all, merely a choice to exercise a constitutional right in a particular way.) He then goes on to ask which rights are inalienable and by implication incapable of being waived and second, under what circumstances can the other (lesser) rights provided for in the Bill of Rights, not be identified as inalienable, be waived by the right-holder? As an observation in passing, it is submitted that the question of the waiver of constitutional rights is much more complicated an issue than even Hopkins suggests. It impacts upon the fact that the Constitution contains a list of non-derogable rights in section 37 dealing with states of emergency and that the Constitution is at pains to stipulate that no Act of Parliament that authorises the declaration of a state of emergency and no legislation enacted or other action taken in consequence of a declaration may permit or authorise (a) indemnifying the state or any person in respect of any unlawful act, (b) any derogation from section 37 of the Constitution or (c) any derogation from a section mentioned in column 1 of the Table of Non-Derogable Rights to the extent indicated opposite that section in column 3 of the Table. It is worth noting that section 37(4) of the Constitution stipulates that any legislation enacted in consequence of a declaration of a state of emergency may derogate from the Bill of Rights only to the extent that – (a) the derogation is strictly required by the emergency and that legislation is consistent with the Republic's obligations under international law applicable to states of emergency. The question of waiver of constitutional rights also impacts upon the interests of South African society in the observation and fulfilment of constitutional rights, upon questions of balancing of rights faced by the constitutional and other courts when dealing with disputes involving constitutional rights, upon questions of equity in contracting and imbalances of power between contracting parties and upon the fact that the Constitution represents a fundamental and irreversible break with the past, which included a system of common law used to enforce and uphold inequality between persons at many different levels and in many different ways and which often did not recognise the rights now enshrined in the Bill of Rights at the fundamental levels of human dignity and equality. Hopkins then goes on to categorise certain rights as inalienable such as the rights to life and human dignity and that any waiver which either directly or indirectly impairs the right-holder's right to life and /or dignity must be invalid and consequently unenforceable. It is submitted that it is unfortunate that these kinds of discussions take place only in the abstract and only in the light of extremes. They are thus fruitlessly simplistic. It is submitted that more often than not, constitutional rights are not wholly alienated or 'waived' but more usually, limited to varying degrees by circumstances and by the consent of the rightholder. It is further submitted that such limitation and consent thereto does not constitute waiver at all, whether contractual or otherwise, but is more often a balancing exercise in which an individual weighs up the relative importance to him or herself of the various rights in play in a particular situation. The tragic case of the surgical separation in July 2003 of 29 year old Iranian conjoined twins Laden and Laleh Bijani is one of the more dramatic examples of the polarisation of two 'inalienable' rights- the right to life and the right to human dignity requiring a choice between the two. The women said that they wanted to be able to see each other face to face

and to pursue independent careers, one as a lawyer, the other as a journalist. They had different interests, different hobbies, different personalities. Due to the fact that they were conjoined at the head one of them was always forced to choose between her interests, career aspirations and hobbies and those of the other. For example although Ladan wanted to be a lawyer, Laleh wanted to be a journalist. They could not go to different classes at university and so Laleh chose to study law with her sister. They decided to undergo dangerous surgery, quite literally putting their lives at risk, for the sake of their human dignity and freedom. If they had signed an indemnity clause in the contract in terms of which the surgery was undertaken, acknowledging the risks and the chances of their survival of the operation were poor but saying that they were adamant that the operation should proceed would this have been unconstitutional in the South African context? A different question is whether in undergoing the surgery they waived their right to life. It is submitted that there was no waiver of any rights. There was only an exercise of choice – a balancing of rights and a decision to prefer a particular right over the other. According to news reports this is pretty much what happened. According to the reports the critical component of the surgery was how to deal with the thick vein that drained blood from their brain to their hearts. Several teams of experts had previously declined to operate on the Bijani sisters because they shared this important vein, which meant that the chances of both sisters surviving the separation surgery was “almost nil,” according to Madjid Samii, president of the International Neuroscience Institute in Hanover, Germany. Samii had evaluated possibilities for separating the Bijani sisters in as early as 1988, but had decided against the procedure because it was “virtually impossible.” In 1997, another team of doctors in Germany also decided against surgery because they “thought one of the twins would die and the other would be at risk” since there was only one vein. The team that actually operated on Laleh and Ladan attempted to solve the vein problem by using the vein grafted from Ladan’s inner thigh in her brain, and “reroute” the shared vein inside Laleh’s head. But soon, Ladan’s grafted vein congested, signalling failure for this plan. Associated Press reports... surgeons Monday night considered whether to call off the rest of the operation and leave the twins joined or “continue with final stage of the surgery, which we knew would be very, very risky,” [Dr.] Loo said. “The team wanted to know once again what were the wishes of Ladan and Laleh,” Loo said. “We were told that Ladan and Laleh’s wishes were to be separated under all circumstances.”

<http://www.ipdx.org/news/000031.html> There was some debate concerning the ethics of carrying out the operation. Jonathan Glover, profession of medical law and ethics at Kings College London was quoted as saying that every operation carries risks and unless the odds against success are overwhelming it is right to present patients with the choice. He said: The risks were high in this case. I would want to know a lot about what they were told, whether they understood it and what their quality of life was like. Were they both in agreement or was one dominant and hustling the other into the operation? ...Normally it would not be desirable to operate where the risks were so high. But these were exceptional circumstances. If they both wanted it over a long period of time and were unwavering then I feel it was their life and they had the right to make that decision.” Michael Wilks, chairman of the British Medical Association’s ethics committee said, “You cannot take the view that doctors should not do things because they are risky. Otherwise there would be no heart transplants. On the other hand, it is fair for doctors to say they won’t do something because they do not believe it is in the patient’s best interests. It was a pretty stark choice these sisters faced.” (Laurance J, ‘Questions raised about risks of operation to separate twins’ (<http://www.nzherald.co.nz/>) See also the report in Guardian Unlimited entitled ‘Doctors Reject Claims they Acted Unethically’

(<http://www.guardian.co.uk/international/story/>) by Aglionby J in which Dr Benjamin Carson, a surgeon from Johns Hopkins University is reported to have said he was struck by the determination of the twins to lead separate lives come what may. He apparently said that “even recognising that the odds were not good, I think it was a worthy humanitarian effort”. He said that it became clear in his early deliberations about the situation that they were going to seek separation and continue to do so until it occurred. He said he felt compelled to become involved because he wanted to make sure they had the best chance. Dr Carson is reported to have rated the chances of success at only 50%.

In his article on waiver of constitutional rights, Hopkins does not take into account decisions taken every day by patients dying of terminal illnesses to take painkilling medication in the certain knowledge that it will shorten their lives. This does not constitute a waiver or partial waiver of the right to life. It is simply the exercise of an inescapable choice between rights. Hopkins states that it is not his submission that all the rights in the Bill of Rights are/ought to be inalienable and incapable of waiver but, he says, taken in context any right may become inalienable if, by losing the right the right-holder simultaneously loses the right to have his or her dignity respected and protected. See further his discussion of ‘the essential substance level’ and ‘the process of loss level’. He argues in closing that the validity of waivers is determined by the ordinary rules of contract law. He states that to summarise the position of the waiver of a constitutional right (other than an inalienable right) is to reiterate his argument that contracts are enforceable unless contrary to public policy. Contracts whose enforcement would entail the violation of a right in the Bill of Rights says Hopkins, are unenforceable because they are contrary to public policy. Bewilderingly, he then goes on to contradict himself by saying immediately thereafter that enforcement of such a waiver would mean in effect the limitation of a contractant’s constitutional right – this can only be done if the requirements for the valid limitation of a constitutional right in the limitations analysis are met. This totally ignores the fact that the limitations analysis referred to in section 36 of the Constitution is conducted only with regard to law of general application since it is only in terms of law of general application that the rights in the Bill of Rights may be limited. He argues that only ‘alienable rights’ are capable of being justifiably limited. It is submitted that the categorisation of the rights in the Bill of Rights is not only unconstitutional but inadvisable due to the fact that they are complex, interdependent and interrelated concepts that do not lend themselves, like the Bijani twins, to separation. Indeed, without straining the metaphor unduly, one could safely say that attempts to regard the individual rights in the Bill of Rights as separate and

contract essentially purports to authorise the person in favour of whom the waiver is made to act in a manner that is contrary to constitutional values and principles. Can such an action (the waiver on the part of the one party to the contract) ever have the effect of justifying what is basically an unconstitutional act on the part of the other party to the contract? Waiver of rights conferred by a statute or by a court order, as opposed to those conferred by a contract, has been recognised as legally possible¹⁹⁵. The problem with waiver is that as soon as a waiver of a right has been communicated to the opposite party it is irrevocable; the right has perished¹⁹⁶. How can a constitutional right be allowed to perish? How can it be revived once it has perished based as it is on a statute which is the foundation for all other law in South Africa and in which it is recognised as fundamental?

7.7 Res Ipsa Loquitur and Strict Product Liability

The *res ipsa loquitur* rule can be of considerable value in the context of the law relating to the delivery of health services in the sense that it can contribute to the evening out to some degree of the imbalance in the provider patient relationship. The effect of the rule is that the mere fact of a particular occurrence warrants an inference of negligence where the occurrence is due to a thing or means within the exclusive control of the defendant. It is described in Hoffmann and Zeffertt's *The South African Law of Evidence*¹⁹⁷ as follows: "If an accident happens in a manner which is unexplained but which does not ordinarily occur

independent concepts could well be ultimately fatal to the Bill of Rights as a whole. See further the discussion on page 352 with regard to the maxim *volenti non fit injuria*.

¹⁹⁵ See *Wright v Wright* 1978 (3) SA 47 (E) in which the court stated: "Where there is no prohibition against waiver the general rule is that any person can enter into a binding contract to waive benefits conferred upon him by law for his sole benefit: *McDonald v Enslin* 1960 (2) SA 314 (O) at p 17. This applies also to a benefit or right conferred by statute: *Tompkins v Goltz* 1978 (1) SA 88 (W) at p 90H. I see no difference in principle between waiver of a right conferred by statute and waiver of one which is derived from a Court order. To my mind both waivers are competent and valid. The only complication in the case where the right is conferred by a Court order is that, as far as the party who must pay maintenance is concerned, the order must be obeyed until it is discharged: *Hadkinson v Hadkinson* (1952) 2 All ER 567. However, that is a matter between the Court and the party owing the obligation and it is for the latter to liberate himself from the terms of the order by obtaining its discharge."

¹⁹⁶ *Mutual Life Insurance Co of New York v Ingle* 1910 TPD 540 at p 550; *Glaser v Millward* 1950 (4) SA p 587 (W); *Moult v Minister of Agriculture and Forestry, Transkei* 1992 (1) SA 688 (Tk)

¹⁹⁷ Hoffman and Zeffertt 4th ed at p 551

unless there has been negligence, the court is entitled to infer that it was caused by negligence.” Unfortunately, although South African courts have been applying the rule for more than a century to various other delictual claims, they have not applied it to claims for medical negligence on the basis of the majority judgment in *Van Wyk v Lewis*¹⁹⁸ in which it was held that the doctrine was not applicable to such claims¹⁹⁹. It seems that they have declined to apply the doctrine to medical negligence cases only because in the medical context, the requirement that the occurrence must fall within the scope of the ordinary knowledge and experience of the reasonable man cannot be met. Van den Heever observes that until the 1924 judgment is successfully challenged and overturned, lower courts are bound to follow its approach because of the principle of *stare decisis*²⁰⁰ followed by the South African legal system²⁰¹. Van

¹⁹⁸ *Van Wyk v Lewis* 1924 AD 438

¹⁹⁹ Van den Heever P ‘Should *res ipsa loquitur* ‘speak for itself’ in medical accidents?’ *De Rebus* November 2002 <http://www.derebus.org.za/archives/2002/Nov/articles/medical.htm> The article is an extract from van den Heever’s unpublished doctoral thesis: ‘The Application of the Doctrine of *Res Ipsa Loquitur* to Medical Negligence Actions: A Comparative Survey’ 2002 University of Pretoria

²⁰⁰ It is submitted that the matter is not quite as simple as this. In *Shabalala v Attorney-General, Transvaal, And Another Gumedde And Others v Attorney-General, Transvaal* 1995 (1) SA 608 (T) Cloete J noted that: “All counsel appearing before me submitted that where a Court is called upon to interpret the Constitution, that Court can depart from other decisions on the same point in the same Division if it disagrees with such other decisions. I cannot agree with this submission. It is settled law that a Court can only depart from the previous decisions of a Court of equivalent status in the same area of jurisdiction where it is satisfied that the previous decision is ‘clearly wrong’: *S v Tarajka Estates (Edms) Bpk en Andere* 1963 (4) SA 467 (T) at 470A; and *cf R v Jansen* 1937 CPD 294 at 297 and *Duminij v Prinsloo* 1916 OPD 83 at 84 and 85.” Cloete J held that: “I see no reason to depart from this salutary principle simply because the point at issue involves an interpretation of the Constitution. I appreciate that s 4(1) of the Constitution provides that ‘This Constitution shall be the supreme law of the Republic . . .’ and that s 4(2) provides that ‘This Constitution shall bind all . . . judicial organs of State at all levels of government’; but those provisions do not in my view mean that the established principles of *stare decisis* no longer apply. Such an approach would justify a single Judge departing from a decision of a Full Bench in the same Division because he considered the interpretation given to the Constitution by the Full Bench to be in conflict with the Constitution, with resultant lack of uniformity and certainty until the Constitutional Court, whose decisions in terms of s 98(4) bind, *inter alia*, ‘all judicial organs of State’, had pronounced upon the question.”

This said, however, he went on to state that: “On the other hand, the interpretation given to s 241(8) in this Division cannot be said to have established a long-standing practice. The general difficulty which I have, with respect, with the decisions in the Transvaal which have hitherto interpreted s 241(8) is that the learned Judges who gave those decisions appear to have applied ordinary principles of statutory interpretation and not to have given sufficient weight to ‘the spirit and tenor of the Constitution’ (Acheson’s case *supra* loc cit). I also believe that I am justified in departing from those decisions for the following additional reasons.”

In *Ex parte Minister of Safety and Security and Others: In re S v Walters and Another* 2002 (4) SA 613 (CC) the Constitutional Court held that neither the fact that under the interim Constitution of the Republic of South Africa Act 200 of 1993 the Supreme Court of Appeal had no constitutional jurisdiction nor that under the (final) Constitution of the Republic of South Africa Act 108 of 1996 it did not enjoy ultimate jurisdiction in constitutional matters warranted a finding that its decisions on constitutional matters were not binding on High Courts. It stated that it did not matter that the Constitution enjoined all courts to interpret legislation and to develop the common law in accordance with the spirit, purport and objects of the Bill of Rights. In doing so, courts were bound to accept the authority and the binding force of applicable decisions of higher tribunals. Kriegler J held that High Courts were obliged to follow legal interpretations of the Supreme Court of Appeal, whether they related to constitutional issues or to other issues, and remained so obliged unless and until the Supreme Court of Appeal itself decided otherwise or the Constitutional Court did so in respect of a

den Heever²⁰² submits that there are reasonable grounds for advancing a persuasive argument that the judgment in *Van Wyk v Lewis*²⁰³ should be overruled. He states that although support for applying the doctrine to medical negligence actions can also be found with reference to constitutional and other considerations, he attacks the judgment in *Van Wyk* on the basis of the following principles.

Van den Heever points out that from the record of the court proceedings, the evidence of Dr Lewis was that he had never been made aware that a swab had been retained and he sought to exculpate himself further by *inter alia* testifying that it was a difficult operation, that time was of the essence and it was in the

constitutional issue. However, the question of the binding effect of decisions of higher tribunals given before the constitutional era was a different issue, was not under consideration in the present case.

In *McNally v M & G Media (Pty) Ltd And Others* 1997 (4) SA 267 (W) Du Plessis J observed that there is nothing in s 35(3) to suggest that the High Court is not, as it has always been, bound by precedent. On the contrary, both 'application' and 'development' imply that what must be applied and developed must be left intact at the outset. He noted that the decision in *Rivett-Carnac v Wiggins* 1997 (3) SA 80 (C) held that 'the Constitution could never have envisaged such a fundamental rejection of precedent so as to empower an individual Judge to overturn decades of precedent developed by the Appellate Division' but that 'the Constitution mandates each Court to examine the common-law rules afresh and if necessary to ensure that the content thereof accords with the principles thereof', an examination which has to be done 'cautiously after a careful examination of the existing principles which underpin the common-law rules and a comparison thereof with the key principles of Constitution'. With these dicta there can be agreement, but with the addition that authorities ordinarily binding may only be deviated from if it can truly be said that they no longer constitute precedent. In order to determine whether a particular judgment is a precedent, it is necessary carefully to examine the full *ratio* of that judgment.

In *Bookworks (Pty) Ltd v Greater Johannesburg Transitional Metropolitan Council and Another* 1999 (4) SA 799 (W) Cloete J made the point that while the Constitution required that its provisions and values be given primacy over the rules of the common law, even when those rules had been invested with the highest stature of pre-constitutional judicial authority, where a superior Court had decided what the effect of the Constitution on established law was, whether substantive or procedural, a lower court had to follow that decision, notwithstanding the supremacy of the Constitution.

In *Afrox Healthcare Bpk v Strydom* fn 186 *supra*, the Supreme Court of Appeal held that as far as pre-constitutional decisions of the Supreme Court of Appeal regarding the common law were concerned, a distinction had to be drawn between three situations which could develop in the constitutional context. First, the situation where the High Court was convinced that the relevant rule of the common law was in conflict with a constitutional provision. In that instance the Court was obliged to depart from the common law as the Constitution was the supreme law. Secondly, the situation where the pre-constitutional decision of the Supreme Court of Appeal was based on considerations such as *boni mores* or public interest. If the High Court was of the opinion that such decision, taking constitutional values into account, no longer reflected the *boni mores* or public interest, the High Court was obliged to depart from the decision. Such a departure would not be in conflict with the principles of *stare decisis* as it had to be accepted that *boni mores* and considerations of public policy were not static concepts. Thirdly, the situation where a rule of the common law determined by the Supreme Court of Appeal in a pre-constitutional decision was not in direct conflict with any specific provision of the Constitution; the decision was also not reliant on any changing considerations such as *boni mores*; but the High Court was nevertheless convinced that the relevant common-law rule, upon the application of s 39(2) of the Constitution, had to be changed to promote the spirit, purport and object of the Constitution. In this situation, the principles of *stare decisis* still applied and the High Court was not empowered by the provisions of s 39(2) of the Constitution to depart from the decisions of the Supreme Court of Appeal, whether such decisions were pre- or post-constitutional.

201 Van den Heever fn 199 *supra*

202 Van den Heever fn 199 *supra*

203 *Van Wyk* fn 198 *supra*

patient's interest to be stitched up and removed from the operating table as soon as possible. He did not conduct his defence on the basis that he had to terminate the operation before finding the missing swab because of the plaintiff's critical condition. He was not even aware that there was a swab missing and if there was he averred that it was the responsibility of the theatre sister employed by the hospital and for whom he was not vicariously liable. Van den Heever argues that a balanced, objective consideration and evaluation of the evidence should have led the court to conclude that the swab was retained post operatively by the patient established a *prima facie* case of negligence (correctly acknowledged by minority judgment of Kotze JA). He observes that the defendant was able to escape liability by tendering acceptable exculpatory evidence and that the facts of the case provide a valuable example of circumstances where the plaintiff should have been permitted to rely on the doctrine of proving only that the swab was post-operatively retained. The *prima facie* inference of negligence based on the retention of the swab would merely have required Dr Lewis to provide an exculpatory explanation of why it had been retained and that it had not been his responsibility to count the swabs and make sure that none were missing. Thus while the outcome of the case may have been no different for Dr Lewis, the court could have avoided setting an undesirable and unfortunate precedent concerning *res ipsa loquitur* that unduly sways the balance of power even more in favour of the provider in the provider-patient relationship. He notes that the finding that *res ipsa loquitur* could not find application in *Van Wyk* on the fact that the court would – in view of the notion that the medical layman knows very little, if anything about complex abdominal surgery – have had also to consider the surrounding circumstances provided by expert medical opinion and submits that the court made two fundamental errors in this regard. The first is that the retention of the swab clearly bespoke negligence, even from the medical layman's point of view. It cannot be argued with any confidence that the court would have had to consider expert medical evidence to be persuaded that the swab should not have been left behind in the patient's body. The court considered the surrounding circumstances only at that stage when the defendant



provided his exculpatory evidence. The majority of the court compounded this material misdirection by elevating a speculative defence to accentuate the complexities of abdominal surgery which had the effect of placing the occurrence outside the realm of the ordinary experience and common knowledge of the medical layman. Secondly the court misconstrued the expert medical evidence in disregarding the evidence that a swab cannot be left in a patient even if it is left behind in a life-threatening intra-operative situation. The evidence was that as soon as the patient was up to a further operation the swab would in any event have to be removed. It is submitted that the judgment in *Van Wyk v Lewis* was possibly partially a consequence of the mystique that surrounded surgeons and other members of the medical profession at that time²⁰⁴ and that the court incorrectly focused on the complexities of abdominal surgery rather than on the much more simple fact that a swab which could logically not have entered the patient's body in any other way, except through surgery, coupled with a history of recent surgery, had evidently been retained in the patient's body consequent upon such surgery. It does not take a medically qualified person to draw the obvious conclusions. Van den Heever submits that the approach of the court conflated a question of law (whether an inference of negligence can be drawn from the occurrence itself) and a question of fact (whether the facts, including the evidence of the defendant, or the absence of such evidence, support the inference of negligence.) He notes that it cannot seriously be contended that the leaving behind of a surgical instrument in the

204

In more modern times medical practitioners are seen rather more as ordinary human beings capable of ordinary human error and rather less as the demigods they were perceived to be in times past. See for instance 'The Practice of Autonomy: Patients, doctors, and medical decisions' *NEJM* Vol 340: 821-822 No 10 March 1999 in which it is stated: "The process of making medical decisions in the United States today is, in theory, a neat and well-defined affair. Authority and responsibility are shared, as mentally and emotionally capable adults choose voluntarily and intelligently from among various options whose relative risks and benefits their personal physicians have fully explained to them. Gone are the days of medical paternalism, when arrogant health care professionals misused their power to force particular treatments on dependent patients who blindly trusted them." See also Patterson J and Conroy B 'New Breed of Informed Patients Put Pressure on Healthcare providers' Cap Gemini Ernst & Young http://www.us.cgey.com/news/current_news.asp in which it is noted that research by Cape Gemini Ernst & Young has found that informed patients are increasing pressure on physicians. Almost one third of doctors surveyed had been asked by patients to prescribe drugs about which they themselves had insufficient knowledge. Boudreau D 'Patient Power' *The Novartis Journal* notes that there is a new breed of healthcare consumers who are no longer content to rely solely on their doctor's word. Van den Heever P, '*Res Ipsa Loquitur* and Medical Accidents: Quo Vadis?' *De Rebus* June 1998 makes the point that recognition of the application of *res ipsa loquitur* in respect of medical accidents would promote equity between parties by accentuating patient interest instead of medical paternalism and serve to combat the so-called conspiracy of silence among doctors. <http://www.derebus.org.za/archives/1998Jun/articles/accident.htm>

body of a patient after the completion of an operation does not create a *prima facie* inference of negligence.

Van den Heever argues that in terms of section 9 of the Constitution everyone is equal before the law and has the right to equal protection and benefit of the law. In this regard, he says it could be argued that the victim of a medical accident is at a procedural disadvantage because of the fact that patients are usually anaesthetised or under the influence of an anaesthetic agent when the accident occurs as a result of which they are completely in the dark as to what actually happened. He says that to permit the plaintiff to rely on *res ipsa loquitur* in these circumstances would level the playing fields between the plaintiff and the defendant to a certain extent by promoting procedural equality. He points out that section 34 of the Constitution also recognises the right to fairness in civil litigation which provides further constitutional motivation for the application of the doctrine to medical negligence actions²⁰⁵.

Van den Heever states that the approach of South African courts to the doctrine of *res ipsa loquitur* with regard to medical negligence actions is out of touch with modern trends and that the more patient-oriented approach in *Castell v De Greef*²⁰⁶ is in line with developments in other common law countries with regard to health care law in general and creates an environment where further traditional and outdated approaches such the approach adopted in *Van Wyk v Lewis*²⁰⁷ can be challenged successfully.

In the spirit of optimism it is thus appropriate to examine in further detail the manner in which the doctrine has been applied in other contexts by South African courts and to explore the central principles. In *Stacey v Kent*²⁰⁸ the court

205 He refers to Carstens P 'Die toepassing van *res ipsa loquitur* in gevalle van mediese nalatigheid' 1999 *De Jure* 19 in this regard.

206 *Castell* 1994 (4) SA 408 (C). Discussed in chapter nine dealing with the private sector.

207 *Van Wyk* fn 198 *supra*

208 *Stacey* 1995 (3) SA 344 (E) at p 352



stated the principle as follows: the rule gives rise to an inference, not a presumption, of negligence. The court is not compelled to draw the inference. At the end of the case the enquiry is where, on all the evidence, the balance of probabilities lies. If it is substantially in favour of the party bearing the onus on the pleadings, he succeeds; if not, he fails. Once the plaintiff proves the occurrence giving rise to the inference of negligence on the part of the defendant, the latter must adduce evidence to the contrary; he must tell the remainder of the story, or take the risk of judgment being given against him. How far the defendant's evidence need go to displace the inference of negligence arising from proof of the occurrence depends upon the facts of the particular case. Mere theories or hypothetical suggestions will not avail the defendant; his explanation must have some substantial foundation in fact and the evidence produced must be sufficient to destroy the probability of negligence inferred to be present prior to the testimony adduced by him. There is, however, no onus on the defendant to establish the correctness of his explanation on a balance of probabilities. The enquiry at the conclusion of the case remains whether the plaintiff has, on a balance of probabilities, discharged the onus of establishing that the collision was caused by negligence attributable to the defendant. In that enquiry the explanation tendered by the defendant will be tested by considerations such as probability and credibility.

In *MacLeod v Rens* the court expressed some reservations about the rule²⁰⁹ and in *Madyosi and Another v SA Eagle Insurance Co Ltd*²¹⁰ the Appellate Division

²⁰⁹ *McLeod* 1997 (3) SA 1039 (E) at p 1048 where it stated: As a particular form of inferential reasoning, *res ipsa loquitur* requires careful handling. It is not a doctrine, as it is sometimes referred to. It propounds no principle and is therefore strictly speaking not even a maxim. What it does do is pithily state a method of reasoning for the particular circumstance where the only available evidence is that of the accident. It boils down to the notion that in a proper case it can be self-evident that the accident was caused by the negligence of the person in control of the object involved in the accident. As such it is not a magic formula. It does not permit the Court to side-step or gloss over a deficiency in the plaintiff's evidence; it is no short cut to a finding of negligence: these are real dangers in the application of the expression. It seems to tempt Courts into speculation. Expressions such as 'in ordinary human experience', 'common sense dictates', and 'obviously', which are regularly employed in reasoning along the lines of the maxim, sometimes only serve to disguise conjecture. Moreover, there is a risk of false syllogism inherent in reasoning that, as the accident would ordinarily not have occurred without negligence on the part of the driver of the vehicle, the defendant, having been the driver, was therefore negligent. Finally, reasoning along the lines of *res ipsa loquitur* leads to the somewhat unsatisfactory finding that the defendant was negligent in some general or unspecific manner."

²¹⁰ *Madyosi* 1990 (3) SA 442 (A)

stated that: In our law the maxim *res ipsa loquitur* has no bearing on the incidence of proof on the pleadings, and it is invoked where the only known facts, relating to negligence, are those of the occurrence itself. It quoted from *Sardi and Others v Standard and General Insurance Co Ltd*²¹¹ where the court stated that:

“At the end of the case the court has to decide whether, on all of the evidence and the probabilities and the inferences, the plaintiff has discharged the onus of proof on the pleadings on a preponderance of probabilities, just as the court would do in any other case concerning negligence. In this final analysis, the court does not adopt the piecemeal approach of (a) first drawing the inference of negligence from the occurrence itself, and regarding this as a *prima facie* case; and then (b) deciding whether this has been rebutted by the defendant's explanation.”

The case of *Wagener v Pharmacare Ltd; Cuttings v Pharmacare Ltd*²¹² involved the extent to which a manufacturer can be strictly liable in delict for unintended harm caused by defective manufacture of a product where there is no contractual privity between the manufacturer and the injured person. The appellant in the first appeal underwent shoulder surgery at a private hospital conducted by a trust. The surgical procedure involved administration of a local anaesthetic called Regibloc Injection (‘Regibloc’) which was manufactured and marketed by the respondent company. As an aftermath of the surgery the appellant was left with necrosis of the tissues and nerves underlying the site of the operation, and paralysis of the right arm. In an action for damages for personal injury which the appellant instituted in the Cape Town High Court, she sued the respondent and the trustees of the trust. She alleged, among other things, that her injury and its sequelae were caused by Regibloc. A virtually identical suit was brought by the appellant in the second appeal, another alleged victim of Regibloc. The two actions were consolidated. One of the causes of action the appellant relied on was that the Regibloc administered to her was defective as a result of negligent manufacture by the respondent. However, that was pleaded only in the alternative. Her main claim was based simply on the allegation that, contrary to the respondent's duty as manufacturer (obviously

²¹¹ *Sardi* 1977 (3) SA 776 (A) at p 780D - E and G - H

²¹² *Wagener* 2003 (4) SA 285 (SCA)

meaning legal duty in the delictual sense) the Regibloc administered was unsafe for use as a local anaesthetic because it resulted in the necrosis and paralysis. The court said that in deciding the issues raised by the appeal it must be accepted, as regards the facts, that the Regibloc in question was manufactured by the respondent, that it was defective when it left the respondent's control, that it was administered in accordance with the respondent's accompanying instructions, that it was its defective condition which caused the alleged harm and that such harm was reasonably foreseeable. It must also be accepted, as far as the law is concerned, indeed it was not disputed, first, that the respondent, as manufacturer, although under no contractual obligation to the appellant, was under a legal duty in delictual law to avoid reasonably foreseeable harm resulting from defectively manufactured Regibloc being administered to the first appellant and, secondly, that that duty was breached. In the situation pleaded there would therefore clearly have been unlawful conduct on the part of the respondent. The essential enquiry was whether liability attaches even if the breach occurred without fault on the respondent's part.

The court observed that if there were strict liability, it would not be open to a manufacturer to rely on proof that it had taken all reasonable care, but then one must ask what real difference that is likely to make. It stated that once there is *prima facie* proof, direct or circumstantial, that the product was defective at the various times material to the action, it is virtually inevitable that *res ipsa loquitur* will apply and require an answer from the manufacturer. It said that whilst the maxim comes into play only if the plaintiff's evidence is such that it can be said that the event (in this case, for example, the necrosis) would not ordinarily occur without there having been negligent manufacture (involving, perhaps, some scientific explanation in addition to the mere fact of the injury) it is perfectly conceivable that the Courts may develop reasons for being readier in some cases of alleged defective manufacture to draw the necessary *prima facie* inference of negligence where expert evidence is extremely difficult for the plaintiff to acquire, and perhaps even more so where administration of a

substance made to be applied to the human body has apparently had an effect quite contrary to the manufacturer's stated aim. If the law requires development to cater for this particular type of suit, then there would be the need for what is but an incremental shift and not a complete rejection of long-standing principle. The court pointed out that the question of that type and degree of development did not arise in the present case but said that it may arise if, and when, the litigation proceeded on the alternative claim. It stated that the same considerations pertain to the possibility that it might well be thought right in future for reasons of policy, practice and fairness between the parties to place the onus on the manufacturer to disprove negligence but noted that this was something for another day. The court ultimately expressed the view that it was the applicability of *res ipsa loquitur*, perhaps even in an extended way, and the possibility of a reverse onus, which militated against the conclusion that the Aquilian remedy was insufficient to achieve protection of the claimant's right in this kind of litigation.

The Supreme Court of Appeal refused to allow strict product liability in this case. It was of the view that the subject was more suited to legislation²¹³. Some of the objections it raised to the imposition of such liability were-

- It is difficult to understand how the Courts could logically, fairly or in principle confine the imposition in this way, whether one looks at the matter from the standpoint of the claimant or that of the manufacturer. Why should only the victims of defectively made medicines have the remedy or, conversely, why should their producers be the only manufacturers strictly liable?

²¹³ *Waegener fn 212 supra* at p 298 Howie P stated that: "What I find significant about all the arguments in favour of strict liability is that, virtually without exception, they would hold good were imposition to be by the Legislature. They do not begin to get to grips with the question which forum it should be. One finds in Neethling, Potgieter and Visser the statement that '(u)ltimately, products liability ought to be based on liability without fault'. The authors then, in support, quote from the article by J C van der Walt ['Die deliktuele aanspreeklikheid van die vervaardiger vir skade berokken deur middel van sy defekte' 1972 *THRHR* 224 at p 247 - 8, p 249] who in turn provides reasons why there should be strict liability but does not say why its imposition should be judicially achieved." [footnotes omitted]

- One of the difficulties which could arise were the Courts to impose strict liability is this. A decision in favour of the appellants would not merely have prospective effect. A finding that strict liability attaches to the respondent would, in effect, declare what the law on this point has always been even if it has never before been so stated. Accordingly, a manufacturer could now, by reason of such declaration, become strictly liable for a product defectively made some years ago in respect of which, absent proof of negligence, it stood in no jeopardy of an adverse judgment. There is no procedural mechanism available by which to avoid that unjust result if the imposition of strict liability were to be by judgment. Were that imposition to be legislative, the relevant statute would not operate retrospectively on a matter of substantive law.
- Howie P pointed out that it was not without significance that in other parts of the world, the imposition had been by way of legislation. The court said that it was no doubt recognised in the countries concerned that the subject of product liability is boundless as regards the possible structures and codes that can be put in place, that the investigation and debate which is part and parcel of the democratic process are the best measures by which to canvass the opinions of all interested parties and to produce a comprehensive set of principles, rules and procedures, all in force from one and the same date. By contrast, said the court, the result sought by the appellants would merely pertain to one type of product and only to manufacturers of such products. The fate of manufacturers of other products or of other articles, the fate of manufacturers of ingredients (as opposed to the manufacturers of entire medicines) and of components, would have to depend on the uncertain and unpredictable frequency with which future disputes spawned cases and those cases spawned judgments.

In the context of health service delivery in the public sector the court in *Pringle v Administrator, Transvaal*²¹⁴ refused to apply the principle of *res ipsa loquitur*, stating that it was clear on the authorities that the onus of proving that the doctor was negligent in one or more of the respects alleged in the particulars of claim rests throughout on the plaintiff. Blum AJ held that the maxim could only be invoked where the negligence alleged depends on absolutes. In the instant case the initial problem was caused by the perforation of the superior vena cava. If the evidence showed that by the mere fact of such perforation, negligence had to be present, then the maxim would have application. He noted that no such evidence had emerged and that since the question of whether negligence was present or not depends upon all the surrounding circumstances, this made the maxim totally inapplicable in cases such as *Pringle*.

In the context of health service delivery in the private sector Marais JA observed in *Broude v McIntosh and Others*²¹⁵ that the trial Judge concluded that the evidence did not establish on a balance of probabilities that the facial nerve was severed during operation. That conclusion, said Marais JA, rested upon a number of subsidiary findings and considerations which, if correct, amply justified it. It was clear that the facial nerve must have sustained some injury during the operation but severance could not be deduced solely by invoking the *res ipsa loquitur* doctrine because there were other potential causes of damage to the nerve which did not entail severance. In *Blyth v Van Den Heever*²¹⁶ counsel for the respondent argued that it is trite law that a practitioner may be negligent in making a wrong diagnosis, but a wrong diagnosis is not necessarily a negligent diagnosis. It may be due to a reasonable error of judgment²¹⁷. He said that triers of fact may tend, albeit unconsciously, to apply the maxim *res ipsa loquitur* to a situation such as the present case where plaintiff has suffered a major vascular catastrophe after being treated by defendant but that such an

²¹⁴ *Pringle* 1990 (2) SA 379 (W)

²¹⁵ *Broude* fn 26 *supra*

²¹⁶ *Blyth* 1980 (1) SA 191 (A)

²¹⁷ See *Mitchell v Dixon* 1914 AD at p 526; *Dube v Administrator, Transvaal* fn 156 *supra* at p 268A.

approach would not be warranted and should be guarded against. The court did not apply the maxim in this case. It also refused to apply the maxim in *Mitchell v Dixon*²¹⁸ stating that that the mere fact that the accident occurred was not in itself *prima facie* proof of negligence.

Strauss²¹⁹ observes that by a slender majority of two to one the Appeal Court in *Van Wyk v Lewis*²²⁰ held in effect that the rule of *res ipsa loquitur* does not apply to medical situations. He observes that generally speaking in the law of negligence “this rule is a great boon to the plaintiff but that even where a swab is post-operatively sewn up inside a patient, there is no presumption of negligence on the part of the doctor”. Strauss himself appears to have strongly criticised the judgment²²¹ but observes that it has nevertheless stood ever since and that in *Pringle*²²² the court once again held that there was no room for the application of *res ipsa loquitur* in medical negligence cases. He notes that in the USA the maxim has gained a strong foothold and has become a powerful tool in the hands of lawyers acting for dissatisfied patients. It has developed into a ‘rule of sympathy’ for the patient and been used to combat the ‘conspiracy of silence’ among doctors.

On the subject of strict liability in respect of products, Strauss²²³ comments that proof of negligence may be facilitated by the principle of *res ipsa loquitur*. He notes that the principle has been applied in South Africa for negligent services²²⁴ involving an exploding boiler in a power station and where a woman’s hair was scorched during a “perm” and that the liability of the person in control of the defective object was at issue in these two cases rather than the manufacturer.

218 *Mitchell* fn 217 *supra*

219 Strauss fn 34 *supra* at p245. See also Strauss SA ‘The Physician’s Liability For Malpractice: A Fair Solution to the Problem of Proof’ 1967 *SALJ* 419

220 *Van Wyk* fn 198 *supra*

221 Strauss SA and Strydom MJ *Die Suid-Afrikaanse Geneeskundige Reg* (1967) 279. See also Birrer C *The Medical Cop-out* (1976) p 118-119 to whom Strauss (fn 34 *supra*) refers in footnote 10 on p 245

222 *Pringle* fn 214 *supra*

223 Strauss fn 34 *supra* at p 264

224 *Clair v Port Elizabeth Harbour Board, Kennedy v The Same* 5 EDC 311 (1887) and *Mitchell v Maison Libson* 1937 TPD 13.



Strauss points out that other systems of law have moved away from the notion of fault liability for defective products and have introduced the concept of strict liability as regards the manufacturer. He notes that this is a form of consumer protection since the manufacturer in marketing his product assumes the role of insurer of consumers who are harmed by the product. Strauss observes that it may be extremely difficult for a patient who alleges that a prescribed drug was defective to prove that his damage is attributable to the negligence of the manufacturer and that the doctrine of *res ipsa loquitur* may perhaps to a certain extent alleviate the burden of proof for the patient. He states that the apparently simply issue of proving a causal connection between the use of the drug and the patient's injury in itself may, however, still present the patient with an insurmountable obstacle.

Neethling *et al*²²⁵ observe that in *Bayer South Africa (Pty) Ltd v Viljoen*²²⁶ the Appellate Division was not in principle opposed to the application of *res ipsa loquitur* where policy considerations justify it. They state, however, that Milne JA, unlike Anglo-American law, wanted to restrict the doctrine to its "normal" application, that is, that it is only applicable in instances where the facts of the case give rise to an inference of negligence. They suggest that the *res ipsa loquitur* inference of negligence should at least be made where a consumer process that he was prejudiced by a defective (unreasonably dangerous) product and that the product was in this state when the manufacturer abandoned his control over it. Ultimately, they say, product liability ought to be based on liability without fault²²⁷. They refer to the statements of van der Walt²²⁸ to the effect that the acceptance of strict liability (non-fault based) in the case of product liability can be justified on the basis of various factors: the public interest in bodily and psychological integrity of a person requires the highest

225 Neethling *et al* fn 18 *supra* at p 224

226 *Bayer* 1990 (2) SA 647 (A) 661-662

227 Neethling *et al* fn 18 *supra* at p325

228 Van der Walt JC 'Die Deliktuele Aanspreeklikheid van die Vervaardiger vir Skade Berokken deur Middel van sy Defekte Produk' 1972 *THRHR* 224 at p242- 243



degree of protection against defective consumer goods; the manufacturer creates through marketing and advertising the belief in the public mind that his product is safe; strict liability serves as an incentive to ensure the utmost degree of care; the manufacturer is from an economic perspective, best able to absorb the risk of damages and to distribute it through price increases and insurance.²²⁹

Strauss refers to a point made by de Jager that the mere fact of registration of a medicine under the Medicines and Related Substances Act will probably be regarded by South African courts as a strong indication that the manufacturer has not been negligent in the design of his product. "After all extreme caution was built into the statutory machinery to ensure appropriate warnings and directions regarding their ultimate use". He notes that de Jager²³⁰ has indicated that manufacturers' liability for injuries to patients caused by defective medicines will probably be limited to the following types of cases:

- Where there has been negligent deviation from the formula submitted for official registration;
- When the manufacturer has failed to warn against adverse side-effects, or to give directions for use as prescribed by the Medicines Control Council;
- When registration of a medicine was cancelled and the manufacturer has failed to withdraw his product from the market within a reasonable time.

It is submitted that de Jager's suggestions are overly simplistic for a number of reasons. Firstly, product liability need not necessarily arise only from the *design* of the drug. This would involve largely patented drugs since generic drugs are not 'designed' to the same degree as much of the development work has already been done by the erstwhile patent holder. The generic drug market is a highly

²²⁹ Loosely translated from Afrikaans by the writer. The original reads as follows: 'Die aanvaarding van 'n skuldlose aanspreeklikheid in geval van produkteaanspreeklikheid kan deur verskeie faktore geregtig word: die openbare belang in die fisies-psigiese welsyn van die mens vereis die hoogste mate van beskerming teen defektiewe verbruiksgoed; die vervaardiger skep deur sy bemarking en advertensie die vertroue by die publiek dat sy produk veilig is; die streng aanspreeklikheid dien as aansporing om die uiterste mate van sorg aan die dag te lê; die vervaardiger is, vanuit ekonomiese oogpunt gesien, die beste in staat om die skadelas te absorbeer en te versprei deur prysverhoging en versekering.'

²³⁰ De Jager FJ "Defective Pharmaceutical Products" 1980 *Businessman's Law* 234

significant sector within the wider pharmaceutical manufacturing environment. There may not be negligent deviation from the formula of the drug so much as negligence in the manufacturing process itself so that certain active ingredients are for instance inadvertently rendered inactive, or that specific storage conditions for the drug, such as refrigeration at a specific temperature, are not followed.

Secondly, no matter how well designed the drug is, manufacturing processes can and do go wrong. Accidents happen on the production line. Contamination of raw materials can occur. The raw materials can be obtained from an inferior source. Insufficient quality guarantees may be obtained by the manufacturer from the supplier of the active pharmaceutical ingredients. It is in recognition of these dangers that the medicines control legislation in South Africa requires manufacturers to comply with what is commonly referred to as GMP or “Good Manufacturing Practice”. This comprises a set of fundamental rules that are essential for the manufacture of safe and effective medicines. The system of licensing of manufacturers of medicines in South Africa requires them to undergo inspections to ensure that they observe GMP. It may happen though that an inspection does not take place at the required time for some reason or that although GMP is generally followed in the manufacturing process there is a lapse on the part of the manufacturer. The GMP inspectors do not maintain a constant watch on the activities of every manufacturer in South Africa. Logistically speaking this is not feasible.

Thirdly there is the question of the indication for which the drug is registered in South Africa. It often happens that drugs are registered for more than one indication in other parts of the world or that new indications for existing drugs are subsequently discovered. The registration process requires approval of registration for specific indications of the drug and not just blanket registration for every possible indication. For example Nevirapine was a registered drug in South Africa for a while before it was registered in respect of the prevention of

mother to child transmission of HIV. It had been registered earlier in respect of other indications but not the prevention of mother to child transmission of HIV because conclusive clinical trial results with regard to this particular indication were still awaited. If a drug is marketed by a manufacturer as being suitable for use for an indication for which it was not registered it will not help the manufacturer to argue that it was registered for another indication and that it is therefore safe for the unregistered indication. Product liability could and, it is submitted, should arise in such a situation.

Fourthly, manufacturers often themselves conduct clinical trials on drugs they have researched and developed. There is clearly potential for a conflict of interests in such circumstances and there may be significant pressures to demonstrate that the drug does what it has been designed to do rather than to conduct objective and scientifically unbiased tests as to what the drug in fact does. There are of course rigorous standards that are set worldwide for clinical trials but it is not impossible for things to go wrong in a clinical trial, negating the results or findings of the trial. Clinical trials are themselves extremely expensive exercises. If an expensive clinical trial fails to meet the strict standards required for clinical trials it is worthless and there is the distinct possibility that some corporate executive's or senior researcher's head will roll. It does not take a psychologist intimately acquainted with human nature to appreciate the possibilities in such a situation. Liability on the part of a manufacturer could arise as a result of defective information obtained from a clinical trial that was presented to the medicines control authority when application was made for the drug to be registered. Facts can be concealed from the medicines registration authority and it is not always possible, despite all reasonable attempts, for that authority to detect defects in clinical trials that in most instances have been conducted on the other side of the world. Consequently the mere fact that a drug has been registered as safe and effective by the Medicines Control Council would not and it is submitted, should not necessarily preclude a claim on the basis of product liability against the



manufacturer. The extreme caution that was built into the medicines registration process is no guarantee of the same extreme caution in the manufacturing process occurring subsequent to registration.

It is submitted that the extreme reluctance of South African courts to apply the principle of *res ipsa loquitur* is based partly on an apparently fairly widespread misunderstanding of its effect in a delictual action and partly on a reluctance to even appear to be moving away from fault based liability. In *Wagener v Pharmicare Ltd; Cuttings v Pharmicare Ltd* the court seemed to prefer the application and even extension of the *res ipsa loquitur* principle to the imposition of strict liability on the manufacturer of a product as being the lesser of two evils.²³¹ With due respect to the learned judge, the real questions in the context of health services delivery appear to be –

- (a) the likelihood of there ever being factual circumstances in which the maxim could be applied in the light of the view of the court in *Van Wyk v Lewis*²³² and more recently in *Pringle*²³³ that the maxim could only be invoked where the negligence alleged depends on absolutes; and
- (b) the chances of the courts being able to bring themselves to apply it in this specific context;

let alone the question of the further development of the maxim so as to resolve broader issues of product liability.

²³¹ *Wagener* 2003 (4) SA 285 (SCA). Howie P stated at p294 : “As regards the problem of proving fault, counsel for the respondent pointed out that even if strict liability were imposed a plaintiff would still have to prove that the product concerned was defective when it left the manufacturer. If that were indeed established, then application of *res ipsa loquitur* would suffice to place the manufacturer on its defence and, in effect, compel an exculpatory explanation, if one existed. In the circumstances it was submitted that proving fault was really no more difficult than proving defectiveness.

²³² *Van Wyk* fn 198 *supra*

²³³ *Pringle* fn 214 *supra*

Thus far, South African courts seem to be oblivious to the obvious²³⁴ imbalance in the provider-patient relationship and there is not yet even any certainty, when these relatively rare cases do come up for decision as to whether they will apply themselves to the process of judicial reasoning required by the Constitution so as to take into account the possibility of the development of the law in such a way as to lend weight, as van der Walt suggests, to the constitutional rights to bodily and psychological integrity. The predilection of the court in *Pringle* to apply the doctrine only where the alleged negligence depends on absolutes does not take into account that where the alleged negligence is so dependent upon absolutes it is probably a lot easier for the defendant to produce evidence of negligence in the normal way and the application of the doctrine in such circumstances is likely to be unnecessary in many instances. Part of the reason

234

Russell Levy, Joint Head of Leigh Day & Co's Clinical Negligence Department, addressed a seminar in the House of Commons on the 6th November 2002 on the subject of how proposed reforms to clinical negligence compensation will impact on patients. He expressed the obvious as follows: "Lord Woolf in his final report to the Lord Chancellor on the civil justice system in England and Wales had the following to say in the chapter concerning medical negligence: 'It would be difficult to exaggerate the effect on potential claimants of the problems that they encounter in obtaining information, coupled with the knowledge that defendants have easy access to medical information and opinion.'

This reflects the fact that the relationship between a doctor and a patient is not an equal one. It is natural for any patient to feel apprehensive about dealings with healthcare professionals in relation to his or her health. It is also natural that patients will place a great deal of trust in the skill and ability of the healthcare professionals treating him or her. The new Civil Procedure Rules start with the overriding objective of enabling the Court to deal with cases justly. In defining such justice the first principle laid down is ensuring that the parties are on an equal footing. The question of who bears the burden of proof was not considered by Lord Woolf. Presumably this was because the burden of proof has traditionally been borne by a claimant and, without thinking further about it, lawyers regard it as axiomatic that this should be so. This blind acceptance that it is somehow right that a claimant should bear the burden of proof means that the resulting inequality in clinical negligence cases passed unnoticed. A modern society demands a modern approach to dispute resolution. It is high time that we examined critically what we currently take for granted and challenge orthodox assumptions where they entrench inequality. A good place to start would be by considering why it is that although one party has the vast bulk, if not all, of the knowledge and information relating to a clinical negligence case as well as the specialist expertise required to interpret that knowledge and information, the burden of proving the case is on the other party. This is on top of the fact that the party without the information and expertise is by definition an individual patient who has been injured or the family of a dead patient. The other party is by contrast an institution or (for general practitioners and in cases of private medicine) is represented by an experienced defence organisation or insurer." He proposes as an alternative a formula for the shifting of the burden of proof along the following lines "An injury to or unexpected death of a patient that occurs in the context of a duty of care relationship with a healthcare provider gives rise to an entitlement to compensation unless the healthcare provider can prove that the injury or death was not caused by a breach of that duty" It is of interest to note that he states that even the benefit of the long-established legal maxim of *res ipsa loquitur* is at present effectively denied to patients in clinical negligence cases. He refers to the case of *Ratcliffe v Plymouth & Torbay Health Authority & Another* (1998) 4 *Lloyds Rep Med* 162 where the Court of Appeal held that despite the judge finding that a spinal anaesthetic was the cause of a patient's neurological damage, he was entitled to conclude that he simply did not know what had happened, that *res ipsa loquitur* was not a principle of law and did not relate to or raise a presumption, and that the courts would be doing the practice of medicine a considerable disservice if, in such a case, because a patient has suffered a grievous and unexpected out-turn from a visit to hospital, a careful doctor was ordered to pay him compensation as if he had been negligent. Levy makes the point that this presumably well intentioned statement highlights the inequity of the position: because the patient was unable to discharge the burden of proof, even though he was asleep at the time the injury occurred, the Court of Appeal felt it right to assume that the doctor was careful rather than to compensate the patient despite the finding of fact that the spinal anaesthetic was the cause of the wholly unexpected adverse outcome.

<http://www.leighday.co.uk/upload/public/attachments/reversingtheburdenofproof.doc>



for the transfer of the evidentiary burden to the defendant by *res ipsa loquitur* is precisely that the plaintiff does not necessarily know what exactly happened and is not necessarily even in a position to identify such 'absolutes'. If the object of the maxim is to give the patient the benefit of the doubt then how can one turn around and say that it should only be applied in circumstances where there can be little doubt to begin with? It is submitted that such an extremely narrow approach defeats the object of the maxim to a large degree since one is effectively saying that the circumstances of the case must be such that there is no significant doubt that there was negligence due to the presence of the 'absolutes' in question.

Given the fact that the maxim only shifts an evidentiary burden, as opposed to the plaintiff's entire burden of proof, such a narrow approach in circumstances such as the provider-patient relationship in which there is a clear imbalance in favour of the provider is hardly justifiable. It is furthermore of some concern to note that the court in *Wagener* implied that an extended *res ipsa loquitur* application could be a viable substitute for strict liability. *Res ipsa loquitur* does not exclude the element of fault from a delictual claim. It simply translates the evidentiary burden of proving fault from the plaintiff into an evidentiary burden of proving an absence of fault onto the defendant. It creates a rebuttable presumption of negligence, regarding a specific fact or circumstance, on the part of the defendant²³⁵. Since the defendant, unlike the plaintiff, is in full possession of all of the facts, if he was not negligent this should not be difficult to prove. It

²³⁵ Richmond and Quinn a law firm in Alaska, point out in their *Litigation Overview*, that the doctrine of *res ipsa loquitur* is "a bridge dispensing with the requirement that a plaintiff specifically prove breach of duty, once that duty and proximate cause have been established" and applies only when an accident ordinarily does not occur in the absence of negligence. *State Farm Fire Cas. Co v Municipality of Anchorage* 788 P.2d 726, 730 (Alaska 1990); *Widmyer v Southeast Skyways, Inc* 584 P 2d 1, 10 (Alaska 1978); *Falconer v Adams*, 974 P 2d 406, 414 (Alaska 1999). They observe that the doctrine of *res ipsa loquitur* permits but does not compel an inference of negligence from the circumstances of an injury and that the doctrine should be applied when (1) the accident is one which does not ordinarily occur in the absence of someone's negligence; (2) the agency or instrumentality is within the exclusive control of the defendant; and (3) the injurious condition or occurrence was not due to any voluntary action or contribution on the part of the plaintiff. They state that by shifting the burden of the production of evidence to the defendant without relieving the plaintiff of the burden of proof, the doctrine makes recovery possible where circumstances render proof of the defendant's specific act of negligence impracticable and the defendant is the party in the superior if not the only position to determine the cause of an accident. *Ferrell v Baxter* 484 P 2d 250, 258 (Alaska 971). They make the point that uncontradicted proof of specific acts of negligence which completely explain the circumstances and cause of the accident renders the doctrine superfluous and inapplicable. (<http://www.richmondquinn.com>)



by no means relieves the plaintiff of the ultimate burden of proving his case including the presence of fault on the part of the defendant. Strict liability, on the other hand, does exactly that. It is based on a public policy point of view that favours the consumer for the reasons mentioned by van der Walt²³⁶. There is a real danger, given the apparent lack of understanding in judicial circles of the import and application of *res ipsa loquitur*, that the two concepts will become conflated and ultimately, once they have been pared down to mere shadows of their former selves, excised from the South African legal system with the razor of conservatism that presently seems to be a favourite logical tool of the Supreme Court and some of the divisions of the High Court in South Africa.

The maxim of *res ipsa loquitur* is not even remotely in the same league as strict (no-fault) liability in favouring the plaintiff. The one operates squarely within a fault-based framework whereas the other is completely outside of it. Judgments that suggest that the one, even in an extended form, could become a substitute for the other are problematic and unfortunate. It is submitted that the fixation of South African courts on fault, their too frequent lack of cognisance of constitutional values and principles and their failure to take seriously the constitutional injunction to develop the common law in accordance with the rights in the Bill of Rights is nowhere more clear²³⁷ than in the reasoning of Howie P in *Wagener*.

The circumstances of the case could not have been simpler. The Supreme Court of Appeal at the outset of its judgment stated that it must be accepted, as regards the facts, that the Regibloc in question was manufactured by the respondent, that it was defective when it left the respondent's control, that it was administered in accordance with the respondent's accompanying instructions, that it was its defective condition which caused the alleged harm and that such

²³⁶ Van der Walt fn 228 *supra*

²³⁷ Except possibly the judgments in the cases of *Carmichele v Minister of Safety and Security and Another* 2001 (1) SA 489 (SCA) and *Afrax Healthcare Bpk v Strydom* fn 186 *supra*

harm was reasonably foreseeable. It must also be accepted, said the court, as far as the law is concerned, indeed it was not disputed, first, that the respondent, as manufacturer, although under no contractual obligation to the appellant, was under a legal duty in delictual law to avoid reasonably foreseeable harm resulting from defectively manufactured Regibloc being administered to the first appellant and, secondly, that that duty was breached²³⁸. The court opted for the view that the existence of instances of strict liability in the law of delict was attributable to special policy considerations obtaining in those cases. Their existence did not advance appellants' case. This conclusion appears to have been reached without any examination of public policy as reflected in the Constitution, specifically with regard to the right to freedom and security of the person including the right to bodily and psychological integrity and the right to human dignity and the provisions of section 39(2) of the Constitution. The court rejected the case of *Kroonstad*²³⁹ as precedent using the compartmentalization argument²⁴⁰ and demonstrating once again the objection that this argument

238 This was on the strength of the judgment in *Ciba-Geigy (Pty) Ltd v Lushof Farms (Pty) Ltd en 'n Ander* 2002 (2) SA 447 (SCA) which was hailed as opening the way for strict product liability in South African law by Neethling J and Potgieter JM 'Die Hoogste Hof van Appèl laat die deur oop vir strikte vervaardigersaanspreeklikheid' 2002 TSAR 582. Unfortunately it is a door that the same court in *Wagener*, effectively shut firmly at the first available opportunity.

239 *Kroonstad Westelike Boere Ko-operatiewe Vereniging Bpk v Botha and Another* 1964 (3) SA 561 (A)

240 The predilection of the courts for the argument that one cannot allow elements or aspects of one area of law to 'contaminate' another is a purist based approach that takes insufficient cognisance of underlying policy considerations that are common to the legal system as a whole. It is submitted that particularly under South Africa's constitutional legal dispensation this argument is even less valid than it may have been in earlier times since it elevates form over substance often without offering any rational explanation for doing so. Whilst legal certainty is important and the value of *stare decisis* is not disputed, the courts themselves have acknowledged that a system which relies totally on precedent has its problems. It is submitted that when there is scant legal precedent upon a particular point the courts are finally forced to return to the wellspring of law in any society – public values and public policy. The building blocks of the law that has gone before or in another related area are taken into consideration and their logic is used to forge solutions to unprecedented cases. This is as it should be if the legal system as a whole is to be a credible and internally consistent framework. However the question in terms of the South African constitutional order is whether the courts should not be more actively considering past precedents in the light of constitutional values and principles in order to ascertain whether or not the former should still hold. After all, law that is inconsistent with the Constitution is invalid. It is not advisable for a court to superficially and without detailed analysis arrive at a conclusion that a right reflected in the Bill of Rights is the same as a similar right that is reflected in the common law – for example the right to bodily and psychological integrity. Whilst it is likely that in most if not all cases there will be some overlap it is not advisable or desirable for the future development of the South African law in a manner that is consistent with the Constitution to assume the extent of that overlap without explicitly exploring the possibility of potential differences. A more thoughtful and enquiring judiciary could greatly benefit and facilitate the constitutional development of the legal system in South Africa at present.

It is of some significance that even prior to the Constitution, in *Government of the Republic of South Africa v Ngubane* 1972 (2) SA 601 (A) the Appellate Division observed that: "Neither the Roman-Dutch law nor any other binding source of law deals specifically with this point. What approach then must this Court adopt? As to that, I agree with the following passage in *The South African Legal System and its Background*, by H. R. Hahlo and Ellison Kahn, p 304: "If there is no Roman-Dutch rule which appears to the court to be applicable to the case... how is the court, bereft of binding legislation, precedent and modern custom, to give a reasoned

values legal form over substance. Howie P stated that “contract and delict, being quite separate branches of the law, have their own principles, remedies and defences. One cannot, because of the absence of contractual privity between the injured party and the manufacturer, simply graft warranty liability onto a situation patently governed by the law of delict.” The court emphasised the binding force of precedent instead of conducting a detailed and comprehensive analysis of public policy and the relevant constitutional rights and values²⁴¹. It chose rather to accept that the right as embodied in the Constitution was the same as that recognised at common law and that since the common law had always required fault as an essential element of a successful claim, the position could be no different at this stage²⁴².

Howie P unconvincingly dismissed the judgement in *Loriza Brahman en 'n Ander v Dippenaar*²⁴³ with the sweeping statement that: “As regards the

judgment? Dealing with this problem, van der Keessel in his *Dictata* approvingly quotes Grotius' statement to the effect that 'wanneer daar in bepaalde sake geen wettelijke bepalinge, privilegies, keure (oftewel stedelike regsreëls) of gebruikregsreëls aangetref word nie, is die Regters reeds van die vroegste tye af onder eed vermaan om in sodanige saak die beste rede te volg soos deur hulle pligsgetrouheid en verstand aan die hand gedoen', adding that judgment will have to be given in accordance with natural law and equity – 'secundum ius et aequitatem naturalem'. See van der Keessel, *Praelectiones*, 1.2.22, (Gonin's translation, vol. 1, p. 29). This does not mean that a Judge is at large to make new law. The learned authors rightly point out at p. 306 that he 'fashions it as far as possible out of materials at hand... though in the process he may within the fabric of the law fashion a new rule'. The foregoing seems to me consistent with what was said by Schreiner, J.A., in *Crookes, N.O., and Another v Watson and Others*, 1956 (1) SA 277 (AD) at p. 290H, namely - 'It is natural, when one is considering a branch of the law on which there is relatively little direct authority, to seek assistance from other portions of the law that seem to present useful analogies; but analogies are only useful if they provide, not merely some solution of the problem under enquiry, but a solution which is satisfactory... Care must be exercised not to force a legal instrument of great potential efficiency and usefulness into a mould that is not properly shaped for it.'"

241 It noted at p294 that: “Most of the cases pre-date the Constitution but that of *Ciba-Geigy* was decided after the Constitution came into operation. The position is, therefore, that the right concerned enjoys the same importance now as it always did and because of the operation of *stare decisis* its enforcement must, subject to the consideration to which I next come, be governed by the same principles as applied before. The binding force of precedent is as effective now as it always was.”

242 Howie P stated: “In evaluating the parties' competing submissions one's starting point is that the right which the appellants seek to protect and enforce is constitutionally entrenched. This is therefore one of the factors to be borne in mind when having regard to the injunction to shape the common law in accordance with the Constitution's spirit, purport and objects. The next consideration is that this same right has also always existed at common law. In that law, its unintended infringement, where (among other consequences) bodily harm results, gives rise to a specific remedy, namely the *Aquilian* action. To succeed in the action, proof of fault in the form of negligence has always been necessary.”

243 *Loriza* 2002 (2) SA 477 (SCA). In that case the facts were that the respondent, while attending a cattle auction, was knocked over and injured by a Brahman heifer-calf named Alicia, the property of the first appellant, a stud farm. The respondent brought an action in a Provincial Division against the first appellant based on the *actio de pauperie* for the damages allegedly sustained by him as a result of Alicia's conduct. The Court a quo made a declaratory order in the respondent's favour. It appeared from the evidence that the respondent had entered the auction pen in which Alicia and about 25 other heifers were being kept pending auction. The respondent, who was busy studying a catalogue, did not see the heifers and was totally unaware of their presence in the pen. None of the other heifers followed Alicia's example. On appeal to the Supreme Court of Appeal it was argued

appellants' reliance on other instances of strict liability, it was pointed out that these have either a long history or a policy-based reason for existence, in both cases peculiar to themselves, and not free from jurisprudential controversy in any event. Any analogy based on them would therefore be false." This is not, it is submitted, a singularly praetorian approach to the South African common law. It would seem that the court felt itself incapable of deducing any policy based approach for the remedy sought in *Wagner* and the fact that the *actio de pauperie* was a policy based remedy for some reason disqualified it as a valid precedent in *Wagner*. It is submitted that the complete opposite view should have prevailed i.e. that where there were significant policy considerations in favour of a particular remedy, the provisions of section 39(2) of the Constitution

on behalf of the appellant that the *actio de pauperie* was an anachronism that should no longer be recognised in our law, inter alia because it involved a primitive form of absolute liability; the *contra naturam sui generis* requirement was confusing and inconsistent; the *actio* was not logically justified; and it often led to unfair results. The second defence put up by the appellant was that Alicia had not acted *contra naturam* because her conduct had to be compared not with that of all other heifers, but specifically with that of the average Brahman heifer, a more highly-strung breed than average. The SCA held that the fact that the *actio*, which was more than 24 centuries old and still formed part of South African law, involved absolute liability was no reason to banish it: the phenomenon of risk-liability was becoming more prevalent and had a useful role to fulfil in areas such as the liability of owners for damages caused by domesticated animals. It held further that that the Court would not be astute to abolish a controversial cause of action that was not unconstitutional or contra bonos mores or fallen into desuetude: rather, it was the duty of the Court where necessary to adapt it and, depending on the circumstances, to either expand or curtail it. The court said that if, instead of the dogmatic view that all 'delictual liability' had to be based on fault, a broad view was adopted that encompassed risk-liability in deserving cases, the only remaining question was whether the *actio* had a useful role to play from a practical point of view. It pointed out that no practical reason relevant to the facts of the present case for the denial of the *actio* was raised and that the time for burying the *actio* had thus not yet arrived. Olivier JA quoted from *O'Callaghan NO v Chaplin* in which the court stated: 'It is satisfactory to find that the action de pauperie still forms part of our law. . . . I think the conclusion is a sound and just one, for if a man chooses to keep an animal, and injury or damage is caused by it to an innocent person, he must make adequate compensation. The owner of the animal and not the person injured must bear the loss. . . . After all, the result arrived at is but the natural development of a doctrine which, as we learn from eminent jurists, such as Wesenbeck, Vinnius, Matthaeus, Huber and others, had already been accepted in most places, notwithstanding the reception of the Roman law. These masters and expounders of the law rightly saw nothing unjust in the view that, as the Roman law regarded *naxae deditio* as merely an alternative mode of solution at the election of an owner, that is of discharging his liability for *pauperies*, the fact of its disappearance did not deprive an injured plaintiff of his right to full compensation to be paid him by the defendant. The doctrine, therefore, which they state was observed in actual practice in their time, has since been accepted by the more modern and maturer jurisprudence, and still prevails as existing law in several civilised European countries as well as in our own.' Howie P's emphasis on legal precedent and the principle of *stare decisis* is thus somewhat selective and once again focuses on form over substance. It is submitted that the rationale behind the *actio de pauperie* is not as peculiar as Howie P would have one believe. It runs like this: If one chooses to have in one's possession something which represents a potential danger to others, then one is liable in the event that the danger in question materialises. The same argument can quite easily be applied in the modern context to the manufacture of pharmaceuticals. If one chooses to be in the business of the manufacture of pharmaceuticals, many of which are essentially potentially dangerous substances, then, in the absence of any contributory negligence on the part of the defendant one should be liable in the event of the materialization of the risk. To put it another way, the fault, it could be said, lies in the choice of business activity. The word 'fault' is not used here in the moral or emotional sense but in the legal, public policy sense. In the policy context it is difficult to understand why the unsuspecting patient should sustain the loss caused by a defective drug especially when that patient's constitutional right to bodily and psychological integrity takes precedence over any right at common law.

should be invoked to develop the common law in keeping with those policy considerations.

If one studies the arguments of *Howie P* against an award based on strict liability they amount to the following:

- Even if one accepted that a case for strict liability could be made out, it is not for the courts to impose that liability but the Legislature despite the admission that: “One is sensitive to the criticism expressed by Prosser that to say that only the Legislature should make changes is to echo ‘the cry invariably raised against anything new whatever in the law’. Nevertheless, what needs to be done is to assess what the new development entails and how best to implement it.” It is submitted that this view is totally contrary to sections 8(3) and 39(2) of the Constitution which require the courts, not the legislature, to develop the common law.
- The court could impose strict liability only if it considered that this was what, in developing the common law, s 8(3) of the Constitution compelled. But, if the Court did so hold, the Legislature would be hamstrung by such conclusion even if the democratic parliamentary process in due course delivered up the conclusion that only certain manufacturers or certain instances of manufacture should be subject to strict liability. This is illustrative of the sort of problem that could indeed arise if the Courts were to alter the law in the respect proposed by the appellants rather than to leave it to Parliament. It is submitted that this argument demonstrates a lamentable lack of understanding of the role and power of legislation. The common law can never ‘hamstring’ the Legislature since it is free to legislate *inter alia* in order to alter the common law. Indeed one of the checks and balances within the doctrine of separation of powers is that in a situation where the Legislature does not approve of a court decision it may legislate to the contrary - provided of

course that such legislation is consistent with the provisions of the Constitution.

- The court's observation that it is not without significance that in the other parts of the world of which mention has already been made, the imposition has been by way of legislation, failed to take into account the imposition of strict liability at its own backdoor such as that in the *actio de pauperie* by courts removed in time rather more than geographical space.²⁴⁴ However, Neethling *et al*²⁴⁵ in fact observe that in Continental systems, liability without fault originated primarily from legislation (it is submitted that this is largely due to the preference by Continental systems for codification of law) while in Anglo-American law, case law played the dominant role. They state that in South Africa both the legislature and the courts contributed to the development of liability without fault. It is thus submitted that the court's reference is to mainly Continental systems of law as opposed to Anglo-American ones such as the South African system and that it has therefore drawn a false and thus invalid comparison. Continental systems are codified whereas the Anglo-American legal systems are common law based.
- There was extensive regulation of the manufacture of medicines without the imposition of strict liability by the Legislature. It could not therefore

²⁴⁴ Vicarious liability is another example of the imposition of strict liability for reasons of public policy. In *Amalgamated Beverage Industries Natal (Pty) Ltd v Durban City Council* 1994 (3) SA 170 (A), Botha JA stated: "It is necessary in this context to revert to the question of vicarious liability. It is seen in the majority judgment as a lesser evil than strict liability. Again, with respect, I am unable to agree. As I have indicated, I regard vicarious liability as but one form of strict liability. Notionally it may be possible to separate strict liability in the form of vicarious liability from the remaining field of strict liability (i.e. where the acts of employees are not involved), but I can perceive no practical profit in doing so. It does not appear from the majority judgment whether vicarious liability is postulated on the premise that there must be mens rea on the part of the servant. If it is, the same difficulties of proving negligence on the part of the servant will certainly be encountered as in the case of the employer. Yet another example is the Praetor's edict *de nautis cauponibus et stabularis* which imposes strict liability on innkeepers in respect of goods brought onto their property by guests and which was found to be still part of South African law by the court in *Gabriel And Another v Enchanted Bed And Breakfast CC* 2002 (6) SA 597 (C). See further the discussion in Neethling *et al* (fn 18 *supra*) p362-380 regarding the *actio de pastu*, *actio de feris*, *actio de effusis vel deiectis*, *actio positi vel suspensi* and the discussions of the law of vicarious liability and agency all of which are common law concepts involving strict liability.

²⁴⁵ Neethling *et al* fn 18 *supra* at p363

have intended strict liability to apply. It is submitted that the existence of extensive regulation of the manufacture of medicines without the imposition of strict liability by the Legislature does not prove anything in terms of individual cases. By its nature, legislation is generic rather than specific. The possibility of the imposition of strict liability by a court cannot be said to have been excluded simply due to a failure on the part of the Legislature to include it in legislation.

- The court posed a series of questions in the judgment to demonstrate the complexities of trying to legislate judicially in the area of product liability. With respect, it is submitted that even if the court had decided in favour of strict liability in the present case, this would not necessarily have meant that every other manufacturer of every other product was also subject to strict liability neither would it have meant necessarily that only, manufacturers of medicines were strictly liable.

It is submitted with respect that the court lost sight of the fact that it was only being asked to ‘legislate’ upon one extremely limited set of facts and that whilst the essence of its reasoning could be extracted and applied to other cases²⁴⁶, those other cases would not necessarily be decided in the same way if the facts differed. For example, it could be argued that product liability for medicines in the same category as Regibloc should be strict for the following reasons:

- Such medicines are administered to the patient by a trained health professional as opposed to being self-administered. There is thus small chance of the medicines being administered contrary to the manufacturer’s instructions;

²⁴⁶ In *National Director of Public Prosecutions And Another v Mohamed NO and Others* 2003 (4) SA 1 (CC) it was observed that “Whatever the case may be, the Court is obliged at all stages of the inquiry to give proper reasons for its conclusion. Such reasons will not only be binding on the litigants but will constitute an objective precedent, with such binding force on other courts as the principles of stare decisis and the status of the Court delivering the judgment dictate.” It is the reasons for the decision which are binding. Since the reasons are heavily dependent upon the facts of the individual case, the facts of other cases would have to be on all fours before the reasons in the particular precedent could be applied to those other cases.

- The patient had no choice as to the kind of local anaesthetic administered and even if consulted as to her preference, would not have been in any position to give a meaningful response unless by some quirk of fate, she was herself a health professional with extensive knowledge of local anaesthetics. The patient's role in the situation is therefore one of extreme passivity;
- The patient is not in a position to ascertain the merits of various local anaesthetics or to determine the chemical components of the medicine and whether it is defective or not;
- The patient is not in a position to read the labelling or other information or warnings on the packaging of the medicine. She is highly unlikely to have handled or inspected the medicine prior to its administration;
- The route of administration (by way of injection) represents a potentially greater danger to the patient than by some other less rapid and invasive route eg oral ingestion. If she decided that the medicine tasted 'bad'; for instance she could have spat it out. Once a medicine has been injected into the bloodstream, however it is impossible for the patient to reverse this process;
- The harm caused was severely disabling and constituted a violation of the patient's right to bodily and psychological integrity;
- It was established that the medicine was defective when it had left the manufacturer's premises;
- It was not disputed that the medicine had caused the injury in question;

- The harm caused was reasonably foreseeable.

This set of circumstances is highly specific to (a) medicines (b) medicines administered by injection (c) local anaesthetics (c) medicines that are not self-administered (d) medicines that are clearly defective upon leaving the control of the manufacturer. It is quite justifiably argued that in such circumstances the imposition of strict liability upon the manufacturer is entirely in accordance with public policy whereas with respect to other types of medicine, taken in different circumstances and with different potential for harm this argument may not apply. Thus the arguments of the court about the need to take into account different kinds of manufacturers of different products and the consequences for them if the court had to impose strict liability in the present case are largely, it is respectfully submitted, specious. The impact of the judgment would have been very much contained by the highly specific nature of the circumstances involved.

7.8 Imperitia Culpae Adnumeratur

This maxim means that ignorance or lack of skill is deemed to be negligence. Neethling *et al*²⁴⁷ observe that the maxim is misleading because South African law does not accept that mere ignorance constitutes negligence²⁴⁸. They note that

²⁴⁷ Neethling *et al* fn 18 *supra* at p136

²⁴⁸ See also Boberg fn 18 *supra* p346 where he states that the maxim *imperitia culpae adnumeratur* is misleading. Lack of skill can never amount to negligence for no one can be skilful at everything. But it may be negligent to undertake work requiring a certain expertise without possession the necessary degree of competence. Van der Walt observes that the maxim *imperitia culpae adnumeratur* can apply only if the task or the engagement in an activity is itself blameworthy. He says that a layman who renders medical assistance in an emergency is not judged by the standard of a doctor. As long as he exercises the care of an ordinary layman in the same situation he is not negligent. Scott TJ in 'Die Reël Imperitia Culpae Adnumeratur As Grondslag Vir Die Nalatigheidstoets Vir Deskundiges' in *Die Delikterege Petere Fontes: L C Stein Gedenkbundel* 124-162 deals with the question of whether the maxim is consistent with the reasonable man test of negligence or whether it introduces a subjective standard of negligence in taking into account the qualifications and skill of the professional person. Scott points out that it is not unreasonable for professionals to undertake tasks for which they are qualified and so the explanation that the negligence consists in the undertaking of a task without the necessary skill as opposed to the lack of skill itself does not apply to professionals. Scott says that the negligence of an expert should be determined by applying the test of the reasonable expert to the actual conduct of the expert. Although this introduces a subjective element to the usually objective reasonable man test for negligence, it will only have the effect of raising the standard – never lowering it. The personal characteristics of the expert remain irrelevant. The ultimate objectivity of the test for negligence is thus not compromised. The question of the layperson who renders emergency medical assistance is an interesting one. From a constitutional

the principle embodied in the maxim applies where a person undertakes an activity for which expert knowledge is required while such person knows or should reasonably know that he lacks the requisite expert knowledge and should therefore not undertake the activity in question. In *Durr v Absa Bank Ltd and Another*²⁴⁹ the court made reference to the maxim with regard to the expert activities of investment brokers²⁵⁰. The court said that the question as to whether the standard must be that of the specific subset of experts to which the defendant belonged or should it be the lower standard of the general set of experts to which the defendant belonged had to be resolved with regard to the standard implied in the defendant's public professions of skill and expertise in relation the nature of the services they were offering. The court said that those who undertake to advise clients on matters including an important legal component do so at their peril if they have not informed themselves sufficiently

perspective, the view has been discussed elsewhere in this thesis that the right contemplated in section 27(3) of the Constitution not to be refused emergency medical treatment is limited to such treatment from suitably qualified persons. A health professional cannot be expected or required to exceed his or her scope of practice in rendering emergency medical treatment in terms of section 27(3) and neither can a layperson be required to give emergency medical treatment since he is not qualified to do so. What would be the legal position where a layperson steps in to give emergency medical assistance of some kind and aggravates the situation for the victim? What would be the legal position of the health professional, such as a nurse, who exceeds her scope of practice in an emergency situation where she is the only person who can render any assistance? Where she handles such situations adequately it is unlikely that the question will ever be put before the courts or the South African Nursing Council but where she does not the maxim of *imperitia culpa adnumeratur* is likely to be raised. The situation of a medical specialist in an emergency medical situation in South Africa is just as interesting. General practitioners can perform a wide range of professional activities due to the extremely wide nature of their scope of practice. However medical specialists despite having greater levels of expertise in some areas and despite having been trained as general practitioners before specialising, have a far narrower scope of practice. What would be the position of a cardiologist faced with an emergency situation in which a woman is giving birth on board an aeroplane upon which he is the only medically trained passenger? If he refused to help could legal action subsequently be taken against him in terms of section 27(3) of the Constitution? Would it make a difference if he was employed by the State or if he was a private practitioner?

249

Durr 1997 (3) SA 448 (SCA)

250

Schutz JA observed that: "Imperitia culpa adnumeratur, says D 50.17.132 - lack of skill is regarded as culpable. That much is accepted by the respondents. But how much skill, they say. We have shown all the skill that an 'ordinary' or 'average' broker, or a bank employing such a one, need show. What more can be asked of us? Two questions arise in this case. (1) In general, what is the level of skill and knowledge required? (2) Is the standard required in judging that level that of the ordinary or average broker at large, or is it that of the regional manager of the broking division of a bank professing investment skills and offering expert investment advice? The answer to the first question is found in the judgment of Innes CJ in *Van Wyk v Lewis* (fn 198 *supra*) at 444 with reference, as it happens, to medical practitioners: 'It was pointed out by this Court, in *Mitchell v Dixon* (1914 AD at 525), that "a medical practitioner is not expected to bring to bear upon the case entrusted to him the highest possible degree of professional skill, but he is bound to employ reasonable skill and care". And in deciding what is reasonable the Court will have regard to the general level of skill and diligence possessed and exercised at the time by the members of the branch of the profession to which the practitioner belongs. The evidence of qualified surgeons or physicians is of the greatest assistance in estimating that level.'

'But the decision of what is reasonable under the circumstances is for the Court; it will pay high regard to the views of the profession, but it is not bound to adopt them.'

For the purposes of this case I do not think that anything need be added to this statement. (Scott LJ in *Mahon v Osborne* [1939] 1 All ER 535 (CA) at 549D-E was to say of Innes CJ's judgment that it was one 'of which I should like humbly to express my admiration'.)

on the law. Schutz JA stated that in real life negligence is not a mere legal abstraction, but must be related to particular facts. However, as a matter of law set in the present factual context, he said he was of the opinion that the relevant standard was not that of the ‘average or typical broker’ as he has been defined. Schutz JA said that to accept that standard would be to allow a definition chosen by a witness for his own purposes to dictate the result, making the enquiry as to what is required of a particular kind of broker pointless. What is actually needed is first to determine what skills the particular kind of broker needs to exhibit, which must depend in large part on what skills he is held out to possess. If this were not so, then the reasoning advanced by the respondents would justify the neurosurgeon being judged by the standards of the general practitioner. That would be contrary to the reference by Innes CJ in *Van Wyk v Lewis* to ‘the branch of the profession to which the practitioner belongs’. He concluded that the appropriate standard is that of the regional manager of the broking division of a bank professing investment skills and offering expert investment advice.²⁵¹ The court quoted with approval the basic rule stated by Joubert (ed)²⁵², 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.”

The court held that given the rule of law concerning the undertaking of activity requiring skill, Stuart (the broker) was in a constant dilemma. Either he had to forewarn the Durrs where his skills ended, so as to enable them to appreciate the dangers of accepting his advice without more ado, or he should not have

²⁵¹ Schutz JA would not accept as a defence the fact that the broker (Stuart) was entitled to rely on regulatory authorities and officials to ensure that all of the risks had been eliminated. He stated at p467 of the judgment: “I would say something about reliance on the various regulatory bodies and officials. They do perform valuable functions in protecting the public against fraud. But for an investment advisor to assume that they have shot out all the predators is ingenuous. New ones always creep in under the wire. Those responsible for lending other people’s money must be ever alert to this and, sometimes helped by the regulatory powers, make their own investigations to the extent reasonably necessary. These powers are not there, after all, to give individual and daily attention to particular lenders, and the grindings of their mills are sometimes slow. Individual attention falls to be given by individual advisors. And then there are also other aids to the investor and his advisor which the State has made available. To what extent did Stuart avail himself of them?”

²⁵² *The Law of South Africa* First Reissue vol 8.1 para 94



recommended the investment. What he was not entitled to do was to venture into a field in which he professed skills which he did not have and to give them assurances about the soundness of the investments which he was not properly qualified to give. Before he recommended the investment in question he should first have sought help which was readily available to him. The court found in favour of the appellant (the plaintiff).

In the public health sector in particular the maxim of *imperitia culpa adnumeratur* is of importance given the constant shortages of health care professionals experienced by this sector. The state is under great pressure, especially in deep rural areas in which it is sometimes almost impossible to recruit health professionals, to provide services with the barest minimum of human resources, and in the worst cases, in the complete absence of suitably qualified and adequately trained personnel. A number of questions arise in this regard which need to be explored in more detail. Health professionals are generally registered with regard to particular scopes of practice. A health professional who exceeds that scope of practice would almost certainly as a general rule fall foul of the law on the basis of the maxim as well as any other professional rules that may be involved.²⁵³ Are there any circumstances,

253

In terms of section 27 of the Nursing Act No 50 of 1978 -

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

however, in which there could be lawful defences to such prima facie illegal acts? With regard to nurses in particular, there is also the matter of section 38A of the Nursing Act²⁵⁴ which is quoted in full in the footnote for the sake of convenience²⁵⁵. A further question is whether the right to emergency medical treatment contemplated in section 27(3) of the Constitution limited by the qualifications of the health professional at the scene or would the health professional who in an emergency medical situation exceeds the bounds of his or her scope of service in coming to the rescue of a patient be able to use section 27(3) as grounds for justification of what would otherwise be an unlawful act?

Necessity or compulsion has been recognised as a defence in criminal law for some time²⁵⁶. It has not apparently arisen in the context of a health professional

²⁵⁴ Nursing Act No 50 of 1978

²⁵⁵ Notwithstanding the other provisions of this Act and the provisions of the Medicines and Related Substances Act 12 *supra* of the Pharmacy Act, 1974 (Act 53 of 1974), and of the Medical, Dental and Supplementary Health Service Professions Act, 1974 (Act 56 of 1974), any registered nurse who is in the service of the Department of Health, Welfare and Pensions, a provincial administration, a local authority or an organization performing any health service and designated by the Director-General: Health, Welfare and Pensions after consultation with the South African Pharmacy Board referred to in section 2 of the Pharmacy Act, 1974, and who has been authorized thereto by the said Director-General, the Director of Hospital Services of such provincial administration, the medical officer of health of such local authority or the medical practitioner in charge of such organization, as the case may be, may in the course of such service perform with reference to-

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

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

²⁵⁶ In *S v Adams v Werner* 1981 (1) SA 187 (A), Counsel CJM Dugard and J M Burchell acting for the appellant, Werner, observed the following with regard to necessity: "In Roman law there was no systematic discussion of the defence of necessity but there are isolated instances in which such a defence was recognized. See D 47.9.3.7; D 9.2.49.1; D 43.24.7.4; D 9.2.29.3; D 19.5.14 pr. Several Roman-Dutch writers considered necessity as a general defence. See Grotius *De Jure Belli ac Pacis* 2.2.6 - 9; Puffendorf *De Jure Naturae et Gentium* 2.6.4 and 5; Van der Keessel *Praelectiones* 47.2.8. Necessity has been recognized as a general defence in modern South African law. See *S v Mahomed and Another* 1938 AD at 34 - 35; *S v Rabodila* 1974 (3) SA 324; *S v Pretorius* 1975 (2) SA 85; *Chetty v Minister of Police* 1976 (2) SA at 452 - 3; *Minister of Police v Chetty* 1977 (2) SA 885; *S v Adams* 1979 (4) SA at 796A - C; Burchell and Hunt *South African Criminal Law and Procedure vol I General Principles* at 283 et seq; De Wet and Swanepoel *Strafreg* 3rd ed at 87 - 88; J V van der Westhuizen *Noodtoestand as Regverdigungsgrond in die Strafreg* (1979) LLD dissertation (Pretoria) 730. Compulsion or duress is a form of necessity and is recognized as a general defence. See *S v Goliath* 1973 (3) SA 1; *S v Miewtwa* 1977 (3) SA 628; *S v Kibi* 1978 (4) SA 173; *S v Alfeus* 1979 (3) SA 145; *S v Petersen* 1980 (1) SA 938. Necessity is prima facie available as a defence to common law crimes and statutory offences. It is, therefore, available to a contravention of the Group Areas Act 36 of 1966 unless the Legislature expressly or impliedly provides otherwise. See *S v Adams* (supra at 798F - H); Burchell and Hunt (op cit at 284); Glanville Williams *Text Book of Criminal Law* (1978) at 555. There is no express exclusion of the defence of necessity and the provision for permits (s 26 (1) of the Group Areas Act 36 of 1966) does not impliedly exclude the defence. See Steyn *Uitleg van Wette* 4th ed at 102 - 106 (and cases cited by the learned author). As to the requirements of the defence of necessity, see Burchell and Hunt (op cit at 285), approved in *S v Pretorius* (supra at 89); *S v Alfeus* (supra at 152H); *S v Adams* 1979 (4) SA at 796A - C. The appellant does not rely on economic



rendering health care services in an emergency situation or otherwise. In a society which still tends to be non-litigious, whether due to the prohibitive costs of legal action or for other reasons, it is unlikely that a health professional who assists someone in a medical emergency in a way that goes beyond his or her scope of practice will be sued on this basis unless the harm caused by the intervention is serious relative to that initially anticipated as a consequence of the emergency itself. Strauss discusses necessity with regard to a situation in which the treatment is against the will of the patient but where the interests of society are at stake for example where medical intervention is necessary to prevent the spreading of a contagious disease. He does not raise the defence in the context of a violation of the provisions of the Health Professions Act or the Nursing Act with regard to scope of practice in circumstances where there was patient consent and for instance the patient's life was at stake. It is submitted that this is the context in which the applicability of the defence of necessity is more likely to arise in practice, especially in the public sector in which there is a severe shortage of suitably qualified personnel in some areas. There is a constitutional right to life which, it could be argued, a health professional was seeking to uphold in acting outside of his or her scope of practice in an emergency situation. Even, however, where the risk was not to life but to limb there is the constitutional right to bodily and psychological integrity. The question is how far these rights would go as justification for the actions of a health care provider in exceeding his scope of practice when assisting a patient. Even if the patient is begging for assistance, there is no-one else to help and the

necessity which "is not a form of necessity that the law recognizes". See *R v Canestra* 1951 (2) SA at 324. The list of legally protected interests is not closed. See JV van der Westhuizen *Noodtoestand as Regverdighingsgrond in die Strafreë* at 553; Burchell and Hunt (op cit at 285 - 8); Glanville Williams *Criminal Law - The General Part* 2nd ed at 756 - 7. Health is a legally protected interest. See *S v Pretorius* (supra at 89 - 90); *R v Bourne* (1939) 1 KB at 692; *S v Johnson* 53 A 1021 (1902) dealt with in Jerome Hall *General Principles of Criminal Law* 2nd ed 426. Family life is a legally protected interest. See *Levy NO and Another v Schwartz NO and Others* 1948 (4) SA at 933; art 6 of the Constitution of the Federal Republic of Germany. The family life of the appellant and his wife was threatened. Privacy is a legally protected interest. See J Neethling *Die Reg op Privaatheid* at 380; D J McQuoid-Mason *The Law of Privacy in South Africa* at 98; *O'Keeffe v Argus Printing and Publishing Co Ltd* 1954 (3) SA 244; *Kidson v SA Associated Newspapers Ltd* 1957 (3) SA 461; *S v A* 1971 (2) SA 293; *Rhodesian Printing and Publishing Co Ltd v Duggan* 1975 (1) SA 590; *S v I* 1976 (1) SA at 783G; *Universiteit van Pretoria v Tommie Meyer Films (Edms) Bpk* 1977 (4) SA at 383 - 4. The legally protected interest may be threatened by force of surrounding circumstances. See *S v Pretorius* (supra at p 89 - 90); *Staffberg v Elliott* (fn 27 supra) at p150. As to the threat having commenced or being imminent, see *S v Mlewetwa* 1977 (3) SA at 631A - B."



health professional knows what must be done to assist the patient, must he refuse treatment on the grounds that he is not qualified to administer it? What constitutes necessity in such a situation? In this regard there is also the difficult distinction between situations of emergency and urgency. A balancing exercise is required with the constitutional rights of the patient being weighed against the transgression by a health professional of the law or at the least, the rules of his or her professional body for which he or she can be disciplined. In the context of the public sector this is most likely to arise where there is no doctor available and the nurses are the only health professionals around who can help the patient. Would the situation be any different if the patient was unable to consent because he or she was unconscious? If so would it be worse or better, for the health professional concerned, than a situation in which there is patient consent in the clear knowledge that the nurse is not qualified to perform a particular procedure but there are no alternatives? Generally speaking the law sanctions actions and omissions in an emergency situation which it would not otherwise. An example is the doctrine of *negotiorum gestio* which allows the interference of one person in the affairs of another (the *dominus*) in the interests of the latter. What is the position then of a health professional who exceeds his or her scope of practice in such a situation. It is submitted that, if the circumstances were such that there was no alternative, that the patient consented to the risks of the treatment and that the health professional in question exercised the same degree of care and skill in administering the treatment as would have been exercised by a reasonable person in the circumstances, a subsequent delictual action against the health professional is not only unlikely but also should not succeed if his or her actions were in accordance with public policy and constitutional values. The maxim *imperitia culpa adnumeratur* should be defeated by the maxim *volenti non fit injuria*. In similar circumstances, where the patient is unable to give consent for some reason, a subsequent action in delict against the health professional could obviously not be defeated by the maxim *volenti non fit injuria* and the health professional runs a greater risk of having the claim against him or her succeed on the basis of the maxim *imperitia culpa adnumeratur*.

However, it remains to be seen how the court will interpret the right not to be refused emergency medical treatment in practice.

Strauss²⁵⁷ observes that medical treatment against the will of the patient is legally permissible within very narrow limitations only. The legal ground of justification upon which the doctor or other person may rely in these cases is necessity. He states that a feature of the typical situation to which the doctrine of necessity generally applies is that the interest of a person (the so-called innocent third person) is sacrificed to protect or rescue the lawful interest of another who is endangered either by a natural force (“inevitable evil”) or by human agency. Therefore, says Strauss, where a doctor – in order to protect the social interest – administers medical treatment to a person against the latter’s will, he (the doctor) may raise the defence of necessity against a charge of assault. Thus a doctor may treat a patient suffering from a dangerous infectious disease against the patient’s will, to prevent the disease from spreading. So too, a doctor may vaccinate healthy persons to prevent the outbreak of a dangerous disease in the community. Strauss notes that although the defence of necessity may be relied upon even where the act intended to ward off the danger is directed not against the interest of an innocent third person but against other interests of the person threatened with the danger, such action, if undertaken against the will of the latter, can in his opinion only in exceptional circumstances be justified on the basis of the doctrine of necessity.²⁵⁸

In the case of *negotiorum gestio* the courts have observed that the gestor is only entitled to reimbursement of expenses and not to remuneration, the underlying principle being that *negotiorum gestio* arises from an act of generosity and friendship and is not aimed at allowing the *gestor* to make a profit out of his

²⁵⁷ Strauss fn 34 *supra*

²⁵⁸ Strauss (fn 34 *supra*) refers to Van der Westhuizen JV *Noodtoestand as Regverdigingsgrond in die Strafbreg* (LLD thesis, University of Pretoria 1979) p 585, p 609 in this regard

administration.²⁵⁹ The *gestor* must have a clear intention to serve the dominus²⁶⁰. The actions of the *gestor* were usually understood to be in situations of urgency in which there was no time or opportunity to contact the dominus.²⁶¹ The *negotiorum gestor* has a right to be compensated for necessary and useful expenses²⁶². This principle is clearly support for the proposition that where a person renders emergency medical treatment in term of section 27(3) of the Constitution, such person is subsequently entitled at least to compensation for necessary and useful expenses. Indeed it is submitted that the concept of *negotiorum gestio* takes on a certain constitutional significance in the light of section 27(3) of the Constitution. *Negotiorum gestio* is informed by the morals or values of society. Thus Hahlo observes that in *negotiorum gestio*, it is generally a good defence to the gestor's claim that the principal had forbidden him to act, but this defence will not avail if the action was morally demanded²⁶³. The values of South African society are reflected in the Constitution. The right

²⁵⁹ *Mt Argun; Sheriff Of Cape Town And Another v Mt Argun, Her Owners And All Persons Interested In Her And Another* 2000 (4) SA 857 (C) *Williams' Estate v Molenschoot and Schep (Pty) Ltd* 1939 CPD 360 at 370 - 2; Blommaert 1981 Tydskrif vir Suid-Afrikaanse Reg 123 at 134

²⁶⁰ In *Standard Bank Financial Services v Taylam* 1979 (2) SA 383 (C) at 387 in Van Zijl JP set out the law in regard to *negotiorum gestorum* as follows: "Our law in regard to *negotiorum gestorum* is based firmly, with but minor divergencies, upon the Roman law. In Roman law the payment of the debt of another without a mandate to do so gives rise to the *actio negotiorum gestorum contraria* and the gestor could recover the amount of such payment together with the interest thereon unless the debtor had some interest in the payment not being made. (See Digest 3.5.43 and 22.1.37.) This quasi-contractual relationship was brought about where the gestor, acting without a mandate, rendered a service to the dominus - in this instance the debtor - and in doing so acted reasonably and in the interest of the dominus with the intention not only of administering the affairs of the dominus but also of being compensated for such administration. This action fell away if the gestor did not intend to serve the dominus, i.e. the gestor mistakenly thought he was administering his own affairs or made payment of a debt *sui lucri causa*. There is a basic difference between the gestores in these two instances. In the first the gestor acted bona fide, but in the mistaken belief that he was serving the dominus. In the latter instance he acted mala fide in his own interest. These two classes of gestor can be described respectively as the bona fide gestor and the mala fide gestor. Neither of them could sue as *negotiorum gestoris* as neither had the intention to serve the dominus. If, however, the dominus had been enriched at their expense they were each given the right to recover from the dominus on the grounds of unjust enrichment."

²⁶¹ In *Maritime Motors (Pty) Ltd v Von Steiger And Another* 2001 (2) SA 584 (SE) the court observed at p 599 that : "He [the counsel for the plaintiff] referred to the following passage in Silke De Villiers and Macintosh The Law of Agency in South Africa 3rd ed at 274: "Not only can a person (gestor) recover expenses on the ground of unjust enrichment when he has paid another's debt (that of his dominus) for his own benefit (*sui lucri causa*), but also when he has done so against the express wishes of the debtor (dominus). The circumstances in which the payment was made contrary to the wishes of the dominus are always an important factor in determining whether the payment was or was not justly done."

It appears from the same work that the term *negotiorum gestor* was originally used to describe the person who acts on behalf of another and solely for the latter's benefit in circumstances of urgency, knowing that he had no such authority to act. There was and could be no question of any relationship arising between the parties by consent. It was further emphasised by the learned authors that the *negotiorum gestor* plays a constantly shrinking role in the world of ever-improving communications because it is quite clear that an unauthorised person should not interfere in another's affairs if it is possible to get in touch with that other.

²⁶² See Van Zyl D H *Negotiorum Gestio in South African Law* (1985) at p 67 - 71.

²⁶³ Hahlo HR 1960 *Annual Survey of South African Law* at p 66 - 7

to life, the right to human dignity and the right not to be refused emergency medical treatment are all suggestive of a greater duty to rescue than previously existed at common law. Whilst it is not suggested that the values in the Constitution require members of society to go about poking their noses into other people's business, they may well expect positive intervening action in circumstances where public mores require it²⁶⁴.

Negotiorum gestio is often associated with actions for unjust enrichment²⁶⁵. It was referred to in the context of health care services in *Behr v Minister of Health*²⁶⁶.

264 They would in other words, inform situations such as that in *Minister van Polisie v Ewels* (fn 63 *supra*) in which Rumpff JA observed that: "Dit wil voorkom of the vraagstuk van 'n late, as deliktuele onregmatige gedrag, tot 'n mate van klaarheid ontwikkel het, vgl. *Silva's Fishing Corporation (Pty.) Ltd. v Maweza*, 1957 (2) SA 256 (AA); *Regal v African Superstate (Pty.) Ltd.*, 1963 (1) SA 102 (AA); *Minister of Forestry v Quathlamba (Pty.) Ltd.*, 1973 (3) SA 69 (A). As uitgangspunt word aanvaar dat daar in die algemeen geen regsplig op 'n persoon rus om te verhinder dat iemand anders skade ly nie, al sou so 'n persoon maklik kon verhinder dat die skade gely word en al sou van so 'n persoon verwag kon word, op suiwer morele gronde, dat hy daadwerklik optree om die skade te verhinder. Ook word egter aanvaar dat in sekere omstandighede daar 'n regsplig op 'n persoon rus om te verhinder dat iemand anders skade ly. Versuim hy om daardie plig uit te voer, ontstaan daar 'n onregmatige late wat aanleiding kan gee tot 'n eis om skadevergoeding. Hierdie gevalle is nie beperk tot 'n eienaar van grond wat deur sy late veroorsaak dat iemand anders deur iets wat in verband staan met sy grond skade ly nie of, in die algemeen, tot gevalle waar daar 'n sekere voorafgaande gedrag ("prior conduct") was nie. 'n Sekere voorafgaande gedrag of die beheer oor eiendom mag 'n faktor wees in die totaal van omstandighede van 'n bepaalde geval waarvan onregmatigheid afgelei word, maar is nie 'n noodwendige onregmatigheidsvereiste nie. Dit skyn of dié stadium van ontwikkeling bereik is waarin 'n late as onregmatige gedrag beskou word ook wanneer die omstandighede van die geval van so 'n aard is dat die late nie alleen morele verontwaardiging ontlok nie maar ook dat die regsdoortuiging van die gemeenskap verlang dat die late as onregmatig beskou behoort te word en dat die gelede skade vergoed behoort te word deur die persoon wat nagelaat het om daadwerklik op te tree. Om te bepaal of daar onregmatigheid is, gaan dit, in 'n gegewe geval van late, dus nie oor die gebruikelike "nalatigheid" van die bonus paterfamilias nie, maar oor die vraag of, na aanleiding van al die feite, daar 'n regsplig was om redelik op te tree.

265 Rubin L, *Unauthorised Administration in South Africa*, pp. 72 - 73, emphasises the distinction between the true action based on *negotiorum gestio* and an action based on enrichment: "There can be little doubt that in most cases a *negotiorum gestio* results in actual enrichment of the dominus. The destruction of the beneficial service rendered by the gestor before the dominus could enjoy it may safely be regarded as a rare occurrence. It is clear, also, that in some cases the same result would be achieved whether the person rendering the service claimed as a gestor or relied on the principle of unjust enrichment; furthermore, that in such cases, the latter course must be recommended because the intention of the plaintiff would be irrelevant, and to that extent the proceedings would be simplified. It must be borne in mind, however, that in the one case the claim is for all the useful and necessary expenses incurred; in the other, it is based upon an entirely different criterion, namely, the extent to which the dominus has been enriched. In the first case the question is whether they are expenses which the dominus would, himself, have incurred, whether the amount thereof represents his actual enrichment or not; in the second case all considerations other than the actual enrichment of the dominus fall away. It follows, therefore, that there are circumstances in which a plaintiff who, able to base his claim on *negotiorum gestio*, nevertheless chose to rely on the principle of unjust enrichment, would, thereby, deprive himself of the right to recover part of the amount which he had expended in the course of the *gestio*. In fact, such a plaintiff would be ill advised to base his claim on the principle of unjust enrichment, unless he had first satisfied himself that he would be entitled to recover no less on that basis than on the basis of *negotiorum gestio*."

266 *Behr* 1961 (1) SA 629 (SR). The court said with regard to a husband's duty to pay for his wife's medical treatment: "If she had such cause, the husband's legal duty to support his wife and provide her with necessities continues despite the cessation of the joint household, and the tradesman who supplies her with necessities such as food or clothing, the landlord who lets her a lodging, the professional man who renders her necessary service, are entitled to recover from the husband. As it is put by Dr. Rubin in his handbook on *Unauthorised Administration (negotiorum gestio)* at p. 62, the tradesman or landlord or professional man is discharging a

7.9 Class Actions

In *Permanent Secretary, Department of Welfare, Eastern Cape, and Another v Ngxuza and Others*²⁶⁷ the applicants decided to proceed with a class action under section 38(c) of the Constitution. This case is currently the leading case on class actions in South Africa. In previous cases, to which Cameron J refers in his judgment in *Nguxa*, the courts had been reticent or reluctant to recognise the possibility of a class action despite the provisions of section 38(c) of the Constitution. *Nguxa* is interesting because it is a case which demonstrates the risks run by the public sector in terms of class actions for logistical systems failure and for ill advised policy decisions. The court did not consider the merits of the case since the application was for leave to institute representative, class action and public interest proceedings against the provincial authorities, with the assistance of the Legal Resources Centre in terms of s 38(b), (c) and (d) of the Constitution on behalf of everyone else in the province who had also had their grants unfairly and unlawfully terminated. The respondents were among tens of thousands of recipients of social disability grants whose grants had unilaterally and without notice been terminated by the Eastern Cape provincial authorities.

The order the applicants in *Ngxuza* applied for had three essential features. First, it permitted the applicants, assisted by the Legal Resources Centre, to litigate as representatives on behalf of anyone in the whole of the Eastern Province whose disability grants were between specified dates cancelled or suspended by or on behalf of the Eastern Cape government ('the class definition'). Associated with this was an order requiring the Eastern Cape government to provide the Legal Resources Centre with the details of the members of the class kept on computer or physical file in governmental records ('the disclosure order'). The order

legal duty resting upon the husband; he is a gestor who has administered the affairs of the dominus, i.e., the husband, and is therefore entitled to compensation from him. This is the basis upon which the judgment of Benjamin J, in *Gammon v McClure*, 1925 CPD 137 at p 139, is based, and the husband's liability to pay compensation to the gestor was enforced in *Coetsee v Higgins*, 5 E.D.C. 352, a case which has subsequently been referred to with approval (see e.g., *Excell v Douglas*, 1924 CPD 472 at p 481)."

267

Nguxa 2001 (4) SA 1184 (SCA)

lastly required the applicants to disseminate through various print and radio media in the Eastern Cape and (with the assistance of the provincial government) by notices at pension pay points information about the class action ('the publication order'). The object of publication was to give members of the class the opportunity, if they wished, to opt out of the proceedings envisaged on their behalf.

Cameron JA observed that in the type of class action at issue in this case, one or more claimants litigate against a defendant not only on their own behalf but on behalf of all other similar claimants. He said that the most important feature of the class action is that other members of the class, although not formally and individually joined, benefit from, and are bound by, the outcome of the litigation unless they invoke prescribed procedures to opt out of it.²⁶⁸ Cameron JA pointed out that although the Constitutional Court had not dealt with the class action specifically, it had pronounced pertinently on the ambit to be accorded all the standing provisions of the interim Constitution, which in material respects are identical to those of the Constitution. He noted that in *Ferreira v Levin NO and Others; Vryenhoek and Others v Powell NO and*

268

Cameron JA observed at p 1192 in *Ngcruza* (fn 267 *supra*) that: "The class action was until 1994 unknown to our law, 6 where the individual litigant's personal and direct interest in litigation defined the boundaries of the court's powers in it. If a claimant wished to participate in existing court proceedings, he or she had to become formally associated with them by compliance with the formalities of joinder. The difficulties the traditional approach to participation in legal process create are well described in an analysis that appeared after the class action was nationally regularised in the United States through a Federal Rule of Court 8 more than 60 years ago: "The cardinal difficulty with joinder . . . is that it presupposes the prospective plaintiffs' advancing en masse on the courts. In most situations such spontaneity cannot arise either because the various parties who have the common interest are isolated, scattered and utter strangers to each other. Thus while the necessity for group action through joinder clearly exists, the conditions for it do not. It may not be enough for society simply to set up courts and wait for litigants to bring their complaints - they may never come. What is needed, then, is something over and above the possibility of joinder. There must be some affirmative technique for bringing everyone into the case and for making recovery available to all. It is not so much a matter of permitting joinder as of ensuring it."

The class action cuts through these complexities. The issue between the members of the class and the defendant is tried once. The judgment binds all and the benefits of its ruling accrue to all. The procedure has particular utility where a large group of plaintiffs each has a small claim that may be difficult or impossible to pursue individually. The mechanism is employed not only in its country of origin, the United States of America, where detailed rules governing its use have developed, but in other countries as well. The reason the procedure is invoked so frequently lies in the complexity of modern social structures and the attendant cost of legal proceedings:

'Modern society seems increasingly to expose men to such group injuries for which individually they are in a poor position to seek legal redress, either because they do not know enough or because such redress is disproportionately expensive. If each is left to assert his rights alone if and when he can, there will at best be a random and fragmentary enforcement, if there is any at all.' [footnotes omitted]



*Others*²⁶⁹, the majority of the court held that these provisions must be interpreted generously and expansively, consistently with the mandate given to the courts to uphold the Constitution, thus ensuring that the rights in the Constitution enjoy the full measure of protection to which they are entitled. Cameron JA stated that the circumstances of this particular case - unlawful conduct by a party against a disparate body of claimants lacking access to individualised legal services, with small claims unsuitable for if not incapable of enforcement in isolation - should have led to the conclusion, in short order, that the applicants' assertion of authority to institute class-action proceedings was unassailable. He said that the applicants' averments about the predicament of other members of the class to some extent rest on hearsay evidence was obvious but that few class actions could be maintained without some element of hearsay. Indeed, he said, if first-hand evidence could be obtained from all those sought to be included, they could as readily be joined, and the need for class proceedings would fall away. He observed that hearsay evidence in any event varies in its import and quality. That produced in this case - from district surgeons, advice offices, civic and political organisations and public authorities - left little doubt that the province's methods were causing widespread misery and injustice. He pointed out that it is precisely because so many people in South Africa are in a 'poor position to seek legal redress' and because the technicalities of legal procedure, including joinder, may unduly complicate the attainment of justice that both the interim Constitution and the Constitution created the express entitlement that 'anyone' asserting a right in the Bill of Rights could litigate 'as a member of, or in the interest of, a group or class of persons'. Cameron JA held that insofar as the judgments in *Lifestyle Amusement Centre (Pty) Ltd and Others v Minister of Justice and Others*²⁷⁰ and *Maluleke v MEC, Health and Welfare, Northern Province*²⁷¹ questioned the availability of the class action in South African law, or suggested different criteria for constituting and defining a class for the

269 *Ferreira* 1996 (1) SA 984 (CC)

270 *Lifestyle* 1995 (1) BCLR 104 (C)

271 *Mahuleke* 1999 (4) SA 367 (T)

purposes of a class action, he was unable to agree with them, and to the extent that they are inconsistent with his judgment in *Nguxa*²⁷² they must be regarded as overruled. He observed that there could be no doubt that the Constitution requires that, once an applicant has established a jurisdictional basis for his or her own suit, the fact that extra-jurisdictional applicants are sought to be included in the class cannot impede the progress of the action. He noted that this is the position also in the United States of America, to the laws of which, together with other foreign countries, the Constitution permits the courts to look when interpreting the Bill of Rights and pointed out that in the USA a plaintiff class action (which is materially different from a defendant class action), the presence of a large preponderance of out-of-state plaintiffs does not impede the proceedings once the original litigants have established jurisdiction in the forum court. It was held that it was clear that the order of the Court *a quo* encompassed only those whose social benefits had unlawfully been discontinued in the same manner as those of the respondents. Cameron JA also held that the appellants' objections had no substance. He said the matter in issue was no ordinary litigation- it was a class action expressly mandated by the Constitution and that the Courts were enjoined by section 39(1)(a) of the Constitution to interpret the Bill of Rights, including those provisions relating to standing, so as to 'promote the values that underlie an open and democratic society based on human dignity, equality and freedom'. He stated that the Courts were also enjoined by section 39(2) to develop the common law, which included the common law of jurisdiction, so as to 'promote the spirit, purport and objects of the Bill of Rights'.

From this case it is clear therefore that class actions are permissible and must be recognised in South Africa and also that the problem of provincial boundaries and the jurisdiction of the different divisions of the High Court could be addressed and need not be an obstacle to class actions.

²⁷² *Nguxa* fn 267 *supra*



Chapter 8

Law of Delict In Health Service Delivery - Public Sector

| | | |
|--------|---|------|
| 8.1 | Introduction | 879 |
| 8.2 | Case Law | 880 |
| 8.2.1 | Rex v Van Schoor | 880 |
| | Facts..... | 880 |
| | Judgment | 882 |
| | Discussion | 884 |
| 8.2.2 | R v van der Merwe | 886 |
| | Facts..... | 886 |
| | Judgment | 886 |
| | Discussion | 887 |
| 8.2.3 | Esterhuizen v Administrator of Transvaal..... | 895 |
| | Facts..... | 895 |
| | Judgment | 900 |
| | Discussion | 903 |
| 8.2.4 | Dube v Administrator Transvaal | 924 |
| | Facts..... | 924 |
| | Judgment | 925 |
| | Discussion | 927 |
| 8.2.5 | S v Mkwetshana | 932 |
| | Facts..... | 932 |
| | Judgment | 933 |
| | Discussion | 936 |
| 8.2.6 | Buls v Tsatsarolakis..... | 938 |
| | Facts..... | 938 |
| | Judgment | 940 |
| | Discussion | 943 |
| 8.2.7 | Magware v Minister Of Health NO | 947 |
| | Facts..... | 947 |
| | Judgment | 949 |
| | Discussion | 952 |
| 8.2.8 | S v Kramer..... | 954 |
| | Facts..... | 954 |
| | Judgment | 959 |
| | Discussion | 964 |
| 8.2.9 | Pringle v Administrator, Transvaal | 973 |
| | Facts..... | 973 |
| | Judgment | 977 |
| | Discussion | 984 |
| 8.2.10 | Collins v Administrator, Cape | 988 |
| | Facts..... | 988 |
| | Judgment | 993 |
| | Discussion | 1007 |



| | | |
|--------|--|------|
| 8.2.11 | C v Minister of Correctional Services | 1015 |
| | Facts..... | 1015 |
| | Judgment | 1017 |
| | Discussion | 1021 |
| 8.2.12 | Silver v Premier, Gauteng Provincial Government..... | 1027 |
| | Facts..... | 1027 |
| | Judgment | 1029 |
| | Discussion | 1031 |
| 8.2.13 | Korf v Health Professions Council of South Africa..... | 1036 |
| | Facts..... | 1036 |
| | Judgment | 1038 |
| | Discussion | 1044 |
| 8.3 | Summary and Conclusions | 1051 |

8.1 Introduction

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

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

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

8.2 Case Law

8.2.1 *Rex v Van Schoor*¹

Facts

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

¹ *Van Schoor* 1948 (4) SA 349 (C)

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

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

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

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

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

Judgment

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

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

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

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

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

Discussion

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



is judged by the standard of the reasonable person who also professes that skill. The standard is an objective and not subjective. It does not take into account the lack of knowledge and experience of the particular practitioner concerned but looks rather at the knowledge and standard of care that one could reasonably expect from a person in the practitioner's position. This case also supports that point made earlier about the different levels of risk associated with the different ways in which medicine is administered for example, orally as opposed to intravenously. The more poisonous the medicine the more care one must exercise since the degree of risk to the patient is increased. In this case the young doctor, no doubt stressed by his new environment and the lack of supervision to which he had become accustomed as part of his training simply failed to think. The information he needed to avoid the risk was apparently on the labelling of the containers of the medicine. All he had to do was read. The difference between being a qualified and registered medical practitioner and a student doctor is that there is no longer anyone else to take responsibility for what goes wrong. This case also demonstrates that if one chooses to engage in an occupation that represents a greater risk to people's life and health than many others, the minimum degree of care and skill that is required is concomitantly higher. The lack of adequate instructions from the more experienced doctor in this case could not save the defendant. Although a failure to give adequate instructions to employees dealing with a dangerous substance has been held to amount to negligence on the part of the employer², the court held in this case

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

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

8.2.2 *R v van der Merwe*³

Facts

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

Judgment

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

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

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

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

Discussion

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

⁴ *Van Schoor* fn 1 *supra*



whilst specialists have defined scopes of practice and may not operate outside of those, a general practitioner's scope of practice is not defined. There is no regulation that prohibits a general practitioner from performing the work of a specialist. In effect this means that a general practitioner can do anything that a specialist may do if he so chooses and not be taken to task for it by the Health Professions Council whilst a specialist may only operate within a relatively narrowly defined scope of practice. Legal principles such as *imperitia culpa adnumeratur* thus come into their own in situations where a general practitioner attempts to do something that should only be undertaken by a medical specialist although for the poor patient this may be cold comfort indeed. Claassen and Verschoor⁵ state that if a practitioner presents himself as a specialist in the sense that he handles a case from a specialist's point of view, or he insists on specialist tariffs or he professes to treat a patient with a special degree of knowledge, care, skill and experience, the law will hold him to this pretext. His performance will then have to comply with the standard of conduct of a reasonable specialist belonging to the same speciality the practitioner professes to be a member of. They point out that Potgieter⁶ submits that the opposite is also true, namely that when a professional person indicates that he possesses a lower degree of skill than the required minimum standard, and the client knowingly still accepts his services then the professional person need only comply with the expressed lower standard of conduct. The current writer submits that a medical specialist registered as such with the Medical and Dental Board of the Health Professions Council of South Africa will in practice have a very hard time convincing a court or anyone else that the patient accepted a lower degree of skill in treatment falling within the scope of the speciality for which he is registered since a person can only in terms of the Health Professions Act⁷ be registered as a specialist once he has satisfied the regulatory body that

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

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

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



he has the necessary skill and experience. The Health Professions Act defines a ‘speciality’, in relation to a medical practitioner, dentist or psychologist, as including any particular subdivision of a speciality in which such medical practitioner, dentist or psychologist specializes or intends to specialize. Section 18 of the Act requires the registrar to keep registers in respect of medical practitioners, dentists, interns, student interns, medical students, dental students, psychologists, intern-psychologists and psychology students or any other health professionals as determined by the council and persons doing community service in terms of section 24A and, on the instructions of the professional board, to enter in the appropriate register the name, physical address, qualifications, date of initial registration and such other particulars (including, in the case of medical practitioners, dentists and psychologists, *the name of their speciality or category*, if any) as the professional board may determine, of every person whose application for registration in terms of section 17 (2) has been granted. In June 2001 the Minister of Health made regulations⁸ in terms of section 35 of the Health Professions Act read together with section 61(1) (f) of that Act concerning specialities and subspecialities in Medicine and Dentistry. In those regulations a general practitioner is defined as “a medical practitioner or a dentist not registered as a specialist”, a “medical specialist” is defined as a “medical practitioner who has been registered as a specialist in a speciality or related specialties and a subspeciality (if any) in medicine in terms of these regulations and a “specialist” is defined as a “medical practitioner or a dentist who has been registered as a specialist in a speciality or relation specialties and subspeciality (if any) recognised in terms of these regulations *and who confines his or her practice to such speciality or related specialties and subspeciality (if any)*” (writer’s italics). In these regulations the requirements for registration of a

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

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

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

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

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

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

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

There may well be those who feel that this situation is far from ideal, while others may argue that there is sufficient control in not allowing such a general practitioner to charge the fees that a specialist would in respect of his specialist work. In response to the latter it is noted that there is no legal restriction⁹ on what a practitioner can charge in terms of fees provided that he is reasonable¹⁰, that many patients do not belong to medical schemes and would not necessarily know whether the rate was that of a specialist or a general practitioner and that where a patient's medical scheme refuses to pay the doctor the higher, specialist, rate, he or she is legally entitled to claim the balance from the patient or to require the patient to pay cash up front and then submit the claim to the medical scheme. It certainly seems that in a legal environment in which a general practitioner may do pretty much as he pleases in terms of work requiring specialised skill and experience, there is much to be said for a more rigorous system of ongoing monitoring and evaluation of general practitioners than presently exists in South Africa. Alternately, there should be attempts to define the scope of practice of a general practitioner to areas and levels within those areas with reference to the scopes of practice of specialists. The problem with this latter solution is that it will not necessarily promote quality of health

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

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

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

It is to be noted that in addition to the legal penalties and sanction that may be imposed upon a health professional for acting negligently, it is also likely that the professional body that has registered him or her will be able to take disciplinary measures in respect of unprofessional conduct. In terms of the Health Professions Act “unprofessional conduct” means improper or disgraceful or dishonourable or unworthy conduct or conduct which, when regard is had to the profession of a person who is registered in terms of this Act, is improper or disgraceful or dishonourable or unworthy. There is a similar definition in the Pharmacy Act¹¹ and the Allied Health Professions Act¹²(AHPA). Although the term is not defined in the Nursing Act¹³, section 28(1) states that the South African Nursing Council may institute an inquiry into any complaint, charge or allegation of improper or disgraceful conduct against any person registered or enrolled under the Act and, on finding such person guilty of such conduct, may impose any of the penalties referred to in section 29 (1): Provided that in the case of a complaint, charge or allegation which forms or is likely to form the subject of a criminal case in a court of law, the council may postpone the holding of an inquiry until such case has been disposed of. The question as to the level of care required to be exercised by a general practitioner who practices a certain speciality without being registered as a specialist in that field must, it is submitted, logically be that of a reasonable general practitioner who is also

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

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

¹³ Nursing Act No 50 of 1978

practising that speciality. It cannot be that of the reasonable specialist in that speciality and who is registered as such and who practices exclusively in that field. If, however, the general practitioner holds himself out to be a specialist then he is publicly professing a certain degree of skill and, as Claassen and Verschoor¹⁴ then rightly state, he should be judged by the same standard as a specialist would be judged. In the context of the Cuban doctors that are sent by Cuba to work in South Africa in the public sector in terms of a government-to-government agreement with Cuba, these doctors are registered in a special category by the Health Professions Council of South Africa as general practitioners in the public sector but usually in connection only with a particular field of practice such as obstetrics and gynaecology for example. Such practitioners thus have a special registration as general practitioners which allows them to practice only in the field designated on their registration certificate. This does not mean that they are medical specialists in the sense referred to in the Health Professions Act and regulations. They have not done the extra periods of practical training and engaged in the further studies required of specialists. They are general practitioners confined to a particular practice area and should therefore also be judged by the standard of the reasonable general practitioner rather than that of the reasonable specialist.

Claassen and Verschoor¹⁵ point out that where a practitioner treats a patient without prior consent, and in the absence of a legally recognized ground of justification, he commits assault. However, where the practitioner negligently injures the patient the wrongdoing will not be classified as assault because assault requires fault in the form of intention. They state that even where consent is obtained by a physician, he may still be guilty of contravening a statutory prescription or assault if his conduct is in conflict with the law. It is submitted that informed consent only protects the health professional or health institution where the act or omission complained of falls within the ambit of the

¹⁴ Claassen and Verschoor *fn 5 supra*

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



consent¹⁶. Those acts and omissions falling outside of the ambit of the consent are obviously not covered by it and since medical interventions in South Africa are *prima facie* unlawful, the absence of consent or a legally recognised justification will mean that they are unlawful. Thus when a patient submits herself to treatment by a doctor it cannot be said that an implied or tacit term of the contract or an element of the relationship is the understanding that the doctor can act carelessly or negligently in writing out a prescription or administering an overdose of a drug.

Strauss¹⁷ observes that there have been several cases in South Africa in which a doctor was held legally liable for drug damage but these cases invariably involved over-prescribing or over-administration, on account of ignorance or carelessness on the part of the doctor, of drugs that are quite safe when used in accordance with the manufacturer's directions. He states that in a case of a drug which was properly designed, developed, tested, registered and distributed and which was prescribed in conformity with the statutory standards, and which is now alleged to be potentially hazardous to patients, proof of negligence on the part of a doctor may be well-nigh impossible. If there is a strong indication that there was no negligence on the part of the manufacturer, this factor, he submits will weigh even more heavily in the favour of the doctor. Strauss does say that it is not inconceivable that in exceptional circumstances a doctor may be held liable for a defective drug. He notes that there is the possibility that a drug despite all the precautions taken to ensure its safety turns out to be unsafe. The thalidomide disaster immediately springs to mind, he says, but other examples in recent pharmaceutical history may also be cited. Without a doubt there is a duty upon the doctor to keep himself adequately informed on developments in the pharmaceutical field in so far as his profession is affected. Strauss points out that, for example, a doctor were to prescribe or administer a drug despite the

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

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

fact that its newly discovered risks have been fully described in a medical journal circulating in his area of practice, an inference of negligence can clearly be drawn. This will also be the case when a manufacturer has withdrawn a drug, the safety of which has become suspect and has given wide notice of its decision. Strauss also gives the example in the case of doctors who do their own dispensing or a doctor who gratuitously hands over pharmaceutical samples to a patient, that where the particular medicine has become unsafe or ineffective due to contamination or a chemical reaction, the doctor could be held liable in delict for any harm suffered by the patient as a result¹⁸. The present writer respectfully concurs with these views.

8.2.3 *Esterhuizen v Administrator of Transvaal*¹⁹

Facts

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

¹⁸ Strauss (fn 17 *supra*) at p 294

¹⁹ *Esterhuizen* 1957 (3) SA 710 (T)

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

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

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

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

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

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

- ii. Become disfigured or deformed in the sense that permanent harm would be done to her epiphyses (growing bone ends) in the treated areas, causing a shortening of the limbs and furthermore that cosmetic changes would set in - a feature described by Dr. Cohen as 'permanent visible damage to the skin - a change in pigmentation - causing the skin to become lighter or darker or blotchy with light and dark patches; the skin might become drier and thinner, stopping sweating in the affected area.'
- iii. Run a risk and be subjected to a possibility of having to suffer amputation of the treated limbs. These consequences and risks arising from the treatment and dosage worked out by Dr. Cohen were known only to himself and no one else. The plaintiff's mother had no knowledge of any danger and anticipated none. The plaintiff, who had been admitted to a ward under the charge of a certain Dr. Adno, enquired from him - before treatment was administered - what was going to happen to her, and was told not to worry about it. As a child of fourteen years, she had no reason to anticipate any danger. The danger, if any, accompanying superficial therapy treatment such as the plaintiff received on the two earlier occasions by means of the Chaoul Unit was infinitely less than that attendant on the proposed or contemplated treatment and dosage for which purpose the Maximar Unit was to be used.

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

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

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

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

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

Judgment

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

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

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

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

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

²⁰ *Stoffberg v Elliot* 1923 CPD 148

²¹ *Dixie* 1950 (4) SA 748 (W) at p 751

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

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

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

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

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

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

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

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

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

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

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

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

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

Discussion

The argument in *Esterhuizen*²⁶ revolved around whether or not the specific consent of the patient or her guardian was necessary and what constituted such consent. The court emphasised the fact that the consent had to be specific and that it was necessary on the basis of the common law right of absolute security of the person. Blanket consent to the general nature or circumstances of the treatment is not sufficient to save the health care provider from a claim in delict²⁷. This is due to the manner in which the courts apply the doctrine of

²⁶ *Esterhuizen* fn 18 *supra*

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

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

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

28

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

- (a) consent must be given freely or voluntarily (*R v McCoy* 1953 (2) SA 4 (SR)) compulsion invalidates the ‘consent’. Compulsion does not have to be extreme to invalidate the consent. It can take the form of economic, social or moral coercion.
- (b) The person giving the consent must be capable of volition. This does not mean that he must have full legal capacity to act but that he is ‘verstandelik ryp genoeg...om die implikasies van sy handelinge te beseef en hy nie geesteskrank is of onder die invloed van verdowingsmiddels wat belemmerend op sy brein inwerk, verkeer nie’ [quoting from Van Der Merwe and Olivier p 91 *Die Onregmatige Daad in die Suid-Afrikaanse Reg*]
- (c) The consenting person must have full knowledge of the extent to of the (possible) prejudice. It is important that the prerequisite knowledge is present especially where consent to the risk of harm is concerned. In such cases the consenting person must have full knowledge of the nature and extent of the risk in order to consent to such risk.
- (d) The consenting party must realise or appreciate fully what the nature and extent of the harm will be. Mere knowledge of the risk or harm concerned is therefore no sufficient; the plaintiff must also comprehend and understand the nature of the harm or risk.
- (e) The person consenting must in fact subjectively consent to the prejudicial act. In this regard they refer to the dictum of Innes CJ in *Waring and Gillow Ltd v Sherborne* 1904 TS 340 at p 344: “It must be clearly shown that the risk (of injury) was known, that it was realized, and that it was voluntarily undertaken. Knowledge, appreciation, consent – these are the essential elements; but knowledge does not invariably imply appreciation, and both together are not necessarily equivalent to consent.”
- (f) The consent must be permitted by the legal order; in other words, the consent must not be *contra bonos mores*. Consent to bodily injury or consent to the risk of such injury is normally *contra bonos mores* unless the contrary is evident. Examples of the latter are cases of participation in lawful sport, medical treatment or cases where the injury is of a very minor nature.
- (g) Finally the impairment must fall within the limits of the consent.

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

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

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

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

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

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

The court in *Van den Berg & Kie Rekenkundige Beampies v Boomprops supra* distinguished *Malilang's* case, however, on the basis that it was designed in terms of English marine law under the Colonial Courts of Admiralty Act 1890 (32 and 54 Vict Ch 27) and that the Appellate Division had been obliged to apply it in the circumstances. It said that: "Soos reeds gemeld is die uitspraak van Corbett AR in *Malilang* se saak geen gesag vir die standpunt dat 'economic duress', soos dit in die Engelse reg erken word, deel van ons reg vorm nie." The court in *Van Den Berg & Kie Rekenkundige Beampies v Boomprops* went on to hold that the concept of economic duress does not form part of South African law. It observed that "Dat daar interessante ontwikkelinge op hierdie gebied tans in die Engelse reg plaasvind en wel op 'n baie breë front is waar. Sien onder andere Chitty (op cit op 537) oor 'unconscionable bargains and inequality of bargaining power' en die opinie van Denning MR in *Lloyds Bank Ltd v Bundy* [1975] QB 339 (CA) ([1974] 3 All ER 757). Dit is blykbaar dan ook so dat hierdie ontwikkeling in die Engelse reg mag meebring dat die onderskeid tussen 'duress' en 'undue influence' kan vervaag en moontlik mettertyd kan verdwyn. Dit is egter nog nie te sê dat ons eie regsontwikkeling hand aan hand daarmee saamloop nie en dit beteken ook nie omdat ons die Engelsregtelike begrip van 'duress of goods' (in die enger sin) soos hierbo bespreek as in ooreenstemming met ons reg aanvaar het, ons die Engelsregtelike regsbeginsels oor 'duress' oorgeneem het en dat dit sonder meer ook die ontwikkelingsgang in ons eie regs wetenskap moet bepaal nie. Sien *Preller and Others v Jordaan* 1956 (1) SA 483 (A) op 493B-C; *Regal v African Superstate (Pty) Ltd* 1963 (1) SA 102 (A) op 106; *Farlam en Hathaway* (op cit op 369 para 4). Daarbenewens moet in gedagte gehou word dat die Engelsregtelike ontwikkeling in hierdie verband grootliks beïnvloed word deur die 'equity' van die Engelse reg en dat ons eie Appèlhof in *Bank of Lisbon and South Africa Ltd v De Oremelas and Another* 1988 (3) SA 580 (A) beslis het dat ons reg nie 'n algemene substantiewe verweer gebaseer op billikheid in die kontraktereg erken nie. Per Joubert AR op 605J-606D. Wat die presiese effek van hierdie saak mag wees op die ontwikkeling van ons reg tot die erkenning van 'n sogenaamde 'economic duress' as grond vir vernietiging van 'n kontrak is nie voor my geargumenteer nie. Ek is nie oortuig dat die beginsels van 'economic duress' in die Engelse reg deel is van ons reg nie. Ek is na geen gesag verwys waarin dit pertinent beslis is nie en ek kon in my eie navorsing ook geen sodanige gesag opspoor nie. Dat ons reg moontlik nog in daardie rigting kan ontwikkel en of in ons gemeenregtelike bronne die nodige aanknopingspunte daarvoor te vind is hoef ek nie oor te besin nie. Ek sien dit nie as my taak waar ek sit as Regter in 'n Hof van eerste instansie nie."

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



assumption of risk' by contrast, is sometimes used to imply *consent to the risk of injury*, a ground of justification, and sometimes to refer to *contributory intent* (a ground for excluding fault or culpability). The recommend that one should ascertain precisely what happened in a particular situation – whether the wrongfulness was excluded because of the consent of the injured, or whether the negligence of a defendant was cancelled by the plaintiff's intention (contributory intent) or whether, although the plaintiff neither consented nor had contributory intent, he was in fact contributorily negligent in respect of his damage because he acted in a manner different from that of the reasonable man²⁹.

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

coercion includes indirect forms of control which determine or limit alternative courses of conduct available to others. Freedom in a broad sense embraces both the absence of coercion and constraint, and the right to manifest beliefs and practices. What may appear good and true to a majoritarian religious group, or to the state acting at their behest, may not, for religious reasons, be imposed upon citizens who take a contrary view.”

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

29

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

create one. Consent in the sense of the maxim³⁰ can be a precursor to a contract but it is not proof in itself that a contract came into existence between the parties³¹. Contracts can be verbal or written, tacit, implied or express. The law of delict may be seen as saying in the context of health service delivery that bodily injury is harmful but if a patient consents (or agrees) to such injury and its consequences then this justifies the harm in that it does away with the element of wrongfulness required for a successful delictual claim. In the context of private health services delivery at least, consent is likely to be as much a contractual concept as it is delictual due to the fact that the patient is usually in terms of the same transaction contracting for health services and undertaking to pay therefor. However, the consent could also be precontractual and may be one of the conditions that induced the contract rather than a term of the contract itself.

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

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

With regard specifically to warnings that would obviate liability and effectively activate the acceptance of the risk by the customer, the court stated that: "An exemption of liability as set out in the above mentioned warnings must be held to exclude liability for negligence. *South African Railways & Harbours v Lyle Shipping Co* 1958 (3) SA 416; *Essa v Divaris* 1947 (1) SA at 767. As respondent did not endeavour to exclude negligence in its warnings or exemption clauses on its tickets, the warnings themselves were insufficient to exempt respondent from liability."

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

context of health services delivery constitutes a waiver of the patient's constitutional rights to bodily and psychological integrity especially in the context of an indemnity clause in hospital admission form. Is consent to medical treatment a form of waiver, i.e. contract, or is it something else? If constitutional rights cannot be limited except in terms of the provisions of section 36 of the Constitution and the consent or *volenti non fit injuria* principle constitutes waiver then this puts providers of health care services in a legally untenable position. It has been observed previously that there is a considerable weight of authority to the effect that constitutional rights cannot be contractually waived³². Christie³³ makes the point that when the parties to an existing contract come together in an agreeing frame of mind and formally or informally agree to vary or discharge their contract, there is no difficulty about describing what has happened as a variation or discharge by agreement, or a cancellation by agreement. But when one of the parties by his words or actions or inaction has evinced an intention not to enforce one or more or all of his rights conferred by the contract, whichever word seems most appropriate is selected from a list which includes abandonment, acquiescence, release, renunciation, surrender, election, relinquishing of a right and waiver. Christie observes that of these words by far the most commonly used is 'waiver' which is regarded in many of the cases as interchangeable with any of the other words. He notes that waiver of a right conferred by the terms of a contract being itself a contract, it can be established without the necessity to establish the requirements of estoppel. A party relying on waiver need only show that he has accepted, usually tacitly, the other party's express or tacit offer to release him from his obligations, but a party relying on estoppel must go further and show that he has acted to his detriment in reliance on the other party's words or conduct. Christie notes that it follows from the contractual nature of waiver of a right conferred by the terms

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

³³ Christie RH *The Law of Contract* p 507

of a contract that the intention to waive must be communicated to the other party. Until then the party who has decided to waive may change his mind as pointed out by Innes CJ in *Mutual Life Insurance Company of New York v Ingle*³⁴. Christie observes further that a further result of the contractual nature of a waiver is that as soon as the contract to waive a right conferred by the terms of a contract is concluded, that right is irrevocably destroyed. It may be replaced by a new right by agreement between the parties but a waived right cannot be resuscitated by a purported withdrawal of the waiver. Christie points out that *dicta* in the Appellate Division have equated waiver with election and says that the equation may be accepted up to a point but it must not be allowed to blur the distinction between waiver of a right conferred by the terms of a contract and waiver of a right conferred by law. He notes that waiver of a right conferred by the terms of a contract is itself a contract but waiver of a right conferred by law, even in a contractual context, is not³⁵.

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

³⁴ *Ingle* 1910 TPD 540 at p550

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

for proof of an implied term of a contract³⁶. It is submitted that in the context of health care services the situation is complicated by the fact that there is often a contractual overlay in the situation that gave rise to the delict. Christie observes that a waiver of a right derived from a contract is itself contractual in nature but this is not necessarily true of the waiver of a statutory right. In the context of health care services, however, the patient usually agrees to 'waive' his or her constitutional rights on the basis of a contract which he enters into with the health care provider. In the private sector in particular, the patient's consent to the contemplated treatment is obtained on a hospital admission form in the case of inpatient treatment. In the case of non-institutional providers such as general practitioners and dentists, written consent is often not obtained at all or only at the beginning of the relationship when the patient fills in a patient registration form in which case, as a 'blanket' consent', it is not worth the paper it is written on most of the time³⁷. In the case of the public sector, the argument for the existence of a contractual relationship between patient and provider is possibly a

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

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

bit weaker than in the case of the private sector but there are certain instances in which one could definitely show contractual relationship between public sector providers and their patients. One could argue that waiver or consent to medical treatment can be by conduct as well as expressly and in writing. However there are fairly strict requirements for tacit or implied waiver of a right³⁸. It is submitted that even if the possibility of waiver of a constitutional right is recognised, the courts should be extremely reluctant to recognise an implied or tacit waiver of such a right because of the dangers of undermining these rights that were so hard won in the process of drafting the Bill of Rights in the Constitution and because of the very real imbalances of power that still exist between consumers and suppliers of goods and services in many contexts in South Africa, not least of which is health care context. In comparison with the

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

rest of the world South Africa is still fairly backward in terms of laws for the protection of consumers against unreasonable or unfair contractual terms³⁹.

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

As stated previously, waiver does not necessarily equate with the exercise of a choice not to exercise a right⁴⁰. A person's decision not to vote does not mean

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

⁴⁰ De Waal J, Currie I, and Erasmus G, *The Bill of Rights Handbook* (Fourth edition) state at p 42 that "Although the distinction may be difficult to make in some cases, the waiver of fundamental rights should be distinguished from a decision to exercise a fundamental right. Where a person chooses not to take part in an assembly or not to join an association they cannot later complain about a violation of their freedoms of assembly or association. The same applies when an arrested person makes an informed choice to co-operate with the police by making a statement or a confession, or when a person allows the police to search their home. Such a person may not object at their trial that the introduction of the evidence violates their right to remain silent or their right to privacy of their home. In principle, the accused may nevertheless object to the use of the evidence if it would render the trial unfair. But in the absence of other circumstances (such as that the accused was improperly persuaded to co-operate) it is difficult to see why the use of the evidence would result in an unfair trial. Waiver is quite different. One is dealing with waiver when someone undertakes not to exercise a fundamental right in future. For example, a contractual restraint of trade is an undertaking to waive the s22 right to occupational freedom for a certain period of time. Or a person may undertake not to disclose sensitive information, or to vote for a certain political party on election day, or to perform nude on stage or to attend religious instruction in a private school. These are, respectively, attempts to waive the rights to freedom of expression, to vote, to privacy and to freedom of religion. The question is then whether someone may be obliged to honour such an undertaking even if they subsequently change their minds. A few general observations must be made at the outset. A waiver cannot make otherwise unconstitutional laws or conduct constitutional and valid. Section 2 of the Constitution provides that laws or conduct inconsistent with the Constitution is invalid."

It is submitted that this statement has to be qualified to allow for situations in which the Constitution itself envisages that consent can render an otherwise unconstitutional action constitutional. An example is to be found in section 12(2) in which a person may not be subjected to medical or scientific experiments without their informed consent. It is also submitted that consent as a legitimating factor is implicit in the section 12(2) right to make decisions concerning reproduction so that a person can decide to be sterilised and that with the informed consent of the patient such sterilisation will be constitutional whereas without it, the operation would clearly be a violation of the patient's constitutional rights.

They continue to state that: "The actions of the beneficiary of the right can have no influence on the invalidity of unconstitutional law or conduct. That is why a person cannot undertake to behave unconstitutionally. Such an undertaking will have no force and effect. Similarly a person cannot waive the indirect application of the Bill of Rights. Two persons cannot undertake for example, that the law of defamation must be applied in future disputes between them without any reference to the Bill of Rights... What individuals may do is waive the right



that he or she waives his or her right to vote, for instance, just as a person's decision not to pursue a delictual claim does not amount to a waiver of his or her right to bodily integrity. The court in *Cape Town Municipality and Another v Belletuin (Pty) Ltd*⁴¹ observed that a waiver amounts to a voluntary relinquishment or abandonment of a right. Is it correct to regard the principle of *volenti non fit injuria* as a form of waiver especially in the case of the constitutional rights to bodily and psychological integrity? Another manner in which this concept is sometimes expressed is 'voluntary assumption of risk'. De Waal *et al* in their discussion on the question of waiver of constitutional rights⁴² making a promising start but then seem to get hopelessly tangled up in the question of freedom rights as opposed to other kinds of rights, the question of whether in fact constitutional rights can be waived or whether the 'right to exercise a fundamental right' may be waived and the problem of the compartmentalisation of constitutional rights. It is the view of the author that there is very little if any practical distinction between a waiver of a constitutional right itself and the waiver of the right to exercise a fundamental right. The thinness of this 'distinction' it is submitted is likely to precipitate the very danger envisaged by Olivier J in the *Transnet* case⁴³ that a waiver of a right is a limitation thereof and that all forms of waiver, estoppel, acquiescence, etc could undermine the fundamental rights guaranteed in the Bill of Rights. He

to exercise a fundamental right. The individual may undertake not to invoke the constitutional invalidity of state or private conduct. However, from a constitutional point of view such a waiver is hardly even decisive of an issue. But it is also seldom irrelevant. While we deal with waiver here as an issue of application, we do not mean to suggest that it must be answered by simply asking whether the individual may exclude him or herself from the benefits of a particular fundamental right in the circumstances of the case. Waiver and, more generally, victim responsibility, may also influence the limitation stage and the remedy that a court will award for breach of that fundamental right. The effect of waiver firstly depends on the nature and purpose of the fundamental right in question. In principle many of the freedom rights may be waived as long as the subject does so clearly and freely without being played under duress or misapprehension. For example the right to occupational freedom is often waived by employees when concluding a contract of employment. There is also no reason why one cannot waive the s14(d) right not to have the privacy of your communications infringed... In contrast to the freedom rights, the nature of the rights to human dignity (s10) to life (s11) and the right not to be discriminated against (s 9(3) and (4)) or the right to a fair trial, does not permit them to be waived. Unlike the freedom rights these rights do not have a positive and negative dimension. The right to freedom of expression for example can be exercised while keeping quiet but the right to dignity cannot be exercised by being abused. One cannot therefore assume that the right is exercised when it is waived as one does subject to some of the other considerations we have mentioned above, with the freedom rights. Although some rights may be waived, it does not mean that the fact of the waiver then becomes legally irrelevant. As stated above, waiver may also be relevant when considering the remedy to be awarded for the violation of a fundamental right.

⁴¹ *Belletuin* 1979 (2) SA 861 (A)

⁴² De Waal *et al* see fn 34 *supra*

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

points out that section 36(1) of the Constitution stipulates that ‘the rights in the Bill of Rights may be limited only in terms of law of general application. . . .’. It is submitted that compartmentalisation of constitutional rights into freedom rights and other kinds of rights is also a dangerous argument since it does not take into account the fact that the Bill of Rights is a synchronous and internally consistent whole. One cannot separate out the right of freedom from the right to human dignity. One cannot separate the right to freedom and security of the person from the right to human dignity or the right to equality. The rights are a matrix of interrelated and interdependent concepts and to use methods of analysis which avoid this truth will ultimately lead to the reduction of the Bill of Rights to the sum of its parts rather than something more. This reduction will inevitably reduce the scope and significance of the underlying values of the Bill of Rights⁴⁴ and ultimately those upon which the Constitution itself rests. It is too mechanistic. Furthermore there is no need to rely on the dissection of the rights out of the Bill of Rights to this extent. The problem should be regarded rather in the light of a balancing exercise that is inevitably required not only of the judiciary in considering the rights of one party versus another or the executive in making policy decisions which may favour some rights over others but also of the individual in exercising his or her own rights in the infinite number of possible circumstances in which individuals in society find themselves. It is a matter of fundamental choices. This is nowhere more clearly illustrated than in the context of health services delivery. A patient who is in agony on his deathbed can exercise his right of access to health care services and to human dignity by requesting powerful painkillers that will inevitably shorten the duration of what life he has left to him. He is preferring his right to human dignity and access to health care services to his right to life. He would rather die

⁴⁴ Section 7(1) of the Constitution states that the Bill of Rights enshrines the rights of all people in our country and affirms the democratic values of human dignity, equality and freedom. Section 1 of the Constitution states that the Republic of South Africa is founded on the following values:

- (a) Human dignity, the achievement of equality and the advancement of human rights and freedoms;
- (b) Non-racialism and non-sexism
- (c) Supremacy of the Constitution and the rule of law;
- (d) Universal adult suffrage, a national common voters roll, regular elections and a multi-party system of democratic government, to ensure accountability, responsiveness and openness.

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

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

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

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

The Bill of Rights is an indivisible web of concepts that cannot be construed or understood in isolation from each other. It is submitted that, the recognition of the need for consent in our law speaks to the constitutional value and right of freedom. Freedom in its turn is based upon the greater and more pervasive right to human dignity⁴⁵. The nature of the right to freedom is not confined to physical freedom. Section 12(1)(a) of the Constitution refers to the right to

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

freedom and security of the person. This could be read in one of two ways. Firstly it could be read as meaning freedom of the person and security of the person. Secondly it could be read as meaning freedom generally and security of the person. The list that follows suggests that the former reading should be followed. However freedom is not only a right in the Constitution. It is a value as well. Consequently a broad interpretation of the concept of freedom must be followed when considering it in the context of the Constitution. Freedom cannot be seen in isolation from the other rights since the Bill of Rights is not merely a list of separate and independent rights but a complex web of interrelated and interdependent rights and freedoms in which the whole is more than the sum of its parts⁴⁶. The constitutional court has said with regard to the apartheid regime and the multiple denials of freedom that occurred thereunder that:

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

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

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

⁴⁷ *Ferreira* fn 46 *supra*

freedoms in the world in the certain knowledge that the capacity or power to exercise them does not exist and that they are therefore meaningless⁴⁸.

For the purist, the doctrine of informed consent on the basis of *Esterhuizen*⁴⁹ may have a slightly different, or possibly less differentiated, basis than at constitutional law where, it is submitted, it would be based more appropriately on the right to bodily and psychological integrity in subsection (2) of section 12 as opposed the right to freedom and security of the person as contemplated in subsection (1) of that subsection. It is of interest that consent to the commission of a wrong is a unilateral juristic act which may be withdrawn by the consenting party at any time⁵⁰.

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

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

⁴⁹ *Esterhuizen* fn 19 *supra*

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

law of delict, must be freely and voluntarily given. Otherwise it does not qualify as consent for this purpose. Freedom implies an absence of coercion or constraint⁵¹. Despite some court decisions to the contrary,⁵² until relatively recently there was some debate around awards of damages purely for mental suffering⁵³. The court in *Clinton-Parker v Administrator, Transvaal Dawkins v Administrator, Transvaal*⁵⁴ noted that with reference to Bester's case, Burchell⁵⁵ correctly concluded that the previous approach had been regarded as too restrictive pointing out that Bester's case held that the brain and the nervous system is just as much part of the physical body as an arm or a leg. He stated:

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

The court commented⁵⁶ that as can be seen from Bester's case and subsequent developments, the erstwhile distinction between a psychological and physical injury has been rejected. In this sense mental injury has come to be regarded as much of a physical injury as more obvious bodily injuries.

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

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

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

⁵³ Burchell J in *Principles of Delict* at p 59 (as quoted by the court in *Bester* (see below) points out that the Courts 'here and in other countries have been cautious about extending liability for negligently caused nervous shock'. He points out that in the early cases in South Africa liability for negligently inflicted nervous shock was restricted by two factors, viz the nervous shock had to result in physical injury and the plaintiff must have feared for his or her own safety. Burchell states: "The first of these restrictions was based on the outdated distinction between mind and matter and based on the view that injury to the physical body was the subject of Aquilian liability and that damage to the individual's nervous system on its own was not sufficient for such liability. The second factor was a way of limiting the scope of potential liability to someone who in fact ran the risk of being physically injured.'

In *Bester v Commercial Union Versekeringsmaatskappy van SA Bpk* 1973 (1) SA 769 (A), the court stated that the reasonable foreseeability test was the test for liability for negligence and that this has repeatedly been set out in numerous authorities. He also pointed out that damages were regularly awarded for shock, pain and suffering, incapacity, loss of amenities of life and shortened life expectation, 'ten minste waar dit met 'n suiwer fisiese besering gepaard gaan'. He concluded that to deny a victim compensation purely on the basis that the shock and consequential harm were not allied to a physical injury cannot be defended logically.

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

⁵⁵ Burchell fn 28 *supra* at p 60

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

Bosshof AJ in *Brenner v Botha*⁵⁷ where he stated that: “The specific interests that are detrimentally affected by the acts of aggression that are comprised under the name of injuries are those which every man has, as a matter of natural right, in the possession of an unimpaired person, dignity and reputation”. They are all rights of personality under the common law⁵⁸.

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

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

The concept of *dignitas* links the concepts of bodily and psychological integrity, dignity and freedom and security of the person⁶⁰. There is also a strong link with

⁵⁷ *Brenner* 1956 (3) SA 257 (T)

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

⁵⁹ *Maisel* 1960 (4) SA 836 (C)

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

the right to privacy⁶¹ which it is submitted is inherent in the right to bodily and psychological integrity despite the fact that it also recognised as a separate right in the Bill of Rights. On the subject of damages for pain and suffering the courts have said in the past that such damages do not fall under the auspices of the *actio injuriarum* but under the *actio legis Aquilia*⁶². It is important to note,

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

- 61 In Hunt P, *South African Criminal Law and Procedure*, vol. II, p 495, the author, after referring to attempts at definition and description of the word “*dignitas*” by the text-writers and the Courts, submits that it “is a somewhat vague and elusive concept which can, however, be broadly described positively in terms of a person’s right to ‘self-respect, mental tranquillity, and privacy.’ These are the elements which have been constantly stressed by the courts. It can be described negatively in terms of his right to freedom from insulting, degrading, offensive or humiliating treatment and to freedom from invasions of his privacy”.
- In *S v A and Another* 1971 (2) SA 293 (T) the court held: “It seems to me that there can be no doubt that a person’s right to privacy is one of, and I quote from Umfaan’s case, “those real rights, those rights *in rem*, related to personality, which every free man is entitled to enjoy”. Accordingly it appears to me that an infringement of a person’s privacy *prima facie* constitutes an impairment of his dignitas. There have been many attempts in the authorities to define “*dignitas*”. In Umfaan’s case, on which Mr. Rosenzweig has relied, Innes, C.J. quoted the following passage: ‘Every person has an inborn right to the tranquil enjoyment of his peace of mind, secure against aggression upon his person, against the impairment of that character for moral and social worth to which he may rightly lay claim, and of that respect and esteem of his fellow-men of which he is deserving, and against degrading and humiliating treatment; and there is a corresponding obligation incumbent on all others to refrain from assailing that to which he has such right.’
- Further on he says: ‘As affecting dignity, there are many illustrations. Insults to chastity, for instance, such as indecent proposals to a woman; forcible and wrongful intrusion into the house of another was looked upon as an *injuria*, not because it was a trespass on the property, but because it was a violation of family sanctity - of that peace and dignity which a free man was entitled to enjoy.’
- Various other definitions are to be found collected in *South African Criminal Law and Procedure*, formerly *Gardiner and Lansdown*, in vol. 2, which is by Hunt, at p 495. I do not think it necessary to refer to the various definitions of this concept as set out in this work. Suffice it to say that I have no doubt that the right to privacy is included in the concept of *dignitas*, and that there is no dearth of authority for this proposition.”
- 62 Thus the court in *Hoffa, No v SA Mutual Fire & General Insurance Co Ltd* 1965 (2) SA 944 (C) held that it would be wrong, both historically and in principle, to classify a claim for damages for pain and suffering, etc., under the *actio injuriarum*; (a) The *actio injuriarum* requires an *animus injuriandi*, whereas this claim (like any other Aquilian relief) can be based on mere *culpa*. See *Matthews v Young, supra*; de Villiers, loc cit. (b) This claim can be ceded, whereas a claim under the *actio injuriarum* is incapable of cession. De Villiers, loc cit; Sande De. Act. Cess. 5.11 (Anders’ translation, p. 58), and see *Botes v Hartogh*, 1946 W.L.D. 157; *Walker v Malterson*, 1936 NP 495. (c) The *actio injuriarum* always incorporates an element of *contumelia*. See *Stoffberg v Elliott*, (fn 18 *supra*) 148; *Mathews v Young, supra*, whereas this is not included under ‘pain and suffering’, see *Radebe v Hough*, 1949 (1) SA 380. Mental shock is not actionable under the *Lex Aquilia*. See *Hamman v Malmesbury D.C.*, 1916 CPD 216; *Layten & Layten v Willcox & Hissinson*, 1944 S.R. 48. (d) The *actio legis Aquiliae* was extended - even in Roman law - to cases of bodily injury. See *Matthews v Young, supra*; *Union Government v Warneke, supra*; Voet, 9.2.11, 47.10.18; van den Heever, op. cit. (e) The *actio injuriarum* constituted an exception to the rule as to transmissibility. See McKerron on *Delict*, 6th ed. p 131; Buckland, pp. 313, 586, 685 - 6; de Villiers, p. 235. (f) Claims for pain and suffering, etc., are merely factors in the assessment of the quantum of the *damnum*. See *Coetzee v S.A.R. & H, supra*. See also *Sandler v Wholesale Coal Supplies*, 1941 AD at pp 194, 199. As to what this *damnum* can comprise, see the authorities collected in Gordon & Suzman *Law of Compulsory Motor Vehicle Insurance*, p. 99. In our law the *actio legis Aquiliae* is no longer penal, but reipersecutory, whereas the *actio injuriarum* is purely penal. McKerron, op. cit, pp. 7 - 9. (g) The *actio injuriarum* is not associated with bodily injury, but with injured feelings where no physical hurt has been done. See *Pauw v African Guarantee*, 1950 (2) SA 132. (h) It would be anomalous in a case of bodily injury to allow certain claims - such as for loss of support, see *Union Government v Lee, supra*, and loss of earnings, see Lockhat’s case, *supra* - to survive the death of the injured person, and others not.”
- In *Government Of The Republic Of South Africa v Ngubane* 1972 (2) SA 601 (A), counsel for the respondent pointed out that “The claim for pain and suffering in respect of an injury to a freeman was unknown to the Roman civil law or to the *actio legis Aquiliae*: Hoffa, *supra* at pp. 950F, 951E; D. 9.1.3; D. 9.3.7. The Roman-Dutch law allowed an action for pain and suffering but this did not have its roots in the Aquilian action although it was often brought at the same time. It could not form part of the Aquilian action because the Aquilian action lay only for patrimonial loss. Hoffa, *supra* at pp. 950H to 952F; *Union Government v Warneke*, 1911 AD at p.

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

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

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See *Southern Insurance Association Ltd v Bailey No 1984* (1) SA 98 (A) in which the Appellate Division noted that: "Our Courts have awarded damages for pain and suffering, disability and loss of amenities on one of two bases. In one line of decisions, in which the *sui generis* nature of the action for pain and suffering from its Germanic roots are noted, damages awarded thereunder are treated as in a certain sense analogous to the *solatium* claimed under an *actio injuriarum*. *Hoffa v SA Mutual & Fire General Insurance Co Ltd* fn 57 *supra* at 955A; *Poigier v Rondalia* 1970 (1) SA at 712G - H; *Regering van RSA v Santam Versekeringsmaatskappy* 1970 (2) SA at 43B; *Government of RSA v Ngubane* 1972 (2) SA at 606E - G 607B. In other decisions, emphasis has been placed on a functional approach to the assessment of damages for non-pecuniary loss. *Geldenhuys v SAR & H* 1964 (2) SA at 235C; *Steenkamp v Minister of Justice* 1961 (1) PH 19; *Pretorius v Geldenhuys* (Corbett and Buchanan (op cit at 805)); *Gonya v Rondalia Assurance Corporation* (Corbett and Buchanan (op cit vol 2 at 311)); *Marine & Trade Insurance v Katz* 1979 (4) SA at 983E - G." The court seemed to prefer the latter approach because it "leads to fewer anomalies and has been successfully applied in four cogent recent judgments of the Supreme Court of Canada."

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

8.2.4 *Dube v Administrator Transvaal*⁶⁴

Facts

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

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

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Dube 1963 (4) SA 260 (W)

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

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

Judgment

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



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

- (1) applying the plaster initially too tightly;
- (2) failing to diagnose the possible onset of a Volkmann's contracture on the 28th June, and to take other measures to arrest the development of the Volkmann's contracture;
- (3) failing to give the plaintiff on the 28th June a clear and unambiguous instruction and warning to return immediately if the pain persisted and/or swelling developed in the hand and fingers.

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

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



patient can reasonably be required to take care of himself or take responsibility for some aspects of his treatment in certain instances since the medical practitioner cannot be expected to do everything that is necessary for the patient's care. The court also referred with approval to a dictum in a Canadian case⁶⁶ which suggested that the failure of a medical practitioner to warn a patient could in certain circumstances constitute negligence on the part of the practitioner. It observed that there was a special duty owed by the hospital, through its servants, to the plaintiff to give him clear and unambiguous instructions as to what he was to do. The plaintiff should have been carefully instructed to watch out for any swelling, pain, blueness or numbness of the hand and fingers and to return (and the need to do so should have been stressed) immediately any such symptoms manifested itself because each would have been a danger sign. The court held that he should also have been warned of the possible consequence of not obeying such an instruction implicitly, namely, of losing the use of his forearm and hand. Trollip J stated that a plaintiff is generally not guilty of contributory negligence if his ostensible lack of care for his own health or safety was caused by the conduct of the defendant which induced or misled him to believe or assume reasonably that his action or inaction would not endanger his health or safety.

Discussion

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

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



responsibility for certain aspects. It is noteworthy that Trollip J also pointed out that not every mistake in diagnosis amounts to negligence. The nub of this case revolves around the fact that the health care provider, a person with expert skill and knowledge, applied a plaster cast to the patient's arm after he sustained a serious injury and failed to tell him of the dangers posed by such a cast when used in conjunction with an injury such as the one he had sustained. The patient was not in a position to have this knowledge as it is not generally known outside of the medical profession and the health care provider in assuming the risk of treating the patient put itself in such a relationship to the patient that it was obliged to exercise a certain degree of care and skill as was required of a reasonable person in the defendant's position⁶⁷. A reasonable medical practitioner would not only have warned the patient about certain danger signs and told him to come back if he noticed them but also would have explained what would happen if he did not immediately seek medical attention. There was a duty upon the provider to ensure that the patient understood the risks to which he had been exposed not only by the injury itself but also the subsequent treatment of it. It is submitted that this is due to the superior position of the provider in terms of knowledge and expertise in relation to that of the patient. The patient, with insufficient medical knowledge, would be likely to assume that now that he has been treated by the experts, the situation is under control and he is on his way to recovery. He is unconsciously relying on the fact that the people who treated him are experts and that they know what is necessary for his recovery. It is submitted that this is reasonable behaviour upon the part of the patient since the people who treated him publicly professed to have the necessary knowledge and skill. They were registered health professionals who had been found by a council of their peers to be suitably qualified and skilled to pursue their professions. This is the reason why in order to transfer the risk for certain aspects of his treatment back to the patient, they had to share with him

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

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

The court held that whether or not the patient was a paying patient or a non-paying patient was of no relevance. The implication to be drawn from this is that even if there is a contractual overlay to the relationship, the duty of care, from a delictual perspective remains unchanged. Dube's case⁶⁸ involved a negligent omission and vicarious liability since the doctor in question was an employee of the state.

The court did not expressly address the question of vicarious liability⁶⁹ although it is clear from its finding that it regarded the employer as vicariously liable as much for the negligent omissions of its employees as for their negligence in applying the plaster cast too tightly. With regard to liability for negligent omissions the court simply referred to the dicta in the Canadian case referred to by Lord Nathan - *Murrin v Janes*⁷⁰.

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

68 *Dube* fn 64 *supra*

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

70 *Murrin* fn 66 *supra*

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

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

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

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

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

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

8.2.5

*S v Mkwetshana*⁷²

Facts

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

⁷² *Mkwetshana* 1965 (2) SA 493 (N)

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

Judgment

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

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

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

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

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

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

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

⁷³ *Van der Merwe* fn 3 *supra*

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

Discussion

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

⁷⁴ *Van Schoor* fn 1 *supra*



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

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

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

8.2.6 *Buls v Tsatsarolakis*⁷⁶

Facts

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

⁷⁵ *Mkwetshana* fn 72 *supra*

⁷⁶ *Buls* 1976(2) SA 891 (T)

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

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

Fee - radiologist - three examinations @ R8, 10 eachR 24.30
R779.30

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

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

- (a) caused two X-ray pictures only of plaintiff's right wrist be taken by a radiologist in the employ of the Krugersdorp Hospital;
- (b) failed to examine plaintiff's right wrist properly and failed to find that the scaphoid bone of this wrist was broken;
- (c) failed to put plaintiff's wrist in plaster and thus to immobilise it, which is the correct and accepted medical practice;
- (d) failed to cause further X-ray pictures to be taken when plaintiff consulted him again on 14 April and complained that he was still suffering much pain;
- (e) failed again to immobilise plaintiff's wrist but advised him to massage it with an ointment;
- (f) advised plaintiff wrongly on 14 April that a further consultation and examination of his wrist was not necessary;
- (g) undertook the examination of plaintiff's right wrist and his treatment without possessing the required knowledge and skill."

Judgment

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



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

The court observed that the standard of care required of a medical practitioner who undertakes the treatment of a patient is not the highest possible degree of professional skill, but reasonable skill and care⁷⁷. It stated that in deciding what is reasonable, the evidence of qualified physicians is of the greatest assistance but that the decision of what is reasonable under the circumstances is, however, for the Court. It will pay high regard to the views of the profession, but it is not bound to adopt them. The question in *Buls'* case was thus not how a specialist orthopaedic surgeon would have acted in the treatment of the plaintiff, but how an average general practitioner, carrying on his duties as a casualty officer in a public hospital, would have acted. Two orthopaedic surgeons gave expert evidence at the trial: one, Mr. Bryer, was called by the plaintiff; the other, Mr. Du Toit, by the defendant. Mr. Bryer's evidence was that Dr. *Buls'* conduct on 7 April was not subject to criticism. The clinical signs at that stage, so far as they were observable by Dr. *Buls* in the circumstances, did not clearly point to a

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

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

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

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

Discussion



In relation to the question of the legal right to be healed raised by Nicholas J in this case, Strauss⁷⁸ submits that the answer is as follows: where a patient consults a doctor who undertakes to treat him, the doctor assumes no greater duty than to treat the patient with due care and skill, unless the doctor has expressly guaranteed that the patient will be healed by his treatment – something which the prudent doctor will not generally do. He notes that this is also the view of the English courts and refers to the case of *Greaves & Co (Contractors) Ltd v Baynham Mickle and Partners*⁷⁹ in which Lord Denning states concerning the ‘employment of a professional man’ that “The law does not usually imply a warranty that he will achieve the desired result, but only a term that he will use reasonable care and skill. The surgeon does not warrant that he will cure the patient. Nor does the solicitor warrant that he will win the case”. However, Strauss points out in another chapter⁸⁰ that a wrong diagnosis may result in a doctor be held liable for damages if the diagnosis is causally responsible for wrong treatment being given to a patient or the patient suffering injury in another manner. It is respectfully submitted that the correct answer to the question in a contractual setting as to whether or not the patient has a right to be healed or cured is dependent upon the terms of the contract, whether express or implied, in each situation. A contract for cosmetic surgery for instance, in which the surgery is carried out for the express purpose of reducing the size of the patient’s breasts by stated measurements gives a right to very specific performance indeed as does a contract for the carrying out of a hysterectomy in order to remove a diseased uterus. Similarly contracts for the removal of an inflamed appendix, for the supply of eyeglasses to correct a visual defect, for a test for a particular genetic defect in a foetus, or for the termination of a pregnancy, or the insertion of an artificial hip are all quite specific in terms of the expected outcome. Failure to do what is minimally

78 Strauss fn 17 *supra* p 40-41

79 *Greaves* [1975] 3 All ER 99 (CA)

80 Strauss fn 17 *supra* at p 252

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

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

⁸¹ *Dube* fn 64 *supra*



effective access, i.e. access to services that are likely to effect a cure, alleviate symptoms or otherwise improve the patient's health status or condition since a narrower interpretation would amount effectively to a denial of the right. To put it differently, access to treatment that does not meet standards of general efficacy, safety and quality is not access for constitutional purposes. It is submitted fourthly that the constitution could in certain circumstances create an obligation on the part of a provider to treat a person in a situation in which the law previously did not recognise such an obligation since the existence of a right of access to health care services, it could be argued, shifts the onus from the person seeking the services to show reasons why a particular provider should have treated him or her, to the provider refusing those services to show reasons why the access was denied. It is submitted fifthly that, due to the fourth submission above, the possibility of a claim in delict involving denial of access, in both obvious and subtle ways, to health care services is greatly enhanced by the existence in constitutional law of a right of access to health care services since previously no such right existed and the question of an obligation to treat a person was thus unlikely to rise except in the narrowest of circumstances⁸².

Claassen and Verschoor⁸³ point out that in *Buls*, the patient for the first time in South African legal history based his action on pure economic loss suffered by him as a result of the alleged negligence of the defendant-practitioner. They note that in previous cases such claims were usually based on the personal injuries or prejudice suffered by the plaintiff. They point out that only two actionable wrongs are known in South African law, namely *damnum injuria datum* (damage wrongfully caused) and *injuria* (injury to personal dignity) and

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

⁸³ *Claassen and Verschoor* fn 5 *supra*

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

8.2.7 *Magware v Minister Of Health NO*⁸⁵

Facts

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

⁸⁴ Neethling, Potgieter and Visser 1989 *Deliktereg*

⁸⁵ *Magware* 1981 (4) SA 472 (Z)

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

- (a) they applied a plaster of Paris cast to plaintiff's ankle without ensuring that it was moulded appropriately to stabilise and prevent slippage of the said fracture dislocation to the ankle;
- (b) after they had applied the said plaster of Paris cast they failed to check the said fracture dislocation by means of X-rays on 3 or 4 April 1978 as they should have done, and only made such a check on 17 April 1978;
- (c) despite the fact that the X-ray taken on 17 April 1978 revealed that the fracture was in an unacceptable position and required immediate correction, they failed to take the appropriate action necessary to correct it.

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

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

4. Defendant admits the negligence alleged in para 7, as particularised in para 6, but avers that such negligence consisted only of acts of omission, not giving rise to delictual liability on the part of defendant
5. Save that it is admitted that plaintiff's injury did not heal as it would have done with the correct treatment, and save that defendant has no knowledge of the quantum of damage alleged, does not admit it and puts plaintiff to the proof thereof, defendant denies the allegations in para 8.

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

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

Judgment

Counsel for the defendant, submitted that the negligence alleged by the plaintiff consisted only of acts of omission and that where there were acts of mere omission there was no liability⁸⁶. Counsel argued that the instant case was one of ineffective treatment and that liability in medical matters depends on a prior act of commission which is something more than the mere acceptance of the patient or the application of ineffective treatment.

Counsel for the excipient referred to two English cases. In England the position appeared to be that doctors and hospital authorities, whenever they accept a patient for treatment, are under a duty to use reasonable care and skill to cure him of his ailment⁸⁷. Reference was also made by counsel for the excipient to *Barnett v Chelsea & Kensington Hospital Management Committee*⁸⁸ in which the deceased had, with two other watchmen, reported to the hospital. They told the nurse in the casualty department that they had been vomiting continuously after drinking tea and wished to see a doctor. The nurse telephoned the doctor and informed him of this. He instructed the nurse to tell the watchmen to see their own doctors. Later the deceased died of arsenical poisoning. It was held that, in failing to see and examine the deceased and in failing to admit him to hospital and treat him, the hospital's casualty officer was negligent and did not discharge the duty of care which in the circumstances was owed to the deceased by the defendant as hospital authority. Smith J noted that *Donoghue v Stevenson* and *Le Lievre v Gold* were referred to in relation to close and direct relations between persons giving rise to a duty to take care, and that Nield J

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

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

⁸⁸ *Barnett* (1968) 1 All ER 1068

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

Smith J in *Magware* observed with regard to South African law that it had been decided by the Appellate Division in South Africa that prior conduct or the control of property are not essential to the creation of a duty to act for the safety of others, although they may be factors in the totality of circumstances from which such a duty is inferred⁸⁹. He noted that Steyn JA in a minority judgment in *Silva's Fishing Corporation (Pty) Ltd v Maweza*⁹⁰ said:

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

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

⁸⁹ *Minister van Polisie v Ewels* 1975 (3) SA 590 (A). In this case it was held that members of the police force had been under a duty to stop another policeman from assaulting a man in a police station. See, particularly, at 596 - 597 (English translation). At 597 Rumpff CJ, having stated that prior conduct or the control of property are not essential requirements for unlawfulness, goes on to say:

“It appears a stage has been reached where an omission is regarded as unlawful conduct when the circumstances of the case are such that the omission not only occasions moral indignation but where the legal convictions of the community require that the omission be regarded as unlawful and that the loss suffered be compensated by the person who failed to act positively. When determining unlawfulness, one is not concerned, in any given case of an omission, with the customary 'negligence' of the bonus paterfamilias, but with the question whether, all facts considered, there was a legal duty to act reasonably.” See, also, 1975 South African Law Journal at 361 and 1975 Annual Survey of South African Law at 170.

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

⁹¹ *King* 1971 (3) SA 540 (RA)

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

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

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

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

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

⁹⁴ *Dube* fn 64 *supra*

⁹⁵ *Blyth* 1980 (1) SA 191 (A)

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

Discussion

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

⁹⁶ *Buls* fn 76 *supra*

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

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

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

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

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

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

8.2.8

*S v Kramer*⁹⁹

Facts

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

⁹⁸ *Ewels* fn 89 *supra*

⁹⁹ *Kramer* 1987 (1) SA (N)

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

- (a) Accused No 1 should have ensured that the endotracheal tube had been correctly inserted by accused No 2. The court *a quo* found that this duty on accused No 1 Arose as a result of the following:
 - (1) Accused No 1 knew that accused No 2 was a relatively inexperienced anaesthetist.
 - (2) Accused No 1 knew that each and every anaesthetist can place an endotracheal tube wrongly.

- (3) Accused No 1 admitted at the inquest that had he checked if the tube had been correctly placed the deceased's death could have been avoided.
- (b) Accused No 1 should not have removed the left tonsil after he had seen the dark blood. In doing so he delayed commencing the resuscitative measures.
- (c) Accused No 1 should not have ordered accused No 2 to inject more scolene, a drug that would paralyse the lungs of the patient and prevent her from breathing normally.

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

1. The court erred in convicting accused No 1 of culpable homicide.
2. The court should have found that the state failed to prove beyond reasonable doubt that:
 - (a) accused No 1 was negligent, either as alleged in the further particulars to the charge sheet or at all;
 - (b) accused No 1's negligence, if any, was causally connected to the death of the deceased.
- 3.1 The court erred in finding that accused No 1 delayed in taking steps to ensure that the intratracheal tube was correctly placed and/or to take resuscitative measures.
- 3.2 The court should have found that once accused No 1 saw that the deceased was bleeding excessively in the throat and that the blood was dark in colour, he:
 - (a) acted immediately in order to ascertain precisely what the cause was of these two phenomena; and/or
 - (b) immediately took steps to establish an airway.
- 3.3 The court should have found that, on Professor Cooper's evidence, the state failed to prove that accused No 1 had not acted properly in the emergency situation in which he, as surgeon, found himself.

- 4.1 The trial court erred in finding that accused No 1 should not have told accused No 2 to use Scoline on the second occasion.
- 4.2 The trial court should have found that it was essential for an intratracheal tube to be reintroduced and that in order to do so a muscle relaxant, such as Scoline, had to be used.
- 5.1 The trial court erred in finding that, before commencing the operation, accused No 1 should have checked to see that the intratracheal tube had been correctly placed by accused No 2.
- 5.2 This finding was in direct conflict with the evidence of Professor Cooper, whose evidence it was that it was not the surgeon's function to ensure that the intratracheal tube had been correctly placed by the anaesthetist.
- 5.3 The trial court furthermore erred in finding that accused No 1 should have foreseen that accused No 2 might insert the intratracheal tube incorrectly.
- 5.4 The trial court should have found that accused No 1, as surgeon, was entitled to assume that accused No 2, who was qualified to act as anaesthetist, would insert the intratracheal tube correctly.

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

- (a) he should not have relied on Sister Lansdown to choose an appropriate length of endotracheal tube as it was possible that the tube which was inserted was too short or that it was not inserted deep enough into the trachea;
- (b) he did not insert the tube into the trachea at all;
- (c) he did not monitor the patient's condition adequately and therefore did not timeously detect that the supply of oxygen to the patient's lungs was inadequate. In coming to this conclusion the court *a quo* found that accused No 2 should have made use of a blood pressure cuff and an ECG machine;
- (d) he should not have frozen at the first signs of a crisis as he was busy with a dangerous undertaking and the patient's life was in his hands.

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

1. The learned magistrate erred in finding that appellant was negligent; alternatively that his negligence caused the death.
2. Regarding the finding that appellant was negligent in relying on an experienced nurse to check the anaesthetic drugs for him, there was no evidence that this conduct constituted negligence or that any mistake was made connected with the drugs or that any such mistake caused the death.
3. Regarding the finding that he was negligent in relying on an experienced nurse to choose an appropriate length of endotracheal tube, there was no evidence that this conduct constituted negligence or that any mistake was made connected with the length of the tube or that any such mistake caused the death.
4. Regarding the finding that he was negligent in failing to check that the endotracheal tube was inserted deeply enough into the trachea, there was no evidence of any such failure or that any such failure caused the death.
5. Regarding the finding that he was negligent in failing to insert the endotracheal tube into the trachea at all:
 - 5.1 the learned magistrate erred in that he relied entirely on appellant's admission at the inquest that it was possible that he had inserted the tube incorrectly;
 - 5.2 there was evidence that the time from oxygenation to the time when the blood went dark, i.e. over 6 minutes, indicated that the tube had been inserted correctly.



6. Regarding the finding that he was negligent in not putting a blood pressure cuff on the child, there was no evidence that this constituted negligence or that the child's life would beyond a reasonable doubt have been saved had the blood pressure cuff been put on.
7. Regarding the finding that he was negligent in not using an ECG, there was no evidence that this constituted negligence or that the child's life would beyond a reasonable doubt have been saved had he used one.
8. The learned magistrate should therefore have held that it had not been proved beyond a reasonable doubt that appellant was negligent in any manner which caused the death and should have acquitted him.

Judgment

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

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



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

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

rested throughout upon the plaintiff: that the mere fact that the accident occurred was not in itself prima facie proof of negligence, and that the maxim *res ipsa loquitur* did not apply. There are excellent reasons for this rule of law, because it seems to me that, if the law required in every case that a practitioner should have the highest degree of skill, it would lead to this result - that in remote country districts, and even in country districts at no very great distance from the large centres, it would be impossible to find a country practitioner who would take the risk of attending a patient, if he was always expected to exercise the highest degree of skill obtainable in the medical profession. The law requires of a doctor a reasonable degree of skill, which is dependent upon the particular circumstances of the case which he has under treatment.'

See also *Coppen v Impey* 1916 CPD 309 at 314 where Kotze J was reported to have said: 'But taking it that the probability is that these ulcers and the consequent condition of the plaintiff's right-hand, are attributable to such a burn, I have next to consider whether this burn is due to negligence or unskillfulness on the part of Dr Impey or his assistant, as alleged in the declaration. Before doing so it will be advisable to state succinctly the law applicable to the responsibility of a medical man in the treatment of his patient. While, on the one hand, he does not undertake to perform a cure, or to treat his patient with the utmost skill and competence, he will, on the other hand, be liable for negligence or unskillfulness in his treatment; for, holding himself out as a professional man, he undertakes to perform the service required of him with reasonable skill and ability.' See further *Buls and Another v Tsatsarolakis* [fn 76 *supra*] at p 893 *in fine* - 894D. See also Boberg, *The Law of Delict* [fn 28 *supra*] at p 346: 'Obviously the ordinary reasonable man test of negligence cannot be applied to an activity calling for expertise that the ordinary man does not possess. One cannot judge a surgeon's conduct by asking how a diligens paterfamilias would have operated, for either he would not have operated at all (which is most likely) or, if he would have operated (in some rare emergency), he would no doubt have done worse than even the most barbarous surgeon. And so there emerges the reasonable expert - a practitioner like the actor, both possessing no especial flare or frailty; the reasonable doctor, the reasonable auditor, the reasonable mechanic. It is he who looks over the actor's shoulder to see if he attains the standard of his peers, for if he does not, he is negligent. That standard, it has been held, is not the highest level of competence: it is a degree of skill that is reasonable having regard to "the general level of skill and diligence possessed and exercised at the time by the members of the branch of the profession to which the practitioner belongs" (per Innes CJ in *Van Wyk v Lewis* fn 22 *supra* at 444). Thus it was held in *Buls v Tsatsarolakis* [fn 69 *supra*] that a general medical practitioner is not expected to display the knowledge and skill of a specialist orthopaedic surgeon.'

The court noted that the same principles are applied in English law. See, inter alia, *Mahong v Osborne* [1939] 1 All ER 535 at 548A - C: 'Before I discuss the Judge's summing up, it is desirable to recall the well-established legal measure of a professional man's duty. If he professes an art he must be reasonably skilled in it. There is no doubt that the defendant surgeon was that. He must also be careful, but the standard of care which the law requires is not insurance against accidental slips. It is such a degree of care as a normally skilful member of the profession may reasonably be expected to exercise in the actual circumstances of the case in question. It is not every slip or mistake which imports negligence, and, in applying the duty of care to the case of a surgeon, it is peculiarly necessary to have regard to the different kinds of circumstances that may present themselves for urgent attention.' See also *Medical Negligence* by Nathan [fn 65 *supra*] at p 22.



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

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

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

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

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

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

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

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

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

Discussion

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

professional to assess the competence of another in a situation in which they are operating as a team and to act in a way that minimises the risk of any deficits in the skill or knowledge of the other professional. The court did say that there may be exceptions for instance in a situation in which the one doctor knows that the other is not fit to perform his duties or is incompetent¹⁰³. It is submitted, however that this is a far cry from a duty to ensure that the other health professionals in the team are competent and sufficiently skilled since this is the duty of the relevant statutory professional body which is required to register them as such on sufficient proof of such professional skill and knowledge. The rule *imperitia culpa adnumeratur* cannot be applied to the team as such, i.e. to a group of individuals collectively. Each must stand on his own two feet in terms of his competence and skill to perform the work he has undertaken. Each member of the team is entitled to rely on the others to perform their roles correctly and effectively and they cannot be held jointly and severally liable for each other's mistakes.

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

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



The concept of scope of practice is a very important element of the lawful delivery of health care services in South Africa. In terms of section 34 of the Health Professions Act¹⁰⁴, registration is a prerequisite for practising a profession in respect of which a professional board has been instituted¹⁰⁵.

Section 36 provides for penalties for practising as a medical practitioner or as an intern, or for performing certain other acts, while unregistered¹⁰⁶. Penalties

104 Health Professions Act fn 7 *supra*

105 Section 34 provides that:

- (1) Subject to the provisions of sections 33 (2) (c) and 39, no person shall practise for gain within the Republic any other health profession the scope of which has been defined by the Minister in terms of section 33 (1), unless he or she is registered in terms of this Act in respect of such profession.
- (2) Any person who contravenes the provisions of subsection (1) shall be guilty of an offence and on conviction liable to the penalties mentioned in section 39.

106 Section 36 provides that:

- (1) Subject to the provisions of subsections (2) and (3) and section 37 any person, not registered as a medical practitioner or as an intern, who-
 - (a) for gain practises as a medical practitioner (whether or not purporting to be registered);
 - (b) for gain-
 - (i) physically examines any person;
 - (ii) performs any act of diagnosing, treating or preventing any physical defect, illness or deficiency in respect of any person;
 - (iii) advises any person on his physical state;
 - (iv) on the ground of information provided by any person or obtained from him in any manner whatsoever-
 - (aa) diagnoses such person's physical state;
 - (bb) advises such person on his physical state;
 - (cc) supplies or sells to or prescribes for such person any medicine or treatment;
 - (v) prescribes or provides any medicine, substance or thing; or
 - (vi) performs any other act specially pertaining to the profession of a medical practitioner;
 - (c) except in accordance with the provisions of the Medicines and Related Substances Act, 1965 (Act 101 of 1965), the Pharmacy Act, 1974 (Act 53 of 1974), the Health Act, 1977 (Act 63 of 1977), the Nursing Act, 1978 (Act 50 of 1978), the Chiropractors, Homeopaths and Allied Health Service Professions Act, 1982 (Act 63 of 1982), and sections 33, 34 and 39 of this Act, performs any act whatsoever having as its object-
 - (i) the diagnosing, treating or preventing of any physical defect, illness or deficiency in any person; and
 - (ii) by virtue of the performance of such act, the obtaining, either for himself or for any other person, of any benefit by way of any profit from the sale or disposal of any medicine, foodstuff or substance or by way of any donation or gift or by way of the provision of accommodation, or the obtaining of, either for himself or for any other person, any other gain whatsoever;
 - (d) pretends, or by any means whatsoever holds himself out, to be a medical practitioner or intern (whether or not purporting to be registered) or a healer, of whatever description, of physical defects, illnesses or deficiencies in man;
 - (e) uses the name of medical practitioner, intern, healer or doctor or any name, title, description or symbol indicating, or calculated to lead persons to infer, that he is the holder of any qualification as a medical practitioner, physician or surgeon, or as an obstetrician or intern or of any other qualification enabling him to diagnose, treat or prevent physical defects, illnesses or deficiencies in man in any manner whatsoever, or that he is registered under this Act as a medical practitioner or an intern;
 - (f) except in accordance with the provisions of the Medicines and Related Substances Act, 1965, the Pharmacy Act, 1974, the Health Act, 1977, the Nursing Act, 1978, the [Associated] Chiropractors, Homeopaths and Allied Health Service Professions Act, 1982, and sections 33, 34 and 39 of this Act, by words, conduct or demeanour holds himself or herself out to be able, qualified or competent to diagnose, treat or prevent physical defects, illnesses or deficiencies in man or to prescribe or supply any medicine, substance or thing in respect of such defects, illnesses or deficiencies; or
 - (g)
 - (i) diagnoses, treats or offers to treat, or prescribes treatment or any cure for, cancer;
 - (ii) holds himself out to be able to treat or cure cancer or to prescribe treatment therefor; or
 - (iii) holds out that any article, compound, medicine or apparatus is or may be of value for the alleviation, curing or treatment of cancer, shall be guilty of an offence and on conviction liable to a fine or to imprisonment for a period not exceeding twelve months or to both such fine and such imprisonment.



for practising as a psychologist or as an intern-psychologist, or for performing certain other acts, while unregistered are provided for in section 37 while section 38 provides for penalties for practising as a dentist, or for performing certain other acts, while unregistered. Section 39 prohibits the performance for gain of certain acts deemed to pertain to other health professions by unregistered persons registrable in terms of the Health Professions Act¹⁰⁷.

The Rules Specifying the Acts or Omissions In Respect of Which Disciplinary Steps May Be Taken By and Professional Board and the Council¹⁰⁸ state that one of the acts by a practitioner in respect of which such steps can be taken is the performance, except in an emergency, of professional acts for which the practitioner is inadequately trained and/or insufficiently experienced, and/or under improper conditions and/or in improper surroundings.

Section 27 of the Nursing Act¹⁰⁹ contains similar provisions in respect of persons practising as registered nurse, midwife, enrolled nurse or nursing auxiliary or for performing certain other acts while not registered or enrolled.¹¹⁰

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

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

¹⁰⁹ Nursing Act fn 13 *supra*

¹¹⁰ Section 27 specified that:

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

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

It is clear from the foregoing that -

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

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

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

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

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

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

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

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

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

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

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

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

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

Claassen and Verschoor¹¹¹ observe that the question often arises whether a practitioner can be held liable for the conduct of physicians nurses and professional assistants employed by a hospital authority but who are assisting the independent practitioner in the treatment of his patients on the hospital premises. Are the said staff members in such an even still regarded as employees of the hospital or are they regarded as servants of the independent practitioner *pro hac vice*? They note that according to Holder, a surgeon is not liable for the negligent routine conduct performed by the hospital staff in preparing a patient for an operation. They same goes for the conduct of hospital staff after the completion of an operation because the surgeon can reasonably accept that they are competent to perform their duties. A surgeon can however, be held directly responsible where he leaves negligent instructions regarding the post-operative care of a patient to the hospital staff. Claassen and

¹¹¹ Claassen and Verschoor fn 5 *supra*

Verschoor¹¹² note that some American courts have applied the so-called *captain of the ship doctrine* in order to resolve some of the issues raised above. According to this doctrine, the surgeon is responsible for everyone who assists him during an operation. It was argued that the surgeon, as captain of the ship, exercised absolute control over every aspect of a particular procedure. They note that the captain of the ship doctrine was finally sunk in *Sparger v Worley Hospital Inc*¹¹³ when the court remarked:

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

It is the view of the writer that this is a doctrine well sunk and that it has no place in South African law. Claassen and Verschoor also discuss the borrowed servant doctrine which acknowledges the fact that a particular employee can be borrowed by one employer from another to perform a certain task which is in the interests of both employers and influences their common objectives. They note that Strauss and Strydom point out that the idea of borrowed servants was introduced to South African law in the decision of *Hartl v Pretoria Hospital Committee*¹¹⁴ but that it was rejected unambiguously in *Van Wyk v Lewis*¹¹⁵ by ruling that a visiting surgeon was not liable for the failure of a hospital nurse to perform an independent duty. They note that according to Burchell and Schaffer¹¹⁶ the relationship between a surgeon and a nurse cannot be equated to that existing between an employer and employee and it is not even analogous thereto even if the nurse may have been under the control of the surgeon during the operation. These authors contend that although the nurse is under the control of the physician during the performance of the operation, the hospital never turns over its full right to exercise control over its employees to an independent practitioner. The nurse remains in the hospital's employment and

112 Claassen and Verschoor fn 5 *supra*

113 *Sparger v Worley Hospital Inc* 547 SW 2d 582 Tex 1977

114 *Hartl* 1915 TPD 336

115 *Van Wyk* fn 24 *supra*

116 Burchell JM and Shaffer RP 1977 'Liability of Hospitals for Negligence' *Businessman's Law* 6(4): 109-111

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

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

8.2.9 *Pringle v Administrator, Transvaal*¹¹⁷

Facts

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

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

¹¹⁷ *Pringle* 1990 (2) SA 379 (W)

- (i) the plaintiff's superior vena cava was torn during the course of the operation;
- (ii) the medical practitioners failed to detect the tear in the plaintiff's superior vena cava at a time when they could and should have done so;
- (iii) they failed to appreciate that the tumour being removed was attached to the superior vena cava and that its removal could result in the severing of the vena cava unless special precautions were taken;
- (iv) they failed to test whether the removal of the tumour would result in excessive loss of blood under circumstances in which they could and should have done so;
- (v) they failed to detect that the plaintiff was losing an excessive amount of blood at a time when they could and should have done so;
- (vi) they failed to avoid the consequences which resulted when, by the exercise of reasonable care and skill, they could and should have done so;
- (vii) that, once haemorrhaging occurred during the operation, they failed to proceed immediately with sternotomy or right thoracotomy in order to stabilise and prevent further or recurrent bleeding.

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

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

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

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

- (a) Loss of earnings at R950 per month for a period of seven years -R77228
 - (b) General damages for pain and suffering, shock, loss of amenities of life and disablement - R20000
- Total- R97 228

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

- (a) Dr Schewitz performed the bronchoscopy and mediastinoscopy by himself in the presence of two anaesthetists.
- (b) Dr Scoccianti and Dr Sishy were present at the second operation and Dr Conlan came into the theatre when the mediastinum was packed.
- (c) The defendant admitted the operation report prepared by Dr Schewitz dated 5 October 1984 without formal proof, as also the operation record.
- (d) It was admitted by the defendant that the plaintiff's superior vena cava was torn during the initial operative procedure, i.e. the mediastinoscopy.
- (e) It was also admitted that the plaintiff suffered brain damage as a result of the operation.
- (f) It was admitted that the thoracotomy was commenced at approximately 12:30 and was concluded at approximately 13:30.
- (g) The defendant was prepared to admit the correctness of the actuarial calculations done by Mr G W Jacobson but was not prepared to admit the correctness of the assumptions on which such calculations were based.
- (h) The defendant admitted that the X-rays were taken in the resuscitation room at some time between 12:10 and 12:30.

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



- (i) The patient had a previous history of carcinoma.
- (ii) The patient presented with opacity of the right lung.
- (iii) An investigation of the mass of the right lung was necessary.
- (iv) There was no unanimity amongst the medical experts in regard to which procedure should have been followed. The type of operation to be performed is a matter of personal choice for the surgeon performing the operation.
- (v) During the course of the mediastinoscopy procedure performed by Dr Schewitz, the patient's superior vena cava was torn as a result of which torrential bleeding occurred.
- (vi) The mediastinum was packed. The plaintiff lost approximately two litres of blood, and a right thoracotomy was performed to repair the damaged vena cava.
- (vii) After the mediastinum was packed there was a time-lag before the thoracotomy was performed. There was a dispute between the medical experts on the reasonableness of the delay which occurred between the first and second operative procedures.
- (viii) The plaintiff went into renal failure and suffered localised brain damage which has resulted in a permanent visual disability.

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

Judgment

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

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

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

118 *Van Wyk* fn 24 *supra*

119 *Whitehouse* [1981] 1 All ER 267 (HL)

120 *Bolam* [1957] 2 All ER 118 at 121

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

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

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

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

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

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

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

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

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

¹²² *Van Wyk* fn 24 *supra* at p 452

of clinical judgment? Referring to the *Whitehouse* case¹²³ *supra*, Blum AJ noted that Lord Edmund Davies said:

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

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

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

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

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

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

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

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

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

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

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

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

Discussion

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

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

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

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



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

In light of the fact that the test for medical negligence is the general principal that the highest degree of professional skill and knowledge is not required of a medical practitioner but only a reasonable level of knowledge and skill, Carstens¹²⁶ poses the question whether a medical practitioner who entertains a different school of thought concerning the medical treatment that should be applied would be negligent if he deviates from the generally accepted technique used by other medical practitioners in operations or treatment. He says it can also be asked what the position would be if there is more than one school of thought in respect of the type of treatment that a patient ought to receive. Carstens notes that in South African positive law direct authority could not be found concerning the concept of different schools of thought within medical practice and its influence on medical negligence. Carstens asks whether, if there is more than one school of thought concerning the nature of the treatment a patient ought to receive, is the doctor bound to that standard of practice which is applied by practitioners of that school of thought to which he subscribes? He refers to *Kovalsky v Krige*¹²⁷ in which a doctor tried to stop the bleeding following on from a circumcision by using ferrous chloride and other doctors gave evidence that they would have used other methods – specifically the use of arterial clamping and tying off. The defendant doctor was not held liable in this case. With regard to the decision in *Pringle*, he notes that the choices between different diagnostic techniques came into the debate. The court in this case had to rely heavily on expert medical testimony and in the pretrial conference there was no agreement between the medical experts as to the process or method that should have been used. It was agreed that the surgeon who had to do the operation could exercise his own personal preference concerning the execution of the operation. The court came to the conclusion that the plaintiff had not discharged the onus of proving that the surgical method or technique used by the surgeon was an incorrect or unsuitable procedure. In Carstens' opinion the

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

¹²⁷ *Kovalsky* 1910 CTR 822

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

8.2.10

Collins v Administrator, Cape¹²⁸

Facts

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

¹²⁸ *Collins* 1995 (4) SA 73 (C)

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

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

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

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

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

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

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



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

Judgment

The question was whether the failure on the part of the hospital staff promptly to replace the tracheostomy tube amounted to negligence in the circumstances. It is trite law, said Scott J, that a patient in a hospital is entitled to be treated with due and proper care and skill. The degree of care and skill that is required is that which a reasonable practitioner would ordinarily have exercised in South Africa under similar circumstances¹²⁹. The court observed that the need for particular care and vigilance in the case of paediatric tracheostomy patients was obvious. Not only was the possibility of accidental decannulation readily foreseeable, but unless immediately remedied the consequences would be fatal. This need for care and vigilance was reflected in the staff allocated to the tracheostomy unit. The court noted that there were undoubtedly other similar units elsewhere in the world where the staff to patient ratio is higher but that a standard of excellence cannot be expected which is beyond the financial resources of the hospital authority. It accepted as reasonable a staff allocation of two nurses to each room of the unit with an overseeing sister during the day and

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

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

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



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

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

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

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

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

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

It followed, said the court that it was of no consequence to Lee-Ann what amount, if any, was awarded to her in respect of non-pecuniary damages. Not only would she never know of the award, she would receive no benefit from it whether knowingly or unknowingly. As counsel for the defendant poignantly put it, 'one cannot even buy her a teddy bear'. Scott J stated that there was something unreal in attempting to compensate her. He said it was like trying to compensate a dead person with money. He observed that had she not been resuscitated and had she died, her claim for non-pecuniary damages would have died with her. It would not have passed to her estate¹³⁰. In truth, said Scott J, she was more dead than alive. Her body continued to function, but her mind was gone. Her parents seldom visited her. Their failure to do otherwise, he said, was understandable. There was nothing to visit. He noted that Lee-Ann merely existed, lying in hospital waiting for her tenuous link with this world to be finally severed. Counsel for the defendant, submitted that as no award of non-pecuniary damages would serve any purpose, it would be proper in all the circumstances for no award to be made under this head.

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

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

¹³¹ *Wise* [1962] 1 All ER 257 (CA)

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

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

¹³² *West* [1963] 2 All ER 625 (HL)

¹³³ *Lim Poh Choo* [1979] 2 All ER 910 (HL)

¹³⁴ *Sigournay* 1960 (2) SA 552 (A)

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

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

¹³⁵ *Benham* [1941] 1 All ER 7 (HL)

¹³⁶ *Skelton* (1966) 115 CLR 94



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

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

¹³⁷ *Gerke* 1966 (3) SA 484 (W)

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

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

In support of the award under this head, Ludorf J in *Gerke* also referred to *Goldie v City Council of Johannesburg*¹³⁹ and *Dickinson v Galante*¹⁴⁰. Scott J said that it appears from the passages quoted that in the former case counsel for the plaintiff disavowed any specific claim for shortened expectation of life along the lines of that accepted in *Benham v Gambling (supra)*, and in the latter case Thomas J rejected the notion of a claim for diminished expectation of life *per se*. In the third case cited, *Roberts NO v Northern Assurance Co Ltd*¹⁴¹, Scott J notes that Burne J appears to have accepted the existence of a claim for the objective loss of life expectation on the basis of what was said by Lord Morris in the *H West & Son* case without further ado¹⁴². The other aspect of the award in *Gerke* upon which Scott J commented was that Ludorf J appears to have accepted the minority view in the *H West & Son* without alluding to that fact.

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

¹³⁹ *Goldie* 1948 (2) SA 913 (W)

¹⁴⁰ *Dickinson* 1949 (3) SA 1034 (SR)

¹⁴¹ *Roberts* 1964 (4) SA 531 (D)

¹⁴² Luntz H'Damages in cases of Brain Injury - Some Developments' (1967) 84 *SALJ* at p 6 also criticises the decision in *Gerke*

¹⁴³ *Reyneke* 1991 (3) SA 412 (W)

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

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

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

¹⁴⁴ *Bailey* 1984 (1) SA 98 (A)

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

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

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

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

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

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

‘This Court has never attempted to lay down rules as to the way in which the problem of an award of general damages should be approached. The accepted approach is the flexible one described in the often quoted statement of Watermeyer JA in *Sandler v Wholesale Coal Suppliers Ltd* 1941 AD 194 at 199: “The amount to be awarded as compensation can only be determined by the broadest general considerations and the figure arrived at must necessarily be uncertain, depending upon the Judge's view of what is fair in all the circumstances of the case.”

I do not think that we should now adopt a different approach. To do so might result in injustice of the kind referred to in Lord Scarman's speech in the *Lim Poh Choo* case.

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

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

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

not punitive, it is compensatory. There is accordingly no basis in our law for an approach such as that adopted in Germany where a nominal award, it would seem, is made to reflect society's demand that some retribution be made for the injustice done to the plaintiff. The same is true of Professor Boberg's suggestion that the courts continue to award a 'nucleus of damages for loss of amenities of life to the unconscious plaintiff a la Gerke' so as to enable 'the law to express society's sympathy with the victim and its sense of outrage at his grievous loss' or the solution offered by Visser and Potgieter Law of Damages at 96, that the award serve as a 'symbolic reparation of the damage' and 'to effect retribution for the injustice, and to soothe the community'. To adopt such a 'solution' would be to import into our modern delictual action a penal element for which, in the view of Scott J there is no justification¹⁴⁶.

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

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

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

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

Discussion

This decision is controversial in the sense that there is a feeling that the award in damages does not sufficiently recognise or acknowledge the extent of the loss sustained. Whilst the logic that damages awarded in terms of the law of delict are compensatory and that therefore the extent to which the plaintiff is able to experience the loss must be taken into account is perfectly understandable there is somehow an absence of satisfaction that justice has been done. Possibly the problem is that this approach is too utilitarian¹⁴⁷. Its basis in cold hard logic does not accord with the general sense of the value of human life and the fact that if one cannot exercise the right to life none of the other rights have any meaning. Although it could be argued that biologically those in a persistent vegetative state are still alive in medical and legal terms, the court in *Clarke v Hurst*¹⁴⁸ argued convincingly that for all other purposes they are not. The question then

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

Acocella N in 'Theories of Justice: Social Conditioning and Personal Responsibility in Roemer's Contribution' (<http://host.uniroma3.it/progetti/csei/comunicazioni/justice.pdf>) points out that: "Theories of justice differ essentially because of different visions, i.e., the intertwining of value judgments and analytic elements concerning the way human 'systems' work (from an economic, social, psychological and biological point of view). Differences in the system of value judgments are thus one of the two causes of divergences in theories of justice."

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

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

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

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

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

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

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

useful. There is no point in transferring resources to a person who has no need of or use for, them. In the context of *Collins*, it is a highly persuasive argument in a country where health care services in the public sector are significantly under-resourced. In terms of traditional legal reasoning, it is not the calculation of damages that is influenced by public policy – only the element of wrongfulness¹⁴⁹. Even in cases where wrongfulness is proven, this on its own is

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



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

In discussing the concept of justice in relation to health Kolm¹⁵⁰ notes fairness about health gives rise to innumerable considerations in the field of health care. At a more global level, he says, there is a tradition of concern about fairness and health induced by the correlations between health and socio-economic status. He notes that the field of conceptual justice is neither the application of a simplistic universal principle (or bundle of a few principles), nor an amorphous heap of *ad hoc* criteria found and applied according to intuition. It is a structured, rational, deductive construct starting from necessary concepts, properties and distinctions and unfolding to applications. A basic issue is whether justice about a particular good, such as health, makes sense, or whether justice should be considered globally. Kolm makes the point that concerning health, the answer is both ambivalent and special because of the particular importance it can have.

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

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

150

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



practical mechanisms for the achievement of justice in other areas of law. In health care the utilitarian approach is particularly problematic and is not generally supportive of constitutional values¹⁵¹. Why should one not allow poor people to sell their organs if it this will improve their lives? Why should they not be able to sell blood and gametes? After all these things are a resource which they possess and upon which others place value. Why should unemployed people who contribute nothing to the economy who have AIDS be treated with expensive antiretroviral drugs if it is cheaper simply to let them die? Of what value to society are their lives? By prolonging their lives one is simply giving them greater opportunity to create AIDS orphans who will become a growing and unnecessary burden on already overstretched state resources. Are such lives of any greater value to society than the life of the baby in *Collins*?

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

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

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

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

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

8.2.11 *C v Minister of Correctional Services*¹⁵³

Facts

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

¹⁵² *Reyneke* fn 143 *supra*

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

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

Judgment

Kirk-Cohen J observed that consent is a defence to many acts which would otherwise be a delict. An obvious example is consent to surgery and that in recent years the concept that consent must be 'informed consent' has found favour with South African courts. In regard to surgery, he noted that informed consent postulates full knowledge of the risks involved and, after being made aware thereof by the surgeon, the patient is then entitled to exercise his fundamental right to self-determination. He referred to *Seetal v Pravitha and Another* NO¹⁵⁴ where it was stated in the headnote that a blood test on an adult without his consent is unquestionably an invasion of his privacy. On the other hand, the privacy of the individual is not in law absolutely inviolable. The debate about compulsory blood tests amounts to a showdown between the idea that the truth should be discovered whenever possible and the idea that personal privacy should be respected. Both ideas are important but neither is sacrosanct. The resolution of that debate will depend largely upon the store the Court sets by each idea, on its own sense of priority in that regard. Kirk-Cohen J noted that since the decision in *Seetal*, and with the ever growing scourge of the HIV virus and Aids, much thought has been given to what the minimum requirements of consent, with particular reference to blood tests for the HIV virus, should be. This too has been referred to almost universally as informed consent. He observed that speaking generally, it is axiomatic that there can only be consent if the person appreciates and understands what the object and purpose of the test is, what an HIV positive result entails and what the probability of AIDS occurring thereafter is. Evidence was led in this case on the need for informed consent before the HIV test is performed. Members of the medical profession and others who have studied and worked with people who have tested HIV positive and with Aids sufferers have developed a norm or recommended minimum requirement necessary for informed consent in respect of a person

¹⁵⁴ *Seetal* 1983 (3) SA 827 (D)

who may undergo such a blood test. Because of the devastation which a positive result entails, the norm so developed contains as a requirement counselling both pre- and post-testing, the latter in the event of a positive result. These requirements have become almost universal in the Republic of South Africa. The judge quoted from the manual prepared by the Department of Correctional Services as to the protocol to be followed before testing a prisoner for HIV¹⁵⁵. It was admitted that this was the standard in all prisons. He observed that he was not called upon to adjudge what the requirements of consent or informed

¹⁵⁵ The manual was entitled "Management Strategy: AIDS in Prisons." The parts quoted by the court are reproduced below for the sake of convenience and to indicate the procedures that should be followed in order for consent to be informed in the case of HIV tests. The court noted that the Department of Correctional Services had itself adopted the concept that informed consent is a prerequisite for testing prisoners and had specified what the norms are. It noted that they were in accord with the views and suggestions of all major contributors in the country.

Paragraph 2.2 reads as follows: "Possible HIV infected persons: Once a person has been exposed to HIV (by high-risk behaviour) he/she can contract the HIV infection. For a period of three weeks to six months, blood tests can be negative and this person will show no signs or symptoms of the disease. This is known as the window period. During this period an infected person can pass on the virus to another person. For this reason the person is considered to be HIV infected and must be treated in the same manner as a positive HIV infected person."

Paragraph 5 provides: "Pre- and post-test counselling to prisoners who are/were involved in high-risk behaviour prior to admission: All individuals who are identified as being involved in high-risk behaviour should be counselled. Pre- and post-test counselling is of the utmost importance and should be done by a competent member (see Counselling to Prisoners point 14). Informed consent must be obtained from a prisoner prior to an HIV antibody test being administered. If the prisoner refuses permission for the tests to be done, it must be brought under (sic) the attention of the medical officer."

The relevant paragraph, or as it is here called 'point 14', reads as follows:

"14. Counselling to Prisoners

14.1 Pretest: potentially HIV infected persons. A prisoner may experience anxiety if he believes he may be HIV infected. The purpose of pretest counselling is to ensure that the prisoner is aware of: what HIV infection means, and is prepared for the progress of the infection; the manner of transmission of the disease and that high-risk behaviour must be avoided; the nature of the test and that his/her consent is required before the test can be administered; the social, psychological and legal implications of the test; and what is to be expected should the result of the test prove positive. The prisoner must be persuaded to avoid high-risk behaviour should the test be negative. The prisoner must also receive information to avoid the spreading of the disease if he is HIV infected. With the above information the prisoner could more readily give his permission for the test to be administered. However, the prisoner must be granted time to consider the information before he gives his permission for the test to be administered. Should the blood tests return a positive result the prisoner may be less shocked if he received pretest counselling.

14.2 Post-test counselling: negative blood test result. Should the blood test return a negative result, the prisoner will most likely feel relieved and happy. This is a crucial time during which to inform the prisoner: that he must understand that prior to the test he was engaged in high-risk behaviour, and that his behaviour has to change; that a second test will have to be administered after three months to ensure that the result remains negative. The virus can be inactive for three months while tests are negative. This is known as the window period. During this time spreading of the infection can take place while the infected person is not aware of his infection. That he may need the help of a psychologist or social worker to help him/her to change his behaviour.

14.3 Post-test counselling: positive blood test results. Comprehensive counselling to prisoners who are informed that their blood tests have proved positive is vitally important. Whereas some prisoners will be relieved to know that they are HIV-infected, others will be shocked to realise that they are infected. Psychologists, social workers and nursing staff should be at hand to support the prisoner and to provide advice so that the result can be accepted. Counselling must therefore be geared towards: helping the prisoner to accept the result; giving the prisoner guidance as regards breaking the news to relatives; giving advice as to the persons to whom the prisoner should disclose his condition; conveying the implications of any further pregnancies; convincing the prisoner that he/she can carry on with a normal life, as they are only HIV-infected and do not as yet have AIDS; signs and symptoms can take up to 10 years to manifest themselves; and convincing the prisoner to avoid high-risk behaviour, thus preventing the further spreading of the disease."

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

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

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

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

¹⁵⁶ *Whittaker* 1912 AD 92.



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

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

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

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

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

Discussion

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

¹⁵⁸ *Jansen van Vuuren* 1993 (4) SA 842 (A)

¹⁵⁹ *Castell* 1993 (3) SA 501 (C); 1994 (4) SA 408 (C)

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

In the broader medical context this case has firmly established that ill-will or spite is not a prerequisite to establish the *animus injuriandi* necessary to ground an action for *injuria* in cases involving a lack of informed consent. It is important to distinguish the question of the invasion of privacy from that of the failure to obtain informed consent. It was, it is submitted, rather more the circumstances in which the consent was purportedly obtained¹⁶⁰, than the failure to obtain adequate informed consent that grounded the claim for *injuria*. Indeed the court found that the plaintiff had known of the purpose of the test, that he did *de facto* consent when he was told what the test was for and that he had a

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

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

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

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

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

The failure to obtain informed consent will not necessarily amount in every case to an invasion of privacy. The problem in the present case was that the circumstances in which the informed consent was sought did not sufficiently recognise or protect the right of the plaintiff to privacy. It is submitted that in circumstances where the patient is unable to ensure that her surroundings are suitably private and that intimate conversations cannot be overheard by others, for example because she is confined to a hospital bed in an open ward, there is a responsibility upon those who can control the patient's environment to ensure that there is sufficient protection and respect for the patient's right to privacy. For example, it would be inadvisable to adopt the view that because a patient is not in a private ward, he or she has given up the right to privacy¹⁶¹. A patient's right to privacy in a health institution can be invaded in many ways. Allowing a patient to be questioned by the press as to his or her condition or giving

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

information to the press about a patient without his or her consent¹⁶² or allowing a patient to be photographed¹⁶³ when he or she is not in a position to take steps

162

In *National Media Ltd and Another v Jooste* (fn 27 *supra*) Harms JA quoted the following words by Warren and Brandeis 'The Right to Privacy' (1890) 4 *Harvard Law Review* 193: and noted that they were well said: "The press is overstepping in every direction the obvious bounds of propriety and of decency. Gossip is no longer the resource of the idle and of the vicious, but has become a trade, which is pursued with industry as well as effrontery. To satisfy a prurient taste the details of sexual relations are spread broadcast in the columns of the daily papers. To occupy the indolent, column upon column is filled with idle gossip, which can only be procured by intrusion upon the domestic circle. The intensity and complexity of life, attending upon advancing civilisation, have rendered necessary some retreat from the world, and man, under the refining influence of culture, has become more sensitive to publicity, so that solitude and privacy have become more essential to the individual; but modern enterprise and invention have, through invasions upon his privacy, subjected him to mental pain and distress, far greater than could be inflicted by mere bodily injury. Nor is the harm wrought by such invasions confined to the suffering of those who may be made the subjects of journalistic or other enterprise. In this, as in other branches of commerce, the supply creates the demand. Each crop of unseemly gossip, thus harvested, becomes the seed of more, and, in direct proportion to its circulation, results in a lowering of social standards and of morality. Even gossip apparently harmless, when widely and persistently circulated, is potent for evil. It both belittles and perverts. It belittles by inverting the relative importance of things, thus dwarfing the thoughts and aspirations of a people. When personal gossip attains the dignity of print, and crowds the space available for matters of real interest to the community, what wonder that the ignorant and thoughtless mistake its relative importance. Easy of comprehension, appealing to that weak side of human nature which is never wholly cast down by the misfortunes and frailties of our neighbours, no one can be surprised that it usurps the place of interest in brains capable of other things. Triviality destroys at once robustness of thought and delicacy of feeling. No enthusiasm can flourish, no generous impulse can survive under the blighting influence."

In that case the issue was whether the appellants (the publisher of two weekly magazines, the *Huisgenoot* and *You*, and the news editor of the former) had wrongly breached the respondent's right to privacy by publishing details of private affairs for 'public delectation' (Melius de Villiers *The Roman and Roman-Dutch Law of Injuries* (1899) at 138 n 32). These magazines have the identical content, the one in Afrikaans and the other in English. The court in its judgment observed that: "The respondent had decided to make the private facts concerning her relationship with Botha public. This decision contracted her right to privacy because she no longer had the wish to keep these facts secret. The publication of the article could therefore not impinge on her right to privacy. This submission is unsound because it attaches no value to the agreement between the parties. As indicated, her willingness to reduce the compass of her privacy was subject to specific conditions or terms and they have not been complied with. That, according to Mr Burger, is beside the point because the cause of action is not one based upon a breach of contract. The response, I fear, is too simplistic. A right to privacy encompasses the competence to determine the destiny of private facts (see Neethling's comment on the judgment of the Court *a quo*: (1994) 57 *THRHR* 703 at 706). The individual concerned is entitled to dictate the ambit of disclosure, for example to a circle of friends, a professional adviser or the public (cf *Jansen van Vuuren and Another NNO v Kruger* 1993 (4) SA 842 (A); Neethling *Persoonlikheidsreg* 3rd ed at 238-9). He may prescribe the purpose and method of the disclosure (cf the facts in *O'Keeffe v Argus Printing and Publishing Co Ltd and Another* 1954 (3) SA 244 (C)...). Similarly, I am of the view that a person is entitled to decide when and under what conditions private facts may be made public. A contrary view will place undue constraints upon the individual's so-called 'absolute rights of personality' (*Minister of Justice v Hofmeyr* 1993 (3) SA 131 (A) at 145I). It will also mean that rights of personality are of a lower order than real or personal rights. These can be limited conditionally or unconditionally and irrespective of motive. The appeal was dismissed with costs.

In *Bernstein And Others v Bester and Others NNO* 1996 (2) SA 751 (CC) the constitutional court noted that: "In *Financial Mail (Pty) Ltd and Others v Sage Holdings Ltd and Another* [1993(2) SA 451 (A)] it was held that breach of privacy could occur either by way of an unlawful intrusion upon the personal privacy of another, or by way of unlawful disclosure of private facts about a person. The unlawfulness of a (factual) infringement of privacy is adjudged 'in the light of contemporary *boni mores* and the general sense of justice of the community as perceived by the Court'. Examples of wrongful intrusion and disclosure which have been acknowledged at common law are entry into a private residence, [*S v I and Another* 1976 (1) SA 781 (RA); *S v Boshoff and Others* 1981 (1) SA 393 (T)] the reading of private documents [*Reid-Daly v Hickman and Others* 1981 (2) SA 315 (ZA)], listening in to private conversations [*S v A and Another* 1971 (2) SA 293 (T)], the shadowing of a person [*Epstein v Epstein* 1906 TH 87], the disclosure of private facts which have been acquired by a wrongful act of intrusion, [eg *Financial Mail (Pty) Ltd and Others v Sage Holdings Ltd and Another supra*] and the disclosure of private facts contrary to the existence of a confidential relationship. [Neethling *Persoonlikheidsreg* at 234 -8; Neethling, Potgieter and Visser *Law of Delict* at 334] (Footnotes omitted)

163

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



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

8.2.12 *Silver v Premier, Gauteng Provincial Government*¹⁶⁴

Facts

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

164

Silver 1998 (4) SA 569 (W)

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

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

- (a) The plaintiff is and was a diabetic. His circulation and the perfusion (movement of blood through the tissues) in his skin would be impaired as a result.
- (b) The plaintiff had to be dialysed, which was done peritoneally (i.e. catheters were inserted into the abdominal cavity to circulate fluid). This gave rise to the risk that there would be a fluid leak and that the skin on which the plaintiff was lying would become wet.



- (c) The plaintiff had a temperature. This would result in the plaintiff sweating and the skin on which he was lying would become moist.
- (d) The plaintiff had to be intubated (i.e. a tube had to be inserted down his throat) so that he could be coupled to a respirator. To enable this to be done, the plaintiff had to be sedated - with the consequence that he was unable to move himself naturally.
- (e) The plaintiff weighed, on his own evidence, approximately 87 kilograms.
- (f) The plaintiff was treated with inotropic drugs and he was hypotensive. Each of these factors would in itself reduce the perfusion of blood in, *inter alia*, the skin.

Judgment

Cloete J observed that if the submissions made by the defendant's counsel were correct, then, accepting the plaintiff's hypothesis that the infection causing his disability could spread from a sacral bedsore, and if, in addition, such a bedsore is likely to have become a source of such an infection despite proper nursing care, the plaintiff cannot succeed in his claim based in delict as the factual test for causation would not have been satisfied¹⁶⁵. The court said that it was aware

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

that the plaintiff's claim was founded in contract and, in the alternative, in delict but said that it saw no reason why the *sine qua non* test should not apply equally to the contractual claim. The loss sustained by the plaintiff was said to have been caused by the breach of an implied term of an agreement that the hospital through its staff and employees would exercise due care, skill and diligence in providing nursing care. Precisely the same facts were relied upon as constituting a breach of the implied term as are relied upon as constituting a breach of the duty of care owed to the plaintiff. Thus said the court, it would be anomalous if the same result did not follow irrespective of the cause of action. Furthermore, the court held that although the question of remoteness of damage for breach of contract was approached (in the absence of a contractual stipulation as to the basis on which compensation is to be made) by determining whether the damage flowed naturally and directly from the defendant's breach or was such a loss as the parties contemplated might occur as a result of such breach¹⁶⁶, it must follow as a matter of logic that as a general rule, the test for factual causation would first have to be satisfied. Cloete J held that on the evidence, it seemed that if the plaintiff developed pressure sores where the skin was breached, as he did on his occiput and heels, despite adequate care in the ICU, he would, on the probabilities, have developed a bedsore at least as serious in the area which was at greatest risk and where bedsores occur most frequently, namely, the sacrum. Cloete J said he found it probable that the sacral bedsore which the plaintiff was likely to have developed anyway, would not have remained very superficial and that it would not have been fairly easy to manage and recoup the situation. He said that on the probabilities, the polymicrobial invasion would have taken place. The fact that other bedsores (those to the head and ankle) healed without complications, did not derogate from this conclusion, as those other bedsores, because of their location, were much less susceptible to contamination by fecal flora. The court held that assuming that the pressure sore on the plaintiff's sacrum was caused by the negligent omission of the nursing staff in the general surgical ward to give proper pressure part care (a question which it found

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

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

Discussion

This case involved the question of causation and whether the harm complained of would have arisen whether or not the nursing staff were negligent in caring for the patient. The court said that if the answer to this question was in the affirmative then there was no need even to consider whether or not the nursing staff had in fact been negligent in caring for the patient since the defendant could not be held liable for harm which would have occurred in the absence of his negligent and wrongful acts or omissions. The reason behind this approach is evident from the debates concerning alternative causes and the approach of the South African law of delict to the effect that the defendant is not liable unless his conduct in fact caused the plaintiff's harm¹⁶⁷. If there is another factor present which would independently of the defendant have in any event caused the harm then causation cannot be attributed to the acts or omissions of the defendant. It is of significance that the court observed that it saw no reason why the *sine qua non* test for causation should not be applied to the contractual claims as well. The *sine qua non* test is a test for factual as opposed to legal causation¹⁶⁸. In *Silver* the court made mention of the problem of alternative causes but was of the opinion that Silver's case was not so exceptional that the

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

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

sine qua non tests for factual causation could not be applied¹⁶⁹. The court did not go into the question of negligence of the nurses in that case because it found an alternative cause for the patient's injuries that would have ousted the alternative cause of any negligence acts or omissions on the part of the nurses. Had the nurses in fact been negligent, the *sine qua non* test would in any event not have been satisfied and the defendant could not have been held liable.

Delictual liability for alternative causes is a subject that occupied the minds of Roman jurists and continues to occupy the minds of South African jurists¹⁷⁰. The

¹⁶⁹ At p 575 – 576 of the judgment the court observed as follows with regard to the *sine qua non* test: "There will, of course, be exceptions, such as that cited by Visser and Potgieter in *Law of Damages* (1993) para 6.3.2 at 80–1: '(W)here a building contractor X is not able to build because Y, who has to deliver cement, and Z, who has to supply bricks, both fail to honour their contractual obligations on the same day and thus cause damage to X (eg he loses profit). According to the *conditio sine qua non* "test", neither Y nor Z has caused damage since, if the breach of contract of each is notionally eliminated, the damage does not fall away!"

The learned authors express the view that common sense must be employed in such cases - an approach emphasised by Corbett JA in *Siman's* case at 917 *in fine*–918A and employed by Lord Wright in *Yorkshire Dale Steamship Co Ltd v Minister of War Transport* [1942] AC 691 (HL) at 706 ([1942] 2 All ER 6) and by Beadle CJ in *Portwood v Svamvur* 1970 (4) SA 8 (RA) at 15F–G. The present is not, however, an exceptional case. In conclusion, on the applicability of the 'but for' test for causation, I would refer to the following passage in the unreported judgment (which I feel obliged to say I gave but in which Labuschagne J concurred) in *Aahwyn J Bezuidenhout and Another v Willie J Jacobus Rossouw h/a Riviera Eiendomme* (WLD, case No A3010/97, delivered on 15 May 1997): 'Gewoonlik waar daar bepaal moet word of 'n sekere gevolg deur die optrede of versuim van een van die partye regtens veroorsaak is, moet daar gekyk word na 'n verskeidenheid van faktore wat 'n waardebeeping deur die Hof verg. Die vraag of die eerste bekendstelling van die eiendom die eintlike verkooptransaksie veroorsaak het, is geen uitsondering nie. In *Aida Real Estate Ltd v Lipschitz* 1971 (3) SA 871 (W) te 873H–874D het Marais R die volgende gesê: "The law with regard to a matter of this kind is usually stated in the following form: The duty of the estate agent, if he is to earn remuneration by way of commission for selling property, is to introduce to his principal (the seller) a purchaser who is willing and financially able to buy the property, and he earns the commission if a sale is concluded with that purchaser at the stipulated price or a price ultimately proved to have been acceptable to the seller. A proviso has been added to the effect that the introduction of the able and willing buyer must have been the effective cause or *causa causans* of the sale. If a new factor intervenes causing or contributing to the conclusion of the sale and the new factor is not of the making of the agent, the final decision depends on the result of a further enquiry - viz, did the new factor outweigh the effect of the introduction by being more than or equally conducive to the bringing about of the sale as the introduction was, or was the introduction still overridingly operative? Only in the latter instance is commission said to have been earned. This enquiry is not a metaphysical speculation in the result of cause and effect. It requires, as is said in *Webranchek v L K Jacobs and Co Ltd* 1948 (4) SA 671 (A), a commonsense approach to the question of what really caused the sale to be concluded, or, to put it differently, as it is said in a restatement of the law in America, whether it is 'just' that the agent should receive credit and compensation for the work he has done for the seller. In regard to this latter version, it may be said in passing that this question has nothing to do with the amount of work the agent put into it. The mere furnishing to the prospective buyer of the principal's address or the location of the property offered may be sufficient to entitle him to claim commission from the seller, provided a line of cause and effect can reasonably be traced from the introduction to the conclusion of the sale.'

Die woorde wat ek gekursiveer het, is belangrik. Dit moet nooit uit die oog verloor word nie dat voordat die gewone vraag (soos in *Aida Real Estate v Lipschitz* (supra) uiteengesit) ontstaan, daar hier - soos in enige ander situasie waar oorsaaklikheid bepaal moet word - eers aan die *sine qua non* (ofte wel "but for") toets voldoen moet word. Met ander woorde, as daar nie gesê kan word dat, was dit nie vir die agent se optrede nie, die gevolg (verkoop van die eiendom) nie sou ingetree het nie, kan die optrede van die agent nooit as oorsaak van die verkooptransaksie bestempel word nie. Andersom gestel, as die verkooptransaksie sou plaasgevind het afgesien van enigiets wat die agent gedoen het, is die agent nie (ingevolge die gewone kontrak tussen 'n agent en die eienaar) op kommissie geregtig nie."

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



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

of Earlsferry notes that: "D 9 2 51 Julian 86 *digesta* contains a substantial extract from one of the most important works on Roman law, written in the second century AD, the high classical period of Roman law. In the *principium* Julian is discussing chap 1 of the *Lex Aquilia*, which gives the owner of a slave the right to claim damages if someone wrongfully 'kills' a slave. Julian considers whether someone "kills" a slave for these purposes if he mortally wounds him and later someone else attacks the slave who dies more quickly as a result. Julian takes the view, which was probably not shared by all jurists that both persons who attacked the slave should be liable for "killing" him. In support of that view he says in D 9 2 51 1 that it follows from the authoritative rulings of the old Republican jurists who held that where a slave was wounded by a number of people in such a way that it was impossible to say whose blow had caused his death, then all of them were liable under the *lex Aquilia*: "...idque est consequens auctoritati veterum qui, cum a pluribus idem servus ita vulneratus esset ut non appareret cuius ictu perisset, omnes lege Aquilia teneri iudicaverunt..."

This passage in Julian's *digesta* is referred to by the later writer Ulpian in D 9 2 11 2 Ulpian 18 ad edictum: "sed si plures servum percusserint, utrum omnes quasi occiderint teneantur, videamus. Et si quidem apparet, cuius ictu perierit, ille quasi occiderit tenetur: quod si non apparet, omnes quasi occiderit teneri Iulianus ait, et si cum uno agitur, ceteri non liberantur: nam ex lege Aquilia quod alius praestitit, alium non relevat, cum sit poena..."

Ulpian considers whether if several people strike a slave, all of them are liable for killing him. He says that if it is clear who struck the blow from which the slave died, that person is liable for killing him. But he reports Julian's view that, if this is not clear, then all of them are liable for killing him. Again the precise factual situation is not spelled out, but it looks as if Ulpian is considering the case of an attack on the slave by several people at once. Since only the actual person whose blow killed the slave is liable if his identity is known, Ulpian must, however, be thinking primarily in terms of the individual liability of the person who does the killing: it is only if you cannot tell whose blow proved fatal that Julian holds that all are liable for killing the slave. A separate rule is adopted for that situation.

I would like to take from these passages the clear implication that classical Roman jurists of the greatest distinction saw the need for the law to deal specifically with the situation where it was impossible to ascertain the identity of the actual killer among the number of wrongdoers. If strict proof of causation were required, the plaintiff would be deprived of his remedy in damages for the death of his slave. In that situation, some jurists at least were prepared, exceptionally, to hold all of the wrongdoers liable and so afford a remedy to the owner whose slave had been killed."

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

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

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

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

Van Rensburg¹⁷² criticises the *sine qua non* test. His criticism is *inter alia* that it is based on a clumsy, indirect process of thought that results in circular logic. It requires the elimination of the alleged causal factor from a sequence of events to ascertain whether the end result would have been the same. However, he says, if one has to apply the same test in asking whether the remaining causative factors led to the end result then one ends up eliminating these as well which means that one ends up with a thought experiment in which there are no causative factors at all. It is submitted that this is a perfect example of the dangers of abstraction in law leading to a logical fallacy. The law cannot be divorced from its factual context. The only causal factor that is subject to the *sine qua non* test is the action or omission of the *wrongdoer*. The *sine qua non* test does not apply to all causal factors of an event – only to those which are attributable to the

¹⁷¹ *Fairchild*, fn 170 *supra*

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

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

8.2.13 *Korf v Health Professions Council of South Africa*¹⁷³

Facts

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

¹⁷³ *Korf* 2000 (1) SA 1171 (T)

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

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

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

1. The applicant could not, it averred, engage in a fishing expedition without showing the relevance of the documents sought to the civil proceedings contemplated by her against Dr Harmse and Witbank Hospital. In the absence of such relevant and rational connection the applicant was not entitled to indiscriminate access to the contents of the file.
2. It said that it was obliged to protect the confidentiality of documents or facts which came before it whenever it conducts or has conducted an investigation in respect of a medical practitioner against whom a complaint of misconduct has been lodged.
3. The applicant was told by the respondent as long ago as 26 June 1995 that the documents sought by her were in the possession of Witbank Hospital over whom the respondent had no jurisdiction or control. This statement was incorrect as the annexure to the respondent's answering affidavit, the document referred to, contained no reference to these documents at all.

Judgment

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

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

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

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

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

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

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

- ‘(a) any department of state or administration in the national, provincial or local sphere of government; or
- (b) any other functionary or institution -
- (i) exercising a power or performing a function in terms of the Constitution or a provincial constitution; or
- (ii) exercising a public power or performing a public function in terms of any legislation,
- but does not include a court or judicial officer;...’

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

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

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

¹⁷⁶ *Baloro* 1995 (4) SA 197 (B)

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

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

interim Constitution¹⁷⁹. In all these cases, the test applied in order to determine whether a body or functionary was an organ of state was whether that body or functionary was directly or indirectly controlled by the state.

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

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

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

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

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

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

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

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

The court ordered that:

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

Discussion

This case is of interest in a number of respects, the medical negligence of the doctor in question being possibly the least of them¹⁸⁰. However it is included in this section because it illustrates a number of points which have been emphasised in this chapter not least of which is the balance of power between the doctor and the patient in terms of accessibility to information and the tendency of medical professionals to protect one another. The court reprimanded the Health Professions Council for apparently interpreting its role as protecting members of the medical profession rather than protecting members of the general public from the medical profession where there is a professional relationship between them¹⁸¹.

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

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

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

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

In the context of the Constitution as it reads presently, there are essentially two questions in principle that are involved in the situation posed by *Korf*. The first is whether the courts would still be correct in applying the control test to ascertain whether or not councils such as the Health Professions Council are in organs of state. The second question is whether the fact that they are organs of state or not is material. This question is posed without a consideration of the provisions of the Promotion Of Access to Information Act¹⁸² for the present. This is firstly because although the Constitution itself mandates this legislation, it has to be consistent with the Constitution in terms of section 2 of the latter¹⁸³. Secondly, the nature of these councils is important because there is differentiation between the manner in which both the Constitution and the Promotion of Access to Information Act approach the right of access to records of public as opposed to private bodies.

In terms of section 32 of the Constitution,

- (1) Everyone has the right of access to-
- (a) any information held by the state; and
 - (b) any information that is held by another person and that is required for the exercise or protection of any rights.

The definition of “organ of state” in the Constitution reads –

“organ of state” means-

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

¹⁸² Act No 20 of 2000

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

- (b) any other functionary or institution-
- (i) exercising a power or performing a function in terms of the Constitution or a provincial constitution; or
 - (ii) exercising a public power or performing a public function in terms of any legislation.”

It is submitted that the Health Professions Council of South Africa and the other statutory professional health councils¹⁸⁴ fall squarely into part (b)(ii) of the definition of “organ of state” in the Constitution.

Furthermore, if one considers other legislation governing organs of state e.g. the Public Finance Management Act¹⁸⁵ and the question of whether or not they are public entities in terms of such legislation, this submission is further reinforced. Although the statutory professional health councils are currently not listed in Schedules 2 or 3 of the Public Finance Management Act, this is due rather more to a legal technicality than any intention on the part of the Legislature since the Act provides in section 47 (2) that the accounting authority for a public entity that is not listed in either Schedule 2 or 3 must, without delay, notify the National Treasury, in writing, that the public entity is not listed. Section 47 (4) of the Act states that the Minister may not list in Schedule 3 *inter alia* any public institution which functions outside the sphere of national or provincial government. Schedule 2 of the Act lists “Major Public Entities” while Schedule 3 lists “Other Public Entities” including “National Public Entities”, “National Government Business Enterprises” “Provincial Public Entities and “Provincial Government Business Enterprises” If one considers the definition of “national public entity” in the Act¹⁸⁶, it is very clear that the Health Professions Council of

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

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

¹⁸⁶ In the PFMA ‘national public entity’ means-

- (a) a national government business enterprise; or
- (b) a board, commission, company, corporation, fund or other entity (other than a national government business enterprise) which is-

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

If one looks at the Promotion of Administrative Justice Act¹⁸⁷ “administrative action” means any decision taken, or any failure to take a decision, by-

- (a) an organ of state, when-
 - (i) exercising a power in terms of the Constitution or a provincial constitution; or
 - (ii) *exercising a public power or performing a public function in terms of any legislation;*

[writer’s italics]

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

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

187 Act No 3 of 2000

legislation and the nature of the functions ascribed to them by that legislation, and the fact that they are very much regulatory bodies¹⁸⁸, the argument in favour of their being organs of state is strong. There is a significant difference between such councils and other statutory bodies falling under the auspices of the Minister of Health such as the Medical Research Council and the National Health Laboratory Services which are not regulatory bodies, whose central functions revolve around commercial transactions with both the public and private sectors and which do not fulfil a regulatory role. In fact these bodies perform functions which can be and are performed by private entities for profit every day. Medical research is not a public function and neither is the provision of laboratory services. The fees charged by these entities are fees for services whereas those charged by the statutory health professional councils are fees dictated by regulation and are designed to cover the costs of their administrative and operational functions – a totally different scenario. The incomes of the Medical Research Council¹⁸⁹ and the National Health Laboratory Services are dependent upon contracts for services concluded with various clients and have a distinctly commercial aspect. The contractual relationships entered into by the statutory health professional councils by contrast, are for services rendered to the councils by third parties in support of the work of those councils eg contracts for auditing, archiving and cleaning services, rental agreements, and employment contracts with staff.

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

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

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

Since the decision in *Korf*, the Promotion of Access to Information Act¹⁹⁰ was passed and has come into operation. Many would argue that since the Act applies not only to organs of state but to private bodies¹⁹¹ as well the arguments raised in *Korf* are now largely academic. However, what was demonstrated in *Korf* was a disturbing attitude on the part of the statutory council involved in obstructing a member of the public in enforcing the constitutional rights of herself and her child. The Department of Health is currently busy with amendments to the Health Professions Act to improve the accountability of the council and the professional boards in certain areas. Furthermore, as stated earlier the Promotion of Access to Information Act itself differentiates between rights of access to public and private bodies.

In the case of the former it simply gives a right of access provided that there exists no ground for refusal as provided for in the Act. It gives a right of access to records of the latter where this is required to exercise or protect a right provided that a request for access is made in the prescribed manner and there exists no ground for refusal contemplated in Chapter 4 of Part 3 of that Act¹⁹². There is thus a primary obstacle to any request for access to the records of a private body in that one must first show that the access is required to exercise or protect a right. The definitions in this Act of “public body” and “private body” are illuminating in the context of the present discussion.

In terms of the Promotion of Access to Information Act-

“public body” means-

¹⁹⁰ Promotion of Access to Information Act No 2 of 2000

¹⁹¹ Section 1 of the Act defines ‘private body’ as-

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

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

(c) any former or existing juristic person,

but excludes a public body”

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

- (a) any department of state or administration in the national or provincial sphere of government or any municipality in the local sphere of government; or
- (b) any other functionary or institution when-
 - (i) exercising a power or performing a duty in terms of the Constitution or a provincial constitution; or
 - (ii) exercising a public power or performing a public function in terms of any legislation;

whereas

“private body” means-

- (a) a natural person who carries or has carried on any trade, business or profession, but only in such capacity;
 - (b) a partnership which carries or has carried on any trade, business or profession; or
 - (c) any former or existing juristic person,
- but excludes a public body;

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

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

8.3 Summary and Conclusions

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

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

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

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

¹⁹³ *Webb* fn 100 *supra*



There are different schools of thought within the science and practice of medicine and other health professions just as there are in any other field of knowledge. The law must make allowances for this. The fact that a particular surgical technique is still practised in the public sector and is still achieving its desired result, despite the fact that it is no longer fashionable in the private sector, does not mean that the public sector practice is unreasonable in terms of the risks posed to the patient. Clinical protocols are some of the most hotly debated issues in the health service delivery environment since, even in medical practice, there is more than one way to skin a cat. In many instances the protocol that is adopted by a particular practitioner will be dictated by his or her own levels of confidence in it and in his or her ability to perform the tasks it requires. One cannot draw an adverse inference simply because a practitioner does not follow a protocol that is within the mainstream of clinical or surgical practice. It is however, important to draw the line between what is an established, although somewhat eclectic, school of thought on the one hand, and pure experimentation on the other. The National Health Act¹⁹⁴ makes provision for specific criteria involving informed consent by the patient to experimental treatment or treatment for research purposes.

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

¹⁹⁴ Act No 61 of 2003

¹⁹⁵ *Collins* fn 128 *supra*

¹⁹⁶ *Soobramoney v Minister of Health, KwaZulu-Natal* 1998 (1) SA 765 (CC)

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

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

¹⁹⁷ *C v Minister* fn 153 *supra*

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

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

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

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

¹⁹⁸ *Kramer* fn 99 *supra*

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

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



Chapter 9

Law of Delict In Health Service Delivery – Private Sector

| | | |
|--------|---|------|
| 9.1 | Introduction | 1057 |
| 9.2 | Case Law | 1059 |
| 9.2.1 | Mitchell v Dixon | 1059 |
| | Facts..... | 1059 |
| | Judgment | 1059 |
| | Discussion | 1060 |
| 9.2.2 | Webb v Isaac | 1061 |
| | Facts..... | 1061 |
| | Judgment | 1062 |
| | Discussion | 1064 |
| 9.2.3 | Stoffberg v Elliott..... | 1067 |
| | Facts..... | 1067 |
| | Judgment | 1068 |
| | Discussion | 1070 |
| 9.2.4 | Van Wyk v Lewis..... | 1072 |
| | Facts..... | 1073 |
| | Judgment | 1074 |
| | Discussion | 1080 |
| 9.2.5 | Dale v Hamilton | 1082 |
| | Facts..... | 1082 |
| | Judgment | 1083 |
| | Discussion | 1084 |
| 9.2.6 | Richter and Another v Estate Hamman | 1086 |
| | Facts..... | 1086 |
| | Judgment | 1087 |
| | Discussion | 1090 |
| 9.2.7 | Blyth v van den Heever | 1092 |
| | Facts..... | 1092 |
| | Judgment | 1094 |
| | Discussion | 1100 |
| 9.2.8 | Correia v Berwind | 1101 |
| | Facts..... | 1101 |
| | Judgment | 1104 |
| | Discussion | 1107 |
| 9.2.9 | Clarke v Hurst NO And Others | 1108 |
| | Facts..... | 1108 |
| | Judgment | 1110 |
| | Discussion | 1124 |
| 9.2.10 | Jansen van Vuuren v Kruger | 1131 |
| | Facts..... | 1131 |
| | Judgment | 1133 |
| | Discussion | 1141 |
| 9.2.11 | Castell v De Greef | 1153 |
| | Facts..... | 1153 |
| | Judgment | 1157 |
| | Discussion | 1173 |



| | | |
|--------|--|------|
| 9.2.12 | Friedman v Glicksman | 1187 |
| | Facts..... | 1187 |
| | Judgment | 1188 |
| | Discussion | 1193 |
| 9.2.13 | Gibson v Berkowitz..... | 1199 |
| | Facts..... | 1199 |
| | Judgment | 1203 |
| | Discussion | 1210 |
| 9.2.14 | Broude v Mcintosh And Others..... | 1211 |
| | Facts..... | 1211 |
| | Judgment | 1217 |
| | Discussion | 1222 |
| 9.2.15 | Mukheiber v Raath | 1222 |
| | Facts..... | 1222 |
| | Judgment | 1226 |
| | Discussion | 1234 |
| 9.2.16 | Michael and Another v Linksfield Park Clinic (Pty) Ltd and Another . | 1260 |
| | Facts..... | 1261 |
| | Judgment | 1266 |
| | Discussion | 1268 |
| 9.2.17 | VRM v The Health Professions Council of South Africa and Others... | 1273 |
| | Facts..... | 1273 |
| | Judgment | 1280 |
| | Discussion | 1282 |
| 9.3 | Summary and Conclusions..... | 1289 |

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 Verschoor² 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 exercised¹¹.

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, Carstens¹² 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 maxim¹³.

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 omstandighede 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 langsaa die aangetaste liggaamsdeel. Ten spyte van die gemelde *prima facie* omstandighede wat die toepassing van die stel reël 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 geleedere 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 uitspraak beslis hoofregter Innes dat die stelreël nie die onus beïnvloed 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 geleedere 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 wees, beide partye in mediese wanpraktyksake alles in hul vermoë moet doen om deskundige mediese getuënis voor die hof te lê. Indien die deskundige mediese getuënis 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 en 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 feitlike 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 getuënis 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' handelwyse wat tot die nadelige gevolg aanleiding gegee het. Die praktiese implikasie van 'n redelike verduideliking sal noodwendig meebring dat die geneesheer dan deskundige mediese getuënis 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 te 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 aanbod van soortgelyke feite om 'n bepaalde afleiding te regverdig.

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

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- (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 pleistukke 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 misdadad 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 gebeurte (absolute gegewe) en die nadelige gevolg is, alvorens daar sprake kan wees van die moontlike aanwending van die stelreël. Sò 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 kousaliteits-element '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 tydens (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 langs aan 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 feitlike 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 verontref nie"

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 man¹⁵. 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 be used for the purposes of vivisection. He remains a human being and he retains his rights of control and disposal of his own body. He still has the 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 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 absolute¹⁶. 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-1; *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 law¹⁷. 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 term¹⁸. 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 rights¹⁹. 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.

Boberg²⁰ notes that T W Price²¹ 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 obtained²².

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 he 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 where 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 not 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 nurse²⁷. The judge recognised that in operations some team 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 context²⁸. 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. Strauss²⁹ 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 doctors³⁰.

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 to the 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 Verschoor³⁴ note in connection with this case that according to Giesen and Fahrenhorst³⁵ 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 culpa 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 activity³⁶. 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 to 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 2 1/2 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 coccydina. 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 coccydina 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 coccydina, 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 coccydynia 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 consent⁴¹. A patient's right to self-determination is not absolute and must be balanced against the interests and *boni mores* 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 warning the 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 *Mathee and Another v Hatz* 1983 (2) SA 595 (W)

⁴² *Blyth* 1980 (1) SA 191 (A)

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 damage⁴³. 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 damages⁴⁵. 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 Rondalla 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)

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 Nathan⁵⁰ 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 *concursum 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 contract therefore does not *per se* debar him from claiming in delict. All that he need show is that the facts pleaded establish a cause 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 *concursum 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 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 do 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 Visser⁵³ 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 delict⁵⁴. 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 Act⁵⁶.

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 proceedings⁵⁸. 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)



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 condition⁶¹;
- (ii) if a killing is intentional it is none the less murder, even though the killer may not have harboured any evil motive⁶²;
- (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 limits⁶³. Thirion J pointed out that, writing on the requirements for delictual liability, Van der Walt⁶⁴ 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 aengheborn 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 privaatreë ’n belange-afweging tussen persone plaasvind aan die hand van die redelikeheid. Die redelikeheidsmaatstaf, 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 regsopvatting van die gemeenskap: die *boni mores*. Die *boni mores* toets is ’n objektiewe redelikeheidsmaatstaf. 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 regsvoortuiging 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 thought 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 regsopvattinge 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 health⁶⁹.

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 life⁷⁰.

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*)



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-making⁷¹. 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 Heever⁷² 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 so⁷⁴. 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 'adekwasië 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 wrongfulness⁷⁵. This approach has not gone uncriticised and du Bois⁷⁶ 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 1 1/2 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



Strauss⁸³ 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 first mentioned 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 an 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. Taitz⁸⁵ 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 *iniuria* 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 Strauss⁹¹:

“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 function⁹². 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 law⁹³. 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 consideration⁹⁴.

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.”

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 moral⁹⁵. He said a legal duty to communicate would, for example, exist in respect of the duty of a medical practitioner to testify in court⁹⁶ or to disclose a notifiable disease in terms of section 45 of the Health Act⁹⁷. 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) at p 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 Act⁹⁹ 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 point¹⁰⁰. 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 principles¹⁰² 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 led 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 detail¹⁰⁴. The right to privacy reinforces and upholds the right to human dignity¹⁰⁵. 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 onverstoortheid’. 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 dierelwe’. 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 loss¹⁰⁷, 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 actions¹⁰⁹.

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 absolute¹¹⁰ 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 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

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 patients¹¹⁴. 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 Act¹¹⁵ 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 Act¹¹⁶ 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 Act¹¹⁷ 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 Act¹¹⁸ 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 records¹¹⁹. 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 Strauss¹²⁰ 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 Act¹²¹. 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 Act¹²². 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".

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- (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



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 belongs¹²⁵. 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 problem¹²⁷. 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 Governors 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 Canada¹³⁰. 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 treatment¹³¹. 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* case¹³². But it does not follow, said Scott J, that the doctor is obliged to point out meticulously each and every complication that may arise¹³³. 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 negligence¹³⁴ 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 Naser 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 281a 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 Giesen¹⁴². 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-disclosure¹⁴³

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 *McLoughlin* 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 foregoing 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

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 Conradi 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 Conradi 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.

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

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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 patient¹⁴⁶. 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 282¹⁴⁸ and p 284¹⁴⁹. He noted that after referring to certain passages from the speech of Lord Templeman in this regard, Giesen¹⁵⁰ 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, 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 law¹⁵³. 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 act¹⁵⁴. 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*, *Staffberg v Elliott* (fn 14 *supra*) at p 149-50; *Lymbery v Jeffries* 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).

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 Giesen¹⁵⁵ and he also referred to a passage from the thesis of Van Oosten¹⁵⁶. 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 patriarchal attitudes. The fundamental principle of self-determination puts the decision to undergo or refuse a medical intervention squarely where it belongs, namely with the patient. It is, after all, the patient's life or health that is at stake and important though his life and health as such may be, only the patient is in a position to determine where they rank in his order of priorities, in which the medical factor is but one of a number of considerations that influence his decision whether or not to submit to the proposed intervention. But even where medical considerations are the only ones



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 involved¹⁵⁹. 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 Brennan 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 49¹⁶¹. 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 authorities¹⁶². 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; *Correia 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 (regverdigungsgrond) 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 law¹⁶⁶. 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 negating unlawfulness¹⁶⁷. 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'. Various 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 iniuria* 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.

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 the 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 says, 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 non fit 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 law¹⁷¹ – 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 consent¹⁷². 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 information¹⁷³. 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 US, 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 autonomy¹⁷⁴. 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 decision¹⁷⁵.

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 homicide¹⁷⁸.

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 6¹⁸¹.”

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 Act¹⁸³ 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 done¹⁸⁴.

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 research¹⁸⁷. 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/pullmanfm.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 push 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 medicines¹⁸⁸. 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 observed¹⁹⁰ that before marketing a new drug many adverse drug reactions (ADRs) may either be suspected from chemical similarity to known drugs or detected in clinical trials. Detection of 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 detail¹⁹¹. 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 treatments¹⁹². 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 so¹⁹³, 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 Act¹⁹⁶ 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 recognised¹⁹⁸. 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*



*Lta*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 born²⁰¹. 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 failed²⁰². 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 analogous 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 recoverable²⁰⁵. 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 Wrongful 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 damage²⁰⁹. 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

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- 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/wrongul_conception.htm

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 recognised 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 life²¹¹.

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-patrimonial ‘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 professional 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

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 Versekeringmaatskappy 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

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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 Daniels 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

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 case²¹⁶. 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 40I-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 subsidiër 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 regs aanspreeklikheid, 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 buigsamheid 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 verwerder 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 defendants²¹⁷.

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 said 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 consequence²²⁰. 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 defendants²²¹. 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 issue²²² 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 Act²²³ 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 Act²²⁴.

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 verwythbaarheid 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 verwythbaarheid (skuld) nie (dit staan in hierdie stadium reeds vas), maar of hy vir die verdere gevolge van sy verwythbare 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 Claassen 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, Claassen 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 Claassen J.

As far as damages were concerned, Claassen 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 psychological 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 bulb* 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

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 although of 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 antenatal 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 costs²²⁸.

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 foregoing 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 applied²³². 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 act²³³. 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 policy²³⁴. 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 case²³⁶. 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 damaged 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 the 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 belongs²³⁸. 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' - test²³⁹. 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, Boberg²⁴¹ 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 cases²⁴² 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 decisiveness²⁴³. 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 3751 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 misrepresentations²⁴⁶. 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

Roederer²⁴⁷ 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 delict²⁴⁸. 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 Anspreklikeid 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 elsewhere²⁵¹ 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 expressly²⁵² 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 Potgieter 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 te spekulereer nie, maar dit is trouens juridies onmoontlik. 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 differently²⁵³. 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 Aswegen²⁵⁴ 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 gemeenskapsordende funksie van die privaatreë. Een van die onwenslike 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 uiteindelijke gevolg, naamlik onbegrensde aanspreeklikheid, is nie. Dan sal sodanige skadeveroorakende optrede steeds onregmatig wees, maar die dader se aanspreeklikheid 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 delict²⁵⁵. Midgley²⁵⁶ 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 a misrepresentation could be approached, common to all approaches, the court pointed out, is the fundamental principle that tortious 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 does 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 intend 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 is 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 notes 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 from 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 *Mkhatswa* 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 JA²⁶⁰. 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 cow²⁶¹. 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 recognizes that facts and legal principles are in the public domain, open to scrutiny but a judge’s intuition remains unarticulated. 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 conceivable²⁶² (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 short 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 sufficient 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 journals²⁶³. 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 is 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 cases²⁶⁴. 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

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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 situations²⁶⁵.

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 story²⁶⁶ 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 court²⁶⁷ and others²⁶⁸ 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 Gumedde 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 *Ngxuzza 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 2001²⁷⁰ 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 not 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 gemenerereg toe te pas soos pre-konstitusioneel deur hierdie Hof neergeleë? 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 gemenerereg 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 gemenerereg 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 gemenerereg 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-konstitusionele 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 Krieglér 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 patterns²⁷² 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 says 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 theory²⁷³, 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 instability²⁷⁴. 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 change²⁷⁵.

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 does 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 Nienaber²⁷⁶. 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 studies 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 conventional 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 simple 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 *emergent 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 pronouncements²⁷⁸. 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 world²⁷⁹. 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 Winkels²⁸⁰ 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, Vandenberghe 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 and 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 our 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 a 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

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 detail²⁸⁴. 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

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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 are 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 tend 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.

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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 simple 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 unreportable²⁸⁷. 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 Act²⁹⁰ (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 Act²⁹⁷ 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 Labuschagne 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 Act²⁹⁹ 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 aquilliese 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 shock³⁰².

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. Strauss³⁰³ 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 Saritam 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 and 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 to 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 Act³⁰⁴, would have required the consent of that same parent or relative to

³⁰⁴

Act No 92 of 1996. 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 children³⁰⁵.

Provided that the termination of the pregnancy shall not be denied because such minor chooses not to consult them.”

305 In section 1 of the Act a woman is defined as “any female person of any age”
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 recognise 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 where ‘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 if 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 therapeutic 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. 31 describes 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 party³⁰⁶), 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 law³⁰⁸. 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 norm³⁰⁹.

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 guiding 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 mores*, 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 constitutional 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.

Chapter 10

The South African Law on Health Service Delivery: Conclusions and Observations

| | | |
|--------|---|------|
| 10.1 | Introduction | 1293 |
| 10.2 | International Law | 1301 |
| 10.2.1 | Criticisms of International Law..... | 1313 |
| 10.2.2 | Imbalance in the Formulation of International Law..... | 1319 |
| 10.2.3 | Compliance With International Law Affords No Protection | 1321 |
| 10.2.4 | ‘Standard Setting’ Approach Not Helpful To The Developing World . | 1324 |
| 10.2.5 | Absolute Rights v Relative Rights | 1327 |
| 10.2.6 | Conclusions Concerning International Law..... | 1329 |
| 10.3 | Constitutional Law | 1330 |
| 10.3.1 | Individual Rights vs Rights as Elements of a System..... | 1331 |
| 10.3.2 | The Right of Access to Health Care Services | 1338 |
| 10.3.3 | Realisation Of The Right Of Access To Health Care Services..... | 1341 |
| 10.3.4 | Horizontal Application..... | 1346 |
| 10.3.5 | Conclusions Concerning Constitutional Law..... | 1348 |
| 10.4 | Administrative Law | 1351 |
| 10.4.1 | The Promotion of Administrative Justice Act No 3 of 2000..... | 1352 |
| 10.4.2 | The Nature of the Function Not the Functionary | 1354 |
| 10.4.3 | The Distinction Between Public and Private Powers..... | 1357 |
| 10.4.4 | Lawfulness..... | 1359 |
| 10.4.5 | Reasonableness..... | 1360 |
| 10.4.6 | Procedural Fairness | 1361 |
| 10.4.7 | Administrative Agreements..... | 1364 |
| 10.4.8 | Conclusions Concerning Administrative Law | 1374 |
| 10.5 | The Law of Contract..... | 1376 |
| 10.5.1 | Tacit or Implied Terms in Healthcare Contracts | 1377 |
| 10.5.2 | Contracts Within The Public and Private Health Sectors..... | 1381 |
| 10.5.3 | Potential Solutions For Health Care Contracts..... | 1383 |
| 10.5.4 | Conclusions Concerning The Law of Contract | 1386 |
| 10.6 | The Law of Delict..... | 1392 |
| 10.6.1 | Constitutional Delicts..... | 1396 |
| 10.6.2 | Unlawfulness | 1397 |
| 10.6.3 | Medicines and Medical Devices..... | 1397 |
| 10.6.4 | Delict in the public v the private sector..... | 1400 |
| 10.6.5 | Conclusions Concerning the Law of Delict | 1401 |
| 10.7 | In Conclusion | 1405 |

10.1 Introduction

The delivery of health services in South Africa embraces a number of areas of law. It has not been possible to cover every area in a thesis such as this. The objective here is

a synthesis of the major areas of law impacting on health service delivery rather than a purely analytical study of the impact on health service delivery of the more obscure areas or minute and detailed analysis of technical points. Whilst fine analytical scrutiny has its place, there is great value in stepping back occasionally to survey the law from a panoramic perspective. It is the only way to approach concepts such as “health law” or “media law” that cut across many different aspects ranging from statutes to the common law and from international to domestic law. In terms of this approach the scope of the thesis is defined by the area of human society, in the present case health services delivery, to which law is applicable rather than the field of law itself such as public or private, contract or delict.

In this chapter the skeins of commonality that were identified in the preceding chapters are drawn together and highlighted. Also the flaws and weaknesses within the various areas of law are identified and considered and where appropriate, suggestions are made as to how they may best be remedied. Ultimately, the role of the courts in ensuring that constitutional values and principles irradiate the common law cannot be overemphasised. It is critical that the judiciary recognises, acknowledges and appreciates the pervasive and structural importance of the Constitution. Unfortunately this appreciation is still significantly lacking amongst some judges. The Constitution is perceived by many as having its own compartment within the larger legal system rather than as the new foundation by which the entire structure now stands (or falls).

There is a common thread running through the five areas of law that are covered in this thesis. Broadly speaking this thread is the Constitution and the values that it represents. Even within international law as a broad concept outside of national boundaries, the South African Constitution is a distinct point of focus. International law also clearly influenced the drafters of the Constitution despite the fact that they still came up with a legal grundnorm that is peculiar to the history and culture of this country. The Constitution in its turn mandates a conscious and continued application of international legal principles in a number of spheres, for example the interpretation of the Bill of Rights. It is the interface through which international law, by a process of osmosis, influences South African domestic law. As the foundation of South Africa’s domestic legal order, the Constitution is the primary sourcebook for the

application and interpretation of the common law, including the law of contract and of delict. Administrative law has become a constitutional construct in its own right whereas previously it was merely a patchwork of statutory and common law decisions that were far from homogenous. In a sense the Constitution therefore serves as the lodestar of the South African legal system, polarising and charging the principles of international law that enter into domestic law with the values, ideals and principles of the South African people. It also serves the same purpose for internal, domestic law, ensuring that, irrespective of the area of law concerned, the legal system in its entirety is a cohesive and integrated whole in conformity with constitutional values and principles. This said, it must be noted that law is a dynamic system. The work of the Constitution will never be complete. There will not be a time where it can be said that the domestic legal system is completely and finally aligned with the Constitution¹, neither will there be a time when constitutional law itself becomes static. That is not the nature of law. There will always be factual permutations that test its strength and push its boundaries. New developments in international law and increasing globalization will maintain the tensions between international law and domestic legal systems and ensure a process of continuous growth and development in legal structure and legal theory both within and outside of South Africa. It is for these same reasons that it is so important to maintain an internally coherent, unitary domestic legal system that accurately reflects the fundamental values and principles of South African society².

There are a number of statutes that specifically govern health service delivery most of which fall within the portfolio of the Minister of Health. They range from statutes governing health professionals and the practice of health care in various disciplines to those dealing with specific health care situations or products such as occupational diseases in mines and works, hazardous substances, human tissue and food and medicines. At present the delivery of health care services in the public sector is

¹ This is not by any means excuse for failure to make a concerted effort to ensure that the 'constitutionalisation' of the South African legal system is of the utmost significance and should be the conscious focus of every practising lawyer here and now. It is simply that in a factual situation in which there was a pre-existing system of law that took hundreds of years to develop, upon which another very different approach has suddenly been imposed, it is likely that the 'matching' or complete integration of every area of the older system with the new approach will take a very long time given that it is within human nature to resist change, that the development of law is as much a process of evolution as revolution, that the extent of legal exegesis necessary to achieve this is quite probably beyond the capabilities of a single generation in any event, and the fact that constitutional law itself is a dynamic concept.

² Simply put, if we know who we are, we can know what we want and where we are going and can ourselves exert an influence on developments on the international legal front that promote and further the national interest.

governed by the Health Act³. The administration of large sections of this statute was assigned to the provincial governments in 1994 but some remained with the National Department of Health. However the National Health Act⁴ was passed by Parliament in 2003 and will soon become operational. This Act will repeal the Health Act and become the central legislation on health service delivery in South Africa in both the public and private health sectors. Since each statute governing health service delivery is quite worthy of a thesis in itself and since the intention of this thesis was not to look at specific situations, products or services as dealt with in the various statutes, specific discussion of individual statutes has mostly been avoided. Where there is a statute that relates to the particular topic under discussion, mention of it has been made in passing and to alert the reader to the fact that it exists and has an impact in a particular area. This thesis focuses on certain aspects of the common law, such as the law of contract and the law of delict, because this tends to be the law upon which relationships between providers and patients - the interface of health services delivery - still largely depends and in terms of which claims in the courts are mostly decided.

Administrative and constitutional law in South Africa, the other two major areas of South African law that impact upon health service delivery, especially in the public sector, and upon which this thesis focuses, cannot be said to consist purely of common law. They are a blend of statutory and common law. The Promotion of Administrative Justice Act and the Constitution itself are central to any discussion of these two areas. Since the Constitution underpins all areas of law in South Africa, careful attention has been given to the treatment of constitutional principles in the context of the areas of the common law that have been covered. The chapter examining international law relating to health service delivery attempts to contextualise the South African legal system within a framework of international concepts and norms in order to ascertain how the former compares. Since international law is not insignificant in South Africa's constitutional legal dispensation it would have been inappropriate not to consider the position of international law with regard to health service delivery. For the sake of completeness passing reference is sometimes made to statutes that govern more specific areas of

³ Health Act No 63 of 1977

⁴ National Health Act No 61 of 2003

health law such as the Medicines and Related Substances Act⁵ or the Medical Schemes Act⁶ but this is more in order to highlight a particular point concerning health service delivery than to examine the statute itself in any depths.

The common law in South Africa tends to be developed piecemeal by the courts in the sense that although the principle of *stare decisis* prevails, there is seldom any attempt to cross reference the principles of different areas of law in order to resolve particular cases. In fact the courts in the past have stoutly rejected arguments that might have the effect of hybridising legal principles and concepts developed in one area with those of another. This thesis is critical of such an approach on the basis that since all law must be interpreted and applied with reference to the Constitution, there should be common policies and concepts informing all areas of law relating to a particular field. The preference is for an outcomes based approach to the application and interpretation of law. In the context of health service delivery in particular, it is demonstrable that a rigidly compartmentalised approach to law, which focuses on the means rather than the end, can lead to illogical and unfair decisions. Internal consistency is necessary not only within but across legal disciplines. From a practical perspective too, people do not limit themselves in their daily activities to particular legal areas. In a context such as health service delivery many different legal principles often converge upon a single situation. Consequently, the approach in this thesis to law is based on this reality. Such people are not concerned with whether a particular activity falls within the realm of the law of contract, delict or administrative law and for the most part, neither are their patients. To them, any law that affects the delivery of health services is relevant and the question is what law or laws govern any given situation. Law is therefore treated as a means to an end rather than an end in itself.

On the whole it would appear that there is still much work to be done in terms of the recognition of constitutional principles relating to the law of health service delivery within other branches of law such as the common law of contract and delict. The Supreme Court of Appeal in particular has on a number of occasions demonstrated a surprising lack of cognisance of central constitutional themes. This leads one to the realisation that, ten years into South African democracy and the constitutional legal

⁵ Medicines Act No 101 of 1965

⁶ Medical Schemes Act No 131 of 1998

order, the process of ‘constitutionalising’ the major part of the South African common law is going to take longer than some might have hoped. South African law lags behind other countries in terms of revised thinking around the purpose of the law of contract, consumerism and the complexity of business and other human relationships in the twenty first century. It is in many ways a reflection of the socio-economic disparities between different levels of South African society. The older, apartheid tempered, approach to law, based on how people who are relatively wealthy would bargain and conduct their affairs, can still be seen existing side-by-side with one of the most progressive, legally elegant constitutions in the world. Wealth is, after all, power. If one’s perception of the power of the individual is based upon an assumption of a certain level of wealth, this will inform the approach one takes when adjudicating matters between contracting parties in terms of the law of contract. If one sees the primary purpose of law as a brake upon transformation - as maintaining the *status quo* in terms of power distribution, or of attacking post-apartheid systems and structures so as to carry a particular historical bias into the present – this view will undoubtedly emerge in the manner of its application. Conversely if one regards law as a vehicle for positive transformation of society and as a means of promoting equality and freedom for all of its members, this will also be reflected in the manner in which the law is applied⁷. One sees a mix of these two approaches to law across the South African judiciary and across the different types of courts. Since the judiciary is a reflection of larger society, this is hardly surprising.

There is much that is admirable about the South African law relating to health service delivery. Compared to the “pie-in-the-sky” of international law, it offers a far more pragmatic and tangible promise of the realisation of human rights goals. It holds a reassurance that socio-economic rights in South Africa are real and enforceable. At the same time, the standard applied to the conduct of government with regard to these rights is one of reasonableness. Whilst some may argue that reasonableness is itself a vague concept that can mean just about anything, it is submitted that reasonableness allows scope for many different points of view, for the possibility of justification of one’s actions from a position of power, for variances based on circumstances, for

⁷ In *Bel Porto School Governing Body And Others v Premier, Western Cape, And Another* 2002 (3) SA 265 (CC) for instance the constitutional court observed: “It is true that, in determining what constitutes procedural fairness in a given case, a court should be slow to impose obligations upon government which will inhibit its ability to make and implement policy effectively. It is also true in a country such as ours, that faces immense challenges of transformation, that we cannot deny the importance of the need to ensure the ability of the executive to act efficiently and promptly.”

argument within the bounds of human weakness and capability that a particular act or omission should be condoned or upheld in law. The concept of reasonableness, it is submitted, covers a multitude of sins in a manner that promotes justice and equality. Reasonableness asks one to think about the consequences of one's actions, to take account of the needs and views of others and to make informed and rational decisions. It implies a standard of objectivity against which one's actions are assessed that is neither impossible to work with nor biased on emotional grounds in favour of a particular view. The concept of reasonableness pervades South African law. It is as much in evidence in constitutional law as it is in the law of contract, the law of delict and administrative law. It is a universal theme capable of lending consistency to law as a whole. In the context of health service delivery, as in law, reasonableness is a very relevant concept. It dictates, for instance, the lengths to which one should go to save a life, the extent of the personal sacrifice one must make to help another, the precautions one must take when administering a dangerous drug, the nature and scope of the information to be given to a patient when seeking his informed consent, the standard of care to be adopted in treating a patient, the nature of the particular surgical procedure chosen to address a particular health condition and the acceptability to society of certain contractual terms.

Reasonableness also suggests and promotes another central tenet of law – fairness. Undue favouring of one person's interests over another is a concern not only of constitutional, administrative⁸ and common law but also of those involved in the field of health care rationing and health service delivery. How does one allocate resources in a manner that is fair and equitable? On what basis does one decide that this patient gets renal dialysis and that one does not? Systems of triage on fields of war and in hospital trauma units alike are concerned with issues of fairness. In the health sector, fairness can literally be a matter of life or death. Fairness in law involves not only a balancing of the interests of the parties concerned but also a balancing of the different rights in the Bill of Rights, a balancing of the constitutional values of equality and freedom and the necessary limitation of constitutional rights⁹. An irrational bias in favour of one right against another could lead to injustice just as surely as an irrational

⁸ *Bongoza v Minister of Correctional Services and Others* 2002 (6) SA 330 (Tk)

⁹ *Director of Public Prosecutions: Cape of Good Hope v Bathgate* 2000 (2) SA 535 (C)

bias in favour of one party against the other since constitutional rights are interrelated and interdependent.

Fairness in turn, is closely associated with equality. For instance unfair discrimination constitutes a denial of equality¹⁰. Equality as a legal concept is context dependent. In the context of health care one does not promote equality by prescribing the same treatment for all irrespective of their health status and health condition. Instead, one achieves equality in health care by addressing the different health problems of everyone in such a manner as to ensure that at the end of the day that they are all as healthy as possible¹¹. Equitable decisions are those that take into account the concerns of all of the parties involved and that deal with them from the perspective of equality. Fairness is a concern of the common law of contract¹² and the law of delict¹³ as well as constitutional¹⁴ and administrative law¹⁵. Flexibility according to context is inherent within the concept of fairness¹⁶.

¹⁰ *S v Botha en Andere* 1994 (4) SA 799 (W); *Bezuidenhout v Bezuidenhout* 2003 (6) SA 691 (C)

¹¹ In *Chairman, Board on Tariffs and Trade, and Others v Brenco Inc and Others* 2001 (4) SA 511 (SCA) Zulman JA noted: "Lord Mustill summarised the duty of a public official or body to act fairly in these lucid terms: 'What does fairness require in the present case? My Lords, I think it unnecessary to refer by name or to quote from, any of the often-cited authorities in which the courts have explained what is essentially an intuitive judgment. They are far too well known. From them, I derive the following. (1) Where an Act of Parliament confers an administrative power there is a presumption that it will be exercised in a manner which is fair in all the circumstances. (2) The standards of fairness are not immutable. They may change with the passage of time, both in the general and in their application to decisions of a particular type. (3) The principles of fairness are not to be applied by rote identically in every situation. What fairness demands is dependent on the context of the decision, and this is to be taken into account in all its aspects. (4) An essential feature of the context is the statute which creates the discretion, as regards both its language and the shape of the legal and administrative system within which the decision is taken. (5) Fairness will very often require that a person who may be adversely affected by the decision will have an opportunity to make representations on his own behalf either before the decision is taken with a view to producing a favourable result, or after it is taken, with a view to procuring its modification, or both. (6) Since the person affected usually cannot make worthwhile representations without knowing what factors may weigh against his interests fairness will very often require that he is informed of the gist of the case which he has to answer.' [*Doody v Secretary of State for the Home Department and Other Appeals* [1993] 3 All ER 92 HL; [1994] 1 AC 531])"

¹² *Dalinga Beleggings (Pty) Ltd v Antina (Pty) Ltd* 1979 (2) SA 56 (A); *Thompson v Scholtz* 1999 (1) SA 232 (SCA); *Lubbe v Volkskas Bpk* 1991 (1) SA 398 (O); *Bouygues Offshore and Another v Owner of the MT Tigr and Another* 1995 (4) SA 49 (C)

¹³ *Midway Two Engineering & Construction Services v Transnet Bpk* 1998 (3) SA 17 (SCA); *Road Accident Fund v Sauls* 2002 (2) SA 55 (SCA); *Saaiman and Others v Minister of Safety and Security and Another* 2003 (3) SA 496 (O); *Premier, Western Cape v Faircape Property Developers (Pty) Ltd* 2003 (6) SA 13 (SCA)

¹⁴ "The common-law principle of fairness is reflected in s 33(1) of our Constitution" per Zulman JA *Chairman, Board on Tariffs and Trade, and Others v Brenco Inc and Others* (fn 11 *supra*)

¹⁵ *Meyer v Iscor Pension Fund* 2003 (2) SA 715 (SCA)

¹⁶ Zulman JA stated in *Chairman, Board on Tariffs and Trade, and Others v Brenco Inc and Others* (fn 11 *supra*): "There is no single set of principles for giving effect to the rules of natural justice which will apply to all investigations, enquiries and exercises of power, regardless of their nature. On the contrary, courts have recognised and restated the need for flexibility in the application of the principles of fairness in a range of different contexts. As Sachs LJ pointed out in *Re Pergamon Press* ([1971] 1 Ch 388 (CA)) ([1970] 3 All ER 535): 'In the application of the concept of fair play, there must be real flexibility, so that very different situations may be met without producing procedures unsuitable to the object in hand. . . . It is only too easy to frame a precise set of rules which may appear impeccable on paper and which may yet unduly hamper, lengthen and, indeed, perhaps even frustrate . . . the activities of those engaged in investigating or otherwise dealing with matters that fall within their proper sphere. In each case careful regard must be had to the scope of the proceeding, the source of its jurisdiction (statutory in the present case), the way in which it normally falls to be conducted and its objective.'" See also *Bongoza v Minister of Correctional Services and Others* 2002 (6) SA 330 (Tk) and *Du Bois v Stompdrift-Kamanassie Besproeiingsraad* 2002 (5) SA 186 (C)

There is another common thread that binds the legal system throughout that is also implied by reasonableness – rationality. There has to be a reason for acting or refraining from acting in a particular way. What is more, the reason must be within the boundaries of common human understanding so that it would constitute a valid reason in the minds of others in similar circumstances. In other words, rationality implies a reason within a framework. A court or government department that gives reasons for its decision which are not based on any commonly understood conceptual framework is acting irrationally. Rationality is reason anchored within a common perception of reality.

The decisions of the judiciary, the actions of the executive¹⁷, the Acts of the legislature must be reasonable, fair¹⁸, equitable and rational. Many of these precepts have been introduced or reinforced by the Constitution. The word ‘reasonable’ occurs some thirty two times in the Constitution, the word ‘fair’ eleven times, while the word ‘equitable’ occurs some sixteen times and ‘equality’ occurs some seventeen times. The word ‘justice’ occurs some fifty four times. These statistics are indicative of the preoccupations of the Constitution with deeper social values and fundamental legal norms.

10.2 International Law

¹⁷ *Logbro Properties CC v Bedderson NO and Others* 2003 (2) SA 460 (SCA)

¹⁸ *Bel Porto School Governing Body and Others v Premier, Western Cape, and Another* fn 7 *supra* - Mokgoro J and Sachs J stated: “There are circumstances where fairness in implementation must outtop policy” and “The objective of judicial intervention under that section is to secure compatibility with fundamental notions of fairness in relation to the exercise of administrative power. Once it has been established that conduct is inconsistent with the Constitution the Court, in addition to declaring such conduct to be invalid to the extent of its inconsistency, may make any order that is just and equitable. Thus, it would not be just and equitable to remedy unfairness to some by imposing unfairness on others. On the other hand, the constitutional rights of some cannot be withheld simply because of some potential knock-on effect on others. The test is one of fairness, not legality.” and “Unlike questions of legality, where the exercise of a power either is lawful or it is not, fairness can be a matter of degree. In this respect we can do no better than repeat what Steyn J recently said in *R v Secretary of State for the Home Department, Ex parte Pierson*: ‘It was suggested that severance would involve “a rewriting” of the policy statement. This is a familiar argument in cases where the circumstances arguably justify a court in saying that the unlawfulness of part of a statement does not infect the whole. The principles of severability in public law are well settled. . . . Sometimes severance is not possible, eg a licence granted subject to an important but unlawful condition. Sometimes severance is possible, eg where a bye (sic) law contains several distinct and independent powers one of which is unlawful. Always the context will be determinative. In the present case the power to increase the tariff is notionally severable and distinct from the power to fix a tariff. . . . It is an obvious case for severance of the good from the bad. To describe this result as a rewriting of the policy statement is to raise an objection to the concept of severance. That is an argument for the blunt remedy of total unlawfulness or total lawfulness. The domain of public law is practical affairs. Sometimes severance is the only sensible course.’” [Footnotes omitted]



Whilst the Constitution makes a number of references to international law¹⁹ discovering what is encompassed by the term ‘international law’, especially with regard to rights relating to health care services, is easier said than done. There are a number of international conventions to which South Africa is a party or a signatory which impact upon discussions of the law relating to health services delivery in South Africa. They are the Convention on the Rights of the Child (CRC), the International Covenant on Economic, Social and Cultural Rights (ICESCR), the UN Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), the African Charter on the Rights and Welfare of the Child and the African Charter on Human and Peoples’ Rights. However the point is made in chapter one of this thesis that these instruments of international law have not expressly or directly been enacted in South African legislation neither have they been applied down to the last detail by the constitutional court. A notable example of the latter is the court’s refusal to interpret the socio-economic rights in the Bill of Rights of the South African Constitution, including the right of access to health care services, with reference to a ‘minimum core’ of obligations as contemplated by the ICESCR Committee. In General Comment No 14 the Committee on Economic, Social and Cultural Rights has stated that the realization of the right to health requires that the state ensure equality of access to a system of health care and provide health services without discrimination. Accessibility in turn, has four overlapping dimensions: non-discrimination, physical accessibility, economic accessibility (affordability) and information accessibility²⁰. The National Health Act embodies these principles of accessibility to a large extent²¹. However when they are interpreted and applied by the

¹⁹ In sections 35, 37, 39, 198, 199, 200, 201, 231, 232 and 233

²⁰ Human Rights Watch ‘VII: South Africa’s Obligations Under International and National Law’
<http://www.hrw.org/reports/2004/southafrica0304/7.htm>

²¹ National Health Act fn 3 *supra*. Thus with regard to economic accessibility section 3 of the Act provides:

- (1) The Minister must, within the limits of available resources—
 - (a) endeavour to protect, promote, improve and maintain the health of the population;
 - (b) promote the inclusion of health services in the socio-economic development plan of the Republic;
 - (c) determine the policies and measures necessary to protect, promote, improve and maintain the health and well-being of the population;
 - (d) ensure the provision of such essential health services, which must at least include primary health care services, to the population of the Republic as may be prescribed after consultation with the National Health Council; and
 - (e) equitably prioritise the health services that the State can provide.
 - (2) The national department, every provincial department and every municipality must establish such health services as are required in terms of this Act, and all health establishments and health care providers in the public sector must equitably provide health services within the limits of available resources.
- and section 4 provides:
- (1) The Minister, after consultation with the Minister of Finance, may prescribe conditions subject to which categories of persons are eligible for such free health services at public health establishments as may be prescribed.
 - (2) In prescribing any condition contemplated in subsection (1), the Minister must have regard to—
 - (a) the range of free health services currently available;
 - (b) the categories of persons already receiving free health services;

courts, it may not be with more than a passing reference to the provisions of the international conventions referred to earlier, since the National Health Act is not specifically enacting these conventions. Whilst they may have an influence in the manner in which the Act is interpreted, it is submitted that the South African courts are more likely to interpret the Act with reference to the Constitution and other relevant legislation such the Promotion of Equality and Prevention of Unfair Discrimination Act, the Promotion of Administrative Justice Act and the Promotion of Access to Information Act²². The constitutional right of access to health care services is part of a matrix of rights created in the Bill of Rights and other provisions of the

- (c) the impact of any such condition on access to health services; and
- (d) the needs of vulnerable groups such as women, children, older persons and persons with disabilities.
- (3) Subject to any condition prescribed by the Minister, the state and clinics and community health centres funded by the state must provide—
 - (a) pregnant and lactating women and children below the age of six years, who are not members or beneficiaries of medical aid schemes, with free health services;
 - (b) all persons, except members of medical aid schemes and their dependants and persons receiving compensation for compensable occupational diseases, with free primary health care services; and
 - (c) women, subject to the Choice on Termination of Pregnancy Act, 1996 (Act No. 92 of 1996), free termination of pregnancy services.

With regard to information accessibility section 6 of the Act provides that –

- (1) Every health care provider must inform a user of—
 - (a) the user's health status except in circumstances where there is substantial evidence that the disclosure of the user's health status would be contrary to the best interests of the user;
 - (b) the range of diagnostic procedures and treatment options generally available to the user;
 - (c) the benefits, risks, costs and consequences generally associated with each option; and
 - (d) the user's right to refuse health services and explain the implications, risks, obligations of such refusal.
- (2) The health care provider concerned must, where possible, inform the user as contemplated in subsection (1) in a language that the user understands and in a manner which takes into account the user's level of literacy and section 10 of the Act stipulates that –
 - (1) A health care provider must provide a user with a discharge report at the time of the discharge of the user from a health establishment containing such information as may be prescribed.
 - (2) In prescribing the information contemplated in subsection (1), the Minister must have regard to—
 - (a) the nature of the health service rendered;
 - (b) the prognosis for the user; and
 - (c) the need for follow-up treatment.

A discharge report provided to a user may be verbal in the case of an outpatient, but must be in writing in the case of an inpatient

and section 12 of the Act provides that –

The national department and every provincial department, district health council and municipality must ensure that appropriate, adequate and comprehensive information is disseminated on the health services for which they are responsible, which must include—

- (a) the types and availability of health services;
- (b) the organisation of health services;
- (c) operating schedules and timetables of visits;
- (d) procedures for access to the health services;
- (e) other aspects of health services which may be of use to the public;
- (f) procedures for laying complaints; and
- (g) the rights and duties of users and health care providers.

With regard to physical accessibility the Bill creates a licensing system in chapter 6 based on need which will regulate the distribution of health establishments throughout the country in accordance with the criteria specified in the chapter.

22

Act No 4 of 2000, Act No 3 of 2000 and Act No 2 of 2000 respectively. As noted below, although section 233 of the Constitution requires courts when interpreting legislation to prefer an interpretation that is consistent with international law over one that is inconsistent with it, international law is generally not helpful when it comes to the level of detail required to resolve specific situations. Furthermore, it is submitted that where the Constitution is not on all fours with international law on a particular issue, the provisions of the Constitution will take precedence as demonstrated by the approach of the Constitutional court to minimum core content of socio-economic rights. A further problem is that it is not entirely clear what is meant by international law. It is fairly obvious that public international law and customary international law are included but it is not so obvious that private international law and *jus cogens* are also intended. The Constitution does not define the term 'international law'. Furthermore, where the provisions of public international law themselves conflict, as can happen with international trade agreements and conventions on human rights from time to time, the dilemma is which international law must the courts prefer. The answer, it is submitted lies in domestic law and more specifically the Constitution. The courts will always revert to the Constitution, as the foundation of the South African legal system, when resolving matters involving socio-economic rights.

Constitution which means that it has to be considered in the context of that matrix and a balancing exercise has to be undertaken in the event of a conflict of rights.

Section 231(4) of the Constitution states that any international agreement becomes law in the Republic when it is enacted into law by national legislation; but a self-executing provision of an agreement that has been approved by Parliament is law in the Republic unless it is inconsistent with the Constitution or an Act of Parliament. The International Health Regulations are the only international agreement that has so far been expressly enacted into law falling within the portfolio of the Minister of Health²³. Since international law binds nation states rather than their individual subjects, international law is unlikely to have direct application within South Africa. However, it clearly can and does exert a strong influence on how legislation within South Africa is formulated and interpreted and, because of the provisions of section 39(1)(b) of the Constitution, is also a factor that cannot be ignored by the judiciary when interpreting the Bill of Rights. It is not, however, only international agreements to which South Africa is a party that inform the domestic legal system. As Dugard²⁴ points out, fears that international human rights law might be narrowly construed to cover only clear rules of customary law, and those human rights conventions to which South Africa is a party, were dispelled by the decision of the constitutional court in *S v Makwanyane and Another*²⁵. The judiciary is enjoined in section 233 of the Constitution when interpreting any legislation, to prefer any reasonable interpretation of the legislation that is consistent with international law over any alternative interpretation that is inconsistent with international law. Moreover, section 233 of the Constitution provides that customary international law *is* domestic law where it is not inconsistent with the Constitution or an Act of Parliament. The problem with international law, especially public international law, is that it sometimes suffers from vagueness as to the practical details necessary for its implementation. The costing of

²³ The International Health Regulations Act 28 of 1974 specifically defines 'the International Health Regulations' as the International Health Regulations adopted by the World Health Assembly at Boston on 25 July 1969, and set out in the Schedule.

²⁴ Dugard *J International Law: A South African Perspective* at p 264

²⁵ *Makwanyane* 1995 (3) SA 391 (CC) where Chaskalson JP stated at p 413: "In the context of s 35(1), public international law would include non-binding as well as binding law. They may both be used under the section as tools of interpretation. International agreements and customary international law accordingly provide a framework within which chap 3 can be evaluated and understood, and for that purpose, decisions of tribunals dealing with comparable instruments, such as the United Nations Committee on Human Rights, the Inter-American Commission on Human Rights, the Inter-American Court of Human Rights, 49 the European Commission on Human Rights, and the European Court of Human Rights and, in appropriate cases, reports of specialised agencies such as the International Labour Organisation, may provide guidance as to the correct interpretation of particular provisions of chap 3." [Footnotes omitted]

legislative measures and the assessment of the resources and infrastructures necessary to implement law are usually neglected aspects of domestic legal systems - especially in developing countries. This is even more true of international law. If it is no small task to quantify the financial and operational implications of domestic law it is almost impossible to do so with regard to international law. The wealthy, developed countries of the world seldom if ever talk directly about the costs of implementing international human rights instruments but readily speak, for instance, of the minimum core of socio-economic rights that should obtain within poverty-stricken developing countries.

Despite the fact that the approach of public international law to health care services is much broader and more comprehensive than that of the South African legal system in that the former recognises the right to health rather than just a right of access to health care services, it is submitted that the approach of the latter is preferable for a number of different reasons. Some of these are apparent in the judgments of the constitutional court dealing with the concept of the minimum core contents of socio-economic rights²⁶. The court in these cases preferred to look at whether the state had acted

²⁶ Thus in *Government of the Republic of South Africa and Others v Grootboom and Others* 2001 (1) SA 46 (CC) the constitutional court observed that: "It is not possible to determine the minimum threshold for the progressive realisation of the right of access to adequate housing without first identifying the needs and opportunities for the enjoyment of such a right. These will vary according to factors such as income, unemployment, availability of land and poverty. The differences between city and rural communities will also determine the needs and opportunities for the enjoyment of this right. Variations ultimately depend on the economic and social history and circumstances of a country. All this illustrates the complexity of the task of determining a minimum core obligation for the progressive realisation of the right of access to adequate housing without having the requisite information on the needs and the opportunities for the enjoyment of this right. The committee developed the concept of minimum core over many years of examining reports by reporting states. This Court does not have comparable information. The determination of a minimum core in the context of the right to have access to adequate housing presents difficult questions. This is so because the needs in the context of access to adequate housing are diverse: there are those who need land; others need both land and houses; yet others need financial assistance. There are difficult questions relating to the definition of minimum core in the context of a right to have access to adequate housing, in particular whether the minimum core obligation should be defined generally or with regard to specific groups of people. As will appear from the discussion below, the real question in terms of our Constitution is whether the measures taken by the state to realise the right afforded by s 26 are reasonable. There may be cases where it may be possible and appropriate to have regard to the content of a minimum core obligation to determine whether the measures taken by the state are reasonable. However, even if it were appropriate to do so, it could not be done unless sufficient information is placed before a Court to enable it to determine the minimum core in any given context. In this case, we do not have sufficient information to determine what would comprise the minimum core obligation in the context of our Constitution. It is not in any event necessary to decide whether it is appropriate for a Court to determine in the first instance the minimum core content of a right." (Footnotes omitted)

In *Minister of Health and Others v Treatment Action Campaign and Others* (No 2) 2002 (5) SA 721 (CC) the constitutional court stated that: "In effect what the argument comes down to is that ss 26 and 27 must be construed as imposing two positive obligations on the state: one an obligation to give effect to the s 26(1) and s 27(1) rights; the other a limited obligation to do so progressively through 'reasonable legislative and other measures, within its available resource'. Implicit in that contention is that the content of the right in ss (1) differs from the content of the obligation in ss (2). This argument fails to have regard to the way ss (1) and (2) of both ss 26 and 27 are linked in the text of the Constitution itself, and to the way they have been interpreted by this Court in *Soobramoney* and *Grootboom*. Section 26(1) refers to the 'right' to have access to housing. Section 26(2), dealing with the State's obligation in that regard, requires it to 'take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of this right'. The reference to 'this right' is clearly a reference to the s 26(1) right. Similar language is used in s 27, which deals with health care services, including reproductive health care, sufficient food and water, and social security, including, if persons are unable to support themselves and their dependants, appropriate social assistance. Subsection (1) refers to the right everyone has to have 'access' to these services; and ss (2) obliges the state to take

reasonably in the circumstances – a very pragmatic and far more tangible approach to socio-economic rights than that postulated by international law. International law, in terms of the minimum core concept, attempts to set a universal benchmark against which all efforts to achieve the realisation of the right to health are to be measured, irrespective of the resources available to a particular country or the circumstances of the individuals whose rights are affected. Whilst such an approach might be appropriate for international law – especially public international law - since its main objective as law seems to be to set norms and standards for various national legal systems to live up to, it is not so useful when it comes to the implementation of more or less the same principles within a domestic legal system. The primary object of the South African domestic legal system is not so much to set norms and standards as it is to ensure that the state fulfils its constitutional obligation to respect, protect, promote and fulfil the rights in the Bill of Rights with regard to the terms in which the Constitution is written. Unlike international law, domestic law must have teeth when it comes to the resolution of specific cases in which particular circumstances obtain with regard to identifiable individuals. It is submitted that the approach of South African domestic law, and more particularly South African constitutional law, to the question of the right of access to health care services has far more meaning and significance for those individuals seeking to enforce that right than do the precepts of international law with its top-down, minimum core approach that is not anchored to the realities of each particular situation. The scarcity of resources is one such reality. A socio-economic right which does not take realities of this nature into account ends

'reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights': The rights requiring progressive realisation are those referred to in ss 27(1)(a), (b) and (c). In *Soobramoney* it was said: 'What is apparent from these provisions is that the obligations imposed on the state by ss 26 and 27 in regard to access to housing, health care, food, water and social security are dependent upon the resources available for such purposes, and that the corresponding rights themselves are limited by reason of the lack of resources.' The obligations referred to in this passage are clearly the obligations referred to in ss 26(2) and 27(2), and the 'corresponding rights' are the rights referred to in ss 26(1) and 27(1). This passage is cited in *Grootboom*. It is made clear in that judgment that ss 26(1) and 26(2) 'are related and must be read together'. Yacoob J said: 'The section has been carefully crafted. It contains three subsections. The first confers a general right of access to adequate housing. The second establishes and delimits the scope of the positive obligation imposed upon the state. . . .'

It is also made clear that 's 26 does not expect more of the sState than is achievable within its available resources' and does not confer an entitlement to 'claim shelter or housing immediately upon demand' and that as far as the rights of access to housing, health care, sufficient food and water, and social security for those unable to support themselves and their dependants are concerned, 'the state is not obliged to go beyond available resources or to realise these rights immediately'. In *Grootboom* reliance was also placed on the provisions of the Covenant. Yacoob J held that in terms of our Constitution the question is 'whether the measures taken by the state to realise the right afforded by s 26 are reasonable'.

Although Yacoob J indicated that evidence in a particular case may show that there is a minimum core of a particular service that should be taken into account in determining whether measures adopted by the state are reasonable, the socio-economic rights of the Constitution should not be construed as entitling everyone to demand that the minimum core be provided to them. Minimum core was thus treated as possibly being relevant to reasonableness under s 26(2), and not as a self-standing right conferred on everyone under s 26(1). He said that a "purposive reading of ss 26 and 27 does not lead to any other conclusion. It is impossible to give everyone access even to a 'core' service immediately. All that is possible, and all that can be expected of the state, is that it act reasonably to provide access to the socio-economic rights identified in ss 26 and 27 on a progressive basis." [Footnotes omitted]

up being hollow and largely unenforceable. The circumstances of the particular case are another reality. It is not enough, said the court in *Grootboom*²⁷ that the measures taken by the state though statistically successful, fail to respond to the needs of those most desperate. The rights of the individual are of paramount importance in considering South African constitutional rights. This does not mean that the rights of the individual must always take precedence over the rights of the collective or of other individuals²⁸. However the statement of the court in *Grootboom* referred to earlier and in other cases²⁹ demonstrates the focus in constitutional law on the individual. Sachs J noted in *Ex Parte Gauteng Provincial Legislature: In Re Dispute Concerning the Constitutionality of Certain Provisions of the Gauteng School Education Bill of*

²⁷ *Grootboom* fn 26 *supra*. Yacoob J observed at p 69 “Furthermore, the Constitution requires that everyone must be treated with care and concern. If the measures, though statistically successful, fail to respond to the needs of those most desperate, they may not pass the test.”

²⁸ The decisions of the courts in *Soobramoney v Minister of Health, KwaZulu-Natal* 1998 (1) SA 430 (D) and *Soobramoney v Minister of Health, KwaZulu-Natal* 1998 (1) SA 765 (CC) and in *Park-Ross And Another v Director: Office For Serious Economic Offences* 1995 (2) SA 148 (C) where the court stated: “While a purposive approach to the interpretation of the Constitution may be required, it does not mean that the rights of individuals entrenched in the Constitution are absolute or limitless or that limitations to such rights are not accepted (see *Rudolph and Another v Commissioner for Inland Revenue and Others NNO* 1994 (3) SA 771 (W) at 774D). It is self-evident that limitations must exist. As stated in the *Corpus Juris Secundum* vol 16A para 451 (at 465-6), in respect of the United States Constitution, they must ‘at times give way when they are in conflict with rights granted for the protection, safety and general welfare of the public. . . .’ Restrictions on (individual) rights are permissible if reasonable and designed to accomplish a purpose properly within the purview of the police power” are sufficient evidence of this.

²⁹ *S v Makwanyane And Another* fn 25 *supra*: “Recognising a right to dignity is an acknowledgement of the intrinsic worth of human beings: human beings are entitled to be treated as worthy of respect and concern....Respect for the dignity of all human beings is particularly important in South Africa. For apartheid was a denial of a common humanity. Black people were refused respect and dignity and thereby the dignity of all South Africans was diminished. The new Constitution rejects this past and affirms the equal worth of all South Africans....But human dignity is important to all democracies. In an aphorism coined by Ronald Dworkin, ‘Because we honour dignity, we demand democracy’. Its importance was recognised too by Cory J in *Kindler v Canada (Minister of Justice)* (1992) 6 CRR (2nd) 193 (SCC) at 237 in which he held that ‘(i)t is the dignity and importance of the individual which is the essence and the cornerstone of democratic government’. [Footnotes omitted]

Ferreira v Levin No And Others; Vryenhoek And Others v Powell No And Others 1996 (1) SA 984 (CC): “Human dignity cannot be fully valued or respected unless individuals are able to develop their humanity, their ‘humanness’ to the full extent of its potential. Each human being is uniquely talented. Part of the dignity of every human being is the fact and awareness of this uniqueness. An individual’s human dignity cannot be fully respected or valued unless the individual is permitted to develop his or her unique talents optimally. Human dignity has little value without freedom; for without freedom personal development and fulfilment are not possible. Without freedom, human dignity is little more than an abstraction. Freedom and dignity are inseparably linked. To deny people their freedom is to deny them their dignity. Although freedom is indispensable for the protection of dignity, it has an intrinsic constitutional value of its own. It is likewise the foundation of many of the other rights that are specifically entrenched. Viewed from this perspective, the starting point must be that an individual’s right to freedom must be defined as widely as possible, consonant with a similar breadth of freedom for others.”

Harksen v Lane NO and Others 1998 (1) SA 300 (CC): “We have interpreted s 8(2) as a clause which is primarily a buffer against the construction of further patterns of discrimination and disadvantage. Underpinning the desire to avoid such discrimination is the Constitution’s commitment to human dignity. Such patterns of discrimination can occur where people are treated without the respect that individual human beings deserve and particularly where treatment is determined not by the needs or circumstances of particular individuals, but by their attributes and characteristics, whether biologically or socially determined.”

Christian Education South Africa v Minister of Education 2000 (4) SA 757 (CC): “The presence of s 31 in the Bill of Rights may be understood as a product of the two-stage negotiation process resulting in the adoption of the final Constitution, in which one of the concerns was how community rights could be protected in a non-racial parliamentary democracy based on universal suffrage, majority rule and individual rights. Constitutional Principle (CP) XI 18 declared that the diversity of language and culture should be acknowledged and protected and conditions for their promotion encouraged. CP XII stated that collective rights of self-determination in forming, joining and maintaining organs of civil society, including linguistic, cultural and religious associations, should be recognised and protected. The Constitution complies with these Principles in a number of different ways. Thus, language rights and rights of belief are first spelt out fully as individual rights in ss 15 and 30, even though they have a community dimension and are frequently exercised in a community setting.”

1995³⁰ that a review of literature by leading authors in the field suggested that over the years there had been a firm movement from the concept of tolerance of religious and other minorities, to that of protection of national groups, to that of guaranteeing rights of individuals. This observation may be true of rights relating to religion but does not necessarily seem to be the case with regard to international rights relating to health care. Article 12(2) of the International Covenant on Economic, Social and Cultural Rights states that:

“The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:

- (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
- (b) The improvement of all aspects of environmental and industrial hygiene;
- (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
- (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.”

The four factors listed above are not, it is submitted, concerned so much with the rights to health of individuals but rather the health of the collective that can be measured in terms of statistics.

The focus of international law thus seems to be more at the macro, collective, level rather than at the micro, individual level when it comes to the right to health. This is understandable since it applies to nation states rather than the individual citizens of those nation states. Domestic law, however, must be binding upon individuals if it is to have any significance or impact upon the manner in which people conduct their affairs. It seems that the primary difference between the approach of the South African legal system and that of international law³¹ to the realisation of socio-economic rights is that the former favours a bottom-up approach whereas the latter favours a top-down approach. The value of the bottom-up approach is that it is a more rational and pragmatic method of ensuring the development of domestic law that is capable of realistically addressing the wide variety of individual needs in South Africa

³⁰ *Ex Parte Gauteng Provincial Legislature* 1996 (3) SA 165 (CC)

³¹ To the extent that international law could be said to have an internally consistent approach.

concerning access to health care services. While concepts such as minimum core may be of direct relevance in homogenous societies with more equitable distributions of wealth and resources, and similar cultural values and beliefs, it is submitted that the diversity of South African society in itself renders the concept problematic in a local context. The available resources in each situation are different. Furthermore different situations call for different kinds of resources at different levels of availability. They do not only vary across parameters such as urban versus rural, public versus private and socioeconomic levels but they also vary in terms of the disease profiles of various populations, the health needs of people in various geographical areas, genetic and cultural differences, community size and type, age groupings etc. At the individual level there are even more variables such as the health status, age, socio-economic status, level of familial or community support, literacy and educational levels, gender etc. Unfair discrimination can be the result of a policy that treats everyone the same since in the health care context, the needs of everyone are not the same. It is submitted that the South African Constitution's emphasis on equality renders the minimum core approach of international law unworkable and in many instances unreasonable because health service delivery has to be personalised to meet the needs of each unique individual.

Public international law still has a significant way to go before it reaches any internal consistency on the general international law front with regard to views on matters such as health care and access to goods and services necessary for the maintenance, preservation and promotion of mental and physical health that, according to international law, is the right of every person. Some of the hottest international legal debates in recent years are represented by the widely differing stances of two international organisations – the World Health Organisation and the World Trade Organisation³². The former actively supports the supply of medicines and other health

³² In 2002 the World Health Organisation and the World Trade Organisation published a document entitled 'WTO Agreements and Public Health: A Joint Study by the WTO and WHO Secretariat'. In the foreword Dr Gro Harlem-Brundtland and Mike Moore of the WHO and WTO respectively note that: "As the world becomes increasingly integrated, it becomes less and less possible for different policy areas to be handled independently of each other. The linkage between trade and health has been the focus of much debate: real concerns should be dealt with and any misunderstandings should be clarified based on sound evidence and rigorous analysis... In both the WHO and the WTO questions of trade and public health feature high on the agenda, and significant advances have been made in the recent past. The endorsement by the international community of the Doha Declaration on the TRIPS Agreement and Public Health is a very visible expression of governments' commitment to ensuring that the rules-based trading system is compatible with public health interests." It is stated in the report that: "While the WTO Agreements explicitly allow governments to take measures to restrict trade in pursuing national health policy objectives, the emphasis in WTO rules is on how policies are pursued without questioning the underlying objective." The Report considers each of the WTO Agreements and their relevance to health. The Report states with regard to the TRIPS Agreement that: "The areas of



care products to developing countries at little or no cost to those countries whilst the interests of the latter lie in the maximisation of the global profits of multinational organisations and the exploitation by them to the full of their hard won intellectual property. Medicines, and to a lesser extent medical devices, are often at the forefront of these debates. Specific international law can have an impact on domestic law. One of the major objections of the Pharmaceutical Manufacturer's Association to the

intellectual property covered by the TRIPS Agreement that are relevant to health include: patents; trademarks including service marks, which are relevant, for example, to combating counterfeit drugs; and undisclosed information, including trade secrets and test data. In respect of each of these areas, the Agreement sets out the minimum standards of protection that must be adopted by each Member. Each of the main elements of protection is defined, namely the subject matter to be protected, the rights to be conferred and permissible exceptions to those rights, and the minimum duration of protection. The standards build on those in the main pre-existing WIPO Conventions, substantive provisions of which are incorporated into the Agreement by reference. While the focus here is on patents, this is only one part of the TRIPS Agreement. One of the purposes of the TRIPS Agreement is, for instance, also to provide for more effective international cooperation against counterfeiting, including international trade in counterfeit goods, such as drugs... Patent protection for pharmaceutical products is an area where the problem of finding a proper balance is particularly acute - namely, between the goal of providing incentives for future inventions of new drugs and the goal of affordable access to existing drugs. It is especially important from a social and public health point of view that new drugs and vaccines to treat and prevent diseases are generated, and that the incentives provided by the patent system effectively promote this. Precisely because of the social value of the drugs so generated, they need to be widely accessible as quickly as possible. The patent system provides for, on the one hand, exclusive rights granted to inventors of new drugs, and, on the other hand, the requirement that for a new drug to benefit from such rights (to be patentable), it must be new, involve an inventive step, be industrially applicable and be fully disclosed, and further that after a term of protection the invention will fall into the public domain and become free and useable by all. In addition, the TRIPS Agreement contains several other provisions enabling governments to implement their intellectual property regimes in a manner which takes account of immediate and longer-term public health considerations. Article 8 explicitly recognizes the right of WTO Members to 'adopt measures necessary to protect public health and nutrition, and to promote the public interest in sectors of vital importance to their socio-economic and technological development, provided that such measures are consistent with the provisions of this Agreement.' Furthermore, the TRIPS Agreement provides for certain exemptions from patentability, the possibility to make limited exceptions to patent owners' exclusive rights, compulsory licensing, and parallel importation. International conventions before TRIPS did not usually specify the minimum standards for patents. Over 40 countries provided no product patent protection for pharmaceuticals prior to the launching of the negotiation of the TRIPS Agreement and some 20 WTO Members still did not do so by the time of the conclusion of the TRIPS negotiations. A few of these countries did not provide process protection in this area as well. The duration of patents was less than 20 years in many countries. TRIPS rules require WTO Members to provide patent protection for any invention, whether a product (such as a medicine) or a process (such as a method of producing the chemical ingredients for a medicine), while allowing certain exceptions. Patent protection has to last at least 20 years from the date the patent application was filed. As in other WTO Agreements, non-discrimination is a core TRIPS principle. With some exceptions, Members must not discriminate on the basis of the nationality of persons or companies (Articles 3, 4 and 5). In addition, Members cannot discriminate between different fields of technology in the availability and enjoyment of patent rights. Nor can they discriminate in these areas on the basis of the place of invention and whether products are imported or locally produced. As the TRIPS Agreement does not define the terms "new", "inventive step" and "non-obvious", national patent laws vary in how they construe these terms for the purposes of evaluating patent applications. Patentability standards which are too lax can make it possible to obtain protection for relatively minor innovations. Some concern has been expressed that this can facilitate what is sometimes referred to as "evergreening" of pharmaceutical patents, meaning that improved versions of the original drug may stay under patent protection even after the original version has fallen into the public domain. Very strict criteria may make it more difficult for small and medium-sized enterprises to use the patent system, especially in developing countries. Regarding eligibility for patenting, governments can refuse to grant patents for three reasons that may relate to public health: (a) inventions whose commercial exploitation needs to be prevented to protect human, animal or plant life or health; (b) diagnostic, therapeutic and surgical methods for treating humans or animals; (c) plant and animal inventions other than micro-organisms, and essentially biological processes for the production of plants or animals other than non-biological and microbiological processes. Under the TRIPS Agreement, governments can make limited exceptions to patent rights provided certain conditions are met. These exceptions must not "unreasonably" conflict with the "normal" exploitation of the patent and must not unreasonably prejudice the legitimate interests of the patent owner, taking into account the legitimate interest of third parties (Article 30). A range of exceptions may be covered by this provision. For example, many countries provide for a "research" or "experimental use" exception to allow researchers to use a patented invention for research, in order to understand the invention more fully. In addition, Article 30 permits countries to allow manufacturers of generic drugs to use the patented invention, without the patent owner's permission and before the patent protection expires, for the purpose of obtaining marketing approval from public health authorities. Generic producers are thus able to market their versions almost as soon as the patent expires. This provision is sometimes called the "regulatory exception" or "Bolar" provision, and has been upheld as conforming with the TRIPS Agreement in a WTO dispute ruling: in a report adopted on 7 April 2000, a WTO dispute settlement panel stated that Canadian law was consistent with the TRIPS Agreement in allowing manufacturers to do so."

Medicines and Related Substances Control Amendment Act³³ was that it allowed the violation of the TRIPS Agreement by the South African government. The matter was eventually settled out of court with the National Department of Health retaining its legislation intact. This is an example of the way in which international law as contained in international agreements can impact upon South African domestic law relating to health service delivery. The hotly contested amendment allowed for parallel importation of medicines by the South African government. To date the state has not invoked this particular provision of the Act. It is submitted that as a developing country, the South African legal system is most likely to run into conflict situations with international law on the medicines front. The manufacturers of pharmaceuticals are largely multinational organisations operating in global markets and they are the ones most likely to invoke international trade agreements in order to counter a legislative innovation or policy directive of the National Department of Health.

The WTO and the WHO note in their joint report that putting WTO rules into practice can raise difficult questions for health policy makers. For example, what happens when, for a given hazard, there is uncertainty about the risk? This poses a challenge for regulatory action, and responses to uncertainty and risk are likely to be different in different countries. Among the factors to be considered may be the trade-restrictiveness and efficacy of the measure to achieve the level of health protection sought. The WHO has developed International Health Regulations in the interests of infectious disease control. In the report it is noted that in exceptional circumstances, infectious disease control may require trade or travel restrictions. In the past, disease outbreak control concentrated on quarantines or trade embargoes. In recent years, a combination of sensitive early warning surveillance systems, rapid verification procedures and international response networks, epidemic preparedness plans and stockpiles of essential medicines has reduced the need to employ trade embargoes or travel restrictions. The Report states that to the extent trade restrictions are used, they should be time-limited and try to minimize disruption to international trade. This is one of the fundamental principles underlying the WHO's current revision of the International Health Regulations. The renewed International Health Regulations will

³³ Medicines Amendment Act 90 of 1997

serve as the legal framework for the WHO's efforts to prevent disease epidemics from spreading globally. The historic purpose of the International Health Regulations is to "ensure the maximum security against the international spread of diseases, with a minimum interference with world traffic." This purpose will continue in the new International Health Regulations.

In the Report³⁴ it is stated that specific measures used to control infectious diseases, whether adopted by national governments, or recommended by WHO in the performance of its IHR duties, may be subject to WTO rules if they affect trade in goods or services. Which rules are relevant will depend on the circumstances of the particular case. For example, while sanitary measures to halt the spread of a food- or animal-borne infectious disease could have a substantial trade impact and would be covered by the SPS Agreement, it is unlikely that regulatory action aimed at mitigating such risks - whatever the pathway or nature of the disease - would run contrary to WTO rules. It is clear from this that the right to health, as envisaged by the WHO³⁵ is something potentially quite different when mitigated by WTO Agreements. The right to health, it seems, must not interfere unduly with world trade³⁶.

The first chapter of this thesis identifies the different kinds of international law and their relevance to and influence upon South African domestic law in terms of sections 231, 232 and 233 of the Constitution. The point is made in this chapter that consistency is a prerequisite of a rational and clearly principled domestic legal system. The lack of consistency in international law is not only within public international law but it is also evident within the *jus cogens* and customary international law. These areas of international law seem to be lacking in clear beacons of common principle and understanding that would suggest an internally consistent approach within international law to the question of the right of access to health care

³⁴ WTO/WHO Report fn 32 *supra*

³⁵ The WHO defines health as "a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity". "Public health" refers to all organized measures (whether public or private) to prevent disease, promote health, and prolong life of the population as a whole.

³⁶ See Mitra S 'WTO Agreements and Public Health: A nexus rather than an agreement' who criticises the WTO/WHO study as having belied the expectations of those who had hoped for a critical analysis of WTO policies and the likely impact they would have on public health, especially in developing countries. Mitra comments that on the question of coherence between health and trade policies the report states that the WHO's objective is "the attainment of all peoples of the highest possible level of health". And what, asks Mitra, has that to do with trade? In this regard the report says, "an underlying assumption is that a liberal international trade regime, subject to reasonably stable and predictable conditions, improves the climate for investment, production and employment creation, and therefore contributes to economic growth and development. Generally the health status of a country is affected positively by such growth."

services or a right to health generally. It is submitted that international law and South African domestic law relating to health service delivery, whilst they may share the same conceptual structures at some deep level, are far from continuous or even contiguous and that while they have some broad common interests, there are many differences in the detail of their respective approaches to this topic.

10.2.1 Criticisms of International Law

There is no country in the world in which international law applies independently of national or domestic law or where it is the only prevailing system of law. Thus even in those countries whose legal systems espouse automatic incorporation, as opposed to legislative incorporation, or international law into their domestic legal systems, this incorporation is by virtue of domestic, often constitutional legal provisions rather than any stipulation within international law itself. As a result, international law has the potential to be differently understood and applied in practice by various nations states. Its homogeneity, as least as far as its practical application is concerned, is thus notional. It follows that the same can be said of its theoretical and practical content. A right to health, or of access to health care services, is still not recognised in the USA - one of the wealthiest countries of all and with one of the most expensive health systems in the world. By contrast, the right of access to health care services has been recognized in Venezuela, a developing country with a marked lack of resources, despite the fact that the Venezuelan government apparently lacks the means to comply with court orders upholding this right³⁷. There has to be a time and place where ideology and reality meet in order for law to become relevant and meaningful. Unfortunately such a happy tête-à-tête seems largely to have eluded international law at least as far as a right to health, or even health care, is concerned.

International law does not take into account inequalities between societies³⁸. Foreign aid, when it is made available, comes with a subtle price tag that sometimes directly

³⁷ Torres, 'The Human Right To Health, National Courts and Access to HIV/AIDS Treatment: A Case Study from Venezuela' *Chicago Journal of International Law* Spring 2002, 105.

³⁸ Kingsbury B 'Sovereignty and Inequality' *European Journal of International Law* 9 (1998) 599-625 observes that inequality is one of the major subjects of modern social and political inquiry but it has received minimal consideration as a theoretical topic in the recent literature of international law. He argues that the lack of other means to cope with inequality is a serious problem for international law that has been wrongly neglected, but that the lack of such an alternative provides a strong reason to adhere to the existing concept of sovereignty, however much it may be "strained by practice and problematized by theory". He states that: "The theory of sovereignty has relieved international lawyers

undermines the sovereignty of the country for whom the aid is destined. The funding in question is often placed in the hands of non-governmental and other private organisations rather than those of the government – no matter how democratically elected. If it is the primary responsibility of the government in question to ensure the progressive realisation of socio-economic and other rights, foreign funding that is channelled away from that government into the private sector has the effect of disempowering government to fulfil its mandate. Yet international law imposes these human rights obligations not upon the private or non-governmental sectors within developing countries but upon their governments. Operationally and functionally speaking therefore, international law is weak³⁹ and subject to manipulation by the

of the need for a general theory of the legal management of inequality in three ways. First the concept of sovereignty underpins a principle of sovereign equality that has attained an almost ontological position in the structure of the international legal system. This ontological status makes enough difference in the processes of international law and politics to modestly vindicate the significance and effectiveness of the system of sovereign equality: thus very small states are procedurally on an equal footing with the largest or most powerful states in the International Court of Justice, and groups of small states have made some difference in the dynamics of multilateral bargaining on issues such as climate change. In the same spirit, legal doctrines of the special status of great powers have been in the descendant since 1945, and such matters as the structure of the Non-Proliferation Treaty or the UN Security Council are dealt with by most legal writers as anomalies, however necessary or enduring, in the scheme of sovereign equality. This conceptual scheme serves, if very unevenly, as a counter to the vast inequalities that might otherwise be expected to feature in the formal structure of the legal system. Second, the concept of state sovereignty allows questions of social and economic inequality among people to be treated in international law as a responsibility of territorial states. International law and legal institutions are able to promote market activity, for example, through the World Trade Organization or the International Monetary Fund, while in theory leaving largely to states the responsibility of mitigating social and economic inequalities associated with markets. Episodic attempts to address economic and social inequality directly through substantial non-market changes in the international legal order have met with little success outside the established human rights and environmental programmes. Despite economic and political turbulence associated in some respects with inequality, concerns about it have remained displaced by preoccupations with reducing the role of the state in economic activity and in major market-distorting egalitarian redistribution. International institutions continue to play important roles in economic development, and political leaders in prosperous countries confronted with concerns about poverty or maldistribution abroad increasingly hope for solutions from the World Bank and other intergovernmental agencies along with bilateral assistance and the much-vaunted voluntary sector. There is, however, a growing incongruence between the increasing market orientation of international law and the inability of international governance institutions or of many sovereign states to cope with problems of inequality that markets alone do not resolve...Third, the theory of sovereignty provides the means by which people can express, and be deemed to have expressed, consent to the application of international legal norms and to international institutional competences. Consent, whether express or tacit, plays a role in legitimating international legal rules and institutional activities in situations where their legitimacy may be in doubt, as where they infringe deeply held egalitarian principles. This legitimating function is of vast importance for the international legal system. It is not clear that in the present state of heterogeneous international society, any non-consensual legitimating principle is viable; and sovereignty appears to be a relatively low cost means to organize 'consent'."

39

For example, Fidler DP 'Globalization, International Law and Emerging Infectious Diseases' notes that although international control plans would involve private organizations like universities and nongovernmental organizations, the primary actors on the emerging infections stage are sovereign states. He states "The action plans are predominantly blueprints for co-operation among states and represent a call for the internationalization of responses to a problem caused by globalization. Put another way, the proposed solutions to the emerging infections threat rely on the sovereign state, while the threat feeds off the impotence of the state in addressing global disease problems. When it comes to public health activities, globalization erodes sovereignty, but the proposed solution makes sovereignty and its exercise critical to dealing with the threat of emerging infections. The consequences of the unavoidable emphasis on international cooperation in the proposed action plans for emerging infections are troubling. To achieve the desired objectives... states will have to agree on many issues and translate such agreement into guidelines or rules. International law becomes important to the effort for emerging infections control. Political leaders, diplomats and scholars have long recognized the weakness of international law in regulating state behaviour. At first glance the prospect of having to rely on a notoriously weak institution of international relations as part of the global effort to combat emerging infections is unsettling.... The success of WHO in globalizing disease control programs might suggest that the defects of international law have not hobbled its effectiveness in improving health care worldwide. However, despite having the authority to do so, WHO has been reluctant to use international law. The International Health Regulations administered by WHO represent the most important set of international legal rules relating to infectious disease control but the regulations only apply to plague, yellow fever and cholera. The importance of health is mentioned in international declarations (for example, see the Universal Declaration of Human Rights art. 25[1]) and treaties (for example see the International Covenant on Economic, Social and Cultural Rights, art.12), leading some legal scholars to argue that international law

more powerful, developed countries to suit their own purposes and further their own causes⁴⁰. The weakness of international law is nowhere more evident than in the

creates a "right to health"; but this "right" does not directly address the control of infectious diseases. WHO has refrained from adopting rules on trade in human blood and organs which does raise issues of infectious disease control as illustrated by the sale of HIV-contaminated blood in international commerce. Issues of disease control also appear in specialized treaty regimes outside WHO such as treaties controlling marine pollution from ships. Other areas of international public health law, for example, rules about infant formula and guidelines on pharmaceutical safety, do not deal with the control of infectious diseases." [Footnotes omitted] Fidler goes on to point out that the emerging infections problem exacerbates basic weaknesses in the law and that these infections pose specific difficulties in the law which are related to the nature of disease and its prevention. He observes that part of the reason that the existing International Health regulations cover only a few diseases might be the unwillingness of the WHO member states to commit to more serious infectious disease control measures. He notes that the vagueness and lack of specificity in the so-called "right to health" also illustrate this problem. Fidler identifies as a specific difficulty the extent of medical and scientific resources needed to establish an effective global surveillance and control network for emerging infectious diseases. Fundamental aspects of the proposed action plans involve improving surveillance networks, public health infrastructures, scientific research and medical and scientific training. He points out that some states, particularly in the developing world do not have the resources to undertake such measures. Unless more affluent countries provide the resources, developing states may use the inequity of wealth in the international system as an argument to complicate negotiating a global agreement. In Parisi F and Sellers M (eds) *International Legal Theory* (a Publication Of The American Society Of International Law Interest Group On The Theory Of International Law) it is stated that: "International law cannot make policy on its own, but people can. Normative knowledge can only serve as a frame of reference, although sometimes a compelling one, for statesmen, political leaders, organizations, corporations, and individuals, who, in the final analysis, are the ones who make the decisions. For normative knowledge, international law, like all law, is ineffective if it lacks "operators", that is, legal subjects entitled to use the law for particular purposes. ("Norms comprise symbols of normative conceptions about reality. A translation of these conceptions is operationalized by the user." B. Holzner *et al.*, Knowledge Application: The Knowledge System in Society 95 (1979).) States, organizations, relevant groups, and individuals can become both target subjects and operators of international legal and institutional frameworks. (The terms "operator," "actors," "decision makers," and "international participants" are used here to refer to international legal subjects that enjoy sufficient access and standing to create policy or make decisions. Thus, for example, states are the only operators and participants with access and standing at the International Court of Justice, though individuals may also become operators before an international human rights court. Presidents, Ministers, leaders of governmental and non-governmental organizations, organizations themselves, and individuals, if entitled with the authority to participate in a decision-making process, are operators or relevant actors....Once we acknowledge the essential role of human actors in international law, we can only ascertain the effectiveness of international law if, in addition to the more traditional bases of legal inquiry, we consider the interaction of what actors believe—or want to believe—the law is." http://law.ubalt.edu/cicl/ilt/2_1_1996.pdf

40 See for instance the views expressed in the following sources: Chang H, *Kicking Away the Ladder: Development Strategy in Historical Perspective* argues that developed countries did not become rich by adopting the 'good practices' and the 'good institutions' that they now present to poorer countries as the essential basis for development. He maintains that the industrialised nations are in this way 'kicking away the ladder' by which they climbed to the top, preventing the developing world from applying the very policies and institutions upon which they themselves had relied in order to develop.

Dichter T, *Despite Good Intentions: Why Development Assistance to the Third World has failed*. The author, himself a veteran aid-agency worker, surveys the history of development assistance from 1945, which has been premised on the belief that the industrialised countries could in some way engineer the acceleration of history in the less-developed world. He argues that the enterprise is internally flawed: the vast differences in power between the donors and recipients of aid, and the organisational imperatives to show 'results', conspire to keep the development industry in business and the unequal relationships intact. If the goal is for aid recipients to become autonomous, free of external control, then the first step has to be to reduce and not increase development assistance, since this serves principally to consolidate the power of the 'helpers'.

Ferguson, J *The Anti-Politics Machine: 'Development', Depoliticization, and Bureaucratic Power in Lesotho*, 1994 Based on a case study of a development project in Lesotho, the author of this work makes a searing critique of the development industry as a whole. The 'anti-politics machine' refers to the process through which outside 'development' agencies and experts wilfully turn the political realities of poverty and powerlessness into 'technical' problems which require an equally technical solution. Using an anthropological approach, the author analyses the institutional framework within which development projects are crafted, revealing how it is that, despite all the 'expertise' that goes into formulating them, these projects often betray a startling arrogance and deep ignorance of the historical and political realities of the communities whom they are intended to help.

Escobar, A *Encountering Development: The Making and Unmaking of the Third World* 1994. In this now classic presentation of post-development thought, Escobar offers a challenging critique of development discourse and practice, arguing that development policies deployed by the West to 'assist' impoverished countries are in effect self-reinforcing mechanisms of control that are just as pervasive and effective as colonialism was in earlier years. To capture the production of knowledge and power in development initiatives, Escobar uses case studies which illustrate how peasants, women, and nature, for instance, become objects of knowledge and targets of power under the 'gaze of experts'. He concludes with a discussion of alternative visions for a post development era.

Note: The reviews quoted above are in *Resources* <http://www.developmentinpractice.org/readers/Methods/resources.pdf> See also Nyamugasira W "Aid, Conditionality, Policy Ownership and Poverty Reduction: A Southern Perspective of Critical issues, Constraints and Opportunities", a background paper presented at the meeting of International Advisory Committee The Reality Aid Project, San Jose, Costa Rica, September 17-21, 2000.

<http://209.130.12.187/jpdfs/jiacwn.pdf>. The author, in asking how conditionality crept into the aid business, states that: "Conditionality is most powerful when collectively imposed. In recent years, individual bilateral donors have ceded much of their decision-making power to the IMF, which certifies that the macroeconomic management of a country is

Venezuelan case of *Cruz Bermudez, et al v Ministerri de Sanidad y Asistencia Social*⁴¹ where the judgment of the court made no difference to the harsh reality of a lack of necessary resources. Law in a vacuum is meaningless. International law in particular, lacks contextual value. While it is useful when it comes to broad general principles it is not instructive with regard to practical considerations involving individual cases.

International law does not regulate multinational corporations despite the enormous global power that they wield. International law applies to the governments of nation states and not private entities⁴². The major innovative pharmaceutical companies in the world fall into this category. They guard their intellectual property rights in the medicines they develop with missionary zeal, regardless of the effect on accessibility to these products for developing countries. Their research and development efforts are, furthermore, largely directed at dealing with the health problems of developed countries because that is where the money lies. Diseases of poverty are, by definition, unlikely to yield significant returns unless they start becoming a threat to the developed world⁴³. International law regulates none of this. In fact in many instances

sound and deserving of support. In addition, donors have increased coordination among themselves and increasingly present a united position to the recipient countries. Conditionality has succeeded because: Firstly, the recipients have been denied other alternative sources of development finance. Donors killed off all alternative channels for poor countries to obtain development finance, starting with independent thinking... Secondly comparative advantage has been applied to block potential to generate own resources, condemning Africa to exporting a narrow range of primary commodities whose exchange value never appreciates. Thirdly there is no ideological alternative, the one that gave so much hope to poor people and without which much of Africa would perhaps not have been liberated, having been finally dismantled. Fourthly, vulnerability has increased as developed countries cause exogenous shocks to already weak and vulnerable economies. Fifthly, South-South cooperation joint initiatives have been thwarted, making it hard for disaffected economies to extricate themselves from destructive conditions. The global economy is designed to work against them. Sixthly, have (sic) failed to learn alternative survival skills, poor countries are unable to create internal conditions that strengthen their negotiating position..."

⁴¹ See Torres fn 37 *supra*

⁴² Forsythe DP 'The Political Economy of Human Rights: Transnational Corporations' notes that "Transnational corporations (TNCs) drive globalization, meaning the increasing economic interconnectedness of the world. Their power is widely recognized. Also increasingly recognized is the good or ill they can do for human rights, especially labor rights. The public regulation of TNCs, especially for social reasons like human rights, has long been problematical. Global international law regulates states primarily, not TNCs...It has been long recognized that business enterprises that operate across national boundaries have an enormous impact on the modern world. If we compare the revenues of the twenty-five largest transnational corporations with revenues of states... we see that only six states have revenues larger than the nine largest TNCs.... The world's 200 largest TNCs are incorporated in just ten states above all in the United States and Japan." <http://www.du.edu/humanrights/workingpapers/papers/14-forsythe-03-01.pdf>

⁴³ Good examples of this are the diseases caused by parasites known as trypanosomes. Chagas' Disease (American trypanosomiasis) affects 16 to 18 million people in Latin America. Chagas disease is named after the Brazilian physician Carlos Chagas who first described it in 1909. The disease is endemic in 21 countries in Central and South America and is found only in the American Hemisphere. Still it affects 16-18 million people in Latin America and 100 million people are at risk of becoming infected. Chagas is caused by a protozoan parasite, *Trypanosoma cruzi*, transmitted to humans by blood-sucking insects known in various countries as the "kissing bug", "vinchuca", "barbeiro" or "chipo". The disease is caused by *Trypanosoma cruzi* (*T. cruzi*), a flagellated protozoan parasite. The parasite is transmitted to humans in two ways, either by a blood-sucking insect, which deposits its infective feces on the skin at the time of biting, or directly by transfusion of infected blood. Humans and a large number of species of domestic and wild animals constitute the reservoir, and the vector insects infest poor housing and thatched roofs. Chagas disease exists in both acute and chronic stages. After initial infection and a subsequent incubation period, the acute phase of infection begins and typically persists for two months. With a mortality rate of 2%-8%, acute disease is generally seen in children and is characterized by fever, swelling of lymph glands, enlargement of the liver and spleen, or local inflammation at the site of infection. But, commonly, there are no acute clinical manifestations, and those infected may remain without symptoms. Approximately one-third of acute cases progress to a chronic stage, which develops some 10-20 years later and can

cause irreversible damage to the heart, esophagus and colon, with dilatation and disorders of nerve conduction in these organs. Patients with severe chronic disease become progressively more ill and ultimately die, usually from heart failure. There is, at present, no effective treatment for such cases. The geographical distribution of the human *T. cruzi* infection extends from Mexico to the south of Argentina. The disease affects 16 - 18 million people and some 100 million people (about 25% of the population of Latin America) are at risk of acquiring Chagas disease. The risk of infection with Chagas disease is directly related to poverty: the blood-sucking triatomine bug which transmits the parasite finds a favorable habitat in crevices in the walls and roofs of poor houses in rural areas and in the peripheral urban slums. The rural/urban migration movements that occurred in Latin America in the 1970's and 1980's changed the traditional epidemiological pattern of Chagas disease and transformed it into an urban infection that can be transmitted by blood transfusion. The figures of infection of blood in blood banks in some selected cities of the continent vary between 3.0 and 53.0 % thus showing that the prevalence of *T. cruzi* infected blood is higher than that of HIV infection and Hepatitis B and C. Two treatments presently exist for Chagas disease in the acute stages: Benzidazole, given as twice-daily intravenous infusions for 60 days. • Nifurtimox, given as three times-daily intravenous infusions for 90 days. Both of these treatments are accompanied by frequent, serious and life-threatening side effects, and the months of treatment required for cure have led to resistance and high levels of treatment failures. Sources: Centers for Disease Control (CDC), United States, Division of Parasitic Disease, Chagas Disease Fact Sheet

http://www.cdc.gov/ncidod/dpd/parasites/chagasdisease/factsheet_chagas_disease.htm

and World Health Organization, Special Program for Research and Training in Tropical Diseases,

<http://www.who.int/tdr>; <http://www.oneworldhealth.org/>

In 'Rare Infection Could Affect U.S. Blood Supply' *Health Highlights: Nov. 18, 2003* it is reported: "A parasitic infection that's rare in the United States but common in Latin America could pose a danger to the U.S. blood supply because there's no test to detect it, *The New York Times* reports. While only nine cases of Chagas disease have been transmitted by blood transfusion or tissue transplant in North America in the past 20 years, more than 18 million people in Latin America are said to be infected. Some 50,000 people in Mexico, Central America and South America die from the disease each year, the newspaper says. A test to detect the disease isn't expected until next year at the earliest. The newspaper cites a Chagas expert at the American Red Cross, who says the risk of acquiring the disease through infected blood is only about 1 in 25,000. Since 1989, several expert panels to the U.S. Food and Drug Administration have recommended that all donated blood be screened for the disease. But no test has been approved yet, and the companies working on one concede they are under no pressure to finish their work, the *Times* reports. An FDA spokeswoman wouldn't rank Chagas among all threats to the U.S. blood supply, but added "we would certainly recommend a Chagas test if one is developed." <http://www.healthfinder.gov/news/newsstory.asp?docID=516099>. In October 2003 the WHO reported on Current global status of Chagas disease as follows: "Large-scale regional initiatives to halt vector-borne transmission and improved screening of blood-donors have been successful. At present, estimates indicate an infection prevalence of 13 million, with 3.0-3.3 million symptomatic cases and an annual incidence of 200,000 cases in 15 countries. The disease remains a priority health problem due to: the need for surveillance and control in areas where sylvatic vectors can invade dwellings; the medical and social costs of care for infected people in the absence of efficient and well-tolerated therapy, especially against the chronic form of the disease; the difficulty in obtaining priority for control activities and vector elimination in areas where vectorial transmission has been interrupted; and the need to continue strengthening mandatory blood-donor screening in endemic areas, as well as in non-endemic areas where increased travel and/or immigration of potentially infected donors might compromise donated blood supplies." It stated that "The complexity of the pathology of Chagas disease and the diversity of its clinical manifestations have made the understanding of its pathogenesis difficult. The autoimmune hypothesis, once widely accepted, has increasingly been challenged by the parasite persistence hypothesis. Arguments for the latter hypothesis come from demonstrations of the presence of parasites in tissues of chronic patients, and the fact that treatments that decrease parasite burden are associated with a decrease in clinical symptoms. The two hypotheses might not be mutually exclusive since anti-immunopathogenic responses in chagasic patients might be driven by the parasite burden. Although further studies are needed, including elucidating the role of the recently described parasitokines, these results indicate an urgent need for the development of new antiparasite drugs, and their evaluation in large-scale randomized clinical trials, as well as for progress in the development of vaccines and immune interventions against pathogenesis." The WHO observes with regard to future outlook: "As the *T. cruzi* genome project... nears completion, new approaches will become available for the identification and validation of new drug targets, early diagnostic indicators of infection and vaccine candidates, and for the elucidation of the mechanisms underlying host cell invasion, immune response and pathogenesis. The challenge will be to transform new knowledge into cost-effective, equitably affordable interventions and to guarantee their access to the patients and populations of endemic countries."

Naula C and Burchmore R 'A Plethora of targets, a paucity of drugs: progress towards the development of novel chemotherapies for human African trypanosomiasis' <http://www.future-drugs.com> note with regard to Human African Trypanosomiasis (HAT) that it is a major health problem in large regions of Africa. The World Health Organisation has estimated that 300 000 people are infected with HAT and 60 million individuals are exposed to the risk of infection. They note that unfortunately developments in chemotherapy have not kept up with the rise of HAT and the drugs that are commonly employed today are the same as those that were in use in the 1950s. This situation, they say, represents a dramatic failure that has been brought about by a combination of the political situation in endemic countries and the economic reality of the global pharmaceutical industry. Trypanosomiasis is fatal if not treated. The authors observe that trypanosomes are the most intensively studied protozoa but most investigators are based in academia and have focused on the many aspects of trypanosome biology that are unique or unusual. They state: "The orphan disease status of HAT has stimulated support for basic research from public and charitable sources and the community of academics that study trypanosomes and related protozoa is extensive... This interest is not matched in the commercial sector, which is critical for drug development. There has been very little progress by the pharmaceutical industry in developing promising leads. An important reason for this failing is the lack of a wealthy market for drugs to treat trypanosomiasis. Non-profit organisations such as the WHO and Medecins Sans Frontieres (MSF) aim to encourage drug development by a variety of mechanisms. Of particular note is the Drugs for Neglected Diseases (DND) working group, and MSF sponsored initiative... HAT is a significant economic and social problem in large areas of Africa. Existing chemotherapies leave much to be desired. However, this situation is not new and the recent history of antitrypanosomal drug development is not encouraging. Nevertheless, there have been recent efforts to encourage and facilitate development of antiparasitic drugs by pharmaceutical companies. Increasing awareness of health problems in the under developed world serves to

it upholds the *status quo*. The World Trade Organisation's interest in intellectual property rights, unaccompanied by any significant desire to counterbalance these against the urgent needs of developing countries, is testimony to this.

A further criticism of international law lacks one of the *essentialia* of law itself – certainty. In some areas, such as customary international law and *jus cogens*, there is not even any certainty as to what constitutes international legal principles and what does not and when the transition to international law is made. Certainty is recognised in the South African legal system as a prerequisite for fairness and credibility of law since it impacts on the reliability of the legal remedies offered by law. International law offers no remedies and no certainty. Its enforceability depends upon the interests and motivations of the few countries that can call themselves global powers. International law, at the enforcement level, seems to be a one way street since those doing the enforcing are generally powerful, developed countries or their agencies and those subject to enforcement activity are developing or significantly weaker countries. The likelihood, rate and intensity of the enforcement intervention seems to be directly proportionate to the mainly financial and commercial interests of the enforcer in the country that is being taken to task⁴⁴.

The practical relevance of international law even as an ideal is questionable when considered against the backdrop of South African constitutional law since any comparison of the right to health in international law has to made be at various levels of complex matrices of rights often beset with their own internal conflicts. The point is made in the first chapter that where there is an internal conflict between constitutional rights, a balancing of rights must take place. Thus where there is an internal conflict between human rights at international law and an internal conflict between similar rights in domestic law, the internal conflict between the domestic rights must first be resolved before any consideration of international law can fruitfully take place since consistency is a prerequisite of a rational and certain

pressure pharmaceutical companies to address these issues. The market for HAT therapy may not at present be wealthy but it is large and poor prospects for vaccine development suggest that HAT may remain a problem in the long term. There is also a very important veterinary market for trypanosomiasis in cattle...It is to be hoped that success with DB 289 or its related compounds will stimulate commercial interest in the development of novel drugs to treat a disease that threatens such a large population...There can be little hope that new drugs for HAT will come to market in the next 5 years. ”

⁴⁴ As the most recent, large scale, interventions by the American and British governments in Iraq would seem to indicate when compared to the relative disinterest in the continuing or relatively recent gross human rights violations in Zimbabwe and Rwanda respectively.

domestic legal system. Considerations of international law in relation to a single right in the Bill of Rights in isolation from the matrix of rights, of which it is but one inextricable element, can lead ultimately to a fragmented and chaotic domestic legal order with a concomitant diminution in value of the very body of rights the latter seeks to confer.

10.2.2 Imbalance in the Formulation of International Law

Not all countries have an equal say in the formulation of international law because not all countries have equal access – or any access at all for that matter – to powerful international organisations such as the World Trade Organisation (WTO)⁴⁵ and other bodies under whose auspices public international law is created. One of the key functions of the World Trade Organisation is to serve as a forum for international trade negotiations. As such it attracts large and powerful developed countries that have equally large and powerful interests in global trade. The magnitude of their bargaining power in relation to much smaller and weaker developing countries whose stake in international trade is exponentially smaller than that of their developed counterparts creates a considerable imbalance in the formulation of international law. This is disjunctive of the fact that public international law that is created under the auspices of the World Trade Organisation impacts not only upon trade issues but significantly affects human rights and other aspects of international law as well. WTO Agreements such as the Agreement on Trade Related Aspects of Intellectual Property (TRIPS) and GATS were formulated before many of the developing countries became members of the WTO. The chances of their being able to effect amendments to the terms of such agreements are slight. The difficulty with which developing countries succeeded in the meeting of the WTO at Doha is testimony to this. The Africa group of negotiators went to Doha opposed to adding new issues to the trade agenda until a

⁴⁵ By February 2002, 144 countries were members of the WTO. Together they account for more than 90 per cent of world trade. In the WTO, gaining membership is not automatic. Countries negotiate their accession to the WTO with existing members. WTO agreements are, in general, ratified in members' parliaments. Currently, several countries are actively negotiating their entry into the organisation, including the Russian Federation. There is growing consensus that WTO membership constitutes a key step towards integrating developing countries into the global economy and the international trading system. Countries that wish to join the WTO must negotiate with existing WTO members and a working party is set up to handle each application. Accession working parties are open to all WTO members, and countries with an interest in the applicant country's trade join the working party. Acceding country governments must then undergo a fact-finding process regarding their trade policy and undertake a series of commitments to bring trade policy into line with the WTO agreements. The accession process can be quite burdensome, complicated, and lengthy. As of February 2002, 16 of the 44 governments that had applied for WTO membership had completed the process and become WTO members. The entire process, which in some cases began before 1995 under the GATT, took between 3 and 10 years, except in the case of China, which recently became a member after 15 years of accession negotiations.

better deal was reached on those already covered. With the notable exception of South Africa, which announced beforehand that it would support the launch of a broad new round of negotiations, most African countries wanted Doha to concentrate on resolving outstanding “implementation issues” such as the failure of Northern governments to reduce tariff barriers to African exports⁴⁶. One of the major steps forward at Doha in terms of the recognition of the needs of developing countries was a declaration on TRIPS and public health was adopted in terms of which the 142 countries stated *inter alia*:

- “1. We recognize the gravity of the public health problems afflicting many developing and least developed countries, especially those resulting from HIV/AIDS, tuberculosis, malaria and other epidemics.
2. We stress the need for the WTO Agreement on Trade Related Aspects of Intellectual Property Rights (TRIPS Agreement) to be part of the wider national and international action to address these problems.
3. We recognize that intellectual property protection is important for the development of new medicines. We also recognize the concerns about its effects on prices.
4. We agree that the TRIPS Agreement does not and should not prevent members from taking measures to protect public health. Accordingly, while reiterating our commitment to the TRIPS Agreement, we affirm that the Agreement can and should be interpreted and implemented in a manner supportive of WTO members’ right to protect public health and, in particular, to promote access to medicines for all.”

The Doha Declaration went on to recognize the right of each member to grant compulsory licences and the freedom to determine the grounds upon which such licences are granted. It also recognised that each member has the right to determine

⁴⁶ Mutume G ‘What Doha means for Africa’ *Africa Recovery* Vol 14 No 4 December 2001 p 3. He observes that: The WTO General Council had decided in December 2000 that the differences over these previous agreements, known as the Uruguay Round, should be resolved before or at Doha. Despite a commitment under Uruguay to reduce import duties, some developing country products exported to industrial nations such as sugar, metals, cereals and textiles, continue to face tariff barriers, in some cases of more than 100 per cent. These are the countries that evangelize in the name of free trade said President Yoweri Museveni of Uganda in an address to the Un General Assembly in New York in November at the same time as the Doha meeting. “What a paradox,” he said. “These double standards must end”. African ministers, says Mutume, went to Doha hoping to obtain binding commitments from rich countries to reduce the agricultural subsidies that enable the North to export cheap food to developing countries, to the detriment of farmers in the South. As well, they wanted binding commitments on food aid, grants and technical assistance from industrialized countries as compensation for the negative impact of removing agricultural import barriers. Finally they sought an explicit affirmation that safeguards on intellectual property rights could be overridden for public health purposes, without fear of triggering trade sanctions or legal challenges. Mutume states that in the end Doha resulted in a broad compromise between the rich and poor countries. The industrialized countries got a mention of the contentious new issues they wanted, but in the face of developing country resistance, agreed to postpone any decision to actually begin negotiations until the next WTO ministerial meeting in 2003. While the developing countries’ emphasis on “implementation issues” such as access for their agricultural and textile goods to industrialized country markets was not actually resolved in Doha, they did win agreement that a review of past accords be incorporated into the new round. Mutume notes that: “Against a backdrop of war and global recession, trade ministers at the World Trade Organization meeting in Doha, Qatar, concluded what Director-General Mike Moore termed an “extraordinarily successful” conference. They agreed to a new round of negotiations aimed at opening vast new areas of the global economy to international competition. But the 9-14 November meeting also exposed the same kind of bitter divisions among the trading powers and between the industrial North and the developing South – that led to the failure of the last WTO ministerial meeting in Seattle in 1999...For proponents of greater trade liberalization, the stakes in Doha seemed considerable. A second failure like the one in Seattle, combined with deepening global recession, they felt, could have spelled a return to widespread protectionism, thereby worsening the world crisis. ‘The cost of failure’, said Mr Moore, ‘would have been very high’. However, with Africa’s share of world trade dropping and its people sliding deeper into poverty, the continent’s trade ministers might well have left Doha wondering about the costs of success and who would pay for them.”

what constitutes a national emergency or other circumstances of extreme urgency, it being understood that public health crises, including those relating to HIV/AIDS, tuberculosis, malaria and other epidemics, can represent a national emergency, or other circumstances of extreme urgency. Of particular importance to developing countries, the Declaration recognized that WTO members with insufficient or no manufacturing capacities in the pharmaceutical sector could face difficulties in making effective use of compulsory licensing under the TRIPS Agreement. It instructs the Council for TRIPS to find an expeditious solution to this problem and to report to the General Council before the end of 2002⁴⁷.

The point is that when TRIPS was first formulated this was apparently not done with reference to other instruments of international law relating to human rights and also without reference to the needs and concerns of developing countries and their other international law obligations. Its effects had to be modified, and then only with considerable difficulty, in order to gain some acknowledgment from the powerful developed countries who first formulated it, of these important issues. International law is clearly not a unified, coherent and internally consistent body of universal legal principles that takes into account the needs of both the powerful and powerless countries of the world. The more cynically minded might regard it as an instrument for the validation of the application of power by dominant countries to those susceptible to domination. Inevitably this is accompanied by debates concerning the north-south global divide.

10.2.3 Compliance With International Law Affords No Protection

Compliance with international law, contrary to expectation, apparently offers no protection from larger and more powerful national interests⁴⁸. The stance of the

⁴⁷ According to Kraus D 'DOHA Declaration on the TRIPS Agreement and Public Health: Current State of Discussion' (<http://www.ige.ch/E/juinfo/j110100.htm>): A solution was subsequently postulated that another Member having manufacturing capacity could issue a compulsory licence for the exportation of the product to the Member lacking such capacity. However the principle of territoriality of patents allow a Member to issue a compulsory licence only predominantly for the supply of the domestic market. While until 2005 exportation is possible from Members enjoying a transition period a long-term solution has to be found which takes all interests into account, including those of victims of pandemics and the necessity to assure further research and development into the needed pharmaceutical products.

⁴⁸ McCadney J, an international trade associate at the Washington DC based law firm Collier Shannon Scott, PLC in an article entitled 'Lessons from South Africa: Striking a Balance Between the Protection of Intellectual Property Rights and Access to Pharmaceuticals in Developing Countries While Complying With TRIPS' written for Security Policy Group International (http://www.spgi.org/articles/mccadney_aidsdrugs.html) observes that "even though South Africa's legislation incorporated permissible, flexible mechanisms of TRIPS, including compulsory licensing and parallel imports, it was met with a backlash of disapproval from developed countries, as well as the global pharmaceutical

United States of America on the TRIPS agreement and the debates relating to access to pharmaceuticals by developing countries is a case in point. The controversy surrounding the South African government's proposed legislation⁴⁹ which would allow the parallel importation of medicines in certain circumstances was hotly debated in a number of international forums all over the world at the time⁵⁰. It would

industry. The disapproval, in large, was in opposition to the threatening erosion of intellectual property rights and ensuing loss of profits earmarked for research and development should other similarly situated countries choose to implement a comparable, albeit WTO compliant, legislation. Herein lies the South African dilemma – what recourse does a country have when it has complied with the governing international treaty to which it is a member, as well as its own law, yet must defend itself from bilateral attack based on actions taken on behalf of public health and indeed national sovereignty? Limitations on the scope of national acts are part of the price of membership to the most prestigious of global treaties. It is for this reason that countries hesitate to join without first negotiating the terms of their succession with exacting scrutiny. In this respect the AIDS pharmaceutical imbroglio speaks of a large imbalance in that developing countries often do not have a seat at the table during treaty negotiations. Like form contracts, they are often bound to the terms that have already been established. More often than not, these terms have been set by developed countries with, although certainly not in all areas, inapposite agendas and contrasting interests from subsequent joining developing country members." She notes that in May of 1998 the United States Trade Representative announced a special 301 out-of-cycle review of South Africa's legislation and placed South Africa on the Special 301 Watch List. Special 301 listing identifies countries believed by the United States to either threaten or inadequately protect American intellectual property rights. Although the listing is no more than a public admonition, it is designed to deter private foreign investment and development.

49

Act 90 of 1997 amending the Medicines and Related Substances Control Act No 101 of 1965

50

See Parmar S 'Access To Drugs Update' http://www.lawyerscollective.org/lc-hiv-aids/magazine_articles/june_2001.thm who writes: "In a surprise move the Pharmaceutical Manufacturers Association (PMA) announced on April 19th that it was withdrawing its legal action against the South African government which had been brought before the Pretoria High Court. Moreover the PMA has stated that it will pay the legal costs incurred thus far by the South African government and friend of the court, the Treatment Action Campaign (TAC). In return the South African government has affirmed its commitment to respecting the World Trade Organizations' (WTO's) rules governing intellectual property rights." The PMA had sought to prevent the coming into effect of section 15(c) of the Medicines and Related Substances Act as amended by Act 90 of 1997, on the grounds that it offered the "potential for abrogation of intellectual property rights". The PMA alleged that the legislation violated the South African Constitution and the TRIPS Agreement to which South Africa, as a member of the WTO is subject. According to Parmar, the PMA's decision to unconditionally withdraw its challenge was attributed to intense international lobbying efforts by several Non-Governmental Organisations (NGOs) and the involvement of UN Secretary General Kofi Annan in negotiations between South Africa and the PMA.

A statement by the Pharmaceutical Research and Manufacturers of America (<http://www.cptech.org/ip/health/phrma/301-00/safrica.html>) reads: "PhRMA member companies appreciate the good will and statements of the current Government of South Africa that it intends to fully meet its multilateral obligations as spelled out in the WTO TRIPS Agreement. PhRMA understands that the U.S Trade Representative's removal of South Africa from the 1999 "Special 301" Watch List in December 1999 was made on the basis of South Africa's statements to this effect and belief that South Africa would come into full TRIPS compliance shortly... Until South Africa completes its own judicial and parliamentary internal review and amendment of the Medicines Act, PhRMA requests that South Africa should be included on the 2000 "Special 301" Watch List". In 'Priority Foreign Countries, South Africa, Intellectual Property Protection' *Phrma: Issues & Policy* it is stated with reference to section 15C of the Medicines and Related Substances Act No 101 of 1965 that: "Given the seriousness of the attack on patent rights and the apparent intransigence of the Government, the South African pharmaceutical industry, with the support of their American and European counterparts, has filed a legal challenge to the Act in South Africa's Constitutional Court. Plaintiffs include the local trade association and 40 individual companies. The suit was filed in February 1998 and as a result the Act has not taken effect. (<http://www.cptech.org/ip/health/phrma/201-99/safrica.html>)

Kasper T, Co-ordinator of the Access to Essential Medicines Campaign for Médecins Sans Frontières – South Africa, in 'Developing Countries Must Stand Firm on People Over Patents' *South Bulletin 11* notes that when South Africa emerged from apartheid, the government was confronted with a problematic pharmaceutical pricing structure: drug companies had set their prices to target the country-within-a-country of the rich, white upper class, essentially ignoring the vast number of (black) people who could not afford these prices. Concerned with matters of equity the government passed the Medicines and Related Substances Control Amendment Act in 1997 to introduce measures to bring down the price of medicines in both the public and private sectors. From the hysterical statements emanating from pharmaceutical company representatives, one might have thought that South Africa was trying to introduce radical legislation, abolishing all patent rights. In reality, nothing is further from the truth: the law is consistent with the World Trade Organization's (WTO) Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS), and all of the most important provisions are already enshrined elsewhere around the world, typically in developed countries. For example, generic substitution – the practice of requiring a pharmacist to prescribe the cheapest available version of drugs that are not patent-protected, unless the patient specifically requests the originator product rather than a generic alternative – is common in countries such as the U.S., the Netherlands and Japan. The creation of a pricing committee with the power to fix a so-called 'single exit price', where the pharmaceutical company sets a single price at which it must sell to all private sector purchasers, is an extremely mild form of price control that is aimed at promoting transparency in pricing and doing away with perverse prescribing practices, such as when a pharmacist is entitled to dispense a particular product as a result of (typically time-limited) discount offers. The most controversial part of the law – which the pharmaceutical industry argued allows the government to abrogate patent rights with no regard to due process – is

seem from the experience of South Africa with regard to the Medicines Amendment Act⁵¹ and the reaction of the developed world to its attempts to improve access to health care services for its people, that international law is designed to benefit primarily developed countries. This is clear from the fact that although the law in question did not and still does not violate the TRIPS Agreement, in the years 1997 to 2000, the American government pressurised South Africa to drop its plans to seek cheaper alternatives to medicines for HIV and AIDS. The US government backed the pharmaceutical companies that took the South African government to court with regard to the Medicines and Related Substances Amendment Act⁵². According to a 1999 US State Department report: “U.S. Government agencies have been engaged in a full court press with South African officials from the Departments of Trade and Industry, Foreign Affairs and Health, to convince the South African government to withdraw or amend the offending provisions of the law”⁵³. When South Africa continued to defend the law, asserting that it was in full compliance with TRIPS requirements, the U.S. Trade Representative placed South Africa on the Special 310 Watch List which lists countries under scrutiny for possible intellectual property violations. A U.S. trade official is quoted as saying “While we don’t say it explicitly, it’s a warning for investors going to that country that there are potential problems with respect to protection of intellectual property”⁵⁴. The failure of other countries of the developed world who were members of the World Trade Organisation to speak out against the hostility of the US government towards South Africa when it became clear

section 15C. The industry arguments on 15C were never likely to succeed given that they ignored two crucial points. First the South African government has insisted, since the law was in draft form, that 15C is aimed solely at enabling parallel importation of medicines (as allowed, for example, within the European Union). Second, the language of 15C is based on a draft of model language on the exhaustion of rights (through which parallel importation is enabled) prepared by a World Intellectual Property Organization Committee of Experts in 1990. Concretely, the fact that parallel importation will be permitted means that South Africa (both government and private bodies) can shop around for the lowest price offered globally on medicines marketed by the patent-holder (or under license from the patent-holder); it will not facilitate the introduction of generic medicines. If South Africa wishes to take advantage of the lower prices frequently offered by generic producers, it will need to issue compulsory licences, which allow the use of a patented product without the consent of the patent holder. Given the weakness of the pharmaceutical industry arguments, it was not particularly surprising that the companies sought a settlement.”

⁵¹ Medicines Amendment Act fn 33 *supra*

⁵² Medicines Amendment Act fn 33 *supra*

⁵³ Chaudhry L ‘U.S. to South Africa: Just Say No’ (<http://www.wired.com/news/politics/0,1283,35874,00.html>)

⁵⁴ Chaudhry L fn 50 *supra*. When it became apparent to even the Americans that the legislation was not in violation of the TRIPS Agreement, a U.S. Trade official stated that: “We consider TRIPS to be a minimum standard.” Under congressional mandate, mere TRIPS compliance is not sufficient to keep a country off the 301 List. While the US trade official would not specify exactly what ‘TRIPS plus’ entailed, reports Chaudhry, he said both compulsory licensing and parallel importing were ‘not considered appropriate’. It is therefore strange to note that, without any further amendments to the South African Medicines legislation on the subjects of parallel importation or compulsory licensing in December 1, 1999, the US Trade Representative announced the removal of South Africa from the Special 301 Watch List, based on a bilateral understanding developed with South Africa under which both Governments reaffirmed their shared objective of fully protecting intellectual property rights under the WTO TRIPS Agreement, while addressing the health issues identified by South Africa. South Africa agreed that it would address health needs in a manner that fully protects intellectual property rights. The US Trade Representative apparently took this action as a result of this understanding, as well as other steps South Africa had taken and was taking to improve further the protection of intellectual property.

that South African law was not in violation of the TRIPS Agreement is remarkable. It is another indicator of the weakness of international law and its tendency to resemble a one-way street. Developing countries must comply with TRIPS as a minimum standard but this apparently does not prevent developed countries from taking further action against a nation state as they see fit. The message seems to be: “You had better comply with this standard of international law because if you don’t, we will penalise you, but if you do and we don’t like it, we will penalise you anyway.” This is born out by the observation of the WTO/WHO Report that the WTO facilitates the implementation, administration and operation of the various covered agreements but the power of initiative in the context of the organization rests not with the Secretariat but with member governments whose representatives constitute and preside over the many councils and committees dealing with issues that arise in connection with the agreements⁵⁵. The certainty factor is once again conspicuous in its absence from international law.

10.2.4 ‘Standard Setting’ Approach Not Helpful To The Developing World

One of the problems that South Africa faces, even internally, is that of the setting of standards. In the health sector particularly, the problem is exacerbated by the significant disparities in wealth that exist across the public and private sectors. The question in setting standards is, does one set a standard that is low enough that the often cash strapped public health sector can attain or does one set the standard much higher, in the full knowledge that it will be unattainable within the public health sector but will challenge the private health sector? If one sets two different kinds of standards, what message does this give to a country with a legacy of apartheid? A similar problem exists with regard to international law which is more often than not developed by the wealthy countries of the northern hemisphere. One of the major roles of international law is to set up global standards to which everyone must aspire but if some of the nations of the world have a head start on others, the race can hardly be said to be fair. If the standard is set with regard to well-resourced, well developed countries and what they are capable of, it is hardly surprising that international law in the eyes of developing countries is of little constructive use.

⁵⁵ WHO/WTO Report fn 32 *supra* at p 26

It is not without significance that the WTO is not a funding organization. It has no mandate to finance development projects. The nature of the technical assistance to developing countries that the WTO does provide is also significant. According to the WTO/WHO Report, the aim of the 'assistance' is both to assist members in the implementation of WTO agreements and to train officials so that they understand the system and its agreements, know how to administer them, and negotiate more effectively. Technical assistance is also extended to acceding countries. The Report states that the training is often rather "legal" and is aimed at providing an understanding of rights and obligations members have under the various agreements. The 'assistance' provided by the WTO to developing countries is thus self-serving in that it is designed to promote and enforce the adherence of those countries to the principles of public international law as formulated by the WTO without assisting them in terms of the resources they might need to observe these principles of law.

Under the WTO agreements, as in the dark, all cats are grey. Countries cannot normally discriminate between their trading partners. A special benefit granted to one country must be granted to all other WTO members⁵⁶. While this may seem superficially to be beneficial to all in that no-one is given preferential treatment, the question is who does this rule actually favour in practice? This principle conveniently ignores the fact that some countries are developing countries and others are developed countries. Their problems, needs and concerns are uniquely different. Health care is an extremely good example of this. Many developing countries have serious problems with tropical diseases such as malaria and cholera and diseases of poverty such as tuberculosis, diseases caused by nutritional deficiencies and HIV/AIDS. Disease profiles in developed countries show diseases of ageing and lifestyle as being the predominant public health problems. The disease profiles of populations in developing countries are clearly very different to those in developed countries⁵⁷. Of the top 13 causes of mortality in Africa only 8 can be considered to significantly

⁵⁶ WHO/WTO Report fn 32 *supra* at p 29. The Report states: This principle, known as most-favoured-nation (MFN) treatment, is enshrined in Article I of the GATT, which governs trade in goods. MFN treatment is also one of core obligations of the GATS (Article II) and the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) (Article 4). Together, those three Agreements cover the main areas of trade covered by the WTO. In general, MFN means that every time a country lowers (or introduces) a trade barrier or opens up a market, it has to do so for the same goods or services or service suppliers from all its fellow WTO Members - whether rich or poor, weak or strong.

⁵⁷ Gwatkin, D and Guillot M 'The Burden of Disease among the Global Poor: Current Situation, Future Trends and Implications for Strategy' World Bank, Washington 2000 p 9 of the top five causes of death, there is only one that overlaps between developed and developing nations – ischaemic heart disease.

affect the developed world⁵⁸. The products and services required to manage and counteract these different disease profiles are very different to those required in developed countries. Malaria drugs and continued research into malaria treatment and prophylaxis are critical to developing countries whereas in developed countries this need is negligible. If public international law on trade governs the supply of such goods and services to developed countries, it is not difficult to appreciate their impact on the health status of people in countries where malaria is a problem. This principle ties the hands of those developed countries that would wish to give more favourable terms to developing countries with the result that the ability of developing countries to enter international markets and their concurrent capacity to improve the lives of their residents is effectively stymied. The principle does not incentivise developed countries to assist developing countries and has the overall effect of maintaining the balance of power in favour of the developed world. The result is that foreign aid is substituted for trade. Developing countries must constantly look to developed countries for financial and other aid instead of becoming empowered, through global trade and world markets, to meet the needs of their people themselves.

According to the WTO/WHO Report, article XX of GATT guarantees the members' right to take measures to restrict imports and exports of products when those measures are necessary to protect the health of humans, animals and plants (Article XX(b)) or otherwise relate to the conservation of natural resources (Article XX(g)). Article XIV of the GATS authorizes members to take measures to restrict services and service suppliers for the protection of human, animal or plant life or health. If the relevant conditions are met, including the good faith obligations inherent in the chapeaux of these Articles, they provide an override of any other obligations, including tariff concessions on goods or specific commitments on services, that WTO members have undertaken under WTO agreements. These provisions recognize that there are cases where members may wish to pursue other legitimate policy objectives, such as health. It is alleged in the WHO/WTO Report that the health exceptions allowed for in GATT and GATS indicate the importance that WTO members assign to national autonomy in the protection of health. TRIPS does not contain an exception for health purposes *per se*, but it does allow measures necessary to protect public health and nutrition,

⁵⁸ Moran M 'Reneging on Doha' *Médecins Sans Frontières*, 2002

provided they are consistent with other TRIPS provisions (TRIPS, Article 8 - Principles). It is submitted that the reality of these concessions to health concerns are belied by the stance of the US towards the South African government on the subject of parallel importation. The question of equality between nations, in terms of their relative resources, levels of development and international obligations is not a notable feature of international law.

10.2.5 Absolute Rights v Relative Rights

International law is generally not helpful when it comes to situations requiring the balancing of conflicting rights. One of the reasons for this, it is submitted, has been quite well captured by Schlemmer-Schulte⁵⁹ who notes that human rights are for structural reasons not the best tools to put a more human face to development. She states that especially economic and social human rights obligations lack teeth as they are formulated as relative rights instead of absolute rights of individuals with their implementation being dependent on the state's capacities and discretionary power in setting policy priorities and that even where human rights are used as benchmarks (e.g. in the regional human rights system), their use requires a sophisticated institutional system, particularly independent courts to develop and clarify their contents for application purposes. She comments that, generally speaking detailed entitlement legislation is a better guarantee of human rights than a mere human rights catalogue. International law provides no assistance or guidance as to how rights should be prioritized or realized in practice. It does not even suggest appropriate vehicles of domestic law for this purpose. For example, in a country in which the majority of people cannot afford to purchase health care products and services, a very important question arises as to the suitability of the law of contract to ensure that their right to access health care services is fulfilled. The World Trade Organization views medicines and the related intellectual property as a commercial commodity that is the subject of international trade. The implication is that commercial law, such as that of contract, is the legal regime of choice as far as these products are concerned. This is not in keeping with the idea of medicines as a public good, to which the World Health

⁵⁹ Schlemmer-Schulte S, a professor of International Law at the University of Leiden in the Netherlands, 'Human Rights in the Work of the World Bank and Its Inspection Panel – Suggestions for Development with a more Human Face' http://www.dse.de/ef/human_rights/Schulte.htm

Organization apparently subscribes, to which everyone should have access irrespective of their ability to pay for them. It also does not recognize the realities of the developing world in which the majority of people are in no position to bargain with multinational manufacturers of pharmaceuticals in order to gain access. In fact one finds that international organizations whose activities revolve around international finance, such as the World Bank, and trade, such as the World Trade Organization, have a remarkably non-interventionist approach when it comes to ensuring that developing countries meet international human rights standards. To be blunt, the international community is not particularly adept at putting its money where its mouth is. Furthermore, offers of financial assistance, when they do come, usually have strings attached with very vested interests visible at the other end. International law, like international development programmes⁶⁰, tends to be fragmented in the sense that it does not offer internally consistent, holistic solutions to problems at a practical level⁶¹. The right to health was first recognized as a fundamental right when in 1946 the Constitution of the World Health Organisation was adopted at the International Health Conference held in New York from 19 June to 22 July, and signed on 22 July by the representatives of 61 states. It has been observed that on a strict understanding a 'right to health' 'implies somewhat absurdly that everyone has the guarantee of perfect health.' The Pan American Health Organisation suggested in 1989 that it would be more correct to speak of a "right to health protection, including two

⁶⁰ Schlemmer-Schulte (fn 59 *supra*) writes "Weaknesses of the international human rights system (in particular United Nations (UN) human rights machinery) have led to calls on international financial institutions such as the World Bank (the Bank) to use their financial muscle to improve implementation of and compliance with international human rights standards. The Bank has, however, been reluctant to follow these calls as it was neither created for the purpose of protecting human rights nor can it so easily change its legally prescribed mandate, or (nor ?) would it be practical to base its work on human rights in order to promote development with a human face....Human rights are, however, of great inspirational value in the improvement of Bank policies. A survey of Bank policies would be useful to help fill substantive gaps (lack of policy on education) and correct formal defects (vague instead of precise directions in the area of gender and adjustment). Finally a human rights inspired review of Bank policy alone will not solve what many consider currently the major problem of development assistance programs. In conjunction with these programs a broader perspective should be used to screen adjustment policies and individual programs carefully, primarily for lack of attention to social concerns. The "Washington Consensus" recipe which has been used by the Bank since the 1980s and which included trade, capital and financial markets liberalization, privatization and fiscal austerity neither promoted global financial economic stability nor led to steady development in several Third World regions. On the contrary the "Washington Consensus" recipe contributed to the outbreak of crises and even exacerbated them. In order to end the social sufferings that occurred during these crises and in their aftermath, no bits-and-pieces solution such as the simple introduction of a labour standard policy is needed by a comprehensive look at the entire recommended adjustment package and a checking of its contents against vital elements of sound economics..."

⁶¹ The statement of Professor T C Van Boven, at the United Nations workshop on 'The Right to Health' in 1979 that: "Three aspects of the right to health have been enshrined in the international instruments on human rights; the declaration on the right to health as a basic human right; the prescription of standards aimed at meeting the health needs of specific groups of persons; and the prescription of ways and means for implementing the right to health", it is submitted is not correct since whilst international instruments such as the ICESCR does specify certain steps to be taken in to realise the right to health, these steps are by no means exhaustive and do not in themselves guarantee the realisation of the right to health. They are also not contextualised with regard to other areas of international law or even with regard to other internationally recognised human rights that also require a great deal of resources. The ICESCR requires states to reduce the stillbirth rate. It has been observed by Izzard R 'Background to the Medicine and Human Rights Module' <http://www.dundee.ac.uk/med&humanrights/SSM/intro/jn-backgrnd.html> that the term 'the right to health' therefore tends to be used for the sake of convenience and implies a reasonable, as opposed to an absolute, standard.

components, a right to health care and a right to healthy conditions”⁶² This inability to agree even on the language to be used to describe the right intended does not bode well for a universally recognized right of access to health care within international law. Furthermore, instead of working with the realities of the situation and establishing measures to cope with the relative nature of the right, it tends to be stated in public international law instruments in the broadest and vaguest of universal terms in a manner that serves only to hide a multitude of sins.

10.2.6 Conclusions Concerning International Law

At the level of customary international law, the conclusion that one draws as to whether or not a right to health has passed into customary international law depends on the theory of customary international law to which one subscribes. This obviously fails one of the most basic tests of law – that of certainty. If one cannot state with any conviction what the law is, how can it be law? Despite the fondest wishes of legal academics in the health arena, if it can at all be said that there is a right to health, or health care, in customary international law, it is only at the most abstract and idealistic level. This is of no assistance to the people of South Africa in the face of the much more concrete and pragmatic arguments of constitutional law and the need to balance conflicting rights.

Whilst there is a considerable body of public international law on the subject of the right to health, much of it is not binding upon South Africa or its subjects. South Africa has not ratified the International Covenant on Economic, Social and Cultural Rights which contains the most comprehensive statement of the right to health in public international law according to its drafters. Furthermore, although South Africa has ratified the Convention on the Rights of the Child (CRC) and the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW), it has not expressly enacted the provisions of these instruments into domestic law. Undoubtedly the Constitutional proscription of unfair discrimination supports the principles of CEDAW and section 28 of the Constitution largely supports those of the CRC. The Promotion of Equality and Prevention of Unfair Discrimination Act is also in keeping

⁶² Fuenzalida-Puelma HL and Scholle Connor, S (eds) 'The Right to Health in the Americas' Pan American Health Organisation, *Scientific Publication No 509*, 1989 at p 600 <http://www.dundee.ac.uk/med&humanrights/SSM/intor/in-backgrnd.html>

with the former but its concerns are much wider than just discrimination against women and are based on the grounds of unfair discrimination identified in the Constitution. Furthermore the constitutional court has expressly and repeatedly refused to apply the public international law concept of minimum core obligations to socio-economic rights as expressed in the South African Constitution.

There is no golden thread of commonality discernible within the various public international law instruments that contain references to rights relating to health. They are often couched in subjective terms that make objective identification of practical standards of quality and levels of care impossible. The content of the right to health care or the right to health, there is even uncertainty as to how best to express it, is quite simply anyone's guess. At best it is an abstract concept that is dependent upon domestic law and local courts for its content. Since this naturally varies from one country to another one cannot help but draw the conclusion that at international law, the right to health care is a vague and somewhat emotional notion that appeals to the higher nature of humankind but adds very little to its practical reality.

10.3 Constitutional Law

As stated previously constitutional law, and more specifically the Constitution, is the central theme running through this thesis. It defines a number of rights relating to health care most notably the right of access to health care services including reproductive care, the right not to be refused emergency medical treatment, the rights of the child to basic health care services and the rights of prisoners to medical treatment.

These rights were previously non-existent at worst and unacknowledged at best. The Constitution has therefore introduced in the relevant sections in the Bill of Rights, certain legal concepts with which the legal systems of many other countries throughout the world, and international law, have still to come to grips. Socio-economic rights, such as that of access to health care services, are still controversial in many countries despite international legal instruments such as the International

Convention on Economic, Social and Cultural Rights, the Convention on the Rights of the Child, the Universal Declaration of Human Rights and the constitution of the World Health Organisation.

10.3.1 Individual Rights vs Rights as Elements of a System

In contrast to international law, there is no express mention of a broad right to health in the Constitution. As stated previously, however, the approaches of the Constitution and international law can be distinguished in that whereas the former tends to have a bottom-up approach the latter has a top-down approach. One would therefore not expect to see a right to health *per se* in the Constitution but rather all of the elements of law necessary to ensure health as an outcome of the application of the Bill of Rights. This is in effect what one finds. The rights in the Bill of Rights are not discrete legal concepts but rather elements of a system of fundamental rights that are inextricably interlinked. It is a requirement of any coherent system that its elements operate in harmony to further or achieve a specific goal. In practice, it is submitted, the constitutional approach is preferable to that of international law which still shows a clear tendency to view rights in isolation from each other. Whilst there are groupings such as the socio-economic rights reflected in the ICESCR and the CRC, such groupings tend not to be contextualised within a single, homogenous system of international law generally. Whilst the Constitution facilitates an integrated and holistic approach that requires a balancing of all relevant rights, international law does not. The constitutional rights to life, dignity, freedom and security of the person, bodily and psychological integrity, privacy, emergency medical treatment, access to health care services including reproductive health care, sufficient food and water, an environment that is not harmful to health or wellbeing and social security all contribute to health as an outcome. The operation of each right with equal strength and power in any single given situation is neither necessary nor appropriate in order to achieve the desired outcome. Their importance varies between different factual situations. It is relative. The constitutional court has committed itself to a purposive approach⁶³ to the interpretation of the Bill of Rights. It is submitted that this approach

⁶³ Thus the constitutional court 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 (1) SA 997 (C) pointed out that: "Following the 'purposive' approach to the interpretation of the Constitution which has been adopted by the Constitutional Court, the right to human dignity which is in issue in the present proceedings must not be construed

is laudable and appropriate in the light of South Africa's historical context and the need to avoid distortion of the spirit of the law through the abuse of the letter of the law such as was all too often the case prior to 1994. It indicates a preoccupation with justice and other values that underpin the Constitution rather than a concern with law, for law's sake. It also indicates the need to approach law and its interpretation in a manner that differs significantly from the thinking that held sway when the South African legal system was essentially driven by the common law as opposed to the Constitution⁶⁴. Regrettably within certain quarters of the South African judiciary this departure from an outmoded jurisprudence is still meeting with considerable resistance⁶⁵. It is at worst a temporary problem stemming from the reluctance of a

in isolation '... but in its context, which includes the history and background to the adoption of the Constitution, other provisions of the Constitution itself and, in particular, the provisions of [the Bill of Rights] of which it is part. It must also be construed in a way which secures for "individuals the full measure" of its protection'+ (per Chaskalson P in the *Makwanyane* case at para [10]; see also *Ferreira v Levin NO and Others, Vryenhoek and Others v Powell NO and Others* (supra at paras [171] - [172] and [255]); *Soobramoney v Minister of Health, KwaZulu-Natal* 1998 (1) SA 765 (CC) (1997 (12) BCLR 1696) at para [16]). In this regard, it is important to bear in mind that a 'purposive' approach and a 'generous' approach to constitutional interpretation do not necessarily or always coincide. As was indicated by Chaskalson P in the *Soobramoney* case at para [17]: "The purposive approach will often be one which calls for a generous interpretation to be given to a right to ensure that individuals secure the full protection of the Bill of Rights, but this is not always the case, and the context may indicate that in order to give effect to the purpose of a particular provision "a narrower or specific meaning" should be given to it." See also *S v Makwanyane and Another* (supra at para [9], note 8 (per Chaskalson P) and at para [325] (per O'Regan J)). The purposive approach was not unknown in the pre-constitutional legal dispensation. See for example the judgment of Davis J in *Levack and Others v Regional Magistrate, Wynberg, and Another* 1999 (4) SA 747 (C) where he stated with reference to a judgment of Watermeyer JA in *S v M* 1963 (3) SA 183 (T) that: "It represents an early example of the purposive approach to interpretation in which the interpreter attempts to define the design or purpose which lies behind the legislation in order to give content to the words employed in the text. The approach adopted in Matemba's case acknowledges that the words employed in the section cannot be interpreted so literally that the provision becomes frozen in the historical context of its initial creation. The purpose of the section should be employed to guide the Court interpreting the provision, so that developments that could not have been foreseen when the provision was initially drafted can be accommodated to promote the purpose of the provision. In following this approach to interpretation it is as well to emphasise that this is but one of a repertoire of approaches which a court may employ in order to give meaning to the text. As Frank Michelman has written, albeit within a constitutional context, various interpretative approaches 'cannot be alternatives amongst which the Judge chooses; there are multiple poles in a complex field of forces, among which Judges navigate and negotiate. I don't believe that any responsible constitutional adjudicator will end up, over any interesting run of cases ignoring any of the factors; perceived verbal significations, perceived concrete intentions, perceived general purposes, perceived and evaluated social consequences, perceived and intuited normative theories or unifying visions.' (1995 (11) SAJHR 477 at 483.) In certain cases the purposive approach represents the most appropriate within the interpretive repertoire in order to guide the process of interpretation. As Smalberger JA said in *Public Carriers Association and Others v Toll Road Concessionaries (Pty) Ltd and Others* 1990 (1) SA 925 (A) at p 943, 'the purpose of a statutory provision can provide a reliable pointer to such interpretation where there is ambiguity'.

⁶⁴ Sachs J noted in *S v Mhlungu and Others* 1995 (3) SA 867 (CC): "In any event, a question mark has to be placed over the usefulness of common law presumptions in interpreting the Constitution. As Wilson J pointed out in a notable dissent, 'such presumptions can be inconsistent with the purposive approach to Charter interpretation which focuses on the broad purposes for which the rights were designed and not on mechanical rules which have traditionally been employed in interpreting detailed provisions of ordinary statutes in order to discern legislative intent'. Sir Rupert Cross suggests that even in relation to ordinary statutes, the increasing use of a purposive approach makes the role of presumptions 'necessarily less important than in the days of more literal interpretation'. The preferred approach, as I have indicated, is not to search for what is general and what is specific, but rather to seek out the essential purposes and interest to be served by the two competing sets of provisions, and then, using a species of proportionality, balance them against each other. The objective is to achieve appropriate weight for each and preserve as much as possible of both. To extend the analogy, there are no trumps, but there are cards of higher and lower value."

⁶⁵ A case in point is *Afrox Healthcare Limited v Strydom* 2002 (6) SA 21 (SCA) in which the court failed to notice and apply the pertinent observations of Sachs J in *S v Mhlungu And Others* (fn 64 supra) to the effect that it is necessary to achieve an appropriate weight for each competing provision especially where, as Carstens P and Kok A point out at p 444 in 'An assessment of the use of disclaimers by South African hospitals in view of constitutional demands, foreign law and medico-legal considerations' *SA Public Law* Vol 18 No 2 2003 p 430, one is an express and specific constitutional right of access to health care services whilst the other, the essentially common law rule of the sanctity of contract (*pacta sunt servanda*) is not. The court also failed lamentably to apply the purposive approach to an interpretation of the right of access to healthcare. This case aptly demonstrates the inability of law alone to promote justice in the absence of a purposive approach to interpretation that turns the focus to the spirit of the law.

previous generation to relinquish the conceptual relics of an unfortunate past and will no doubt disappear with time and the processes of attrition. The purposive approach does not preclude the limitation of rights⁶⁶. Indeed in the context of the right of access to healthcare services which is inherently limited by the available resources referred to in section 27(3) of the Constitution the purposive approach would include conscious cognisance of such limitation⁶⁷. It is submitted that the meaning of the right

66

Jones J in *Phato v Attorney-General, Eastern Cape, and Another; Commissioner of the South African Police Services v Attorney-General, Eastern Cape, and Others* 1995 (1) SA 799 (E) observed the following: "Hogg *Constitutional Law of Canada* 3rd ed 1992 puts it thus at para 33.7(c) (at 814-15): 'The Court has generally assumed that a "purposive" approach and a "generous" approach are one and the same thing - or at least are not inconsistent. Indeed, statements of the purposive approach have nearly always been accompanied - often in the same sentence - by statements of the generous approach. In the case of some rights, that is correct: a purposive interpretation will yield a broad scope for the right. In the case of most rights, however, the widest possible reading of the right, which is the most generous interpretation, will "overshoot" the purpose of the right, by including behaviour that is outside the purpose and unworthy of constitutional protection. The effect of a purposive approach is normally going to be to narrow the scope of the right. Generosity is a helpful idea as long as it is subordinate to purpose. Obviously, the Courts in interpreting the Charter should avoid narrow, legalistic interpretations that might be appropriate to a detailed statute. But if the goal of generosity is set free from the limiting framework of purpose the results of a generous interpretation will normally be inconsistent with the purposive approach.'

One of the reasons for placing proper limits upon the content of a fundamental right in chap 3 is the interplay between the interpretative process of defining the right in the first place and the adjudicative process of determining whether a restriction upon the constitutional right as defined is justified in terms of s 33 of the Constitution. Hogg (op cit) poses the problem and the solution in the following manner in para 33.7(b) (at 812-13): 'In *R v Oakes* ((1986) 26 DLR (4th) 200) . . . the Court decided to prescribe a single standard of justification for all rights, to make that standard a high one, and to cast the burden of satisfying it on the government. This insistence that the test of justification be a stringent one is, in practice, inconsistent with the insistence that the guaranteed rights be given a generous (broad) scope. If the scope of the guaranteed rights is wide, they are bound to reach conduct that is not really worthy of constitutional protection. If Parliament or a Legislature attempts to regulate conduct that is guaranteed only by virtue of an artificially wide definition of the Charter rights, the courts are going to strive to uphold the legislation. Since the courts can uphold the legislation only under s 1 (in our case s 33), they will strive to find that it is satisfied, and the inevitable result will be the erosion of the *Oakes* standard of justification.' The author proceeds to give examples of the connection between defining a right and determining when a restriction upon it is justified. Some of them show the lengths to which it has been necessary to go to place a workable and common-sense restriction on a right which has been given too wide a content. For example, 'Soliciting for the purpose of prostitution is protected by the Constitution (because it is, like advertising, constitutionally protected as part of the widely defined freedom of expression) which would no doubt surprise many Canadians, but few would be surprised to find that the Criminal Code has been upheld under s 1 (the limitation clause) - although the case for justification was weak. Similar comments could be made about hate propaganda, obscenity, defamation and nude dancing, which are some of the other activities caught by the broad scope of s 2(b) of the Charter of Rights' (op cit). He continues: 'Does it make much difference whether the Court gives a wide interpretation to rights and relaxes the standard of justification under s 1, or gives a narrow interpretation to rights and maintains the stringent standard of justification called for by *Oakes*? If we assume that the outcome of cases will be much the same under either approach, the second approach is surely preferable, because it will reduce the volume of litigation and limit the policy-making role of the Courts. If the scope of the guaranteed rights is wide, and the standard of justification is relaxed, then a large number of Charter challenges will come before the Courts, and will fall to be determined under s 1. Since s 1 requires that the policy of the legislation be balanced against the policy of the Charter, and since it is difficult to maintain meaningful standards to constrain the balancing process, judicial review will become even more unpredictable than it is now. While there are signs that some Judges welcome such extensive powers, most Judges will be concerned to stem the wasteful floods of litigation to limit the occasions when they have to review the policy choices of legislative bodies, and to introduce meaningful rules to the process of Charter review. These purposes can be accomplished only by restricting the scope of the Charter rights.' I think that this reasoning is sound. It proposes a disciplined and far-sighted approach to interpretation. I would only add the reminder that any limit upon the definition or content of a chap 3 right must, of course, be in accordance with proper and acceptable rules of constitutional interpretation, which should not be 'narrow, legalistic interpretations that might be appropriate to a detailed statute' (Hogg (op cit))." Hogg is also quoted with approval in *Shabalala v Attorney-General, Transvaal, And Another Gumedde and Others v Attorney-General, Transvaal* 1995 (1) SA 608 (T). In this case Cloete J also noted that: "In *Cachalia et al, Fundamental Rights in the New Constitution* (1994) the following is said at 11-12: 'A generous interpretation of a Charter would require a court to interpret the language in the widest possible manner. By contrast a purposive interpretation is predicated upon the purpose of the right, with the result being that the widest possible interpretation will not inevitably be the one which will be supported. . . . It is submitted that this approach to constitutional interpretation is one which South African Courts would do well to follow if they wished to put chap 3 of the Constitution in the best and most coherent possible light.'"

67

Thus in *Soobramoney v Minister of Health, Kwazulu-Natal* (fn 28 *supra*) the constitutional court observed specifically with regard to the right of access to healthcare services that "Unlike the Indian Constitution ours deals specifically in the bill of rights with certain positive obligations imposed on the State and, where it does so, it is our duty to apply the obligations as formulated in the Constitution and not to draw inferences that would be inconsistent therewith. This should be done in accordance with the purposive approach to the interpretation of the Constitution which has been adopted by this Court. Consistently with this approach the rights which are in issue in the present case must not be

of access to health care services in section 27(1) of the Constitution must be interpreted be ascertained by an analysis of the purpose of such a guarantee. It must be understood in the light of the interests it was meant to protect. This analysis is to be undertaken, and the purpose of the right is to be sought, by reference to the character and larger objects of the Constitution itself, to the language chosen to articulate the specific right, to the historical origins of the concepts enshrined, and where applicable, to the meaning and purpose of the other specific rights and freedoms with which it is associated within the text of the Constitution. The interpretation should be a generous rather than a legalistic one, aimed at fulfilling the purpose of the guarantee and securing for individuals the full benefit of the Constitution's protection⁶⁸.

In the past, health care services were effectively denied to the majority of people in various ways. Health professionals condoned human rights violations in their failure to speak out when they were called in to treat the results of gross violations of human bodily and psychological integrity. They did their work secure in the knowledge that should their conduct towards their patients in these cases have amounted to something less than professional, the authorities, including the statutory professional body responsible for disciplining medical practitioners for unprofessional conduct, could not have cared less and their patients certainly had no choice in the matter. The quality of the health services people received from health professionals prior to 1994 was thus largely dependent upon the ethical beliefs and principles, or lack thereof, of the individual professional in question⁶⁹. Access to health care services does not, it is

construed in isolation ' . . . but in (their) context, which includes the history and background to the adoption of the Constitution, other provisions of the Constitution itself and, in particular, the provisions of (the bill of rights) of which (they are) part'. The purposive approach will often be one which calls for a generous interpretation to be given to a right to ensure that individuals secure the full protection of the bill of rights, but this is not always the case, and the context may indicate that in order to give effect to the purpose of a particular provision 'a narrower or specific meaning' should be given to it." [footnotes omitted]

⁶⁸ *S v Makwanyane and Another* fn 25 *supra* para 9 at p 403.

⁶⁹ See Sidley P 'South Africa's Doctors Apologise for Apartheid Years' *British Medical Journal* 1995 311 p 148 in which it is noted that the apology stated that: "the association remained silent on race and public policies affecting the medical profession and the community. Examples include the restriction of medical school admissions on the basis of race, the segregation of hospitals and other health facilities, the maintenance of separate waiting rooms by doctors and tolerating interference with doctors' treatment of prisoners and detainees. . . . While the apology is long overdue, the association has made no mention of specific incidents that helped to isolate it internationally during the apartheid years – incidents such as the organisation's refusal to deal with the medical and ethical issues raised by the death of Steve Biko, a political activist who died in prison in the late 1970s and the inadequate performance of the district surgeon attending to him. One of these, Dr Benjamin Tucker, was a member of the association. The association refused to take action against him and to dissociate itself from the South African Medical and Dental Council's refusal to discipline the district surgeons." See also Williams J R 'Ethics and Human Rights in South African Medicine' *Canadian Medical Association Journal* 18 April 2000; 162 (8) who observes that the failings of South Africa's medical profession were revealed at the Truth and Reconciliation Commission hearings as being of two kinds: toleration or active promotion of inequities in health care and complicity in gross violations of human rights. The commission's report condemns the Medical Association of South Africa for failing to draw attention to: "(a) the effects of the socioeconomic consequences of apartheid on the health of black South Africans, (b) the fact that segregated health care facilities were detrimental to the provision of health, (c) the negative impact on the health of millions of South Africans of unequal budgetary allocations for the health



submitted mean access to unprofessional, unethical or otherwise unacceptable health care services that do not take into consideration a patient's rights to human dignity, to bodily and psychological integrity, to equality and to life. This cannot be the access that was contemplated in the Constitution because the right of access to health care services has to be read in the light of the character and larger objects of the Constitution itself. The sacrifice of such fundamental rights on the altar of the sanctity of contract is unjustifiable and in itself unconstitutional since the state is obliged, in terms of section 7(2) of the Constitution to respect, protect, promote and fulfil the rights in the Bill of Rights. The sanctity of contract is a common law right that does not appear in the Bill of Rights. Furthermore, only a strained interpretation of the right to freedom can include sanctity of contract since, on a purposive interpretation, the right to freedom does not mean the right to conduct oneself in a manner that contradicts the principles and values of the Constitution or that undermines the rights contemplated therein. The interests that the right of access to health care services were meant to protect are not only the procedural aspects of access but also the substantive aspects. It is submitted that access to health care services that are not of a sufficient quality or standard necessary to achieve their intended purpose is not access as contemplated by the Constitution. The condonation of unprofessional or unethical conduct that adversely affects the health or wellbeing of a patient is in fact tantamount to a denial of access. It is submitted that a purposive interpretation of the right of access to health care services is the only one capable of giving meaning to the right, of fulfilling the purpose of its guarantee and securing for individuals the full benefit of the Constitution's protection. A legalistic interpretation will only result in the very inequities that the Constitution as a whole is designed to preclude.

care of difference 'racial groups', (d) the fact that solitary confinement is a form of torture and (e) the severe impact of detention on the health of children." The report, notes Williams, is equally critical of similar failings on the part of the South African Medical and Dental Council, the body responsible for licensing, ethics and standards of practice. He notes that the Truth and Reconciliation Commission hearings witnessed numerous accounts of gross human rights violations in the health care sector. Many examples of misconduct of the district surgeons who were responsible for the health care of prisoners, apart from that of Steve Biko were reported, especially complicity in torture by police interrogators. This involved among other things, advising torturers on how not to leave telltale signs on their victims and falsifying medical reports and death certificates to omit any mention of the effects of torture. Other physicians who worked in emergency wards of hospitals routinely broke patient confidentiality by reporting patients with gunshot wounds to the police. Despite many complaints the South African Medical and Dental Council habitually failed to discipline or even investigate physicians involved in state-sanctioned violations of human rights. Williams notes that the medical profession's complicity in apartheid cannot be explained by ignorance of the human rights abuses that were being perpetrated. He states that although individual physicians may not be to blame for ignorance of basic principles of medical ethics, the same cannot be said for the medical profession as a whole. It is this history, it is submitted, that must be taken into account when interpreting the right of access to health care services in section 27(1) of the Constitution. It is this history that the court in *Afrox Healthcare v Strydom* (fn 65 *supra*) chose to ignore in making its decision on disclaimers used in South African hospitals, suggesting that the threat of disciplinary action by a professional body was a sufficient deterrent and remedy for the patient who is the victim of negligent and unprofessional conduct.

A right to health *per se* is not only vague but unnecessary in South African law. Socio-economic rights at international law have been criticised as being relative rather than absolute⁷⁰ and this has been equated with a lack of teeth. The comment has also been made that detailed entitlement legislation is a better guarantee of human rights⁷¹ than a mere human rights catalogue such as is found, it is submitted, at international law. However, it is further submitted that it is not the relative nature of the rights that are problematic. It is rather a weakness of international law that it can only at best provide a catalogue of rights without any meaningful content. This is precisely because rights cannot exist in a vacuum independently of the structures and values of the society in which they operate. Since international law by definition cannot accommodate the variations in social structures and values of the different nations of the world it cannot satisfactorily address the content of socio-economic and other rights. The strength of the constitutional Bill of Rights lies in the fact that all of the rights it contains are relative. The relative nature of the rights in the Bill of Rights is clearly seen in numerous dicta of the courts⁷². The relativity is also contained in the constitutional notion that the rights must not only be fulfilled, they must also be protected, respected and promoted. In the health care context, health care services do not always promote and fulfill life, particularly if one accepts that life is a state that is not necessarily dependent upon access to health care services. It is submitted in chapter two that emergency medical treatment essentially protects life much more than it promotes or fulfills it. It is life preserving not life fulfilling. Thus in terms of the Constitution, not only different contexts but also different obligations impact upon

⁷⁰ Schlemmer-Schulte fn 59 *supra*

⁷¹ Schlemmer-Schulte fn 59 *supra*

⁷² *Rudolph and Another v Commissioner for Inland Revenue and Others NNO* fn 28 *supra*; *Qozeleni v Minister of Law and Order and Another* 1994 (3) SA 625 (E); *Soobramoney v Minister of Health, KwaZulu-Natal* fn 28 *supra* (Durban High Court); *De Reuck v Director of Public Prosecutions, Witwatersrand Local Division, and Others* 2003 (3) SA 389 (W). See also Van der Vyver *D Seven Lectures on Human Rights* (quoted with approval by the court in *Phato v Attorney-General, Eastern Cape, and Another; Commissioner of the South African Police Services v Attorney-General, Eastern Cape, and Others* 1995 (1) SA 799 (E) and also in *Shabalala v Attorney-General, Transvaal, and Another Gumedede and Others v Attorney-General, Transvaal* 1995 (1) SA 608 (T)) who says at p 64-5: 'The lesson to be learned from the West German Constitution is that a bill of rights does not and, if it were to be feasible, cannot imply that the rights and freedoms it contains ought to confer unrestricted claims and competencies. I have gained the impression that the generally entertained distrust in South African of human-rights ideas has to a large extent been cultivated upon this false notion - which may, incidentally, have been inspired by the sweeping phraseology of the American Bill of Rights and certain international human-rights documents - that human rights are supposed to be absolute rights. The truth is that all rights and freedoms claimed by an individual have their appropriate boundaries to be determined, in general, by both the equal rights and freedoms of other persons and by state or community interests - provided that state interests are restricted in view of the true function of a state as an historical community destined to create and preserve law and order. Nor ought the scope and importance of one right or freedom to be preferred over that of another. . . . In short, the only significance of a bill of rights would be that the government is constantly reminded that the rights and freedoms it contains have been regarded as of special importance for the preservation of a free society, that those rights and freedoms can be abridged in the specified circumstances and to the specified extent only, and that restrictions upon those rights and freedoms ought always to remain the exception and not the rule. Inclusion of a particular right or freedom in a bill of rights ought in no way to change its nature or ambit.'

different rights differently. The right to life is not absolute in the sense that one cannot choose to give it up. In South African law everyone has the right to refuse medical treatment even if, without that treatment, the patient would surely die⁷³. It is also relative in the sense that the sacrifice of the life of one may be necessary to save the lives of many and therefore fully justifiable in certain albeit limited circumstances. In the context of health services delivery more than most one encounters such situations in which those rendering such services are forced to make difficult choices. When the courts, on rare occasions, are asked to make, or at least adjudicate, these choices it becomes international news, for instance in the case of *Soobramoney*⁷⁴. However health professionals and public health administrations are obliged to make such choices often as a normal part of the execution of their professional duties. In the case of the former one, sees this frequently in the form of triage procedures within trauma units that experience a sudden influx of critically injured people consequent upon a multiple motor vehicle accident or some other manmade or natural disaster. In the case of the latter it takes the form of resource rationing decisions that have to be made in order to achieve the most effective and optimal distribution and utilisation of limited resources. In such circumstances anyone who tries to argue that the right to life is absolute is nothing short of naïve. There are many who would argue that life without dignity and freedom is no life at all. A pertinent example of the truth of this argument in the health care context is that of the persistent vegetative state in which the unfortunate patient in *Clarke v Hurst*⁷⁵ found himself.

Rights are thus relative as between different individuals who hold the same or different conflicting rights, as between each other when viewed in the context of a single individual who holds a number of conflicting rights and also as between the individual and society as a collective – the latter often represented by the State. The relativity of rights is also evident in the varying obligations to respect, protect, promote and fulfill them. The possibilities for legal permutations between these various planes of relativity are infinite when combined with the various factual permutations that can arise in real life. Thus one can have a decision in *Soobramoney*,

⁷³ In the case of Jehovah's witnesses they choose to value their right to freedom of conscience, religion, belief and opinion above their right to life when it comes to blood transfusions. The right to refuse a blood transfusion has been recognised by a South African court in *Phillips v de Klerk* TPD (unreported) March 1983 (see Strauss SA *Doctor Patient and the Law: A Selection of Practical Issues* p 29 and 94)

⁷⁴ *Soobramoney* fn 28 *supra*

⁷⁵ *Clarke* 1992 (4) SA 630 (D)

which favours the rights of a group over those of a single individual, sitting comfortably side by side with a judgment in the *TAC*⁷⁶ and *Grootboom*⁷⁷ cases which focus very much upon the rights of individuals. The point is that relativity of rights promotes flexibility of law and flexibility of law in its turn permits justice to prevail in different circumstances.

10.3.2 The Right of Access to Health Care Services

The right of access to health care services should not be confused with the notion that there is a right to indefinitely evade death⁷⁸. It is submitted that this view of the court in *Soobramoney* is entirely consistent with the spectrum of health services contemplated by the Constitution since the latter include palliative care in a hospice setting which involves the psychological preparation of the individual for death and the alleviation of physical suffering in the end stages of life. It was the view of the constitutional court in *Soobramoney* that life includes death and that one cannot therefore take the attitude that the right of access to health care services precludes death from the equation. If one did so, then it is submitted that the term “health care services” could not be read to include the kinds of services rendered by hospices. This principle is exceptionally important when one is dealing with limited resources in the delivery of health services. If it were not recognized, people would be able to demand access to the most expensive, latest technological developments in health care in the world solely on the basis that this would prolong their lives.

The point is made in chapter two of this thesis that there can be fundamental differences, and even conflict, between a right to health and a right of access to health care services. The example is used of spraying dwellings with DDT, an environmentally harmful substance, in an effort to protect the inhabitants from malaria carrying mosquitoes. The concept of a right to health in South African law is likely to be of limited value since it is the interaction of the various rights in the Bill of Rights which will determine the outcome of a particular case involving health care services rather than a global consideration of a right to health *per se*.

⁷⁶ *Minister of Health and others v Treatment Action Campaign and Others* (No 2) fn 26 *supra*

⁷⁷ *Government of the Republic of South Africa and Others v Grootboom and Others* fn 26 *supra*

⁷⁸ *Soobramoney v Minister of Health, Kwazulu-Natal* fn 26 *supra*

It is clear that the right of access to health care services is justiciable⁷⁹. Although the term ‘health care services’ is not defined in the Constitution, it is submitted that the scope of the health care services contemplated in the Constitution is very broad, including as it does ‘reproductive health care’. Pregnant women are not ill but they are entitled to health care services in support of their pregnancy. The term “health care services” means more than just curative or therapeutic services because the term “health care” suggests the promotion, maintenance and preservation of health as much as it does the restoration of health. It also means more than just “medical treatment” as evidenced by the use of this term in section 27(3) of the Constitution to distinguish it from the right referred to in section 27(1). There is thus an important distinction drawn in the Constitution itself between “health care services including reproductive health care” on the one hand and “medical treatment” on the other. The right in section 27(3) refers to “emergency medical treatment”, suggesting that there are other kinds of medical treatment. However the section 27(1) of the Constitution refers to a right of access to health care services as opposed to “medical treatment”. It is submitted that medical treatment is therefore a subset of the health care services contemplated in section 27(1) of the Constitution.

The right expressed in section 27(1) of the Constitution is not a right to health care services but a right of *access* to health care services. It is argued that this acknowledges and supports the other rights in the Bill of Rights such as the rights to dignity and bodily and psychological integrity. In keeping with these other rights, health services may only be lawfully rendered on the informed consent of the patient because it is a right of access and not a right to health services. The language of the Constitution in expressing the right to health care services also indicates a certain responsibility upon the individual to avail him or herself of the services in question. Access is a channel or path by means of which an object is attained – it is not the object itself. The individual must therefore walk that path if he or she wishes to obtain the health services to which it leads. A person cannot complain that health services have not been delivered to him when they are accessible to him.

⁷⁹ *Grootboom* fn 26 *supra*

A further implication of a right of access to, as opposed to a right to, health services is that the state is not obliged, in terms of the manner in which the right is expressed in section 27(1) of the Constitution to provide health services. It can ensure access without necessarily providing the health services itself. Thus if a person is a contributor to a medical scheme which assures her access to private health care facilities she is not necessarily entitled to free health care services from the state at public health facilities merely by virtue of section 27(1). Indeed she may not be entitled to *any* health care services at a public health establishment, whether she pays for them or not, if she has sufficient access to equivalent health services in the private sector. Similarly if the state adopts a means test in order to decide who should contribute to the costs of their health care services at a public health establishment and who should obtain those services free of charge, such an attitude on the part of the state would not necessarily be unconstitutional provided that the fees payable are reasonable in relation to the means of the patient and consistently applied to everyone in the same means category.

The question of a medical scheme member's rights as against the state when he or she exhausts the benefits available under the scheme depends upon whether or not the required treatment is available to patients commonly serviced within the public health sector. A good example of this is the treatment of AIDS through the use of antiretroviral drugs. If these drugs are available to public sector patients but there is no mandatory requirement for medical schemes to provide benefits to secure the same treatment then a medical scheme member would be entitled to access the drugs at a public health establishment. This does not, however, mean that such access will be free of charge if there is a system of fees generally applicable within the public sector based upon the patient's ability to pay. In South Africa, at present, membership of a medical scheme is voluntary. Therefore people can choose to belong to a medical scheme, which in most cases still assures them of a certain degree of access to private health facilities, or they can choose not to in which case they will have to pay out of their own pockets for access to those same private health facilities or avail themselves of health services in the public sector where they may still be obliged to contribute towards the costs of those services on the basis of a means test. Where the treatment in question is highly specialized and is not available in the public sector, it is submitted that a medical scheme member who exhausts his medical scheme benefits

in obtaining such highly specialized treatment will have no right to claim those same services from the state on the basis of section 27(1) of the Constitution. Sections 213 to 215 of the Constitution make provision for the allocation of revenue and the mechanisms that must be employed in this regard. It is submitted that the state also has a right to allocate resources on the basis of sections 85 (in the case of the President in Cabinet) and 125 (in the case of provincial governments) which provide the authority for the developing and implementing of national and provincial policy, coordinating the functions of state departments and provincial administrations and performing any other executive functions assigned to them by the Constitution or legislation. It is submitted that provided that decisions by the state concerning the allocation of resources are lawful, fair, rational and reasonable and meet the criteria laid down in *inter alia Soobramoney*, the courts will be extremely reluctant to interfere with such decisions since, constitutionally speaking, they are the province of executive government and not the judiciary.

The point is made in chapter 2 that “access” implies much wider obligations upon the state than mere availability of health care services and that the obligations of the state in respect of section 27(1) do not stop at the boundaries of the jurisdiction of the national and provincial departments of health. Access implies adequate roads to and from health facilities, reliable transport services from people’s homes to health establishments, sufficient numbers of suitably qualified and skilled health professionals to be able to provide the required services, adequate supplies of water and sanitation, the maintenance of government buildings and facilities from which or within which health services are delivered and the allocation of sufficient funding to the various state departments concerned to ensure that they can fulfil these mandates. The right of access to health care services therefore impacts upon the roles and functions of the departments of provincial and local government, public works, transport, water affairs and the national and provincial treasuries.

10.3.3 Realisation Of The Right Of Access To Health Care Services

The Constitution requires the progressive realisation of the right of access to health care services and obliges the state to take reasonable legislative and other measures to

achieve this. In cases such as *Grootboom*⁸⁰, *Soobramoney*⁸¹, and *TAC*⁸² the constitutional court has provided some guidelines as to the approach that should be adopted in this regard. In *Grootboom* the court stated the following broad principles:

- (1) Questions involving socio-economic rights must be considered on a case-by – case basis, considering the terms and context of the relevant constitutional provision and its application to the circumstances;
- (2) The rights must be understood in two contexts – firstly their textual context and secondly their social and historical context;
- (3) Socio-economic rights cannot be considered in isolation but must be considered in the setting of the Constitution as a whole;
- (4) The obligations imposed upon the state are not absolute or unqualified. The state’s obligation with regard to socio-economic rights is defined by three key elements –
 - (a) the obligation to take reasonable legislative and other measures;
 - (b) to achieve the progressive realisation of the right; and
 - (c) within available resources;
- (5) Policies and programs must be determined in the light of the creation by the Constitution of different spheres of government and the allocation of powers and functions amongst these different spheres thus emphasising their obligation to co-operate with one another in carrying out their constitutional tasks;
- (6) The formation of policies and programs are just one of the aspects of the task that must be reasonable. Implementation of such programs and policies must also be reasonable;

⁸⁰ *Grootboom* fn 26 *supra*

⁸¹ *Soobramoney* fn 28 *supra*

⁸² *TAC* fn 26 *supra*

- (7) In order to be reasonable, a program must be balanced and flexible and make appropriate provision of attention to crises and to short, medium and long term needs;
- (8) A program excluding a significant segment of society is not reasonable;
- (9) Reasonableness had to be understood in the context of the Bill of Rights as a whole, especially the constitutional requirement that everyone be treated with care and concern and the fundamental constitutional value of human dignity;
- (10) Accessibility has to be progressively facilitated, requiring the examination of legal, administrative, operational and financial hurdles which have to be lowered over time;
- (11) The obligation does not require the state to do more than its available resources permit. This means that both the content of the obligation in relation to the rate at which it is achieved as well as the reasonableness of the measures employed to achieve the result are governed by the availability of resources;
- (12) There is a balance between goal and means. The measures must be calculated to attain the goal expeditiously and effectively but the availability of resources is an important factor in determining what is reasonable;
- (13) The national government bears the overall responsibility for ensuring that the state complies with its obligations with regard to socio-economic rights;
- (14) Provision must be made for relief for those in desperate need. Programs and policies that do not cater for them are unconstitutional.

In the *TAC* case many of these principles were simply endorsed by the court with reference to *Grootboom*. The court in *Grootboom* approved of the principles laid down in the judgment in *Soobramoney*.

The court in *TAC* added the following principles or refinements to those referred to in *Grootboom*:

- (1) A policy that excludes those that can reasonably be included is unconstitutional;
- (2) Not everyone can immediately claim access to benefits;
- (3) State policy must take into account disparities in access between the private and public sectors;
- (4) An approach that nothing but the best should be provided is unconstitutional if it has the effect of denying access to a benefit that is substantive even though less than optimal;
- (5) Transparency of government policies and programmes and widespread communication of such policies and programmes in an essential element of the State's obligations with regard to the progressive realisation of socio-economic rights

From *Soobramoney* the following principles emerge:

- (1) The criteria for the courts in deciding whether or not interfere with a decision of the political organs and medical authorities responsible for such matters as stated by the court are rationality and good faith.
- (2) In support of the purposive approach to the interpretation of the right of access to health care services the court observed that the constitutional commitment to address the deplorable conditions of great poverty, high levels of unemployment, inadequate social security and widespread lack of access to clean water and adequate health services, is expressed in the preamble which, after giving recognition to the injustices of the past, states:
'We therefore, through our freely elected representatives, adopt this Constitution as the supreme law of the Republic so as to -

Heal the divisions of the past and establish a society based on democratic values, social justice and fundamental human rights;

...

Improve the quality of life of all citizens and free the potential of each person.’ Therefore one the central purposes of the right of access to health care services is to improve the quality of life of all citizens and free the potential of each person. This carries the implication that health services that fail unreasonably to achieve these objectives cannot be regarded as the kind of health services to which access is contemplated by the Constitution.

- (3) The right not to be refused emergency medical treatment must not be confused with the right of access to health care services.
- (4) The purpose of the right not to be refused emergency medical treatment seems to be to ensure that treatment be given in an emergency, and is not frustrated by reason of bureaucratic requirements or other formalities. A person who suffers a sudden catastrophe which calls for immediate medical attention should not be refused ambulance or other emergency services which are available and should not be turned away from a hospital which is able to provide the necessary treatment. What section 27(3) requires is that remedial treatment that is necessary and available be given immediately to avert that harm.
- (5) The government, which is responsible for health services, has to make decisions about the funding that should be made available for health care and how such funds should be spent. These choices involve difficult decisions to be taken at the political level in fixing the health budget, and at the functional level in deciding upon the priorities to be met. A court will be slow to interfere with rational decisions taken in good faith by the political organs and medical authorities whose responsibility it is to deal with such matters.
- (6) The state’s failure to provide a particular kind of health care service for everyone is not necessarily unconstitutional but must be considered in the light

of prevailing circumstances, including the availability of resources and how rationally they have been deployed.

10.3.4 Horizontal Application

It is submitted that the foregoing principles are not necessarily confined to the delivery of health care services by the state. If the fact is accepted that the wording of the right of access to health care services in section 27(1) of the Constitution is sufficiently wide that the state is not necessarily obliged to itself deliver health care services to every individual and that it can take other measures to ensure access, such as the regulation of medical schemes and health establishments and professionals in the private sector and the provision of health financing in terms of a social health insurance scheme, then the right of access to health care services cannot be regarded as imposing a corresponding obligation upon the state alone. The fact that state resources may be overburdened and incapable of accommodating everyone who needs health care services cannot be used as justification to argue that the State's obligations in terms of section 27(1) begin and end with the public health sector. A purposive interpretation of sections 27(1) and 27(2) of the Constitution, it is submitted, obliges the state to take reasonable legislative and other measures to ensure that the right of access to health care services is also capable of realisation within the private sector and this obligation will remain for as long as the state itself does not have the capacity to render health care services to everyone. For this reason, it is submitted that the constitutional principles outlined above apply, *mutatis mutandis* to the private health sector as much as they do in the public health sector. Moreover they must infuse and inform other areas of law that are applicable in the context of health service delivery, such as the law of contract to the extent that contracts are used as the legal vehicle for the provision of health care services, the law of delict to the extent that it redresses the wrongs done to patients in the provision of health care services and administrative law to the extent that it applies to the decisions and conduct of statutory professional bodies, private entities performing a public function (for example members of the private health sector who have been awarded state tenders for the delivery of health services or the supply of health products) and governmental institutions and public entities (including the Medicines Research Council and the National Health Laboratory Services).

The question of payment for health care services within the private sector is not necessarily a bar to the application of section 27(1) to providers of health care services in the private sector. Patients are required to make payments in respect of health care services in the public sector where a means test demonstrates that they have the necessary resources. This is not unconstitutional. In the private health sector such a means test is simply less overt since one cannot access health services in the private sector in the absence of the means to pay for them. Since in many instances patients serviced by both the public and the private health sectors have the means to pay (whether by virtue of their membership of a medical scheme, because of some kind of social insurance scheme such as is currently provided for occupational illnesses and injuries in terms of the Compensation for Occupational Injuries and Diseases Act or by virtue of their own personal resources) it would be a mistake to use this single issue in isolation as a justification for the horizontal inapplicability of the right in section 27(1) within the private sector.

It is further submitted that the right contemplated in section 27(1), as seen against the wider context of the Bill of Rights, applies equally to all persons whether they access health care services in the public or the private sector. Thus a refusal by a private sector provider to treat a patient in a manner or on a ground that is unfairly discriminatory or that unreasonably impacts on the patient's rights to psychological or bodily integrity would be just as unconstitutional as a similar refusal within the public sector. An unreasonable refusal by a private provider of health care services to treat a patient or to comply with certain statutorily imposed standards of quality in regard to a particular patient could most certainly be argued as impacting upon his or her constitutional right of access to health care services. Contractual terms that vitiate or nullify the constitutional right of access to health care services cannot and should not be upheld by courts of law since the courts form a part of the state and the state is required to take reasonable legislative and other measures to respect, protect, promote and fulfil the rights in the Bill of Rights⁸³. This obligation, it must be noted, does not specifically extend to rights other than those expressed in the Bill of Rights. The

⁸³ In *President of the Republic of South Africa and Others v United Democratic Movement (African Christian Democratic Party and Others Intervening; Institute for Democracy in South Africa and Another as Amici Curiae)* 2003 (1) SA 472 (CC) the court observed that the three branches of government are indeed partners in upholding the supremacy of the Constitution and the rule of law. In *President of the Republic of South Africa and Another v Hugo* 1997 (4) SA 1 (CC) the court said that there are only three branches of government, viz legislative, executive and judicial.

sanctity of contract is one that falls within the common law rather than constitutional law. Since the common law must be informed by and developed so as to be consistent with the Constitution, there is in any event a constitutional mandate for judiciary to prefer constitutional rights to rights at common law where there is a conflict.

10.3.5 Conclusions Concerning Constitutional Law

Due to the fact that the rights in the Bill of Rights cannot be construed in isolation, questions involving the right to health care services are unlikely to be resolved only with regard to the right expressed in 27(1) and indeed they should not be. The rights in the Bill of Rights are interdependent and interconnected and a right of access to health care services is no exception. Other rights that are most likely to be involved are the right to human dignity, the right to life, the right to freedom and security of the person, the right to bodily and psychological integrity, the right to an environment that is not harmful to health or wellbeing. The approach of the courts to the right of access to health care should be considerably broader than it is at present in order to fully embrace this idea of rights as a composite concept. From the judgments discussed in the second chapter of this these, including the adoption of the constitutional court of the purposive approach to the Bill of Rights, it is clearly wrong to adopt a narrow and purely analytical approach to constitutional rights. Since constitutional rights themselves are not applied in a vacuum but may well be contextualized even further within the common or statutory law, one can no longer justifiably adopt a purely reductionist approach to these areas of law either. Legal synthesis and the construction of the right within its factual and legal contexts against a background of constitutional values and broad constitutional principles is essential if one is to give effect to the spirit of the law as embodied in the Constitution throughout the South African legal system. A meagre, starkly analytical approach that fails to take account of these issues is unlikely to infuse the common law with constitutional values and is even more likely to fall short of that most elusive of social goals – justice. Sarat and Kearns⁸⁴ point out that contrary to popular belief, law is often

⁸⁴ Sarat A and Kearns T R (eds) *Justice and Injustice in Law and Legal Theory*. In chapter one, Sarat observes the following: "Justice, Drucilla Cornell argues, "is precisely what eludes our full knowledge." We cannot "grasp the Good but only follow it. The Good . . . is a star which beckons us to follow." While justice, or what Cornell calls the Good, is, on her account, always present *to* law, it is never completely realized *in* law. Or, as Judith Butler puts it, ["T]he law posits an ideality . . . that it can never realize, and . . . this failure is constitutive of existing law." Law exists both in the "as yet" failure to realize the Good and in the commitment to its realization. In this failure and this commitment, law is

associated rather more with injustice than with justice despite the fact that in earlier times law and justice were perceived as synonymous. South Africans in particular have good reason to know the truth of this and just how naïve is the idea that law and justice are one and the same⁸⁵. In the book by Sarat and Kearns⁸⁶, the point is made that Commentators from Plato to Derrida have called law to account in the name of justice, asked that law provide a language of justice, and demanded that it promote the attainment of justice. The fact that justice itself is a balancing exercise, often between the interests of the individual and the collective, is no small coincidence⁸⁷. Human

two things at once: the social organization of violence through which state power is exercised in a partisan, biased, and sometimes cruel way, and the arena to which citizens address themselves in the hope that law can, and will, redress the wrongs that are committed in its name. These thoughts remind us that running throughout the history of jurisprudence and legal theory is a concern about the connections between law and justice and about the ways law is implicated in injustice. Commentators from Plato to Derrida have called law to account in the name of justice, have asked that law provide a language of justice, and have demanded that it promote, insofar as possible, the attainment of a just society. Yet the justice described is elusive, if not illusory, and in some scholarship disconnected from the embodied practices of law, including law's violence. In an earlier day, speaking about law and justice was not so vexing or difficult. Justice (*ius* meaning "law") was a legal term, pure and simple. At the outset, then, "justice was defined and constituted by laws which were 'given' and held to be unchanging and unchangeable. This ineluctable link between justice and law, as put forth by Hobbes, had the virtue of making the boundaries of justice more or less clear; but it had the considerable vice of labelling even heinous, iniquitous laws just. Justice could do no critical/reconstructive work because it was impossible to think of justice as external to law. Apart from Hobbes, most natural-law thinkers have resisted this result by insisting that unjust laws are not law, though doing so meant the end of any easy identification of positive or human law with "real" or binding law. The alternative, embraced by perhaps a majority of those who continue to be at ease in this idiom, is to cut justice and law free from one another, to insist that justice is more than mere conformity to law, and to acknowledge that even unjust laws might nonetheless be law. Most recently, the distance between law and justice has been recognized in postmodern theorizing about ethics. Thus, as Douzinas and Warrington argue, "[J]ustice has the characteristic of a promissory statement. A promise states now something to be performed in the future. Being just always lies in the future, it is a promise made to the future, a pledge to look into the event and the uniqueness of each situation. This promise, like all promises, does not have a present time, a time when you can say: "there it is, justice is this or that." Suspended between the law and the good...justice is always still to come or always already performed." Severance of the definitional tie between justice and law has left both notions free (if also bound) to acquire new identities. In both cases, former boundaries have been enlarged. Thus, matters other than those directly regulated by law (for example, the distribution of wealth) are viewed as falling under the purview of justice, and patently unjust legal arrangements (for example, apartheid in South Africa) are accepted as lawful despite their moral repugnance. But as Clarence Morris notes, "Though there can be law without justice, justice is realized only through good law. In fact, law and legal theory continue to be shaped by concerns about justice and injustice, just as understandings of these latter notions are shaped by an awareness of law and the concerns of legal theory." [Footnotes omitted].

Pecarelli A M in "Reflections on Law and Justice" <http://www.dcba.org/brief/octissue/1997/art11097.htm> recalls the following anecdote concerning two of America's more famous judges: "A conversation reported to have occurred between U.S. Supreme Court Justice Oliver Wendell Holmes and U.S. Circuit Court of Appeals Justice B. Learned Hand, at the time sitting on the Second Circuit Court of Appeals in New York, emphasizes a dilemma which has concerned me for sometime.

Justice Holmes and Justice Hand, had lunch together. Afterward as Hand exited Holmes' carriage and Holmes began to drive off, Hand, in a sudden onset of enthusiasm, ran after him, crying: "Do justice sir, do justice"; to which Holmes stopped the carriage and reproved Hand: "That is not my job. My job is to apply the law."

Pecarelli comments that: "It is my opinion, based on my years of private practice and public service, that: Justice cannot be declared by judicial fiat within a legal system. Justice is transitory when the adjudication of a dispute is consistent with one person's preconceived concept of a desired result, but is inconsistent with another person's concept of a desired result. Justice requires a fundamental understanding and uniform result desired by all. Justice is considered a special virtue of what is the just thing to do in the circumstances of actual life or as a directive for acting toward each other to do or not to do something that concerns the other, the performance of which elicits approval. The source of the approval may be from another person or society in general. Justice, sometimes, is described or defined as the imposition of obligations or duties which supplies its own sanction and needs no norm or standard by which it is to be measured. In each such instance a range of meaning is expressed in which precision is transitory. The dilemma becomes acute in attempting to reconcile the objectivity of Positive Law, or the objectivity/subjectivity of Sociological Law, and the subjectivity of Natural Law. The expectation that the purpose of law is to increase justice creates an ambiguity. Law and justice are not mutually inclusive as the adjudication of a dispute may be perceived by some people in a given society as justice, while others could perceive the adjudication of the same dispute as injustice.

85

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87

See Dyzenhaus *D Judging The Judges, Judging Ourselves* for further views on this subject.

Sarat fn 84 *supra*

See Kastner F 'How To Deal With Paradoxes of Justice: The Ultimate Difference Between a Philosophical and a Sociological Observation of the Legal System' Paper for the Conference "The Opening of Systems Theory at Copenhagen Business School, May 23-23 2003 <http://asp.cbs.dk/ccc/> who notes that: "There had been a certain

rights considerations in particular often seem to raise this type of dichotomy and in the field of public health it is also common. What benefits the individual does not always benefit society as a whole and the cost of treating and individual may at times even be detrimental to the collective as *Soobramoney's* case so clearly shows. The constitutional court has made considerable headway in setting out some guiding principles for executive government as to how to approach socio-economic rights. Many of these principles are very prominent aspects of administrative law and the concept of administrative justice or more detailed glosses on these principles. Transparency, the consideration of the interests of everyone concerned as opposed to only a single sector, the need to make provision for exceptions to the general rule, the importance of taking all of the relevant factors into account when designing a programme affecting socio-economic rights, reasonableness of not only programme design but also implementation – many of these principles as outlined above can be seen as being based in or stemming from administrative law considerations such as that of *audi alteram partem*, that those tasked with decision-making must apply their minds, that the facts and merits of each case must be taken into account, that there must be no bias (*nemo iudex in sua causa*), or unfair prejudice, in deciding for or against a particular individual or grouping, that decisions must be taken *bona fides*, and that everyone should be given an opportunity to make representations stating her particular case. These are all well recognised and established principles of administrative law and arise from its preoccupations with fairness and the principles of natural justice. It is fitting that this should be the approach of the constitutional court since this is in keeping with the doctrine of separation of powers in terms of which it is the function of the executive to make the policy decisions, to determine the allocation of resources and to manage them in a manner that fulfils its own peculiar obligations in terms of the Constitution. The court cannot substitute its own judgment or opinion for that of the executive branch of government merely because believes that this is preferable⁸⁸. As the court in *Soobramoney* stated clearly:

discomfort accompanied by every attempt to codify justice in law at all times...Between the simple law and its permanently changing subjected matter... diverge an insurmountable abyss: for what is just for everybody is not doing justice to everyone".

⁸⁸ Thus in *Premier, Mpumalanga, and Another v Executive Committee, Association of State-Aided Schools, Eastern Transvaal* 1999 (2) SA 91 (CC) at para 41 the constitutional court states: "In determining what constitutes procedural fairness in a given case, a court should be slow to impose obligations upon government which will inhibit its ability to make and implement policy effectively (a principle well recognised in our common law and that of other countries). As a young democracy facing immense challenges of transformation, we cannot deny the importance of the need to ensure the ability of the Executive to act efficiently and promptly. On the other hand, to permit the implementation of retroactive decisions without, for example, affording parties an effective opportunity to make representations would flout another important principle, that of procedural fairness. . . . Citizens are entitled to expect that government policy will ordinarily

“ The provincial administration which is responsible for health services in KwaZulu-Natal has to make decisions about the funding that should be made available for health care and how such funds should be spent. These choices involve difficult decisions to be taken at the political level in fixing the health budget, and at the functional level in deciding upon the priorities to be met. A court will be slow to interfere with rational decisions taken in good faith by the political organs and medical authorities whose responsibility it is to deal with such matters.”⁸⁹

In view of these observations the importance of administrative law in the delivery of healthy care services cannot be overstated.

10.4 Administrative Law

Administrative law can be a highly confusing and technical area of law with which many people, including government officials, are largely unfamiliar. It is traditionally not an area of law that has preoccupied the private sector to any significant extent. Section 33 of the Constitution states that everyone has the right to administrative action that is lawful, reasonable and procedurally fair. It further states that everyone whose rights have been adversely affected by administrative action has the right to be given written reasons and that national legislation must be enacted to give effect to these rights.

In *Pharmaceutical Manufacturers Association of SA and Others: In re Ex parte President of the RSA and Others*⁹⁰ it was held that administrative law, which occupies a special place in South African jurisprudence, is an incident of the separation of powers under which courts regulate and control the exercise of public power by the other branches of government.

Principles of administrative law under the common law should not be seen as separate from those under the Constitution⁹¹.

not be altered in ways which would threaten or harm their rights or legitimate expectations without their being given reasonable notice of the proposed change or an opportunity to make representations to the decision-maker.”

⁸⁹ *Soobramoney* fn 28 *supra* at p776

⁹⁰ *Pharmaceutical Manufacturers* 2000 (2) SA 674 (CC)

⁹¹ Chaskalson P stated in *Pharmaceutical Manufacturers* fn 84 *supra* that: “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

10.4.1 The Promotion of Administrative Justice Act No 3 of 2000

The Promotion of Administrative Justice Act⁹² (PAJA) defines administrative action as -

“any decision taken, or any failure to take a decision, by-

- (a) an organ of state, when-
 - (i) exercising a power in terms of the Constitution or a provincial constitution; or
 - (ii) exercising a public power or performing a public function in terms of any legislation; or
- (b) a natural or juristic person, other than an organ of state, when exercising a public power or performing a public function in terms of an empowering provision, which adversely affects the rights of any person and which has a direct, external legal effect, but does not include-
 - (aa) the executive powers or functions of the National Executive, including the powers or functions referred to in sections 79 (1) and (4), 84 (2) (a), (b), (c), (d), (f), (g), (h), (i) and (k), 85 (2) (b), (c), (d) and (e), 91 (2), (3), (4) and (5), 92 (3), 93, 97, 98, 99 and 100 of the Constitution;
 - (bb) the executive powers or functions of the Provincial Executive, including the powers or functions referred to in sections 121 (1) and (2), 125 (2) (d), (e) and (f), 126, 127 (2), 132 (2), 133 (3) (b), 137, 138, 139 and 145 (1) of the Constitution;
 - (cc) the executive powers or functions of a municipal council;
 - (dd) the legislative functions of Parliament, a provincial legislature or a municipal council;

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.” He also held that he could not “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. Whilst there is no bright line between public and private law, administrative law, which forms the core of public law, occupies a special place in our jurisprudence. It is an incident of the separation of powers under which courts regulate and control the exercise of public powers by the other branches of government. It is built on constitutional principles which define the authority of each branch of government, their inter-relationship and the boundaries between them. Prior to the coming into force of the interim Constitution, the common law was ‘the main crucible’ for the development of these principles of constitutional law. The interim Constitution which came into force in April 1994 was a legal watershed. It shifted constitutionalism, and with it all aspects of public law, from the realm of common law to the prescripts of a written constitution which is the supreme law. That is not to say that the principles of common law have ceased to be material to the development of public law. These well-established principles will continue to inform the content of administrative law and other aspects of public law, and will contribute to their future development. But there has been a fundamental change. Courts no longer have to claim space and push boundaries to find means of controlling public power. That control is vested in them under the Constitution, which defines the role of the courts, their powers in relation to other arms of government and the constraints subject to which public power has to be exercised. Whereas previously constitutional law formed part of and was developed consistently with the common law, the roles have been reversed. The written Constitution articulates and gives effect to the governing principles of constitutional law.”

⁹² Promotion of Administrative Justice Act fn 22 *supra*

- (ee) the judicial functions of a judicial officer of a court referred to in section 166 of the Constitution or of a Special Tribunal established under section 2 of the Special Investigating Units and Special Tribunals Act, 1996 (Act 74 of 1996), and the judicial functions of a traditional leader under customary law or any other law;
- (ff) a decision to institute or continue a prosecution;
- (gg) a decision relating to any aspect regarding the appointment of a judicial officer, by the Judicial Service Commission;
- (hh) any decision taken, or failure to take a decision, in terms of any provision of the Promotion of Access to Information Act, 2000; or
- (ii) any decision taken, or failure to take a decision, in terms of section 4 (1);”

In terms of the Act, ‘administrator’ means an organ of state or any natural or juristic person taking administrative action.

In terms of PAJA ‘decision’ means any decision of an administrative nature made, proposed to be made, or required to be made, as the case may be, under an empowering provision, including a decision relating to-

- (a) making, suspending, revoking or refusing to make an order, award or determination;
- (b) giving, suspending, revoking or refusing to give a certificate, direction, approval, consent or permission;
- (c) issuing, suspending, revoking or refusing to issue a licence, authority or other instrument;
- (d) imposing a condition or restriction;
- (e) making a declaration, demand or requirement;
- (f) retaining, or refusing to deliver up, an article; or
- (g) doing or refusing to do any other act or thing of an administrative nature, and a reference to a failure to take a decision must be construed accordingly”

These are important definitions. Their extent of their applicability to the exercise of various powers exercised by government officials is not always clear⁹³. In the context

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See for instance *Minister of Home Affairs v Eisenberg & Associates: In Re Eisenberg & Associates v Minister of Home Affairs and Others* 2003 (5) SA 281 (CC) in which Chaskalson CJ observed that: “The definition of ‘decision’ does not refer to the making of regulations and it is not clear whether this constitutes administrative action for the purposes of PAJA. Moreover, the definition of ‘administrative action’ specifically excludes ‘any decision taken, or a failure to take a decision, in terms of s 4(1)’. It may be open to doubt, therefore, whether reliance could be placed on PAJA in the

of the delivery of health care services it would seem that a refusal to deliver up a health record, the imposition of a condition or restriction upon access to a health service, the refusal of a certificate of need to a health facility could all fall under the definition of the term 'decision' a PAJA. The performing of the public function or exercise of the public power in question must have a direct, external legal effect in order for it to be classified as administrative action under PAJA. The exercise of a public power or the performance of a public function by a natural or juristic person that does not have such an effect is clearly not administrative action for the purposes of PAJA.

The constitutional right to administrative action contemplated in section 33 of the Constitution must be pursued and enforced in terms of the PAJA. In *Jayiya v Member of the Executive Council for Welfare, Eastern Cape, and Another*⁹⁴ the court made the point that where the lawgiver has legislated statutory mechanisms for securing constitutional rights, and provided, of course, that they are constitutionally unobjectionable, they must be used. It found that the Promotion of Administrative Justice Act did not provide for the kind of relief afforded to the appellant in paragraphs 2(c) and 3 of the order.

10.4.2 The Nature of the Function Not the Functionary

In *Pennington v Friedgood and Others*⁹⁵, the court stated that it was in agreement with the following words of Devenish, Govender and Hulme⁹⁶:

circumstances of this case. The scope of PAJA and its relationship to administrative law principles based in common law is also not entirely clear." In *South African Shore Angling Association and Another v Minister of Environmental Affairs* 2002 (5) SA 511 (SE) Erasmus J observed that: "Counsel for applicant submits that in s 6, PAJA simply re-enacts the common law. He suggests that for an administrative action to be regarded as lawful, reasonable and procedurally fair, it must now comply with the provisions of s 6(2) of PAJA *supra*. He submits that, in particular, paras (h) and (i) are of the utmost importance insofar as it is there provided that the action must be reasonable and must not be unconstitutional or unlawful. Counsel for respondent have a somewhat different view of the legislation. They submit that s 6 of PAJA was intended as an exhaustive codification of the law relating to the judicial review of the exercise of public power. They submit that this understanding of the intended scope of the Act is fortified by the decision of the 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) (2000 (3) BCLR 241) at para [51], where Chaskalson P says that judicial review of the exercise of public power is a constitutional matter that takes place under the Constitution and in accordance with its provisions. Whatever the precise status of common-law principles in proceedings for judicial review of administrative action may be, clearly those proceedings are now conducted under s 6 of PAJA. The basic approach, however, is the same as before: the Court considers the administrative action in the light of the evidence."

⁹⁴ *Jayiya* 2004 (2) SA 611 (SCA)

⁹⁵ *Pennington* 2002 (1) SA 251 (C)

⁹⁶ Devenish GE, Govender K and Hulme D *Administrative Law and Justice in South Africa* at p 25

“Administrative action’ is the conduct of public authorities and indeed private entities when they exercise public powers, perform public functions or are obliged to exercise authority in the public interest. This means that common-law review now only applies in a very narrow field in relation to private entities that are required in their domestic arrangements to observe the common-law principles of administrative law. This applies in relation to voluntary associations, such as sporting clubs and religious organisations.”

It is clear from this that the question of whether or not an activity such as the delivery of health care services falls within the purview of administrative law depends not on whether the functionary or entity delivering those services is a public or private body but whether the delivery of health care services is a public function or is the consequence of an exercise of a public power or authority in the public interest⁹⁷. It is submitted that in a situation in which a private entity has been contracted by the state to deliver health care services pursuant to the constitutional obligations of the state contemplated in section 27(1) of the Constitution decisions of that private entity could constitute administrative law decisions depending on the terms of the contract and the nature of the decisions taken. The provision of health care services to patients in the absence of a contractual relationship between the provider and the patient, it is submitted, could promote an inference that the relationship is governed by administrative law to the extent that the provision of those health care services is regarded as a public function.

To take a practical example –

The provincial governments are required by section 16 of the Health Act No 63 of 1977 to provide hospital facilities and services. There appears to be nothing in the Act to prevent a provincial government from contracting with a private sector hospital group to provide these services and to ensure the carrying out of those daily activities sufficiently to fulfil the provincial government’s obligations as contemplated. If the provincial government itself had performed these activities this would no doubt have constituted a public function. Why should the situation change simply because a private provider has now been contracted to do the job? To the extent that the private provider fails to comply with administrative law in the decisions it takes concerning

⁹⁷ The court in *Pennington* (fn 95 *supra*) stated: “Since the advent of the Constitution and, pursuant thereto, the PAJA, a requisite jurisdictional fact for success on judicial review is that the impeached conduct must constitute administrative action. From the above-quoted dicta from *Pharmaceutical Manufacturers* and from the PAJA, it is clear that whether such conduct constitutes administrative action falls to be decided by reference to whether such action amounts to the exercise of public power or the performance of a public function.”

the provision of those health care services, it should be subject to administrative law review in the same manner in which the provincial government would have been. This is not to suggest that the contractual relationship between the provincial government and the private provider could ever have the effect of absolving the former from its constitutional obligations in terms of section 27(1). However the arrangement does have the effect of bringing the private provider within the purview of administrative law.

The question as to whether or not a juristic person or entity other than an organ of state is performing a public function was considered in the case of *Transnet Ltd v Goodman Brothers (Pty) Ltd*⁹⁸. In that case, which was decided before PAJA came into effect, the court carefully considered the nature of the duties of Transnet. It noted in this regard that from the history of the creation of Transnet, one could only deduce that all the powers and functions of the former S A Transport Services were transferred to Transnet, which was now obliged to exercise the said powers and perform the said functions. In doing so, Transnet merely stepped into the shoes of the SA Transport Services. Like the latter, it is performing a public service and function and exercising all the powers of a government department. Furthermore, said the court, the state is the only member and shareholder of Transnet; the entire commercial enterprise of the state (previously existing as the South African Transport Services), including all assets, liabilities, rights and obligations, was transferred to Transnet; the state is the only member and shareholder of Transnet and controls Transnet; an employee of Transnet is deemed to be an employee of the state; Transnet is obliged to provide a service that is in the public interest; the Minister of Transport is entitled to make regulations on a large range of matters relating to the control and functioning of Transnet. These observations were supported by the legislative provisions that established Transnet.

⁹⁸ *Transnet* 2001 (1) SA 853 (SCA)The court observed in this case: “The right to equal treatment pervades the whole field of administrative law, where the opportunity for nepotism and unfair discrimination lurks in every dark corner. How can such right be protected other than by insisting that reasons be given for an adverse decision? It is cynical to say to an individual: you have a constitutional right to equal treatment, but you are not allowed to know whether you have been treated equally. The right to be furnished with reasons for an administrative decision is the bulwark of the right to just administrative action.”

The court in *Transnet* observed that according to the *SARFU*⁹⁹ case what has to be taken in consideration is, *inter alia*, the source of the power exercised, as well as ‘. . . the nature of the power, its subject-matter, whether it involves the exercise of a public duty, and how closely it is related on the one hand to policy matters which are not administrative, and on the other to the implementation of legislation, which is’ and that the implementation of legislation is an administrative responsibility, and will ordinarily constitute ‘administrative action’ within the meaning of s 33 .

10.4.3 The Distinction Between Public and Private Powers

In *Pennington v Friedgood*¹⁰⁰ the court held that the distinction between public and private (or non-public) powers is reflected in a comparison of four decisions: on the one hand, *Dawnlaan Beleggings (Edms) Bpk v Johannesburg Stock Exchange and Others*¹⁰¹ and *Johannesburg Stock Exchange and Another v Witwatersrand Nigel Ltd and Another*¹⁰² and on the other hand, *Herbert Porter & Co Ltd and Another v Johannesburg Stock Exchange*¹⁰³ and *Cape Metropolitan Council v Metro Inspection Services (Western Cape) CC and Others*¹⁰⁴. After examining the relevant dicta in these cases the court observed that a medical scheme is a body corporate. It noted that in terms of the Act it acquires such status upon registration and that it is governed by the Act, the regulations and the scheme rules. Such rules, said the court, constitute the contract between the scheme and its members.¹⁰⁵ A meeting of the members of a scheme is thus similar to a meeting of the members of a company. Both acquire status in terms of an Act of Parliament. Hodes AJ found that the relationship between the trustees (the first to fourth respondents) and the members of the scheme is governed by the Medical Schemes Act, the regulations and the rules. In the case of a company the relationship between members and the company is governed by the Companies Act and the articles of association of that company. He held that just as a meeting of shareholders of a company is not subject to the review of the High Court, so too the proceedings of an annual general meeting of a medical scheme are also not subject to

⁹⁹ *President of the Republic of South Africa and Others v South African Rugby Football Union and Others* 2000 (1) SA 1 (CC)

¹⁰⁰ *Pennington* fn 95 *supra*

¹⁰¹ *Dawnlaan Beleggings* 1983 (3) SA 344 (W)

¹⁰² *Witwatersrand Nigel Ltd* 1988 (3) SA 132 (A)

¹⁰³ *Herbert Porter* 1974 (4) SA 781 (T)

¹⁰⁴ *Cape Metropolitan Council* 2001 (3) SA 1013 (SCA)

¹⁰⁵ *Meaker NO v Roup, Wacks, Kaminer & Kriger and Another* 1987 (2) SA 54 (C) at 61G - 62C.

the review of the High Court, for they do not constitute administrative action. Judicial review is a remedy to curb improper or inappropriate exercise of public power. Nothing contained in the Act, the regulations or the scheme rules, said Hodes AJ, imports a requirement by the trustees to observe the common-law principles of administrative law.

In *Cronje v United Cricket Board Of South Africa*¹⁰⁶ the court pointed out that in exceptional cases private bodies are vested with public powers by statute. It said that they are then subject to the rules of public law in the exercise of those powers. Those rules may expressly or by necessary implication prescribe the manner in which their powers must be exercised. If the repository of the power does not exercise them in the prescribed way, its conduct is subject to judicial review under public law. But these consequences flow, not from the nature of the body or the impact of its conduct, but from the underlying statute. Kirk-Cohen J noted that the rules of natural justice are thus in the first place rules of public law, but they do sometimes apply in the sphere of private law, but then only when they are incorporated by contract. Contracts between private individuals and bodies, he said, are ordinarily not governed by the rules of natural justice but they may be incorporated expressly or by necessary implication, depending upon the terms of the contract. Such a right may even be granted to an outsider if a private body by contract extends such a right to an outsider¹⁰⁷. The court stated that it is only where the constitution of a voluntary association incorporates the rules of natural justice that they then apply between the association and its members or those with whom it has privity of contract. The rules do not apply to a non-member who is not a party to the contract.

Despite this, it is submitted that where the Board of Trustees of a medical scheme acts in a manner that adversely and unlawfully impacts upon a member's constitutional rights of access to health care services, human dignity, privacy or bodily or psychological integrity or in a manner that is unfairly discriminatory, it can be taken to task on the basis of constitutional law. Since constitutional law itself incorporates

¹⁰⁶ *Cronje* 2001 (4) SA 1361 (T)

¹⁰⁷ Examples of this are *Marlin v Durban Turf Club and Others* 1942 AD 112 at 126 - 7, *Anschutz v Jockey Club of South Africa* 1955 (1) SA 77 (W) at 80, *Jockey Club of SA v Transvaal Racing Club* 1959 (1) SA 441 (A) at 450, *Turner v Jockey Club of South Africa* 1974 (3) SA 633 (A) at 645 - 6, *Theron en Andere v Ring van Wellington van die NG Sendingkerk in Suid-Afrika en Andere* 1976 (2) SA 1 (A) at 21D, *Carr v Jockey Club of South Africa* 1976 (2) SA 717 (W) at 721 - 2, *Government of the Self-Governing Territory of KwaZulu v Mahlangu and Another* 1994 (1) SA 626 (T) at 634 - 5 and *Lamprecht and Another v McNeillie* 1994 (3) SA 665 (A) at 668.

many of the principles of administrative law, the decision of the Board of Trustees could in certain cases be set aside on grounds closely resembling those of administrative law.

Despite the views of Hodes AJ in *Pennington*¹⁰⁸, it is submitted that there are many similarities between the Boards of Trustees of medical schemes and bodies that exercise a public function. They may not act outside of the boundaries of the Medical Schemes Act¹⁰⁹ and Regulations for instance. They are obliged to ensure that the scheme provides for a minimum package of benefits as contemplated in the Act and spelled out in the Regulations. They may not step outside of the boundaries of the scheme rules which must be lodged with and approved by the Registrar of Medical Schemes in terms of the Medical Schemes Act. Medical schemes are free to determine their own rules only up to a point. Section 29 of the Act contains detailed provisions concerning matters for which the scheme rules must provide. It is respectfully submitted that the statement of Hodes AJ to the effect that nothing contained in the Act, the regulations or the scheme rules imports a requirement by the trustees to observe the common-law principles of administrative law was not strictly correct. Section 57(6) of the Medical Schemes Act states –

“The board of trustees shall-

- (a) take all reasonable steps to ensure that the interests of beneficiaries in terms of the rules of the medical scheme and the provisions of this Act are protected at all times;
- (b) act with due care, diligence, skill and good faith;
- (c) take all reasonable steps to avoid conflicts of interest; and
- (d) act with impartiality in respect of all beneficiaries.”

10.4.4 Lawfulness

It has been held that it is fundamental to the principle of the rule of law that entities act within the powers lawfully conferred upon them. It will be recalled that lawfulness

¹⁰⁸ *Pennington* fn 105 *supra*

¹⁰⁹ Medical Schemes Act No fn 5 *supra*

is one of the aspects of the right to administrative justice contemplated in section 33 of the Constitution. In *Kolbatschenko v King No and Another*¹¹⁰ the court held that it was only in highly exceptional cases that a court would adopt a hands off approach where a discretion has been exercised or an executive or administrative decision made which directly affects the rights or interests of an individual applicant. At common law, lawfulness is determined on the basis of public policy. It is a concept that is fundamental not only to administrative law but also to the law of contract and delict. The link between public policy and the values expressed in the Constitution was elucidated in *Ryland v Edros*¹¹¹ in which the court held that the values of equality, tolerance of diversity and recognition of the plurality of South African society were among the values that underlie the Constitution and that those values “irradiate” the concepts of public policy and *boni mores* that the courts have to apply. Public policy and constitutional values are inextricably intertwined. Administrative action that is contrary to public policy as informed by constitutional values is unlawful and subject to administrative review.

10.4.5 Reasonableness

Reasonableness is another aspect of the right to administrative action in terms of section 33 of the Constitution. Significantly it is also the standard by which contractual clauses are adjudicated in relation to public policy and against which the actions or omissions of a tortfeasor are measured in terms of the law of delict. As such it is a concept that is central to South African law generally as opposed to one limited area. Reasonableness and rationality are two sides of the same coin. In order to be reasonable an administrative decision must be rational i.e. it must be justifiable¹¹². Administrative decisions moreover must be rationally related to the purpose for which the administrative power was given. Thus in administrative law, administrative action must be consistent with the objects of the empowering statute. In *S v Manamela and Another (Director-General of Justice Intervening)*¹¹³ the court pointed out that reasonableness is a legal commonplace in the courts which are required to apply it daily in determining the standard of care expected of persons in ordinary life.

¹¹⁰ *Kolbatschenko* 2001 (4) SA 336 (C)

¹¹¹ *Ryland* 1997(2) SA 690 (C)

¹¹² *Manfongosi and Others v United Democratic Movement and Others* 2002 (5) SA 567 (TK.H)

¹¹³ *S v Manamela* 2000 (3) SA 1 (CC)

Reasonableness is clearly another of those golden threads that runs through the larger body of South African law. The constitutional court criticised the decision of the government not to provide Nevirapine in public sector health facilities in the grounds of reasonableness. Although this was a policy decision rather than an administrative one and so was not subject to administrative review *per se* this did not preclude the court from setting it aside *inter alia* on the grounds that it was unreasonable. The chances are that if the concept of reasonableness, as applicable to administrative action, had been applied by the state in the determination of its policy in the provision of Nevirapine then the *TAC* case¹¹⁴ would not have materialised. Reasonableness is a cross-boundary issue. It is not confined to administrative action or a particular field of law. This is its value as a unifying factor within the South African legal system. The court in *Grootboom*¹¹⁵ stated that a policy that excludes a significant sector of society is not reasonable. Similarly, it is submitted, administrative action that excludes or prejudices a significant sector of society is unreasonable.

10.4.6 Procedural Fairness

Procedural fairness is the last of the three aspects of administrative justice explicit in section 33(1) of the Constitution. Like lawfulness and reasonableness, it is a pervading principle of administrative justice rather than an isolated aspect thereof. Procedural fairness invokes the principles of natural justice as expressed in the maxims *audi alteram partem* and *nemo iudex in sua causa*. Notice and comment procedures are important in the process of administrative decision-making. Section 4 of PAJA makes provision for notice and comment procedures to be followed or public inquiries to be held where administrative action 'materially and adversely affects the rights of the public' In *Mafongosi and Others v United Democratic Movement and Others*¹¹⁶ the court stated that there were no separate principles applicable to the exercise of power by functionaries other than organs of state where the rights entrenched in section 33 of the Constitution were involved. Procedural fairness it is submitted is particularly important in decisions involving the allocation or distribution of resources. The emphasis of the constitutional court on not only the rationality of

¹¹⁴ *TAC* (No 2) fn 26 *supra*

¹¹⁵ *Grootboom* fn 26 *supra*

¹¹⁶ *Mafongosi* fn 112 *supra*

programmes affecting socio-economic rights but also the *implementation* of those programmes supports this conclusion. Procedural fairness is directly concerned with the practical aspects of health service delivery. In the context of public health services for instance, would it be procedurally fair to ‘fast-track’ medical scheme patients by putting them in a different queue to those queuing for the same service who are not medical scheme beneficiaries? Similarly would it be procedurally fair to stop a particular health service to which people had previously enjoyed access without notifying them of the intention to do so? It is submitted that procedural fairness is of considerable significance in ensuring absence of bias in administrative action and that decisions involving the allocation of health resources are according to objective, rational criteria.

4.5 Administrative Bodies Other Than Organs of State Involved in Health Services Delivery

It is likely that the Health Professions Council of South Africa, the South African Nursing Council, the Pharmacy Council, the Allied Health Professions Council, the Dental Technicians Council and possibly even the Council for Medical Schemes, the Medical Research Council, the National Health Laboratory Services will be regarded as exercising a public function on the strength of the judgment of the court in *Association of Chartered Certified Accountants v Chairman, Public Accountants' and Auditors' Board*¹¹⁷. In that case the court observed that the Board clearly exercises a public power, that it is a creation of statute and that the source of its power is to be found in the Public Accountants' and Auditors' Act¹¹⁸. It noted that the Board also appears to fulfil a public function in terms of the said legislation since it is a regulatory body entrusted with the task of ensuring that proper standards are maintained in the accounting and auditing profession. It functions in close co-operation with structures of state authority, its members are appointed by the Minister and include persons selected among the persons holding office as state functionaries, it is also dependent upon the state for infrastructural support.

¹¹⁷ *Association Of Chartered Certified Accountants* 2001 (2) SA 980 (W)

¹¹⁸ Public Accountants' and Auditors' Act No 80 of 1991

Section 13(1)(g) of the Act vested the Board with the discretionary power to prescribe the degrees, diplomas and other qualifications which entitled any person to exemption from the requirements to be complied with by persons desiring to be registered as accountants and auditors. The applicant had made a formal application to the Board in terms of the Act for the recognition of its examinations for the purposes of exemption of its members from having to sit at the Board's examination. The Board, received, understood and considered the application in performance of its statutory powers. On 11 and 12 June 1996 the executive committee of the Board resolved that it would accept the education and training programmes of the applicant but that the applicant's candidates would still have to write the Board's qualifying examination for 'an interim period'. The court found that the rejection by the Board of the recognition sought by the applicant constituted an administrative act or decision taken by the Board in the exercise of its discretionary powers as a public body. It observed that at common law a right to administrative action arises where such act or decision affects the rights, privileges or liberty of another¹¹⁹ and that this well-established ground for judicial review of public power has been subsumed under the Constitution. The court found that the Board's decision has plainly affected the rights and interests of the applicant. In that it had determined its rights. The applicant asserted that it was indirectly affected by the Board's decision because the value of its examinations would be greatly enhanced if the exemption sought were granted. Boruchowitz J held that the applicant's reputation had also been adversely affected as the Board expressly impugned the standards applied by the applicant in its programmes, courses and examinations and that its decision constituted 'administrative action' that was reviewable in terms of section 33 of the Constitution. It is submitted that the councils referred to above who operate in the health sector, whilst they may not be organs of state as defined in the Constitution¹²⁰, are very much capable of administrative action on the same basis as the Public Accountants and Auditors Board.

¹¹⁹ *Minister van Onderwys en Kultuur en Andere v Louw* 1995 (4) SA 383 (A) at 388H; *Toerien en 'n Ander v De Villiers NO en 'n Ander* 1995 (2) SA 879 (C) at 885E - F.

¹²⁰ In *Korf v Health Professions Council of South Africa* 2000 (1) SA 1171 (T) the court stated that: "The issue whether or not the respondent is an organ of State arose squarely in *Mistry v Interim National Medical and Dental Council of South Africa and Others (supra)*. In that case both Booysen J, who dismissed the applicant's claim for interim relief, and McLaren J, who dismissed the applicant's claim for final relief, applied the control test and concluded that the respondent's predecessor was not an organ of State. It will serve no purpose to repeat the facts set out at 947 - 8 of the judgment which led the Court to come to this conclusion. There has been no material change. The State is not in control of the respondent. The respondent is not an organ of State." It is submitted that to the extent that Korf seems to give the impression that only organs of state can exercise a public power or perform a public function it is clearly wrong. If the refusal of the Health Professions Council to grant access to the records sought had been approached on the grounds of administrative law to the extent that the decision of the Council not to grant access constituted administrative action it would have been subject to review by the courts. In any event both PAJA and the Promotion of Access to Information

10.4.7 Administrative Agreements

Burns¹²¹ observes that it has been said that although South African courts have recognised the administrative disposition and private law contract concluded by the state, they have not as yet, recognised the administrative law agreement. She notes that it has also been said that these administrative agreements in which the state acts in its capacity as an organ of state and exercises a measure of state authority fall somewhere in between the boundary of public law and private law. Public authorities are not empowered to conclude contracts which are incompatible with the proper exercise of their powers and duties: such contracts or actions are void because the authority has exceeded its power and has acted *ultra vires*. Burns says the question is whether the state is liable for damages arising from administrative agreements, such as a contract between the municipality and private agency regarding the removal of rubbish in its municipal area. Where a private contractor performs its contractual obligations negligently, an individual such as a ratepayer who suffers damage as a result of this negligence may sue the private contractor for damages in delict. To succeed in delict, all the elements of the delict must be proved, namely that the action was wrongful, the contractor was at fault, that the damage was caused by the contract, and so on. What is the position asks Burns, where a private contractor is unable to meet the financial commitments arising from claim negligence? Since the individual ratepayer is not party to the original contract, he or she is unable to sue the state for damages based on this contract. The situation then leads to the inevitable question of how and from whom the ratepayer may recover damages. Burns notes that although there are a number of administrative agreements entered into between the state and independent contractors in South African law, the law has not as yet laid down any general rules relating to the liability of these independent contractors for the negligent exercise of the contractual duties or a failure to exercise these duties. The question is whether one simply accepts that the state is not liable for damages under these circumstances once it has concluded a contract with a third party. She says the most important issue to be addressed by lawyers and the courts alike is whether the ultimate

Act No 2 of 2000 have subsequently overtaken this decision and it is unlikely to be followed to the extent that it is now inconsistent with these two statutes.”

¹²¹ Burns Y, *Administrative Law Under The 1996 Constitution* p 316

responsibility lies for damages, which ensue under these circumstances and that a further question to be addressed is whether there are certain public functions, which are categorised as essential services and which remain the responsibility of the state at all times? In other words, can it be said that the state cannot divest itself of its responsibility for these essential services, even when services are provided by an independent contractor? The liability of the state for administrative agreements is anything but clear, says Burns. At this stage, a delictual claim against the state for the negligent action of independent contractors will in all probability unsuccessful. Burns notes that a further point which militates against the success of a delictual claim is that the state will generally not be in a position to supervise or exercise control over the actions of the private agency, while it is fulfilling its contractual obligations. She asks whether it could not be argued that the state should compensate individuals for damages, where, for example, it has acted negligently in contracting with the private agency in question? If it becomes apparent that from the outset, the appointed private agency was unable to perform the function required, one could argue that the state was negligent and therefore liable in delict. Burns observes that currently administrative agreements are governed in the main by the rules of private law and courts are influenced by the private law of contract when determining the rules which applied to administrative agreements. She suggests that once the courts recognise the true nature and extent of the administrative agreements, they will be in a position to develop legal rules to address the issues which she raises.

It would seem that the primary question to be answered with regard to so-called administrative contracts is whether elements of public law, more specifically administrative law, should be applied to what is fundamentally a contractual relationship. It is submitted that the short answer is a qualified 'yes'. However, it is submitted that the motivation for doing so should stem from the Constitution itself rather than common law considerations such as whether or not claims should be entertained against the state under the law of delict. The discussion of this issue by Burns approaches the question of administrative agreements from only one limited angle – that of when the state should be held legally liable for the work of a contractor who has been hired to fulfil a statutory obligation of the state. It is submitted that where there is a constitutional right to the public service in question and particularly where there is an obligation upon the state to take reasonable legislative and other



steps to achieve the realisation of the right¹²², administrative law principles should apply to the measures taken by the state to fulfil the rights in the Bill of Rights. The other measures that the state can take in fulfilling its constitutional obligations in section 27(2) could well include contractual measures with providers of health services in the private sector. It is submitted that principles of administrative law should not only be applicable to these contracts but also to the contracts concluded between the private sector provider and those to whom it is rendering health services. This is in keeping with the provisions of the PAJA. A contract that arises between a private health service contractor to the state and a beneficiary of those services should not be differently construed merely because the state is at a relationship once removed from the beneficiary. Furthermore, it is submitted that the question of whether or not the state can be held delictually liable for the actions of its contractors should be determined in accordance with the normal principles of the law of delict. The failure of the state to fulfil its constitutional obligations may or may not give rise to a delictual claim depending upon the individual circumstances of each case. It is also not necessarily the case that if a delictual claim can only be brought against the contractor that an applicant would not be able to claim some form of relief against the state in respect of its failure to meet its constitutional obligations. To assume, as Burns seems to, that the state in interposing a third party contractor between itself and the beneficiary can escape liability or even avoid its constitutional obligations is not correct¹²³. Burns¹²⁴ is apparently of the view that if the contractor cannot meet the claim in delict then the state should be obliged to do so because the contractor is executing the state's mandate. It is submitted that this view seems to be based on the feeling that the state, as a larger target with far more resources should be made liable for the contractor's unlawful and negligent conduct. This argument it is submitted, uses the same justifications as those used for vicarious liability of employers for the actions of employees¹²⁵ and is tantamount to saying that that a contractor should be

¹²² Such as that contained in section 27(2) of the Constitution which obliges the state to take reasonable legislative and other measures to achieve the progressive realisation of the rights to health care services, sufficient food and water and social security (the rights contemplated in section 27(1))

¹²³ The state's obligations with regard to socio-economic rights are contained inter alia in section 27(2) of the Constitution. It is submitted that any attempt to interpret a contract contrary to the provisions of this section or any attempt to alter the state's obligations as set out in here by way of a contractual arrangement would in itself be unconstitutional and should not be upheld by a court of law.

¹²⁴ Burns fn 121 *supra*

¹²⁵ Burchell J *Principles of Delict* states at p 215 that: "In terms of the principles of vicarious liability, an employer is made liable for the wrongs (delicts) committed by his or her servants in the course and scope of the servant's employment. The employer need not be personally at fault in any way but the wrong of the servant is imputed or transferred to the employer who often has the 'deeper pocket' or 'broader financial shoulders' to compensate the person injured by the

regarded in the same light as an employee in this respect. It is submitted, however that the considerations even if one regards the state in the same light as an employer and the contractor in the same light as an employee, there are some materially different and important considerations in which the position of the state differs from that of an ordinary employer. Firstly the state, unlike employers in the private sector, is not acting for its own personal gain in conducting its business. Secondly the state is obliged to find ways of realising the achievement of socio-economic rights. The state's obligations may be even more specific in terms of some empowering statute. There is generally no general legal obligation upon an employer to conduct a particular business or even in many instances a more specific legal obligation to conduct it in a particular manner¹²⁶. Fourthly, if the only sustainable manner in which the state can achieve the progressive realisation of the right of access to certain healthcare services is to transfer some of the risk to the private sector, why should this be problematic? Social health insurance envisages a situation in which everyone who earns a certain income is obliged to make some kind of contribution to the costs of his or her health care – this is in effect a transfer of some level of risk from the state to the individual citizen. If a state run social health insurance fund enters into a capitation agreement with a provider of private health care services because the state is unable to provide those services itself in a particular area or if it contracts a private provider to provide certain 'high tech' health services because they carry a high degree of risk that it cannot itself sustain for various reasons, why should the state be held liable for the contractor's wrongdoing? The 'broad financial shoulders' of the state may not be as broad as Burns¹²⁷ would like to believe. Fifthly, the state, unlike the private sector employer, cannot freely choose with whom it contracts. It is bound to follow tender procedures and the principles of administrative justice in selecting those with whom it contracts. It cannot simply identify and approach a party of its choice to perform the required services. In the tender process, the state cannot consider parties who have not submitted their tender documentation in time or whose documentation is incomplete or who have not tendered at all - even if the officials dealing with the tender are aware that such parties may be the best ones for the job and those that have submitted

servant's negligence...A number of other justifications for vicarious liability have been advanced: the employer's fault in the selection of the servant (*culpa in eligendo*); the servant's acts are those of the master; and the theory which seems to be gaining prominence – the employer by engaging a servant to carry out his or her interests, creates a risk or danger for the community and the employer should, therefore bear the financial loss if this risk materialises.

¹²⁶ Over and above the usual legal substratum that exists in all societies and that is generally preoccupied with the concept of not harming one's fellow citizens by or in pursuing one's business activities.

¹²⁷ Burns fn 121 *supra*

tenders correctly are actually second choice. Time constraints within and around tender processes sometimes preclude the possibility of a second bite at the cherry. There are also administrative law constraints - especially if other parties who have tendered for the work seem on the documentation submitted to be capable of performing it adequately. The state generally does not have any way of checking, apart from asking for references, as to the suitability of a contractor to do the job because unlike the employer in the private sector, the state is not 'in the business' and does not have personal knowledge and experience of who is in fact good and who is not.

Quite aside from these considerations, however, it is a general rule of South African law that an employer is not responsible for the negligence or wrongdoing of an independent contractor employed by him. The exception is where the employer itself has been at fault or negligent with regard to the conduct of the third party contractor¹²⁸. It is submitted that Burns' attempts to support the concept of administrative contracts using arguments based on an extension of the concept of vicarious liability in terms of the law of delict are ill conceived. The application of the principles of administrative justice, it is submitted, would go a long way towards achieving equality in access to health care services and other constitutional rights across the public and private sectors because of the preoccupation of administrative law with reasonableness and fairness. The allocation of resources to and within health care services is central to the delivery of health care services whether by the private or public sector. The right of access to health care services is not such, it is submitted that it can be confined only to the public sector, although different considerations may be applicable with regard to the legal nature of the relationship between the parties. For instance, why should a private sector provider's abandonment of a patient be any less unconstitutional than a public sector provider's abandonment of a patient?

¹²⁸

See for instance Burchell J fn 125 *supra* at p 227 and the discussion of *Langley Fox Building Partnership (Pty) Ltd v de Valence* 1991 (1) SA (A). Burchell makes the important point in discussing this case that the relationship of the principal and the contractor in this case more closely resembled that of employer and employee in view of the level of control assumed by the principal over the contractor. He points out that the line between a master-servant and employer-independent contractor is a fine one and that particularly since South African courts have indicated some support for the risk theory of vicarious liability, it is not too far fetched to see the relationship between principal and contractor in this case as based also on the right of control that the principal had over the contractor. The Appellate Division, despite its decision in this case, was at pains to stress the general rule that a principal is not liable for the wrongdoing of the contractor.



It may be helpful in answering the primary question as to when administrative law principles should be applied in a contractual context to consider whether the act of contracting in each instance constitutes administrative action as defined in the PAJA with reference to both organs of state and other entities. The definition of administrative action in the PAJA has already been canvassed elsewhere. The point to note is that all organs of state derive their power from statutes. Even the power to enter into binding contracts is derived from the State Liability Act. This does not necessarily mean that every act of contracting by an organ of state constitutes administrative action. Otherwise Burns and the courts would not even be considering whether the private law of contract governs contracts to which an organ of state is a party let alone applying it. Furthermore, administrative action is not confined in the PAJA to organs of state¹²⁹. It is submitted that the PAJA in principle supports the concept of administrative contracts but not necessarily the associated discussion by Burns of claims against the state in delict flowing from such contracts.

In *Independent Municipal And Allied Trade Union and Others v MEC: Environmental Affairs, Developmental Social Welfare and Health, Northern Cape Province, and Others*¹³⁰, Steenkamp AJP noted that in *Goodman Bros (Pty) Ltd v Transnet Ltd*¹³¹ the court ruled that the respondent and decision-maker in regard to the decision to terminate the agreement was a public authority and since its authority to appoint the first applicant derived from a public power, it must follow that its authority to terminate the agreement with the first applicant similarly derived from a public power. This, together with the peculiar content of the agreement, rendered the agreement an administrative agreement. The Supreme Court of Appeal in *Cape Metropolitan Council v Metro Inspection Services (Western Cape) CC and Others*¹³² referring to Burns¹³³ held that it served little purpose to classify the agreement between the first respondent and the appellant as an administrative agreement and that

¹²⁹ It is significant to note in this regard that in terms of the PAJA, 'empowering provision' means a law, a rule of common law, customary law, *or an agreement*, instrument or other document in terms of which an administrative action was purportedly taken (writer's italics). The definition of administrative action, includes any decision taken, or any failure to take a decision, by a natural or juristic person, other than an organ of state, when exercising a public power or performing a public function in terms of an empowering provision which adversely affects the rights of any person and which has a direct, external legal effect.

¹³⁰ *Independent Municipal* 1999 (4) SA 267 (NC)

¹³¹ *Goodman Brothers* 1998 (4) SA 989 (W). The court in this case referred to the decision in *Administrator, Transvaal, and Others v Zenzile and Others* 1991 (1) SA 21 (A).

¹³² *Cape Metropolitan* fn 104 *supra*

¹³³ Burns fn 121 *supra*

the question remained whether the cancellation of the agreement constituted 'administrative action'. The court in this case found that *Zenzile*¹³⁴ was no authority for the proposition that, if a public authority derived its authority to enter into a particular contract from a public power, its authority to terminate the contract similarly derived from a public power, entitling the other contracting party to the benefit of the application of the principles of natural justice before cancellation of the contract. The court held further that section 33 of the Constitution was not concerned with every act of administration performed by an organ of state, but was designed to control the conduct of the public administration when it exercised a public power, and that whether or not conduct amounted to 'administrative action' depended on the nature of the power being exercised. Other relevant considerations, said the court, were the source of the power, the subject-matter, whether it involved the exercise of a public duty, and how closely it was related to the implementation of legislation.

One of the distinguishing features of an administrative agreement according to these cases is that it involved an agreement to render public services. The situations covered so far have been those in which the organ of state contracts with a third party to perform a service which the organ of state is empowered and obliged to perform. Thus in the health care context an administrative agreement might come into being if a provincial government enters into a public private partnership with a private hospital group to fulfil the former's obligations to provide hospital services in a particular area. Whether or not this amounted to an administrative agreement would depend, according to the courts, on whether the contract involves the exercise of a public duty, how closely it is related to the implementation of legislation and whether the agreement was for the rendering of public services. However in the context of health service delivery, the contractual relationship in question could be with the patient directly. Legislation such as the Health Act mandates the delivery of health care services by organs of state but does not preclude a contract as the legal vehicle for that delivery. It is submitted that such a contract should be an administrative contract in the sense that although it is governed by the private law of contract administrative law principles should also be applicable to the relationship. In other words the relationship is a legal hybrid that is governed by the principles of more than just one field of law.

¹³⁴ *Zenzile* fn 131 *supra*

The interesting question is whether health care services are ‘public services’. In other instances whether services are public or not is fairly straightforward since most people would readily concede that waste disposal, sanitation services and the provision of water supplies are public services. Whilst there may well be private contractors who are frequently contracted to perform such services, they are essentially the responsibility of the municipality concerned in terms of Schedule 5 of the Constitution. Private contractors wishing to undertake these services would contract with the municipality in question as opposed to individual ratepayers. In the health care context the situation is a little different in the sense that where a private provider renders health care service to a patient, the contractual relationship is still usually with that patient directly as opposed to some organ of state that could be said to be responsible for the provision of health care services. Must one assume that when a health care service is rendered by a private provider it is not a public service but that when it is rendered by an organ of state it is? The further question would then be why services that are essentially identical in nature change their identity on the basis of who renders them? Is there any sound reason in law why this should be so? Alternately are all health care services public services in which case what are the implications for private providers of health care services? The final alternative is that health care services are not public services irrespective of whether or not they are rendered within the public or private health sectors.

*In Ex Parte Chairperson of the Constitutional Assembly: In Re Certification of the Amended Text of the Constitution of the Republic of South Africa, 1996*¹³⁵ the court noted that in terms of IC 126 (the Interim Constitution) a provincial legislature is given jurisdiction to make laws with regard to all matters which fall within the functional areas which are specified in IC Schedule 6 but the national Parliament itself also has legislative competence in those areas. A conflict between a law passed by a provincial legislature and an Act of Parliament in these areas is regulated by the relevant parts of IC 126, which read as follows:

‘(3) A law passed by a provincial legislature in terms of this Constitution shall prevail over an Act of Parliament which deals with a matter referred to in ss (1) or (2) except

¹³⁵ *Certification Judgment* 1997 (2) SA 97 (CC)

insofar as the Act of Parliament is *inter alia* necessary to set minimum standards across the nation for the rendering of public services',¹³⁶ This principle has been carried through into the Constitution in section 146 (2) but without explicit reference to 'public services'. Significantly this term seems to have been replaced by the phrase 'government services'. Thus national legislation prevails over provincial legislation where the former is necessary for "the promotion of equal opportunity or equal access to government services".

In *Directory Advertising Cost Cutters v Minister For Posts, Telecommunications and Broadcasting and Others*¹³⁷ the court stated that it is interesting to note that in Canada the courts have rejected a functional link with government as the test for the applicability of their Charter of Rights and Freedoms. Van Dijkhorst J observed that the control test is applied, which looks to an institutional or structural link with government to determine whether a public body is covered by the Charter and that it is irrelevant that a university and hospital are performing a 'public service' as long as they do so independently of government. These remarks, said Van Dijkhorst J, should be read against the background of s 32 of the Charter in terms of which it is applicable to 'government'. He stated that the Courts had to define the scope of that concept. Unlike the Constitution, the Charter does not apply to the private sector or to non-governmental actors in the public sector¹³⁸. The question of whether or not a service is a public service is clearly not so easily decided simply with reference to whether it involves a right in the constitutional Bill of Rights. Section 8(2) of the Constitution sets out the parameters as to when the Bill of Rights binds a natural or juristic person. It 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 that right. One also cannot assume that simply because a private provider is rendering health care services that this is not a public service or function since the PAJA expressly acknowledges the possibility that a private body can perform a public function.

¹³⁶ See also *Western Cape Provincial Government and Others: In Re DVB Behuising (Pty) Ltd* 2001 (1) SA 500 (CC).

¹³⁷ *Directory Advertising Cost Cutters* 1996 (3) SA 800 (T)

¹³⁸ Van Dijkhorst J referred to Hogg *Constitutional Law of Canada* 3rd ed 34-13; Jones & De Villars *Principles of Administrative Law* 2nd ed 42-7; *McKinney v University of Guelph* [1990] 3 SCR 229; *Harrison v University of British Columbia* [1990] 3 SCR 451; *Stoffman v Vancouver General Hospital* [1990] 3 SCR 483; *Douglas College v Douglas/Kwantlen Faculty Association and Others* [1990] 3 SCR 570

In *Independent Municipal and Allied Trade Union and Others v MEC: Environmental Affairs, Developmental Social Welfare and Health, Northern Cape Province, and Others*¹³⁹ the predecessor-in-title to the second respondent (the HDC) had entered into an agency agreement with predecessor-in-title of the first respondent's department (the department) to render certain primary health services on the latter's behalf in terms of s 20(1)(d) of the Health Act¹⁴⁰, which agreement could be terminated on one year's notice. In this case the court held that the performance of health services by first respondent was a statutory power and if the agency agreement was concluded in terms of statutory power then it was an administrative action. Similarly the termination of the agency agreement was also an administrative action. It also held that the HDC had no statutory or constitutional right to perform health services because health services formed no part of the second applicant's functions unless expressly identified in terms of the Regional Services Councils Act¹⁴¹ and that the HDC had not proved that these functions had been identified. The court found that that the first respondent was not obliged in law to consider the provisions of the Local Government: Municipal Structures Act¹⁴² which were not in existence when he took his decision in 1997 or in September 1998 and, accordingly, the HDC had no statutory function to render health services. The functions rendered by the HDC stemmed from the agency agreement. By cancelling the agency agreement, said the court, the first respondent had not infringed any statutory or constitutional rights of the HDC. It held, further, that the *audi* rule was not applicable to first respondent as an employer in terms of the agency agreement, but it may have been applicable in terms of the doctrine of legitimate expectation. The court found that taking into consideration all the circumstances and evidence, the doctrine of legitimate expectation applied and the third and other applicants were entitled to a fair hearing by the first respondent before their employment was terminated by the HDC as a result of the termination of the agency agreement. It stated that that the duty of the first respondent to afford the third and other applicants a fair hearing and to grant them an opportunity to make representations in compliance with the audi principle would only have come into existence when the first respondent decided that he was intending to compel the HDC to terminate the employment of the third and other applicants. In such a case he was

139 *Independent Municipal* fn 130 *supra*

140 Health Act fn 3 *supra*

141 Regional Services Councils Act No 109 of 1985

142 Local Government: Municipal Structures Act No 117 of 1998

obliged by the administrative law to afford the third and other applicants a fair hearing before he decided whether to compel the second applicant to terminate the employment of the third and further applicants. The parties to the contract in this case were both apparently organs of state, the one being the North West Regional Services Council and the other Administration of the Province of the Cape of Good Hope which is why the court said that the applicants did not have a right to render primary health services.

It is submitted that administrative agreements could prove to be a useful concept in the context of contracts for health services both as between an organ of state as principal and a private provider as contractor and between a private or public provider of health care services on the one hand and the patient on the other. In order to ascertain, however, whether the agreement is one to which the principles of administrative law are applicable, regard should be had to the circumstances of each individual case, in the light of the factors mentioned by the courts in the cases referred to above, such as the content of the contract, and whether the act of contracting constitutes administrative action. A further question that cannot be explored in any depths in this thesis is whether an administrative agreement is essentially an administrative relationship that contains certain principles of the law of contract or whether it is essentially a contractual relationship that contains certain principles of the administrative law. The response is likely to be that this depends on the context and that generally speaking one might say that in the case of a public sector provider the former would be prevalent and in the case of a private sector provider the latter is more likely. Some may consider that attempts at such levels of refinement, though exploratory, are too presumptuous in light of the relative paucity of recognition given by the courts thus far of the broad concept of administrative agreements.

10.4.8 Conclusions Concerning Administrative Law

Administrative law, especially in the public health sector, offers an alternative basis in law to pure contract for the provider-patient relationship. In many ways it is preferable to a purely contractual relationship because of the many inbuilt protections and legal requirements for administrative action. Contracts can be unfair but courts can and still do refuse to strike them down purely on this basis. Administrative action

on the other hand is much more likely to be struck down on grounds of unfairness. The fees payable by patients in the public sector are often published in the form of regulations that can be attacked on constitutional grounds. Regulations are usually subject to notice and comment procedures before they are promulgated giving interested parties an opportunity to make representations. In the private sector, the patient usually has little or no choice in the fees that he or she must pay and no say in the setting of them either.

Although policy decisions are not within the scope of administrative law, decisions involving the implementation of legislation are. Thus to the extent that a health official in the public sector does not observe the principles of administrative justice in implementing a regulation concerning fees payable for health care services or the nature of the services that must be provided in terms of a legislative provision his or her actions can be challenged on administrative law grounds. Subject to what has been said earlier on the subject of administrative agreements, there is no equivalent protection in the purely private health care environment in which patients are generally restricted to remedies based on the law of delict or of contract. The considerations of these areas of law elsewhere in this thesis demonstrate that they do not yield results that are entirely satisfactory from the point of view of the patient.

In the public sector, treatment protocols and guidelines developed pursuant to an empowering provision of a statute such as section 16 of the Health Act¹⁴³ would have to be with due regard to the principles of administrative law. Treatment programmes cannot be unfairly discriminatory either in terms of the nature of the treatment administered to different patients or in terms of the procedure in terms of which the treatment is administered. Treatment guidelines must be fair and rational and implemented fairly and reasonably. Health care services must, in terms of administrative law, be efficient and avoid undue or unnecessary delays. It is submitted that the principles of administrative law are an extremely useful and effective mechanism for ensuring distributive justice in the health sector and it is a great pity that they apply rather more to organs of state and other public bodies than they do to private entities. Concepts of fairness, reasonableness and lawfulness, however are not

¹⁴³ Health Act fn 3 *supra*

confined to the private sector, and thanks to the Constitution, they are likely to become increasingly applicable in more varied ways in fields of law that have in the past been regarded as purely private.

10.5 The Law of Contract

There are many things the courts could do to ensure that the law of contract reflects and upholds the principles and values of the Constitution. The bases upon which to achieve this are easily identifiable since they are the same themes that permeate the other fields of law that are discussed in this thesis – the themes of public interest, *bona fides* or good faith, public policy, reasonableness and fairness. What is more, they have a clearly recognised mandate in terms of the Constitution to develop the common law¹⁴⁴. It would seem that in the law of contract more so than any other area of law, the courts are particularly incapable of making the transition to a constitutional way of thinking. Perhaps it is because of an ingrained view that the law of contract, more than any other area of law, is within the domain of private law and that the Constitution, which many perceive to be primarily public law, should not be permitted to intrude in private affairs. It is submitted that this view of the Constitution is neither appropriate nor correct given the provisions of section 8 and the fact that it states categorically that the Bill of Rights applies to all law. The provisions of section 2 of the Constitution also leave no room for doubt in stating that the Constitution is the supreme law of the Republic and that law or conduct inconsistent with it is invalid. Moreover an unwarranted preoccupation with classification of law into various categories does not take into account either the constitutional dispensation that superseded a legal system based essentially upon the common law, the fact that justice cannot be confined with artificial conceptual boundaries or that law that is based on a Constitution must be seen as an internally consistent and coherent system.

¹⁴⁴ In *Carmichele v Minister of Safety and Security and Another (Centre For Applied Legal Studies Intervening)* 2001 (4) SA 938 (CC) Ackermann and Goldstone JJ stated: "It needs to be stressed that the obligation of Courts to develop the common law, in the context of the s 39(2) objectives, is not purely discretionary. On the contrary, it is implicit in s 39(2) read with s 173 that where the common law as it stands is deficient in promoting the s 39(2) objectives, the Courts are under a general obligation to develop it appropriately. We say a 'general obligation' because we do not mean to suggest that a court must, in each and every case where the common law is involved, embark on an independent exercise as to whether the common law is in need of development and, if so, how it is to be developed under s 39(2). At the same time there might be circumstances where a court is obliged to raise the matter on its own and require full argument from the parties."

10.5.1 Tacit or Implied Terms in Healthcare Contracts

In the fourth chapter of this these it is suggested that certain tacit terms are implicit within contracts for healthcare services whether they are rendered within the public or the private sector. These are –

- 1 The provider must take all reasonable steps to ensure that the health professional, egg the nurse, doctor or physiotherapist, in the employ of the provider is qualified to perform the services the patient is receiving and such professional meets with the licensing requirements of any law with respect to his or her profession¹⁴⁵.
- 2 The patient will be treated with a reasonable degree of professional skill and care and to a standard required by the professional and ethical rules of the profession to which the relevant health practitioner belongs¹⁴⁶.
- 3 Decisions concerning the patient's treatment will be taken by the provider in a manner that is lawful, reasonable and procedurally fair¹⁴⁷. In practice this means that the patient will be consulted before such decisions are taken and that he or she will be informed of the decision before it is taken.

¹⁴⁵ See *Mterwa v Minister of Health* 1989 (3) SA 600 (D) in which the court said "The two Transvaal cases, as well as *Buls and Another v Tsatsarolakis* 1976 (2) SA 891 (T), neither mention nor support the distinction, which is pivotal to the decision in the Lower Umfolosi case, between professional work over which the hospital is said to have no control and for which it is accordingly not liable, and managerial or administrative duties performed by an employee, for which it is responsible. In the Transvaal cases the issue was simply whether the particular member of staff was negligent in the exercise of his duties, regardless of whether he was part of a professional team or not." See also *Buls and Another v Tsatsarolakis* 1976 (2) SA 891 (T) *Minister van Polisie en 'n Ander v Gamble en 'n Ander* 1979 (4) SA 759 (A); *Minister of Police v Rabie* 1986 (1) SA 117 (A).

¹⁴⁶ In *Van Wyk v Lewis* 1924 AD 438 at p 444 and p 448, it was held that "in deciding what is reasonable the Court will have regard to the general level of skill and diligence possessed and exercised at the time by the members of the branch of the profession to which the practitioner belongs". See also *Blyth v Van Den Heever* 1980 (1) SA 191 (A) and *Durr v Absa Bank Ltd And Another* 1997 (3) SA 448 (SCA) in which the court observed: "Not only did the Judge below adopt the 'typical broker' test, but he held that Mrs Durr tendered no evidence as to the duties and functions of bankers under circumstances such as exist in this case. That is not entirely correct. Mr Goldhawk had said: 'If a person holds himself out as an expert and there is support, such as a financial institution confirming that he's an expert, then any person dealing with him should be entitled to expert advice. There's the analogy of if you get into a taxi and the taxi driver is a bad driver, does that remove any negligence claim you may have against him?' Mr Goldhawk is a chartered accountant and a specialist investigating accountant. He was appointed as such by the liquidators of 'Supreme' and gained a deep insight into the group and its penumbra. In *Jansen Van Vuuren and Another NNO v Kruger* 1993 (4) SA 842 (A) the court said "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." See also *Dube v Administrator, Transvaal* 1963 (4) SA 260 (W).

¹⁴⁷ *Janse Van Rensburg NO and Another v Minister of Trade and Industry and Another NNO* 2001 (1) SA 29 (CC); *Winckler and Others v Minister of Correctional Services and Others* 2001 (2) SA 747 (C) Section 33(1) guarantees everyone the right to administrative action that is lawful, reasonable and procedurally fair. See also *South African Veterinary Council and Another v Veterinary Defence Association* 2003 (4) SA 546 (SCA). It is submitted that the same considerations should be applicable to such decisions in the private sector. Equality is not just a constitutional right. It is also a constitutional value. Why should patients in the private sector be treated differently to those in the public sector in terms of considerations of administrative justice? In what basis could one justify an absence of procedural fairness to private sector patients?



- 4 The patient's informed consent will be obtained with regard to treatment that is administered to him or her prior to the administration of such treatment¹⁴⁸.
- 5 The provider undertakes to render the health services in accordance with the patient's consent and on the basis of the information supplied to the patient in order to obtain that consent¹⁴⁹.
- 6 The patient will be informed of the fact that treatment is of an experimental nature or is being conducted in the course of research and will be given the opportunity to refuse such treatment before it is administered¹⁵⁰.
- 7 The patient's health information will be kept confidential and will not be used in a way that will cause harm to the patient. It will not be disclosed to anyone without the patient's prior consent¹⁵¹.
- 8 The patient is entitled to rely on and act in accordance with the advice of the health professionals treating him or her in their capacity as experts¹⁵².
- 9 Unless specifically stated otherwise in express and unambiguous terms the provider does not undertake to cure the patient¹⁵³.

¹⁴⁸ *Lybery v Jefferies*, 1925 AD 236; *Esterhuizen v Administrator, Transvaal* 1957 (3) SA 710 (T); *Richter and Another v Estate Hammann* 1976 (3) SA 226 (C); *Castell v De Greef* 1994 (4) SA 408 (C); *Broude v Mcintosh and Others* 1998 (3) SA 60 (SCA)

¹⁴⁹ *Esterhuizen v Administrator, Transvaal* fn 149 *supra*
¹⁵⁰ Section 12(2)(c) of the Constitution

¹⁵¹ *Jansen Van Vuuren and Another NNO v Kruger* 1993 (4) SA 842 (A)

¹⁵² In *Pinshaw v Nexus Securities (Pty) Ltd and Another* 2002 (2) SA 510 (C) the court said that "Clients are wont to place their trust not just in the company, but also in the individuals within the company with whom they deal. Clients tend to expect, and in my view are entitled to expect, the exercise of skill and care from the individual advisers and managers. A failure to exercise appropriate skill and care can have devastating consequences, as Durr's case *supra* illustrated. Furthermore, financial advisers and managers can vis-à-vis their immediate clients contract out of or limit liability, and as I see the position, they can for delictual purposes do the same for their employees. To fix Van Zyl with a duty to Mrs Pinshaw, in the circumstances pleaded, strikes me as being fair and in accord with the legal convictions of the community. It seems to me, therefore, that policy considerations favour upholding the duty rather than negating it."

¹⁵³ In *Buls and Another v Tsatsarolakis* fn 145 *supra* the court commented: "Every man has a legal right not to be harmed; but is there, apart from a contract, a legal right to be healed? It is no doubt the professional duty of a medical practitioner to treat his patient with due care and skill, but does he, merely by undertaking a case, become subject to a legal duty, a breach of which founds an action for damages, to take due and proper steps to heal the patient? It is an interesting question but, because it was not argued and because it is not necessary for the purposes of the present decision to answer it, I shall not discuss it further." See Strauss *Doctor, Patient and the Law* at p 40-41 at which he submits that where a patient consults a doctor who undertakes to treat him, the doctor assumes no greater duty than to treat the patient with due care and skill, unless the doctor has expressly guaranteed that the patient will be healed by his treatment – something which the prudent doctor will not generally do.



- 10 The provider will always act in the best interests of the patient and will only administer treatment that is medically necessary¹⁵⁴.
- 11 The patient will not be abandoned by the provider. Alternative health services will be provided where the provider can no longer provide the health care services previously supplied to the patient. The provider will ensure that where a course of treatment has commenced it will be completed¹⁵⁵.
- 12 The provider is entitled to payment for health care services where this is provided for by law or by mutual agreement and the patient or other person responsible for the patient is liable to pay a reasonable price for such services¹⁵⁶.
- 13 In the absence of provisions in law to the contrary, the patient will not be detained against his or her will by the provider¹⁵⁷.
- 14 The provider will take reasonable measures to ensure the health and safety of the patient while he or she is receiving health services at the provider's premises¹⁵⁸.
- 15 The goods supplied to the patient in the course of medical treatment are fit for the purpose for which they were supplied and are free of latent defects¹⁵⁹.

¹⁵⁴ See *The State v Sikunyana and Others* 1961 (3) SA 549 (E) in which the court stated: "The medical practitioner who performs a dangerous operation with his patient's consent incurs no criminal responsibility if just cause for the operation exists, for the law does not regard his conduct as improper: but if 'there is no just cause or excuse for an operation, it is unlawful even though the man consents to it' - vide *Bravery v Bravery*, 1954 (3) A.E.R. 59 at p. 67, per Denning, L.J. Any intentional act which involves the likelihood of bodily harm to another and which is not recognised by modern usage as a normal and accepted practice of society is forbidden by law and is in no way dependent upon the absence of consent on the part of the victim." It is submitted that due to the nature of the services provided the relationship between provider and patient is fiduciary and that where there is a conflict of interests between the provider and patient it is the duty of the latter to declare it to the patient and to ensure that the patient's interests are not compromised.

¹⁵⁵ *Applicant v Administrator, Transvaal, And Others* 1993 (4) SA 733 (W)

¹⁵⁶ See the discussions in the chapter on the law of contract of the legislation in the different provinces and their fee regulations. It is submitted that where the price in the private sector is unreasonably high, this will impact on the constitutional right of access to health care services and may justify state intervention such as is presently happening in terms of section 22G of the Medicines and Related Substances Act No 101 of 1965 with regard to the pricing of medicines.

¹⁵⁷ Section 12(1) of the Constitution

¹⁵⁸ *Beaven v Lansdown Hotel (Pty), Ltd* 1961 (4) SA 8 (N) *Regal v African Superstate (Pty.) Ltd* 1963 (1) SA 102 (AD); *Quathlamba (Pty) Ltd v Minister Of Forestry* 1972 (2) SA 783 (N); *Bronte Hotel (Pvt) Ltd v Low* 1974 (2) SA 353 (R); *Kritzinger v Steyn En Andere* 1997 (3) SA 686 (C). See also section 9(1) of the Occupational Health and Safety Act No 85 of 1993 which states that "Every employer shall conduct his undertaking in such a manner as to ensure, as far as is reasonably practicable, that persons other than those in his employment who may be directly affected by his activities are not thereby exposed to hazards to their health or safety." The definition of 'employer' in the Act is wide enough to include the state.

¹⁵⁹ In *Curtaincrafts (Pty) Ltd v Wilson* 1969 (4) SA 221 (E), the court said that a purchaser of an article is entitled to expect is that the article shall be free from such latent defects as are not to be expected in an article of that quality, price and type, unless he obtains a warranty in expressly wider terms. *Kroonstad Westelike Boere-Ko-Operatiewe Vereniging Bpk v Botha and Another* 1964 (3) SA 561 (A) Liability for consequential damage caused by latent defect attaches to a

16 The patient's constitutional rights to life, bodily and psychological integrity, human dignity, privacy, freedom and security of the person, freedom of religion, belief and opinion, and access to health care services will be respected, protected, promoted and upheld by the provider¹⁶⁰.

These provisions are clearly supported by both the common law and the Constitution in most instances. It is submitted, furthermore, that in terms of the officious bystander test, if one had to ask any patient and provider in the process of concluding a contract whether or not such terms should be included, one or both of them is guaranteed to reply with an impatient affirmative. It is submitted that an acknowledgement by the courts of these terms and a legal base from which to adjudicate matters involving contracts for health care services would go a long way towards addressing the current defects in the law of contract as it pertains specifically to such services. The point is made repeatedly in this thesis that law must be considered and applied within its factual context in order to have any meaningful result. Where that context is specialised or structured in a particular manner and generalizations that are valid within other contexts are clearly inapplicable or inappropriate such generalizations cannot rationally or reasonably be applied.

merchant seller, who was unaware of the defect, where he publicly professes to have attributes of skill and expert knowledge in relation to the kind of goods sold.

See also *Crawley v Frank Pepper (Pty) Ltd* 1970 (1) SA 29 (N) A seller is obliged to disclose all material latent defects which unfit or partially unfit the *res vendita* for the purpose for which it was intended to be used. By operation of the Aedilitian Edicts, as expounded and adopted in our law, into every contract of sale there is imported a warranty by the seller against such latent defects. Although a seller may contract out of his obligations to disclose and out of the statutorily imported warranty against latent defects, the existence of which he does not know at the time of the sale, if he purports to contract out of his obligation to disclose and of the implied warranty against material latent defects unfitting, or partially unfitting, the *res vendita* for the purpose for which it is sold, and those defects are present to his mind at the time of the sale, but he remains silent about them although he must know that to disclose their existence would cause a prospective buyer either not to purchase at all or to insist on a lower price than he otherwise would pay, he will be given the 'replication of fraud' (*de dolo replicationem*).

See also *Holmdene Brickworks (Pty) Ltd v Roberts Construction Co Ltd* 1977 (3) SA 670 (A) where it was held that a merchant who sells goods of his own manufacture or goods in relation to which he publicly professes to have attributes of skill and expert knowledge is liable to the purchaser for consequential damages caused to the latter by reason of any latent defect in the goods. Ignorance of the defect does not excuse the seller. Once it is established that he falls into one of the above-mentioned categories, the law irrebuttably attaches this liability to him, unless he has expressly or impliedly contracted out of it. The liability is additional to, and different from, the liability to *redhibitorian* relief which is incurred by any seller of goods found to contain a latent defect. Broadly speaking, a defect may be described as an abnormal quality or attribute which destroys or substantially impairs the utility or effectiveness of the *res vendita* for the purpose for which it has been sold or for which it is commonly used. Such a defect is latent when it is one which is not visible or discoverable upon an inspection of the *res vendita*.

160

This is an obligation imposed upon the state by section 7(2) of the Constitution. However it is submitted that in the healthcare context where a patient is often weak and debilitated, physically or mentally incapacitated and has no control over his or her immediate personal environment it would not be difficult to argue that the same considerations apply *mutatis mutandis* to private sector providers of health care services. To suggest any different would be unconstitutional in terms of section 2 of the Constitution. To the extent that a patient is temporarily or even permanently unable to enforce or protect his or her own constitutional rights to dignity, life, privacy, bodily and psychological integrity etc, it is submitted that it is the responsibility of the person in whose care he or she resides to reasonably do so.

10.5.2 Contracts Within The Public and Private Health Sectors

Recognition must be given to the fact that the Constitution has irrevocably altered the commercial status of health care services. The rights that are granted in section 27(1) and 27(3) mean that health care services can no longer be regarded as simply another commodity in trade. The law of contract, it is submitted, must be influenced and informed by this fact whether the services are delivered in the private or the public health sector. To suggest otherwise is to ignore the Constitution. There is therefore now an added dimension to the business of those in the private health sector who trade in health care products and services. There is a constitutional obligation upon the state to take legislative and other measures to achieve the realisation of the right of access to health care services that is not restricted to the public sector. The Minister of Health has recently publicly acknowledged the important role of the private health sector in the delivery of health care services and categorically denied claims that the state is trying to destroy it. However, the private health sector will have to undergo certain fundamental paradigm shifts in order to avoid the perpetuation of its previous flaws and weaknesses and to align its operations with constitutional principles. Its reluctance to transform is evident from the litigation by the National Convention on Dispensing and others challenging the provisions of the Medicines and Related Substances Act concerning the requirement that health professionals other than pharmacists who wish to dispense medicines must obtain a licence from the Director-General to do so¹⁶¹. This is also evidenced by the litigation in the Cape High Court against the regulations on the pricing of medicines by *inter alia* New Clicks Ltd, the Pharmaceutical Society of South Africa and the Netcare group of private hospitals¹⁶². The court battles are an apparently unavoidable step in the process of transformation of the health sector that was contemplated in policy documentation going back to 1996¹⁶³. The regulations concerning the pricing of medicines alone indicate that contracts for involving health care services will have to be considered in a somewhat different light to what they were previously.

¹⁶¹ Judgment is due to be handed down in the Pretoria High Court on 02 July 2004, subsequent to the time of writing.

¹⁶² At the time of writing judgment has been reserved by the court.

¹⁶³ The National Drug Policy which clearly spells out the principles that have subsequently been legislated is dated October 1996. A copy is available at <http://www.doh.gov.za>

It is submitted that while contracts between patient and provider in the public health sector are by no means essential to the delivery of health care services, they can nevertheless play a valuable role in a number of respects. Firstly they serve to emphasise the importance of a patient as an individual to be respected and treated with dignity. Secondly they highlight the fact that the patient has certain entitlements and expectations regarding the health services he or she has contracted for and that there is a legal relationship between the provider and the patient that the courts are able and willing to uphold. Patients in the public sector are too often treated in a dehumanising and demeaning way that does not acknowledge their intrinsic and inestimable worth as human beings. Thirdly, a consciously contractual relationship that is negotiated with a patient, even a non-paying patient, obliges public health officials to talk to and interact with patients as equals, to enquire as to their needs and requirements and to understand that they may incur legal liability should they fail to uphold agreed terms. Contracts can have the effect of humanising the private health sector if they are used in such a way as to promote this. There is thus much to be said for contractual relationships even within the public health sector, between patient and provider. Having said this it is deeply ironic that the law of contract as applied to contracts for health services in the private sector has had the exact opposite effect.

Within the private sector, although there is a general assumption that contracts are the legal vehicles of choice for the delivery of health care services, the law of delict has assumed a significant weight in the adjudication by the courts of cases where contracts existed between the parties. It has been noted elsewhere in this thesis that the courts seem to prefer to adjudicate matters on the basis of the law of delict than on the law of contract given the choice. The difference between the law of contract and the law of delict in terms of the damages that can be awarded may have something to do with this since, in terms of the law of contract, damages may not be awarded for pain and suffering and similar almost inevitable consequences of contractual breach where the contract in question is for health care services. This is a failing of the law of contract specifically in the health services context which arises directly as a consequence of a compartmentalised approach to law that seeks to keep the legal principles underpinning the law of delict firmly in the box labelled 'delict'. It is a failure to recognise that they could and should be of more universal application within

specific contexts where the principles of fairness, reasonableness and public policy so demand.

The value of a contract to a patient in the private health sector is presently significantly limited and may even be negative rather than positive, given the decision of the Supreme Court of Appeal in *Afrox*. The law of contract offers little or no guarantees that one will be treated in good faith in a fair, reasonable, professional or even ethical manner neither does it afford one any remedies in the event of the failure of the provider to do so. It prefers the inferred 'constitutional' principle of sanctity of contract to the express constitutional right of access to health care services because a visually impaired court could not see how a contractual term could limit the latter. The result is that on the whole, the private health care contract presently serves as nothing more than a convenient means for the provider to enforce payment for the services in question. The requirements of informed consent transcend the law of contract and are not dependent upon the law of contract for their enforceability. It is, significantly, the law of delict that comes to the rescue in this regard. It is quite probably not in the private patients best interests to enter into any kind of a contractual relationship with a private hospital given that such a contract is now, thanks to the Supreme Court of Appeal, guaranteed to deprive him or her of his rights and remedies in terms of the law of delict. The irony is that a private hospital patient may not even have any real choice as to whether or not to contract with the provider given the imbalance of power in favour of the provider which the Supreme Court of Appeal has recently heavily reinforced in *Afrox*. It may be that the price increase implemented by the Supreme Court of Appeal in respect of private health care services in at least the hospital sector, with its reputedly higher standards of professional care, is currently way too high for patients such as the applicant in the *Afrox* case. At least within the public sector a patient is virtually guaranteed of a sympathetic judicial ear where the respondent is the government and one can be certain that any attempts by the state to apply the judgment in *Afrox* to its own contractual relationships with patients will not be upheld by any court.

10.5.3 Potential Solutions For Health Care Contracts

Since the judiciary has unquestionably failed consumers in the context of contracts for private health services delivery it may be appropriate for the legislature to intervene if not generally within the law of contract then specifically in the law of contract relating to health care services. This would not be without precedent. There is an Act called the Housing Consumers Protection Measures Act¹⁶⁴ which provides the following with regard to the conclusion of agreements and implied terms in regard to housing in section 13 –

- (1) A home builder shall ensure that the agreement concluded between the home builder and a housing consumer for the construction or sale of a home by that home builder-
 - (a) shall be in writing and signed by the parties;
 - (b) shall set out all material terms, including the financial obligations of the housing consumer; and
 - (c) shall have attached to the written agreement as annexures, the specifications pertaining to materials to be used in construction of the home and the plans reflecting the dimensions and measurements of the home, as approved by the local government body: Provided that provision may be made for amendments to the plans as required by the local government body.

- (2) The agreement between a home builder and a housing consumer for the construction or sale of a home shall be deemed to include warranties enforceable by the housing consumer against the home builder in any court, that-
 - (a) the home, depending on whether it has been constructed or is to be constructed-
 - (i) is or shall be constructed in a workmanlike manner;
 - (ii) is or shall be fit for habitation; and
 - (iii) is or shall be constructed in accordance with-
 - (aa) the NHBRC Technical Requirements to the extent applicable to the home at the date of enrolment of the home with the Council; and
 - (bb) the terms, plans and specifications of the agreement concluded with the housing consumer as contemplated in subsection (1);
 - (b) the home builder shall-
 - (i) subject to the limitations and exclusions that may be prescribed by the Minister, at the cost of the home builder and upon demand by the housing consumer, rectify major structural defects in the home caused by the non-compliance with the NHBRC Technical Requirements and occurring within a period which shall be set out in the agreement and which shall not be less than five years as from the occupation date, and notified to the home builder by the housing consumer within that period;
 - (ii) rectify non-compliance with or deviation from the terms, plans and specifications of the agreement or any deficiency related to design, workmanship or material notified to the home builder by the housing

¹⁶⁴ Housing Consumers Protection Act No 95 of 1998

- consumer within a period which shall be set out in the agreement and which shall not be less than three months as from the occupation date; and
- (iii) repair roof leaks attributable to workmanship, design or materials occurring and notified to the home builder by the housing consumer within a period which shall be set out in the agreement and which shall not be less than 12 months as from the occupation date.

Housing, like health care services, is the subject a constitutional right¹⁶⁵. It is submitted that there is arguably sufficient motivation for similar legislative provisions with regard to health care services not only on the basis of the law of contract but also to address the failure of the courts to apply the maxim *res ipsa loquitur* to delictual claims in this context and to protect consumers of health care services against unscrupulous, unfair or unconstitutional practices by providers of such services. The legislative provisions in question could assist consumers of health care services in stipulating what they need to do in order to shift the evidentiary burden to the shoulders of the expert respondent.

Closer to home in terms of section 47 of the National Health Act –

- (1) All health establishments must comply with the quality requirements and standards prescribed by the Minister after consultation with the National Health Council.
- (2) The quality requirements and standards contemplated in subsection (1) may relate to human resources, health technology, equipment, hygiene, premises, the delivery of health services, business practices, safety and the manner in which users are accommodated and treated.
- (3) The Office of Standards Compliance and the Inspectorate for Health Establishments must monitor and enforce compliance with the quality requirements and standards contemplated in subsection (1).

It may be that this section will give sufficient powers to the Minister of Health to ensure that exculpatory clauses in private hospital contracts are largely harmless to patients if they are permitted at all.

The Consumer Affairs (Unfair Business Practices) Act¹⁶⁶ could also afford a measure of assistance. In terms of this Act, “business practice” includes-

- (a) any agreement, accord, arrangement, understanding or undertaking, whether legally enforceable or not, between two or more persons;

¹⁶⁵ Section 26 of the Constitution stipulates that everyone must have access to adequate housing and that the state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of this right.

¹⁶⁶ Consumer Affairs Act No 71 of 1988

- (b) any scheme, practice or method of trading, including any method of marketing or distribution;
- (c) any advertising, type of advertising or any other manner of soliciting business;
- (d) any act or omission on the part of any person, whether acting independently or in concert with any other person;
- (e) any situation arising out of the activities of any person or class or group of persons,

but does not include a practice regulated by competition law

and

‘unfair business practice’ means any business practice which, directly or indirectly, has or is likely to have the effect of-

- (a) harming the relations between businesses and consumers;
- (b) unreasonably prejudicing any consumer;
- (c) deceiving any consumer; or
- (d) unfairly affecting any consumer.

The Act establishes mechanisms for the investigation of unfair business practices and their prohibition. There are also consumer affairs courts in various provinces that exist in terms of provincial legislation and that have powers to adjudicate matters affecting consumers in terms of that legislation. At least in such forums it is likely that there will be a focus on the more modern approach of consumerism and considerations such as unreasonableness, good faith and fairness will occupy centre stage.

10.5.4 Conclusions Concerning The Law of Contract

The law of contract as a legal vehicle for health services delivery is presently not ideal. This is not so much due to the fact that the concept of a contract as a binding agreement between two parties is in itself problematic as it is to the antiquated approach of South African courts to this area of the law. To be blunt, the law of contract has not kept pace with sociological and commercial developments whether these are expressed in terms of changing structures and groupings within society or in terms of shifts in balance of power brought about by concepts such as mass production and the increasing idea that certain items are public rather than private goods to which everyone should have access whether or not he or she is able to pay for them. Worst of all there is still an almost complete failure to incorporate constitutional principles and values into the law of contract. Whereas developments in other countries in the law of contract have seen conscious acknowledgement of the need to afford greater protection to consumers, to ensure that contracts are

fundamentally fair and reasonable as between parties in a world where the balance of power is usually heavily in favour of the powerful and wealthy corporate entities that comprise the supply side of the market and to create conditions in which the interests of the individual consumer in the bargaining situation are taken into account by the law that supports the concept of contract as an instrument of trade and commerce, courts in South Africa remain either impervious or oblivious to the need and importance of ensuring similar developments in South African law. In areas such as health care services where the circumstances and the nature of the item of trade in and of themselves should make it quite obvious that there is an unacceptable imbalance of power that should be rectified in order to avoid injustice no less a body than the Supreme Court of Appeal has said that it cannot see the difference between providers of health care services and any other service provider¹⁶⁷. The result is that South African law of contract appears to remain largely trapped within a judicial mindset that would be at home in the Victorian era¹⁶⁸.

The problems within the South African law of contract have not gone unremarked. The South African Law Commission in 1996 in a paper¹⁶⁹ entitled 'Unreasonable Stipulations In Contracts and The Rectification of Contracts' stated that with the rise of the movement for consumer protection in the early seventies, it became the generally accepted view in most first world countries that legislative action was required to deal with contractual unconscionability and noted that the South African proponents of granting such a power of review to the courts support legislation that will introduce the doctrine of unconscionability and the concomitant review power of the courts. Furthermore, said the Commission, the question is being asked whether the "unconscionability" or the "good faith" approach should be followed. In the end, the two approaches may be thought to lead to the same result. When considering the historical background of the South African law, and taking into account the general use of the unconscionability approach by the legal systems close to our own, the

¹⁶⁷ *Afrox Healthcare v Strydom* fn 65 *supra*

¹⁶⁸ Matlala D 'The Law of Contract: When the Supreme Court of Appeal Fails to Act', Senior Lecturer, University of Venda <http://wwwserver.law.wits.ac.za/workshop/workshop03/WWLSMatlala.doc> points out that, in the case of the law of contract, the courts are still happy to follow a statement made by Chief Justice Innes a century ago in *Burger v Central South African Railways* 1903 TS 571 to the effect that it is a sound principle of law that a man, when he signs a contract, is taken to be bound by the ordinary meaning and effect of the words which appear over his signature' even though it has the effect that a partially literate and partially sighted signatory is held bound by certain Latin expressions which he does not understand (*Mathole v Mothe* 1951 (1) SA 256 (T) or that a signatory who cannot read or write any language is held bound by a document written in English which she did not understand and which was apparently misrepresented to her (*Khan v Naidoo* 1989 (3) SA 724 (N))

¹⁶⁹ Discussion Paper 65 (Project No 47) (1998)

unconscionability criterion is considered advisable. The Commission expressed the widespread disappointment that was felt when the Appellate Division saw fit to do away with the *exceptio doli* in *Bank of Lisbon and South Africa (Ltd) v de Ornelas*¹⁷⁰.

The team that did the preliminary research work for the Discussion Paper identified a number of common provisions which could and should receive the critical attention of the legislature:

- (i) Clauses reversing the ordinary burden of proof and requiring a debtor to prove facts which according to the ordinary rules of evidence the creditor would have had to prove, e.g. usually the creditor (seller) has to prove delivery of the goods sold; a clause reversing this burden of proof makes it virtually impossible for the debtor (buyer) to prove the negative of non-delivery.
- (ii) Under the existing parol evidence rule, facts extrinsic to the written documents may not be adduced in evidence to modify or contradict the writing. A verbal assurance by a creditor may thus not be proved and relied on by the debtor if it contradicts the written contract.
- (iii) Clauses excluding, waiving or limiting the protection afforded by consumer protection legislation or legislation aimed at the modification of unfair contract terms.
- (iv) The research team proposed a review of, but not a witch-hunt against exemption clauses. These clauses do have a legitimate place but they should

¹⁷⁰ *Bank of Lisbon* 1988 (3) SA 580 (A). The SALC put it as follows: "The Appellate Division held that on a correct interpretation of the contract the bank was indeed entitled to retain the securities. But the respondents relied on a counter-argument, that the conduct of the bank was contrary to the view our society takes of what is right or wrong in the requirements of good faith. They relied on the common-law remedy of the *exceptio doli generalis*. In theory, this was a defence available to a defendant, who, though liable according to the letter of a contract and in strict law, could show that implementation of the contract would be unconscionable or inequitable. But even before this case was heard, this remedy was not rigorously applied by our courts. Yet one could have hoped that a doctrine of relief against unconscionable claims could be founded on this *exceptio*. It was not to be. In this case the majority of the Appellate Division Bench, per Joubert J A, decided "... once and for all, to bury the *exceptio doli generalis* as a superfluous, defunct anachronism. *Requiescat in pace*" (let it rest in peace). The learned judge also held that equity could not override a clear rule of law; neither could the application of good faith do so. The "clear rule of law", presumably, was the rule that contracts must be performed according to their terms. For those hoping that our courts would develop a doctrine of relief in cases of unconscionability, the judgment was a great disappointment."

not be tolerated where, in the circumstances of a particular case, their implementation would lead to harsh and unjust results.

- (v) Choice-of-law clauses, whereby parties agree that legislation, other than that of South Africa, should apply to a contract concluded and implemented here and adjudicated upon by a South African court, should be limited to contracts concluded between foreign contracting parties or between South Africans and foreigners contracting in the ordinary course of their profession or business.
- (vi) Clauses by which rights and defences are lost in the case of cession or discounting of contracts. It appears that there is a standard practice by which a seller sells goods to a purchaser on condition that if the seller cedes or discounts the contract to a third party (e.g. a bank or financial institution) the purchaser will not be able to raise any defence (e.g. that the goods suffered from latent defects, that warranties were not honoured) against the third party.
- (vii) Clauses under which the weaker party submits to the jurisdiction of a magistrates' court, but the stronger party (the seller, usually) does not agree that it may be sued in such court.
- (viii) Clauses by which jurisdiction is conferred upon a court which would not otherwise have had jurisdiction in the matter, to the detriment of, usually, the debtor, by the stratagem of a clause under which it is "acknowledged" that the contract had been concluded or executed or breached in the area of jurisdiction of the said court, etc.
- (ix) Clauses by which jurisdiction is limited to the High Court, thereby making it more difficult for the weaker party to gain access to the courts, in the light of the higher costs of litigation in the High Court.
- (x) Clauses by virtue of which the usual defences available to a debtor under a contract of suretyship (the benefit of prior exclusion, the benefit of division,

the benefit of simultaneous citation and division of debt, the benefit of cession of actions) and to a debtor under a contract of loan (the exception of non-payment of the capital of the loan) are excluded.

(xi) Clauses by which certain rules of court are waived, e.g. that in provisional sentence cases the creditor must prove the legality of the document sued upon or the amount of the debt.

(xii) Clauses waiving -

“all exceptions, defences, benefits and rights, of whatever nature, the content and meaning thereof being known by me”.

(xiii) Clauses by which certain statutory defences, e.g. by the Prescription Act¹⁷¹, the Agricultural Credit Act¹⁷² or the Moratorium Act¹⁷³, are waived.

(xiv) Clauses by which a claim for damages for breach of contract is excluded, e.g. where an agricultural co-operative or a seed company sells infertile seed to a farmer.

The research team found that courts in Germany, England, the USA, Sweden, Israel, the Netherlands and Denmark may take judicial action against unfair terms, in addition to which preventative control may also be used against unfair terms¹⁷⁴. It proposed that legislation should make it possible to test terms in standard contracts against the criterion of good faith. A number of people made important comments¹⁷⁵.

¹⁷¹ Prescription Act No 68 of 1969

¹⁷² Agricultural Credit Act No 28 of 1966

¹⁷³ Moratorium Act 25 of 1963

¹⁷⁴ See also the more recent observations of Carstens P and Kok A in ‘An assessment of the use of disclaimers by South African hospitals in view of constitutional demands, foreign law and medico-legal considerations’ *SA Public Law* vol 18 No2 2003 who point out that in the USA courts have rejected exculpatory agreements signed by patients on the basis that these agreements affect the public interest and cannot be upheld and that the German law of contract recognises in principle that exculpatory clauses/disclaimers in hospital contracts whereby medical negligence is excluded are against public policy

¹⁷⁵ The Commission noted that in a valuable contribution to the research project, the renowned jurist, Prof Hein Kötz of the Max Planck Institute at Hamburg, advised as follows regarding the question of private litigation as a remedy as opposed to administrative control. Enacting new substantive rules on the control of unfair contracts terms is an important step. What is equally important, however, is to consider whether there exist adequate mechanisms through which these

The Commission eventually published the 1998 document¹⁷⁶ to which Davis J referred in *Mort NO v Henry Shields-Chiat*¹⁷⁷. It recommended the introduction of the principles of fairness and good faith in the law of contract and that legislation is necessary to effect the necessary changes. The Commission prepared draft legislation (under the cumbersome but self explanatory title of ‘Control of Unreasonableness, Unconscionableness or Oppressiveness in Contracts Bill’) which accompanied its report. The draft Bill met with a significant amount of criticism by those who apparently do not perceive the pressing need to remedy the situation and who still naïvely believe that the courts are capable of the job¹⁷⁸.

Regrettably the South African judiciary does not demonstrate the neutrality and objectivity that one would hope from so eminent an institution as the bench¹⁷⁹. Matlala goes so far as to say that the inability of the judges to rigorously pursue and implement the spirit, purport and objects of the Constitution as regards contractual fairness, equity, dignity and equality may be one reason for the President to be careful

rules are to be made effective. The mechanism normally available is private litigation in which an individual bases his claim or his defence on the invalidity of the contract term on which his opponent relies. For various reasons this mechanism, if taken alone, cannot be regarded as a satisfactory solution of the problem. If an unfair contract term is used throughout an industry it may affect the interests of many people at the same time, but the individual injury will often be so small that there is no point in seeking redress by way of bringing or defending the court action. Sometimes the unfair contract term will typically harm people who are too poor to pay for the expenses of litigation but are too ‘rich’ to qualify for legal aid, if legal aid is available at all. Even where legal aid is available the persons affected may belong to population groups who lack the skills and sophistication required to make use of existing procedures. On the other hand, the interest at stake for the party who proposed the unfair term is typically much larger than the interest of the other side. As a result, there is a strong incentive for the proponent of an unfair term to buy the other side off and thus keep the clause out of the courtroom. Even where a particular clause has been held invalid by a court there is nothing to stop the proponent of the clause to continue its use with impunity in the hope that other less aggressive or less sophisticated parties will fail to pursue their rights in the mistaken belief that the clause is effective. In sum, it is all very well to enact rules defining unfair contract terms and to give the courts a power to set them aside. This will not get you very far in an area where there are few plaintiffs around who are in a position to make an effective use of the available controls by way of private litigation. This is why most European legal systems have not confined themselves to the enactment of substantive provisions on unfair contract terms. They have developed new control systems which do not, like traditional litigation, depend on the existence of an aggrieved individual willing and able to bring or defend a court action. Instead, public officials or consumers organisations have been given standing to institute control procedures before the ordinary courts or special tribunals which may lead to injunctions or cease-and-desist orders if contract terms used or recommended by the defendant are found invalid under the applicable substantive law.

176 *Report on Unreasonable Stipulations in Contracts* fn 169 *supra*

177 *Mort* 2001 (1) SA 464 (C)

178 Cornelius SJ *Principles of the Interpretation of Contracts in South Africa* (2002) at p 94; Hefer JJK ‘Billikheid in Die Kontraktereg Volgens Die Suid-Afrikaanse Regskommissie’ 2000 *Tydskrif vir Hedendaagse Romeins-Hollandsereg*

179 The present writer can state from personal experience that many judges, even a few of those at the level of the constitutional court, do not even attempt to conceal their hostility when the executive branch of government is a party to litigation before them. Whilst it may be an inevitable, though unfortunate, consequence of a liberal constitutional dispensation that it has become fashionable to sue the state, and more particularly the executive branch of government, it is submitted that it is completely alien to the spirit and intent of the Constitution to have a judiciary that is clearly predisposed against the state. One can only hope that the judiciary fails in its apparent attempts, whether conscious or subconscious, to provoke a constitutional crisis. The Constitution is the embodiment of the values and principles of a democratic state that is peculiarly South Africa. It is the culmination of the blood, sweat and tears of many thousands of people who, over the years, considered it worth fighting for. It is not fitting for the judiciary, of all institutions, to ignore or demean it, although, given the role of the judiciary in South African history prior to 1994, it is hardly surprising that it does so.

when it comes to making judicial appointments¹⁸⁰. He points out that in view of the Constitution and its Bill of Rights there is no more reason for South African courts to hesitate in reading constitutional imperatives and values into all contracts. He states that the refusal of the Supreme Court of Appeal to do this in respect of contracts is disappointing to say the least. It is not the intention here to repeat or revisit the work of the South African Law Commission but rather to highlight the fact that the problems with the South African law of contract have been documented at least as far back as 1995.

Whilst there have been a few glimmers of hope that South African contract law is beginning to evolve in the right direction 'being that happy state in which principles of good faith, fairness, equity and reasonableness underpin the law of contract'¹⁸¹, such as may be gleaned from the decisions in *Eerste Nasionale Bank van Suidelike Afrika v Saayman NO*¹⁸², *Mort NO v Henry Shields-Chiat*¹⁸³, *Shoprite Checkers (Pty) Ltd v Bumpers Schwarmas CC and Others*¹⁸⁴, it is submitted that still has a long way to go as is clear from the decisions of the Supreme Court of Appeal in *Afrox Healthcare Bpk v Strydom*¹⁸⁵ and *Brisley v Drotosky*¹⁸⁶.

10.6 The Law of Delict

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. Without detracting from the immense 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. They also have the power to develop the common law in order to align it with the Constitution. Health care services and products are not just another commodity. For one thing they are the

¹⁸⁰ Matlala fn 168 *supra* states that: "One can easily foresee a situation unfolding in which when future appointments are made, preference is given to nominees who are considered as likely to give effect to the 'spirit, purport and objects' of the Constitution. Were this to be the case the judiciary would have nobody but itself to blame for its inability to take the lead in developing the common law, and in so doing take into account the interest of justice as required by s 173 of the Constitution or promoting the spirit, purport and objects of the Bill of Rights when developing the common law as required by s 39(2)"

¹⁸¹ Matlala fn 168 *supra*

¹⁸² *Saayman* 1997(4) SA 302 (SCA)

¹⁸³ *Mort* fn 177 *supra*

¹⁸⁴ *Shoprite Checkers* 2002 (6) SA 2002 (C)

¹⁸⁵ *Afrox* fn 65 *supra*

¹⁸⁶ *Brisley* 2002 (4) SA (1) (SCA)

subject of constitutional rights. They are also, paradoxically, dangerous to health and even life if misused or misapplied and so delictual considerations involving being in control of a dangerous thing come into play for health professionals. The standard of care under the law of delict is thus modified to the standard of the reasonable health professional who is practising in the same field and at the same level of expertise as the respondent¹⁸⁷. Thus one would not judge a general practitioner by the standards of a gynaecologist neither would one judge a nurse against the standards of a physiotherapist or a medical officer in a district hospital by the standards of an orthopaedic surgeon. Lack of skill or experience is no defence if a health professional undertakes treatment in respect of which he or she has not been trained or of which he or she has insufficient personal experience¹⁸⁸. It is permissible for health professionals to observe and respect each other's scopes of practice when working as a team and one cannot be held liable for the delict or wrongdoing of another¹⁸⁹.

There is some degree of convergence between the law of contract and of delict. This 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. The law of delict is not as problematic as the law of contract when it comes to the provision of health care services but there are borderline cases such as that of *Collins v Administrator Cape*¹⁹⁰ when the principles of the law of delict seem somehow to fall slightly short of justice. The principle that the law of delict seeks to restore the victim of a civil wrong to the position in which he occupied before that wrong is not honoured in this particular case because, according to the reasoning of the court, the harm done was so great that no amount of compensation could achieve this objective. The logic that no amount of money can make up for the loss of use of an arm or an eye or a good name but that courts still award amounts in damages for these kinds of injuries anyway did not convince the court in *Collins* that damages should be awarded in respect of a child who was left in a persistent vegetative state due to the negligence of the respondent. Whilst the point is made that the object of the law of delict is compensation, and not

¹⁸⁷ See for instance *Van Wyk v Lewis* fn 146 *supra*; *Dube v Administrator, Transvaal* fn 146 *supra*; *Michael and Another v Linksfield Park Clinic (Pty) Ltd* 2001 (3) SA 1188 (SCA)

¹⁸⁸ *Rex v Van Schoor* 1948 (4) SA 349 (C); *R v Van der Merwe* 1953 (2) PH H 124 (W)

¹⁸⁹ *Van Wyk v Lewis* fn 146 *supra*; *S v Kramer* 1987 (1) SA (N)

¹⁹⁰ *Collins* 1995 (4) SA 73 (C)

punishment which is the domain of the criminal law, the fact is that not all delicts are crimes, that not all crimes are prosecuted successfully and that criminal sanctions such as imprisonment and fines payable to the state are not always appropriate when the respondent involved is a corporate entity such as a private company or a provincial government. It is submitted that there is scope for the argument that in some cases compensation is not merely the making good of a loss, it can also mean satisfaction in the sense that society's need for justice to be done and to be seen to be done is satisfied. The point is also made that it is not only the individual who has an interest in the successful prosecution of a delictual claim – broader society also has an interest. This is clearly evidenced in the considerations that the courts apply in the test for unlawfulness when adjudicating delictual claims. The legal convictions of the community play a key role. Why should the legal convictions of the community not also influence the consideration of awards in damages in certain cases? Scott J's approach to distributive justice in the case of *Collins* is distinctly utilitarian in the sense that the resources must remain where they are most useful. There is no point in transferring resources to a person who has no need of or use for, them. In the context of *Collins*, it is a highly persuasive argument in a country where health care services in the public sector are significantly under-resourced. In terms of traditional legal reasoning, it is not the calculation of damages that is influenced by public policy – only the element of wrongfulness¹⁹¹. Even in cases where wrongfulness is proven, this

¹⁹¹ In fact the argument that there are no public policy considerations applicable in assessing the quantum of damages is not correct. The element of legal causation for the purpose of limiting the extent of the damages for which a defendant is liable is also very much dependent on public policy considerations. With regard to the purely compensatory nature of damages in delict, see the dicta of Scott J in *Zysset and Others v Santam* 1996 (1) SA where he states: "The modern South African delictual action for damages arising from bodily injury negligently caused is compensatory and not penal. As far as the plaintiff's patrimonial loss is concerned, the liability of the defendant is no more than to make good the difference between the value of the plaintiff's estate after the commission of the delict and the value it would have had if the delict had not been committed. See *Dippenaar v Shield Insurance Co Ltd* 1979 (2) SA 904 (A) at 917B. Similarly, and notwithstanding the problem of placing a monetary value on a non-patrimonial loss, the object in awarding general damages for pain and suffering and loss of amenities of life is to compensate the plaintiff for his loss. It is not uncommon, however, for a plaintiff by reason of his injuries to receive from a third party some monetary or compensatory benefit to which he would not otherwise have been entitled. Logically and because of the compensatory nature of the action, any advantage or benefit by which the plaintiff's loss is reduced should result in a corresponding reduction in the damages awarded to him. Failure to deduct such a benefit would result in the plaintiff recovering double compensation which, of course, is inconsistent with the fundamental nature of the action. Notwithstanding the foregoing, it is well established in our law that certain benefits which a plaintiff may receive are to be left out of account as being completely collateral. The classic examples are (a) benefits received by the plaintiff under ordinary contracts of insurance for which he has paid the premiums and (b) moneys and other benefits received by a plaintiff from the benevolence of third parties motivated by sympathy. It is said that the law balks at allowing the wrongdoer to benefit from the plaintiff's own prudence in insuring himself or from a third party's benevolence or compassion in coming to the assistance of the plaintiff. Nor, it would seem, are these the only benefits which are to be treated as *res inter alios actae*. In *Mutual and Federal Insurance Co Ltd v Swanepoel* 1988 (2) SA 1 (A) it was held, for example, that a military pension which was in the nature of a solatium for the plaintiff's non-patrimonial loss was not to be deducted. Nonetheless, as pointed out by Lord Bridge in *Hodgson v Trapp and Another* [1988] 3 All ER 870 (HL) at 874a, the benefits which have to be left out of account, 'though not always precisely defined and delimited', are exceptions to the fundamental rule and 'are only to be admitted on grounds which clearly justify their treatment as such'. It is submitted this baulking of the law to which Scott J refers is based on none other than consideration of public policy. In fact Scott confirms this subsequently in the judgment when he goes on to observe: "It is doubtful whether the distinction between a benefit which is deductible and one which is not can be justified on the basis of a single jurisprudential principle. In the

on its own is insufficient to succeed in a claim in delict. The object of pursuing such a claim is compensation for the loss suffered. Therefore the nature and extent of that loss, i.e. damages must be proven. Where the loss is so great that no amount in damages will constitute satisfactory compensation, the utilitarian approach is that no award of compensation can be made. It is submitted, however, that the common law is no longer only about cold logic expressed in utilitarian terms. It is also about values, more specifically constitutional values and even more specifically the rights to life and to bodily and psychological integrity and the weight that South African society has attached to these concepts. If cold logic is the only legal standard then why should people not be able to sell their body parts for what they can get for them? Why should one treat people who are suffering from terminal illnesses such as certain kinds of cancer and AIDS? Why waste valuable resources on those with a death sentence over their heads when such resources could be better spent in giving those who can recover from other less serious ailments a better chance to do so? Why treat the aged with increasingly expensive medicines and surgical interventions for that matter? Of what utilitarian value are their lives once they reach retirement age? This is why the decision in *Collins* sits so uncomfortably. Those who defend it point out that one must

past the distinction has been determined by adopting essentially a casuistic approach and it is this that has resulted in a number of apparently conflicting decisions. Professor Boberg in his *Law of Delict* vol 1 at p 479 explains the difficulty thus: '(W)here the rule itself is without logical foundation, it cannot be expected of logic to circumscribe its ambit.'

But, whatever the true rationale may be, if indeed there is one, it would seem clear that the inquiry must inevitably involve to some extent, at least, considerations of public policy, reasonableness and justice (see *Santam Versekeringsmaatskappy Bpk v Byleveldt* 1973 (2) SA 146 (A) at 150E-F and 153B-C; see also Neethling, Potgieter and Visser *The Law of Delict* 2nd ed at 221-2). This in turn must necessarily involve, I think, a weighing up of mainly two conflicting considerations in the light of what is considered to be fair and just in all the circumstances of the case. The one is that a plaintiff should not receive double compensation. The other is that the wrongdoer or his insurer ought not to be relieved of liability on account of some fortuitous event such as the generosity of a third party.

Another case which clearly demonstrates the relevance of public policy considerations to the quantum of damages is *Jones v Krok* 1996 (1) SA 504 (T). In that case Kirk-Cohen J stated obiter that: It is the policy of South African law and practice that for breach of contract the injured party is entitled to no more than compensation for the damages actually suffered by him. The quantum is not in any way dependent upon, or influenced by, the reprehensible behaviour of the defendant or the flagrancy of the breach (*Administrator, Natal v Edouard* 1990 (3) SA 581 (A)). The same applies to the assessment of the quantum of damages under the *lex Aquilia*: see *Santam Versekeringsmaatskappy Bpk v Byleveldt* 1973 (2) SA 146 (A) 152H. It is thus trite that the award of punitive damages in such instances, in which category falls the award in this case, is alien to our legal system. The mere fact that awards are made on a basis not recognised in this country does not entail that they are necessarily contrary to public policy. Whether a judgment is contrary to public policy depends largely upon the facts of each case.... In principle it would be wrong to refuse to enforce a foreign order of punitive damages merely because it is unknown in this country. In my view it cannot be said that the principle involved is necessarily unconscionable or excessive or exorbitant." Provisional sentence was refused on the grounds that (a) while the appeal was still pending in the US Court of Appeal, the judgment of the US Court was not a final one; (b) the award of punitive damages was contrary to public policy and a foreign order for such damages would not be enforced by South African Courts; and (c) the award of compensatory damages rested 'upon the same foundation' as the award of punitive damages and would thus not be enforced. In *Jones v Krok* 1995 (1) SA 677 (A) the Appellate Division reversed the decision of Kirk-Cohen J holding *inter alia* with regard to the Court a quo's refusal of provisional sentence on the grounds that the award of 'compensatory' damages by the foreign Court had been 'arbitrary' and that it would be contrary to public policy to enforce it, the Court held that there had been no valid basis for such findings and, in any event, that such findings seemed to have involved entering into the merits of the case adjudicated upon by the US Court, which was not permissible. It concluded that public policy afforded no ground for denying the appellant relief in respect of the amount of US\$13 670 987. Although Kirk-Cohen J concluded that the punitive award of damages would not be enforced the *obiter dicta* in this judgment indicate that there may be circumstances in which damages that are not purely compensatory could be recognised. This view seems to have been supported by the Appellate Division in reversing the decision of Kirk-Cohen J.

be fair to the respondent too. Unfortunately in view of the weight that is attached to life and the ability to enjoy it is such that one cannot help but feel that the scales are balanced rather more in favour of the victim on these thankfully rare occasions.

10.6.1 Constitutional Delicts

The question of constitutional delicts, which can best be described as unconstitutional conduct that is unlawful, blameworthy and which causes personal or patrimonial loss to a person is discussed in chapter five of this thesis. It is submitted that if such a delict is recognised, the most likely situation is that described by the court in *Soobramoney v Minister of Health, Kwazulu-Natal*¹⁹² in reviewing the facts of the Indian case of *Paschim Banga Khet Mazdoor Samity and Others v State of West Bengal and Another*¹⁹³. It was a case in which constitutional damages were claimed. The claimant had suffered serious head injuries and brain haemorrhage as a result of having fallen off a train. He was taken to various hospitals and turned away, either because the hospital did not have the necessary facilities for treatment, or on the grounds that it did not have room to accommodate him. As a result he had been obliged to secure the necessary treatment at a private hospital. It appeared from the judgment that the claimant could in fact have been accommodated in more than one of the hospitals which turned him away and that the persons responsible for that decision had been guilty of misconduct. There is no magic in the term ‘constitutional delict’, however. The act or omission would still have to satisfy the requirements of the law of delict before it could fall within the ambit of the law of delict. The added element would simply be that the delict constituted a violation of the Constitution. The unconstitutionality of the act or omission would go a long way to proving its unlawfulness. The question of whether it is constitutional to contract out of delictual liability was settled for the present in the case of *Afrax Healthcare v Strydom*¹⁹⁴ which has already been discussed but judging from the amount of criticism that this decision has attracted it is unlikely to be the last word on the subject for very long.

¹⁹² *Soobramoney* fn 28 *supra*

¹⁹³ *Paschim* 1996 (AIR) SC 2426.

¹⁹⁴ *Afrax* fn 65 *supra*

10.6.2 Unlawfulness

The element of wrongfulness or unlawfulness in the context of the law of delict is particularly well placed to accommodate the golden themes of reasonableness, public policy (*boni mores*), fairness and good faith. The courts have openly acknowledged that a determination of wrongfulness requires a value judgment¹⁹⁵. The values of South African society are to be found primarily in the Constitution whilst some writers¹⁹⁶ have argued that the legal convictions of the community at common law are wider than just those principles and values contained in the Constitution it is submitted that only to the extent that common law policy considerations can be regarded as logically and legally consistent extensions of the constitutional values and principles, can they legitimately be applied in deciding claims in the law of delict. Those that contradict constitutional values and principles clearly cannot stand. In the context of health care services, Burchell points out that a person who occupies a special or protective relationship towards another may be under a legal duty to protect that person from harm. For instance a gaoler is under a legal duty to protect a prisoner from being assaulted or to obtain prompt medical treatment for a sick detainee¹⁹⁷. The courts have recognized this principle *inter alia* in the cases of *Magware v Minister of Health NO*¹⁹⁸ and *Dube v Administrator Transvaal*¹⁹⁹.

10.6.3 Medicines and Medical Devices

The subject of medicines and medical devices raises the question of strict liability on the part of manufacturers in the health sector. It has been observed that in the United States strict liability for physical injury to person and property caused by defective products has been the result of long and complicated development and that the most common justification for strict liability is that the manufacturer has created the risk of personal injury or other tangible damage and should, therefore bear the consequences of the creation of the risk²⁰⁰. In South African law the principle enunciated in

¹⁹⁵ See for instance *Aucamp and Others v University of Stellenbosch* 2002 (4) SA 544 (C)

¹⁹⁶ Leinius B and Midgely JR "The Impact of the Constitution on the Law of Delict" (2002) 119 *South African Law Journal (SALJ)* p17

¹⁹⁷ Burchell fn 125 *supra* at p 43

¹⁹⁸ *Magware* 1981 (4) SA 472 (Z)

¹⁹⁹ *Dube* fn 146 *supra*

²⁰⁰ Burchell fn 125 *supra* at p246. He notes that Prosser and Keeton in *Prosser and Keeton on Torts*, p 678 identify four possible theories of recovery under the complexities of products liability law: '(1) strict liability in contract for breach of a warranty, express or implied; (2) negligence liability in contract for breach of an express or implied warranty that the

*Donoghue v Stevenson*²⁰¹ a manufacturer who intends his product to reach the consumer in the form in which it left him, with no reasonable possibility of intervening inspection, owes a duty to take care that the consumer does not suffer injury or loss as a result of using the product still generally prevails and delictual liability is for the most part fault based. In the case of medicines and medical devices their use contrary to the instructions of the manufacturer can have the effect of nullifying a claim in delict on the ground that the fault does not lie with the manufacturer but with the user. Moreover in situations in which medicines and medical devices are administered or applied by someone other than the patient, for example a health professional, the chain of causation and fault that might have led back to the manufacturer can begin and end with the health professional in question. The fact is that health products are not ordinary consumer goods and that their specialized nature complicates matters when it comes to questions of who in the supply chain is liable. Furthermore, medicines do not come with a guarantee of efficacy. Some medicines are more or less effective than others from one individual to another depending upon the infinite number of variations in biochemistry and illness within the human body. One person's medicine may quite literally be another's poison and this through no fault of the manufacturer. Strict liability would be particularly difficult to impose in the context of medicines in the absence of highly specific circumstances where the liability of everyone except the manufacturer can convincingly be ruled out.

In *Wagener v Pharmacare Ltd; Cuttings v Pharmacare Ltd*²⁰² the court considered just these circumstances with regard to a local anaesthetic called Regibloc. It was manufactured by the respondent, it was defective when it left the respondent's control, it was administered in accordance with the respondent's accompanying instructions, it was its defective condition which caused the alleged harm and such harm was reasonably foreseeable. The court observed that if there were strict liability, it would not be open to a manufacturer to rely on proof that it had taken all reasonable care, but then one must ask what real difference that is likely to make. It stated that once there is prima facie proof, direct or circumstantial, that the product was defective at the

product was designed and constructed in a workmanlike manner; (3) negligence liability in tort largely for physical harm to persons and tangible things, and (4) strict liability in tort largely for physical harm to persons and tangible things.”

201 *Donoghue* [1932] AC 562 (HL)

202 *Wagener* 2003 (4) SA 285 (SCA)

various times material to the action, it is virtually inevitable that *res ipsa loquitur* will apply and require an answer from the manufacturer. It said that whilst the maxim comes into play only if the plaintiff's evidence is such that it can be said that the event (in this case, for example, the necrosis) would not ordinarily occur without there having been negligent manufacture (involving, perhaps, some scientific explanation in addition to the mere fact of the injury) it is perfectly conceivable that the courts may develop reasons for being readier in some cases of alleged defective manufacture to draw the necessary *prima facie* inference of negligence where expert evidence is extremely difficult for the plaintiff to acquire, and perhaps even more so where administration of a substance made to be applied to the human body has apparently had an effect quite contrary to the manufacturer's stated aim. The choice of a health professional of a particular medical device or medicine for use on or by a patient cannot be attacked on the basis of fault unless it was unreasonable when compared to the choices of other health professionals practicing the same discipline.

It is submitted with regard to medicines that product liability need not necessarily arise only from the *design* of the drug. This would involve largely patented drugs since generic drugs are not 'designed' to the same degree as much of the development work has already been done by the erstwhile patent holder. There may not be negligent deviation from the formula of the drug so much as negligence in the manufacturing process itself so that certain active ingredients are for instance inadvertently rendered inactive, or that specific storage conditions for the drug, such as refrigeration at a specific temperature, are not followed. No matter how well designed the drug is, manufacturing processes can and do go wrong. Accidents happen on the production line. Contamination of raw materials can occur. The raw materials can be obtained from an inferior source. Insufficient quality guarantees may be obtained by the manufacturer from the supplier of the active pharmaceutical ingredients. It is in recognition of these dangers that the medicines control legislation in South Africa requires manufacturers to comply with what is commonly referred to as GMP or "Good Manufacturing Practice". There is also the question of the indication for which the drug is registered in South Africa. It often happens that drugs are registered for more than one indication in other parts of the world or that new indications for existing drugs are subsequently discovered. The registration process requires approval of registration for specific indications of the drug and not just

blanket registration for every possible indication. The use of the medicine for an indication in respect of which it has not been registered can hardly be blamed upon the manufacturer in the absence of conduct on his part which promotes or advocates such use.

In *Wagener v Pharmacare Ltd; Cuttings v Pharmacare Ltd* the court seemed to prefer the application and even extension of the *res ipsa loquitur* principle to the imposition of strict liability on the manufacturer of a product as being the lesser of two evils²⁰³ However, the predilection of the court in *Pringle v Administrator, Transvaal*²⁰⁴ to apply the doctrine only where the alleged negligence depends on absolutes does not take into account that where the alleged negligence is so dependent upon absolutes it is probably a lot easier for the defendant to produce evidence of negligence in the normal way and the application of the doctrine in such circumstances is likely to be unnecessary in many instances. Part of the reason for the transfer of the evidentiary burden to the defendant by *res ipsa loquitur* is precisely that the plaintiff does not necessarily know what exactly happened and is not necessarily even in a position to identify such 'absolutes'. It is submitted that such an extremely narrow approach defeats the object of the maxim to a large degree since one is effectively saying that the circumstances of the case must be such that there is no significant doubt that there was negligence due to the presence of the 'absolutes' in question.

10.6.4 Delict in the public v the private sector

There is no difference in principle between delicts committed by the state and those committed by private entities or persons. The private sector and the public sector tend to have certain operational differences with regard to the manner in which they render health care services and so in practice different emphases are likely to be placed on different aspects of the law of delict within the two sectors.

²⁰³ *Wagener* 2003 (4) SA 285 (SCA). Howie P stated at p 294: "As regards the problem of proving fault, counsel for the respondent pointed out that even if strict liability were imposed a plaintiff would still have to prove that the product concerned was defective when it left the manufacturer. If that were indeed established, then application of *res ipsa loquitur* would suffice to place the manufacturer on its defence and, in effect, compel an exculpatory explanation, if one existed. In the circumstances it was submitted that proving fault was really no more difficult than proving defectiveness."

²⁰⁴ *Pringle* 1990 (2) SA 379 (W)

Vicarious liability is, for example, of much greater interest to the public sector than the private sector in terms of the risks it poses simply because the public sector employs more kinds of health professionals than does the private sector. Furthermore the state, unlike the private sector does not purchase public liability insurance but self-insures instead which means that there is no sharing of risk by the public sector with other providers of health care services.

The public sector is concerned with the public demand for health care services in a quite different way to the private sector and legal issues involving the rationing of health care services, for instance, are much more likely to be an issue in the public sector than in the private sector.

In the public sector, by contrast, competitive issues are not nearly as significant as they are in the private sector although the sharp divide that once existed between these two sectors in terms of their respective 'turf' is becoming less distinct in that changes to medical schemes legislation allow for the designation by medical schemes of public health facilities as preferred providers and some public hospitals are actively targeting as patients medical scheme members.

In the private sector commercial considerations such as reductions in public liability insurance premiums, are more likely to lead to contractual avoidance of delictual liability whereas in the public sector the courts are likely to invoke the constitutional obligations of the state to strike down attempts at contractual avoidance of such liability.

10.6.5 Conclusions Concerning the Law of Delict

The law of delict in relation to health services delivery has its blind spots. The persistent refusal by the courts to apply the doctrine of *res ipsa loquitur* to claims involving health care services has recently been the subject of a doctoral thesis of its own²⁰⁵. Whilst the Supreme Court of Appeal has demonstrated the same unfortunate

²⁰⁵ See Van den Heever P, unpublished doctoral thesis entitled 'The application of the doctrine of *res ipsa loquitur* to medical negligence actions: A comparative survey' 2002 *University of Pretoria*. He revisits *Van Wyk v Lewis* fn 146

tendencies in the law of delict as it has in the law of contract to ignore the Constitution, the constitutional court has given some promising and enlightened judgments involving the law of delict such as *Carmichele v Minister of Safety and Security and Another (Centre for Applied Legal Studies Intervening)*²⁰⁶. As regards the common law there are a great many more cases involving health care services that have been decided on the basis of the law of delict than on that of the law of contract with the courts displaying an apparent preference for the former where they have a choice. While the same set of facts can give rise to a claim both in terms of the law of delict and for breach of contract under the law of contract, it is preferable given the current weaknesses in the law of contract to have one's claim adjudicated in terms of the law of delict.

Although the law of delict essentially seeks to place the claimant in the position in which he or she found himself prior to the unlawful act or omission whereas the law of contract seeks to place the claimant in the position he or she would have occupied had the contract been fulfilled, in the context of health services delivery this is more often than not, a notional distinction at best since it is a general feature of the law of contract relating to health services delivery that the contract seldom guarantees a specific outcome. There is no implied or express undertaking to cure the patient except in specialised cases such as cosmetic surgery and sterilisation procedures in which the term 'cure' is itself usually inappropriate. Since pain and suffering and non-patrimonial loss are almost an inevitability in cases of breach of contracts for health services, and since the law of contract only recognises and permits damages for patrimonial loss, this is another reason to prefer the law of delict when dealing with claims involving health service delivery. Of course, such a choice is not always possible given that the elements of a delict, namely conduct that is unlawful, blameworthy and causes of damage or injury to property or person. The boundaries between the law of contract and the law of delict are by no means set in stone.

Burchell²⁰⁷ points out that a breach of contract is also a civil wrong but that the traditional approach has been to draw a distinction between a delict and a breach of

supra 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.

²⁰⁶ *Carmichele* fn 144 *supra*

²⁰⁷ Burchell J fn 125 *supra* at p 3

contract in terms of a separate but equal approach. He notes that it was said that a delict consists of a breach of a duty imposed by law independently of the will of the party bound whereas a breach of contract consists of a breach of a duty voluntarily assumed. This distinction, says Burchell, is not entirely satisfactory for a number of reasons not least of which is that it describes a delict solely in terms of a breach of a duty, rather than an infringement of a right or interest. It is submitted that this distinction is clearly not in keeping with the central importance accorded to the concept of rights by the Constitution. Burchell states that the traditional distinction between delict and breach of contract also requires modification in the light of the Appellate Division decision in *Lillicrap, Wassenaar and Partners v Pilkington Bros*²⁰⁸. In his commentary on this case he observes that commentators have been equally consistent in their criticism of the judgment of Grosskopf AJA as they have been in praise of the approach taken by Smuts AJA. The thrust of the criticism of Grosskopf's judgment is that it draws too rigid a line between physical loss and pure economic loss and unduly prevents a desirable confluence of contract and delict. Burchell notes that there are differences between the remedy for breach of contract and for delict but states that where fault is present and no damages for pain and suffering are claimed, there is a major area of potential overlap between the two forms of civil remedy. It is submitted that even the justifications for differences between the two areas of the law in terms of the kinds of damages payable are flimsy enough in certain contexts, such as that of health care services, that one can argue that damages for pain and suffering should be payable in terms of the law of contract where such damages are an inevitable or probable consequence of breach. Burchell suggests that there is a possible and less stringent approach to Grosskopf AJA's reasoning. He asks whether Grosskopf AJA was not merely stating that an infringement of a pure economic loss interest (which may also amount to a breach of contract) *may* be unlawful in delict but is not *per se* unlawful since policy factors may militate against unlawfulness. It is submitted that Lillicrap's case is in a sense at the opposite end of the spectrum to delictual claims involving health services delivery in terms of a contract since in the former the applicant's sought to recover damages for purely patrimonial loss in terms of the law of delict because the claim in contract had prescribed. In the case of the latter the debate concerning the conflation of delictual and contractual remedies is

²⁰⁸ *Lillicrap* 1985 (1) SA 475 (A)

whether damages for non-patrimonial loss should be permitted in terms of the law of contract. It nevertheless illustrates the reluctance of the courts to permit cross-pollination between areas of law. Burchell states that a more helpful definition of a 'delict' is one which states the essence of the type of wrong concerned and which draws a fundamental distinction between criminal and delictual liability, while leaving open the possibility of a confluence of delictual and contractual liability²⁰⁹.

The law of delict is far from static and 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 mores*, has been lauded by more than one academic writer and seems generally to have served the legal system well.

The question of causation is divided into factual and legal causation the latter being concerned with the limitation of liability on public policy principles. The *sine qua non* test generally works quite well in most cases but in situations where there are multiple probable causes that are so entangled that it is impossible to clearly identify a single cause the law of delict becomes more problematic. One solution put forward seems to be based upon the concept joint and several liability but this has been criticised and that there should in such cases be an open departure from the *conditio sine qua non* approach to factual causation. In such cases perhaps only the element of legal causation, as established on the basis of public policy principles, should be the deciding factor. In the health care context where there are a number of different health professionals taking care of a patient situations may arise where it is not always possible to establish whether the actions of a particular individual caused the harm. It is conceivable that the error of one can be compounded or exacerbated by others who should have picked up on it and failed to do so. In such situations the application of the *conditio sine qua non* test may well yield unsatisfactory results and the question of causation may have to be decided on the basis of legal causation alone.

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Burchell fn 125 *supra* suggests at p 10 the following definition: "A delict is an unlawful, blameworthy (i.e. intentional or negligent) act or omission which causes another person damage to person or property or injury to personality and for which a civil remedy for recovery of damages is available." He points out, however, that one disadvantage of this definition is that it does not accommodate an important, fast developing fact of the law of delict – liability based not on fault but strict or no-fault liability.

Whilst the courts in the past²¹⁰ have tended to refer to the right to security of the person as an absolute right this clearly is no longer correct under the present constitutional dispensation. The right to security of the person is now expressed in section 12 of the Constitution and all constitutional rights are relative as was pointed out earlier in this chapter. They are all interdependent and interrelated. Informed consent is essential in order to justify conduct which would ordinarily constitute a violation of the right to freedom and security of the person and bodily and psychological integrity. It is therefore a concept which is totally consistent with these rights and also the right to human dignity in the Constitution. The National Health Act enacts certain provisions which will have the effect of creating statutory requirements for informed consent whereas previously it was a purely common law construct. The provisions in the Act are, however, fairly comprehensive and if anything broaden the common law concept of informed consent in providing that where a person other than the patient has the power to give consent on the patient's behalf, the patient must nevertheless wherever possible be consulted and informed at a level best suited to his or her capacity and understanding of the treatment to be administered and his or her wishes must be taken into account. This is important for the protection, and promotion of the patient's right to human dignity even where the patient is a child or a very old person whose mental faculties may not be what they were in her youth .

10.7 In Conclusion

The law as it relates to health service delivery is clearly a complex and voluminous topic to which a single thesis, no matter how ambitious, can only partially do justice. Nonetheless it has become clear in the course of the journey reflected within this thesis that health care law in its broadest sense, including medical law, is a worthy subject of study, debate and discussion in its own right. The factual context in which law is applied is becoming increasingly important since legal principles considered in the abstract can at best only deliver abstract answers that have no practical relevance for the real world. It is when one contextualises the law, for instance in the area of health care, that one realises its significance and its strengths and weaknesses in that context. Health care law is an internationally recognised subject that is not necessarily

²¹⁰ For instance in *Stoffberg v Elliott* 1923 CPD 148

widely taught or even accepted as a legitimate area of study by some South African universities. This is unfortunate. The law of contract as it relates to information and telecommunication systems, it is submitted, is very different in practical terms to the law of contract as it relates to the media or to health care for the simple reason that the context in which the law is applied cannot be separated from the law itself. Considerations of public policy, of which the law expressly takes cognisance, as is clear from the examination in this thesis of international, constitutional, administrative, contractual and delictual law, can be very different, depending on the context. Furthermore, what is fair and reasonable in a purely commercial context may not be fair and reasonable in a public health context. The view of health care as a public good is at odds with the need of the private health sector to make a profit. Health law straddles commercial law as well as human rights law. Just as there is tension is within international law with regard to the exploitation of intellectual property and trade rights as opposed to international human rights so in health law there is a tension between humanitarian beneficence and the need to make money. Even in the public sector, which is not profit driven, the management of income and expenditure presents a constant headache to health officials who must find ways to optimise the utilisation of resources. There is a significant ethics base with regard to health care that quite possibly has no parallel in any other area of human activity. Since the time of Hippocrates people have discussed and debated the many and varied aspects of health ethics. The ethical aspects of health care must have an influence on the health law to which they are so closely related by way of public policy. After all principles of ethics are in many ways distillations of the *boni mores* or public policy in a particular area.

Health care is an area of many legal interfaces such as the interface between the law of contract and the law of delict or that between constitutional law and the law of contract or that between administrative law and constitutional law or that between the law of delict and constitutional law. The Constitution itself underpins them all. The five areas of law that have been chosen for study are considered not only in terms of their own content but also in terms of their interaction with one another. It is only upon the examination of boundary conditions that many areas of knowledge become meaningful. Health law abounds with boundary conditions. One can study the content of the individual traditional branches of law up to a point but the concept of a legal

system only becomes meaningful when one also examines the friction between its elements and the manner of their interaction. The five areas of law examined in this thesis are the major building blocks for health law in South Africa but one cannot derive a significant understanding of health law by studying them separately. It is only in combining them in the context of health care that one comes up with a legal discipline in its own right. This study of the law of health care thus demonstrates that the whole is more than the sum of its parts.

It has been shown in this thesis that the five areas of law considered are but facets of a larger whole, that they are not discrete and cannot be isolated from the broader underlying constructs that link them all. The crystal lattice that binds and structures them into the greater whole of a legal system consists of the principles and values expressed in the Constitution. The Constitution thus manifests not only as a single facet of the law. It also represents its underlying molecular structure. There is consequently no better way of perceiving its internal harmony and construction than to examine a number of areas of law and the manner in which they interface. A further benefit is that this promotes greater internal consistency within the legal system and strengthens and enriches each of the different facets of law through a process of logical and moral reinforcement by the others. Like most crystals, the law is not perfect. It has its flaws and these have been highlighted as they have emerged from the study embarked upon in this thesis. Like crystals in their natural environment, the law is capable of refinement, growth and development. It is subject to all kinds of environmental pressures and forces. It is a dynamic system. Herein lies hope for positive change and growth and the possibility of remedying the flaws that impair its purity and beauty. For the law is beautiful. It has a certain elegance of logic, a certain rightness of reason, which when correctly understood and applied, is no less entrancing than the constructs of higher mathematics.

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Explanatory Notes on Formatting

1. In the main body of this thesis, the initials of the authors are given only in the first occurrence of the reference within a chapter. Thereafter, only their surnames are used in indicating the reference in the remainder of the chapter since these are cross-referenced to the first occurrence of their names. Their initials are also reflected in the Bibliography below.
2. The year of publication of textbooks is not given in the body due to the fact that, unlike periodicals, these change with much less frequency and are not essential to locating the relevant text and there is enough detail in the footnotes without further complicating them unnecessarily. However, for the sake of completeness the year of publication is given in the Bibliography below.
3. Where a passage from a judgement or textbook is quoted and the quote itself contains references to other materials, the format of these references has not been altered to follow the format in the text of the thesis on the basis that it is a quote and as such must remain unaltered.
4. With regard to journal references their abbreviated names are used in the main body of the text and also in this Bibliography since their full names can be found by referring to the Table of Abbreviations.
5. References to case names appear in the main body of the text in italics except when they are intended as references to the people themselves in which case they appear as regular text: eg *Soobramoney* means the case of *Soobramoney v the Minister of Health, KwaZulu-Natal* while Soobramoney means the applicant in that case.

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| Commissioner For Inland Revenue v Friedman And Others NNO | 1993 (1) SA 353 (A) |
| Community Development Board v Revision Court, Durban Central, and Another | 1971 (1) SA 557 (N) |
| Consol Ltd t/a Consol Glass v Twee Jonge Gezellen (Pty) Ltd And Another | 2002 (6) SA 256 (C) |
| Cook v Aldred | 1909 TS 150 |
| Coppen v Impey | 1916 CPD 309 |
| Coronation Brick (Pty) Ltd v Strachan Construction Co (Pty) Ltd | 1982 (4) SA 371 (N) |
| Couws v Jester Pools (Pty) Ltd | 1968 (3) SA 563 (T) |
| Crawley v Frank Pepper (Pty) Ltd | 1970 (1) SA 29 (N) |
| Crimpers Salon (Pty) Ltd v Thomas | 1981 CPD unreported |
| Crookes, N.O., and Another v Watson and Others | 1956 (1) SA 277 (AD) |
| CTP Ltd and Others v Independent Newspapers Holdings Ltd | 1999 (1) SA 452 (W) |
| Curtaincrafts (Pty) Ltd v Wilson | 1969 (4) SA 221 (E) |



Curtaincrafts (Pty) Ltd v Wilson

1969 (4) SA 221 (E)

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| Da Silva and Another v Coutinho | 1971 (3) SA 123 (A) |
| David Wuhl (Pty) Ltd and Others v Badler and Another | 1984 (3) SA 427 (W); |
| Davis v Additional Magistrate, Johannesburg, and Others | 1989 (4) SA 299 (W) |
| Dawnlaan Beleggings (Edms) Bpk v Johannesburg Stock Exchange and Others, Johannesburg Stock Exchange and Another v Witwatersrand Nigel Ltd and Another | 1983 (3) SA 344 (W) |
| 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) |
| Dawood And Another v Minister Of Home Affairs And Others; Shalabi And Another v Minister Of Home Affairs And Others; Thomas And Another v Minister Of Home Affairs And Others | 2000 (1) SA 997 (C) |
| De Beer v Keyser And Others | 2002 (1) SA 827 (SCA) |
| De Freitas and Another v Society of Advocates of Natal and Another | 2001 (3) SA 750 (SCA) |
| De Klerk v Old Mutual Insurance Co Ltd | 1990 (3) SA 34 (E) |
| De Reuck v Director Of Public Prosecutions, Witwatersrand Local Division, And Others | 2003 (3) SA 389 (W) |
| De Waal v Ziervogel | 1938 AD 112 |
| Delange v Costa | 1989 (2) SA 857 (A) |
| Desai and Others v Greyridge Investments (Pty) Ltd | 1974 (1) SA 509 (A) |
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| Dhanabakium v Subramanian | 1943 AD 160 |
| Dibley v Furter | 1951 (4) SA 73(C) |
| Dippenaar v Shield Insurance Co Ltd | 1979 (2) SA 904 (A) |
| Director of Public Prosecutions:Cape of Good Hope v Bathgate | 2000 (2) SA 535 (C) |
| Distillers Corp Ltd v Modise | 2001 (4) SA 1071 (O) |
| Drewtons (Pty) Ltd v Carlie | 1981 (4) SA 305 (C) |
| Du Bois v Stompdrift-Kamanassie Besproeiingsraad | 2002 (5) SA 186 (C) |
| Du Plessis And Others v De Klerk And Another | 1996 (3) SA 850 (CC) |
| Du Plessis v Semmelink | 1976 (2) SA at 503A |
| Du Preez v Truth and Reconciliation Commission | 1997 (3) SA 204 (A) |
| Dube v Administrator, Transvaal | 1963 (4) SA 260 (W) |
| Duminij v Prinsloo | 1916 OPD 83 |
| Duncan v Minister Of Law And Order | 1986 (2) SA 805 (A) |
| Durban Add-Ventures Ltd v Premier, Kwazulu-Natal, And Others | 2001 (1) SA 389 (N) |
| Durban's Water Wonderland (Pty) Ltd v Botha and Another | 1999 (1) SA 982 (SCA) |
| During NO v Boesak and Another | 1990 (3) SA 661 (A) |
| Durr v Absa Bank Ltd And Another | 1997 (3) SA 448 (SCA) |

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| East London Western Districts Farmers' Association And Others v Minister Of Education And Development Aid And Others | 1989 (2) SA 63 (A) |
| Edelstein v Edelstein NO and Others | 1952 (3) SA 1 (A) |
| Eerste Nasionale Bank Van Suidelike Afrika Bpk v Saayman No | 1997 (4) SA 302 (SCA) |
| Ellis and Others v Laubscher | 1956 (4) SA 692 (A) |
| Epol (Pty) Ltd v Bezuidenhout | 1980 (3) SA 624 (T) |
| Epstein v Epstein | 1906 TH 87 |
| Ericsen v Germie Motors (Edms) Bpk | 1986 (4) SA 67 (A) |
| Eskom v Rini Town Council | 1992 (4) SA 96 (E) |
| Essa v Divaris | 1947 (1) SA 753 (A) |
| Estate Breet v Peri-Urban Areas Health Board | 1955 3 SA 523 (A) |
| Esterhuizen v Administrator Transvaal | 1957 (3) SA 710 (T) |
| Ex parte Chairperson of the Constitutional Assembly: In re: Certification of the Constitution of the Republic of South Africa | 1996 (4) SA 744 (CC) |
| Ex Parte Coetzee Et Uxor | 1984 (2) SA 363 (W) |



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| Ex parte Dixie | 1950 (4) SA 748 (W) |
| Ex Parte Gauteng Provincial Legislature | 1996 (3) SA 165 (CC) |
| Ex parte James | 1954 (3) SA 270 (SR) |
| Ex parte Minister of Safety and Security and Others, In re S v Walters and Another | 2002 (4) SA 613 (CC) |
| Ex parte Minister van Justisie: In re S v Grotjohn | 1970 (2) SA 355 (A) |
| Ex Parte North Central And South Central Metropolitan Substructure Councils Of The Durban Metropolitan Area And Another | 1998 (1) SA 78 (LCC) |
| Ex Parte Oppel And Another | 2002 (5) SA 125 (C) |
| Excell v Douglas, | 1924 CPD 472 |
| Executors of Meyer v Gericke, | 1880 Foord 14 |
| F | |
| Faircape Property Developers (Pty) Ltd v Premier, Western Cape | 2000 (2) SA 54 (C) |
| Fedsure Life Assurance Ltd And Others v Greater Johannesburg Transitional Metropolitan Council And Others | 1999 (1) SA 374 (CC) |
| Ferreira v Levin No And Others; Vryenhoek And Others v Powell No And Others | 1996 (1) SA 984 (CC) |
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| Fiat SA v Kolbe Motors | 1975 (2) SA 129 (O) |
| Fidelity Guards Holdings (Pty) Ltd T/A Fidelity Guards v Pearmain | 2001 (2) SA 853 (SE) |
| Filmer And Another v Van Straaten | 1965 (2) SA 575 (W) |
| Financial Mail (Pty) Ltd And Others v Sage Holdings Ltd And Another | 1993 (2) SA 451 (A) |
| Financial Services Board And Another v De Wet No And Others | 2002 (3) SA 525 (C) |
| FJ Hawkes & Co Ltd v Nagel | 1957 (3) SA 126(W) 132 C |
| Forsyth And Others v Josi | 1982 (2) SA 164 (N) |
| Fose v Minister Of Safety And Security | 1997 (3) SA 786 (CC) |
| Fourie NO v Hansen and Another | 2001 (2) SA 823 (W) |
| Fourie v Santam Insurance Ltd | 1996 (1) SA 63 (T) |
| Frame v Palmer | 1950 (3) SA 340 (C) |
| Frankel Pollak Vinderine Inc v Stanton NO | 2000 (1) SA 425 (W) |
| Frankel v Ohlsson's Breweries | 1909 TS 957 |
| Fredman v Yates | [1923] WLD 9 |
| Friedman v Glicksman | 1996 (1) SA 1134 (W) |
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| Garden Cities Incorporated Association Not For Gain v Northpine Islamic Society | 1999 (2) SA 268 (C) |
| Gardener v East London Transitional Local Council And Others | 1996 (3) SA 99 (E) |
| Gassner No vMinister Of Law And Order And Others | 1995 (1) SA 322 (C) |
| Geddes v Ban Reservoir | 3 AC 430 |
| Gelb v Hawkins | 1960 (3) SA 687 (A) |
| Geldenhuys v Minister Of Safety And Security And Another | 2002 (4) SA 719 (C) |
| George v Fairmead (Pty) Ltd | 1958 (2) SA 465 (A) |
| George v Shimwell Bros | 1910 TPD 890 |
| Gerke NO v Parity Insurance Co Ltd | 1966 (3) SA 484 (W) |
| Gibson v Berkowitz | [1997} 1 All SA 99 (W) |
| Gillespie v Toplis | 1951 (1) SA 290 (C) |
| Girdwood v Girdwood | 1995 (4) SA 698 (C) |
| Glaser v Millward | 1950 (4) SA 587 (W) |
| Gluckman v Schneider | 1936 AD 151 |
| Godfrey v Paruk | 1965 (2) SA 738 (D) |
| Goldie v City Council of Johannesburg | 1948 (2) SA 913 (W) |
| Goodman Brothers (Pty) Ltd v Rennies Group Ltd | 1997 (4) SA 91 (W) |
| Govender v Minister of Safety and Security | 2000 (1) SA 959 (D) |
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| Government of the Republic of South Africa v Fibre Spinners & Weavers (Pty) Ltd | 1978 (2) SA 794 (A) |
| Government Of The Republic Of South Africa v Ngubane | 1972 (2) SA 601 (A) |
| Government of the Self-Governing Territory of KwaZulu v Mahlangu and Another | 1994 (1) SA 626 (T) |
| Grant and Another v Stonestreet and Others | 1968 (4) SA 1 (A) |
| Greater Johannesburg Transitional Metropolitan Council v Eskom | 2000 (1) SA 866 SCA |
| Grobler NO v Boikhutsong Business Undertaking (Pty) Ltd and Others | 1987 (2) SA 547 (BG) |
| Groenewald v Groenewald | 1998 (2) SA 1106 (A) |
| Grootboom v Graaff-Reinet Municipality | 2001 (3) SA 373 (E) |
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| Hack v Venterspost Municipality and Others | 1950 (1) SA 172 (W) |
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| Hamman v Malmesbury D.C. | 1916 CPD 216 |
| Hamman v Moolman | 1968 (4) SA at 348E |
| Harksen v Attorney-General, Cape, And Others | 1999 (1) SA 718 (C) |
| Harper v Webster | 1956 (2) SA 495 (FC) |
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| Hay v The Divisional Council of King William's Town | (1880) 1 EDC 97 |
| Helgesen v SA Medical and Dental Council | 1962 (1) SA 800 (N) |
| Hepner v Roodepoort-Maraisburg Town Council | 1962 (4) SA 772 (A) |
| Hepworth Ltd v Snelling, | 1962 (2) P.H. A.48 |
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| Hermer v Fisher and Others | 1960 (2) SA 650 (T) |
| Hewatt v Rendel | 1925 TPD 679 |
| Hleka v Johannesburg City Council | 1949 (1) SA 842 (A) |
| Hoffa NO v SA Mutual Fire & General Insurance Co Ltd | 1965 (2) SA 944 (C) |
| Holmdene Brickworks (Pty) Ltd v Roberts Construction Co Ltd | 1977 (3) SA 670 (A) |
| Holomisa v Argus Newspapers Ltd | 1996 (2) SA 588 (W) |
| Honey & Blanckenberg v Law | 1966 (2) SA at 46 |
| Horty Investments (Pty) Ltd v Interior Acoustics (Pty) Ltd | 1984 (3) SA 537 (W) |
| Humphrys v Laser Transport Holdings Ltd and Another | 1994 (4) SA 388 (C) |
| I | |
| In re Knoop | 10 SC 198 |
| Independent Municipal And Allied Trade Union and Others v MEC: Environmental Affairs, Developmental Social Welfare And Health, Northern Cape Province, And Others | 1999 (4) SA 267 (NC) |
| Inkatha Freedom Party And Another v Truth And Reconciliation Commission And Others | 2000 (3) SA 119 (C) |
| International Shipping Co (Pty) Ltd v Bentley | 1990 (1) SA 680 (A) |
| Inter-Science Research and Development Services (Pty) Ltd v Republica Popular de Mocambique | 1980 (2) SA 111 (T) |
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| Investments CC and Others v Minister of Safety and Security and Others | 1997 (7) BCLR 925 (E) |
| Iscor Pension Fund v Marine and General Trade Insurance Co Ltd | 1961 (1) SA 178 (T) |
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| J De Moor (Edms) Bpk v Beheerliggaam Van Outeniqua 75/80 | 1985 (3) SA 997 (T) |
| Jackson v SA National Institute For Crime Prevention And | 1976 (3) SA 1 (A) |



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| Jackson v SA National Institute for Crime Prevention and Rehabilitation of Offenders | 1976 (3) SA 1 (A) |
| Jacobson v Carpenter-King | 1998 TPD unreported |
| Jaffe & Co (Pty) Ltd v Bocchi and Another | 1961 (4) SA 358 (T) |
| Jaga v Dönges N.O. and Another | 1950 (4) SA 653 (A) |
| Jajbhay v Cassim | 1939 AD 537 |
| Janse Van Rensburg No And Another v Minister Of Trade And Industry And Another NNO | 2001 (1) SA 29 (CC) |
| Jansen van Vuuren v Kruger | 1993 (4) SA 842 (A) |
| Jayiya v Member Of The Executive Council For Welfare, Eastern Cape, And Another | 2004 (2) SA 611 (SCA) |
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| Jockie v Meyer | 1945 AD 354 |
| Jodaiken v Jodaiken | 1978 (1) SA 784 (W) |
| Joel Melamed And Hurwitz v Cleveland Estates (Pty) Ltd; Joel Melamed And Hurwitz v Vorner Investments (Pty) Ltd | 1984 (3) SA 155 (A) |
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| Jones v Krok | 1996 (1) SA 504 (T) |
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| Kemp And Another v Republican Press (Pty) Ltd | 1994 (4) SA 261 (E) |
| Kempston Hire (Pty) Ltd v Snyman | 1988 (4) SA 371 (SE) |
| Kern Trust (Edms) Bpk v Hurter | 1981 (3) SA 607 (C) |
| Khala v Minister of Safety and Security | 1994 (4) SA 218 (W) |
| Khumalo and Others v Holomisa | 2002 (5) SA 401 (CC) |
| Kidson v SA Associated Newspapers Ltd | 1957 (3) SA 461 (W) |
| Kleyenstrüber v Barr And Another | 2001 (3) SA 672 (W) |
| Klopper En Andere NNO v Engelbrecht En Andere NNO | 1998 (4) SA 788 (W) |
| Knight v Hemming | 1959 (1) SA 288 (FC) |
| Knop v Johannesburg City Council | 1995 (2) SA 1 (A) |
| Knox D'Arcy Ltd and Another v Shaw and Another | 1996 (2) SA 651 (W) |
| Kotze en Genis (Edms) Bpk en 'n Ander v Potgieter en Andere | 1995 (3) SA 783 (C) |
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| Kritzinger v Steyn En Andere | 1997 (3) SA 686 (C) |
| Kroonstad Westelike Boere Ko-operatiewe Vereeniging Bpk v Botha and Another | 1964 (3) SA 561 (A) |
| Kruger v Boltman | 1933 (1) PH A3 |
| Kruger v Coetzee | 1966 (2) SA 428 (A) |
| Kwele v Rondalia Assurance Corporation of SA Ltd | 1976 (4) SA 149 (W) |

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| La Grange v Schoeman And Others | 1980 (1) SA 885 (E) |
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| Lampert v Hefer N.O. | 1955(2) SA 507 (A) |
| Lamprecht and Another v McNeillie | 1994 (3) SA 665 (A) |
| Landmark Real Estate (Pty) Ltd v Brand | 1992 (3) SA 983 (W) |
| Langeberg Voedsel Bpk v Sarculum Bpk | 1996 (2) SA 565 (A) |
| Larbi-Odam and Others v Member of the Executive Council for Education (North-West Province) and Another | 1998 (1) SA 745 (CC) |
| Latham v Sher | 1974 (4) SA 687 |
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| Le Roux v Visser | [191 1] EDL 381 |
| Levy NO and Another v Schwartz NO and Others | 1948 (4) SA 930 (W) |



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| Lillicrap, Wassenaar and Partners v Pilkington Brothers (SA) (Pty) Ltd | 1985 (1) SA 475 (A) |
| Lower Umfolosi District War Memorial Hospital v Lowe | 1937 TPD 31 |
| Lowe v Johnstone | [1907] TS 1069 |
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| Lymbery v Jefferies | 1925 AD 236 |
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| M G Holmes (Pty) Ltd v National Transport Commission And Another | 1951 (4) SA 261 (T) |
| Mabaso v Felix | 1981 (3) SA 865 (A) |
| Macala v Maokeng Town Council | 1993 (1) SA 434 (A) |
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| Macleod v Rens | 1997 (3) SA 1039 (E) |
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| Maharaj v Chairman, Liquor Board | 1997 (1) SA 273 (N) |
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| Malilang and Others v MV Houda Pearl | 1986 (2) SA 714 (A) |
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| Maqungu And Another v Assistant Magistrate, Whittlesea, And Another | 1977 (2) SA 359 (E) |
| Marais v Edelman | 1934 CPD 212 |
| Marais v Richard en 'n ander | 1981 (1) SA 1157 (A) |
| Marine & Trade Insurance Co Ltd v F Katz NO | 1979 (4) SA 961 (A) |
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| McCain Frozen Foods (Pty) Ltd v Beestepan Boerdery (Pty) Ltd | 2003 (3) SA 605 (T) |
| McCann v Goodall Group Operations (Pty) Ltd | 1995 (2) SA 718 (C) |
| McMurray v H L & H (Pty) Ltd | 2000 (4) SA 887 (N) |
| McMurray v H L & H (Pty) Ltd | 2000 (4) SA 887 (N) |
| Mcnally v M & G Media (Pty) Ltd And Others | 1997 (4) SA 267 (W) |
| Meaker NO v Roup, Wacks, Kaminer & Kriger and Another | 1987 (2) SA 54 (C) |
| Medforum Hospitaal (Edms) Bpk v Departementshoof, Departement Gesondheid en Welsyn: Administrasie Volksraad en Andere | 1994 (4) SA 852 (T) |
| Meskin NO v Anglo-American Corporation of SA Ltd and Another | 1968 (4) SA 793 (W) |
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| Michael & Another v Linksfeld Park Clinic (Pty) Ltd & Another | 2001 (3) SA 1188 (SCA) |
| Midway Two Engineering & Construction Services v Transnet Bpk | 1998 (3) SA 17 (SCA); |
| Miller And Another NNO v Dannecker | 2001 (1) SA 928 (C) |
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| Minister Of Finance And Others v EBN Trading (Pty) Ltd | 1998 (2) SA 319 (N) |
| Minister of Forestry v Quathlamba (Pty) Ltd | 1973 (3) SA 69 (A) |
| Minister of Health and Another v Maliszewski and Others | 2000 (3) SA 1062 (SCA) |
| Minister of Health and others v Treatment Action Campaign and Others (No 2) | 2002 (5) SA 721 (CC) |
| Minister Of Home Affairs v Eisenberg & Associates: In Re Eisenberg & Associates v Minister Of Home Affairs And Others | 2003 (5) SA 281 (CC) |
| Minister of Justice v Hofmeyr | 1992 (3) SA 108 (C) |



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| Minister of Land Affairs and Another v Slandien and Others | 1999 (4) BCLR 421 (LCC) |
| Minister of Law and Order and Others v Hurley and Another | 1986 (3) SA 568 (A) |
| Minister of Law and Order v Kadir | 1995 (1) SA 303 (A) |
| Minister of Law and Order v Ngobo | 1992 (4) SA 822 (A) |
| Minister of Police v Chetty | 1977 (2) SA 885 |
| Minister of Police v Mbilini | 1983 (3) SA 705 (A) |
| Minister of Police v Rabie | 1986 (1) SA 117 (A) |
| Minister of Police v Skosana | 1977 (1) SA 31 (A) |
| Minister of Safety and Security and Another v Gaqa | 2002 (1) SACR 654 (C) |
| Minister of Safety and Security and Another v Xaba | 2003 (2) SA 703 (D) |
| Minister Of Safety And Security v Van Duivenboden | 2002 (6) SA 431 (SCA) |
| Minister of the Interior and Another v Mariam | 1961 (4) SA 740 (A) |
| Minister van Landbou-Tegniese Dienste v Scholtz | 1971 (3) SA 188 (A) |
| Minister van Onderwys en Kultuur en Andere v Louw | 1995 (4) SA 383 (A) |
| Minister van Polisie en 'n Ander v Gamble en 'n Ander | 1979 (4) SA 759 (A) |
| Minister van Polisie v Ewels | 1975 (3) SA 590 (A) |
| Minister van Wet en Orde v Matshoba | 1990 (1) SA 280 (A) |
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| Mkhatswa v Minister Of Defence | 2000 (1) SA 1104 (SCA) |
| Moaki v Reckitt & Colman (Africa) Ltd | 1968 (3) SA 98 (A) |
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| Moore v Minister of Posts and Telegraphs | 1949 (1) SA 815 (A) |
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| Mort No v Henry Shields-Chiat | 2001 (1) SA 464 (C) |
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| Mouton v Die Mynwerkersunie. | 1977 (1) SA 119 (A) |
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| Mthembu v Letsela and Another | 1998 (2) SA 675 (T) |
| Mufamadi And Others v Dorbyl Finance (Pty) Ltd | 1996 (1) SA 799 (A) |
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| Mukheiber v Raath And Another | 1999 (3) SA 1065 (SCA) |
| Muller v Mutual And Federal Insurance Co Ltd And Another | 1994 (2) SA 425 (C) |
| Muller v Pam Snyman Eiendoms-konsultante (Pty) Ltd | 2001 (1) SA 313 (C) |
| Multilateral Motor Vehicle Accidents Fund v Meyerowitz | 1995 (1) SA 23 (C) |
| Mutual and Federal Insurance Co Ltd v Swanepoel | 1988 (2) SA 1 (A) |
| Mutual Life Insurance Company of New York v Ingle | 1910 TPD 540 |
| Mzeku and Others v Volkswagen SA (Pty) Ltd and Others | 2001 (4) SA 1009 (LAC) |
| Nasionale Behuisingskommissie v Greyling | 1986 (4) SA 917 (T) |
| National Chemsearch (SA) (Pty) Ltd v Borrowman and Another | 1979 (3) SA 1092 (T) |
| National Coalition For Gay And Lesbian Equality And Another v Minister Of Justice And Others | 1999 (1) SA 6 (CC) |

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| National Coalition of Gay and Lesbian Equality v Minister of Justice | 1991 (1) SA 6 (CC) |
| National Media and Others v Bogoshi | 1998 (4) SA 1196 (SCA) |
| National Media Ltd And Another v Jooste | 1996 (3) SA 262 (A) |
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| Neethling v Du Preez And Others; Neethling v The Weekly Mail And | 1994 (1) SA 708 (A) |



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| Neuhoff v York Timbers Ltd | 1981(4) SA 666 (T) |
| New Heriot Mining Co v Union Government | 1916 AD 421 |
| New National Party of South Africa v Government of the Republic of South Africa and Others | 1999 (3) SA 191 (CC) |
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| Newman v Prinsloo and Another | 1973 (1) SA 125 (W) |
| Ngema v Minister of Justice, KwaZulu | 1992(4) SA 349 (N) |
| Novick v Benjamin | 1972 (2) SA 842 (A) |
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| Ocean Accident and Guarantee Corporation Ltd v Koch | 1963 (4) SA 147 (A) |
| Odendaal v Bethlehem Romery Bpk | 1954 (3) SA 370 (O) |
| O'Keeffe v Argus Printing & Publishing Co Ltd | 1954 (3) SA 244 (C) |
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P

| | |
|--|------------------------|
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| Phato v Attorney-General, Eastern Cape, And Another; Commissioner | 1995 (1) SA 799 (E) |



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| Q | |
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| R | |
| R v Baxter | 1929 EDL 189 |
| R v Canestra | 1951 (2) SA 317 (A) |
| R v Chipesa | 1964 (4) SA 472 (SRA) |
| R v Damascus | 1965 (4) SA 598 (SR) |
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| R v Du Plessis | 1950 (1) SA 297 (O) |
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| R v Makali | 1950 (1) SA 340 (N) |
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| R v Nel | 1921 AD 339 |
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| R v Rossouw | 1960 (3) SA 326 (T) |



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| R v Van der Merwe | 1950 (4) SA 124 (O) |
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| R v Victor | 1943 TPD 77 |
| R v Werner | 1947 (2) SA 823 |
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| R. v Makali | 1950 (1) SA 340 (N) |
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| Republic of South Africa v Fibre Spinners & Weavers (Pty) Ltd | 1978 (2) SA 794 (A) |
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| Rex v Jack, | 1908 T.S. 131 |
| Rex v Jolly and Others, | 1923 AD 176 |
| Rex v Kelamon, | 14 S.C. 329 |
| Rex v Umfaan, | 1908 TPD 62 |
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| Roberts NO v Northern Assurance Co Ltd | 1964 (4) SA 531 (D) |
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| Ryland v Edros | 1997(2) SA 690 (C) |
| S | |
| S v A and Another | 1971 (2) SA 293 (T) |
| S v Adams | 1979 (4) SA 793 (T) |
| S v Adams S v Werner | 1981 (1) SA 187 (A) |
| S v Alfeus | 1979 (3) SA 145 (A) |
| S v Banda and Others | 1989 (4) SA 519 (BG) |
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| S v Bezuidenhout | 1964 (2) SA 651 (A) |



| | |
|--|-----------------------|
| S v Bochris Investments (Pty) Ltd | 1988 (1) SA 861 (A) |
| S v Boshoff and Others | 1981 (1) SA 393 (T) |
| S v Botha en Andere 1994 (4) SA 799 (W); Bezuidenhout v Bezuidenhout | 2003 (6) SA 691 (C) |
| S v Bradbury | 1967 (1) SA 387 (A) |
| S v Daniëls en 'n Ander | 1983 (3) SA 275 (A) |
| S v De Bellocq | 1975 (3) SA 538 (T) |
| S v de Bellocq | (1968) unreported |
| S v Dobson | 1993 (4) SA 55 (E) |
| S v Dodo | 2001 (3) SA 382 (CC) |
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| S v Gaqa | 2002 (1) SACR 654 (C) |
| S v Goliath | 1972 (3) SA 1 (A) |
| S v Harksen; Harksen v President of the Republic of South Africa and Others; Harksen v Wagner No and Another | 2000 (1) SA 1185 (C) |
| S v Hartmann | 1975 (3) SA 532 (C) |
| S v Jana | 1981 (1) SA 671 (T) |
| S v Johnson | 1969 (1) SA 204 (A) |
| S v Jordan And Others (Sex Workers Education And Advocacy Task Force And Others As Amici Curiae) | 2002 (6) SA 642 (CC) |
| S v Julius | 1984 (2) SA 480 (O) |
| S v Kibi | 1978 (4) SA 173 (E) |
| S v Kramer | 1987 (1) SA (N) |
| S v Lawrence; S v Negal; S v Solberg | 1997 (4) SA 1176 (CC) |
| S v Mahomed and Another | 1938 AD |
| S v Makwanyane and Another | 1995 (3) SA 391 (CC) |
| S v Manamela and Another (Director-General of Justice Intervening) | 2000 (3) SA 1 (CC) |
| S v Marengo | (1990) unreported |
| S v Marx | 1962 (1) SA 848 (N) |
| S v McBride | 1979 unreported |
| S v Mhlungu & Others | 1995 (3) SA 867 (CC) |
| S v Mkwetshana | 1965 (2) SA 493 (N) |
| S v Mokgethi en Andere | 1990 (1) SA 32 (A) |
| S v Mtetwa | 1977 (3) SA 628 (E) |
| S v Mxhosa | 1986 (1) SA 346 (C) |
| S v Ndamase | 1979 (3) SA 346 (N) |
| S v Petane | 1988 (3) SA 51 (C) |
| S v Petersen en Andere | 1980 (1) SA 938 (A) |
| S v Peveritt | 1940 AD 213 |
| S v Pretorius | 1975 (2) SA 85 (SWA) |
| S v Progress Dental Laboratory(Pty) Ltd And Another | 1965 (3) SA 192 (T) |
| S v Rabodila | 1974 (3) SA 324 (O) |
| S v Ramagaga | 1965 (4) SA 254 (O) |
| S v Robinson and Others | 1968 (1) SA 666 (AD) |
| S v Stellmacher | 1983 (2) SA 181 (SWA) |
| S v Tarajka Estates (Edms) Bpk en Andere | 1963 (4) SA 467 (T) |
| S v V | 1972 (3) SA 611 (AD) |
| S v van Rensburg | 1987 (3) SA 35 (T) |
| S v Williams | 1986 (4) SA 1188 (A) |
| S v Xaba | 2003 (2) SA 703 |
| S v Zuma and Others | 1995 (2) SA 642 (CC) |
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| SA Medical and Dental Council v McLoughlin | 1948 (2) SA 355 (A) |
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|---|------------------------|
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| Savvides v Savvides and Others | 1986 (2) SA 325 (T) |
| Schnellen v Rondalia Assurance Corporation of South Africa | 1969 (1) SA |
| Scholtz v Thompson | 1996 (2) SA 409 (C) |
| Schoonbee And Others v MEC For Education, Mpumalanga And Another | 2002 (4) SA 877 (T) |
| Schultz v Butt | 1986 (3) SA 667 (A) |
| Schutte v Schutte | 1986 (1) SA 872 (A) |
| Sea Harvest Corporation (Pty) Ltd and Another v Duncan Dock Cold Storage (Pty) Ltd and Another | 2000 (1) SA 827 (SCA) |
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| Seetal v Pravitha and Another NO | 1983 (3) SA 827 (D) |
| Sentrachem Ltd v Prinsloo | 1997 (2) SA 1 (A) |
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| Silva's Fishing Corporation (Pty) Ltd v Maweza | 1957 (2) SA 256 (A) |
| Silver v Premier Gauteng Province Government | 1998 (4) SA 569 (W) |
| Siman & Co (Pty) Ltd v Barclays National Bank Ltd | 1984 (2) SA 888 (A) |
| Simon's Town Municipality v Dews And Another | 1993 (1) SA 191 (A) |
| Simonlanga and Others v Masinga and Others | 1976 (2) SA 732 (W) |
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| Spes Bona Bank Ltd v Portals Water Treatment South Africa (Pty) Ltd | 1983 (1) SA 978 (A) |
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| Stacey v Kent | 1995 (3) SA 344 (E) |
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| Steyn v LSA Motors Ltd | 1994 (1) SA 49 (A) |
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| T | |
| T Marsden v National Employers General Insurance Company Limited | case No 7992/88, delivered in the WLD on 24 September 1990 |
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| Ten Brink No And Another v Motala And Others | 2001 (1) SA 1011 (D) |
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| The State v Sikunyana And Others | 1961 (3) SA 549 (E) |
| The State v Sikunyana And Others | 1961 (3) SA 549 (E) |
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| Tsose v Minister of Justice and Others | 1951 (3) SA 10 (A) |
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U

| | |
|--|---------------------|
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V

| | |
|---|---------------------------------------|
| V v V | 1998 (4) SA 169 (C) |
| Van Biljon and Others v Minister of Correctional Services | 1997 (4) SA 441 (C) |
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| Van den Berg v Tenner | 1975 (2) SA 268 (A) |
| Van der Berg v Coopers & Lybrand Trust (Pty) Ltd and Others | 2001 (2) SA 242 (SCA) |
| Van der Merwe v Kenkes (Edms) Bpk | 1983 (3) SA 909 (T) |
| Van Der Merwe v Smith NO en 'n Ander | 1999 (1) SA 926 (C) |
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| Van Heerden and Another v Joubert NO and Others | 1994 (4) SA 793 (A) |
| Van Oudtshoorn v Northern Assurance Co Ltd | 1963 (2) SA 642 (A) |
| Van Rensburg v South African Post Office Ltd | 1998 (10) BCLR 1307 (A) |
| Van Rooyen And Others v The State And Others (General Council Of The Bar Of South Africa Intervening) | 2002 (5) SA 246 (CC) |
| Van Wyk v Hermanus Municipality | 1963 (4) SA 285 (C) |
| Van Wyk v Lewis | 1924 AD 438 |
| Van Wyk v Thrills Incorporated (Pty) Ltd | 1978 (2) SA 614 (A) |
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| Venter and Others v Credit Guarantee Insurance Corporation of Africa Ltd and Another | 1996 (3) SA 966 (A) |
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W

| | |
|---|-----------------------|
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| Wagener v Pharmacare Ltd; Cuttings v Pharmacare Ltd | 2003 (4) SA 285 (SCA) |
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| Webb v Isaac | 1915 EDL 273 |
| Webranchek v L K Jacobs and Co Ltd | 1948 (4) SA 671 (A) |
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|--|-----------------------|
| Weinerlein v Goch Buildings Ltd | 1925 AD 282 |
| Wells v Alumenite Co | 1927 AD 69 |
| Whittaker v Roos | 1912 AD 131 |
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| Wohlman v Buron | 1970 (2) SA 760 (C) |
| Wolman and Others v Wolman | 1963 (2) SA 452 (A) |
| Wright v Wright | 1978 (3) SA 47 (E) |

X

| | |
|--|---------------------|
| Xenopoulos And Another v Standard Bank Of SA Ltd And Another | 2001 (3) SA 498 (W) |
|--|---------------------|

Z

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| Zantsi v the Council of State (Ciskei) and Others, | 1995 (4) SA 615 (CC) |
| Zysset and Others v Santam Ltd | 1996 (1) SA 273 (C) |



Table of Cases (Foreign)

A

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TABLE OF STATUTES

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B

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C

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Companies Act No 61 of 1973
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Correctional Services Act No 111 of 1998

D

Dental Technicians Act No 19 of 1979
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E

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H

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I

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L

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M

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N



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O

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P

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R

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