

## Chapter 1

### INTRODUCTION

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#### 1.1 General Introduction

When embarking on researching and writing this thesis, the writer had to overcome formidable challenges. Not only was the writer obliged to travel legal landscapes which included, the law of contract, the law of delict, medical law and ethics and foreign/international law, the writer also encountered along this academic journey, the changed political landscape in South Africa. Significantly, since the adoption of the final Constitution in 1997, the constitutional supremacy has brought about a renaissance on the political and legal spectrum. The new legal order in South African with its overarching constitution emphasizes values in a way that the pre 1994 legal system had not catered for. <sup>1</sup> The influence of this constitutional supremacy has brought about an ineffaceable impact on the understanding, nature, scope and application of the aforementioned legal landscapes, more especially, the law of contract and medical law, specifically in its common law context. <sup>2</sup> Both these landscapes together with the other legal landscapes feature very prominently in finding answers to one of the most controversial and hotly debated issues on the present-day medico-legal scene in South Africa, namely can a hospital or other medical care giver validly exclude their professional liability by entering into a contract with the patient which contract, contains an exclusionary clause indemnifying the hospital or other medical caregiver from their professional liability brought about by their negligent acts causing harm to the patient? Although the Supreme Court of Appeal in the much criticized case of *Afrox Healthcare Bpk v Strydom* <sup>3</sup> held that the elementary and

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<sup>1</sup> Currie and De Waal (2005) 7ff.

<sup>2</sup> Carstens and Pearman (2007) 1.

<sup>3</sup> 2002 (6) SA 21 (SCA).

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 and therefore allowed a private hospital to exploit its position of power relative to that of the patient, few issues seem to have united academic commentators as much as a jointly perceived need to have the principle laid down in the judgement, overturned.<sup>4</sup> Besides the bevy of journal articles which have taken issue with this controversial subject matter, until recently,<sup>5</sup> this subject matter received very scant attention in the textbooks.<sup>6</sup> Nor has any academic thesis and dissertation canvassed this subject matter with any real substance. No attempt has previously been made where foundational principles of contract law, medical law and ethics, the law of delict and statutory law in context of the Constitution have been canvassed on an integrative level as means to find answers to the subject matter in question. An integrative approach, especially, under the value-driven Constitution is followed in this dissertation in attempting to find an answer to the key question surrounding this thesis. Whereas the practice of disclaimers in hospital contracts was traditionally assessed within the framework of the law of contract, under the influence of a value-driven Constitution, any assessment of the validity of disclaimers in hospital contracts ought post-constitutionally be executed with reference to a multi-layered approach, which has as its foundation constitutional supremacy, followed by the applicable principles of common law in the legal landscapes of contractual law, the law of delict and medical law followed as well by foreign and international law, relevant legislation, interpretative case law (as a source of the positive law) and, considerations of medical ethics. In the new paradigm this multi-layered approach dictates that broader medico-legal considerations on an interdisciplinary and purposive approach must be followed.<sup>7</sup>

This multi-layered approach serves as an aid in the quest to find the applicable legal position which will eventually offer the solution to the problem in question. The following example

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<sup>4</sup> The near-unanimity of scholarly opinion is contained in various journal articles including Carstens and Kok (2003) 18 *SAPR/PL* 430 18; Van den Heever *De Rebus* (April 2003) 47-48; Jansen and Smith (2003) *Journal for Juridical Science* 28(2) 210, 218; Tladi (2002) 17 *SAPR/PL* 473, 477. See Cronje-Retief (2000) 474; Naude and Lubbe (2005) 122 *SALJ* 444; Pearmain (2004); Bhana and Pieterse (2005) 122 *SALJ* 865 at 888; Lewis (2003) 120 *SALJ* 330; Brand *ESR Review* Vol. 3 No 2 September 2002 published by the Socio-Economic Rights Project, University of the Western Cape; Hopkins *De Rebus* (June 2007) 22, 24.

<sup>5</sup> For the most recent comments see Carstens and Pearmain (2007) 288, 290, 320, 458-470.

<sup>6</sup> For the old established views see Gordon, Turner and Price (1953) 153ff, 188ff; Strauss and Strydom (1967) 317ff; Strauss (1991) 305; Claassen and Verschoor (1992) 103.

<sup>7</sup> Carstens and Kok (2003) 78 *SAPR/PL* 430 18, 449.

serves as an illustration of the foregoing premise: In the assessment of, for example, whether a hospital or other healthcare provider can validly exclude their professional liability for damages caused through their negligent acts by including in an agreement with the patient an exclusionary or exculpatory clause? The Constitution provides that *"Everyone has the right to have any dispute that can be resolved by the application of the law decided in a fair public hearing before a court or, where appropriate, another independent and impartial tribunal or forum."* <sup>8</sup>

In addition, an aggrieved person has a right to seek judicial redress by seeking the assistance of a court of law was imported into our common law, <sup>9</sup> before the advent of the constitution.

Save for the regulations <sup>10</sup> which control the licensing of private hospitals, the attempt by the South African Law Reform Commission <sup>11</sup> to introduce legislation in South Africa to legislate against unfair terms in contracts <sup>12</sup> and the Consumer Protection Bill <sup>13</sup> more

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<sup>8</sup> In terms of Section 34 of the Constitution Act 108 of 1996 under the heading "Access to Courts."

<sup>9</sup> cf. *Schierhout v Minister of Justice* 1925 AD 417; See also *Nino Bonino v De Lange* 1906 TS 120 at 123-4. More recently the Constitutional Court in the case of *Barkhuizen v Napier* 2007 (5) SA 323 (CC) confirmed this position.

<sup>10</sup> The regulations were published in the Government Gazette on the 1st February 1980 No 2948 in an attempt to regulate the reasonable degree of care and skill which ought to be maintained by private hospitals in maintaining a license held by the licensure. Regulation 25(23) requires that: *"All services and measures generally necessary for adequate care and safety of patients are maintained and observed."*

<sup>11</sup> In January 2003 the South African Law Commission was re-named the South African Law Reform Commission. The acronym SALRC will be used.

<sup>12</sup> The SALRC "Unreasonable Stipulations in Contracts and the Rectification of Contracts" Project 47 (April 1998). The commission when considering the whole question of the reviewability of unfair terms in contracts *inter alia* exclusionary clauses expressed the view that there was a need to legislate against contractual unfairness, unreasonableness, unconscionable-ness or oppressiveness in all contractual phases. Despite the recommendations of the commission, none of the recommendations were ever implemented.

<sup>13</sup> The Consumer Protection Bill (Government Gazette 28629 GN R489, 15 March 2006) conforms to the values, spirit and purport of the Constitution. The preamble provides that:  
*"The people of South Africa recognize -  
That it is necessary to develop and employ innovative means to -  
(a) fulfil the rights of historically disadvantaged persons and to promote their full participation as consumers;  
(b) protect the interests of all consumers, ensure accessible, transparent and efficient redress for consumers who are subjected to abuse or exploitation in the marketplace; and  
(c) give effect to the internationally recognised customer rights."*  
Section 3(1) goes on to provide that -  
*"The purpose of the Act is to promote and advance the social and economic welfare of consumers in South Africa by-*

recently published by the Department of Trade and Industry for public comment, there is at this point in time no statutorily defined and entrenched legislation which may be utilized to counter unfair and unreasonable exclusionary or exculpatory clauses often found in private hospital contracts entered into with their patients therefore, when considering the validity of exclusionary clauses in hospital contracts a multi-layered approach needs to be adopted. Commencing with considerations of medical ethics, the hospital and its staff are ethically obliged by professional rules or codes <sup>14</sup> or by virtue of statutory regulations, to exercise due care and skill. <sup>15</sup> The general public therefore has an expectation that when they are treated by the hospital staff that they will be treated in a professional manner and in accordance with professional standards which will not cause the public harm. <sup>16</sup> But, a

(a) *establishing a legal framework for the achievement and maintenance of a consumer market that is fair, accessible, efficient, sustainable and responsible.* "

In Chapter 2, which deals with fundamental consumer rights, special attention is given to the question of notice to the consumer of clauses which provide for exemption from liability. Section 50(1) provides that any provision in an agreement in writing that purports to limit in any way liability of the supplier is of no force and effect unless:

"(a) *the fact, nature and effect of that provision is drawn to the attention of the consumer before the consumer enters into the agreement;*

(b) *the provision is in plain language .....*; and

(c) *if the provision is in a written agreement, the consumer has signed or initialled that provision indicating acceptance of it.*" Further provisions require that the attention of the consumer be drawn to similar exemptions from liability at an early stage and in a conspicuous manner and in a form that is likely to attract the attention of an ordinarily alert consumer, having regard to the circumstances (section 50(2)(b)(i)). The section dealing with determination of whether a term of a contract is unfair or unreasonable provides that a court must have regard to all the circumstances of the case and in particular, the bargaining strength of the parties relative to each other, and whether the consumer knew or ought reasonably to have known of the existence and extent of the term, having regard to any custom of trade and any previous dealings between the parties (section 58(1) (a) and (c)).

<sup>14</sup> In order to promote ethical conduct within the medical profession, the Health Professions Council of South Africa in consultation with the professional boards, has in terms of the Health Professions Act 56 of 1974 as amended Act 89 of 1997, drawn up a code of conduct made from time to time for medical practitioners, dentists, psychologists and practitioners of supplementary health services. See Carstens and Pearmain (2007) 264ff for a discussion of the code. Likewise the Nursing Act 50 of 1978 also regulates the conduct of the nurses.

<sup>15</sup> The regulations governing the licensing and maintaining reasonable degree of care and skill in order to promote the welfare and safety of the patients in private hospitals is set out in the publication of the Government Gazette on the 1st February 1980 No 2948, Regulation 25(23).

<sup>16</sup> Several writers internationally, (including South Africa) have written extensively about the influence of medical ethics on the doctor/hospital-patient relationship. See Jones (1998) 18; Mason and McCall Smith (1991) 14-17; Ficarra (1995) 147ff who states that as medicine operates in an ethical climate *"it is essential that ethical principles be applied to the physician-patient interaction."* Skegg (1988) 8. For South African writings see Beauchamp and Childress (2001) 1-7, 27 hold the view that normative ethics have enjoyed a remarkable degree of continuity from the days of Hippocrates until the 20th century. According to the writers, normative ethics include the responsibility of medical practitioners to comply with *"..... standards of conduct, including moral principles, rules, rights and virtues."* A violation of these norms *"..... without having a morally good and sufficient reason"* constitute immoral or improper conduct. See also Carstens and Kok (2003) 18 *SAPR/PL* 449-451 who, with South Africa's acquired status as a constitutional state, view the role of normative medical ethics

dilemma belies the situation where a private hospital making use of an admission form containing an exclusionary clauses or waiver, enters into an agreement with a patient who freely and voluntarily signs away his/her rights to claim damages from the hospital or its staff arising from the negligence of the hospital staff. A dichotomy emerges in that on the one hand, medical ethics dictates that the conduct of the hospital staff and/or medical practitioner ought as its aim, promote the welfare and well-being of the patient and not cause the patient any harm. On the other hand, the principles of the freedom of contract and the sanctity of contract, dictate that contracts freely entered into should be upheld and not interfered with save for where public policy so demand. In assessing the validity of exclusionary clauses or waivers in hospital contracts the dilemma or conflict crystallizes: How does one harmonise or synchronise the application of exclusionary or exculpatory with the various layers or landscapes referred to earlier? Questions that need to be begged, include, should the common law, on the contractual law terrain, be developed to embed notions of fairness and justice when courts are called upon to adjudicate on the validity of exclusionary clauses or waivers? Should the doctrine of freedom of contract and the sanctity of contract be allowed to operate by our courts where the enforcement of the contractual terms, are in conflict with the constitutional values, even though the parties may have consented to them? Should the relative situation of the contracting parties be made a relevant consideration in determining whether a contractual term is contrary to public policy? To what extent should concepts of consumer protection be recognised which require that received notions of the freedom of contract and sanctity of contracts be revisited especially in our present constitutional era as means to refuse to give legal effect to imposed, onerous and one-sided terms buried in standard form contracts? Should the values that underlie our Constitution now be taken as the benchmark to measure the validity of exclusionary clauses in hospital contracts? To what extent should applicable medical ethics also play a role when adjudicating on the validity of exclusionary clauses? Is the common law to be taken as the point of departure (in so far as it is not in conflict with the Constitution), or does the Constitution reign supreme in finding the law and solving the problem? Traditionally, the practice of disclaimers in hospital contracts would have been assessed within the framework of the law of contract, it is clear, under the influence of a value-driven constitution, any assessment thereof post-constitutionally, now dictates that this is no longer the case. Broader medico-legal considerations, on an interdisciplinary and purposive approach wherein normative medical ethics and medical law play a fundamental role may be harnessed to determine the validity or the practice of exclusionary clauses or

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in the form of codes/instruments as "*a protective measure of human rights*" in that "*to do no harm*" and "*to act in the best interest of the patient.*"

waivers in hospital contracts.<sup>17</sup>

Besides medico-legal considerations, the Constitution, with its strong socio-economic rights-base in terms of which everyone, *inter alia*, has access to healthcare services<sup>18</sup> and everyone has the right to approach the courts<sup>19</sup> has a supreme role to play in pronouncing on the validity of exclusionary clauses in hospital contracts. What about the influence of foreign and international law? To what extent should the South African courts make use of constitutional aides, more in particular, section 39 of the Constitution, where neither the common law nor statutory law gives clear direction? The law with regards to the validity of exclusionary clauses or disclaimers against liability for medical negligence, in the context of health care services, is well settled in a number of foreign jurisdictions. On a comparative level, in countries such as the United Kingdom, the United States of America and the Federal Republic of Germany these types of clauses have met with judicial and legislative resistance.<sup>20</sup>

The Constitutional Court if confronted to pronounce on the validity of exclusionary clauses or waivers in hospitals may very well look to foreign law in considering their validity. Besides foreign law, international law *inter alia* the Hippocratic Oath, the Declaration of Geneva (1968) and the International Code of Medical Ethics; the Declaration of Helsinki (as revised in 2000) which is at the heart of medical ethics, are equally applicable to exclusionary clauses or waivers against medical negligence in hospital contracts.<sup>21</sup>

The validity of exclusionary clauses/waivers against medical negligence in hospital contracts despite the Supreme Court of Appeal's decision in *Afrox Healthcare Bpk v Strydom*,<sup>22</sup> and

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<sup>17</sup> See Carstens and Kok (2003) 18 *SAPR/PL* 430, 449 quoting Steyn *The Law of Malpractice Liability in Clinical Psychiatry* Unpublished LLM Dissertation UNISA (2003) 3-27.

<sup>18</sup> Carstens and Pearmain (2007) 2.

<sup>19</sup> Hopkins "Exemption clauses in contracts" *De Rebus* (June 2007) 22, 24.

<sup>20</sup> Carstens and Kok (2003) 18 *SAPR/PL*. See also the acceptance of foreign/international law in the Constitutional Court dictum of *Carmichele v Minister of Safety and Security (Centre for applied legal studies intervening)* 2001 (4) SA 938 (CC) Para 37.

<sup>21</sup> Carstens and Kok (2003) 18 *SAPR/PL* 430, 451 quoting with authority Mason and McCall Smith (1991) 439-446; Roth "*Medicine's ethical responsibility*" in Veatch (2d) *Cross Cultural Perspective in Medical Ethics* (1989) 150, 153; Veatch (1989) 2; Beauchamp and Childress (1994) 3.

<sup>22</sup> 2002 (6) SA 21 (SCA).

which is clearly out of step with the judicial resistance shown in other foreign jurisdictions clearly remains a complex and voluminous topic as may be observed from the nature and content of this thesis. It has become clear in the course of the journey undertaken by this thesis that the validity of exclusionary clauses/waivers in hospital contracts is a worthy subject to study, debate and writing the law as it presently stands in South Africa with regard to the validity of exclusionary clauses or waivers, makes inroads into the well-being and welfare of the patients often leading to harsh results. In this regard, and in the course of the journey reflected within this thesis one realises the significance of the need for a change in judicial course, alternatively, legislative intervention.

It is hoped that this thesis will assist in bringing about change in the field of contract law when the question of the validity of exclusionary clauses or waivers is reviewed, officially. Considerations of public policy which represent the legal convictions of the community are also taken cognisance by the law when examining for example contracts which are immoral or *contra bonos mores*. The rationale for the existence of public policy in modern times lies in the broader concept of paternalism in which the courts protect the weaker party in a contractual arrangement, especially, where public interest is affected.<sup>23</sup> The ever-changing context and texture of society influences public policy.<sup>24</sup> In this regard, what is fair and reasonable in a purely commercial context may not be fair in a medical context. Public policy may demand that in the latter instance certain conduct will not be tolerated. The principles of the ethics base, founded on the Hippocratic Oath, are said to be distillations of the *boni mores* or public policy which ought to influence judicial thinking when health care is affected.

It is against the foregoing backdrop that this introductory chapter to this thesis has been designed. It is of paramount importance to deal firstly, with the basic concept, nature and scope of exclusionary clauses in the general commercial sense and thereafter consider briefly how exclusionary clauses or waivers fit into a medical context. Secondly, there is a need to explain the title of this thesis and how it came about that the research of this nature was undertaken. This is followed by an explanation of the constitutional underpinning of this thesis with reference to the synthesis of various branches of law. The

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<sup>23</sup> See Hawthorne "The Principle of Equality in the Law of Contract" 1995 (58) *THRHR* 167 173; Christie (2002) 3H-20-3H-21 suggests that it is especially in cases of inequality of bargaining power that public policy play a satisfactory role; See further Joubert *The Law of South Africa* (1987) 133; Hawthorne "Closing the open norms in the law of contract" (2004) 67 (2) *THRHR* 294 at 298.

<sup>24</sup> See Christie *The Law of Contract* (2006) 400, 403; Joubert (1987) 133; Christie (2002) 3H-11.

synthesis translates into some legal and practical questions to be posed. In the final section of this chapter, the approach and methodology followed are explained.

## 1.2 THE CONCEPT EXCLUSIONARY CLAUSE OR WAIVER IN THE LAW OF CONTRACT

The concept "exclusionary clauses" has over time been referred to in many ways. In this regard, reference has been made to "exemption clauses"; "indemnity clauses"; "exculpatory clauses" and "waivers".

It is not a modern day concept but has its roots firmly embedded in the Roman law period. Exclusionary clauses during this period took the form of informal *pacta*. The purpose these types of clauses seem to serve included, they served as a bar to litigation and provided a defence to a debtor if sued by a creditor. In all, exclusionary clauses limited or excluded certain rights and duties of contractants during this period.<sup>25</sup> Exclusionary clauses in contract found their way into Roman Dutch law;<sup>26</sup> thereafter into Europe as early as the fifteenth century and eventually into England in the seventeenth century.<sup>27</sup> The rationale for the recognition of exclusionary clauses is founded in the principle of freedom of contract which in turn, is based on social, economical and political philosophies in respect of which Grotius remarked "*man's right to contract*".<sup>28</sup> With the advent of standard form contracts, exclusionary clauses found their way into these types of contracts so much so that in modern days these types of clauses are still firmly embedded in standard form contracts.<sup>29</sup> It was especially, during the nineteenth century and influenced by the so-called philosophy of *laissez-faire*, that mass produced standardized contracts with mass produced exclusionary clauses incorporated therein, spread to all forms of business enterprises,

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<sup>25</sup> See Van Dorsten "The Nature of a Contract and Exemption Clauses" 1986 (49) *THRHR* 189, 196; Zimmerman *The Law of Obligations* (1990) 508, 563.

<sup>26</sup> Van Dorsten 1986 (49) 189 at 197; The writer with reference to the work of Lee *Commentary on The Jurisprudence of Holland by Hugo Grotius* (1936) 1.3.1 holds the view that it was especially Grotius who advocated that agreement may be used to confirm or limit the normal incidents of a contract.

<sup>27</sup> Aronstam *Consumer Protection, Freedom of Contract and the Law* (1979) 16-17; Holdsworth *History of English Law* (1923) 290-295.

<sup>28</sup> Aronstam (1979) 1.

<sup>29</sup> Aronstam (1979) 16-17 demonstrates the influence of exclusionary clauses in standard form contracts by referring to their large scale usage in charter agreements, Bill of Lading agreements and the so-called 'common carrier' cases in which skippers of carriers sought to exonerate themselves from discharging their public functions *inter alia* their duties. See also McClaren "Contractual limitation of liability for negligence" *Harvard Law Review* (1914-1915) 550.

including, transport, insurance and banking as well as trade. This remains very much the position today.<sup>30</sup> Their usage also subsequently extended to medical agreements, especially, hospitals.<sup>31</sup> The effect of exclusionary clauses on the law of contract when interpreted by the courts was that judges were very reluctant during the nineteenth and early part of the twentieth century to interfere with contractual arrangements and to limit the contractual powers of the contracting parties.<sup>32</sup> The judges at the time were very much influenced by the philosophy of *laissez-faire*, which meant, that the law should interfere with people as little as possible and not play such a paternalistic role.<sup>33</sup> The position was at the time summed up by Sir George Jessel, an eminent English judge at the time in the case of *Printing and Numerical Registering Co v Sampson*:

*"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."*<sup>34</sup>

In time, although the initial introduction of standardized contracts, may have been done with a noble intent, fierce competition amongst businessmen led to some businesses using exclusionary clauses in business contracts as a means of exploiting their economic power.<sup>35</sup> Although these type of contracts found universal favour including the jurisdictions of South Africa, the United Kingdom and the United States of America, it was the rising of consumer organizations, who countered the exploitation of especially, the weaker contracting parties, through the usage of exclusionary clauses.<sup>36</sup> One of the many

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<sup>30</sup> Yates *Exclusion clauses in contracts* (1982) 2; Slawson "Standard form contracts and Democratic Control of Lawmaking power" *Harvard Law Review* Vol. 84 (1971) 529 believes that in modern day, ninety-nine percent of all contracts appear in the form of standard contracts. See also Lenhoff "Contracts of adhesion and the freedom of contract: A Comparative study in the light of American and Foreign Law" *Tulane Law Review* (1962) Vol. XXXVI 482; Turpin "Contracts and Imposed Terms" *SALJ* (1956) 144.

<sup>31</sup> Swarthout "Validity and construction of contract exempting hospital or doctor from liability for negligence to patient" *Annotations* 6 ALR 3d 704-707; Robinson "Rethinking the allegation of medical malpractice risks between patients and practitioners" *Law and Contemporary Problems* Vol. 49: No 2 (1986) 173 at 184-188 .

<sup>32</sup> Atiyah *An Introduction to the Law of Contract* (1995) 3.

<sup>33</sup> (1875) L.R. 19 Eq. 465.

<sup>34</sup> *Printing and Numerical Registering Co v Sampson* (1875) L.R. 19 Eq. 465.

<sup>35</sup> Yates (1982) 4.

<sup>36</sup> Aronstam "Unconscionable contracts: The South African Solution (1979) 42 *THRHR* 18-19; Aronstam (1979) 23; Kötz "Controlling Unfair Contract Terms: Options for Legislative Reform" *SALJ* (1986) 405 at 413; Yates (1982) 2; Deutsch *Unfair Contracts* (1977) 3.

objections to the utilization of standardized contracts was the fact that the legal transaction entered into between the contracting parties when entering into the contract, was that the transaction was concluded without a give-and-take of bargaining between the parties, but, the weaker party often just had to adhere to the terms prescribed by the business enterprises. For that reason standardized contracts have also come to be known as "contracts of adhesion". A significant feature of these types of contracts was, and continues to be the position today, that the customer has no bargaining power, alternatively, unequal bargaining power.<sup>37</sup>

The era of consumerism brought about new thinking and legal jurisprudence. The legal jurisprudence was founded on morality in that man must respect man and not take advantage of his weakness. For that reason the ethos that contracts were there to honour and enforce was being challenged by the moral principle that one should not take advantage of an unfair contract.<sup>38</sup>

Another troublesome feature of exemption clauses in standardized contracts is the fact that business enterprises use the clause to exonerate themselves from liability in virtually "any circumstances whatsoever". Strong resistance to such attempts also followed as consumer organisations pushed for these types of clauses to be regulated.<sup>39</sup>

Insofar as the application of exemption clauses in the South African context is concerned, these types of clauses in, especially, standard form contracts, have never lost their application, despite criticism being launched from time to time regarding the unequal bargaining power which the parties possess when entering into these types of agreements.<sup>40</sup> The South African courts, influenced very much by English law, have also

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<sup>37</sup> Aronstam (1979) 42 *THRHR* 18-19; the writer refers to these types of clauses as "take it or leave it" contracts. See also Aronstam (1979) 23; Kötz (1986) *SALJ* 405 at 413; Yates (1982) 2; Deutsch (1977) 3; Lenhoff *Tulane Law Review* Vol. XXXVI (1962) 482.

<sup>38</sup> See Atiyah (1995) 11; Yates (1982) 405.

<sup>39</sup> Atiyah (1995) 11-12; Borrie "Legislative and Administrative controls over standard forms of contract in England." (1995) 317 at 321; Deutsch *Unfair Contracts* (1977) 4; Yates (1982) 4-5.

<sup>40</sup> For the application of exemption clauses in commercial contracts see the bevy of legal writings Van der Merwe et al (2003) 214-216, 225-226; Kerr *The Principles of the Law of Contract* (1998) 400; Christie (2006) 204-205; Delpont "Exemption Clauses: The English Solution" *De Rebus* (December 1979) 641; Kahn *Contract and Mercantile Law* (1988) 33-34; Lubbe and Murray Farlam and Hathaway *Contract Cases, Materials and Commentary* (1988) 34; O'Brien "The Legality of Contractual terms exempting a contractant from liability arising from his own or his servant's gross negligence or dolus" *TSAR* (2001) 3 597; Turpin "Contract and Imposed Terms" *SALJ* (1956) 144; Ramsden "The Meaning of Mutual Mistake and Exemption Clauses" *SALJ* (1975) 139; Lotz "Caveat Subscriptor: Striking down exemption clauses" *SALJ* (1974) 421-424; Van Loggerenberg "Unfair

recognized exclusionary clauses in contract.<sup>41</sup> Principles such as the freedom of contract and the sanctity of contract have often been used by the South African courts in recognizing these types of clauses.

Although universally the different jurisdictions have accepted the use of exemption clauses, legal writers and the courts alike have sought and given protection for the public against the abuse of exemption clauses by using aides as means to set limits for their operations. The limits include *inter alia* interpreting exemption clauses narrowly and in certain instances where exemption clauses in standard form contracts are undesirable and unreasonable, to limit their effect or even striking them down in the interest of public policy.<sup>42</sup>

The English law<sup>43</sup> and the American law<sup>44</sup> jurisdictions have adopted similar aides to limit the effect of exclusionary clauses where the abuse of exemption clauses adversely affects the public.

In time, despite the implementation of the fore stated aides, the legislature also stepped in in the United Kingdom by enacting both the Unfair Contract Terms Act 1977 as well as the Unfair Terms in Consumer Contracts Regulations 1994 as measures to direct the courts to declare exclusionary clauses as void in certain circumstances. One of the reasons for the legislative intervention in the United Kingdom is said to have included the inconsistency the courts have shown in denouncing these clauses to be contrary to public policy.<sup>45</sup> Similarly, the United States of America enacted the Uniform Commercial Code 1952 and the

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exclusion clauses in contracts: A Plea for Law Reform" Emeritus lecture University of Port Elizabeth (1987) 1-5; Kahn "Standard-form Contracts" *Businessman's Law* (November 1971) 49-50; Wille and Millen *Mercantile Law of South Africa* (1984) 34; Van Dorsten "The Burden of Proof and Exemption Clauses" 1984 (47) *THRHR* 36.

<sup>41</sup> See *Henderson v Hanekom* (1903) 20 SC 513 at 519; *Osry v Hirsch, Loubser and Co Ltd* 1922 (CPD) 53; *Wells v South African Alumenite Company* 1927 (AD) 69. See also *Burger v Central South African Railways* 1903 (TS) 571; *Mathole v Mothle* 1951 (1) SA 456 (T).

<sup>42</sup> Christie (1996) 204; Van der Merwe et al (2003) 214; Kerr (1998) 404-406; Delpont *De Rebus* (December 1979) 641; Kahn (1988) 34; Lubbe and Murray (1988) 340; Aronstam (1979) 33-36; Turpin (1956) 73 *SALJ* 144; Van Loggerenberg (1987) 4-5.

<sup>43</sup> See McKendrick *Text, Cases and Materials* (2003) 169; Stone *The Modern Law of Contract* (2003) 226; Stone *Principles of Contract Law* (1998) 169; Treitel *The Law of Contract* (2003) 221; Beatson *Anson's Law of Contract* (2002) 439; Poole *Textbook on Contract Law* (2004) 200.

<sup>44</sup> See Williston *Contracts* (1972) Para 171 41; Von Hippel "The Control of Exemption Clauses - A Comparative Study" *International and comparative law quarterly* (Vol. 16) July 1967 591 at 599; Deutsch (1977) 20-21.

<sup>45</sup> Poole (2004) 209.

Restatement of the Law of Contracts 1981 as means to limit exclusionary clauses where public policy so dictates.<sup>46</sup> Although some attempts have been made in South Africa<sup>47</sup> to regulate contractual provisions which are unfair, unreasonable or unconscionable, no legislation has so far been enacted to limit the use of exclusionary clauses where necessary. Exclusionary clauses or waivers as was previously stated also found their way into hospital contracts. The application of these types of clauses amount to this, when a patient is admitted to a private hospital for an operation and post-operative medical treatment, a patient or his/her family is expected to sign an admission form which contains an indemnity clause which seeks to exonerate the hospital and its staff from professional liability arising from the staff's negligence causing the patient harm. The effect of the patient entering into such an agreement with the hospital amounts *inter alia* to this, despite healthcare professionals being ethically obliged by their professional rules to take due and proper care and exercise their professions with diligence, hospitals, should they be allowed to contractually get away with it, would break with ethical traditions which have been in place since the time of Hippocrates. The practice, if condoned, could have catastrophic results for the patient.<sup>48</sup>

No other legal subject matter in recent times has sparked off livelier debate than reviewing the validity of exclusionary clauses in hospital contracts, pronounced in the *Afrox v Strydom* case. Few issues seem to have united academic commentators as much as questioning the soundness of the judgement by Brandt JA and the jointly perceived need to ensure that courts refused, on grounds of public policy, to enforce such contract terms which are clearly unfair or unconscionable.<sup>49</sup> The grounds relied on by the court in *Afrox v*

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<sup>46</sup> Von Hippel *International and Comparative Law Quarterly* (Vol. 16) (July 1967) 591 at 599.

<sup>47</sup> The South African Law Commission in 1998 published their findings in the Unreasonable Stipulations in Contracts and the Rectification of Contracts and drafted draft legislation in the form of the Unfair Contractual Terms Bill had as its aim the controlling of unfair, unreasonable and unconscionable contractual provisions. More recently the Consumer Protection Bill published for comment in Government Gazette 28629 GN R489, 15 March 2006 under auspices of the Department of Trade and Industry highlights the need to protect the historically disadvantaged persons and to protect the interest of consumers. The Bill of Rights focused on the curtailment of clauses exempting contracting parties from liability. The bargaining strength and notice to the other party are but two criteria to be considered when assessing the validity of exemption clauses as suggested.

<sup>48</sup> See the discussion of Pearmain "A Critical analysis of the Health Service Delivery in South Africa" (Unpublished LLD Thesis, University of Pretoria, 2004) 701-713 on the disastrous consequences which may flow from the decision of the Supreme Court of Appeal in the case of *Afrox Healthcare Bpk v Strydom* 2002 (6) SA 21 (SCA); See also Carstens and Pearmain (2007) 458-470.

<sup>49</sup> For the academic scholarly remarks see Carstens and Kok (2003) 78 *SAPR/PL* 430 18; Van den Heever *De Rebus* (April 2003) 47-48; Jansen and Smith 2003 *Journal for Juridical Science* 28(2) 210, 218; Tladi (2002) 17 *SAPR/PL* 473, 477; See Cronje-Retief (2000) 474; Naude and Lubbe (2005) 122 *SALJ* 444; Pearmain (2004); Bhana and Pieterse (2005) 122 *SALJ* 865 at 888; Lewis (2003) 120 *SALJ* 330; Brand *ESR Review* Vol. 3 No 2

Strydom; do not accord with the extensive statutory control which is being waged against standard-form contracts, including exemption clauses, in many overseas jurisdictions.<sup>50</sup> There is a need therefore to seek a closer alignment with the position in related legal systems. The United Kingdom in this regard has enacted the English Unfair Contract Terms Act, 1977 which provides that "a person cannot by reference to any contract term exclude or restrict his liability for death or personal injury resulting from negligence." Similarly, the European Community Council Directive on Unfair Terms in Consumer Contracts has caused several other European countries to prohibit the exclusion or restriction of business liability to consumers for death or personal injury by way of standard contract terms. This has been done in Germany and the Netherlands, for example. In France, and in the United Kingdom's Unfair Terms in Consumer Contracts Regulations, and in the EC Directive itself, terms excluding liability for bodily injury are not totally blacklisted as they are in Germany and the Netherlands.<sup>51</sup>

Although there is no case law in point whether exclusionary clauses in hospital contracts will be outlawed by the English courts, it appears however, that the legislative provisions will be followed, which will result in these type of clauses being declared invalid. The law with regard to exclusionary clauses in hospital contracts in the United States of America has also been settled. Whereas the United Kingdom would rely upon legislation to adjudicate on the validity of these types of clauses, the American law relies on their common law. The legal position in America amounts to this, while all exclusionary clauses or waivers are not, *per se*, invalid and therefore unenforceable, where they are found to involve public interest, they will not be held to be valid. As the medical profession and medical practices affect public interests, the profession and medical practices are governed by public regulations that involve health, safety and welfare as well as ethics. Any conduct that threatens standards of conduct or behaviour and in turn, curbs them from discharging their professional duties would not be tolerated. Therefore, exclusionary clauses in hospital contracts have been outlawed and are therefore invalid and unenforceable.<sup>52</sup>

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(September 2002) published by the Socio-Economic Rights Project University of the Western Cape; Hopkins *De Rebus* (June 2007) 22, 24; See the most recent writings of Carstens and Pearmain (2007) 288, 290, 320, 458-470.

<sup>50</sup> Naude and Lubbe (2005) 122 *SALJ* 444 at 457.

<sup>51</sup> South African Law Commission Report on Unreasonable Stipulations in Contract and the Rectification of Contracts (Project 47, 1998); See also Jansen and Smith (2003) *Journal for Juridical Science* 28(2) 210 at 217.

<sup>52</sup> See *Olson v Molzen* 558 California S.W. 2d 429 (Tenn. S.Ct. 1977); *Meiman v Rehabilitation Centre* 444 S.W. 2d 881 (KY 1969) and the landmark case of *Tunkl v Regents of University of California* Ga. Cal 2d 92, 32 Cal RPTS 33 P. 2d 491 (1963).

As stated above, this thesis explores the legal question whether exclusionary clauses or waivers in hospital contracts in South Africa should, in the light of the decision of *Afrox v Strydom* still be enforced, or has the time not arrived that legal reform bring about a reversal of the decision?

### 1.3 EXPLANATORY NOTE ON THE NEED FOR THE RESEARCH UNDERTAKEN BY THIS THESIS

The need, for the research undertaken in this thesis, namely, a critical analysis of exculpatory clauses in medical contracts, calls for some explanation. It is to be noted that the whole idea to research the subject matter and to compile this dissertation emanated from a medical negligence case the writer was engaged with some decade ago.<sup>53</sup>

In this case, the St George's Hospital (Pty) Ltd in Port Elizabeth was the owner of a private hospital. The First and Second Plaintiff's in this matter were husband and wife. When the Second Plaintiff was admitted to the hospital for the purpose of having the birth of her baby induced, she was requested to sign an admission form containing an exclusionary or exculpatory clause in which she undertook not to sue the hospital or its staff for damages or loss of any nature whatsoever for any act or omission by the hospital or its staff, save for wilful default on the part of the hospital. After issuing summons on behalf of the two plaintiffs, the defendant filed a special plea in which the hospital pleaded that they had been absolved from any liability. The hospital and its staff having been absolved from liability by the second plaintiff having signed an indemnity included in the admission form. From the outset it was realized that, as very little had been written about this subject matter<sup>54</sup> and no South African case authority to rely on, it would be an onerous task to ward off the special plea. What was also learnt during this period was that this was the *modus operandi* of the private hospitals to scare litigants off from litigating against them. Being mindful of the arduous task that surrounded me, the writer saw fit to approach Professor Strauss at the University of South Africa for guidance. Under his very capable and able generalship writer spent ten days acquiring knowledge about the subject matter. It was especially the use of comparative legal studies and drawing from foreign jurisdictions, which eventually put writer in the position of successfully getting his opponents to withdraw their special

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<sup>53</sup> *Huges and Hughes v The St George's Hospital (Pty) Ltd* Unreported case, case no 2368/97 decided in the South Eastern Cape Local Division.

<sup>54</sup> At that stage, the only academic material originating from South Africa that was available was that of Gordon, Turner and Price *Medical Jurisprudence* (1953) and Strauss *Doctor, Patient and The Law: A selection of practical issues* (1991) 305.

plea. This not only caused the clients great satisfaction, it also created an awareness amongst lawyers acting on behalf of private hospitals, that their tide in intimidating litigants (often the patients) to withdraw their claims may, in future, be stemmed.

Inspired by the new find and encouraged by the broadened knowledge that writer gained in contract law and medical law and how they interface, it was further realized that a greater need existed to undertaken more extensive research and to provide an analysis and exposition of this sphere of law for the practical benefit both of those responsible for pronouncing on the validity of these type of clauses in South Africa, and, of those whose lives are affected by the often hurtful and damaging effect of these clauses.

The research undertaken and discussed in this dissertation covers a wide spectrum of themes including, various landscapes of South African law. They include: a historical overview and development of the doctor-patient relationship with great emphasis being placed on medical ethics, *inter alia*, the duty of care and legal remedies available to the patient; the contractual relationship between the doctor/hospital and the patient with specific emphasis on the nature of the agreement and the effect of such an agreement; the formalistic requirements, where applicable, is also discussed with emphasis on the formation of the contract, the terms of the agreement and the different forms of consent; the mutual duties and obligations between the doctor/hospital and patient is briefly discussed; the doctor/hospital's general duty towards the patient as founded in delict is comprehensively discussed, followed by a discussion on when the doctor/hospital's general duty of care may be limited or excluded, including, a brief discourse on the doctrine of *volenti non fit iniuria* and assumption of risk. This is followed by a discussion on a number of selected principles found in the general law of contract, including, the freedom of contract, the influence of the *caveat subscriptor* rule, the principle of fairness, the doctrines of unconscionableness and public policy. A comprehensive discussion on the influence of exclusionary clauses on the law of contract is covered, which includes the general recognition of exclusionary clauses, factors which influence exclusionary clauses *inter alia* fraud, public policy, the status and bargaining power of contractants, public interests, statutory duty. This is followed by a detailed discussion on constitutional issues surrounding the law of contract and how the Constitution impacts on exclusionary clauses in hospital contracts. Finally, the legitimacy of exclusionary clauses in medical contracts is analysed dealing firstly, with the adjudication of exclusionary clauses in hospital contracts in its present context and secondly, the proposed adjudication of exclusionary clauses in hospital contracts is laid out.

#### 1.4 CONSTITUTIONAL "UNDERPINNING" OF THE TEXT

Law is generally shaped by the legal convictions of the community and imposes its commands in the interests of the community.<sup>55</sup> This position is particularly entrenched in the constitutional order in which the South African legal system finds itself in post the introduction of the Constitution<sup>56</sup> and its predecessor, the Interim Constitution.<sup>57</sup> In this regard law is created based on the fundamental beliefs and values of the society, by and for which, it is written.<sup>58</sup> Public policy and public interest play fundamental roles in influencing the roles of the legislature and the judiciary in creating and applying the law.<sup>59</sup>

The new South African legal order is anchored in the promotion of social justice<sup>60</sup> and the entrenchment and safeguard of human rights.<sup>61</sup> In this regard both the preamble<sup>62</sup> and the founding provisions<sup>63</sup> of the South African Constitution emphasize social justice and the

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<sup>55</sup> Davis J in *Mort NO v Henry Shields-Chiat* 2001 (1) SA 464 (C) at 474J-475F and cited with approval by Olivier JA in *Brisley v Drotzky* 2002 (4) SA 1 (SCA); 2002 (12) BCLR 1229 (SCA) at Para 69 stated "*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.*"

<sup>56</sup> Constitution of the Republic of South Africa Act 108 of 1996.

<sup>57</sup> Interim Constitution Act 200 of 1993.

<sup>58</sup> Carstens and Pearmain (2007) 7.

<sup>59</sup> See Currie and De Waal (2005) 9 who comment on the role of the courts when reviewing to strike down for example an Act of parliament that has as its object to 'thwart the will of the ..... people'. These causes Ngcobo J to remark in the majority judgement of *Barkhuizen v Napier* 2007 (5) SA 323 (CC) Para (73): "*Public policy, it should be recalled "is the general sense of justice of the community, the boni mores, manifested in public opinion."* Quoted from *Lorimar Productions Inc and Others v Sterling Clothing Manufacturers (Pty) Ltd; Lorimar Productions Inc and Others v OK Hyperama Ltd and Others; Lorimar Productions Inc and Others v Dallas Restaurant* 1981 (3) SA 1129 (T) at 1152-3; and *Schultz v Butt* 1986 (3) SA 667 (A) at 679B-E. Ngcobo J in the *Barkhuizen* judgement Para 28 also describe the value of public policy as representing "*..... The legal convictions of the community ..... represent ..... those values that are held most dear by the society.*"

<sup>60</sup> See Currie and De Waal (2005) 2ff.

<sup>61</sup> Currie and De Waal (2005) 2ff; The majority decision lead by Ngcobo J in the case of *Barkhuizen v Napier* 2007 (5) SA 323 (CC) makes it clear that our constitutional democracy is founded on, among other values ..... "*The values of human dignity, the achievement of equality and the advancement of human rights and freedoms and the rule of law.*"

<sup>62</sup> The preamble of the Constitution of the Republic of South Africa, 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.*"

<sup>63</sup> Section 1 of the Constitution provides:  
"*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.*"

underlying importance of public values to law. Interestingly, the authors Carstens and Pearmain,<sup>64</sup> state that the underlying importance of the public values founded in the preamble of the founding provisions is not a new idea and draw an analogy with the values adopted in Roman law<sup>65</sup> which they believe were very much central to Roman law and especially, the law of contract.<sup>66</sup> The position according to Carstens and Pearmain<sup>67</sup> survived beyond the time of Rome as the Roman-Dutch writers also advocated for social justice and the promotion of public values.<sup>68</sup> There are a number of cases in South African law which have also expressed the underlying importance of public values to law.<sup>69</sup> More recently in the much criticized case of *Afrox Healthcare Bpk v Strydom*, the Supreme Court of Appeal, whilst accepting that unequal bargaining power is indeed a factor which, together with other factors, can play a role in considerations of the public interest, Brandt 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

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<sup>64</sup> Ulpian declared that the basic principles of the law are to live honourably, not to harm another and to render to each his own (D26 1 1 1 0 1). Ulpian says (D26 45 1 26): "*Generaliter novimus turpes stipulationes nullius esse momenti*". (We generally recognize that immoral stipulations have no validity). See also Papinian (Dig 28 7 15) "*Nam quae facta laedunt pietatem, existimem, verecundiam no stram et et generaliter dixerim contra bonos mores fiunt, nefacere no 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).

<sup>65</sup> Carstens and Pearmain (2007) 8.

<sup>66</sup> Carstens and Pearmain (2007) 8 suggest that the Romans 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 turpen causam continent non sunt observanda; vevoti se pacisar ne furti agard vel injuriarum, si feceris: expedit enim timere furti vel injuriarum 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 delicts. For it is generally beneficial that there be fear of the penalty for theft or insult.*)

<sup>67</sup> (2007) 8.

<sup>68</sup> Carstens and Pearmain (2007) 8 quotes Grotius 3.1.42 and 43 who 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 crime or consideration*". See also Du Plessis "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 Keesel, 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".

<sup>69</sup> *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* 1981 (1) SA 1157 (A); *Pakendorf v De Flanigh* 1982 (3) SA 146 (A); *Edouard v Administrator Natal* 1989 (2) SA 389 (N).



is to the advantage of the stronger party will be in conflict with the public interest. Consequently the court held 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 hospital. Brandt JA also found that it cannot *ipso facto* be found that a contractual provision in terms of which a hospital is indemnified against the negligent actions of its nursing staff to be principally contrary to the public interest.<sup>70</sup> Brandt JA in this regard relies on the judgement of Cameron JA in *Brisley v Drotsky*<sup>71</sup> in which it was stated:

*"The 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 preceptive restraint ..... contractual autonomy is part of freedom. Shorn of its obscene excesses, contractual autonomy informs also the constitutional value of dignity."*

Brandt JA relying on the dictum of Steyn CJ in *SA Sentrale Ko-op Graanmaatskappy Bpk v Shifren en Andere*<sup>72</sup> in which it was held: *"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"* stated that the constitutional nature of contractual freedom embraces in its turn the principle *pacta sunt servanda*.<sup>73</sup>

In the light of all the criticism the aforementioned dictum had to endure, the question can be begged, whether exclusionary clauses in medical/hospital contracts are contrary to public policy as evidenced by the constitutional values, in particular, those found in the Bill of Rights, and if so, on what basis?<sup>74</sup> At the heart of this issue is the fact that the South

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<sup>70</sup> 2002 (6) SA 21 (SCA).

<sup>71</sup> 2002 (4) SA 1 (SCA).

<sup>72</sup> 1964 (4) SA 760 (A).

<sup>73</sup> The dictum of Brandt JA has been severely criticized by several South African academic writers so much so that Sachs J in the minority judgement and with reference to standardized contracts remarked in the case of *Barkhuizen v Napier* 2007 (5) SA 323 (CC) remarked: *"Few issues seem to have united academic commentators as much as a jointly perceived need to ensure that courts refused on grounds of public policy to enforce contracts, or contractual terms, that were unfair or unconscionable."* Carstens and Kok (2003) 18 *SAPR/PL* at 430 are very critical of the judgement in that the court ignored normative medical ethics and values namely, 'to do the patient no harm' and 'to act in the best interest of the patient'. Hawthorne 2004 67 (2) *THRHR* 294 at 301-302 is equally critical of the dictum in that instead of going with the mainstream of foreign jurisdictions *inter alia* the United Kingdom, United States of America and the Federal Republic of Germany, in which disclaimers in medical contracts are viewed as an infringement of the *boni mores* or against public policy Brandt JA chose business considerations to uphold these type of clauses.

<sup>74</sup> Since the advent of our constitutional democracy, the South African Constitution itself is a powerful indicator of public policy. See Carstens and Pearmain 2007 (5) SA 323 (CC). In the majority judgement of the Constitutional Court case of *Barkhuizen v Napier*, Ngcobo J emphasized "ordinarily, constitutional challenges to contractual terms

African law of contract, as with many of the ideologies of western societies, still adopts an individualistic free market view as its point of departure. Great emphasis is placed on the principle that contracts are concluded on the basis of consensus which points to the recognition of private autonomy as the basis for contractual liability. Private autonomy means *inter alia*, that everyone who makes a decision must assume responsibility for his/her decisions. The underlying reasoning is that contractants, as independent free participants in legal intercourse contract with one another of their own free will and on an equal footing.

The consequence is that as long as the contractants, judged externally, have reached consensus, the courts as a rule are not interested in the fairness of the transaction that has been concluded. The basic rule is *pacta sunt servanda* must be honoured.<sup>75</sup> But in certain

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will give rise to the question of whether the disputed provision is contrary to public policy. "*Public policy represents the legal convictions of the community; it represents those values that are held most dear by society. Determining the contents of public policy was once fraught with difficulties. That is no longer the case. Since the advent of our constitutional democracy, public policy is now deeply rooted in our Constitution and the values which underlie it.*" (Para 28) He goes on to state "*What public policy is and whether a term in a contract is contrary to public policy must now be determined by reference to the values that underlie our constitutional democracy as given expression by the provisions of the Bill of Rights. Thus a term in a contract that is inimical to the values enshrined in our constitution is contrary to public policy and is, therefore, unenforceable.*" Para 29. The court then goes and lays down the following approach to constitutional challenges to contractual terms, namely, "*..... determine whether the term challenged is contrary to public policy as evidenced by the constitutional values, in particular, those found in the Bill of Rights. This approach leaves space for the doctrine of pacta sunt servanda to operate, but at the same time allows courts to decline to enforce contractual terms that are in conflict with the constitutional values even though the parties may have consented to them.*" Consequently, the court held that section 34 not only reflects the foundational values that underlie our constitutional order, it also constitutes public policy. (Para 33). The court found that an unreasonable or unfair time limitation clause in general will be contrary to public policy as public policy takes into account the necessity to do simple justice between individuals and public policy is informed by the concept of ubuntu. When a time limitation clause does not afford the person bound by it an adequate and fair opportunity to seek judicial duress, it would be contrary to public policy as it is inconsistent with the notions of fairness and justice. But, the court held that there was no reason in logic or in principle why public policy would not tolerate a time limitation clause in contracts subject to the considerations of reasonableness and fairness. (Para 48).

In a minority judgement Sachs J however highlights the following objective factors that might provide pointers to what public policy requires with regard to standard form contracts in general and to the terms limiting access to court in particular. Sachs J consequently considered international practice in open and democratic societies such as the United Kingdom and other European countries which strive for the curtailment of unreasonableness, unconscionable ness or oppressiveness which these types of contracts often bring with them. Sachs J also considered the legal convictions of the community which demand consumer protection against one-sided terms. He concludes: *Public policy, now animated by section 34 of the Constitution, gives someone a right to access to the courts.* See further the comprehensive discussion of the case of *Ryland v Edros* 1997 (2) SA 690 (C) in Carstens and Pearmain (2007) 8-9. In the foretasted case the court based its decision on the "*change in the general sense of justice of the community .....*" and the "*fundamental alternation in regard to the basic values on which our civil policy is based .....*"

<sup>75</sup> See *Brisley v Drotzky* 2002 (4) (A) (SCA) 15G-16F; *Afrox Healthcare Bpk v Strydom* 2002 (6) SA 21 (SCA) 38B-C and *Santos Professional Football Club v Ingesund* 2003 (5) 73 (C) where the *Brisley* decision was followed without considering the possible constitutional implications of enforcing the particular contract (86E/F-87D/E).

instances, in terms of the common law, in spite of the consensus that has been reached, a contracting party can avoid contractual liability *inter alia* where the contract would be illegal or against public interest;<sup>76</sup> or that he/she was persuaded by misrepresentation, duress or undue influence to enter into the contract. With the advent of the Constitution and its predecessor, the Interim Constitution, the Constitution has had significant influence on the development of private law, and specifically the law of contract,<sup>77</sup> based on human dignity, equality and freedom (Section 39(1)(a)); and when developing the common law, to promote the spirit, purport and objects of the Bill (Section 39(2)).<sup>78</sup>

Given the reasons for the constitutional revolution in South Africa and the aims and objectives to create social justice in this land of ours, I venture to suggest that the Bill of Rights radiates a spirit of collectivism and humanitarianism. Social or communal values are emphasized in contrast to private autonomy and individualism, which traditionally formed the basis of the law of contract. According to the principles of collectivism legal subjects are regarded as social beings will have the advantage and disadvantages that are inextricably attached to life in a collecting society. Great emphasis is placed on solidarity and commitment to the ethic and altruism.<sup>79</sup> In terms of this approach individuals or groups

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<sup>76</sup> *Magna Alloys and Research v Ellis* 1984 (4) SA 874 (A).

<sup>77</sup> In this regard it needs to be emphasized that the Bill of Rights contained in chapter 2 of the Constitution not only has a "vertical" effect (in other words only in respect of the relations between organs of the State and its subjects) but also enjoys "horizontal effect" (in other words also in respect of the relations between legal subjects *inter se*). Section 8(2) of the Constitution expressly provides:  
*"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."*  
For confirmation of this position see *Holomisa v Khumalo* 2002 (3) SA 38 (T); *Brisley v Drotosky* 2002 (4) SA 1 (SCA) 59 D/E-G and 20E-H. The Bill of Rights also binds the judiciary. In this regard section 8(1). The Bill of Rights also binds every court, tribunal or forum. The positive duty entails:  
*"To promote the values that underlies an open and democratic society."*

<sup>78</sup> The Chief Justice Langa CJ in the Constitutional Court case of *Barkhuizen v Napier* 2007 (5) SA 323 (CC) obiter makes an interesting remark, namely, section 39(2) is not the only acceptable approach to challenging the constitutionality of contractual terms and suggests without deciding the matter, that section 8 of the Bill of Rights may directly apply to contractual terms challenged, as well. With regard to a claim for damages in delict the Constitutional Court decided in *Carmichele v Minister of Safety and Security* 2001 (4) SA 938 (CC) that the constitutional duty of the courts to develop the common law in accordance with the Bill and the values underlying it, means that the principles and concepts of the common law must be tested against these values (955F/G-956C). There is a striking difference between the basis of the Bill and that of the law of contract, namely, the equality or purported equality of the contracting parties. Under the common law the law of contract provides that contractants are economically equal and negotiate as equals. In practice however that is often a mere fiction. The Bill on the other hand is specifically aimed at creating equality between the subjects. (Section 9(1)). Equality includes the full and equal enjoyment of all rights and freedom (Section 9(2)). To promote the achievement of equality measures may be taken which are designed to protect or advance persons, or categories of persons, who have been disadvantaged. (Section 9(2)).

<sup>79</sup> See Grove "Die Kontraktereg, altruisme, keusevryheid en die Grondwet" 136 2003 *De Jure* 134; Pieterse "Beyond

may lawfully claim that all other members of society should support and foster their interests. A consequence of this approach is to achieve fairness in the relations between participants in modern commerce.<sup>80</sup>

The validity of exclusionary clauses or waivers in medical contracts is, as seen hereinbefore, influenced by the Constitution. Besides the influence of the Constitution, their validity is also influenced by other factors as more fully set out hereinafter.

It is trite to say 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 where it arises. Because, rights tend to be flavoured by the jurisprudence that gives birth to them, when a particular right is reflected as the subject matter of more than one area of law and is developed separately on different legal fronts, there is the potential for dissonance.<sup>81</sup>

When an answer is sought to a legal problem affecting or impacting on such a right, it follows therefore that proponents of the principles and theories of the subject matter involved, will attempt to conceptualise the right as a single legal construct. To this end, when one is confronted with the question of the right to enforce the validity of exclusionary clauses in hospital contracts, the question needs to be begged which branch of law needs to be followed should such a right claimed, be denounced. In South Africa, exclusionary clauses traditionally, have been assessed within the framework of the law of contract.

This includes both exclusionary clauses in general commercial contracts as well as the practice of disclaimers in hospital contracts. Although the use of disclaimers in hospital contracts is traditionally assessed within the framework of the law of contract, with the adoption of the new value-driven Constitution, any assessment post-constitutionally as was discussed before, must be done in accordance with the values that underlie the Bill of Rights and which affect the spheres of law in general, including the law of contract.<sup>82</sup>

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the Welfare State: Globalisation of neo-liberal culture and the constitutional protection of social and economic rights in South Africa" *Stell.LR* 2003 1, 3.

<sup>80</sup> The express object of the Bill of Rights generally is to protect legal subjects, so that they can function effectively in a democratic society that is based on the principles of human dignity, equality and freedom. Compare for example the provisions of sections 7(1), 36(1) and 39(1) and (2). Legal subjects are not only protected as individuals, but also where they act in the context of a group. See in this regard sections 15, 17, 18, 23(2), 29(3), 30 and 31.

<sup>81</sup> Pearmain (2004) Introduction Page X.

<sup>82</sup> See Cockrell "Rainbow Jurisprudence" (1996) *SAJHR*; Botha The values and principles underlying the 1993 Constitution (1994) *SAPL* 233; Van der Walt "Tradition on trial: A critical analysis of civil-law tradition in South

In so far as the effect of the constitutional values on the Law of Contract is concerned, it has been stated over and over before that all law in South Africa, including the common law, which regulates the enforcement of contracts, must promote the values underlying the Bill of Rights.<sup>83</sup>

Besides the recognition of values such as openness, dignity, equality and freedom, what is mooted is, that other values underlying the Constitution including fairness and good faith also be recognised.<sup>84</sup> Strong arguments have also been put forward to promote the adoption of normative values and ethics in especially, medical contracts.<sup>85</sup>

The use of disclaimers in hospital contracts should therefore also be assessed by referring to medico-legal considerations. In this regard the influence of normative ethics and medical law on the practice of disclaimers or exclusionary clauses/exculpatory clauses in hospital

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African Property Law" (1995) 11 *SAJHR* 169 at 191-192.

<sup>83</sup> See Hopkins "Standard-form Contracts and the Evolving Idea of Private Law Justice: A Case of Democratic Capitalist Justice versus Natural Justice" *TSAR* (2003) 1 150 at 157. The writer holds the view that the values include openness, dignity, equality and freedom. The writer however, suggests that besides the aforementioned values, the courts must also broaden the values to include fairness and reasonableness. See also Cockerell: "Private Law and the Bill of Rights: A threshold issue of Horizontality" *Bill of Rights Compendium* (1997). See also Christie *Bill of Rights Compendium* (1997) 3H quoting Devenish *A Commentary on the South African Constitution* (1998) 101-102, Davis *Democracy and Deliberation: Transformation and the South African Legal Order* (1999) 162 holds the view that the Constitution "seeks to infuse all South African Law with the spirit of its fundamental values so that the legal system can promote a society based on human dignity, freedom and equality". The writers Bhana and Pieterse (2005) 123 *SALJ* 865 states that whilst acceptance must be given to the values of freedom and equality nonetheless caution the writers at (879), liberty and contractual freedom is not immune from limitation.

<sup>84</sup> See Tladi (2002) 17 *SAPR/PL* 473 at 477. Besides recognizing freedom as a Constitutional value, the writer suggests that other values underlying the Constitution *inter alia* fairness, dignity and equality, especially the drive towards substantive equality should also be recognized. For the influence of the value of equality see also Hawthorne "The Principle of Equality in the Law of Contract" 1999 (58) *THRHR* 157 at 166-167; Hawthorne "Public Policy and Micro-Lending - Has the Unruly horse died?" (2003) 66 *THRHR* 116. The legal writers also plead for the reintroduction of the value of good faith in contract. According to Bhana and Pieterse (2005) 123 *SALJ* 890 this will ensure a just and equitable law of contract.

<sup>85</sup> Bhana and Pieterse (2005) 123 *SALJ* 865 at 879. They persuasively argue that: "The law of contract, as a branch of the common law, is equally meant to embrace normative and constitutional values so as to adapt to the changing needs of the community. It is therefore difficult to discern a cogent explanation for contract law's apparent need for more certainty and its attendant 'elevated' status." See also Carstens and Kok (2003) 18 *SAPR/PL* 430 at 449 also convincingly argue that the practice of especially disclaimers in hospital contracts under the influence of a value-driven Constitution now dictates that normative medical ethics and broader medico-legal considerations ought to be considered when the purposive approach is adopted.

contracts should be considered.<sup>86</sup>

The question therefore, whether exclusionary or exculpatory clauses ought to be declared void and unenforceable in South Africa, should not be restricted to the common law of contract. The question of varying degrees needs to be addressed in a number of different legal areas, notably, the common law of contract, constitutional law, medical law, medical ethics, the common law of delict and statutory law, international law and foreign law. The extent to which these areas of law can be utilized is one of the issues explored in this thesis. An extensive comparative study is made in this thesis of the common law approach in the United States of America, as well as, the legislative approach in England to the issue surrounding the validity of exclusionary clauses in hospital contracts. The validity of exclusionary clauses or waivers will be examined by way of a series of situational questions and must be answered in the light of the Constitutional Bill of Rights and the legal theory behind its construction which serves as a grundnorm.

#### 1.4.1 SYNTHESIS: SOME LEGAL QUESTIONS

It was previously stated hereinbefore that this thesis is pursued by having regard to six broad areas of law including, the law of contract, the law of delict, constitutional law, medical law and medical ethics, statutory law as well as foreign and International. To illustrate the importance of the possibility of synthesis of various branches of the law, the question may be posed whether one single branch of the law may provide the answer to the question whether exclusionary clauses in medical contracts ought to be declared invalid and unenforceable? Conversely, whether the synthesis of the various branches of the law will not yield the answer to the question whether exclusionary clauses in medical contracts ought to be declared invalid and unenforceable? To display the importance of the possibility of synthesis of the various branches of the law, the question may be posed whether the Constitution standing on its own will provide the answers to the questions posed hereinbefore or whether the common law of contract and delict should be used to underscore and remedy violations of constitutional rights that satisfy the recognized common law requirements for contract and delict. In other words, does the Constitution create another, new category of invalidating a contract or a delict outside the common law,

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<sup>86</sup> Carstens and Kok (2003) 18 *SAPR/PL* 430 at 449 espouse that: *"The notion that any assessment of law within a medico-legal contract (such as disclaimers against medical negligence in hospital contracts) should be interpreted on a holistic inter-and-multidisciplinary approach has, by analogy, persuasively been argued by Steyn The Law of Malpractice Liability in Clinical Psychiatry Unpublished LLM Dissertation UNISA (2003) 3-27. See also Carstens and Pearmain Foundational (2007) 468.*

which may be developed in accordance with Constitutional law principles or is it more logical to develop the common law of contract law or 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, namely, would the invalidation of a contract arising from a common law defence and which in itself also involves a violation of a constitutional right, render the 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? The same questions may be asked about the effect of a delict. Would a delict, which in itself involves a constitutional right, render the delict unconstitutional? Must one consider two separate actions for the same wrong, one in terms of constitutional law and one in terms of delict?

Judging by the authorities with regard to delict, there is a clear distinction between a constitutional wrong and a delict even though these two fields may overlap.<sup>87</sup> In so far as the relationship between the Constitution and the law of contract is concerned, it has been stated over and over before that all law in South Africa, including the common law that regulates the enforcement of contracts, must promote the values that underlie the Bill of Rights.<sup>88</sup> But, from the legal opinion expressed by the legal writers, courts do not

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<sup>87</sup> Neethling, Potgieter, Visser *Law of Delict* (1999) 22-23 quoted by Pearmain (2004) page x of the Introduction paragraph who draws this distinction on the basis that "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.

<sup>88</sup> See Hopkins *TSAR* (2003) 1 150 at 157. The writer holds the view that the values include openness, dignity, equality and freedom. The writer however, suggests that besides the aforementioned values, the courts must also broaden the values to include fairness and reasonableness. See also Cokerel: *Bill of Rights Compendium* (1997). See also Christie *Bill of Rights Compendium* (1997) 3H quoting Devenish *Commentary on the South African Constitution* (1998) 101-102, Davis *Democracy and Deliberation: Transformation and the South African Legal Order* (1999) 162 holds the view that the Constitution "seeks to infuse all South African Law with the spirit of its

necessarily decide matters on pure constitutional lines but rather, courts do have a duty to develop the common law so as to promote the spirit, purport and objects of the Bill of Rights. Apart from constitutional values some academic writers have advocated that normative medical ethics and broader medico-legal considerations ought to be considered as well.<sup>89</sup> Others have favoured public policy as a means of developing the common law of contract in conformity with the Bill of Rights,<sup>90</sup> whereas, some academic writers suggest that the unequal bargaining position of the contracting parties, unjust and unreasonable clauses, as well as, contracts contrary to good faith ought to be considered when

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*fundamental values so that the legal system can promote a society based on human dignity, freedom and equality".* The writers Bhana and Pieterse (2005) 123 SALJ 865 states that whilst acceptance must be given to the values of freedom and equality nonetheless caution the writers at (879), liberty and contractual freedom is not immune from limitation. Consequently the writers' state: "*It is accordingly clear that the value of freedom does not equate with complete individual liberty and does not found an independent right to unlimited contractual liberty. What is also clear is that the meaning of the value of freedom in the 1996 Constitution is substantially less than its meaning in classical liberal theory. In particular, the value of freedom is reined in significantly by its interactions with the constitutional values of equality and dignity, as will now be contemplated.*"

The writers emphasize in particular the value of equality when they state (at 880): "*To this end, the value of equality (and the right in which it finds concrete expression) aids the transformation of South African society into an ultimately more egalitarian one through measures which may, to varying extents, limit a variety of individual liberty interests. In the contractual realm, for instance, such liberty-limiting measures include provisions of the Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000. This Act declares both the imposition of contractual terms, conditions or practices that have the effect of perpetuating the consequences of past unfair discrimination and the unfair limiting or denial of contractual opportunities to be practices which may amount to (prohibited) unfair discrimination.*"

<sup>89</sup> Pearmain (2004) Introduction Page X

<sup>90</sup> It is Christie *Bill of Rights Compendium* (1997) 3H-21 who convincingly argue that the Constitution itself provides an exceptionally reliable statement of seriously considered opinion, by reason of the widespread consultation and negotiation that preceded the drafting of the Constitution. Christie with reference to the case of *Ryland v Edros* 1997 (2) SA 690 (C) in which Farlam J was able to depart from *Ismail v Ismail* 1983 (1) SA 1006 (A) in which potentially polygamous Muslim marriages had been held contrary to public policy by radiating the effect of many provisions of the interim Constitution from which it was clear that such marriages could no longer be regarded as contrary to public policy. De Voss "Pious wishes or directly enforceable human rights? Social justice and economic rights in South Africa's 1996 Constitution" 1997 SAJHR 67 101 advocates similarly that this can be reached by treating as *contra bonos mores* any provision which is clearly at odds with the basic principles enshrined in the Bill of Rights. Van Aswegen "The Future of South African Contract Law" 1994 (57) THRHR 448 at 451 on the other hand suggests that the values underlying fundamental rights protected in the Bill of Rights, should be considered as important policy factors determining public policy in the circumstances. The author goes on to state all principles of contract law will have to be interpreted as far as possible in accordance with the values underlying fundamental rights. An example suggested by the author is that the present principle of *pacta sunt servanda* should be interpreted to conflict as little as possible with fundamental rights such as equality etc. It is especially Hawthorne 1995 (58) THRHR 157 who opines that the principle of equality is one of the cornerstones of South Africa's Constitution. The author suggests that other policy considerations than the principle of *pacta sunt servanda* (which was once one of the foundations of the classical theory of contract) ought to be considered for example public interest. See also the writings of Christie *Bill of Rights Compendium* 3H-21 who, like Hawthorne, suggests that public policy is the most satisfactory instrument for dealing with cases of inequality of bargaining power.

developing common law.<sup>91</sup>

The South African courts have emphasized some of the common law contractual factors which, in the new constitutional order, influence the courts in deciding on the validity of contractual provisions or contracts in their entirety. They include public policy,<sup>92</sup> fairness, justice, reasonableness and good faith.<sup>93</sup>

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<sup>91</sup> Support for the development of the open norms of the South African common law to include *bona fides*, public policy and *boni mores* in accordance with the constitutional mandate, is also promoted by Hawthorne "The End of *Bona fides*" (2003) 15 SA Merc. LJ 271 at 277. Hopkins TSAR 243-1150 at 157 states that the Bill of Rights, is a guarantee to all South Africans that their fundamental rights will be protected against infringement. An area of concern, raised by the writer, is that contracts are often entered into between contracting parties where there is a huge disparity in their bargaining power, for example, in standard-form contracts. Such contracts ought to receive different treatment from the courts, especially, in those where there is no radical difference in bargaining power. A solution suggested by Hopkins is that as public policy is already entrenched in our common law and in particularly the law of contract wherein contracts contrary to public policy are declared unenforceable, the Bill of Rights should itself provide for an exceptionally reliable statement of seriously considered public opinion. This solution according to Hopkins is compatible with the rationale behind Section 39(2) of the Bill of Rights - that the common law be developed so as to be made compliant with the values that underlie the Constitution. To this end, it is argued that any standard-form contract that contains a clause that conflicts with the provisions of the Bill of Rights, is *prima facie* unenforceable, unless, good cause is shown by the contracting parties relying on the clause. Hopkins also persuasively argues that the enquiry by the judges in adjudicating these matters ought no longer to be restricted to judicial precedent, contractual capacity and the legality of the transaction. Instead, they will have to grapple with issues such as fairness and reasonableness as well. See also Christie *Bill of Rights Compendium* (1997) 3H-7.

<sup>92</sup> The Constitutional Court per Ngcobo J in a majority judgement in *Barkhuizen v Napier* 2007 (5) SA 323 (CC) lay down the proper approach to the constitutional challenges to contractual terms when he stated: "*Ordinarily, constitutional challenges to contractual terms will give rise to the question of whether the disputed provision is contrary to public policy. Public policy represents the legal convictions of the community; it represents those values that are held most dear by the society. Determining the content of public policy was once fraught with difficulties. That is no longer the case. Since the advent of our constitutional democracy, public policy is now deeply rooted in our Constitution and the values which underlie it. Indeed, the founding provisions of our Constitution make it plain: our constitutional democracy is founded on, among other values, the values of human dignity, the achievement of equality and the advancement of human rights and freedoms, and the rule of law.*" The courts go on to state: "*What public policy is and whether a term in a contract is contrary to public policy must now be determined by reference to the values that underlie our constitutional democracy as given expression by the provisions of the Bill of Rights. Thus a term in a contract that is inimical to the values enshrined in our Constitution is contrary to public policy and is, therefore, unenforceable.*" And adds: "*In my view, the proper approach to the constitutional challenges to contractual terms is to determine whether the term challenged is contrary to public policy as evidenced by the constitutional values, in particular, those found in the Bill of Rights.*"

<sup>93</sup> In the case of *Barkhuizen v Napier* Ngcobo J also commented as follows to the role the Constitution plays in respect of contracts, namely: "*All law, including the common law of contract, is now subject to constitutional control. The validity of all law depends on their consistency with the provisions of the Constitution and the values that underlie our Constitution.*" The court goes on to say: "*The application of the principle pacta sunt servanda is, therefore, subject to constitutional control.*" The courts do recognize the role fairness, justice and reasonableness plays in contract law, but, consequently holds that public policy ensures their existence. As to the recognition of good faith, the court rejects the idea that good faith ought to serve as one of the constitutional values governing the law of contract. In this regard the court states: "*As the law currently stands good faith is not a self-standing role, but an underlying value that is given expression through existing rules of law.*"

It is especially, when one investigates the important question, namely, to what extent can the rights enshrined in the Bill of Rights be waived or limited, that one finds how dependent one area of law is on another. Take for example the guaranteed right to access to the courts in terms of section 34 of the Constitution. Section 34 of the Constitution gives expression to a foundational value, namely, guaranteeing to everyone the right to seek the assistance of a court and further, guaranteeing orderly and fair resolutions of disputes by courts or independent and impartial tribunals. In a recent judgement in the case of *Barkhuizen v Napier*<sup>94</sup> the Constitutional Court did not decide the issue regarding the influence of section 34 on pure constitutional lines but again emphasized the role that the common law concept of public policy plays even when deciding Constitutional issues. In so far as the common law position is concerned, our courts have over the last century held that any term in a contract which deprives a party of the right to seek judicial redress is contrary to public policy and in conflict with the common law.<sup>95</sup> As the common law position has not been changed since the adoption of section 34 of the Constitution,<sup>96</sup> it is likely that when the Constitutional Court is to pronounce on the validity of an exclusionary clause in which a contractual party undertakes to exonerate the other contractual party

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Quoting the authority Hutchinson "Non-variation clauses in contract: Any escape from the Shifren straitjacket?" (2001) 118 SALJ 720 at 743-4 and quoted with approval in Brisley above at Para 22, the court suggests "*Good faith 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 contracts.*"

<sup>94</sup> 2007 (5) SA 323 (CC) at Para (31) the court put the position as follows:  
*"Our democratic order requires an orderly and fair resolution of disputes by courts or other independent and impartial tribunals. This is fundamental to the stability of an orderly society. It is indeed vital to a society that, like ours, is founded on the rule of law. Section 34 gives expression to this foundational value by guaranteeing to everyone the right to seek the assistance of a court."*  
 The court at Para (33) relying on public policy concluded:  
*"Section 34 therefore not only reflects the foundational values that underlie our constitutional order, it also constitutes public policy."*

<sup>95</sup> See *Nino Bonino v De Lange* TS 120; *Share-out v Minister of Justice* 1925 (AD) 417; See also *Administrator, Transvaal and Others v Tab and Others* 1989 (4) SA 729 (A) at 764E; *Apex Air (Pty) Ltd v Borough of Vryheid* 1973 (1) SA 617 AD at 621F-G.

<sup>96</sup> See Christie *Bill of Rights Compendium* (2002) 3H-50 who summarizes the position as follows:  
*"Section 34 cannot have been intended to change this common law position, as it expressly provides for a fair public hearing before another independent and impartial tribunal or forum where appropriate."*  
 With regard to self-help agreements in the form of *parate executie* the author suggests that any such agreement must be carefully examined so that it can be determined whether its effect is to contravene the common law and Section 34 by ousting the jurisdiction of the courts. This position was confirmed by the South African courts in *Bock v Duburora Investments (Pty) Ltd* 2004 (2) SA 242 (SCA) 247-248 and the two Constitutional Court judgements of *Chief Lesapo v North West Agricultural Bank* 2000 (1) SA 409 (CC) and *First National Bank of South Africa Ltd v Rosenberg* 2000 (3) SA 626 (CC).

from liability arising from the other party's negligence, for example medical or hospital contracts, that the court will use the common law in conjunction with constitutional law in providing the answer.<sup>97</sup>

Besides using the common law aspect of public policy in conjunction with section 34 of the Constitution to establish whether a right to access to the courts can be waived, similarly, whether the right to healthcare services can be waived, is measured by weighing up s27(1) of the Constitution with the common law<sup>98</sup> and statutory law.<sup>99</sup> In the new Constitutional order where no law exists or law reform is necessary, for example, where competing rights conflict with the values in the Constitution, the Constitution has provided several aides to interpreting the Bill of Rights. These aides include the use of both international and foreign law.<sup>100</sup>

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<sup>97</sup> The legal writer Hopkins in a most recent publication "Exemption clauses in contracts" *De Rebus* (June 2007) 22 at 24 suggests that if one were to take the proposition seriously that the Bill of Rights is an accurate statement of public policy " ..... then it follows that contracts which violates provisions of the Bill of Rights (if enforced) without good reason should be deemed unconstitutional and therefore in violation of public policy with the result that they should be unenforceable." In *Barkhuizen v Napier* Ngcobo J delivering the majority judgement emphasized the value of Section 34 of the Constitution which "not only reflects the foundational values that underlie our constitutional order, it also constitute public policy". The court consequently considered the common law position of an aggrieved person's right to seek the assistance of a court of law and whether the time-bar clause 5.2.5 was contrary to public policy and unenforceable? As to the nature of the clause, the court stated: "What is also apparent from the clause is that it does not deny the applicant the right to seek judicial redress; it simply requires him to seek judicial redress within the period it prescribes failing which the respondent is released from liability. It is in this sense that the clause limits the right to seek judicial redress."

<sup>98</sup> Hospitals and other healthcare providers are ethically obliged by their professional rules to take due and proper care and exercise their mandate and professions with diligence. The promotion and maintenance of medical standards are embodied in the Hippocratic Oath, the Declaration of Geneva, and other codes of medical ethics. The underlying rationale for the promotion and maintenance of the standards stems from the philosophy that respect for human life needs to be maintained. See Smit "Die Geneeskunde en die Reg" *De Jure* 117-118; Mason and McCall Smith (1991) 3-6. It is especially the writers Carstens and Kok (2003) *SAPR/PL* 449-451 who persuasively argue that in the Constitutional state wherein we find ourselves, the role of normative medical ethics is "a protective measure of human rights" namely "to do no harm" and "to act in the best interest of the patient". To this end, the writers argue that disclaimers against medical negligence in hospital contracts would amount to an unreasonable/unfair/unethical acceptance on the part of the patient to contract to his/her potential harm. After all, the medical practitioner (and hospital) is ethically bound not to harm. The right to have access to healthcare services, it is submitted, notionally brings about such a right, but it also brings about an obligation on the part of the medical practitioner and/or hospital not to harm the patient. Constitutionally therefore, this obligation to maintain a standard of due and skill cannot be compromised.

<sup>99</sup> In so far as statutory controls are concerned, the regulations published in the Government Gazette on the 1st February 1980 No 2948 No 6832 control the reasonable degree of care and skill which has to be maintained by private hospitals in securing a license granted to them. Regulation 25(23) of the regulations so published requires that "all services which are reasonably, generally and necessary for adequate care and safety of patients, are maintained and observed."

<sup>100</sup> For the use of international law the position has been stated as follows: When interpreting the Bill of Rights, a

#### 1.4.2 SYNTHESIS: SOME PRACTICAL QUESTIONS

The questions posed above and the manner in which they are answered have a direct impact on practical questions asked regarding the validity of exclusionary clauses in medical contracts in South Africa. Some of these questions go to the heart of exclusionary clauses in medical contracts. They confront issues such as, should these types of contracts still be tolerated, alternatively, has the time not come that these types of clauses should be outlawed in South African jurisprudence? Some practical questions in this context are:

- Given the new South African constitutional order, has the time not come for our legal jurisprudence to depart from the antiquated views so frequently expressed in respect of the law of contract, namely, that the principles of freedom of contract and the sanctity of contract are supreme? Instead, should we not follow the new Constitution with all its values and embrace a new ethos in the contractual sphere based on fairness, reasonableness and justice?

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court, tribunal or forum must therefore consider international law. See Blake "The World's law in one country: the South African Constitutional Court's use of public international law" 1998 *SALJ* 668; Botha "International law in the Constitutional Court" 1995 *SAYL* 668 as quoted in Christie *Bill of Rights Compendium* (2002) 1A-21. According to the learned author the rule is peremptory, but, except where international agreements and international law are law in South Africa, a court is not obliged to apply international law, it must merely consider it. The learned author relies on ss231, 232 and 233 of the Constitution which indicate that the Constitution "..... is the primary source of the protection of human rights in South Africa, in principle, international agreements become part of South African law only after they have been enacted as Acts of parliament and customary international law is law in the Republic unless it is inconsistent with the Constitution or an Act of parliament. See *LS v AT* 2001 2 *BCLR* 152 (CC); 2001 1 *SA* 1171 (CC) Para (27). " For the use of foreign law it is especially in the case of *Carmichele v Minister of Safety and Security* 2001 (4) *SA* 938 at 954ff the Constitutional Court relied heavily on foreign law to develop the common law in particular in the field of delictual liability by extending the general duty of care in accordance with spirit, purport and objects of the Bill of Rights as intended in Section 39(2) of the Constitution. In this case the court found the prosecution and the police had a duty imposed on them not to perform any act infringing on the dignity, equality and freedom of citizens but rather to provide appropriate protection to everyone through and structures designed to afford such protection. Where such rights are infringed, the court held there is no ground for immunity of public officials from delictual causes by the public. This case is filled with foreign law cases ranging from Canadian Law, English Law and American Law and the European Court of Human Rights. The said cases pioneered the Constitutional Court in developing the common law. In the first instance the court supported the dictum of Tacobuclli J in the Canadian decision of *R v Solitude* (1992) 8 *CRR* (2d) 173 (1991) 2 *GCR* 654 quoted with approval in *Du Plessis v De Klerk* 1996 (3) *SA* 850 (CC) 1996 (5) *BCLR* 658 at pares [15] - [24] wherein the index discussed the role judges should play in adopting the common law. In this regard the iudex held: "*Judges can and should adapt the common law to reflect the changing social, moral and economic fabric of the country. Judges should not be quick to perpetuate rules whose social foundation has long since disappeared. Nonetheless there are significant constraints on the power of the Judiciary to change the law. In a constitutional democracy such as ours it is the Legislature and not the courts which have the major responsibility for law reform. The Judiciary should confine itself to those incremental changers which are necessary to keep the common law in step with the dynamic and evolving fabric of our society.*"

- As the core feature of the doctor/hospital-patient relationship is built on the promotion and maintenance of medical standards advancing the interests of the patient, should the courts, when assessing the validity of exclusionary clauses in medical/hospital contracts, not consider the values built into the doctor/hospital-patient relationship, given the fact that exclusionary clauses in medical/hospital contracts have the potential to compromise the relationship?
- Given the fact that normative ethics have played such a fundamental role in the practice of medicine *inter alia* setting standards of conduct and serving as a protective measure in maintaining these standards, does it not follow that exclusionary clauses with their apposite aim are in direct conflict with normative ethics?
- Does it not follow that given the nature, aims and objectives of exclusionary clauses in medical/hospital contracts that they do not serve the best interests of the patient and runs counter to the fiduciary nature of the doctor/hospital-patient relationship?
- As the obligation to act in the utmost good faith and not to allow a doctor/hospital's personal interests to conflict with their professional duty is fundamental to the doctor/hospital-patient relationship, does it not follow that exclusionary clauses in medical/hospital contracts are in conflict with such an obligation?
- Is it in public interest that, despite a patient consenting thereto, through the use of exclusionary clauses in medical/hospital contracts, the doctor/hospital are allowed to compromise the long standing standards of conduct expected of the medical profession?
- Should a doctor/hospital that stands in a position of trust in relation to his/her/its patient, exploit the relationship by using exclusionary clauses to relax the degree of care and skill expected of him/her/it?
- Should a patient rightfully be allowed to abandon a potential claim for damages flowing from the negligent conduct of a doctor or hospital by signing an agreement which includes a waiver of rights or exclusionary clause, built into the agreement?

- Why seek professional help if it means that despite professional standards being set for them and ethical rules being in place for centuries, that doctors/hospitals can, by way of agreement, be allowed to compromise professional standards resulting in patients suffering loss?
- Should the classical law principles of freedom of contract and the sanctity of contract reign supreme, despite, the inequality the weaker party to the contract, for example, a patient in the doctor/hospital-patient relationship, may face in the contractual relationship?
- Should there be fair dealings in contract, especially, where a degree of bargaining unfairness is present in concluding agreements?
- Should good faith be developed as a safety valve to ensure a minimum lack of fairness in contracting?
- Should the courts protect the weaker party to a contract where the parties stand in an unequal bargaining position and declare such contracts or contractual provisions to be invalid and unconscionable?
- Should exclusionary clauses or other contractual provisions which would result in extreme unfairness, or as a result of other policy convictions and contrary to the interests of the community, be declared invalid and unenforceable?
- Should exclusionary clauses or disclaimers excluding gross negligence or negligence or both be denounced as against public policy and unenforceable?
- Should the doctor/hospital's duty of care be regarded as inalienable even in the face of the doctor/hospital's contractual freedom? Put differently, can the obligation of the doctor/hospital to maintain and exercise reasonable care in treating a patient imposed by law, be avoided by contract?
- Should the prevailing standards of care bestowed on healthcare providers be declared a non-negotiable duty of public service?

- What effect should the regulation which governs the licensing of private hospitals and which aims to maintain standards of care and skill in treating a patient, have in the face of exclusionary clauses or waivers?
- Should the objective criteria such as fairness, reasonableness and conscionability in contracts not be given greater weight when assessing standard form contracts, more especially, exemption clauses or waivers in medical or hospital contracts?
- Should the fact that a patient stands in an unequal bargaining position to that of a medical practitioner/hospital not cause the contractual liberty of a contracting party to be scrutinized against the values that animate the Constitution?
- Does freedom of contract, when abused by the stronger contracting party resulting in unreasonable and unjust contracts, undermine the values enshrined in the Constitution and the Bill of Rights?
- Should the right to healthcare services be placed on the same footing as suppliers of other services? Put differently, should the courts put a greater premium on the constitutional right to healthcare services as that of a supplier of other services?
- Should a contracting party, relying on the principles of contractual freedom and the sanctity of contract validly be able to get the other contracting party to agree to waive his/her right to healthcare services as guaranteed by the constitutional values which include the doctor's/hospital's ethical duty of proper care and diligence?
- Can a right to access to healthcare services be waived or limited in any way or should such a right be declared as inalienable?
- When considering the validity of exclusionary clauses or waivers in contract should greater weight not be given to the right of access to the courts as provided for in terms of section 34 of the Constitution as opposed to the principles of freedom of contract and sanctity of contract?
- To what extent can international law and foreign law authorities assist in developing the common law, especially, the law of contract, more especially, when the Constitutional Court is confronted with pronouncing on the validity of

exclusionary clauses or waivers in hospital contracts?

- Should private agreements in the form of exemption clauses or waivers, which aim to reduce or diminish a hospital or other healthcare provider's statutory or ethical duties, be tolerated or should they be struck down as contrary to public policy?

It should be clear at this juncture, in view of the questions posed hereinbefore, that the Constitution, as a foundational source would now have a profound influence should the validity of exclusionary clauses in hospital contracts be reviewed and ultimately impact greatly on the decision-making of the Constitutional Court when called upon.

## 1.5 APPROACH AND METHODOLOGY

The thesis explores the questions raised above, and others, in the context of six broad areas of law, namely, the law of contract, constitutional law, medical law and medical ethics, the law of delict, statutory law as well as foreign and international law. The fore stated areas of law have in some instances been covered separately. Besides investigating the nature, scope and application of exclusionary clauses and how some of the six broad areas of law impact on them, a comparative legal study is made of the legal position with regard to exclusionary clauses, especially those clauses in medical contracts, in three jurisdictions separately. The jurisdictions are South Africa, England and the United States of America. The analysis of this thesis is cast in considering the views expressed by legal writers in the different jurisdictions, the findings of the courts on various aspects of law in the aforementioned jurisdictions and, formulating legal opinion on various aspects of law. The purpose is to find common ground in an attempt to answer the question which forms the subject of this thesis, namely, should exclusionary clauses in hospital contracts be declared invalid in South Africa? More particularly the research material is divided into twelve chapters in the following way:

### 1.5.1 DIVISION OF RESEARCH MATERIAL

- Chapter two explores the concept doctor-patient relationship from its infancy and its development through centuries of medical practice, until the present. The key components of the doctor-patient relationship include the internationally recognized principle that the doctor/hospital owes the patient the duty to take care and to act reasonably, as well as, normative medical ethics in which values such as conscience and intuitive sense of goodness, good faith and loyalty, fiduciary trust and responsibility play fundamental roles. This chapter also includes a discourse on

the issue of licensing which is aimed at regulating the health, welfare and safety of the public, especially, patients who receive medical treatment.

- Chapter three considers the nature of the doctor-patient relationship with specific reference to the contractual relationship between the doctor and patient. This chapter considers the nature of the contractual relationship as it appears in the jurisdictions of England, the United States of America and South Africa. This chapter also considers, in particular, the consensual nature of the relationship.

What appears from this chapter, as well, is that a trust position is created between the doctor and patient wherein the doctor undertakes, arising from the nature of his or her position or profession, that reasonable care and skill will be exercised towards the patient once the relationship commences.

- Chapter four covers the general principles of the law of contract in a South African medical context. What is considered in this chapter is the formation of the contract including the capacity to contract as well as the intention of the parties to create such a relationship. The chapter goes further in exploring the formalities which need to be complied with and what terms could be included in the contract. Finally this chapter also covers the necessity of obtaining the patient's consent including the different forms of consent.
- Chapter five covers the mutual duties and obligations between the doctor and patient arising from the law of contract in a South African medical context. This duty includes the doctor's general duty to treat the patient and to exercise due care and skill. It also covers, separately, the hospital's duty towards the patient.
- Chapter six, deals with the doctor/hospital/other healthcare provider's general duty of care in delict. This arises independently of any contract. This general duty of care may even exist side by side with the contractual obligation. This chapter also considers the standard of care that needs to be exercised against the backdrop of medical ethics.
- Chapter seven considers when, and under what circumstances, may a doctor/hospital/other healthcare provider limit or exclude his/her/its duty of care with specific reference to the doctrine of *volenti non fit iniuria* in a general context

as well as the medical context. The same consideration is given to the concept “assumption of risk”. The considerations in this chapter include a comparative study in the jurisdictions of South Africa, England and the United States of America.

- Chapter eight covers the foundational concept in the law of contract, namely, freedom of contract and how it influences the commercial sphere in general.
- Chapter nine deals with the *caveat subscriptor* rule in the law of contract and pursues a discussion on the general defences available to the *caveat subscriptor* rule.
- Chapter ten explores three selective concepts which impact on contractual freedom. They include the principle of fairness, the doctrine of unconscionability and the doctrine of public policy. This chapter examines the impact that they have on the law of contract in the jurisdictions of South Africa, England and the United States of America.
- Chapter eleven examines the recognition of exclusionary clauses in general as they appear in the jurisdictions of South Africa, England and the United States of America.
- Chapter twelve analyses various factors impacting on the validity of exclusionary clauses in general. These factors include fraud or dolus, public policy, the status and bargaining power of the contracting parties, public interests and statutory duty. An analysis of their impact includes the jurisdictions of South Africa, England and the United States of America.
- Chapter thirteen examines constitutional issues surrounding the law of contract and how the South African Constitution and the Bill of Rights impact on exclusionary clauses, especially those in medical/hospital contracts.
- Chapter fourteen explores the focal point of the research undertaken in this thesis. The legitimacy of exclusionary clauses in medical contracts is examined as they appear in South Africa, England and the United States of America. This chapter offers some concluding thoughts on the subject matter of this thesis.

The method employed to deal with the investigation into the validity of exclusionary or exculpatory clauses, otherwise known as waivers in medical/hospital contracts, is firstly to get a greater understanding of the doctor/hospital-patient relationship by expounding and discussing the foundations and principles of the relationship. The method applied in researching the history and development of the doctor/hospital-patient relationship reveals that the term owes its birth to the promotion and maintenance of medical standards and that the doctor/hospital has to exercise a duty of care towards the patients to attain that standard. What the research also reveals is that the relationship arises both contractually and from the doctor's general duty of care founded in tort or delict. The present exposition reveals that in the modern era the principles upon which the relationship between doctor/hospital and patient are founded remains universally very much intact. The relationship continues to be shaped and influenced by a strong commitment to long-standing principles of medical ethics which play a major role.

The traditional sociological nature of the doctor/hospital-patient relationship was founded on the paternalistic model in which the authority was invested in doctors by society because of their knowledge of bodily functions and disease. The paternalistic model was influenced to change due to the evolution in political philosophies *inter alia* nationalism and liberalism. Moreover, the paternalistic model in the modern day transformed into the autonomy or contract model which reflects the basic human right to self-determination. A high premium was placed on the protection of the individual under consumer sovereignty. Besides, the patient was seen to play a more active role in the relationship, the fiduciary nature of the relationship between the doctor/hospital and patient also emerged in which doctors/hospitals were expected to act with utmost good faith and loyalty and not to allow their personal interests to conflict with their professional duty. It is especially, the latter phenomenon, which is of tremendous importance in offering some concluding thoughts on the subject matter of this thesis.

What is also undertaken, in this context, is an investigation into the modern nature of the doctor/hospital-patient relationship as it appears in contemporary medical practice. To this extent and purpose, the nature of the relationship, including, the contractual relationship in a medical context as well as the general duty of care which naturally flows from the relationship is investigated as it appears within the framework of the South African, English and United States of American legal systems. What is also investigated is to what extent and under what circumstances may a doctor/hospital/other healthcare provider limit or exclude his/her/its duty of care, by using the doctrine of *volenti non fit iniuria* and the

assumption of risk, as a ground of justification in both the general, as well as the medical context?

Although the validity of exclusionary clauses or waivers could have been investigated within the framework of other legal systems as well, it was, for the following reasons decided to do a comparative law investigation within the aforementioned legal systems. There can be no question about it; all three legal systems are representative of the most important legal families, universally. Whereas England and the United States of America typify what is known as common law systems, South Africa especially, with the adoption of its new Constitution, is known as a hybrid system.<sup>101</sup> All three countries have had a tremendous development in the medical law sphere. Although English law has not had the challenges that South African law and that of the United States of America had to endure in pronouncing on the validity of exclusionary clauses, nonetheless, English law has been specifically chosen because of its close historical bond with South African law, as it appears from the Positive law. With regard to medical and contract law, the English and South African courts have often referred with approval, to each other's dicta.<sup>102</sup> More recently the South African courts, on occasions, have referred especially to the English legislation which was instituted to curb unfair and unreasonable exclusionary clauses in contract.<sup>103</sup>

The United States of America has been specifically chosen as the courts in America have had similar challenges in pronouncing on the validity of exclusionary clauses in medical contracts.<sup>104</sup>

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<sup>101</sup> David and Brierly *Major Legal Systems in the World Today* (1978) 21-73; Van Zyl *Beginsels van Regsvergelyking* (1981) 131 at 170-196 284.

<sup>102</sup> See in this regard the English case of *Chatterton v Gerson* (1981) 1 QB 432 which refers with approval to the South African case of *Stoffberg v Elliott* 1923 CPD 148; See further the case of *Castell v De Greef* 1994 (4) SA 408 in which the South African court relies heavily on English law in concluding in the end that the development of other common law countries like Canada, the United States of America and Australia should rather be following the English law; See also *Burger v Central South African Railways* 1903 TS 571; *Mathole v Mothle* 1951 (1) SA 456 (T) in which English rules and principles regarding exclusionary clauses were entrenched.

<sup>103</sup> See in this regard the South African cases which referred to the English Unfair Contract Terms Act 1977. See the Supreme Court of Appeal judgement of *Johannesburg Country Club v Stott and May NO* 2004 (5) SA 511 (SCA); See also the Constitutional court judgement of *Barkhuizen v Napier* 2007 (5) SA 323 (CC).

<sup>104</sup> See the leading case of *Tunkl v Regents of the University of California* 50 Cal 2d 92, 32 Cal Rptr 37 383 P.2d 441.

The question surrounding the validity of exclusionary clauses in medical contracts is settled in the United States of America and much can be learnt from them.

Relying upon the three forestated jurisdictions, a comprehensive investigation is also made into the role of the law of contract generally in the commercial sphere. What is also considered is the influence of freedom of contract and how the promotion of consumerism and other philosophies have impacted in curbing unlimited freedom of contract. Consideration is also given to the *caveat subscriptor* rule and the general defences to the rule. Three factors influencing the law of contract and which impacts on the unlimited use of exclusionary or exculpatory clauses are also signalled out for investigation. These factors include the principle of fairness, the doctrines of unconscionability and public policy. The investigation into the role of the said three factors together with a full consideration of the recognition of exclusionary clauses in the three jurisdictions in general, paves the way for a comprehensive investigation into the validity of exclusionary clauses in medical contracts, which forms the purpose of the present thesis. Moreover, the basis, principles and problems surrounding exclusionary clauses in medical contracts are researched. Furthermore, the aim and object of the thesis is to provide a proper theoretical and practical legal framework within which to adjudge the validity or put differently, the invalidity, of exclusionary clauses or waivers in medical contracts, within which the hitherto wrongly developed South African law of exclusionary clauses in medical contracts, may be corrected and further developed in future.

The method employed further, is to attempt to find answers in the Constitution of the Republic of South Africa, the Constitution being the supreme law of the Republic and in respect of which, all law, be that the common law, or the statutory law, is subordinate. Another reason for turning to the Constitution to find answers to the question which forms the subject of this thesis, is because the Constitution affects not only the relationship between the State and other government structures and its citizens, but also, private relations between business enterprises and their clients, including, the relationship between hospitals and patients. The values included in the Constitution, and emphasized by the Constitution, hold the key to the question under consideration.

Although there are here and there some differences between the legal systems themselves, the overall integrated survey reveals much common ground to draw from in order to find solutions to the question posed. The emphasis in presenting this thesis is on providing an overall picture and on synthesis rather than on a fragmented picture and on antithesis.

### 1.5.2 EXPLANATORY NOTE ON SOURCE REFERENCING AND BIBLIOGRAPHY

An extensive bibliography to this thesis is provided. The bibliography comprises of a listing of books, journal articles, academic theses and dissertations, and reports; a table of cases divided into South African Law and foreign Law; a table of statutes; and a list of abbreviations. It was decided, unlike other theses of this nature, where only the principal sources and cases and statutes are listed, to list the bibliography, with reference to every source cited in full, to avoid the possibility that important sources became obscured in some footnote.

One of the main objectives was to incorporate most, if not all, of the principal books and texts, academic theses and dissertations and journal articles on the subject matter ever written in South Africa. This was also the aim with reference to the discussion of related case law and legislation.

In addition the same approach was followed in including as many foreign law sources in certain chapters as possible. These included books, journal articles, academic theses and dissertations, and reports; a table of cases, a table of statutes, and a list of abbreviations.

At this point it needs to be emphasized that the theses and principles covered under the different landscapes of South African law as well as foreign law, was daunting in selection, but, it is submitted, reflect the foundational principle of South African medical law and ethics, the law of contract generally and how it interfaces with the doctor-patient relationship; the doctor-patient relationship relating to the law of delict, specifically in the context of the doctor/hospital's duty of care and the possible exclusions of the duty of care by utilizing the doctrines of *volenti non fit iniuria* and voluntary assumption of risk; the influence of exclusionary clauses in the law of contract and what factors impact on the use of exclusionary clauses in hospital contracts; the Constitution and its interface with, and broad impact on, medical law and ethics, the law of contract, the law of delict and statutory regulations as well as foreign/international law.

Although some comparative research was done in this thesis to seek out and include foreign law from the jurisdictions chosen for the research, especially, where they have dealt with issues similar to those under discussion, it is not claimed that all sources have been exhausted.

Although some criticism may legitimately be lodged at the voluminous work produced with this thesis, the size is attributable to the following:

- The thesis covers wide multitude of various legal landscapes. Some of these landscapes may be uncharted territories to some of the readers who may not have intimate knowledge of every area of law;
- The answer sought to the key question which forms the core subject matter of this thesis cannot be found without pursuing the different legal landscapes;
- The Constitution in the new constitutional order shapes the ordinary law and must inform the way legislation is drafted by the legislatures and interpreted by the courts and the way the courts develop the common law.

The Constitution permeates all laws in South Africa. The Constitution also requires consistency of all other law not only with itself but also between various fields of law.<sup>105</sup> As exclusionary clauses in medical contracts touches various fields of law *inter alia* medical law and ethics, the law of contract, the law of delict, statutory law and constitutional law, one cannot analytically assess the validity of exclusionary clauses in medical contracts without examining these major fields of law. In that way one may detect inconsistencies which the Constitution does not tolerate. As the Constitution unites all major fields of law, the structure of this thesis reflects the ideal approach to law - that there is a single legal system with many facets rather than a number of different systems that operates independently of each other.

The Constitution directs South African courts to consider international law and allows them to consider foreign law. This is the approach followed in this thesis. In many of the chapters a comparative study of various concepts and principles in the different fields of law is made.

### 1.5.3 ACKNOWLEDGEMENT OF THE CONTRIBUTION OF PAST AND PRESENT SOUTH AFRICAN WRITERS ON THE TITLE EXCLUSIONARY CLAUSES IN MEDICAL CONTRACTS

Researching and writing a thesis of this nature is comparable to ascending a steep and precipitous mountain. As is the case with the climbing of any mountain, the mountain

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<sup>105</sup> Carstens and Pearmain (2007) 17.

fortress is often obscure and precarious, unless that fortress has been explored and one can literally walk the same path as that undertaken before. In this regard, writer was fortunate that in many respects writer was able to pursue the charted footsteps of eminent South African writers, past and present, who have written, and still write prolifically, on the different legal landscapes revealed during this research. It was only during this academic ascendancy, researching this thesis, that one realises the vast and profound influence their writings have had over a period of time, and the significant contributions they have made, and continue to make, to South African legal jurisprudence.

When writer first started out ascending the academic mountain in assessing the law pertaining to the validity of exclusionary clauses in medical contracts, it became evident that it was a path less followed. Very little was written at the time on the subject matter in the South African jurisdiction. In time however, especially, after the controversial judgement of Brandt JA in the case of *Afrox Healthcare Bpk v Strydom*,<sup>106</sup> the path was followed more frequently in search of an answer to the question whether a hospital or other professional person *inter alia* nursing staff and/or doctor may validly exclude or restrict their liability to patient, for breach of their duty owed to the patient? In the end, as so eloquently stated before, it "turned out to be more of a pilgrimage where one could walk `in the steps' of previous writers and write the chapters while standing on their shoulders".<sup>107</sup> All that was required in the end was to contextualise the underlying themes and principles and align them with the constitutional demands in the post-constitutional era.

In thanking those who have assisted in the preparation of this thesis it is necessary to recall those who have contributed to the researching and writing of this thesis. I have particular debts of gratitude to repay a number of people. When first embarking on researching this subject matter in preparation of the medical negligence trial referred to earlier, I was privileged to share ideas with Professor Strauss, of the University of South Africa, with whom I spent a considerable time at the school of law of the University of South Africa. During our discussions Professor Strauss, brought to bear his great knowledge of medical law in South Africa as well as other foreign jurisdictions. His knowledge, wisdom and inspirational passion for law, influenced me immensely. So much so that, after finalising the case, I enrolled for the LLD Degree at my academic home for the last ten years, again I was

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<sup>106</sup> 2002 (6) SA 21 (SCA).

<sup>107</sup> The eloquence in which the academic path of research is described is quoted from Carstens and Pearmain (2007) 18.

very fortunate to have met up there with another academic giant, Professor FFW van Oosten, whom has sadly passed away since. Professor van Oosten, not only discussed innumerable points in this thesis with me while it was in gestation and while it was being written, he also introduced me to the complexities of academic legal writing.

Intellectually, my greatest debt is owed to Professor Pieter Carstens, whom I salute for his patience, valuable suggestions and detailed comments and without which; I would not have been saved academic embarrassment. Thank you, Professor Carstens, for providing me with a stimulating intellectual environment through which you guided me with dedication, unwavering support and warm academic friendship. I have also derived enormous benefit from reading your outstanding contribution to contemporary legal-medical literature. I owe you more than I can say.

It remains to acknowledge the debt that I owe to all those colleagues with whom I have profitably discussed some of the themes in this thesis and whom remained loyal in their belief that post the *Afrox Healthcare Bpk v Strydom* case more than ever before, judicial rethink, alternatively, legislative intervention is necessary to ensure that standards of fairness and reasonableness compliant with the legal convictions of the community in the contemporary society, is maintained.

## 1.6 CONCLUDING REMARKS

It will be demonstrated and witnessed in this thesis, that the quest for finding answers to the central theme of this thesis cannot be concentrated on in one area of law, be that the law of contract, be that medical law and ethics, be that the law of delict. What will also be borne out in this thesis is that the different areas of law or legal landscapes, as described, interface. The Constitution, being the Supreme Law, also underpins the other fields of law. The core issue under investigation in this thesis, namely, a critical analysis of exclusionary clauses in medical contracts, therefore, has to be considered not only in terms of its contractual content, but also in terms of the interaction between the law of contract, medical law and ethics, statutory law and constitutional law. What is also considered is the effect of international law and foreign law principles on the South African legal landscape dealing with the different fields of law. Although one can study the content of individual traditional branches of law to a certain extent, the study only becomes meaningful when one studies the interaction between the different fields of law given the fact that the Constitution unifies them all into a single, all encompassing, legal system. The values and principles expressed in the Constitution cement all the fields of law into the greater whole

of a legal system. For that reason, there is no better way of analysing the central theme of this thesis than to examine the different fields of law applicable as they interface.

In this regard, the validity or enforceability of exemption clauses in medical contracts can no longer be measured by way of traditional means and by dealing with the question under the sanctity of contract rule. Instead, the question will always be dealt with by having regard to the principles and values of the Constitution. To this end, it is particularly, rights to freedom of contract, access to healthcare with accompanying ethical standards of care, equality and access to court, which will play a role.

Furthermore, in weighing up these constitutional rights and their accompanying values and principles, the courts should consider which of the rights have been infringed when they question the enforceability of a contractual provision. Where a contractual provision tends to bring about a limitation of a constitutional right then it will be in violation of public policy, unless, it is reasonable and justifiable, as provided for in S30 of the Constitution.

No matter how high a premium we place on the sanctity of contract rule, the freedom to contract can never serve as a justification for enforcing a private agreement that has the aim and effect of unreasonably limiting the other party's constitutional rights.

## Chapter 2

### HISTORICAL OVERVIEW AND DEVELOPMENT OF THE DOCTOR-PATIENT RELATIONSHIP

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#### 2.1 Introduction

This chapter includes an investigation into the nature of the doctor-patient relationship and how it originated during the ancient period and developed throughout many centuries in the practice of medicine. A truly analytical and balanced assessment of the validity of exclusionary clauses or waivers in medical contracts involving doctors/hospitals/other healthcare providers and patients, which form the core theme of this thesis, cannot be made without an evaluation of the legal aspects of the doctor-patient relationship. The term doctor-patient relationship has been deliberately chosen for this chapter as the relationship between the patient and the doctor goes back much further than, as will be seen in this chapter, the hospital and patient relationship. It should however be borne in mind that there is much concurrency in the legal aspects between the doctor-patient as is the position in the hospital-patient relationship.

The doctor-patient relationship is of import to the central theme of this thesis. As an expansive discussion of the various features will be superfluous for the nature of the research undertaken with this thesis, a brief discourse follows. Central to the relationship between doctor/hospital and patient is the fact that the nature of the relationship is essentially a private law matter and is governed by the law of obligations: that is to say by the law of contract and the law of delict.<sup>1</sup> In the absence of a contract between the parties, the relationship is therefore governed by the law of delict. The establishment of the legal relationship between the doctor/hospital and the patient depending upon whether it is founded in contract or in delict, will thus reveal many legal aspects. When a contractual relationship is established, the salient features of the relationship will be revealed which will include *inter alia* the existence of the agreement, the terms of the agreement, whether there has been a breach of any of the terms agreed to, whether the agreement had been terminated etc.<sup>2</sup> Like the law of contract, the law of delict imposes a duty of reasonable care on the doctor/hospital in respect of the patients. In consequence thereof, the doctor/hospital is obliged to take reasonable care to prevent harm from occurring to the patient. This can obviously, when not adhered to, lead to liability for negligence. Equally, it is therefore important to establish such a relationship between the doctor/hospital and the patient outside a contractual relationship.<sup>3</sup> The doctor/hospital and patient relationship also indicates, when assessing the nature of the relationship, what sociological model is applicable to the relationship. Whereas traditionally, the paternalistic model was prevalent in which the doctors would take action or make decisions on behalf

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<sup>1</sup> See Van Oosten "Medical Law - South Africa" in *International Encyclopaedia of Law* (Ed Blanpain R) (1996) 53. The writer expresses the view that in the ordinary course of events, the relationship between the parties is a contractual one. But since the breach of a duty of care and negligence may underlie both breach of contract and a delict; the same act or omission by a doctor/hospital may result in liability for both. Similar views are expressed by Strauss and Strydom (1967) 104ff; Strauss (1991) 3; For South African case law see *Van Wyk v Lewis* 1924 AD 438, 450-451; *Correia v Berwind* 1986 (4) SA 60 (Z) 63; *Edouard v Administrator Natal* 1989 (2) SA 368 (D) 385ff; *Magware v Minister of Health* 1981 (4) SA 472 (2) 476.

<sup>2</sup> For a comprehensive discussion on the salient features and legal aspects of the contractual relationship between the doctor/hospital and patient see Van Oosten (1996) 54ff. Strauss and Strydom (1967) 104ff; Strauss (1991) 3ff. One of the essentialia of the conclusion of an agreement between the contracting parties is the principle of an offer and acceptance. For parties to reach true consensus there must be a clear understanding of the terms agreed to. See *Serf Commercial and Industrial Properties (Pty) Ltd v Silberman* 2001 (3) SA 952 (SCA) 958. This is particularly relevant in cases where informed consent is required for example 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 the alternative to it. See *Castell v De Greef* 1994 (4) SA 408 (C); *Broude v McIntosh* 1998 (3) SA 60 (SCA); *Minister of Health v Treatment Action Campaign (No 2)* 2002 (5) SA 721 (CC). See also the comprehensive discussion on the legal aspects of the contractual relationship between the hospital/doctor and patient in Carstens and Pearmain (2007) 404ff.

<sup>3</sup> See Van Oosten (1996) 57-58; Strauss and Strydom (1967) 104ff; Carstens and Pearmain (2007) 406-407.

of their patients,<sup>4</sup> this has changed over the last four decades. Influenced by the ethos and philosophy of consumerism, the sociological model changed to the patient 'autonomy' or 'contract' model<sup>5</sup> wherein the patient is seen as an autonomous purchaser of services. It assumes that persons are free to choose between different courses of action. Their consent is required. This, it is submitted, will be a factor to be considered when assessing the validity of medical contracts exonerating the doctor/hospital from professional liability arising from their negligence. The doctor-patient relationship is not a new concept nor is the term a modern invention. The term, albeit in unwritten form, first emerged during the ancient period. Although priestly, medicine was practiced at the time. The concept doctor-patient relationships was not known in its present form, nonetheless, a relationship between healer and patient was in fact recognised at the time.

The term owes its birth to the promotion and maintenance of medical standards. Where harm was caused to a patient, this led to sanction.

In terms of the historical tract of the recognition of the relationship between doctor-patient, the relationship received more prominence during the rule of King Hammurabi (1792 BC) in which the exercise of a duty of care towards the patient became formalistic. It was during this period that traces of medical ethics and the standard of conduct are founded.<sup>6</sup>

The Babylonians in 2500 BC broadened the relationship with the introduction of greater obligations on the healers, including, penal and civil sanctions for the deviations from the standard of conduct. The term doctor-patient relationship continued to be refined. It was especially during the Greek period that Greek writings emerged which focused on the virtues and high moral standards and strong ethical values required from doctors. The writings of Hippocrates (460-360BC), who is generally acknowledged as the father of medical science, through his influential philosophy of the time, impacted very much on medical science in ancient Greece. His Hippocratic Oath is undoubtedly one of the greatest

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<sup>4</sup> The doctor was seen as benevolent and will only undertake actions not harmful to the patient and therefore the patient's explicit permission was not necessary. See Benatar "The Changing Doctor-patient relationship and the New Medical Ethics" *SA Journal of Continuing Medical Education* Vol. 5 (April 1987) 27; See also Strauss "Geneesheer, Pasiënt en Die Reg: 'n Delikate Driehoek 1987" *TSAR* 1ff.

<sup>5</sup> See Benatar (1987) 29; See also Strauss *TSAR* 1987-1 1ff.

<sup>6</sup> It was Hammurabi's belief at the time that "*the strong may not oppress the weak*". See Chapman *Physicians, Law and Ethics* (1984) 5.

contributions to the practice of medicine.<sup>7</sup> The Hippocratic Oath then became the touchstone of modern medical ethics which have bound physicians in their conduct for many centuries. The Hippocratic Oath at the same time influenced the doctor-patient relationship and continues to do so today.<sup>8</sup> One of the objectives of the Oath was to prohibit the doctor taking advantage of the patient because of the nature of their relationship which was built on a position of trust.

The Roman Era was characterized by a lack of advancement of scientific development in medicine,<sup>9</sup> but, in a legal sense, the nature of the doctor-patient relationship was regulated by the *Lex Aquilia* which defined negligent medical conduct.<sup>10</sup> At the same time, remedies inter alia the *Lex Cornelia* and the *Lex Pompeia* were founded to deal with civil and criminal transgressions against patients.<sup>11</sup> A further significant feature of this era is the emergence of a clear identification of the nature of the doctor-patient relationship which was founded on the one hand, on contract based on Ulpianus' writings and on the other hand on the doctor's duty to take care under the *Lex Aquilia*. Consequently, legal remedies were founded during the Roman Era in both contract and delict.<sup>12</sup> A clearly identifiable standard of conduct for medical practitioners were founded and measured against the yard stone *imperitia culpa adnumeratur* which included ignorant conduct.<sup>13</sup>

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<sup>7</sup> Jones *Hippocrates* (1923) 291. See also Strauss and Strydom (1967) 175; for a discussion of the influence of Hippocrates at the time see Carstens and Pearmain (2007) 610.

<sup>8</sup> Edelstein *Legacies in Ethics and Medicine* (1977) 75 believes that the Hippocratic Oath embodies the truth between the doctor and the patient.

<sup>9</sup> Carstens and Pearmain (2007) 611.

<sup>10</sup> Frier *A Casebook on the Roman law of Delict* (1967) 39.

<sup>11</sup> Amundsen "The Liability of the Physician in Roman Law" *International Symposium on Society, Medicine and Law* (ed Karplus J) (1973) 21.

<sup>12</sup> Amundsen (1973) 20; Frier (1967) 39.

<sup>13</sup> Amundsen (1973) 22 discusses the nature and effect of the standard of care citing the *Digesta* 50 17 32: "(Gaius 7 ad edictum provinciale): *Imperitia culpa adnumeratur*"; *Inst Just* 4 3 7 "*Imperitia culpa adnumeratur, veluti si medicus ideo servum tuum occiderit, quod eum male secuerit aut perperam ei medicamentum dederit*". Translated "*Imperitia is defined as lack of professional skill, lack of capacity, lack of knowledge, generally, incompetence relative to the standards that were expected of a person giving services, whether artisan or physician, craftsman or architect, whether acting under contract or mandate.*" According to Carstens and Pearmain (2007) 613 this rule entailed that ignorance or incompetence was regarded as negligence, i.e. the absence of professional skill and experience which are required and set by the medical profession i.e., the physician performing an operation in an unskilful or incompetent manner.

The post Roman Era saw the development of medical ethics with the introduction of forensic medicine and medical jurisprudence. Further legal remedies inter alia the *Leges Barbarorum* and the *Lex Visigothorum* were founded which further regulated the conduct of doctors. The Renaissance period consolidated the doctor's duty of proper care and skill, the breach whereof, lays the medical practitioner open to an action of trespass in tort. A fundamental feature of this era was the introduction of medical practice in furtherance of public service. A service ideal was executed, devoted to the client's interests.<sup>14</sup>

The Roman Dutch Era was characterized by a strong commitment in documenting, by way of legal writings, the duties of medical practitioners and the requirements for legal liability. It was especially the writings of De Groot, Vinnings, Noodt, Vinnius and Huber who brought into discourse the role of the medical practitioner and his liability for medical negligence. It appears that in this regard the moral convictions of the community and public policy played a significant role in determining the delictual and criminal liability of medical practitioners.<sup>15</sup>

The nature of the relationship between the doctor/hospital/healthcare provider-patient during the Pre-Modern and Modern era very much remained the same and has been shaped by a strong commitment to long-standing principles of medical ethics in which conscience and the intuitive sense of goodness, public conscience, responsibility, the Hippocratic Oath, the sanctity of life and bodily integrity play a major role.<sup>16</sup> Trust and respect also continue to influence the relationship. Normative ethics including the responsibility of medical practitioners and hospitals to comply with standards of conduct, including moral principles, rules, rights and virtues continue to dominate the relationship.<sup>17</sup> Adequate care

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<sup>14</sup> Berkhouwer and Vorstman *Die Aansprakelijkheid van de Medicus voor Beroepsfouten door Hem en Zijn Helpers Gemaakt* (1950) 18-19; Porter *The Greatest Benefit of Mankind* (1999) 85ff; Rhodes *An Outline History of Medicine* (1985) 37-38; Cronje-Retief (2000) 23-24; See also the more recent publication of Carstens and Pearmain (2007) 615.

<sup>15</sup> See De Groot in his *Inleidinge tot die Hollandsche Rechts-Geleerdheid* 3 33 5; See also Scott: "Die Reël Imperitia Culpae Adnumeratur as Grondslag vir die Nalatigheidstoets vir Deskundiges in die Deliktereg" - *Petere Fontes LC Steyn Gedenkbundel* (1981) 134; For a comprehensive discussion on the influence of Roman Dutch Law see Carstens and Pearmain (2007) 616-617.

<sup>16</sup> See the writings of Jones (1996) 18ff; The writers Mason and McCall-Smith (1991) 14-17 in particular, emphasizes the role of medical ethics in the doctor-patient relationship; See also Ficarra (1995) 147ff; Skeggs (1988) 8.

<sup>17</sup> The writers Beauchamp and Childress (2001) 1-7 hold the view that normative ethics dictate to the medical practitioner the responsibility he/she has to show in maintaining standards of conduct, including moral principles and virtues; See also the very enlightened article by Carstens and Kok 2003 *SAPL* 430, 449-451.

and safety of patients confirming the 'social contract' between the practitioner and patient in which the practitioners pledge to act to the benefit of their patients also remain a feature of the nature of the relationship in the modern constitutional state in which South Africa finds itself today. Normative medical ethics in the form of codes/regulations is viewed as a protective measure of human rights namely to do the patient no harm and to act always in the best interests of the patient.<sup>18</sup>

What has changed, however, in the nature of the doctor-patient relationship is the legal characterisation of the relationship and the sociological construction thereof.<sup>19</sup> In so far as the legal characterisation is concerned, a shift in the foundation of liability has taken place. Whereas the medical practitioner, prior to the modern era, incurred liability arising from his common calling and his deviation from his duty to use proper care and skill,<sup>20</sup> in the modern era the medical practitioner's liability arises *ex contractu* alternatively *ex delicto* or simultaneously.<sup>21</sup>

The relevance of establishing whether the doctor or hospital's staff's liability arises *ex contractu* alternatively *ex delicto* is to prevent a situation where patients could waive all or some of their delictual rights and negotiate the terms of liability through private contracts.  
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<sup>18</sup> See Veatch (1997) 21; Carstens and Kok 2003 *SAPL* 430, 449-451.

<sup>19</sup> See Benatar (April 1987) 27; See also Strauss (1987) *TSAR* 1ff.

<sup>20</sup> Picard and Robertson *Legal Liability of Doctors and Hospitals in Canada* (1996) 1-2 state that in order to protect the public, certain legal constraints and expectations were placed on those who professed such a calling. These included, in particular, a legal duty to use proper care and skill. In turn, the seed of negligence action sprang to life; See also Teff *Reasonable Care - Legal perspectives on the doctor patient relationship* (1994) 159 states that originally the civil liability of doctors was derived from their status or calling and was rooted in the failure to exercise the skill and diligence expected in their calling. As, in some respects, medical transactions seem to fall more naturally within the realms of private law, the liability of doctors also came to be seen as contractual, especially, with the influence of the law of contract; See also Holdsworth *History of English Law* (1923) iii.

<sup>21</sup> Van Oosten (1996) 57-58; See also the discussion of Carstens and Pearmain (2007) 407-409 with reference to the cases of *Van Wyk v Lewis* 1924 AD 438 and *Pinshaw v Nexus Securities (Pty) Ltd* 2002 (2) SA 510 (C) why it is so important to establish before a litigant engages in litigation, whether the claim is founded in contract or in delict. It is therefore important to decide upon which field either in contract or in delict the cause of action arises. The Pinshaw matter dealt with an indemnity clause exonerating the directors from liability arising from pure economic loss. The plaintiff proceeded against the first defendant on contract and against both the first and second defendants in delict. The court found that the same facts may give rise to a claim for damages *ex delicto* as well as one *ex contractu* and allows a plaintiff to choose which he wishes to pursue.

<sup>22</sup> In this regard Teff (1994) 167 states that maintenance of high standards in health care is seen as an overriding need, not to be jeopardized by allowing providers to exercise their bargaining power to the detriment of relatively vulnerable and inferior patients. This, warns the writer, could lead to widespread diminution of standards,

The traditional sociological nature of the doctor-patient relationship was founded on the paternalistic model in which authority was invested in doctors, by society, because of their knowledge of bodily functions and disease. The doctor, akin to that of the role of the parent, is seen to give guidance and direction to the patient.<sup>23</sup>

The paternalistic model in which the doctor took actions or decisions on behalf of the patients, if necessary without their permission, sometimes even with coercion, has in the modern day been transformed into the autonomy or contract model which reflects the basic human right to self-determination in which the patient is seen as an autonomous purchaser of medical services and who is afforded protection under consumer sovereignty. The main features of the autonomy or contract model include the patients are seen to play a much more active roll in the relationship and the decision-making process. Consent by the patient is of utmost importance in promoting this model. The fiduciary nature of the relationship between the doctor and patient is another feature which emanates from the latter model in which the relationship is seen to have been built on trust and confidence, and in which doctors have an obligation to their patients to act with utmost good faith and loyalty and not to allow their personal interests to conflict with their professional duty.<sup>24</sup>

It will be argued when assessing the validity of exclusionary clauses in medical contracts that the doctors/hospitals modus in making use of these types of clauses to exonerate them from liability is very much based on the paternalistic position the doctor once occupied. It will be argued as well that to allow them to regulate their relationship in this regard, is an improper derogation from an area of public concern, namely, to maintain medical standards in public interest. Our common law, especially, Roman-Dutch law and foreign law *inter alia* English law; have had a tremendous influence on the development of the South African common law. Although Section 39 of Chapter 2 of the Bill of Rights contained in the Constitution 1996 Act 108 of 1996 makes provision for considering international law and foreign law, South African Courts have frequently stressed that

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contrary to the interests of patients and is difficult to reconcile with the ethical obligations of doctors.

<sup>23</sup> Picard and Robertson (1996) 3; Benatar (April 1987) 27ff.

<sup>24</sup> Picard and Robertson (1996) 3; Benatar (April 1987) 27ff; See also Grubb "A Survey of Medical Malpractice Law in England: Crises? What crises? (1985) 1 *J Contemp Health Law and Policy* quoted in Giesen "From Paternalism to Self-Determination to Shared Decision Making" *Law and Medicine Acta Juridica* (1988) 107 at 115 highlights the change towards the patient's self determination when he states:  
*"Paternalism was more appropriate to a by-gone age when the population were presumed to be uneducated and therefore incapable of playing an equal role in the doctor-patient relationship. Such a view has no foundations in our present society and consequently does not have any right to be reflected in our legal system."*

foreign law and/or international law should not carte blanche be followed by our courts but rather with circumspection.<sup>25</sup>

Nevertheless, in a medical context, our courts have at times followed the trend of other countries such as England, the United States of America, Canada and Germany.

The Appellate Division (as it was known then) as long ago as 1924 in the case of *Van Wyk v Lewis*,<sup>26</sup> through a minority judgement of Kotze JA, relied on the English decision of *Hillyer v The Governors of St Bartholomew's Hospital*<sup>27</sup> to answer the question of *res ipsa loquitur* and finding 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.

In the case of *Castell v De Greeff*<sup>28</sup> both the court a quo and the Appeal Court relying upon English law as well as the United States of America, considered whether informed consent should form part of South African law? Scott J delivering the judgement in the court a quo noted that the House of Lords in *Sidaway v Governors of Bethlem Royal Hospital and Others*<sup>29</sup> declined to adopt the doctrine and instead reaffirmed the 'Bolam'

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<sup>25</sup> In the Constitutional Court case of *Bernstein v Bester* 1996 BCLR 449 (CC), 1996 2 SA (CC) par (133), Kriegler J (Didcott J concurring) stated: "*I however wish to discourage the frequent and, I suspect, often facile resort to foreign 'authorities'. Far too often one sees citation by counsel of, for instance, an American judgement in support of a proposition. The precepts of section 35(i) of the (Interim) Constitution are also clear: where applicable, public international law in the field of human rights must be considered, and regard may be had to comparable foreign case law. But that is a far cry from blithe adoption of alien concepts or inapposite precedents*". See also *Ferreira v Levin*; *Vryenhoek v Powell* 1996 1 BCLR 1 (CC), 1996 1 SA 984 (CC) par (190). See however the strong view adopted by the Constitutional Court in *Carmichele v Minister of Safety and Security* 2001 (4) SA 938 (CC) 955-960 with regard to the provisions of s39(1) of the Constitution when developing the common law. Ackermann et Goldstone JJ had this to say: "(39) *It needs to be stressed that the obligation of Courts to develop the common law, in the context of the s39 (2) objectives, is not purely discretionary. On the contrary, it is implicit in s39(2) read with s173 that where the common law as it stands is deficient in promoting the s39(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 s39(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.*" The court subsequently drew on international law i.e. European Convention on Human Rights as well as the European Court judgement of *Osman v United Kingdom* 29 EHHR 245 to decide the issue.

<sup>26</sup> 1924 AD 438.

<sup>27</sup> 1909 2 KB 828.

<sup>28</sup> 1993 (3) SA 501 (C); 1994 (4) SA 408 (C).

<sup>29</sup> (1985) 2 WLR 480 (HL); (1985) 1 ALL ER 643 at 488.

test and consequently said that in his view, there was no justification for adopting it in South African law.

Delivering the decision on appeal Ackerman J stated that there can be no justification for not introducing or adopting the doctrine of informed consent in South African law. He added that there was indeed a necessity for introducing a patient-orientated approach in this connection. Ackerman J held that it is clearly for the patient to decide whether he or she wishes to undergo the operation. This, he added, was in the exercise of the patient's fundamental right to self-determination. In this regard Ackerman J relied heavily on the writings of the international writer *Giesen*<sup>30</sup> as well as two leading decisions of the Australian courts<sup>31</sup> which dealt with the right to self-determination. He consequently held that the principles contained therein should be adopted in South African law as it accords with development in common law in countries like Canada, the United States of America and Australia, as well as judicial views on the continent of Europe.<sup>32</sup>

In a subsequent case of *Pops v Revelas*,<sup>33</sup> the court considering the aspect of consent in hospital consent forms, looked at the doctrine of informed consent. Consequently the court considered the principles laid down by Ackerman J in his decision in *Castell* but placed great emphasis on Canadian law, more particularly the 1980 Supreme Court decision of *Reibl v Hughes*<sup>34</sup> and *Haluska v University of Saskatchewan et al.*<sup>35</sup>

Professional negligence in which a specialist gynaecologist allegedly failed to advise the

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<sup>30</sup> *International Medical Malpractice Law* (1988) 375 after drawing attention at page 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, Giesen 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."

<sup>31</sup> *F v R* (1983) 33 SA SR 189 and *Rogers v Whitaker* (1993) 67 AL JR 47.

<sup>32</sup> Per Ackerman J in *Castell v De Greef* 1994 (4) SA 408 (C).

<sup>33</sup> Unreported case heard in the Witwatersrand Local Division and judgement delivered on the 5th August 1999.

<sup>34</sup> (1980) 114 DLR (3d) 1 (Can SC).

<sup>35</sup> (1965) 153 D.L.R. (2d) 436 (Sask. C.A.).

patient of the risk of the patient being pregnant with a potentially and/or disabled infant - the plaintiff wanting to terminate her pregnancy if there was such a risk was the subject for decision-making in the case of *Friedman v Glicksman*.<sup>36</sup> In this case the court also relied heavily on many reported judgements in foreign countries. 'Wrongful pregnancy' or 'wrongful birth' according to Goldblatt J is a common claim in the American courts. The court consequently agreed with the reasoning of the American court in *Berman v Allan*<sup>37</sup> stating that the reasoning of the American courts is sound and fit comfortably within the *Aquilian* action. Goldblatt J consequently remarked that a doctor acts wrongly if, he either fails to inform his patient, or incorrectly informs the 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.

Similarly, the Supreme Court of Appeal, in the case of *Mukheiber v Raath*<sup>38</sup> Olivier JA, when referring to the so-called actions for 'wrongful conception', 'wrongful birth', 'wrongful life' observed how troublesome these type of cases had been in the courts in England, the United States of America, Canada and Germany. Having relied previously on foreign law where the position seemed less clear in South Africa, it is surprising that Brandt JA in the *Afrox* case did not even consider the trend which countries such as the United Kingdom and the United States of America had taken to deal with exclusionary clauses in medical contracts. Had Brandt JA resorted to giving objective consideration to the legal position of exclusionary clauses in medical contracts, the result of the *Afrox* case may very well have been different.

It is especially in the shift in the doctor-patient paradigm from a paternalistic model to the patient autonomy model, which the court, in *Castell v De Greef* 1994 (4) SA 408 (6) relied heavily on the American doctrine of informed consent, in changing, the legal position in South Africa.

It must be emphasized that although, the nature of the relationship between the medical practitioner and the patient has been described differently over many centuries, what has emerged with certainty is that the relationship arises both contractually and from the doctor's duty to take care. The latter owes its existence to the creation of such rules

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<sup>36</sup> (1996) (1) SA 1134 (W).

<sup>37</sup> 404 A 2d 8 (1979).

<sup>38</sup> 1999 (3) SA 1065 (SCA).

assisting in the setting of outer limits of acceptable conduct -a minimum standard of professional behaviour which may, very well, arise independently of any contract but at the same time, creates a norm when the medical practitioner and the patient enter into a contractual relationship.

## 2.2 Historical Overview of the Doctor-Patient Relationship and its Development

### 2.2.1 General

As was pointed out earlier, the concept Doctor-Patient Relationship is not a modern invention. It has existed ever since medicine was practiced. Likewise, the doctor's duty to take care and to act reasonably towards his patient is equally as old.<sup>39</sup>

Although philosophy, religion, normative ethics, the Hippocratic Oath and other factors *inter alia* public policy and the moral convictions of society, have shaped the nature of the duty to take care and to act reasonably, nonetheless, this duty still remains the cornerstone of medical practice today. It has emerged as a fundamental principle inherent in the doctor-patient relationship.<sup>40</sup> Equally, the contractual relationship, in which the doctor's duty to take care play a major role between the doctor-patient, is not a modern invention as it was recognised as far back as the Roman Era.<sup>41</sup> Since medical practice first emerged, various ethical codes, regulations and the Hippocratic Oath itself were created wherein a standard of care was formulated, the purpose of which, was to protect the general public against conduct of doctors who breached their duty to take care and/or contractual relationship. At the same time, various remedies were founded and made available to patients and their dependants, who would sue those doctors who had deviated from the laid down standard of care.<sup>42</sup> Later, with the invention of hospitals and the

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<sup>39</sup> Mason and McCall-Smith (1991) 3ff; Picard and Robertson (1996) 1ff; Teff (1994) 159ff; Holdsworth (1923) iii; Rhodes (1985) 7ff; Cronje-Retief (2000) 24-25; Carstens and Pearmain (2007) 607ff.

<sup>40</sup> Van Oosten (1996) 53; Rhodes (1985) 11-12; Porter (1999) 54-61; Carstens and Pearmain (2007) 619ff.

<sup>41</sup> Van Oosten (1996) 53 states that as a general rule the contract between the doctor/hospital and patient takes the form of letting and hiring of work (*locatio conductio operis*). This thinking is in line with the Roman law thinking. See Zimmerman *The Law of Obligations Roman Foundations of the Civil Tradition* (1990) 393 who states that the Medicus practice was that of a *locatio conductio operis*; Amundsen (1973) 17 equally recognize the contractual relationship in Roman Law.

<sup>42</sup> Van Oosten (1996) 57; Amundsen (1973) 17; Picard and Robertson (1996) 2ff; Nathan *Medical Negligence* (1957) 7; Teff (1994) 160.

establishment of other health care providers, the remedies available for the breach of the duty to take care as well as the breach of the contractual obligations extended to those patients and their families who felt aggrieved.<sup>43</sup> The recognition given to the doctor/hospitals duty to take care and the contractual obligations he/she or it has towards the patient, will become important strands in the investigation into whether it is acceptable practice that a doctor, hospital or other health-care providers may protect himself, herself or itself, against liability for alleged negligence in treating the patient or for some other form of malpractice, in getting the patient to sign a waiver of claims, indemnity form or a so-called "disclaimer" prior to the intervention.

## 2.2.2 The Ancient Period

It was during this period that the first traces of the history of medicine are found. It was during this period that through the Science of Palaeopathology the history of medicine is introduced and made known to modern man.<sup>44</sup>

The most striking characteristics of the era of pre-historical medicine were the belief in the supernatural: Supernatural forces were thought to cause diseases, supernatural reason was accordingly used as diagnostic methods and treatment was supernatural in character.<sup>45</sup>

In time, especially in the period 5000 - 4000BC in the Eastern Mediterranean, medicine was predominantly of a magical or religious nature in which priests practiced medicine in which the religious beliefs of the day played a major role in diagnostic methods and treatment.<sup>46</sup>

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<sup>43</sup> Mason and McCall Smith (1991) 6.

<sup>44</sup> See the definition of Palaeo Pathology: *'Palaeo-'* Oxford Advanced Learner's Dictionary 10th impression 1994. *'Palaeo-pathology'* as spelt by Castiglioni Medicine 13. *Palaeo-, palae-, US paleo-, pale- comb form. Indicates ancient or prehistoric; [Greek palaio, from palaios, ancient, from palai, long ago.] Reader's Digest Universal Dictionary 1988 1113. Pathology n. 1. The scientific study of the nature of disease, its causes, processes, development, and consequences. 2. the anatomical or functional manifestations of disease, or of a particular disease, for example changes in organs and tissues. Reader's Digest Universal Dictionary 1988 1134. See also Cronje-Retief (2000) 23-24. The author states that it was through the science of palaeo pathology that "the first obscure evidence of primitive man's medicine is frowned which were instinctive medicine, empirical medicine, magic medicine and priestly medicine." See also Castiglione Medicine (1975) 13 14 51.*

<sup>45</sup> See Cronje-Retief (2000) 24 - It is the supernatural element according to the author that distinguished primitive medicine from modern medicine. See also Peters et al *Medical Practice* (1981) 1.

<sup>46</sup> See Cronje-Retief (2000) 24; See also Peters et al 33-44.

Even as far back as the ancient days despite the practice of magic medicine and priestly medicine, the promotion and maintenance of medical standards although primitive and unwritten, was recognised. During this period individuals emerged who felt a calling to treat the ill and to find ways to cure human ailments. The underlying rationale behind this movement of healing stems from the philosophy that the creation of man necessitates the preservation of life.<sup>47</sup> Although the healers during this period were very much influenced by supernatural powers, there was a strong belief that medicine consisted of care and compassion for the sick and injured.<sup>48</sup>

For that reason restrictions were placed on the conduct of the doctor, in that it was expected of the doctor to exercise a duty of care towards the patient.

Though the promotions and maintenance of medical standard was unwritten at first, the Babylonian and Egyptian societies who were more sophisticated in their approach. In this regard it was especially King Hammurabi of Mesopotamia 1792 BC who promulgated rules and sanctions to control the activities of physicians and surgeons. What followed was the adoption of the first case of medical ethics and a standard of conduct, for the physicians at the time.<sup>49</sup>

The case of Hammurabi was conceived by the Babylonians around 2500BC and detailed. The nature of the conduct required of physicians at the time as well as the doctor's penal and civil responsibility and medicine fees were specified.<sup>50</sup>

In particular the development of ancient Egyptian medicine took place parallel and

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<sup>47</sup> See Smit "Die Geneeskunde en Die Reg" (1976) *De Jure* 107 - 119; Mason and McCall Smith (1991) 3 - 6 This continued to be the position during the later periods for the Declaration of Geneva, the Hippocratic Oath and other Codes of Medical Ethics endorse this principle. The Declaration of Geneva includes *inter alia* the following undertaking: "I will maintain the utmost respect for human life from the time of conception; even under threat. I will not use my medical knowledge contrary to the laws of humanity." See further The Appendices which include the Hippocratic Oath and other Codes of Medical Ethics.

<sup>48</sup> Rhodes (1985) 7; Picard and Robertson (1996) 7.

<sup>49</sup> The Code of Hammurabi contained medical ethical rules and legislation and provided professional fees for physicians. See the discussion of the influence of the Code Carstens and Pearmain (2007) 609.

<sup>50</sup> Sanbar et al (1995) 6; See also Cronje-Retief (2000) 24-25; See further Chapman (1984) 5 who states that the essence of the code of ethics at the time centered around Hammurabi's belief "that the strong may not oppress the weak."

independently to that of Mesopotamia. Although during this period supernaturalism still had a strong influence to bear over the practice of medicine, what emerged as well, is priestly medicine during which period the rationalisation of patient's diagnosis and diseases steadily emerged. During this period the Egyptian papyri were promulgated, the first documented descriptions of the priest-physician, as well as methods of establishing diagnosis and appropriate treatment decisions. It also served as an ethical code, in which, the priest-physician's penal responsibility was documented in that, innovative or unconventional treatment on a patient that caused the death of the patient could result in the killing of the treating physician.<sup>51</sup>

Religious medicine continued to make inroads during this period. It was particularly during this period that Jewish medicine with strong religious overtones emerged. Prophets such as Amos, Jeremiah and Isaiah sounded strong ethical messages to leaders of Israel and Judah, which were redirected centuries later to include the medical profession which occupied the same status as priests and judges at the time. What lay at the foundation of Jewish medicine was social ethics and even social hygiene.<sup>52</sup> It was during this period that under the Talmudist Body of Laws the *Nezikin* (from the Hebrew root meaning "to damage or injure") provided for the first traces of the duty to take care. It was then that the duty arose. If one has in one's control, something, which, if misapplied may do damage. Negligence (*pehiah*), in Talmudic law, included every kind of breach of duty, whether recklessness, gross carelessness or ordinary negligence.<sup>53</sup> It was during this era that Isaac Israel produced a medical works entitled: *"The Book of Admonitions to the Physicians"* in which his precepts about thorough knowledge, attention to patients, and prompt response to their needs were emphasized.<sup>54</sup> The ideal doctor as depicted in ancient Hebrew writings had to possess strong virtues and high moral standards. What was also expected of the doctor was to take good care of the patient with the aid of such medicines and cures as are required.<sup>55</sup> Medicine practiced in other religions with strong ethical values also became known through writings. In this regard medicine of ancient Persia and India was perceived to be a magical experience, which later changed into a

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<sup>51</sup> See Cronje-Retief (2000) 25; See also Sanbar et al (1995) 6.

<sup>52</sup> See Cronje-Retief (2000) 26; See also Sanbar et al (1995) 6; See further Chapman (1984) 10 - 14. The author expresses the view that during this period the issue of *"righteousness"* was advocated which implied *"benevolence, kindness, generosity, the burning compassion for the oppressed."*

<sup>53</sup> Chapman (1984) 13.

<sup>54</sup> Burns *Legalities in Ethics and Medicine* (1997) 3.

<sup>55</sup> Margalith *"The Ideal Doctor as Depicted in Ancient Hebrew Writings"* published in Burns (1977) 7 - 11.

religious ideation and Hindu medical mores, recorded as akin to those of Babylonians and the Greeks, whereas Persian medical ethics had an Arabian flavour.<sup>56</sup> Although ancient Greek medicine during this period was still characterised by Greek physicians maintaining that Gods punished people through illness, and, ritual sacrifices and purification ceremonies were used to cure their patients, it was the Hippocratic medicine (460 - 360BC) which rescued ancient Greek medicine, in that the supernatural stigma was exchanged for rational considerations of scientific value, such as clinical observations.<sup>57</sup>

It is the Hippocratic Oath which is the touchstone of modern medical ethics and which has bound physicians in their conduct for many centuries and has also served as a teaching environment in the teaching of Moslem, Jewish and Christian physicians thereby spreading throughout the Middle East and Europe.<sup>58</sup> The Hippocratic Oath very much influenced the doctor-patient relationship and continues to do so in modern times.<sup>59</sup> The object of the oath was clearly aimed at protecting the general public as the doctor was prohibited from doing that which would cause harm to his patient. An undertaking was also given by the doctor that he would not take advantage of the relationship between doctor and patient. For that reason, a relationship built on trust, became a focal point in medical practice.<sup>60</sup> The said Oath then remains the cornerstone of modern medical ethics and indicates the prevailing ethos of how doctors ought to behave towards their patients. During the period of Hippocratic medicine midwives appeared and a textbook for midwives was also compiled.<sup>61</sup> With the rise of intellectual levels during the Greek period, certain morals, ethics and rights actions were established and documented which had as their object, the enforcement of the doctor's duty of care. Ethics during this period were very much influenced by philosophy, in which, virtue and justice and other values played a

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<sup>56</sup> See Cronje-Retief (2000) 26; See also Castiglioni (1975) 80 - 97; See further Chapman (1984) 7.

<sup>57</sup> See Cronje-Retief (2000) 27; See also Peters et al 2 (1983).

<sup>58</sup> See Cronje-Retief (2000) 27; see also Sanbar et al (1995) 6; See further Chapman (1984) who states: *"that the oath `... cannot be looked on as a great source of medical ethics, its chief purpose much more mundane and pragmatic."* **Contra** Edelstein (1977) 75 who states: *"That the Hippocratic Oath became the nucleus of all medical ethics. All men of all religions embraced the Oath and its ideals as being the embodiment of truth."*

<sup>59</sup> Rhodes (1985) 11 - 12; Carstens and Pearmain (2007) 610.

<sup>60</sup> Porter (1999) 54 - 61. The position of trust which the doctor occupies, has in modern times, been emphasized as the core of the fiduciary model. See also Picard and Robertson (1996) 4-5 who when promoting the fiduciary model, state that doctors have an obligation to their patients, to act with utmost good faith and loyalty.

<sup>61</sup> See Cronje-Retief (2000) 29; See also Castiglioni (1975) 146.

predominant role.<sup>62</sup>

### 2.2.3 The Roman Era

The Romans did not speak highly of the ability of their own physicians, considering physicians of low status. Because of the development of Greek medicine and the empowerment of physicians who became endowed with high levels of skill, Greek physicians were encouraged to do work in the Roman Empire. This resulted in Greek physicians entering into contracts to provide medical services throughout the Roman Empire.<sup>63</sup>

Although Roman medicine did not nearly achieve or equal the scientific developments of the Greeks, what is significant of this era is the Romans introduced an outstanding system of law in which medical law or legal medicine featured.<sup>64</sup>

The *Lex Aquilia* included several references to physicians and medical care, for example, if a surgeon operated negligently on a slave or abandoned his patient, he would be guilty of negligence.<sup>65</sup>

With regard to medical ethics it is especially Cicero in Cicero's *De Officiis* (written 46 - 43 B.C.) who concentrated, in his writings, on the justice-righteousness (law-ethics) concept. In this regard he condemns the practice of abstaining from "*doing for one's own profit only what the law expressly forbids.*"<sup>66</sup>

He also speaks of practices that are not forbidden by statute or civil law, but that they are nevertheless forbidden by moral law. He also cites Plato's view that: "*.... The first ethical concern of the ruler is to place the good of the people above his own interests; the ruler is the servant of the people, not the other way round.*" The doctor's duty is thus compared

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<sup>62</sup> Rhodes (1985) 11-12.

<sup>63</sup> See Cronje-Retief (2000) 29; See also Chapman (1984) 36-38; See further Peters et al 3 (1981) 3; Carstens and Pearmain (2007) 611ff.

<sup>64</sup> See Cronje-Retief (2000) 29; Carstens and Pearmain (2007) 612.

<sup>65</sup> Chapman (1984) 36-37; Amundsen (1973) 20; Buckland *Textbook of Roman Law from Augustus to Justinian* (1950) 556; Van Zyl *History and Principles of Roman Private Law* (1983) 264ff; See also Carstens and Pearmain (2007) 613ff.

<sup>66</sup> Chapman (1984) 40.

with that of the ruler.<sup>67</sup>

What was installed during this period in the minds of the physicians is that it was the physicians' obligation to place his patient's interests above the loyalty to the medical guild. Medicine was recognised as a calling with an ethical commitment focusing on the patient. This belief was founded on the philosophy of the physician's compassion and love of mankind. Medical humanism was broadly advocated, in which it was generally believed "*where there is no love of people, and where good and bad are given the same value, medicine is degraded and, in a sense ceases to be a profession.*" It was also not so much the desire for money and glory as the desire for knowledge of the science that was promoted by teachers of medicine.<sup>68</sup>

Galen, the Greek physician and teacher of ethics, in particular emphasizes virtue and duty and combined Hippocratic and Stoic Hellenic ethics.<sup>69</sup>

#### 2.2.3.1 The Roman System of Legal Medicine

In this respect, although the procedure of licensing was not put in place during this period, the profession during this period, unlike the ancient period, also became controlled; a protective measure was put in place in that only those who acquired the skill to treat people had the authority to treat people. What also crystallized during this period is the fact that the duties of the doctor and the standard of care were defined and formally documented. During this period, regulations were also put into place, regulating the doctor-patient relationship. New laws were formulated imposing penalties for those practitioners who did not comply with the required standards of practice as well as their prescribed duties.<sup>70</sup>

#### 2.2.3.2 The Duties of the Doctor

The doctor's duties during this period were defined by the distinguished legal writings of Ulpianus and Gaius. It is from the writings of Ulpianus that the contractual relationship (*ex contractu*) as well as the doctor's duty to take care, under the *Lex Aquilia*, first emerged.

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<sup>67</sup> See Chapman (1984) 40.

<sup>68</sup> See Cronje-Retief (2000) 29; Chapman (1984) 40-42 who quotes from the writings of Scribonius Larcus, a Roman physician, who wrote on the physician's obligations.

<sup>69</sup> See Sanbar et al (1995) 7.

<sup>70</sup> For a full discussion see Amundsen (1973) 17-25; Cronje-Retief (2000) 30.

### 2.2.3.2.1 The Standard of Care

Although the sources are silent on individual cases concerning negligent or ignorant malpractice in Roman law, the negligence of experts, as with medical practitioners was measured by the "*imperitia culpa adnumeratur*" rule.<sup>72</sup>

In Roman law, both forms of malpractice, whether negligent malpractice or ignorant, malpractice was measured against the failure to observe the standard of conduct that the law requires. What was expected was a reasonable degree of care measured against the conduct of the reasonable man.<sup>73</sup>

It can safely be assumed that the onus rested with him who alleged that the doctor was negligent.<sup>74</sup>

It was also generally accepted that medical negligence could also be proved by way of the principle *res ipsa locitur*.<sup>75</sup>

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<sup>71</sup> See Amundsen (1973) 17-25; See Zimmerman (1990) 393-395 who states that as physicians were able to work for merces, they could render their services under a contract of *locatio conductio*. Both Ulpianus .D. 9, 2, 7 8; Gaius D.9, 2, 8 wrote that the doctor was said to be liable *ex locatio*: "*Proculus ait, si medicus servum imperite secuerit vel ex locato vel ex lege Aquilia competere actionem.*" See further Buckland (1963) 500 on the position of the liability of the *medici ex contractu*. But Zimmerman (1990) at 1028 highlights the rationale for broadening the liability outside the contractual field. It is said that the contractual relationship did not impose such a strict degree of diligence on the parties. See further the discussion by Carstens and Pearmain (2007) 613-614 of the examples found in the *Digest: Ad Legem Aquiliam* and where the physician was liable in terms of the *Lex Aquilia* to pay compensation. Inst 4 3 7; Van Zyl (1983) 264ff also deals with the aspect of Aquilian liability.

<sup>72</sup> In this regard lack of skill is reckoned as a fault. A doctor will therefore be blamed for being negligent where he performs an operation or embarks on the treatment of a patient well knowing that he did not possess the necessary knowledge or experience, and the patient is injured as a result thereof. It is based on the fundamental principle that mere existence of the detrimental occurrence caused by an act performed by the Defendant constitutes a *prima facie* factual presumption that the Defendant had been negligent. See in this regard Carstens and Pearmain (2007) 613-514; See further Amundsen (1973) 22.

<sup>73</sup> See Amundsen (1973) 22; Carstens and Pearmain (2007) 613.

<sup>74</sup> See Amundsen (1973) 24 Digesta 50 17 32; Inst Just 4 37. See also Carstens and Pearmain (2007) 614; this appears very much to be the position today. *Mitchell v Dixon* 1914 (AD) 525; *Dale v Hamilton* 1924 (WLD) 200; *Coppen v Impey* 1916 (CPA) 320, 322, *Van Wyk v Lewis* (1924) 444 - 445, 462 - 464; *Afrox Healthcare Bpk v Strydom* 2002 (6) SA 18.

<sup>75</sup> See Amendment (1973) 25; See further Van den Heever "The Application of the Doctrine of *Res ipsa Locitur* to Medical Negligence Cases: A Comparative Survey" (Unpublished LLD Thesis, University of Pretoria, 2002) 13ff quoted in Carstens and Pearmain. This position has very much remained the position in South Africa today. In certain cases the maxim still applies as strict translation of the maxim entails that the facts of the case speak for

#### 2.2.3.2.2 Legal Remedies

Legal remedies during the Roman Era were founded both in contract as well as in malpractice or both.<sup>76</sup>

#### 2.2.3.2.3 Breach of Contract

Ulpianus recognised an action based on contract of service (*ex locatio*) where, for example, the doctor unskilfully operates on a slave.<sup>77</sup>

#### 2.2.3.2.4 Malpractice

Acts loosely defined as malpractice were subdivided into three areas namely:

- (i) **Wilful Malpractice** - This involves treatment undertaken with the intention of causing an injury to, or death of, the patient;
- (ii) **Negligent Malpractice** - This excludes criminal intent, but includes gross negligence, or failure to provide proper attention by an act or omission as a result of which a patient is injured or killed.
- (iii) **Ignorant Malpractice** - Here the physician's lack of competence proves harmful or fatal to the patient, i.e. *imperitia culpa adnumeratur*. The legal advices available to the aggrieved party or his family depended very much upon the *animus* with which the act or omission was committed.<sup>78</sup> In this regard the following remedies were recognised.

#### 2.2.3.2.5 Remedy for Wilful Malpractice

During this period physicians were at times employed to poison people of high standing

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*itself. See in this regard Van Wyk v Lewis* 1924 438; *Webb v Isaac*; 1915 (Ed L) 273; *Coppen v Impey* (1924) 509.

<sup>76</sup> See Zimmerman (1990) 393ff in which the author discussed the position of physicians with regard to their liability in contract more specifically, *ex locatio*; See also Buckland (1950) 305. Zimmerman (1990) 1026ff discusses the content of the Aquilian claims in Roman law arising from the liability of the Medici arising from their actions or failure to act which included compensation for the infliction of bodily harm, medical expenses and loss of income. See further the discussion of Amundsen (1973) 20ff; Buckland (1950) 556ff.

<sup>77</sup> For a very informative discussion of the work of Ulpianus and the liability of physicians for negligent malpractice see Carstens and Pearmain (2007) 613; See also Buckland (1990) 556; Van Zyl (1983) 264ff; Amundsen (1973) 20; *Digesta* 48, 8, 15.

<sup>78</sup> See Amundsen (1973) 21; See the discussion on the *imperitia* rule and the influence of the *Digesta* 50, 17, 32; *Inst Just* 4 3 7 on the practice of medicine in Roman law by Carstens and Pearmain 613-614; Van Zyl (1983) 264ff; Buckland (1990) 556.

and benefited through their act by being paid by the beneficiaries. Similarly, physicians were also accused often being legacy hunters whereby they benefited directly through their wilful conduct. They could then be charged criminally. <sup>79</sup>

#### 2.2.3.2.5.1 *Lex Cornelia de sicariis et veneficis*

This was criminal remedy available where as a result of the presence of *dolus* the doctor, through poisoning, caused the death of another. But it made no difference whether the physician himself poisoned another or was an accessory to the act, he would, either way, be guilty of homicide. <sup>80</sup>

#### 2.2.3.2.5.2 *Lex Pompeia de parricidiis*

This was also a criminal remedy available where the death penalty was imposed upon a doctor who was found guilty of the poisoning of a relative. <sup>81</sup>

#### 2.2.3.2.5.3 *Other Regulations*

Regulations were imposed during this era which were particularly aimed at preventing Doctors from exploiting their influence in the doctor - patient relationship, by getting the patients to act to their detriment. Ulpianus introduced the *adversa medicamenta* whereby regulations were put in place to punish the doctor who coerced his patient to act to his or her detriment. For example, a physician who compelled a sick man to sell his possessions would be punished and ordered to return that which he had received by coercion. <sup>82</sup>

#### 2.2.3.2.6 *Lex Aquilian Action*

The *Lex Aquilian* action had as its aim an element of compensation, in that under the provisions of the *Lex Aquilia*, a person responsible for the death of a slave, or for his injury, was obliged to compensate the slave owner the highest value of the slave during his last year's working life prior to his death. Although it is not clear what compensation would be paid if the slave was merely injured, it is suggested the owner would be paid the loss of value of the slave, either temporary or permanent, as well as the expenses involved

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<sup>79</sup> See Amundsen (1973) 21; Berkhouwer and Vorstman (1950) 16ff; Carstens and Pearmain (2007) 612.

<sup>80</sup> See Amundsen (1973) 20-21; For a discussion of the role of the *Lex Cornelia* in Roman law see Carstens and Pearmain (2007) 612.

<sup>81</sup> See Amundsen (1973) 21.

<sup>82</sup> See Amundsen (1973) 21; Carstens and Pearmain (2007) 613 cites the writings of Ulpianus Digesta 50 13 3.

in the medical care.<sup>83</sup>

In order to succeed with a claim under this action, the aggrieved had to rely on *culpa* which freely translated, means "negligence". It was generally accepted during the Roman Law Era that negligence signified the failure to comply with a standard of conduct which the law required. The presence of *culpa* generally involved the failure to use a reasonable degree of care, *non intellegere quod omnes intellegunt*; put differently, not acting as a reasonable man would act or a failure to exercise the same *diligentia* as the reasonable man place in the same circumstances would have observed.<sup>84</sup>

The negligence of an expert, for example a physician, besides being measured against the presence of *culpa*, was also measured against the yardstick *imperitia culpa adnumeratur*. As previously stated *imperitia* is defined as lack of professional skill, lack of capability, lack of knowledge, incompetence relating to the standards that were expected of a person providing services.<sup>85</sup>

This rule was applied during this era where for example a physician conducted an operation in an incompetent manner<sup>86</sup> or giving a slave medicine without having acquired the knowledge becoming the suitability of the medication.<sup>87</sup>

#### 2.2.3.2.7 Institutiones of Justinianus

This was a remedy aimed at punishing the physician for his negligence in not providing adequate post operative care, alternatively, not providing care at all. In this regard a physician would act negligently if after performing an operation on a slave he omitted to further treat the patient as a result of which the slave died.<sup>88</sup>

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<sup>83</sup> See Zimmerman (1990) 1026 on the different heads of damages offered by the *Lex Aquilia* including compensation.

<sup>84</sup> See Buckland (1950) 556; Van Zyl (1983) 264ff; Carstens and Pearmain (2007) 613-614 state that the concept *culpa* can be interpreted in both a narrow sense, meaning negligence, and in a broader context, namely, it is indicative of fault; See further the discussion of Amundsen (1973) 21-22.

<sup>85</sup> The rule *imperitia culpa adnumeratur* rule is described in both the Digesta 50 17 32 and the Institutes of Justinian Inst Just 4 3 7: "*Imperitia culpa adnumeratur, veluti si medicus ideo servum tuum occiderit, quod eum male secuerit aut perperam ei medicamentum dederit*". For a discussion of the rule and the effect of the imperitia rule see Carstens and Pearmain (2007) 613-614; Van Zyl (1983) 214; Amundsen (1973) 22.

<sup>86</sup> Carstens and Pearmain (1973) 613 describes the rule as indicative of the absence of professional skill and experience which were required and set by the medical profession; See also the discussion of Amundsen (1973) 22 highlighting the provisions of the Digesta 9 2 7 8.

<sup>87</sup> Carstens and Pearmain (1973) 613-614 highlighting the writings of Gaius D9 2 8; See also Amundsen (1973) 22.

<sup>88</sup> Carstens and Pearmain (2007) 614 cites the Inst Just 4 3 6: "*Praetera si medicus qui servum tuum secuit*

## 2.2.4 The Post Roman Era

### 2.2.4.1 The Medieval Era and the middle Ages

It is noteworthy to record that the development of medical ethics, particularly during this Era began to make inroads. In this regard, it was the Judea-Christian influence which directed medical ethics. In this instance, the Christian belief was that disease stemmed from sin, the devil or witchcraft and could be countered only by prayer and recovery was perceived as a miracle.<sup>89</sup>

As medicine was governed by the law and the law was administered by the Priests, religion and medical practices were, therefore, inseparable. Religious doctrines it was felt widely benefited the community.<sup>90</sup> During this era the Jewish people were fighting for survival as a nation. The principle was accepted that the rights of the individual must be sacrificed for the good of the community. This resulted in people who were infected with, for example, venereal diseases to being isolated.<sup>91</sup>

The above philosophies were ultimately received into Christian cultures who adopted the concepts of equality, charity and devotion to the less fortunate. Medicine during this period was also kept alive in monasteries which became hospitals of the day and where medicine was practiced.<sup>92</sup>

This period was known as the learning period and 'self-discovery of man'. It laid the foundation for major advances in the field of medicine *inter alia* the first authentic works on the medical-legal field were published in Italy which emphasized the interrelationship of the subject to both medicine and the law. In this period the first medical textbook was published.<sup>93</sup>

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*dereliquerit curationem atque ob id mortuus fuerit servus culpae reus est*". See also the discussion of the Institutes of Justinianus Inst Just 4 3 6 dealing with the physician failing to provide post-operative care.

<sup>89</sup> Cronje-Retief (2000) 31; See also Peters et al 3 (1981) 3.

<sup>90</sup> Mason and McCall Smith I (1991) 6.

<sup>91</sup> Mason and McCall Smith (1991) 6.

<sup>92</sup> Mason and McCall Smith (1991) 6; Peters et al (1981) 3; Cronje-Retief (2000) 31.

<sup>93</sup> See Cronje-Retief (2000) 51 - 52; See also Curran *Health Law* (1998) 2. The author opines that the medico-legal field is today termed medical law.

This era also brought with it 'forensic medicine', created in Germany, as well as legal medicine, created in Italy, in which the first autopsies were performed for legal purposes. In this way knowledge of anatomy was gained.<sup>94</sup>

During this period the subject of 'medical jurisprudence' was also founded which included subjects such as forensic psychiatry, forensic pathology and public health regulations.<sup>95</sup>

#### 2.2.4.1.1 Legal Remedies

During this period legislation in the form of the *Leges Barbarorum* and *Lex Visigothorum* were put in place to regulate the conduct of doctors. It was the second mentioned legislation which was particularly severe against a specific type of treatment excessively engaged in, predominantly by those who were of the medical profession whose level of competence was low.

##### 2.2.4.1.1.1 Leges Barbarorum

The laws required that a near relative be present if a physician subjected a female patient to venesection. There was also a provision that where treatment was given under contract and if, under such circumstances the patient died, the physician received no fee.<sup>96</sup>

##### 2.2.4.1.1.2 Lex Visigothorum

The penal sanctions introduced by this legislation were particularly severe against a specific type of treatment excessively engaged in, particularly by those members of the medical profession whose level of competence was low.<sup>97</sup>

#### 2.2.5 The Renaissance Period

During this era fourteenth-century English judges began to require physicians to treat their patients with diligence. It was therefore required by law that when the doctor attended patients, he did so with proper care and skill. A failure by a physician to adhere to a duty imposed by law made the physician liable to an action of trespass on the case of

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<sup>94</sup> Peters et al (1981) 4; See also Curran (1998) 2 who states that 'forensic medicine' has come to mean that part of the medical field concerned with the presentation of medical data in courts of law; Cronje-Retief (2000) 53.

<sup>95</sup> Curran (1998) 3.

<sup>96</sup> See Chapman (1984) 45; Van Zyl (1983) 615ff; Carstens and Pearmain (2007) 615.

<sup>97</sup> Carstens and Pearmain (2007) 615 states that it was especially in the West-Gothic Empire (about 500 AD) that the liability of physicians was explicitly regarded by legislation and uses the example of specific provisions pertaining to bloodletting. See also Berkhouwer and Vorstman (1990) 19; Amundsen (1973) 18.

negligence and the physician could be sued in tort.<sup>98</sup>

It was during the late middle ages (starting about 950AD) that universities were founded in which medicine was taught, which subject had as its foundation Greek philosophies.<sup>99</sup>

One of the greatest medical accomplishments during this period was also achieved with the establishment of hospitals.<sup>100</sup>

Medical ethics were inspirational in the founding of hospitals during this period in that Christians founded the first hospitals as a result of the duty they perceived they had to their fellow man.<sup>101</sup>

The founding of the College of Physicians of London (1518) which was preceded by the Royal Charter of Incorporation occurred during this period. The College's main endeavours were to safeguard the status of physicians and the standard of medical practice. The aim was to provide the best service to the public. Entry qualifications were introduced during this period in an attempt to regulate the profession i.e. the physicians conduct was guarded by the College's ethical statutes.<sup>102</sup> Several acts concerning the ethical conduct of physicians were also introduced in the period 1523-1523.

One of its main aims was to control ethical conduct in an endeavour to increase the value of the services rendered.<sup>103</sup>

#### 2.2.6 The Post Renaissance Period

During the seventeenth century hospitals opened in the major cities of the United States and Canada. The number of hospitals also increased in France and England.<sup>104</sup>

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<sup>98</sup> Holdsworth (1923) 385-386; See further Cronje-Retief (2000) 50; Giesen (1988) 4.

<sup>99</sup> Giesen (1988) 4; Peters et al (1981) 3; See also Castiglioni (1975) 375.

<sup>100</sup> Peters et al (1981) 3.

<sup>101</sup> Carmi *Hospital Law* (1988) 7; Castiglioni (1975) 304 refers to hospitals in 1100 AD. In this regard an 'Act concerning physicians and surgeons' was passed in 1512.

<sup>102</sup> See Chapman (1984) 62-64; Giesen (1988) 4-5.

<sup>103</sup> Giesen (1988) 5.

<sup>104</sup> Castiglioni (1975) 659-660; See further Peters et al (1981) 126; Cronje-Retief (2000) 36.

Although this century did not bring about major development in medical practice, specialities developed and surgery was accorded the dignity of being comparable to medicine. <sup>105</sup>

During this century greater emphasis was also placed on the diagnosis of the patient. <sup>106</sup>

The eighteenth century saw a world-wide growth in hospitals and conditions at previously established hospitals faced major improvements, especially in Europe. Practice of medicine in England also became very well organised. <sup>107</sup>

During this era the London's Royal College of Physicians revived the social contract concept which, comprised of a set of moral norms applicable to the established profession. These norms dictated that, not only did the practitioner have to do technically competent and high-quality work, but that he adhered to a service ideal as well, which was devoted to the client's interests. The patient's interest's, more than primal or commercial profit, should guide decisions when the two are in conflict. The service ideal was the pivot around which the moral claim to professional status revolved. <sup>108</sup>

It was particularly Thomas Percival's writings which influenced general thinking in the profession. In this regard see a chapter in his book on the duties of physician - "An enquiry into the Duties of Men in the Higher and Middle Classes of Society in Great Britain, Resulting from Their Respective Stations, Professions, and Employments." The authors' main theme included:

*"Diligent and early attention and an honest exertion of his best abilities are the primary duties which the physician owes to his patient. The performance of them is virtually promised, for he knows that it is universally expected when he undertakes the case of the sick man; and consequently, if he neglects to fulfil them, he is guilty of a direct breach of his engagement."*

He continues to state that:

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<sup>105</sup> Rhodes (1985) 52; Castiglioni (1975) 577; Cronje-Retief (2000) 36.

<sup>106</sup> Rhodes (1985) 52.

<sup>107</sup> The start of National Health Services although slow, commenced practice. See Castiglioni (1975) 659-660; Carmi (1988) 659.

<sup>108</sup> Chapman (1984) 77.

"... The physician's concern for the patient's recovery must be uninfluenced by private and personal considerations, and that he must show "all affectation of mystery." <sup>109</sup>

The Americans during this period also adopted Percival's Ethics. The Boston Physicians Association citing Percival's Ethics created the code of medical policy which provided *inter alia*: "Every man who enters a fraternity, engages by a tacit contract not only to submit to the law, but to promote the honour and interest of the association so far as is consistent with morality and the general good of mankind."

During the nineteenth century all American states finally required all medical practitioners to hold medical licenses reserving practice of medicine for those properly trained and credentialed. <sup>110</sup>

During the industrial revolution, with an increase in personal injury cases flowing from industrial accidents, negligent action in medical malpractice cases replaced the customary English Common Law concept of a duty in the doctor-patient relationship. <sup>111</sup>

The twentieth century, owing to politics, governmental powers, social and economic structures, advancing technologies and legal expansion, ushered in health-care services including National Health Policies in major countries such as England and America. <sup>112</sup>

This era also saw an increase in malpractice suits especially in the United States. <sup>113</sup>

### 2.2.7 The Roman Dutch Era

This period was characterized by a strong commitment in documenting by way of legal writings, the duties of medical practitioners and prescribing, the requirements for liability.

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It was particularly writers such as De Groot in his *Inleiding tot die Hollandsche Rechts-*

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<sup>109</sup> Chapman (1984) 82 - 83; See also *Veatch Medical Ethics (1997) 9*.

<sup>110</sup> Castiglioni (1975) 760; Chapman (1984) 103-104.

<sup>111</sup> Fleming *The Law of Torts* (1992) 113 137 138; Picard et al (1996) 2; Giesen (1988) 4.

<sup>112</sup> See Cronje-Retief (2000) 43.

<sup>113</sup> Giesen (1988) 101.

<sup>114</sup> See De Groot *Inleiding tot die Hollandsche Rechts-Geleerdheid* 3 33 5; See also Scott (1981) 134.

Geleerdheid wherein the writer illustrates by way of examples under which circumstances a physician incurs liability. In this regard the writer provides as follows:

*"Dat de dood door iemands schuld is toegekomen, waer onder mede begrepen is verzuim ofte onwetenheid van een geneesmeester, vroedwif, verzuim ofte onverstand van een waghanaer ofte schipper, of der zelve zwackheid in't bestieren van schip ofte paerden"* <sup>115</sup>

From the foretasted quotation of De Groot the following appears to be the legal position namely, in Roman Dutch Law mere ignorance, lack of understanding and weakness are equal to guilt for which the physician incurs liability. <sup>116</sup>

In essence that appeared to have been the position in Roman law as well. The *imperitea* rule was thus received in Roman Dutch Law. <sup>117</sup>

Vinnings with reference to the *Digesta* <sup>118</sup> cautioned against this type of practice wherein a physician can without just cause incur liability for the death of a patient; Vinnings was of the view that the mere fact that a patient dies, is not *per se* indicative that the physician was negligent. <sup>119</sup> One thing is certain, with the introduction in 1532 of Section 134 of The Constitution Criminalis Carolina, physicians who caused the death of a patient through their lack of skill were severely punished, as severe forms of punishment were prescribed in this article. <sup>120</sup>

Noodt emphasized the need for the physician's liability which arose from his professional mistakes. According to Noodt, a duty of care arises as soon as the physician has

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<sup>115</sup> Scott (1981) 136; See also the discussion of Carstens and Pearmain (2007) 616 on the role of the *imperitia* rule in the Roman-Dutch law.

<sup>116</sup> Scott (1981) 135; Carstens and Pearmain (2007) 616.

<sup>117</sup> See Scott (1981) 136.

<sup>118</sup> D 1 18 6 7.

<sup>119</sup> Scott (1981) 136; It is debatable whether this rule is still applicable in the South African Law particularly in view of the fact that it is not so much unskillfulness in itself which constitutes negligence, but rather an engagement in an undertaking which requires skill with the knowledge that skill is wanting - Boberg, *The Law of Delict* 1st ed (1984) 347, Neethling, Potgieter and Visser - *The Law of Delict* 2ed (1994) 134, Van Oosten - *Medicine and Law* (1986) 21; Contra the cases in which the rule was applied; *Coppin v Impey* 1916 (KPA) 309, *Dale v Hamilton* 1924 (WLD) 184, *R v Van der Merwe* 1953 2 PH (W) 124, *S v Mkwetshana* 1965 2 SA (493) (W) 496 – 497.

<sup>120</sup> Scott (1981) 136; Berkhouwer and Vorstman (1950) 24; See also Carstens and Pearmain (2007) 616-617.

undertaken to treat the patient. There is a duty to continue treating the patient even after an operation. The untimely abandoning of a patient when further treatment is indicated "*Quia intempeseva desperavii*" would undoubtedly lead to the liability of the physician should the patient die in the process.<sup>121</sup>

Huber, the prominent writer, advocated during this period, that physicians ought to be held accountable for their actions where patients suffer damage arising from the physician's treatment.<sup>122</sup> During this period public policy and the moral convictions of society played a major role in determining what conduct of physicians constituted delictual and criminal liability. Voet when defending the application of the imperitea rule<sup>123</sup> stated:  
*"Sicur enim medico imputari eventus mortalitatis neo debet, ita quoque practestu humanae fraglitas delictum decipientis in periculo homines vana medicinae faciendae pactantis epoxium esse fas non est."*<sup>124</sup>

The crux of the matter locked up in the fore stated quotation is that it will be against public policy if physicians are excused for causing damages through their inexperience or clumsiness.<sup>125</sup>

#### 2.2.8 The Pre-Modern and Modern Era

The relationship between the doctor and patient/healthcare provider and patient during this period has remained very much intact and has been shaped by a strong commitment to long-standing principles of medical ethics<sup>126</sup> in which, conscience and intuitive sense of

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<sup>121</sup> Berkhouwer and Vorstman (1950) 24; See also Carstens and Pearmain (2007) 617.

<sup>122</sup> See Berkhouwer and Vorstman (1950) 24; Carstens and Pearmain (2007) 617.

<sup>123</sup> See Scott (1981) 138 - 140. The writer states the above is still very much part of our legal system today. Particularly with the introduction of the Bill of Rights in the Interim Constitution and the Final Constitution which followed, greater emphasis is placed on social responsibility. See also *Cape Town Municipality v Bakkerers* 2000 (3) SA 1049 (A) at 1056 F-G, *Cape Metropolitan Council v Graham* ALL South African Law Reports February (2001) 1 ALL SA 215 (A) at 218 h-i.

<sup>124</sup> See Voet - *Commentarius ad Pandectas* 9 2 13.

<sup>125</sup> See Scott (1981) 138.

<sup>126</sup> See Jones (1998) 18. Mason and McCall Smith (1991) 14-17 who believes that in the doctor/patient relationship, medical ethics play an important role in that: "*trust and respect continue to influence the relationship.*" See further Ficarra (1995) 147ff who states that as medicine operates in an ethical climate "*it is essential that ethical principles be applied to the physician-patient interaction.*" See also Skegg (1988) 8. Beauchamp and Childress (2001) 1-7, 27 hold the view that normative ethics have enjoyed a remarkable degree of continuity from the days of Hippocrates until the 20th century. According to the writers, normative ethics include the responsibility of medical practitioners to comply with "... standards of conduct, including moral

goodness,<sup>127</sup> public conscience,<sup>128</sup> responsibility,<sup>129</sup> the Hippocratic Oath,<sup>130</sup> the sanctity

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*principles, rules, rights and virtues.*" A violation of these norms "..... without having a morally good and sufficient reason" constitutes immoral or improper conduct. The writers state that in addition thereto, health professionals and scientists are also given moral direction which comes through "the public policy process, which includes regulations and guidelines promulgated by government agencies, the aim of which is to govern a particular area of conduct" which includes "abstaining from causing harm to others." The latter thinking, it is submitted, corresponds with the position in South Africa today. The regulations published in the Government Gazette on the 1st February 1980 No 2948 No 6832 regulate the reasonable degree of care and skill which has to be maintained by private hospitals in maintaining a license held by the licensure. One of the relevant regulations 25(23) requires that: "All services and measures generally necessary for adequate care and safety of patients are maintained and observed." Veatch (1997) 21 views the codes regulating the conduct of medical practitioners as a "social contract" between the practitioners and the patients in which the practitioners pledge to "..... act to benefit their patients..... ." For the nature and scope of ethics see Strauss "Ethics in the Treatment of Mental Patients: Some Aspects" in Van Wyk and Van Oosten (Eds) *Nihil Obstat: Feesbundel vir WJ Hosten/Essays in Honour of WJ Hosten* (1996) 181. Steyn *The Law of Malpractice Liability in Clinical Psychiatry* (unpublished LLM dissertation UNISA 2002) 67-68 defines ethics as "the science of rules of moral conduct which should be followed because they are good in themselves." According to Strauss in Steyn (N152) 67 "Ethical considerations can never be excluded from the administration of Justice, which is the end and purpose of all civil law." With reference to the functions of the Health Professions Council of South Africa op cit 189 in Steyn (n157) 68 Strauss opines that "ethical rules certainly do have a significant degree of enforceability." Steyn (2003) 68 correctly, it is submitted associates himself with Strauss when he declares that the set of standards of practice born from ethics and law are "reinforcing and enriching." See also Carstens and Kok (2003) 18 *SAPR/PL* 449-451 who, with South Africa's acquired status as a constitutional state, view the role of normative medical ethics in the form of codes/instruments as "a protective measure of human rights" in that "to do no harm" and "to act in the best interest of the patient". In this regard with reference to disclaimers against medical negligence in hospital contracts which forms the core of the research of this thesis. Carstens and Kok (2000) 450 persuasively argue: "..... disclaimers against medical negligence in hospital contracts would amount to an unreasonable/unfair/unethical acceptance on the part of a patient to contract to the possibility of harm (in the form of personal injury/death resulting from medical malpractice) by an attending medical practitioner (albeit in the hospital setting) who is ethically bound not to harm."

<sup>127</sup> Mason and McCall Smith (1991) 7 state that "Conscience, directed by an intuitive sense of goodness, lies in the heart of ethics."

<sup>128</sup> Skegg (188) 8 endorse the idea when he states: "The conduct of doctors is circumscribed by public conscience." Mason and McCall Smith (1991) 7 attach great value to public conscience and warn that "the practice of medicine cannot be conducted solely on the basis of the individual conscience; the conduct of doctors is circumscribed by the public conscience ..... "It is against this ethical background that the validity of exclusionary clauses in hospital contracts will be investigated as means to determine ultimately whether the exclusion of negligence in hospital contracts favours public attitudes. Put differently, whether regulating the relationship with the patient in this way, does not constitute an improper derogation from an area of legitimate public concern.

<sup>129</sup> Hans *The Imperative of Responsibility* (1984) 6, 90-95 regards responsibility as the centre of the ethical stage which is borne out by the cliché "he is responsible, because he did it." The significance thereof according to Hans, is the doer must answer for his deed and is thus responsible for its consequences. So strong is his belief in the intrinsic value of responsibility that he argues: ".... responsibility is as unconditional and irrevocable as any posited by nature can be ..... "See also Van Niekerk "Ethics for Medicine and Medicine for Ethics" *SAFR J. Philos* (2002) 21 (1) 35.

<sup>130</sup> It is widely felt that the Hippocratic Oath remains a precursor of modern ethical codes. See Teff (1994) 72 who regards the Oath as "a powerful symbol of the doctor's responsibility." The author advocates that its future existence lies in the maintenance of high ethical standards and a sense of obligation to serve the best interests of

of life,<sup>131</sup> bodily integrity,<sup>132</sup> played a major role. What has changed during the Pre

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the patients. See also Giesen *Acta Juridica* (1988) 114. See further Sanbar et al (1999) 6 who view the Hippocratic Oath as the "*touchstone of modern medical ethics.*" For a comprehensive discussion see also Mason and McCall-Smith (1991) 439-446; Carstens and Kok (2003) 450.

<sup>131</sup> Brazier - *Medicine, Patients and The Law* (1992) 29-30 emphasizes the sanctity of life as a cornerstone of ethics in that religious followers and even non-believers share a deep seated instinct that taking human life is wrong as "*life is man's most precious possession.*" Included in the Declaration of Geneva, the Hippocratic Oath and other codes of medical ethics is an undertaking which doctors take namely: "*I will maintain the utmost respect for human life, from the time of conception; even under threat, I will not use my medical knowledge contrary to the Laws of Humanity.*" See also Mason and McCall Smith (1991) Appendices A - F, pp 251 - 261.

<sup>132</sup> A high premium is placed in the modern era on the respect for bodily integrity as means to maintain a high level of ethical conduct. This principle has been included on a wide scale internationally in private Canons of Professional Conduct, Constitutional Legislation as well as the Common Law in both case law as well as academic writings. In *America* the *Canons of Professional conduct* have been promulgated by the American Medical Association which contains ethical standards. Section 1 of the preamble thereof reads: "*The principal objective of the medical profession is to render service to humanity with full respect for the dignity of man.*" See Waltz *Medical Jurisprudence* (1971) 29. See also Sanbar et al (1999) 7; In *South Africa* the conduct of doctors and practice of medicine are governed by ethics contained in the Health Professions Council of South Africa rules of conduct for medical practitioners and dentists, and the guidelines on ethics for medical research. In *England* the nature of service to patients and the accompanying ethical conduct are contained in the National Health Service (General Medical Services) regulations 1992. See also Scott *The General Practitioner and the Law of Negligence* (1995) 16 - 17. The rights of the individual to bodily integrity has found it's way into the constitutional regimes of both the *United States of America* as well as the *South African Constitution*. In *America* this right is based on the premise that every person has the right to determine what shall be done to his own body. See Prosser and Keeton on the *Law of Torts* 5th Ed (1971) 190; See also Teff (1994) 98. The *South African Constitution* acknowledges a patient's right to bodily integrity. Section 12(2) (C) of Act 108 of 1996 provides that "*everyone has the right to bodily and psychological integrity, which includes the right not to be subjected to medical or scientific experiments without their informed consent.*" Internationally, although there is no single source of health rights in international law, many conventions recognizes the patient's right to bodily integrity. See McHale et al *Healthcare Law: Text cases and materials* (1997) 7. See also Art 25 of the *Universal Declaration of Human Rights* as well as Art 12 of the *International Covenant and Economic, Social and Cultural Rights*. The highest attainable standard of physical and mental health is guaranteed under Art 12. In *England*, despite the absence of a written constitution or bill of rights, the rights issue with regard to the bodily integrity is recognised by their common law. In *South Africa* the patient's right to bodily integrity at common law is regulated by the doctrine of informed consent. See Van Oosten - "The Law and Ethics of Information and Consent in Medical Research 2000 *THRHR* (63) 9; Van Oosten (1992) 13; See also Strauss (1991) 3, 91; Claassen and Verschoor (1992) 57-58; Strauss and Strydom (1967) 178. In *South Africa* the principle of the patient's protection to bodily integrity under the doctrine of informed consent was decided in a number of cases. See *Stoffberg v Elliott* 1923 148 at 149 - 150; *Lymbery v Jefferies* 1925 (AD) 236 at 240; *Ex Parte Dixie* 1950 (4) SA 748 (W) 751, *Rompel v Botha* 1953 (T) (Unreported) discussed in *Esterhuizen v Administrator Transvaal* 1957 (3) SA 710 T 719; *Lampert v Hefer*, 1955 (2) SA 507 (A) 508. The patient's protection of bodily integrity at *English Common Law* is recognised through the doctrine of informed consent. See Skegg (1984) 76; See also Kennedy (1988) 177 - 178; Kennedy and Grubb (1998) 110; Brazier (1992) 73 - 74, Teff (1994) 94; Scott (1995) 85 - 94. As far as case law is concerned refer to the matters of *Lindsey County Council v Marshall* (1936) 2 ALL ER 1076 (HL); *Bolam v Friern Hospital Management Committee* (1957) 2 ALL ER 118 (QB); *Chatterton v Gerson* (1981) 1 ALL ER 257 (QB); *Sidaway v Bethlem Royal Hospital Governors* (1985) 1 ALL ER 643 (HL). The *American Common Law* position regarding the preservation of the patient's bodily integrity is highlighted by the American Academic writers Waltz et al (1971) 153; Sanbar et al (1995) 120 -121; Holder *Medical Malpractice Law* (1975) 225. As far as case law is concerned the *locus classicus* is certainly the case of *Schloendorff v Society of New York Hospital* 105 NE 92, NY 1914 in which Justice Cardozo stated "*Every human being of adult years and sound mind has the right to determine what should be done with his own body and a surgeon who performs an operation without his patient's consent commits an*

Modern Era and the Modern Era is the legal characterisation of the doctor-patient relationship,<sup>133</sup> as well as the Sociological Construction<sup>134</sup> which comprises of the

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*assault for which he is liable in damages*". In *Natanso v Kling* 350 P 2d 1093, 354 P 2d 670, KANS 1960 the court held "A man is the master of his own body."

<sup>133</sup> It was particularly during the Ancient Period that the medical profession and particularly the doctor-patient relationship were characterized by the common calling of those who desired to treat people. Arising from the doctor's status as a member of that calling developed the doctor's duty to use proper care and skill. See Picard and Robertson (1996) 1; *Cogg v Bernard* (1703) 2ld RAYM.909, 92 E.R. 107 (K.B.); *Banbury v Bank of Montreal* (1918) A.C. 626 at 657 (H.L.) The concept of duty in the doctor-patient relationship as described by Fleming - *The Law of Torts* 1992 101-102 as "Containing in it the seed of the negligence action which sprang to life in the fertile environment of the industrial revolution." What followed was for nearly a century most actions against doctors have been based on negligence. See Picard and Robertson (1996) 2 who state: "With the development of the Law of Contract, the original basis for liability was suppressed by a contractual one in that, the patient's request for treatment and the doctor's response by commencing care were regarded as consonant with the principle of offer and acceptance." See in this regard Holdsworth (1923) 385 -386; Picard and Robertson (1996) 2. One of the causes of action relied upon to prove the doctor's liability at contract, was that the physician when commencing treatment of the patient, possessed and would have due care and skill. See Giesen (1988) 6 - 7; See also *Slater v Baker* (1767) 2 WELS 395, 95 ER 860.

<sup>134</sup> In this regard the doctor-patient relationship has undergone major changes. The traditional paternalistic model, in which authority was invested in doctors by society arising from their knowledge of bodily functions and disease, was called into question. The paternalistic model equally is based on the belief that doctors subscribe to the moral attributes embodied in the Hippocratic Oath. There are strong links in this model between medicine and religion. The doctor akin to a parent gives guidance and direction and the patient, as with the child, is expected to co-operate. See Picard and Robertson (1996) 3; Benatar (1987) 27; Strauss "Geneesheer, Pasiënt en Die Reg: 'n Delikate Driehoek" *TSAR* 1987 1; Giesen "From Paternalism to Self-determination to Shared Decision making" *Acta Juridica* (1988) 114; McHale et al (1997) 8-9. What has emerged is a more popular modern day model namely, the patient 'autonomy' or 'contract' model, which reflects the basic human right to self-determination in which the patient is seen as an 'autonomous purchaser of services' who is afforded protection under consumer sovereignty. See Teff (1994) 94, 100-101; Benatar (1987) 29; Strauss (1983) 2-3; Giesen (1988) 116; Kennedy (1988) 178; McHale et al 76-77. Patients in this model are seen to play a much more active role in the relationship and the decision-making process. Consent by the patient is of paramount importance in the decision-making process which in turn, seeks to transfer some power to the patient in areas which affects the patient's self-determination i.e. in cases of chronic illness. See Picard and Robertson (1996)3; Strauss (1987) 4; Giesen (1988) 116; Kennedy (1988) 178. A direct result of the creation and recognition of this model is the doctrine of consent which has in modern history become a significant feature in the doctor patient relationship. See Benatar (1987) 29; Strauss (1983) 4. What has also emerged in more modern times is a reviewed interest in the fiduciary nature of the doctor-patient relationship in which the said relationship is one of trust and confidence and in which doctors have an obligation to their patients to act with utmost good faith and loyalty and not to allow their personal interests to conflict with their professional duty. See Picard and Robertson (1996) 4 who emphasize the fiduciary nature of the relationship. The Canadian Courts in particular have also emphasized the fiduciary nature of the relationship. In the case of *Norberg v Wynrib* 1992 72 D.L.R. (4th) 448 See McLachlin J deciding on a damages claim arising from sexual exploitation by the doctor and the patient expresses himself as follows: "*The relationship of physician and patient can be conceptualized in a variety of ways. It can be viewed as a creature of contract, with the physician's failure to fulfil his or her obligations giving rise to an action for breach of contract. It undoubtedly gives rise to a duty of care, the breach of which constitutes the tort of negligence. But perhaps the most fundamental characteristic of the doctor-patient relationship is its fiduciary nature. I think it is readily apparent that the doctor-patient relationship shares the peculiar hallmark of the fiduciary relationship - trust, the trust of a person with inferior power that another person who has assumed superior power and responsibility will exercise that power for his or her good and only for his or her good and in his or her best interests. Recognizing the fiduciary nature of the doctor-patient relationship provides the law with an analytic model by which physicians can be held to the high standards of dealing with their patients which the trust accorded them requires.*"

traditional paternalistic model and the patient autonomy model. Both these models, notwithstanding the era in which they were used or continue to be used, have played a significant role in medical practice and medical law. In the traditional paternalistic model authority was vested in doctors by society arising from their knowledge of bodily functions and disease. The paternalistic model, equally, is based on the belief that doctors subscribe to the moral attributes embodied in the Hippocratic Oath. There are strong links in this model between medicine and religion. The doctor is akin to a person who gives guidance and direction and the patient, as with the child, is expected to co-operate.

In this model the patient is completely passive and the doctor active. The patient cannot contribute in any meaningful way to the interaction within the relationship, and all the decision-making power, lies with the doctor.<sup>135</sup>

In time, this model lost ground to the patient autonomy model within the sociological construction. Various factors influenced the change in the preference shown for this model. The factors include *inter alia* the shift towards consumerism and modern thinking and the recognition and promotion of the doctrine of informed consent.<sup>136</sup>

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Academic writers have expressed strong views in favour of the fiduciary aspects of medical practice and in particular its usefulness in providing "a dynamic tool for reshaping the doctor-patient relationship as means to finding a proper balance in the discourse between patient and doctor." See Chapman (1984) 140 who describes the fiduciary relationship between the doctor and patient as "..... One in which the patient's interests are placed first and foremost in the time-honoured traditions of service, duty and honour." See also Picard and Robertson (1996) 4. What is of particular concern for the academic writers as well is the continued undue influence and imbalance in the power of decision-making which exist between doctor and patient arising from his status as doctor or of his being better informed than the patient. See Kennedy (1983) 181. In the past courts in countries like England (and I submit in South Africa as well) by reason of policy, maintained a desire not to expose the doctor to a burden of litigation which may harm the perceived good image of the profession and disturb the balance in the doctor-patient relationship. See Kennedy (1983) 181. By relying on the breach of the doctor's fiduciary duty Picard and Robertson (1996) 6 opine that reliance thereon may even enable the patient to avoid the Statute of Limitations defence that would otherwise apply. In South African Law the fiduciary relationship between the Director of a company and the company itself is recognised. See Cilliers and Benade (1982) 327. In the medical law sphere save for the comments of Strauss (1993) no authority, exist otherwise which indicate whether the South African Courts may follow the approach of the Canadian Courts or not. What is important however for purposes of this research is to investigate to what extent the fiduciary relationship which exists between the provider of medical services and the patient, flowing from the unique nature of the medical service provided, impact upon the validity of exclusionary clauses in hospital contracts? Put differently, does the entrenched fiduciary duty in the case of, for example, a hospital to act with the utmost good faith arising from the type of medical service it provides, vitiate a patient's consent usually given when completing a hospital admission form which admission form especially in private hospitals, contain an exclusionary clause exercising liability of a hospital for negligent acts or omissions?.

<sup>135</sup> Picard and Robertson (1996) 3; Benatar (1987) 27; Strauss *TSAR* (1987) 1; Giesen (1988) 114; McHale et al (1997) 8-9; Teff (1994) 77ff.

<sup>136</sup> Picard and Robertson (1996) 3; Teff (1994) 89, 94ff states that respect for personal dignity and by implication for minority views, justifies putting a high value on patients exercising decision-making powers; See further Benatar (1987) 29 who advocates that the rationale for the preference for the patient autonomy model is based more on

What has emerged is a more popular modern day model namely, the patient 'autonomy' or 'contract' model, which reflects the basic human rights to self-determination in which the patient is seen as an 'autonomous purchaser of services' who is afforded protection under consumer sovereignty.<sup>137</sup> Patients in this model are seen to play a much more active role in the relationship and the decision-making process. Consent by the patient is of paramount importance in the decision-making process which in turn, seeks to transfer some power to the patient in areas which affects the patient's self-determination i.e. in cases of chronic illness etc.<sup>138</sup> A direct result of the creation and recognition of this model is the doctrine of consent which has, in modern history, become a significant feature in the doctor-patient relationship.<sup>139</sup>

What has also emerged in more modern times is a renewed interest in the fiduciary nature of the doctor-patient relationship, in which the said relationship is one of trust and confidence and in which doctors have an obligation to their patients to act with utmost good faith and loyalty and not to allow their personal interests to conflict with their professional duty.<sup>140</sup> Academic writers<sup>141</sup> have especially expressed strong views in

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social justice based on rights issues; Strauss *TSAR* (1987) opines that the human rights culture has very much influenced such change in the preferred model; Support for this thinking can be found in Giesen (1988) 116ff as well. For the most recent comments by Carstens and Pearmain (2007) 877 see the authors' opinion, namely, the shift from medical paternalism to patient autonomy accords with the provisions in the Bill of Rights, more particularly section 12(2) (b) and (c) which promote the doctrine of informed consent.

<sup>137</sup> Teff (1994) 94, 100-101; Benatar (1987) 29; Strauss (1983) 2-3; Giesen (1988) 116; Kennedy (1988) 178; McHale et al 76-77.

<sup>138</sup> Picard and Robertson (1996) 3; Strauss (1987) 4; Giesen (1988) 116; Kennedy (1988) 178.

<sup>139</sup> Benatar (1987) 29; Strauss (1987) 4; See also the discussion of the foundations of the doctrine of informed consent by Carstens and Pearmain (2007) 877 in which the writers state: Informed consent is undoubtedly the foundation or core of the patient/doctor relationship, emanating from the law of obligations and underscored by ethical considerations. It represents, as it were, the beginning of either an amicable and harmonious encounter between patient and doctor (if informed consent is adequately explained and obtained), or an acrimonious relationship with the potential for litigation (if the informed consent-procedure is neglected or compromised and which has been borne out by the decisions in *Stoffberg v Elliott* CPD 148; *Esterhuizen v Administrator, Transvaal* 1957 (3) SA 710 (T); *Castell v De Greef* 1994 (4) SA 408 (C); *Broude v McIntosh* 1998 (3) SA 60 (SCA); *Jacobson v Carpenter-Kling* 1998 (T) unreported; *Oldwage v Louwrens* (2004) 1 ALL SA 532 (C); *McDonald v Wroe* unreported case no 7975/03 (CPD); *Louwrens v Oldwage* 2006 (2) SA 161 (SCA).

<sup>140</sup> Picard and Robertson (1996) 4 emphasize the fiduciary nature of the relationship. The Canadian Courts in particular have also emphasized the fiduciary nature of the relationship. In the case of *Norberg v Wynrib* 1992 72 D.L.R. (4th) 448 see McLachlin J deciding on a damages claim arising from sexual exploitation by the doctor and the patient expresses himself as follows: "*The relationship of physician and patient can be conceptualized in a variety of ways. It can be viewed as a creature of contract, with the physician's failure to fulfil his or her obligations giving rise to an action for breach of contract. It undoubtedly gives rise to a duty of care; the breach of*

favour of the fiduciary aspects of medical practice and in particular its usefulness in providing *"a dynamic tool for reshaping the doctor-patient relationship as means to finding a proper balance in the discourse between patient and doctor."*

What is important however, for purposes of this research, is to investigate to what extent the fiduciary relationship which exists between the provider of medical services and the patient, flowing from the unique nature of the medical service provided, impact upon the validity of exclusionary clauses in hospital contracts? Put differently, does the entrenched fiduciary duty in the case of, for example, a hospital to act with utmost good faith arising from the type of medical service it provides, vitiate a patient's consent usually given when completing a hospital admission form, which admission form, especially in private hospitals, contain an exclusionary clause exorcising liability of a hospital for negligent acts or omissions?

#### 2.2.8.1 The Doctor-Patient Relationship in the Sociological Construction in a Contemporary South Africa

The changes in the doctor-patient relationship paradigm in South Africa has, it is submitted, very much followed the trend of other countries such as England, United States of America, Canada, Germany to mention just a few. In this regard there can be no doubt about it; there has been a noticeable shift from paternalism to patient autonomy.

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*this constitutes the tort of negligence. But perhaps the most fundamental characteristic of the doctor-patient relationship is its fiduciary nature. I think it is readily apparent that the doctor-patient relationship shares the peculiar hallmark of the fiduciary relationship - trust, the trust of a person with inferior power that another person who has assumed superior power and responsibility will exercise that power for his or her good and only for his or her good and in his or her best interests. Recognizing the fiduciary nature of the doctor-patient relationship provides the law with an analytic model by which physicians can be held to the high standards of dealing with their patients which the trust accorded them requires."*

<sup>141</sup> See Chapman (1984) 140 who describes the fiduciary relationship between the doctor and patient as *"..... one in which the patient's interests are placed first and foremost in the time-honoured traditions of service, duty and honour."* See also Picard and Robertson (1996) 4. What is of particular concern for the academic writers as well is the continued undue influence and imbalance in the power of decision-making which exist between doctor and patient arising from his status as doctor or of his being better informed than the patient. See Kennedy (1983) 181. In the past courts in countries like England and, I submit, in South Africa as well by reason of policy, maintained a desire not to expose the doctor to a burden of litigation which may harm the perceived good image of the profession and disturb the balance in the doctor-patient relationship. See Kennedy (1983) 181. By relying on the breach of the doctor's fiduciary duty Picard and Robertson (1996) 6 opine that reliance thereon may even enable the patient to avoid the Statute of Limitations defence that would otherwise apply. In South African law the fiduciary relationship between the Director of a company and the company itself is recognised. See Cilliers and Benade (1982) 327. In the medical law sphere, save for the comments of Strauss, (1993) no authority exist otherwise which indicate whether the South African Courts may follow the approach of the Canadian Courts or not.

The first traces of a change in judicial attitude toward the concept of patient autonomy in South African medical law occurred as far back as 1923 when Watermeyer J in the case of *Stoffberg v Elliot* <sup>142</sup> instructed the jury in the following terms:

*"In the eyes of the law every person has certain absolute rights which the law protects. They are not dependent on statute or contract, but they are rights to be respected, and one of the rights is absolute security to the person. Any bodily interference or restraint of 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."*

The court continued:

*"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 may submit himself for medical treatment, but I am not going into that; I am not going to attempt to define the exact limits of the medical treatment, because they do not seem to me to be material in this case, but he does not consent to such surgical treatment as a doctor may consider necessary. By going into hospital, 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 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 over his own body, and is a wrong entitling him to damages if he suffers any."* <sup>143</sup>

But more recently it is especially the South African academic writers <sup>144</sup> who have come

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<sup>142</sup> 1923 CPD 148. The facts briefly stated amounted to this: The plaintiff claimed \$10 000 in damages for assault. The plaintiff was admitted to hospital for surgery 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 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.

<sup>143</sup> *Stoffberg v Elliott* 1923 CPD 149-150. The approach was followed much later in the *Castell v De Greef* case 1994 (4) SA 408 (C) when Ackerman J endorsed the shift in the paradigm by remarking at 420: *"I am of the opinion that there is not only a justification, but indeed a necessity, for introducing a patient orientated approach ....."*

<sup>144</sup> The eminent writer Van Oosten *The Doctrine of Informed Consent in Medical Law* (Unpublished doctoral thesis, University of South Africa, 1989) at 414 endorses the shift in the paradigm when he states:

*"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 professionalized 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 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."*

See also the role of patient autonomy in the light of the new Constitution discussed by Carstens and Pearmain

out strongly in favour of the paradigm shift from medical paternalism to patient autonomy.

In conclusion it needs to be emphasized it is especially the influence of normative medical ethics and its *sub strata* such as conscience, responsibility and the Hippocratic Oath, as well as the change in the legal characterisation of the doctor-patient relationship and the attendant sociological construction thereof, which it is submitted, will possibly pave the way in finding a solution to the core of our investigation, namely, whether a practitioner may validly exclude his/her liability from a negligent act by getting the patient to sign a disclaimer in a hospital contract.

Ever since medicine was first practised a certain standard of care was formulated as means to protect the general public against the conduct of practitioners who breached their duty to take care. Although at first unwritten, nevertheless, everyone was made aware of the standard of conduct <sup>145</sup> from which medical ethics developed.

#### 2.2.10 Legal Opinion

Since the first traces of the practice of medicine there has always been a desire to regulate and structure the practice of medicine. Ever since the earliest of times when certain individuals felt that spiritually they had been called upon to heal disease and ailments affecting human beings, there has been a concern for those they treated. The limitations placed on healers during the primitive period were not quite the same as during the era of modern medicine. The degree of limitation was very much influenced during the primitive period by the belief that disease and affliction were caused by supernatural powers, whereas, during the modern era, less emphasis was placed on the cause of disease by the supernatural power and the medical man was judged more on his conduct. <sup>146</sup> But, notwithstanding the era in which medicine was practiced what was common cause was the strong philosophical feeling that existed, namely, that the creation of man brought with it, the sanctity of life. It is for that reason that protective measures, it was so felt from early times, had to be put in place to preserve life. <sup>147</sup> During the ancient period in which

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(2007) 879ff

<sup>145</sup> Smit "Die Suid-Afrikaanse Geneeskunde en Die Reg" (1976) *De Jure* 107-119; Mason and McCall-Smith (1991) 3-6, Rhodes (1985) 7; Picard and Robertson (1996) 7.

<sup>146</sup> Smith *Taylor's Principles and Practice of Medical Jurisprudence* (1905) 1ff; Schwär, Olivier and Loubser *Die ABC van Geregtelike Geneeskunde* (1984) 1ff; Smit (1976) *De Jure* 107; Strauss (1987) *TSAR* 1; Carstens LLD Thesis (1996) 106ff; Carstens and Pearmain (2007) 608.

<sup>147</sup> Smith *Taylor's Principles and Practice of Medical Jurisprudence* (1905) 1ff; Schwär, Olivier and Loubser *Die ABC*

the priests practiced medicine and assumed the roles of physicians,<sup>148</sup> the limitations placed upon the physicians were not as sophisticated as formal regulations that followed, there was nonetheless, certain control over the conduct of physicians.<sup>149</sup>

What followed during the rule of Hammurabi of Mesopotamia, some 5000 years ago, was the first tract of formalism when the rules pertaining to the conduct of physicians and accompanying penalties for breach of their expected conduct was documented.<sup>150</sup> The Code of Hammurabi, it is submitted, forms the hallmark of the origin of the doctor-patient relationship. Not only did the code contain medical ethical rules and legislation regulating the conduct of the physicians, it also provided for professional fees and penalty provisions where physicians transgressed.<sup>151</sup> It was the Greeks who continued the momentum of formalising the regulating of medicine and expanding medical ethical rules. It was especially, the work of Hippocrates (460-360BC), who wrote the Hippocratic Oath, that contained the first basic ethical rules for accepted medical practice.<sup>152</sup>

The Romans, in contrast to the Greeks, did not make significant contributions towards the advancement of medical science.<sup>153</sup> What they did achieve, however, was to create in

*van Geregte Geneeskunde* (1984) 1ff; Smit (1976) *De Jure* 107; Strauss (1987) *TSAR* 1; Carstens LLD Thesis (1996) 106ff; Carstens and Pearmain (2007) 608.

<sup>148</sup> Berkhouwer and Vorstman (1950) 14; Massengill *A Sketch of Medicine and Pharmacy* (1943) 18; See also Carstens and Pearmain (2007) 608.

<sup>149</sup> See the discussion of Carstens and Pearmain (2007) 608 who opine that although the historical incidences recorded in the ancient period are not necessarily indicative of medical negligence as it is understood today, nonetheless, limitations were placed on professional acts committed by physicians. Physicians were also held accountable where they deviated from expected 'medical practice'.

<sup>150</sup> The Code of Hammurabi contained the first signs of ethical rules and legislations as means to prevent physicians from doing harm to the patients. See Carstens and Pearmain (2007) 609; Massengill (1943) 19; Ackernecht *A Short History of Medicine* (1968) 17.

<sup>151</sup> Massengill (1943) 19; Ackernecht (1968) 17 give examples of the penalties for medical negligence *inter alia*, the amputation of a physician's hands where he causes the death of the patient or a patient loses sight as a result of an operation to his eyes. See also Carstens and Pearmain (2007) 609.

<sup>152</sup> Jones *Hippocrates* (1923); Strauss and Strydom (1967) 175; Massengill (1943) 22; Carstens and Pearmain (2007) 610 all share the view that this ethical medical code for physicians is undoubtedly one of the greatest contributions to the practice of medicine and continues to play a significant role in contemporary medicine today. See Edelstein L "The Hippocratic Oath: Text, Translation and Interpretation" in *Cross Cultural Perspectives in Medical Ethics Readings* (ed Veatch RM) (1989) 6 on the effect of the Hippocratic Oath in a Historical sense; For the comments on the role of the Hippocratic Oath in modern medicine see Teff (1994) 72; Giesen *Acta Juridica* (1988) 114; Sanbar et al (1999) 6. The writers place a great premium on the value of the Oath on the doctor/hospital-patient relationship in modern day medical practice.

<sup>153</sup> Carstens and Pearmain (2007) 64.

their legal system, legal rules pertaining to identification and proof of the different forms of medical malpractices. In this regard, Roman law clearly distinguished between intentional malpractice, negligent malpractice and ignorant malpractice.<sup>154</sup> The *Lex Cornelia de Siciariis et veneficis* was put in place by the Romans to punish these physicians, who were convicted of homicide where the physician administered poison to a patient or was an accomplice thereto.<sup>155</sup> Negligent malpractice and ignorant malpractice were classified under the concept of *culpa*.<sup>156</sup> The presence of *culpa* is indicative of failure to act with the necessary skill and care: *non intellegere quod omnes intellegunt* (italics) - in other words, by not acting like the reasonable person in the same circumstances, or failure to act with the same degree of *diligentia* expected from a reasonable person in the same circumstances.<sup>157</sup>

The negligence of experts, such as physicians, is also assessed in context of the rule *imperitia culpa adnumeratur*. According to this rule, ignorance or incompetence was regarded as negligence.<sup>158</sup> The *Imperitia* rule, in principle, is indicative of the absence of professional skill and experience which are required and set by the medical profession.<sup>159</sup>

Roman law also recognized compensation to be paid to a patient who felt aggrieved through the conduct of the physician. Depending on whether the wrong was committed *ex contractu* or *ex delicto* the patient could claim by relying on the contractual relationship and, specifically, the breach thereof, alternatively, delict and show that there was a breach of the doctor's duty to take care under the *Lex Aquilia*.<sup>160</sup> In the post Roman era and more

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<sup>154</sup> Berkhouwer and Vorstman (1950) 16ff; Amundsen (1973) 20; Carstens and Pearmain (2007) 612.

<sup>155</sup> Amundsen (1973) 20; See also Carstens and Pearmain (2007) 612-613 who hold the view that the *Lex Cornelia* forced physicians to be very cautious in the choice of administering medication.

<sup>156</sup> For a discussion of the concept *culpa* see Carstens and Pearmain (2007) 613; See also Van Zyl (1983) 264. *Culpa* is also known as 'negligence' which in turn can be defined as the failure to comply with standards of conduct required by law.

<sup>157</sup> Van Zyl (1983) 264; See also Carstens and Pearmain (2007) 613.

<sup>158</sup> For a discussion of the rule see Carstens and Pearmain (2007) who quote the Digesta 50 17 32: "Gaius 7 ad edictum provinciale): Imperitia culpa adnumeratur" Inst Just 4 3 7: "*Imperitia culpa adnumeratur, veluti si medicus ideo servum tuum occiderit, quod eum male secuerit aut perperam ei medicamentum dederit.*"

<sup>159</sup> Examples can be found in the physician performing an operation in an unskilful or incompetent manner or wrong medication was prescribed. See Carstens and Pearmain (2007) 613-614.

<sup>160</sup> For legal writings on the physician's liability *ex contractu* see Zimmerman (1990) 393-395; Buckland (1963) 500; Carstens and Pearmain (2007) 613-614. For discussions on the claims *ex delicto* under the *Lex Aquilia* see Van Zyl (1983) 264ff.

specifically, the medieval era and the middle ages, under the Judea-Christian influence the philosophy of humanism was greatly advocated. Community interest is weighed more heavily than individual interest. Medical ethics were further promoted.<sup>161</sup> During this period legislation in the form of the *Leges Barbarorum* and *Lex Visigothorum* were put in place to regulate the conduct of doctors.<sup>162</sup> During the Renaissance period, the courts began to place great emphasis on the doctor-patient relationship. More over, courts placed a premium on the doctor's obligation to treat their patients with diligence and to exercise proper care and skill. Any deviation from the standards set by the profession was met with successful tortuous claims against the doctors.<sup>163</sup> The late middle ages saw the founding and establishment of hospitals. Medical ethics played a significant role in establishing hospitals. It was the Christians who founded the first hospitals as a result of their perceived duty they had to their fellow man.<sup>164</sup>

During the eighteenth century the Royal College of Physicians in London promoted, as part of the training of physicians, moral norms which included service ideals devoted to client's interests.<sup>165</sup> The patient's interest was regarded as primary. Where there was a conflict between client's interests and the commercial interest of doctors, the former was pivotal.<sup>166</sup> The Roman Dutch era also did not make any major contributions to medical science. But writers in the like of De Groot, Noodt, Huber and Voet, all made their own contributions in formulating the duties of medical practitioners and the requirements for liability.<sup>167</sup> The *imperitia* rule was received in Roman Dutch law from Roman law. The rule was applied to assess the negligent or ignorant conduct of the physician.<sup>168</sup> What also emerged during this era are the public policy considerations and the moral convictions of society influenced the criminal and delictual liability of physicians.<sup>169</sup>

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<sup>161</sup> Peters et al (1981) 3; Cronje-Retief (2000) 31; Mason and McCall Smith (1991) 6.

<sup>162</sup> Chapman (1984) 45; Van Zyl (1983) 615ff; Carstens and Pearmain (2007) 615.

<sup>163</sup> Holdsworth (1923) 385-386; Giesen (1988) 4; Cronje-Retief (2000) 50.

<sup>164</sup> Castiglioni (1975) 304.

<sup>165</sup> Chapman (1984) 77; It was Thomas Percival's writings at the time which influenced the thinking of the day. He wrote that the patient's interest should not be influenced by private and personal considerations.

<sup>166</sup> Scott (1981) 136ff; Carstens and Pearmain (2007) 616-617.

<sup>167</sup> Scott (1981) 134; Carstens and Pearmain (2007) 616ff.

<sup>168</sup> Scott (1981) 138ff; See also Massengill (1943) 79ff; Carstens and Pearmain (2007) 73ff.

<sup>169</sup> Scott (1981) 138ff; See also Massengill (1943) 79ff.

Voet in particular wrote about excluding physicians from liability when he stated that it will be against public policy if physicians are excused for causing damages through their inexperience or clumsiness.<sup>170</sup>

The need for maintaining a strong bond between the doctor and patient, based on a strong medical ethical foundation, continued during the pre-modern and modern era.<sup>171</sup> The medical ethical foundation on the other hand has as its crust conscience and intuitive sense of goodness;<sup>172</sup> public conscience;<sup>173</sup> responsibility;<sup>174</sup> the Hippocratic Oath;<sup>175</sup> the sanctity of life.<sup>176</sup> What did change, especially going from the pre-modern era to the modern era, is the legal characterisation of the doctor-patient relationship. In the beginning, especially during the ancient period, the doctor-patient relationship was characterized by the common calling of those who desired to treat people.<sup>177</sup> The common calling, influenced by the sociological constructions, was then replaced by the paternalistic model. This model was characterized by the authority which society vested in the doctor, arising from the doctor's knowledge of bodily functions and diseases,<sup>178</sup> in the

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<sup>170</sup> Scott (1981) 138-140 cites Voet Commentarius ad Pandectas 9 2 13 who wrote "*Secut enim medico imputari eventus mortalitatis non debet, ita quoque praetextu humanae fragilitatis delictum decipientis in periculo homines vana medicinae faciendae jactantia innoxium esse fas non est*".

<sup>171</sup> Jones (1998) 18; Mason and McCall Smith (1991) 14-17; Ficarra in Sanbar et al (1995) 147ff; Skegg (1988) 8. The writers share a common view that the relationship between doctor and patient is very much influenced by trust and respect. Beauchamp and Childress (2001) 1-7, 27 put the relationship down to moral principles, rights and virtues. Veatch (1997) 21 on the other hand describe the relationship as a "social contract" between the practitioners and the patients in which the practitioners pledge to "*..... act to benefit their patients .....*" For a similar view see Carstens and Kok (2003) 18 SAPR.PL 449-451

<sup>172</sup> Mason and McCall Smith (1991) 7.

<sup>173</sup> Skegg (1988) 8; Mason and McCall Smith (1991) 7.

<sup>174</sup> Hans (1984) 90-95 argues that so strong is the belief in the intrinsic value of responsibility that "*.... responsibility is an unconditional and irrevocable as any posited by any nature can be .....*" See also Van Niekerk (2002) 35.

<sup>175</sup> Teff (1954) 72; Giesen (1988) 114; Sanbar et al (1991) 6; Mason and McCall Smith (1991) 439-466; Carstens and Kok (2003) 456.

<sup>176</sup> Brazier (1992) 29-30; Mason and McCall Smith (1991) 251-261.

<sup>177</sup> Picard and Robertson (1996) 1-2; Holdsworth (1923) 385-386.

<sup>178</sup> Picard and Robertson (1996) 3; Benatar (1987) 27; Strauss TSAR (1987) 1; Giesen (1988) 114; Teff (1994) 72ff.

doctor-patient relationship.<sup>179</sup> In this relationship the patient plays a very passive role, whilst the doctor even with decision making plays an active role. A shift in consumerism brought about new thinking in which the patient's right to share the decision making process with the doctor was promoted. The patient autonomy model became the preferred model in the modern world.<sup>180</sup> The thrust of the argument supporting the change in the sociological construction is founded on the thinking that the patient autonomy or contract model reflects the basic human right to protection under consumer sovereignty.<sup>181</sup>

With the patient autonomy model, patients are seen to play a more active role in the relationship and the decision making process.<sup>182</sup> A direct result of the creation and recognition of this model is the doctrine of informed consent which, in the modern era, has become a significant feature of the doctor-patient relationship. South Africa has very much followed the trend of the foreign jurisdictions *inter alia* England, United States of America, Canada and Germany etc in accepting the patient autonomy model.<sup>183</sup>

### 2.3 Summary and Conclusions

An assessment of the origin and development of the doctor patient relationship reveals that the law, since time immemorial, has been desirous of regulating and structuring the medical profession. Such regulation is mainly aimed at the protection of the patients and the general public who seek the services of doctors and/or hospitals.

To this end, an assessment of the origin and development of the doctor-patient relationship reveals that the law, since time immemorial, has been desirous of regulating and structuring the medical profession. Such regulation is mainly aimed at the protection of the patients and the general public who seek the services of doctors and/or hospitals.

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<sup>179</sup> Picard and Robertson (1996) 3; Teff (1994) 89; Benatar (1987) 29; Strauss TSAR (1987) 1; Giesen (1988) 116ff; See also the more recent writings of Carstens and Pearmain (2007) 877 who believe that the change in the sociological construction accords with the new constitutional thinking which promotes the doctrine of informed consent.

<sup>180</sup> Teff (1934) 94; Benatar (1987) 29; Strauss (1983) 2-3; Giesen (1988) 116.

<sup>181</sup> Picard and Robertson (1996) 22; Strauss (1987) 4; Giesen (1988) 116; Kennedy (1988) 178.

<sup>182</sup> Benatar (1987) 29; Strauss (1987) 4; Carstens and Pearmain (2007) 877.

<sup>183</sup> For the first traces of its acceptance see *Stoffberg v Elliott* 1923 CPD 149-150; What followed were the strong comments by Ackermann J in *Castell v De Greef* 1994 (4) SA 408 (C). The South African writers Van Oosten (1989) 414, Carstens and Pearmain (2007) have very much endorsed the shift in the paradigm from paternalism to patient autonomy.

The doctor-patient relationship has for centuries been the cornerstone of setting standards of conduct, serving as a yardstick to measure whether the standard of conduct had been deviated from, which ultimately results in civil or criminal sanction. From the time that the relationship between the doctor (healer during the ancient period) and patient was first recognized, it had as its foundation, the duty to take care and to act reasonably towards the patient. The establishment and development of the doctor-patient relationship and its accompanying duty to take care, has very much been influenced by the forces of philosophy, religion, normative ethics, and the Hippocratic Oath. Other factors which influenced the relationship and shaped the duty of care and to act reasonably, include public policy and the moral convictions of society. The purpose of embodying the doctor-patient relationship with a standard of care to be observed is said to be to protect the general public against conduct of doctors who breached their duty to take care. With the founding of hospitals and the establishment of other healthcare providers, the same principles apply to the hospital-patient relationship as that of the doctor-patient relationship.

It was during the Roman period that the distinguished legal writers Ulpianus and Gaius first recognized that the doctor's duty of care is recognized in contract and in delict. For that reason, where a doctor deviates from the standard of conduct founded upon the doctor-patient relationship, the doctor's liability arose *ex contractu* or under the *Lex Aquilia*. Various legal remedies were found throughout centuries and made available to the aggrieved parties to seek relief against the conduct of the doctors and/or hospitals.

In the modern era, the principles upon which the relationship between doctor/hospital and patient are founded remains universally very much intact. It is believed that as in the past, the relationship will continue to be shaped and influenced by a strong commitment to long-standing principles of medical ethics in which conscience and intuitive sense of goodness, public conscience, and responsibility play a major role. What has changed however, during the modern era is the legal characterisation of the doctor-patient relationship, as well as the sociological construction. To this end, the doctor-patient relationship is no longer characterized by the common calling of those who desired to treat people. This was replaced by the recognition of the doctor in his professional capacity, whose duty of care is founded either in their contractual relationship or the general relationship. Insofar as the sociological construction is concerned, the doctor-patient relationship has also undergone major changes in that there has been a tremendous shift from the traditional paternalistic model to the more modern patient autonomy or contract model. In the first model, greater

authority vested in doctors, who, because of their knowledge, were bestowed with greater authority by the general society. Their decisions were hardly called into question. With the second model patients are seen to play a much more active role in the relationship and the decision-making process, greater power has been transferred to the patient. What has also emerged is the recognition of the fiduciary nature of the doctor-patient relationship in which the said relationship is one of trust and confidence and in which doctors have an obligation to their patients to act with the utmost good faith and loyalty and not to allow their personal intentions to conflict with their professional duty. What has also emerged is the recognition of a greater consumer-orientated society in which the rights of patients are protected and advanced. Patients, who sign indemnity forms exonerating the doctor/hospital from liability for their negligence, resulting in the patient suffering damages, may very well be challenged on consumer protection lines. Having now established that the doctor/hospital-patient relationship arises in the modern day context, from a relationship founded on contract or a general relationship, in the following Chapter the nature of the doctor-patient relationship will be considered. It will be seen in the two subsequent chapters that the doctor-patient relationship arising *ex contractu* plays a significant role in the practice of medicine.

What will be looked at will be the nature of the contractual relationship, when the relationship commences and, where a contractual relationship is entered into, what formalities need to be complied with.

## Chapter 3

### The Contractual Relationship between the Doctor/Hospital-Patient

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### 3. THE NATURE OF THE DOCTOR/HOSPITAL-PATIENT RELATIONSHIP

#### 3.1 Introduction

This Chapter, together with Chapter Four, deals with the subject of the nature of the doctor-patient relationship with specific reference to the contractual relationship between the doctor/hospital and the patient. The nature of the doctor-patient relationship is considered in an introductory way dealing with both the general duty of care in a general relationship and the contractual relationship as they exist side by side between the doctor/hospital and patient. The nature of the contractual relationship between the doctor and patient and when it commences are dealt with in this Chapter Three. The commencement date may be of importance to show in civil litigation whether a relationship in contract has been established.

It is to be noted in this discussion that the commencement of a doctor/hospital-patient relationship in express contracts are more easily discernable than in implied contracts.

Likewise, it appears from written, as opposed to implied contract arising from either oral agreements or merely by conduct from either oral agreements or merely by conduct, these principles relating to the nature of the relationship, especially, the commencement thereof, and the nature of the contractual relationship dealt with in Chapter Three, as well as the rest of this thesis, will be done by doing a comparative study in countries including South Africa, England and the United States of America. These countries have been specifically chosen for the research undertaken in this thesis. The countries have, as appears more specifically from Chapter 1, <sup>1</sup> been chosen for the research undertaken in this thesis because firstly, of their standing as the most important legal families, universally and secondly, because of their commonality. <sup>2</sup> All these systems have also experienced tremendous development in the medical law sphere. English law has been specifically chosen because of the close historical bond with South African law, as it appears from the positive law. <sup>3</sup> More recently the South African courts have also on occasions referred, especially to English legislation which was instituted to curb unfair and unreasonable exclusionary clauses in contract. <sup>4</sup> The United States of America was chosen because of the similar challenges they had to endure in pronouncing on the validity of exclusionary clauses in medical contracts. <sup>5</sup> Chapter Four, deals with the more formalistic nature of the law of contract in the South African medical context. This includes the formation of the contract and the legal requirements for establishing the agreement. Chapter Five, deals with the duties and obligations that flow from such a contractual relationship between the doctor/hospital and patient. What also falls to be dealt with is the general relationship between the doctor/hospital and patient outside the contractual terrain. This is dealt with in

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<sup>1</sup> See the discussion on page 36.

<sup>2</sup> Whereas the United States of America and England typifies what is known as common law systems, South Africa since the adoption of the new constitutional order is known as a hybrid system. See David and Brierly (1978) 21-73; Van Zyl (1981) 170-196.

<sup>3</sup> The courts in jurisdictions, South African as well as that of England, have throughout history often referred with approval to each others dicta. This includes medical law as well as contract law. See in this regard the English case of *Chatterton v Gerson* (1981) 1 QB 432 which refers with approval to the South African case of *Stoffberg v Elliott* 1923 CPD 148; See further the case of *Castell v De Greef* 1994 (4) SA 408 in which the South African court relies heavily on English law in concluding in the end that the development of other common law countries like Canada, the United States of America and Australia should rather be following the English law; See also *Burger v Central South African Railways* 1903 TS 571; *Manhole v Mothle* 1951 (1) SA 456 (T) in which English rules and principles regarding exclusionary clauses were entrenched.

<sup>4</sup> See in this regard the South African cases which referred to the *English Unfair Contract Terms Act* 1977. See the Supreme Court of Appeal judgement of *Johannesburg Country Club v Potts* 2004 (5) SA 511 (SCA). See also the Constitutional court judgement of *Barkhuizen v Napier* 2007 5 SA 323 (CC).

<sup>5</sup> See the leading case of *Tunkl v Regents of the University of California* 50 Cal 2d 92. 32 Cal RPTR 37 383 P.2d 441.

Chapter Six. In this chapter the general duty of the doctor/hospital is explored encompassing the nature of the duty of care, the standard of care and the influencing factors impacting on the standard of care to be exercised by the doctor. Chapter Seven, deals with the limiting or exclusion of the doctor/hospital's duty of care. In order to have a better understanding of the subject matter it calls for a discussion of the of legal concepts including, the doctrine of *volenti non fit iniuria* and assumption of risk when applied as a ground of justification in a general context. What falls to be dealt with, further, in this chapter is a discussion of whether these general grounds of justification can be applied by way of limitation or exclusion in a medical context.

The material was too voluminous to include in a single chapter. In any event, it was felt that it might be more useful to structure the material in this way so that the nature of the doctor/hospital and patient relationship as it arises generally or contractually be dealt with separately for ease of reference and comparison.

The nature of the relationship between, especially, the doctor-patient has over centuries been described in different ways. Originally the duty to use proper care and skill emanated from their status as medical practitioners. They were there to protect the general public from any mishaps. The nature of their relationship was built on the position of trust that the doctor occupied. The doctor was also generally viewed as a person endowed with specialist expert knowledge and the services provided were executed against the backdrop of highly confidential nature. Besides the recognition given to the general nature of the doctor-patient relationship in which the doctor was expected to exercise a duty of care towards the patient, the contractual relationship stemming from the relationship as such, was also traditionally recognised. From the aforementioned, traditionally, the nature of the relationship between the doctor/hospital and the patient took two distinct forms. It needs therefore to be emphasised that although the nature of the relationship between the doctor and patient has been described differently over the past six centuries,<sup>6</sup> what has emerged

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<sup>6</sup> Originally the duty to use proper care and skill attached to the doctor's status. The purpose was to protect the public from the mishaps of doctors: See Strauss and Strydom (1967) 175. The writers describe the nature of the relationship between the doctor and patient as one emanating firstly, from the position of trust that the doctor occupies, stemming from his specialized expert knowledge and the highly confidential nature of his services and secondly, from the contractual relationship between the doctor and patient. Gordon, Turner and Price (1953) 75 support the view that when a patient consults a medical practitioner, the patient enters into a contractual relationship with the doctor; See further Schwär Olivier and Laubscher - *Die ABC van Geregtelike Geneeskunde* (1984); The authors share the view that although the traditional view is that the doctor-patient relationship is usually one in contract nevertheless, a contractual relationship is not the only that subsists between a doctor and patient, as the doctor's duty to exercise care and skill arises independently of any contract. Support for the view can also be found in the dictum of *Correia v Berwind* 1986 (4) 60 (ZHC). The finding of the court also underlines the legal principle of medical ethics namely the doctor-patient relationship is not necessarily dependant upon the agreement between the parties. Take, for example, an emergency situation where the patient is unconscious and unable to enter into an agreement. That notwithstanding, results in legal and ethical obligations arising, to which

with certainty, is that such a relationship arises both contractually and from the doctor's duty to take care. What has also emerged from the discussion in Chapter Two is the strong commitment to long-standing principles of medical ethics and values which dominate the doctor-patient relationship, in the practise of medicine. The long-standing principles of medical ethics and values, as was seen earlier, have also resulted in the creation of legal rules assisting in setting the outer limits of acceptable conduct - a minimum standard of professional behaviour. Besides the creation of rules governing the minimum standard of professional behaviour in general terms,<sup>7</sup> the Law of Contract also regulates the relationship between the doctor and patient.<sup>8</sup>

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the doctor is bound. The view expressed in *Correira v Berwind* I submit is the preferred view as the doctor-patient relationship may very well arise independently of any contract.

<sup>7</sup> In modern times, internationally, the conduct of doctors and the practice of medicine are governed by the existing International and several National medico-ethical codes of conduct. See Van Olsten (1996) 33. South African doctors and other healthcare providers are also governed by medico-ethical codes. The most significant codes are the Health Professions Council of South Africa Rules of Conduct for Medical Practitioners and Dentists and the national code of conduct contained in the South African Medical Research Councils (MRC) Guidelines on Ethics for Medical Research. See the South African Medical Research Council, Guidelines on Ethics for Medical Research (1993). The National Code of Conduct is very much influenced by medical practice. See Van Olsten Encyclopaedia (1996) 37. Legal principles on the other hand are brought into line with medical practice and societal needs. See Van Olsten Encyclopaedia (1996) 38 who uses the example of the South African Law Commission's engagement in projects, i.e. projects on euthanasia and living wills. See Suid-Afrikaanse Regskommissie Eutanasië en die Kunsmatige Instandhouding van Lewe Projek 86 (1994).

<sup>8</sup> Support for this view in South Africa can be found in both academic writings as well as case law. See Van Oosten Encyclopaedia (1996) 53; Strauss (1993) 20; Claassen and Verschoor (1992) 115; Strauss and Strydom (1967) 104; Joubert (1983) 144; Gordon et al (1953) 69; See also the *dicta*: *Van Wyk v Lewis* (1924) AD 438, 443, 450-451; 455 -456; *Correira v Berwind* 1986(4) SA 60 (Z) 63 ff 66; *Edouard v Administrator Natal* (1989) (2) 389 ff; *Administrator Natal v Edouard* 1990 (3) 385 ff; *Castell v De Greef* (1994) 420, 425; *Hewat v Rendel* 1925 (TPD) 679, 691; *Allott v Paterson and Jackson* (1936) SR 221, 224; *Nock v Minister of Internal Affairs* (1939) SR 286, 290 ff.; *Dube v Administrator Transvaal* 1963 (4) SA 260 (T) 266; *Magware v Minister of Health* (1981) (4) SA 472(Z), 476, 477; *Lillicrap, Wassenaar and Partners v Health* (1989) (3) SA 600(D), 604; *Ramsamop v Moodley* 1991 (N) (unreported), discussed by Strauss SA 1991(4) SAPM 16; *Jansen van Vuuren v Kruger* 1993 (4) SA 842 (A) 848-849; *Friedman v Glicksman* (1996) (1) SA 434; *Clinton Parker v Administrator Transvaal* (1995) (W) (Unreported) pp.1 ff. 58. 68.

In England support can be found in academic writings. See Kennedy and Grubb Principles of Medical Law (1998) 286 - 288 in which the writer argues that it is only when treatment or other health care is private; a contractual relationship will arise between the doctor and the patient and usually the clinic or institution and patient. But under the National Health System, it is today generally accepted that there is no contractual relationship between a doctor, general practitioner or hospital doctor and the patient. See also Kennedy and Grubb *Medical Law, Text and Materials* (2000) 52 - 3; See also Teff *Reasonable Care* (1995) 61 - 2; Jones *Medical Negligence* (1994) 19 - 20; 69 -70; Nathan *Medical Negligence* (1957) 8 - 10; Powell *Professional Negligence* (1992) Par. 1 - 16; Jones and Burton *Medical Negligence Case Law* (1995) 26. Martin *Law relating to Medical Practise* (1979) 138; Wright *Medical Malpractice* (1984) 10 -11. In so far as case authority is concerned see *Everard v Hopkins* (1615) 80 ER 1164; *Slater v Baker and Stapleton* (1767) 95 ER 860; *Coggs v Bernard* (1703) 92 ER 107; *Pfizer Corp v Minister of Health* (1965) AC 512 (HL); *Thake v Maurice* (1986) QB 644(A); *Eyre v Measday* (1986) 1 ALL ER 488 (CA); *Hotson v East Berkshire Health Authority* (1984) 389; *Myers v Brent Cross Service Co* (1934) 1 K.B. 46. American academic writers and case law also support the view that the Law of Contract regulates the relationship between the doctor and patient. See Waltz *Medical Jurisprudence* (1971) 40; Furrow et al *Health Law Cases, Materials and Problems* (2000) 234 - 237; Sanbar et al *Legal Medicine* (1995) 62 -63; Holder *Medical Malpractice Law* (1978) 1 - 7; Sidley *Law and Ethics* (1985) 183. The American Case Law supports the recognition of a contractual relationship between the doctor and patient. See *Cartwright v Barthlomew*, 64 S.E. 2d 323 (GA. App

The development of both the general relationship and contractual relationship in the doctor/hospital-patient relationship brings about civil liability for doctors and/or hospitals which are founded in delict<sup>9</sup> (otherwise known as tort) or contract.<sup>10</sup>

1951; *Childs v Weis*, 440 S.W. 2d 104 (TEX.CIV. App 1969); *Hiser v Randolph* 617 P.2d 774, 776 (Ariz.App. 1980); *Murray v University of Pa. Hosp*, 490 A.2d 839 (Pa Super 1985); *Sander v Geib, Elston, Frost Professional Association*, 506 N.W. 2d 107, 114 (S.D. 1993); *Weils v Billars* 391 N.W.2d 668 (S.D. 1986); *Jones v Malloy* 412 N.W.2d, 837, 841 (Neb. 1987); *Tisdale v Pruitt*, 394 S.E. 2d 857 (S.C.App.1990); *Weaver v University of Michigan Board of Regents* 506 N.W.2d 264 (Mishap. 1993); *Lopez v Aziz* 852 S.W.2d 303 (Tex.App. - San Antonio) 1993); *Powers v Peoples Community Hosp Auth* 455 N.W.2d 371 (Mich.App.1990); *Cartwright v Bartholomew*, 64 SE 2d 323, GA 1951; *Suburban Hospital Association v Mewhinney*, 187 A 2d 671, Md. 1963; *Zipkin v Freeman*, 436 SW 2d 753, Mo 1968; *Barnes v Gardner*, 9 NYS 2d 785, NY 1939; *Rule v Cheeseman*, 317 P 2d 472, Kans 1957; *Hawkins v McCain*; 79 SE 2d 493, NC 1954; *Marvin v Talbott*, 30 Cal Rapt. 893, Cal 1963; *Robins v Finestone*, 127 NE 2d 330, NY 1955; *Caldwell v Missouri State Life Insurance Co.*, 230 SW 566, Ark 1921; *Cameron v Eynon*, 3 A 2d 423, Pa 1939; *Stohlman v Davis*, 220 NW 247, Neb. 1928; *Gross v Partlow*, 68 P 2d 1034, Wash 1937.

<sup>9</sup> The Law of Delict as it is known in *South Africa* (as opposed to its counterpart known as the Law of Torts in England and the United States of America) places a duty of reasonable care on doctors and/or hospitals in their conduct towards their patients. The said duty is preventative in nature, in that the doctor and/or hospital guard against harm being done to the patient. See Van Oosten (1996) 57; Gordon et al (1953) 106; Strauss and Strydom (1967) 159; Claassen and Verschoor (1992) 178. For the general discussion of the role of delict in the South African jurisdictions see Neethling, Potgieter and Visser *The Law of Delict* (2005) 2ff. See also the discussion by Carstens and Pearmain (2007) 489ff on the influence of the law of delict in a medical context. See also *Correia v Berwind* 1986 (4)66; *Van Wyk v Lewis* 1924 (AD) 443-444; *Collins v Administrator Cape* 1995 (4) 73. Where, as a result of a doctor's/hospital's action or conduct, the duty of reasonable care is transgressed causing the patient to die or physical or mental harm, the doctor may very well be civilly and/or criminally liable. See also *Kovalsky v Krige* (1910) 20; *Mitchell v Dixon* (1914) 519; *Webb v Isaac* (1915) 273; *Allott v Paterson and Jackson* (1936) 321; *Ex parte Rautenbach* (1938) 150; *Nock v Minister of Internal Affairs* (1939) 286; *Dube v Administrator Transvaal* 1963 (4) 260; *S v Mkwetshana* 1965 (2) 493; *St Augustine Hospital (Pty) Ltd v Le Breton* 1975 (2) 530; *Richter v Estate Hammann* 1976 (3) 226; *Blyth v Van den Heever* 1980 (1) 191; *S v Bezuidenhout* 1985 Unreported; *Pearce v Fine*; *Pringle v Administrator Transvaal* 1990 (2) 379; *Castell v De Greef* (1994) 408; *Friedman v Glickman* 1996 (1) SA 1134 (W); *Clinton-Parker v Administrator Transvaal* (1990) (2) SA 37 (W); *Edouard v Administrator Natal* 1989 (2) 368 372; *Administrator Natal v Edouard* 1990 (3) 581, 585. The Law of Tort is a well known remedy in medical negligence cases in England. According to Kennedy *Principles of Medical Law* (1998) 292 - 3 civil negligent claims against doctors is by far founded in the tort of negligence as opposed to the breach of contract in England. The latter in the medical context, is an exception rather than the rule. See also Nathan (1957) 8; Jones (1994) 18; in tort, as with delict in South Africa, a duty of care is owed by the doctor and/or hospital in their conduct towards their patients. A breach of that duty, by not exercising reasonable care and skill and resulting in harm to the patient, will result in civil liability in tort. Kennedy (1998) 292 -3; Jones (1994) 18; Taylor *Medical Malpractice* (1980) 28 - 31; Lewis *Medical Negligence - A Plaintiff's Guide* (1984) 123 - 126; Kennedy and Grubb *Medical Law* (1994) 70 - 71; Wright (1982) 2 - 3, 8 - 17; Jackson and Powell *Professional Negligence* (1987) 291; Scott *The General Practitioner and the Law of Negligence* (1995) 6, 8; *Sidaway v Bethel Royal Hospital Governors* (1985) AC 871 1 ALL 643; *Maynard v West Midlands RHA* (1984) 1 WLR 634 (HL); *Wisher v Essex AHA* (1987) QB 730 (CA); *Jones v Manchester Corp* (1952) QB 852; *Cassidy v Minister of Health* (1951) 2KB 343; *R v Bateman* (1925) (9) 4 LTKB 791; *White v Jones* (1995) 2 AC 207 (HL); *Henderson v Merritt Syndicates Ltd* (1999) 2 AC 145 (HL); *Capital and Counties Pty v Hampshire CC* (1997) 2 ALL ER 865 (CA); *F v West Berkshire Health Authority* (1989) 2 ALL ER 545; *Likely Iron Co v McMullan* (1934) AC 1; *Everett v Griffiths* (1920) 3 K.B. 163; *Lampher v Phipos* (1838) 8 CP 475; *Eyre v Measday* (1986) ALL ER 488; *Bolom v Friern Hospital Management Committee* (1957) 2 ALL ER 118; *Sidaway v Governors of Bethlem Royal Hospital* (1985) 2 WLR 480.

It is apparent that in *America*, as in *England*, a doctor and/or hospital incurs civil liability owing to an act or omission in that, the doctor and/or hospital owes his/her/it's patient a duty of care and, notwithstanding, has breached that duty, resulting in the patient suffering harm. See Waltz and Inbau (1971) 41; Furrow et al (2000) 234-237; Sanbar et al (1995) 119 - 120, 132 - 133; Holder *Medical Malpractice Law* (1975) 40; Sidley *Law and Ethics* (1985) 184; The principle is also supported by the following *dicta*: *Louden v Scott* 194 Pac. 488 (ST.CT.

What has also emerged during the discourse in Chapter Two is that although the relationship arising from contract or the general relationship is distinct, the interest protected in both instances remains the general wellbeing of the patient. The duty of care in both contract or in general, remains one, merely, the exercise of reasonable care towards the patient. In both instances the duty is preventative in nature, namely, to guard against harm being done to the patient.

What also emerges to be different is that the remedies in contract differ from those offered in delict. The reason lay in that the professional liability of medical practitioners is determined by the rules of delict (tort) or contract. Although there is a clear distinction in the rules governing delictual (or tortuous) or contractual liability, the contractual obligations

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Mont. 1920); *Pike v Honsinger* 49 N.E. 760 (CT APP. N.Y.1898); *Bardessono v Michels* 91 CAL. RPTR. 760, 764, 478 2d 480, 484 (CAL 1970); *Hall v Hildun* 466 SO. 2d 856, 872-73 (MES/1885); *Delaney v Rosenthal* 196 NE 2d 878; Mass 1964; *Schultz v Feigal* 142 NW 2d 84, Minn. 1966; *Orthopaedic Clinic v Hanson* 415 P 2d 991, Okla. 1966; *Bauer v Otis* 284 P 2d 133, Cal 1955.

<sup>10</sup> For the *South African* Law position see Claassen and Verschoor (1992) 115; Strauss and Strydom (1967) 107 111; Joubert LAWSA (1983) 144; Gordon, Price and Turner (1957) 74; Van Oosten Encyclopaedia (1996) 56; See also the following case law: *Meyers v Abramson* (1952) 124; *Edouard v Administrator Natal* 1989 (2) 385 368 (D) 389; *Jansen van Vuuren v Kruger* 1993 (4) SA 842 (A) 848-849; *Sutherland v White* 1911 EDL 407; *Recsez's Estate v Meine* (1943) EDL 277; *Hewatt v Rendel* 1925 TPD 678.

With regard to English Law, support can be found in academic writings. See Kennedy (1998) 286 - 288 in which the writer argues that it is only when treatment or other health care is private; a contractual relationship will arise between the doctor and the patient and also the clinic or institution and the patient. Under the National Health System, it is generally agreed that there is no contractual relationship between a doctor (Contractual General Practitioner or Hospital Doctor) and the patient. See also Kennedy and Grubb (1994) 52 - 3; Teff (1995) 61 - 2; Jones (1994) 19 - 20; 69 - 70; Nathan (1957) 8 - 10; Powell (1992) Par. 1 - 16; Jones and Burton (1995) 26; See further Martin (1979) 138; Wright (1986) 10 - 11. *American* academic writers and Case Law also support the view that the Law of Contract recognizes the relationship between the doctor and patient. See Waltz (1971) 40; Furrow et al (2000) 234 - 237; Sanbar et al (1995) 62 -63; Holder (1975) 1 - 7; Sidley (1985) 183. For the *American* case law see *Cartwright v Barthlomew* 64 S.E. 2d 323 (GA. App) 1951; *Klein v Williams* 12 SO 2d 421 (S.CT MISS 1943); *Childs v Weis* 440 S.W. 2d 104 (TEX.CIV. App 1969); *Hiser v Randolph* 617 P.2d 774, 776 (Ariz.App, 1980); *Stewart v Rudner* 84 N.W. 2d 816, 822 - 23 (Mich. 1957); *Murray v University of Pa. Hosp* 490 A.2d 839 (Pa Super 1985); *Sander v Geib, Elston, Frost Professional Association* 506 N.W. 2d 107, 114 (S.D. 1993); *Pope v St John*, 862 S.W. 2d 657, 661 (Tex App - Austin 1993); *McKay v Cole* 625 So.2d 105 (Fla. App. Dist 1993); *Jewson v Mayo Clinic* 691 F.2d 405 (8th Cir 1982); *Weils v Billars* 391 N.W. 2d 668 (S.D. 1986); *Childs v Weis* 440 S.W.2d 104 (Tex. Civ.App. 1969); *Jones v Malloy* 412 N.W.2d. 837, 841 (Neb. 1987); *Tisdale v Pruitt* 394 S.E. 2d 857 (S.C.App. 1990); *Weaver v University of Michigan Board of Regents* 506 N.W. 2d 264 (Mich.App. 1993); *Lopez v Aziz* 825 S.W.2d 303 (Tex.App - San Antonio) 1993); *Stewart v Rudner*, 84 N.W.2d 816 (Mich. 1957); *Labarre v Duke Univ.*, 393 S.E.2d 321 (N.C. APP 1990); *Powers v Peoples Community Hosp Auth* 455 N.W.2d 371 (Mich.App.1990); *Scarzella v Saxon*, 436 A.2d 358 D.C.App. 1981); *Cartwright v Bartholomew*, 64 SE 2d 323, GA 1951; *Tveldt v Haugen*, 294 NW 183, ND 1940; *Harris v Fireman's Fund Indemnity Co.*, 257 P 2d 221, Wash 1953; *Rule v Cheeseman*, 317 P 2d 472, Kans 1957; *Hawkins v McCain*; 79 SE 2d 493, NC 1954; *Marvin v Talbott*, 30 Cal Rptr. 893, Cal 1963; *Gluckstein v Lipsett*, 209 P 2d 98, Cal 1949; *Childers v Frye*, 158 SE 744. For other international law see Giesen (1988) 6 - 8, 9 - 10. The writer recognizes that the doctor and/or hospital liability is founded in contract or tort or both. The author argues that in the past century and a half most actions against physicians have been founded on negligence. For a similar view see Picard and Robertson (1996) 2, 173 - 175, 334, 339. The writers argue that the duty of care exists independently of any contract between the doctor and patient. Civil liability may therefore be found on negligence, in both tort and contract.

of a doctor are usually no greater than the duties owed in delict (tort). So is the duty to exercise reasonable care in delict (tort), effectively, the same as the implied term to exercise reasonable care in providing medical services in a contract.<sup>11</sup>

What also appeared from the discourse in Chapter Two is that although the functions of the law of contract and the law of delict may be different, particularly, with regard to their primary purposes and the interests they aim to protect, especially with regard to private treatment, a concurrent duty in both delict and contract arises. Consequently, as will be seen *infra*, the patient's claim may be pleaded both in contract or tort or both in the alternative.<sup>12</sup>

With the nature and scope of the doctor-patient relationship being comprehensively discussed in both Chapter Two and this Chapter Three, what will follow is an extensive discussion of the doctor's contractual relationship with his patient *inter alia* the nature of the relationship, how such a relationship commences, how the relationship is terminated and the consequences that flow from the breach of such relationship.

A contractual relationship will be found to exist in most cases between a doctor and patient albeit in the form of a tacit agreement. The nature of the agreement is that the doctor

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<sup>11</sup> See in this regard the South African authorities. Van Oosten *Encyclopaedia* (1996) 53, 57; Claassen and Verschoor (1996) 118ff; Gordon et al (1953) 106 ff; Strauss 2ed (1984); See also *Van Wyk v Lewis* AD 438, 443, 450-451, 455-456; *Correia v Berwind* 1986 (4) SA 60; 63ff; *Edouard v Administrator Natal* 389 ff; *Administrator Natal v Edouard*; 585 ff; *Castell and De Greeff* (1994) 420, 425 cf; *Hewatt and Rendel* (1927) 679, 691; *Allott v Paterson and Jackson* 1936 SR 221., 224; *Nock v Minister of Internal Affairs* 1939 SR 286, 290 ff; *Dube v Administrator Transvaal* 266; *Magware v Minister of Health* 1981 (C) SA 472, 476, 477; *Lillicrap, Wassenaar and Partners v Pilkington Brothers (Pty) Ltd* 1987 (1) SA 475 (AD); *Ramsamop v Moodley* 1991 (N) (unreported) discussed by Strauss SA 1991(4) *SAPM* 162; *Jansen van Vuuren v Kruger* 1993 (4) SA 842 (A) 848-849; *Friedman v Glickman* 1996 (1) SA 1134; *Clinton-Parker v Administrator Transvaal* 1996 (2) SA 37 (W).

For the English legal position see Kennedy (1998) 283, 294; Jones (1994) 20 states: "*The duty to exercise reasonable care in the tort of negligence is effectively the same as the implied term to exercise reasonable care in a contract to provide medical services. If anything, the stricter duties are to be found in the former.*" See also Lewis (1988) 123 ff; Kennedy and Grubb (1994) 70; Wright (1984) 10 - 11. See also the *dicta* *Thake v Maurice* (1986) 1 ALL E.R. 497; *Eyre v Measday* (1986) 1 ALL E.R. 488; *Esso Petroleum v Mardon* (1976) 2 ALL ER 5 CA. For the American legal position see Waltz (1971) 45 ff; Furrow et al (1995) 237 - 238; Sanbar et al (1995) 62-63; Holder (1975) 42. For the American case law see *Leighton v Saredant*, 27 N.H. 460 (S.Ct. N.H. 1853); *Adkins v Ropp* 14 NE 2d 727, Ind. 1938; In the case of *Kozan v Comstock* 270 F 2d 839, 844 (5 CIR 1959) the American position is stated as follows: "*It is true that usually a consensual relationship exists and the physician agrees impliedly to treat the patient in a proper manner. Thus, a malpractice suit is inextricably bound up with the idea of breach of implied contract. However, the patient-physician relationship, and the corresponding duty that is owed, is not one that is completely dependent upon contract theory. On principle then, we consider a malpractice action as tortious in nature whether the duty grows out of a contractual relationship or has no origin in contract.*" For other International views see Giesen (1988) 1 24-25; Picard and Robertson (1996) 175.

<sup>12</sup> Claassen and Verschoor (1990) 118; Neethling Potgieter and Visser (2005) 4 - 5; Joubert *LAWSA* (1983) 144 - 145; Strauss and Strydom (1967); See also *Van Wyk v Lewis supra* 438; *Correia v Berwind supra* 63 - 66; For English law see also Jones (1994) 20; Jackson and Powell (1992) 118; Wright (1984) 11; Giesen (1988) 33.

undertakes to diagnose the patient's complaint and to treat the patient without the doctor guaranteeing that the patient will be cured of his or her ailment. The broad duty therefore, that flows from such a relationship, is that the doctor undertakes no more than to treat the patient with the amount of skill, competence and care which may reasonably be expected of the practitioner in his field of medicine.

Hospital authorities similarly, may also incur liability resulting from a breach of contract where they have failed to carry out an undertaking.

The existence of a contractual relationship between the medical practitioner and the patient provides evidentiary materials to establish contractual liability where the exercise of reasonable care and skill has been breached. For that reason, as has been stated before, it is vitally important to establish when the contractual relationship between the medical practitioner and the patient commences. This, in turn, is of paramount importance for determining whether such a relationship has been established. The success of civil litigation or a possible conviction in a criminal case depends largely on the establishment of such a contractual relationship.

The importance in determining the commencement of the contractual relationship between the doctor/hospital and patient has been stated in all three jurisdictions chosen for the research undertaken in this thesis.

The commencement of a contractual relationship between a medical practitioner and the patient is not dependant upon some legal formalities expected in, for example, a land transaction matter.<sup>13</sup> Writing is therefore no prerequisite for the commencement of a contractual relationship between the medical practitioner and the patient. That being the case, in the majority of instances, in practise, the contractual relationship between the medical practitioner and the patient arises from a tacit agreement, through mere conduct for example, the doctor consults the patient in the surgery and thereafter commences treatment or the doctor is summoned to attend to a patient elsewhere and commences treatment.<sup>14</sup>

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<sup>13</sup> Van Oosten (1996) 54; Gordon et al (1953) 78; Claassen and Verschoor (1992) 59; See also what was stated by the court in *Myers v Abrahamson* 1951 (3) SA 438 (C).

<sup>14</sup> Gordon et al (1953) 54; Van Oosten (1996) 59; Carstens and Pearmain (2007) 345; both the authors Christie *The Law of Contract* (2001) 93-95 and De Wet and Yates (1978) 307ff recognize the ordinary terms of agreement which are entered into tacitly. See further the case of *Bulls and Another v Tsatsarolakes* (1976) SA 851 (T). The English legal position is set out in the following sources and cases: Kennedy and Grubb (1994) 71ff; Wright (1984) 22; Kennedy (1988) paragraph 515ff; Jones (1994) 23ff; Jones (1991) 16; See the following cases: *Eyre v Measday* (1986) ALL E.R. 488 C.A. 493; *Thake v Maurice* (1986) 1 ALL E.R. 497; *Greaves and Co (Contractors)*

There are also instances in which express agreements between the medical practitioner and the patient are indicated, for example where more serious operations and/or more complicated treatment/surgery is undertaken and the informed consent of the patient is required. In those instances, it is strongly recommended that written agreements between medical practitioners and patients be pursued. The advantage of written contracts may be stated briefly, namely, they fall into the category of express contracts which are easily discernable, in that they are more formalistic in nature, resulting in a greater certainty for both the medical practitioner and the patient of the terms and conditions of what was agreed to, and can be established more easily.<sup>15</sup>

The nature of the contractual relationship between the medical practitioner and the patient has been described differently by the legal writers<sup>16</sup> over the years, often varying from a contract of mandate, to a contract of service, to a contract of leasing and hiring. What has emerged from their writings however, unanimity amongst them that the legal relationship between the medical practitioner and the patient is a consensual one,<sup>17</sup> founded upon the fact that in general terms, the medical practitioner is a free agent or independent contractor who, when committing himself in treating the patient, creates a position of trust with the patient, wherein the medical practitioner undertakes, arising from the nature of the profession, that he/she will exercise reasonable care and skill. A breach of such trust will result in civil or criminal liability. On the other hand, the patient does generally possess the necessary autonomy to enter into such relationship or not.

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*v Boynham Mezule and Partners* (1975) 3 ALL E.R. 99. For the American authorities see Waltz (1971) 46; Furrow et al (1995) 236ff; Sanbar et al (1995) 62-63; Holder (1975) 3-4; *Pike v Honsinger* 49 NE 780 New York (1898); *Ramberg v Morgan* 218 N.W. 492 (S.CT.IOWA 1928); *Williamson v Andrews* 27 N.W. 6 (S CT. MINN 1936); *McBride v Roy* 58 P 2d 886 (S CT. OKLA 1936); *Chilmet v Campbell* 188 N.W. 2d 601 (MICH 1971).

<sup>15</sup> Strauss and Strydom (1967) 105 suggest that especially, with more complicated treatment or surgery doctors will be wise to reduce the agreement to writing in that it will spell out the nature of the treatment, the complications and risks accompanying the procedure and the nature and extent of the patient's informed consent. See also Strauss (1991) 8-9; Claassen and Verschoor (1992) 59; Joubert (1983) 144. For English law see Kennedy and Grubb (1998) Para 5.11-5.12; Jones (1996) 23; For American law see Furrow (1995) 234ff; Holder (1975) 1ff.

<sup>16</sup> Some writers have described the contract between doctor/hospital and patient as that of letting and hiring of work (*locatio conductio operis*); See Van Oosten (1996) 54; Gordon et al (1953) 75; Strauss (1991) 69. The relationship was also described in the case of *Myers v Abrahamson* (1951) (3) SA 438 (C), 1952 (3) SA P121 (C) as letting and hiring of services (*locatio conductio operarum*); See De Wet and Yeats (1978) 307-308; Strauss and Strydom (1967) 104. The contract between the doctor and patient has also been described as a contract as mandate. The patient in the relationship is regarded as a mandator and the doctor the agent. See Strauss and Strydom (1967) 104; Claassen and Verschoor (1992) 115.

<sup>17</sup> Van Oosten (1996) 63; Strauss and Strydom (1967) 105; Strauss (1991) 3; Claassen and Verschoor (1992) 116; Gordon et al (1953) 69-70. Recognition in English law is expressed by Kennedy and Grubb (1998) Fn 21 Para 5.07. The American law also recognizes that a relationship cannot commence between the doctor and patient unless consensus has been reached between the parties. See Furrow et al (1995) 235; Hill and McMenamin in American College of *Legal Medicine* (1995) (C) 49-50; Holder (1975) 1ff.

This position in England is discernable from the position in South Africa in that the majority view amongst the legal writers appears that the position articulated hereinabove, only applies to the relationship between private practitioners and their patients. The same cannot be said in instances where patients receive treatment under the National Health Service Scheme. The position in the United States of America however, appears to accord with the South African position.

The existence of a contractual relationship between the medical practitioner and the patient provides evidentiary materials to establish contractual liability where the exercise of reasonable care and skill has been breached. For that reason, it has been stated before, it is vitally important to establish when the contractual relationship between the medical practitioner and the patient commences. This, in turn, is of paramount importance for determining whether such a relationship has been established. The success of civil litigation or a possible conviction in a criminal case depends largely on the establishment of such a contractual relationship.

But, notwithstanding the fact that the agreement is not reduced to writing, it has been stated before that the principles of offer and acceptance and consensuality do nevertheless govern the commencement of the relationship.<sup>18</sup>

### 3.2 The Contractual Relationship between Doctor and Patient

The legal relationship between the doctor and patient as stated before is founded in contract and the doctor's duty to take care.<sup>19</sup>

The contractual relationship will be found to exist in most cases between a doctor and his patient. Ordinarily the contract entered into by the parties takes the form of a tacit agreement whereby the doctor undertakes to diagnose the patient's complaint and to treat him in the usual manner. By undertaking to treat the patient, a doctor does not however guarantee that the patient will be cured of his or her ailment or complaint.<sup>20</sup>

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<sup>18</sup> Van Oosten (1996) 63; Strauss and Strydom (1967) 105; Strauss (1991) 3; Claassen and Verschoor (1992); Gordon et al (1953) 69-70. Recognition in English law is expressed by Kennedy and Grubb (1998) Fn 21 Para 5.07. The American law also recognizes that a relationship cannot commence between the doctor and patient unless consensus has been reached between the parties. See Furrow et al (1995) 235; Hill and McMenamin in American College of *Legal Medicine* (C) 49-50; Holder (1975) 1ff.

<sup>19</sup> Van Oosten (1996) 53; Strauss and Strydom (1967) 104ff; Strauss (1991) 3ff; Carstens and Pearmain (2007) 404ff.

<sup>20</sup> For South African Law see: Strauss and Strydom (1967) 105 ff; Strauss (1991) 5; Joubert *LAWSA* (1983) 144; Claassen and Verschoor (1992) 115 - 110; Van Oosten *Encyclopaedia* (1996) 54 ff; *Bulls and Another v Tsatsarolakes* (1976) SA 891 (T); Christie (2001) 93ff; De Wet and Yeates (1978) 307-308; Carstens and

Unless the doctor expressly guarantees a cure, the patient might be able to claim damages for breach of contract in the event of the doctor failing to fulfil his undertaking. But in the ordinary course of events the doctor undertakes no more than to treat the patient with the amount of skill, competence and care which may reasonably be expected of a practitioner of his branch of medicine.

If a doctor departs from the patient's express instructions or fails to treat the patient in the manner tacitly agreed upon, the doctor may be liable for breach of contract and may be denied the right to claim remuneration.<sup>21</sup>

Hospital authorities may also be held liable for damages resulting from a breach of contract where the hospital doctors have failed to carry out an undertaking to provide adequate treatment. The liability arises from the hospital authority's liability for the acts of professional negligence on the part of the employees.<sup>22</sup>

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Pearmain (2007) 345ff. The English legal position is set out in the following sources and cases: Kennedy and Grubb (1994) 71 ff; Wright (1984) 22; Kennedy (1988) Paragraph 515 ff; Jones (1994) 23 ff; Jones (1991) 16; See the following cases: *Eyre v Measday* (1986) ALL E.R. 488 C.A. 493; *Thake v Maurice* (1986) 1 ALL E.R. 497; *Greaves and Co (Contractors) v Baynham Mezule and Partners* (1975) 3 ALL ER 99.

For the American authorities see *Waltz* (1971) 46; *Furrow et al* (1995) 236 ff; *Sanbar et al* (1995) 62 - 63; *Holder* (1975) 3 - 4; *Pike v Honsinger* 49 NE 760 New York (1898); *Ramberg v Morgan* 218 N.W. 492 (S. CT. IOWA 1928); *Williamson v Andrews*; 27 N.W. 6 (S. CT. MINN 1936); *McBride v Roy* 58P 2d 886 (S. CT. OKLA 1936); *Ghilmet v Campbell* 188 N.W. 2d 601 (MICH 1971).

<sup>21</sup> The South African position is set out in: *Strauss and Strydom* (1967) 107; *Joubert LAWSA* (1983) 144; *Claassen and Verschoor* (1992) 116; *Gordon et al* (1953) 74; *Van Oosten Encyclopaedia* (1996) 54 ff; *Sutherland v White* 1911 ED L 407. The English position is discussed in the following sources and case law: *Kennedy* (1998) Paragraph 5.13 ff; *Jones* (1991) 17 ff; *Kennedy and Grubb* (1994) 72 ff; *Wright* (1984) 22; *Eyre v Measday* (1986) 1 ALL E.R. 488; *Thake v Maurice* (1986) 1 ALL E.R. 479.

The American Law authorities also describe the instances when a doctor may be liable if he tacitly agreed to guarantee the outcome of his or her treatment and the result does not turn out to be that what he/she guaranteed. See *Waltz* (1991) 46; *Furrow et al* (1995) 236 ff; *Sanbar et al* (1995) 62 - 63; *Holder* (1978) 3 - 4; For case law see *Leighton v Sargeant* 27 N.H. 460 (S. CT. PA 1853); *Guelnet v Campbell* 188 N.W. 2d 601 MICH 1971; *McLandkas v McWhite PA* (10 Haris) 261 (S.CT. PA 1853).

<sup>22</sup> The South African position with regard to hospital liability *ex contractu* is set out in: *Van Oosten Encyclopaedia* (1996) 86 ff; See also *Strauss* (1991) 299 ff; *Claassen and Verchoor* (1992) 98. As far as case law is concerned see *Lower Umfolozo District War Hospital v Lowe* 1937 NP 1. In a later decision *Mtetwa v Minister of Health* 1989 (3) SA 600 (D) the court lay down the principle when the liability arises *ex contractu* when the court stated: "The degree of supervising and control 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." See also in this regard *Esterhuizen v Administrator Transvaal*; *Dube v Administrator Transvaal*; *Magware v Department of Health*; *Mtetwa v Minister of Health*; *Soumbabis v Administrator of the Orange Free State*; *Pringle v Administrator Transvaal*; *Collins v Administrator Cape*; *Clinton Parker v Administration Transvaal*; *cf. St Augustine Hospital (Pty) Ltd v Le Breton* pp 537 - 538; *Bulls v Tsatsarolakis*; *Edouard v Administrator Natal*; *Administrator Natal v Edouard*; *Burger v Administrateur Kaap* 1990 (1) SA 483 (C). In England the position regarding the liability of private hospitals has crystallized. Hospitals incur liability through the professional conduct of their staff in using the doctrine of vicarious liability. See *Jackson and Powell* (1997) 320; *Nathan* (1957) 129

### 3.2.1 COMMENCEMENT OF THE CONTRACTUAL RELATIONSHIP

The commencement of the contractual relationship between the doctor/hospital/other healthcare providers and patient is of paramount importance for determining whether a relationship has been established. This ultimately will be vital during civil litigation in that, in the absence of evidence proving the existence of such a relationship, the Plaintiff's chances of being successful with his/her civil suite may be diminished. Likewise, in a criminal case, the existence of a relationship between physician and patient may be vital in sustaining a conviction.<sup>23</sup>

The commencement of a physician-patient relationship in express contracts is more easily discernable than in implied contracts. An express contract is generally more formalistic in nature, albeit written or oral in that, the contract between doctor/hospital/other healthcare providers may begin with a specific agreement between the two for diagnosis and/or treatment. This may take the form of an oral agreement, usually preceded by the doctor disclosing to the patient sufficient information that will enable the patient to make an informed decision about a proposed treatment or procedure, and the patient's acceptance commonly known as informed consent.<sup>24</sup>

Similarly, written contracts will usually include the terms of the agreement *inter alia* the proposed treatment or procedure to be followed by the doctor/hospital/other healthcare provider, the provision of facilities to be utilized, the staff who will assist and the doctor

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ff; for case law see *Gold v Essex County Council* (1942) 2 KB 294; *Cassidy v Minister of Health* (1951) 2 KB 343; *Collins v Herts County Council* (1997) 1 KB 598; *Roe v Minister of Health* (1954) 2 QB 66. Uncertainty prevails whether hospitals operated under the National Health Service would incur liability for their conduct as employer, especially as it is believed that no contractual relationship comes into being between the doctor and the patient nor is there a contractual relationship between the patient and the hospital such as the NHS Trust. See Kennedy (1998) 286 ff; Jones (1994) 19 ff; Jones (1991) 15 ff; Kennedy and Grubb (1994) 68 ff; The position is set out in *Hotson v East Berkshire Area Health Authority* (1987) 1 ALL ER 210 in which the court stated: "I am quite unable to detect any rational basis for a state of the law, if such it be, whereby in identical circumstances Dr A who treats a patient under the national health service, and whose liability thereby falls to be determined in accordance with the law of tort, should be in a different position from Dr B who treats a patient outside the service, and whose liability therefore falls to be determined in accordance with the law of contract, assuming, of course, that the contract is in terms which impose on him, neither more, nor less, than the tortious duty." The position in America as in South Africa is more certain in that hospital authority incur liability as a result of the conduct of its staff members, through the doctrine of vicarious liability. See Holder (1975) 211; See also Bertolet and Goldsmith *Hospital Liability Law and Practise* (1987) 326; See further Sanbar et al (1995) 156 ff; For case law see *Alden v Provincial Hospital* 383 F 2d 163 (DC 1963); *Daring v Charlestown Community Hospital* 33 ILL 2d NR 2d 253 (1965).

<sup>23</sup> Gordon et al (1953) 78; Van Oosten (1996) 54; Strauss and Strydom (1967) 105; For English authority see Kennedy and Grubb (1998) Para 5 12ff; Jones (1996) 25. For American authority see Furrow et al (1997) 234ff; Holder (1978) 3ff.

<sup>24</sup> See McQuoid-Mason and Strauss 17 LAWSA (1983) 144-145; Van Oosten Encyclopaedia (1996) 54-55; Strauss and Strydom (1967) 104-110; Strauss (1991) 8-10; Gordon Turner and Price (1953) 75-78.

who will be treating the patient and/or perform surgery, if necessary.<sup>25</sup>

More frequently, in cases involving cosmetic surgery and procedures, or instances where patients are to be admitted to hospitals, the usual procedure before cosmetic surgery and the procedures alike are performed, alternatively, when a patient is admitted to the hospital, he or she will be requested by the physician or hospital clerical staff, depending on the circumstances of the case, to sign a consent form which, in hospital matters, will be contained in a pre-printed admission form. Certain private hospitals make use of such admission forms containing an exemption clause which is signed by the patient as a condition of admission to the hospital.<sup>26</sup> The validity of the said exemption clause forms the subject of research in this matter.

More difficult, however, is to establish when an implied contract is created. The commencement thereof, it is submitted, may depend upon the circumstances inferred from the conduct of the physician and patient. The most obvious conduct from which an implied contract between doctor and patient may be inferred is where the patient submits himself or herself for examination and the doctor examines the patient. It has also been held before that where doctor talks with a patient by telephone, a contractual obligation may arise for the doctor especially, where medical advice is given.<sup>27</sup> But the identification of such an implied contract is not always that obvious.

### 3.2.1.1 SOUTH AFRICA

#### 3.2.1.1.1 Legal Writings

As stated previously ordinarily the contract entered into between the doctor/hospital/other healthcare providers and patient takes the form of a tacit agreement, in terms of which, the doctor/hospital/other healthcare provider undertakes to diagnose the patient's complaint and to treat him or her in the usual manner. Generally, no legal formalities are required for tacit agreements, as writing is no prerequisite for the commencement of such relationship. The

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<sup>25</sup> See McQuoid-Mason and Strauss 17 *LAWSA* (1983) 144-145; Van Oosten *Encyclopaedia* (1996) 54-55; Strauss and Strydom (1967) 104-110; Strauss (1991) 8-10; Gordon Turner and Price (1953) 75-78.

<sup>26</sup> Van Oosten (1996) 88; Strauss (1991) 305; Claassen and Verschoor 102-103.

<sup>27</sup> Van Oosten (1996) 54-51; Strauss and Strydom (1967) 105; Strauss (1991) 3ff; Carstens and Pearmain (2007) 405. The South African legal writers seem to apply the following test when determining whether a contract had arisen or not namely, the influence of a contract between the parties will depend upon the circumstances of each case and public policy considerations. See also the principles enunciated in *Edouard v Administrator, Natal* 1989 (2) SA 368 (D). English law adopts a very similar approach. See Kennedy and Grubb (1998) Para 3.37ff; See also Jackson and Powell (1997) 592. Similar views are expressed in America. See Waltz and Inbau (1971) 41; Furrow et al (2000) 235ff; Holder (1975) 1ff.

contract between the doctor/hospital/other healthcare provider and patient generally comes into being by way of mere conduct. South African writers have a difference of opinion as to exactly when the contract is concluded. <sup>28</sup>

### 3.2.1.1.2 Case Law

The commencement of the contractual relationship between the doctor/hospital and patient has received scant attention from the South African Courts. Although the courts, unlike the academic writers, have paid scant attention to the implied agreements between the doctor/hospital and the patient, nevertheless, in a number of decisions our courts recognise the commencement of the relationship by relying on the doctrine of consent as a manifestation of an express agreement between the doctor/hospital and patient.

In the case of *Correira v Berwind* <sup>29</sup> the Zimbabwean High Court endorsed the principle of an implied agreement between the doctor and patient, as stated by Lord Nathan in *Medical Negligence* (1957) 15 as follows: *"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 from contract."* <sup>30</sup>

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<sup>28</sup> See Gordon, Turner and Price (1953) 78 who share the view that: *"Notwithstanding the contract being express or implied, the contract to treat a patient begins from the moment the practitioner accepts the case."* Contra Van Oosten (1996) 54 who states that: *"Such a tacit agreement comes about by the patient consulting the doctor and the doctor attending to the patient."* Contra also Strauss and Strydom (1967) 105 who advocate that: *"Before an agreement can be said to have come into operation it must be clear from their conduct that consensus had been reached between the parties."* A classical example mentioned by the authors is where a doctor is summoned to a person who is ill. *"The fact that he is summoned to attend to the sick is an implied indication that he or she instructs the doctor to treat him or her. When the doctor commences his examination and treatment of the patient he or she by his or her conduct consensually concludes the agreement."* See however McQuoid-Mason and Strauss LAWSA (1983) Volume 17 Par 144 who state that: *"An undertaking by a doctor to examine the patient and to diagnose his or her condition does not necessarily amount to an undertaking to treat the patient personally."* This is especially so if the patient has to be referred to a specialist or another professional when an agreement commences between that specialist or other professional and the patient. See also Dada and McQuoid-Mason - *Introduction to Medical-Legal Practices* (2001) 4.

<sup>29</sup> 1986 (4) SA 60 (ZHC).

<sup>30</sup> *Correira v Berwind* 1986 (4) 60 (ZHC).



Express agreements between doctors/hospitals and patients in modern days have however; become the order of the day particularly when any unusual procedures are contemplated by practitioners. In these instances the procedure and the risks involved is first discussed with the patient hereafter the patient has an opportunity to consent. It is commonly known as informed consent. The patient's consent has often been held to be essential for medical intervention and the act of consent, it is submitted, indicates the commencement of the contractual relationship. This principle was clearly demonstrated in *Stoffberg v Elliott*<sup>31</sup> when the court remarked: " ..... 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 this right of security and control of his own body, and is a wrong, entitling him to damages if he suffers any." <sup>32</sup>

As to the prerequisite in obtaining proper consent see *Ex Parte Dixie*<sup>33</sup> in which Millen J stated: "*With reference to a surgical operation, as a matter of law, that 1such 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 proper consent where the operation is urgently necessary and cannot with due regard to the patient's interests be delayed.*" <sup>34</sup>

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<sup>31</sup> 1923 (CPD) 148.

<sup>32</sup> *Stoffberg v Elliot* 1923 (CPD) 148.

<sup>33</sup> 1950 (4) SA 748 (W).

<sup>34</sup> *Ex Parte Dixie* 1950 (4) SA 748 (W) at 751.

In an unreported decision of *Rompel v Botha*<sup>35</sup> referred to in *Esterhuizen v Administrator, Transvaal*<sup>36</sup> the court with reference to the requirements for valid consent held: *"There is no doubt that a surgeon who intends operating on a patient must have 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 a 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 serious condition, I have no doubt that a patient should be informed of the risks he does run. If such dangers are not pointed out to him then, in my opinion, the content of the treatment is not in reality consent - it is consent without knowledge of the possible injuries. On the evidence defendant did not inform him/her of the possible dangers, and even if plaintiff did consent to such 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."*<sup>37</sup>

In *Esterhuizen v Administrator, Transvaal*<sup>38</sup> the court dealing with the following facts concluded: *"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 irritation of the tissues to the extent that the possibility of necrosis (death of tissues) and a risk of amputation 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*

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<sup>35</sup> Unreported judgement TPD 1953.

<sup>36</sup> 1957 (3) TPD 712.

<sup>37</sup> *Rompel v Botha* Unreported judgement 1957 (3) TPD 712.

<sup>38</sup> 1957 (3) TPD 712.

*consent, he does so at his own peril.*"<sup>39</sup>

In *Richter and Another v Estate Hamman*<sup>40</sup> Watermeyer J makes the following remarks regarding prior consent: "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. 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."<sup>41</sup>

In a more recent judgement of *Castell v De Greef*<sup>42</sup> the court when assessing the right of existence of consent in a medical law context in South Africa, concluded: "*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 1924 AD 438 at 451; Correira v Berwind 1986 (4) SA 60 CH at 63 and Verhoef v Meyer supra at 32 et seq. of the unreported Transvaal Provincial Division judgement and 26-9 of the unreported Appellate Division Judgement).*"<sup>43</sup>

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<sup>39</sup> *Esterhuizen v Administrator, Transvaal* 1957 (3) TPD 712.

<sup>40</sup> 1976 (3) SA 226 (C).

<sup>41</sup> *Richter and another v Estate Hamman* 1976 (3) SA 226 (C).

<sup>42</sup> 1994 (4) SA 408.

<sup>43</sup> *Castell v De Greef* 1994 (4) SA 408 at 425 F-G.

In the latest case involving informed consent in *McDonald v Wroe*<sup>44</sup> the court in relying on the case of *Castell v De Greef*<sup>45</sup> concluded *inter alia* that had the defendant warned the plaintiff of the risk of permanent nerve damage, she would probably have undergone the procedure at a later stage.

Though writing is no prerequisite for the commencement of a contractual relationship between the doctor and patient the prudent doctor in certain instances prefer to have the agreement reduced to writing.

It is submitted that a written contract in certain instances will also result in greater certainty for both the practitioner and patient.<sup>46</sup>

#### 3.2.1.1.3 Legal Opinion

- (1) The commencement of the contractual relationship between the doctor/hospital/other healthcare providers and the patient has a twofold significance, firstly, to establish whether the relationship has been established and secondly, when it was established. The importance thereof lies in civil or criminal litigation, as proof of the existence of the relationship, may result in success in a civil suite and likewise, a possible conviction in a criminal case.
- (2) The commencement of express contracts are made easily discernable than that of implied contracts. In the former event, the contract is generally more formalistic in nature. When in writing, it does result in greater certainty for both practitioner/hospital/other healthcare provider and the patient.<sup>47</sup> Even when not in

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<sup>44</sup> Unreported case No 7975/03 (CPD) delivered on 6 March 2006.

<sup>45</sup> 1994(4) SA 408 (C).

<sup>46</sup> See Strauss and Strydom (1967) 105 who advise that especially with more serious operations, written agreements, serve an important purpose in that, it highlights the nature of the operation and the functions of the practitioner. It also serves to provide proof of the exact terms of agreement between the practitioner and the patient in a civil action. See also McQuoid-Mason and Strauss LAWSA (1983) Vol. 17 Par 144 who emphasize the importance of reducing unusual procedures to paper particularly where informed consent of the patient is required. *"The doctor in that way will apprise the patient of the risks involved so that the patient may make an informed decision whether he consents to the practitioner proceeding with the treatment or procedure or not."*

<sup>47</sup> Strauss and Strydom *Die Suid-Afrikaanse Geneeskundige Reg* (1967) 105ff. The writers advise that when in writing, especially with more serious operations, it serves an important purpose namely it highlights the nature of

writing, the agreement is usually preceded by the practitioner disclosing certain information to the patient after the practitioner was called out to see the patient or the patient calls on the practitioner and discusses illness. In the latter event, it is more difficult to establish when the implied contract is created.

- (3) A major reason therefore is that with tacit agreements, generally, no legal formalities are required, as writing is no prerequisite for the commencement of such relationship.
- (4) In South Africa, the tacit agreement between the doctor/hospital/other healthcare provider and patient generally comes into being by mere conduct for example where the patient submits himself or herself for examination and the doctor examines the patient. Uncertainty however prevails in South African Law as to exactly when the tacit agreement is concluded.<sup>48</sup> It is submitted that the preferred view is consensual conduct from which it is clearly inferred that the patient desires the treatment and the practitioner agrees to treat the patient. It is therefore recommended that through their conduct it must be made clear of their common understanding and intention.
- (5) Written agreements are however indicated as far as possible as they create greater certainty.<sup>49</sup>

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the operation, the functions of the general practitioner and specialist as well as the exact terms of the agreement between practitioner/hospital/other healthcare provider and patient; McQuoid-Mason and Strauss *LAWSA* (1983) Vol. 17 Par 144 also highlight the importance of written agreements in that it will apprise the patient of the risks involved. The patient will therefore be in a better position to make an informed decision. See the *dicta Stoffberg v Elliot* 1923 (CPD) 148 149-150. *Ex Parte Dixie* 1950 (4); *Rompel v Botha* TPD 1953 (Unreported) referred to in *Esterhuizen v Administrator, Transvaal* 1957 (3) TPA 712.

<sup>48</sup> It has been stated before that the commencement of a tacit agreement takes place from the moment the practitioner accepts the case, Gordon, Turner and Price *Medical Jurisprudence* (1957) 78. It has also been stated that the onset of such an agreement is the patient consulting the doctor and the doctor attending the patient. See Van Oosten *Encyclopaedia* (1996) 54. The preferred view it is submitted, is advocated by Strauss and Strydom *Geneeskundige Reg* (1967) 105 namely consensus between the practitioner and patient is vital for the commencement of the agreement. The fact that the practitioner is summoned to attend to the sick is an implied indication that the patient wants to enter into an agreement. The commencement of the examination and treatment of the patient, manifest consensual conduct in reaching a tacit agreement. *Contra* however the situation where the practitioner examines a patient and diagnose the illness but refers the patient for specialist treatment and/or surgery. McQuoid-Mason and Strauss *LAWSA* (1983) Volume 17 Par 144; Dada and McQuoid-Mason *Introduction to Medico-legal Practises* (2001) 4. For the South African *dicta* indicating the commencement of tacit agreements see *Correia v Berwind* 1986 (4) 60 (ZHC). The court places the commencement of the tacit agreement the moment the practitioner assumes the responsibility for the care of the patient.

<sup>49</sup> Strauss and Strydom *Die Suid-Afrikaanse Geneeskundige Reg* (1967) 105 recommends that especially more serious operations and/or more complicated treatment/surgery should be reduced to writing where possible. Where informed consent is required, it is also desirable. McQuoid-Mason and Strauss *LAWSA* (1983) Vol. 17 Par 144;

### 3.2.1.2 ENGLAND

#### 3.2.1.2.1 Legal Writings

In English Law from what was stated previously, contractual relationships between the general practitioner and patient flows generally from private contractual agreements only, which means a General Practitioner who treats a patient under the National Health Service Regulations and likewise, a hospital doctor who treats a patient in a National Health Service Hospital, does not enter into a contractual relationship *per se*.<sup>50</sup>

For the purposes of the research undertaken in this thesis, it is therefore of import, to establish exactly when the contractual relationship between the doctor/hospital and patient in private practise commences. After all, it is only once it can be established that a relationship between a doctor and patient had come into being, that thereafter, the law imposes a duty thereon. English legal writers, as that of its South African counterparts have paid scant attention to exactly when such contractual relationship commences.<sup>51</sup>

#### 3.2.1.2.2 Case Law

In England, very few cases deal with the commencement of the contractual relationship between the doctor and patient. In *Coggs v Bernard*<sup>52</sup> and *Banbury v Bank of Montreal*<sup>53</sup> the courts by implication found that the patient's submission to treatment is an offer for

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<sup>50</sup> See Kennedy *Principles of Medical Law* (1998) 286; Kennedy and Grubb *Medical Law, Text and Materials* (2000) 64; Teff *Reasonable Care* (1995) 161-162; Jones *Medical Negligence* (1994) 18 – 20.

<sup>51</sup> See Kennedy and Grubb *Principles of Medical Law* (1994) 69 who state that: "Although the coming into existence of a contract between a doctor and patient is critical there is little guidance to be found in the law as to when the contract is formed." The authors are however of the view that the answer lies 'in the principle of offer and acceptance (together with consideration)'. Relying on the writings of Picard and Robertson (1984) 1-2 the authors endorse the principle namely: "The contractual relationship between the doctor and patient is founded on the patient requesting treatment (the offer) and the doctor's commencement of care (the acceptance)." Difficulty in identifying the offer phase in the relationship is encountered where a child for example is too immature to enter into the relationship himself/herself or an adult who is unconscious or mentally incompetent is unable to request medical treatment. It also occurs in emergency situations in which a person is unable to request treatment. In those instances Kennedy and Grubb (1994) 76 - 80 suggest the 'offer' for medical services will be part of 'parental responsibility' in terms of *The Children's Act* 1989 alternatively if the circumstances so dictate, the request must be made by someone who has 'the legal authority to act on the other's behalf to bring the relationship of doctor and patient into existence.' Examples given by the authors relate to 'a local authority under *The Children's Act* 1989' or the 'Supreme Court in terms of the Supreme Court Act 1981'. Where the patient is an adult who is unconscious or is otherwise mentally incompetent the 'offer' for medical services may be executed in terms of the Medical Regulations and the Mental Health Act 1983. In instances involving emergencies in which a person is unable to make a request "the mere undertaking by the doctor to provide medical services and taking care of the patient' will result in 'a duty in law."

<sup>52</sup> (1703) 2 LD RAYM 909.

<sup>53</sup> (1918) AC 626.

medical treatment whereas the doctor's willingness to treat the patient can be regarded as an acceptance to enter into a contractual relationship.

English Case Law has also recognised instances where a patient due to mental incompetence or unconsciousness is incapacitated or incapable of consenting to medical treatment.<sup>54</sup>

What is significant is that in English Law the above is distinguishable from the so-called 'emergency' cases. In the so-called 'emergency' cases the patient although capable in normal life of consenting is unable to do so due to circumstances beyond the patient's control. The patient can therefore not request medical treatment. The relationship is concluded by the doctor undertaking the care of the individual. Once the doctor undertakes to treat the patient in an emergency situation a duty in law will arise.<sup>55</sup>

### 3.2.1.2.3 Legal Opinion

(1) Very little has also been written in English Law as to exactly when the contractual relationship between the doctor/healthcare provider/hospital and the patient commences.

(2) It appears that the only authority *in casu*, apart from the English *dicta* is to be found in

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<sup>54</sup> See *Ref (A Mental Patient: Sterilization)* 1990 2 AC1, 1989 2 ALL ER 545 (HC) in which the court recognized the principle of necessity as providing justification for seeking medical treatment on behalf of a patient who is unable or incapable from doing so. The court motivated the position as follows: "*When a person is rendered incapable of communication either permanently or over a considerable period of time (through illness or accident or mental disorder), it would be an unusual use of language to describe the case as one of 'permanent emergency' - if indeed such a state of affairs can properly be said to exist. In truth, the relevance of an emergency is that it may give rise to a necessity to act in the interests of the assisted person, without first obtaining his consent. Emergency is however not the criterion or even a prerequisite, it is simply a frequent origin of the necessity which impels intervention. The principle is one of necessity, not of emergency.*"

<sup>55</sup> The above principle is best illustrated by the facts in *Barnett v Chelsea and Kensington HMC* (1968) ALL ER 1068: At about 5am on Jan 1, three night watchmen drank some tea. Soon afterwards all three men started vomiting. At about 8am the men walked to the casualty department of the defendant's hospital, which was open. One of them, the deceased, when he was in the room in the hospital, lay on some armless chairs. He appeared ill. Another of the men told the nurse that they had been vomiting after drinking tea. The nurse telephoned the casualty officer, a doctor, to tell him of the men's complaint. The casualty officer, who was himself unwell, did not see them, but said that they should go home and call in their own doctors. The men went away, and the deceased died some hours later from what was found to be arsenical poisoning. Cases of arsenical poisoning were rare, and, even if the deceased had been examined and admitted to the hospital and treated, there was little or no chance that the only effective antidote would have been administered to him before the time at which he died. Nield J hearing the matter then asked himself the following question: 'Is there, on these facts, known to be created a relationship between the three watchmen and the hospital staff such as gives rise to a duty of care in the defendants which they owe to the three men?' The answer he gave was: "*I have no doubt that [the nurse] and [the doctor] were under a duty to the deceased.*"

*Kennedy and Grubb*<sup>56</sup> who advocates that as the relationship between the doctor/hospital/healthcare provider and patient is built upon the principle of offer and acceptance, in respect of which, the request by the patient for treatment is seen as an offer and the doctor's commencement of care as an acceptance.

(3) English Law does recognise instances where, due to age or incapacity or mental incompetency, other people or agencies may assume "parental responsibility" in making the offer to treat, on behalf of the patient.<sup>57</sup>

(4) In the so-called emergency cases, where although a patient in normal life, is capable of consenting, but because of the de facto position he or she finds himself or herself then the principle of offer and acceptance is not applicable as the mere undertaking of the care of the patient will trigger of the duty of care.<sup>58</sup>

### 3.2.1.3 UNITED STATES OF AMERICA

#### 3.2.1.3.1 Legal Writings

The contractual relationship between the doctor and patient in America as was stated earlier described by legal writers as a consensual one<sup>59</sup> regardless whether the contract is express or implied.

The legal writers recognize that the contractual relationship between doctor and patient is founded on the principle of offer and acceptance.<sup>60</sup>

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<sup>56</sup> *Medical Law: Text with Materials* (1994) 52-3; See the dicta *Coggs v Bernard* (1703) 2 LD RAYM 909; *Banbury v Bank of Montreal* (1918) AC 626.

<sup>57</sup> Kennedy and Grubb *Medical Law, Text and Materials* (1994) 52-3 state that, where due to age, in the case of a minor, or due to incapacity or mental incompetency, the patient is not capable of consenting. i.e. making the offer for treatment, the 'offer' for medical services may come from those who, in terms of the *Children's Act* 1989, have the necessary "parental responsibility". The Supreme Court in terms of the *Supreme Court Act* 1981 may exercise such responsibility. In terms of the *Mental Health Act* 1983 those in a position to do so may make the offer for medical services. In emergency situations, where the patient is unable to make a request the undertaking by the doctor to provide medical services and the taking care of the patient results in a duty to take care. See also the dictum of *Ref (A Mental Patient: Sterilization)* 1990 2 AC 1, 1989 2 ALL ER 545 (HL).

<sup>58</sup> *Barnett v Chelsea and Kensington HMC* 1968 ALL ER 1068.

<sup>59</sup> See Williston *A Treatise on the Law of Contracts* (1957) Vol. 10, Chapter 39, Paginated 1286 - 1286A. In this regard the author states: "The relationship of physician and patient being a consensual one resembles that of attorney and client." See also Waltz and Inbau (1971) 40-41; Furrow et al (2000) 235ff; Voight in Sanbar et al (1995) 209; Holder 1ff.

<sup>60</sup> See Furrow et al (1995) 235: "When a patient goes to a doctor's office with a particular problem, she is offering to enter into a contract with the physician. When the physician examines the patient, she accepts the offer and an implied contract are created. The physician is free to reject the offer and send the patient away, relieving herself of any duty to that patient." See also Morris and Moritz *Doctor, Patient and the Law* 5ed (1971) 135 who describes the commencement of the relationship as: "The physician-patient relationship begins when the physician, in

For that reason the contractual relationship commences when the criteria for the commencement of the relationship is met.

### 3.2.1.3.2 Case Law

The American Courts have also held that the relationship between a physician and patient is consensual arising out of an express or implied contract.<sup>61</sup>

### 3.2.1.3.3 Legal Opinion

(1) The American authorities also recognise that the contractual relationship between the doctor/hospital/healthcare provider and the patient is a consensual one based upon the principle of offer and acceptance.<sup>62</sup>

(2) There are instances when due to age or incapacity, the minor or unconscious patient

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*response to the express or implied request that he treat the patient, undertakes to render services. The mere rendering of such services alone, even as may be necessary in an emergency, does not give rise to the relationship. The physician is, nevertheless, required to use due skill and care in administering treatment.*" It is a well established rule in America that generally a physician must have the patient's consent to the proposed treatment before that treatment can be initiated. See in this regard Sanbar et al (1995) 274. In instances involving minors the general rule is that a minor must obtain the consent of a parent or guardian who will have to enter into the relationship with the physician on behalf of the minor. See Sanbar (1995) 274. The authors Sanbar (1995) 274 with regard to minor consent exceptions, list a number of instances when the minor himself or herself may consent to 'selected or limited medical care' without the advice or consent of parents *inter alia* 'contraception, physical examination for rape, abortion etc. In the above situation it is submitted the commencement of the contractual relationship is dependant on the parent or guardian alternatively the minor himself or herself. In the so-called 'emergency cases' Sanbar et al (1995) 276 state that: "*Most physicians understand that where there is imminent danger of death without emergency treatment, consent will be implied.*" The express contract according to Holder (1975) 1 commences 'with a specific agreement between the physician and patient for treatment.' An example thereof is the patient asks the physician to treat him and the physician agrees to do so. See Holder (1975) 1. In more sophisticated procedures the physician is obliged to explain the full procedure and all its facts to the patient so much so that, the patient has an understanding of the treatment involved, so that the patient has the right to accept or reject the proposed contract for the physician's services on the basis of informed consent. See Holder (1975) 1.

<sup>61</sup> See *Hankerson v Thomas* (Mun. Ct App DC) 148 A 2d 583; In *Spencer v West* (CA App) 126 S2d 423 the court described the relationship as follows: "*The relation between a doctor and patient is a consensual one wherein the patient knowingly seeks the assistance of a physician and the physician accepts him as a patient.*" See also *Ivedt v Haugen* 70 ND 338, 294 NW 183, 132 ALR 379. *Contra Kennedy v Parrott* 243 NC 355, 90 SF2d 754, 56 ALR 2d 696, where the court held that "*when [a] person consults a physician or surgeon [who] agrees to accept him as a patient, it does not create a contract in the sense that term is ordinarily used. It is more apt to say that it creates a status or relation rather than a contract.*" But the court held the physician to the same standard of care he would have been held to had he expressly contracted to enter the relationship.

<sup>62</sup> Williston *A Treatise on the Law of Contracts* (1957) Vol. 10, Chapter 39, Paginated 1286-1286A; Furrow et al *Health Law* (1995) 235; Morris and Moritz *Doctor and Patient and The Law* (1971) 135. The writers are *ad idem* that in order to comply with the doctrine of informed consent the patient is expected to make an express or implied request that he or she be treated (the offer) and the doctor responds by undertaking to treat (the acceptance). See also the *American dicta* endorsing the consensual relationship between doctor and patient *Hankerson v Thomas* (MAN CT.APP DC) 148 A 2d 583; *Spencer v West* (CA APP) 1265 2d 423; *Zveat v Haugen* 70 ND 338, 29 4 NW 183, 132 ALR 379.

cannot consent to treatment himself or herself. In those instances, a guardian or parent asks the doctor to treat the patient.<sup>63</sup>

(3) In the so-called 'emergency cases' where due to the condition of the patient he or she cannot personally consent to treatment, in those instances consent is implied.<sup>64</sup>

### 3.2.2 NATURE OF THE CONTRACT BETWEEN THE DOCTOR/HOSPITAL AND OTHER HEALTH CARE PROVIDERS AND THE PATIENT

#### 3.2.2.1 SOUTH AFRICA

##### 3.2.2.1.1 Legal Writings

As was stated earlier the question is often begged what type of contract comes into being when the doctor/hospital and/or other healthcare provider enters into a relationship? The answer is not that certain as the nature of the contract between the doctor/hospital and/or healthcare providers and patient has often been described in many ways in South Africa by our legal writers.<sup>65</sup>

Whatever the preference exercised by the legal writers as to what species the contract belongs, what has emerged is that the legal relationship between the doctor/hospital and other healthcare providers and patient is a consensual one<sup>66</sup> entered into on an *ad hoc* basis. It is submitted that the foretasted opinion aligns with two fundamental principles

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<sup>63</sup> Sanbar et al *Legal Medicine* (1995) 274ff. The writers also point out instances where the minor himself or herself can consent for example contraception, physical examination in rape cases, abortions.

<sup>64</sup> Sanbar et al *Legal Medicine* (1995) 274ff.

<sup>65</sup> See Strauss and Strydom (1967) 104 describes the agreement as "*one falling under the Species Contract of Mandate, in terms of which, the doctor/hospital and/or other healthcare providers, acting as agent, undertakes to examine the patient as mandator and make a diagnosis and, if so requested by the patient, to administer the necessary treatment or perform a required operation.*" A similar view is adopted by Claassen and Verschoor (1992) 115; See also Strauss and Strydom (1967) 104 who argue on the other hand that "*the possibility of a Contract of Service arising between the doctor and patient cannot be excluded.*" Van Oosten Int. Encyclopaedia (1996) 88-89 who holds the view that as a general rule, "*the contract between doctor/hospital and patient takes the form of letting and hiring of work (locatio conductio operis).*" He states that as an exception to the rule "*the agreement may take the form of letting and hiring of services (locatio conductio operarum).*" The author argues it may on occasions even take the form of a contract of sale, for example a dentist supplying and fitting a patient with a denture or a hospital supplying and fitting a patient with an artificial leg.

<sup>66</sup> See Strauss and Strydom (1967) 105; See further Claassen and Verschoor (1992) 115; See also Strauss (1991) 3 who prefers to describe the relationship as a consensual legal relationship rather than that of the professional right of the doctor, advocated by De Wet and Van Wyk (1978) 4-5. It is submitted that the concept consensual legal relationship is preferred in that, it is founded on the cornerstone of the law of contract namely no agreement comes into being without agreement being reached between the contracting parties. This is often referred to *consensus ad litem*. Therefore before any legal rights and obligations are vested in any of the contracting parties, a contractual relationship between the parties first has to come into being. See Christie - The Law of Contract in South Africa (1996) 21 - 26; Kerr (1967) 1 -3; Van der Merwe et al (1993) 13 - 14; De Wet and Yates, (1978) 7.

namely: The doctor as a free agent or independent 'contractor' in general terms, may accept or refuse patients, as he chooses.<sup>67</sup> The consensual legal relationship between the doctor/hospital and/or other healthcare providers and patient is also recognised by the patient's autonomy<sup>68</sup> model to which has been much referred earlier.

Generally a person has control over his or her own body, even where medical treatment is involved. Apart from the doctor-patient relationship being described by many theorists as a consensual one, broad consensus has been reached amongst legal writers that the relationship between the doctor and patient is based on trust. In this way the doctor undertakes, arising from the nature of his or her position or profession, that reasonable care

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<sup>67</sup> Although the legal position at one stage in our law was, as a general rule, the independent practicing doctor was under no obligation to treat any person requesting his services and was at liberty to select or refuse such patients at will. See Strauss and Strydom (1967) 175 et seq.; McQuoid Mason and Strauss (1991) 3; LAWSA (1983) Volume 17 Par 189. Nonetheless, the traditional rule needs to be qualified in two respects namely: Where a doctor, arbitrarily and unreasonably refuses to attend to a seriously ill or injured person, the doctor may be held liable if the patient cannot manage to get another doctor and suffers harm. This accords with the departure from the traditional belief in our Law of Delict namely; there is no positive duty on a person to ward off danger facing another person. See in this regard the Appellate Division judgements of *Silva's Fishing Corporation (Pty) Ltd v Mameza* 1957 (2) SA 256(A) 260 H and *Peri-Urban Areas Health Board v Munarin* 1965(3) SA 367 (A) 323E. This aligns with the opinion of Johannes Voet in the Commentarius ad Pandectas 9.2.3 quoted by Gane *The Selective Voet being the Commentary on the Pandectas* (1955 - 1958) wherein it is stated that: "A doctor who refuses to attend a patient cannot be held liable under the Aquilian Law, 'although' adds Voet, "It would suit the duty of the good man to come to help the imperilled fortunes of his neighbour, if he can do it without hurt to himself." The position since the decision of *Minister van Polisie v Ewels* 1975 (3) SA 590 (A) has changed in that the court held that delictual liability may be founded on 'pure' omission in those instances where the circumstances so warrant and in which a legal duty to act positively arise. Commenting on the judgement Strauss (1991) 25 states that "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 comments made by Strauss it is submitted accords with the rules of the South African Medical and Dental Council (now the Health Provisions Council) (1978) in that: "A medical practitioner is free to decide whomever he will serve. A practitioner may, however, be required to justify his actions should unnecessary suffering or death result from his refusal to attend to a patient in case of an emergency, a practitioner is obliged to render assistance under all circumstances." See also McQuoid-Mason and Strauss LAWSA Volume 17 (1983) 145-146. A further deviation from the general rule arises once a doctor has accepted a patient and has embarked upon a specific course of treatment, he may then not unilaterally abandon the patient where such abandonment might be harmful to the patient (unless the patient makes it impossible for the doctor to continue treating him or her). See Strauss (1991) 3; See also Claassen and Verschoor (1992) 117. It is submitted that a patient's failure to co-operate makes it impossible for the doctor to treat him or her; the doctor may resile from the contract. See Claassen and Verschoor (1992) 117; See also Strauss and Strydom (1967) 113; LAWSA Volume 17 (1983) Par 145.

<sup>68</sup> The Patient Autonomy model (also known as the Contract Model) discussed earlier in this Chapter, regulates the relationship between the doctor and patient and has, in particular, for the last century, made inroads in medical law jurisprudence. Many social scientists, medical writers, as well as legal writers, have distinguished and encouraged the importance of patient autonomy. Through the model mutual participation between the doctor and patient (often referred to as shared decision making or informed consent) is encouraged. Paternalism as a model in which the doctor takes action or makes decisions on behalf of patients where necessary often without the patient's permission and sometimes even with coercion has to a large extent been pushed into the background. See Benatar (1987) 27 et seq.; See also Strauss (1987) *TSAR* 1 et seq.; See also Carstens and Pearmain (2007) 404ff.

and skill will be exercised during the treatment of the patient.<sup>69</sup> Once a position of trust is created, the doctor may not conduct himself in a careless or negligent way. If he does, resulting in any harm to the patient, the patient may sue the doctor for breach of contract formed on the breach of trust alternatively in delict.<sup>70</sup>

### 3.2.2.1.2 Case Law

The contractual relationship between the doctor/hospital and other healthcare providers and patient has, since the case of *Argus Printing and Publishing Co v Van Niekerk*<sup>71</sup> been recognised by the South African Courts and that of Zimbabwe. What has often also been of a contentious nature is whether the relationship between the doctor/hospital and patient stems from the Law of Obligations or from the Law of Contract *per se*? The South African Courts, over a number of decades, have also had to contend with the question, under what species of contract certain agreements entered into between the doctor/hospital and patient, resorted.<sup>72</sup>

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<sup>69</sup> See Strauss and Strydom (1967) 111; See also De Wet and Yeats (1978) 348; Christie (2001) 348, The latter authors base their reasoning on the fact that, as the relationship between the doctor and patient is based on a contract of mandate (also known as a mandatory), a position of trust is created. The doctor in this regard undertakes to execute his or her duties with the necessary good faith and with the utmost care and skill; see also the discussion on the contractual relationship between healthcare provider and patient *Carstens and Pearmain* (2007) 404-406.

<sup>70</sup> See Strauss and Strydom (1967) 111 who argue that the nature of the relationship between doctor and patient is established on trust. That together with the unique nature of services rendered is factors which may very well be relied upon in a legal suit against the doctor. *Carstens and Pearmain* (2007) 321 in this regard discusses the fiduciary relationship between the doctor and the patient which is built on trust. Black in *Black's Law Dictionary* defines the fiduciary duty as "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."

<sup>71</sup> (1895) 2 P40; Other cases in which the courts have given recognition to the contractual relationship between the doctor and patient include *Kovalsky v Krige* (1910) 20 OTR 822; *Tulloch v Marsh* 1910 TPA 453; *Oates v Niland* 1914 KPA 976; *Sutherland v White* 1911 ODP 407; *Webb v Isaac* 1915 ODP 273; *Hewat v Rendel* 1925 TPA 679; *Recsei's Estate v Meiring* 1943 ODP 277; *Bulls v Tsatsarolakis* 1976 (2) SA 891 (T); *Correia v Berwind* 1986 (4) ZHC 60; *Friedman v Glicksman* 1996 (1) SA 1134 WLD at 1138; *Castel v De Greef* 1994 (4) SA 408 CPD at 425; *Silver v Premier, Gauteng Provincial Government* 1998 (4) SA 569 WLD at 574-575.

<sup>72</sup> In *Administrator, Natal v Edouard* 1990 (3) SA 581 (AD) the court was asked to adjudicate *inter alia* on whether the Appellant was in law obliged to compensate the Respondent arising from a faulty sterilization operation? The court recognised the contractual relationship between the hospital and patient and dismissed the appeal. A similar question had to be decided in the case of *Correia v Berwind* (1986 (4) 60 at 63. Mfalila J looking at the relationship between the doctor and patient found "it is usually one of contract" but cautions the court "this is not the same thing as saying that a contractual relationship is the only one that can subsist between a doctor and patient." The court endorsed the comment of Lord Nathan, *Medical Negligence* (1957) "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 exist 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 concludes that the Law of Contract and the Law of Obligations can exist side by side in the legal relationship of doctor and patient." The court continues: "As between a doctor and patient there can exist both contractual and delictual liabilities." This is often referred to as concurrent liability and very much

### 3.2.2.1.3 Legal Opinion

(1) The nature of the contract between the doctor/hospital/healthcare provider and patient has pre-eminently been described by our legal writers and courts alike, as a consensual one, entered into on an *ad hoc* basis.<sup>73</sup>

(2) The fore stated opinion, it is submitted, is founded upon two fundamental principles namely: Firstly, a doctor in private practise is generally regarded as a free agent or independent 'contractor' who may accept or refuse patients, as he chooses,<sup>74</sup> the

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recognised in South African Law. See *Van Wyk v Lewis* 1924 AD 438; *Lillicrap, Wassenaar and Partners v Pilkington Brothers SA (Pty) Ltd* 1985 1 SA 475 (A); *Otto v Santam Versekeringsmaatskappy Bpk* 1992 (3) SA 615 (O); *Tsimatalupoulos v Hemingway, Isaacs and Coetzee CC* 1993 (4) SA 428 (C). Our courts have also in a number of cases found that the contract between doctor/hospital and patient takes the form of letting and hiring of work. (*locatio conductio operis*). In *Kovalsky v Krige* 1910 P824 the court regarded the responsibility of a doctor in this type of agreement "to bring a fair, reasonable and competent degree of skill and ability." See also *Coppen v Impey* 1916 309. Our courts have also in a number of cases stated the contract between doctor/hospital and patient takes the form of letting and hiring of services. (*locatio conductio o perarum*) See *Myers v Abrahamson* (1951) (3) SA P438. In this case, the court held, that the agreement between the doctor, the patient and his spouse, for the doctor to accompany them to the USA and to continue treating the patient and to pursue his post graduate studies, should be regarded as a contract of service. On a number of occasions our courts have also distinguished between a contract of letting and hiring of services and a contract of sale. See *Tulloch v Marsh* 1910 TPD P453; *Sutherland v White* 1911 EDL P407; *Oates v Miland* 1914 CPD P976; *Kruger v Boltman* 1933 (1) PH ANO 3. In the latter case the supplying and fitting of dentures were regarded as a contract of sale. Likewise in *Shield v Minister of Health* 1974 (3) SA P276 (RAD) it was held that the supplying and fitting of an artificial leg to a patient by the hospital constituted a contract of sale.

<sup>73</sup> Strauss and Strydom *Die Suid-Afrikaanse Geneeskundige Reg* (1967) 105; Claassen and Verschoor *Medical Negligence in South Africa* (1992) 115; Strauss *Doctor Patient and the Law* (1991) 3. This view, it is submitted, is founded on the cornerstone of the Law of Contract in that no contract comes into being without agreement first being reached, also known as *consensus ad litem*. It follows therefore, before any legal rights and obligations vest in any of the contracting parties, *consensus ad litem* first has to take place. Christie *The Law of Contract in South Africa* 1996 21-26; Kerr *Principles of the Law of Contract* (1967) 1-3; Van der Merwe et al *Contract - General Principles* (1993) 13-14. For the recognition of the contractual relationship between doctor and patient see *Kovalsky v Krige* (1910) 20 OTR 822; *Tulloch v Marsh* 1910 TPA 453; *Oates v Niland* 1914 KPA 976; *Sutherland v White* 1911 ODP 407; *Webb v Isaac* 1915 ODP 273; *Hewat v Rendel* 1925 TPA 679; *Recsei's Estate v Meiring* 1943 ODP 277; *Bulls v Tsatsarolakis* 1976 (2) SA 891 (T); *Correia v Berwind* 1990 (4) ZHC 60; *Friedman v Glickson* 1996 (1) SA 1134 WLD at 1138; *Castell v De Greef* 1994 (4) SA 408 CPD at 425; *Silver v Premier, Gauteng Provincial Government* 1998 (4) SA 569 (WLD) at 574-575.

<sup>74</sup> Strauss and Strydom *Die Suid-Afrikaanse Geneeskundige Reg* (1967) 175ff; Strauss *Doctor Patient and the Law* (1991) 3 McQuoid-Mason and Strauss *LAWSA Volume 17 Par 189*. This accords with the traditional belief found in the South African Law of Delict namely there is no positive duty upon a person to act. *Silva's Fishing Corporation (Pty) Ltd v Maweza* 1957 (2) SA 256 (A) at 260H; *Peri-Urban Areas Health Board v Munarin* 1965 (3) SA 367 (A) 323E. The aforementioned *dicta* align with the common law writer, Johannes Voet in the *Commentarius ad Pandectas* 9.2.3. The situation, it is submitted, has changed ever since the judgement of *Minister van Polisie v Ewels* 1975 (3) SA 590 (A). In this case the court found that delictual liability may be founded on 'pure' omission in those instances where the circumstances so warrants and in which a legal duty to act positively arises. Strauss *Doctor Patient and The Law* (1991) 24 opine in this regard that a court may well find against a doctor, where in the case of an injured or ailing person, and the doctor is aware of the patient's condition, but nevertheless, unreasonably refuses or fails to attend to the patient. Strauss's opinion accords with the Health Professional Council of South Africa's Regulation (2001) regarding emergency cases. See also McQuoid-Mason and Strauss *LAWSA Volume 17* (1983) 145-146. The patient autonomy model as discussed *supra* emphasizes the control which the individual has over his/her own body where medical treatment is involved.

consensual relationship between the doctor and patient is also recognised by the patient autonomy model in its quest for shared decision-making by the doctor and patient. Secondly, the relationship between doctor and patient is based on trust. In this way, the doctor, arising from his/her position, undertakes to exercise reasonable care and skill during the treatment of the patient.<sup>75</sup> Once a position of trust is created between the doctor and patient, the doctor may not breach that position of trust by conducting himself/herself in a negligent manner without incurring liability. This, I submit, will be one of the factors that will be advanced against the recognition of exclusionary clauses in hospital contracts in which the hospital/doctor/other healthcare provider exonerates itself/himself/herself against liability.

### 3.2.2.2 ENGLAND

#### 3.3.2.2.1 Legal Writings

Historically the legal obligations of a doctor in England were derived from his status and "common calling", that is, to exercise the skill and diligence expected of his calling.<sup>76</sup> Because of the nature of the doctor's obligations, most legal actions against doctors were edictal in nature.

In time the action was founded on the principle of *assumpsit*. That is the duty arises by reason of the assumption of responsibility for the care of the patient. But with the development of the law of contract, this basis for liability was superseded by claims in contract. It was acknowledged that where a doctor treated a patient for payment, the action is founded in contract.<sup>77</sup>

In more recent times in Britain, when considering actions founded in contract, a clear distinction is made between patients who receive treatment under the National Health Service Scheme and those who enter into a private relationship with a doctor and hospital.

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Shared decision-making or informed consent is encouraged in terms of this model. See Benatar "The Changing Doctor-patient relationship and the New Medical Ethics" *SA Journal of Continuing Medical Education* (1987) Vol. 5 April 27ff; Strauss "Geneesheer, Patient en Die Rag - 'n Delikate Driehoek" (1987) *TSAR* 1ff.

<sup>75</sup> It is especially those writers who argue that the type of contract which exists between doctor and patient is one of a contract of mandate who advance the argument that from such agreement a position of trust is created. Strauss and Strydom *Die Suid-Afrikaanse Geneeskundige Reg* (1967) 111; De Wet and Yeats *Die Suid-Afrikaanse Kontraktereg* (1978) 348. The writers opine that in creating the trust position the doctor undertakes to execute his or her duties with the necessary good faith and with the utmost care and skill.

<sup>76</sup> See Kennedy and Grubb (1998) 285 – 285.

<sup>77</sup> See Kennedy and Grubb (1998) 286; See also Jones (1996) 18; See further Wright (1993) 15.

Despite the difference of opinion amongst the legal writers in England, namely, whether a contractual relationship arises between a patient and the hospital in circumstances where the hospital provides treatment under the National Health Service Scheme, the majority view amongst English writers, appears to be that patients, who are treated under the National Health Service Scheme, do not enter into a contractual relationship with the general practitioner or hospital doctor. Equally, there is no contractual relationship between the patient and the hospital, where the patient is cared for. The agreement is twofold, namely, medical services within the National Health Service Scheme are provided to the patient pursuant to a statutory obligation and secondly, no consideration is given by the patient to the doctor for his services.<sup>78</sup> A contrary argument is advanced however by other critics, in that, the statutory obligation in the NHS System is not necessarily inconsistent with a contractual arrangement.

It is further argued that consideration may indirectly be provided by the patient since his inclusion upon the doctor's medical list will result in remuneration being paid by the health authority to the doctor.<sup>79</sup>

The type of contract that arises between the doctor/hospital and patient has widely been recognised in England as a contract of service.<sup>80</sup>

There are circumstances, however, in which the contract between doctor and, particularly, the hospital and patient is regarded as a contract of sale.<sup>81</sup>

English writers when analysing the nature of the contractual relationship between the

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<sup>78</sup> See Kennedy and Grubb (1998) 285 - 286; See further Jones (1996) 18 - 19; See also Jones and Burton (1995) 26.

<sup>79</sup> Kennedy and Grubb (1998) 286 - 288.

<sup>80</sup> This stems from the fact that professional medical practice in England during the nineteenth century in particular, was explicitly commercial in nature in that the relationship between the doctor and patient was characterized by a fee-for-service structure. See Teff (1996) 159 - 160, 173 who describes the role of the ordinary physician as "*maybe more readily perceived as 'selling' services than they are actually supplying work and materials as when giving patients drugs, medical devices, injections, or blood transfusions.*"

<sup>81</sup> The following transaction has been held to constitute a contract of sale namely the supply and fitting of dentures; the supply of vaccine, drugs, prosthetics, heart pace makers or artificial heart valves. See Jones (1996) 27 - 28; See also Kennedy and Grubb (1998) 292 who express the view that: "*The law implies terms in respect of services or goods provided to patients.*" In England such protection is afforded by *inter alia* the *Supply of Goods and Services Act 1982* in respect of which 'fitness for purpose' and 'satisfactory quality' has to be present when medical services and products are supplied.

doctor/hospital and patient are less clinical in their approach.<sup>82</sup>

### 3.2.2.2.2 Case Law

The implied duty to exercise care and skill in carrying out an operation received the attention of the English Court of Appeal in two leading cases. What also comes strongly to the fore in both cases is the principle that generally the doctor does not warrant that he will cure the patient unless the doctor expressly guarantees the result.

In *Eyre v Measday*<sup>83</sup> the Plaintiff sought to recover damages from the Defendant, a

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<sup>82</sup> Although the existence of a contractual relationship between the doctor/private hospital and the patient is *per se* recognised, little (if any) emphasis is placed on the consensual nature of the contractual relationship. See Kennedy and Grubb (1998) 283-292; Jones (1996) 18-28; Jones (1991) 14-20; Kennedy and Grubb (1994) 64-73; Martin (1979) 138-139; Wright (1994) 6-11; Jackson and Powell (1986) 590-593. What emerged however is the great emphasis placed by the writers upon the terms implied in the contract between doctor (and hospital) and patient. See Kennedy and Grubb (1998) 283- 292; Jones (1996) 23-28; Jones (1991) 16-20; Nelson-Jones and Burton (1995) 26-31. Wright (1986) 10-11, 16-17; Jackson and Powell (1997) 591-593. The terms implied in the contractual relationship between the doctor (or hospital) and patient briefly amounts to this namely when the doctor (or hospital) assumes to diagnose, advise, treat and/or provide a service to the patient and/or provides goods to the patients, he/she or it undertakes to exercise reasonable care and skill. See Kennedy and Grubb (1998) 292; See also Jones (1996) 20; Jones (1981) 16 - 17; See further Kennedy and Grubb (1994) 70 -71; Wright (1984) 16 - 19; Jackson and Powell (1997) 591 - 592: The terms also imply that where goods alone are supplied or where goods are supplied together with services, such services are fit for the purpose they are provided and the goods so provided are of satisfactory quality. These obligations are implied by *The Supply of Goods and Services Act 1982* and cannot be excluded. See in this regard Kennedy and Grubb (1998) 292; Jones (1996) 27; Jones (1991) 19; Kennedy and Grubb (1999) 71; Nelson and Burton (1995) 28. Although the doctor (or hospital) when undertaking to provide medical services inherits therewith an obligation by law to exercise reasonable care and skill he nevertheless is not expected to perform miracles. See Jones (1996) 23 who holds the view that unless the doctor gives a contractual warranty that he will achieve a particular result the courts are reluctant to infer such a warranty in the absence of an express term. See also Jones (1991) 16 - 17; Kennedy and Grubb (1994) 71 - 72; Jackson and Powell (1992) Para. 1.10. summarize the relationship between the professional person and his/her client as: "*In every contract between a professional man, and his client there will be express or implied terms defining the nature of the engagement. Thus if a surveyor is instructed to produce a report on certain property, there is an express or implied obligation to inspect it. If a surgeon agrees with his patient to perform a particular operation, there may be an implied term that he will give the necessary supervision thereafter until the discharge of the patient. If a solicitor is instructed to affect the grant of an option, there are implied terms that he will draw up the option agreement and effect registration. The importance of specific terms such as these is that a professional man will be liable if he breaks them, quite irrespective of skill and care which he has exercised.*" From the sources consulted, very few writers have entered the debate whether patient autonomy is to be preferred to that of paternalism as the ideal doctor-patient relationship model. See however Kennedy (1998) 178 who relies on 'consent as an ethical doctrine which guarantees respect for persons'. The authors prefer shared decision-making as an ideal model in which, neither medical paternalism nor patient sovereignty dominates. See also McHale et al (1997) 76 - 87 who opine that '*although the vestiges of the old medical paternalism linger on, particularly in the area of consent and capacity and provision of reproductive advice and treatment, nevertheless self-determination has become recognised as perhaps, the dormant principle of medical ethics.*'

<sup>83</sup> 1986 1 ALL E.R. 488; See also *Dendoas v Yackel* (1980) 109 D.L.R. (3d) 45 (B.C.S.C.) where there was a similar confusion between doctor and patient, the patient believing that the doctor's emphasis on the 'irreversible' and permanent nature of the sterilization procedure meant that there was no chance of a future pregnancy. Bouck J. held that since there was no clear meeting of minds on this essential term the claim in contract must fail.

surgeon, based on breach of contract arising from a botched sterilisation operation. The facts relied upon appear to be the following:

The Plaintiff underwent a sterilisation operation performed by the Defendant. The Defendant had explained the nature of the operation (a laparoscopic sterilisation), emphasising that it was irreversible, but he did not inform the Plaintiff that there was a less than one percent risk of pregnancy occurring following such a procedure. Both the Plaintiff and her husband believed that the operation would render the Plaintiff completely sterile. The Plaintiff subsequently became pregnant. She issued proceedings claiming that the Defendant was in breach of a contractual term that she would be rendered irreversibly sterile and/or a contractual warranty to that effect, which induced her to enter the contract. It was common cause that the contract was embodied partly in oral conversations and partly in the written consent form signed by the Plaintiff. Slade LJ in analysing the legal obligations of the doctor to his patient with whom he has contracted to carry out the operation concluded: *"Applying the Moorcock principle, I think there is no doubt that the Plaintiff would have been entitled reasonably to assume that the Defendant was warranting that the operation would be performed with reasonable care and skill. That, I think, would have been the inevitable inference to be drawn, from an objective standpoint. The contract did, in my opinion, include an implied warranty of that nature."*<sup>84</sup>

The Court of Appeal ultimately concluded that it was a contract to perform a particular operation, not a contract to render the Plaintiff sterile. Additionally, there was neither an express nor an implied warranty that the procedure would be an unqualified success. Although the Plaintiff could reasonably have concluded from the Defendant's emphasis on the irreversible nature of the operation that she would be sterilised, it was not reasonable for her to have concluded that he had given her a guarantee that she would be absolutely sterile.

A similar case involving a sterilisation procedure namely: In *Thake v Maurice*<sup>85</sup> the Plaintiff sought to recover damages from the Defendant, a surgeon, based on breach of contract.

The facts relied upon appear to be the following:

The Plaintiffs, a married couple consulted the defendant, a surgeon, privately, in order for

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<sup>84</sup> *Eyre v Measday* (1986) 1 ALL E.R. 488.

<sup>85</sup> 1986 1 ALL ER 497.

the husband to undergo a vasectomy as they did not wish to have any more children. The defendant explained the procedure to the plaintiffs and he pointed out that although it was possible to restore the husband's fertility he could not guarantee it, and that the plaintiff's should regard the operation as permanent. The plaintiff's signed a consent form which stated, *inter alia*: "I have been told that the object of the operation is to render me sterile and incapable of parenthood. I understand that the effect of the operation is irreversible." The operation was carried out and appeared successful. However, almost three years later, the wife discovered that she was pregnant. The operation had naturally reversed itself by a process known as late re-canalization and the husband's fertility had been restored. Subsequently, a child was born and the plaintiff's sued the defendant in negligence and for breach of contract. The plaintiff's claimed that they had not been warned of the risk of reversal and that this was negligent. Further they claimed a breach of contract in that the defendant was negligent. Further they claimed a breach of contract in that the defendant had guaranteed the success of the operation namely the husband's infertility.

In the course of his judgement Nourse LJ remarked:

*"The particular concern of this court in Eyre v Measday was to decide whether there had been an implied guarantee that the operation would succeed. But the approach of Slade LJ in testing that question objectively is of equal value in a case where it is said that there has been an express guarantee. Valuable too are the observation of Lord Denning MR in Greaves and Co (Contractors) Ltd v Boynham, Meikle and Partners (1975) 3 ALL ER 99 at 103-104, (1975) 1 WLR 1095 at 1100 which I now quote in full:*

*"Apply this to the employment of a professional man. 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."*

Emphasising the inexact nature of medical science and unpredictability of medical treatment, Nourse LJ and Neill LJ held that a doctor would only be held to have guaranteed the success of an operation if he expressly said so in clear and unequivocal terms."

Nourse LJ in this regard remarked:

*"..... A professional man is not usually regarded as warranting that he will achieve the desired result. Indeed, it seems that that would not fit well with the universal warranty of reasonable care and skill, which tends to affirm the inexactness of the science which is professed. I do not intend to go beyond the case of the doctor. Of all sciences medicine is one of the least exact. In my view a doctor cannot be objectively regarded as guaranteeing the success of any operation or treatment unless he says so much in clear and unequivocal terms."*

Neill LJ concurred adding that *"while both the plaintiffs and the defendant expected that sterility would result, that does not mean, however, 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 that it would have the desired result.*" <sup>86</sup>

### 3.2.2.2.3 Legal opinion

(1) English Law, when analysing the nature of the contractual relationship between the doctor and patient, is less clinical in its approach. Besides recognising the existence of the contractual relation between the doctor and the patient *per se*, little (if any) emphasis is placed on the consensual nature of the contractual relationship. <sup>87</sup>

(2) What English writers and the courts do emphasize are the terms implied in the contractual relationship between the doctor (or hospital) and the patient, which includes, the obligation by law to exercise reasonable care and skill, although, the doctor/hospital is not expected to perform miracles. <sup>88</sup>

## 3.2.2.3 UNITED STATES OF AMERICA

### 3.2.2.2.1 Legal Writings

In the United States of America the physician-patient relationship besides ordinarily considered to be based on contract, the type of contract more frequently recognised is one of contract of service. <sup>89</sup>

The contract between physician and patient has also been described by distinguished writer Furrow <sup>90</sup> as 'one belonging to the Law of Obligations'.

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<sup>86</sup> *Thake v Maurice* (1986) 1 ALL ER 497.

<sup>87</sup> Kennedy and Grubb *Medical Law: Text with Materials* (1998) 283-292; Jones *Medical Negligence* (1996) 18-28; Martin *Law Relating to Medical Practise* (1979) 138-139; Wright *Medical Malpractice* (1986) 6-11; Jackson and Powell *Professional Negligence* (1997) 590-593. The closest the consensual nature of the agreement came to be recognised in English Law is the case of *Mendoas v Yackel* (1980) 109 D.L.R. (3d) 45 (B.C.S.C.) which concerned the meeting of the minds.

<sup>88</sup> Kennedy and Grubb *Medical Law: Text with Materials* (1998) 283-292; Jones *Medical Negligence* (1996) 23-28; Nelson-Jones and Burton *Medical Negligence Case Law* (1995) 26-31; Wright *Medical Malpractice* (1986) 10-11, 16-17; Jackson and Powell *Professional Negligence* (1997) 591-593. What do emerge from the writings are obligations once imposed and which becomes an implied term in the agreement cannot be excluded in any way. The implied duty to exercise care and skill received the courts attention on the well-known cases of *Eyre v Measday* 1986 1 ALL E.R. 488 and *Thake v Maurice* 1986 1 ALL E.R. 497. It was emphasized in both *dicta* that although the courts recognize the implied duty to take care it does not mean that it excludes a warranty that the patient will be cured.

<sup>89</sup> See Waltz (1971) 40 who describes the nature of the contract of service as "... the physician promising to perform professional services in exchange for the patient's promise to pay a reasonable fee for them." See also Furrow et al (1995) 235.

<sup>90</sup> Furrow et al (1995) 235 describes the contractual nature of the physician-patient relationship as 'one founded on an obligation'. Once the physician has accepted to treat the patient he/she is bestowed with an obligation of

The nature of the contractual relationship between physician and patient has also in certain cases been described as a consensual relationship.<sup>91</sup>

The physician-patient relationship is generally accepted by most American writers to have been founded on contract, express or implied.<sup>92</sup> Although the physician, unless he agrees otherwise, is generally expected to act with reasonable skill and care, he or she is not considered a guarantor of good results.<sup>93</sup>

### 3.2.2.3.2 Case Law

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'continuing attention'. Treatment obligations cease if the physician can do nothing more for the patient or where surgery is involved to provide follow-up care *"until the threat of post-operative complications is past."* See also Morris and Moritz (1971) 135 who recognizes the obligations which flow from the physician-patient relationship in that *"in the absence of a specific agreement he/she shall attend to the care of the patient as long as it requires attention unless he/she gives notice of his/her intention to withdraw or he/she is dismissed by the patient."*

<sup>91</sup> The consensual nature of the relationship according to Morris and Moritz (1971) 135 *"flows from the principle of offer and acceptance."* *Contra* Sanbar et al (1995) 62 who describe the physician and the patient relationship as *".... one based on a fiduciary relationship between the physician and the patient in which the physician impliedly promises the patient that he or she will exercise that degree of skill ordinarily possessed by his or her colleagues and practise according to accepted standards."* See also Sidley (1985) 183 who describes the fiduciary relationship as *".... the utmost good faith with respect to all aspects of the diagnosis and treatment process."* Holder (1975) 1 advocates the consensual relationship between the physician and patient when he states: *"For a valid contract to exist, however, there must be mutuality of understanding between the parties as to the terms of the agreement."* See in this regard also Kramer and Kramer *Medical Malpractice* (1983) 6 who describe the consensual relationship between the physician and patient as that of *"a voluntary agreement."*

<sup>92</sup> See Waltz (1971) 40-41 in which the writer states: *Although occasionally a formal, written contract is drawn up between the doctor and the patient, the agreement more likely, simply arises by implication from the behaviour of the parties.* In the latter instances although there are no express terms to the agreement, the physician according to Waltz nevertheless when embarking upon treatment, *"represent to the patient that he has the necessary training, knowledge, and skill and that he will employ those assets in the way any reputable physician ordinarily would."* See also Furrow et al (1995) 234-236 who extend the realm of the implied contract to include *"... to properly perform his or her medical function."* See also Sanbar et al (1995) who recognizes the implied contract between physician and patient as one in which *".... the physician warrants that he or she will treat the patient with the degree of skill ordinary possessed by members of the medical profession."* See further Holder (1975) 3; Sidley (1985) 183 who defines the implied contract as *"to act with reasonable skill and care and to comply with other reasonable obligations of the profession."*

<sup>93</sup> See Waltz (1971) 46 who describes the physician's standard of care as *"unvarying perfection"* of which the *".... workings of miracles are no more expected of the medical profession than any other calling."* In other words, despite man's knowledge in the field of medicine the stage has not yet been reached whereby a *"flat guarantee of total success is expected whenever treatment is undertaken."* The effect thereof according to Waltz is *"when a qualified practitioner competently performs the work for which he has been trained the result may be good or bad; the fact that it sometimes is bad in no way brings about tort or contract liability."* In that regard erroneous diagnosis according to Waltz *".... is not always indicative of lack of proper skill."* See also Furrow et al (1995) 237; See Sanbar et al (1995) 67ff who opine that although physicians are free to guarantee or ensure a result or guarantee improvement or a cure they would be *"foolish to be more than optimistic or encouraging."* See also the caution rendered to the American physicians by the author Alton (1977) 24. The author states that physicians are there *"..... to treat not to cure."* According to Holder (1975) 3 the American courts are very reluctant to *"assume a guarantee or warranty from a physician that he will cure the patient."*

An implied contract has in principle been accepted in general terms in a number of cases. Its existence has been justified in that it has been defined in a number of American decisions as: *"One not created by the explicit agreement of the parties but inferred by the law as a matter of reason and justice from their acts or conduct, the circumstances surrounding their translation making it a reasonable or even necessary assumption that a contract existed between them by tacit understanding."*<sup>94</sup>

As early as 1898 the highest court in New York established the existence of an implied contract between the physician and patient. The facts relied upon in *Pike v Honsinger*<sup>95</sup> are: The patient had been kicked in the knee by a horse and treated by the physician, the defendant. It was claimed that he had treated the patient in a negligent manner, resulting in a failure of the bones to unite. The court found: *"The law relating to malpractice is simply and well settled, although not always easy of application. A physician and surgeon, by taking charge of a case, impliedly represents that he possesses, and the law places upon him the duty of possessing, that reasonable degree of learning and skill that is ordinarily possessed by physicians and surgeons in the locality in which he practices, and which is ordinarily regarded by those conversant with the employment as is necessary to qualify him to engage in the business of practising medicine and surgery. Upon consenting to treat a patient, it becomes his duty to use reasonable care and diligence in the exercise of his skill and the application of his learning to accomplish the purpose for which he was employed. He is under the further obligation to use his best judgement in exercising his skill and applying his knowledge."*

But, warns the court, the physician is not expected to use anything more than his best judgement nor is he or she a guarantor of good results: "The rule requiring him to use his best judgement does not hold him liable for a mere error of judgement, provided he does what he thinks is best after careful examination.

His implied engagement with his patient does not guarantee a good result, but he promises, by implication, to use the skill and learning of the average physician, to exercise reasonable care and to exert his best judgement in the effort to bring about a good result."<sup>96</sup>

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<sup>94</sup> *Pike v Honsinger* 49 NE 760, NY 1898; See also *Landon v Kansas City Gas* CC 10 F 2d 263, DC KANS 1926; *Calamelo v Missouri State Life Insurance Co* 230 SW 566 ARK, 1921.

<sup>95</sup> 49 NE 760, NY 1898.

<sup>96</sup> *Pike v Honsinger* 49 NE 760, NY 1898.

In a later judgement in the case of *Adkins v Ropp*<sup>97</sup> the Supreme Court of Indiana expanded on this definition in 1938. The case involved a patient who had lost the sight of one eye. He claimed that the defendant had been negligent in removing a foreign body from it and the eye had then become infected as the result of the negligence. The defendant argued that the infection was an unavoidable result of the original injury. The court held:

*"When a physician and surgeon assumes to treat and care for a patient, in the absence of a special agreement, he is held in law to have impliedly contracted that he possesses the reasonable and ordinary qualifications of his profession and that he will exercise at least reasonable skill, care and diligence in his treatment of him. This implied contract on the part of the physician does not include a promise to effect a cure and negligence cannot be imputed because a cure is not effected, but he does impliedly promise that he will use due diligence and ordinary skill in his treatment of the patient so that a cure may follow such care and skill, and this degree of care and skill is required by him, not only in performing an operation or administering first treatments, but he is held to the like degree of care and skill in the necessary subsequent treatments unless he is excused from further service by the patient himself, or the physician or surgeon upon due notice refuses to further treat the case."*<sup>98</sup>

But there are cases in which the courts have been prepared to find that a doctor has guaranteed a particular result, and when he has failed to achieve it, they have allowed the patient to succeed in an action for breach of contract. An American case involving cosmetic surgery illustrates this. In *Sullivan v O'Connor*<sup>99</sup> a professional entertainer, sued the defendant because of the condition of her nose after he had operated. Justice Kaplan described the plaintiff's condition as follows:

*".... judging from exhibits, the plaintiff's nose had been straight, but long and prominent; the defendant undertook by two operations to reduce its prominence and somewhat to shorten it, thus making it more pleasing in relation to the plaintiff's other features. Actually the plaintiff was obliged to undergo three operations, and her appearance was worsened. Her nose now had a concave line to about the midpoint, at which it became bulbous; viewed frontally, the nose from bridge to midpoint was flattened and broadened, and the two sides of the tip had lost symmetry. This configuration evidently could not be improved by further surgery."*

The ultimately succeeded in her claim for breach of contract. The court went on, however, to warn of the difficulties facing plaintiffs who allege that a doctor guaranteed success:

*"It is not hard to see why the courts should be unenthusiastic or sceptical about the contract theory. Considering the uncertainties of medical science and the variations in the physical and psychological conditions of individual patients, doctors can seldom in good faith promise specific results. Therefore it is unlikely that physicians of even average integrity will in fact make such promises. Statements of opinion by the physician with some optimistic colouring are a different thing, and may indeed have therapeutic value. But patients may transform such statements into firm promises in their own minds, especially when they have been disappointed in the event, and testify in that sense to sympathetic juries. If actions for breach of promise can be readily maintained, doctors, so it*

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<sup>97</sup> 14 NE 2d 727, IND 1938.

<sup>98</sup> *Adkins v Ropp* 14 NE 2d 727 IND 1938.

<sup>99</sup> (1973) 296 NE 2d 183 (CAL.SUP Ct).

is said, will be frightened into practising 'defensive medicine'. On the other hand, of these actions were outlawed, leaving only the possibility of suits for malpractice, there is fear that the public might be exposed to the enticements of charlatans, and confidence in the profession might ultimately be shaken. The law has taken the middle of the road position of allowing actions based on alleged contract, but insisting on clear proof. Instructions to the jury may well stress this requirement and point to tests of truth, such as the complexity or difficulty of an operation as bearing on the probability that a given result was promised." <sup>100</sup>

### 3.2.2.3.3 Legal Opinion

(1) Legal writers and the courts in the United States of America recognise the consensuality of an agreement in the physician-patient relationship. <sup>101</sup>

(2) In the absence of an express agreement, an implied term is present in all other agreements between the doctor and patient. The nature of the implied term is that the doctor will exercise reasonable skill and care when treating the patient. <sup>102</sup>

(3) The implied term to exercise reasonable care and skill does not include a warranty of cure. In this regard no doctor is seen as a guarantor of good results. <sup>103</sup>

### 3.3 Summary and Conclusions

The nature of the doctor/hospital-patient relationship has for many centuries and continues today, to play a significant role in the practise of medicine. The relationship between the doctor/hospital and patient has been founded on normative ethics and values and the long-

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<sup>100</sup> *Sullivan v O'Connor* (1973) 296 NE 2d 183 (CAL.SUP. Ct).

<sup>101</sup> Morris and Moritz *Doctor Patient and the Law* (1971) 135 acknowledges that the consensual nature of the relationship is founded on the contractual principle of offer and acceptance. Holder *Medical Malpractice Law* (1975) 1 refers to the consensual element of the agreement as the "mutuality of understanding between the Parties ....." It has also been referred to as a voluntary agreement. See Kramer and Kramer *Medical Malpractice* (1983) 6. *Contra* Sanbar et al *Legal Medicine* (1995) 62 who describes the nature of the doctor-patient relationship as a fiduciary one in which the doctor impliedly undertakes to exercise that degree of skill "ordinarily possessed by his or her colleagues in accordance with acceptable standards." See also Sidley *Law and Ethics* (1985) 183 who advocates good faith in all the practitioner's endeavours.

<sup>102</sup> Waltz *Medical Jurisprudence* (1971) 40-41 state that when a doctor accepts the patient and undertakes to treat him or her he/she gives out to the patient that he/she possesses the necessary training, knowledge, and skill and that he/she will employ those assets. Furrow et al *Health Law* (1995) 234-236; Sanbar et al *Legal Medicine* (1995) 62ff; Holder *Medical Malpractice Law* (1975) 3; Sidley *Law and Ethics* (1985) 183. For the recognition of implied terms in the contractual relationship between doctor-patient see *Pike v Honsinger* 49 N.E 760 NY (1898); *Landon v Kanes City Gas* CC 10f 2d 263, DC KANS (1926).

<sup>103</sup> Waltz *Medical Jurisprudence* (1971) 46 states that the implied agreement to exercise reasonable care and skill does not include the working of miracles; Furrow et al *Health Law* (1995) 237; Sanbar et al *Legal Medicine* (1995) 62ff expresses the view that although practitioners are free to guarantee results they would be "foolish to be more than optimistic or encouraging." See also Alton *Malpractice* (1977) 24; Holder *Medical Malpractice* (1975) 3ff for case law in which it was held that the implied term of the agreement does not include a warranty to success or a cure. See *Adkins v Ropp* 14 NE 2d 727, Ind. 1938. For a case involving cosmetic treatment and surgery in which the court held there was a guarantee to produce a certain result see *Sullivan v O'Connor* (1973) 296 NE 2D 183 (CAL SUP.CT).

standing principles of medical ethics and values dominate the relationship.

The long-standing principles involving ethics and values, resulting in the creation of legal rules set the outer limits as to how the doctor/hospital should conduct himself/herself/itself towards the patient. What has also crystallized from the relationship is the minimum standard of professional behaviour expected of the doctor or hospital.

Foundational to the doctor/hospital-patient relationship is that the behaviour of the practitioner or hospital arises in the general sphere from their relationship, alternatively, from a contractual relationship created by them. But, notwithstanding the distinct creation of the relationship, what has emerged is that the interest protected remains the same, namely the well being of the patient. The duty of care in both contract or in general, remains one, namely, the exercise of reasonable care towards the patient and to guard against the harm being done to the patient.

Furthermore, although the professional liability of medical practitioners/hospitals is founded upon different rules some in delict (also known in other jurisdictions as tort) or in contract, the contractual obligations are usually no greater than the duties owed in delict (tort). The duty to exercise reasonable care in delict is effectively the same as the implied term to exercise reasonable care in contract.

Because of the distinction between the rules of contract and those of delict, the establishment of the existence of a contractual relationship between the doctor/hospital and the patient will provide evidentiary materials to establish contractual liability where the exercise of reasonable care and skill is breached. It is for that reason that it is, at times, necessary to establish precisely when the relationship commenced. The success of civil litigation or a possible conviction in a criminal case is dependant largely on whether such a relationship has come into being and if so, when.

The commencement of the relationship is not always easy to establish. Unlike, for example, a land transaction matter where the terms are reduced to writing, writing is no prerequisite for establishing a contractual relationship. In most instances a tacit agreement arises through mere conduct. There are however, instances where express agreements are entered into with the patient. This occurs especially, in the hospital-patient relationship where more serious operations and/or complicated treatment/surgery are undertaken and the informed consent of the patient is required.

There is unanimity that when regard is had to the nature of the legal relationship between

the doctor/hospital and the patient, that it is a consensual one. It needs to be indicated that whatever the terms concluded, the central term remains that the doctor/hospital will exercise reasonable care and skill. From the nature of the relationship, a position of trust is created between the doctor/hospital and the patient. The effect thereof is that the practitioner/hospital may not conduct himself/herself/it in a careless or negligent way. Should this occur the patient may sue the doctor for breach of contract formed on the breach of trust.

The next chapter will deal with the formation of the medical contracts. In this chapter aspects such as, what type of agreements may validly be entered into will be looked at, also, what will be looked at in more depth, are the different terms which may be included in medical contracts. Consent is a fundamental concept in the doctor/hospital and patient relationship. Consequently, in Chapter Four the different forms of consent will be looked at as well as the effect of consent.