THE INVOLUNTARY DETENTION AND ISOLATION OF PATIENTS INFECTED WITH EXTREME RESISTANT TUBERCULOSIS (XDR-TB): IMPLICATIONS FOR PUBLIC HEALTH, HUMAN RIGHTS AND INFORMED CONSENT

Minister of Health, Western Cape v Goliath 2009 2 SA 248 (C)

1 Introduction

Public health-care providers (public hospitals) and related health-care services in South Africa have in recent times been under severe strain due to the seemingly uncontrollable increase in dangerous infectious airborne diseases like Extreme Resistant Tuberculosis (hereinafter "XDR-TB"). Ultimately these health-care providers/services have been challenged, not only in the diagnosis and treatment of XDR-TB patients, but specifically to control and curtail the spread thereof by effectively managing sufferers by way of forced isolation and monitoring to ensure that they abide by the rules and strict treatment regime related to XDR-TB. The said challenge has become exacerbated specifically in public health-care facilities where patients suffering from XDR-TB fail to abide by the treatment regime and regularly abscond from follow-up appointments, posing a real threat of infection to the community at large. Consequently public health-care providers and communities have increasingly questioned whether it is possible to invoke some mechanism legally whereby the involuntary isolation of patients with XDR-TB in State-funded health-care facilities could be effected. It goes without saying that such a mechanism (by way of a court order/court authorisation) would have a definite and marked influence on a patient's right to bodily integrity and freedom (as contemplated in s 12 of the Constitution of the Republic of South Africa, 1996) and will pose significant challenges to any constitutional limitation (as contemplated in s 36) and related legislation (such as the National Health Act 61 of 2003). Ultimately the question under consideration is whether the public's right to be protected from potentially dangerous infectious diseases constitutionally trumps the right of an individual sufferer to bodily integrity. It is in this regard that the present case under discussion offers far-reaching perspectives (see the instructive article by Van Wyk "Tuberculosis and the limitation of Rights in South Africa" 2009 *THRHR* 92ff; see also Department of Health *Draft National Infection Prevention and Control Policy for TB MDR-TB and XDR-*

TB April 2007; see in general Editorial "XDR-TB – A Global Threat" 2006 *The Lancet* 964; and Blum and Talib "Balancing Individuals' Rights Versus Collective Good in Public Health Enforcement" 2006 *Medicine and Law* 273ff).

2 The facts

The salient facts of the case appear from the judgment of Griesel J: The applicant (the Provincial Minister of Health of the Western Cape) applied in the Cape High Court for an order that the first and fourth respondents (the respondents), both XDR-TB sufferers, be admitted to the Brooklyn Chest Hospital; that they remain there and that they abide by the rules of behaviour for XDR tuberculosis patients at the said hospital. The court issued a *rule nisi* to this effect. The respondents counter-applied for an order declaring their detention inconsistent with their right to freedom in section 12 (the right to bodily integrity) of the Constitution. It is to be noted that after the papers were served on the respondents and they were duly readmitted to the facility, answering affidavits together with a counter-application were delivered on their behalf. (Sadly, two of the four respondents originally cited – the second and third respondents – have succumbed to the disease since the launch of these proceedings). In their counter-application the respondents joined as fifth to eighth respondents the National Minister of Health, the Minister for Justice and Constitutional Development (incorrectly cited as the "Minister of Justice"), the South African Social Security Agency (SASSA) and the Minister of Social Welfare and Development. In their counter-application, the first and fourth respondents sought an order declaring their detention to be inconsistent with their right to personal freedom as enshrined in section 12 of the Constitution. They also sought further declaratory relief and a structural interdict. The court referred to the first and fourth respondents in the main application collectively as "the respondents" and to the other respondents in the counter-application by their official designations (see par [1] to [7] of judgment).

3 The judgment

3 1 Judicial recognition of the clinical manifestation of XDR-TB

The court deemed it firstly necessary to explain the clinical manifestation of XDR-TB. In this regard it was noted that tuberculosis is an airborne disease caused by the micro-organism *Mycobacterium tuberculosis*. The disease is a communicable one and, where it affects the lungs – which happens in about 75 % of cases – then the disease may be transmitted through infectious droplets which are produced whenever the infected person coughs, sneezes, spits or sings. Categories of persons particularly susceptible to contracting tuberculosis include children younger than 5 years, patients who are HIV-positive, as well as patients with a range of other conditions which

affect the immune system and result in higher susceptibility to tuberculosis infection, such as, *inter alia*, diabetics, alcoholics and patients on steroids.

The court further considered the medical evidence that tuberculosis can be divided into drug-sensitive tuberculosis and drug-resistant tuberculosis. Multi-drug-resistant tuberculosis (MDR-TB) is resistant to what is known as the first-line drugs, whereas XDR-TB is an extension of MDR-TB and is resistant, in addition, to certain further drugs. The principles of treatment for MDR-TB and for XDR-TB are the same, the main difference being that XDR-TB is associated with a much higher mortality rate than MDR-TB because of a reduced number of effective treatment options. With regard to the undisputed medical evidence it was ruled that it is clear that XDR-TB is a highly infectious and dangerous disease, having been described as "a serious global health threat" where prevention and deterrence, rather than treatment after the fact, are of prime importance.

With regard to the official management of XDR-TB in South Africa, the court found that this aspect was addressed through detailed "Policy Guidelines" issued in July 2007 by the *Director: Tuberculosis Control in the National Department of Health*. This policy, which draws heavily from the World Health Organisation (WHO) Guidelines, is currently implemented by the province and at the said hospital. As XDR-TB patients have a much reduced chance for cure and a very high risk of premature death, the guidelines are imperative: management of these cases should be prioritised using the same basic principles as those for MDR-TB. XDR-TB patients must be hospitalized, preferably at the MDR-TB referral centres, where additional infection control measures such as isolation facilities should be provided.

In assessing the Brooklyn Chest Hospital as an appropriate medical facility, the court observed that this facility is at present the only dedicated public-health facility in Cape Town that treats XDR-TB patients. The facility specialises in the treatment of tuberculosis and is staffed by specialist medical practitioners skilled in the treatment of XDR-TB. The treatment lasts for between 18 and 24 months, consisting of the administration of a minimum of five drugs at a total cost (in respect of the required drugs) of approximately R63 000 per patient. Sputum conversion from positive to negative in XDR-TB patients is regarded as an indication of successful treatment. Once sputum culture conversion has occurred for three consecutive cultures, taken at monthly intervals, the patient is at minimal risk of transporting the disease, and the disease can be managed on an outpatient basis. The court found that the said policy guidelines indicate that all patients with XDR-TB should have their treatment initiated in hospital because of the toxicity of the drugs, the monitoring and management of side effects, and protection from indiscriminate prescribing to avoid further and even more resistant strains of tuberculosis. However, it was borne out by the undisputed evidence that the majority of XDR-TB patients – including the present respondents – have a history of irresponsible compliance with TB treatment. According to Griesel J this gives rise to the dilemma as to how the

objectives of the policy guidelines are to be achieved where the patients are not willing to submit to voluntary isolation and treatment (see par [8] to [14] of the judgment).

3 2 The issues

The court crisply distilled the issues to be adjudicated by stating that it is undisputed that the compulsory isolation of the respondents at the facility amounts to a deprivation of freedom. *The first question for decision is whether such deprivation is "arbitrary" or "without just cause", juxtaposed against the principle that the limitation on the freedom of movement of patients with infectious diseases is reasonable and justifiable in "an open and democratic society based on human dignity, equality and freedom", as contemplated by section 36(1) of the Constitution* (see par [19] and [21] of the judgment) (own emphasis).

The second question to be adjudicated upon relates to the nature and scope of the legal framework applicable to the respondents' submission that *in the present state of the law in South Africa, there is "no constitutionally valid statutory basis for the arrest and the detention of persons such as the respondents"* (see par [22] of the judgment) (own emphasis).

The third issue dealt with the merits of the counter-application lodged by the respondents (see par [32] of the judgment).

3 3 The ruling

In dealing with the first issue, that the deprivation of the freedom of the said patients was in fact "arbitrary or without just cause" when pitted against the provisions of section 36 of the Constitution, the court answered the question in the negative. In fact, it was stated that in the light of the authorities, it is abundantly clear that, in principle, the limitation on the freedom of movement of patients with infectious diseases is reasonable and justifiable in "an open and democratic society based on human dignity, equality and freedom", as contemplated by section 36(1) of the Constitution. In this regard the court relied on Article 12 of the UN International Covenant on Civil and Political Rights; Article 25 of the Siracuse Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights 5(5); Article 5 of the European Convention on Human Rights (1950); The Ontario Health Protection and Promotion Act 7(7); section 14(1) of the Constitution of Ghana of 1992 (by way of comparison in terms of other foreign law); and Article 6 of the African Charter on Human and Peoples' Rights (1981/1986). All the mentioned instruments justify limitations to individual freedom for the protection of the public health/interest. In particular the court considered and was swayed by an authoritative article by Singh, Upshur and Padayatchi "XDR-TB in South Africa" 2007 *Public Library of Science* 4 (http://medicine.plosjournals.org), wherein the authors persuasively argue (with reference to various authorities) that the use of involuntary detention may legitimately be

countenanced as a means to assure isolation and prevent infected individuals possibly spreading infection to others (see par [19] of the judgment).

The court then proceeded to deal with the applicable legal framework to assess the respondents' submission that there is no constitutionally valid statutory basis for the arrest and detention of XDR-TB sufferers. In this regard Griesel J considered the applicant's founding affidavit wherein reliance is mainly placed on the provisions of section 7 of the National Health Act 61 of 2003. The said provision reads, *inter alia*, "that a health service may not be provided to a user without the user's informed consent (s 7(1)), *unless it is authorised in terms of any law or court order* (s 7 (1)(c)) or *failure to treat the user, or group of people which include the user, will result in a serious risk to public health …* (s 7(1)(d))". In dismissing the respondents' submission, as stated, the court invoked the *Regulations Relating to Communicable Diseases and the Notification of Notifiable Medical Conditions* (published in terms of ss 32, 33 and 34 of the previous Health Act, as well as s 1 of the National Health Act 61 of 2003 (in context of the definition of "health service")), by applying a purposive approach to the provisions of section 7, read with section 1 of Act 61 of 2003, which according to Griesel J, is wide enough to encompass the involuntary isolation of patients with infectious diseases at a State-funded health-care facility, such as the facility in question (see par [23] to [27] of the judgment).

In addition, (in context of the applicable legal framework) the court ruled that it is undoubtedly preferable that the full statutory and regulatory framework be put into place and implemented as soon as practically possible by promulgating the draft regulations that have been published for comment as long ago as January 2008. However, the court found that this does not mean that until such time as the regulatory framework is in place, the MEC is powerless to give effect to his statutory duty to "provide services for the management, prevention and control of communicable and non-communicable diseases". In this regard the court applied a comparative approach by placing reliance on the situation pertaining in Canada, as it appears from the facts in *Toronto (City Medical Officer of Health) v Deakin* ([2002] OJ No 2777 (Ontario Court)). In this case the respondent, a TB patient E, brought a challenge in terms of the Canadian Charter of Rights and Freedoms to the extension of his treatment order by the medical officer of health, under a regulatory scheme. He had consented to a four-month detention and treatment order and this was extended for a further four months in order to control his TB. The patient argued that his continued detention violated his constitutional liberty rights. The court accepted that his Charter Rights were violated, but concluded that the infringement was justified to protect public health and prevent the spread of TB. It appeared from the evidence, *inter alia*, that the patient was being detained at the facility in question "in a magnetically locked room, which has a special ventilation system to deal with potentially contagious airborne bacteria. Two security guards took turns outside his door. When he was escorted outside, on the seven daily "smoke breaks" he was physically restrained to prevent

his escape. He was placed in the locked room after two incidents where he absconded from the Centre and scaled a wall - in one case to go and buy a case of beer – arguably putting community members at risk of contracting tuberculosis. He had also been shackled to the bed on several occasions when he purportedly became violent and hurled items around his room" – details which prompted the Canadian Court to grant an order of further detention (see par [28] to [30] of the judgment).

In assessing the third issue, namely the counter-application lodged by the respondents, the court mainly considered the declaratory orders which sought to clarify the physical conditions in the facility with regard to adequate medical treatment, adequate reading material and visitation rights which should be adhered to, should an order be granted to detain the respondents (see par [32] to [34] of the judgment). In this regard Griesel J ruled that the respondents do indeed fall within the category of "everyone who is detained" as contemplated by section 35(2) of the Constitution and considered the MEC's stance that it was not disputed that the respondents are entitled to conditions of isolation "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". In this regard the court was informed by the MEC that prior to the launching of the present application, steps had already been taken to improve the conditions of isolation at the facility for XDR-TB patients. Since then a number of further improvements have been implemented, including, the implementation of a psycho-social rehabilitation programme; the appointment of further counsellors; implementing a further system in terms of which patients receive further written instructions in addition to the written consent forms signed at the time of initiating treatment; and the provision of newspapers and television, including satellite television. As for "adequate reading material" and an "adequate reading and recreational facility", copies of newspapers as well as other reading material are available in the library at the facility. There are also facilities in which the respondents can communicate with and be visited by their spouses or partners, next of kin and chosen religious counsellor and legal practitioners.

Having ruled that the requirements of section 35(2)(e) of the Constitution have been met, the court declined to grant the relief sought as per the declaratory orders as part of the counter-claim on the present papers as declaratory relief could only be granted if the interested persons against whom or in whose favour the declaration will operate are identifiable and had an opportunity of being heard in the matter. This, the court observed, is not the position in the present case. The court further stated that the present respondents do not purport to bring a "class action" on behalf of those patients, or indeed on behalf of any other interested parties. Consequently the declaratory relief could not be granted (see par [32] to [41] of the judgment).

3 4 The order

In conclusion the court granted the following order: (a) compelling the respondents to be admitted to the Brooklyn Chest Hospital; (b) authorising the sheriff, if necessary, to request members of the South African Police Services to assist him in ensuring that the respondents are admitted to Brooklyn Chest Hospital and remain there until their compliance with paragraph (c) below; (c) compelling the respondents to remain at Brooklyn Chest Hospital until they have fulfilled the criteria for negative sputum culture conversion for XDR-TB for a period of three consecutive months; (d) compelling the respondents to adhere to the rules of behaviour for XDR-TB patients at the Brooklyn Chest Hospital; (e) no order was made with regard to the counter-application, but leave was granted to the respondents, if so advised, to renew the counter-application, duly amplified in so far as may be necessary, upon notice to the other parties and interested persons (see par [43] of the judgment with which Yekiso J concurred).

4 Assessment

It is submitted that this judgment may be assessed on two distinct levels: in the first instance it is instructive in that judicial recognition is unequivocally given to the clinical manifestation of XDR-TB as a highly infectious disease, based on medical evidence. This recognition is of importance, as there can be no doubt after this ruling that the disease in question poses a serious threat for public health and public health-care services in South Africa, and that time is indeed of the essence to effectively curtail and manage the spread of the disease. In this regard the ruling is reminiscent of the pivotal judgment of the Constitutional Court in *Hoffmann v South African Airways* (2001 1 SA 1 (CC)) in context of the judicial recognition of the clinical manifestation of HIV/AIDS, despite the stance taken by political denialists and dubious scientists (see Blum, Carstens and Talib "Governmental Public Policy: Three Cautionary Tales from Malaysia, South Africa and the United States" 2007 *Medicine and Law* 615 625-632). In the second instance, the judgment illustrates the applicable constitutional construction, with specific reference to the limitation clause where the right to bodily integrity is pitted against public health-care concerns and public policy.

It is to be noted that the complex question whether the constitutional right to bodily integrity and/or privacy may be limited where the public interest/policy is paramount, has, in principle, been the subject in previous case law. In the case of *Minister of Safety and Security v Gaqa* (2002 1 SACR 654 (C)), Desai J granted a court order for the surgical removal of a bullet (fired by the police), lodged in the leg of an alleged robber, without his consent, in order to be used as evidence in a later criminal trial. The court ruled that the interests of justice/public policy in this instance, in context of the limitation clause, trumped the suspect's right to bodily integrity/privacy. In the later case of *Minister of Safety and Security v Xaba* (2003 2 SA 703 (D)), where the facts were the same as in *Minister of Safety and Security v Gaqa*

(*supra*), Southwood AJ refused to grant such an order, as the court ruled that the surgical removal of the bullet without the consent of the suspect cannot constitutionally be justified. The court further noted that the answer to the complex problem of reaching a balance between the interests of the individual and the interests of the community of having crimes solved by using surgical intervention should be dealt with by the Legislature. However, in the case of *S v Orrie* (2004 3 SA 584 (C)) the court held that the involuntary taking of blood samples from suspects in a murder case for purposes of a DNA analysis was justified. Although an involuntary blood test undoubtedly entails an invasion of the subject's right to privacy and bodily integrity, such rights are not inviolable and, in appropriate circumstances, must yield to other public considerations (for a comprehensive discussion of these cases, see Carstens and Pearmain *Foundational Principles of South African Medical Law* (2007) 972 ff; see also *M v R* 1989 1 SA 416 (O); and *D v K* 1997 2 BCLR 209 (N) 220 I)). Although the aforementioned cases were not considered by the court in the present case under discussion, the court's ultimate approach and constitutional construction cannot, with respect, in principle be faulted. However, it is submitted that a consideration of the jurisprudence in the aforementioned cases, in context, could indeed have been highly instructive and would undoubtedly have added value to the judgment. Be that as it may, in context of constitutional and human rights law, it is now quite clear that within the domain of XDR-TB, the limitation of a sufferer's right to bodily integrity is justifiable and reasonable in an open and democratic society in the face of considerations of safety and public health. Such a limitation will be justified even if it entails that the sufferer is arrested, detained and isolated without consent (see Currie and De Waal *The Bill of Rights Handbook* (2005) 315ff; and Hassim, Heywood and Berger *Health and Democracy* (2007) 30ff); compare *Midi Television (Pty) Ltd t/a E-TV v Director of Public Prosecutions (Western Cape)* (2007 2 SACR 493 (SCA)), where it was ruled that where constitutional rights have the potential to be mutually limiting, in that full enjoyment of one right necessarily curtails the full enjoyment of another, these rights should not be reconciled by weighing the value of one right against another, since all the protected rights have equal value. It is not so much the values of the rights themselves that are to be weighed, but rather the benefit flowing from the intrusion to be weighed against the loss that the intrusion would entail (only if the particular loss outweighs a particular benefit to the extent that it would meet the requirements of section 36, would the intrusion be legally valid). It is also to be noted, as an additional consideration (although this aspect was not argued or considered in the present case under discussion) that section 24 of the Constitution affords everyone the right to live in an environment that is not harmful to his/her health or well-being. In this regard, and in context, the public's right to a healthy and *safe* environment also trumps the right to bodily integrity of a patient infected with XDR-TB, not to be involuntary detained and isolated where the latter's actions pose a real danger to public health (compare for example the *Hazardous Biological Agent Regulations* as per GN R1390 dated 27 December 2001, promulgated in terms of section 43 of the Occupational Health and Safety Act 85 of 1993. The content of

Annexure B (*Hazardous Biological Agents Guidelines*) and Annexure C (*Precautions for Workplaces*, inclusive of isolation regimes) are to be noted; compare Blum and Talib 2006 *Medicine and Law* 274ff in context of Severe Acute Respiratory Syndrome (SARS)).

It is also in context of consent and specifically informed consent that the court's comments are to be noted. In this regard the court considered the statutory boundaries of informed consent as provided for in sections 6 and 7 of the National Health Act 61 of 2003. These provisions were assessed in order to dismiss the respondents' submission that there is no constitutionally valid statutory basis for the arrest and detention of XDR-TB sufferers in South Africa. It is submitted that the court's interpretation of section 7 of the said Act and subsequent ruling, based on the purposive approach, are correct. However, it is submitted, that there is also an *alternative* approach to the limitation of rights in this case that could have been followed, with reference to the common law ground of justification of necessity which was neither invoked by the applicant nor considered by the court. It is trite law that necessity is a ground of justification that justifies the act committed by a person in protection of the person's own or somebody else's legally recognised interest that is endangered by a threat of harm which has already commenced or is imminent and cannot be averted in another way, provided that the person is not legally compelled to endure the danger and the interest protected by the protective act is not out of proportion to the interest infringed by the Act. The requirements for the successful application of necessity are (a) there has to be some form of emergency situation; (b) it does not require that the patient (in context the XDR-TB sufferer) was incapable of consenting or that the intervention must not be against his/her will or that the intervention must be in his/her best interest; and (c) the intervention is to be performed in society's best interest (see Carstens and Pearmain 909ff; compare also Strauss and Strydom *Die Suid-Afrikaanse Geneeskundige Reg* (1967) 237ff; Van Oosten *The Doctrine of Informed Consent in Medical* Law (unpublished LLD thesis, UNISA, 1989) 425ff; Strauss *Doctor Patient and the Law* (1991) 31 and 91-92; Claassen and Verschoor *Medical Negligence in South Africa* (1992) 75ff; Van Oosten "Some Reflections on Emergencies as Justification for Medical Intervention" in Ahrens (ed) *Festschrift für Erwin Deutsch zum 70 Geburtstag* (1999) 673-684; Coetzee *Medical Therapeutic Privilege* (unpublished LLM dissertation, UNISA, 2001) 83ff; Steyn *The Law of Malpractice Liability in Clinical Psychiatry* (unpublished LLM dissertation, UNISA, 2002) 91ff; Strauss "Medical Law – South Africa" in Blanpain and Nys (eds) *International Encyclopaedia of Laws* (2007) par [83]ff; see also, in context, *Stoffberg v Elliot* 1923 CPD 148; *Esterhuizen v Administrator, Transvaal* 1957 3 SA 710 (T); and *VRM v The Health Professions Council of South Africa* [2003] JOL 1944 (T)). It follows then that the involuntary arrest, detention and isolation of the XDR-TB sufferers could just as well have been justified in terms of necessity as public policy and safety to public health outweigh the sufferers' right to bodily integrity and patient autonomy. Had the court considered necessity as an alternative to the constitutional construction, the judgment

could have been an ideal conduit to have developed the common law in accordance with the spirit and purport of the Bill of Rights as mandated by the Constitutional Court in *Carmichele v Minister of Safety and Security* (2002 1 SACR 79 (CC)). Such an alternative consideration/construction would also have given effect to a multi-layered approach which has as its source the applicable supreme provisions of the Constitution; the applicable principles of the common law; relevant legislation; interpretative case law and, considerations of medical ethics. Only then does the applicable legal framework become integrated and harmonised.

At a time when public health, nationally and globally, is more under threat than ever in the face of so called "Swine Flu" (H1N1-virus), Severe Acute Respiratory Syndrome (SARS) and other infectious diseases, the judgment, in terms of its constitutional construction, is generally to be welcomed. However, there is merit in the ruling by Griesel J and the persuasive arguments by Van Wyk (2009 *THRHR* 110-113) that relevant legislation/regulations should be introduced in South Africa whereby the rights and duties of patients/health-care users and health-care providers, in the domain of XDR-TB, should be defined and articulated, not only in terms of involuntary arrest, detention and isolation, but also with reference to procedural safeguards, human rights, public health-care law and medical ethics.

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