

**A CRITICAL ANALYSIS OF THE DOCTOR-PATIENT RELATIONSHIP IN CONTEXT OF
THE RIGHT TO ADEQUATE HEALTH CARE.**

By

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ABSTRACT

The purpose of this thesis is to prove the existence of the right to adequate healthcare through a critical analysis of the law of obligations, constitutional law and international law framed in the wider focal point of South African medical law.

The Constitution only makes provision for the right to access to health care. Conclusively this thesis will have to establish a link between a minimum standard in health care and the Constitution.

It is submitted that the most efficacious method of establishing this link is with the duty of care, which is intrinsically linked to the doctor-patient relationship. If a critical analysis of the doctor-patient relationship can establish a clear link between the duty of care and state liability then such a link can successfully be applied to the Constitution. If this link is transposed onto the Constitution, a critical evaluation of the rights in the Bill of Rights will then reveal the most applicable right that can house the right to an adequate standard of health care.

Such an analysis is only part of the solution however. In order to make this right effective, the international body of medical laws must be critically analysed and juxtaposed against this adequate standard. This carries the dual purpose of adding normative content as well as determining the current state of South Africa's obligations under international human rights law, and to what extent those obligations have been discharged.

Finally, and most significantly, the right to adequate healthcare, as it was forged in the international legal analysis, will be transposed onto the current South African jurisprudence of socio-economic rights. This practical application will then be reflected onto the new National Health Care Insurance to show conclusively that the current governmental approach of effecting health care is wholly inoperable and will ultimately result in significant harm and extensive human rights violations. This is based on the government only considering access to health care sufficient to discharge its duties and being totally incapable of effectively managing its resources.

The core outcome for this thesis is to prove the existence of the right to adequate healthcare. Secondary outcomes are tracing the history of medicine to illustrate the creation and evolution of the doctor-patient relationship, a critical analysis of the application of medical ethics to South African law of obligations, a critical analysis of the Constitution and its fundamentals, an exhaustive evaluation of South Africa's duties and accomplishments under its international obligations and effectively applying the right to adequate healthcare which is diametrically opposed to the current course South Africa is taking to provide health care.

Keywords: medical law, constitutional law, medical ethics, history of medicine, history of medical ethics, law of contract, law of delict, constitutional fundamentals, human rights law, South African international law, international public health law, international human rights law, socio-economic rights in the international human rights system, African regional human rights, socio-economic rights jurisprudence and the National Health Care Insurance plan.

PLAGIARISM DECLARATION	I
ABSTRACT	II
1. CHAPTER 1 - INTRODUCTION	1
1.1. INTRODUCTION	1
1.2. MOTIVATION FOR RESEARCH	2
1.3. HYPOTHEIS, RESEARCH QUESTION AND OUTCOMES	2
1.4. OVERVIEW OF CHAPTERS	4
1.5. METHODOLOGY AND LIMITATIONS	5
1.6. VALUE CONTRIBUTION OF RESEARCH	6
1.7. CONCLUSION	7
2. CHAPTER 2 – ANALYSING THE DOCTOR-PATIENT RELATIONSHIP	8
2.1. INTRODUCTION	8
2.2. A CRITICAL ANALYSIS AND EVALUATION OF THE DOCTOR-PATIENT RELATIONSHIP	10
2.2.1. INTRODUCTION	10
2.2.2. THE PURPOSE OF THE DOCTOR-PATIENT RELATIONSHIP	10
2.2.3. DEFINING THE DOCTOR-PATIENT RELATIONSHIP THROUGH HISTORY	11
2.2.3.1. Introduction	11
2.2.3.2. Pre-Historic and Ancient Medicine (3000 BCE – 899 CE)	12
2.2.3.2.1. Pre-Western Medicine (3000 BCE – 460 BCE).....	12
2.2.3.2.2. The Birth of Western Medicine (459 BCE – 449 CE)	13
2.2.3.2.3. Conclusion	16
2.2.3.3. Medieval and Early Modern Era Medicine (450CE – 1799 CE)	17
2.2.3.3.1. Introduction.....	17
2.2.3.3.2. Medicine in the Pre-Renaissance Era (450CE – 1349 CE).....	17
2.2.3.3.3. Medicine in the Renaissance Era and the Scientific Revolution (1350 CE – 1799 CE).....	20
2.2.3.3.4. Conclusion	25
2.2.3.4. Middle Modern Era to Present Day (1800 – Present Day)	25
2.2.3.4.1. Introduction.....	25
2.2.3.4.2. Medicine in the 19 th Century (1800 – 1899)	25
2.2.3.4.3. Medicine in the 20 th Century up to and including the 2 nd World War (1900-1945)	29
2.2.3.5. Medicine in the Modern Era (1946 – Present Day).....	35
2.2.3.6. Defining the Doctor-Patient Relationship	37
2.2.3.7. Conclusion.....	37
2.2.4. A CRITICAL LEGAL ANALYSIS OF THE DOCTOR-PATIENT RELATIONSHIP.....	39
2.2.4.1. Introduction	39
2.2.4.2. The Law of Contracts	40
2.2.4.2.1. Introduction.....	40
2.2.4.2.2. Consensus.....	41

2.2.4.2.3.	Contractual Capacity.....	44
2.2.4.2.4.	Legality.....	46
2.2.4.2.4.1.	Public Interest.....	46
2.2.4.2.4.2.	Boni Mores.....	47
2.2.4.2.4.3.	Bona fides.....	50
2.2.4.2.4.4.	Conclusion.....	50
2.2.4.2.5.	Possibility.....	50
2.2.4.2.6.	Conclusion.....	51
2.2.4.3.	The Law of Delict.....	51
2.2.4.3.1.	Introduction.....	51
2.2.4.3.2.	Conduct.....	52
2.2.4.3.3.	Wrongfulness.....	53
2.2.4.3.4.	Causation.....	55
2.2.4.3.5.	Fault.....	56
2.2.4.3.6.	Loss or Damage.....	56
2.2.4.3.7.	Conclusion.....	56
2.2.4.4.	Medical Necessity.....	57
2.2.4.5.	Vicarious Liability.....	58
2.2.5.	<i>CONCLUSION</i>	60
2.3.	<i>CONCLUSION</i>	61
3.	CHAPTER 3 – THE DOCTOR-PATIENT RELATIONSHIP AND THE CONSTITUTION.....	63
3.1.	INTRODUCTION.....	63
3.2.	CONSTITUTIONAL FUNDAMENTALS.....	64
3.2.1.	<i>INTRODUCTION</i>	64
3.2.2.	<i>FUNDAMENTAL CONSTITUTIONAL PRINCIPLES</i>	64
3.2.2.1.	The Rule of Law.....	64
3.2.2.2.	Constitutionalism.....	65
3.2.3.	<i>CONCLUSION</i>	67
3.3.	APPLYING THE CONSTITUTION.....	67
3.3.1.	<i>INTRODUCTION</i>	67
3.3.2.	<i>DEFINING APPLICATION</i>	68
3.3.3.	<i>DIRECT APPLICATION</i>	68
3.3.4.	<i>INDIRECT APPLICATION</i>	70
3.3.5.	<i>CONCLUSION</i>	71
3.4.	INTERPRETING THE CONSTITUTION.....	71
3.4.1.	<i>INTRODUCTION</i>	71
3.4.2.	<i>THE COURT APPROACH TO THE INTERPRETATION OF HUMAN RIGHTS</i>	72
3.4.2.1.	The Text of the Right.....	72
3.4.2.2.	The Role of Context.....	73
3.4.2.3.	The Purpose of the Right.....	74

3.4.2.4.	Generous Interpretation	75
3.4.3.	SECTION 39 OF THE CRSA	75
3.4.4.	CONCLUSION	78
3.5.	THE RIGHTS THAT GOVERN HEALTH CARE AND THE DOCTOR-PATIENT RELATIONSHIP	78
3.5.1.	INTRODUCTION	78
3.5.2.	THE RIGHT TO LIFE.....	79
3.5.3.	THE RIGHT TO HUMAN DIGNITY.....	80
3.5.4.	THE RIGHT TO SECURITY IN AND CONTROL OVER ONE’S BODY.....	81
3.5.5.	THE RIGHT TO ACCESS TO HEALTH CARE.....	82
3.5.6.	CONCLUSION	83
3.6.	CONCLUSION	83
4.	CHAPTER 4 – ADDING NORMATIVE CONTENT TO THE RIGHT TO ADEQUATE HEALTH CARE	85
4.1.	INTRODUCTION:.....	85
4.2.	DEFINING INTERNATIONAL HEALTH LAW:.....	86
4.2.1.	ON INTERNATIONAL LAW:.....	87
4.2.1.1.	Monoism vs. Dualism:.....	88
4.2.1.2.	Sources of International Law:	89
4.2.1.2.1.	Treaties	90
4.2.1.2.2.	International Custom.....	94
4.2.1.3.	Concluding remarks on International Law	95
4.2.2.	CONCLUSION	96
4.3.	A BRIEF HISTORY ON INTERNATIONAL HEALTH LAW	97
4.3.1.	A HISTORY ON PUBLIC HEALTH LAWS AND IT’S TRANSITION FROM DOMESTIC TO INTERNATIONAL.....	97
4.3.2.	INTERNATIONAL PUBLIC HEALTH LAW: A CENTURY OF MEDICAL TREATIES.....	100
4.4.	THE CONSTITUTION OF THE WORLD HEALTH ORGANISATION	102
4.4.1.	INTRODUCTION AND HISTORY	102
4.4.2.	THE ROLE PLAYED BY THE WHO FROM 1948 TO PRESENT DAY.....	103
4.4.3.	CONCLUDING REMARKS OF HEALTH AS AN INTERNATIONAL LEGAL NORM	104
4.5.	HEALTH AS A HUMAN RIGHT	105
4.5.1.	INTRODUCTION	105
4.5.2.	DEFINING HUMAN RIGHTS	105
4.5.2.1.	Classifying Human Rights	106
4.5.2.2.	State Responsibility and the Obligations of States.....	108
4.5.3.	DEFINING AND APPLYING SOCIO-ECONOMIC RIGHTS.....	109
4.5.3.1.	Introduction	109
4.5.3.2.	The obligations imposed by socio-economic rights	109
4.5.3.2.1.	The Obligation to Respect	109

4.5.3.2.2.	The Obligation to Protect	110
4.5.3.2.3.	The Obligation to Fulfil	111
4.6.	A CRITICAL ANALYSIS ON THE EVOLUTION OF THE RIGHT TO HEALTH IN INTERNATIONAL HUMAN RIGHTS 112	
4.6.1.	<i>INTRODUCTION</i>	112
4.6.2.	<i>THE UNIVERSAL DECLARATION ON HUMAN RIGHTS (UDHR)</i>	112
4.6.2.1.	Introduction and History	112
4.6.2.2.	Article 25 – The Right to Health	114
4.6.2.3.	Conclusion of the right to health in the UDHR	115
4.6.3.	<i>THE INTERNATIONAL COVENANT ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS</i>	116
4.6.3.1.	Introduction and History	116
4.6.3.2.	State Obligations under the ICESCR	117
4.6.3.2.1.	On the Obligation to “Take Steps ... Appropriate Means”	118
4.6.3.2.2.	On the Progressive Realisation	118
4.6.3.2.3.	On Minimum Core Obligations	120
4.6.3.2.4.	Conclusion	120
4.6.3.3.	Article 12 – The Right to Health	121
4.6.3.3.1.	The Right to Health Care	122
4.6.3.3.2.	State Obligations	122
4.6.3.3.2.1.	Availability	123
4.6.3.3.2.2.	Accessibility	123
4.6.3.3.2.3.	Acceptability and Quality	123
4.6.3.3.3.	Combining the Four Duties into the General State Obligations on Realising Rights	123
4.6.3.3.3.1.	The Obligation to Fulfil the Right to Health	124
4.6.3.3.3.2.	Health and the Minimum Core	124
4.6.3.4.	Conclusion on the right to health under the ICESCR	125
4.6.4.	<i>THE AFRICAN CHARTER ON HUMAN AND PEOPLES’ RIGHTS</i>	126
4.6.4.1.	Introduction and History	126
4.6.4.2.	State Obligations under the ACHPR	127
4.6.4.3.	The Right to Health	128
4.6.4.4.	Conclusion on the right to health in the African Charter	129
4.7.	CONCLUSION	130
5.	CHAPTER 5 – APPLYING THE RIGHT TO ADEQUATE HEALTH CARE AND THE NATIONAL HEALTH INSURANCE	131
5.1.	INTRODUCTION	131
5.2.	CONVERTING THE RIGHT TO ADEQUATE HEALTH CARE FROM HYPOTHETICAL TO JUSTICIABLE	132
5.2.1.	<i>INTRODUCTION</i>	132
5.2.2.	<i>ON THE INTERPRETATION OF SOCIO-ECONOMIC RIGHTS IN SOUTH AFRICA</i>	133
5.2.2.1.	Introduction	133
5.2.2.2.	<i>Soobramoney</i>	133

5.2.2.3.	<i>Grootboom</i>	134
5.2.2.4.	<i>TAC</i>	135
5.2.2.5.	<i>Conclusion</i>	136
5.2.3.	<i>THE HYPOTHETICAL STATEMENT OF FACTS</i>	136
5.2.4.	<i>APPLYING THE CASE LAW TO THE RIGHT TO ADEQUATE HEALTH CARE</i>	138
5.2.5.	<i>REMEDIES FOR VIOLATING THE RIGHT TO ADEQUATE HEALTH CARE</i>	140
5.2.6.	<i>CONCLUSION</i>	141
5.3.	THE NHI: ILLUSTRATING THE DISASTER OF ACCESS-ONLY	142
5.3.1.	<i>INTRODUCTION</i>	142
5.3.2.	<i>A CRITICAL EVALUATION OF THE NHI POLICY PAPER</i>	143
5.3.2.1.	<i>Introduction (Par 1-6)</i>	143
5.3.2.2.	<i>Problem Statement (Par 7-16)</i>	143
5.3.2.3.	<i>Quality of Health care (Par 22-23)</i>	144
5.3.2.4.	<i>Health care Expenditure in South Africa (Par 24-28)</i>	144
5.3.2.5.	<i>Distribution of Financial and Human Resources (Par 29-32)</i>	145
5.3.2.6.	<i>National Health Insurance (Par 50-51)</i>	146
5.3.2.7.	<i>Principles of National Health Insurance in SA (Par 52)</i>	146
5.3.2.8.	<i>Objectives of National Health Insurance (Par 53-55)</i>	147
5.3.2.9.	<i>The Re-Engineered Primary Health Care System (Par 66-78)</i>	148
5.3.2.10.	<i>Health Care Benefits under National Health Insurance (Par 79-96)</i>	150
5.3.2.10.1.	<i>Designation of Hospitals</i>	151
5.3.2.10.2.	<i>Conclusion</i>	152
5.3.2.11.	<i>Accreditation of Providers of Health Care Services (Par 97-100)</i>	152
5.3.2.12.	<i>Conclusion</i>	153
5.4.	CONCLUSION	154
6.	CHAPTER 6 – CONCLUSION	156
6.1.	INTRODUCTION	156
6.2.	REVIEWING THE CONCLUSIONS OF THE PREVIOUS CHAPTERS	156
6.2.1.	<i>CHAPTER 2</i>	156
6.2.2.	<i>CHAPTER 3</i>	157
6.2.3.	<i>CHAPTER 4</i>	157
6.2.4.	<i>CHAPTER 5</i>	158
6.3.	CONCLUDING REMARKS	158
	BIBLIOGRAPHY	160
	LEGISLATION	160
	<i>INTERNATIONAL LEGAL INSTRUMENTS</i>	160
	<i>SOUTH AFRICAN LEGISLATION</i>	160
	BOOKS	161

JOURNAL ARTICLES.....	163
CASE LAW	167
<i>INTERNATIONAL TRIBUNAL AND INTERNATIONAL COURT DECISIONS.....</i>	<i>167</i>
<i>REGIONAL TRIBUNALS AND REGIONAL COURT DECISIONS</i>	<i>167</i>
<i>SOUTH AFRICAN CASE LAW</i>	<i>167</i>
<i>FOREIGN CASE LAW</i>	<i>169</i>
CONFERENCE AND PANEL HEARING DOCUMENTS.....	169
<i>PUBLISHED THROUGH INTERNATIONAL CONFERENCES.....</i>	<i>169</i>
<i>PUBLISHED THROUGH REGIONAL CONFERENCES.....</i>	<i>170</i>
<i>PUBLISHED THROUGH SOUTH AFRICAN CONFERENCES.....</i>	<i>170</i>
<i>PUBLISHED THROUGH FOREIGN CONFERENCES.....</i>	<i>170</i>
INTERNET RESOURCES.....	170

1. Chapter 1 - Introduction

1.1. INTRODUCTION

The largest problem with the current system of legal education is that law is compartmentalised. Students are introduced to friendly flow-charts that vaguely describe different branches of law, as if they are separate islands of thought. This combined with the death of critical legal arguments are the reason the South African universities are producing so many young professionals who lack any discernible legal reasoning or argumentative ability.

The inestimable benefit that comes from working in medical law is that no other branch of law, with the possible exception of jurisprudence, and allows for such a dramatic inter-play between the different branches of South African law.¹ While every agreement between a doctor and patient is regulated by contract law, that contract is regulated by the Constitution, and in the more corporate environment of modern health care, by commercial legal systems such as the law of companies.

The basis for medical law, and all law in South Africa,² remains the Constitution of the Republic of South Africa, 1996.³ In particular the Bill of Rights creates new rules concerning the treatment of patients by physicians (S 12(2) of the CRSA), as well as what a person living in South Africa can expect the government to provide (S 27 of the CRSA). It is in the operation of S 27 of the CRSA, that this thesis finds its creation.

S 27 of the CRSA provides for every person, in South Africa, to have access to health care, insofar as that access is reasonable considering available resources. While South Africa, during the drafting of the CRSA, made it patently clear that the focus would only be on access to health care, this thesis will attempt to use the extensive body of medical law to prove that there is room for elements beyond access, and in particular there exists a right to adequate health care.

¹ Carstens and Pearmain, *Foundational Principles of South African Medical Law*; LexisNexis; 2007.

² In terms of S 2 of the CRSA.

³ Further referred to as the CRSA.

1.2. MOTIVATION FOR RESEARCH

In 1994, when South Africa officially shrugged off the chains of oppression in a bloodless revolution, this country was filled to the brim with hope. Not only hope for peace, but hope for a bright future where all people within this great country can claim to be equal. Alas, as with most revolutions, the hope of a new day was quickly supplanted with bitter memories of our past and embittered revolutionaries leading the people. It was also during this time that the Constitution was drafted. Originally sprung from the seeds of the sunset clauses, those non-negotiable rights distilled from the Freedom Charter would ultimately become the basis for the Bill of Rights.⁴ It was during this drafting process that the drafters of the CRSA decided to include specific socio-economic rights. While many people argued that there was no place for socio-economic rights in the CRSA, the drafters argued that South Africa would be a beacon for human rights realisation. A shining example for other countries to follow when implementing a Bill of Rights.

Unfortunately, 18 years on, not much has changed. While South Africa has socio-economic rights in its Constitution, it remains a deeply divided and unjustifiably unequal country, divided along economic lines, as opposed to racial lines. It is this stagnation that resulted in the author's realisation that there was in fact a need for change. Starting with an undergraduate dissertation in how to best realise the right to access to health care, and culminating in this thesis. The question of whether South Africa can be limited by access to health care alone, whether the incredible depth of medical legal knowledge cannot be used to guarantee the people living in this state something more to use against a deeply cynical government.

Further, with the creation of the National Health Insurance, it is submitted, that the public health care (and possibly private health care) system in South Africa will be subjected to unbearable stress, and will literally implode upon itself, causing significant harm. It is therefore essential to consider if a less destructive option was present in the CRSA, which could help restore the injustices and inequality of modern day South Africa, without destroying public health care.

1.3. HYPOTHEIS, RESEARCH QUESTION AND OUTCOMES

The hypothetical basis for this thesis is as follows: Can an element of medical law be applied to the CRSA, and have that application result in the guarantee of a right? The questions to be answered is what in the South African medical law can be used to create a legal duty;

⁴ Currie and de Waal, *The Bill of Rights Handbook*; Juta; 2005 at 2-7.

how can that legal duty be applied to the Bill of Rights and ultimately whether this legal duty can become a legal responsibility that can be enforced against the state.

Therefore the research question can be formulated as: Does the South African medical law contain a duty that, when augmented with the CRSA, would ultimately result in a right? And can such a right ever be effectively applied and enforced?

It is submitted that, if one critically analyses the doctor-patient relationship in South African law, then that relationship culminates in a duty, on the part of the physician, to take the necessary steps to avoid harm. In other words the relationship contains an adequate standard of care. If one can extend this standard of care to the state, through the law of obligations, it is further submitted that the state then becomes a party to the violation when the doctor-patient relationship is breached. If one takes the doctor-patient relationship, and the subsequent duty, and contrast that onto the CRSA then one is provided with an existing right that guarantees this minimum standard of care. Finally if one takes this minimum standard of care and coalesce this with the existing international medical law, then a concrete right is formulated and given normative content that guarantees the right to adequate health care. If one then applies this right to the current jurisprudence for socio-economic rights, then one is provided with an enforceable effective right to an adequate standard of health care.

Therefore the outcomes of this thesis are:

- A critical analysis of the doctor-patient relationship to prove the existence of a minimum standard of care.
- Critically comparing and contrasting this standard of care, and the doctor-patient relationship, to the CRSA in order to determine whether this minimum standard of care can be afforded constitutional protection and implementation.
- A critical analysis of the current public international health law, in order to determine the normative content of the right to adequate care, as well as further justifying the need for this standard.
- Finally a critical analysis of this right to adequate care, in the current South African constitutional jurisprudence, in order to give effect to the right, and determine whether it can be enforceable.

1.4. OVERVIEW OF CHAPTERS

It is submitted that the most effective and methodical of achieving the research outcomes and answering the research question are as follows:

In order to confirm the first outcome, Chapter 2 requires that this thesis first define and determine what the doctor-patient relationship is. In order to critically analyse the doctor-patient relationship in SA law, it is first pertinent to realise the ethical outcomes of the relationship, by tracing its development through history, in order to have an effective understanding of the relationship and the weight attached to it. After furnishing the reader with this understanding, Chapter 2 shall then progress to critically analyse the interaction of the doctor-patient relationship in the law of obligations, in order to best determine the legal nature of the duties of the parties. Focus shall also be placed on determining if the state can be made liable under the law of obligations, to reflect its role as the provider and violator of health care.

Armed with a thorough understanding of the legal nature of the doctor-patient relationship, as well as the duties imposed by it, the thesis proceeds to Chapter 3. In this chapter the CRSA is critically evaluated, in order to determine whether a right, or rights, exist that attempt to safeguard the doctor-patient relationship and by extension the duty of care. And further can this duty be interpreted to impute a constitutional obligation upon the state as well, to provide an adequate standard of health care? If this is answered in the affirmative then a *prima facie* right is created.

However this *prima facie* right only partially answers the research question. It may be argued that the right may or may not exist. This is why Chapter 4 focuses on utilising the extensive body of international medical law to add normative content to the right in question. This analysis also serves to buttress the right in the domestic legal application, as the treaties that will be applied have all been assented to by South Africa.

In the penultimate chapter, Chapter 5, the right to adequate health care as defined by international law, will be applied to the South African socio-economic jurisprudence, in order to determine whether the right is a mere paper tiger, or something substantial and enforceable against the state. Chapter 5 shall also critically evaluate the state response to the crisis in public health care, which is the creation of the National Health Insurance, and thoroughly critique the policy, highlighting that over-focussing on access to health care is what caused the crises in the first place.

Finally, this thesis shall conclude with Chapter 6. In the conclusion chapter the author shall determine if the thesis outcomes were substantiated by summarising each chapter. Finally

the author shall make concluding remarks and recommendations on the current situation and the affirmative finding for the research question.

1.5. METHODOLOGY AND LIMITATIONS

The great fictional detective Sherlock Holmes once remarked “*Data! Data! Data! I cannot make bricks without clay!*”⁵ In the similar way that the great detective used assumptive and presumptive logic to build his case, this thesis requires bedrock of critical thinking and assumptive reasoning to confirm the outcomes listed above. Building from this bedrock foundation, the ground level of this thesis shall be a literature study of primal legal resources as formulated through the Constitution, common law and legislation. Unfortunately when dealing with socio-economic rights, there is a pragmatic duty upon the author to temper their idealism with positivism, and only seek those legal duties which can be proven through the strictest of reasoning. It is imperative to only record those suppositions that can be proven through the black-letter operation of South African law.

All the chapters follow an explanatory and analytical methodology that serve to firstly convey understanding, and then exploit that understanding to comply with the research outcomes. This thesis is further governed exclusively by South African law even the international instruments reflected upon have been selected because South Africa is a signatory or a party to the treaty. It must be stressed again, that the duty to be as positivistic as possible is essential in order to effectively answer the research question.

With any significant legal undertaking it is necessary for the author to reflect upon the scope of the work undertaking, and limit that scope, so as to focus on the outcomes at hand. While every chapter sets out where limitations were made, it is only suitable for the author to make allowances for the larger evasions and exclusions.

This topic shall focus exclusively on the public health care system. While it would be ideal to determine the relationship of the right to adequate health care in the commercial environment that is private health care, it is simply not possible in light of the textual restrictions placed on the author.

The extensive ethical discussions on the doctor-patient relationship have been omitted to provide more focus on the changing nature of medical practice and the doctor-patient relationship.

⁵ Conan-Doyle, “The Copper Breeches” in *The Adventures of Sherlock Holmes*; Human & Rousseau; 1982.

Further the Constitutional analysis omits discussions on which parties have standing to bring the matter, as well as a substantive limitations analysis. This is done partly to conserve space and partly because the Constitutional Court has analysed the limitations of a socio-economic right beyond reasonableness.

While many treaties exist that specifically focus on the right to health in international law, this thesis shall only focus on the more famous treaties and only on those treaties signed (at least) by South Africa.

Finally, while the Policy Paper on the National Health Insurance is much longer than the evaluation in Chapter 5 suggests, this thesis could only focus on the most pertinent parts, and reluctantly the economic implications of the NHI could not be properly studied and analysed.

1.6. VALUE CONTRIBUTION OF RESEARCH

Before one can undertake the mammoth task of penning a thesis, it is essential to realise why this research is being undertaken. Not only for the purposes of publishing a thesis that advances, in some small or grand way, the course of law; but also for a personal reason to grow academically and start down the path of academic excellence.

While the author was defending his undergraduate thesis, the realisation slowly dawned that South Africa had a completely wrong-footed approach to realising and implementing socio-economic rights. While, in the short-term, it seems more effective to focus on progressively realise individual elements of a right, the South African government had stalled completely and hid behind the access to health care and progressive realisation, like a tortoise would hide behind its shell.

Unfortunately government does not change easily. It takes substantive effort and frequently a change of power before states move towards adopting a different attitude. The benefit with the South African legal system is that violations of the CRSA can be used to demand change, whether a government wishes to or not.

It is in this ultimate representation of a citizen's power that this thesis finds meaning. When it is proven that the right to adequate health care exists, it is an *assegai* that can be used against an executive that has thrown all its weight behind the ruinous policy of National Health Insurance.

This thesis serves a quadruple purpose in terms of adding value to the current legal development of medical law, human rights law and constitutional law.

Firstly it will prove that once the state attempts to realise the different minimum core obligations of the right to health, then it can realise the error of its ways and correct years of unnecessary hardship.

Secondly, this thesis will prove that the current course the executive has set, in lieu of the deplorable socio-economic rights jurisprudence, is one that will end in disaster.

Thirdly, this thesis will act as a galvaniser to effectively set out South Africa's obligations under international law regarding the right to health.

And finally this thesis will prove that a legal principle that may be considered abstract can be applied, through the CRSA, to create a binding obligation upon the state. It serves as a challenge for other scholars of socio-economic rights to ensure the remaining rights are also progressively realised.

1.7. CONCLUSION

While it has been established that South Africa faces a dark situation regarding its commitments to health care, it must be stressed that this thesis shall not attempt to prophesise doom and gloom alone. Through the proper application of the CRSA, it is hoped that those affected by the changes or those that can afford to will raise the CRSA as a shield against this oppressive regime. It has been too long since the people of South Africa rose up and demanded what was fair and right, and this thesis hopes to be another brick in that wall of resistance.

Upon his inauguration Nelson Mandela famously said *"Never, never and never again shall it be that this beautiful land will again experience the oppression of one by another and suffer the indignity of being the skunk in the world. Let freedom reign!"* For too long has the state been able to oppress the citizenry into believing that socio-economic rights are an unachievable ideal. For too long has the government been allowed to live off the spoils of a system designed to bring equality. It is time for ordinary South Africans, and those residing permanently within the borders, to rise up and use the CRSA to demand change and true equality.

2. Chapter 2 – Analysing the Doctor-Patient Relationship

2.1. INTRODUCTION

The relationship between doctor and patient is perhaps the longest-standing example of a special relationship, not simply in law but in human history. Tablets from the time of Hippocrates have mentioned the need of a special relationship between a physician and her patient. Unfortunately no legal relationship is as unbalanced as the doctor-patient relationship.⁶ While a doctor can elect to treat a patient, or simply pass the patient on; a patient lacks that ability. Generally speaking, a patient will approach the doctor when sick, and when there is a desperate need to be healed.

The purpose of this chapter shall be to critically analyse both the concept of the doctor-patient relationship as well as critically analyse the interaction of the doctor-patient relationship in South African private law. This is because the majority of court decisions and journal articles have been decided in terms of the private law of South Africa.⁷ The following chapter shall be tasked with analysing how the CRSA impacted and implemented the doctor-patient relationship.

In order to best effect the purpose, it is submitted that the discussion shall progress as follows: firstly the term doctor-patient relationship shall be defined. While it is near impossible to define a term that has such wide implications, and changes throughout history, the crux of the definition and the purpose the doctor-patient relationship shall be established. Once that is completed the discussion shall then track the evolution of the doctor-patient relationship throughout history, as it has changed and adapted with the medical sciences. At the conclusion of this critical evaluation, the author shall then proceed to conclude on the ethical understanding of the doctor-patient relationship, and provide a definition that will be used in the second part of the discussion.

Armed with a critical understanding of the doctor-patient relationship, and the elements thereof, this discussion can then proceed to apply this definition to the existing South African

⁶ *Ibid* Carstens, fn. 1 at 878 and 883.

⁷ *Idem* Carstens at 283 and 284.

law of obligations. The rationale behind this application is to attempt to analyse to what extent South African law has adapted and applied the doctor-patient relationship. While the modern day understanding of the doctor-patient relationship is focused on the rights of the patient, how has that understanding translated today? Another *raison d'être* exists for this application, and that is the research question expounded in the introductory chapter.

For the purposes of this thesis, this chapter shall attempt to answer two questions essential to proving whether or not the doctor-patient relationship can be used to bind the state to a minimum standard of adequate care. The first question is whether the doctor-patient relationship can be used to demand not simply a particular service from the doctor, but an expectation that the service will be of an acceptable standard. The second question is whether the doctor-patient relationship can be extended in some way to allow the state to be bound by it. This question will require extensive consideration, as the state cannot simply become a party to a significant legal relationship.

In order to best achieve these outcomes in the parameters provided, the following methodological principles shall be present throughout this chapter. Firstly this chapter is formed on the foundation of a critical thought approach. All the information collected in this chapter shall be subjected to critical thought and application. While critical thought is the core discipline espoused by this chapter, it alone cannot be enough to achieve the outcomes set out afore. That is why, for the first part of the chapter, the historical and comparative approach must be used. In order to effectively trace the evolution of the doctor-patient relationship, it is essential to fully appraise the development of not only the doctor-patient relationship and its components, but to juxtapose and compare that evolution to the development of medicine in Western Europe. In the second part of this chapter, critical legal analysis shall be buttressed by the twin disciplines of positivistic reasoning and constructive interpretation. While natural law is an accepted legal discipline, it cannot provide the level of certainty required by this chapter, and therefore the law that is discussed must be followed as strictly as possible. Yet this is not always prudent or possible, and in such an event constructive interpretation, being interpretation that is wholly inclusive of the relevant information shall be used to best establish and elucidate the doctor-patient relationship and its interaction with the South African private law.

Ultimately, at the final conclusion of this chapter, the reader shall have been provided with a concrete understanding of the doctor-patient relationship, and the various elements thereof. Further the reader shall also be able to critically analyse this definition and its application to the South African Private Law. Finally, it is submitted that the first elements underpinning the research question shall be proven.

2.2. A CRITICAL ANALYSIS AND EVALUATION OF THE DOCTOR-PATIENT RELATIONSHIP

2.2.1. INTRODUCTION

In order to apply something, it is first necessary to understand what it is. While the doctor-patient relationship is a legal term that is simply bandied about, there is a definite need to first ascertain the character of this concept, as well as what it might entail. In order to understand and evaluate the doctor-patient relationship it is first imperative to establish the purpose of the doctor-patient relationship. After establishing the purpose of the doctor-patient relationship, this chapter can progress to defining the doctor-patient relationship by critically evaluating the evolution of the doctor-patient relationship throughout history, juxtaposed against the backdrop of the progress of medicine in Western Europe.

Finally, after this evaluation has been completed, can this discussion focus on defining the concept of the doctor-patient relationship, and discuss the various principles that accompany the doctor-patient relationship, such as patient autonomy and informed consent.

2.2.2. THE PURPOSE OF THE DOCTOR-PATIENT RELATIONSHIP

It has already been stressed, but for being an intrinsic building block of medical law and health care law, very few practitioners and attorneys understand what precisely the doctor-patient relationship is. Generally it can be understood to be the affiliation and rapport that builds up between health care provider (the doctor, nurse or dentist) and the health care recipient (the patient and to a lesser degree their family).⁸

It has been proven, through clinical study, that the more comprehensive and ameliorate the relationship, the more effective the standard of care and efficacy of treatment.⁹ To be most effective this relationship must be supported by five key values: mutual respect; knowledge; trust; shared values and perspectives about illness, death and life as well as time.¹⁰

⁸ Scott and Vick, "Patients, Doctors and Contracts: An Application of Principal-Agent Theory to the Doctor-Patient Relationship," (1999) *Scottish Journal of Political Economy*, Volume 46 at 111-134.

⁹ Gupta, "Humanity in Medicine," (2011) *J Med Ethics Hist Med*, Volume 4 at 3.

¹⁰ *Idem* Gupta at 3.

This relationship is heavily influenced by conduct on both sides. From the patient informing herself of conditions and challenging the diagnosis, to the physician misdiagnosing the patient. Generally mistrust in the physician would result in the patient seeking alternative care or terminating the relationship completely.

Friedenberg contrasts the doctor-patient relationship to the relationship between a flyer and an aircraft carrier.¹¹ While flying with SAA, for example, creates the expectation that the flyer will arrive at the destination, often clinical treatment is fraught with more issues. Patients may expect to come in for a routine treatment only to discover terminal illness and die. Interestingly, while killing passengers may affect the relationship between flyer and carrier, the death of a patient may actually strengthen the relationship between a doctor and a family, as long as the doctor (in the mind of either the patient and/or the family) did their utmost to treat the patient. This espouses the trust concept of the doctor-patient relationship.

In conclusion, it can be held that the doctor-patient relationship exists as a conduit for effectively practicing medicine (by the health care provider) and effective therapeutic treatment (for the health care recipient). While it must be stressed that treatment is not the only outcome for the doctor-patient relationship, it is by far the most efficacious. Other possible outcomes for the doctor-patient relationship include establishing a loyalty to a specific provider, such as a mental health professional or practice of general practitioners; ensuring patients become more acquainted with self-treatment and medication, as well as continuing health education and finally enriching the health care provider's own professional development.

2.2.3. DEFINING THE DOCTOR-PATIENT RELATIONSHIP THROUGH HISTORY

2.2.3.1. Introduction

After having established the purposes behind the doctor-patient relationship, the next step in this discussion shall be to trace the history of relationships between care givers and care recipients. The reason for this further analysis shall be to trace how the outcomes were shaped and more importantly how the nature of the relationship has changed between care giver and care recipient.

While the field of medicine is much wider than the evolution of European or Western Medicine, this thesis shall focus almost exclusively on the evolution of European medicine. It

¹¹ Friedenber, "Patient-Doctor Relationships," (2003) *Radiology*, Volume 226 at 306-308.

must however be pointed out, that were pertinent; the focus shall shift to Near Eastern or Middle Eastern medical science.

The Oxford English Dictionary defines medicine as that field, of applied sciences, that focusses on the diagnosis, treatment and prevention of illnesses. The following discussion shall focus on evaluating the evolution of medicine throughout Western civilization, starting with the shamanism of ancient *Homo sapiens* and concluding with the rise of narrative medicine in the modern era. At the conclusion of this discussion the reader will understand the continuous evolution of medicine, and the impact that evolution has had on the doctor-patient relationship.

2.2.3.2. Pre-Historic and Ancient Medicine (3000 BCE – 899 CE)

2.2.3.2.1. Pre-Western Medicine (3000 BCE – 460 BCE)¹²

Perhaps the best indicator for pre-historic medical practice is the practices of traditionally indigenous persons, specifically those persons who are migratory hunter-gatherers.¹³ Due to the migrant nature of the ethnic grouping, health care is focussed primarily on treatment with herbs and braces, as well as spiritual health care (i.e. spirit cleansing). It is not entirely unreasonable to conclude that until about 1000 BCE this would be the focus of ancient health care.

Specifically in the case of spiritual health care, it must be noted that priests often took up the role of the caretaker.¹⁴ It can be assumed that the first relationship would have been one of fear. A patient seeking care in pre-historical times would feel threatened either because their injury would cause them to hamper the free movement of the ethnic grouping or it would cause them to be excommunicated from the group (or city) due to being spiritually impure. It caused a lack of trust based on inexperience and ignorance, especially for serious injuries and most illnesses.

¹² This section is sourced mainly from Horstmannshoff, Stol and Tillburg, *Magic and Rationality in Ancient Near-Eastern and Greco-Roman Medicine*; Brill Publishers; 2004 from 92.

¹³ E.g. the San people of Southern Africa and the Pygmy people of Central Africa.

¹⁴ The earliest legal record found, the Code of Ur-Nammu, does not specifically list doctors as a profession but distinguishes priesthood from sorcery. It may be presumed that those who undertook to study medicine may have been accused under this provision.

From this time, however, certain members of civilization started studying medicine, and the foundation of the medical profession was laid. The first recorded mention of doctors, in Western and Middle Eastern medicine) is in the Code of Hammurabi.¹⁵ From this point on, even if medicine was still linked to religion, it became subjected to academic study.¹⁶ This is evident from surviving manuscripts such as the *Diagnostic Handbook*, presumably authored by Esagil-kin-Apil around 1060 BCE. Together with the rise of Egyptian medicine, Near-Eastern medicine focused on prognosis, examination, diagnosis and prescription. This is the first written record of health care being approached in a scientific manner.¹⁷ The Hippocratic *Corpus* specifically mentions the impact of the Babylonian doctors in forming his own opinions on treatment.

With the rise of Near-Eastern medicine, health care started becoming a science, as opposed to religious hokum. The importance of which, was removing much of the mysticism around medical health. However because concepts such as infection, bacteria and public health were still in infancy, the ancient Greeks and Romans replaced the mysticism of the gods with the mysticism of nature.

2.2.3.2.2. The Birth of Western Medicine (459 BCE – 449 CE)¹⁸

The birth of modern 'Western' or science based medicine is attributed to ancient Greece, around the 5th Century BCE. Although ancient civilizations had little understanding of pathogens or bacteria, it is during this era where we find that the Greeks attempted to diagnose illnesses by analysing the symptoms of the disease, as well as record these symptoms for future medical practitioners.

Hippocrates, is perhaps the best known of the ancient Greek doctors, and is often credited as the father of modern medicine.¹⁹ While there were physicians in Ancient Greece,

¹⁵ While there is no talk of the relation between doctors and patient, rules are set down to remunerate the doctor for work done.

¹⁶ *Ibid* Horstmannshoff, fn. 12 at 99.

¹⁷ Although it would still be millennia before the scientific method would truly be formed.

¹⁸ This entire discussion is sourced mainly from Garrison, *History of Medicine*; W.B Saunders Company; 1966 at 96-100.

¹⁹ Diamantis and Grammaticos, "Useful Known and Unknown Views of the Father of Modern Medicine, Hippocrates and his Teacher Democritus," (2008) *Hellenic Journal of Nuclear Medicine*, Volume 1; 2 at 11.

practicing before him,²⁰ his diagnostic tools and diagnostic tools are the earliest definite record humanity has, where medicine was practiced as a science, and not a religion. Further he was also the first person, in recorded history, to argue that illness is not caused by a curse from the gods, but by nature.

Born around 460 BC in Kos, Greece; Hippocrates is perhaps most famous for the *Hippocratic Corpus*, a collection of ancient medical texts authored during his life and by his students after his death. The Hippocratic method was based around the misconstrued belief that illness was caused by a crisis point. It was believed that the body existed from four humours: black and yellow bile, blood and phlegm; and during an illness these four humours would be out of balance, causing a crisis point. It was believed that this crisis point would cause the body to start losing against the illness, and death would follow.

In line with this balance, Hippocratic treatment was focused on restoring the balance as well as allowing nature to take its course.²¹ Hippocratic medicine was not an invasive form of medical practice, but a passive form. Treatment was therefore a generalised therapy designed at immobilising the patient and allowing her to rest. While this treatment proved ineffective for most diseases, it was exceptionally effective at treating broken bones.

While modern medicine has marched on, Hippocrates made several practical contributions to modern medicine, most famous of which is the clubbing of the fingers in Eisenmenger's syndrome. Further Hippocrates also originated the practice of categorising illnesses as acute, chronic, endemic or epidemic. Despite these contributions the *Hippocratic Corpus* made another considerable contribution to modern medicine, in setting out the professional relationship between doctor and patient.

Ancient Greece is famous as the birthplace of analytical and practical philosophy.²² While Hippocrates narrowly pre-dated the birth of virtue ethics,²³ he seems to have understood that a special relationship exists between a patient and the treating physician. In the *Hippocratic Corpus*, the book entitled as *The Law*,²⁴ Hippocrates postulates on the nature of the physician. Hippocrates argues that the physician should be calm, honest, understanding, serious and well-maintained. The physician is expected to control his practice and keep

²⁰ Such as Democritus.

²¹ Specifically termed as *vis medicatrix naturae* or the healing power of nature.

²² As it was the literal birthplace of philosophers like Socrates, Plato, Aristotle, Diogenes and Epictetus.

²³ Virtue ethics being the basis for the modern study of ethics.

²⁴ Originally titled as *Ἐπισημίμων* and translated by Adams.

detailed records of treatments performed and observations of patients.²⁵ Further Hippocrates also stressed the importance of teaching, and that practising physicians must be properly taught before practicing. The *Hippocratic Corpus* also contains the 'Hippocratic Oath' which contains the tenements of a successful physician at the time of drafting, but now is mostly a tradition of graduating a medical degree.

The *Hippocratic Corpus* initiated the concept of the doctor as the dominant factor in the doctor-patient relationship. The patient, scared, timid and lacking knowledge, would come to the highly trained and professional physician to receive treatment. While this abstract has changed completely, it would be this attitude that would preside over medicine until very recently.

While there were many medical researchers and physicians after Hippocrates, such as Pliny the Younger, only one other physician necessitates focus. Aelius Galenus, born in 129 CE, in Bergama, Turkey. Known today as Galen, he is perhaps the most prolific medical researcher to have ever lived, and certainly the most prolific of all the ancients.

The reason this discussion has to focus on Galen is twofold; firstly his texts became the basis for medical practice right up to the Renaissance and secondly he purported the belief that a physician needs to be a philosopher as well, introducing philosophical concepts into the medical sphere.²⁶

As a scientist, Galen was among the first recorded physicians to understand the value of pathology. Due to legal restrictions, Galen performed vivisections and dissections on pigs and primates. While the anatomical dissections may not have been clinically relevant, they revealed a lot of information regarding anatomy. Galen was the first person to link paralysis with the spinal cord, prove that the voice originates in the larynx, differentiate between motor and sensory nerves and experiment with artificial respiration. Galen also experimented with the circulatory system, but notably made the error of separating the venial and arterial system instead of accepting they form part of one system. Galen was also an incredibly skilled surgeon, and could correct cataracts, something that would not be done for over a millennium.²⁷

²⁵ Margotta, *The Story of Medicine*; Golden Press; 1968 at 66.

²⁶ Brian, "Galen on the Ideal of the Physician" (1979) *South African Medical Journal* 52 at 936-938 as well as Drizis, "Medical Ethics in a Writing on Galen" (Fall 2008) *Acta Med Hist Adriat*, Volume 6 at 333-336.

²⁷ Galen, *On Anatomical Procedures* and Galen, *On the Brain*.

As a philosopher Galen continued the work of Hippocrates, by questioning the role of the physician and how a physician should conduct their practice. It must be stressed that in his work *'That the Best Physician is also a Philosopher,'* Galen only discusses the role of the physician. It would still be some time before the patient aspect of the doctor-patient relationship would receive attention. Galen argues in the book that a physician should incorporate theory, experimentation and observation into their practice. Through doing this the physician can continue to teach themselves, as well as treat their patient. This is a further extension of Hippocrates, where the focus was on theory and observation.

While religion still played a role in medicine, the ancient Greeks and Romans introduced the concept of disease being caused by nature. With this revolution the physician became the most important person in the doctor-patient relationship.

2.2.3.2.3. Conclusion

Before the classical period medicine was seen as an extension of religion. If one were religiously pure it was concluded one would be healthy. While this view was challenged by the ancient Egyptians and ancient Babylonians, the role of religion in medicine was still almost intrinsic. The impact this had on the doctor-patient relationship was severe. Regardless of skill, doctors were either a conduit to the gods (apothecary and shamanism) or were completely irrelevant.

With the rise of the Greeks and the Romans, it was concluded that nature had as much a role to play as religion. It can be presumed that ancient Greeks and Romans still prayed to the gods for health, but second to that, the physician stepped in to restore health. While the lack of dissection, scientific method and medical schools still resulted in there not being complete health, there was a movement afoot that would culminate in the scientific revolution starting during the late medieval period.²⁸

Understanding the purpose behind the doctor-patient relationship during this period may prove to be difficult. Due to the lack of information, historians cannot definitively state what the ancient opinion was regarding physicians. For instance, in ancient Greece many physicians were nobility, and worthy of respect. But during the Roman Republic many physicians were slaves captured by the marauding Roman armies, which resulted in physicians being related to slavery.

²⁸ Roughly from 1500 – 2000 BCE.

Ultimately what can be concluded however, is at the conclusion of the Ancient Era, physicians realised that practicing medicine was not only about treatment. Ancient physicians experimented with treatment options as well as conduct and visual appearance. While the modern concept of a profession cannot easily be transposed on an ancient physician, it can be accepted that they acted like professionals. The role of the patient in this consideration received no attention, and would continue to receive no attention for quite a while longer.

2.2.3.3. Medieval and Early Modern Era Medicine (450CE – 1799 CE)

2.2.3.3.1. Introduction

The Ancient Era ended with the sacking of Rome. While the subsequent Dark Ages were not nearly as dark or scientifically backward as Hollywood would have one believe, there was still an almost total absence of scholarship, experimentation and standardised medical education. It was almost as if Europe travelled back in time to pre-history where religion supplanted medical acumen.

Fortunately, in the peak of the dark ages (The 10th and 11th Century) many European scholars started reviving scientific experimentation and record keeping. These sparks, fanned by the intellectual climate from the Middle East, eventually caught into the wildfire that was the scientific revolution.

This discussion shall focus on that era in medical history. The purpose of which is to determine how the enlightened physician would re-discover her philosophical side and how experimentation created the physician as a scientist first, philosopher second and healer lastly. This state of affairs would lead modern medicine into the precipice that was the 1800's where the prevention and diagnosis of illnesses far out-stripped the treatment of illnesses.

2.2.3.3.2. Medicine in the Pre-Renaissance Era (450CE – 1349 CE)

With the sackings of Rome (410 BCE and 455 BCE), the Eastern Roman Empire had seemingly abandoned Western Europe.²⁹ While there was significant activity amongst the Germanic ethnicities in Europe, especially the Franks, Goths and Vandals, the sacking of

²⁹ But for a single invasion in the 500's by Justinian I, Constantinople never attempted to retake Rome or claim Italy as part of the empire.

Rome legitimised the small kingdoms that each group had amassed. While this period has become known as the dark ages, it was in fact the birth of modern Europe. Unfortunately for the continuation of medicine (or any other scientific discipline for that matter) academic study was suspended until civilization restored itself.

However while the academic side of medicine was sputtering out, the practical side of medicine faced a revival. While many monks had access to the works of antiquity, such as Galen's various treatises, many Western civilizations effectively taught themselves how to cure many common ailments. From the setting of bones, treatment of wounds and creation of pharmaceuticals the practical side of medicine flourished. Of particular importance though, is the fact that many of these actions were performed by ordinary civilians. While it is impossible to tell if people up to this point understood their own capacity to treat illness, this was a definite turning point in the power relations between healer and the healed.

Europe however, was still facing the problems of not having academic study to rely on. As was stated previously, though Galen's teaching formed the basis for medical practice in this era, he was mistaken about many points. Luckily Europe was close enough to Medieval Arabia, and was about to benefit extensively from their academic study.

Muhammad ibn Zakariya al-Razi (Latinised as Rhazes), born on the 28th of August 865 in Rey, Iran. Rhazes, together with Galen, are considered to be the greatest physicians of the pre-modern era and both are famous for not only discoveries, but also prolific publishing.³⁰ Known colloquially as the father of paediatrics and is known for using observation and experiment to distinguish measles from smallpox.³¹ The justification for the inclusion of Rhazes to this discussion is his views of medical ethics. He was vociferous in his attacks on frauds and swindlers who pretended to be doctors and publically admitted that even the best trained physicians cannot know everything. He also advocated that physicians who lose patients to serious illnesses, such as cancer, should not blame themselves for failing to save the patient's life. It is interesting to note this acceptance of fault. As will be discussed later,³² many subsequent physicians viewed themselves as both unassailable as well as omniscient, which lead to serious medical errors. Rhazes also took another leap forward, when he published his *A Medical Adviser for the General Public*. This book focussed on educating ordinary citizens, the poor and the traveller on common maladies and illnesses, and the most effective way to treat those illnesses. This step in remedial medicine also accepted that

³⁰ Browne, *Islamic Medicine*; Goodword Books; 2001 at 44 as well as Tschanz; "Arab Roots in Modern Medicine" (2003) *Heart Views* at 4.

³¹ *Idem* Browne at 45-46.

³² *Op cit* at 36-42.

the patient has the ability to self-treat, and that the physician was not the be all and end all of health care.

Abu al-Qasim al-Zahrawi, born in 936 CE at Al-Andalus. Known in the West as Abulcasis, he is colloquially known as the father of surgery. In the year 1000 Abulcasis published his mammoth manuscript, the *Kitab al-Tasrif*.³³ In this 30 chapter boo, dealing with topics as broad as dentistry,³⁴ surgery³⁵ and obstetrics.³⁶ Abulcasis can be credited with creating Kocher's method of treating shoulder dislocations,³⁷ Walcher's position in obstetrics, identifying the hereditary nature of haemophilia, suturing the temporal artery to treat migraines³⁸ and the use of catgut for internal suture. While Abulcasis makes specific mention of both Hippocrates and Galen, he criticises their work for being too academic.³⁹ Another important point was that Abulcasis also wrote on the importance of a positive doctor-patient relationship.⁴⁰ Abulcasis writes that patients should be treated, regardless of their economic and social status, but more importantly he writes of the importance of having a good relationship. Throughout the treatise he mentions when methods would be uncomfortable and councils his students to warn the patient. This is the first recorded mention of patient's rights as well as viewing the patient as a core tenement of medicine.

The second notable physician of the age, Anna Komnene, was born in 1083 at Istanbul.⁴¹ The daughter of Emperor Alexios I Komnenos of Byzantium, this Greek princess would introduce hospital administration to the fledging public health system in Istanbul, administering a hospital that, at one time, housed over a 1000 beds. She also broke the gender barrier by teaching at the hospital, and was considered an expert in gout.

It is also during this period that medicine differentiated into two separate branches. While doctors or physicians focused on the study of medicine, a new class of professional was rising in Europe. The barber-surgeon was originally a type of camp follower during medical campaigns. While most battlefield aid was given by monks, sisters or imams; the barber-surgeon was seen as a hanger-on that eventually became a battlefield necessity. While

³³ al-Zharawi, *Kitab al-Tasrif*; University of California Press; 1973.

³⁴ *Idem* al-Zharawi at 66.

³⁵ *Idem* al-Zharawi at 1.

³⁶ *Idem* al-Zharawi at 624.

³⁷ *Idem* al-Zharawi at 92.

³⁸ Something recently popularised by South African doctor, Elliot Shevel.

³⁹ *Idem* al-Zharawi at 2.

⁴⁰ *Idem* al-Zharawi at 4-6.

⁴¹ Constantinople at the time.

mostly focusing on removing arrows and performing battlefield amputations, the barber-surgeon eventually became a mainstay of daily life. Someone, lesser trained than a physician, that could treat patients.

Perhaps the best known of these barber-surgeons was Ambroise Paré. Born in 1510 at Laval, France; Paré is frequently referred to as one of the fathers of surgery as well as modern pathology. Practicing at a most frustrating time, when gunpowder came to the fore in Europe which resulted in horrible and untreatable injuries, Paré is famous for arguing that he merely bandages the wounded while God heals them. This is not to say Paré was an ineffective surgeon. Paré introduced the concept of ligation of arteries during amputation and was a fervent campaigner against the more popular cauterisation.⁴² Paré also published *Reports in Court*, which contained instructions on how to phrase a medical report for a legal proceeding.

The middle ages are often considered to be a dark period for scientific development. While medicine in Europe did not advance as much as it would in the next 300 years, certain aspects of modern day medicine came to the fore. Firstly, the patient attained an identity other than a sufferer. The patient gained a self-awareness that would be forgotten until the later modern era. This is of particular importance for the topic at hand. When patients realise that they can treat themselves, the position of the classic paternal doctor becomes eroded.

It has also been shown that this period led to an increase in public health. Hospitals were being established, and while pathogens were virtually unknown, the basis of sanitation was laid in this period.

2.2.3.3.3. Medicine in the Renaissance Era and the Scientific Revolution (1350 CE – 1799 CE)

The middle ages in Europe came to an end with the Black Death plague. Climaxing during 1348 and 1350, the plague was responsible for the deaths of between 30% and 60% of the population of Europe.⁴³ It was also the defining moment for the European civilization. Not only did the plague alter the intellectual climate at the time, from an attitude focussed on

⁴² Paré, "A Surgeon in the field," in McLaughlin and Ross (eds.), *The Portable Renaissance Reader*; Penguin Books; 1981 at 558-563.

⁴³ Austin-Alchon, *A pest in the land: New World Epidemics in a Global Perspective*; University of New-Mexico Press; 2003 at 21.

securing reward for the after-life to an attitude of living for the moment.⁴⁴ This together with the fruitful economic situation helped propel Europe into a rebirth, or a Renaissance.

While the Black Death ran rampant Western civilization also realised the need for public health care. More importantly, the responsibility for this recently discovered discipline was assumed by the state (or in the event of Medieval Europe severely affected city states). The method of prevention was horribly ineffective,⁴⁵ such as removing the dead (which was ineffective due to the pathogen being spread by rats) and the burning of quarantined sections of the city. But the creation of state mandated quarantine helped transform how the state administered health care.

When one considers the philosophy of humanism which was the driving force behind the Renaissance, whereby the study of the five humanities (poetry, grammar, history, moral philosophy and rhetoric) in order to recover, assimilate and interprets the learning and values of antiquity.⁴⁶ Humanism was a celebration of the human mind, as opposed to the medieval celebration of Christianity. It was during this period that the texts mentioned above, as well as many others, were studied exhaustively by scholars working from newly established universities (such as Oxford, Cambridge and Paris) or universities that were experiencing a rebirth themselves (such as Bologna, Florence and Rome).

While the Renaissance initially busied itself with art and literature it laid the foundation for the scientific revolution of the 16th Century. In the *Annus Mirabilis* there was 1543, two books were published that redefined science. *De revolutionibus orbium coelestium* by Copernicus⁴⁷ and *De humani corporis fabrica* by Vesalius.⁴⁸

Andries van Wesel (Latinised as Vesalius) was born on the 31st of December 1514 in Brussels, Belgium. Known as the father of anatomy, he was born into a family of doctors, Vesalius studied medicine at the University of Paris, where he was fond of studying anatomy. Of particular importance was his meticulous sketches made of anatomical tables,

⁴⁴ Tuchman, *A Distant Mirror*; Ballantine Books; 1978 and Skinner, *The Foundations of Modern Political Thought*; Cambridge University Press; 1978 at 69.

⁴⁵ Foucault, *Folie et Dérison: Histoire de la Folie à L'âge Classique* or *Madness and Civilization*; Pantheon Books; 1961.

⁴⁶ Burke, "The Spread of Italian Humanism" in Goodman and MacKay (eds.), *The Impact of Humanism on Western Europe*; 1990; Longman at 2.

⁴⁷ Copernicus, *De revolutionibus orbium coelestium* or *On the Revolution of Heavenly Spheres*; 1543.

⁴⁸ Vesalius, *De humani corporis fabrica* or *On the Fabric of the Human Body*; 1543.

which would eventually be published as *Tabulae Anatomica Sex* in 1538. These sketches became the basis for *De humani corporis fabrica*.

What makes *De humani corporis fabrica* such a pioneering book was the meticulous sketches made by Jan Stephen van Calcar,⁴⁹ which showed the body in various poses, with meticulous labelling of the various bones and muscles responsible for keeping that pose.⁵⁰ Also notable was the sketches of the various organs, especially the brain, circulatory system and vascular system. What makes *De humani corporis fabrica* unique was that the Galenic method, whereby a physician relies on established practise and personal observation, was overthrown and replaced with the Baconian method, or scientific method.⁵¹ While his work set the standard for future anatomical textbooks, such as the famous Gray's Anatomy,⁵² Vesalius sought truth and would make corrections where he had been proven wrong.

While the achievements of the thousands of physicians working in this period cannot be listed in full, this discussion shall focus on some of the more pertinent discoveries especially those concerning public health care, patient rights and medical ethics.

Garcia de Orta, born circa 1501 in Castelo de Vide, Portugal; was a pioneer of tropical medicine. In his work, *Colóquios dos simples e drogas da India*⁵³ Orta methodically describes several medicinal substances that were unknown in Europe at the time as well as methodically describes cholera, including records of an autopsy of a cholera victim. Continuing on the study of foreign and tropical medicine, Giacomo Pylarini, born during 1659 in Cefalonia, Greece; became the first recorded Westerner to practice inoculation, in this case the vaccination of children in Anatolian Venice through variolation. This work was completed by Edward Jenner, the father of immunisation, born on the 17th of May 1749 in Berkeley, England. Jenner is most famous for developing the smallpox vaccine. What separates Jenner from previous immunologists though, was his meticulous scientific method. Operating from the hypothesis that cowpox is less dangerous than smallpox, Jenner sought about comprehensively proving the benefits of infecting a healthy person in order to prevent

⁴⁹ Born 1499 at Cleves, Germany.

⁵⁰ *The Anatomical Plates of Pietro de Cortona*; Dover; New York; 1986.

⁵¹ Scientific method is defined as a method, procedure, practice or technique whereby systematic observation, measurement and experimentation result in the formulation, examination, analysis and modification of a hypothesis.

⁵² Gray, *Anatomy: Descriptive and Surgical*; Longman; 1858 which has become the *locus classicus* of anatomical medicine.

⁵³ Orta, *Colóquios dos simples e droggas da India* or *Colloquies on the Simples and Drugs of India*; Date of publishing and publisher unknown.

greater harm. This principle, which will be discussed subsequently, wherein the physician is expected to cause harm in order to prevent harm, is one of the most polemic principles in medical ethics, and has laid the basis for some of the worst medical experimentation in recorded history.

William Harvey, born on the 1st of April 1578 in Folkestone, England; was the first physician to describe the circulatory system in its entirety.⁵⁴ In his book, *De motu cordis*,⁵⁵ Harvey comprehensively describes the circulatory system as well as the heart, lacking only the microscopic detail that was popularised by Anton van Leeuwenhoek.⁵⁶ What make William Harvey of special significance were his attitudes on health care and medical education. Appointed to the office of the Luminal lecturer at the Royal College of Physicians, London; Harvey set out several canons that would enable him to best educate his students:⁵⁷

- *"To show as much as may be at a glance, the whole belly for instance, and afterwards to subdivide the parts according to their positions and relations.*
- *To point out what is peculiar to the actual body which is being dissected.*
- *To supply only by speech what cannot be shown on your own credit and by authority.*
- *To cut up as much as may be in the sight of the audience.*
- ***To enforce the right opinion by remarks drawn far and near⁵⁸, and to illustrate man by the structure of animals.***
- *Not to praise or dispraise other anatomists, for all did well, and there was some excuse even for those who are in error.*
- *Not to dispute with others, or attempt to confute them, except by the most obvious retort.*
- *To state things briefly and plainly, yet not letting anything pass unmentioned which can be seen.*
- *Not to speak of anything which can be as well explained without the body or can be read at home.*

⁵⁴ Michael Servetus, a Spanish Renaissance man and physician was the first to record it, but unfortunately his works were destroyed al heresy by the Calvinist Protestants.

⁵⁵ Harvey, *De motu cordis* or *On the Motion of the Heart and Blood*; 1628; Publisher unknown.

⁵⁶ The inventor of the microscope.

⁵⁷ Power, *William Harvey: Masters of Medicine*; T. Fisher Unwin; 1987 at 62-64.

⁵⁸ Author's emphasis.

- *Not to enter into too much detail, or in too minute dissection, for the time does not permit.*
- *To allot a definite time to each part of the body (i.e. first day's lectures dedicated to the abdomen, the second to the thorax, the third to the brain and so on.)"*

While there have been many masters of medicine in the preceding ages, this record allows one to understand the nature of medical education during the scientific revolution. Of particular import is the acceptance that all his students were sufficiently taught, that Harvey only had to concentrate on the matters anatomical that were either relevant to his lesson or relatively unknown. Also, the need to enforce the right opinion is of particular importance. In the subsequent discussion on the philosophical issues of medical ethics, one of the recurring factors in physicians acting like their teachers, and while the study of anatomy, for instance, requires exacting perfection, the enforcement of one opinion can and probably will result in autocratic thinking.⁵⁹

Finally the second contribution Harvey made to health care, his general canons on treatment in hospitals:⁶⁰

- ***"That none be taken into the Hospital but such as be curable, or but a certain number of such as are curable."***⁶¹
- *That none lurk here for relief only or for slight causes.*⁶²
- *That the Chirurgions (Surgeons), in all difficult cases or where inward physic may be necessary, shall consult with the Doctor, at the times he sitteth once in the week and then the Surgeon himself relate to the Doctor what he conceiveth of the cure and what he hath done therein.*
- *That no Chirurgion (Surgeon) or his man do trepan the head, pierce the body, dismember, or do any great operation on the body of any but with the approbation and the direction of the Doctor..."*

This general canon contains two very worrying mind-sets. The first is that the physician is solely responsible for deciding what illnesses are worrying or serious enough to entertain her attention and that the outcome of practicing medicine is linked only to what can be cured.

⁵⁹ *Op cit* at 29-35.

⁶⁰ *Ibid* Power, fn.57 at 99-103.

⁶¹ Author's emphasis.

⁶² Author's emphasis.

While it must be stressed that English has evolved from that spoken in the 16th Century to modern day Queen's English, the subtext of these rules are extremely perturbing. It is during this epoch that the concept of physician as the dominant party in treatment comes to the fore and that the patient is only along for the ride. What is also interesting to note is the hierarchy between surgeon and physician.

2.2.3.3.4. Conclusion

While the old myth of Europe being a backwater during the Middle Ages has been dispelled, one cannot underestimate the great leap forward that was the scientific revolution. Brought about by the Renaissance and the Black Death, the medical innovation that occurred in 300 years, from the publishing of *De humani corporis fabrica* to the discovery of blood circulation and immunology, the lot of the ordinary civilian was much improved. And the medical researchers and physicians had only, seemingly, scratched the surface of medical knowledge. However this great medical advancement came at a significant cost. The almost deification of physicians, and the acceptance that all medical opinions are correct would have a significant and atrocious result in the early 20th Century.

2.2.3.4. Middle Modern Era to Present Day (1800 – Present Day)

2.2.3.4.1. Introduction

While the 19th Century saw further advances in medicine, the worrying trend of physician as god became more and more pronounced. This discussion shall focus on the evolution of medicine, in perhaps the most exciting epoch, where humanity finally learned to understand disease and the pathogenic causes of disease as well as the birth of anaesthetised surgery. The outcome of this discussion shall focus on the rise of modern medicine during this era, and the changing attitudes amongst practicing physicians as they became more and more deified.

2.2.3.4.2. Medicine in the 19th Century (1800 – 1899)

At the death of the 18th Century, Edward Jenner had successfully developed the first vaccine, but humanity was still faced with the question of what causes disease. While the

masters of the past realised that some diseases were caused by hereditary factors⁶³ and others by environmental effects, such as dirty water.⁶⁴ But mankind still failed to understand what caused most diseases, and why many diseases spread like wildfire, while others seemed far less infectious.

The 19th Century also saw the rise of two revolutionary practices. The first practice was the discovery of anaesthesia and the ability to perform life-saving surgery that would have otherwise resulted in death. The second massively revolutionising practice was the creation of supplemental medical disciplines, the most famous of which is nursing. Both these innovations allowed physicians more power and the ability to innovate. Unfortunately the second innovation also led to the physician being unable to identify with patients, and lose all sense of bedside manner.

It is perhaps ironic that the person responsible for understanding disease was not a medical doctor. Louis Pasteur, born on the 27th of December 1822 in Dole, France; was a chemist and a pioneer of microbiology. First working in the field of molecular asymmetry, Pasteur moved on to studying microscopic life.⁶⁵ Pasteur demonstrated in that fermentation was caused by micro-organisms. It was during these experiments that Pasteur, and a young German chemist called Robert Koch formulated the germ theory.⁶⁶ The germ theory purports that most diseases are caused by micro-organisms, such as viruses and bacteria. His proposal to prevent micro-organisms from entering the body resulted in Joseph Lister developing antiseptic methods for surgery. Operating from this theory, Pasteur hypothesised that creating a weaker form of the disease to trigger immunity would cause inoculation. While this is by no means a new theory, Pasteur was the first to properly document the approach to be used. However it is unjust to discuss only Pasteur when Robert Koch, born on the 11th of December in Clausthal, Germany; contributed extensively to germ theory as well. While relatively younger than Pasteur, Koch's work was no less influential. A tribute to both men is that the German and French Centres for Disease Control are named after Pasteur and Koch respectively. Between them they created vaccines for anthrax, rabies, tuberculosis and cholera. Further Koch specialised germ theory by crafting his postulates.

⁶³ Such as Haemophilia. *Op cit* at 25.

⁶⁴ Such as Cholera. *Op cit* at 25-26.

⁶⁵ Walsh, "Louis Pasteur" in the *Catholic Encyclopaedia*; Robert Appleton Company; 1913.

⁶⁶ Ullmann, "Pasteur-Koch: "Distinctive Ways of Thinking About Infectious Diseases" (2007) *Microbe (American Society of Microbiology)* 2 (8) at 383 – 387.

Koch's postulates ask four questions before a micro-organism can be considered a pathogen.⁶⁷

While the final human comprehension of disease was born in a laboratory, thanks to the scientific method, the two subsequent examples of surgery and nursing illustrate how this came to affect the practice of medicine in the West.

In 1799, Humphrey Davy discovered the anaesthetic properties of nitrous oxide, and announced those findings in the year 1800. It would take 42 more years, and a very bloody American Civil War, before physicians decided to experiment with anaesthesia. The first recorded surgery under anaesthesia was performed by Crawford Long, born on the 1st of November 1815 in Danielsville, USA. Long observed that diethyl ether (commonly known as ether) caused the same physiological effects as nitrous oxide, and in 1842 excised a tumour from a patient, whilst she was under the effect of ether.⁶⁸ This was followed by the innovations of Joseph Lister in the field of antiseptic surgery. Joseph Lister was born on the 5th of April 1827 in Upton, England; and in 1867 he campaigned for the use of carbolic acid⁶⁹ as an antiseptic agent. Prior to this methodology, hospitals were notoriously unhygienic with accepted terms such as "Good old surgeon stink" to describe the smell from old surgeon frocks as well as no facility for washing the hands. This is because the prevailing belief was that infection was caused by bad air, or miasma. After studying Pasteur's reports on micro-organisms, Lister decided to experiment with carbolic acid, as it was the least harmful chemical solution he could think of, that was still effective. Lister also experimented by dipping cotton wool in carbolic acid and then applying the cotton wool to the wounds of an eleven year old boy. After the six week healing period he removed the bandage to discover that the boy's wound had healed cleanly, with no infection or risk thereof.⁷⁰ Subsequent to this discovery he published the *Antiseptic Principle of the Practice of Surgery*. These guidelines, although adapted for modern practice, remain in effect in this very day.

⁶⁷ Koch, "Untersuchungen über Bakterien: V. Die Ätiologie der Milzbrand-Krankheit, begründet auf die Entwicklungsgeschichte des *Bacillus anthracis* or Investigations into Bacteria: V. The Etiology of Anthrax Based on the Ontogenesis of *Bacillus anthracis*." (1876) *Cohns Beitrage zur Biologie der Pflanzen* **2** (2) at 277-310.

⁶⁸ Long, "An Account of the First Use of Sulphuric Ether by Inhalation as an Anaesthetic in Surgical Operations" (1849) *Southern Medical and Surgical Journal*, 5, at 705-713.

⁶⁹ Commonly known as Phenol.

⁷⁰ Lister, "On a New Method of Treating Compound Fractures, Abscesses, etc. with Observation on the Conditions of Suppuration" (1867) *The Lancet*; Volumes 89 ; Issue 2272 at 326-329 as well as Volume 90; Issue 2291 pages 95-96.

With the rise of surgery, where the patient was unconscious for the operation, as well as the implementation of antiseptic precautions; a new era was born in medicine. Prior to these developments surgery was accepted as being frequently fatal, while these improvements ensured routine surgeries could be completed safer and that the only risk lied in the procedure. There exists a menacing factor however, and that was that both procedures were completed on patients. And while we do not know whether they consented to the procedure, it can be assumed that they had no idea they were part of the study. The lack of consent from the patient, or the lack of informed consent, in that the patient understood why the conduct was made, ultimately resulted in one of the worst medical tragedies in the brief history of humanity.

The second massive development in medicine in the 19th Century was the rise of nursing. Nursing, as a profession, focuses on the care of patients, specifically in the post-operative state, where many patients need extensive and intensive care to ensure success. While nursing, in the form of assistants to the physician and nuns can be traced back to Ancient times, the rise of nursing as a profession is fairly recent.

Florence Nightingale, born on the 12th of May, 1820 in Florence, Italy; was the first person to critically approach the concept of patient care. While she was nursing before the Crimean War (1853-1856) it was during this war that she used statistics and history to usher in the concept of a professional nurse. There is something deeply ironic that battlefield medicine caused, or helped cause, some of the key surgical, pharmaceutical and frail care developments. The Crimean War was notable for the exceptionally poor logistics of English Command. This poor planning lead to a literal jam in delivery of medical supplies and evacuation of the wounded, causing the latter to stockpile within the port of Scutari⁷¹ while the former stockpiled in the Black Sea. It was in this atrocious environment that Florence Nightingale arrived at, in 1854. The situation that faced her, and her 38 volunteer nurses, was a makeshift hospital with almost no medicine, terrible hygiene and almost constant mass infections worsened by Army command's almost total apathy and indifferent to the situation.⁷² Using her influence, she appealed through *The Times of London* and was rewarded when a pre-fabricated hospital arrived, and was setup outside Renkioi.

It was during this period that Nightingale received the larger than life persona as the lady with the lamp, working tirelessly while others slept. Perhaps more concrete are her

⁷¹ Modern day Üsküdar, Turkey.

⁷² Gill, Gill and Gill, "Nightingale in Scutari: Her Legacy Re-examined" (2005) *Clinical Infectious Diseases* **40** (12) 1799-1805.

achievements in the Crimean. While no record exists of Nightingale arguing for better sanitation,⁷³ her quest to ensure adequate nutrition and proper supply did help ensure proper care of her wards. At the end of the war, once she reviewed the statistics, she came to realise the importance of hygiene and proper living conditions.

Ellis Shipp was born on the 20th of January 1847 in the Utah Territory, USA; she was one of the first female doctors in the USA, and the woman who founded the School of Nursing and Obstetrics in 1879 as well as the Desert Hospital Association. While not much information exists about her, she was instrumental in the training of midwives as well as educating mothers on basic medicine, so as to ensure they were the first line of medical knowledge.

What is essential for this discussion is to note that throughout this period it became accepted that nurses had the bedside manner and were responsible for caring for patients, while the physicians themselves were seen as noble scientists, pushing the boundaries of medical research. While the 1800's saw the birth of modern medical practice, with the inclusion of nurses and the rise of proper surgery, it also saw the rise of patient experimentation. And such experimentation shall unfortunately be a common theme as medicine in the 20th Century is analysed and evaluated.

2.2.3.4.3. Medicine in the 20th Century up to and including the 2nd World War (1900-1945)

The 20th Century witnessed the pinnacle of warfare in the First World War (1914-1918) and barely two decades later witnessed the next worst example in the Second World War (1939-1945) and accompanying the latter was accompanied the worst examples of human experimentation in human history. The 20th Century also saw the rise of the patient and her having human as well as patient rights as well as the ascent of ethical medicine and health care as a relationship between patient and doctor. For now the focus shall remain on medicine as strict science, and how that proposition resulted in serious violations of ethics and subsequently created human rights.

While the 20th Century saw the discovery of human blood types in 1901 by Karl Landsteiner, the invention of the EKG in 1903 by Willem Einthoven, and the discovery of Insulin by Frederick Banting and Charles Best in 1921 but to name a few,⁷⁴ this conversation shall rather focus on the impact of the two wars on the shaping of medicine and consideration of

⁷³ *Ibid* Gill, fn. 72 at 1802 -1805.

⁷⁴ In total the amount of medical discoveries for this period are in excess of a hundred.

health care. The reason for this linkage is because of the profound impact of both World Wars on the intellectual climate of the world.

The First World War was fought between the United States; Great Britain, her colonies and protectorates as well as her allies France and her colonies; Russia (until the Treaty of Brest-Litovsk) and Japan (The Triple *Entente*) against Germany and her colonies; the Austro-Hungarian Empire and the Turkish Empire (The Triple Alliance). While the war was predominantly fought in Western Europe, there was also an Eastern European theatre; a Mesopotamian theatre; a Persian theatre; an Anatolian theatre; a Southern and Eastern African Theatre and an Atlantic Theatre. There were some skirmishes in the Pacific but there was never significant German involvement in that region. Ultimately costing the lives of 22,477,500 persons (on the side of the *Entente*) and 16,403,000 (on the side of the Alliance) it was mankind's bloodiest war until the outbreak of the Second World War.

While the First World War had little direct impact on the world of medicine, except for the fast tracking of several vaccines, what happened right after the war had an incredible impact on the world of public health. In 1918 the entire planet faced a massive Influenza pandemic. Colloquially known as the Spanish Flu, it is estimated that at least 3% of the World's Population was infected (Around 50 Million people),⁷⁵ and was possibly responsible for more deaths than either AIDS or the Black Plague.⁷⁶ In the face of such a pandemic many states took significant public health steps in order to curtail the damage, including extensive quarantine and legal enforcement of personal hygiene, the most common example being the \$50 fine for sneezing in public in New York.

The fear of another pandemic, as well as the lessons learnt from the First World War caused a desire for knowledge, especially around how diseases were distributed. Unfortunately this desire for knowledge resulted in widespread state sanctioned medical experiments. This discussion shall focus on the three most severe examples leading up to and during the Second World War.

The following three tragedies occurred during and after the Second World War. The Second World War (1939 – 1945) was fought between the United Kingdom, her colonies and her

⁷⁵ Taubenberger and Morens, "1918 Influenza: The Mother of All Pandemics" (2006) *Centres for Disease Control and Prevention*; Archived on 1 October 2009 and accessed on 20 September 2012; available at www.ncbi.nlm.nih.gov/pubmed/16494711 and Patterson, "The Geography and Mortality of the 1918 Influenza Pandemic;" (1991) *Bull Hist Med.* **65** (1): 4-21.

⁷⁶ *Idem* Patterson at 4 as well as Barry, *The Great Influenza: The Epic Story of the Deadliest Plague in Human History*; Penguin Books; 2004.

protectorates; France until capitulation, followed by the Nationalist and Socialist French Underground; the Union of Soviet Socialist Republics excluding Bulgaria and finally the USA (the Allies) against the National Socialist Republic of Germany and her colonies; Italy and her colonies and the Imperial Empire of Japan (the Axis of Evil). While the war was focussed on the Western and Eastern European theatres there was also an extensive Pacific naval/marine campaign. Other notable theatres included Northern, Eastern and Southern Africa; Arabia and South-East Asia. The Second World War ultimately cost the lives of 61,000,000 (Allies) and 12,000,000 (Axis). In terms of bloodshed it was the bloodiest war in human history with the Eastern European campaign attributing around 6,000,000 deaths.

In 1932, the U.S Public Health Service initiated a massive clinical trial in Tuskegee, Alabama. The subjects of the test were about 600 poverty-stricken African American sharecroppers and farm hands, who were purposely infected with syphilis and left without treatment in order to establish the natural progression of the illness.⁷⁷ What makes this trial so despicable, apart from the fact that it ran until 1972, was that the subjects were never informed that they were infected with syphilis. They continued to live their lives normally and engage in sexual relations with their wives and other partners. What complicates matters even more was that many patients discovered they had syphilis and were openly lied to by the researchers. The subjects were also required to submit to painful spinal taps and were lied to about the procedures. At the conclusion of the study, about 30 years after it was confirmed that penicillin could cure syphilis and invalidating the study, the final toll was 74 of the original 399 men survived with 28 dying from syphilis and a 100 dying from syphilis related causes. Tragically at least 40 wives were infected with syphilis and 19 children were born with congenital syphilis. Dr John Heller, the director of the Public Health Service's Division of Venereal Disease famously argued that the doctors and nurses involved were merely following orders. The expression "Simply following orders," is one that will come up again and again.

Possibly the greatest tragedy from the Tuskegee trials was the fact that the study was no longer medically relevant, by the 1940's, but still continued simply to see what would happen. No prosecutions were brought against the men responsible, and no lawsuits were filed by the victims of this heinous crime. When Peter Buxtun blew the whistle on this corrupt

⁷⁷ Caldwell and Prince, "Aortic Regurgitation in the Tuskegee Study of Untreated Syphilis" (1973) *J Chronic Dis* 26 (3) at 187-194 and Shuman and Olansky *et al*, "Untreated Syphilis in the Male Negro; Background and Current Status of Patients in the Tuskegee Study" (1955) *Journal of Chronic Diseases* 543, Volume 2.

and atrocious experiment it was ended a day later.⁷⁸ Fortunately, in response to this, the US legislature passed the National Research Act which requires studies to detail the full procedure to test subjects. This however was done too little too late.

While it has been established that the US engaged in one severely ethically questionable human experiment at the time, the infamy resulting from that experiment would pale to the experiments run by the Nazi's⁷⁹ and the Japanese.⁸⁰

When the Nazi Party seized control of Germany in 1933, the leader of the party, Adolf Hitler, sought to eliminate threats to his Aryan vision.⁸¹ Threats to this vision included any racially impure person such as blacks, gypsies, dwarves, homosexuals, the mentally handicapped and Ethnic Jews. Of this target list, the latter two groups were almost exclusively targeted for extinction by the Nazis. While genocide and mass murder are terrible crimes, what made matters far more shameless was that actual physicians were involved in committing these war crimes. At the conclusion of the war, during the Nuremburg Trials, the matter of *United States v Karl Brandt, et al*⁸² proved to be a watershed in the conception and execution of medical ethics.

The Nazi medical genocide officially started against the mentally handicapped, the infirm and the mentally insane in 1933, with the passing of the Law on the Prevention of Genetically Defective Progeny, and was extended to the sterilisation of Jews, Roma people and homosexuals.⁸³ After about 4 years as many as 300,000 patients had been sterilised, and at the conclusion of the war records indicate that around 400,000 people were sterilised, many against their will and most without ever knowing the procedure happened.⁸⁴ What made

⁷⁸ An African-American statistician, William Carter-Jenkins, attempted to have the experiment stopped in 1968, but was unsuccessful. Carter-Jenkins would later found *The Drum Magazine*, which attempted to highlight and prevent racism in the USA.

⁷⁹ The National Socialist Party of Germany and in particular the Schutzstaffel (or the SS) were guilty of these extensive experiments.

⁸⁰ Unit 731, administered by Shirō Ishii.

⁸¹ The Aryan people, initially from the Kush region in India, were worshipped by the Nazi party as being racially pure and considered to be the complete human being.

⁸² *The United States v Karl Brandt, et al* (1946) Nuremburg also known as the Doctors Trial was prosecuted against 23 physicians who were actively involved in war crimes just prior to and during the Second World War.

⁸³ Gardella, "The Cost-Effectiveness of Killing: An Overview of Nazi 'Euthanasia'" (1999) *Medical Sentinel* 4 at 132-135.

⁸⁴ Dahl, "Selection and Destruction-Treatment of 'Unworthy to Live' Children in the Third Reich and the Role of Child and Adolescent Psychology" (2001) *Prax Kinderpsychl Kinderpsychiatr* 1; (50) at 170-191.

matters even worse was that many doctors felt the sterilisation procedure took too long, and sought way to hasten the procedure. Two doctors took it upon themselves to experiment and find faster ways. Karl Brandt, the personal physician to Adolf Hitler, was put in charge of the T-4 Euthanasia Programme, which was over-seeing this whole process. Brandt also determined that if a woman was impregnated by someone who was mentally handicapped or infirm, then that foetus would be aborted, and any children of such a union would be placed in the camps.⁸⁵ At his trial Karl Brandt justified his actions by saying “Any personal code of ethics must give way to the total character of war.” Brandt would be sentenced to death, by hanging, for his crimes. Carl Clauberg was another sterilisation fanatic, and was infamous for his experiments regarding x-ray sterilisation. While people, but mostly women, would wait for the experiments to start, they would be bombarded by X-rays or radiation, and this would frequently result in sterilisation and horrific burns. Clauberg died in Soviet custody, before the Doctor’s Trial.

The Nazi’s experimented on people in many other ways, including frostbite experiments where people of different ages were sent into the wild and studied while they froze to death, or were immersed in ice water until death. The Nazis also experimented with weapon wounds, poisonous gas, poisons, high altitude and organ transplants. Joseph Mengele was a particularly loathsome individual, who was notorious of conducting vivisections of his subjects, especially dwarves and twins. One of the more chilling stories was that Mengele once rounded up 14 pairs of twins at Auschwitz, promptly killed them, and then meticulously dissected them all. The most shocking part of the experiments performed by Mengele was that they were never even proper experiment. His notes were in an atrocious state and most of his hypotheses were disproven or impossible to prove.

Many of these atrocities were made public during the Doctors Trial, in 1946. 23 persons were charged with four counts each. Conspiracy to commit a war crime or crime against humanity, war crimes including human experimentation, crimes against humanity and membership of a criminal organisation (being the SS). Unfortunately the tribunal found the first charge (that of conspiracy to commit a crime against humanity or a war crime) beyond its jurisdiction.⁸⁶ 20 of the 23 accused were all medical doctors and all the accused were charged under counts 2 and 3.⁸⁷ Ultimately 7 accused were acquitted due to intervention by

⁸⁵ *Ibid* Dahl, fn. 84 at 170-175.

⁸⁶ *Ibid* Brandt, fn. 82 173-174.

⁸⁷ *Idem* Brandt at 8-18.

the US or USSR,⁸⁸ or due to lack of evidence.⁸⁹ 9 were sentenced to imprisonment but all sentences were eventually commuted.⁹⁰ And 7 were sentenced to death.

Of particular import, in the *Brandt v United States* case was proceedings devoted to the medical efficacy of the procedure, as well as extensive analysis of the ethics of the experiments. On page 65 of the judgement the Court finds that the work done was valuable for the evolution of science, and throughout the section the Court assesses the value of the research, especially the Typhoid research. The stance of the Court, after only determining the scientific value of the experimentation was: “How many people were sacrificed we cannot figure out today; how many people were saved by these experiments we, of course, cannot prove. The individual who owes his life to these experiments doesn’t know it, and he perhaps is one of the accusers of the doctors who assumed this difficult task.”⁹¹

Unfortunately the reasoning of the Court, once it decided the matter of the ethics of the experiment, it focused on the Hippocratic understanding of medical ethics.⁹² That meaning that the physicians’ ethical crimes were based around doing harm directly to the patient, and not necessarily the lack of consent or the pursuit of science. After judgement was delivered on the 19th of August 1947, the Nuremburg Court adopted the 6 points submitted to it by Leo Alexander, and added a further 4 points. While these 10 points on experimentation, called the Nuremburg Code, has little to no legal weight, it became the guiding standard for human experimentation in the United States and globally one the World Medical Association incorporated it, known as the Helsinki Declaration.

In order to effectively conclude the evaluation of medicine for the period 1800-1946, one must first understand the world view of the physician at the time. Medicine was viewed as a science, as it should be, but the outcomes of medicine were forgotten. Instead of treating illness, the physicians of the day were obsessed with understanding illness, and experimenting with it. While human experimentation remains, to this day, an essential step in medical evolution, the physicians of the time viewed all their patients, especially the poor patients or the morally infirm patients as experiments. The culmination of this thought was felt in the 1930’s when the two strongest countries in the world committed atrocities against their own population, unheard of since the Trans-Atlantic slave trade. It was hoped, at the conclusion of the Doctor’s Trial, that humanity would never see the horror perpetrated during

⁸⁸ In the event of Kurt Blome who did extensive cancer experimentation.

⁸⁹ *Ibid Brandt*, fn. 82 at 174; 171-300.

⁹⁰ *Idem Brandt* at 171-300.

⁹¹ *Idem Brandt* at 70.

⁹² *Idem Brandt* at 82- 86.

the Second World War. Unfortunately it was only once the attitudes concerning medicine changed, that the standard of medical practice followed suit.

Before navigating to the fruition of the doctor-patient relationship during the modern era, one first needs to touch base. In the period preceding the scientific revolution, doctors were seen, by in large, as servants of the community, walking the fine line between educating themselves and treating patients. With the rise of the scientific method, it has been observed, that the balance skewed towards scientific development. Now, one can understand this, as medicine was such an alien field, that it required a foundational understanding. But, as with most scientific fields, once the foundational information is discovered, it leaves the discoverer with more questions than answers, added to this the fact that practicing medicine was, in itself, scientific experimentation.

However this attitude of physician as a scientist first, has resulted in several atrocities. While the concept of the mad scientist is a clichéd stereotype, one has to consider the thought process and scientific method during the Tuskegee experiments, for instance. Physicians seemingly became obsessed with scientific advancement, and the fame that accompanies it, and were blinded to attempting to treat illness.

2.2.3.5. Medicine in the Modern Era (1946 – Present Day)

In the idyllic setting, one would imagine the Doctor's Trial setting a new standard for the practice of medicine. That the concept of patient autonomy, encompassing the rights the patient could expect, would supersede the scientific desire to understand illness. That, if a patient were to be experimented on, that they would fully understand why the experiment was happening. Unfortunately this was not the case, the 1950's and 1960's saw large scale human experimentation, and this is only that experimentation that is freely available. The USSR has several thousand documents that are under censorship or have been classified that would paint a different picture of human experimentation in the USSR. This is not considering the experimentation that was often performed in Third World Countries, at the supervision of large pharmaceutical companies.⁹³

This discussion shall focus on a watershed moment during the modern era, where the pursuit of scientific goals would finally take a backseat to the rights and interests of the

⁹³ Washington, *Medical Apartheid*; Anchor Books; 2006 at 390-393 as well as Kabler, "A Threat to the Nation and a Threat to Men: The Banning of Depo-Provera in Zimbabwe" (1981) *Journal of Southern African Studies* **24** (2) at 347.

patient. While this should come with a significant disclaimer, as several countries, like North Korea, still continue to experiment on humans; it changed the intellectual climate amongst medical researchers. The rationale changed from sacrificing anything for science to ensuring that the relationship between physician and patient would not be compromised at the expense of compromising the patient.

Project MKULTRA, running from 1953 until 1973, was an American covert research operation, run by the CIA.⁹⁴ The experiments themselves focussed on the use of mind altering substances, such as LSD. The tests were what substances could make people more and less effective, including the impact of alcohol and drugs on the human system and what chemicals could be used to coerce the truth out of individuals.⁹⁵ The reason why MKULTRA has a special significance comes from the lawsuits that followed the conclusion of the experiment. In terms of American Law, a member of the armed services cannot sue the US government for any harm that occurs during their service.⁹⁶ In 1987, the US Supreme Court affirmed this doctrine during the *Stanley*⁹⁷ decision. The majority of the Court held that allowing the soldiers to sue the military would infringe on the separation of powers. What are unique are two of the dissenting opinions in this matter. The first dissention, by Justice Brennan, focuses on the Nuremberg Code. Justice Brennan argues that the US military held that standard against the Germans, but continued to experiment against unwilling or unknown subjects. Following on from this was Justice O'Connor's dissent argues that no rule should insulate the perpetrators of unethical experiments against law suit. The *Stanley* decision, while unsuccessful in terms of legal liability, it served as a cautionary that unethical experimentation may result in legal liability. The focus on the Court was on the lack of informed consent.

While informed consent will be discussed in depth later,⁹⁸ it pertains to the patient having the right to both choose the treatment and to fully understand the consequences and after-effects of the treatment. While it has been observed that physicians since the 19th Century were more than willing to experiment without informing the patient, since the Second World

⁹⁴ The United States Senate, "Project MKULTRA, the CIA's Program of Research into Behavioural Modification. Joint Hearing before the Select Committee on Intelligence and the Subcommittee on Health and Scientific Research of the Committee on Human Resources;" 95th Congress; First Session; US Government Printing Office; 8 August 1977 at 2-4.

⁹⁵ *Ibid* Joint Hearings, fn. 94 at 5-7.

⁹⁶ *Feres v United States* 340 U.S. 135 (1950).

⁹⁷ *United States v Stanley* 438 U.S. 669.

⁹⁸ *Op cit* at 92 – 138.

War, this mind-set changed to allow the patient to decide treatment. This step, more than any other, caused the shift in intellectual climate that was discussed earlier. When the philosophical aspects of the doctor-patient relationship are discussed, this shift in ethical thinking shall be extensively explored and analysed.

2.2.3.6. Defining the Doctor-Patient Relationship

Following the evolution of the doctor-patient relationship throughout history, it is now possible to attempt to define the current understanding of the doctor-patient relationship.

The doctor-patient relationship is that special legal relationship that exists when a physician undertakes to treat a patient. While this relationship is inherently beneficial to the physician, safeguards have been created, especially through the *Nuremburg Laws*, which aim to protect the patient from this imbalance. These safeguards are patient autonomy, the belief that all patients have the rights to make decisions regarding their treatment and informed consent. Informed consent is an element of patient autonomy that gives the patient the right to demand full disclosure from the physician.

2.2.3.7. Conclusion

The purpose of this extensive evaluation was to ascertain the origin of the doctor-patient relationship, and to determine how this relationship changed throughout history. While this brief evaluation could not possibly hope to capture the sheer intricacies of neither the doctor-patient relationship nor the frequent conflict between religion and medicine. However, this discussion set out to generally evaluate the doctor-patient relationship, and in that it was successful.

While Ancient Greece saw the first ever recorded mention of the doctor-patient relationship, it can be presumed to have been in existence since pre-historic medicine. There is an inherent imbalance to the power relationship between a patient and a physician, normally because the physician can make the patient healthy again, and considering the strong link between pre-historic medicine and shamanism, and the birth of the doctor-patient relationship can be reasoned. While this link was forged between religion and medicine, the ancient Greeks reasoned that the link should be between nature and medicine. While they had no idea what caused illness, it was reasoned to be a condition of nature rather than a condition of the spirit. In the Medieval ages it was discovered that certain patterns exist, in relation to certain diseases. The prominent authors of the age also set about recording all

their knowledge, and when that knowledge entered Europe, it was considered perfected knowledge.

With the rise of the Scientific Revolution, that knowledge was critically evaluated and found wanting. There was a definite desire in Western medicine to know as much as possible about disease, including the treatment and prevention thereof. Scientists experimented with various materials and spent countless hours dissecting (and vivisectioning possibly) human bodies to determine how everything worked. Unfortunately this attitude affected the doctor-patient relationship. No longer was medicine seen as a way to alleviate suffering, it was seen as a pure science with an inexhaustible pool of test subjects. But this relationship could not last forever. In the wake of the tragedies of the 21st Century, those in charge of teaching medicine, practicing medicine and enforcing medical standards had to consider the weight of physicians as scientists, and came to the realisation that the doctor-patient relationship in such an event was derisive and incomplete.

It is submitted, that the doctor-patient relationship can be divided into two completely separate fields. The first is medical paternalism, founded on the principle of the physician knows best and acted upon through therapeutic privilege and acting without consent. The second is patient autonomy, founded upon the Nuremberg Code.

Currently the doctor-patient relationship is still in this period of transition. While the broadly unethical medical experiments seemed to have stopped, and in their place we have seen the ascension of patient autonomy, there is still much uncertainty as to what patient autonomy actually contains, and significantly how best to realise and obtain autonomy. While medicine has progressed from a relationship where the doctor was the dominant partner, to one where the doctor and patient are equal consenting partners in treatment, there exists a need to critically analyse the doctor-patient relationship from the two dominant perspectives that governs its existence.⁹⁹ This is why the discussion shall now focus firstly on the legal interpretation and application of the doctor-patient relationship, which governs the law behind the doctor and patient; and then on the ethically-philosophical interpretation and application which governs the rules doctors, hospitals and professional organisations set themselves to ensure professional growth and exceptional care.

⁹⁹ *Ibid* Carstens, fn. 1 at 288.

2.2.4. A CRITICAL LEGAL ANALYSIS OF THE DOCTOR-PATIENT RELATIONSHIP

2.2.4.1. Introduction

Armed with a definition and understanding of the doctor-patient relationship, the next logical step shall be to analyse the doctor-patient relationship, insofar as it operates within the law. While there are several ethical objections to juxtaposing an ethical relationship to a legal norm, said objections will be discussed during the ethical-philosophical critical analysis. The purpose of this critical analysis shall be to determine how, currently, South Africa approaches the doctor-patient relationship through interacting with the law. In other words, what precedents, acts and legal regulations administer the relationship?

Medical law in South Africa occupies a rather tenuous position. While most other legal disciplines can be easily consigned to contractual law, family law or administrative law; medical law cannot be so easily categorised. The commission of medical practice can reverberate in the law of delict, contractual law, human rights law, criminal law and constitutional law. Medical law can be defined as that branch of the private and public law that governs the various medical relationships, including the doctor-patient relationship, hospital-patient relationship, state-patient relationship and state-doctor relationship.¹⁰⁰ This step is especially pertinent considering that patient rights have only become broadly applicable in the latter half of the 20th Century. Further how has SA managed to legalise medical ethical conceptions, and is such legalisation to the benefit or detriment of the doctor-patient relationship.

The structure of this discussion shall be as follows: The doctor-patient relationship in South African law is primarily found in two legal disciplines, contract law and the law of delict.¹⁰¹ Therefore this discussion shall commence with a critical analysis of contract law and its interaction with the doctor-patient relationship. Following this the discussion shall then focus on the law of delict and its interaction with the doctor-patient relationship. Of primary importance will be the elements of fault and causation (as these two specifically pertain to the level of care given) but, as with the contract law discussion, all the elements shall be discussed and analysed. Armed with an understanding of how the doctor-patient relationship has impacted the law behind the practice of medicine, the discussion shall then shift to the medical professional, and how the elements of patient autonomy and informed consent has gone to protect the physician from a legal suit. It is submitted therefore, that the focus on this discussion shall initially focus on the elements of the law of obligations, before dealing with

¹⁰⁰ *Ibid* Carstens, fn. 1 at 4-5.

¹⁰¹ *Idem* Carstens at 283-284.

the defences that arise out of violations of obligations. After briefly concluding on the role of private law for the doctor-patient relationship the discussion shall then proceed to consider the role of legislation on the doctor-patient relationship, with special focus on the National Health Act.¹⁰² After this juxtaposition and comparison the discussion shall then be concluded in order to determine if the outcomes were achieved.

The outcomes for this discussion shall be a thorough legal understanding of the doctor-patient relationship through understanding the important role that the law of obligations plays on health care in South Africa; the impact of public law, such as the National Health Act on the existing law; a definitive answer of whether the current law surrounding the doctor-patient relationship can be extended to include a minimum service guarantee and finally concrete reasons for why the existing law pertaining to the doctor-patient relationship is not sufficient to extend the parties beyond that of doctor and patient, and possibly hospital.

A further outcome to be observed is the difficult position ethical considerations like the doctor-patient relationship and informed consent are placed in, when those ethical considerations are simply ramrodded into existing legal maxims and considerations. For particular import is how South African courts have completely misunderstood the importance of these considerations, and simply continued to decide cases on the existing law, instead of attempting to develop the law.

While it was mentioned at the start of this chapter, the following point must be reiterated. The role of the CRSA in the doctor-patient relationship will only be discussed in Chapter 3 of this thesis.¹⁰³ The purpose of postponing the constitutional analysis is to first understand the law as it is, before determining how the CRSA can interact with and better those laws.¹⁰⁴

2.2.4.2. The Law of Contracts

2.2.4.2.1. Introduction

In order to execute a legal contract in South Africa, four elements¹⁰⁵ have to be complied with namely: contractual capacity, consensus between the parties, legality and possibility.¹⁰⁶

¹⁰² National Health Act 61 of 2003.

¹⁰³ *Op cit* at 63-84.

¹⁰⁴ *Ibid* Carstens, fn. 1 at 283.

¹⁰⁵ Hutchinson *et al*, *The Law of Contract*; Oxford University Press; 2009 as well as Nagel (Ed), *Commercial Law*; 2006; Lexis Nexis at 37.

However these are not the only requirements necessary to conclude a contract. There also needs to be consensus on the terms or performance of the contract as well as consensus on the parties to the contract.

While this legal understanding on the execution of a contract has been around since 1652, the novel concepts of a doctor-patient relationship and specifically one based around patient autonomy is quite recent in South African law,¹⁰⁷ not to mention South African contract law. This has resulted in the unfortunate position where the elements of patient autonomy have been jammed into existing contractual requirements and elements. It will be shown that this action has resulted in severe detriment to the patient, especially through the illustration of *Afrox Healthcare Bpk v Strydom*.¹⁰⁸ This is currently the leading case on the doctor-patient relationship and the application thereof within the law of contract, and proves just how detrimental the current doctor-patient relationship application truly is.

This discussion shall focus on the elements of a contract, in order to determine whether the principles of the doctor-patient relationship, especially those of patient autonomy, have found application in the fundamental elements of concluding a contract. The purpose of this analysis is twofold. Firstly to determine whether a concept as complex as the doctor-patient relationship can simply be transposed onto existing law and secondly to determine if the standard of the doctor-patient relationship causes a minimum standard of care to exist that can be enforced against the doctor.

2.2.4.2.2. Consensus

The element of consensus can be described as the cornerstone element of a contract. Contracts by their very nature are based around the free consent of parties to undertake specific actions, which conversely separates them from a delict wherein the parties are forced to undertake restitutive action.¹⁰⁹ This element of consensus is further complicated by the nature of public law in South Africa.¹¹⁰ Because South Africa guarantees access to health care to all citizens and permanent residents, it is often difficult to ascertain when a contract comes into being between a patient and their treating physician, or the actual

¹⁰⁶ There is a fifth element, referred to as formalities, but this is an optional element unless the law requires formalities such as the contract should be in writing, which goes to the lawfulness of the contract.

¹⁰⁷ Bhana and Pieterse, "Towards a Reconciliation of Contract Law and Constitutional Values: *Brisely* and *Afrox* Revisited" 2005 *SALJ* 865 at 866-867.

¹⁰⁸ *Afrox Healthcare Bpk v Strydom* 2002 (6) SA 21 (SCA) also see the extensive analysis in Bhana (2005).

¹⁰⁹ *Ibid* Nagel, fn. 105 at 42 as well as Bhana (2005) at 866-870.

¹¹⁰ *Ibid* Carstens, fn. 1 at 309.

hospital they sign into. Generally speaking, when an offer is made and accepted, then a contract comes into being, however there is authority in South African law that creates special circumstances whereby offer and acceptance are almost negated.¹¹¹ What this effectively means is that where a patient interacts with a public hospital, the physicians who are responsible for her treatment do enter into a *de facto* contractual relationship with the patient. In other words, once the patient submits for treatment, the legal doctor-patient relationship comes into existence.

Significantly more important however is consensus as informed consent. While the term informed consent has been bandied about in this chapter, it has until now, lacked a proper definition. Informed consent is where the required consent transcends the simple agreement to a procedure, but requires the treating physician to explain the procedure and the outcomes (both positive and negative) to the patient.¹¹² Unfortunately, while this seems a straightforward position, informed consent has been awkwardly forced onto contract law (and the law of delict). The reason for this awkward situation is two-fold; firstly the concept of informed consent has become linked to therapeutic privilege, and has fallen into the common law defence of *volenti non fit iniuria*.¹¹³ Secondly, because of this link to *volenti non fit iniuria* is primarily a defence raised during the commission of a delict, and the use of informed consent for contractual law normally only arises when the patient is incapable of consenting.¹¹⁴ What can be concluded however is that informed consent is another level of consent that must be affected once consensus has been reached.

The marriage of therapeutic privilege and informed consent adds another wrinkle to the doctor-patient relationship, in that therapeutic privilege is completely contrary to the best interest of the patient, and patient autonomy.¹¹⁵ It accepts the very patronising position whereby the physician always knows best, and the patient is simply accepted to follow that opinion.¹¹⁶ As has been stated above, the doctor-patient relationship is a special relationship between a party that is inherently at a disadvantage (the patient) and another party who can

¹¹¹ *Godfrey v Paruk* 1965 (2) SA 738 (D) at 743 C as discussed in *ibid* Carstens, fn. 1 at 310-311.

¹¹² *VRM v The Health Professions Council of South Africa* (2004) 20 SAJHR 309 at 312.

¹¹³ The defence whereby the person who caused damage cannot be held liable because the 'victim' understood the risks but acted anyway. From the Latin for the willing cannot claim injury.

¹¹⁴ *Idem* Carstens at 313-315.

¹¹⁵ *Idem* Carstens at 316.

¹¹⁶ Bhana (2005) at 868-870.

completely control the negotiation and execution of the agreement (the doctor). This special fiduciary relationship is discussed at length by Christie.¹¹⁷

The first reported case where there was a question of consensus and informed consent was that of *Edouard*.¹¹⁸ The facts of this case are as follows: The Respondent's wife was admitted to a local hospital, in order to undergo a Caesarean section. During the procedure, the wife was also supposed to be sterilised, by undergoing tubal ligation. During the birth the sterilisation was not completed, and consequently the wife fell pregnant again, shortly after the birth. The Court was tasked with determining whether the applicant was liable for the cost of support for the fourth child, on behalf of the parents. Further the Court also had to determine whether general damages could be awarded for the non-patrimonial loss suffered by the wife of the Respondent. The Court used the waiver, signed by the wife, to prove that both parties had consented to the procedure being performed.¹¹⁹ But before one commences to laud the court for distinguishing between consent to perform a procedure and informed consent, it must be pointed out that the promised performance on the part of the applicant, namely the sterilisation, was never performed. If it unclear what the situation would have been had the wife been sterilised, but the operation failed.

It is submitted that while the law should seek to protect the patient in this relationship, or implement the concept of patient autonomy to provide the patient with more rights, it has in fact failed dismally at this task as can be seen from the case of *Afrox Healthcare Bpk v Strydom*.¹²⁰

Briefly the facts of *Afrox* were that the respondent, S, went to the applicant's hospital for a routine surgery. During the post-operative period one of the nurses employed by the applicant cleaned the sutures but mistakenly retied the bandages far too tight, resulting in the respondent losing his leg and suffering damages. The Court *a quo* found for the respondent hence the appeal. The Court found that there was no distinction between a supplier of medical care and a supplier of any other service.¹²¹ If one contextualises the finding it equates the doctor-patient relationship to any other client-distributor relationship. It further created the unfortunate position where the contract maxim of *caveat scriptor*¹²²

¹¹⁷ Christie, *The Law of Contract*; LexisNexis; 2001 at 320-322 which is completely summarised and applied in *idem* Carstens at 316-319.

¹¹⁸ *Administrator, Natal v Edouard* 1990 (3) SA 581 (A).

¹¹⁹ *Idem Edouard* at 596.

¹²⁰ *Ibid Afrox*, fn. 108.

¹²¹ See the discussion of *Afrox* in *ibid* Carstens, fn. 1 at 458-460.

¹²² Let the signor beware.

superseded informed consent. This case clearly indicates the difficult position the doctor-patient relationship exists in, in South African private law.

While the concept of informed consent is well established as an ethical discipline and an entrenched element of patient autonomy in the doctor-patient relationship, insofar as South African law is concerned it exists only to either bully the health care providers or to create liability. Where it should have been founded that the respondent lacked consent to have effectively concluded the contract, the court found that because he signed a document he did not understand, he forfeited all rights as a patient.

At the outset of the consensus discussion the point was made that once a doctor, in the public health sphere, consents to see a patient, then a contractual relationship exists between them, which translates into the doctor-patient relationship. As soon as this relationship comes into existence, then there is a duty upon the doctor to inform the patient completely, which is called informed consent. While exceptions such as therapeutic privilege exist, it is generally accepted to be incompatible with the fiduciary understanding of the doctor-patient relationship.¹²³ Unfortunately the *Afrox* case has completely muddied the waters around this conclusion. It is submitted that, according to *Afrox*, there exists no special relationship between doctor and patient.

2.2.4.2.3. Contractual Capacity

Contractual capacity is defined as the capability or competence of a person or group of people to form and conclude a contract.¹²⁴ While this requirement seems straightforward, it is imperative to define and discuss the legal concept of a person. A person is defined as a legal subject, who can bear legal responsibilities and rights.¹²⁵ The concept of a person is further divided into a natural person, who is a human being; and a juristic person being an artificial person created by the law. A juristic person must be a society, with a fixed amount of members, which can exist separately from its members. The most common example of a juristic person is a company.¹²⁶

When one considers the interaction between the doctor-patient relationship and contractual capacity, one is generally faced with regulations pertaining to consent, and in particular the

¹²³ *Ibid* Carstens, fn. 1 at 313-315.

¹²⁴ *Ibid* Nagel, fn. 105 at 37.

¹²⁵ Davel and Jordaan, *Law of Persons*; Juta; 2010 at 3.

¹²⁶ *Idem* Nagel at 76 as well as *idem* Davel at 3-6.

freedom to enter into contracts. Juxtaposed on the doctor-patient relationship, it can be viewed as the freedom to select. Either the patient being able to choose which physician they would want to treat them, or the physician being allowed to choose which patients to see and treat. This freedom to contract is founded on the principle of *pacta sunt servanda*.¹²⁷

This discussion is especially pertinent in the public health sphere of South Africa, where it is mandated that doctors cannot refuse treatment. The question that rises from this point however, is does the patient forge a contract with the treating doctor, or does the patient enter into a contract with the state, as the provider of public health care,¹²⁸ who steps into the role of a quasi-doctor-patient relationship. However, the public health system in South Africa is collapsing. Hospitals are tearing at the seams, and the sheer number of patients seeking health care will only increase,¹²⁹ and here it is submitted is another clear illustration of the inherently iniquitous doctor-patient relationship, except in this case the rub runs both ways. As was illustrated above, the state plays the role of supervisor and distributor of health care, while the doctor is simply tasked with treatment. While the ethically religious doctor may object to certain treatments, the system is geared towards performing any treatment asked of the physician.

Unfortunately the public health care patient is still faced with a much graver situation. With the thriving private health care enterprise in South Africa, it can be presumed that the average public health care consumer is too poor to afford private health care. From this inherent weakness, the public patient who is seriously ill simply reports to a public hospital and must accept whatever treatment is doled out.¹³⁰ If the workforces are rude, or the nurses apathetic or the hospital *sans* beds, the patient must simply endure the undeserved hardship while attempting to heal them. It is in light of this that a brief contemplation of the *Afrox* case,¹³¹ becomes so much more befuddling. While *Afrox* was not decided in the realm of public health care, the principle can still be distilled and contextualised in the realm of public health care. And that principle is that the doctor-patient relationship is no different from any

¹²⁷ From the Latin for agreements must be honoured. For a detailed understanding of the concept see the case discussion of *Bank of Lisbon and South Africa Ltd v De Ornelas* 1998 (3) SA 580 (A) in *ibid* Carstens, fn. 1 at 323 footnote 113.

¹²⁸ *Idem* Carstens at 325.

¹²⁹ *Idem* Carstens at 325-327 as well as *op cit* at 136-138.

¹³⁰ *Ibid* Carstens, fn. 1 at 327-328.

¹³¹ *Ibid Afrox*, fn. 108.

other contractual relationship, which effectively means the patient can simply elect to ignore or refuse treatment.

In order to successfully conclude the discussion on the freedom of contract, in the context of contractual capacity, it is necessary to highlight the nature of the doctor-patient relationship in the public health sphere. Where the private sphere allows the discerning patient to research and search for a treating physician, the public sphere cannot allow such luxuries.¹³² In line with this, it can be concluded that the nature of the parties in the public health sphere cannot, as *Afrox* found, be similar to any other contract. The state plays the role of the cook in *Oliver Twist*, being approached by the poverty stricken of South Africa and asked to dole out a little more; and because of this significant power position, its power as a contracting party needs urgent reflection.

2.2.4.2.4. Legality

On the face of it, legality seems simple enough to define. Legality is the principle of contract law that requires agreements to be lawful and legal, so a contract to murder someone would be illegal and therefore could not be a valid contract.¹³³ Two broad illegalities exist, a contract that is illegal to statutory provisions¹³⁴ and a contract that is illegal due to common law violations. Contracts contrary to common law are also further subdivided as contracts contrary to the *boni mores* of society¹³⁵ and contracts that are contrary to public interest.¹³⁶ To this a third category should be added, contracts that are executed in bad faith.¹³⁷

2.2.4.2.4.1. *Public Interest*

Public interest is one of the few discussions, in this chapter, that necessitate the application of the CRSA, specifically S 7 of the CRSA. Section 7 of the CRSA places a duty upon the state to “respect, protect, promote and fulfil the rights in the Bill of Rights.” This quote, it can

¹³² *Idem* Carstens at 234-325.

¹³³ *Ibid* Nagel, fn. 105 at 80-81.

¹³⁴ For example a contract of sale that allows the sale of liquor to a minor.

¹³⁵ *Ibid* Nagel, fn. 105 at 81.

¹³⁶ *Idem* Nagel at 81.

¹³⁷ While the requirement that contracts be fair and reasonable have been rejected by the courts in the matter of *Brisley v Drotosky* 2002 (4) SA 1 (SCA), it is still pertinent to discuss the value of reasonableness in the context of South African medical law.

be argued, best reflects the concept of public interest. Because S 2 of the CRSA places the CRSA at the apex of South African law, any conducts or agreements that fails to respect, protect, promote or fulfil human rights, it would be contrary to public policy.¹³⁸ In the matter of *Ex parte North Central and South Central Metropolitan Substructure Councils of the Durban Metropolitan Area*¹³⁹ the Court held that the concept of public interest is almost impossible to define clearly, as it frequently exists of conflicting and differing elements. What the Court does find however is that public interest acts as a yoke connecting the private law of obligations to the public law considerations. Carstens holds that all health legislation is, by its very nature, public-interest legislation.¹⁴⁰

It is submitted however, that the current status of the doctor-patient relationship and specifically informed consent, is openly contrary to the public interest. While it may be argued that the inherent iniquitousness of the public health system is the *status quo* for public health systems throughout the world; the reasoning that a patient is no more entitled to special protection than someone purchasing a motor vehicle clearly flies in the face of public interest. While S 27 of the CRSA provides an individual with the right to access to health care, it is submitted that S 12 of the CRSA¹⁴¹ provided all patients in South Africa with the protection of patient autonomy. This protection ought to have been extended in the *Afrox* matter,¹⁴² but the Court failed to properly apply the principles of patient autonomy *vis-à-vis* the doctor-patient relationship.

2.2.4.2.4.2. *Boni Mores*

Boni Mores can be defined as public policy. While it is exceptionally difficult to *prima facie* distinguish between public policy and public interest, it is submitted that through analysing the decision in *Friedman v Glicksman*¹⁴³ the position will be clarified.

The definition for *boni mores* was elucidated in the matter of *Eerste Nasionale Bank van Suiderlike Afrika Bpk. V Saayman NO*.¹⁴⁴ The facts, which are succinct to earlier discussions

¹³⁸ *Ibid* Carstens, fn. 1 at 289-290 and Barnard, "A Different Way of Saying: On Stories, Text, A Critical Legal Argument for Contractual Justice and the Ethical Element of Contract in SA" 2005 *SAJHR* 279 at 282-284.

¹³⁹ *Ex parte North Central and South Central Metropolitan Substructure Councils of the Durban Metropolitan Area* 1998 (1) SA 78 (LCC) at XXXX.

¹⁴⁰ *Idem* Carstens at 291.

¹⁴¹ *Op cit* at 81-82.

¹⁴² *Ibid Afrox*, fn. 108.

¹⁴³ *Friedman v Glicksman* 1996 (1) SA 1134 (W).

on contractual capacity and consensus, are as follows: An elderly woman, of 85, of was almost completely blind and deaf was asked, by her son, to sign documents. Unbeknown to the woman, who was told the documents were share options in favour of her son, the documents were actually severely prejudicial to her interests and her rights as a shareholder. The documents themselves were never explained to the old woman, and she was never able to read through the documents. While the majority of the Court held that the old woman lacked contractual capacity, the minority judgement critically analysed the concept of *boni mores* and their relation to public interest.¹⁴⁵ The minority judgement approached *boni mores* not as the concrete legal perception of public interest, but rather as the intangible ethics around a contract. So while it may not be black letter law that invalidates the contract, the lack of ethical consideration that directly impacts society's values of justice, fairness and reasonableness should result in the contract being declared unlawful. In his summary of the decision, Carstens focuses on the coupled nature of *boni mores* and public interest, as well as *bona fides* and reasonableness,¹⁴⁶ but he goes on to lament that the element of *boni mores* has frequently been incorporated with public interest, or simply confused for public interest.¹⁴⁷ Returning to the leading case on contractual doctor-patient relationships, that of *Afrox*,¹⁴⁸ wherein the Respondent argued that the waiver was *contra boni mores* because the legal duty, in terms of informed consent, was on the hospital to draw his attention to the waiver.¹⁴⁹

To summarise the position this far, the Court's (in *Afrox*) abject failure to recognise the principles of the doctor-patient relationship in South African law as well as the necessity of informed consents as the corner stone of patient autonomy, and therefore of the doctor-patient relationship; can now be compounded with the Court's unreasonable and mind boggling refusal to consider the *boni mores* that result from patient autonomy and attempting to balance the doctor-patient relationship.¹⁵⁰ It is submitted that the atrocities committed during the earlier half of the 20th Century were caused, in part, by *boni mores* not being considered. Had the American government canvassed the citizenry, it would be unlikely that the Tuskegee Syphilis Trials would have commenced.

¹⁴⁴ *Eerste Nasionale Bank van Suidelike Afrika Bpk. V Saayman NO 1997 (4) SA 302 (SCA).*

¹⁴⁵ *Idem Saayman* at 319. For a comprehensive analysis of the judgement see *Ibid* Carstens, fn. 1 at 297-301.

¹⁴⁶ *Idem* Carstens at 301.

¹⁴⁷ Bhana (2005) at 893-895.

¹⁴⁸ *Ibid Afrox*, fn. 108.

¹⁴⁹ *Idem* Carstens at 302-302 and 467-470.

¹⁵⁰ Barnard (2005) at 284-286 as well as Bhana (2005) at 874-875.

And while this discussion does not mean to equate a gross human rights violation with the decision in *Afrox*, it must be worryingly noted that the Court in *Afrox* did so completely ignore the basic tenets of the doctor-patient relationship that it almost completely invalidates the application of the doctor-patient relationship to contractual law.¹⁵¹

Fortunately where *Afrox* has failed the basic tenets of the doctor-patient relationship, the case of *Friedman*¹⁵² sought to apply, at the very least, the concept of *boni mores*. The facts of *Friedman* were that the plaintiff consulted with the defendant, a specialist gynaecologist, regarding her pregnancy. The plaintiff made it clear to the defendant, who agreed, that she wished to terminate the pregnancy if the risk of the foetus being born abnormal or disabled would be greater than the normal risk. This agreement was then concluded reflecting this. After a battery of tests the defendant advised his patient, the plaintiff, that there was no greater risk than normal for the foetus to be born abnormally or disabled, and that it was “quite safe for her to proceed to full term.”¹⁵³ The baby was unfortunately born with disabilities, and the plaintiff alleged that the defendant had acted negligently in his advice. Of particular import for this discussion however were the plaintiff’s allegations that the failure to correctly diagnose the foetus was a breach of the contract between herself and the defendant.

The court first had to decide whether the agreement between the parties was *contra bonos mores*. Using the (now repealed) Abortion and Sterilisation Act, the Court held that abortions were permissible if the birth of the child would be born with a significant mental or physical defect, provided the decision rests with the mother.¹⁵⁴ This position is commendable, as the Court actually subjected a contract to the existing public policy, and found that an agreement to terminate a foetus was in not contrary to public opinion.¹⁵⁵ The Court should be further commended for carefully applying the *boni mores* principle to a very emotive question, that of wrongful life, and justifying its findings. While it is unsatisfactory that there was no discussion of the doctor-patient relationship as it pertained to the agreement, the *Friedman* matter can still be commended for applying some of the contract rules surrounding the doctor-patient relationship.

¹⁵¹ Barnard (2005) at 290-292.

¹⁵² *Ibid Friedman*, fn. 143.

¹⁵³ *Ibid Carstens*, fn. 1 at 737.

¹⁵⁴ *Idem Carstens* at 439-440.

¹⁵⁵ *Idem Carstens* at 441.

2.2.4.2.4.3. *Bona fides*

Bona fides can be defined as the requirement that a contract should be concluded in good faith. While *bona fides* is a foundational principle of the law of contract, it is not a physical requirement of lawfulness, e.g. a contract that will result in the eviction of a mother and child from a house, while not in good faith, is not illegal *per se*. In the matter of *Brisley*¹⁵⁶ the Court, while finding that the *bona fides* requirement isn't binding, also laments that the concept has lacked definition and structure in the South African context.¹⁵⁷

Bona fides is an interesting case study for this thesis, as they are themselves an ethical concept that seeks definition in the existing law, much like the doctor-patient relationship. *Bona fides* can currently be argued to underpin the two-pronged test for lawfulness that is discussed directly *supra*.¹⁵⁸ It is submitted that the doctor-patient relationship, while also an element of the good faith between a doctor and patient, benefits from a more concrete position of being both an element of public interest as well as public policy.

2.2.4.2.4.4. *Conclusion*

At the outset of this discussion it was stated that legality seems to be a simple enough consideration. If a contract is not statutorily illegal, the offending clause is then transposed against the interests of society and the values of society. While both these terms are problematic to define, and lose meaning through definition, they can be linked with the principle of *bona fides* and more importantly interrelated with the values of the CRSA.

It will be submitted, *infra*, that the doctor-patient relationship pertaining to patient autonomy is guaranteed in the CRSA.¹⁵⁹ This creates the situation whereby medical waivers need to be critically evaluated against the values of patient autonomy in order to ensure the patient is adequately protected against malpractice and therapeutic privilege. Conversely, the doctor can also rely upon this legality to argue that informed consent was given or that medical necessity predicated the need to agree to a contract, in the event of an emergency.

2.2.4.2.5. Possibility

¹⁵⁶ *Ibid Brisley*, fn. 137.

¹⁵⁷ *Idem Brisley* as well as Bhana (2005) at 899-893.

¹⁵⁸ *Ibid Carstens*, fn. 1 at 294-296 as well as the decision of *Mort NO v Henry-Shields Chiat* 2001 (1) SA 464 (C) at 474-475.

¹⁵⁹ *Op cit* at 81-82.

The final element to be critically analysed is that of possibility. This element requires that the undertaking is actually physically possible or determinable.¹⁶⁰ The very nature of the doctor-patient relationship almost precludes this agreement, as the contract between doctor and patient is to heal the patient to the best of the physician's abilities.

2.2.4.2.6. Conclusion

The purpose of this discussion was to determine how the elements of a contract interact with the elements of the doctor-patient relationship, specifically those related to patient autonomy. Unfortunately this discussion has proven that, with regard to the elements of capacity and consensus, that there is much work to be done. Whereas informed consent should be an advanced form of consensus, it seems to be equated to the general consent granted when signing a contract.¹⁶¹ And while the patient in a public hospital should have the right to choose physicians, or seek alternative care if they are upset with the current therapy they are bound to suffer under a hostile public health system.

Unfortunately the *Afrox* case¹⁶² has also, for the time being, removed the only possible defence a patient would have under contract law. While it is submitted that the element of lawfulness contains strong link to the CRSA, and that any conduct incompatible with the CRSA is not in the public interest, nor in the *boni mores* of society.¹⁶³ However the Court in *Afrox* failed to decide upon this matter, and simply continued along the line that no special contractual relationship exists between a nurse and hospital, *in casu*, and a patient.

It can be concluded, that the elements of a valid contract may contain principles of the doctor-patient relationship, but those principles carry almost no legal weight currently, and cannot be used to enforce a minimum standard upon the treating doctors.¹⁶⁴

2.2.4.3. The Law of Delict

2.2.4.3.1. Introduction

¹⁶⁰ *Ibid* Nagel, fn. 105 at 86-87.

¹⁶¹ *Op cit* at 43-44 and 47-49 for the discussion on *Strydom*.

¹⁶² *Ibid Afrox*, fn. 108.

¹⁶³ Bhana (2005) at 893-895.

¹⁶⁴ *Ibid* Carstens, fn. 1 at 377 and Bhana (2005) at 894.

The second branch of law, under the law of obligations, is the law of delict. A delict can be defined as that branch of private law that governs the relationship between people, where one person causes another person's legitimate interest to be infringed. When such infringement occurs and damage is suffered, the person causing damage has an obligation to compensate the sufferer.¹⁶⁵ There are five elements to establish the existence of a delict namely: conduct, wrongfulness, causation, fault,¹⁶⁶ and loss or damage.¹⁶⁷

Due to the ever fluctuating and mutable nature of the law of delict, especially when it is applied to medical law, it is submitted that the elements of the doctor-patient relationship, specifically that of patient autonomy, have been better applied. This is because civil wrongdoing, as Carstens points out, always relates to the balance of power.¹⁶⁸

Therefore the structure of this discussion shall commence with a critical analysis of the elements of a delict, with the fundamental principles of the doctor-patient relationship applied to each one where relevant. Following this the principles of the doctor-patient relationship shall be applied to necessity and vicarious liability.¹⁶⁹ This is because these two concepts in the law of delict utilise special interpretations and applications of the doctor-patient relationship, and further assist in proving whether the state has a duty to provide an adequate standard of care.

The outcome of this application shall be to determine how the doctor-patient relationship has been understood within the concept of a delict, in medical law, and to contrast this understanding with the deficiency of doctor-patient relationship elements in the law of contract.

2.2.4.3.2. Conduct

Conduct can be defined as any act or omission by a human being, or a juristic person through its members.¹⁷⁰ For the law of contracts, the doctor-patient relationship comes into existence as soon as a doctor consents to see a patient, so it can be expected that once an

¹⁶⁵ Neethling, Potgieter and Visser, *Law of Delict*; LexisNexis; 2005 at 3-5.

¹⁶⁶ Either negligence (*culpa*) or intention (*dolus*).

¹⁶⁷ *Ibid* Carstens, fn. 1 at 495 as well as *idem* Neethling at 3-5.

¹⁶⁸ *Idem* Carstens at 489.

¹⁶⁹ The Latin maxim that equates lack of skill to negligence.

¹⁷⁰ *Idem* Carstens, fn. 1 at 496 as well as *idem* Neethling at 23-24.

act of treatment is committed then the doctor-patient relationship comes into existence for the law of delict.

In the matter of *Stoffberg v Elliott*¹⁷¹ the Court held that by simply entering a hospital or doctor's office, a man does not consent to surgical treatment, whether such treatment is medically necessary or no.¹⁷² This situation does not exclude medical necessity however. However, the Court in *Broude v McIntosh*¹⁷³ held that where the physician intended to heal the patient, they should not be held liable for making a simple omission or failing to explain the full detail of a procedure to a patient. This viewpoint is, with respect, completely incorrect. The principle of "absolute security of the person"¹⁷⁴ is one that predates the CRSA, which also provides all individuals with a right of "freedom and security of the person."¹⁷⁵ Carstens correctly points out, that while informed consent is an essential element to providing treatment, as per *Stoffberg*, it is frequently overlooked by physicians.¹⁷⁶ The arguments raised by physicians that the patients wouldn't understand or couldn't understand as well as, in the public sphere especially, that there simply isn't enough time to explain the complete procedure are, with respect, entirely without merit. The issue faced in South Africa, is that it is far simpler for doctors and hospitals to hang indemnities and waivers outside their premises, to be signed upon entry, than to ensure proper medical care is given. And while the State attempts to enforce this informed consent requirement,¹⁷⁷ it is still met with an almost total disregard until the patient is harmed, and salvaging the doctor-patient relationship is too late.¹⁷⁸

2.2.4.3.3. Wrongfulness

Wrongfulness can be defined as whether the public opinion and sentiment, in light of the CRSA, would disapprove of the conduct.¹⁷⁹ As was observed during the discussions on the

¹⁷¹ *Stoffberg v Elliott* 1923 CPD 148.

¹⁷² *Ibid* Carstens, fn. 1 at 500.

¹⁷³ *Broude v McIntosh* 1998 (3) SA 60 (SCA).

¹⁷⁴ *Idem* Carstens at 502.

¹⁷⁵ Section 12 of the CRSA.

¹⁷⁶ *Idem* Carstens at 502-503.

¹⁷⁷ *Op cit* at 78-83.

¹⁷⁸ *Idem* Carstens at 503 with special attention to footnote 34.

¹⁷⁹ *Ibid* Neethling, fn. 165 at 39-41 as well as *Van Duivenboden v Minister of Safety and Security* [2001] 4 All SA 127 (C).

lawfulness requirement of contract law, this is an area where the law may seem incredibly simple, but is frequently misunderstood.¹⁸⁰ The *locus classicus* for wrongfulness is the matter of *Carmichele*.¹⁸¹ The Court held in this case that the CRSA remains the supreme consideration for wrongfulness, especially if that wrongfulness is found in wholly in the common law.¹⁸² It must be stressed that the CRSA, and in particular the Bill of Rights, should be the sole consideration for wrongfulness. The *boni mores* and the legal convictions of the community still need to be seriously considered before a decision on wrongfulness can be taken.¹⁸³

While wrongfulness is straightforward when the law has been broken, it takes a different character once ethical considerations come into play. As was seen, *supra* with the lawfulness requirement for contracts, the Courts have tended to err with specific regard to medical ethics and especially in the case of patient autonomy as an element of the doctor-patient relationship.¹⁸⁴ Medicine unfortunately operates in a sphere of calculated risks and where success is not always certain.¹⁸⁵ Even the concept of a routine surgery, such as removal of wisdom teeth or an appendectomy, carries serious and significant risk to the patient. It is in line with these risks that informed consent is of the utmost importance. If the patient can be informed of the procedure completely, including the risks involved and the benefits conferred, then the calculated risk of wrongfulness could be mitigated by both Section 12 of the CRSA and the *boni mores*. It can be argued that if doctors trusted their patients more, and take the time to communicate decisions to the patient, then South Africa would see far less frivolous law suits and also increase the confidence of doctors. Further, such steps would also ensure more balance to the doctor-patient relationship, which would recreate the trusting and forgiving relationship between patient and doctor.¹⁸⁶

¹⁸⁰ *Ibid* Carstens, fn. 1 at 515.

¹⁸¹ *Carmichele v Minister of Safety and Security (Centre for Applied Legal Studies Intervening)* 2001 (4) SA 938 (CC).

¹⁸² *Idem Carmichele* at par 56 – 57.

¹⁸³ *Idem* Carstens at 516-518 as well as Leinius and Midgley, “The Impact of the Constitution on the Law of Delict;” 2002 *SALJ* 19.

¹⁸⁴ *Op cit* at 132-136.

¹⁸⁵ South African Law Commission, *Working Paper 51 “Limitation of Professional Liability”* 1989 (Project 70) in *idem* Carstens at 521-522.

¹⁸⁶ It is not impossible to conclude that a trusted physician who admits to making a mistake, and assists in the rectifying of the mistake or satisfaction thereof, would be more trusted than a physician who hides behind armies of attorneys and an indemnity waiver.

2.2.4.3.4. Causation

In order for an unlawful conduct to become a delict, that conduct must cause the victim actual harm (factual causation) and be sufficiently linked to the conduct in order to be liable for the loss (legal causation).¹⁸⁷ The test for causation is the *sine qua non* test, whereby the Court asks whether the harm would have occurred despite the conduct.¹⁸⁸

In the matter of *Silver*¹⁸⁹ the Court had to determine whether the causation for medical malpractice was invalidated by an external factor significantly contributing to the harm. In this case, the plaintiff sued based on a bedsore turning septic and argued the sepsis was caused by the nurses' failure to adequately care for him. The defendant responded by raising several factors that significantly contributed to the formation of the bedsore, including the diabetes of the plaintiff. The court held that if there was a contributing cause to the harm suffered, the defendant could not be seen as the cause of the harm.¹⁹⁰ It must be stressed that the contributing factors in *Silver* were extraordinary, and materially affected the *sine qua non* test. Had the contributory causes only slightly expedited the bedsore or faintly increased the bedsore occurring the court would have to have reasoned differently.

For the purposes of the doctor-patient relationship, serious thought has to be given to the impact of these alternative causes. As was discussed *supra*,¹⁹¹ under wrongfulness, medicine operates in the field of calculated risk. This is why the physician should seek to eliminate as many of these risks as possible.¹⁹² This is why taking a comprehensive medical history is essential for the successful practice of medicine. Even if this medical history is used to defend a claim against the physician, it significantly reduces the chances of unforeseen circumstances.¹⁹³

¹⁸⁷ *Muller v Mutual and Federal Insurance Co Ltd* 1994 (2) SA 425 (C) as well as *ibid* Neethling, fn. 165 at 159-160.

¹⁸⁸ *Ibid* Carstens, fn. 1 at 509 as well as *Minister of Police v Skosana* 1977 (1) SA 31.

¹⁸⁹ *Silver v Premier, Gauteng Provincial Government* 1998 (4) SA 569 (W).

¹⁹⁰ *Idem Silver* at 575-576 as discussed in *idem* Carstens at 830-831.

¹⁹¹ *Op cit* at 78-83.

¹⁹² *Ibid* Carstens, fn. 1 at 512-515.

¹⁹³ *Louwrens v Oldwage* 2006 (2) SA 161 (SCA).

2.2.4.3.5. Fault

Fault can be divided into two forms of fault, *culpa* (negligence) and *dolus* (intent). While intentional malpractice is not unheard of it is far rarer. Intentional harm requires the treating physician to purposely seek to harm the patient and can be linked with the Tuskegee Syphilis experiment or the Nazi human experimentation, and can be linked more with criminal assault than medical malpractice.¹⁹⁴

Culpa is the more common form of fault in medical malpractice, and is the result of the physician failing to reasonably foresee and prevent the harm caused by her actions, and this test is referred to as the reasonable person test.¹⁹⁵ Fault in itself is deeply personal, and as such cannot really be attributed to lapses in the doctor-patient relationship or the doctor-patient relationship as a whole.

2.2.4.3.6. Loss or Damage

Loss or damage is the actual harm caused by the conduct. This harm can take two forms, patrimonial loss which is the actual pecuniary loss suffered by the patient and non-patrimonial loss which relate to non-financial harm such as emotional suffering or disfigurement.¹⁹⁶

It is difficult to link the doctor-patient relationship to actual harm. The reason behind this is once harm is suffered the doctor-patient relationship is negated. The doctor-patient relationship has been stated to be that relationship of trust between the physician and the patient, built on the foundation that the physician would heal the patient to the best of their ability.¹⁹⁷

2.2.4.3.7. Conclusion

It has been submitted that the law of delict has proven to be much more conducive to the doctor-patient relationship. It is uncertain why this dichotomy exists. If anything the doctor-

¹⁹⁴ *Ibid* Carstens, fn. 1 at 522.

¹⁹⁵ *Kruger v Coetzee* 1966 (2) SA 428 (A) and *idem* Carstens at 522-523.

¹⁹⁶ *Idem* Carstens at 523-537 as well as *ibid* Neethling, fn. 165 at 195-201.

¹⁹⁷ *Op cit* at 35-38.

patient relationship would seemingly operate within contract law far better. It can be presumed that the elements of a delict are more open to interpretation and reinterpretation and those delictual matters are decided *de novo*. Contractual matters on the other hand are subjected to a closed list of defined and interpreted rules and every matter is juxtaposed to those rules.

It can be concluded that the law of delict is more open to the elements of the doctor-patient relationship and this explains why the tenets of the doctor-patient relationship have found more application in the law of delict.

2.2.4.4. Medical Necessity

Necessity is a defence that can be raised against unlawfulness. It is based around the proposition that certain acts, while unlawful or unethical, is permissible because prohibiting the act will result in imminent harm or death. The *locus classicus* for necessity is the English case of *R v Bourne*.¹⁹⁸ In this case, a surgeon instigated an abortion on a girl of 15, because the baby was conceived from a rape. The surgeon also believed that the life of the girl was at risk because of the pregnancy. *Bourne* also found that there needs to be a threat to the life of the patient, as a threat to the health of the patient is not enough.¹⁹⁹

Struass²⁰⁰ argues that only three grounds exist in South African law: 1) where the patient consents to the intervention; 2) *negotiorum gestio* which allows a doctor to administer emergency care where the patient is incapacitated or unconscious and 3) where the interests of society are at stake such as during quarantine. He argues that *Stoffberg*²⁰¹ creates a certain absolute rights that are not dependant on statute or contract. Strauss's argument should be juxtaposed against the CRSA, which contains the right to freedom and security of the person,²⁰² but also contains a limitation clause²⁰³ that results in none of the rights in the Bill of Rights being absolute.

This situation is best explained through the twin cases of *Xaba*²⁰⁴ and *Gaqa*.²⁰⁵ While both these cases will be extensively discussed *infra*,²⁰⁶ the both decisions dealt with when a

¹⁹⁸ *R v Bourne* [1938] AEE ER 615 (CC).

¹⁹⁹ *Idem Bourne* at 617-618 as well as *ibid* Carstens, fn. 1 at 541.

²⁰⁰ Strauss, *Doctor, Patient and the Law: A Selection of Practical Issues*; Van Schaik; 1991 at 31.

²⁰¹ *Ibid* Stoffberg, fn. 171.

²⁰² Section 12 of the CRSA.

²⁰³ Section 36 of the CRSA.

²⁰⁴ *Minster of Safety and Security v Xaba* 2003 (2) SA 703 (D).

surgeon could surgically intervene and remove a, non-life threatening, bullet against the wishes of the patient and with the patient being conscious to give consent. This requires a balance to be achieved between the right to bodily integrity and the interests of justice. It is interesting to note that *Gaqa* came to the conclusion that the interests of justice superseded the interests of the individual while *Xaba* correctly determined that there were less extreme methods of proving guilt, and that surgical intervention would not succeed under the defence of necessity.

It can be concluded that necessity exists where there are competing interests against patient autonomy and either life-saving care or the interests of society. As has been concluded *supra* the protection of patient autonomy is by its very nature also in the interest of society. This special defence therefore illustrates the protection delictual law offers the concept of patient autonomy, as pronounced in *Stoffburg*.²⁰⁷

2.2.4.5. Vicarious Liability

As Carstens points out, the liability of physicians working in public health care is almost always vicarious in nature.²⁰⁸ The State Liabilities Act also makes specific provision for state liability arising out of public malpractice.²⁰⁹ Vicarious liability is a form of strict liability where one person, in a position of authority, becomes liable for the delict of another.²¹⁰ In *Masuku v Mdlalose*²¹¹ the Court held that the common-law test for vicarious liability, being that the violator acted within the scope of their employment, has been consistently applied to the delicts of police officers.²¹² The Court distilled this test and elucidated two elements of the test: 1) the person doing wrong must be an employee of the state and (2) that the wrongful conduct was performed during the course or scope of employment by the state. In order for vicarious liability to succeed both these elements must be proven by the alleging party.

Strauss makes the argument that, for vicarious liability to exist in the medical sphere, there must be a relationship of superiority where an individual has legal authority over another the

²⁰⁵ *Minister of Safety and Security v Gaqa* 2002 (1) SACR 654 (C).

²⁰⁶ *Op cit* at 88.

²⁰⁷ *Ibid Stoffberg*, fn. 171.

²⁰⁸ *Ibid* Carstens, fn. 1 at 545.

²⁰⁹ Section 1 of the State Liabilities Act 20 of 1957.

²¹⁰ It can also extend to drivers of a vehicle. See *ibid* Neethling, fn. 165 at 338.

²¹¹ *Masuku v Mdlalose* 1998 (1) SA 1 (SCA).

²¹² *Idem* Carstens at 545.

conduct of another individual.²¹³ It is this argument that impedes the use of vicarious liability against medical professionals.²¹⁴ This is the *dicta* in the case of *Lower Umfolosi District War Memorial Hospital v Lowe*²¹⁵ where the Court found that the negligent conduct of a nurse could not make the hospital legally responsible for the damage. The *Lower Umfolosi* decision, while deciding on the professional conduct of a nurse, was completely silent on the possible vicarious liability had the nurse made an administrative error, for instance. Carstens argues that there should be a distinction between professional conduct in the scope of the employment and managerial or administrative staff who are controlled by the hospital.²¹⁶

Further the concept of control has been reduced to a mere indicator of employment. This concept is best illustrated by analysing the matter of *F v The Minister*.²¹⁷ The facts briefly were that F, a 13 year old girl was brutally assaulted by the second respondent in this matter, who was a police officer at the time of the attack. While the second respondent was not off-duty, he was dressed in plain clothes and was driving an unmarked police car. The court using the test elucidated by the CC in *K v the Minister*,²¹⁸ which requires two questions to be answered. Firstly whether the wrongful acts were done for the purposes of the employee, or in other words, did the employee order the wrongful acts. If this question is answered in the negative then the second question is whether there is a close link between the employee's acts in her own interest, and the purposes of the business of the employer.²¹⁹ While the Court found that the conduct of the policeman could in no way be linked to the purposes of the SAPS, it did have to consider whether his crime was sufficiently linked to the purposes of the police. The Court found that the commission of the rape was not sufficiently linked to the investigation of crime, and dismissed the case.²²⁰

It can be submitted that vicarious liability, in the case of medical malpractice, exists in two distinct forms. Firstly if the employee is a hospital administrator or an employee tasked with management or administration; secondly if the employee (regardless of function) commits

²¹³ *Ibid* Strauss, fn. 200 at 281.

²¹⁴ *Ibid* Carstens, fn. 1 at 548 further makes the point that professionals are punished by their own professional bodies, and there is no need to take the employer to task.

²¹⁵ *Lower Umfolosi District War Memorial Hospital v Lowe* 1937 TPD 31.

²¹⁶ *Idem* Carstens at 548-550.

²¹⁷ *F v Minister of Safety and Security and Another* 2012 (1) SA 536 (CC).

²¹⁸ *K v The Minister of Safety and Security* 2005 (6) SA 419 (CC).

²¹⁹ *Idem* K at par 32.

²²⁰ *Idem* K at par 176-177.

the unlawful action either through fulfilling the purposes of the employee, or the violation can be sufficiently linked to the purposes of the business.

Therefore, Q.E.D, if the administrators of the public hospitals in South Africa can be proven to be mal-administering the hospitals and it can further be proven that said malpractices cause harm to the patients, then it can be concluded that the state would be liable for said violations. It is further submitted that this reasoning allows the state to be linked, delictually, to the doctor-patient relationship, as a violating party where the minimum standards of health care are not met.

2.2.5. CONCLUSION

In the introduction to the critical analysis of the doctor-patient relationship, the outcomes were made clear. It is submitted that all of the outcomes have been proven. Through exhaustively observing and analysing the interaction between the laws of obligations the following conclusions can be drawn: The law of contract, although it may seem *prima facie* suited for the doctor-patient relationship, is in fact ill-suited to best realise the relationship and the rights of the patient.²²¹ While consensus governs the realms of contracts, the courts have shown that mere consensus in signing a waiver is enough, regardless of the public interest imposed by informed consent and the patient autonomy it seeks to protect. It has also been shown that while the principles of the doctor-patient relationship influence the *boni mores* of a society, the courts have been reluctant to alter the current contractual law regime in order to protect the patient.

Regarding the law of delict, the opposite is true. The law of delict has seemingly welcomed the doctor-patient relationship with a strong emphasis on the rights of patients into the fold, making specific provision for the dual concepts of patient autonomy and informed consent. Further, the ethical considerations to the doctor-patient relationship have found meaning and application during when the unlawfulness of the delict is determined. The only worrying factor is that the principles of patient autonomy and informed consent have seemingly been turned against the patient. When the physician wishes to escape liability, she will raise the defence that she duly informed the patient and the patient consented, however such concerns are not material enough to erode the strong representation in the law of delict.

Finally, through critically analysing the defence of necessity in the law of delict, it has been proven that the autonomy of the patient is the guiding light for any intervention made, unless

²²¹ Bhana (2005) at 893-895 as well as Barnard (2005) at 290-292.

such intervention can be justified against the *boni mores*. Further, this discussion has managed to extend the duties envisioned by the doctor-patient relationship without compromising on the nature of the relationship. Through the use of vicarious liability it can be shown that if the public health care is incorrectly administered, then the state can be seen as one of the violators of patient autonomy.

2.3. CONCLUSION

At the start of this chapter it was submitted that the outcomes of this chapter shall be a concrete understanding of the doctor-patient relationship and the elements it entails. It is submitted that through an exhaustive analysis, the reader has been provided with the core tenets of the doctor-patient relationship, with special attention being paid to the dual concepts of patient autonomy and informed consent. The reader now understands that the doctor-patient relationship is not some abstract rule of thumb, but therapeutic tool to aid in the healing process, where the betrayal the doctor-patient relationship causes significant harm not only to the patient, but their trust in the medicine.

Following an exhaustive and extensive application of the doctor-patient relationship on the law of contracts and the law of delicts, it has been found that the law of delicts is better suited to housing the doctor-patient relationship and is especially well-suited to applying the values of patient autonomy. It is also through the interaction of the law of delict, that the doctor-patient relationship becomes more than an ethical guide; it is held that the doctor-patient relationship becomes a subset of rules governing the professional relationship of the doctor and the legal implications of her actions. This was the first element of proving the research question. Now that it's been proven that the doctor-patient relationship consists of hard and enforceable law, the second element needs to be proven.

The second element of the research question was proving that the doctor-patient relationship could be extended to make the state liable for contravening the requirements thereof. Basically, if the state does not ensure an adequate standard of health, can such a circumstance be seen as a violation of the doctor-patient relationship? This can be answered in the affirmative, provided that the employees of the state actively mismanage the health resources. This point has been proven in the introductory chapter, and shall be discussed in Chapter 5.²²²

²²² *Op cit* at 131-155.

It can be argued that, through defining and applying the doctor-patient relationship, the state can be made liable for failing to adequately provide an adequate standard of health care.

3. Chapter 3 – The Doctor-Patient Relationship and the Constitution

3.1. INTRODUCTION

In the previous chapter, it was proven that the doctor-patient relationship could be extended to include a minimum standard of care. The shortcoming of this analysis is that in order for a legal action to exist, a delict has to be committed first. This necessitates the need for constitutional incorporation, in order to extend the cause of action, and further solidify it in law. If it can be proven that the doctor-patient relationship is constitutionally protected, it can be concluded that the minimum standard of care is also constitutionally guaranteed. This adds another level of legal protection for the doctrine of minimum care, and the “right to adequate health care.”

The purpose of this chapter is to apply the doctor-patient relationship, formulated in the previous chapter, to the CRSA. The research question posed at the outset of this thesis, whether the doctor-patient relationship can be seen to make provision for a right the adequate health care, can only be verified if it is shown that the doctor-patient relationship can be extended into an existing right, and such an extension is reasonable and justifiable in an open and democratic society.²²³

The most effective way of determining this relationship is to critically analyse the role of application of the Bill of Rights, in order to determine the relationship of the state as a provider of health care, protector of human rights and the eventual violator (or co-violator) of those rights. The next step would be critically dissection of interpretation under the CRSA, especially considering the special interpretative steps when interpreting socio-economic rights.²²⁴ This will include a general discussion on S 39 of the CRSA, special focus on interpreting socio-economic rights and finally how the doctor-patient relationship can best be given effect in the CRSA, in order to establish the doctor-patient relationship. The penultimate step shall be to briefly analyse the limitations clause, S 36 of the CRSA, on the doctor-patient relationship and the “right to adequate health care,” in order to best give effect to this right and to ensure that said right can be justiciable.

²²³ In other words, both find content in the Bill of Rights and be justiciable under S 36 of the CRSA.

²²⁴ This is because socio-economic rights frequently include an internal limitations clause subjected to “Reasonableness.” *Op cit* at 132-136.

For the purposes of this thesis, this chapter shall ascertain that the doctor-patient relationship does provide a basic right to adequate health care, thereby providing a *prima facie* answer to the research question. There is still need, in the subsequent chapter, to provide further legitimisation for the right to adequate health care.

Finally, at the conclusion of this chapter, the reader shall be furnished with a half-substantiated affirmative answer to the research question. It will be proven that the CRSA does in fact provide for the right to adequate health care, through applying the doctor-patient relationship to the Bill of Rights, and that the state's private law liability can be extended to apply to the Bill of Rights. This answer shall be further substantiated through Chapter 4, where the international law implications of the right to adequate health care is analysed.

3.2. CONSTITUTIONAL FUNDAMENTALS

3.2.1. INTRODUCTION

While the CRSA is founded on more than two principles, the principles of rule of law and constitutionalism deserve special mention, as they will facilitate certain sections of this chapter at a later time. It is accepted that the CRSA was further founded upon the principles of democracy and accountability²²⁵ as well as separation of powers.²²⁶

This discussion shall first briefly elucidate the concepts of rule of law and constitutionalism and juxtapose those concepts on the situation facing the country prior to adopting the CRSA. Following this elucidation, there will be a brief discussion on the South African Revolution of 1994, and how this event shaped the CRSA.

3.2.2. FUNDAMENTAL CONSTITUTIONAL PRINCIPLES

3.2.2.1. The Rule of Law

The relationship between person and state is another example of a special legal relationship. With the rise of humanism in the 15th Century, many of the notable authors and jurists focussed specifically on the human, and its relationship with the state.²²⁷ It was through the rise of humanism that the core axiom of rule of law. The rule of law is the principle that the

²²⁵ *Ibid* Currie, fn. 4 at 13 - 18.

²²⁶ *Idem* Currie at 18 – 22.

²²⁷ *Op cit* at 20-22 as well as Hobbes, *Leviathan*; Collins; 1962 and Locke, *Two Treatise on Government*; Cambridge; 1988.

government must act in accordance with pre-existing and distinct rules that are enforced by an impartial judiciary bound through fair procedures.²²⁸ This effectively results in two elements: firstly that everyone in the state, including the state itself and all its organs and parastatals as well as all natural and juristic persons, must obey the law;²²⁹ and secondly that the state can only act insofar as the law permits it to act.²³⁰ It is accepted that the state has been gifted with immense power to comply with its duties. It is further accepted, though, that a state must balance this power effectively, and avoid the arbitrary use of its power.²³¹ While the rule of law is linked with the concept of legality, meaning the state's conduct should always be legal, the CRSA links the rule of law to the content of the law as well.²³² Therefore, the state is not merely obliged to uphold the rights in the Bill of Rights, but the state is also bound to ensure that their enforcement is not subject to arbitrary decisions, such as the decisions of a hospital administrator when paying interior designers supersedes paying food suppliers.

While it is terrible that South Africa suffers from an abundance of violations regarding the rule of law, during the Apartheid era, it is with heavy irony that the Courts of the Apartheid state are mentioned. While magistrates, judges and prosecutors seemed to embody the laws they enforced, many administrative and judicial liberties were taken with prisoners, including the acceptance of unlawful evidence and an *ad hoc* decision regarding the continued detainment of awaiting trial prisoners who had not been charged.

3.2.2.2. Constitutionalism

While the rule of law provides for a state to be bound by its laws, constitutional supremacy holds that a state must draw its powers from a supreme constitution.²³³ This effectively means that a state must find the balance between the ability to govern and the ability to rule responsibly and avoid undue oppression. A Constitution can be seen as an agreement between the state and the people occupying its territory, which definitely sets out the state's power and responsibilities. Constitutionalism is, in itself, made effective through three principles: constitutional supremacy; justiciability and entrenchment.

²²⁸ Dicey, *An Introduction to the Study of the Law of the Constitution*; Macmillan; 1959 at xcvi- cli.

²²⁹ *Minister of Public Works v Kyalami Ridge Environmental Association* 2001 (3) SA 1151 (CC) at par 87.

²³⁰ *Idem Kyalami* at par 35.

²³¹ *Pharmaceutical Manufacturers Association of SA: In re: ex parte President of the Republic of South Africa* 2000 (2) SA 674 (CC) at par 85.

²³² *Ibid* Currie, fn. 4 at 12.

²³³ *Idem* Currie at 8 as well as Botha, *Statutory Interpretation: An Introduction for Students*; Juta; 2005 at 116.

Constitutional supremacy is the principle whereby the constitution, as a set of rules, has precedent over all other laws within the state and, including those laws in existence and those that will come into existence. The constitution also binds all the branches of government and has priority over all the actions taken by the state. Further any law that conflicts with the constitution is considered unconstitutional, and is unenforceable.²³⁴ This is provided by S 2 of the CRSA that states that any law or procedure not in conformity with the CRSA shall be invalid and that obligations imposed by the CRSA must be fulfilled. These obligations are given form through S 8 of the CRSA (to be discussed *infra*)²³⁵ which provides that the Bill of Rights has supremacy over all other forms of law, and that the Bill of Rights binds all the branches, as well as organs, of the state.²³⁶

Justiciability is the principle whereby the judiciary is empowered to enforce the constitution on the state and its organs. It is not simply enough to state the state must respect the rule of law and the constitution, and cross one's fingers.²³⁷ S 172 of the CRSA sanctions the South African Courts to, jurisdiction permitting, declare any law or practice to be invalid, if said law or practice is inconsistent with the CRSA, or declare it invalid insofar as it's inconsistent. Further S 165(5) of the CRSA binds all state branches and organs to execute an order made by the Court. This also binds parliament to amend or cross out sections within an Act or even repeal the entire Act. While this raises the spectre of parliamentary sovereignty and the will of the people, it must be stressed that the Courts are bound to not arbitrarily exercise this power. In one of the most notable examples, that of *Makwanyane*²³⁸ where the Constitutional Court found the death penalty to be unconstitutional and unconscionable in South Africa, despite vociferous public support for the penalty. The Court held that even the will of the people was bound to the laws of the Constitution, and could not trample the human rights of prisoners on death row.

The final element of entrenchment, dictates that amending the constitution cannot be made by simple parliamentary majority, but rather by a special majority.²³⁹ S 74 of the CRSA supplies an outline for amending the CRSA, which generally requires two-thirds majority in

²³⁴ *Executive Council of the Western Cape Legislature v President of the Republic of South Africa* 1995 (4) SA 877 (CC) at par 62.

²³⁵ *Op cit* at 67-71.

²³⁶ Also, private individuals in certain situations.

²³⁷ *Ibid* Currie, fn. 4 at 9.

²³⁸ *S v Makwanyane and Another* 1995 (3) SA 391 (CC).

²³⁹ *Idem* Currie at 10.

the National Assembly as well as two-thirds majority in the National Council of Provinces if it is an amendment in the Bill of Rights.

Prior to the adoption of the interim constitution of 1993, South Africa was governed through parliamentary supremacy. This means that the laws crafted by parliament were supreme over all other rules, including the common law. This created an imbalance, whereby parliament could create laws to suit the political climate, and often did. Examples of this include the Terrorism Act of 1967 and the Unlawful Organisations Act of 1960 which aimed to reduce the power and protest of the ANC, PAC and SACP.²⁴⁰

3.2.3. CONCLUSION

The purpose of this discussion was to establish the fundamental, and relevant, principles of the CRSA. These principles underpin the subsequent application and interpretation steps, especially on the principle of the state being liable for not only those textual rights, but any subsequent rights and duties that are proven.

3.3. APPLYING THE CONSTITUTION

3.3.1. INTRODUCTION

It has been shown that the state can be included in the doctor-patient relationship, if the doctor or medical professional in the employment of the state had caused the doctor-patient relationship to fracture.²⁴¹ The most common way for this to happen was, through vicarious liability, where the patient failed to receive the highest standard of care. An example of this would be a doctor having to use a dull scalpel because the hospital has not ordered in fresh surgical supplies or a patient unable to get healthy because the hospital has no food to serve.

However the link between vicarious liability and the state failing in its duty to protect and promote human rights is tenuous at best.²⁴² This is where S 8 of the CRSA comes into play. S 8 of the CRSA provides for the application of the Bill of Rights on all individuals, groups,

²⁴⁰ *Ibid* Currie, fn. 4 at 8.

²⁴¹ *Op cit* at 61 -62.

²⁴² Pieterse, "Health Care Rights, Resources and Rationing" 2007 *SALJ* 514 at 515-518 as well as Van der Walt, "Progressive Indirect Horizontal Application of the Bill of Rights: Towards a Co-Operative Relation Between Common Law and Constitutional Jurisprudence" (2001) *SAJHR* 341 at 341-344.

juristic persons and the state. This section will be shown to buttress the liability of the state due to the state failing to protect or promote human rights.

At the conclusion of this discussion it will be demonstrated that S 8 of the CRSA effectively takes the vicarious liability of the state, in preventable situations where state inaction resulted in a doctor or a medical professional failing in their duty to provide a minimum standard of care, and transmuted that liability to a constitutional liability as the state failed to discharge its duties.

3.3.2. DEFINING APPLICATION

S 8 of the CRSA sets out two distinctive types of application in SA Constitutional Law. Direct application is where the dispute results in a breach of the Bill of Rights as ordinary law.²⁴³ An example of this direct application is where the state, through its police officers, causes the death of striking miners. The miners' right to protest and right to life has been violated. In such an event the Bill of Rights will generate its own remedies as the ordinary legal remedies are generally deemed to be insufficient.

The second type of application is indirect application. It is accepted that the CRSA establishes an "objective normative value system."²⁴⁴ This value system, to be discussed *infra*, applies to all interpretation, development and application of common and statutory law in South Africa.²⁴⁵ This application is termed indirect application, and importantly does not supersede the law in question. What indirect application strives for is the perseverance and consolidation of those normative values in the operation of the statutory and common law.

3.3.3. DIRECT APPLICATION

In order for direct application to exist, four specific requirements must be met. If one requirement is missing the application moves into the realm of indirect application. These four elements are identifiable beneficiaries; identifiable duties imposed; time and territorial effect of the Bill of Rights.²⁴⁶

²⁴³ *Ibid* Currie, fn.4 at 32.

²⁴⁴ *Idem* Currie at 32.

²⁴⁵ *Ibid Carmichele*, fn. 181 at par 56.

²⁴⁶ *Idem* Currie at 35-64.

An identifiable beneficiary normally requires that there is a person (either natural or juristic) that either benefits from the right or is protected through a right.²⁴⁷ While interpretation may step in to determine to what extent a juristic person can benefit from civil and political rights or how a prisoner is defined, for the purposes of application all that is necessary is that there exists a person. For the purposes of the suggested right to adequate health care, the beneficiary would be every person seeking public health care. It must be stressed that this right to adequate health care will be proven to exist only where the state (or its agents) is proven to have not adequately provided for proper health care. It should not be seen as a general constitutional indemnity against medical malpractice, or an attempt to unconstitutionally medical malpractice.

The requirement of an identifiable duties imposed pertains to the horizontal and vertical application of the Bill of Rights, in other words can the Bill of Rights be considered to bind the other party in the legal relationship? Traditionally the relationship between individual and state is considered a vertical power relationship.²⁴⁸ This is because the relationship is inherently unequal; the state for instance has an exclusive monopoly on the use of force or the allocation of resources.²⁴⁹ The CRSA also specifically provides for a horizontal application, where private individuals act unconstitutionally. It can be said that respecting human rights isn't the sole ambit of the state, in South Africa. For the right to adequate health care the relationship should be considered to be strictly vertical. The focus of this dissertation is solely on public health care, but it would not be entirely unreasonable to conclude that private health care should also pursue an adequate standard.

The requirement of time is very straightforward. An unconstitutional law or practice becomes unconstitutional the moment the constitution takes effect.²⁵⁰ The function of the Court is simply to confirm this practice and declare the law or conduct to be unconstitutional. It must be noted however that neither the CRSA nor the Interim Constitution of 1993 are retrospective in their operation. This embodies the legalistic maxim of *nullum crimen, nulla poena sine praevia lege*.²⁵¹ This effectively means that any unconstitutional conduct executed before the constitution cannot be punished in terms of the constitution. This principle does not apply to indirect application, as indirect application does not result in the

²⁴⁷ *Ibid* Currie, fn. 4 at 35.

²⁴⁸ *Idem* Currie at 43.

²⁴⁹ S 8(1) of the CRSA specifically binds all the branches of state and organs of state to respect the provisions of the CRSA.

²⁵⁰ *Ferreira v Levin NO* 1996 (1) SA 984 (CC) at par 82 at par 158.

²⁵¹ No crime can be committed, nor punishment imposed, without pre-existing law.

constitution working retroactively; it simply serves to raise the legal discourse.²⁵² For the right to adequate health care, while it would be near impossible to raise the previous conduct of the state in order to sue for damages, it should still be possible to declare the current health care delivery strategies unconstitutional.

The requirement of territorial application is a doctoral thesis in itself, but for the purposes of this thesis it's the general rule that the CRSA only applies to the territory of the Republic of South Africa.²⁵³

3.3.4. INDIRECT APPLICATION

Indirect application effectively results in the Bill of Rights not binding the respective actors.²⁵⁴ The principle being that a legal dispute should be settled through ordinary law (such as private law rules or administrative decisions) which is interpreted and developed with reference to constitutional values of the Bill of Rights, before seeking to directly apply the Bill of Rights to a dispute.²⁵⁵ While indirect application exists regarding legislation, this dissertation shall focus exclusively on the indirect application of the common law, as the Chapter 2 has shown the common law to be the almost exclusive realm of the doctor-patient relationship.²⁵⁶ However the argument this chapter will prove is that there exists a right to adequate care in the CRSA, thereby ensuring that the matter is subject to direct application.

Common law has always been that law, developed and interpreted by the Courts, which has repeatedly been changed, revised or removed in order to reflect the changing social, moral and economic values of a society.²⁵⁷ The CRSA has now constitutionally authorised the Courts to develop common law, but within the conventions and character of the CRSA.²⁵⁸

²⁵² *Ibid* Currie, fn. 4 at 59.

²⁵³ *Idem* Currie at 63.

²⁵⁴ *Idem* Currie at 64.

²⁵⁵ *Ibid* Ferreira, fn. 250 at 199; *Ex parte Minister of Safety and Security: in re S v Walters* 2002 (4) SA 613 (CC) at par 64.

²⁵⁶ *Op cit* at 39-62.

²⁵⁷ Van der Walt (2001) at 290-292.

²⁵⁸ *S v Thebus* 2003 (6) SA 505 (CC) at par 31.

3.3.5. CONCLUSION

The purpose of this discussion was to highlight the extent to which the CRSA binds the state to its duty. While there was still much left unsaid, such as the impact of indirect horizontal application on the contracts between individuals (such as between a doctor and patient), the most important matters were touched on. This thesis shall attempt to prove that an existing right contains a minimum standard of care, and that minimum standard of care can be viewed as a right to adequate health care. Such a right would be subject to direct application, as the necessary right is guaranteed in the CRSA, and binding upon the state.

3.4. INTERPRETING THE CONSTITUTION

3.4.1. INTRODUCTION

In order to effectively determine the scope of the rights, it is essential to first determine how to interpret the CRSA and further, to what extent the CRSA can be read into. The purpose of this discussion therefore, is an exhaustive analysis of constitutional interpretation, in order to determine the extent to which a right can be read into. Botha and others²⁵⁹ hold the view that constitutional interpretation follows the same rules as statutory interpretation, but are focused on determining the values inherent in the CRSA.

These values are found in S 1 of the CRSA, and include the values of human dignity, equality and human freedoms; non-racialism and non-sexism; supremacy of the Constitution and a robust democracy.

As Botha²⁶⁰ notes, the CRSA is divided into two foundations, the formal power map, which contains the rules of state such as presidential duties, national symbols and duties of the courts; and a substantive foundation. This discussion will focus on the substantive basis, meaning the element of the CRSA that deals with the fundamental values underpinning the CRSA including the Bill of Rights.²⁶¹ There is also a duty upon the state to act on violations or possible violations,²⁶² ensuring that the state must at all times realise its duty to promote, protect and fulfil rights.

²⁵⁹ See further *ibid* Botha, fn. 233 at 114-115 and *ibid* Currie, fn. 4 at 145 as well as *Matiso v Commanding Officer, Port Elizabeth Prison* 1994 (4) SA 592 at par 597G/H.

²⁶⁰ *Idem* Botha at 115.

²⁶¹ Chapter 2 of the CRSA.

²⁶² Section 7 of the CRSA.

There is currently a large body of law devoted to the interpretation of the Constitution, not to mention the CRSA's own regulations pertaining to its interpretation. Therefore this discussion shall be divided into two parts. The first part deals with the Constitutional Court's interpretation of the Bill of Rights, and the values it places on the text, purpose, broadness or generosity and the context in which the interpretation is placed.²⁶³ The second part will focus on the constitutional provisions found in S 39 of the CRSA.

At the conclusion, the question of whether a right, specifically a socio-economic right, can be read into a civil and political right. If both of these approaches find in the affirmative, the first step in realising the research question will be completed.

3.4.2. THE COURT APPROACH TO THE INTERPRETATION OF HUMAN RIGHTS

3.4.2.1. The Text of the Right

As Currie rightly points out²⁶⁴ the first step in interpreting is to look at the ordinary meaning of the words describing the right. This seems simplistic, however the ordinary meaning of words are perhaps the best indication of the "legislator's intent." Further, as law itself is constructed from words, it is essential to ensure that these blocks are not ignored.

This view is supported by the decision in *Zuma*²⁶⁵ where the Court held that the ordinary meaning of the words must always be a factor in interpretation. Further that the text itself should set limits on the interpretation. Therefore the right to housing cannot be interpreted as the right to have a caravan. In *Makwanyane*²⁶⁶ the Constitutional Court contemplated the ordinary meaning and added the requirements of generosity, purpose, in order to best realise the values of the CRSA. This is due to the nature of the text in the- CRSA. Several of the rights were drafted to be as abstract as possible, in order to ensure that they could be applied liberally.²⁶⁷

²⁶³ Similar to the method used by *ibid* Currie, fn. 2 at 147-159 as well as *ibid* *Makwanyane*, fn. 238 at par 9.

²⁶⁴ *Ibid* Currie, fn. 4 at 147.

²⁶⁵ *S v Zuma* 1995 (2) SA 642 (CC) at par 17.

²⁶⁶ *Idem* *Makwanyane* at par 9.

²⁶⁷ *Idem* Currie at 147-148.

3.4.2.2. The Role of Context

One cannot discuss the ordinary meaning of text without appraising the context in which it was written. Context can be both in the wider political sense of the meaning (the drafting behind the CRSA and the history of South Africa) or the narrower textual meaning (the actual text of the CRSA).²⁶⁸

Insofar as the broader political context is concerned the *dictum* in *Shabalala*²⁶⁹ sums the position up quite nicely. The CRSA is not simply a codification of an acceptable past; it is rather a decisive break from the unjust and indefensible practices promulgated by an unjust system. The CRSA is a definitive break from the apartheid culture and promulgate an open and democratic society. The CC has also frequently referenced the past injustices of the apartheid system in several decisions, such as *Soobramoney*²⁷⁰ when determining the scope of a right or the failure of the state to adequately provide for its citizens.

Another aspect of history discussed by Currie²⁷¹ is the role of the drafting behind the provisions when determining context. Although the Court has dismissed the role of political statements and declarations during the drafting²⁷² it has approved of the background materials used when negotiating and drafting the CRSA, the so-called *travaux preparatoires*.²⁷³ This is because these preparatory documents were often drafted by technical committees specialising in the rights concerned, and therefore experts in the field. The weight attached to these documents however, is determined on a case to case basis.²⁷⁴ Further that in order to be relevant the report must be accepted and in-line with the values of the CRSA.

Curie correctly concludes that when determining the broader context of a right, the history of SA will always play a more prominent role to the drafting history, but the drafting history will still be relevant when determining the context of the right.²⁷⁵

²⁶⁸ *Fedsure Life Assurance Ltd v Greater Johannesburg Transitional Metropolitan Council* 1999 (1) SA 374 (CC) at par 170 as well as *ibid* Currie, fn. 4 at 153.

²⁶⁹ *Shabalala v Attorney General of the Transvaal* 1996 (1) SA 725 (CC) at par 26.

²⁷⁰ *Soobramoney v Minister of Health, KwaZulu-Natal* 1998 (1) SA 765 (CC) at par 16.

²⁷¹ *Idem* Currie at 154-156.

²⁷² *Ibid* Makwanyane, fn. 238 at par 18.

²⁷³ *Idem* Makwanyane at par 17-18.

²⁷⁴ E.g. Substantive data on health care may not be relied upon as the population has far outstripped that of 1996.

²⁷⁵ *Idem* Currie at 156.

The second aspect of textual context is perhaps one of the most important aspects of Constitutional interpretation. This provides that the rights are not read independently, but rather read together, to ensure that the widest possible effect is achieved. The most relevant example of this reading is *Soobramoney*²⁷⁶ where the Court read the right to life together with the right to access to health care, and found that there was no duty upon the state to provide life-saving treatment to critical or terminal patients. This approach however has been used to limit rights instead of S 36, as was seen in *Soobramoney* where the Court focussed only on the “most relevant right.”

3.4.2.3. The Purpose of the Right

In *Zuma*²⁷⁷ the Court approved the *dictum* in *R v Big M Drug Mart Ltd.*²⁷⁸ This *dictum* held that the meaning behind a right can only be established by the purpose of the right. In a South African context, this would entail reading the right against S 1 of the CRSA, in order to determine what the right seeks to protect and to give credence to the right that best promotes the values of the CRSA.

However this step is quite difficult, as identifying the values and interests being protected can be quite difficult. Take for example the right to freedom of association. If the purpose of said right is simply to encourage a robust democracy then there is little point in protecting the right to associate with cultural or economic societies. If however the purpose of the right is extended to personal liberty, it will then hinge on the autonomy of a person and therefore protect her from associating with any group, political or not.

The *locus classicus* on the purposive interpretation is the Namibian corporal punishment decision,²⁷⁹ where Mahomed CJ made it clear that purposive is not based around the interpreters’ personal views, but rather an objective value judgement based on the norms and values of the citizenry as well as the global community as a whole. Further such an approach requires constant questioning, as “yesterday’s orthodoxy might appear to be today’s heresy.”²⁸⁰

²⁷⁶ *Ibid Soobramoney*, fn. 270 at par 15.

²⁷⁷ *Ibid Zuma*, fn. 265 at par 15.

²⁷⁸ *R v Big M Drug Mart Ltd* 1985 18 DLR (4th) 321 at par 395-396.

²⁷⁹ *Ex Parte Attorney General, Namibia: In Re Corporal Punishment by Organs of State* 1991 (3) SA 76 (NmSC) at par 91D/F.

²⁸⁰ *Idem Attorney General: Corporal Punishment*, at par 91E/F.

It must also be stressed that although the norms and values of society are considered when determining the purpose of a right, the Court must not factor in public opinion. The purpose behind a right is ultimately a judicial decision.²⁸¹ The reasoning behind this is to protect the marginalised members of society as well as the minority who disagree with public opinion.²⁸²

3.4.2.4. Generous Interpretation

This requirement binds the interpreter to favour the protection offered by a right against the restriction of the right. What this means is that the interpreter should seek to interpret the right as widely as possible in order to convey as much protection as possible. The *locus classicus* for this principle is the *dictum* of Lord Wilberforce in *Fisher*,²⁸³ where it was held that a supreme Constitution requires a generous interpretation in order to fully protect and promote the human rights it contains.²⁸⁴

This approach was examined comprehensively in the decision of *S v Mhlungu*²⁸⁵ where the Court referred to Lord Wilberforce and added that a Constitution is *sui generis* and therefore requires a broad, liberal and purposive interpretation, in order to ensure that it does not become stagnant legislation, but that it plays a dynamic role in day to day life.

It may be argued that overly-broad interpretation will affect the *ius certum* of a state, as the rights cannot always be quantified, but such an approach is imprudent. Due to the existence of a general limitations clause²⁸⁶ any interpretation still must be rationalised against the purpose of the right. It is in line with this that Curie argues that the Courts favour a purposive interpretation and only rely on the generous view when it is not in conflict with the purpose of a right.²⁸⁷

3.4.3. SECTION 39 OF THE CRSA

“39. Interpretation of the Bill of Rights

(1) When interpreting the Bill of Rights, a court, tribunal or forum-

²⁸¹ *Ibid Makwanyane*, fn. 238 at par 88.

²⁸² *Idem Makwanyane* at par 88 as well as *Ibid Currie*, fn. 4 at 150.

²⁸³ *Minister of Home Affairs (Bermuda) v Fisher* [1980] AC 319 (PC) at par 328-329.

²⁸⁴ *Ibid Zuma*, fn. 265 at par 14.

²⁸⁵ *S v Mhlungu* 1995 (3) SA 391 (CC) at par 8.

²⁸⁶ S 36 of the CRSA.

²⁸⁷ *Idem Currie* at 152-153 as well as *Ibid Ferreira*, fn. 250.

(a) must promote the values that underlie an open and democratic society based on human dignity, equality and freedom;

(b) must consider international law; and

(c) may consider foreign law.

(2) When interpreting any legislation, and when developing the common law or customary law, every court, tribunal or forum must promote the spirit, purport and objects of the Bill of Rights.

(3) The Bill of Rights does not deny the existence of any other rights or freedoms that are recognised or conferred by common law, customary law or legislation, to the extent that they are consistent with the Bill.”

S 39 of the CRSA has often been criticised for being vague and requiring rather extensive interpretation.²⁸⁸ That being said, it’s still important to note the specific guidelines, required by the CRSA, when attempting to interpret a right.

S 39(1) of the CRSA calls for the interpreter to have a value-based approach to any rights interpretation. What this effectively means is that the interpretation should be founded on the values of the CRSA, much like the purposive approach and not be concerned with the realities of society, but rather the ideal *boni mores*, much like the generous approach.²⁸⁹ Therefore the first part of S 39(1) of the CRSA can be seen as an extension of the jurisprudence surrounding interpretation. However S 39(1) of the CRSA also deals specifically with international law. In *Makwanyane* the Court held that both binding and non-binding instruments can be used to aid interpretation. It is also imperative to note that international law, in terms of S 39(1) of the CRSA cannot be used to prove the existence of rights, but rather aid their interpretation.²⁹⁰ The role of binding international law on South Africa will be discussed subsequently.²⁹¹

S 39 of the CRSA deals with the interpretation of the Bill of Rights, and can be read as a general interpretation clause, whereby the drafters give guidelines as to the interpretation of the CRSA.²⁹²

²⁸⁸ *Ibid* Currie, fn. 4 at 147 and *ibid* Botha, fn. 233 at 119.

²⁸⁹ *Idem* Currie at 159.

²⁹⁰ Dugard, “The Role of International Law in Interpreting the Bill of Rights” (1994) 101 *SAHJR* 208.

²⁹¹ *Op cit* at 92-138

²⁹² *Idem* Botha at 118 and *Idem* Currie at 145.

S 39(1) of the CRSA places three clear duties upon any interpreter of the Constitution. Firstly the values that underlie the CRSA must be promoted, in order to realise an open and democratic society founded upon dignity, equality and freedom.²⁹³ Secondly the interpreter must consider international law²⁹⁴ and thirdly may consider foreign law.²⁹⁵ Of these duties, perhaps the most pertinent for this discussion is the duty to promote the values of the CRSA, as well as the use of international law. Finally the Court may use the domestic law from other countries to aid interpretation. However the foreign law is mostly used as a guideline, and is rarely applied directly.²⁹⁶

S 39(2) of the CRSA is of little application to the interpretation of the CRSA, but speaks volumes when it comes to applying the CRSA.²⁹⁷ S 39(2) of the CRSA is used to justify the indirect application of the Bill of Rights.²⁹⁸ This means that when applying legislation or common law, the Court should always ensure that the application is made in line with the CRSA.

S 39(3) of the CRSA simply provides that the Bill of Rights does not close off legislative or common law avenues. Therefore if someone refuses to raise their right to housing they may still raise the applicable defence in terms of the Prevention of Illegal Eviction Act. The only qualifier being that the domestic rights cannot be inconsistent with the CRSA.

A question that has never received any attention is the role of international law and whether any rights conferred upon individuals can be relied upon. S 39(3) of the CRSA expressly provides for legislation, common law and customary law. And although domesticating treaties falls under the realm of the legislature, no international human rights instruments have ever been domesticated.

This question is especially pertinent if one factors in the research question of this thesis. If there is an international right to adequate health care, can someone rely on S 39(3) of the CRSA to demand this right? Unfortunately due to the lack of writing on this question it is open for debate. On the one hand the duty on the Court to develop the human rights law of a state, in line with the decision in *Carmichele*.²⁹⁹ On the other hand there is the risk that

²⁹³ S 39(1)(a) of the CRSA.

²⁹⁴ S 39(1)(b) of the CRSA.

²⁹⁵ S 39(1)(c) of the CRSA.

²⁹⁶ *Ibid Makwanyane*, fn. 238 at par 26.

²⁹⁷ Section 8 of the CRSA.

²⁹⁸ *Ibid Currie*, fn. 4 at 64-67.

²⁹⁹ *Ibid Carmichele*, fn. 181.

binding treaties then automatically become binding on a State, changing the status of international law in South Africa.

3.4.4. CONCLUSION

The question that was posed at the start of this discussion was to what extent a right can be read into. This discussion has proved that there is a duty upon the Court to interpret a right as widely as possible, provided such an interpretation is in line with the foundational values of the CRSA and does not exceed the boundaries of the text. Further than any interpretation is read in context to the history of South Africa and most importantly be read together with other applicable rights.

An important caveat to remember is not to allow for a restriction in the contextual interpretation, unless such a restriction is made in terms of S 36 of the CRSA, or in the case of a socio-economic right, such as health care, that such a right is not unreasonable.³⁰⁰

Further there is a duty on the state to ensure that international law is consulted when interpreting the right.

Therefore if it is proven that there is a duty to ensure adequate health care in the CRSA, then such an interpretation should be valid.

3.5. THE RIGHTS THAT GOVERN HEALTH CARE AND THE DOCTOR-PATIENT RELATIONSHIP

3.5.1. INTRODUCTION

As was stated above, now that there is clarity on the extent to which rights may be interpreted, the next step will be to determine which rights can be interpreted to provide for the health of a population, and then further to analyse these rights in order to establish which right best provides for an adequate standard of care.

The rights that will be critically analysed in order to determine whether it can provide for an adequate standard are the right to life,³⁰¹ human dignity,³⁰² freedom and security of the

³⁰⁰ *Ibid Soobramoney*, fn. 270 at par 43-44.

³⁰¹ S 10 of the CRSA.

³⁰² S 11 of the CRSA.

person,³⁰³ and access to health care.³⁰⁴ The reason for such an exhaustive list is because although one right ultimately provide for patient autonomy as a starting point to reason adequate health care, the other right contextually provide for this right as well and therefore aid the interpretation of the right to adequate health care.

The structure of this discussion shall be a broad and purposive interpretation of the rights listed in order to evaluate their suitability as a right providing adequate health care.

It must also be stressed that although the analysis will be as comprehensive as possible, it cannot be exhaustive. The focus is on finding the right that best provides for a reasonable standard of health care and an extensive discussion on access to health care therefore, will not assist in proving the research question.

3.5.2. THE RIGHT TO LIFE

Although it is trite law that there is no hierarchy of rights, it can easily be argued that the right to life is still the most fundamental right in the CRSA. This is because without life, no other right can be enjoyed.³⁰⁵ In terms of S 7(2) of the CRSA the state has a duty to protect and promote the rights concerned, therefore there is a duty upon the state to preserve and protect life, just as much as there is a duty upon the state to not allow for the arbitrary taking of a life. This positive duty, meaning that the state must take steps to realise the right, is confirmed in *Makwanyane*³⁰⁶ and was further elucidated in *Carmichele*.³⁰⁷ Effectively this duty requires the state to enforce any laws that protect its citizens. The most common example being the enforcement of criminal law. However no decision has determined whether the duty to protect life has been extended to include health and health care, other than abortion and euthanasia. Therefore the duty to protect life cannot be held to concern itself with the standard of health care.

However O'Regan's *ratio* in *Makwanyane*³⁰⁸ that the right to life is concerned with more than just the right to live does extend the right to life into the realm of the right to health. O'Regan argued that the CRSA extends to more than just life, but to the human existence and the

³⁰³ S 12(2)(b) of the CRSA.

³⁰⁴ S 27(1) of the CRSA.

³⁰⁵ *Ibid Makwanyane*, fn. 238 at par 100-105.

³⁰⁶ *Idem Makwanyane* at par 117 and 168.

³⁰⁷ *Ibid Carmichele*, fn. 181 at par 45.

³⁰⁸ *Ibid Makwanyane*, fn. 238 at par 326-327 and approved in *ibid Soobramoney*, fn. 270 at par 31.

need to live a dignified life. However as Currie points out³⁰⁹ this element of the right to life is only read together with socio-economic rights, but is still subject to the availability of resources and reasonability.

Therefore although the right to life can mean the right to a life worth living, there is no jurisprudence to support the argument that it can provide for an adequate standard. In fact the Courts seem reluctant to include any socio-economic responsibility when applying the right.³¹⁰ Therefore the right to life is of some application when protecting health, but not enough to argue any tangible duty on the state.

3.5.3. THE RIGHT TO HUMAN DIGNITY

If the right to life is the most fundamental human right, a close second is surely the right to dignity. Not only is it a foundational value of the CRSA it is also at the core of an “objective, normative value system.”³¹¹ Due to the foundational nature of dignity it is always considered when interpreting a right, however due to the broad nature of dignity, can it be argued that the right sufficiently provides for good health³¹² and subsequently for an adequate standard of health care.

Perhaps the best place to start is Chaskalson’s *dicta* in the *Makwanyane* decision where he held that although a life with dignity is impossible unless there is a realisation of socio-economic rights. However this view was immediately placed in context with the general interests of society and the allocation of resources.

However the issue with dignity as a human right is that it’s based on the philosophies of Emmanuel Kant. Therefore there has been precious legal analysis of the right to dignity, other than being a fluffy feel-good right.³¹³

Dignity does however lay the eventual basis for autonomy, in that the Kantian philosophy espoused autonomy as the basis for dignity.³¹⁴

³⁰⁹ *Ibid* Currie, fn. 4 at 290.

³¹⁰ *Idem* Soobramoney at par 15.

³¹¹ *Ibid* Carmichele, fn. 181 at par 56.

³¹² Barret, “*Dignatio* and the Human Body” (2005) *SAJHR* 525 at 534-535.

³¹³ Barrett (2005) at 546.

³¹⁴ Barrett (2005) at 537 as well as Kant, *Fundamental Principles of the Metaphysics of Morals* as translated by Abbot; 1949.

Therefore even though dignity can be used as a launch pad for the inclusion of the right to an adequate standard of health care, it will be best used in conjunction with another for substantial right. The role of dignity cannot be underestimated in rights analysis; however one cannot attempt to read a rather substantial right into the CRSA, based on such an open right.

3.5.4. THE RIGHT TO SECURITY IN AND CONTROL OVER ONE'S BODY

S 12(2) of the CRSA provides for the bodily and psychological integrity of the person, and provides specifically for the security in and control over one's body.³¹⁵ This right provides for more than the feeling of security as a person, and seeks to ensure that every person makes decisions concerning her body. A textual analysis on "security in" and "control over" reveal that both can be read together but are ultimately diverse. "Security in" extends to the right a person has against physical or psychological invasions by the state or a third party, whereas "control over" denotes the free exercise of autonomy over one's body.³¹⁶ In order to effectively interpret the scope of S 12(2) (b) of the CRSA, it's essential to analyse both these terms.

"Security in" has been extensively discussed in the matters of *Gaqa*³¹⁷ and *Xaba*.³¹⁸ In both these decisions the High Court had to determine whether the surgical removal of a bullet from a suspect constituted a violation of the right to bodily and psychological integrity. In *Gaqa* the Court rather erroneously held, that the surgical removal was a justifiable limitation, as the interest of society in capturing a murder suspect outweighed the accused's right to bodily integrity.³¹⁹ In the matter of *Xaba* the Court held that the removal of the bullet could not be a justifiable limitation based on the lack of law of general application.³²⁰ Both these cases however still made the point that the autonomy of the individual is pertinent in any decision to allow the invasion of the body.

"Control over" is more significant in this thesis as it provides for the individual to make decisions controlling one's body. This undoubtedly provides an individual with the ability to

³¹⁵ S 12(2)(b) of the CRSA.

³¹⁶ Bishop and Woolman, "Freedom and Security of the Person" in Woolman and Bishop (eds), *Constitutional Law of South Africa*; Juta; 2007 at 40-85.

³¹⁷ *Ibid Gaqa*, fn. 205 at par 658H.

³¹⁸ *S v Xaba*, fn. 204 at par 708H

³¹⁹ *Idem Gaqa* at 659.

³²⁰ *Idem Xaba* at 714.

make decisions concerning their health and well-being, and further read with “security in” provides any person with the right to patient autonomy. Although there is a wealth of knowledge concerning the general autonomy of a person, this thesis is focused specifically on autonomy as it extends to patients.

Section 12(2)(b) of the CRSA can be seen, therefore, as providing all people with a reasonable expectation of adequate care. Most people who visit physicians do not expect malpractice, and subsequently expect the physician to do their best to treat the patient. This expectation is so incredibly important, that it can be seen as a right. The existence of a right to adequate care, that physicians are not human rights violators if they cause harm, but rather that they are constitutionally obliged to attempt to treat every patient to the best of their abilities.

3.5.5. THE RIGHT TO ACCESS TO HEALTH CARE

S 27(1) of the CRSA provides for access to health care services subject however that such access is reasonable.³²¹ This right is also subject to progressive realisation, whereby the full realisation of the right can be staggered.³²² The question that needs to be asked is can it be implied that reasonable access contains a specific standard.

In order to answer this question effectively, there needs to be an analysis of the current jurisprudence governing S 27 of the CRSA, and the realisation of socio-economic rights in general. In *Soobramoney* the Court held that the right to life and dignity is related to the access of health care,³²³ although there is still a need to account for the resources of the State. Further that there is no violation of the right to health if critical non-emergency care is necessary. Subsequently every socio-economic case has been focussed on the right to access, and any interpretation was focussed on access. This situation was further confounded in the *TAC* judgement.³²⁴ In *TAC* the Court held that there was no need to provide a minimum core when it came to access to health care, as the state could not provide for everyone, and further that the reasonability test was sufficient.³²⁵ If ever there was an argument for the inclusion of a basic standard of health care, *TAC* clearly rejected it.

³²¹ S 27(2) of the CRSA.

³²² Pieterse (2007) at 521-525.

³²³ *Idem Soobramoney*, fn. 270 at par 8.

³²⁴ *Minister of Health v Treatment Action Campaign No.2* 2002(5) SA 721 (CC).

³²⁵ *Ibid TAC*, fn. 324 at par 37-38.

The exclusion of minimum core obligations proves the current apathy for socio-economic rights, at least on the part of the judiciary.

When socio-economic rights were included there was much debate and much hope for the adequate realisation and justiciability of the rights,³²⁶ but such rights quickly became “ropes of sand” or “hollow rings.”³²⁷

3.5.6. CONCLUSION

After having exhaustively applied the interpretation principles of the CRSA, it has been shown that while many rights assist in the protection of health care, only one specifically provides for a doctor-patient relationship based on patient autonomy and a reasonable expectation of adequate care.

Utilising S 12(2) (b) of the CRSA, it can be proven that there does in fact exist a right to adequate health care. The logic behind this being that because a patient can expect a treating physician to heal them, to the best of the physician’s abilities, and because this expectation exists as an element of the doctor-patient relationship, a right of every person to expect adequate care can be read into S 12(2)(b) of the CRSA.

This right should be married to S 27(1) of the CRSA, and both seen as guarantors of the right to health care in South Africa. That there is not simply a free and fair access to health care, but that the patient can expect said health care to be of an adequate standard.

3.6. CONCLUSION

The outcome of this chapter was to, at least *prima facie*, prove the research question. Does the CRSA provide for a right to adequate health care, through an application of the doctor-patient relationship? It has been shown that S 12(2)(b) of the CRSA does in fact provide a reasonable expectation of adequate health care, and such an expectation has sufficient gravitas to be considered a right.

It must be stressed however that this right is still lacking in content and must still be subjected to the limitations clause. In the following chapters, Chapter 4 shall reflect this right on the existing international law in order to determine the content of the right, as well as

³²⁶ Scott and Macklem, “Constitutional Ropes of Sand or Justiciable Guarantees? Social Rights in a New South African Constitution” (1992) 141 *University of Pennsylvania Law Review* 1.

³²⁷ *Ibid* Soobramoney, fn. 270 at par 8.

providing international law justification for its existence. Chapter 5 shall focus on how this right can best be given effect to, by applying the limitations clause to it, as well as the reasonableness test the Courts apply then dealing with socio-economic rights. At the overall conclusion in Chapter 6, this *prima facie* answer will be a complete and comprehensive understanding of what is required for the right to adequate health care.

4. Chapter 4 – Adding Normative Content to the Right to Adequate Health care

4.1. INTRODUCTION:

The right to health in international human rights discourse is perhaps one of the most analysed and discussed rights to ever exist. This is not only because the right to health is a socio-economic right that requires a state to expend funds to realise, but more so because the right to health is the perhaps one of the most important rights to be penned. It can be inferred that, without proper health, none of the various rights can be properly enjoyed. The famous example of a scholar trying to learn while dying from malnutrition is frequently employed.

The fundamental challenge that is faced in international human rights law, however, is defining the right to health. Health is defined in the Oxford Concise Dictionary as “the soundness of body or a general state of physical well-being.”³²⁸ The definition is clearly problematic as there can be no certainty it can easily be argued that the right to health should contain reference to housing, food and water and even environment as all of these impacts the physical well-being of a person. It must also be stressed that health is an umbrella term that can cover several different disciplines for example health can refer to health care, proper nutrition, public sanitation and parks and recreation.

While, the focus of this thesis relies solely on the definition of health care, and the use of the doctor-patient relationship to realise this right, it is essential to first determine the inter-relatedness of the international right to health and health care. Furnished with this comprehension, this discussion can attempt to utilise the international norms and standards to add normative value to the right to adequate health care, as envisioned by the research question.

The outcome of this discussion shall be to distil and juxtapose these international norms and regulations to the adequate standard of health care. This carries the dual function of adding normative content to the right to adequate health care as well as effectively setting the parameters of this right to adequate care.

³²⁸ “Health” in the Oxford Dictionary of English; 3rd Edition; 2011.

The outline of this chapter shall be as follows: Firstly there will be a comprehensive discussion on the principles of international law, in order to furnish the reader with the fundamental knowledge to read and comprehend the development of health as a legal norm and health as a human right. Secondly the discussion shall focus on the development of public international health law, considering its foundation in the 17th and 18th Century, followed by a lengthy exposition on the role of the WHO, and the norms it has created concerning public health care and the need for an adequate standard. Lastly the human rights aspect of the right to health shall be critically analysed and evaluated, in order to determine if there exists an obligation upon the state to provide effective infrastructure and the elusive adequate standard.

The outcome of this chapter shall be two-fold. Firstly, through a thorough analysis of the right to health care this thesis shall have added normative content for the application of the right to adequate health care. The second outcome will be that this thesis shall prove that the current strategy to realise the right to health care is not only unproductive and incorrect, but it is also a violation of the international right to health under the African Charter and the ICESCR.

While the title of this thesis places the focus solely on the doctor-patient relationship, and how it can be envisioned to realise a right to adequate health care, it is submitted that simply proving the existence without determining the context and content would be wildly irresponsible and academically reprehensible.

4.2. DEFINING INTERNATIONAL HEALTH LAW:

“Just as domestic public health law cannot be easily contained within a single legal area, international law relating to health spreads across virtually every aspect of international relations. In short, ‘international health law’ goes far beyond what WHO may adopt under its legal powers and involves diverse international legal regimes developed in different contexts by different international and nongovernmental organisations.”³²⁹

As Fidler correctly points out, it is impossible to simply consider health as a stand-alone principle. Health ultimately is inclusive or everything pertaining to development. Both as an individual and as a society.³³⁰ Health is essential for the enjoyment of any other right,

³²⁹ Fidler, “International law and Global Health” (1999) 48 *Kansas UL Rev* 1 at 39.

³³⁰ *Ibid* Soobramoney, fn. 270 as well as Scott (1992) at 1.

entitlement or life in general; and as the Constitutional Court has pointed out: without good health there can be no enjoyment of the other rights³³¹ and ultimately that the socio-economic rights guaranteed in the CRSA will simply have an empty knell.³³²

Health law is generally defined as one of two elements. The first concerns itself with the individual, and is generally referred to as health care or private health care,³³³ whereas the second concerns itself with health which concerns itself with the good health of a population, rather than an individual.³³⁴ This is considered to be public health law.

A practical example would be the state sponsorship of condoms. Health care law would be whether the condoms benefit the individual and targets her enjoyment of this benefit, public health law targets society as a whole and concerns itself with the statistics concerning effectiveness.

It is important to note this distinction as the reason for analysing both health as an international norm (the public health law) and health as a human right (health as health care).

4.2.1. ON INTERNATIONAL LAW:

As several hundred textbooks have been devoted to the study of international law³³⁵ this section shall deal only with that law which is most applicable in this case, namely the distinction between monist and dualist states, the sources of international law, the conflict between international treaty law and international humanitarian law and finally a discussion on international human rights.

³³¹ *Ibid Makwanyane*, fn. 238.

³³² *Idem Soobramoney* at par 8.

³³³ Fidler, *International Law and Public Health*; Transnational Publishers; 2000 at 5.

³³⁴ *Idem* Fidler (fn. 329) at 40-43

³³⁵ Dugard, *International Law: A South African Perspective*; Juta Publishers; 2005.

4.2.1.1. Monoism vs. Dualism:

Dugard and others³³⁶ point out that there are currently two main approaches when one considers the domestic application of international rules. These two systems are the Monoist view and the Dualist view.

The concept of Monoism is defined as the system whereby municipal law and international law are regarded as manifestations of the same law. The reason behind this lies in the philosophical view that all law stems from one single point, and consequently that all law should have equal standing.³³⁷ Dualism on the other hand holds that the municipal and international legal systems differ so exceedingly in both source and justiciability that international law principles can only apply domestically should a state adopt said laws domestically.³³⁸

In South Africa the position regarding treaties was somewhat mixed,³³⁹ with S231 of the CRSA stating that the executive has the responsibility to negotiate and sign treaties but a treaty is only binding upon South Africa when passed through both houses of the Legislative, unless it's a technical, administrative or executive treaty, which does not require ratification. S 231 of the CRSA further goes on to entrench the dualist nature of South African law by stating any treaty enacted upon by the Legislative is law unless it is proven to be unconstitutional or inconsistent with an Act of Parliament. Further all treaties entered into before 1994 are binding.

What is important to notice is the role that customary international law plays in both systems. In a monoist state the customary international law becomes equated with the domestic customary laws,³⁴⁰ unless such a custom is in clear conflict with the domestic laws and in the case of South Africa international domestic law is considered domestic law unless it conflicts with the CRSA or an Act of Parliament.³⁴¹

³³⁶ *Ibid* Dugard, fn. 335 at 47. See also Starke "Monoism and Dualism in the Theory of International Law" (1936) 17 *BYIL* 66.

³³⁷ Lauterpacht, *International Law: Being the Collected Papers of Hersch Lauterpacht* Vol.1 (1970) at 217.

³³⁸ *Idem* Lauterpacht at 216.

³³⁹ *Idem* Dugard at 58-62.

³⁴⁰ *Idem* Dugard at 48.

³⁴¹ S 232 of the CRSA.

The importance of this distinction is one fundamental to the understanding of health as it interacts with international law. As will be discussed subsequently; the history of international health law is one born from treaties, but more than that, one born from domestic regulations adapted on an international scale. Further the role on increasing importance when dealing with the sources of international law insofar as international custom is concerned require a clear distinction and knowledge of the fundamental approaches concerning application of international rules.

Further in direct application to this thesis the inclusion of international law as an interpretive aid in S 39(2) of the CRSA allows a citizen to require the Court to analyse international obligations or at least previous interpretations of rights. This read with *Carmichele*³⁴² places a duty on the State to seek constant development and to realise every right to the fullest of its ability.

4.2.1.2. Sources of International Law:

The purpose of this discussion shall be to furnish the reader with an understanding of the sources of international law and the specific duties and requirements of each. This discussion shall focus on treaties and custom as the key sources of international law. The purpose of this discussion is ultimately for the reader to understand the scope of international law and the duties that come with it.

Article 38 of the Statute of the International Court of Justice provides for four sources of international law. The four sources are treaties, international custom accepted by nations and *ius cogens*³⁴³ which are all binding. Further it allows for international court decisions and academic opinions as supplementary sources.³⁴⁴

Although no hierarchy exists in the sources, many authors³⁴⁵ have made the submission that there is indeed said hierarchy. Firstly treaties act as international legislation and take a role of primary importance.³⁴⁶ Also, it is simpler to prove a state's obligations based on a treaty as all that is required is a signature. International custom takes the role of customary law,

³⁴² *Ibid Carmichele*, fn. 181 at par 34-38.

³⁴³ Those international norms applicable to all civilised nations, such as preventing war crimes.

³⁴⁴ *Ibid Dugard*, fn. 335 at 27 as well as Dekker, *On the Foundations and Sources of International Law*; The Hague; 2006.

³⁴⁵ *Ibid Dugard*, fn. 335 at 27-28.

³⁴⁶ *Idem Dugard* at 28 and 29.

which is similar to domestic custom, once it is proven to exist then it exists. The *Lotus* case³⁴⁷ has defined the most important element and the reason why treaty law and custom take preference. That is the concept of acceptance. No State can accidentally encumber itself with treaties or custom, said State must always accept the law either through signing or ratification. This distinguishes treaties and custom from *ius cogens* and opinions, as the latter two do not require the State to accept the rules, merely compliance.

It is important to note that there exists a tool to negate the acceptance defined above, and that tool is the right of a state to make reservations on a treaty or indicate a willingness not to be bound by international custom. This is provided for in Article 19 of the Vienna Convention on the Law of Treaties (further referred to as the Vienna Convention),³⁴⁸ as well as the *North Sea Continental Shelf Case*.³⁴⁹ The significance of this is that unless a State expressly refuses an international rule the State in question will be bound by said rule. Either as a treaty or a treaty that has become custom.

For purposes of this discussion the author shall not deal with principles of civilised nations as there is a substantial body of work that is not really of application. Further the persuasive sources of academic opinion and case decisions, they serve only as interpretive aids or as informal *stare decisis* in order to ensure the international bodies don't act in a way that guarantees uncertainty.

4.2.1.2.1. Treaties

It must first be noted that South Africa is not a party to the Vienna Convention. Therefore, strictly speaking, South Africa isn't bound to the international interpretive guides. However it is a widely accepted point amongst learned authors that the Vienna Convention has attained that status of international custom and can therefore not be ignored. The Constitutional Court in the matter of *Harksen v President of South Africa*³⁵⁰ accepted that there are principles in the Vienna Convention that find application, such as the fact that domestic law can never over-rule international law obligations, but also held that there is no definite

³⁴⁷ *Lotus Case (France v Turkey)* 1927 PCIJ Reports No. 10 at par 18.

³⁴⁸ Opened for signing on the 23rd of May 1969 and enforced from the 27th of January 1980 but never signed or ratified by South Africa.

³⁴⁹ *North Sea Continental Shelf Cases (West Germany v Netherlands Inter Alia)* 1969 ICJ Reports (3) at pars 44-45.

³⁵⁰ *Harksen v President of South Africa* 2000 (2) SA 825 (CC) at 835 – 836.

position of the customary value of the Vienna Convention.³⁵¹ This debate is severely mooted however in light of the treaties being analysed as South Africa is still bound to the treaties it has signed and ratified.

The second elephant in the room is the language used in Section 231 of the CRSA. Section 231 of the CRSA expressly provides for “International Agreements” and not treaties. This has led to a belief that an international agreement can cover binding treaties as well as unenforceable informal agreements between States.³⁵² This matter was discussed very briefly in the *Harksen*³⁵³ case although no definition for an international agreement was ever discussed. Currently the view is that an international agreement is synonymous with a treaty.³⁵⁴

A treaty is defined in Article 2(1)(a) of the Vienna Convention as an international agreement concluded between States which is written and is governed by international law.³⁵⁵ From this definition it is clear that the overriding principle in treaty law is that of *pacta sunt servanda*,³⁵⁶ and is provided for in Article 26 of the Treaty. In this thesis the focus shall be placed on multilateral constitutional³⁵⁷ and legislative³⁵⁸ treaties, those being treaties signed by a multiple of states that, respectively, found a new international body or bind states to a specific law or create new laws.³⁵⁹

³⁵¹ Ironically, Article 38 provides for the “customisation” of treaties for unsigned States, however South Africa can still invoke the principle that it cannot be bound by what it did not sign.

³⁵² *Ibid* Dugard, fn. 335 at 63 as well as Botha, “Treaty making in South Africa: A Reassessment” (2000) 25 *SAYIL* 69 at 75-78 as well as Scneeberger, “A Labyrinth of Tautology: The meaning of the term ‘International Agreement’ and its significance for South African Law and Treaty-making Practice” (2001) *SAYIL* 1 at 5-7 and 32.

³⁵³ *Idem Harksen* at par 21, 52-54 and 59.

³⁵⁴ Schneeburger (2001) at 32-40 and Botha (2000) at 71 and *idem* Dugard at 63.

³⁵⁵ Several points can be gleamed from the original text, however for purposes of this thesis this contains the most important elements.

³⁵⁶ Translated as “Agreements must be kept.”

³⁵⁷ The WHO Constitution.

³⁵⁸ The UDHR, ICESCR and ACHPR.

³⁵⁹ *Ibid* Dugard, fn. 335 at 28 as well as *S v Petane* 1988 (3) SA 51 (C) at 61E/F.

In order to assent to a treaty the treaty must be signed and in the case of multilateral treaties there is normally an additional requirement of ratification.³⁶⁰ This allows a State to reevaluate whether it wishes to be bound to the treaty it signed, the only proviso being that once a treaty is signed a state cannot act in such a manner as to defeat the purpose of the treaty.³⁶¹ The CRSA places the duty to sign and negotiate treaties with the executive;³⁶² however ratification rests with the legislative.³⁶³ Practically speaking the Department of International Relations³⁶⁴ negotiates and drafts treaties on behalf of the executive.

Now that there is clarity on the signing of treaties the next issue to be dealt with is reservations. Article 2(1)(d) of the Vienna Convention defines a reservation as an autonomous statement made by a State during signing, ratifying or assenting to a treaty which purports to exclude or amend certain provisions of the treaty in its application to the aforementioned State. The purpose therefore of a reservation is to allow a State to limit the way in which it allows the treaty to interfere with its statehood. Although there is a large body of work dealing with reservations,³⁶⁵ this thesis shall deal exclusively with Article 19 of the Vienna Convention. This Article states that a State can make a reservation provided the treaty provides for reservations,³⁶⁶ that the treaty does provides for general reservations and not specific ones³⁶⁷ and finally that the reservation does not defeat the purpose of the treaty.³⁶⁸ Therefore, similar to signing a treaty, once a State indicates its wish to be bound to a treaty it cannot act in such a way as to defeat the treaty. Of the three treaties being discussed, all have a reservation clause, and South Africa has never made any reservations pertaining to the treaties. South Africa signed the WHO Constitution in 22 July 1946 and ratified the Constitution on the 7th of August 1947. South Africa signed the ICESCR on the 3rd of October 1994 but has never ratified the treaty. South Africa signed the ACHPR on the 9th of July 1997 and the Charter was ratified on the same day.

In light of all this it is clear that South Africa is at least bound to the WHO Constitution and the ACHPR and cannot act in a way as to defeat the purposes of the ICESCR.

³⁶⁰ Article 26 of the ICESCR as well as Article 63 of the ACHPR.

³⁶¹ Article 18 of the Vienna Convention as well as *idem* Dugard at 409 for a discussion of this principle.

³⁶² In terms of S 231 of the CRSA

³⁶³ In terms of S 231(3) and (4) of the CRSA and Botha (2000) at 73-74.

³⁶⁴ The former Department of Foreign Affairs.

³⁶⁵ Topics such as reservations not assented to by other State Parties.

³⁶⁶ Article 19(a) of the Vienna Convention.

³⁶⁷ Article 19(b) of the Vienna Convention.

³⁶⁸ Article 19 (c) of the Vienna Convention.

Finally there must also be a discussion pertaining to the interpretation of treaties. The purpose of this discussion shall be to inform the reader as to the standards used when interpreting the treaties later, and further an insight into the drafter's intention when drafting said instruments. Article 31 of the Vienna Convention requires that a treaty be interpreted in terms of the ordinary meaning of the words used and their specific context, but also taking into account the object and purpose of the treaty. Article 32 of the Vienna Convention provides that when interpreting a treaty the Judge many consider drafting documents at the treaty's conclusion in order to supplement a given reading. Further Article 31(3) of the Vienna Convention allows for the establishment of an agreement between signatories on how to interpret the treaties. These sections, read with Dugard and others³⁶⁹ allows the reader to elucidate the following three methods of interpretation: The textual method, intention of the signatories and the contextual method.

The textual method can easily be defined as the black and white reading of the law. Generally favoured by positivists it favours the view that the law should not have anything read into it that does not belong there.³⁷⁰ However in the case of multilateral treaties and especially those referencing socio-economic rights there is often a lot of room to interpret the aforementioned rights, such as the right to health. The second method to be considered is the intention of the parties signing the treaty by taking into account the *travaux preparatoires*³⁷¹ for instance; however this method becomes problematic when dealing with multilateral human rights instruments.³⁷² This is because when most documents are open for signing the signatories often proclaim high value, but then fail to act on this intention, such as in the African regional human rights system. Therefore the provision is normally interpreted subject to how a treaty has been realised, which is especially problematic when dealing with socio-economic rights.

This leads us finally to the most relevant interpretation method, namely the teleological. This method was best elucidated in the *South West Africa Cases*³⁷³ of 1962. In these cases the Court accepted all the interpretive methods at one stage or another but ultimately held that in

³⁶⁹ *Ibid* Dugard, fn. 335 at 417 – 421 as well as Lauterpracht H "Restrictive Interpretation and the Principle of Effectiveness in the Interpretation of Treaties" (1949) 26 *BYIL* 48 as well as Dugard, *The South West Africa/Namibia Dispute*, University of California Press, 1973.

³⁷⁰ *Idem* Dugard (fn. 339) at 417.

³⁷¹ Preparatory works such as negotiation documents provided for in Article 32 of the Vienna Convention.

³⁷² *Idem* Dugard (fn. 339) at 418.

³⁷³ *South West Africa Cases (Libya and Ethiopia v South Africa)*, *Preliminary Objections* 1962 ICJ Reports 318.

the case of an ambiguity, that the purpose and aims of the treaty be considered in order to establish the most effective meaning. Ultimately the Court rejected the teleological view in the 1966 decision³⁷⁴ in favour of the textual method and the original signatory method; however this still does not preclude the reader from considering the purpose behind a treaty. In conclusion the ultimate outcome of this discussion was to analyse the role the purpose of a treaty plays in international law and the weight the intention of the signatory plays. It was found that South Africa has bound itself to the outcome (at the very least) of all the treaties it has signed, and furthermore that a purposive reading is necessary in order to fully understand the content of specific rights. Therefore should it be proven later that a restrictive reading of the right to health violates the purpose of a treaty it can be concluded that South Africa has violated that treaty.

4.2.1.2.2. International Custom

The second source that requires particular focus is that of Custom. Due to the lack of an effective legislature in the international realm, Dugard correctly points out the need for custom.³⁷⁵ The need for custom lies in the requirement for certainty in international law, as well as domestic law. This discussion shall deal with international custom in the general application by analysing the requirements of *usus* and *opinion iuris* and then analyse the role that UN Declarations and 'Soft Law' has on the formation of custom. The purpose of this shall be to determine the weight of customary interpretations on the right to health as well as to analyse the role the UNHCR should have in terms of international law.

Article 38(b) of the ICJ Statute provides for law that is evidenced by general practice, provided said law is accepted. This creates two requirements for a practice to become international custom. These requirements are *usus* (generally settled practice) and *opinio iuris* (a will to be bound). Of the requirements the easier one to prove is *usus*. *Usus* simply requires that a State be proved to have generally accepted an international practice. This was discussed at length in the matter of *S v Petane*.³⁷⁶ In this matter the Court held that general practice does not include the actions of the UN, but rather a generally settled practice by the States concerned, where time itself isn't a factor. This finds conformity with

³⁷⁴ *South West Africa, Second Phase* 1966 ICJ Reports 6 at par 48.

³⁷⁵ *Ibid* Dugard, fn. 335 at 29.

³⁷⁶ *Ibid* *Petane*, fn. 359 at par 57G – 61E.

the ICJ's findings on *usus*.³⁷⁷ Dugard also points out that settled South African state practice can easily be ascertained through the *South African Yearbook of International Law*.³⁷⁸

The requirement of *opinion iuris* is much harder to determine. This element speaks to the psychological acceptance of a specific practice. Discussion here is aimed at the *North Sea Continental Shelf Cases*³⁷⁹ where the ICJ held that there must be definite and clear acceptance of the norm. There is much debate on whether a general acceptance can indicate this, although a strict reading of the *North Sea Continental Shelf Case* does not allow for such a reading.³⁸⁰

It is clear therefore that South Africa, once showing the indication to be bound by a generally accepted custom, shall have that custom incorporated into the domestic law of the State. Due to the fact that the international law in this thesis is bound to international treaty this section will find application in the method whereby the right to health was adjudicated to simply how the right has been interpreted in other systems.

The question however remains as to the role that 'soft law'³⁸¹ sources may have on international custom. Dugard correctly points out that such laws cannot truly be binding upon a State, as there is not true justiciability. However 'soft law' can be most beneficial as it allows for a useful guide to state conduct.³⁸² This conversation is expressly pertinent when dealing with the role of the UNHDR.

In conclusion, this analysis provided the reader with an understanding of how international custom is formed and applied. It has also provided the reader with an appreciation for those norms that lack legal status but can inform the current policy.

4.2.1.3. Concluding remarks on International Law

Taking into account what has been said about international law the following points need to be made. Firstly that regardless of how a State applies international law it must still accept that it has limited its sovereignty and is bound by certain provisions. Further that this Chapter

³⁷⁷ *The Arrest Warrant Case (DRC v Belgium)* 2002 ICJ Reports 3 at pars 53-54.

³⁷⁸ *Ibid* Dugard, fn. 335 at 29.

³⁷⁹ *Ibid North Sea Continental Shelf*, fn. 349 at pars 44-45.

³⁸⁰ Weil, "Towards Relative Normativity in International Law" (1983) 77 *AJIL* 413 at 417.

³⁸¹ Briefly it is that international law which is by its nature non-binding or simply lacks the status of a law.

³⁸² *Idem* Dugard at 38 as well as Olivier, "Relevance of 'Soft Law' as a Source of International Human Rights" (2002) *CILSA* 289.

shall concern itself with international instruments mostly and selectively apply custom where there is a *lacuna* in the treaty law. Further the entire discussion shall be under-pinned with human rights cases and author's opinions in order to illustrate the correct interpretation.

4.2.2. CONCLUSION

As was stated above, the purpose of this discussion was to forge a definition for international health law. If one looks at the expansive definition offered by Grad³⁸³ it is that branch of health care that deals with the public itself, and requires as wide a definition as possible in order to ensure the State performs its duty adequately. Grad further points out that the modern understanding does not only cover traditionally medical grounds but can be extended to sanitation work and hospital administration.³⁸⁴ Grad also makes the point, and is supported by Fidler³⁸⁵ that public health also cannot function without legislation to administer it.³⁸⁶ Taking into account the definition provided by Arai-Takahashi³⁸⁷ that it is that body of law aimed at protecting and advancing health.

Considering the international impact on the definition it may be argued that the international aspect comes from the several treaties and agreements published from 1851 to the present day. It must however be stressed that the agreements published before the 1947 rights revolution are grounded solely in the self-interest of the State whereas those published subsequently could easily be accused of becoming paper promises.³⁸⁸ It is light of this situation in the international law that State responsibility must be even more pronounced. In order to finally give effect to the values of a right based global system, in other words. Therefore the definition of international health law would read as follows:

³⁸³ Grad, "Public Health Law: Its Form, Function, Future and Ethical Parameters" in Fidler, D *International Law and Public Health*; Transnational Publishers; 2001 at 31.

³⁸⁴ *Idem* Grad at 32.

³⁸⁵ *Idem* Grad at 32-34.

³⁸⁶ This requirement also finds application in Article 63 of the WHO Constitution which places a duty on the State to inform the WHO of its health legislation.

³⁸⁷ Arai-Takahashi, "The Role of International Health Law and the WHO in the Regulation of Public Health" in Martin and Johnson (eds.) *Law and the Public Dimension of Health*; Cavendish; 2001 at 115 as well as Bellanger, "The Future of International Health Legislation" (1989) 40 *International Digest of Health Legislation* 1 at 1.

³⁸⁸ *Idem* Fidler at 52 and 53.

International health law, for the purposes of this thesis is that branch of health law and health care law that deals with promoting the good health of a general population, inasmuch as the laws are contained in international instruments or exercised through international custom. Understanding what is aimed to be protected allows the reader to analyse effectively the methods used to protect the right to health.

4.3. A BRIEF HISTORY ON INTERNATIONAL HEALTH LAW

Now that a definition for international health law has been furnished the next step will be to analyse the history and development of this law. The progression of this discussion shall focus on domestic public health law in Europe and the USA and how this law developed to into public international health treaties during the 1800's and the creation of the first national bodies designed to combat the spreading of disease. Special attention shall also be paid to the creation of global health agencies after WW1 and how these agencies amalgamated to become the WHO. Further the evolution of socio-economic rights during the 1930s shall be analysed up to the creation of the UNHDR.

The purpose of this analysis is to furnish the reader with a working knowledge of the evolution of international health instruments as well as the concept of the right to health, in order to appreciate significant inroads made from the UNHDR to the ACHPR.

4.3.1. A HISTORY ON PUBLIC HEALTH LAWS AND IT'S TRANSITION FROM DOMESTIC TO INTERNATIONAL

Public health has been an issue since time *in memorio*. Ancient Sumerians and Egyptians understood the need to have barber shops and to have a general state of cleanliness and the Romans and Greeks understood the need to separate waste from urban areas. However this topic shall focus on the advent of the Smallpox vaccine in 1820 and the creation of epidemiology as a science that catapulted Western Europe and later the USA into what is commonly referred to as the sanitary revolution, and the birth of modern public health.

As Fidler correctly points out two factors tend to shape public health systems. These are the scientific knowledge as a society begins to understand a disease and public tolerance when it comes to stringent methods of disease control. If one were to specifically study Europe in the 17th and 18th Century one can see this development at its most effective. During the height of the industrial revolution every capital in Europe was booming. Several thousand people streamed to the cities on a monthly basis, and ultimately those people were condemned to a slow death from malnutrition in the overcrowded slums around the city. It

was in these slums that Smallpox (*Variola Vera*) was running wild and by the end of the 18th Century was responsible for over 400,000 deaths a year and it is believed more than half the working class would die before their fifth birthday.³⁸⁹

It was in this climate that the general population first learnt how to effectively deal with infectious diseases. There is writing on similar reactions to the black plague and cholera outbreaks; however it was during this period that society and specifically the State started responding to the extreme health crisis. The first step was the quarantining of any person suspected of carrying the illness. Several boats would wait in port as doctors examined sailors suspected of bringing illness into the country. It was also during this period that the first general hospitals were made available for voluntary admission, but with the adoption of the Poor Laws in England and the USA several institutions became mandatory and the physically ill were forced into quarantine.³⁹⁰ The issue however was that society was dealing with problems superficially. And most illnesses were seen as blight on the poor due to the unsanitary living conditions of the poor. The issue was that infectious diseases were still seen as something the poor suffered for being poor. Also in the case of diseases such as cholera and yellow fever they were considered alien and caused by foreigners, resulting in the further isolation of non-Europeans in Europe.³⁹¹ However it was also this introduction of cholera that leads to the shift in public health. As was stated, up to this point quarantine was the first reaction to any illness however there was no scientific understanding of pathogens or disease prevention. Therefore as a knee-jerk reaction the quarantine was often more harmful than good or simply not administered effectively.³⁹²

It was also around this time that a forgotten field in medicine, and potentially one of the fields that have resulted in the most lives saved, came to the fore. Epidemiology is an evidence-based field of medicine where the practitioner analyses risk data for diseases and determines optimal methods of preventing disease. Possibly the most famous practitioner was Doctor John Snow who published maps of London highlighting cholera hotspots. This scientific advancement also leads to one of the most important revelations in public health. The sanitary revolution or sanitary awakening possibly saved more lives than any medical

³⁸⁹ Henderson and Moss, "Smallpox and Vaccinia" in Plotkin and Orenstein, *Vaccines*; Philadelphia Saunders; 1999.

³⁹⁰ *Ibid* Fidler, fn. 333 at 8-9 as well as Lindermann, *Medicine and Society in Early Modern Europe*; Cambridge; 2010 at 193.

³⁹¹ *Ibid* Arai-Takahashi, fn. 387 at 116.

³⁹² *Ibid* Fidler, fn. 333 at 52.

advancement before or since. The *onus* shifted from quarantining patients to improving living conditions. It was also during this period that a serious change in the intellectual climate occurred. It was during this period where the concept of state responsibility for public health became a reality.

Another report that became instrumental in reforming public health was the *General Report on the Sanitary Conditions of the Labouring Population of Great Britain* published in 1838 by a London lawyer named Edwin Chadwick. In this report the average age of death for gentry as 36 whereas labourers rarely made it to 16. In order to remedy this tragedy Chadwick proposed the creation of a national board of health and a sewage system. Inspired by the Chadwick report an American named Lemuel Shattuck conducted the *Report of the Massachusetts Sanitary Commission* published in 1850, wherein Shattuck documented the causes and effects of poor sanitation in several Bostonian neighbourhoods and analysed the impact of poor living and ignorance on health. Unfortunately for him the American Civil War caused his report to be ignored, but shortly after the war his report was reopened and change started occurring.

It must be stressed that knowledge of pathogens was still incredibly basic and several reports were based around inconsistencies such as fowl air causing disease, but this was simply teething problems in what was fast becoming a global revolution. Disease was no longer seen as an individual struggle but rather as a social responsibility. And more importantly the foundation was laid for State organisations to administer healthy living and a clean environment.

After the creation of Epidemiology the next core development in public health care was the development of Bacteriology and Virology. These two fields were created out of a need to understand disease. During the sanitation awakening several doctors realised that there was still a prevalence of disease, and endeavoured to discover the cause. Trailblazers such as Jenner who invented the Smallpox vaccine and Pasteur who discovered the role bacteria played in nutrition helped shape the modern understanding of disease and introduced the exceptional scientific scrutiny applied to food preparation and storage as well as to public health operations, such as mass inoculations. Therefore by the end of the 19th Century health care was experiencing a boom. Prevention became better than cure, but a cure was also possible.

It was also during this stage that the final evolution in disease prevention occurred. As Bacteriology and Virology made more and more progress it became established that illness

was caused by an individual, and therefore that the individual should be targeted for treatment. It was also during this period that health care professionals realised they couldn't cure every illness. The role of prevention was identified, especially in terms of public health care, as the focal point in combatting illness. It was also with this realisation that the role of the State began to expand. By the middle of the 20th Century several countries had their own health departments, specially focussed on general sanitation and preventing disease. It was also from the sanitary revolution up to about 1936 that we find active international agreements concerning health care and sanitation, especially of immigrants.

Therefore by the 1950's it was accepted that the general administration of health care, the prevention of infectious diseases and the general sanitation of a city were within the authority of a State. Citizens began attaching more weight to clean living and for the purposes of this thesis the reader has been furnished with an explanation as to how health care fell within the ambit of the State and why it is essential to have a body regulate the health care of a population.

4.3.2. INTERNATIONAL PUBLIC HEALTH LAW: A CENTURY OF MEDICAL TREATIES

As stated in the previous point, during the 19th Century, Europe was undergoing extensive social transformation in the form of a sanitary revolution. A revolution born out of fear from non-European people and the perceived diseases they communicated to the "socially superior European." However it was with the introduction of cholera into Europe, which was a new disease from a foreign location, which caused France to call for an international agreement to discuss disease prevention. It was in this spirit that there were a series of sanitary conventions held between 1851 and 1938.³⁹³ Despite six international conferences where two treaties were negotiated but never made effective, it still took Europeans forty-one years to realise the first pan-European multilateral treaty. This was followed in 1897 with the International Sanitary Convention Applicable to Plague. This moved was emulated in the Americas with the adoption of the Inter-American Sanitary Conference held in 1905.³⁹⁴ The issue with these conferences is that they focused too much on a perceived threat of viral invasion from the "uncivilised people" and not enough on concrete steps to combat disease.

³⁹³ *Ibid* Fidler, fn. 333 at 56-57 publishes an extensive table of all the conferences, both effective and ineffective.

³⁹⁴ *Ibid* Arai-Takahashi, fn. 387 at 116-117.

Fidler correctly points out that this was instead a period of over regulation, insofar as international agreements were concerned.³⁹⁵

It was in this climate that the USA and Europe realised the need for permanent bodies that enforced international sanitary regulations. In the Americas the International Sanitary Bureau was established in 1902 and in Europe the *L'Office International d'Hygiene Publique* was established in 1907. After the First World War the Health Organisation of the League of Nations was established in 1919. Working together these bodies proposed the mass extermination of mosquitos as well as several campaigns targeting specific diseases such as leprosy, malaria and yellow fever. Perhaps the shining moment for the Health Organisation was the prevention of typhus epidemics in the USSR during the 1920's.

It was not until after the Second World War that the world decided to convene a truly global public health body. It was for this reason that the WHO was constituted in 1948. This institution signalled the long awaited changing of the guard in modern public health. It must be noted that the WHO achieved what it did on the shoulders of the aforementioned bodies,³⁹⁶ however due to the truly global nature of the WHO and the proactive nature of its programmes have lead several authors to conclude that the WHO is truly and improvement on the older bodies.³⁹⁷

It is relevant to note that the role international bodies have played in the actual administration of health care has not been as critical to the administration of health care as the domestic administration. The role of the WHO will be discussed under the WHO Constitution, in order to determine if the situation has remained unchanged, however the key lesson to take from this discussion is that the State domestically seems to be in a far greater position to provide health care than an international body.

³⁹⁵ Fidler, "The Future of the WHO: what role for international law?" (1998) 31 *Vanderbilt J Trans L* 1079 at 1083.

³⁹⁶ Sharp, "The New World Health Organisation" (1947) *AJIL* 509 at 511.

³⁹⁷ *Ibid* Arai-Takahashi, fn. 387 at 117.

4.4. THE CONSTITUTION OF THE WORLD HEALTH ORGANISATION

4.4.1. INTRODUCTION AND HISTORY

The first international multilateral treaty to make express provision for the best attainable state of health was the WHO Constitution. Article 1 expressly provides for the attainment of all peoples of the highest possible level of health. In order to effectively place this exceptional requirement it is essential to first understand the intellectual climate of the world in 1947 and the need to create the WHO.

In order to analyse the establishment of the WHO a brief section must be devoted to the finding of the United Nations, and the role the UN played in establishing a body tasked with improving global health. During the horrors of the Second World War, the leaders of the big three Alliance Partners³⁹⁸ declared during the Tehran Summit in 1943 that a global body must be established to identify and solve pertinent issues in society, such as health. It was in light of this Declaration that, on 25 April 1945, the UN Conference of International Organisation was founded in San Francisco. The body, tasked with drawing the UN Charter, was reconstituted as the United Nations on the 24th of October 1945 when the five permanent members of the Security Council ratified the UN Charter.

The UN Charter is in itself a remarkable document. Drafted and signed during the first half of 1945 the Charter is perhaps one of the oldest multilateral global instruments as well as a constitutional treaty. Attention must be drawn to Article 62 of the UN Charter where the Economic and Social Counsel of the UN to manufacture reports on health³⁹⁹ as well as other grounds,⁴⁰⁰ and to make recommendations to the General Assembly. In particular Article 62(2) of the UN Charter places a further duty upon the Counsel to ensure the promotion of rights and fundamental freedoms. The Preamble of the Charter as well as Article 1 specifically mentions dignity, equality as well as self-determination.

It was during this environment that the actual human cost of the Second World War was being calculated. The human cost of the war was immense. It is estimated that over sixty million people died during the war. With this cost however came substantial technological advancement, part of which could be applied to health care and sanitation. In light of this delegations from China and Brazil petitioned the Economic and Social Counsel to

³⁹⁸ Namely Winston Churchill from the UK, Franklin D Roosevelt from the USA and Iosef Stalin from the USSR.

³⁹⁹ The 1947 Chronicle of the WHO makes specific mention of the Brazilian Delegation's insistence on the inclusion of health in this Article at page 3.

⁴⁰⁰ Such as education and culture.

recommend the convention of a global health agency.⁴⁰¹ After several conferences in 1947, including the formation of a technical preparatory body, the WHO was formed on the 7th of April 1948. Articles 3 and Article 5 of the Constitution of the WHO provide membership to those States who sign the Constitution of the WHO. South Africa signed on the 22nd of July 1946 and formally accepted the Constitution on the 7th of August 1947.⁴⁰²

It must be noted that the intention of the WHO was the use of international law to effectively combat the scourges of public health. This is proven by the extensive issuing power of the WHO.⁴⁰³ For the purposes of this discussion the applicable Articles to exam are Articles 1 and 2 of the Constitution of the WHO. Article 1 provides for the achievement of the “highest possible level of health,” and Article 2 provides for several duties including the duty to promote improved standards of health⁴⁰⁴ and to assist in developing an informed public opinion of health care.⁴⁰⁵ This is by no means the entire scope of the WHO’s duties, but this is the most applicable sections dealing with the topic at hand. It is further important to note the definition of health in the preamble, as the “complete mental, physical and social well-being and not merely the absence of disease or infirmity.” The relevance of this definition goes to the earlier submission that health is an umbrella term that covers health care, but that health care is in itself not the key concern for the provision of health care.

4.4.2. THE ROLE PLAYED BY THE WHO FROM 1948 TO PRESENT DAY

In order to fully appreciate the international law element of health a critical evaluation must be carried out on the successes and failures of the WHO. The purpose of such a study shall be to determine the values a global body places on the concept of health care and whether it is pertinent to the delivery of health care as a whole.

Sharp argued that the *ad hoc* treaty approach, while important in the evolution of health, was not sufficient for the realisation of the highest standard of health. He held the view that the WHO Constitution provided a periodic promulgation of international law that would ensure greater certainty and ultimately improve health law.⁴⁰⁶ It is regrettable that this high ideal was

⁴⁰¹ Resolution 61 Sessions 1 Established the World Health Organisation on 14 December 1946.

⁴⁰² United Nations, “http://treaties.un.org/Pages/View?Details.aspx?src=TREATY&mtsdg_no=IX-1&chapter=9&lang=en” accessed on the 18th of July 2011.

⁴⁰³ Such as Article 21 of the WHO Constitution as well as Fidler (1998) at 1087.

⁴⁰⁴ Article 2(o) of the WHO Constitution.

⁴⁰⁵ Article 2(r) of the WHO Constitution.

⁴⁰⁶ Sharp, “The New World Health Organisation” (1947) *Am. J Int’l* 509 at 524-525.

never properly realised. As Fidler points out there was an age of neglect in the WHO as there were only two regulations published under Article 21 of the WHO Constitution and said regulations dealt with nomenclature.⁴⁰⁷ The WHO also took an active role in smoking regulations, however this did not move beyond a general framework. Further the WHO required extensive reporting when there was a mass outbreak of certain diseases;⁴⁰⁸ however this process invariably broke down as States often failed to report.⁴⁰⁹

It must however be noted that the WHO was intimately involved in the mass-vaccinations for the 70's and 80's. Under the watch of the WHO series pandemics such as polio and smallpox were all but eliminated, however the situation facing the WHO in the latter half of the 20th Century was clearly alarming. The WHO had not taken any active steps in combatting the latest infections HIV nor that of drug-resistant TB.⁴¹⁰ It is also lamentable that the WHO seemed so reluctant to interact with the Commission on Economic, Social and Cultural Rights after passing the ICESCR. Further, considering the active discourse between States prior to the creation of the WHO it was a crying shame that the WHO became so reluctant to involve itself in taking an active role in international health issues.

Due to the lack of enforcing new rules and regulations there is still no clarity on the role of medical infrastructure in the provision of international public health. It must be noted that the landmark Alma-Ata conference⁴¹¹ did insist on an adequate provision of health such a declaration is merely interpretive, and not indicative of any concrete duty to provide for an effective infrastructure.

4.4.3. CONCLUDING REMARKS OF HEALTH AS AN INTERNATIONAL LEGAL NORM

The WHO can easily be accused of never attempting to realise a global public health order, but instead focusing on combatting and exterminating disease.⁴¹² Although the WHO did

⁴⁰⁷ *Ibid* Fidler, fn. 395 at 1089.

⁴⁰⁸ World Health Organisation, International Health Regulations, 1983 at 5.

⁴⁰⁹ *Idem* Fidler at 1090.

⁴¹⁰ Taylor, "Controlling the Global Spread of Infectious Diseases: Towards a Reinforced Role for the International Health Regulations" (1997) *House L Review* 1327 at 1333.

⁴¹¹ WHO, *Primary Health Care: A Report of the International Conference on Primary Health Care Alma-Ata, USSR*, 6-12 December 1978, Health for All Series No 1, 1978.

⁴¹² *Ibid* Arai-Takahashi, fn. 387 at 136 as well as *Idem* Fidler at 1101.

achieve measured success in combatting epidemics and disease, it was left wanting when it came to providing states with the tools to ensure domestic health.

Insofar as the thesis is concerned it is unclear or whether there exists a duty to ensure adequate health care, and therefore attention needs to be given the individual right to health instead.

4.5. HEALTH AS A HUMAN RIGHT

4.5.1. INTRODUCTION

Now that there has been a substantial analysis of the international legal concept of health, the focus must now shift to the concept of health as a human right. The outline of this discussion shall be an analysis of the concept of a human right, followed by that of a socio-economic right and finally a critical analysis of the treaties, in order to determine whether the concept of adequate standard of health care can be read into the treaty as it stands, and whether failure to meet this standard would result in a violation of the right.

4.5.2. DEFINING HUMAN RIGHTS

Human rights are notoriously difficult to define, but can be widely accepted to be those legal benefits, which are essential for life, that accrue to individuals simply because they are human.⁴¹³ The Committee on Economic, Social and Cultural Rights⁴¹⁴ defines a human right as “fundamental, inalienable and universal entitlements belonging to individuals and, under certain circumstances, groups of individuals and communities.”⁴¹⁵ It is clear from both definitions that, in a broad sense, human rights are the keys to achieving a full and complete life, and impact, generally, on the relationship between a person (or people) and the state. Armed with a broad definition, the next step is determining the different types of human rights. There are currently two methods of classification. The first method is known as the

⁴¹³ Ssenyonjo, *Economic, Social and Cultural Rights in International Law*; Hart Publishers; 2009 at 9 and Wallace, *International Law*; Sweet and Maxwell; 2005 at 225 and Donnelly, “Human Rights, Democracy and Development” (1999) 21 (3) *Human Rights Quarterly* 608 at 612.

⁴¹⁴ Established in terms of the ICESCR, to promote and protect the rights contained within.

⁴¹⁵ Article 15(1)(c) of General Comment 17: “The Right of Everyone to Benefit from the Protection of the Moral and Material Interests Resulting from Any Scientific, Literary or Artistic Production of which She is the Author.” 12 January 2006; CESCR.

'generational classification' and attempts to classify all the rights *fora* into three generations.⁴¹⁶

4.5.2.1. Classifying Human Rights

The First Generation are the civil and political rights, associated with the social turmoil of the 17th and 18th Century.⁴¹⁷ These rights tend to be bound to the concept of personal liberty.⁴¹⁸ These rights are generally defined as having a negative duty, as they require the State to not-interfere in the enjoyment of rights. These rights have generally been given preference in realisation.⁴¹⁹

The second generation of rights are the socio-economic rights and are associated with the socialist revolutions in the early 20th Century.⁴²⁰ These rights confer a duty to interfere upon the state, and are therefore considered positive rights. Positive rights however allow a state to progressively realise the right, and is subject to the available resources should fiscal expenditure be required.⁴²¹ It is this principle that has made socio-economic rights almost impossible to enforce and has led to the impression that these rights are mere bench-marks and not justiciable.⁴²²

Further socio-economic rights, being linked to socialism, contrasted starkly to the Western view of personal freedoms and therefore the realisation of many of these rights were actively resisted by the West.⁴²³ This is why, even in the post-Cold War world, there is still the view that socio-economic rights are inferior to their civil and political counterparts.

⁴¹⁶ See Vasak, "A Thirty Year Struggle: The Sustained Efforts to Give Force of Law to the UDHR" [November 1977] *UNESCO Courier* 29.

⁴¹⁷ Such as the American and French Revolutionary philosophers.

⁴¹⁸ *Ibid* Ssenyonjo, fn. 413 at 10 as well as Osiatynski, *Human Rights and Their Limits*; Cambridge; 2009 at 5-7.

⁴¹⁹ *Idem* Ssenyonjo at 10 and *idem* Osiatynski at 37-40 and *ibid* Arai-Takahashi, fn. 387 at 163-165

⁴²⁰ *Idem* Osiatynski at 7-8 and Winks, "A Covenant of Compassion: African Humanism and the Rights of Solidarity in the African Charter on Human and Peoples' Rights" 2011 *AHRLJ* 447 at 451-453.

⁴²¹ See Article 2 of the ICESCR.

⁴²² *Idem* Ssenyonjo at 10-12 and *idem* Arai-Takahashi at 164-165 and Dowell-Jones, *Contextualising the International Covenant on Social, Economic and Cultural Rights: Assessing the Economic Deficit*; Martinus Nijhoff Publishers; 2004 at 14-19.

⁴²³ *Idem* Ssenyonjo at 15 and Stark, "Economic Rights in the United States and International Human Rights Law: Toward an 'Entirely New Strategy'" (1992) 44 *Hastings Law Journal* 79 at 130 and Alston, "Economic and Social

The final generation of rights are the collective and solidarity rights and are associated with the development of states after colonisation. These rights confer both positive and negative duties upon the state, but more importantly apply to groups of people instead of to an individual. The ACHPR is perhaps the most comprehensive repository of these collective rights, as it provides for the Peoples' Rights.⁴²⁴ These rights have been criticised due to the fact that human rights should attach to individuals,⁴²⁵ with the exception of the right to self-determination,⁴²⁶ however such a view is clearly based on the Eurocentric approach to human rights, and not the Afrocentric view inclusive of *Ubuntu*.⁴²⁷ The current jurisprudence however is geared towards incorporating these collective rights into current human rights jurisprudence on a global scale.⁴²⁸

However as stated above, this generational perspective is problematic at best. This is because, jurisprudentially speaking, the generations focus on the differences between the rights, instead of the similarities.⁴²⁹ Further there is a tacit implication that certain rights are more important, or should deserve more attention than other rights, or that the first generation rights should be realised before moving on to the second generation.⁴³⁰ Conversely it may even be suggested that the first generation rights should make way for the second or third generation rights.⁴³¹

Rights" in Henkin L and Hargrove J (eds.) *Human Rights: An Agenda for the Next Century*; ASIL; 1994 at 151-154.

⁴²⁴ Articles 19-24 of the ACHPR.

⁴²⁵ See Sieghart, *The Lawful Rights of Mankind*; Oxford; 1986 at 161.

⁴²⁶ Which is referenced in Article 1 of the International Covenant on Civil and Political Rights and the ICESCR

⁴²⁷ The concept that the individual is dependent on the group. See also Wa Mutua "Savages, Victims and Saviours: The Metaphor of Human Rights" (2001) 42 *Harvard International Law Journal* 201 at 204.

⁴²⁸ Winks (2011) at 13-15 as well as Wa Mutua (2001) at 204 as well as Dersso, "The Jurisprudence of the African Commission on Human and Peoples' Rights with Respect to Peoples' Rights" (2006) 6 *AHRLJ* 358 at 360-364.

⁴²⁹ Such appoint has little practical implementation; however it still comes down to a mind-set. See also Eide, *Right to Adequate Food as a Human Right* UN Document E/CN.4/Sub.2/1987/23.

⁴³⁰ *Ibid* Ssenyonjo, fn. 413 at 11 as well as *supra* fn. 425.

⁴³¹ Alston and Simma "The Sources of Human Rights Law: Custom, *Ius Cogens* and General Principles" 1992 (12) *Australian Yearbook of International Law* 95.

The second method whereby rights are classified is the parallel approach. This method purports that the rights themselves,⁴³² have evolved in such a way that they are now parallel. This method is based around the fact that rights were developed in conjunction with one another, especially during the creation of the UDHR, and therefore should be read together. This view has achieved more momentum in recent decades with the Proclamation of Tehran (1968)⁴³³ and the Vienna Declaration (1993),⁴³⁴ which both unequivocally states that the full realisation of civil and political rights is impossible without the enjoyment of socio-economic rights and *vice versa*. For example if a woman has the freedom to choose who she wishes to marry but dies in childbirth her right to health was still violated, even if there was realisation of a civil and political right.⁴³⁵

The reason to consider both methods of classification will be made clear subsequently when discussing socio-economic rights, but pertain mostly to the justified marginalisation of socio-economic rights.

4.5.2.2. State Responsibility and the Obligations of States

One of the core elements of human rights is that they apply to the relationship between the individual and the state. The reason for this is that the State ultimately has the authority to bind itself to human rights, either in its domestic law or international obligations.⁴³⁶ And further the state has the ability to abuse its powers to the detriment of the people within the state, and human rights are seen as an insulator against such practices.⁴³⁷

In order for a State to conform to this responsibility, it has three obligations to commit to. These are the obligations to respect, promote and fulfil human rights.⁴³⁸ Further Article 2 of both the ICCPR and ICESCR as well as Article 1 of the ACHPR provide for these duties.

⁴³² Especially civil and political rights and socio-economic rights.

⁴³³ Par 13 of the Proclamation of Tehran, International Conference of Human Rights; Tehran; 22 April 1968; UN Doc A/CONF 32/41.

⁴³⁴ Par 5 of the Vienna Declaration and Programme of Action; World Conference on Human Rights; Vienna; 25 June 1993; UN Doc A/RES/60/251.

⁴³⁵ Conversely if a man has work provided for him by the state, but is summarily executed for any reason, there is still a rights violation.

⁴³⁶ *Ibid* Ssenyonjo, fn. 413 at 17 as well as Eide and Eide "Article 25" in Alfredsson and Eide (eds.) *The Universal Declaration of Human Rights: A common Standard of Achievement*; 1999; Martinus Nijhoff at 535.

⁴³⁷ *Idem* Ssenyonjo at 17 and *Idem* Eide at 535.

⁴³⁸ *Ibid* Eide, fn. 429 at 66 as well as *idem* Eide at 534-536.

Due to the vast and expansive nature of obligations, the discussion shall be focussed to State obligations related to socio-economic rights.

4.5.3. DEFINING AND APPLYING SOCIO-ECONOMIC RIGHTS

4.5.3.1. Introduction

As was stated previously, socio-economic rights entered the international human rights discourse with two severe handicaps. First was the fact that these rights require direct action from the State, especially financial expenditure, and secondly is the fact that socio-economic rights are considered to be the socialist rights, and were much maligned by the Western nations during the Cold War.⁴³⁹

The purpose of this discussion shall be to analyse socio-economic rights, paying special attention to how these rights are enforced and ultimately realised. The purpose behind this discussion is to provide the reader with the necessary tools to understand the analysis of the treaties below and ultimately the practical limitations in giving effect to socio-economic rights.

4.5.3.2. The obligations imposed by socio-economic rights⁴⁴⁰

As was briefly discussed above, there are three duties a state must discharge in order to comply with its obligations and responsibility. These duties are the duty to respect, the duty to promote and the duty to fulfil.⁴⁴¹ The purpose of this discussion shall be to analyse the three obligations, in order to fully determine the scope of socio-economic rights in general.

4.5.3.2.1. The Obligation to Respect

⁴³⁹ *Ibid* Ssenyonjo, fn. 413 at 14 and Oloka-Onyago “Reinforcing Marginalised Rights in the Age of Globalisation, International Mechanisms, Non-State Actors and the Struggle for Peoples’ Rights in Africa” (2003) 18(4) *American University International Law Review* 851 at 851-914.

⁴⁴⁰ The Maastricht Guidelines (1998) 20(3) *Human Rights Quarterly* 691-704 (Appendix F).

⁴⁴¹ In the context of socio-economic rights Article 33 of General Comment 14 “The Right to Health” 11 August 2000; CESCR (further referred to as General Comment 14), as well as *Social and Economic Rights Action Group (SERAC) v Nigeria* (2001) AHRLR 60 (ACHPR 2001) at 44-48.

The first obligation requires a state to avoid taking action that may interfere with the enjoyment of the right.⁴⁴² On a practical level this prohibits the state from enacting policy or legislation that will violate the right, and to repeal all laws that actively hamper this right. An example would be the Bantu Education Act⁴⁴³ that extended access to education arbitrarily to all the races but one. The state clearly violated its duty to respect the right by enacting legislation that actively detracts from the access to education.

This is also the obligation that confers the negative duty aspect of socio-economic rights, as the state isn't always required to take direct action, but rather to simply avoid interfering.

4.5.3.2.2. The Obligation to Protect

The second obligation requires the state to prevent other parties such as non-state actors,⁴⁴⁴ other individuals⁴⁴⁵ and other organs of State from interfering with the enjoyment of the particular socio-economic right. If one also considers regional authority from Europe and America,⁴⁴⁶ then the duty is also extended to compel a state to ensure the enjoyment of the socio-economic rights, particularly for vulnerable groups.⁴⁴⁷ The rationale behind this link is to provide extra protection to the marginalised societies in any state, such as women or children.⁴⁴⁸

If the obligation to respect was the generally negative duty, the obligation to protect is the 'fence-sitting' duty that requires equal parts positive action with negative respect. The obligation is ultimately discharged if a state creates an environment to allow all individuals

⁴⁴² *Ibid* SERAC, fn. 441 at par 45 and *ibid* Ssenyonjo, fn. 413 at 23 and Ssenyonjo, "Economic, Social and Cultural Rights: An Examination of State Obligations" in Joseph and McBeth (eds.) *Research Handbook on International Human Rights Law*; Edward Elgar Publishing; 2010 at 41-42.

⁴⁴³ Act 47 of 1953.

⁴⁴⁴ *Idem* SERAC where a corporations were shown to have violated human rights.

⁴⁴⁵ *Ibid Carmichele*, fn. 181 where an individual threatened the safety of a community.

⁴⁴⁶ *Airey v Ireland*, Appl No 6289/73, judgement of 9 October 1979, Series A, No 32 (1979-80) 2 EHRR and *Velasquez Rodriguez v Honduras*, judgement of 29 July 1988, Inter-AmCtHR (Ser C) No 4 (1988).

⁴⁴⁷ *Idem* Ssenyonjo (fn. 413) at 24 as well as CEDAW, the CRC, African Women's Protocol and the Protocol on the African Child all prove the marginalisation of women and children.

⁴⁴⁸ During the rights analysis subsequently it will become clear that these two groups receive more protection in all the rights, but especially socio-economic rights.

the freedom to realise the socio-economic rights.⁴⁴⁹ Further if the realisation of the right is interrupted by another, then the state is tasked with utilising its due diligence to prevent, prohibit and remedy the interruption. An example of this duty is where a company causes severe harm to the health of any people working at the company. The state is obliged to investigate the cause of the health damage, prohibit the company from damaging the health of the employees and ensuring that the employees are restituted for the damages suffered.

4.5.3.2.3. The Obligation to Fulfil

The final obligation on the state is also the traditional socio-economic requirement. In order to discharge this duty a state must adopt measures such as legislation, executive policy, budget, judicial and all other measures to ensure the full realisation of the right for those people who cannot realise the right themselves.⁴⁵⁰ In order to realise this fulfilment three conditions should be met, namely facilitation; promotion and provision.⁴⁵¹

Facilitation requires a state to ensure that the positive measures necessary for the enjoyment of the right to be present. Practically speaking this requires the state to ensure that the systems necessary for rights realisation are present, adequate and available to all. For example that the department dealing with public housing has the necessary staff and power to ensure that every person receives a house or, for purposes of this thesis, that a hospital have the necessary infrastructure to not only allow access to patients, but an adequate standard of care.

Promotion requires a state to take the necessary steps to maintain the realisation of socio-economic rights. The steps necessary depend on the particular right, and would normally be referred to in the General Comment on a specific right. The specific steps necessary for the realisation of health will be discussed when the ICESCR is discussed later.

Provision requires a state to provide those who cannot possibly realise the rights themselves with the realised right. This is especially pertinent when dealing with the rights of women, children and the poorest of the poor.⁴⁵² This requirement is another protective measure

⁴⁴⁹ *Ibid* Ssenyonio, fn. 413 at 24 and *ibid* Dowell-Jones, fn. 422 at 19-21.

⁴⁵⁰ *Idem* Ssenyonio at 25 and *ibid* Eide, fn. 429, at 172 and *ibid* SERAC, fn. 441 at par 47.

⁴⁵¹ *Idem* Ssenyonio at 25 and *idem* Eide at 128-155.

⁴⁵² See Skolgy, "Is there a Right not to be Poor?" 2(1) *Human Rights Law Review* 59 and 79-80 for a discussion on the role poverty plays in gross human rights violations.

aimed at protecting those who cannot protect themselves and it another crucial element to this thesis.⁴⁵³

4.6. A CRITICAL ANALYSIS ON THE EVOLUTION OF THE RIGHT TO HEALTH IN INTERNATIONAL HUMAN RIGHTS

4.6.1. INTRODUCTION

In the following discussion the UDHR,⁴⁵⁴ ICESCR⁴⁵⁵ and the ACHPR⁴⁵⁶ shall be critically analysed in order to evaluate and chart the evolution of the right to health, both in terms of state obligations as well as realisation of the right.

In order to ensure an affective analysis the history and political climate behind the document must also be analysed. As was stated above, the incorporation and realisation of socio-economic rights was considered to be socialistic and was subsequently marginalised by the West.⁴⁵⁷

The eventual outcome of this discussion shall be to determine whether the right to health has always contained, or came to contain, an element of reasonable care. That is to say does the international provision of the right require states to provide more than access to the right? And further can the failure to meet this standard be seen as, at the minimum, serious a violation of the right to health.

4.6.2. THE UNIVERSAL DECLARATION ON HUMAN RIGHTS (UDHR)

4.6.2.1. Introduction and History

The UDHR has the particular distinction of being the first global human rights instrument.⁴⁵⁸ Although never accorded a treaty status, the UDHR is still relevant as it also contains specific mention of the right to health.

⁴⁵³ Briefly as public health care in South Africa is generally only utilised by the extremely impoverished there must be a duty on the State to ensure effective realisation.

⁴⁵⁴ Article 25 of the UDHR.

⁴⁵⁵ Article 12 of the ICESCR.

⁴⁵⁶ Article 16 of the ACHPR.

⁴⁵⁷ *Op cit* at 109-110.

⁴⁵⁸ Samnøy "The Origins of the Universal Declaration of Human Rights" in Alfredsson and Eide (eds.) *The Universal Declaration of Human Rights: A common Standard of Achievement*; 1999; Martinus Nijhoff at 3.

The history of the UDHR is one forged in the tragic bloodshed of both World Wars and the Holocaust. It was in this environment in 1946 that the nations of the world came together to form the United Nations, and in terms of Article 1(3) of the UN Charter strive to adopt a universal declaration on human rights.⁴⁵⁹ It was also developed around Franklin D Roosevelt's landmark State of the Nation Address in 1941, also known as the Four Freedoms Speech.⁴⁶⁰

It was in terms of this that the Economic and Social Council of the UN met in April 1946 to constitute the Commission on Human Rights. This commission then drafted the UDHR in three sessions.⁴⁶¹ Finally on the 10th of December 1948 the UDHR was adopted universally with only eight nations abstaining from the vote.⁴⁶²

Unfortunately the UDHR was merely a declaration by the General Assembly, and was never intended to be binding.⁴⁶³ The sway held by the UDHR in international human rights law, however, has been immense. The UDHR can be seen as the originating document for both the ICCPR and the ICESCR, further several of the rights it contains were formulated into domestic rights and the UDHR has become the yardstick whereby states can gauge compliance with human rights. It is because of this that the UDHR can be seen as having attained the status of customary international law, as *usus* and *opinion iuris* can be proven.⁴⁶⁴ This situation however must be cautiously approached, as the UDHR was designed to be as vague as possible to ensure adoption,⁴⁶⁵ and further this view was rejected in the *Petane*⁴⁶⁶ decision for that very reason. Ideally the view is that the UDHR may form customary international law, but that it depends on the right in question.⁴⁶⁷

⁴⁵⁹ *Ibid* Samnøy, fn. 458 at 4-8.

⁴⁶⁰ *Idem* Samnøy at 2-3. It was in this speech that FDR declared there should be freedom of speech, freedom of worship, freedom from fear and freedom of want.

⁴⁶¹ From January/February 1947, December 1947 and May/June 1948 also see *idem* Samnøy at 5.

⁴⁶² Unfortunately the Union of South Africa was amongst them.

⁴⁶³ *Idem* Samnøy at 10. Only Australia, India and the UK were in favour of a binding instrument. And the UK insisted on excluding socio-economic rights.

⁴⁶⁴ *Ibid* Tehran Declaration, fn. 433.

⁴⁶⁵ *Idem* Samnøy at 15-16.

⁴⁶⁶ *Ibid* *Petane*, fn. 359.

⁴⁶⁷ *Ibid* Dugard, fn. 335 at 315 argues that the rights to equality, bodily integrity, freedom from torture and fair trial form the *corpus* of international law and should be seen as international custom.

The final point to highlight in the UDHR is the lack of reference to state duty or state obligation. This places any interpreter at a disadvantage, as it must be proven to bind states, instead of having the instrument itself provide for that obligation.

4.6.2.2. Article 25 – The Right to Health

“(1) Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

(2) Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.”

Upon analysing Article 25, the following can be elucidated from it: Firstly that an individual has the right to an adequate standard of living, rather than a right to health exclusively. This right to an adequate standard of living includes the provision of housing, food and health care.⁴⁶⁸ Further every individual is entitled to welfare when they cannot provide for themselves. Finally women and children are extended special protection and are identified as vulnerable groups.

This Article, when read together with Article 22 of the UDHR provides for the socio-economic rights in the UDHR.⁴⁶⁹ Further that health is seen as inseparable from an adequate standard of living. The question to be considered now is the state’s obligations when dealing with this Article. Does the Article discuss the extent to which the state must assist, and the standard of care necessary to realise this right?

The first issue to address is whether the state is responsible for the provision of these rights at all. Generally in human rights discourse it is accepted that the state bears an obligation to realise rights, however in the case of Article 25, the section dealing with the state obligations was removed during the drafting process.⁴⁷⁰ It must be accepted

⁴⁶⁸ *Ibid* Eide, fn. 436 at 523.

⁴⁶⁹ *Idem* Eide at 523-524.

⁴⁷⁰ *Idem* Eide at 526-527.

however that someone has a corresponding duty to realise the right and as the state consented to the UDHR, the duty must fall with them.

The second issue to deal with is the obligations placed upon the state when realising this right. From the text it's clear that the duty to respect requires the state not to interfere with the property of an individual, especially food, as well as to not interfere with the health of any individual. In the event of a state taking steps to increase the health facilities it offered such a step would be seen as breach of this obligation. The obligation to protect would oblige the State to ensure that others cannot interfere with these rights. Especially, in terms of Article 25(2) of the UDHR, where the rights of women and children are concerned. Finally the obligation to fulfil is evident in the last section of Article 25(1) of the UDHR. The state has an obligation to provide social security where the realisation is impeded by factors such as poverty, widowhood or old age.⁴⁷¹

Unfortunately nowhere in this Article does the UDHR provide for the scope of the obligations necessary. There is no mention of state duty, and therefore it is impossible to ascertain the standard necessary when realising the right. This places the individual in a tenuous position, as the state can easily shirk its obligations or simply realise the rights half-heartedly. If there is one piece of scathing criticism on the UDHR, it is this failure to ensure the duties of the state are spelled out.

4.6.2.3. Conclusion of the right to health in the UDHR

The right to health in the UDHR forms part of the right to adequate standard of living. Although adequate standard is provided for, it is unfortunately not as an element of health, but of development, which is the umbrella term health falls under. Health in itself has no proper standard and from the UDHR it's unclear if the state's obligations require a state to ensure realisation at all.

What is key to note however is the importance health plays in development, and therefore the need to elucidate this role further.

⁴⁷¹ *Ibid* Eide, fn. 436 at 533-537.

4.6.3. THE INTERNATIONAL COVENANT ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS

4.6.3.1. Introduction and History

The ICESCR formed a watershed in the international human rights discourse. Born from the principles in the UDHR, it was the first multinational treaty that provided for socio-economic rights. Due to the extensive nature of the ICESCR, it would be impossible to analyse every element of the treaty in-depth.

Therefore this analysis shall deal with a brief history of the ICESCR as well as a discussion on the political climate.⁴⁷² Following that the general provisions regarding state obligations begs some attention. Whereas the UDHR simply focussed on the individual, the ICESCR provided extensively for the state and the actions and conduct required realising the ICESCR. Special attention must be given to the concept of progressive realisation in this discussion.

Finally the right to health under the ICESCR, as well as its development in General Comment 14 will be critically analysed in order to determine the obligations of the state and the elusive adequate standard practice.

In 1950 it was decided, by the General Assembly, to create a single covenant, a binding commitment on states to realise all human rights.⁴⁷³ However, as the Cold War continued between the USA and the USSR, this position was reversed. It was decided that there should be two separate covenants⁴⁷⁴ as the USA feared the socialist impact socio-economic rights would have on global politics.⁴⁷⁵ Although both covenants were developed and opened for signing at the same time, and reflected the same principles, there was still some delay before the Covenant entered into force on the 3rd of January 1967.⁴⁷⁶

⁴⁷² The ICESCR was drafted at the height of the Cold War.

⁴⁷³ GAR 421 (V) of 4 December 1950.

⁴⁷⁴ GAR 543 (VI) of 5 February 1952.

⁴⁷⁵ See *Ibid* Ssenyonjo, fn. 413 at 27 as well as Kenner, "Economic and Social Rights in the Legal Order: The Mirage of Invisibility" in Hervey and Kenner (eds.) *Economic, Social and Cultural Rights – A Legal Perspective*; Oxford; 2004 at 2-24.

⁴⁷⁶ With South Africa, Belize, The Comoros, Cuba, Sao Tome and the USA being the only signatory parties not having ratified the treaty.

What is essential to note is that the ICESCR does not allow for derogation of rights. Simply put, derogation is where the substance of the right can be violated in order to ensure national harmony.⁴⁷⁷ The ICESCR allows for states to set their own limitations⁴⁷⁸ on the rights contained, provided they do not conflict with the substance of the right. This exclusion contains a fundamental statement for state obligations. States must realise, to some extent, the socio-economic rights.⁴⁷⁹ This ensures that states can never attempt to escape from their obligations, nor alter the fundamentals of the right that needs realisation.

4.6.3.2. State Obligations under the ICESCR

Although state obligations have been discussed above, it is pertinent to note the requirements of the ICESCR. Under the ICESCR states are obliged to undertake three responsibilities. States must progressively realise the rights to the maximum of their available resources,⁴⁸⁰ assist other countries to realise these rights⁴⁸¹ and finally ensure that the socio-economic rights are as enjoyed without discrimination. For the purposes of this discussion only Article 2(1) as it pertains to progressive realisation shall be discussed.

Article 2(1) reads as follows: “1. Each State Party to the present Covenant undertakes to take steps ... especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures.”

Article 2(1) of the ICESCR has been accused of being vague, confusing and wholly unsatisfying.⁴⁸² This is based around the fact that the overall textual reading of the Article doesn't seem to oblige the state to take any action, according to a reading, it seems as if the state has total freedom to implement the right as it wishes. Further, as the CDESCR is the controlling body of the ICESCR, how can they determine what a state should do to realise its

⁴⁷⁷ Article 3 of the ICCPR allows it when there is a public emergency.

⁴⁷⁸ A limitation is where a portion of a right is compromised in the interest of society as a whole. An example would be limiting the access to specific and expensive treatments in order to ensure general access to cheaper and uncomplicated treatment.

⁴⁷⁹ *Ibid* Ssenyonjo, fn. 413 at 39-42 as well as Alston and Quinn “The Nature and Scope of Obligations under the ICESCR” (1987) 9 *Human Rights Quarterly* 156 at 217.

⁴⁸⁰ Article 2(1) of the ICESCR.

⁴⁸¹ Article 2(1) of the ICESCR.

⁴⁸² *Idem* Ssenyonjo at 50-51 and *ibid* Dowell-Jones, fn. 422 at 20-21.

resources?⁴⁸³ Luckily this situation has been somewhat remedied by the creation of the Limburg Principles⁴⁸⁴ and the Maastricht Guidelines.⁴⁸⁵ These two documents, though not binding, assist immensely in the interpretation and application of the ICESCR. Further the CESCR has published several General Comments to address interpretation and implementation issues with regard to specific rights or obligations in the treaty.⁴⁸⁶

4.6.3.2.1. On the Obligation to “Take Steps ... Appropriate Means”

The first part of Article 2(1) of the ICESCR calls upon states to take all appropriate steps within its means, and singles out the adoption of legislation. Generally speaking South Africa has adopted legislation targeted at promoting a good standard of health care,⁴⁸⁷ however this provision leaves room for “all appropriate means.” All appropriate means entails that a state cannot simply enact legislation and be done with it, there needs to be engagement from all of the organs of the state to ensure realisation.⁴⁸⁸ This requires states to act exhaustively to realise these rights, and not simply set targets and become complacent after achieving those targets.⁴⁸⁹ The duty therefore, is to constantly move forward when realising these rights. Also, these steps must be taken as quickly as possible, with the expectation that the negative elements of the rights must be realised immediately.⁴⁹⁰ The understanding is that the more complex the provision, the longer time may be needed.⁴⁹¹

4.6.3.2.2. On the Progressive Realisation

⁴⁸³ *Idem* Ssenyonjo at 52 where he argues this on the basis of submitting communications to the CESCR.

⁴⁸⁴ UN Doc E/CN.4/1987/17, Annex.

⁴⁸⁵ Dankwa, Flinterman and Leckie “Commentary to the Maastricht Guidelines on Violations of Economic, Social and Cultural Rights” (1998) 20 *Human Rights Quarterly* 705-730.

⁴⁸⁶ *Ibid* Ssenyonjo, fn. 413 at 52.

⁴⁸⁷ The introduction of the National Health Act 61 of 2003.

⁴⁸⁸ Par [1]-[2] General Comment 3 “On the Nature of States Parties’ Obligations” 14 December 1990 CESCR, as well as *idem* Ssenyonjo at 53-55.

⁴⁸⁹ The CESCR has affirmed this by agreeing that not even open warfare should prevent states from realising the rights. See CESCR “Concluding Observations: Iraq” UN Doc E/1998/22 (20 June 1998) pars 253 and 281.

⁴⁹⁰ General Comment 14 as well as *Idem* Ssenyonjo at 54.

⁴⁹¹ For example, if a state undertakes to build a house for every individual, it would be unreasonable to require them to do so immediately, however a state cannot take years to return houses expropriated unlawfully.

The first element to discuss when analysing progressive realisation is the term. If one analyses the phrase “to achieving progressively the full realization,” the conclusion is that obligations must be achieved in a structural manner, that continues to move forward. These disallow a state from either regressing, without taking appropriate action to soften the blow, on previous measures⁴⁹² or postpone obligations until it decides to realise them. This is confirmed in General Comment 3 where the CESCR recognises the “realities of the real world, and the difficulties involving full realisation.”⁴⁹³

The second element is the element of “available resources.” There are two issues concerning available resources. Firstly the use of the term available and secondly the second is how to determine whether resources were used to their maximum availability.⁴⁹⁴ The CESCR has defined “maximum available resources” as the resources available domestically, as well as those resources available through international cooperation.⁴⁹⁵ This means that a state must utilise all sources of income to the best of its ability, and should there not be sufficient resources in the state, to mobilise resources from private industry.⁴⁹⁶ Another duty the state has, in terms of this definition, is to address any factors that are harmful to available resources. A relevant example of this is battling corruption. Corruption actively diverts available resources from the public sector into personal interest. Further it has been held on several occasions that corruption is harmful to the poor as they cannot afford to be corrupt.⁴⁹⁷ Further, although state sovereignty allows the state to realise the rights it gives importance to, it is generally accepted that human rights realisation must take

⁴⁹² Thus if a state provided social security to all citizens, it cannot rescind the policy to conserve resources unless it can prove direct harm to the citizens.

⁴⁹³ Par 9 of General Comment 3 on State Obligations, fn. 493.

⁴⁹⁴ Robertson, “Measuring State Compliance with the Obligation to Devote the ‘Maximum Available Resources’ to Realising Economic, Social and Cultural Rights” (1994) 16 *Human Rights Quarterly* 693 at 694 as well as Chapman, “A ‘Violations Approach’ for Monitoring the International Covenant on Economic, Social and Cultural Rights” (2006) 18 *Human Rights Quarterly* 23 at 31.

⁴⁹⁵ CESCR “Statement: An Evaluation of the Obligation to Take Steps to the ‘Maximum of Available Resources’ Under an Optional Protocol to the Covenant” UN Doc E/C.12/2007/1 (10 May 2007) at par 5.

⁴⁹⁶ Chapman and Russel, *Core Obligations: Building a Framework for Economic, Social and Cultural Rights*; Intersentia; 2002 at 5.

⁴⁹⁷ Olanyian, “The African Union Convention on Preventing and Combatting Corruption” 2004 4 *AHRLJ* 74 at 91-92.

spending priority, especially in the case of vulnerable groups.⁴⁹⁸ Therefore when determining whether a state has maximised its potential resources, one needs to determine whether the state freed up the necessary resources, and whether those resources were made available as much as possible.

4.6.3.2.3. On Minimum Core Obligations⁴⁹⁹

Even though states may use the lack of resources as a justification for failure to realise, there exist specific obligations, under every socio-economic right, that force a state to realise those obligations. These are often seen as either the most fundamental elements of the right⁵⁰⁰ or the right essential to the protection of vulnerable groups.⁵⁰¹ The minimum core obligation of a right must be realised as soon as possible, and cannot be negotiated. Even the CESCR is unequivocal about these obligations, and maintains that failure to meet the minimum core is ultimately a violation of the right⁵⁰² and that lack of resources does not negate the failure to meet state obligations.⁵⁰³

4.6.3.2.4. Conclusion

Before analysing the right to health it is essential to touch base, and consider several key issues relating to state obligation. Under the ICESCR, a state has a duty to realise the core elements of any right immediately, or give priority to it as soon as possible. If a state has realised this minimum core then it has a duty to proactively pursue the full realisation of the rights. Further, a state has the duty to ensure full availability of its resources for realising human rights, and must actively prevent acts that encroach upon these resources.

⁴⁹⁸ *Idem* Robertson at 700 as well as CESCR “Concluding Remarks on the Philippines” UN Doc E/c.12/1995/7 at par 21.

⁴⁹⁹ This is extensively discussed in *ibid* Ssenyonjo, fn. 413 at 65-67.

⁵⁰⁰ Such as the access to health care or obligatory primary education. See also *ibid* Chapman, fn. 496 at 9.

⁵⁰¹ Such as access to obstetrics for women or the access to food for children. See also *Government of South Africa v Grootboom* 2001 (1) SA 46 (CC) at [31].

⁵⁰² General Comment 3 at par 10.

⁵⁰³ General Comment 3 at par 11.

4.6.3.3. Article 12 – The Right to Health

“1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:

The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;

The improvement of all aspects of environmental and industrial hygiene;

The prevention, treatment and control of epidemic, endemic, occupational and other diseases;

The creation of conditions which would assure to all medical service and medical attention in the event of sickness.”

Article 12 of the ICESCR is perhaps the most complete right to health in international human rights law, second only to the extensive protection offered by the African Women’s Protocol.⁵⁰⁴ It calls for the highest attainable standard of health, as opposed to merely forming part of the highest adequate standard of life. The right to health has suffered needlessly from being underdeveloped and rarely applied, due to the fact that it is a socio-economic right, and only seriously considered after the Cold War.⁵⁰⁵ At one stage the right to health, under the ICESCR, was considered to be vaguer than its predecessor in the UDHR.⁵⁰⁶ It was only with the publishing of General Comment 14 on the Right to Health in 2000 that the right had finally begun to be defined again.⁵⁰⁷

In General Comment 14, the CESCR divides health into two broad concepts. The concept of health care and the factors that underlie the good health of a person,⁵⁰⁸ such as access to food and water, health education, a healthy work environment and participating in decisions regarding public health.⁵⁰⁹ For the purposes of this thesis, the author shall critically analyse

⁵⁰⁴ Article 14 of the Protocol to the African Charter on the Rights of Women in Africa.

⁵⁰⁵ *Ibid* Ssenyonjo, fn. 413 at 315.

⁵⁰⁶ Alston “Out of the Abyss: The Challenges Confronting the New UN Committee on Economic, Social and Cultural Rights” (1987) 9 *Human Rights Quarterly* 332 at 531.

⁵⁰⁷ *Idem* Ssenyonjo at 315-316.

⁵⁰⁸ General Comment 14, at par 4 and 11.

⁵⁰⁹ *Idem* Ssenyonjo at 324-326.

the concept behind health care and deal with the socio-economic factors that contribute to good health where appropriate.

4.6.3.3.1. The Right to Health Care

Even though health is an all-inclusive right, health care is still the aspect that underpins the right as a whole. When one thinks of health, one considers hospitals or doctors rather than food or housing. Generally the right to health care is concerned with providing a right to access to any health care facility they might need.⁵¹⁰ The right to health care can therefore be seen as “a system of health protection that provides equality of opportunity for people to enjoy the highest attainable standard of health.”⁵¹¹ It is essential to note Article 12(2)(d) of the ICESCR, which obliges the state to ensure that medical care is provided when necessary. This has been linked to pre and post natal care especially, which is provided for in Article 12(2)(a) of the ICESCR. This Article also places a duty on the state to ensure that proper emergency medical care is present,⁵¹² especially when read with Article 12(2)(c) of the ICESCR.

4.6.3.3.2. State Obligations

Upon analysing the right to health, it is essential to consider the state obligations, especially the specific obligation required by General Comment 14.⁵¹³ When defining the right to health, the CESCR found that the right could not be defined without considering the duties it would place on the state. The CESCR ultimately provided for four duties the state must comply with in order to have achieved the right to health. These are availability, accessibility, accessibility and quality. It must be stressed that these four obligations relate to the realisation of health, and not the minimum core. The minimum core will be discussed later.

⁵¹⁰ General Comment 14 at par 8.

⁵¹¹ *Ibid* Ssenyonjo, fn. 413 at 325.

⁵¹² General Comment 14 at par 16.

⁵¹³ General Comment 14 at par 12.

4.6.3.3.2.1. *Availability*

The first general duty is that a state must make health available. This entails two distinct obligations upon a state. First that it must guarantee a **functioning**⁵¹⁴ public health and health care system inclusive of goods, services and programmes. The second element pertains to the underlying causes of good health and requires a state to ensure food and sanitation is sufficiently available. It can be reasoned therefore, that a state must have adequate funding for public health care and health facilities to realise the right to health.⁵¹⁵

4.6.3.3.2.2. *Accessibility*

This requirement pertains to the general understanding of health care. This is the requirement that health care should be open to everyone, and not simply one group in society. This requirement has been discussed at length,⁵¹⁶ and need not be analysed for purposes of this thesis.

4.6.3.3.2.3. *Acceptability and Quality*

It is necessary to discuss these two duties mutually, as read together they provide for the adequate standard in health care provision. Acceptability requires that the health care be of a set quality. "Medicine rejected in the North because they are beyond their expiry date must not be recycled to the South."⁵¹⁷ Acceptability is also extended to the minimum standard expected of health care providers as well as acceptable drugs and sanitation. It also requires that special care be taken when dealing with marginalised groups, so as to not violate their dignity or right to bodily integrity.

4.6.3.3.3. Combining the Four Duties into the General State Obligations on Realising Rights

As was stated above, a state has three obligations when realising socio-economic rights.⁵¹⁸ The obligations to respect, protect and fulfil (which in turn consists of the duties to facilitate and provide) must be discharged before a right can be realised. The question facing the

⁵¹⁴ Author's emphasis.

⁵¹⁵ *Ibid* Ssenyonjo, fn. 413 at 331.

⁵¹⁶ *Ibid* TAC, fn. 324.

⁵¹⁷ Hunt, "Special Rapporteur by Rapporteur on Economic, Social and Cultural Rights" UN Doc A/HRC/7/11 at par 54.

reader now is how these three obligations interact with the four obligations, specific to the right to health. This is because, as discussed above, failure to comply with these obligations will amount to a violation of the right.

Due to the extensive discussion previously and the self-limitation of this thesis the author shall discuss only the state obligation to fulfil the right to health care. The purpose of this discussion shall be to analyse the extent to which an adequate standard is necessary when realising the right to health, and ultimately to prove that the adequate standard is a minimum core obligation.

4.6.3.3.3.1. The Obligation to Fulfil the Right to Health

The obligation to fulfil binds a state to adopt measures to ensure the realisation of the right. In this case of health such measures can be the training medical staff to fill the hospitals, ensuring that the hospitals bid for the most comprehensive tenders and, most importantly, to appoint experts in the medical field to administer hospitals. Further, the duty to provide health care to the people who cannot afford private care is of particular note in this thesis. Currently in South Africa the public health care is considered to be the poor man's service. Generally those who can afford it utilise the extensive network of private hospitals. In Chapter X this point will be elaborated further, as it can be argued that an impediment to the adequate standard is the perfusion of such an extensive private health care network.

4.6.3.3.3.2. Health and the Minimum Core

Finally, the discussions concerning defining health and the scope of state duties can culminate in a critical analysis of the minimum core rights guaranteed by the ICESCR. As was stated above⁵¹⁹ the minimum core is the most basic service levels that every right is expected to achieve. In the context of health, it must be seen as the level below which medical services must never fall, regardless of resource constraints.⁵²⁰ The CESCR there are six core obligations,⁵²¹ which must be achieved in order to determine a minimum core. None of these conditions deal with an adequate standard of health care, but are focussed on providing access to health essentials and health care. Although it can be argued that there needs to be an effective system implemented to realise these obligations, such an obligation

⁵¹⁹ *Op cit* at 120.

⁵²⁰ *Ibid* Ssenyonjo, fn. 413 at 341 and Chapman "The Right to Health: Conceptualising a Minimum Core Content" UN Doc E/C.12/1993/WP.24 and *ibid* Alma-Alta, fn. 411 at par 50.

⁵²¹ General Comment 14 at par 43.

is still not minimum core. However the CESCR provides for five more obligations⁵²² that have been read to add to the minimum core,⁵²³ in that the obligations follow after complying with the first six obligations. Of these the fifth requirement is most illuminating. States are obliged to “provide adequate training for health personnel.”

It was stated in the introduction that the purpose of this thesis would be to analyse the treaties extensively, in order to determine whether there exists an adequate standard of health. It is submitted that such a requirement is present in General Comment 14 on the Right to Health.⁵²⁴ In order to ensure that health is provided, there must be an effective system to ensure the rollout is done appropriately. In order to ensure effective medical education, medical information, concrete vaccination plans and adequate health care, there must be an effective infrastructure.⁵²⁵ This infrastructure is the adequate standard of health care. It can therefore be concluded that the General Comment 14, and by extension the right to health imply a minimum core obligation upon the state to ensure an infrastructure designed not only to provide access, but a reasonable standard of health care.

Due to the fact that the provision of adequate health care is a minimum core obligation, the right is easily justiciable.⁵²⁶ Further in the *TAC* decision⁵²⁷ confirms South Africa’s intention to be bound by the minimum core, and further that failure to meet minimum core obligations will result in a violation of the right.

4.6.3.4. Conclusion on the right to health under the ICESCR

It has been shown that the current interpretation of the right to health under the ICESCR binds states to ensure certain minimum standards are met. Of these minimum core standards, there is an implied, contextual standard that requires the effective infrastructure of a right to health. This infrastructure requires that the right to health must not only be given access to, but that the realisation of health care must be of a high standard. This high standard permeates the ICESCR in the determination of suitable medicine as a duty to

⁵²² General Comment 14 at par 44

⁵²³ *Idem* Ssenyonjo at 342-343.

⁵²⁴ General Comment 14 at par 12(d).

⁵²⁵ *Ibid* Ssenyonjo, fn. 413 at 343.

⁵²⁶ Justiciability pertains to the ability of an individual to litigate the state obligation and compel the state to realise the right. *Idem* Ssenyonjo at 348-350.

⁵²⁷ *Ibid* *TAC*, fn. 324 at 135.

ensure acceptability and quality. Further an adequate infrastructure underpins the entire process of providing health. If there is no administration, the right can never be realised.

It may still be argued that as a signatory party South Africa is still not bound entirely by the ICESCR however and therefore that a violation of the minimum core would not defeat the purpose of the ICESCR. It is submitted that the failure to ensure an adequate infrastructure is a material violation that defeats the obligation under the right to health, and therefore defeats the purpose of the treaty. Further South Africa has signed and ratified the ACHPR, which may bind South Africa to the same standard.

4.6.4. THE AFRICAN CHARTER ON HUMAN AND PEOPLES' RIGHTS

4.6.4.1. Introduction and History

After the dissolution of the colonial state, Africa was entering a bold new era as an organisation of free states, however the extensive human rights violations in the 1970's caused the respective leaders to consider the need for a definitive statement on human rights, in the African tradition.⁵²⁸ In 1978 two colloquiums were held, the Butare colloquium where it was held that there is indeed a link between human rights and development, and further that lack of resources should never impact realisation of civil and political rights.⁵²⁹ The second colloquium Senegal Colloquium it was held that not only civil and political rights deserved attention but also socio-economic rights as the rights depended upon one another.⁵³⁰ This led to the members of the OAU declaring Africa's intention to protect human rights, especially the right to development, and called for experts in human rights to draft the African Charter.⁵³¹ The right to development was seen as the key development, as it links both civil and political and socio-economic rights together.⁵³²

The African Charter was therefore drafted to include both socio-economic rights and civil and political rights. This was a bold step, as during the drafting and adoption of the ACHPR, the

⁵²⁸ Mbazira "Enforcing the Economic, Social and Cultural Rights in the African Charter on Human and Peoples' Rights: Twenty Years of Redundancy, Progression and Significant Strides" (2006) 6 *AHRLJ* 333 at 337-339.

⁵²⁹ As quoted by Ouguergouz *The African Charter on Human and Peoples' Rights: A Comprehensive Agenda for Human Dignity and Sustainable Democracy in Africa*; Kluwer; 2003 at 21.

⁵³⁰ *Idem* Ouguergouz at 24-25.

⁵³¹ AHG/Dec 115 (XVI) Rev 1 'Decision on Human and Peoples' Rights in Africa', 16th ordinary session of the OAU Assembly of Heads of State and Government, Monrovia, Liberia 16-20 July 1979.

⁵³² *Idem* Ouguergouz at 181.

world was in the grips of the Cold War, and as discussed above, socio-economic rights were relegated to second chair in global rights discourse.⁵³³

The ACHPR entered into force on the 21st of October 1986, and was signed and assented to by South Africa on the 9th of July 1996. This document is often forgotten when discussing human rights discourse, despite the tremendous achievement the ACHPR has realised in 25 years.⁵³⁴ The ACHPR further laid the groundwork for bodies such as the African Court of Justice and the African Court on Human and Peoples' Rights, which will ensure states realise the rights. The over-arching criticism of the ICESCR for instance, is that it's a toothless bulldog as it cannot enforce the rights it promotes.

The purpose of this discussion shall be a critical analysis of the right to health, and state duties pertaining to such a duty. The purpose of this is to determine whether the right to health in the ACHPR can be extended to include a minimum core obligation to ensure adequate health care and infrastructure.

4.6.4.2. State Obligations under the ACHPR

It must be noted that only three socio-economic rights are provided for in the ACHPR, namely the right to work,⁵³⁵ the right to health⁵³⁶ and the right to education.⁵³⁷ Except for the three obligations required by every right,⁵³⁸ there is no mention of progressive realisation or minimum core obligations. It may be argued that the need for progressive realisation was excluded to oblige states to realise all the rights immediately,⁵³⁹ however such a position would be untenable due to the severe resource problems faced by Africa.⁵⁴⁰ Fortunately the African Commission has interpreted the ACHR in several communications, and this allows the reader insight into the ACHPR.

⁵³³ Odinkalu "Implementing Economic, Social and Cultural Rights Under the African Charter on Human and Peoples' Rights" in Evans and Murray (eds.) *The African Charter on Human and Peoples' Rights: The System in Practice*; Cambridge; 2002 at 181.

⁵³⁴ Murray "International Human Rights: Neglect and Perspectives from African Institutions" (2006) 55 *International and Comparative Law Quarterly* 193.

⁵³⁵ Article 15 of the ACHPR.

⁵³⁶ Article 16 of the ACHPR.

⁵³⁷ Article 17 of the ACHPR.

⁵³⁸ *Op cit* at 109-112.

⁵³⁹ *Ibid* Odenkalu, fn. 532 at 196 as well as Mbazira (2006) at 340-341.

⁵⁴⁰ Mbazira (2006) at 341.

In the *Purohit* decision⁵⁴¹ the argument that socio-economic rights must be realised immediately was rejected.⁵⁴² The Commission held that the ACHPR must provide for progressive realisation, to the same standards as the ICESCR. This means that parties to the ACHPR must realise the rights involved to the same excruciating standards set out *supra*.⁵⁴³ The Commission in fact seemed to adopt the requirements as set out in General Comment 3 of the CESCR,⁵⁴⁴ which is factually correct as there are many similarities between the ACHPR and the ICESCR.⁵⁴⁵

Although the ACHPR makes no mention of minimum core, if the progressive realisation is read in, then it is logical to allow for minimum core. Further, the South African Constitutional Court rejected the minimum core in *TAC*⁵⁴⁶ and described minimum core as the core obligations that would violate dignity were they not met, but criticised the standard as being too vague. It further states that failure to meet this minimum core would be a violation of the right.

It can be reasoned therefore that state obligations are similar to the obligations under the ACHPR, the question however is if these obligations concerning health are similar as well.

4.6.4.3. The Right to Health

Article 16 – The Right to Health

“1. Every individual shall have the right to enjoy the best attainable state of physical and mental health.

2. State Parties to the present Charter shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick.”

Article 16(1) of the ACHPR is an exact copy of Article 14 of the ICESCR, further Article 16(2) of the ACHPR is a condensation of Article 14(2) of the ICESCR, focussing instead on the

⁵⁴¹ *Purohit v The Gambia* 2003 (AHRLR) 96 (ACHPR 2003) at 84.

⁵⁴² Mbazira “The Right to Health and the Nature of Socio-Economic Rights Obligations Under the African Charter: The *Purohit* case” (2005) 6(4) *ESR Review* 15.

⁵⁴³ *Op cit* at 120-125.

⁵⁴⁴ Par 1-2 of General Comment 3.

⁵⁴⁵ Mbazira (2006) at 353.

⁵⁴⁶ *Ibid TAC*, fn. 324 at par 28.

broader sweeps concerning the right to health. Although General Comment 14⁵⁴⁷ was not interpreted with the African jurisprudence the Commission recently published a statement on socio-economic rights in Africa,⁵⁴⁸ where the Commission declares that the right to health should contain, *inter alia* availability and accessibility of health facilities of a reasonable standard. Further the duty to ensure availability and quality was mentioned in the *Free Legal Assistance v Zaire*⁵⁴⁹ when the Commission held that Zaire had violated the right to health by not providing basic services such as medicines, drinking water and electricity. The requirements of availability, accessibility and acceptance was provided for in the *Purohit*⁵⁵⁰ where the Commission held that the right to health contains the duty to provide facilities, access to goods and services and that mentally ill patients be treated in such a way as to ensure their dignity.

It is thus clear that the values purported in General Comment 14⁵⁵¹ must find applicability in the African Context. This is further cemented by Article 14(2)(a) of the African Women's Protocol,⁵⁵² wherein the State is obliged to provide health care that is adequate.

4.6.4.4. Conclusion on the right to health in the African Charter

As the ACHPR drew extensively from the ICESCR, it should be able to draw from the inspiration of the General Comments as well. Ultimately this allows for a contextual reading of the ACHPR to come to a similar conclusion. That the right to health inherently requires states to ensure an effective infrastructure, to best ensure an adequate standard is provided for all.

Added to this the requirements found in Article 14(2) (a) of the African Women's Protocol, and it is clear that South Africa is bound by the adequate health care standard.

⁵⁴⁷ General Comment 14 at par 12.

⁵⁴⁸ African Commission on Human and Peoples' Rights "Statement from Seminar on Social, Economic and Cultural Rights in the African Charter" (2005) 5 *AHRLJ* 182 at 186.

⁵⁴⁹ *Free Legal Assistance Group and Others v Zaire* (2000) *AHRLR* 74 (ACHPR 1995) at 47.

⁵⁵⁰ *Ibid Purohit*, fn. 540 at par 80-83.

⁵⁵¹ *Op cit* at 120-125.

⁵⁵² The Protocol to the African Charter on the Rights of Women in Africa entered into force on the 25th of November 2008 and ratified by South Africa on the 17th of December 2004.

4.7. CONCLUSION

In terms of the WHO Constitution, and the conduct of the WHO from its creation, it is unclear whether this duty exists. The WHO has made a declaration providing for the standard, but this declaration carries little weight, and is generally considered to have a poor legal value.

Upon analysing the UDHR, reference to the reasonable standard was found, however there was no mention of state duty or how a state would realise this right. Ultimately it is a joint reading of the right to health under the ICESCR and the ACHPR that provides for this standard.

The obligation of a state to fulfil the right, read with the specific duty of a state to ensure acceptability and quality as well as the minimum core obligation referenced in General Comment 14 on the Right to Health all prove the fact that the right to health, and specifically health care, cannot be realised simply by providing access to health care, but can only be realised by providing access to a quality and acceptable standard of health care.

The purpose of this chapter was to provide normative content for the right to adequate healthcare. Utilising the minimum core obligations under the right to health it's been proven that there is a duty upon the state to provide for a certain standard of care, and most importantly that this duty cannot be ignored or left unfulfilled. While it can be correctly argued that the adequate standard is an undertaking by the state to, at all times, ensure that the health care provided is of the highest quality, such a conclusion is ultimately impossible to realise. What is essential is being able to realise the right as effectively as possible, which is why the CRSA will be reintroduced, with its socio-economic rights jurisprudence.

5. Chapter 5 – Applying the Right to Adequate Health Care and the National Health Insurance

5.1. INTRODUCTION

While the previous chapters have ascertained that a right to adequate care exists, and that said right is both legally necessary and essential; the final task facing this thesis must then be to clearly set the parameters for this right. A right has no value if it is not effective, nor reasonable. Only through realising how the right can be made justiciable can this thesis ask the most important research question of justifying the topic.

The purpose of this chapter is, thusly, to furnish the right to adequate health care with definitive parameters, so as best to give it effect and make it justiciable. This is doubly-true for socio-economic rights, as they frequently lose all meaning due to non-enforcement by the Courts.⁵⁵³ This chapter shall also critically review the new National Health Insurance Policy, and rightly criticise it for the short-sighted and cynical approach by Government towards effectively providing health care.

In order to realise these outcomes, this chapter shall progress as follows: Firstly, the right to adequate care shall be critically analysed and juxtaposed against the current right to access to health care, s 27(1) and (2) of the CRSA, as well as the current socio-economic case law, in order to best give effect to the right. It is unfortunate that no socio-economic decision has ever considered S36 of the CRSA, but the reasonability test can be argued to contain elements of the limitations analysis.⁵⁵⁴ Finally, and most importantly, this analysis shall commence to the apex of determining an effective remedy. It is only through an effective remedy existing, that rights can be made justiciable, especially since the courts seem so loathe to craft a remedy of their own.

In order to realise this outcome effectively, a hypothetical case pertaining to cronyism in public hospitals shall be used to effectively illustrate the right to adequate health care and how it can be utilised in the South African legal system.

⁵⁵³ Scott (1992) at 1-3 as well as Wesson, “*Grootboom* and Beyond: Reassessing the Socio-Economic Jurisprudence of South African Constitutional Court” (2004) *SAJHR* 448.

⁵⁵⁴ *Op cit* at 134.

Armed with this effective and justiciable right, the focus shall then shift on the current health care delivery model and in particular the National Health Insurance Policy.⁵⁵⁵ It will be conclusively shown that while these policies make an admirable attempt at providing sweeping access to health care, they ensure a complete regression insofar as the actual standard of the health care will be considered. Through this application of the right to adequate health, the inter-play between adequate standard and access will also be made clear, further substantiating the need for Government to rethink their current health policies. This application shall culminate in proving that the NHI specifically, and the general health care policies broadly, are wholly unconstitutional.

Insofar as the thesis is concerned, this chapter serves as the climax, after labouring through many critical analyses and evaluations; this thesis has progressed to answering the research question in the affirmative. However, simply answering the question is not enough. The question also needs to be practically applied and given effect to, especially considering that this thesis argues for the creation of a new right in the CRSA.

At the conclusion of this chapter, it will have been shown that the right to adequate health care is indeed justiciable. If properly applied, this right would actually result in less of a burden to the state than the current access only policy. Further, it will also be shown that, with the operation of the right to adequate health care, that the NHI is wholly unconstitutional and, without the operation of the right to adequate health care, which the NHI is a terribly short-sighted and cynical approach by a Government that has become desperate to provide something it cannot comprehend.

5.2. CONVERTING THE RIGHT TO ADEQUATE HEALTH CARE FROM HYPOTHETICAL TO JUSTICIABLE

5.2.1. INTRODUCTION

The purpose behind this discussion is to turn the hypothetical right to adequate health care into an actual and justiciable right. The only way to successfully achieve this transformation is to first comprehend how the South African Constitutional Court has applied socio-economic rights in the past, and the strict interpretation the Court has generally given these rights, and to apply this interpretation to the right to adequate health care. In order to further

⁵⁵⁵ Further referred to as the NHI.

illustrate, practically, how this right may be utilised a statement of facts will be created and applied to the socio-economic jurisprudence.⁵⁵⁶

The structure of this discussion shall therefore be a brief discussion on the jurisprudential evolution of the Constitutional Court in socio-economic matters, followed by the hypothetical statement of facts. Following this the jurisprudence of the Court shall be applied as well as the limitations clause in the CRSA. Finally the discussion shall shift from application of law to determining the nature of the remedies, and most importantly what remedies will most effectively realise the right to adequate health care.

5.2.2. ON THE INTERPRETATION OF SOCIO-ECONOMIC RIGHTS IN SOUTH AFRICA

5.2.2.1. Introduction

The Constitutional Court has decided on several socio-economic matters, but three cases in particular are of vital import, as they laid the foundation for all subsequent decisions. These are the matters of *Soobramoney*,⁵⁵⁷ *Grootboom*⁵⁵⁸ and *TAC*.⁵⁵⁹ These three cases shall be discussed briefly, and the essential elements of their decisions shall be used to illustrate the Court's approach to socio-economic rights.

5.2.2.2. *Soobramoney*

In *Soobramoney* the Court was presented with the following facts:⁵⁶⁰ S, the applicant, was a 41 year old male who was suffering from, *inter alia*, chronic irreversible renal failure. S was being kept alive through daily dialysis treatments, but the Respondent terminated these treatments as it had a set policy for not treating chronic irreversible renal failure. S argued, before the Constitutional Court, that this was a violation of his right to emergency medical treatment (S 27(3) of the CRSA) and failing that the policy was a violation of his right to access to health care (S 27(1) of the CRSA). The Court found that S 27(2) of the CRSA binds the state to realise access to health care within its limited resources.⁵⁶¹ The Court, rather interestingly, took the view that S 27 of the CRSA could be seen as a group right,

⁵⁵⁶ Pieterse (2007) at 520-523.

⁵⁵⁷ *Ibid Soobramoney*, fn. 270.

⁵⁵⁸ *Ibid Grootboom*, fn. 501.

⁵⁵⁹ *Ibid TAC*, fn. 324.

⁵⁶⁰ *Idem Soobramoney* at par 1.

⁵⁶¹ *Idem Soobramoney* at par 11.

because everyone relying on public health was entitled to access to health care.⁵⁶² The Court promulgated the ‘available resources test.’ This test requires the Court to determine whether the state has the resources to provide for the right. If the state lacks said resources, then the Court argues that it cannot take action.⁵⁶³ While this test seems almost brutally pragmatic, it is the correct approach to adopt when dealing with socio-economic rights. While effectively sentencing S to death, there would be no value in rights that are simply banded about without any state accountability.

Soobramoney also highlighted the Court’s plight in attempting to enforce rights where the demand far exceeds the supply.⁵⁶⁴

*“We live in a society in which there are great disparities in wealth. Millions of people are living in deplorable conditions and in great poverty. There is a high level of unemployment, inadequate social security, and many do not have access to clean water or to adequate health services. These conditions already existed when the Constitution was adopted and a commitment to address them, and to transform our society into one where will be human dignity, freedom and equality lies at the heart of our new constitutional order. **For as long as these conditions continue to exist that aspiration will have a hollow ring.**”⁵⁶⁵*

Soobramoney went further than any other case to highlight the need for proper resource management and, especially, accountability from the state as to attempt to responsibly provide access to all who need it. While the interpretative guideline of broad interpretation, strict limitation was ignored,⁵⁶⁶ it was justified because socio-economic rights are always limited by available resources.⁵⁶⁷

5.2.2.3. Grootboom

In *Grootboom*, the *locus classicus* of socio-economic jurisprudence, the court was presented with a class action suit, administered by G.⁵⁶⁸ G and 899 others were living in an informal settlement, in the Western Cape, that flooded every winter. When they moved to land that

⁵⁶² *Ibid Soobramoney*, fn. 270 at par 31.

⁵⁶³ *Idem Soobramoney* at par 11-13.

⁵⁶⁴ *Idem Soobramoney* at par 8.

⁵⁶⁵ Author’s emphasis.

⁵⁶⁶ *Op cit* at 75.

⁵⁶⁷ The rejection of minimum core (*op cit* at 135-137) has already been shown to be in violation of our international human rights commitments, and possibly unconstitutional (*op cit* at 131).

⁵⁶⁸ *Ibid Grootboom*, fn. 501 at par 10.

was above the water table they were summarily evicted and upon returning to their old location, they found it to have been occupied by another group. Forced to live on sports fields with no shelter from the elements, *G et al* brought this matter to Court. The Court held that this state of affairs was, indeed, a violation of the right to housing as it was unreasonable. While initially accepted,⁵⁶⁹ *Grootboom* has come under severe scrutiny because it rejected the minimum core concept; muddied the waters around the concept of reasonableness and, most damning of all, failed to craft and enforce an appropriate remedy.⁵⁷⁰

While the concept of minimum core and the rejection thereof has been discussed, *Grootboom* is relevant for this discussion for the latter reason. Firstly the Court was completely silent on the reasonableness criteria. S 26(2) of the CRSA provides that the state must provide housing as much as it is reasonably possible. It is also unclear as to whether the reasonableness is linked to the S 36 of the CRSA, whether the ends justify the means test for reasonableness,⁵⁷¹ or whether it's linked to the administrative concept of reasonableness?⁵⁷² However while the Court found the current housing plan to be unreasonable, it failed to justify why it found the plan to be unreasonable and most lamentably failed to order the state to take any action, thereby raising the spectre of unenforceable rights.⁵⁷³

5.2.2.4. TAC

In the *TAC* matter, the Court had to decide on the following facts: T, and NGO, brought this complaint because the Department of Health had a policy refusing to provide expecting HIV Positive mothers with free Neverapine. The respondent argued that the Neverapine was dangerous, but this submission was rejected by both the trial Court and the Constitutional Court. While the Court was silent, yet again, on what was meant by reasonableness and

⁵⁶⁹ De Vos, "*Grootboom*, the Right to Access to Housing and Substantive Equality as Contextual Fairness" (2001) *SAJHR* 258.

⁵⁷⁰ Bilchitz, "Giving Socio-Economic Right Teeth: The Minimum Core and its Importance" (2002) *SALJ* 484; Bilchitz, "Towards a Reasonable Approach to the Minimum Core: Laying the Foundations for Future Socio-Economic Rights Jurisprudence" (2003) *SAJHR* 1 and finally Swart, "Left Out in the Cold? Crafting Constitutional Remedies for the Poorest of the Poor" (2005) *SAJHR* 215.

⁵⁷¹ Wesson (2004) at 460-465 as well as Bilchitz (2002) at 496-502.

⁵⁷² As is found in *Bato Star Fishing (Pty) Ltd v Minister of Environmental Affairs and Tourism* 2004 (4) SA 490 (CC).

⁵⁷³ Wesson (2004) at 448-450.

how that reasonableness was impacted by the fact that the medicine was provided at no cost to the state.⁵⁷⁴

What makes *TAC* such an ineffective decision is the Court's acceptance that it was reluctant to create binding remedies on the executive? While the Court is correct in raising the separation of powers, this hesitancy borders on cowardice. The Court cannot reasonably be expected to take the duty of delivering access to health care upon itself, but it can use mandatory interdicts and prohibitive interdicts to create a timetable for delivery.⁵⁷⁵ Further the Court could simply refer the matter to the Legislature, to review current policy. Yet there is a deafening silence from the Courts regarding the remedy.

5.2.2.5. Conclusion

With the drafting of the CRSA, many notable academics criticised the inclusion of socio-economic rights in the CRSA, as they would be unenforceable.⁵⁷⁶ Lamentably it can be argued that the Constitutional Court, post *Soobramoney* has made socio-economic rights completely unenforceable by refusing to provide remedies and permitting uncertainty over the reasonableness element. Further there exists much confusion as to the role of limitations in socio-economic rights. Whether the internal qualifiers are significant enough to limit the rights, or whether the Constitutional Court has simply never found a case substantive enough to warrant limitations analysis.

It is in this hostile environment that the right to adequate health care needs to find meaning and appropriate application, and possibly through this provide some tangible meaning to the included socio-economic rights in the CRSA.

5.2.3. THE HYPOTHETICAL STATEMENT OF FACTS

In order to effectively determine the scope of the right to adequate health care, it would behove this discussion to use an example to illustrate the current problems facing the standard of health care, and to operate from this example using the reasoning of the Constitutional Court, especially in *Soobramoney*, to elucidate and justify this right.

⁵⁷⁴ *Ibid TAC*, fn. 324 at par 38-39.

⁵⁷⁵ Swart (2003) at 215-220.

⁵⁷⁶ Davis, "The Case Against the Inclusion of Socio-Economic Demands in the Bill of Rights Except as a Directive Principle" (1992) *SAJHR* 475 from 475-480 as well as Scott (1992) at 5-10.

X brings a suit against the National Minister of Health. Her action is based in her suffering a severe infection because doctors had to use their cell phones to light a darkened surgical theatre, and missed removing several cotton swabs that had been placed inside X for the surgery. It had come to light that during a power failure emergency generators should commence providing the hospital with power, but the administrator failed to account for their inspection. The administrator, who already has an extensive record of poor decisions and unaccountable conduct, who has also never received any medical training, argues that he had no money to pay the generator inspectors.⁵⁷⁷

X argues that, while she was never denied access to the hospital, she had a right to adequate health care, in terms of S 12(2)(b) of the CRSA, and that by allowing the hospital to fall into a state of disrepair, her right was violated by the state.

From the hypothetical case it is clear that the public hospital is running in the red. The majority of all South African public hospitals are currently running in situations of medium to high crises.⁵⁷⁸ This means the majority of South African hospitals lack the basic equipment to treat patients, such as bedding and bandages, and this is not even taking account of the lack of proper hospital machinery.⁵⁷⁹ The problem is further compounded by the fact that currently most public hospitals run budgets in excess of 200 Million Rand.⁵⁸⁰ Currently a significant problem in the realisation of the access to health care is the fact that money is being thrown at the problem, without real solutions being proposed or targeted.⁵⁸¹ What is especially harmful is the concept of cost-cutting and corner cutting to attempt to reduce financial constraints. This ultimately results in over-worked physicians and nurses having to administer overpopulated wards.⁵⁸²

⁵⁷⁷ Staff Reporter, "Bara, a Place of Shame" in *The Star Newspaper Online*; published on 12 September 2012; accessed on 28 September 2012; www.iol.co.za/the-star/bara-a-place-of-shame-1.1381046#.UJ-JW4fucig.

⁵⁷⁸ Von Holdt and Murphy, "Public Hospitals in South Africa: Stressed Institutions, disempowered management" *The National Planning Commission Online*; published 28 April 2006; accessed on 1 October 2012;

<http://www.npconline.co.za/MediaLib/Downloads/Home/Tabs/Diagnostic/InstitutionandGovernance2/Public%20hospitals%20in%20South%20Africa-Stressed%20institutions,%20disempowered%20management.pdf> at 4.

⁵⁷⁹ *Idem* Von Holdt at 19-20.

⁵⁸⁰ *Idem* Von Holdt at 4-6.

⁵⁸¹ *Idem* Von Holdt at 10-12.

⁵⁸² *Idem* Von Holdt at 19-21.

As of 2012 the Department of Health has yet to implement an actual infrastructure plan to provide a sustainable set of universally adopted norms and benchmarks.⁵⁸³ The situation is so dire that these basic guidelines are not even in place, and are still being developed. This is the leadership the hospitals have to deal with. While the cronyism is an extensive problem, those few administrators who attempt to run an effective institution seemingly receive no help from the national department.⁵⁸⁴

5.2.4. APPLYING THE CASE LAW TO THE RIGHT TO ADEQUATE HEALTH CARE

From the decisions of *Soobramoney*, *Grootboom* and *TAC*, it becomes clear that the test employed by the Court is whether the claim is reasonable in light of available resources. In other words, can the state afford what the plaintiff is suing for.

In *Soobramoney* the Court expressly focussed on the financial situation of the Respondent, and seemingly took the view that available resources extend only to finances.⁵⁸⁵ While the financial well-being of the hospital results in effective realisation, it would be incredibly short-sighted to only focus on available resources as only being those fiscal resources necessary to realise the right. This is the benefit of having a right to adequate health care. While both access to health care and adequate health care are resource dependant, utilising both effectively not only increases the burden on the state, but does so in a way that sets clear parameters and goals.

In order to determine to what extent available resources plays a role, it is pertinent to first consider the positive and negative duties associated with the right to adequate health care. Negative duties require that the state seek to protect the right,⁵⁸⁶ meaning that the state should not purposely interfere, or through inaction cause the right to be violated. For the right to adequate health care this means the state should at all times be aware of this minimum standard and ensure all public health facilities are equipped with the most basic equipment. Insofar as the positive obligations are concerned, this extends to the state having to take steps to ensure the health care is of an adequate standard, and constantly adjust the current delivery to the minimum expected standards.

⁵⁸³ Department of Health, *The Annual Report 2011/2012*; Government Gazette; 2012 at 67-68.

⁵⁸⁴ *Ibid* Von Holdt, fn. 577 at 6-7.

⁵⁸⁵ Scott (1992); Swart (2005); Wesson (2004) and Pieterse (2007) at 514-516 all focus specifically on financial and fiscal resources.

⁵⁸⁶ *Op cit* at 107 – 109.

This discussion brings the debate back into the realm of minimum core obligations for the right to health. While it has been shown that the minimum core obligations of the right to health have remained purposely vague,⁵⁸⁷ it has also been shown that access to health care as well as adequate health care are minimum core obligations for the universal international right to health.⁵⁸⁸ Take the example of the failed generators. While they did not impede access to health care, they did cause the adequate standard of health care to drop considerably. Or the untrained hospital administrator, which did not impede access to health care, but through his inaction, caused X to suffer a poor standard of health care.

The question to be asked is whether it is possible to realise adequate health care, in its minimum core, which requires little or no fiscal spending. In other words, while the positive obligations exist, and are subject to the reasonable resources whether the situation exists where significant change can occur without incurring substantial costs. In other words how can the right to adequate health care be progressively realised?⁵⁸⁹

It is submitted that by implementing the principles of effective management from the administrators⁵⁹⁰ and by having the department of health lead from the front by setting out infrastructure guidelines and accelerating the creation of health schools and implementing proper health education, it will have achieved a foundation for the minimum core of adequate health care.

It is puerile to want to saddle an over-burdened system with more obligations, but health care and the judicial implementation of health care rights, stands at a crossroads. Currently the policy towards health care is focused solely on having as many South Africans are able to access a poorer and poorer hospital system. Currently the Annual Health Report only focusses on the development of hospitals as a primary health care service distributor.⁵⁹¹ Hospitals will eventually vitiate into death traps filled to bursting point with thousands of patients.

This thesis has shown that a second path exists, but that this path is one that will require extensive investment, in terms of time and effort, which will disable the current bureaucratic nightmare that is public hospitals. If the focus is removed from admitting everyone to a treating physician in a hospital, and rather towards creating a holistic health care

⁵⁸⁷ *Op cit* at 124-126.

⁵⁸⁸ *Op cit* at 118-126 where the 6 requirements are listed.

⁵⁸⁹ *Op cit* at 126 and 130-131.

⁵⁹⁰ *Ibid* Von Holdt, fn. 577 at 25-26.

⁵⁹¹ *Ibid* Annual Health Report 2011/2012, fn. 589 at 67.

environment where the chain of care goes from trained family members, to clinical nurses and then only to a general practitioner; it is submitted that there will be a noted decrease in the staggering amount of individuals who seek hospital care. If the National Department of Health makes a serious effort to listen to the physicians, nurses and even administrators working in public health, and actually implement their suggestions the burden on the health care system will be lessened, or at least made manageable.⁵⁹²

The progressive realisation of the right to adequate care need not, initially, require mass amounts of fiscal investment. Nor that it can be used as a way to get free services from the government. But it can be used as a policy directive, and a measuring stick for the health care needs in the country. Should X bring her matter before the Constitutional Court, it is submitted that they would find the minister of health had violated that right by not imposing stricter infrastructure guidelines, but that the individual harm suffered by X cannot result in monetary compensation.

5.2.5. REMEDIES FOR VIOLATING THE RIGHT TO ADEQUATE HEALTH CARE

It is a basic tenet of the rule of law, that in order for a right to exist it must be judicially enforceable.⁵⁹³ This generally means that if Z is censored by the state for criticising the president, then Z can use her freedom of expression to have the state not censure her.

Unfortunately socio-economic rights are not capable of such simple resolution when they are litigated. As was stated *supra*, the Courts in *Grootboom* and *TAC* were disinclined to make any binding order against the executive when it came to enforcing the socio-economic rights.⁵⁹⁴ The arguments the Court raises are that it is incapable of determining the subtleties of ruling a population and more importantly that it is not the function of the Courts to administer the law.⁵⁹⁵ This is similar to the reasoning the Court has used to reject minimum core obligations. How can judge best assess what is more important between paying for a generator repairman and paying the electricity bill?

⁵⁹² *Ibid* Von Holdt, fn. 577 at 25-27.

⁵⁹³ *Op cit* at 64-67.

⁵⁹⁴ *Op cit* at 135-137 as well as Swart (2005) at 215 and Mbazira, "Appropriate, Just and Equitable Relief in Socio-Economic Rights Litigation: The Tension Between Corrective and Distributive Forms of Justice" 2008 *SALJ* 71 at 71.

⁵⁹⁵ *Ibid TAC*, fn. 324 at par 32.

While it is submitted that the maxim of *ius dicere non facere*⁵⁹⁶ is an essential element to the separation of powers, that the principle of constitutionalism demands of judges to enforce the constitution where the state fails to uphold it.⁵⁹⁷ And while it is more convenient to make constitutional issues someone else's problem, the Courts have themselves failed to uphold the CRSA.

It is submitted that while a judge cannot be expected to make an order on the minutiae of setting policy, the CRSA does empower the Courts to use interdicts to compel the state to take certain actions. As Swart correctly points out, the use of a structural interdict,⁵⁹⁸ will actually create consequences for the state failing to deliver, and reduce the chances of the same socio-economic violations returning to court year on year.⁵⁹⁹ While such orders must be delicately crafted, the Court has shown it can create such orders, and the argument that they lack the necessary skill can be summarily rejected.⁶⁰⁰

While the argument can also be made for constitutional damages, in terms of the *Fose*⁶⁰¹ such a step would need to be carefully assessed. While the constitutional damages would link with the delictual claim that caused the positive obligation of the right to adequate health care, such damages would probably result in the state stonewalling further, instead of attempting to deliver the rights involved.

5.2.6. CONCLUSION

Socio-economic rights in South Africa are a collection of empty peals. As harsh as this may seem, there is no other way around the matter. The Constitutional Court has been loath to actually ensure the implementation and efficacy of socio-economic rights, preferring to make declaratory orders decrying the state of affairs, but not taking any further steps.⁶⁰²

It is in this hostile environment that this thesis attempts to interject another right. However as socio-economic rights have become unenforceable, a shift in mind-set has occurred, where the socio-economic rights have become aggressive state directives.⁶⁰³ While it was easy to

⁵⁹⁶ A judge only speaks the law, but doesn't make it.

⁵⁹⁷ Mbazira (2008) at 80-82.

⁵⁹⁸ As found in *August v Electoral Commission* 1999 (3) SA 1 (CC).

⁵⁹⁹ Swart (2005) at 236-240 as well as Mbazira (2008) at 84-87.

⁶⁰⁰ Bilchitz (2003) at 15-18 and Swart(2005) at 238.

⁶⁰¹ *Fose v Minister of Safety and Security* 1997 (3) SA 786 (CC) at par 69.

⁶⁰² Mbazira (2008) at 89-93.

⁶⁰³ Davis (1992) at 477-480.

pass the right to access to health care on, as the state directive is to only provide access, the right to adequate health care seeks to remedy this troubling situation.

It seems almost paradoxical to argue that increasing the duties of the state can result in the state lessening its burden, but if the state utilises the minimum core obligations as a yardstick, then most rights will find application.

It seems almost paradoxical to argue that increasing the duties of the state can result in the state lessening its burden, but if the state utilises the minimum core obligations as a yardstick, then most rights will find application. If the right to adequate health care is progressively realised by cost-cutting measures and reviewing and completely overhauling the current hospital administration policies, then the initial period will not cause extensive fiscal loss. If the state actually considers the delivery of these rights, and in particular health care, instead of building cloud castles of universal access to hospitals then health care in this country can actually become profitable and effective, as opposed to the absolute nightmare it is now.

5.3. THE NHI: ILLUSTRATING THE DISASTER OF ACCESS-ONLY

5.3.1. INTRODUCTION

The NHI is a system of health care financing whereby all South Africans will have access to appropriate, efficient and quality health care services.⁶⁰⁴ The NHI was created as a public health care answer to the ever-expanding private health care system.⁶⁰⁵ While this sounds admirable, and like a commitment to change, the subsequent evaluation shall show that by ignoring the right to adequate health care, the Department of Health has no created a monstrosity geared towards the realisation of broad access to health care, but lacking in the ability to actually guarantee proper care. By linking the entire system through public hospitals, the Department of Health will actually result in the current over-burdened system crashing completely.

The purpose of this critical evaluation shall be to prove that the NHI system is unworkable and will result in unfathomable damage to the public health care system. It will be shown that the knee-jerk reaction and over-committal to access to health care will result in the eventual destruction of public health care in South Africa.

⁶⁰⁴ Par 1 of the National Health Insurance in South Africa Policy Paper (Further referred to as the NHI Policy Paper) of 2011. Published in the Government Gazette, No.4, 12 August 2011.

⁶⁰⁵ Par 3 NHI Policy Paper.

This discussion shall consist of a critical evaluation of the NHI policy document, with reflections on how not considering the right to adequate health care will result in significant damage.

5.3.2. A CRITICAL EVALUATION OF THE NHI POLICY PAPER

5.3.2.1. Introduction (Par 1-6)

The NHI, as was stated earlier, was created as a public health care response to the current medical aid driven private health care. While the Policy Paper specifically makes mention of the current health care system is imbalanced and sides with the wealthy who can afford proper treatment,⁶⁰⁶ especially when paying for out of pocket treatment at a private facility. In order to achieve this, the NHI calls for four key interventions to happen simultaneously: a complete transformation of health care services and delivery; a complete overhaul of the health care system; radical change in administration and management of public facilities and a comprehensive package of health care underpinned by a reengineered concept of primary health care.⁶⁰⁷

The Department must be praised for the commitment to change, especially considering that it, itself, has finally admitted that its administration of public health facilities have resulted in a reduction of service capacity, and further that its policies are one of the main hurdles towards achieving decent health care in South Africa. What should not be condoned however is the fact that the Department has seemingly blamed the imbalance solely on the private health care industry. Or that it relies on “us versus them” language to make it sound like a small portion of the population is benefitting while everyone else toils away. Especially considering that the state has its private health care administered by GEMS, meaning it is part of this minority. It will be shown later how this mentality creates a massive impediment for the actual realisation of health care in South Africa.

5.3.2.2. Problem Statement (Par 7-16)

The problem statement reflects on the racial history of South Africa, and rightly so. It is deeply unfortunate however that the confrontational language is still used. While it does not necessarily impact the delivery of health care services, the Department continues its long – standing tradition of blaming everyone else for the problems facing health care in South

⁶⁰⁶ Par 5 NHI Policy Paper.

⁶⁰⁷ Par 6 NHI Policy Paper.

Africa.⁶⁰⁸ It is also worrying that the Department lays the blame for the current health care inequality squarely at the feet of the medical schemes, and by implication the white population.⁶⁰⁹ It is further worrying that the focus currently is not on raising the standard of health care, but rather on equalising the health care system.

The Problem Statement paints a bleak picture, but admirably the Department has noted that the largest crises facing the public health care system is the unsustainability, high cost and high curative implications that come from having a hospital driven health care system.⁶¹⁰ It is also commendable that the Department admits that the worsening standard of care is one of the major causes for public patients to seek private care.⁶¹¹

5.3.2.3. Quality of Health care (Par 22-23)

While the Department raised the issue that many people escape to private health care, because of the shocking state of the standard of health care, it does almost nothing to address this issue, only listing a few specific areas where quality has been found lacking like personnel attitudes, cleanliness, long waiting times and infection.⁶¹² What is utterly lamentable and not surprising is the fact that the Department makes no mention of fixing the quality issue, only stating that it is at the heart of the NHI.⁶¹³

While the Department can be commended for its use of emotive and touching language it must be stressed that up to this point there has been little mention of how to fix the majority of the issues facing the health care industry. One can almost expect the NHI simply being created as a method to make the Department seem almost relevant again.

5.3.2.4. Health care Expenditure in South Africa (Par 24-28)

South Africa currently spends around 8.5% of its GDP on health care, with a split of 4.1% being spent on private health care⁶¹⁴ and 4.2% being spent on public health care.⁶¹⁵ While

⁶⁰⁸ Par 7 NHI Policy Paper.

⁶⁰⁹ Par 9 NHI Policy Paper.

⁶¹⁰ Par 12 NHI Policy Paper.

⁶¹¹ Par 14 NHI Policy Paper.

⁶¹² Par 22 NHI Policy Paper.

⁶¹³ Par 23 NHI Policy Paper.

⁶¹⁴ Covering around 8.2 Million people. Par 26 NHI Policy Paper.

⁶¹⁵ Covering around 42 Million people. Par 26 NHI Policy Paper.

the WHO recommends that countries spend around 5% of their GDP.⁶¹⁶ This simply illustrates the point that simply by throwing money at a problem won't fix it. While government still places the focus on health care solely on guaranteeing access, and not on delivering an adequate standard, the same problems will continue to persist.

The near 10% South Africa spends on health care has resulted in a situation where hospital costs have increased by 121% and private specialists have increased by 120%.⁶¹⁷ While the Department blames greedy doctors and administrators, it does point out that even private medical schemes have only doubled their contribution rates in a seven year span, ultimately resulting in early exhaustion of benefits or severely limiting access to health care.⁶¹⁸ While a large portion of the increase is made by the doctors themselves, it still oversimplifies the modern health care industry. Expensive private health cares, and expensive public health care for that matter, are simply becoming a fact of life. Creating the NHI cannot undo the global pharmaceutical driven industry. It is also with a worrying note that the emotive language that sets the haves against the have-nots is criticised. It almost seems that every time the Department deliver substandard reports, they couch it in blaming language targeted at the medical schemes, private patients and doctors.

5.3.2.5. Distribution of Financial and Human Resources (Par 29-32)

The Department makes the point that, due to the reduced number of patients in private health care, that there is a much more constructive patient to doctor ration in private health care.⁶¹⁹ Per capita expenditure for private health care is around R12 000 compared to the R2766 for public health care.⁶²⁰ While this significant imbalance is not an effective way to increase the minimum standard of quality and the adequate standard of health, it is submitted that the NHI is still not the solution. Further, the Department had another opportunity to discuss methods of retaining public health care specialists and encouraging them to practice public health care, but simply states that it's finalising a health strategy in human resources.⁶²¹

⁶¹⁶ Par 24 NHI Policy Paper.

⁶¹⁷ Par 27 NHI Policy Paper.

⁶¹⁸ Par 27 NHI Policy Paper.

⁶¹⁹ Par 30 NHI Policy Paper.

⁶²⁰ Par 31 NHI Policy Paper.

⁶²¹ Par 30 NHI Policy Paper.

5.3.2.6. National Health Insurance (Par 50-51)

At the heart of the Policy Paper are the reasons for the creation of the NHI. The Department once again raises the spectre of the two-tiered system,⁶²² but this time makes the argument that the investment in the NHI will result in one hand feeding the other. While this realisation is commendable, the author disagrees with the Department, as to how best to achieve this. If one considers the American model of health care, where generally all hospitals provide for public health care, while the use of hospital insurance can increase the therapeutic options (such as whether non-emergency MRI's can be taken) and post-treatment options (like having a personal room or a night nurse). The creation of the NHI will increase the amount of money available in the public sphere, but the Department has yet to show the ability to distribute those funds correctly.

The NHI will also attempt to increase the general level of health in South Africa. As well as increasing the disease prevention infrastructure.⁶²³ Unfortunately this is couched in the same descriptive language, but lacking in any real commitment or plan.

5.3.2.7. Principles of National Health Insurance in SA (Par 52)

The principles chapter sets out the 8 principles the NHI are built on, and interestingly enough reflect all the minimum core obligations that are necessary to realise the right to health. The question may be raised that if the Department utilises minimum core, whether it will be open for inclusion when another health care matter is brought before the Constitutional Court.⁶²⁴

The principles the NHI are based around are the right to access, social solidarity, effectiveness, appropriateness, equity, affordability and efficiency.

The right to access is simply a repetition of the S 27 of the CRSA right to access with a commitment that health care should be free at the point of use and that people should benefit according to their health profile. While these goals are commendable, it is submitted that they are financially idealistic and impossible to obtain. Instead of arguing for subsidised health care or incentives for not seeking hospital care, the focus is on broad spectrum free health care. This is, at best, a pipedream.

Social solidarity is the principle whereby a person does not contribute more than she ought to, considering her age, risk profile and financial status. One has to question the efficacy of

⁶²² Par 50 NHI Policy Paper.

⁶²³ Par 51 NHI Policy Paper.

⁶²⁴ Bilchitz (2003) at 23-26.

this decision considering the over-burdened middle class and their already substantial contributions to fuel, electricity and income tax.

Effectiveness, while being the key element towards raising the adequate standard of health care, is simply acknowledged as being achievable through evidence-based medicine and better management of public health care facilities which will result in an increase in the average life expectancy. Yet again, the NHI Policy Paper misses the point. What the current public health care system needs is not more money, or more access but rather smarter management and better use of resources.

Appropriateness contains the government commitment towards adopting and creating new health care service delivery models, which are appropriate to South Africa. Once again referral is made to the new Primary Health Care Model.

Equity or fairness is defined as providing those with the greatest need with timely access to health care services. This is an extension to access to health care, in that the access should be open to marginalised members of society. The question of whether this would be opened to non-contributing foreigners or those with critical pre-existing conditions is left unanswered for now.

Affordability is simply mentioned as having the health care service traded as a public good at a reasonable cost. The reasonability of the cost, or what model it will be compared to is not discussed.

Efficiency, which can be linked to effectiveness, relates to the administration of public health care on the national, provincial and local levels, and eliminating unnecessary costs. Unfortunately no mention is made of what these costs would be, or how the actual employment numbers would impact the cost model.

While all the elements for the realisation of the right to health are present, the worrying lack of detail and attempts to provide too much, too soon, result in the principles of the NHI not really carrying any weight, or providing any certainty to someone on the outskirts of the system. No mention is made of how the amount contributed with impact the service given, or whether high contributors will get more efficient service for instance.

5.3.2.8. Objectives of National Health Insurance (Par 53-55)

The Department states that the attainment of universal coverage, as defined by the WHO, as the core objective of the NHI. Universal coverage is the progressive development of the

health care industry as well as the financing mechanisms supporting it, to the point where every individual has access to quality and necessary medical care while being protected from financial hardships negating this coverage.⁶²⁵ The Department uses the argument that other countries have successfully implemented effective national health insurance programmes, without comparing successes, or seemingly taking account of the problems faced by those countries.⁶²⁶

The listed objectives of the NHI are simply paraphrased versions of the principles of the NHI, such as improved access to quality health care services; to pool risks and funds to achieve social equity; to standardise the cost of health care and finally to strengthen the public sector. As was discussed above, while the goals of strengthening the public sector and achieving social equity are achievable, the current plan is not the right plan to achieve that.

5.3.2.9. The Re-Engineered Primary Health Care System (Par 66-78)

The Primary Health Care System⁶²⁷ is based around the Alma Ata definition of health.⁶²⁸ Briefly this means that health is not the absence of illness, but rather a state of total wellbeing including physical and mental health. The PHS will be designed to extend beyond the traditional hospital and clinic setting, with a focus on community outreach.⁶²⁹

With health care administered through District Authorities (that are administered through the district hospitals such as Bara and Steve Biko Academic) the focus of PHS will be on prevention of disease and promotion of good health.⁶³⁰ And all members of the population (which could be read to include non-contributors) are entitled to a comprehensive PHS package.⁶³¹ And that this package will be included in the mandatory insurance, applicable over private and public health care.⁶³²

⁶²⁵ Par 53 NHI Policy Paper.

⁶²⁶ Par 54 NHI Policy Paper. Consider especially Canada, where private health care is illegal, and many Canadians cross the border into the US to get prompt, non-emergency, treatment.

⁶²⁷ Further referred to as the PHS.

⁶²⁸ *Ibid* Alma Ata, fn. 417.

⁶²⁹ Par 66 NHI Policy Paper.

⁶³⁰ Par 67 NHI Policy Paper.

⁶³¹ Par 69 NHI Policy Paper.

⁶³² Par 68 NHI Policy Paper.

PHS will be delivered through 3 broad streams, namely: District based clinical specialist teams supporting the delivery of PHS; School based PHS and municipality based PHS.⁶³³

District based PHS, for the moment, consists of teams specialising in family medicine to combat the scourge of maternal mortality.⁶³⁴ This system can be compared with the general health care practice, where ill patients see a nurse or GP and then seek further treatment as is demanded by the illness.⁶³⁵ There is some uncertainty as to what is meant by a specialist as the Policy Paper now starts to distinguish between a GP and specialist. If one follows the ordinary meaning rule, it should apply to any physician that has completed a specialisation course, such as OB/GYN or Internal Medicine. This model is based around the fact that the critically ill can have access to specialists before they become terminal.⁶³⁶ While these outcomes are commendable, the list of specialists⁶³⁷ fails to include specialist surgeons, psychiatrists, trauma surgeons, oncologists, internists, dieticians and nuclear physicians. While the scourge of maternal mortality must be combatted, the Department succumbs to its previous failings of over-focusing in on one discipline while allowing the other disciplines to spiral out of control. There is room for the National Department of Health to assign more specialists to this area, but one must wonder if their long-term vision is severely handicapped by this regulation.

School PHS consists of teams of nurses that focus on the prevention of illnesses, especially amongst children.⁶³⁸ This is especially relevant to childhood immunisations such as the MMR vaccination.⁶³⁹ This programme can be commended for focussing on the mental development of children, and focusing on sexual education, childhood abuse and nutritional education.⁶⁴⁰ The only flaw in this delivery system is the exclusion of other medical professionals that are not nurses. No mention is made of whether nurses have the authority to escalate matters to the district PHS.

Municipal PHS consists of teams of health professionals that will be allocated to certain areas and families.⁶⁴¹ Their task is to collate information on health problems and risky

⁶³³ Par 70 NHI Policy Paper.

⁶³⁴ Par 71 NHI Policy Paper.

⁶³⁵ Par 73 NHI Policy Paper.

⁶³⁶ Par 73 NHI Policy Paper.

⁶³⁷ In Par 71 NHI Policy Paper.

⁶³⁸ Par 74 NHI Policy Paper.

⁶³⁹ Par 74 NHI Policy Paper.

⁶⁴⁰ Par 76 NHI Policy Paper.

⁶⁴¹ Pat 77 NHI Policy Paper.

behaviour. They will also assist in identifying common maladies and implementing interventions if there is an outbreak of communicable diseases.

5.3.2.10. Health Care Benefits under National Health Insurance (Par 79-96)

Furnished with a definition for PHS, the next logical step will be to determine what benefits will be provided under the NHI. A benefit package is defined as “how different types of services are organised into different levels of care in the public sector.”⁶⁴² It also focuses on what can be achieved according to the available resources. The design of the packages, by the Department, are based on considerations such as improving access to health care, offering financial protection to marginalised groups and enhancing redistribution of health care services. While the Department does not source these considerations, it is incredibly difficult to believe that these packages are not also tailored to ensure as high a standard as possible is maintained for as large a possible population group.⁶⁴³

Every package will be linked to norms and practices that set out the measurable targets that the package should achieve. Unfortunately the Department is silent on what these targets are, so one can assume it's the principles and objectives of the NHI. Specific mention here is made of “acceptable standards of care.”⁶⁴⁴ Unfortunately this term is not defined anywhere, but is a definitive commitment to needing to raise the adequate standard of health care.

The service package for district based PHS, are based around making the health care available at convenient hours while being adequately staffed, ensuring fair treatment of patients and compliance with core quality standards. Yet again the outcome of the PHS is linked with proving a quality service, but the Department fails to properly account for what is adequate service.⁶⁴⁵ Special mention is also made of public health interventions designed to reduce the disease burden while being cost effective.⁶⁴⁶

The services that a patient can expect at a hospital will be linked to a defined comprehensive package that is appropriate to the relevant referral systems as well as the appropriate level of care. This will be based on primary, secondary, tertiary and quaternary levels of care. These four levels of care remain undefined.

⁶⁴² Par 79 NHI Policy Paper.

⁶⁴³ Par 81 NHI Policy Paper mentions the international law consideration, and as the exhaustive international law application in this thesis proved, it is unlikely that effective health care would be ignored.

⁶⁴⁴ Par 82 NHI Policy Paper.

⁶⁴⁵ Par 84 NHI Policy Paper.

⁶⁴⁶ Par 84 NHI Policy Paper.

5.3.2.10.1. Designation of Hospitals

Due to the expected overhaul of the public health care system, all the hospitals in SA will be redesigned. The smallest hospital will be a district hospital, followed by a regional hospital and then a tertiary hospital and finally the central hospital.⁶⁴⁷ A specialised hospital is also created under this new change. The Department specifically notes that while this hierarchy exists to streamline care, no patient should be refused access to any hospital if they are in need of treatment.⁶⁴⁸

A district hospital is the smallest sized hospital focusing primarily on family medicine, OB/GYN, general surgeries and paediatrics.⁶⁴⁹ The package of care provided for these hospitals include emergency care; in-patient care; out-patient care; rehabilitation; care for the elderly; diagnostic services, paediatric care and obstetrics.⁶⁵⁰

A regional hospital will offer a broad range of specialist services. It is understood from the Policy Paper that these hospitals will generally require referral from district hospitals for matters requiring a specialist such as general surgery; orthopaedics; general internal medicine; paediatrics; OB/GYN; psychiatry; radiology and anaesthetics.⁶⁵¹

A tertiary hospital will provide patients with an exceptional level of specialist care and post-specialist care. These hospitals will also be the training hospitals for new physicians as well as provide the backbone for medical research. Examples of services offered include cardiology; cardiothoracic surgery; nuclear medicine; ENT specialists; haematology; oncology and ophthalmology.⁶⁵²

Central hospitals will form the apex of the new classification of hospitals. These hospitals will be super specialised and offer specialist training and referral. They are also considered national hospitals. These hospitals will also receive high-end equipment and expertly trained staff.⁶⁵³

⁶⁴⁷ Par 88 NHI Policy Paper.

⁶⁴⁸ Par 89 NHI Policy Paper.

⁶⁴⁹ Par 90 NHI Policy Paper.

⁶⁵⁰ Par 91 NHI Policy Paper.

⁶⁵¹ Par 93 NHI Policy Paper.

⁶⁵² Par 94 NHI Policy Paper.

⁶⁵³ Par 95 NHI Policy Paper.

Specialised hospitals are those hospitals designed for one purpose only, such as mental hospitals or eye hospitals.⁶⁵⁴

5.3.2.10.2. Conclusion

While the new classification of hospitals is a step that should be commended, this is also a step that will require precise administration and control. The question of whether the Department can effectively control this system, and not simply sit with central hospitals that are swarmed with patients, is one that will require significant limitation of the right to access to health care, in favour of the adequate standard doctrine, so as to maintain the functions of the various hospitals.

5.3.2.11. Accreditation of Providers of Health Care Services (Par 97-100)

The Office of Health Standards Compliance,⁶⁵⁵ a creature of statute, shall be tasked with overseeing the entire accreditation process. Consisting of three units, an inspection unit; a norms and standards unit and an ombudsman, the OHSC will set the norms and regulations for NHI accreditation as well as establishing a minimum standard of health care.⁶⁵⁶ The OHSC will also be charged with ensuring that the health care provided is effective, which means that they shall ensure the adequate standard of health care.⁶⁵⁷ One has to seriously ask why it has taken the Department 19 years before establishing such an office to oversee all the hospitals, instead of desperately trying (and failing) to inspect and maintain the hospitals by itself.

While many of the ideas promulgated by the Policy Paper are inventive and revolutionary, the average public health care patient must lament that it took the introduction of the NHI before the Department sought to test them. And with the teething problems that come with any large-scale redevelopment, these inventive organisations will no doubt fall to the wayside or become irrelevant as the NHI progresses.

⁶⁵⁴ Par 96 NHI Policy Paper.

⁶⁵⁵ Further abbreviated as the OHSC.

⁶⁵⁶ Par 97 NHI Policy Paper.

⁶⁵⁷ Par 98 NHI Policy Paper.

The Policy Paper also makes special provision for minimum accreditation standards. Once again, one is left begging the Department why it has only developed, or caused to develop, these standards now, instead of implementing them right after *Soobramoney*.⁶⁵⁸

5.3.2.12. Conclusion

It must be stressed that this discussion cherry-picked the elements of the NHI, that was either an inventive opportunity or will result in a massive downturn in the realisation of the right to health in South Africa.

While many of the ideas under the NHI deserve praise, such as the reclassification of hospitals or the creation of the OHSC, it has yet to be determined whether these plans will find application. The Policy Paper is eerily quiet on how it will ensure that patients do not simply flock to the exceptional central hospitals, or to what extent the OHSC can reduce the access to a district hospital that is understaffed, for instance.

And this uncertainty ties into the major criticism for the NHI. The policy document is quiet on so many of the concrete details necessary. No mention is made of the CRSA, and how it would impact the realisation of the NHI. While there is a definite focus on providing an adequate standard of health care, no attempt is made to codify the minimum acceptable standards. The Policy Papers are also filled with emotive language and ideals befitting a preamble, but not necessarily suited to realising the right to health.

And while this discussion only focused on critiquing the legislation behind the NHI, volumes can still be written on the tenuous nature of the Canadian and English national health care services. While both countries benefitted from having a brilliant hospital system that was eventually brought under state control, the South African public hospitals are barely functioning as is.

The second problem facing the NHI, as possibly the most pressing, is that it is a nationwide tithe on health care. The National Department of Health has already shown an almost childlike inability to administer funds and develop resources, and now it seeks to increase the amount of money it will receive exponentially, without really developing community health resources, for instance. Currently most rural clinics are ill-attended because citizens in the areas just don't know about them.

⁶⁵⁸ Par 100 NHI Policy Paper. *Ibid Soobramoney*, fn. 270.

Further, the fact that the National Department of Health is still preaching concepts such as free universal health care without progressively making the right to health care effective or adequate can only result in a nationwide mandatory system that allows access to all people within the borders, but are understaffed, infectious death-traps. No mention is made in the Policy Paper on how to establish the medical infrastructure or how the suppliers will be governed and paid.

The final verdict of the NHI is a damning one. It is a policy based in hypotheticals and ideal situations, without any serious grounding in actually providing for the resources, or implementing those resources effectively. While the idea of building a new public health system from the ground up is incredibly attractive, the average middle class citizen who will end up contributing the lions share to this fund will have to rely on promises and plans from a department famous for failing to deliver, and then blaming other parties. It would be like being forced to invest money in your brother-in-law's genius "can't fail" scheme, which always results in failure.

5.4. CONCLUSION

It has been said that the current public health system rests at a crossroads. After 19 years, the National Department of Health has had a string of miserable failures. From a publically ridiculed AIDS policy to a public hospital system that can be seen as one of the great failures of post-Apartheid South Africa. Currently the Department is on the precipice of taking a step into the NHI it is not ready for, and a step that will result in tragic consequences, not only for providing broad-spectrum equality and public health care but also in terms of actual human cost. Unfortunately the modern economic model of health care results in public health care being a labour of love, and if the NHI goes through the reduction in fees will make it more so. Without providing physicians with a suitable alternative, the Department is hoping young doctors will wish to stay in a public practice that is extensively over-burdened for a lot less money than they could make elsewhere.

The Department of Health, with able assistance from the Courts, have attempted to progressively realise the broadest element of the health care, namely access to health care, without paying heed to the other elements of the right to health. It is this failure that has resulted in the dominance of private health care, and the slow destruction of public health care. It is forsaking the infrastructure involved in maintaining a hospital or refusing to consider that health care should be effective and comprise of a minimum standard that has resulted in the failure of public health.

While it would behove the Department to seriously consider its policies, and create a new public health care system based on the actual realisation of the elements of the right to health, the Department has now determined to do this, but against the disastrous background of the NHI. Perhaps the most telling problem is this: the NHI is driven by health care from doctors. Currently the estimated population of South Africa is around 51 million people.⁶⁵⁹ If it is presumed that the average GP can only effectively treat and diagnose 35 patients per day,⁶⁶⁰ then that requires a workforce of, roughly, 1.5 million general practitioners. Currently there are about 39 thousand doctors registered with the Health Professions Council of South Africa.⁶⁶¹ One can only hope the Department realises its mistake before serious and long-term damage is caused.

⁶⁵⁹ Statistics South Africa, *Mid-Year Population Estimates 2011*; published on 27 July 2011 and accessed on 1 November 2012; available at www.statssa.gov.za/Publications/P0302/P03022011.pdf at 2.

⁶⁶⁰ If the doctor sees 3 patients every hour in a 12 hour day or 3.5 patient every hour in a 10 hour day.

⁶⁶¹ HPCSA, *Number of Registered Healthcare Practitioners 31 March 2012*; published on 31 March 2012 and accessed on 1 November 2012; available at www.hpcsa.co.za/statistics.php.

6. Chapter 6 – Conclusion

6.1. INTRODUCTION

In order to effectively conclude this thesis, it is first necessary to complete a broad overview of what has been achieved through this thesis, before being allowed to conclude this thesis. It has been conclusively shown that, not only does there exist a right to adequate health care, but that the progressive implementation of that right will ultimately result in the correction of many of the current imbalances.

While this thesis reflected on painful moments in human history, and the development of human rights to ensure such tragedies would become the exception and not the norm, it has also successfully celebrated human history and scientific development, as well as the legal development where the average citizen or resident can turn around and fend off the machinations of the state.

Most importantly, this thesis has also shown that, if socio-economic rights were approached differently, then socio-economic rights can return to the forefront of constitutional development.⁶⁶² If the Court will accept that the executive has consented to minimum core obligations, by incorporating them in policy documents, it can set about (or through *amicus curiae*) to establish progressive goals for the realisation of those rights and more importantly bind the state to achieving those goals.

6.2. REVIEWING THE CONCLUSIONS OF THE PREVIOUS CHAPTERS

6.2.1. CHAPTER 2

In Chapter 2 the concept of the doctor-patient relationship was first established. In order to have effectively analysed the doctor-patient relationship, it was essential to have a concrete and profound understanding of the relationship and the duties it imposes. After using a historical comparison this understanding was met and the application of the law to the relationship could get underway.

It was further proven that the current law of contract, especially through the *Strydom* matter,⁶⁶³ is in direct violation of the principles of the doctor-patient relationship, and it follows that such a violation is considered *contra bonis mores*. It was also conclusively established that the doctor-patient relationship finds its form and function in the operation of

⁶⁶² Van der Walt (2001) at 362-363.

⁶⁶³ *Ibid Afrox*, fn. 108.

the law of delict. Not only are the duties expected of a physician clearly set out, but the consequences of failing those duties are also made clear. Finally the law of delict, in providing for vicarious liability, allows for the state that, through inaction, allows a physician or nurse to violate the duty of care to be held liable for the violation of the duty of care. This conclusion set the foundation for the findings in Chapter 3.

6.2.2. CHAPTER 3

In Chapter 3, it was first necessary to review the constitutional foundations of the CRSA. In order to determine where the CRSA needs to go, it is essential to understand where it came from. After this study, the task at hand was to determine how the CRSA applied to the relationship between the inactive state and patient before finally progressing to a critical study of the principles behind interpreting a right in the Bill of Rights.

After this foundational knowledge was set, this thesis could then proceed to analyse the various rights applicable to health care and the doctor-patient relationship, before settling on the right to security over and control of one's body as the basis for the right to adequate health care, in terms of S 12(2)(b) of the CRSA.

However simply making this conclusion was not nearly substantive enough, as the right to adequate health care still lacked normative content, and more legal support.

6.2.3. CHAPTER 4

In Chapter 4, South Africa's international obligations regarding the right to health were exhaustively cogitated. Firstly South Africa's commitments under international public health care law were analysed, before determining that while they required a high standard of care, this was not equitable to the standard of care found through the operation of S 12(2)(b) of the CRSA.

Fortunately because of the exhaustive work done in order to realise the international right to health, this thesis could proceed to critically analyse and evaluate the operation of the right to health under the UDHR, then the ICESCR and finally the ACHPR in order to effectively determine what was meant by the right to adequate health care. It was ultimately concluded that the right to adequate health care was the minimum core obligation of the right to health that ensured the right to health was made effective.

6.2.4. CHAPTER 5

Armed with a proper understanding of the right to an adequate standard of health care, the discussion could finally progress into the application stages. The task was to determine whether the right to adequate standard could be made effective and justiciable. It was shown, overwhelmingly so, that by focussing on the progressive realisation of the adequate standard that actual change could be wrought. Ultimately it was proven that while the adequate standard right required some fiscal commitment from the state, that it was still possible to utilise the right without causing the state to undergo substantial economic hardships.

Finally, armed with the knowledge that the public health care system was capable of being improved, the ire of this thesis turned upon the NHI. It was shown that while the NHI may have caused true innovation in the public health sphere, the actual policies of the NHI were overbroad and impossible to enforce. The ultimate point was made that the National Department of Health is incapable of administering resources appropriately and that giving them more resources would be a dire decision.

6.3. CONCLUDING REMARKS

At the outset of this mammoth task Chapter 1 concluded with the famous “*never again*” quote from Nelson Mandela’s inauguration. While the author allowed himself a small measure of sensationalism, the motivations behind those words need to be seriously reflected upon. South Africa faces a dire situation, because the racial policies of Apartheid have now been replaced with an economic Apartheid.

What makes this economic Apartheid so much worse is that it is governed over by an apathetic state, which is seemingly more concerned with enrichment, than actual change. And while the minority parties fight over trifling matters, the current government is passing extraordinarily dangerous measures to attempt to realise a right in the most indecorous way.

The argument must be made again; that the health portfolio is so essential, that it should be removed from the political auspices of government and regulated over by a council of health professionals, with government providing a broader oversight. The South African government has shown, time and time again, that it is unqualified and inept at providing health care, choosing to rather focus on pie-in-the-sky ideas of free universal health care that doing its utmost to progressively realise the right to health care in South Africa through balancing access and adequate standard or effectiveness.

Unfortunately health care is where the state seemingly makes its money, and as a portfolio it is unlikely to ever be separated to ensure effective administration. This effectively means that the only protection available against the state is found in the interpretation and application of minimum core obligations to best realise socio-economic rights.

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