WISH-FULFILLING MEDICINE:

LEGAL AND BIOETHICAL PERSPECTIVES

WITH REFERENCE TO THE PRACTICE OF COSMETIC SURGERY

by

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Summary

This study seeks to answer the question whether wish-fulfilling or non-therapeutic medicine, extreme forms of cosmetic surgery in particular, should be legal. Whether non-therapeutic procedures are or should be legal has become a matter of increasing importance, as such procedures are undertaken frequently and can even be said to be commonplace. This question is investigated with reference to the South African framework of medical law. The practice of wish-fulfilling medicine, with an emphasis on cosmetic surgery, is analysed in terms of the Constitution, the South African common law and legislation as primary sources of law. Textbooks and writings of authors are utilised as secondary sources of law. The ethical sphere of medical law and how this influences the phenomenon of wish-fulfilling medicine is explored in depth. This is done with reference to the ethical rules and regulations for healthcare practitioners as published by the Health Professions Council of South Africa, textbooks and writings of authors. This dissertation essentially consists of 4 parts. Firstly, the phenomenon of wish-fulfilling medicine is examined in context of the common law. As wish-fulfilling medicine is a relatively new phenomenon, the common law does not provide us with much guidance. The only alternative we are left with is to approach wish-fulfilling medicine in terms of the broader principles of consent to harm. An investigative discourse is conducted on whether a patient’s consent is sufficient justification for the performance of ethically suspect and radical non-therapeutic surgery. The discourse takes place in context of the defence of informed consent as indicated by the common law maxim of \textit{volenti non fit iniuria}. Secondly, the constitutional framework surrounding wish-fulfilling is investigated. The specific fundamental human rights protected in the Bill of Rights that are applicable to wish-fulfilling medicine, cosmetic surgery in particular, are discussed in detail. The rights relate to human dignity, autonomy, privacy and bodily and psychological integrity. By applying a constitutional conception of human dignity, the question is answered whether cosmetic surgery most likely promotes or impedes human dignity. In this regard, the relationship between autonomy and dignity and the question whether autonomous individuals should be prevented from participating in activities that might limit their dignity is addressed. The same enquiry is made in relation to the other fundamental human rights applicable to cosmetic surgery. The limitation of these fundamental human rights in terms of section 36 of the Constitution is then addressed. Thirdly, some of the common ethical objections raised against cosmetic surgery and wish-fulfilling medicine in general is addressed. Most of these objections are repudiated and solutions are suggested for others. These objections relate to
the goals of medicine and the disease-enhancement dichotomy, complicity arguments, arguments regarding human nature and naturalness, justice and accessibility, concerns regarding the autonomy of the patient’s wish and concerns regarding the application of Principlism. The conclusion is reached that cosmetic surgery, even extreme forms thereof, should be legal and that preference must be given to patient autonomy in the context of privately paid for wish-fulfilling medicine. However, this pro-cosmetic surgery stance is not without exceptions, conditions and certain reservations. It is concluded that the performance of cosmetic surgery necessitates a degree of ethical conduct on the part of the cosmetic surgeon that surpasses the level of ethical conduct normally required between a physician and patient, as the relationship between a cosmetic surgeon and a patient differs from the traditional physician-patient relationship. In the final chapter, recommendations are therefore made concerning certain safeguards that need to be put in place in order to prevent ethical abuses. These safeguards include some practical guidelines that might prevent ethically suspect behaviour on the part of the cosmetic surgeon. This behaviour relates to three aspects, namely: unethical advertising, informed consent (particularly with regards to the physician’s duty of disclosure) and patient selection. These recommendations, particularly those concerning a broader duty of disclosure in the context of informed consent to elective procedures, are made with reference to a case selection study of Canadian law.

**Key terms:** cosmetic surgery, elective surgery, wish-fulfilling medicine, consent to harm, therapeutic objective, dignity, patient autonomy, bodily and psychological integrity, privacy, bioethics, goals of medicine, complicity, naturalness, justice, Principlism, informed consent, duty of disclosure, medical advertising, patient selection.
## Contents

**Title page**

**Summary**

**Chapter 1**

**Introduction**

1 1 Purpose and Problem Statement ................................. 1
1 2 Research Methodology .................................................. 2
1 3 Definitions and Clarifications ......................................... 2

**Chapter 2**

**Common Law Perspectives on Wish-Fulfilling Medicine**

2 1 Introduction ................................................................. 10
2 2 Nature of the Maxim Volenti Non Fit Injuria ...................... 11
2 3 Purpose and Function of the Doctrine of Informed Consent .................................................. 12
2 4 Difference Between Volenti Non Fit Injuria and Voluntary Assumption of Risk ........ 13
2 5 Requirements and Restrictions ......................................... 14
2 6 The Defence of Volenti Non Fit Injuria in South African Medical Law ......................... 16
2 7 Standard of Disclosure .................................................... 20
2 8 The Physician's Liability in the Case of a Lack of Informed Consent .................................. 22
2 9 The Boni Mores Requirement ............................................. 26
2.10 The Relevance of a Therapeutic Indication for Purposes of Determining Lawfulness

2.10.1 Academic Opinion on Distinguishing Between Therapeutic and Non-Therapeutic Objectives for Purposes of Determining Lawfulness

2.10.2 South African Case Law Distinguishing Between Therapeutic and Non-Therapeutic Objectives for Purposes of Determining Lawfulness

2.10.3 Foreign Case Law Pertaining to the Relevance of a Therapeutic Indication for Purposes of Determining Lawfulness

2.11 Conclusion

Chapter 3

Constitutional Perspectives on Wish-Fulfilling Medicine

3.1 Introduction

3.2 Section 10 of the Constitution: Right to Human Dignity

3.2.1 Constitutional Conception of Dignity

3.2.2 The Importance of Autonomy in Health Care Decisions

3.3 Section 12(2) of the Constitution: Right to Bodily and Psychological Integrity

3.4 Section 14 of the Constitution: Right to Privacy

3.4.1 Constitutional Conception of Privacy

3.5 Application of the Constitutional Framework Pertaining to Wish-Fulfilling Medicine

3.6 Conclusion
Chapter 4

Bioethical Perspectives

4 1 The Unique Relationship Between Bioethics and Law ................................................. 65
4 2 The Goals of Medicine and the Disease/Enhancement Dichotomy................................. 66
4 2 1 Two Schools of Thought on the Goals of Medicine ............................................... 68
4 2 2 Two Schools of Thought on the Concepts of Health and Disease ............................... 74
4 3 Complicity Arguments ................................................................................................. 82
4 4 Human Nature and Naturalness ..................................................................................... 86
4 5 Justice and Accessibility ............................................................................................... 93
4 6 Autonomy of the Patient’s Wish ................................................................................... 96
4 7 Competing Principles: Non-Maleficence, Beneficence and Justice Versus Patient Autonomy ......................................................................................................................... 99
4 8 Conclusion .................................................................................................................... 103

Chapter 5

Practical Recommendations for Reform

5 1 Introduction ..................................................................................................................... 104
5 2 Unethical Advertising .................................................................................................... 108
5 2 1 Unethical Advertising and the Consumer Protection Act 68 of 2008 ......................... 111
5 3 Broader Duty of Disclosure .......................................................................................... 114
5 3 1 Broader Duty of Disclosure: The Canadian Position ................................................. 118
5 4 Additional Practical Guidelines Concerning the Procurement of Informed Consent ....... 122
5 5 Patient Selection ............................................................................................................ 126
Chapter 6

Final Conclusions

6 1 Conclusions ......................................................................................................................... 143

6 1 1 Hypothesis .......................................................................................................................... 143

6 1 2 Conclusions Regarding Common Law Perspectives on Wish-Fulfilling Medicine .... 143

6 1 3 Conclusions Regarding Constitutional Perspectives on Wish-Fulfilling Medicine ..... 144

6 1 4 Conclusions Regarding Bioethical Concerns and Recommendations for Reform...... 145

6 1 4 1 Impact on Advertising ...................................................................................................... 146

6 1 4 2 Impact on Informed Consent and Disclosure ................................................................. 147

6 1 4 3 Impact on Patient Selection ............................................................................................. 149

6 1 5 Conclusions Regarding Physician Liability and Ethics .................................................... 149

6 1 6 Final Thoughts ................................................................................................................... 150
Bibliography

Primary Sources of Law

South African Legislation

South African Case Law

Secondary Sources of Law

Papers and Articles

Chapters in Books

Books

Foreign Case Law

Encyclopaedias

Government or Official Publications

Dissertations and Theses
1 1 Purpose and Problem Statement

Medical techniques and technology are increasingly being used for purposes that seemingly deviate from the traditional goals of medicine. Medical techniques and technology are often implemented, not to prevent or cure illness, but to fulfil a patient’s personal, individual and ostensibly non-medical wishes.¹ These wishes are often aimed at improving certain human characteristics beyond their normal healthy state.² A prime example of wish-fulfilling medicine is cosmetic surgery. The pursuit of beauty by means of cosmetic surgery is big business in modern societies and South Africa is catching up very fast in this particular area. With the rise of cosmetic surgery, the contemporary body, instead of being a dysfunctional object requiring medical interventions, has become a primary symbol of identity and a commodity, not unlike “a car, a refrigerator, a house, which can be continuously upgraded and modified in accordance with new interests and greater resources”.³ Cosmetic surgery has in fact become a “modern body custom”.⁴ As exciting as this might be to some, certain legal and ethical issues must not be overlooked. The fact remains that cosmetic surgery involves the performance of very invasive surgical operations on otherwise healthy individuals for the sake of improving appearance. Should wish-fulfilling medicine, extreme forms of cosmetic surgery in particular, therefore be legal? Whether non-therapeutic procedures are or should be legal has become a matter of increasing importance, as such procedures are undertaken frequently and can even be said to be commonplace. This question will be investigated with reference to the South African framework of medical law. When investigating the South African medical law, a multi-layered approach is called for. The practice of wish-fulfilling medicine, with an emphasis on cosmetic surgery, will therefore be analysed in terms of the Constitution, the South African common law, legislation and medical ethics. Thereafter,  

¹ Buyx “Be Careful What You Wish For? Theoretical and Ethical Aspects of Wish-Fulfilling Medicine” 2008 *Medicine, Healthcare and Philosophy (Med Healthc Philos)* 134.  
recommendations will be made concerning certain safeguards that need to be put in place in order to prevent ethical abuses.

1.2 Research Methodology

The following research methodologies will be employed: Wish-fulfilling medicine (with frequent reference to cosmetic surgery) will be considered within the context of contemporary South African medical law. A systematic review of South African medical law will be conducted with reference to the Constitution, the common law, case law and applicable legislation as primary sources of law. Textbooks and writings of authors will be utilised as secondary sources of law. The ethical sphere of medical law and how this might influence the phenomenon of wish-fulfilling medicine will be explored in quite some depth. This will be done with reference to the ethical rules and regulations for healthcare practitioners as published by the Health Professions Council of South Africa, textbooks and writings of authors. Certain recommendations to ensure the ethical practice of cosmetic surgery will be made at the very end of the discussion. These recommendations, particularly concerning a broader duty of disclosure in the context of informed consent to elective procedures, will be made with reference to the Canadian legal position in this regard. A case selection study of Canadian law will be conducted. The aim of the case selection study is not to compare the South African position to the Canadian one, but simply to provide an example of a legal system already implementing and benefiting from some of the suggestions that will be put forward in this study concerning a broader duty of disclosure in the case of purely elective procedures.

1.3 Definitions and Clarifications

Throughout this dissertation reference will be made to certain terms and concepts that are either ubiquitous in contemporary bioethical debate or commonly used in the practice of aesthetic medicine and cosmetic surgery. Some of these terms and concepts merit brief discussion. For purposes of this dissertation, the following terms and concepts will, unless indicated otherwise, carry the indicated meanings. This brief discussion will not only aim to define and explain some lesser known terms and concepts, but also to indicate, where appropriate, the inherent ambiguity and contentious nature thereof.
“Bioethics” - There is no universal agreement on the definition of bioethics. Bioethics started as a branch of applied ethics and is still considered a kind of philosophy of action and ethical decision-making. Bioethics refers to the “systematic, pluralistic and interdisciplinary study involving the theoretical and practical moral issues raised by the life sciences and humanity’s relationship with the biosphere”. Bioethics is therefore concerned with value questions that arise in the areas of health care, the professional patient relationship and biomedical research. It focuses on issues such as medical ethics, the rights and duties of health professionals and patients, the social impact of technology and the impact of biomedical, behavioural and genetic research.

“Body dysmorphic disorder” - According to the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders, body dysmorphic disorder is as a preoccupation with an imagined or slight defect in appearance that leads to markedly excessive concern. The preoccupation causes significant distress or impairment in social, occupational, or other areas of functioning. Complaints usually involve imagined or slight flaws of the face or head, however any other part of the body may be the focus of concern. The preoccupation could also focus on several body parts. Individuals suffering from this disorder experience intense distress over their supposed deformity and describe their preoccupation as “intensely painful”, “tormenting” and “devastating”. Individuals suffering from this disorder often spend hours every day thinking about the defect and these thoughts dominate their lives.

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6 Id 50.
7 Ten Have & Jean The UNESCO Universal Declaration on Bioethics and Human Rights: Background, Principles and Application (2009) 32.
9 American Psychiatric Association Diagnostic and Statistical Manual of Mental disorders (2000) 507, hereafter referred to and referenced as the “DMS-IV”.
10 Ibid.
11 Ibid.
12 DMS-IV 508.
13 Ibid.
14 Ibid.
Normal functioning is significantly impaired, as feelings of low self-esteem often lead to the avoidance of work, school or public situations.15

**“Body integrity identity disorder”** - Body integrity identity disorder is an extremely rare phenomenon marked by extreme emotional distress due to the presence of one or more body parts, usually a limb, which the patient feels should not be there.16 People suffering from body integrity identity disorder typically believe that a particular limb does not belong to them or is not a part of their body and as such they feel “over complete”.17 This discomfort is so strong that it interferes with routine functioning.18 Patients are usually motivated to seek amputation of the healthy limb.19 Psychologists and neurologists explain this phenomenon in different ways, but a successful psychotherapeutic or pharmaceutical therapy is not known.20

**“Cosmetic plastic surgery”** - The most universally accepted definition of cosmetic surgery is the definition adopted by the American Medical Association.21 According to the American Medical Association cosmetic surgery is performed to reshape normal structures of the body in order to improve the patient's appearance and boost their self-esteem.22 Examples of popular surgical procedures that are considered to be cosmetic include the removal of excess skin and fat from the abdominal area23, the removal of excess fat, skin and muscle below the

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15 Ibid.
18 Patrone 2009 *JME* 541.
19 Ibid.
20 Müller 2009 *AJOB* 36.
23 This is known as an abdominoplasty or a tummy tuck.
eyes in order to improve drooping upper eyelid skin and puffy bags below the eyes\textsuperscript{24}, the augmentation and enhancement of the breasts, the removal of exercise-resistant fat deposits with a tube and a vacuum device\textsuperscript{25} and the reshaping of the nose, typically achieved by changing the shape of the tip or bridge or removing dorsal humps.\textsuperscript{26} There also exists a plethora of non-surgical medical procedures aimed at anti–aging and beautification. These procedures are less invasive than cosmetic surgery, but carry medical risks nonetheless. Examples of common non-invasive cosmetic procedures that can only be performed by a licensed physician include a wide variety of dermal and facial fillers to fill facial lines and wrinkles, paralysing drugs injected into the facial muscles to temporarily remove wrinkles, deep chemical peels to rejuvenate and exfoliate the skin and fractional lasers that resurface and remove the top layers of the skin.

\textbf{“Genetic enhancement”} - According to the National Human Genome Research Institute genetic enhancement refers to the transfer of genetic material intended to modify non-pathological human traits.\textsuperscript{27} Genetic enhancement can be described as efforts to make someone better than well by optimising his or her human characteristics or capabilities.\textsuperscript{28} In this regard, genetic intervention to avoid the birth of a child with cystic fibrosis would be defined as genetic therapy, whereas genetic intervention to increase the height of an otherwise normal unborn child would qualify as genetic enhancement.\textsuperscript{29} When the goal is enhancement, the gene may increase the functioning of normal genes or may be superseded with genes that have been designed to produce the desired enhancement.\textsuperscript{30} Furthermore, gene insertion may have an effect on a single individual through somatic cell modification, or it

\textsuperscript{24} This is known as a blepharoplasty.
\textsuperscript{25} This procedure is better known as liposuction.
\textsuperscript{26} This procedure is generally referred to as a rhinoplasty or a nose job.
\textsuperscript{27} National Human Genome Research Institute “Genetic Enhancement” <http://www.genome.gov/10004767> (accessed 10 March 2012).
\textsuperscript{28} Ibid.
\textsuperscript{29} Resnik & Langer “Human Germline Therapy Reconsidered” 2001 \textit{Human Gene Therapy (Hum Gene Ther)}1450.
may target the gametes, in which case the resulting effect could be passed on to future generations.31

“Human enhancement” - Juengst describes human enhancement in the context of bioethics as those interventions intended to improve human form or functioning beyond what is necessary to sustain or restore good health.32 Pellegrino believes human enhancement refers to interventions designed to “increase, intensify, raise up, exalt, heighten, or magnify”.33 These terms indicate that enhancement therefore involves going beyond what exists, whether it be a certain state of affairs, a bodily function or trait, or a general limitation associated with human nature.34 These interventions therefore go beyond the conventional goals of medicine.35 Savulescu also suggests the possibility of a welfarist definition of enhancement.36 According to such a definition human enhancement refers to “any change in the biology of psychology of a person which increases the chances of leading a good life” under those particular circumstances.37

“Medicalization” - Medicalization refers to the process by which human problems or behaviour that is ordinarily thought to be non-medical become defined and treated as actual illnesses or disorders.38 Zola describes medicalization as a "process whereby more and more of everyday life has come under medical dominion, influence and supervision".39 Conrad believes that medicalization involves the process whereby human problems enter the jurisdiction of the medical profession due to the fact that a medical framework or definition

31 Ibid.
34 Ibid.
35 Ibid.
37 Ibid.
has been applied to understand or manage the problem. Medicalization is essentially a socio-cultural process. This process may sometimes be due to the direct involvement or intentional expansion of the medical profession. In the context of cosmetic surgery, one might argue that small breasts have become medicalized as the medical condition “micromastia” has been created by physicians to describe breasts that are considered to be abnormally small. Another example is the medicalization of excessive dissatisfaction with one’s body which has now been diagnosed by the DMS-IV as a disorder (body dysmorphic disorder).

“Non-therapeutic medical interventions” - Non-therapeutic medical interventions refer to medical procedures aimed at improving “human form or functioning beyond what is necessary to sustain or restore good health”. Non-therapeutic medical interventions are also sometimes referred to as human enhancement or wish-fulfilling medicine. It could also be said that these interventions aim to make individuals better than well or beyond that which is normal. The United States President’s Council on Bioethics described non-therapeutic medical interventions as the “use of biotechnical power to alter, by direct intervention, not disease processes but the ‘normal’ workings of the human body and psyche, to augment or improve their native capacities and performance”.

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40 Conrad 1992 *Annu Rev Sociol* 211.
41 Ibid.
42 Ibid.
46 Ibid.
“Reconstructive plastic surgery” - Reconstructive surgery is performed on abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumours or disease. Reconstructive surgery is normally performed to improve the body’s function, but may also be done to achieve a normal appearance. Examples of surgeries that are considered to be reconstructive include breast reconstructions, cleft lip or palate repairs, flap surgery, surgery to correct webbed toes or fingers, reduction mammoplasties, the reconstruction of facial features after trauma, scar revision and skin grafts.

“Therapeutic medical interventions” - Therapeutic medicine refers to medical interventions directed at “restoring or bringing an individual’s morphology and capacities within a normal range”. The United States President’s Council on Bioethics describes therapeutic medicine as “the use of biotechnical power to treat individuals with known diseases, disabilities, or impairments in an attempt to restore them to a normal state of health and fitness”.

49 Ibid.
50 A surgical procedure designed to reconstruct a woman’s breast after a mastectomy (the removal of the breast in order to treat breast cancer) using autologous tissue or prosthetic materials like silicone implants.
51 The surgical correction of a congenital split in the roof of the mouth or the middle of the upper lip.
52 Flap surgery involves transporting healthy, live tissue from one location of the body to another. It is typically used to repair defects left behind after traumatic injury or mastectomy. Flap techniques are also used in facial reconstruction after skin cancer excision.
53 A surgical procedure to reduce the size and improve the shape of the breasts. The surgery is aimed at relieving the symptoms associated with unusually large, pendulous breasts.
54 Surgery performed to improve the condition or appearance of a scar anywhere on the body.
55 This procedure involves a piece of skin being taken from a donor area and surgically grafted at the site of an injury or burn. A skin graft differs from flap surgery, as a flap is transferred with its blood supply intact, whereas a graft is a transfer of tissue without its own blood supply.
56 Karpin & Mykitiuk 2008 MLR 414.
57 President's Council on Bioethics 13.
“Wish-fulfilling medicine” - Wish-fulfilling medicine refers to physicians employing medical services (medical technology, techniques, drugs etc.) in a medical setting in order to fulfill the unambiguously stated, prima facie non-medical wish of a patient to enhance their subjective functioning, appearance or health.\textsuperscript{58} Wish-fulfilling medicine is therefore a novel way of referring to certain non-therapeutic, elective and enhancement procedures with an emphasis on the importance of the patient’s request thereof.\textsuperscript{59} Wish-fulfilling medicine includes an enormous range of practices such as cosmetic surgery, the use of pharmaceuticals to take someone from a normal, but less desired or less socially rewarding state to another normal, but more desired or more socially rewarding state, the use of pre-implantation genetic diagnosis by prospective parents to select the sex of their future child, the performance of an elective caesarean section, physician assisted suicide and the use of sex and/or growth hormones to reverse the signs and symptoms of aging.\textsuperscript{60} The patient’s corresponding wishes usually relate to a more youthful appearance, social acceptance, increased endurance and performance in all areas of life or simply convenience.\textsuperscript{61}

\textsuperscript{58} Buix 2008 Med Healthc Philos 134; Asscher et al “Wish-Fulfilling Medicine in Practice: a Qualitative Study of Physician Arguments” 2012 Journal of Medical Ethics (JME) 327.
\textsuperscript{59} Asscher et al 2012 JME 327.
\textsuperscript{61} Buix 2008 Med Healthc Philos 134.
Chapter 2  Common Law Perspectives on Wish-Fulfilling Medicine

2.1 Introduction

In this chapter, the phenomenon of wish-fulfilling medicine will be examined in context of the common law. As wish-fulfilling medicine is a relatively new phenomenon, the common law does not provide us with much guidance. The only alternative we are left with is to approach wish-fulfilling medicine in terms of the broader principles of consent to harm. An investigative discourse will be conducted on whether a patient’s consent is sufficient justification for the performance of ethically suspect and radical non-therapeutic surgery. The discourse will take place in context of the defence of informed consent as indicated by the common law maxim of \textit{volenti non fit iniuria}. This chapter will commence with a discussion on the meaning of the maxim. The defence indicated by the maxim is recognised in South African medical law in the form of the informed consent doctrine. The purpose and function of the informed consent doctrine as it is applied in South African medical law will be made clear. The South African case law pertaining to the application of the doctrine of informed consent and the scope of disclosure will be addressed. Furthermore, the nature of the legal liability incurred by a physician due to a lack of informed consent will be addressed with reference to case law and academic opinion. For consent to operate as a valid defence that excludes the element of unlawfulness or wrongfulness of a crime or delict, certain requirements have to be met. The requirements of the defence in general as well as in medical context will be discussed. The common law stance regarding the moral limits of consent will be addressed. This will be done with reference to the \textit{boni mores} requirement as understood in terms of the common law. The question whether the common law requires a therapeutic objective for medical interventions to be lawful will form an important part of the discussion, as wish-fulfilling medicine is generally considered to be non-therapeutic and unnecessary. In this regard, the viewpoints of several authors as well as South African case law will be assessed. When determining whether the common law requires a therapeutic objective for medical interventions to be lawful, reference will also be made to foreign case law. When interpreting and developing the common law, section 39(1)(c) of the Bill of Rights permits us to consider foreign law. Considering the scarcity of local authority or opinion on the requirement of a therapeutic objective, foreign case law offers some helpful insights and practical examples of cases that have appeared before foreign courts.
2.2 Nature of the Maxim Volenti Non Fit Iniuria

The legal relationship between a physician and a patient is regulated by the contract between the parties and the law of delict.\(^{62}\) In terms of both contract and delict, the physician’s right to operate upon or treat a patient is based entirely on the patient’s consent.\(^{63}\) When a person willingly consents to an act, in the form of either a specific harmful act or an activity involving a risk of harm, he or she cannot complain that a delict has been committed against him or her.\(^{64}\) The mere harming of another is not sufficient reason for invoking the criminal law or the law of delict; the harming must also be wrongful. Under appropriate circumstances consent to harm nullifies the wrongfulness of the harm. This principle is recognised by Roman law, common law and Roman-Dutch law and is commonly expressed by the *volenti non fit iniuria* maxim.\(^{65}\) The rationale underlying the recognition of the maxim is based on individualism or autonomy, in terms of which individuals must determine their own destinies and are therefore allowed to limit their own rights as they please.\(^{66}\) The courts are therefore not inclined to protect a consenting party against his or her own foolishness in permitting others to do him or her harm.\(^{67}\) The defence indicated by the maxim comprises a wide field and is recognised in South African medical law in the form of the informed consent doctrine. In terms of this defence, a patient’s informed consent serves as a justification for conduct that would otherwise constitute a wrongful act.\(^{68}\) The recognition of

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the defence in medical law stems from the contractual relationship between a physician and a patient, in terms of which the patient’s consent plays a crucial role.69

2 3 Purpose and Function of the Doctrine of Informed Consent

The purpose and function of the informed consent doctrine are twofold. Firstly, it ensures the patient’s right to self-determination, autonomy and freedom of choice. Secondly, it facilitates a rational decision-making process by which the patient can weigh and balance the advantages and disadvantages of the proposed intervention in order to make an enlightened choice concerning the matter.70 The doctrine of informed consent is the guardian of individualism.71 It guards the patient's right to control his or her own fate in medical matters and promotes his or her status as an autonomous human being.72 Informed consent is also crucial in establishing and enhancing the relationship between a physician and a patient.73 The doctrine of informed consent has radically changed the dynamics of the physician-patient relationship in the sense that medical paternalism has been rejected in favour of a more patient-centred approach.74 The medical decision-making process used to be a consensual process in which the physician proposed a course of action and the patient consented. The doctrine of informed consent has transformed this process into a participatory one in which

“No man can complain of an act which he has expressly or impliedly consented to.” Carstens & Pearmain 875 describe the maxim as: “No harm is done to someone who consents thereto.” Gordon et al Medical Jurisprudence (1953) 188 state that in terms of this defence, a person has the freedom to “consent to an act prima facie wrongful and cannot afterwards complain of it”. Parmanand “The Consenting Plaintiff and the Boni Mores: the Proper Perspective” 1986 Journal of South African Law 340 states the general import of the maxim is that “no injury is done to him who intends it, is willing or consents thereto”. Burchell & Hunt South African Criminal Law and Procedure (1997) 127 describe the defence as: “An injury is not done to one who consents.” 69 Lerm 340; Carstens & Pearmain 875-6.
72 Meisel 1979 Wis Law Rev 414; Berg et al 11; Carstens & Pearmain 883.
73 Lerm 172; Carstens & Pearmain 877.
74 Carstens & Pearmain 886; Berg et al 19; Grimm “Informed Consent For All! No Exceptions” 2007 New Mexico Law Review (NMLR) 39.
the patient is allowed to play a far more active role. Medical interventions performed without the patient’s informed consent, on the basis of the patient’s-best-interest and the physician-knows-best criteria, are unlawful and constitute a violation of the patient’s autonomy. The doctrine therefore guards against overreaching on the part of the physician. The doctrine also protects the bodily integrity of the patient by attaching civil and/or criminal liability to any sort of medical treatment or intervention that takes place without the patient’s consent. On the other side of the coin, the doctrine provides a defence to a physician who treats or performs a surgical intervention on a patient who did in fact consent to the treatment or operation.

### 2.4 Difference Between *Volenti Non Fit Iniuria* and Voluntary Assumption of Risk

For purposes of this study, *volenti non vit iniuria* must be distinguished from the defence of voluntary assumption of risk. The defence of voluntary assumption of risk, like that of *volenti non fit iniuria*, excludes the element of unlawfulness. Some writers consider the defence of voluntary assumption of risk to be an extension and wider form of the doctrine of *volenti non fit iniuria*. Consent to potential risks and side-effects after an operation is an example of the wider form of consent. Others are of the opinion that voluntary assumption of risk does not entail consent to a specific harm, but rather consent to the risk of harm. In this sense, *volenti non fit iniuria* entails consent to the invasion of a specific interest, whereas assumption of risk involves the exposure to risks emanating from a particular source of danger and the assumption of the risk of harm connected with that particular source of danger or activity. It is consent to the invasion of a specific interest that the current study is concerned with.

75 Meisel 1979 *Wis Law Rev* 421; Berg et al 19; Carstens & Pearmain 877.
77 Meisel 1979 *Wis Law Rev* 414.
78 Van Oosten *The Doctrine of Informed Consent in Medical Law* (LLD dissertation 1989 UP) 14; McKerron 67; Burchell 140; Boberg 724.
79 Van der Merwe & Olivier *Die Onregmatige Daad in die Suid-Afrikaanse Reg* (1989) 95.
80 Lerm 317; Burchell 140; Neethling et al 90.
2.5 Requirements and Restrictions

The application of the maxim is not without restrictions and in certain circumstances individual freedom is curtailed. For consent to operate as a defence that excludes the element of unlawfulness or wrongfulness of a crime or delict, certain requirements have to be met. In this regard, the consent of the party who consented to the infliction of harm is of paramount importance. The consent must manifest itself externally in order to qualify as a legal act.\(^{81}\) Generally, the consent must be given by the plaintiff or complainant him- or herself.\(^{82}\) The conduct must fall within the confines of the consent given and must therefore not exceed the boundaries of the consent given.\(^{83}\) The consenting party must have consented to the entire transaction, inclusive of all its consequences.\(^{84}\) The consent must be given clearly and unequivocally.\(^{85}\) The consent must be given prior to the conduct in question.\(^{86}\) The consent must be given by a person capable in law of consenting.\(^{87}\) In this sense, capacity to contract does not equal capacity to give valid consent.\(^{88}\) Consent can only be valid if the person consenting to the harm is capable of forming an intention and of understanding what he or she is consenting to.\(^{89}\) The consent must be given freely and voluntarily, that is, not induced by fear, coercion or fraud.\(^{90}\) The consenting party must have had full knowledge and must have been aware of the nature and extent of the harm or risk.\(^{91}\) The consenting party must have appreciated and understood the nature and extent of the harm or risk.\(^{92}\) Many of these requirements relate to the authenticity of the consent, in other words, the capacity of the consenting party to make a truly autonomous decision to consent to harm. Some find it

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81 Van Oosten 19; Van der Walt & Midgley 144; Esterhuizen v Administrator Transvaal 1957 3 SA 710 (T).
82 Van Oosten 19; Grimm 2007 NMLR 42. See also s 6-9 of the National Health Act 61 of 2003.
83 Van Oosten 189; Van der Walt & Midgley 142; National Media Ltd v Jooste 1996 3 SA 262 (A).
84 Van Oosten 18; Van der Walt & Midgley 142.
85 Van Oosten 19; Du Preez (2011) 11.
86 Van Oosten 19; Snyman Strafreg (2006) 126.
87 Van Oosten 17; Burchell & Milton 344; Burchell 68; Van der Walt & Midgley 144; Snyman 125; Grimm 2007 NMLR 40.
88 Burchell & Milton 344; Burchell 68; Neethling et al 92; Grimm 2007 NMLR 40.
89 Van Oosten 17; Burchell & Milton 344.
90 Van Oosten 17; Burchell 68; Van der Walt & Midgley 142; Snyman 125; Neethling et al 92; Grimm 2007 NMLR 40.
91 Van Oosten 18; Van der Walt & Midgley 141; Snyman 125; Neethling et al 93.
92 Van Oosten 18; Van der Walt & Midgley 142.
difficult to imagine that consent to serious bodily harm or a serious infringement to one’s dignity could ever be truly authentic. In this regard, O’Neill observes:

[T]his is a desperate line of argument: there is all too much evidence that people sometimes genuinely consent to action which may seem deeply unacceptable, even to action that profoundly injures, oppresses or degrades them. Across the board insistence that any consent to such action must be flawed merely suggests an underlying refusal to consider the possibility that justification requires more than actual consent.93

In this regard, the importance of the *boni mores* requirement becomes evident. According to this requirement, the consent must be recognised by law and must not be *contra bonos mores*.94 Consent will only constitute a valid defence if it is in the interests of public policy that the particular act be rendered lawful by virtue of the victim’s consent. As such, consent will not operate as a valid defence if the prevailing convictions of the community question its lawfulness.95 In this sense, the *boni mores* places a legal limit on individual autonomy and acts as an external safeguard that invalidates the plaintiff's consent if the infringement to which he or she has consented to is unreasonable in terms of the existing *boni mores*.96 On the other hand, the *boni mores* requirement can also endorse the plaintiff’s consent, thereby absolving the defendant from any blame. As with the defence in general, in medical context, the maxim of *volenti non fit iniuria* can only operate as a successful defence if certain requirements are met. These requirements are set out in case law and have recently been incorporated into national legislation.97

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94 Van Oosten 17; Burchell & Milton 324, Van der Walt & Midgley 143; Neethling et al 94.
95 Lerm 291; Burchell & Milton 324; Van der Walt & Midgley 143.
96 Parmanand 1986 *TSAR* 340; Burchell & Milton 324.
97 S 6 of the National Health Act 61 of 2003 states the following:
Every health care provider must inform a user of
(a) the user’s health status except in circumstances where there is substantial evidence that the disclosure of the user’s health status would be contrary to the best interests of the user;
(b) the range of diagnostic procedures and treatment options generally available to the user;
(c) the benefits, risks, costs and consequences generally associated with each option; and
(d) the user’s right to refuse health services and explain the implications, risks, obligations of such refusal.
The Defence of Volenti Non Fit Iniuria in South African Medical Law

The defence of *volenti non fit iniuria* and the requirement of informed consent have long been recognised by legal scholars and courts in South African medical law. In South African law, the consent of a patient to medical treatment is regarded as falling under the defence of *volenti non fit iniuria*. The informed consent requirement, as a prerequisite for the defence of *volenti non fit iniuria*, was recognised by our courts as early as 1923 in the case of *Stoffberg v Elliott*. In this case, the patient had contracted cancer of the penis. He was admitted to hospital to be operated on. When he regained consciousness he discovered that his cancerous penis had been amputated without his consent. Watermeyer J held that:

> In the eyes of the law, every person has certain absolute rights which the law protects. They are not dependent upon a statute or upon a contract, but they are rights to be respected, and one of those rights is the right of absolute security of the person. Nobody can interfere in any way with the person of another, except in certain circumstances … Any bodily interference with or restraint of a man’s person which is not justified in law, or excused in law, or consented to, is a wrong, and for that wrong the person whose body has been interfered with has a right to claim such damages as he can prove he has suffered owing to that interference.

Watermeyer J continued:

> A man, by entering a hospital, does not submit himself to such surgical treatment as the physicians in attendance upon him may think necessary; he may submit himself for medical treatment, but I am not going into that; I am not going to attempt to define the exact limits of medical treatment, because they do not seem to me to be material in this case, but he does not consent to such surgical treatment as the physician may consider necessary. By going into hospital, he does not waive or give up his right of absolute security of the person; he cannot be treated in hospital as a mere specimen, or as an inanimate object which can be used for the purposes of vivisection; he remains a human being, and he retains his rights of control and disposal of his own body; he still has the right to say what

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98 *Stoffberg v Elliott* 1923 CPD 148.
99 *Stoffberg v Elliott* 148.
operation he will submit to, and, unless his consent to an operation is expressly obtained, any operation performed upon him without his consent is an unlawful interference with his right of security and control of his own body, and is a wrong entitling him to damages if he suffers any.\textsuperscript{100}

The defence was also recognised in \textit{Esterhuizen v Administrator, Transvaal}, when Bekker J stated the following: “It is usual to include in the defence of \textit{volenti non fit iniuria}, or as I call it for convenience, consent, cases of voluntary acceptance of risk as well as cases of permission to inflict intentional assaults upon oneself, as in the case of surgical operations.”\textsuperscript{101}

Bekker J continued:

Indeed if it is to be said that a person consented to bodily harm or to run the risk of such harm, then it presupposes, so it seems to me, knowledge of that harm or risk; accordingly mere consent to undergo x-ray treatment, in the belief that it is harmless or being unaware of the risks it carries, cannot in my view amount to effective consent to undergo the risk or the consequent harm.\textsuperscript{102}

In this case, the patient was a ten-year-old girl. She and her father had consulted a physician concerning a small lump that had developed below her right ankle. The physician removed the lump and sent it for analysis. It was diagnosed as a manifestation of Kaposi’s haemangiosarcoma. The physician advised the girl’s mother to take her for superficial X-ray treatments. From the evidence it appeared that both her parents had agreed that X-ray treatment was the appropriate next step. The girl’s wound healed completely, but a few months later more lumps appeared on her feet and her right hand. She had to be subjected to further X-ray treatments at the same hospital. The treatments were successful, but unfortunately new lumps appeared four years later. This time the lumps covered her entire body. The patient’s mother instructed that she be sent to the same hospital again for the same treatment, however this time another physician took care of the girl. This physician’s prognosis was very dire and as such he decided to administer radical X-ray treatment. The

\begin{flushright}
\textsuperscript{100} \textit{Ibid.}\textsuperscript{.}
\textsuperscript{101} \textit{Esterhuizen v Administrator, Transvaal} 249.
\textsuperscript{102} \textit{Ibid.}
\end{flushright}
The physician was well aware of the fact that the radical X-ray treatment would cause severe irradiation of the tissues in the treated areas and might cause ulceration of these tissues. He was also well aware of the fact that the radical X-ray treatment would do permanent harm to the girl’s growing bone ends in the treated areas, thereby causing a shortening of the limbs, disfiguring the girl and perhaps even necessitating amputation of the treated limbs. The physician failed to disclose these risks to the patient or her mother and did not find it necessary to obtain the mother’s consent to the treatment. As a result of the treatment, both the girl’s legs and her right hand had to be amputated. In an action for damages for assault, the court held that the physician had more than enough time and opportunity to procure the mother’s consent. The court rejected the argument that, as the girl had been brought to the hospital at the request of her mother, she had consented to the ultimate radical treatment on the basis that the hospital had a discretion to do what is best for the girl in order to preserve her life, regardless of the consequences. The court also rejected the contention that the patient had given implied consent based on the fact that she had previously been treated there for the same condition. This contention was rejected, due to the fact that the later radical X-ray treatment was far more severe than the earlier superficial X-ray treatments.

*Castell v de Greef*[^103^], a 1994 decision of a Full Bench of the Cape Provincial Division, is the case that originally imported and introduced the doctrine of informed consent into South African medical law. In this case, Ackerman J explicitly acknowledged the maxim of *volenti non fit iniuria* as a defence in South African medical law when he stated the following: “South African law generally classifies *volenti non fit iniuria*, irrespective of whether it takes the narrower form of consent to a specific harm or the wider form of assumption of risk of harm, as a ground for justification excludes the unlawfulness or wrongfulness element of a crime or delict.”[^104^] In *Castell v de Greef*, the plaintiff was a forty-four-year-old woman with a history of breast cancer. She had previously undergone surgery to remove lumps in her breasts, but when further lumps were discovered, the plaintiff’s gynaecologist recommended a mastectomy and referred her to the defendant cosmetic surgeon. The plaintiff consulted with the defendant and discussed the operation with the defendant at some length. The plaintiff eventually agreed on the performance of a subcutaneous mastectomy and breast

[^103^]: Castell v De Greef 1994 4 SA 63 (C).
[^104^]: Castell v De Greef 79.
reconstruction, that is, the surgical removal of as much of the breast tissue as possible with a simultaneous reconstruction of the breasts using silicone implants. The operation was an initial success in the sense that upon completion all seemed fine. However, as a result of the operation, a discoloration of the plaintiff’s areolae, necrosis of the breast tissue and a discharge that exuded an offensive odour developed. Moreover, the plaintiff contracted an infection, suffered significant pain, embarrassment and psychological trauma, and had to undergo several additional surgical procedures to repair the damage. The plaintiff subsequently sued the defendant for damages. One of the causes of action was that, prior to the mastectomy, the defendant had been under a duty to warn the plaintiff of the material risks and complications associated with the procedure as well as any alternative procedures which might minimise, reduce or exclude such risks or complications. The plaintiff averred that she had not given informed consent to the procedure, as the defendant had failed to properly disclose the material risks and complications.

Ackermann J examined the trends in America, Canada, England and Australia regarding informed consent, and concluded that it was time to shift the focus from a physician-centred approach to a patient-oriented approach.\textsuperscript{105} He stated that it is clearly for the patient to decide whether he or she wishes to undergo the operation, in the exercise of the patient’s fundamental right to self-determination.\textsuperscript{106} Ackermann J used the example of a woman who refuses to undergo a mastectomy, even though it is the only way she can avoid a premature death by cancer. According to Ackerman J, it is “wholly irrelevant that her attitude is, in the eyes of the entire medical profession, grossly unreasonable, because her rights of bodily integrity and autonomous moral agency entitle her to refuse medical treatment”.\textsuperscript{107} The court held that a physician is under a legal duty to obtain the patient’s informed consent to any medical intervention. According to the judgment, the following requirements have to be satisfied in order for consent to be properly procured: (a) the consenting party "must have had knowledge and been aware of the nature and extent of the harm or risk"; (b) the consenting party "must have appreciated and understood the nature and the extent of the harm or risk"; (c) the consenting party "must have consented to the harm or assumed the risk"; (d) the

\textsuperscript{105} Castell v De Greef 74.
\textsuperscript{106} Ibid.
\textsuperscript{107} Ibid.
consent "must be comprehensive, that is extend to the entire transaction, inclusive of its consequences".\textsuperscript{108} There is a clear relationship between knowledge and consent. Lawful consent cannot be obtained unless the consenting party knows and appreciates what it is that he or she is consenting to. Consent is therefore not sufficient; it must be accompanied by knowledge and appreciation.\textsuperscript{109} Knowledge and appreciation is constitutive of informed consent. Furthermore, knowledge and appreciation commonly depends on adequate information being provided to the consenting party by physician.\textsuperscript{110} A patient is usually an ignoramus in medical matters and as such the physician, as an expert, is saddled with a legal duty to provide the patient with the necessary information that will ensure knowledge and appreciation on the part of the patient.\textsuperscript{111} It is the inequality of knowledge so inherent to the physician-patient relationship that necessitates appropriate information from the physician in order to procure the patient’s informed consent.\textsuperscript{112} As knowledge and appreciation is required for consent, information in turn becomes a \textit{sine qua non} for valid consent.

\section*{2.7 Standard of Disclosure}

As far as the standard of disclosure required for informed consent to medical treatment is concerned, \textit{Castell v de Greef} remains the definitive ruling in this regard.\textsuperscript{113} The court in \textit{Castell v de Greef} overturned the earlier judgement in \textit{Richter v Estate Hammann}\textsuperscript{114}, where the court held that the physician’s conduct, by informing a patient of the material risks accompanying the proposed treatment or procedure, should be evaluated in terms of the

\begin{itemize}
  \item \textsuperscript{108} \textit{Castell v De Greef} 80.
  \item \textsuperscript{109} Van Oosten 1995 \textit{De Jure} 167; Van der Walt & Midgley 142; Neethling \textit{et al} 94; Berg \textit{et al} 102; Carstens & Pearmain 878; Grimm 2007 \textit{NMLR} 44.
  \item \textsuperscript{110} Van Oosten 22; Van der Walt & Midgley 141.
  \item \textsuperscript{111} Van Oosten 1995 \textit{De Jure} 167; Carstens & Pearmain 879.
  \item \textsuperscript{112} Van Oosten 22; Carstens & Pearmain 877.
  \item \textsuperscript{113} Note that the Supreme Court of Appeal in \textit{Louwrens v Oldwage} 2006 1 All SA 197 (SCA) accepted the patient-centred approach as set forth in \textit{Castell v de Greef}, yet simultaneously applied the paternalistic reasonable doctor test. The Supreme Court of Appeal essentially failed to choose between these two mutually destructive approaches and applied both. It is therefore submitted that the precedent set by \textit{Castell v de Greef} still holds, as the Supreme Court of Appeal did not explicitly overrule the subjective patient-centred approach as set forth in \textit{Castell v de Greef}. In this regard, see Wilson “When is a risk of medical treatment material?” 2006 \textit{De Rebus} 22. This point is also argued by Carstens & Pearmain 886-7.
  \item \textsuperscript{114} \textit{Richter v Estate Hammann} 1976 3 All SA 497 (C).
\end{itemize}
standard of the reasonable medical practitioner. The court in *Richter v Estate Hammann* postulated this approach as follows:

In reaching a conclusion a court should be guided by medical opinion as to what a reasonable physician, having regard to all the circumstances of the particular case, should or should not do. The court must, of course, make up its own mind, but it will be assisted in doing so by medical evidence.115

The court in *Castell v de Greef* held that only material risks need to be disclosed.116 In formulating the test for materiality, the court referred to the Australian case of *Rogers v Whitaker*.117 In this case, a patient was rendered completely blind in one of her eyes as a result of a remote risk eventuating following surgery on her right eye. When considering whether to have the operation, the patient questioned her physician comprehensively about the possible complications in respect of both eyes. The likelihood of the risk eventuating was extremely low. The defendant physician argued that the test for materiality is a matter of current expert medical opinion. However, the court found that the matter could not be determined solely with reference to the current state of responsible and competent professional opinion and practice.

This view was also held in *Castell v de Greef*. The court held that expert medical evidence is relevant to determine what risks are associated with a particular treatment and it could also have a bearing on their materiality, but materiality is not a question that is to be concluded on the basis of expert medical evidence alone.118 The court adopted substantially the same test for materiality as in *Rogers v Whitaker*. In terms of this test, a risk is material if, under the circumstances of the specific case, a reasonable person in the patient’s position, if warned of the risk, would probably attach significance to it; or the physician is or should reasonably be aware that the particular patient, if warned of the risk, would probably attach significance to it.119 The court therefore rejected the paternalistic “reasonable physician” test in favour of the more patient-oriented “reasonable patient” test, whereby the physician’s duty to inform is

115 *Richter v Estate Hammann* 504.
116 *Castell v De Greef* 80.
117 *Rogers v Whitaker* 1992 175 CLR 479.
118 *Castell v De Greef* 81.
established with reference to the needs and expectations of the particular patient, rather than the prevailing insights of the medical profession. The court in Rogers v Whitaker held that, although the likelihood of the risk occurring was very remote, the physician was nevertheless obliged to tell the patient of this risk, because he should have been reasonably aware of the fact that the particular patient, if warned of the risk, was likely to attach significance to it. Based on the facts, the court in Castell v de Greef decided that the plaintiff had been aware of all the material risks prior to the performance of the procedure and that she had in fact given informed consent. The plaintiff’s action based on lack of informed consent was dismissed. The formulation in Castell v de Greef is in accordance with the fundamental right of individual autonomy and self-determination. It signified an unambiguous move away from the traditional model of medical paternalism.

2.8 The Physician’s Liability in the Case of a Lack of Informed Consent

Assuming the intervention was performed with the necessary care and skill, in what manner can a physician be held legally liable, in a case where the court finds that the patient did not give his or her informed consent to a medical intervention? If the intervention constitutes an infringement of the patient’s personality rights, or more particularly his or her physical integrity, the appropriate form of liability would be civil or criminal assault. Civil assault (in terms of the actio iniuriarium) is the physical infringement of a patient’s bodily integrity (physical and psychological) without his or her consent. The patient’s bodily and psychological integrity is protected against any and all factual infringements of a person’s body or psyche, regardless of whether the infringements occurred with or without violence or pain. In order to establish liability under the actio iniuriarium, the bodily infringement does not have to be accompanied by contumelia in the form of an insult.

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120 Van Oosten 1995 De Jure 174; Carstens & Pearmain 877.
121 Ibid.
122 Therefore excluding the possibility of negligence.
123 Van Oosten 451; Van der Walt & Midgley 111.
125 Nienaber 2008 THRHR 370; Van der Walt & Midgley 48; Neethling et al 301.
126 Nienaber 2008 THRHR 370; Van der Walt & Midgley 48 & 111; Neethling et al 12 & 302.
requirements must however be met before the *actio iniuriarum* can be successfully relied upon. The infringement must not be trivial, it must be wrongful, and it must be committed *animo iniuriandi*. For the *actio iniuriarum* to succeed, the plaintiff patient must prove intent on the part of the defendant physician. The physician must therefore have foreseen and reconciled him- or herself with the possibility of the consent being unlawful. Criminal assault is the unlawful and intentional application of direct or indirect force to another person. The sanctity of a person’s physical body emanates from society’s belief in the sanctity of human life and as such criminal law punishes the unlawful application of force to a person’s physical body. According to the *Castell v de Greef* judgement, a failure to adequately inform a patient constitutes assault and not negligence. In this regard, the court held that a failure on the part of the physician to disclose the material risks associated with a medical intervention does not constitute negligence arising from the breach of a duty of care. The matter must be understood in context of contractual consent to harm and the assumption of an unintended risk. The court therefore placed a medical practitioner’s duty to disclose information to obtain informed consent within the framework of the wrongfulness element (with *volenti non fit iniuria*) rather than with the fault element of a delict (intention or negligence).

Recently, the Supreme Court of Appeal in *Broude v McIntosh* cast some doubt on the validity of the assault construction. In this case, the appellant was left paralysed on the left side of his face after an operation. He sued for damages caused by the first respondent surgeon’s allegedly negligent conduct. The claim was grounded on the surgeon’s conduct before, during and after the operation. The claim grounded on the first respondent’s conduct before the operation was based upon his alleged failure to inform the patient of all the risks associated with the particular procedure and the existence of possible alternative procedures. Concerning the claim based on the first respondent’s conduct before the operation, Marais JA

127 Nienaber 2008 *THRHR* 370; Van der Walt & Midgley 111; Neethling *et al* 302.
128 Nienaber 2008 *THRHR* 370; Van der Walt & Midgley 111.
129 Nienaber 2008 *THRHR* 377; Snyman 432.
130 Nienaber 2008 *THRHR* 377.
131 *Castell v De Greef* 79.
132 *Ibid*.
133 *Broude v McIntosh* 1998 3 SA 60 (SCA) 68.
expressed his reservations about the conceptual soundness of the construction of a lack of informed consent constituting assault. The court held that it was a bizarre notion that a surgical intervention, performed by a well-intentioned physician, who had obtained the patient’s consent, should be characterised as an assault simply due to the fact that the physician had failed to mention a few risks. The court held that the construction is conceptually unsound, because the physician’s conduct will constitute assault even if the operation is a success and the risk does not eventuate. The approach of the court in Broude v McIntosh has been criticised as confusing unlawfulness with fault. A lack of informed consent constitutes assault, because consent negates unlawfulness and not fault. Luckily, Marias JA did not overrule the decision in Castell v de Greef. His comments regarding his reservations about the construction of a lack of informed consent constituting assault were made obiter dictum. The approach in Castell v de Greef has since been followed in the decisions of Jacobson v Carpenter-Kling, Pop v Revelas and Oldwage v Louwrens.

The defendant in Oldwage v Lourens was a vascular surgeon. After examining the plaintiff, who was experiencing pain in his back and leg, the defendant determined that the plaintiff had a vascular circulation condition. An angiogram and an electrocardiogram confirmed the diagnosis. The defendant subsequently informed the plaintiff that a by-pass operation was necessary to relieve him of his pain. After the operation, the plaintiff was still experiencing pain in his right leg. The plaintiff then decided to consult a neuro-surgeon. The neuro-surgeon concluded that a laminectomy was necessary to relieve the plaintiff of his pain. After the laminectomy was performed, the pain in the plaintiff’s leg disappeared. However, the plaintiff subsequently suffered from claudication of his other leg. It became apparent that the claudication was caused by the vascular operation, that claudication was an inherent risk of the vascular operation, and that the defendant had failed to inform the plaintiff of this risk. The plaintiff brought a claim for damages against the defendant. One of the grounds on which the plaintiff based his claim was a lack of informed consent. The plaintiff averred that

134 Carstens & Pearmain 687.
135 Ibid.
136 Id 682.
138 Pop v Revelas 1999 WLD unreported.
139 Oldwage v Louwrens 2004 1 SA 532 (C).
the operation constituted an assault, as he was not properly informed of the risks associated with the operation. In considering whether the plaintiff had consented to the procedure performed by the defendant, the court applied the doctrine of informed consent. In this regard, the trial court followed the approach adopted in *Castell v De Greef*. The trial court held that for a medical practitioner to be able to rely on a patient's consent as a valid defence, the patient must not only have consented to the operation, but must also have appreciated and consented to the risks and consequences associated with the operation. Applying this test, the trial court found that the plaintiff had not been properly counselled before the vascular operation; that alternatives had not been discussed properly with him; and that he had not been advised of the material risks associated with the operation. Accordingly, it was concluded that the plaintiff had not given his informed consent to the operation and that the defendant's conduct constituted assault.

It is unfortunate that *Broude v McIntosh* was not the last or the only case in which the Supreme Court of Appeal gave an “ambivalent, confusing and contentious” judgement concerning the construction of a lack of informed consent constituting assault. On appeal, the court in *Louwrens v Oldwage* deviated from the judgement made by the trial court. Of significant importance to the present discussion, is the manner in which the court of appeal dealt with the question whether an absence of consent constitutes assault. The court referred to the patient-oriented approach adopted in *Castell v de Greef*, yet simultaneously applied *Richter v Estate Hammann*, thereby invoking the incorrect standard of the “reasonable physician”. This is problematic, because the approach followed in *Castell v de Greef* is in direct opposition to the approach followed in *Richter v Estate Hammann*. The court in *Castell v de Greef* was in favour of patient autonomy, whereas the court in *Richter v Estate Hammann* endorsed a paternalistic “physician-knows-best” approach. These two concepts cannot possibly be reconciled. As Carstens and Pearmain state: “One either has to choose medical paternalism over patient autonomy or *vice versa*.” The two judgements and concepts are “mutually destructive on the same facts and cannot co-exist in harmony”.

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140 Carstens & Pearmain 683.
141 *Louwrens v Oldwage* 2006 1 All SA 197 (SCA).
142 Carstens & Pearmain 685.
143 *Id* 686.
The court failed to choose between these two mutually destructive concepts and applied both, simultaneously failing to address the issue whether absence of consent amounts to negligence or assault.\textsuperscript{145} However, with reference to case law and an overwhelming amount of academic opinion, one can safely assume that a lack informed consent does indeed constitute assault and not negligence.

If the intervention also contains an element of \textit{contumelia} and therefore not only impairs the patient’s bodily integrity, but also his or her \textit{dignitas}, the physician may be held liable for criminal or civil \textit{iniuria}.\textsuperscript{146} Criminal or civil \textit{iniuria} is the unlawful and intentional impairment of another person’s \textit{dignitas}.\textsuperscript{147} \textit{Dignitas} relates to a person’s right to and subjective feelings of dignity, self-respect, privacy, and mental tranquillity.\textsuperscript{148} In context of non-therapeutic medical interventions, the plaintiff patient’s right to dignity will likely be compromised. In order to constitute criminal or civil \textit{iniuria}, the infringement of a plaintiff’s dignity must be accompanied by \textit{animus iniuriandi} on the part of the physician defendant.\textsuperscript{149} The infringement must also be reasonably serious.\textsuperscript{150} Whether a factual infringement of dignity is wrongful or not, would depend on the existing interpretation of the \textit{boni mores}.\textsuperscript{151}

\textbf{2.9 The \textit{Boni Mores} Requirement}

Consent \textit{per se} is not sufficient justification for any sort of bodily harm, including surgery. A wide variety of wish-fulfilling medical procedures are available, but not everything that is medically possible and would happily be privately paid for, should necessarily be allowed.\textsuperscript{152} Individual autonomy is limited by considerations of individual and social responsibility and public interests necessitate that reasonable limits be placed on the capacity to limit one’s own

\begin{footnotesize}
\begin{thebibliography}{99}
\bibitem{145} \textit{Id} 685-6.
\bibitem{146} Van Oosten 452; Van der Walt & Midgley 48; Snyman 433.
\bibitem{147} Nienaber 2008 \textit{THRHR} 377; Van der Walt & Midgley 113.
\bibitem{148} \textit{Ibid}.
\bibitem{149} Van der Walt & Midgley 113; Neethling \textit{et al} 12.
\bibitem{150} Nienaber 2008 \textit{THRHR} 377; Van der Walt & Midgley 114; \textit{De Lange v Costa} 1989 2 SA 857 (A) 862.
\bibitem{151} Nienaber 2008 \textit{THRHR} 372; Van der Walt & Midgley 114.
\bibitem{152} Schramme “Contested Services, Indirect Paternalism, and Real Liberty” \textless http://www.philosophie.unihamburg.de/Team/Schramme/Manuskripte/_Contested%20services.pdf\textgreater (accessed 31 March 2012).
\end{thebibliography}
\end{footnotesize}
This is why, for purposes of the criminal law, consent on the part of the victim will generally not excuse the crime of the offender. A crime is not just much harm committed against the victim. It is also harm committed against the community as a whole. This is why people are not allowed to authorize others to commit crimes. Society recognizes that beyond a certain threshold, which is subject to variation, the harm which individuals are allowed to inflict upon themselves is likely to somehow be harmful to the rest of society. In this regard, utilitarianism curtails the potential excesses of liberalism. Consent will only constitute a defence in criminal law if the lack of a victim’s consent is an actual element of the particular crime or in cases where it eliminates the harm or evil which the law defining the offence was seeking to prevent in the first place. However, the maxim might still function as a defence against civil liability, despite the fact that the act complained of is of a criminal nature. This view is generally accepted, due to the fact that there are “no imperious reasons of policy or justice requiring that a willing party to a criminal act should receive compensation from his particeps criminis for the resulting injury”. The recognition of consent as a defence in criminal law essentially depends upon identifying the societal objectives of the crime in question. In *S v Collett*, the court held that in terms of public policy, the fact that that a servant signed an agreement permitting his master to inflict corporal punishment upon him, is no defence against charge of assault. In *CF Santam Insurance Co Ltd v Vorster*, the court held that it is contra bonos mores to agree to be a party to the commission of a crime such as the racing of vehicles at dangerously high speeds on public highways. Similarly, consent given by a mentally competent individual is an
essential requirement for a lawful medical intervention, but consent will never be a valid
defence if the act consented to is contra bonos mores.164

In S v Sikunyana165, O’Hagan J stated the following: “While it may be difficult to draw a
sharp dividing line between that which is lawful when consented to and that which is
unlawful irrespective of consent, the primary test is to be found in considerations of public
policy.”166 Even if a fully competent individual gives the most complete consent to the
infringement of his or her bodily integrity, it will not suffice to legalise the infringing act if
there are public grounds for prohibiting the act.167 The legality of a patient’s consent to an
infringement of his or her bodily integrity is ultimately a debate concerning on the one hand,
the philosophy of individualism with which the maxim volenti non fit iniuria has come to be
associated, and on the other, the role of the boni mores in limiting that freedom.168 It is
generally unnecessary to apply the standard of boni mores in each and every situation.169

Proof of the existence of an accepted ground of justification, such as volenti non fit iniuria,
conclusively demonstrates the reasonableness, and therefore lawfulness, of the defendant’s
conduct.170 The boni mores test is therefore only applied in borderline and novel cases.171

The phenomenon of wish-fulfilling medical interventions is an example of borderline or
novel cases, where one is forced to turn to the boni mores for guidance. Controversial wish-
fulfilling medical interventions, such as extreme forms of cosmetic surgery, is problematic
due to the fact that the boni mores might call the validity of the patient’s consent into
question. In such a case, the physician’s conduct will also be regarded as unlawful.172

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164 Strauss Toestemming tot Benadeling as Verweer in die Strafreg en die Deliktereg (LLD dissertation 1961
UP) 417.
165 S v Sikunyana 1961 3 SA 549 (E).
166 S v Sikunyana 551E -F.
167 S v Collett 209.
168 Parmanand 1986 TSAR 338.
169 Neethling et al 43.
170 Ibid.
172 Parmanand 1986 TSAR 338.
cases like these, we are dealing with the question of wrongfulness, as the defendant's act is *contra bonos mores*, despite the presence of consent.\(^\text{173}\)

Public policy or the *boni mores* should not be understood as the customs of society or a particular community or of all ethical rules existing in society.\(^\text{174}\) In determining whether consent is *contra bonos mores*, the dominant legal convictions of the community concerning the lawfulness of the particular conduct in question must be applied.\(^\text{175}\) Due to the fact that the law does not provide us with a convenient solution or rule regarding the issue of the limits to consent, it actually borrows a solution from public policy.\(^\text{176}\) In this regard, the concept of good morals constitutes a legal criterion, as it is the lawfulness of the consent that is under consideration.\(^\text{177}\) The *boni mores* as a legal standard, looks at the reasonableness of the defendant’s conduct. This involves a comparative evaluation of the conflicting interests of the parties concerned as well as considerations of policy and social interest.\(^\text{178}\) In addition the extent of the interests involved, other factors that must be taken into consideration include the nature and seriousness of the injury, the motives and intentions of the parties and the social purpose of the consent or assumption of risk.\(^\text{179}\) The more valuable the object attacked, for example bodily integrity or dignity, the more likely it is that the aggression will be deemed *contra bonos mores*.\(^\text{180}\) Wrongfulness depends on whether or not one acted reasonably. The reasonableness of the act depends on the religious, social, ethical and moral views of the community, the seriousness of the injury and the purpose of the defendant's action.\(^\text{181}\) According to Strauss, the consent and the harmful act are inextricably linked to one another and as such they form a whole.\(^\text{182}\) The autonomy and freedom of the patient in consenting to, or in most cases actually requesting, being subjected to a particular harm is therefore a factor

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173 *Id* 347.
174 Strauss 1964 *SALJ* 183.
175 Van der Walt & Neethling *et al* 34.
176 Strauss 417.
177 Strauss 1964 *SALJ* 183.
178 Van der Walt & Midgley 143; Neethling *et al* 34; Parmanand 1986 *TSAR* 338.
179 Van der Walt & Midgley 143; Neethling *et al* 35.
180 Strauss 1964 *SALJ* 183; Parmanand 1986 *TSAR* 338.
181 Parmanand 1986 *TSAR* 338.
182 Strauss 420.
that must be taken into consideration when judging the lawfulness of extreme forms of cosmetic surgery.\textsuperscript{183}

\section*{2.10 The Relevance of a Therapeutic Indication for Purposes of Determining Lawfulness}

In context of medical interventions, the law recognises that one can lawfully consent to surgery, as surgery is not \textit{contra bonos mores}. The question is, above and beyond consent which isn’t sufficient on its own, what makes surgery lawful? In this regard, it must be kept in mind that although consent is the primary legalising factor in South African medical law, it is not the only legalising factor.\textsuperscript{184} Why is it that an act that would otherwise constitute a serious assault, is considered lawful when the person committing the act is a physician? Certainly, one cannot state that the identity of the actor (in other words the fact that the actor is a physician) is the sole reason for the surgery’s lawfulness. Perhaps it has something to do with the nature of the act (the surgery) itself. This leads one to question whether, legislative exceptions aside\textsuperscript{185}, the therapeutic nature of a medical intervention is at the heart of what makes a medical intervention lawful. The praiseworthiness and lawfulness of a curative or therapeutic medical intervention is beyond dispute, but what about operations performed for other reasons such as vanity, economic considerations or even for the sake of novelty?

\subsection*{2.10.1 Academic Opinion on Distinguishing Between Therapeutic and Non-Therapeutic Objectives for Purposes of Determining Lawfulness}

There seems to be a distinction between those who believe that a therapeutic objective is a prerequisite for lawful surgery and those who believe that any legally sanctioned, justifiable objective is sufficient. Strauss agrees that a patient’s consent \textit{per se} is not

\begin{footnotesize}
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\item \textsuperscript{183} \textit{Id} 421.
\item \textsuperscript{184} Pearmain \textit{A Critical Analysis of the Law on Health Service Delivery in South Africa} (LLD dissertation 2004 UP) 756.
\item \textsuperscript{185} For example, the exceptions created in terms of the Choice on Termination of Pregnancy Act 92 of 1996 and the Sterilization Act 44 of 1998 by virtue of which non-therapeutic procedures such as abortions and sterilizations are legalized.
\end{enumerate}
\end{footnotesize}
sufficient justification for the performance of radical surgery of a non-therapeutic nature. Whether such surgery is lawful or not depends on whether the objective of the surgery is legally sanctioned or at the very least justifiable. Strauss states that the objectives of both the defendant as well as the plaintiff must be considered in order to determine the character of the particular act. This is not to say that a depraved motive is an element of unlawfulness; it simply gives us some insight into the objective nature of the act. If the infringement of the plaintiff’s bodily integrity or dignity is committed for the sake of satisfying some perversive urge, it is exactly this perversive objective that is condemned by society. If however, the objective is legally sanctioned, then the consent is valid and lawful. As far as cosmetic surgery is concerned, Strauss states that even grave cosmetic interventions are justified, provided that: (a) the object of the surgery is the assuagement of some undesirable psychological state caused by unsightly outward appearances; and (b) the cosmetic improvement outweighs the minimal risk to the patient’s health or life. At first glance, Strauss seems to be of the opinion that a therapeutic indication is not a prerequisite for lawful cosmetic interventions. However, by requiring that the object of the surgery must be the assuagement of some undesirable psychological state, he is essentially endorsing at least some form of therapeutic outcome, albeit subjective and psychological. It is uncertain whether Straus is of the opinion that the suffering must emanate from an objectively unsightly outward appearance. Considering the subjectivity of aesthetics, it would be difficult to objectively determine whether a patient is unattractive enough to warrant surgery. Even if we assume that Strauss is of the opinion that a therapeutic objective is redundant, he still believes that a physician cannot lawfully perform a completely useless operation. According to Strauss, consent to undergo a completely useless operation, undertaken by a surgeon who knows it is useless, is contra bonos mores. A useless operation would be contra bonos mores, irrespective of the degree of care and skill with which the operation is performed. In this regard, Smith states the following:

Surgery is a violent art; its disciples assail disease by force and direct attack in order to extirpate or alter an abnormal bodily condition. No matter how skilfully done, the

186 Strauss 468.
187 Id 421.
189 Ibid.
breaking of bodily continuity is attended by risk, even in so-called minor surgery, and it is therefore a primary canon of practice to avoid subjecting a patient to the hazards of an unnecessary operation.190

Other authorities explicitly require both a therapeutic indication as well as informed consent as justification for lawful medical interventions. Giesen states that a physician who performs an operation with the consent of the patient may nevertheless find him- or herself faced with legal difficulties, if the operation is not medically indicated.191 Burchell and Hunt are also of the opinion that the purpose of an operation is relevant when determining its lawfulness.192 Burchell states that, despite the serious injuries involved, a patient can lawfully consent to surgery, because it is performed for a therapeutic purpose.193 The operation will therefore generally be lawful, as long as the purpose is curative or therapeutic.194 However, where the procedure is non-therapeutic and serious risks to life, health or person are involved, the fact that it is a licensed physician performing the procedure will not render it lawful.195 Williams states that all medical procedures must be undertaken for a genuinely therapeutic purpose.196 He is of the opinion that therapy gives justification to some cosmetic surgery, but not all.197 According to Williams, the justification for “padding bosoms, chiselling noses, and restoring hymens lost in premarital encounters, is that the patient is pleased and it may be socially or materially advantageous, rather than that the operation is a psychiatric necessity”.198 Barnard et al, with reference not only to legal considerations, but also religious, moral and ethical questions, state that sterilisations are lawful, but only if it is performed for therapeutic reasons. Sterilisations

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193 Burchell & Milton 333.
194 Burchell et al 133; Burchell 334.
195 Burchell et al 133; Burchell & Milton 335.
197 Ibid.
198 Ibid.
performed for other reasons, for example to have sexual intercourse without risking the responsibility of parenthood, are unlawful.\textsuperscript{199} Also with reference to sterilisations, Strauss and Strydom state that the majority view seems to be that the performance of sterilisations for non-therapeutic purposes is unlawful.\textsuperscript{200} Van Oosten rejects this notion, as it does not take the fact that consent is universally accepted as sufficient justification for non-therapeutic interventions, such as purely diagnostic, experimental and cosmetic interventions, into consideration.\textsuperscript{201} Bosman also requires the objective of a medical intervention to be socially approved, however a socially approved objective is not necessarily a therapeutic or palliative objective.\textsuperscript{202} Smith also seems to reject the requirement of a therapeutic indication. He states that a mere desire for beauty warrants the performance of surgical procedures that are not attended by an appreciable risk of death.\textsuperscript{203} Objectives which involve purely personal interests, even interests as frivolous as vanity, should therefore provide sufficient justification for the performance of cosmetic surgery. Smith states that if individuals have such dominion over their bodies that they may prohibit life-saving surgery where an emergency exists, there is no reason why they should not be allowed to beautify their bodies by means of surgical intervention.\textsuperscript{204}

\section*{2 10 2 South African Case Law Distinguishing Between Therapeutic and Non-Therapeutic Objectives for Purposes of Determining Lawfulness}

The case of \textit{Edouard v Administrator, Natal}\textsuperscript{205} provides the most well-known, and seemingly the only, example of a South-African court distinguishing between therapeutic and non-therapeutic interventions for purposes of determining the lawfulness of the procedure. This case was decided before the enactment of the Sterilization Act.\textsuperscript{206} In \textit{Edouard v Administrator, Natal}, the court held that an agreement for a sterilisation to be performed on a married woman with her husband’s consent, where the reason for the operation is the

\begin{footnotesize}
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\item \textsuperscript{199} Barnard \textit{et al Die Suid Afrikaanse Persone- en Familiereg} (1994) 23.
\item \textsuperscript{200} Strauss & Strydom \textit{Die Suid Afrikaanse Geneeskundige Reg} (1967) 250.
\item \textsuperscript{201} Van Oosten 1995 \textit{De Jure} 166.
\item \textsuperscript{202} Bosman \textit{Social Welfare Law} (1982) 529.
\item \textsuperscript{203} Smith 1942 \textit{Rocky Mtn L Rev} 286.
\item \textsuperscript{204} \textit{Ibid.}
\item \textsuperscript{205} \textit{Edouard v Administrator, Natal} 1989 2 SA 368 (D).
\item \textsuperscript{206} The Sterilization Act 44 of 1998.
\end{enumerate}
\end{footnotesize}
prevention of the birth of a child whom they would be unable to support, is not contrary to public policy. The court left open the question whether sterilisations performed for other reasons would be lawful.\textsuperscript{207} The trial court’s decision was confirmed on appeal. The appeal court also specifically confined its judgement to sterilisations performed for socio-economic reasons.\textsuperscript{208} Hereby, the court ostensibly accepted that a socially acceptable objective, like family planning and maintaining a reasonable standard of living, is an adequate justification for the performance of an invasive medical intervention.

\textbf{2 10 3 Foreign Case Law Pertaining to the Relevance of a Therapeutic Indication for Purposes of Determining Lawfulness}

Foreign case law offers several interesting examples of courts distinguishing between therapeutic and non-therapeutic objectives for the sake of determining the lawfulness of medical interventions. In terms of German case law, if a physician carries out an operation at the insistent request of the patient and the physician is sceptical about the therapeutic value thereof, he or she has a duty to inform the patient of these doubts with a view to discourage the patient from undergoing the operation.\textsuperscript{209} If the physician fails to make his or her reservations known, German law considers it to be a case of insufficient disclosure.\textsuperscript{210} As such, the patient’s consent will be rendered invalid and the physician will be held liable for any damages incurred by the patient. German case law offers an example of a case where a sterilization was deemed to be lawful, despite the fact that the operation was not medically indicated. In one case\textsuperscript{211}, the sterilization was performed on a woman with three children. It was performed with the consent of her husband. The court held that, despite the fact that the operation was not medically indicated, it was still performed with just cause. Presumably, the mere fact that the woman did not wish to have any more children was sufficient justification for the procedure.\textsuperscript{212} In \textit{Bravery v Bravery}, the court held that unless an operation was performed for some or another “just cause”, it may be considered \textit{contra bonos}

\begin{itemize}
\item \textsuperscript{207} \textit{Edouard v Administrator, Natal} 381; Burchell & Milton 336.
\item \textsuperscript{208} \textit{Administrator, Natal v Edouard} 1990 3 SA 581 (A) 593.
\item \textsuperscript{209} Köln Cologne 5 Mar 1976 9 U 183/74 VersR 1978 551.
\item \textsuperscript{210} \textit{Ibid}.
\item \textsuperscript{211} 29 June 1976 BGHZ 67 48.
\item \textsuperscript{212} \textit{Ibid}.
\end{itemize}
mores even if informed consent was obtained.\textsuperscript{213} Under the circumstances of the case, the
court held that a vasectomy performed for the sole purpose of preventing the transmission of
a hereditary disease is lawful. In \textit{Custodio v Bauer}, the court held that a sterilization
performed for family limitation, motivated solely by personal or financial considerations, is
not \textit{contra bonos mores}.\textsuperscript{214} In another German case, the court held that a patient could not
validly consent to the non-medically indicated correction her labia and as such damages were
awarded.\textsuperscript{215} The court in the \textit{Attorney-General Reference} case, per Lord Lane held that “it is
not in the public interest that people should try to cause or should cause each other actual
bodily harm for no good reason”.\textsuperscript{216} According to Lord Lane, reasonable surgical
interference is an example of such an exception, as it can be justified as being in the public
interest.\textsuperscript{217} Although he did not explicitly refer to the distinction between therapeutic and
non-therapeutic surgical interventions, Lord Lane’s comment can be understood as endorsing
the view that a surgical interference need not necessarily be therapeutic in order to be lawful.
It only needs to be reasonable. Unfortunately, Lord Lane provided no further guidance as to
what might amount to unreasonable surgery, how the public interest was engaged, or how far
it extended.\textsuperscript{218}

An interesting example of a case dealing with the defence of \textit{volenti non fit iniuria} is that of \textit{R v Brown}.\textsuperscript{219} Despite the fact that the case does not deal with the lawfulness of consent to a
medical interventions, the comments made by the court in relation to the moral limits of
consent is relevant to this study. In 1990 five British men were convicted of assault
occasioning actual bodily harm. The conviction was due to the men partaking in consensual
sadomasochistic sexual practices throughout a period of ten years. None of the men ever
filed a complaint or made any grievances known regarding these activities. They partook in
these activities voluntarily and with the fullest consent. The men’s extracurricular activities

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\item\textsuperscript{213} \textit{Bravery v Bravery} 1954 3 ALL ER 59 (CA) 67.
\item\textsuperscript{214} \textit{Custodio v Bauer} 59 Cal Rptr 463 App 1967.
\item\textsuperscript{215} Düsseldorf 15 Nov 1984 8 U 189/83 NWJ 1985 684 VersR 1986 63.
\item\textsuperscript{216} No 6 of 1980 1981 QB 715.
\item\textsuperscript{217} \textit{Id} 716.
\item\textsuperscript{218} Elliott “Body Dysmorphic Disorder, Radical Surgery and the Limits of Consent” 2009 \textit{Medical Law Review (Med L Rev)} 163.
\item\textsuperscript{219} \textit{R v Brown} 1993 2 ALL ER 75 (HL).
\end{itemize}
were discovered by the police in a completely unrelated investigation. The men appealed against the judgment of the trial court. Their contention was that a person cannot be guilty of assault in respect of acts that are consensual and private. They contended that consent should be a recognised defence to the charge of assault, since a person has complete dominium over his or her own body. People should be allowed to do whatever they want to their bodies, including allowing it to suffer extreme pain and torture. The Court of Appeal dismissed the appeal. The House of Lords affirmed the Court of Appeal’s decision. The majority of the Law Lords held that it is against the public interest that a person should wound or cause actual bodily harm to another for no good reason and, in the absence of such a reason, the victim's consent did not constitute a defence to a charge of assault. According to the House of Lords, the satisfaction of sadomasochistic desires did not provide the men with a good reason for inflicting gross harm on one another. The court held that one cannot consent to harm occasioned by an unlawful activity. Consent is only a defence when the harm in question results from a lawful activity. The stance seems to accord with the standpoint held by Strauss, when he states that it is impossible for the particular act to be contra bonos mores, whilst consent thereto is not.220

2.11 Conclusion

In light of the abovementioned authority, it seems reasonable to conclude that the common law does not require a therapeutic objective for a medical intervention to be lawful. Essentially, the common law relating to a patient’s consent to bodily harm occasioned by a physician is the same as the law governing other relationships between human beings. The objective of the medical intervention must be socially acceptable. It is very difficult to determine whether a non-therapeutic operation serves a socially acceptable objective. Decisions are based on the court’s perception of the social acceptability and utility of the particular activity and are made on a case-by-case basis. This allows the changing boni mores to determine which activities are classified as unlawful. It can be a delicate question of public policy in order to identify what non-therapeutic surgeries are socially acceptable, particularly when fundamental human rights such as the patient’s right to human dignity, privacy and bodily integrity are involved. In the next chapter, the interpretation of the boni mores will be taken further and the importance and influence of underlying constitutional

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220 Strauss 420.
values will form the focus of the discussion. In South Africa, the Constitution itself is a powerful indicator of public policy.\textsuperscript{221} Furthermore, in a constitutional era it is no longer acceptable to discuss the \textit{boni mores} without reference to the Constitution and its underlying values. The constitutional framework surrounding wish-fulfilling must therefore be investigated. This will form the focus of the next chapter.

\textsuperscript{221} Carstens & Pearmain 8.
Chapter 3  Constitutional Perspectives on Wish-Fulfilling Medicine

3 1 Introduction

The specific fundamental human rights protected in the Bill of Rights that are applicable to wish-fulfilling medicine, cosmetic surgery in particular, are discussed in detail below. The meaning of human dignity in South African constitutional law will form the focus of the first part of this chapter. By applying a constitutional conception of human dignity, the question will be answered whether cosmetic surgery most likely promotes or impedes human dignity. In this regard, the relationship between autonomy and dignity and the question whether autonomous individuals should be prevented from participating in activities that might limit their dignity will be addressed. The same enquiry will be made concerning the other fundamental human rights that are applicable to cosmetic surgery. This includes the right to bodily integrity and the right to privacy. The limitation of these fundamental human rights in terms of section 36 of the Constitution will then be addressed.

3 2 Section 10 of the Constitution: Right to Human Dignity

Section 10 of the Constitution states the following: “Everyone has inherent dignity and the right to have their dignity respected and protected.” The Constitution repeatedly refers to human dignity as both a right and a value and all things considered, human dignity is arguably the most important right as well as the most important value contained in the Bill of Rights. Human dignity also plays an important role in many international human rights instruments and as a legal concept human dignity has become somewhat inescapable.

222 S 10 of the Final Constitution of the Republic of South Africa, hereafter referred to “the Constitution”.
223 S 1 of the Constitution states that South Africa is founded on the values of “human dignity, the achievement of equality, and the advancement of human rights and freedoms”. S 7 reads that the Bill of Rights is an instrument that “affirms the democratic values of human dignity, equality and freedom”. S 36 permits limitations provided that they are “reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom”. Furthermore, s 39 states that when interpreting the Bill of Rights “the values that underlie an open and democratic society based on human dignity, equality and freedom” must be promoted.
224 The preamble of the Charter of the United Nations commits its members to the “dignity and worth of the human person”. The preamble of the Universal Declaration of Human Rights states that the inherent “dignity” and the “equal and inalienable rights” of all persons are the “foundation of freedom and justice and peace”.

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Human dignity is central to the protection of all other rights and every other right has a component consisting of human dignity, as such human dignity can be described as a “pre-eminent value in the Constitution, even more so than the right to life”. This stance was reiterated by Chaskalson when he wrote that: “The affirmation of human dignity as a foundational value of the constitutional order places our legal order firmly in line with the development of constitutionalism in the aftermath of the second world war.” Furthermore, human dignity lies at the heart of the prohibition against unfair discrimination and the infringement of human dignity due to unequal treatment amounts to *prima facie* unfair discrimination. Human dignity also differs from other fundamental rights in the sense that it has a residual function. This means that the right to human dignity finds application where more specific rights that give expression to human dignity do not. However, more often than not, dignity is applied as an objective normative value and not as an individual right. Courts ordinarily do not apply dignity as a first order right where the “primary constitutional breach occasioned may be of a more specific right”. Cowen explains this as follows:

Dignity as a right is ‘elevated’ in relation to other rights, but only in the sense that it is seen to embrace and inform other rights. Other rights may be seen as incidences of dignity itself or, put less strongly, the meaning of other rights can also be located in the idea of protecting human worth. The implication of this is that one would see the protection of bodily and psychological integrity, for example, as a component of protecting human worth-or dignity-and thus

Furthermore, s 1 of the Universal Declaration of Human Rights states that: “All human beings are born free and equal in dignity and rights.” The African Charter on Human and Peoples’ Rights states in s 5 that every person “shall have the right to the respect of the dignity inherent in a human being”. A 3 of the Protocol to the African Charter on Human and People’s Rights on the Rights of Women in Africa state that: “Every woman shall have the right to dignity inherent in all human beings and to the recognition and protection of her human and legal rights.” See also Henette -Vauchez (2011) 33.


226 Chaskalson 2000 *SAJHR* 196.

227 *Prinsloo v Van der Linde* 1997 6 BCLR 759 (CC) 31.


embraced also in the right to dignity. But a legal claim that fits the right to bodily and psychological integrity would more likely be dealt with under that right even though it is also embraced by the broader right to dignity. Sometimes the choice of right will be determined by whether there are internal limitations on those rights. The dignity right then for practical purposes serves as a flexible and residual right.  

3 2 1 Constitutional Conception of Dignity

There is a very close connection between human dignity and healthcare, as health is essential to life and human dignity. Furthermore, decisions regarding one’s body and the effect that those decisions have on your relationship with your own body is deeply personal. As such, the decisions affect one’s dignity. Appeals to human dignity and claims that some feature of current medical practice violates human dignity are ubiquitous in contemporary bioethical discourse. The same can be said for certain forms of cosmetic surgery. Cosmetic surgery, while generally pursued to beautify, enhance and perfect, can do the exact opposite when used inappropriately. As Bordanoski rightly states: “Excessive cosmetic surgery can transform acts which were undertaken to conform to societal images of beauty into ‘freakish’ acts of body modification, divorced from their original intentions of conforming to socially sanctioned ideals of beauty.” Consider the real-life, albeit extreme, example of Brian Zembic, the high-stakes gambler who became famous when he agreed to undergo a breast augmentation with silicone implants as part of a $100, 000 wager or Jocelyn Wildenstein, the famous New York socialite, who had undergone so many cosmetic procedures that she unintentionally transformed herself into the “cat woman”. Although rare, some patients suffering from body identity integrity disorder actually request the amputation of healthy

231 Carstens & Pearmain 29.
233 Ibid.
234 Konik The Man with the $100 000 Breasts:and Other Gambling Stories (1999) 240; Bogdanoski 2009 Griffith L Rev 507.
limbs. Others want their anatomy shaped to replicate the appearance of reptiles. One might argue that such an operation violates the inherent dignity of the human body. More commonplace examples might include an exotic dancer who asks her surgeon to give her extraordinarily large breast implants so that she can find a niche in the competitive market of exotic dancing, a young black woman asking her surgeon to lighten her skin and narrow her nose or a woman asking her surgeon to perform a labiaplasty, a cosmetic procedure that some feminists compare to female circumcision. Of particular significance to the present discussion, is female genital cosmetic surgical procedures. There is an increasing demand for this procedure. The permissive approach of the law towards cosmetic surgery, genital cosmetic surgery in particular, stands in stark contrast to the restrictive approach taken by the law in relation to female genital mutilation and its supposed threat to dignity.

Depending on the definition of human dignity, cosmetic surgery might either promote or impede human dignity. It is therefore very important to have a correct understanding of the term. Despite the pervasive reference to human dignity in biomedical literature, it is rarely defined. This had led some to conclude that human dignity is indefinable and therefore a useless concept for the ethical analysis of medical technologies. It has been said of dignity, that its meaning is so unclear, and its use so vast, that it is not much more than a vague rhetorical device. Some constitutional lawyers are of the opinion that dignity can


only be defined on a case-by-case basis or that it can only be defined negatively.\(^{239}\) There is no denying the fact that the concept of human dignity is indeed “complex, ambiguous and multivalent”.\(^{240}\) Proof of this is the fact that appeals to dignity are often used to support diametrically opposed positions. For example, death with dignity organisations often appeal to a loss of dignity during end of life suffering to support their arguments, whereas anti-euthanasia organisations appeal to respect for the dignity of human life to oppose euthanasia. It has also been said that dignity-based jurisprudence is not conducive to principled decision-making, as it allows judges to resort to subjective values rather than objective rules.\(^{241}\) Even our Constitutional Court has acknowledged that human dignity is “a difficult concept to capture in precise terms”.\(^{242}\) However, the concept of human dignity is certainly not a mere empty slogan. Such a stance would be completely unacceptable in an open and democratic society based on human dignity, equality and freedom. The Constitutional Court identified human dignity as the hallmark of the new constitutional order very early on in \(S \, v \, M a k w a n y a n e\).\(^{243}\) The Constitutional Court has since referred to human dignity repeatedly, particularly in the case of controversial issues such as the death penalty\(^{244}\), termination of pregnancy\(^{245}\), marriage between homosexual individuals\(^{246}\), religious freedom\(^{247}\) and prostitution,\(^{248}\) just to name a few.\(^{249}\) The importance of human dignity is clearly beyond dispute, but its meaning is very far from clear. Despite the prominence and importance of

\(^{239}\) Botha 2009 \(S e l l\, L R\) 182.
\(^{240}\) Moody 1998 \(J G S W\) 14.
\(^{241}\) Botha 2009 \(S e l l\, L R\) 172.
\(^{242}\) National Coalition for Gay & Lesbian Equality \(v\) Minister of Justice 1999 1 \(S A\) 6 (CC) 28; Currie & De Waal 273.
\(^{243}\) \(S \, v \, M a k w a n y a n e\).
\(^{244}\) Ibid.
\(^{245}\) Christian Lawyers Association of South Africa \(v\) Minister of Health 1998 11 BCLR 1434 (T).
\(^{246}\) Minister of Home Affairs \(v\) Fourie 2006 3 BCLR 355 (CC).
\(^{247}\) Christian Lawyers Association of South Africa \(v\) Minister of Health.
\(^{248}\) \(S \, v \, J o r d a n\) 2001 10 BCLR 1055 (T) 642.
human dignity, the Constitutional Court has not yet adopted any definitive or comprehensive definition thereof and has acknowledged that human dignity is difficult to define.250

In its broadest sense, the Constitutional Court has defined human dignity as the intrinsic worth of all human beings and the source of a person’s innate rights to freedom and physical integrity from which several other rights emanate.251 The Constitutional Court has explained the concept of human dignity by stating that simply by virtue of being human, “human beings are entitled to be treated as worthy of respect and concern”.252 Human beings are therefore not “commodities to which a price can be attached”, but rather “creatures with inherent and infinite worth” that deserve to be treated as ends in themselves as opposed to mere means to an end.253 Human dignity has been recognised by the Constitutional Court as a right “concomitant to life itself and inherent in all human beings”.254 The Constitutional Court therefore does not regard human dignity as something that is linked to virtue. It can neither be earned nor deserved. Potentially relevant to the question of extreme forms of cosmetic surgery and its impact on human dignity, is the fact that the Constitutional Court has stated that human dignity inheres in various aspects of what it means to be human, including, but not limited to the fundamental dignity of the human body.255 In this regard, the Constitutional Court in S v Jordan stated that the Constitution regards there to be an inherent respect in the human body and that the “constitutional commitment to human dignity invests a significant value in the inviolability and worth of the human body”.256

251 S v Dodo 2001 3 SA 382 (CC) 38; Bernstein v Bester 1996 2 SA 751 (CC) 148; S v Makwanyane 327; National Coalition for Gay & Lesbian Equality v Minister of Justice 29; Currie & De Waal 273.
252 S v Makwanyane 327.
254 S v Makwanyane 311.
255 S v Jordan 74.
256 S v Jordan 74 & 81.
The Constitutional Court has adopted both a classic liberal conception of human dignity as well as a conception of human dignity rooted in ubuntu respectively. In *Ferreira v Levin*, Ackerman J held that human dignity refers to the need to respect the uniqueness of the individual and the need to permit personal development. In this regard, Ackerman J stated that:

> Human dignity cannot be fully valued or respected unless individuals are able to develop their humanity, their ‘humanness’ to the full extent of its potential. Each human being is uniquely talented. Part of the dignity of every human being is the fact and awareness of this uniqueness. An individual's human dignity cannot be fully respected or valued unless the individual is permitted to develop his or her unique talents optimally. Human dignity has little value without freedom; for without freedom personal development and fulfilment are not possible. Without freedom, human dignity is little more than an abstraction. Freedom and dignity are inseparably linked. To deny people their freedom is to deny them their dignity. Although freedom is indispensable for the protection of dignity, it has an intrinsic constitutional value of its own.\(^{257}\)

Autonomy is certainly a *conditio sine qua non* for personal development and as such, in terms of the definition of human dignity put forward by Ackerman J, autonomy is also an element of human dignity.\(^{258}\) Haysom connects autonomy with self-actualisation or self-realisation when he states that in order to respect an individual’s autonomy, the individual’s “worth as self-actualising must be protected”.\(^{259}\) The Constitutional Court has also recognised the connection between autonomy and self-actualisation on several other occasions.\(^{260}\) The

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257 *Ferreira v Levin* 1996 1 SA 984 (CC) 49.


259 Haysom 131.

260 In *Barkhuizen v Napier* 2007 7 BCLR 691 (CC) 57 the court defines autonomy as: “[T]he ability to regulate one’s own affairs, even to one’s own detriment.” In *NM v Smith* 2007 7 BCLR 751 (CC) 131 the court describes autonomy as the ability to choose how you want to live your life, albeit within the overall framework of a broader community. In *Ferreira v Levin* 50 the court stated that: “An ‘open society’ most certainly enhances the argument that individual freedom must be generously defined. It is a society in which persons are free to develop their personalities and skills, to seek out their own ultimate fulfilment, to fulfil their own humanness and to question all received wisdom without limitations placed on them by the State. The ‘open
The notion that autonomy forms an important part of dignity was put forward by O’Regan J in *NM v Smith* when she stated the following in regard to human dignity, privacy and freedom: “Underlying all the constitutional rights is the constitutional celebration of the possibility of morally autonomous human beings independently able to form opinions and act on them.” O’Regan J acknowledged that the Constitution “seeks to assert and promote the autonomy of individuals”. This conception of human dignity was also adopted by the Constitutional Court in *Barkhuizen v Napier*, when Ngcobo J stated that autonomy, or the “ability to regulate one’s own affairs, even to one’s own detriment, is the very essence of freedom and a vital part of dignity”. The ability to live an autonomous life, that is, a life of one’s choice in accordance with your own conception of the good, was once again confirmed to form an important part of dignity by the Constitutional Court in *MEC for Education: Kwazulu Natal v Pillay* when Langa CJ stated that an “entitlement to respect for the unique set of ends that the individual pursues” is a “necessary element of freedom and of dignity of any individual”. Also, in *President of the Republic of South Africa v Hugo*, it was confirmed that dignity is “at the heart of individual rights in a free and democratic society”. This particular understanding of human dignity “secures the space for self-actualisation”. This is not to say that autonomy is an independent right, as this stance has already been rejected by the Constitutional Court in *S v Jordan*. Furthermore, it is not being averred that society’ suggests that individuals are free, individually and in association with others, to pursue broadly their own personal development and fulfilment and their own conception of the ‘good life’.”

261 *NM v Smith* 145-6.
262 Ibid.
263 *Barkhuizen v Napier* 57.
264 *MEC for Education: Kwazulu-Natal v Pillay* 2008 2 BCLR 99 (CC) 64.
265 *President of the Republic of South Africa v Hugo* 1997 4 SA 1 (CC) 41.
267 See *S v Jordan* 53 where the court stated that: “While we accept that there is manifest overlap between the rights to dignity, freedom and privacy, and each reinforces the other, we do not believe that it is useful for the purposes of constitutional analysis to posit an independent right to autonomy. There can be no doubt that the ambit of each of the protected rights is to be determined in part by the underlying purport and values of the Bill of Rights as a whole and that the rights intersect and overlap one another. It does not follow from this however that it is appropriate to base our constitutional analysis on a right not expressly included within the Constitution.”
dignity is completely synonymous with autonomy, after all one can make an autonomous decision to have your own dignity violated and as such dignity and autonomy can arguably be in opposition to each other. All that is being averred is that autonomy and dignity are complementary concepts. Dignity therefore presupposes a sphere of personal autonomy, even though it is not synonymous with individual freedom and self-fulfilment. This contention has its roots not only in constitutional jurisprudence and contemporary human rights literature, but also in Kantian philosophy in terms of which autonomy promotes dignity in the sense that it allows an individual to lay down the rules of their own morality. The fact that human dignity is closely related to the notion that human beings are moral agents who are capable of shaping their own identity is often expressed by philosopher and legal scholar, Martha Nussbaum. Nussbaum expresses this notion as follows:

The core idea is that of the human being as a dignified free being who shapes his or her own life in cooperation reciprocity with others, rather than being passively shaped or pushed around by the world in the manner of a ‘flock’ or ‘herd’ animal. A life that is really human is one that is shaped throughout by these human powers of practical reason and sociability.

Autonomy is valuable for the pursuit of dignity if it is exercised in the pursuit of the good without prescribing any particular conception of the good. Some individuals have values that differ from the dominant social values and their controversial choices could make for better, more autonomous lives. These values lead them to choices that appear irrational to most, but that are acceptable within their particular worldview, as it truly contributes to their conception of a worthwhile life. A good or worthwhile life might include the pursuit of some physical ideal through the performance of extreme surgery. Controversial choices,

268 Botha 2009 Stell LR 204.
269 Post “Dignity, Autonomy and Democracy” <http://www.escholarship.org/uc/item/8h98x8h9# page-32> (accessed 26 January 2013). See also Ferreira v Levin 52 where Ackerman J refers to a Kantian conception of dignity and its relation to freedom/autonomy.
271 De Roubaix 2011 JPRAS 372.
273 De Roubaix 2011 JPRAS 372.
where competent and rational, should therefore even be encouraged as they “increase the richness of the tapestry of living”.\textsuperscript{274} In this regard, the British philosopher, John Stuart Mill, stated the following:

I have said that it is important to give the freest scope possible to uncustomary things, in order that it may in time appear which of these are fit to be converted into customs. But independence of action, and disregard of custom, are not solely deserving of encouragement for the chance they afford that better modes of action, and customs more worthy of general adoption, may be struck out; nor is it only persons of decided mental superiority who have a just claim to carry on their lives in their own way. There is no reason that all human existence should be constructed on some one or small number of patterns. If a person possesses any tolerable amount of common sense and experience, his own mode of laying out his existence is the best, not because it is the best in itself, but because it is his own mode.\textsuperscript{275}

In contrast with this classic liberal conception of dignity, Makgoro J, in \textit{Ferreira v Levin}, opined that although the individual is not completely irrelevant when it comes to dignity, the individual should not be regarded as an isolated entity. People are interdependent and bound to a community and as such human dignity is a relational value.\textsuperscript{276} In terms of this definition, dignity therefore “encompasses both the autonomy of the individual and her membership of and boundedness to the community.”\textsuperscript{277} Makgoro J then put forward an understanding of human dignity as part of \textit{ubuntu} or humaneness, in which the community or group plays an essential role. In this regard, Lange J, in \textit{S v Makwanyane}, stated that:

An outstanding feature of \textit{ubuntu} in a community sense is the value it puts on life and human dignity. The dominant theme of the culture is that the life of another person is at

\textsuperscript{274} Savulescu “Autonomy, the Good Life and Controversial Choices” <http://www.practicalethics.ox.ac.uk/_data/assets/pdf_file/0007/28168/controversial_choices.pdf> (accessed 10 June 2012).
\textsuperscript{276} Liebenberg 2005 \textit{SAJHR} 11; Botha 2009 \textit{Stell LR}187.
\textsuperscript{277} Botha 2009 \textit{Stell LR} 187.
least as valuable as one's own. Respect for the dignity of every person is integral to this concept.278

The court in Port Elizabeth Municipality v Various Occupiers was also recognising such a collective conception of dignity when it stated the following:

It is not only the dignity of the poor that is assailed when homeless people are driven from pillar to post in a desperate quest for a place where they and their families can rest their heads. Our society as a whole is demeaned when state action intensifies rather than mitigates their marginalisation.279

A communitarian conception of human dignity can be described as social justice with an emphasis on compassion for vulnerable individuals in the community. This conception of human dignity is rooted in the communal nature of traditional African societies. In contrast, the classic liberal conception of human dignity is rooted in individual rights and any derogation from individual liberty for the sake of the collective good must be properly justified in terms of the limitation clause.

It is important to avoid both a “radical individualist conception of a self that is unencumbered by social ties and relations” on the one hand as well as a “thick, essentialist view of a self that is incapable of escaping the strictures imposed by culture and religion” on the other.280 A communitarian conception of human dignity seems more appropriate in cases concerning socio-economic rights as opposed to cases concerning highly personal rights such as the patient seeking wish-fulfilling surgery’s right to bodily integrity and privacy. Dignity is a wide and all-encompassing concept; as such no single conception of dignity is correct or incorrect. When we talk about the dignity of a patient seeking wish-fulfilling surgery, it is submitted that it would be more appropriate to refer to the classic liberal conception of dignity, with an emphasis on autonomy, as opposed to a communitarian sense of dignity rooted in ubuntu. This is because autonomy is so important in personal decisions regarding healthcare.

278 S v Makwanyane 225.
279 Port Elizabeth Municipality v Various Occupiers 2005 1 SA 217 (CC) 18.
280 Botha 2009 Stell LR206.
322 The Importance of Autonomy in Health Care Decisions

In Castell v De Greef, the court emphasised the importance that the Constitution places on a patient’s fundamental right to self-determination and rights of bodily integrity and autonomous moral agency. It has been said that health is an “essential prerequisite to the exercise of personal autonomy and an irreducible condition of human flourishing”. Control over physical and mental health is an essential facet of personal autonomy and the pursuit of health through the exercise of personal choices is an expression thereof. Similarly, individuals must be autonomous in order to make informed choices regarding the pursuit of health. A right to health therefore also includes a right to gain control over one’s sense of physical and psychological wellbeing. In this regard, it is important to remember the enormous impact that individual behaviour, attitudes and choices have on health status. It has been argued that the importance of autonomy in healthcare should not be overestimated, as the holders of rights are not isolated and socially disconnected entities.

In Soobramoney v Minister of Health, Kwazulu–Natal, Sachs J stated that rights related to healthcare must not just be considered in terms of the usual legal context structured around the ideas of human autonomy. Sachs J opined that such rights must also be evaluated in terms of a new “analytical framework based on the notion of human interdependence”, as a healthy life depends upon social interdependence. This is very true, but it is submitted that in the context of privately paid for wish-fulfilling procedures such as cosmetic surgery, the broader social and material dimensions of the pursuit of health becomes less relevant. The close relationship between dignity and autonomy in the context of healthcare must also be kept in mind. As such, the emphasis on autonomy is warranted.

283 Pieterse 2008 SALJ 555.
284 Ibid.
288 Soobramoney v Minister of Health, Kwazulu–Natal 1998 1 SA 765 (CC) 54.
3 3 Section 12(2) of the Constitution: Right to Bodily and Psychological Integrity

Section 12 of the Constitution protects health-related autonomy interests. Section 12(2)(a) and section 12(2)(b) protects the right to bodily and psychological integrity, which includes, but is not limited to, the right to make decisions about reproductive health and the right to security in and control over your body. The essence of the right to freedom and security of the person is negative, that is, the right to be left alone. There is a difference between a right to “security in” your body as opposed to a right to “control over” your body. A right to security in your body refers to the protection of your bodily integrity against intrusion by the State and your right to be left alone, whereas a right to control over your body refers to physical autonomy, self-determination and the right to live the life of your choice.

In the healthcare context, the right to bodily and psychological integrity usually implies a right not to receive medical treatment against your will and a right to informed consent. In terms of a wide interpretation of the right to bodily and psychological integrity, it also includes a right to make autonomous decisions regarding your own body. Such a reading is consistent with the fact that the right to bodily and psychological integrity explicitly includes the right to make decisions regarding reproductive health. According to Pieterse, the right to bodily integrity includes the autonomous pursuit of health through lifestyle-related choices. Reproductive autonomy is just one of the manifestations of this freedom. According to Pieterse, it is therefore conceivable that “the failure to respect autonomy-related elements of the right to health may, in several contexts, amount to an infringement of the constitutional right to bodily and psychological integrity”. In this regard, it is important to keep in mind that “health” is a very broad concept and includes wellbeing. The right to bodily and psychological integrity includes the autonomous pursuit of health through lifestyle-related choices.

289 Pieterse 2008 SALJ 557.
291 Swanepoel 110-11; Currie & De Waal 308.
292 Swanepoel 110; Currie & De Waal 308; Pearmain 121-2; Pieterse 2008 SALJ 558; Carstens & Pearmain 30.
293 Pieterse 2008 SALJ 558.
294 See Christian Lawyers v Minister of Health 2004 10 BCLR 1086 (T) 1093I-1094C where the court stated that the ability to make decisions regarding termination of pregnancy furthers the enjoyment to the constitutional right to bodily and psychological integrity, dignity and privacy. Also see discussion in Pieterse 2008 SALJ 563.
295 Pieterse 2008 SALJ 560.
psychological integrity becomes relevant in the context of wish-fulfilling medicine, extreme forms cosmetic surgery in particular, as some individuals may undergo such procedures in the pursuit of wellbeing. A patient who therefore makes the autonomous decision to undergo extreme or strange elective surgery in pursuit of their conception of wellbeing, might have their right to bodily and psychological integrity violated should they be refused.

3 4 Section 14 of the Constitution: Right to Privacy

Section 14 of the Constitution protects the right to privacy, which includes the right not to have one’s person, home or property searched, one’s possessions seized or the privacy of one’s communications breached. South Africa is one of the few countries in the world with an express right to privacy contained in its Bill of Rights. The Constitutional Court has stated that there is a “manifest overlap” between the right to privacy and the right to human dignity and freedom and that each reinforces the other. Furthermore, it has been acknowledged that the right to privacy “serves to protect and foster” human dignity. The right to privacy is relevant to wish-fulfilling medical practices, as decisions concerning healthcare and what one chooses to do with one’s body is extremely intimate and personal. The autonomy to make such intimate decisions in relation to intensely significant aspects of one’s personal life could reasonably be argued to be protected by the right to privacy. In this regard, it has been said that the right to privacy is protected for instrumental reasons, namely the “realisation of a value-autonomous identity”, and as such privacy is a valuable aspect of personhood, human dignity in particular.

3 4 1 Constitutional Conception of Privacy

The concept of privacy is notoriously difficult to define in both philosophy and law. In Bernstein v Bester, Ackerman J referred to scholars Dionisopoulos and Ducat and their

296 S v Jordan 53.
297 S v Jordan 81.
298 S v Jordan 76.
300 Currie 2008 TSAR 549; Bernstein v Bester 65; NM v Smith 32.
suggestion that the concept of privacy consists of three core elements. The first core element constitutes the “place-oriented conceptions of privacy”, which defines the right to privacy in spatial terms. The second core element refers to the “person-oriented conceptions of privacy”, where the emphasis is shifted from place or property to the actual person involved. Lastly, the third concept refers to how the “right inheres in certain relationships”, such as the relationship between spouses. In this regard, it is worth mentioning that the Constitutional Court in *S v Jordan* clarified any confusion surrounding the spatial metaphors used in *Bernstein v Bester*. Such metaphors are somewhat misleading to the extent that they suggest that privacy is confined to or relates to a space or a place. This is incorrect. The fact that conduct takes place in or outside of the inner sanctum is not crucial in determining whether or not the conduct merits protection. What matters is whether the conduct is dignity-affirming, and whether it therefore conforms to the primary purpose of the right to privacy. In *Bernstein v Bester*, it was also stated that the right to privacy extends to all those areas of one’s life that one can legitimately expect to be kept private. A legitimate expectation of privacy has both a subjective as well as an objective component. The subjective component refers to the individual’s subjective expectation of privacy, whereas the objective component refers to the objective reasonableness of that expectation in the eyes of society. Concerning the subjective component of privacy, it has been said that privacy is what feels private. Privacy is therefore what can reasonably be considered to be private.

Concerning the scope of the right to privacy, the court in *Bernstein v Bester* stated that the concept of privacy is an amorphous and elusive one which has been the subject of much

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301 *Bernstein v Bester* 65.
303 Currie & De Waal 322-3; *S v Jordan* 81. See also Sachs J concurring with the fact that the right to privacy protects persons and not places in *National Coalition for Gay and Lesbian Equality v The Minister of Justice* 116.
304 Currie & De Waal 322-3; *S v Jordan* 81.
305 Currie & De Waal 318; *Bernstein v Bester* 75; Currie 2008 *TSAR* 551.
306 *Ibid*.
307 Currie & De Waal 318; *Bernstein v Bester* 75.
308 Currie & De Waal 318.
The court then confirmed that the scope of privacy is closely related to the concept of identity and that the right to privacy is “not based on a notion of the unencumbered self, but on the notion of what is necessary to have one’s own autonomous identity”. However, as De Vos rightly states: “[O]ne’s identity is multi-levelled and depending on who one is and what activity one is engaged in the level of privacy protection will differ.” De Vos therefore likens the right to privacy to an onion and states that the right to privacy “has many layers and the closer one gets to the skin the less protected it is”. This is also what Ackerman J means when, referring to privacy, he states that the Constitution calls for a “multi-levelled recognition of identity”. Ackermann J held that the right to privacy must be understood as recognising a continuum of privacy rights that starts with a wholly inviolable inner self, moving to a relatively impermeable sanctum of the home and personal life, and ending in a public realm where privacy does not enjoy much protection. In this regard, the court in Bernstein v Bester, per Ackerman J, stated the following:

The relevance of such an integrated approach to the interpretation of the right to privacy is that this process of creating context cannot be confined to any one sphere, and specifically not to an abstract individualistic approach. The truism that no right is to be considered absolute, implies that from the outset of interpretation each right is always already limited by every other right accruing to another citizen. In the context of privacy this would mean that it is only the inner sanctum of a person, such as his/her family life, sexual preference and home environment, which is shielded from erosion by conflicting rights of the community. This implies that community rights and the rights of fellow members place a corresponding obligation on a citizen, thereby shaping the abstract notion of individualism towards identifying a concrete member of civil society. Privacy is acknowledged in the truly personal realm, but as a person moves into

309 Bernstein v Bester 65.
310 Ibid.
312 Ibid.
313 Bernstein v Bester 66.
communal relations and activities such as business and social interaction, the scope of personal space shrinks accordingly.

In a truly personal realm, such as what you choose to do to your body, an expectation of privacy is therefore far more likely to be considered reasonable. According to McGregor and Moore, the Constitution recognises an “inviolable sphere of privacy beyond the reach of public authority”. This means that “certain matters that arise in this private sphere of autonomy cannot be judged upon or regulated by the state”. In *S v Jordan*, the court stated that “there can be no doubt that autonomy to make decisions in relation to intensely significant aspects of one’s personal life” is included in the right to privacy. Similarly, in *National Coalition for Gay and Lesbian Equality v The Minister of Justice* the court, per Ackerman J, stated that the right to privacy “recognises that we all have a right to a sphere of private intimacy and autonomy”. Privacy therefore does not only pertain to a one’s home, body and property, but also to certain types of very personal and intimate decisions. In this regard, the right to privacy includes the right “to be left alone” and the right of an individual “to live his or her life as he or she pleases”. The right to privacy is therefore relevant to wish-fulfilling medical practices, as the decision to alter your body is an extremely personal and intimate one.

### 3.5 Application of the Constitutional Framework Pertaining to Wish-Fulfilling Medicine

It is difficult to determine whether certain forms of extreme cosmetic surgery violate human dignity. Due to the fact that human dignity is regarded as the basis of human rights and as it is so often used in combination with more specific rights, dignity sometimes features on both

314 Currie & De Waal 318.
316 Swanepoel 115.
317 *S v Jordan* 76.
318 *National Coalition for Gay and Lesbian Equality v The Minister of Justice* 32.
319 Currie 2008 TSAR 552.
320 *NM v Smith* 32.
sides of a dispute. 321 Two or more aspects of dignity are therefore placed in opposition to another. In cases where dignity conflicts with dignity, a court has no choice but to engage in a balancing act. 322 When autonomous and competent patients willingly consent and choose to have things done to their bodies that violate their human dignity, the state’s duty to protect dignity, even against self-degradation, stands in opposition to the individual’s autonomy and right to self-determination. 323 In the case of extreme surgery, the self-worth and inherent dignity of human body component of dignity stands in opposition to the autonomy component of human dignity.

Assuming for the moment that some forms of extreme surgery do violate human dignity, the question arises whether one is allowed to consent to the limitation of one’s own dignity and whether the State has an interest in preventing autonomous individuals from engaging in activities that represent some sort of an insult to dignity. Can the protection of dignity override free and autonomous consent? It might be assumed that if one has the right to be protected from the violation of the right to human dignity, then one should also be free from the paternalistic imposition of its unwanted benefits. 324 In terms of a classic liberal autonomy-based approach to dignity, it seems perfectly rational that individuals should be allowed to limit their own dignity. Conversely, individuals will probably not be allowed to limit their own dignity in terms of a communitarian-based approach. 325 There are numerous examples of ways in which the paternalistic protection of human dignity limits freedom. In some jurisdictions people are actually prohibited from exercising their freedom in order to protect their own dignity or the dignity of others. Examples include the prohibition of prostitution, dwarf-tossing and peepshows.

The South African the position in this regard is somewhat vague and usually depends on the particular context. Whilst the Constitutional Court generally adopts a very anti-paternalistic

322 Botha 2009 Stell LR 194; Fick 66.
323 Botha 2009 Stell LR 195; Fick 66.
324 De Schutter (2000) 494; Fick 102.
approach, particularly in the case of gay rights, a distinctly paternalistic approach was adopted in the case of prostitution. In *S v Jordan*, the Constitutional Court upheld the criminalization of prostitution based on the fact that it violates the prostitute’s human dignity. It is very telling that the court was of the opinion that the harm to the prostitute’s dignity was mainly ascribable to her own free choice to enter into the profession. The court’s finding that the violation of the prostitute’s dignity arises not from the law which criminalises the conduct of the prostitute instead of the patron, but from her own autonomous conduct is quite controversial.

In justification of upholding the criminalization of prostitution, the court in *S v Jordan* stated the following:

> The very nature of prostitution is the commodification of one’s body. Even though we accept that prostitutes may have few alternatives to prostitution, the dignity of prostitutes is diminished not by section 20(1)(aA) but by their engaging in commercial sex work. The very character of the work they undertake devalues the respect that the Constitution regards as inherent in the human body.

The reference to the inherent dignity of the human body as well as the fact that the court was of the opinion that the nature of a prostitute’s work, despite the presence of consent, devalues human dignity, reminds one of German jurisprudence. In Germany, as in South Africa, dignity’s paradoxical relationship to freedom has been discussed in cases in which individuals willingly participate in certain acts, usually sexual, that others regard as degrading, undignified or unnatural. In terms of German constitutional law, human dignity does not only refer to the individual dignity of the person, but also to the dignity of man as a species. Dignity is therefore not at the disposal of the individual. As such, the State may limit the rights of autonomous individuals seeking to limit their own dignity. As it can be difficult to identity a violation of the dignity of a particular individual, it is often argued that

327 Ibid.
328 *S v Jordan* 74.
certain practices violate the dignity of humanity as a whole.331 For example, the German Federal Administrative Court ruled that peepshows should be banned as the women’s dignity, by exposing themselves for payment, was being violated. The fact that competent women were willingly consenting to being objectified did not, in the eyes of the court, change the fact that their dignity was being violated.332 In the peepshow case, as in S v Jordan, the right to human dignity did not function as the foundation of human rights, but instead allowed for otherwise well-established rights to be limited and for the liberal principle according to which “all that is not prohibited is permitted” to be overturned.333 According to Hennette-Vauchez’s interpretation of the case, it was therefore not the dignity of prostitutes or peepshow performers that the judges were trying to protect. It was an “abstract and completely objectivised” concept of human dignity that they were seeking to protect.334 Another interesting example of the apparent irrelevance of the individual’s consent to undignified treatment, is the dwarf-throwing case. In the famous dwarf-throwing case, the French Supreme Administrative Court held that the prohibition of dwarf-throwing games were valid insofar as the prohibition was grounded in the principle of human dignity. The fact that the dwarves were all competent consenting adults looking to earn a living, was irrelevant in the eyes of the court.335 In this case, the court held that “the respect for human dignity, an absolute concept if any, cannot accommodate any kind of concession dependent on subjective appreciations”.336

Consent is essential to many dimensions of the private law, as well as the constitutional order itself. However, it is submitted that, despite the importance of consent in law, the giving and withholding of consent, even with full freedom and knowledge, should not be the only

332 BVerwGE 64 1981; Mccrudden (2008) 705; Botha 2009 Stell LR 182-4; Fick 103; Hennette-Vauchez 2011 LJCL 37.
determining factor in the demarcation of legal rights and duties. 337 Wright argues that in order to arrive at the correct legal outcome, one must go further than merely determining the presence or absence of free and knowledgeable consent. 338 He argues that consent is not an ultimate value, but only a substitute for something else. Making legal rights and duties dependent on consent usually serves human dignity. Dignity and consent are commonly linked, however they are not indistinguishable or interchangeable concepts and they may therefore come into conflict with one another. The law should not just blindly and uncritically serve an individual’s subjective whims, wishes and desires. Human dignity is a more fundamental value, as it is central to humanity and it is what makes us human. 339 A patient’s consent can therefore not be a defense against a charge of assault in the case of extreme elective surgery if it degrades human dignity to a serious degree. 340 As important as personal autonomy is to the law and our constitutional order, human dignity is equally or more important and as such certain forms of harmful conduct should be prohibited even if it is consensual. 341 Wright argues that we can deemphasise the all-importance of consent for the sake of human dignity without coercively imposing, through legal or social means,


338 Wright 1995 BU L Rev 1398.


340 For example, the amputation of a patient suffering from body integrity identity disorder’s healthy limb might fall into this category.

341 Wright 1995 BU L Rev 1398-9; Dan-Cohen 2000 Cal L Rev 777-8; Chiesa 2011 2 OSJCL 02. Also see Chiesa 2011 OSJCL 203 where he provides the following alternative explanation from prohibiting certain forms of harmful consensual conduct: “Consent is not a defense to certain batteries because, in addition to promoting personal autonomy, the criminal law also cares about encouraging certain types of socially acceptable conduct and discouraging certain socially unacceptable acts. Thus, our current criminal laws allow parents to pierce the ears of their baby girls, but do not authorize them to tattoo their children. They allow boxers and mixed martial arts fighters to beat each other to a pulp in the ring or cage, but do not authorize the general citizenry to engage in street fights or barroom brawls. Our current criminal law authorizes the severing of body parts for the purposes of a sex change operation, but not for the purposes of satisfying the desires of those who suffer from body dysmorphic disorder. What these laws have in common is that they criminalize conduct that for some reason or another is deemed to be socially unacceptable.”
intolerant majoritarian norms on minorities. Wright argues that individual dignity can therefore be safeguarded and encouraged without undermining autonomy, as no true form of dignity could ever be repressive or intolerant. The right to self-determination and autonomy gives a patient the right to make informed decisions and even to refuse treatments, but it does not normally give a patient the right to demand a particular form of treatment. Despite the high value placed on personal autonomy, it is therefore submitted that consent cannot be a valid defense in cases where the harm crosses the threshold of degrading the human dignity to a serious degree. However, this threshold would have to be very high if we are to protect personal autonomy. This threshold must be particularly high in the case of cosmetic surgery, due to a factor that might be called "heightened electiveness". The term denotes cases where the special role of personal values or preferences causes, or should cause, a greater than ordinary concern about and more aggressive and independent protection of patient choice.

In above scenario it is assumed that some cosmetic practices might violate human dignity in terms of a communitarian conception of human dignity. Freedom is therefore limited for the sake of dignity. On the other side of the coin, it can be said that extreme surgeries might also be dignity-enhancing in terms of a liberal autonomy-based understanding of dignity. If so, refusal to perform the surgery would violate the patient’s dignity, privacy and bodily integrity. The rights enshrined in the Constitution may be limited or restricted and are not absolute. The Constitution does not prohibit the limitation of human dignity and is silent as far as the inviolability of dignity is concerned.

342 Wright 1995 BU L Rev 1399.
343 Ibid.
348 Ibid.
349 Botha 2009 Stell LR 196.
terms of section 36, and like the rest of the Constitution, section 10 can be amended with a two thirds majority of the members of the National Assembly and Senate sitting jointly.\(^{350}\) In this regard, section 36(1), the limitation clause, states the following:

The rights in the Bill of Rights may be limited only in terms of law of general application to the extent that the limitation is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom, taking into account all relevant factors, including-

\begin{itemize}
  \item[a)] the nature of the right;
  \item[b)] the importance of the purpose of the limitation;
  \item[c)] the nature and extent of the limitation;
  \item[d)] the relation between the limitation and its purpose; and
  \item[e)] less restrictive means to achieve the purpose.
\end{itemize}

\(^{350}\) S 62(1) of the Constitution.

In \textit{S v Makwanyane}, the Constitutional Court adopted the following approach to the application of the general limitation clause in terms of the interim Constitution:

The limitation of constitutional rights for a purpose that is reasonable and necessary in a democratic society involves the weighing up of competing values, and ultimately an assessment based on proportionality. This is implicit in the provisions of s 33(1)[IC]. The fact that different rights have different implications for democracy, and in the case of our Constitution, for 'an open and democratic society based on freedom and equality', means that there is no absolute standard which can be laid down for determining reasonableness and necessity. Principles can be established, but the application of those principles to particular circumstances can only be done on a case-by-case basis. This is inherent in the requirement of proportionality, which calls for the balancing of different interests. In the balancing process, the relevant considerations will include the nature of the right that is limited, and its importance to an open and democratic society based on freedom and equality; the purpose for which the right is limited.
and the importance of that purpose to such a society; the extent of the limitation, its efficacy, and particularly where the limitation has to be necessary, whether the desired ends could reasonably be achieved through other means less damaging to the right in question. In the process regard must be had to the provisions of s 33(1)[IC], and the underlying values of the Constitution, bearing in mind that, as a Canadian Judge has said, 'the role of the Court is not to second-guess the wisdom of policy choices made by legislators.'

Human dignity may therefore be limited, but it would be very difficult to justify the limitation of human dignity in an open and democratic society based on human dignity, equality and freedom. The right to human dignity is of fundamental importance to the Constitution's ambition to create an open and democratic society based on human dignity, freedom and equality and will therefore carry a great deal of weight when balancing the competing rights in terms of the section 36 enquiry. Section 36 will be applied very strictly in the case of a limitation of human dignity, even more so if the violation of human dignity is accompanied by the violation of other rights such as the patient’s right to privacy and bodily integrity in the case of wish-fulfilling surgery. As was explained above, in addition the patient’s right to human dignity, his or her constitutionally enshrined right to privacy and bodily and psychological integrity also comes into play in the case of extreme wish-fulfilling surgeries. The simultaneous limitation of a patient’s dignity, bodily integrity and privacy would require an extremely convincing justification. The rights to human dignity, privacy and bodily integrity are individually essential and collectively foundational to the value system prescribed by the Constitution. Compromise them and the society to which we aspire

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351 S v Makwanyane 104.
352 In this regard, it must be remembered that the Bill of Rights, the right to human dignity included, applies vertically (between the State and citizens) as well as horizontally (between private individuals). S 8(1) of the Constitution states that: “The Bill of Rights applies to all law, and binds the legislature, the executive, the judiciary and all organs of state.” In terms of s 8(2) “A provision of the Bill of Rights binds a natural or a juristic person if, and to the extent that, it is applicable, taking into account the nature of the right and the nature of any duty imposed by the right.”
353 Currie & De Waal 178.
becomes illusionary. Any significant limitation of any of these rights would therefore require a very compelling countervailing public interest in justification therefore.354

The proportionality enquiry in terms of section 36 requires weighing up the harm caused by the limitation of a fundamental right against the purpose, in other words the benefits, of the particular limitation.355 The limitation of the patient’s right to dignity, privacy and bodily and psychological integrity might be justified if the purpose of the limitation is to protect the human dignity of others or another interest which enjoys a similar status in terms of the Constitution. Even then, the relation or causal connection between the limitation and its purpose will be closely scrutinised and no discretion will be afforded in regard to finding alternative and less restrictive ways of limiting the right.

The way in which the limitation affects the rights concerned must also be taken into consideration. It would be difficult to justify the limitation of the right if the limitation impedes the right to a significant extent or if the limitation relates to the core or heart of the specific right. According to Botha, dignity has emerged as the major mechanism by means of which the Constitutional Court has attempted to mediate value conflicts.356 The closer a limitation of a person’s right to privacy, autonomy or bodily integrity comes to the core of a person’s fundamental human dignity, the more persuasive the justification of the limitation will have to be.357 Conversely, more leeway will be given to the legislature to limit privacy, autonomy and bodily integrity in areas that are further removed from the core of dignity.358 According to Botha, a limitation of autonomy or privacy would probably also constitute a serious violation of human dignity if “the restrictive measure objectifies or degrades the human person” and “inhibits the capacity of the individual to forge an autonomous identity and to form intimate relationships” to a significant extent.359 Here, spatial and layer metaphors are used to describe the core of personal autonomy. Any limitation of this core or

354 Ex Parte Minister of Safety and Security: In Re S v Walters 2002 4 SA 613 (CC) 28.
355 Currie & De Waal 178.
356 Botha 2009 Stell LR 215.
357 Botha 2009 Stell LR 215; Bernstein v Bester 65-7; NM v Smith 136.
358 Ibid.
359 Botha 2009 Stell LR 204.
essence will be a limitation of the very heart of autonomy and in effect also of human dignity. On the other hand, areas of individual freedom and self-fulfilment that are further removed from the core of individual autonomy, identity and self-worth, or closer to the skin of the proverbial onion as De Vos describes it, would be more susceptible to legitimate limitations.\textsuperscript{360} In distinguishing between the core of human dignity and peripheral or further removed areas, Botha suggests that such definitions must necessarily remain vague and will largely depend on the courts characterisation of the interest at stake.\textsuperscript{361} Rather than placing an unconditional ban on the violation of dignity, this approach remains sensitive to differences of degree.\textsuperscript{362} Limitations that therefore go to the heart or essence of the individual’s inherent human dignity and worth would probably not pass constitutional scrutiny, whereas marginal limitations further removed from the core of the individual’s dignity will be allowed more easily.\textsuperscript{363}

In the area of wish-fulfilling medicine, it could be argued that any limitation of a patient’s privacy, autonomy and bodily and psychological integrity would in fact go to the heart of dignity. Prohibiting individuals from doing to their bodies what they truly desire and long for will in effect rob such individuals of the ability to live their lives in accordance with their own conception of the good. Furthermore, such individuals will be prevented from presenting themselves to the world and subsequently relating to others in the manner they feel most comfortable with. Such a limitation, apart from being very paternalistic, would constitute a gross violation of that which lies at the heart of dignity. This is not to say that a limitation that goes to the heart of human dignity would never be justifiable, but there would have to be a very pressing social need to do so. Such a compelling countervailing public interest would be difficult to identify in the case of the personal realm of wish-fulfilling surgery. It is difficult to imagine how an idiosyncratic decision made by an individual in his or her private sphere could disadvantage the interests of society to such an extent that it needs to be prohibited. At most it can be argued that that a more restrictive and paternalistic regulatory approach to extreme surgery should be taken, as the possibly exists that such

\textsuperscript{360} Botha 2009 Stell \textit{LR} 204; De Vos “Why the Right to Privacy is Like an Onion” \textlangle http://constitutionally speaking.co.za/why-the-right-to-privacy-is-like-an-onion\textrangle (accessed 28 January 2013).
\textsuperscript{361} Botha 2009 Stell \textit{LR} 216.
\textsuperscript{362} \textit{Id} 215.
\textsuperscript{363} \textit{Ibid.}
autonomous decisions may perpetuate certain negative socio-cultural messages.\textsuperscript{364} In this regard, Bogdanoski believes that some surgeries are authorized by the State, because they promote “socio-culturally acceptable forms of embodiment”.\textsuperscript{365} On the other hand, some surgeries should be prohibited, because they give rise to “transgressive embodiment”.\textsuperscript{366}

3.6 Conclusion

It is clear that wish-fulfilling medical practices, cosmetic surgery in particular, involves several fundamental constitutional rights. It has been shown that should an autonomous patient seeking to alter his or body be prevented from doing so, his or her constitutional rights to dignity, privacy and bodily integrity will be affected. It has also been shown that some harmful and transgressive forms of cosmetic surgery might actually impede human dignity. Whether cosmetic surgery impedes or promotes human dignity depends on what conception of human dignity one adopts as well as the nature of the particular cosmetic procedure. Cosmetic surgery generally promotes human dignity if one adopts a liberal, autonomy-based conception of human dignity. However, even if one adopts an autonomy-based conception of human dignity, it can be argued that certain forms of extreme and transgressive cosmetic surgery nevertheless impede human dignity. It is these forms of cosmetic surgery that should be prohibited, even in the presence of an autonomous patient’s informed consent. However, these transgressive forms of cosmetic surgery are quite rare and the average patient will generally not be interested in undergoing such procedures. It has been shown that most forms of cosmetic surgery are quite acceptable and may even be dignity enhancing. The prohibition of any particular form of cosmetic surgery and the subsequent limitation of the patient’s constitutional right to human dignity, autonomy, privacy and bodily integrity would therefore necessitate a very convincing justification grounded in public interests. Such compelling countervailing public interests are difficult to identify in the personal realm of wish-fulfilling surgery, however from a bioethical perspective some broader ethical arguments can certainly be made against the practice of cosmetic surgery. These arguments are based on several ethical concerns. These concerns will be discussed in the next chapter.

\textsuperscript{364} Bogdanoski 2009 \textit{Griffith L Rev} 503.
\textsuperscript{365} \textit{Ibid.}
\textsuperscript{366} \textit{Ibid.}
Chapter 4  Bioethical Perspectives

41 The Unique Relationship Between Bioethics and Law

Considering the fact that this is a dissertation in law, it might be useful to open this chapter with a brief explanation of the reasons for dedicating such a substantial portion of this dissertation to the “non-legal” spheres of morality and ethics. It is fairly obvious that many things that are unethical are not necessarily illegal and vice versa. The law creates minimally acceptable standards, whilst ethics helps us to determine how a person should ideally behave. Furthermore, breaking the law usually gives rise to some sort of a legal sanction, whereas this is rarely the case with unethical behaviour. However, the relationship between bioethics and law differs from the relationship between law and other fields such as anthropology or history in several ways.

Apart from economics, law has not influenced or been influenced by other disciplines in the significant way that law has influenced “the agenda, development and current state of bioethics”. The relationship between autonomy and bioethics and its legal expression in the form of the informed consent doctrine is just one example of this influence. When a body, such as the Health Professions Council of South Africa, creates an ethical code it will always keep the law in mind, as the former should not contradict the latter. The same can be said for the courts. When an ethical issue gives rise to a legal case, the court should ideally remain aware of any decisions that have already been made by an ethical body and should consider the adequacy of those decisions.

An argument can be made that the law should be more cognisant of ethical concerns, particularly in the case of controversial medical issues. An argument can certainly be made that, in some areas, no difference should exist

368 Ibid.
372 Ibid.
between what is legal and what is morally sound in terms of accepted ethical values. This is particularly true in the field of medical law, because medical care and decisions about one’s life and health is so profoundly intimate and intertwined with one’s sense of dignity and bodily integrity. This gives medical law a unique moral dimension. The fact that bioethical issues often give rise to legal cases is also indicative of the fact that the relationship between law and bioethics differs from the relationship between law and other disciplines.373 Most other fields are merely of academic concern, whereas bioethical theories are regularly considered in court cases and legislation.374

For the abovementioned reasons, this study will address some of the common ethical objections raised against cosmetic surgery and wish-fulfilling medicine. This study will seek to repudiate most of these objections and will suggest solutions to others. These objections relate to the goals of medicine and the disease-enhancement dichotomy, complicity arguments, arguments regarding human nature and naturalness, justice and accessibility, concerns regarding the autonomy of the patient’s wish and concerns regarding the application of Principlism.

4.2 The Goals of Medicine and the Disease/Enhancement Dichotomy

The view that health is one of the core goals of medicine, or even the only goal of medicine, is often upheld.375 This idea was expressed by Edmund Pellegrino and David Thomasma, American philosophers of medicine, when they described medicine as “an activity whose essence appears to lie in the clinical event, which demands that scientific and other knowledge be particularized in the lived reality, of a particular human, for the purpose of attaining health or curing illness, through the direct manipulation of the body, and in a value-laden decision matrix”.376 However, the growing tendency for medicine to be used for

373 Capron & Michel 1993 LLALR 33; Miola 2006 J Clin Ethic 22.
374 Capron & Michel 1993 LLALR 33.
purposes that seemingly deviate from the traditional goals of medicine has left it facing an unprecedented identity crisis.\textsuperscript{377} Medical techniques and technology are progressively being used not to prevent or cure illness, but to fulfil a patient’s personal, individual and ostensibly non-medical wishes.\textsuperscript{378} These wishes are often aimed at improving certain human characteristics beyond their normal healthy state. According to some commentators, these wishes are non-medical, as they do not relate to the prevention or cure of any established disease or illness.\textsuperscript{379} In particular, there is much debate between bioethicists on whether the aims of cosmetic surgery serve any of the goals of medicine. In this regard, Miller \textit{et al} describe cosmetic surgery as “a most unusual medical practice” and state that “invasive surgical operations performed on healthy bodies for the sake of improving appearance lie far outside the core domain of medicine as a profession dedicated to saving lives, healing, and promoting health”\textsuperscript{380}.

The emphasis on the goals of medicine relates to medicine’s status as a profession. In contrast to business, a purely economic enterprise, a profession operates according to an internal end or \textit{telos}.\textsuperscript{381} This \textit{telos} not only defines the goals that the profession aims to achieve; it also defines the profession in its entirety.\textsuperscript{382} For medicine this \textit{telos} has traditionally been thought to be the health of the patient.\textsuperscript{383} There is no longer uniform agreement on what the goals of medicine are or should be or whether it is a closed or open-ended list of goals.\textsuperscript{384} There is not only disagreement on the content of medicine’s list of true goals, but also whether such a body of core medical goals even exist at all and what its origin


\textsuperscript{378} Buyx 2008 \textit{Med Healhce Philos} 134; Asscher \textit{et al} 2012 \textit{JME} 327.

\textsuperscript{379} \textit{Ibid.}

\textsuperscript{380} Miller \textit{et al} “Cosmetic Surgery and the Internal Morality of Medicine” 2000 \textit{Cambridge Quarterly of Healthcare Ethics (Camb Q Healthc Ethics)} 353.


\textsuperscript{383} Devereaux 164; Little 163.

\textsuperscript{384} Buyx 2008 \textit{Med Healhce Philos} 137; Hanson & Callahan 3.
might be. Some are of the opinion that agreed core medical goals do in fact exist, whilst others are of the opinion that instead of core goals, only goals belonging to individual persons really exist.\textsuperscript{385} Assuming that core medical goals do exist, some presume that such goals are inherent to the nature of medical practice, whilst others argue that they are socially constructed and relative to cultural and/or historical values.\textsuperscript{386} The scope of core medical goals also tends to be construed in a variety of different ways. Physician-philosophers interpret medical goals in terms of the framework of a physician-patient relationship, whereas others are of the opinion that medicine should be understood in broader and narrower senses with corresponding goals.\textsuperscript{387} There is also controversy surrounding the question of whose goals we are referring to; the goals of physicians, patients or those of society?\textsuperscript{388} These questions are not of mere academic concern, but are of great practical and ethical relevance. The economic, social, legal, ethical and educational consequences for health care can vary considerably depending on whether health is understood as an individual’s happiness, aptness and ability to work or simply as the absence of recognisable pathology in the body and mind.

\textbf{4.2.1 Two Schools of Thought on the Goals of Medicine}

As far as the goals of medicine are concerned, one can clearly distinguish between two schools of thought. On the one hand, there are those who are of the opinion that the goals of medicine should be limited to healing and the prevention of illness and disease. On the other hand, there are those who are willing to include the pursuit of happiness or quality of life as a legitimate goal of medicine. There is clearly an inherent conflict between the lists that include the pursuit of wellbeing, a better quality of life and happiness as a legitimate goal of medicine, as opposed to those lists that are restricted to healing and prevention of illness and

\textsuperscript{385} Engelhardt \textit{The Foundations of Bioethics} (1996) 196; Callahan \textit{False Hopes: Why America’s Quest for Perfect Health is a Recipe for Failure} (1998) 16-7; Buyx 2008 \textit{Med Healthc Philos} 137; Hanson & Callahan 11.
\textsuperscript{386} Buyx 2008 \textit{Med Healthc Philos} 137; Pellegrino 58; Hanson & Callahan 15.
\textsuperscript{388} Fleischhauer & Hermeren \textit{Goals of Medicine in the Course of History and Today: a Study in the History and Philosophy of Medicine} (2005) 309; Buyx 2008 \textit{Med Healthc Philos} 137.
Enhancement can therefore either be a legitimate pursuit of medicine or an unacceptable practice that falls beyond the boundary of legitimate medicine, depending on the school of thought one adheres to.

Those who subscribe to the essentialist list of core medical goals argue that non-therapeutic procedures are not consistent with the traditional goals of medicine and that by performing enhancement procedures the medical profession risks becoming the “handmaiden of biotechnology” or a profession of mere technical means at the service of any end whatsoever. According to these commentators, medicine should only aim to satisfy the medical needs of the patient; not any and all human desires. Medicine may therefore satisfy certain legitimate human desires, but desire satisfaction *per se* is not a goal of medicine. In terms of this framework, the proper goal of medicine is to restore normal functioning. Any treatment that goes beyond therapy and aims to make a patient “better than well” falls beyond the purview of legitimate medical practice and should be prohibited. The World Health Organization’s definition of health as “a state of complete physical, mental, and social well–being” would therefore be far too expansive in terms of this narrow framework and goals such as a person’s wellbeing would fall well beyond the proper sphere of medicine. Proponents of this view, such as Leon Kass and Norman Daniels, attempt to set limits to what is appropriately medical by arguing that medicine is primarily

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389 The narrower definitions generally emanate from political and legal documents, whereas the wider definitions tend to be the opinions of scholars extracted from books and journal articles that take a far more philosophical approach to the debate.

390 Pellegrino “Biotechnology, Human Enhancement, and the Ends of Medicine” <http://cbhd.org/content/biotechnology-human-enhancement-and-ends-medicine> (accessed 02 February 2012); De Roubaix 2011 *JPRAS* 13; Hanson & Callahan 11.

391 Devereaux 164.

392 *Ibid*.


concerned with the cure of diseases; diseases being a departure from species-typical normal functioning.\textsuperscript{396} For Kass and Daniels, the goals of medicine are completely independent of individual desires or cultural notions.\textsuperscript{397} By appealing to the proper goals of medicine they attempt to exclude from medicine all interventions, such as cosmetic surgery, artificial insemination and sterilisation, that are not aimed at remedi ing somatic difficulties.\textsuperscript{398} Proponents of the normal function model see the distinction between therapy and enhancement as a useful tool in the fight against what they consider to be the medicalization of social problems.\textsuperscript{399} To provide a much cited example, proponents of the normal function model distinguish between shyness or shortness caused by an illness and shyness or shortness simply caused by bullying or unfavourable genetic makeup.\textsuperscript{400} In terms of the normal function model, only shyness or shortness caused by an identifiable illness merits medical treatment, whereas shyness or shortness caused by life or genetics does not deserve the services of a health care system with finite resources.\textsuperscript{401}

Considering the enormous changes in medicine during our century, a re-examination of the traditional goals of medicine is in order.\textsuperscript{402} In order to determine the goals of medicine and the meaning of illness and suffering we are required to refer to a normative framework outside of medicine. By implication, this study rejects the notion that there is a morality inherent to medicine, but instead takes more of a social constructionist view.\textsuperscript{403} We can only know the goals of medicine by also asking non-medical questions like what the end of human

\textsuperscript{396} Kass “Regarding the End of Medicine and the Pursuit of Health” 1975 \textit{The Public Interest} 20; Engelhardt 414; Nordenfelt 2007 \textit{Med Health Care Philos} 5; Parens 3.
\textsuperscript{397} Kass 1975 \textit{The Public Interest} 23; Engelhardt 414.
\textsuperscript{398} Parens 4; Juengst 43; Bogdanoski 2009 \textit{Griffith L Rev} 505.
\textsuperscript{399} Parens 4; Dees 2008 \textit{KIEJ} 377; Buyx 2008 \textit{Med Healthc Philos} 135; Karpin & Mykitiuk 2008 \textit{MLR} 416.
\textsuperscript{400} Parens 4.
\textsuperscript{401} Buyx 2008 \textit{Med Healthc Philos} 133; Hanson & Callahan 3.
\textsuperscript{402} Miller \textit{et al} 2000 \textit{Camb Q Healthc Ethics} 353- 4, argue that medicine is governed by an internal morality. This internal morality consists of goals proper to medicine, role-specific duties and clinical virtues. The professional integrity of physicians is constituted by loyalty and adherence to this internal morality. Practices that are not supported by the goals of medicine and/or conflict with one or more of the internal duties of physicians are considered violations of the internal morality of medicine.
living and flourishing is. In terms of this framework, modern medicine necessitates additional, new goals or at the very least the traditional goals and concepts such as health and suffering need to be interpreted in new ways in order to accommodate wish-fulfilling medical practices such as cosmetic surgery. This requires a balancing act between loyalty to the moral wisdom of the past and crucial adaptation to modern-day circumstances.

It could even be said that some non-medical ends that necessitate medical skills are also worth pursuing. Even if everyone agreed that the goals of medicine should be limited to the treatment and prevention of illness and that we must follow a narrow interpretation of health-related concepts, this still does not mean that it is inherently immoral to use medical technology for non-medical purposes. This relates to the so-called “Schmocter Problem”. Schmocters don’t practice medicine, nor are they interested in practicing medicine. Instead they practice “schmedicine” and as such the proper goals of medicine are not of any concern to them. Schmocters combine their expert medical knowledge and biotechnology to enhance human capabilities and traits beyond what is considered to be medically necessary. Schmocters don’t need to rely on insurance reimbursements as they sell their services to consumers, of which there are many, willing to pay for such services. Deciding which of these non-medical ends are worth pursuing will likewise require looking beyond medicine for the answers. If a medical procedure is developed for therapeutic purposes, there does not seem to be anything inherently immoral about using that procedure for non-medical purposes such as cosmetic enhancement. There are certainly many morally disturbing non-medical uses of medical technology, such as the use of steroids by professional athletes or the use of laxatives by anorexics, however these uses of medicine are

405 Hanson & Callahan 103; Pellegrino 55.
408 Resnik 2000 *Camb Q Healthc Ethics* 368; Parens 10.
409 Parens 10.
410 Id 11.
411 Ibid.
not morally disturbing because they are non-medical, but because they violate several other moral principles such as fairness and non-maleficence.\textsuperscript{412}

A patient’s physical function cannot be said to be more important than his or her psychological wellbeing. Some concede that requests for cosmetic surgery might be motivated by genuine suffering, but are adamant about the fact that it is not a physician’s responsibility or a legitimate medical goal to relieve any and all pain and suffering that afflicts human beings.\textsuperscript{413} They argue that physicians are only required to relieve suffering that emanates from a disease or physiological dysfunction.\textsuperscript{414} The alternative, according to these commentators, would be the medicalization of every facet of human existence.\textsuperscript{415} Such an essentialist definition places arbitrary limits on the goals of medicine, as the limits of medicine can be expanded or contracted by societal agreement.\textsuperscript{416} An essentialist approach also loses sight of the importance of personal suffering in determining the goals of medicine and defining related concepts such as health and illness.\textsuperscript{417} There are no convincing reasons why physicians should not relieve emotional or psychological suffering, as the source of suffering is not all-important. What matters is the fact that physicians have the ability to alleviate that suffering.\textsuperscript{418} Emphasis should not be placed on the cause of the condition, but rather the amount of suffering that the patient is experiencing.\textsuperscript{419} An example of this would be low self-esteem or depression due to unhappiness with one’s physical appearance. As unlikely as it might be, a few sessions with a psychiatrist could also alleviate this kind of suffering. However, when faced with a variety of treatment options, the patient should be allowed to choose the option with which he or she feels most comfortable with, with

\textsuperscript{412} Resnik 2000 \textit{Camb Q Healthc Ethics} 369.
\textsuperscript{413} Miller \textit{et al} 2000 \textit{Camb Q Healthc Ethics} 358.
\textsuperscript{414} See for example the Hastings Center’s research report on the goals of medicine which clearly limits pain and suffering to pain and suffering caused by “maladies”.
\textsuperscript{415} Parens 4; Pellegrino “Biotechnology, Human Enhancement, and the Ends of Medicine” <http://cbhd.org/content/biotechnology-human-enhancement-and-ends-medicine> (accessed 02 February 2012); Scripko 2010 \textit{JME} 294.
\textsuperscript{416} Pellegrino 57.
\textsuperscript{417} Hanson & Callahan 104; Scripko 2010 \textit{JME} 294.
\textsuperscript{418} Little 163; Parens 20.
\textsuperscript{419} Chadwick 27; Little 163; Parens 20.
reference to the risks, benefits, their personal situation and individual values.\textsuperscript{420} For many patients cosmetic surgery happens to be the treatment option most likely to rapidly and permanently eradicate their suffering. It has been shown that cosmetic surgery actually results in measurable and significant improvement in the long-term psychosocial functioning and psychological wellbeing of the patient.\textsuperscript{421} The majority of clinical interview investigations, surveys and anecdotal reports concerning cosmetic surgery indicate high levels of patient satisfaction and generally positive psychological outcomes, including improvements in depression and anxiety.\textsuperscript{422} These accounts stand in stark contrast to a rhetoric that often concentrates on the unattainable character of contemporary beauty ideals, portraying cosmetic surgery as a Sisyphean task.\textsuperscript{423} Studies have shown that very few people who choose to undergo cosmetic surgery do so in order to attain perfect beauty; most of them simply want to feel better about themselves or want to look normal.\textsuperscript{424} As such, cosmetic surgery often achieves exactly the goals intended by those who undergo the procedures. An individual’s satisfaction with his or her life also has further causal consequences. People who are satisfied with life are much more capable of dealing with the difficulties of life.\textsuperscript{425} It is also known from psychosomatic theory, although the detailed causal mechanisms are not certain, that an individual’s state of happiness and satisfaction can rid him of her of a particular illness.\textsuperscript{426} In many ways quality of life is health-enhancing and as such, improving quality of life by medical means is health-enhancing in an indirect sense. This is why some scholars, such as Nordenfelt, are willing to include the pursuit of happiness or quality of life

\textsuperscript{420} Müller 2009 \textit{AJOB} 40.
\textsuperscript{423} Gimlin 2000 \textit{Qualitative Sociology} 80.
\textsuperscript{424} Sarwer et al 1998 \textit{PRS} 1136; Gimlin 2000 \textit{Qualitative Sociology} 80; Adams 2010 \textit{QHR} 757; Mantese et al “Cosmetic Surgery and Informed Consent” 2006 \textit{Michigan Bar Journal} (MIBJ) 27.
\textsuperscript{426} Nordenfelt 2001 \textit{Health Care Analysis} 22.
as a legitimate goal of medicine. For them health has value insofar as it is instrumental in the attainment of quality of life.427

4 2 2 Two Schools of Thought on the Concepts of Health and Disease

Deciding on what the goals of medicine are or should be, is inextricably linked to our understanding of concepts such as health, illness, suffering and wellbeing.428 There are two main schools in the literature on defining the concepts of health and disease. Scholars favouring a naturalist theory of health and disease, the most well-known scholar being Boorse, argue that health-related concepts are value-free theoretical notions that can be objectively described in the same sense as the concepts of atom, metal and rain are value-neutral and descriptive.429 For Boorse, disease is “the inability to perform all typical physiological functions with at least typical efficiency”.430 Disease is therefore “a type of internal state which is either an impairment of normal functional ability, in other words a reduction of one or more functional abilities below typical efficiency, or a limitation on functional ability caused by environmental agents”.431 For Boorse, health is simply a statistically normal functional ability or the absence of disease.432 It is clear that functional ability is of paramount importance to Boorse and according to him survival and reproduction, not quality of life, are the crucial biological goals tied to ideal biological functioning.433 As evolution is not concerned with optimising the comfort and pleasure of human beings or realising their personal goals, neither is Boorse. For Boorse, that which is statistically most typical is indicative of the species design and the closer an individual approaches this design, the healthier he or she is.434 Health is therefore the conformity to the species design and not

427 Nordenfelt 2001 Health Care Analysis 16.
428 Nordenfelt 2007 Med Health Care Philos 5; Buyx 2008 Med Healthc Philos 137.
431 Boorse 1977 Philosophy of Science 567.
434 Kovács 1998 Med Health Care Philos 31; Engelhardt 199; Boorse 17.
conformity of this design to our values. Clearly, wish-fulfilling and non-therapeutic procedures do not belong in healthcare system where disease is understood in terms of this framework.

It is difficult to define disease simply by appealing to evolution and reproductive fitness, without considering a specific environment, a set of goals or how well adapted an individual is. From an evolutionary standpoint Boorse’s argument fails, as the environment and species is constantly adapting and changing. From a secular point of view, we are the product of arbitrary forces which have adapted us to environments in which we don’t necessary live in anymore. It is therefore actually the atypical characteristics that usually enable species to survive and thrive above others. Furthermore, even a descriptive account of health entails an evaluation of the state of affairs as desirable or not. There must at least be some evaluative and subjective component to health-related concepts. In terms of a normativist approach to defining health as disease, health and disease are essentially evaluative concepts, which are based on social, moral and cultural norms. Calling a condition a disease is therefore a negative value judgement similar to calling someone unattractive. Conditions are only recognised as diseases when they frustrate the goals of particular individuals or if they prevent the realisation of a particular understanding of a good and virtuous life. When a person is categorised as ill or deformed, an adverse judgement is made, irrespective of whether one is dealing with tuberculosis or an unattractive nose for

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436 Engelhardt 201.
438 Engelhardt 201.
443 Engelhardt 202.
which the patient is seeking cosmetic surgery. Arguing for a normativist approach to defining health-related concepts, Reznek states the following: “[W]hether some condition is a disease depends on where we choose to draw the line of normality, and this is not a line we can discover … rather, we invent disease status by imposing our distinction between disease and normality on the world.” According to Sade, health should be understood as “the condition of a living thing whose biological functions are operating in a way that promotes uncompromised living, holding the organism’s flourishing life as the standard”. Disease can be classified as biological dysfunction, but health is a much richer concept that includes both biological and moral values. Therefore, the goal of a living thing is not mere survival, but “a life appropriate to that particular kind of being”. This theory refers not only to survival, but also to the individual’s quality of life or wellbeing. In this regard, the meaning of wellbeing becomes relevant. Wellbeing is a fairly elusive concept that is subject to an individual’s thoughts, feelings and beliefs, all of which changes with time and place. The concept of wellbeing is integral to a value-laden understanding of health and illness, but not to a naturalist understanding of health-related concepts. Nordenfelt defines health as a person’s ability, given the standard circumstances related to a cultural norm, to achieve his most essential goals in life. This definition recognises the interrelatedness of health, happiness and the environment. For Nordenfelt, diseases are those physical or mental conditions, which, in the majority of people under standard circumstances, prevent individuals from attaining their minimal happiness. A person can therefore be ill,

444 Engelhardt 204.
449 Scripko 2010 JME 284.
450 Ibid.
not only if the person’s prospects for survival have decreased, but also if he or she does not feel well or has become restricted in relation to some goal other than mere survival.\textsuperscript{453} For Wakefield, disorders are also negative conditions that cause social concern and as such social values are involved.\textsuperscript{454} However, Wakefield believes that understanding the concept of disorder as a completely value- and culture-relative notion with absolutely no scientific content will leave the concept open to unconstrained use for the purposes of social control.\textsuperscript{455} Wakefield argues that health has both an objective component, that of natural function, as well as an evaluative component, that of wellbeing.\textsuperscript{456} With reference to mental disorders, Wakefield argues that a disorder is neither a purely scientific concept nor mere dysfunction as defined by evolutionary theory.\textsuperscript{457} To qualify as a disorder, the dysfunction must also cause substantial harm to the individual under present environmental circumstances in terms of present cultural standards. The disorder must therefore be a “harmful dysfunction”, harmful being a “value term based on social norms” and dysfunction being a “scientific term referring to the failure of a mental function to perform a natural function for which it was designed by evolution”.\textsuperscript{458} This approach seems to be compatible with the definition of health as set out in The Constitution of the World Health Organization. The Constitution of the World Health Organization defines health as “a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity”.\textsuperscript{459}

Another drawback of an essentialist and biostatistical approach to defining health-related concepts, is the fact that it rules out several accepted and regularly performed elective medical practices such as reconstructive plastic surgery, sterilisation, selective caesarean births, abortions and sex change operations that ostensibly do not promote the patient’s health.\textsuperscript{460} One could certainly draw a comparison between cosmetic surgery and medical practices such as abortion and contraception. Both an unwanted pregnancy as well as an

\textsuperscript{453} Nordenfelt 2007 Med Health Care Philos 6.
\textsuperscript{454} Wakefield 1992 Am Psychol 376.
\textsuperscript{455} Ibid.
\textsuperscript{457} Wakefield 1992 Am Psychol 383.
\textsuperscript{458} Id 373.
\textsuperscript{459} Preamble to the Constitution of the World Health Organization.
\textsuperscript{460} Miller \textit{et al} 2000 Camb Q Health Ethics 354.
intense dissatisfaction with one’s appearance interferes with the ability to function normally in social life. Even a vasectomy, an invasive medical procedure, typically aimed at the prevention of an unwanted pregnancy belonging to someone other than the patient, is considered to be in pursuit of the patient’s health.461

Furthermore, an essentialist or biostatistical approach is based on the incorrect presumption that one can make a clear distinction between therapy and enhancement and that enhancement procedures are somehow “beyond therapy”.462 The distinction between therapy and enhancement is usually made by either referring to the concept of disease or by referring to the statistical and theoretical notion of species-typical normal functioning.463 Therapeutic interventions, the argument goes, are directed toward “restoring or bringing an individual’s morphology and capacities within a normal range”, whereas enhancement procedures improve “human form or functioning beyond what is necessary to sustain or restore good health”.464 This distinction is untenable, not just because some enhancement procedures may in fact be partly therapeutic and both therapeutic and enhancement procedures result in an improvement of some sort, but also because the meaning and scope of therapeutic medicine, the distinction between health and disease and the boundaries of normality are tenuous.465

Normality is a mere theoretical construct inseparable from social, cultural and historical context.466 All knowledge is influenced by history and culture and this influence is particularly evident in medicine.467 The use of vaccines as prophylactics, the discovery of anaesthesia and even the adoption of public health measures have dramatically increased our normal life expectancy.468 Not only have contemporary notions of normality therefore

461 Id 357.
462 Chadwick 26.
463 Juengst 32.
466 Karpin & Mykitiuk 2008 MLR 414; Scripko 2010 JME 295; Engelhardt 204.
467 Engelhardt 190.
468 Jones 2006 MH 79.
changed beyond recognition since the beginning of the twentieth century, but these notions also differ from one part of the world to another.\textsuperscript{469} Despite the fact that there are considerable differences in cultural values regarding human function, the excruciating pain and feeling of impending death is likely to render myocardial infarction a unfavourable condition across all cultures, however colour blindness, the inability to roll up the sides of one’s tongue and not being able to taste phenylthiocarbamide, just to name a few, may be considered actual diseases or defects depending on the environment in which persons find themselves and their personal and cultural goals.\textsuperscript{470} Similarly, despite the fact that schizophrenia has a biological basis, in some cultures schizophrenics are prized as gifted or sacred, while in most western cultures they are viewed as mentally ill.\textsuperscript{471} The disease/enhancement distinction in the context of species-typical normal functioning becomes particularly problematic when one considers beneficial personal enhancements such as intellect or moral sensitivity, as opposed to some physiological functions such as heart rate.\textsuperscript{472} Species-typical functioning is both a statistical and a theoretical notion, however theoretically it is far more difficult to determine species-typical intellect, social grace or moral sensitivity.\textsuperscript{473} In this sense the species-typical normal model does not provide much guidance in cases of enhancing such personal capacities.

Another interesting point is made by Jones when he states that we must not only ask what is normal, but also what should we allow to remain normal.\textsuperscript{474} He uses low-grade, subclinical depression, with which many people live their whole lives, as an example. If we do not recognise low-grade depression as an illness, it follows that treatment thereof with drugs constitutes a form of enhancement. However, regardless of the delineation of clinical depression, there is absolutely no virtue in living with low-grade depression if it can in fact be treated. Children who are short due to pituitary gland malfunctions are considered to be suffering from a disease that prevents them from living fully normal lives.\textsuperscript{475} As such, the

\begin{flushleft}
\textsuperscript{469} Jones 2006 \textit{MH} 78; Gilman (1998) 4.
\textsuperscript{470} Engelhardt 204.
\textsuperscript{471} Resnik 2000 \textit{Camb Q Healthc Ethics} 367,
\textsuperscript{472} Parens 7; Juengst 29.
\textsuperscript{473} \textit{Ibid}.
\textsuperscript{474} Jones 2006 \textit{MH} 78.
\textsuperscript{475} De Grazia \textit{Human Identity and Bioethics} (2005) 263; Dees 2008 \textit{KIEJ} 377.
\end{flushleft}
Food and Drug Administration approved the use of human growth hormone injections in very short children.476 However, children that are short due their particular genetic makeup suffer equally, yet treating them would be considered a forbidden form of enhancement in terms of the normal function model.477 Parens rightly asks the question whether the treatment/enhancement distinction obscures the medical profession’s responsibility to respond to the suffering of both the boys.478 The distinction not only seems somewhat artificial, contradictory and arbitrary, but also deeply unfair. The distinction seems even more arbitrary when one takes into account the fact that many treatments (such as those considered to be too experimental or expensive) are not covered by health insurance, whereas several non-therapeutic or enhancement procedures (such as abortion, sterilization and vaccinations) are in fact covered by health insurance.479

The boundaries between cosmetic surgery and reconstructive plastic surgery, widely accepted as a core medical practice in pursuance of accepted medical goals, also seem indistinct. Some argue that reconstructive plastic surgery aims to correct an objectively discernible deformity, whereas cosmetic surgery is aimed at defects that are completely subjective or even non-existent.480 This might be true, but this distinction is not particularly relevant, as both reconstructive plastic surgery as well as cosmetic surgery are guided by aesthetic considerations. There will always remain a large grey area in some cases between cosmetic surgery and reconstructive surgery. For example, the removal of unsightly excess skin on the stomach after pregnancy, as with reconstructive surgery, involves restoring damaged structures to their former, normal, state. However, abdominoplasty is generally considered to be a purely cosmetic procedure as opposed to reconstructive. There are both therapeutic as well as elective or non-therapeutic components to many surgeries. The patient’s mixed motives will always affect the balance between these therapeutic and elective or non-

476 Dees 2008 KIEJ 377.
478 Parens 6.
therapeutic components. In the Canadian case of Kelly v Hazlett, the court held that cosmetic values have to be weighed carefully in the balance. The court acknowledged that in the case of a cosmetic procedure, there is usually more than mere improved appearance involved, as the procedure may also improve the functioning of that particular individual in society. In this regard, cosmetic surgery can be considered a psychological intervention or at the very least a surgical procedure with psychological consequences. Furthermore, a patient with a reconstructive problem does not necessarily suffer more than a patient with a purely cosmetic problem. It cannot be said that one is more socially acceptable than the other. It does not seem fair to grade a patient’s suffering in this manner. The self-perceived need of a patient to undergo cosmetic surgery is often so deeply entrenched psychologically, that the surgery takes on the nature of a medically necessary surgery for that particular patient.

The distinction between therapeutic and non-therapeutic medical procedures is just far too vague to form the ethical basis of an argument in favour of the rejection of all non-therapeutic procedures. When evaluating the ethical aspects of a particular medical intervention, we should not concern ourselves with the therapy-enhancement distinction. Instead, we should ask whether the intervention poses substantial risks, offers considerable benefits, violates or promotes human dignity etc. However, that does not mean that the distinction must be completely ignored or that it has absolutely no working relevance. In chapter 5 it will be shown how the differences between therapeutic and non-therapeutic procedures might be addressed in the field of professional ethics and the process of informed consent in order to ensure professionalism, patient safety and patient autonomy.

482 Kelly v Hazlett 1976 1 CCLT 1 (Onth HC).
483 Ibid.
486 Resnik 2000 Camb Q Healthc Ethics 374.
4.3 Complicity Arguments

In contemporary society, the human body is understood as having the potential for limitless change, “undetermined by history, social location or even individual biography”. The contemporary body, instead of being a dysfunctional object requiring medical interventions, has become a primary symbol of identity and a commodity, not unlike “a car, a refrigerator, a house, which can be continuously upgraded and modified in accordance with new interests and greater resources”. In this regard, cosmetic surgery has been criticised as being complicit in the creation of harmful societal conceptions, not just of beauty, but of normality. According to some, cosmetic surgery has regressed from a “genuine medical practice to a mere commodity that works within the context of a culture of appearance that is highly restrictive and which is less a culture of beauty than it is a system of control based on the physical representations of gender, age, and ethnicity”. One cannot deny the fact that a patient’s dissatisfaction with his or her appearance may at times be the result of immoral practices or ideologies. The societal norm the patient is trying to meet is certainly steeped in injustice when requesting a reduction of an ethnic nose, the westernisation of oriental eyes or the lightening of dark skin. As Morgan explains it: “What is being created in all of these instances is not simply beautiful bodies and faces but white, Western, Anglo-Saxon bodies in a racist, anti-Semitic context.” Whether this statement is accurate or not is debatable, but it is certainly undeniable that the suffering that cosmetic surgery attempts to alleviate is oftentimes caused by social attitudes and norms concerning appearance, not biological disease or dysfunction. Some patients have actually adopted these societal norms and want

487 Bordo 1990 MQR 657; Gimlin 2000 Qualitative Sociology 80.
488 Gimlin 2000 Qualitative Sociology 80; Finkelstein 87; Adams 2010 QHR 757.
489 Little 171; Parens 17.
490 Atiyeh et al 2008 Aesth Plast Surg 829.
830 Gimlin 2000 Qualitative Sociology 89; Bordo 22; Bogdanoski 2009 Griffith L Rev 505.
492 Morgan “Women and the Knife: Cosmetic Surgery and the Colonization of Women’s Bodies” 1991 Hypatia 36.
493 Little 163; Goering 173; Adams 2010 QHR756; Parens 10.
very much to meet it, whilst other patients reject these norms, but suffer nonetheless because the society they live in treats them differently.\textsuperscript{494}

The question of complicity is often discussed in feminist literature on cosmetic surgery. According to some feminist scholars, women, much more than men, are defined by their appearance and to some extent the nature and worth of a woman are seen as residing in her appearance.\textsuperscript{495} To retain her self-worth and even her job she must remain attractive.\textsuperscript{496} It is often argued that, as the virtue of beauty is more central to female virtues and historically women have been more closely associated with body than with mind, deviations from societal norms of appearance are also more highly punished in women than in men.\textsuperscript{497} As Little explains it: “[A] man who fails in this category has failed in something that is only incidental to his nature; a woman has sinned against one of her deepest charges.”\textsuperscript{498} It therefore makes sense that it is predominantly women who choose to undergo cosmetic surgery.\textsuperscript{499} According to Little, what is problematic about women undergoing cosmetic surgery to meet these societal norms, is the fact that the cost imposed on women by society for failing to live up to these norms is “excessive, punitive, unfair or cruel”.\textsuperscript{500} Furthermore, the actual content of these norms is morally suspect and based on unjust societal beliefs and attitudes that reinforce a value system that subjugates and objectifies women’s bodies.\textsuperscript{501}

Some feminist scholars acknowledge that cosmetic surgery is a means by which women can relieve their own suffering, thereby becoming “embodied subjects” rather than “objectified bodies”, albeit within the constraints of a patriarchal society.\textsuperscript{502} However, most feminist scholars, such as Bordo, still regard cosmetic surgery to be the very source of women’s suffering.\textsuperscript{503} Bordo believes that women who consider cosmetic surgery to be a way out of

\footnotesize{494 Little 163.  
495 Little 167; Heyes & Jones 8; Davis (2003) 93.  
497 Little 166; Adams 2010 \textit{QHR} 756; Davis (2003) 93.  
498 Little 166.  
500 Little 166; Parens 10.  
501 Little 166; Amadio 2010 \textit{JAMA} 401; Parens 10.  
503 Parens 19.}
suffering are fooled by the cosmetic industry’s rhetoric of personal empowerment and very much mistaken about the extent to which they are free to choose what to do with their bodies in a patriarchal society.504

It might be of academic importance to note that women’s suffering has multifaceted social and historical roots, but as Parens rightly asks, why should the source of suffering make any difference to a surgeon who has the means to relieve that suffering?505 The implications of cosmetic procedures for the conceptualisation of the body and identity are valid concerns, however such broader moral concerns are not necessarily relevant to the moral responsibilities of medicine. To suggest that the medical profession should act as a moral high ground, guiding the rest of society, seems paternalistic. In the context of the physician-patient relationship, one might argue that it is a physician’s duty to put these broader moral concerns aside and focus on having compassion for the patient and alleviating suffering where possible.506 However, in addition to the moral responsibilities that a physician has toward his or her patients, medicine as an institution also has responsibilities toward society as a whole.507 Medicine, as one of the central institutional authorities in our society, enjoys particularly high status.508 Some argue that by participating in these practices, medicine is openly sanctioning the suspect norms underlying society’s fixation with external appearance and as such the medical profession is complicit to the injustice.509 Furthermore, in the eyes of society, medicine is principally concerned with health and healing. By participating in, and therefore sanctioning, the practice of cosmetic surgery and the norms that underlie it, these “norms of appearance” get blurred with norms of health and healing.510 The mere fact that medical means are being employed to achieve these ends elevates the importance of these ends in the eyes of society.511 Furthermore, the fact that physicians derive financial benefit

505 Parens 20.
506 Little 169.
507 Little 169; Goering 181; Amadio 2010 JAMA 401.
508 Little 172; Amadio 2010 JAMA 402.
509 Little 169; Goering 177; Davis (2003) 101.
510 Little 172; Goering 179; Amadio 2010 JAMA 402.
511 Little 172; Amadio 2010 JAMA 402.
from performing these surgeries heightens the moral ambiguity of their involvement. This is mainly due to the fact that physicians, cosmetic surgeons in particular, may become personally and financially invested in the preservation and exploitation of the suspect norms that underlie these surgeries.  

It is submitted that the real problem lies in the fact that a number of physicians are endorsing, perhaps even exploiting and reinforcing, ethically suspect norms and practices for personal financial gain. Ethical cosmetic surgeons have a responsibility to speak out publicly against the content of suspect norms of women’s appearance. Furthermore, ethical cosmetic surgeons should allow a true appreciation of the injustices that underlie norms of appearance to influence and enhance the process of informed consent. By reminding patients of the option not to have a surgery and exposing patients (through videos, conversation or pamphlets) to a variety of narratives and women’s real life experiences of cosmetic surgery, cosmetic surgeons will be able to speak out against the pressures women face, whilst still using surgical skills in cases where there seems to be no other path out of suffering. As Little explains it, cosmetic surgeons should “decry the pressures that lead to patients’ suffering, much as they would decry the prevalence of a virus, and would change that aspect of society if they could”. During the interim however, cosmetic surgeons should be solely motivated by the genuinely noble goal of relieving human suffering and any act of complicity should be done reluctantly.

513 Little 170; Davis (2003) 36; Mantese et al 2006 MIBJ 27. 
514 Little 173; Bogdanoski 2009 Griffith L Rev 504. 
515 Little 174; Amadio 2010 JAMA 402. 
516 Little 174; Davis (2003) 77; Bogdanoski 2009 Griffith L Rev 504. 
517 Little 171. 
518 Little 171; Parens 20.
4.4 Human Nature, Normality and Naturalness

Appeals to human nature are very common in the literature pertaining to the ethics of human enhancement through biotechnology.\(^{519}\) This particular issue is not all that relevant to the comparatively uncontroversial practice of cosmetic surgery, because cosmetic surgery does not fundamentally alter those qualities and attributes that make us human. The human nature debate must however be touched upon, because of the vast implications it holds for other forms of human enhancement. The main concern is that enhancement changes or destroys human nature and that doing so is inherently immoral.\(^{520}\) This concern is based on the premise that altering or destroying human nature *per se* is immoral.\(^{521}\) Another closely related concern is that altering or destroying human nature is immoral, as it undermines our ability to ascertain the good.\(^{522}\) This concern is based on the premise that human nature provides a standard without which we will not be able to make intelligible, justifiable judgements about what is good.\(^{523}\)

According to Resnik, in order to explore the issue in depth, we need to answer two questions. Firstly, we need to determine what qualities or traits make us human. Secondly, we need to ask ourselves whether it would necessarily be immoral to change those qualities or traits.\(^{524}\) Philosophers have been attempting to determine what qualities or traits make us human ever since Aristotle defined man as the rational animal.\(^{525}\) Since Aristotle, the dominant philosophical conception of human nature has been that of a set of characteristics that are common to all human beings and that distinguish us from other animals.\(^{526}\) According to Resnik, it is difficult to specify necessary and sufficient conditions for a thing to be human; therefore human nature is best understood as a collective concept in that it can be equated

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521 Buchanan 2009 *Bioethics* 141.
523 Buchanan 2009 *Bioethics* 141.
524 Resnik 2000 *Camb Q Healthc Ethics* 369.
526 Buchanan 2009 *Bioethics* 142; Sippi (2011) 196.
with a list of characteristics.\textsuperscript{527} Some of these characteristics include physical traits and abilities, psychosocial traits and abilities and phylogenetic traits.\textsuperscript{528} If however one assumes that there are natural kinds, then these characteristics will be essential in the sense that we will not be human without them.\textsuperscript{529} A layperson will probably understand human nature as a list of dispositions that all human beings have and that throughout history have shaped our behaviour across a wide range of human activities, regardless of the cultural context.\textsuperscript{530} On the other side of the spectrum, an evolutionary biologist would probably define human nature as those inborn characteristics that most humans have as a result of our shared evolutionary development.\textsuperscript{531}

The most important enquiry is whether altering those traits that make us human would be morally wrong. The moral rightness or wrongness of altering the traits that make us human would be immaterial if it was impossible to alter those traits and qualities in the first place. Whether those traits and qualities can be altered will largely depend on our understanding of what constitutes human nature and the scientific and technological means at our disposal. Based on an understanding of human nature as collection of physiological, psychosocial and phylogenetic traits and abilities, it is in fact possible to alter human nature with the aid of modern-day science and technology.\textsuperscript{532} The extent to which we are able to alter these traits and characteristics will only expand with time and further advances in biotechnology and science.

As far as the moral status of altering human nature is concerned, it can be said that in terms of most moral theories, with the exception of a natural law approach, altering human nature or what we understand human nature to be, could be either morally sound or immoral. It is necessary to briefly refer to certain well known moral theories when discussing the alteration of human nature, if only to illustrate that most moral theories are inherently vague and are not

\begin{itemize}
  \item \textsuperscript{527} Resnik 2000 \textit{Camb Q Healthc Ethics} 369.
  \item \textsuperscript{528} Ibid.
  \item \textsuperscript{529} Buchanan 2009 \textit{Bioethics} 142; Sippi (2011) 196.
  \item \textsuperscript{530} Buchanan 2009 \textit{Bioethics} 142.
  \item \textsuperscript{531} Ibid.
  \item \textsuperscript{532} Resnik 2000 \textit{Camb Q Healthc Ethics} 370.
\end{itemize}
very helpful for practical decision making in this regard. It would therefore be difficult to make a strong argument against the enhancement of human nature based solely on a moral theory such as Aristotelian virtue ethics, Utilitarianism or Kantian deontological ethics.

From the perspective of Aristotelian virtue ethics, endeavours to alter human nature are morally sound insofar as they accord with virtue. Aristotle believed that our purpose in life is to achieve “eudemonia”, which is usually translated as human flourishing. Central to this theory was that we can only achieve a state of eudemonia by becoming virtuous. Aristotle was not particularly helpful in explaining what virtue is and insisted that we can only acquire an understanding of virtue by actually becoming virtuous ourselves. It can be said that Aristotelian virtue ethics reflect the reality that morality is not concerned with following a certain set of rules, but rather with becoming a certain type of person. For Aristotle, a virtuous person is a person who knows which actions are virtuous and who then intentionally performs those actions solely because he or she knows that those actions are virtuous. We cannot determine whether altering human nature is morally sound or virtuous without actually becoming virtuous ourselves and that usually takes a lifetime. Clearly, this moral theory lacks a straightforward decision-making procedure and as such it would be very difficult to formulate a convincing argument against human enhancement based upon Aristotelian virtue ethics. Virtue ethics are useful in helping one become a certain type of person, someone who lives a good life, but it is not a particularly useful tool for practical decision-making or policy formulation.

Utilitarianism is a consequentialist theory which holds that the morality of an action is determined solely by the goodness or badness of its consequences. For a utilitarian, the right action is determined by referring to the consequences of that action, rather than the intention with which it was performed or the nature of the action itself. Utilitarianism

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534 Ibid.
535 Ibid.
evaluates actions in terms of their consequences for happiness. From a utilitarian perspective, human enhancement could therefore be morally right or wrong depending on the consequences thereof. Human enhancement would be morally acceptable if it produces the greatest happiness of the greatest number, in other words, if it produces a greater balance of good, rather than bad consequences. Genetic interventions that improve the human immune system will therefore probably be morally sound, whereas interventions that result in harmful mutations would be immoral.

From the perspective of Kantian ethics, attempts to alter human nature would be moral as long as it does not violate the moral law. Kant believed the only thing good in itself is a good will. A good will is good in itself, because it is intrinsically good and not simply good in relation to something else. For Kant, a good will is one that, faced with a choice between acting out of inclination and acting out of reverence for the moral law, will always choose to act out of reverence for the moral law. To act out of reverence for the law is to act on a categorical imperative, in other words, an imperative that binds us unconditionally and irrespective of our personal desires. The most well-known of Kant’s formulations of the categorical imperative included: “I am never to act otherwise than so that I could also will that my maxim should become a universal law” and “never act in such a way that we treat humanity, whether in ourselves or in others, as a means only but always as an end in itself”. In terms of Kantian ethics, the alteration of human nature would therefore be immoral if such attempts either violate our dignity and autonomy or if a universal maxim permitting human enhancement generates a logical or practical contradiction (in other words,

537 Glickman 525.
539 Resnik 2000 Camb Q Healthc Ethics 370.
541 Kant 396; MacIntyre 448-9.
destroys itself).\textsuperscript{544} Cosmetic surgery or more futuristic examples of wish-fulfilling medicine such as genetic enhancement might violate some of these principles, but it would depend on the circumstances. There does not seem to be anything inherently immoral about medical enhancement per se. The moral status of a particular form of human enhancement is wholly contingent on its relation to other moral concerns such as utility, autonomy, dignity and virtue.\textsuperscript{545} Certain forms of enhancement will be morally justifiable, as long as they are safe and effective. According to Resnik, one can even justify the use of genetics for cosmetic purposes, as it will benefit patients.\textsuperscript{546}

However, proponents of a natural law approach would disagree with the aforementioned viewpoints. According to a natural law approach, there is in fact something inherently immoral about altering the human form.\textsuperscript{547} This argument is based on an assumption that the human form as is has inherent worth and is morally sacred.\textsuperscript{548} In this regard, Fukuyama writes the following:

The deepest fear that people express about technology is not a utilitarian one at all. It is rather a fear that, in the end, biotechnology will cause us in some way to lose our humanity—that is, some essential quality that has always underpinned our sense of who we are and where we are going.\textsuperscript{549}

Those who support this standpoint seem to believe that natural selection has designed human beings to possess certain traits and characteristics and that changing those traits and characteristics would be an affront to nature’s wisdom.\textsuperscript{550} According to Resnik, this “neo-Darwinian” perspective is excessively optimistic and naïve, as it assumes that natural selection is faultless.\textsuperscript{551} This cannot be true, as there are many unfavourable or simply

\textsuperscript{544} Kant 403; Singer 460; Resnik 2000 \textit{Camb Q Healthc Ethics} 370; Resnik \textit{et al} 147.
\textsuperscript{545} Resnik 2000 \textit{Camb Q Healthc Ethics} 370.
\textsuperscript{546} Id 368.
\textsuperscript{547} Resnik 2000 \textit{Camb Q Healthc Ethics} 370; Resnik \textit{et al} 152.
\textsuperscript{548} Resnik 2000 \textit{Camb Q Healthc Ethics} 370; Baylis & Robert 2004 \textit{Bioethics} 12.
\textsuperscript{549} Fukuyama 101.
\textsuperscript{550} Resnik 2000 \textit{Camb Q Healthc Ethics} 370; Resnik \textit{et al} 154.
\textsuperscript{551} Resnik 2000 \textit{Camb Q Healthc Ethics} 371; Resnik \textit{et al} 155.
useless aspects to human nature such as the appendix.\textsuperscript{552} Furthermore, there are some traits that human beings do not possess that would be very useful, such as perfect immune systems, concentration levels, memory and boundless imagination.\textsuperscript{553} Nothing in our evolutionary history points to a reason why we should not improve upon our biological design.\textsuperscript{554} Some even believe that one cannot depend on natural selection to provide a beneficial long-term result for a particular group of organisms, as it is too opportunistic and short-sighted.\textsuperscript{555} Human intervention would allow for a more successful and beneficial evolution than the “haphazard, opportunistic ways of nature”, whose only aim is reproductive success rather than quality of life.\textsuperscript{556} Enhancement technology must therefore be used not only to protect, but also to pursue human goods such as intelligence and beauty. The argument against enhancement that is based on the preservation of human nature also seems to rest on the premise that human nature is somehow static; something it is clearly not.\textsuperscript{557} There is not even consensus on exactly what human nature is. Whether human nature should serve as a source of normative assessment is highly doubtful.\textsuperscript{558} As human nature has evolved in response to an enormous range of arbitrary forces, it is difficult to imagine how it can be indicative of what is desirable in terms of the traits human beings should possess.\textsuperscript{559}

At first glance, some forms of enhancement seem unnatural, because it reaches beyond what we perceive as normal for human beings.\textsuperscript{560} Christian bioethicists argue that enhancement technologies redefine certain normal imperfections as defects and ultimately devalue the created self as made by God.\textsuperscript{561} This argument seems to rest on an assumption that we know what normal human capabilities are or could be.\textsuperscript{562} This assumption is false, as concepts of

\begin{thebibliography}{99}
\bibitem{552} Resnik 2000 \textit{Camb Q Healthe Ethics} 371.
\bibitem{553} Resnik 2000 \textit{Camb Q Healthe Ethics} 371; Baylis & Robert 2004 \textit{Bioethics} 12.
\bibitem{554} Caplan & Elliot 2004 \textit{PLOS Medicine} 173.
\bibitem{555} Scripko 2010 \textit{JME} 293; Baylis & Robert 2004 \textit{Bioethics} 4.
\bibitem{556} Scripko 2010 \textit{JME} 293.
\bibitem{557} Caplan & Elliot 2004 \textit{PLOS Medicine} 173.
\bibitem{558} Buyx 2008 \textit{Med Healthe Philos} 139; Engelhardt 412.
\bibitem{559} Caplan & Elliot 2004 \textit{PLOS Medicine} 173.
\bibitem{560} Siipi 2011 \textit{Trames} 190.
\bibitem{561} Baylis & Robert 2004 \textit{Bioethics} 6; Scripko 2010 \textit{JME} 295.
\bibitem{562} Scripko 2010 \textit{JME} 295.
\end{thebibliography}
normality are entrenched in observed standards of health, disability and disease.\textsuperscript{563} As we merely observe these concepts, they rely on our perception and therefore our subjective interpretation of them.\textsuperscript{564} Furthermore, defining naturalness as statistical normality is not helpful, as it neither provides a persuasive argument for enhancement being unnatural, nor a basis for the argument that enhancement is immoral based on this perceived unnaturalness.\textsuperscript{565} What is statistically normal differs greatly depending on the place and time. These differences are dependent upon many factors, for example nutrition, education, scientific knowledge and the available medical care. Besides, not all statistically normal conditions are desirable and medical procedures on statistically normal conditions are usually not regarded as forms of enhancement, but rather as therapeutic treatments.\textsuperscript{566} The fact that enhancement might somehow alter or destroy human nature is not a completely convincing argument against enhancement. Whether a particular human characteristic or trait could justifiably be tampered with would depend upon a number of factors such as the desirability of that characteristic or trait and whether in attempting to change it we would be sacrificing or risking other things we rightly value.\textsuperscript{567} The question whether a particular trait or characteristic is part of human nature as such, is therefore irrelevant. If human nature is simply a description of what is typical for human beings today, there is no reason why it should not be improved upon or enhanced.\textsuperscript{568}

As far as undermining our ability to make judgements about the good is concerned, it cannot be said that in altering human nature we would inevitably undermine our ability to make judgements about what is good. As Buchanan rightly states: “[W]e already possess standards of evaluation that are independent of our nature in the sense that we can and do make coherent judgements about the defective aspects of human nature, and if those defects were remedied this need not affect our ability to judge what is good.”\textsuperscript{569} Human beings are able to

\textsuperscript{563} Keenan “Whose Perfection is it Anyway?: A Virtuous Consideration of Enhancement” 1999 \textit{Christian Bioethics (Christ Bioeth)} 114; Scripko 2010 \textit{JME} 295.
\textsuperscript{564} Wachbroit “Normality as a Biological Concept” 1994 \textit{Philosophy of Science} 587; Scripko 2010 \textit{JME} 295.
\textsuperscript{565} Siipi 2011 \textit{Trames} 191.
\textsuperscript{566} \textit{Id} 192.
\textsuperscript{567} Buchanan 2009 \textit{Bioethics} 145.
\textsuperscript{568} Siipi 2011 \textit{Trames} 197.
\textsuperscript{569} Buchanan 2009 \textit{Bioethics} 150.
apply perfectly sound judgement about what elements of human nature are good or bad. We accept that some human traits that have evolved are actually very bad. This same judgement can supply justifiable reasons for altering that nature. According to Buchanan, by appealing to human nature when making judgements about the good, we are merely placing limitations on our conception of what can be good for us, that is, only that which is part of our nature. Altering our nature will not result in the inability to judge what is good; it will simply create new borders to our conception of the good. Furthermore, even if our ability to make evaluative judgements about the good is somehow dependent upon our nature, it does not logically follow that it is dependent upon every single aspect of our nature.

4.5 Justice and Accessibility

A further argument against wish-fulfilling medical practices is that it is unjust. The question of distributive justice is of practical importance, but it does help us answer the question whether wish-fulfilling medicine per se is unethical. The issue of justice and accessibility will therefore only be discussed briefly. The problem with wish-fulfilling medicine is that it is generally only the wealthy, informed and educated who have access to new biomedical enhancement technologies. The lucky few who already have access to economic resources are able to gain access to new biomedical technologies and use of these technologies to make them stronger competitors for even more resources. This will inevitably create an even wider gap between the haves and the have-nots.

Buchanan et al, referring to genetic enhancement, argue that this inequality of access should be minimised and that the have-nots should be able to partake in the full range of medical alternatives to ensure equality of opportunity. This seems idealistic at best. It is difficult to imagine how wish-fulfilling medicine could belong to the standard services offered by a

570 *Id* 149.
571 Buchanan 2009 *Bioethics* 149.
574 Baylis & Robert 2004 *Bioethics* 12; Parens 8; Lin & Allhoff 2008 *Nanoethics* 259.
health care system already facing an enormous lack of resources. Currently, there is not equal access to even the most essential medical treatment, except for in a strictly negative sense. It is therefore unlikely that there will ever be universal access to enhancement technologies.\textsuperscript{576} One might argue that there is nothing wrong with new science and technology improving the lives of a privileged few. After all, this is and has always been the case with most new technologies.\textsuperscript{577} We have always tolerated some level of inequality or unequal distribution of competitive advantages in society on the basis of ability to pay.\textsuperscript{578} For example, it would seem absurd to forbid the possession of the newest iPhone, because not everybody can afford one and by allowing the sale of such devices we are knowingly creating even greater inequality. Even this trivial example generalizes to a point where no progress would be ethically acceptable. That seems not only practically, but also ethically absurd. Of course, it must be added that from an ethical and moral point of view there is an enormous difference between purchasing the newest gadget or tool and purchasing new capacities. Unlike gadgets or tools, new capacities do far more than just provide a competitive advantage; they are often also intrinsically good and confer certain non-competitive benefits that might be universally desirable.\textsuperscript{579}

Despite all of these concerns, most contemporary theories of justice do not call for any redistribution.\textsuperscript{580} From a libertarian point of view, enhancement procedures should simply be distributed in terms of a free market, as inequalities in property and information are not unfair.\textsuperscript{581} On the other hand, communitarians would argue that enhancement procedures should either be financed according to the community’s conception of the common good or it should be completely excluded from medicine.\textsuperscript{582} Rawlsian liberal egalitarianism seems to be the main theory regarding accessibility and distribution of health care services. However, even if we regard the process as reasonable or valid to start with, it is very difficult to determine what would emerge through a Rawlsian process. In terms of a Rawlsian concept

\textsuperscript{576} Parens 15.
\textsuperscript{577} Ibid.
\textsuperscript{578} Brock 60.
\textsuperscript{579} Parens 16.
\textsuperscript{580} Buyx 2008 \textit{Med Healthc Philos} 140; Lin & Allhoff 2008 \textit{Nanoethics} 259.
\textsuperscript{581} Buyx 2008 \textit{Med Healthc Philos} 140.
\textsuperscript{582} Ibid.
of equality of opportunity, “those who are at the same level of talent and ability, and have the same willingness to use them, should have the same prospects of success regardless of their initial place in the social system”. Enhancement procedures should therefore be made available to those with the most talent and willingness to use it, as long as they contribute to the improvement of the conditions of the worst-off. In terms of a Rawlsian concept of equality of opportunity, enhancement procedures might not be included in the standard services offered by a health care system with limited resources. According to Buyx, if patients had a claim to enhancement procedures based on a Rawlsian conception of equality of opportunity, those procedures would enter into competition with other medical services and would lead to an endless number of claims to interventions that can reasonably be construed using equality of opportunity. This will place enormous financial strain on the health care system.

Norman Daniels has an influential theory regarding justice and accessibility to enhancement procedures. His theory indicates that, from a democratic perspective, there is no reason why all citizens should have equal access to enhancement procedures. Daniels grounds the provision of healthcare on the basis of democratic values. For Daniels, all citizens are entitled to medical interventions in so far as those interventions perform an equalizing function by countering the disadvantages that people suffer as a result of accidents or diseases. According to Daniels, healthcare has public value only in so far as it functions as an instrument of the State that protects citizens from arbitrary disadvantage. Enhancement procedures therefore do not have real public value, as they merely enhance the wellbeing of individuals in areas where they are not necessarily arbitrarily disadvantaged. State-funded healthcare should therefore have a normalizing function and nothing more. From the

584 Buyx 2008 Med Healthc Philos 140.
587 Ibid.
perspective of the State, normal functioning of its citizens is of important political significance, because it secures the ends of democratic political morality.\textsuperscript{588} John Rawls, from whose theory Daniels heavily borrows, explains the relationship between normal functioning and a democratic State when he states the following: “A person is someone who can be a citizen, that is, a fully cooperating member of society over a complete life.”\textsuperscript{589} Normalizing therefore enables individuals to function as cooperative, contributing citizens insofar as it enables them to take part in social interactions and share in common social responsibilities.\textsuperscript{590} For Daniels, healthcare is therefore of unique moral importance in the sense that it contributes to the preservation of our status as fully functioning citizens.\textsuperscript{591}

With reference to John Rawl’s moral theory for a framework of a society rooted in justice, Volandes suggests a workable solution that will allow medicine to embrace enhancement technology without eroding its own moral status.\textsuperscript{592} With reference to Viagra for improved sexual performance in normal people, Volandes argues that enhancement technologies can remain available to those able to afford medical luxuries, but the profits from such sales should subsidise medical care for those unable to afford medically necessary health care.\textsuperscript{593} It might therefore be possible that inequalities in the context of biotechnology could be arranged in a way that will benefit those who are worst-off. The feasibility of such an approach is uncertain and easily merits an entire study on its own, but as the question of distributive justice is of practical importance and does not contribute to answering the question of whether wish-fulfilling medicine \textit{per se} is unethical, it will not be discussed in any further detail in this particular study.

\textsuperscript{589} Rawls (1999) 397.
\textsuperscript{592} Volandes “Envying Cinderella and the Future of Medical Enhancements” 2006 \textit{Medical Humanities} 76.
\textsuperscript{593} \textit{Ibid.}
Autonomy of the Patient’s Wish

One of the most important doctrines of modern medical law and ethics is the protection and promotion of patient autonomy. This is why the doctrine of informed consent has been widely accepted. In the case of cosmetic surgery, the decision making process is guided by strong wishes on the patient’s part. Unfortunately, a strong wish can compromise the decision making ability by functioning as an internal source of pressure. In this sense, autonomy might be compromised in the case of cosmetic surgery. Whether the decision to undergo cosmetic surgery could ever truly be autonomous is uncertain. After all, wishes do not develop in a vacuum, but are shaped by society. In a consumer driven society obsessed with physical appearance, some argue that the decision to undergo cosmetic surgery cannot possibly be an authentic decision.

The question of the autonomy of a cosmetic surgery patient’s wish is often discussed in feminist literature. Feminist scholars argue that women who undergo cosmetic surgery do not act autonomous, as they are coerced by societal ideals to have their bodies altered. Their decision to undergo cosmetic surgery is not rational and therefore they lack agency. Some even argue that medicine actually creates these new wishes that are neither authentic nor autonomous. Feminist writer, Kathy Davis, believes women are constrained in their decisions to undergo cosmetic surgery. She believes that women’s “willingness to calculate the risks of surgery against its benefits can only make sense in a context where a person is able to view her body as a commodity, as a possible object for intervention- a business venture of sorts”. Similarly, Morgan regards cosmetic surgery as an extension of a beauty industry that is preoccupied with the colonization of women’s bodies by means of technology.

594 Buyx 2008 Med Healthc Philos 139.
595 Ibid.
596 Buyx 2008 Med Healthc Philos 139; Scripko 2010 JME 294; Adams 2010 QHR 756.
598 De Roubaix 2011 JPRAS 13; Heyes & Jones 7; Bordo 23.
600 Maio “Is Aesthetic Medicine Really Medicine? An Ethical Critique” 2007 Handchirurgie, Mikrochirurgie, Plastische Chirurgie (Handchir Mikrochir Plast Chir) 238 ; Buyx 2008 Med Healthc Philos 139; De Roubaix 2011 JPRAS 13; Goering 175.

- 97 -
and surveillance.\textsuperscript{602} Unfortunately, Morgan strips women of any agency whatsoever by simply dismissing the wide variety of interesting motivations and narratives that the women in her study cited for undergoing cosmetic surgery.\textsuperscript{603} According to Morgan then, women who undergo cosmetic surgery are victims, powerless consumers obedient to a patriarchal system and mindless receptors who have internalized society’s norms.\textsuperscript{604} This is not necessarily true. Being influenced by society’s conceptions or ideals is not necessarily tantamount to being pressured into a decision.\textsuperscript{605} The desire to be beautiful is a very basic desire and the patient’s innate aesthetic sense and the importance of beauty to the patient personally is often his or her primary reason for requesting cosmetic surgery.\textsuperscript{606} Furthermore, medical technology is neutral and is not itself driving us in any particular direction.\textsuperscript{607} We decide where it should be headed.

It should also be mentioned that most scholarly discussions of cosmetic surgery have come from a feminist perspective and deal exclusively with women’s experience.\textsuperscript{608} Feminist scholars have thus far only really discussed women’s dissatisfaction with their bodies within a social and patriarchal context and have tended to exclude men from their evaluation.\textsuperscript{609} Kathy Davis avers that just 10 per cent of cosmetic surgery operations performed in the United States is carried out on men, yet in order to make this claim she first excludes those operations specifically aimed at men such as hair transplants, circumcisions, cosmetic ear surgery and cosmetic dentistry.\textsuperscript{610} Qualitative research has shown that the reasoning of male cosmetic surgery patients is perfectly rational and that agency plays a central role in their

\textsuperscript{603} Holliday & Cairnie 2007 J Consum Cult 60; Heyes & Jones 7; Bordo 23.
\textsuperscript{606} Atiyeh et al 2008 Aesth Plast Surg 831; Amadio 2010 JAMA 402.
\textsuperscript{607} Caplan & Elliot 2004 PLOS Medicine 174.
\textsuperscript{608} Holliday & Cairnie 2007 J Consum Cult 58.
\textsuperscript{609} Holliday & Cairnie 2007 J Consum Cult 58; Heyes & Jones 11.
\textsuperscript{610} Holliday & Cairnie 2007 J Consum Cult 58; Davis (1995) 21.
decision-making process. Male patients are concerned with their appearance and believe that they will benefit from surgery in the form of job advancement and improved relationships. The same validation process can be discerned amongst female patients. Both men and women’s consumption of cosmetic surgery seems to represent an investment in “body capital”. Women and men who choose to undergo cosmetic surgery can be seen as consumers exercising choice and engaged in a project of the self. It could be argued that these patients just intuitively grasp what social scientists have learned over the last four decades, namely that people associate physical attractiveness with numerous highly favourable personality traits including intelligence, competence and social desirability. These narratives challenge certain feminist theories about cosmetic surgery and disrupt the commonly held belief that cosmetic surgery is an issue that only affects women. There are many diverse reasons why both women and men undergo cosmetic surgery. Ultimately, there is no strong empirical information available to deny or assert the autonomy of patients choosing wish-fulfilling procedures and any misgivings regarding autonomous decision-making can be adequately addressed by careful evaluation of patient motivation and quality of information in each individual case.

4 7 Competing Principles: Non-Maleficence, Beneficence and Justice versus Patient Autonomy

“Principlism”, as articulated in Beauchamp and Childress’s Principles of Biomedical Ethics, has been widely adopted as the standard approach to contemporary bioethical issues. The principles of autonomy, beneficence, non-maleficence and distributive justice, “promised in their formulation an operational tool for evaluating and adjudicating case-based ethical

611 De Roubaix 2011 JPRAS 13.
613 De Roubaix 2011 JPRAS 13.
618 Buyx 2008 Med Healthe Philos 139.
619 See Beauchamp & Childress Principles of Biomedical Ethics.
Beauchamp and Childress suggest that these four principles are of equal moral importance and should be applied differentially as specific situations demand.621

Despite the fact that Beauchamp and Childress refused to put forward a hierarchical ranking of the four principles, autonomy has emerged as the most powerful and central principle of the four.622 In this regard, Wolpe states the following: “The conflict between liberal individualism (autonomy) and responsibility to the common good (justice, beneficence) has characterised bioethical thought since its inception, and so has the realisation that the struggle was being won by the ethic of individual liberty.”623 Callahan acknowledges that autonomy is given a place of honour, because the “thrust of individualism, whether from the egalitarian left or the market orientated right, is to give people maximum liberty in devising their own lives and values”.624 Pellegrino considers the triumph of autonomy to be “the most radical reorientation in the long history of the Hippocratic tradition” and just about irreversible.625 Some scholars, such as Wolpe, Callahan, Ackerman and Childress himself, argue that there is no inherent reason why autonomy should be considered the primary or default ethical principle in medical ethics.626 Other scholars, such as Engelhardt, Katz and Veatch, defend it and argue for an even more absolute form of autonomy.627 Perhaps the application of the four principles approach can and should legitimately vary from one person to the other; from one set of medical circumstances to the other; and from one culture to the other.628 Those who desire less emphasis on respect for autonomy can apply a different balance or harmony between the four principles.629 In context of elective surgery, as opposed to emergency life-

621 Wolpe 43.
622 De Roubaix 2011 JPRAS 366; Wolpe 43.
623 Wolpe 43.
624 Callahan “Principlism and Communitarianism” 2003 Journal of Medical Ethics (JME) 298.
626 Wolpe 43.
627 Ibid.
629 Ibid.
saving surgery or surgery on a child or mentally disabled person, it is morally desirable for the value of autonomy to enjoy precedence.

Individual autonomy is the cornerstone of democratic thinking and of most contemporary theories of ethics.\textsuperscript{630} The court’s adoption of a more patient-centred approach in \textit{Castell v De Greef} recognised a patient’s fundamental right to autonomy and self-determination and was indicative of the new direction in which South African law was moving.\textsuperscript{631} The subsequent adoption of the final Constitution and entrenchment of the right dignity,\textsuperscript{632} the right to life,\textsuperscript{633} the right to bodily integrity,\textsuperscript{634} the right to privacy\textsuperscript{635} and the right to freedom of opinion and belief\textsuperscript{636} bears out this movement and indicates that South African society is founded upon the underlying values of autonomy and self-determination.\textsuperscript{637} The recognition of the right of every individual to self-determination has become an imperative under the Constitution.\textsuperscript{638} Cosmetic surgery “can be seen as the (partial) product of the kind of agent introduced during the Enlightenment and, as such, its theory and practice contributes to a cultural and political milieu in which those liberal democratic values and logics can thrive”.\textsuperscript{639} Dworkin suggests that two different meanings are attached to autonomy and the dominance of the self in medical law.\textsuperscript{640} The one is liberal individualism and the other has more to do with privacy than liberty.\textsuperscript{641} Two important maxims of a liberal outlook are relevant when considering the legitimacy of cosmetic surgery. Firstly, accept competent decisions even when they seem foolish. This is also called anti-paternalism. Secondly, do not impose particular conceptions

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630 De Roubaix 2011 \textit{JPRAS} 365. \\
631 Thomas 2007 \textit{SALJ} 189; \textit{Castell v De Greef} 426B. \\
632 S 10 of the Constitution. \\
633 S 11 of the Constitution. \\
634 S 12(2) of the Constitution. \\
635 S 14 of the Constitution. \\
636 S 15 of the Constitution. \\
637 Thomas 2007 \textit{SALJ} 189. \\
638 \textit{Christian Lawyers’ Association v National Minister of Health} 1059. \\
639 Fraser “The Agent Within: Agency Repertoires in Medical Discourse on Cosmetic Surgery” 200 \textit{Australian Feminist Studies (AFS)} 32. \\
640 Dworkin “Getting What We Should From Doctors: Rethinking Patient Autonomy and the Doctor-Patient Relationship” 2003 \textit{Health Matrix} 238. \\
641 \textit{Ibid.} \\
\end{tabular}
\end{footnotesize}
of the good on other people. This is also called neutrality. The notion of liberty also refers to the harm principle, which states that freedom to make and act on one’s decisions must enjoy priority, unless those decisions harm others in a significant way. It is submitted that the guiding principle must be one that maintains a high bar of suspicion when someone else’s personal values pervade moral arguments. Value toleration and freedom of choice are essential ingredients of a just liberal arrangement that does not legislate morality. We arrive at the best internal and social arrangements by allowing informed agents to be guided by their own values in choosing cosmetic surgery.

Furthermore, autonomy is what makes any sort of morality possible. Autonomy is therefore morally precious and should be respected, nurtured and developed. In context of medical ethics, the other three ethical principles cannot function properly without respect for individual autonomy. Beneficence and non-maleficence necessitate respect for the autonomy of the individuals one is trying to help. When attempting to benefit individuals, whilst doing as little harm as possible, one still needs to discover and respect what the proposed beneficiary regards as beneficial or harmful and what he or she regards as the most beneficial and least harmful option under the particular circumstances. One only needs to think of a Jehovah’s Witness’s attitude towards a blood transfusion to illustrate this point. The other moral principles also seem to inevitably lead back to the principle of respect for autonomy. An example of this is the fact that non-maleficence has been formulated as a right not to have your mind or body harmed by someone else. That formulation is basically a historical variant of respect for patient autonomy. Autonomy does not play an inconsequential role when it comes to justice in health care. In distributive justice, one must still pay attention to the beneficiary’s autonomous views, including the possible rejection of an offer to meet their

643 Dworkin 2003 Health Matrix 238.
644 Volandes 2006 Medical Humanities 74.
645 Ibid.
646 Agar “Liberal Eugenics” 1998 Public Affairs Quarterly (PAQ)139.
647 Gillon 2003 JME 310.
648 Gillon 2003 JME 310; Callahan 2003 JME 288.
649 Callahan 2003 JME 288.
650 Ibid.
needs. Appropriating the resources must also happen by means of a political and legal system, which through a democratic process, will respect the autonomy of those individuals whose resources are being reduced and distributed. 

**4 8 Conclusion**

Many of the abovementioned ethical concerns have a deeply philosophical undertone. When confronted by these concerns, the average physician will probably assert that these concerns are just far too academic and abstract to be of any practical concern in a physician’s everyday life and practice. However, not all of these concerns are so abstract that it completely excludes the possibility of physicians adopting certain practical guidelines to address at least some of these problem areas. Whilst some of these concerns relate to broader philosophical debates such as human nature and naturalness or societal conceptions of normality and beauty, others relate to more concrete matters that physicians might actually be able to address in the everyday practice of medicine. As mentioned above, the distinction between therapeutic and non-therapeutic medical procedures is far too vague to form the ethical basis of an argument against all non-therapeutic procedures. However, that does not mean that physicians must completely ignore this distinction or that it has absolutely no working relevance. In the following chapter, it will be explained to what extent physicians should in fact refer to this distinction during the process of informed consent in order to ensure professionalism, patient safety and patient autonomy. Furthermore, concerns regarding medicine’s complicity in the conceptualisation of the body and the possibility of medicine’s exploitation of destructive norms of appearance for the sake of financial gain, can to some extent be addressed by following ethical advertising guidelines and by allowing a true appreciation of the injustices that underlie norms of appearance to influence and enhance the process of informed consent. It is also by means of a careful process of informed consent, patient selection and evaluation that any misgivings regarding autonomous decision-making by cosmetic surgery patients can be adequately addressed. All of these recommendations will be discussed in detail in the next chapter.

651 Gillon 2003 *JME* 311.

5.1 Introduction

The performance of cosmetic surgery necessitates a degree of ethical conduct on the part of
the cosmetic surgeon that surpasses the level of ethical conduct normally required between a
physician and patient, as the relationship between a cosmetic surgeon and a patient differs
from the traditional physician-patient relationship. This is essentially due to the
distinction, albeit tenuous, between elective and non-elective forms of medical treatment.
Distinguishing between elective and non-elective medical treatments is difficult, but cosmetic
surgery is usually elective in the sense that cosmetic surgery is opted for by a patient more
freely and not for reasons of medical necessity in the narrow sense of the word. In some
countries the courts have been hesitant to accept a distinction between elective and
therapeutic or non-elective procedures, as all operations are elective in the sense that the
patient always has a choice whether or not to undergo the procedure. What these courts
have not taken into consideration, is the fact that there is a very real distinction between
situations where the patient has very little choice about undergoing the procedure, as the
treatment is indicated as the best or only option, and situations where the patient can
comparatively afford not to undergo the procedure. This standpoint was expressed quite
elocutently by McCarthy J, in the Irish case of *Walsh v Family Planning Services Ltd*, when
he held that:

> All surgery, in a sense, is elective although the election may have to be implied
> from the circumstances rather than determined as express… A patient’s condition
> may be such as to demand surgical intervention as the only hope for survival.
> Such may be called non-elective surgery. The patient given the choice between
> enduring pain and having limb replacement surgery or fusion surgery may
> technically be electing as between pain and the surgery but the election may be

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653 Atiyeh et al 2008 *Aesth Plast Surg* 830.
655 *Sidaway v Bethlem Royal Hospital Governors* 1985 1 ALL ER 643 (HL); *Gold v Haringey Health Authority* 1987 2 ALL ER 888 (CA).
more apparent than real. An extreme of elective surgery would be what is purely cosmetic—simply to improve the natural appearance rather than to remedy the physical results of injury or disease. Even it may have an element of quasi-medical care because of the psychological reaction of the patient to personal appearance. A like argument may be advanced in respect of contraceptive surgery, male or female. Such surgery does not have a direct effect on the health or wellbeing of the patient nor in prolongation of life; it may alleviate marital stress or other domestic pressure and in that sense be therapeutic. Essentially, however, it is for the improvement of the sex life of the couple concerned.656

Cosmetic surgery, as an example of elective surgery, is a treatment which comparatively the patient can afford not to undergo.657 Conventionally, a patient experiencing specific symptoms seeks help from a physician and the physician makes a subsequent diagnosis based on objective scientific knowledge.658 The diagnosis is followed by the performance of a suitable treatment, provided of course that the physician has obtained the patient’s informed consent to the administration of such treatment.659 Conversely, cosmetic surgery patients generally have no symptoms and therefore a resultant diagnosis is impossible.660 When performing cosmetic surgery, cosmetic surgeons are subjecting otherwise perfectly healthy individuals to medical risks, side effects and complications for benefits that are, arguably, non-medical.661 The treatment selection is determined, or at the very least guided, by the patient’s wishes.662 The patient chooses to have cosmetic surgery, rather than the surgery being an absolute necessity, therefore the decision whether or not to undergo surgery is a joint process.663 Communication between the cosmetic surgeon and the patient takes place on a different level, as the patient typically expects to relate more democratically with the

656 Walsh v Family Planning Services 1992 1 IR 496 517-8.
657 Healy 1998 MLJI 27.
659 Ibid.
661 Devereaux 163; Buyx 2008 Med Healthc Philos 134.
Positions of interaction are therefore uniquely different for both the patient as well as the cosmetic surgeon. In the case of therapeutic or non-elective operations, the patient is often reluctant to consent to surgery and must even be persuaded by the physician, whereas the cosmetic surgery patient requests the operation and sometimes actually talks the cosmetic surgeon into performing it. The cosmetic surgeon does not play a crucial role in determining the course of treatment and primarily acts as a source of information to the patient.

Furthermore, when aesthetics are involved, the success of the treatment is entirely dependent on the patient’s subjective opinion. More so than in the case of non-elective or therapeutic surgery, psychological factors are particularly relevant in the case of cosmetic surgery. The motivation for cosmetic surgery differs from therapeutic or non-elective surgery and is often overlooked by the cosmetic surgeon or disguised by the patient. The patient may appear to be very well adjusted, but it must be kept in mind that cosmetic procedures will always involve the patient's psyche. The cosmetic surgery patient has the luxury of indulging in his or her own personal whims, wishes and unrealistic expectations. The cosmetic surgeon must therefore be cognizant of underlying psychological manifestations and take into consideration that behind every request for cosmetic change, there is always the desire for an improved self-esteem.

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666 Wright & Wright “A Psychological Study of Patients Undergoing Cosmetic Surgery” 1975 Archives of Otolaryngology Head and Neck Surgery (Arch Otolarygol Head Neck Surg) 145.
670 Wright & Wright 1975 Arch Otolarygol Head Neck Surg 145.
Changes in the public’s attitude toward the physician's role are particularly prominent in cosmetic surgery, because of the differences between cosmetic surgery and other areas of medicine. We live in an era where physicians are seen as health providers and patients as health consumers within a larger health industry. According to Wright, technological advancements have widened the sphere of modern medicine, but it also tends to objectify medicine and mislead the public. An inherent danger is that medicine can be oversold and patients may unconsciously try to contract with their physicians for a product or have unrealistic expectations of success. Then, when the patients find that despite the wonders of modern medicine they cannot buy miracles, they may still want to see the physician as an all-knowing healer. Modern-day physicians, particularly cosmetic surgeons, therefore find themselves confronted with patients who apparently understand the capabilities of modern medicine and who want to have more say in the physician-patient relationship, yet they do not want to abandon the traditional concept of the physician's role.

Cosmetic surgeons, more so than any other medical specialists, also face inherent conflicts of interests, as performing cosmetic surgery and other cosmetic procedures is a lucrative venture, particularly as it’s often a market of repeat customers. To some extent all physicians face a variation of this problem, namely that their livelihoods depend on performing the interventions they recommend. However, economic self-interest is far less blatant when a general surgeon insists that a sick patient have an appendectomy, even if he or she stands to profit from the procedure, as opposed to when a cosmetic surgeon suggests a patient undergo some extra liposuction along with their abdominoplasty or a chin augmentation along with their rhinoplasty.

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673 Wright 1980 Arch Otolarygol Head Neck Surg 466.
674 Ibid.
675 Wright 1980 Arch Otolarygol Head Neck Surg 466; Bordo 28.
676 Wright 1980 Arch Otolarygol Head Neck Surg 466.
679 Ibid.
Due to these differences between cosmetic surgery and conventionally therapeutic or non-elective surgery, this study will suggest some practical guidelines that might prevent ethically suspect behaviour on the part of the cosmetic surgeon. This behaviour relates to three aspects, namely: unethical advertising, informed consent (particularly concerning the physician’s duty of disclosure) and patient selection.

5.2 Unethical Advertising

The relationship between a patient and his or her cosmetic surgeon resembles a commercial contract and the cosmetic surgery market follows the standard laws of economics.680 This is partly due to the fact that consumers pay for cosmetic surgery directly.681 As cosmetic procedures are elective and are not covered by health insurance, the cosmetic surgery market is marked by consumer sovereignty, stiff competition and aggressive advertising by cosmetic surgeons.682 Cosmetic surgeons face major competition from existing providers of cosmetic surgery, including fellow surgeons and members of other specialities offering the same type of service.683 Patients therefore have increasing bargaining power over cosmetic surgeons, because they are becoming more sensitive to prices and are willing to shop around for surgeons based on prices.684 Furthermore, non-surgical substitutes offered by aesthetic medical practitioners or mere cosmetologists are becoming increasingly popular.685 Cosmetic surgeons need to remain competitive; as a result their livelihoods depend on advertising.686

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685 Atiyeh et al 2008 Aesth Plast Surg 833.
Medical ethics traditionally prohibited advertising by physicians.\(^{687}\) This traditional prohibition was probably due to some concern for the status of the profession. Advertising was considered to be beneath the dignity of physicians as learned professionals distinct from mere tradesmen.\(^{688}\) This is no longer the case and medical advertising is permitted, provided that the advertisements are not “unprofessional, untruthful, deceptive or misleading or causes consumers unwarranted anxiety that they may be suffering from any health condition”.\(^{689}\)

Despite the fact that medical advertising is legal, it is certainly not ethically unproblematic and there are moral boundaries that should not be crossed.\(^{690}\) Demand-stimulating advertising is ethically suspect, as these advertisements put cosmetic surgeons in the position of selling non-medically indicated invasive procedures to potentially vulnerable individuals.\(^{691}\)

Patients experience subtle, but undue influence in the form of demand stimulating advertising by cosmetic surgeons.\(^{692}\) This might result in the performance of multiple elective procedures that put healthy patients at physical risk. In this regard, some cosmetic surgeons tend to promote their own commercial interests over the patient’s best interest. The increased use of mainstream advertising techniques such as price information and promotional tactics in cosmetic surgery may also adversely affect the reputation of the medical profession and compromise professional integrity.\(^{693}\)

Furthermore, cosmetic surgery is far more dangerous than other consumer product categories which employ mainstream advertising techniques.\(^{694}\)

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\(^{687}\) Miller et al 2000 Camb Q Healthc Ethics 355; Panfilov & Larkin 9; Atiyeh et al 2008 Aesth Plast Surg 834.  
\(^{688}\) Miller et al 2000 Camb Q Healthc Ethics 355.  
\(^{689}\) S 3(1) of schedule 1 of the Ethical and Professional Rules of the Health Professions Council of South Africa.  
\(^{690}\) Atiyeh et al 2008 Aesth Plast Surg 834.  
\(^{692}\) Hennink-Kaminski & Reichert 2011 Sexuality and Culture 42; Sullivan 114.  
\(^{693}\) Miller et al 2000 Camb Q Healthc Ethics 360; Hennink-Kaminski & Reichert 2011 Sexuality and Culture 42.  
\(^{694}\) Hennink-Kaminski & Reichert 2011 Sexuality and Culture 42.
The use of sexual appeals and sexual content is another example of how cosmetic surgeons are employing questionable commercial marketing techniques to sell surgery.\textsuperscript{695} Such advertisements intensify the existing controversy surrounding cosmetic surgery marketing, further compromising perceptions of the medical profession, as it juxtaposes the lowermost common denominator of marketing, namely that sex sells, with markers of professional competence.\textsuperscript{696} Cosmetic surgery advertising often plays upon the layperson’s insecurities and emotional susceptibilities whilst minimising or completely omitting the fact that cosmetic procedures are every bit as risky as other medically indicated procedures.\textsuperscript{697} Using nudity and other sexual appeals in advertising to sell cosmetic surgery certainly plays upon the consumer’s fears and anxieties, as cosmetic surgery is often performed to enhance physical attractiveness with mate attraction as the ultimate goal.\textsuperscript{698} For the same reasons that sexual appeals are used to sell commercial products, sex-related outcomes can therefore also be used to promote cosmetic surgery.\textsuperscript{699} The vulnerability of cosmetic surgery patients as well as the imbalance of power and knowledge between cosmetic surgeons and patients necessitate that cosmetic surgery advertising be approached with caution.\textsuperscript{700} Mainstream advertising techniques not only erode trust in the physician-patient relationship, it also wears away at the public’s confidence in the medical profession.\textsuperscript{701} That being said, medical advertising, provided that it is ethical, might be beneficial if it educates the public, empowers patients to take ownership of their healthcare decisions and leads to an increase in the productivity of physician patient encounters.\textsuperscript{702}

\begin{itemize}
\item \textsuperscript{695} Miller \textit{et al} 2000 \textit{Camb Q Healthc Ethics} 360; Hennink-Kaminski & Reichert 2011 \textit{Sexuality and Culture} 42.
\item \textsuperscript{696} \textit{Ibid}.
\item \textsuperscript{697} Adeoye & Bozic “Direct to Consumer Advertising in Healthcare: History, Benefits and Concerns” 2007 \textit{Clinical Orthopaedic and Related Research (CORR)} 98; Atiyeh \textit{et al} 2008 \textit{Aesth Plast Surg} 835.
\item \textsuperscript{698} Sarwer \textit{et al} 1998 \textit{Clin Psychol Rev} 2; Hennink-Kaminski & Reichert 2011 \textit{Sexuality and Culture} 45.
\item \textsuperscript{699} Hennink-Kaminski & Reichert 2011 \textit{Sexuality and Culture} 45.
\item \textsuperscript{700} Miller \textit{et al} 2000 \textit{Camb Q Healthc Ethics} 355.
\item \textsuperscript{701} Devereaux 170.
\item \textsuperscript{702} Adeoye & Bozic 2007 \textit{CORR} 97; Atiyeh \textit{et al} 2008 \textit{Aesth Plast Surg} 834.
\end{itemize}
5.2.1 Unethical Advertising and the Consumer Protection Act 68 of 2008

The Consumer Protection Act\(^{703}\) has a significant influence on medical marketing\(^{704}\) or advertising, as the CPA regulates marketing activities related to goods and services.\(^{705}\) Service refers to work performed by a person for the direct or indirect benefit of another, including the provision of information, advice or consultation.\(^{706}\) A consultation with a physician or performance of a surgical intervention could therefore be understood as a service in terms of the CPA.\(^{707}\) As a purchaser of goods and services, a patient qualifies as a consumer in terms of the CPA.\(^{708}\) As the CPA is applicable to patients they have, \textit{inter alia}, a right to fair and reasonable marketing, fair and honest dealing and disclosure and information under the Act.\(^{709}\) In terms of the CPA, service providers are prohibited from marketing goods and services in a manner that is misleading, fraudulent, or deceptive, in respect of the nature thereof, conditions of supply, price, or any other material aspect.\(^{710}\) Physicians should neither verbally, nor through their conduct, directly or indirectly express or imply, false, misleading, or deceptive representations concerning any material fact of the service to be rendered, or the goods to be supplied.\(^{711}\) The use of exaggeration, innuendo and ambiguity, in respect of a

704 In terms of s 1 the Consumer Protection Act, advertisement means “any direct or indirect visual or oral communication transmitted by any medium, or any representation or reference written, inscribed, recorded, encoded upon or embedded within any medium, by means of which a person seeks to-
(a) bring to the attention of all or part of the public-
(i) the existence or identity of a supplier; or
(ii) the existence, nature, availability, properties, advantages or uses of any goods or services that are available for supply, or the conditions on, or prices at, which any goods or services are available for supply;
(b) promote the supply of any goods or services; or
(c) promote any cause.”
material fact, must be avoided too.\textsuperscript{712} This would include a misrepresentation about a physician’s status, for example, that a practitioner is a board certified cosmetic surgeon when this is not true. It would also include a failure to correct any misunderstanding on the part of the patient, for example, regarding the benefits of a cosmetic procedure. Failure to disclose material facts such as possible risks and complications would also constitute a contravention of this section.\textsuperscript{713} When recommending treatment, cosmetic surgeons should therefore take specific care to ensure that all material facts are disclosed.\textsuperscript{714} It will be argued below, that in the case of cosmetic surgery, material facts likely include all possible risks and complications, even very remote ones. The cosmetic surgery patient, like any other consumer, also has the right to restrict unwanted direct marketing.\textsuperscript{715} A cosmetic surgeon therefore needs to offer recipients of his or her electronic marketing the option to opt out or unsubscribe and he or she must record the fact that the particular patient does not wish to receive printed marketing material.\textsuperscript{716} When distributing promotional material, cosmetic surgeons will need to check whether any of their patients have registered a recording on a national registry prohibiting unwanted direct marketing, otherwise known as a pre-emptive block.\textsuperscript{717}

An agreement to undergo cosmetic surgery to some extent resembles a consumer contract and consumerist language is often used in discussions about cosmetic surgery, however cosmetic surgeons have to remain aware of the fact that the agreement to undergo cosmetic surgery is not a mere consumer contract.\textsuperscript{718} The contractual model of human interactions based on consumer satisfaction might be suitable for business, but not for cosmetic surgery. Unlike most consumer relationships, cosmetic surgery involves an asymmetrical relationship of

\textsuperscript{712} S 41(1)(b) of the Consumer Protection Act 68 of 2008.
\textsuperscript{713} Van den Berg 2011 \textit{SAFPJ} 598.
\textsuperscript{714} Ibid.
\textsuperscript{715} S 32 of the Consumer Protection Act 68 of 2008.
\textsuperscript{716} Van den Berg 2011 \textit{SAFPJ} 597.
\textsuperscript{717} Ibid.
\textsuperscript{718} Examples of the similarities between a consumer contract and cosmetic surgery are the use of advertising in cosmetic surgery, the emphasis on the subjective preferences and wishes of the patient and the increasingly blurred distinction between consumers and patients.
power and carries an inherent risk of morbidity and other serious health risks.\(^{719}\) To be a good physician requires a life-long commitment to sound professional and ethical practices and an overriding dedication to the best interests of one’s patients.\(^{720}\) Physicians must be acutely aware of the tension between consumer-orientated commercial practices and traditional medical ethics “as defined by a tradition reaching back to Hippocrates”.\(^{721}\) They must keep in mind that patient autonomy is not synonymous with consumer sovereignty, as informed consent is a prerequisite to ethical medical treatment.\(^{722}\) The Hippocratic Oath calls for physicians to apply their skill according to their ability and judgement, not just their technical skill, and to protect patients from harm and injustice, not just from unfair business practices.\(^{723}\) If medicine loses sight of these ethical standards it risks losing its traditional status as a profession.\(^{724}\) Physicians must keep in mind that the practice of health care will essentially always be a moral enterprise and that being a physician is all that a cosmetic surgeon should ever be.\(^{725}\) Members of the medical profession, particularly those involved with the practice of cosmetic surgery, should take steps to restrict the unethical marketing of invasive, elective or non-therapeutic procedures.\(^{726}\) Furthermore, leaders of the medical profession involved with the practice of cosmetic surgery should encourage attention to professional ethics in the context of specialty training of cosmetic surgeons.\(^{727}\) Cosmetic surgery advertising says as much about the surgeon as it does about his or her product.

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\(^{721}\) Devereaux 170.


\(^{723}\) Ringel 1998 Arch Derm 430.

\(^{724}\) Devereaux 164.


\(^{726}\) Miller \textit{et al} 2000 Camb Q Healthcare Ethics 363.

\(^{727}\) \textit{Ibid.}\[113]
question is no longer “Should cosmetic surgeons advertise?”, but rather “When cosmetic surgeons advertise, what are they telling the public about themselves?”

5 3 Broader Duty of Disclosure

There are certain unique considerations regarding informed consent in cosmetic surgery. Currently, the nature and scope of the information that must be disclosed by a physician is set out in section six of the National Health Act. The physician must give the patient a general idea, in broad terms and in layperson’s language, of the nature, scope, consequences, risks, dangers, complications, benefits and disadvantages and prognosis of, and also the alternatives to the proposed intervention, as well as the patient’s right to refuse treatment. Referring to the current legal position, Carstens and Pearmain state that all material and usual risks should be disclosed. However, there is no need to disclose unusual or remote risks, unless they are serious or typical, respectively, or the patient makes enquiries about them. In terms of the test of disclosure as set forth in Castell v De Greef, a risk is material if, under the circumstances of the specific case, a reasonable person in the patient’s position, if warned of the risk, would probably attach significance to it; or the physician is or should reasonably be aware that the particular patient, if warned of the risk, would probably attach significance to it.

729 S 6 of the National Health Act 61 of 2003 states the following:
User to have full knowledge
(1) Every health care provider must inform a user of
(a) the user’s health status except in circumstances where there is substantial evidence that the disclosure of the user’s health status would be contrary to the best interests of the user;
(b) the range of diagnostic procedures and treatment options generally available to the user;
(c) the benefits, risks, costs and consequences generally associated with each option; and
(d) the user’s right to refuse health services and explain the implications, risks, obligations of such refusal.
730 Carstens & Pearmain 885; Wear 257.
731 Carstens & Pearmain 885.
732 Ibid.
733 Castell v De Greef 81.
To give effect to the second leg of the test as set forth in *Castell v De Greef*, the particular patient’s circumstances will have to be considered. It is unlikely that a physician will always be aware of such personal idiosyncratic circumstances, therefore it would be reasonable to expect the physician to make thorough inquiries.734 In terms of the second leg of the test, one might ask whether a cosmetic surgeon should reasonably be aware of the fact that cosmetic surgery patients are likely to attach significance to all risks, even remote and unusual ones. There are no medical indications for cosmetic surgery. This could mean that the scope of risk information provided to the cosmetic surgery patient must be wider as there is no obvious medical reason for the patient to run those risks.735 Giesen is of the opinion that it is necessary to disclose even remote risks in the case of purely elective procedures that carry no inherent therapeutic benefit.736 He specifically states that very rigorous disclosure standards should be imposed in the case of purely cosmetic procedures.737 According to Giesen, the maxim applicable in such cases reads as follows:

A comprehensive and even detailed explanation of the possible consequences and risks (including less frequent or rare risks) of the proposed procedure is all the more indicated and indispensable the less urgent the treatment or operation seems to be and the more likely it would seem that this particular patient, if properly informed, might, even with regard to a rare risk, decide to forego the procedure rather than to submit to it.738

In the light of new medical technologies, it is unlikely that standard informed consent procedures still adequately serve their original intention. Medical treatments were far simpler and there were far fewer elective procedures when the doctrine of informed consent was developed.739 Perhaps informed consent should be contextualised by creating different categories of informed consent for different procedures.740 It cannot be argued that more stringent disclosure requirements in the case of purely elective procedures would place

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734 Thomas 2007 *SALJ* 191.
736 Giesen 107.
737 Ibid.
738 Id 333.
740 Id 602.
unnecessary pressure on an already overburdened medical profession. Purely elective procedures, cosmetic surgery in particular, form only a very small part of medical practice. One might ask whether physicians could reasonably be expected to place medical treatments into legalistic categories in advance of every instance of disclosure.\textsuperscript{741} The answer is yes, physicians are perfectly capable of understanding the law. In the case of cosmetic surgery, one could safely assume that most, if not all, cosmetic procedures are essentially elective even if they do contain some element of therapeutic benefit. Moreover, the distinction between elective and therapeutic procedures is a medical or contextual distinction; it is not inherently legalistic at all.\textsuperscript{742} Physicians will always hold the authority to determine whether and to what extent their patient’s wish to undergo a particular surgery contains a medical component, but the extent to which the surgery is therapeutic or purely elective will be formed based upon an analysis of the facts which should be readily known to a physician after a basic consultation with his or her patient.\textsuperscript{743} The fact that the elective-therapeutic distinction will usually not be clearly evident actually strengthens the case for requiring cosmetic surgeons to discover what their patients anticipate and hope for, especially where it is possible that the patient can afford to not undergo the surgery.

Cosmetic surgeons tend to provide patients with only a limited amount of information on the risks involved. A very detailed account of the risks involved is considered to be redundant, as patients are thought to be frightened unnecessarily by such accounts.\textsuperscript{744} This state of affairs is unacceptable. It is not conducive to the attainment of proper informed consent. Furthermore, it is paternalistic, as cosmetic surgeons consider patients to be in need of information only up to the point that they feel reassured about a procedure’s safety. It suggests that a decision about safety has been made prior to the informed consent process and that patients are only informed about the outcome of that decision, which is that the procedure is safe.\textsuperscript{745} Withholding information that might scare a patient cannot be justified on the basis of non-maleficence, as cosmetic surgery isn’t medically necessary. If a patient decides to forego the cosmetic procedure after hearing comprehensive explanation of possible

\textsuperscript{741} Healy 1998 \textit{MLJI} 28.
\textsuperscript{742} \textit{Ibid.}
\textsuperscript{743} Healy 1998 \textit{MLJI} 28; Pitts-Taylor 153.
\textsuperscript{744} Fraser 2003 \textit{AFS} 34; Panfilov & Larkin 6; Grimm 2007 \textit{NMLR} 39.
\textsuperscript{745} Fraser 2003 \textit{AFS} 34.
risks, it won’t do any harm to his or her health. Cosmetic surgery might have both psychological and functional benefits for the patient, but it is not an essential operation in the sense that it treats a life threatening condition. The patient must therefore be very clear in his or her own mind that he or she truly understands the possible complications and that the benefits outweigh the risks of the operation.  

Furthermore, several studies have shown that providing the patient with additional information concerning the purpose and effects of an operation might actually have a positive therapeutic effect. Patients who were comprehensively informed concerning the nature, risks and benefits of a procedure have been shown to be less anxious before and after the operation, have less pain, use fewer post-operative medications and recover faster than patients who received only routine care during the process of informed consent. It is also in the cosmetic surgeon’s best interest adopt a broad duty of disclosure and to spend quality time obtaining informed consent. When complications do occur, a patient is less likely to take legal action against the cosmetic surgeon if they feel that he or she had made every effort to inform them of all the possible risks and felt that he or she had been honest, conscientious, concerned and thorough. Furthermore, despite the lack of data available on the medical and psychological impact of a good rapport between patient and cosmetic surgeon, at least one study has found a significant link between the surgeon’s emotional reaction to the patient and the postoperative course.

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748 Ibid.
531 Broader Duty of Disclosure: the Canadian Position

The Canadian position on informed consent for elective procedures is of significant importance to the present discussion. The general rule concerning informed consent was formulated and refined by the Supreme Court of Canada in 1980 in the landmark case of *Reibl v Hughes*.\(^{751}\) In this case, the court had to decide whether a patient had given proper informed consent to a carotid endarterectomy procedure that had left him paralyzed at the one side of his body.\(^{752}\) *Reibl v Hughes* was a landmark case, as it clearly rejected the old, paternalistic standard of disclosure (the reasonable physician standard) and replaced it with a new, more patient-centred approach (the reasonable patient standard).\(^{753}\) The court held that a physician has a duty to disclose all material risks associated with a procedure. Material risks are those risks which the physician knows or ought to know a reasonable person in the patient’s position would consider relevant.\(^{754}\) These are risks which either frequently materialise or risks which have very serious consequences when they do materialise.\(^{755}\) It is now well established in Canadian law that the duty of disclosure is not confined to risks, but extends to all material information that a reasonable person in the patient’s position would consider relevant.\(^{756}\) In particular, the patient must be informed of any available alternatives to the proposed treatment, as well as the material risks associated with the alternative treatments.\(^{757}\) Furthermore, if the physician knows or should know that the particular patient deems some unique fact relevant to the decision whether or not to undergo the prescribed treatment, the physician must disclose that fact as well.\(^{758}\) In order to determine what a patient might deem relevant, the physician must consider the physical, mental and socio-economic status of the patient.\(^{759}\) In *Zamparo v Brisson*, the court held

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\(^{751}\) *Reibl v Hughes* 1980 14 CCLT 1 (SCC).


\(^{753}\) *Ibid*.


\(^{755}\) *Ibid* 179.


\(^{757}\) *Ibid*.

\(^{758}\) *Reibl v Hughes*.

\(^{759}\) Ferguson 1984 *Adv Q* 180. In this regard, see par 3.1.4 of the HPCSA’s “Guidelines for Good Practice in the Health Care Professions, Seeking Patient’s Informed Consent: The Ethical Considerations” which states that: “When providing information, health care practitioners must do their best to find out about patients’ individual needs and priorities. For example, patients’ beliefs, culture, occupation or other factors may have a
that if the physician is not that well acquainted with a particular patient he or she must give
the patient advice based on the presumption that the patient is an ordinary or average
person.760 Thereafter, the physician must ask the patient whether there are any special facts
that might distinguish the patient from an ordinary or average person.761 The patient may
then add facts which remove him from the average class and provide the physician with
additional information upon which to base his or her recommendation.762

Canadian medical law is unique in the sense that several cases have stated that different rules
apply to elective interventions. Although Canadian courts initially characterized cosmetic
surgery as therapeutic, on the basis that it is psychologically beneficial, this approach is no
longer followed.763 In many cases the cosmetic surgery involved did not hold any therapeutic
benefits, but courts felt compelled to identify it as such, as it was thought that all non-
therapeutic surgical interventions were illegal.764 The term “elective procedures” is used by
Canadian courts to refer to medical procedures of which any therapeutic benefits are
secondary.765 It can safely be said that cosmetic surgery has now been categorised as an
elective procedure by the Canadian courts.766 In terms of Canadian law, the fact that a
procedure is not medically required, but merely elective, must be brought to the attention of

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760 Zamparo v Brisson 1981 16 CCLT 66 (Ont CA).
761 Ferguson 1984 Adv Q 180.
762 Ibid.
763 Somerville “Medical Interventions and the Criminal Law: Lawful or Excusable Wounding” 1980 McGill
(MLJ) 765.
764 Somerville 1980 MLJ 82.
765 Picard Legal Liability of Doctors and Hospitals in Canada (1984) 91; Hajgato v London Health Association
1982 36 OR2d  669 (Ont HC) 680.
766 Picard 91; LaFleur v Cornelis 1980 28 NBR 2d 569; White v Turner 1981 15 CCLT 81 (Ont CA); Mac
Donald v Ross 1983 24 CCLT 242 (NS SC TD); Guertin v Kester 1981 20 CCLT 225 BCSC; Hankins v
Papillon 1980 14 CCLT 198 (Que SC).
the patient, as he or she might choose to postpone or forego the treatment. As far as the scope of disclosure in the case of an elective procedure is concerned, the court in White v Turner, a leading case on this subject, held that when an operation is elective, “even minimal risks must be disclosed to patients”. According to the court, this statement rings even more true if the predominant aim of the surgery is a cosmetic one. In Hankins v Papillon it was held that:

In the cases of plastic surgery, however, where the decision to be made by the patient is more subjective and personal than therapeutic, I believe the doctor has a duty to be especially careful to disclose completely all the risks, and certainly, any special risks, as well as the consequences for the patient should such risks materialise. In matters of this kind, there is normally no urgency, the relevant problems can be explained to the patient, and the patient can weigh the medical risks against his own non–medical desires and priorities. Since there is no therapeutic need for the operation, a patient might well decide that he would prefer to live with a blemish rather than take the risk. In White v Turner Mr Justice Linden described “unusual or special risks” as follows:

As for ‘unusual or special risks’, these are those risks that are not ordinary, common, everyday matters. These are risks that are somewhat extraordinary, uncommon and not encountered every day, but they are known to occur occasionally. Though rare occurrences, because of their unusual or special character, the Supreme Court has declared that they should be described to a reasonable patient, even though they may not be ‘material’. There may, of course, be an overlap between ‘material risks’ and ‘unusual and special risks’. If such a special or unusual risk is quite dangerous and fairly frequently encountered, it could be classified as a material risk. But even if it is not very dangerous or common, an unusual or special risk must be disclosed.
With reference to cosmetic surgery of the breast, Mr Justice Linden held that the possibility of scars opening up and requiring further surgery and the risk of keloid scarring were “special and unusual risks” that should have been disclosed.\(^{773}\) He also found that the possibility of imperfect breast shape, asymmetry of the breasts, stretch marks and scars were material risks that should have been disclosed.\(^{774}\) Mr Justice Linden further held that where an operation is elective, as it was in that particular case, even minimal risks must be disclosed to the patient.\(^{775}\) \textit{A fortiori}, in a case where the predominant aim is a cosmetic one, possible risks affecting the appearance of the breast should be classified as material.\(^{776}\) In \textit{Videto v Kennedy} the court, referring to a case of an elective laparoscopic sterilisation, held that the fact that an operation is elective means that it need never have been performed in the first place.\(^{777}\) The court conceded that whilst it may be unnecessary or even a harmful to warn the patient of minimal or rare risks in the case of an operation that is medically necessary, the frequency of the risk becomes irrelevant when the particular operation is unnecessary for the patient’s medical welfare.\(^{778}\) The trial judge in \textit{Videto v Kennedy} held that even minimal risks (three chances in a thousand) should be disclosed.\(^{779}\) In \textit{La Fleur v Cornelis}\(^{780}\), the defendant cosmetic surgeon performed a rhinoplasty on the plaintiff, an attractive young woman who wanted to reduce the size of her nose. He failed to inform her about the 10 percent risk of scarring. The surgery left a scar and indentation on the plaintiff’s nose which could not be removed by further surgery. Despite the fact that the scar was noticeable, the results were not monstrous and the plaintiff remained attractive. Regardless, the plaintiff sued the defendant, alleging negligence based, \textit{inter alia}, on the fact that he had failed to inform her of the risks involved. The court held that when a physician performs surgery on an otherwise healthy body for cosmetic purposes only, a very high degree of risk disclosure is required, because the procedure is not medically necessary and the results plainly visible.\(^{781}\) There is also Canadian authority that requires a physician to disclose and explain alternative methods or

\(^{773}\) Picard 95.

\(^{774}\) \textit{Ibid}.

\(^{775}\) White \textit{v Turner} 103.

\(^{776}\) \textit{Ibid}.

\(^{777}\) \textit{Videto v Kennedy} 1981 17 DLR 307 (Ont HC).

\(^{778}\) \textit{Ibid}.

\(^{779}\) Ferguson 1984 \textit{Adv Q} 181.

\(^{780}\) \textit{La Fleur v Cornelis}.

\(^{781}\) Picard 499.
techniques to a patient who wants to get sterilised. Some argue that this rule can be generalised to apply to all elective procedures. Canadian law seemingly acknowledges the fact that a cosmetic surgery patient is usually very eager to proceed with the procedure prior to consulting with the physician. The physician needs to temper the patient’s enthusiasm with a sobering conversation about all the possible risks and complications. Even though a physician is required to inform the patient of the elective nature of the procedure, it has been held that a physician does not have an obligation to advise the patient whether or not to have the surgery. The physician must therefore provide the patient with all the relevant information, but ultimately it is for the patient to decide whether or not to undergo the surgery.

5.4 Additional Practical Guidelines Concerning the Procurement of Informed Consent

Besides adopting a broader duty of disclosure, this study will suggest a few additional guidelines for obtaining proper informed consent in the case of elective surgery, specifically cosmetic surgery. The informed consent should preferably be obtained by the cosmetic surgeon him- or herself, as it is advisable that the person obtaining the informed consent should be capable of performing the procedure themselves. At the very least, the person should have received specialist training in advising patients about the particular procedure.

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782 Zimmer v Ringrose 1981 16 CCLT 51 (Alta CA) 60.
783 Picard 93; Sunne v Shaw 1981 CS 609 (Que SC).
785 Ibid.
786 Zamparo v Brisson.
787 Picard & Robertson 126.
789 Anderson & Wearne 2007 JRSM 97. In this regard, par 5.1 of the HPCSA’s “Guidelines for Good Practice in the Health Care Professions, Seeking Patient’s Informed Consent: The Ethical Considerations” states that: “A health care practitioner providing treatment or undertaking an investigation, has the responsibility to discuss it with the patient and obtain consent, as the practitioner will have a comprehensive understanding of the procedure or treatment, how it is to be carried out, and the risks attached to it. Where this is not practicable, health care practitioners may delegate these tasks provided they ensure that the person to whom they delegate: 5.1.1 Is suitably educated, trained and qualified;
Having a nurse or another member of staff obtain informed consent from the patient is unlikely to ever be satisfactory, as they can neither perform the procedures themselves, nor do they have specialist training that will enable them to discuss specific and rare risks. Successful relationships between physicians and patients depend upon mutual trust. In the interest of maintaining the relationship of trust between a patient and physician, the surgeon should discuss the risks with patient in depth him- or herself. Furthermore, adjuncts such as printed pamphlets and photographs, no matter how detailed and complete, do not relieve the cosmetic surgeon of the obligation to personally obtain informed consent from the patient. Ideally the process of informed consent should consist of more than the mere exchange of information. It should be a process of shared decision-making. It could even be argued that the process of informed consent should, at least to some extent, be a therapeutic process during which the cosmetic surgeon helps the patient to establish a sense of control, develop realistic expectations and prepare emotionally for the surgery.

A patient must validly consent to a medical procedure. Consent will not be valid if it is obtained under duress. In practice, this will usually relate to the timing of the informed consent. If the consent is only obtained upon the day of the surgery, the patient may feel under duress to proceed with the operation, as all the arrangements have been made. A patient may develop doubts upon learning about the procedure in more detail, but will be unable to discuss these concerns with the cosmetic surgeon at length due to a lack of time. Consent that was obtained at an earlier date can and should be confirmed on the day of surgery, but it is not acceptable to fully obtain consent for the first time on the day of the surgery itself. It would be wiser to obtain informed consent during the initial consultation or even to schedule a second consultation prior to the surgery for the specific purpose of

5.1.2 Has sufficient knowledge of the proposed investigation or treatment and understands the risks involved; and
5.1.3 Acts in accordance with the guidance in this Booklet.”

793 Anderson & Wearne 2007 JRSM 97.
explaining the procedure once more and refreshing the patient’s memory as to the possible risks and complications. A patient is usually overwhelmed during an initial consultation and may therefore forget to ask certain questions or it may not even occur to them to ask questions at all. Furthermore, excited or nervous patients usually don’t recall or understand most of the information given to them by the cosmetic surgeon during an initial consultation. Studies on the extent to which information is forgotten by patients in a variety of medical settings indicate that patients do in fact forget information relevant to their particular treatment. Studies have further shown that patients do not only fail to recall information, but they also tend to understand less of the information presented to them than their physicians believe they have understood. It is therefore advisable that patients should go home after the initial consultation, reflect on the information given to them by their cosmetic surgeon, and then return with any additional concerns or questions. The cosmetic surgeon’s duty to obtain informed consent should not be regarded as a once-off duty. As circumstances may change, it is a continuing duty. If patients are unable to recall important aspects of the risks and benefits of surgery, then this continuing duty of informed consent remains unfulfilled. A second consultation is therefore advisable.

794 Nugent “Cosmetic Surgery on Patients with Body Dysmorphic Disorder: the Medical, Legal and Ethical Implications” <http://works.bepress.com/cgi/viewcontent.cgi?article=1004&context=Kristen_nugent> (accessed 14 February 2012); Panfilov & Larkin 19; Grimm 2007 NMLR 45.


798 Wallace 1986 Soc Sci Med 30; Grimm 2007 NMLR 40. In this regard, par 4.4.1 of the HPCSA’s “Guidelines for Good Practice in the Health Care Professions, Seeking Patient’s Informed Consent: The Ethical Considerations” states that: “Obtaining informed consent cannot be an isolated event. It involves a continuing dialogue between health care practitioners and their patients which keeps them abreast of changes in the condition of patients and the treatment or investigation the practitioners propose. Whenever possible, health care practitioners should discuss treatment options at a time when the patient is best able to understand and retain the information.” See also Medical Protection Society “Consent to Medical Treatment in South Africa: An MPS Guide”<http://www.medicalprotection.org/Default.aspx?DN=ff2225e6-3afa-47be-83b1-20182e96ed56> (accessed 30 January 2013).


800 Sykes “Managing the Psychological Aspects of Plastic Surgery Patients” 2009 Current Opinion in Otolaryngology and Head and Neck Surgery (Curr Opin Otolaryngol Head Neck Surg) 323; Nugent “Cosmetic
absence of any evidence of coercion or deception, a signed informed consent form generally raises a strong presumption that the cosmetic surgeon did in fact fulfil his or her duty of disclosure.801 However, even though informed consent forms delineate the risks and drawbacks of a procedure and require the patient to take the affirmative act of signing his or her name, patients often sign these forms either without reading them or without taking in its content.802 A second consultation during which the cosmetic surgeon can check the patient’s comprehension of the meaning of the forms is therefore one more way in which a cosmetic surgeon can further ensure adequate patient understanding. Such a policy does not only demonstrate the cosmetic surgeon’s commitment to obtaining the patient’s subjective informed consent, as opposed to simply discharging a legal duty in the most convenient way possible, but it also gives him or her an opportunity to observe the patient a second time for any symptoms of body dysmorphic disorder.803 A second consultation provides the cosmetic surgeon with the opportunity to properly analyse possible areas of psychological concern.804 Screening patients for purposes of patient selection is pivotal in the case of cosmetic surgery as will be elaborated upon and explained below.

801 Nugent “Cosmetic Surgery on Patients with Body Dysmorphic Disorder: the Medical, Legal and Ethical Implications” <http://works.bepress.com/cgi/viewcontent.cgi?article=1004&context=Kristen_nugent> (accessed 14 February 2012). In this regard, the HPCSA’s “Guidelines for Good Practice in the Health Care Professions, Seeking Patient’s Informed Consent: The Ethical Considerations” states that physicians should: “Allow patients sufficient time to reflect, before and after making a decision, especially where the information is complex or the severity of the risks is great. Where patients have difficulty understanding information, or there is a lot of information to absorb, it may be appropriate to provide it in manageable amounts, with appropriate written or other back-up material, over a period of time, or to repeat it.” See also Medical Protection Society “Consent to Medical Treatment in South Africa: An MPS Guide” <http://www.medicalprotection.org/Default.aspx?DN=ff2225e6-3afa-47be-83b1-20182e96ed56> (accessed 30 January 2013).


803 Nugent “Cosmetic Surgery on Patients with Body Dysmorphic Disorder: the Medical, Legal and Ethical Implications” <http://works.bepress.com/cgi/viewcontent.cgi?article=1004&context=Kristen_nugent> (accessed 14 February 2012).

5.5 Patient Selection

There are unique challenges regarding cosmetic surgery patient selection. Considering the large numbers of individuals who choose to undergo cosmetic surgery, it is probable that all of the major psychiatric diagnoses occur in this population. However, certain disorders, particularly those with a body image component, may be more prevalent in cosmetic surgery patients and may contraindicate surgery. Furthermore, studies have shown there to be a strong correlation between preoperative psychological problems and adverse postoperative effects such as depression, general unhappiness with the surgical results, suicidal thoughts, feelings of anger and resentment toward the cosmetic surgeon and the onset of psychotic episodes. Studies have shown that factors such as youthfulness, unrealistic expectations, previous unsatisfactory cosmetic surgery, a disproportionate concern over a minimal deformity, motivation based on relationship issues and a history of depression, anxiety, body dysmorphic disorder, thought disorders and eating disorders are all associated with poor psychological outcomes. If surgery does not prove to be a solution to these problems, these types of patients might have severe adjustment traumas when they come to the realisation that their difficulties were caused by factors other than their physical appearance. When psychological problems are blamed solely on a cosmetic deficiency, removal of the deficiency may actually increase the severity of the problem and the cosmetic

809 Holder 1972 JAMA 1102.
surgeon risks feeding the patient’s pathology and violating the ethical principle of non-maleficence. An emotional reaction such as this may lead to allegations that the cosmetic surgeon, not the patient, was at fault. These patients are generally hard to please and can become litigation-minded quite easily. Cosmetic surgeons are taught how to and when to operate, but being taught when not to operate is often discounted. The challenge that cosmetic surgeons face is how to identify, prior to surgical intervention, those patients who may have a poor result in terms of psychological adjustment and psychosocial functioning in spite of a technically acceptable result. As “appearance is so laminated to psychological cohesion” and because psychological factors are at the root of most requests for cosmetic surgery it is submitted that a legal duty on the part of the cosmetic surgeon to remain sensitive to widely recognised dangerous symptomology should exist. Cosmetic surgeons could only benefit from being acutely aware of the psychological undercurrents and possible psychiatric disorders such as body dysmorphic disorder, unrealistic expectations or heightened narcissism not remediable with surgery. The success of a physician-patient relationship is based on good communication. Cosmetic surgeons, more so than most other specialists, need to be careful listeners with clinical acumen that extends beyond the typical borders of medical illness.

810 Holder 1972 JAMA 1102; Cantor 2005 Semin Cutan Med Surg 159.
811 Holder 1972 JAMA 1102.
812 Holder 1972 JAMA 1102; Nugent “Cosmetic Surgery on Patients with Body Dysmorphic Disorder: the Medical, Legal and Ethical Implications” <http://works.bepress.com/cgi/viewcontent.cgi?article=1004&context=Kristen_nugent> (accessed 14 February 2012); Carstens & Pearmain 708.
5 5 1 The Psychiatric or Psychological Evaluation

It would of course be unreasonable to expect cosmetic surgeons to conduct extensive personality tests on their patients.\(^{819}\) An actual psychiatric or psychological evaluation is impractical as a routine screening process.\(^{820}\) Psychiatric or psychological evaluations are expensive, laborious and time-consuming.\(^{821}\) They certainly represent an astute patient selector, but besides being impractical, psychiatric or psychological evaluations could also be unreliable if employed by the untrained, inexperienced interviewer.\(^{822}\) A true psychiatric or psychological evaluation is also likely to put the real problem patients on their guards, as they will probably recognise what is going on and manipulate their way through the screening process.\(^{823}\) According to Wright and Wright, a simplified, fairly stereotyped counselling routine is needed.\(^{824}\) Such a routine would ideally encourage the patient to communicate forthrightly with his or her cosmetic surgeon and would safeguard even the less experienced cosmetic surgeons.\(^{825}\)

Issues pertaining to the perceived physical flaw itself should be addressed.\(^{826}\) Patients should articulate and describe their concern with their appearance in detail.\(^{827}\) They should be questioned about the length of time they have been concerned with the perceived deformity, the length of time they have been considering undergoing cosmetic surgery and the circumstances that occasioned the current consultation.\(^{828}\) The cosmetic surgeon must determine whether the patient has undergone any previous cosmetic procedures and whether the patient was satisfied with the results of those surgeries. A history of previous surgeries,

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821 Ibid.
822 Wright & Wright 1975 *Arch Otolarygol Head Neck Surg* 150.
824 Wright & Wright 1975 *Arch Otolarygol Head Neck Surg* 150.
825 Ibid.
826 Honigman *et al* 2004 *PRS* 1235.
827 Pruzinsky “Psychological Factors in Cosmetic Plastic Surgery: Recent Developments in Patient Care” 1993 *Plastic Surgical Nursing* (Plast Surg Nurs) 64; Honigman *et al* 2004 *PRS* 1235; Panfilov & Larkin 12.
828 Honigman *et al* 2004 *PRS* 1235.
performed by different cosmetic surgeons, particularly if the patient was dissatisfied with most or all of these procedures, is reason for concern.\textsuperscript{829} Any history of legal proceedings or apparent hostility toward previous cosmetic surgeons should also raise major concern.\textsuperscript{830} Unrealistic expectations and improper motivations regarding the outcome of the procedure have also been shown to predict a poor psychological outcome.\textsuperscript{831} The cosmetic surgeon should therefore assess the patient’s expectations of both the proposed procedure and the desired outcome in cosmetic and personal terms.\textsuperscript{832} The patient should be questioned in order to determine exactly what he or she desires, the realism of his or her expectations and his or her ability to accept imperfect results.\textsuperscript{833} A distinction should be made between expectations regarding an improved self (for example an improved self-esteem) and expectations regarding enhanced external parameters (for example ending social isolation or getting a promotion at work).\textsuperscript{834} Studies have shown the latter to be a reason for concern.\textsuperscript{835} If the patient thinks that cosmetic surgery will provide a solution to social or interpersonal problems, the cosmetic surgeon should be wary of performing the procedure.\textsuperscript{836} The cosmetic surgeon must carefully clarify what cosmetic surgery can and cannot accomplish.\textsuperscript{837} If a patient refuses to enter into a mutual contract of responsibility with the cosmetic surgeon or does not view the surgery realistically, he or she may become a problem patient.\textsuperscript{838} Simply asking a patient to state his or her motivation and expectations for the surgery may be insufficient. The mentally unstable patient may give misleading or inaccurate reasons for

\textsuperscript{830} Honigman et al 2004 \textit{PRS} 1235.
\textsuperscript{831} Pruzinsky 1993 \textit{Plast Surg Nurs} 64; Honigman et al 2004 \textit{PRS} 1235; Sykes 2009 \textit{Curr Opin Otolaryngol Head Neck Surg} 324; Panfilov & Larkin 12.
\textsuperscript{833} Reich 1975 \textit{PRS} 9; Simon 1978 \textit{Ariz L Rev} 682; Panfilov & Larkin 12.
\textsuperscript{835} Honigman et al 2004 \textit{PRS} 1235; Panfilov & Larkin 12.
\textsuperscript{836} Honigman et al 2004 \textit{PRS} 1235.
\textsuperscript{837} Wright & Wright 1975 \textit{Arch Otolaryngol Head Neck Surg} 150.
\textsuperscript{838} \textit{Id} 151.
wanting the surgery and conceal his or her true, unhealthy motivations.\footnote{Simon 1978 \textit{Ariz L Rev} 671.} The reality is that many patients are far too sophisticated to reveal their true, unhealthy motivations during a simple diagnostic examination.\footnote{Wright & Wright 1975 \textit{Arch Otolarygol Head Neck Surg} 146; Simon 1978 \textit{Ariz L Rev} 671.} However, the cosmetic surgeon might be able to spot dangerous symptomology by paying attention to a patient’s unrealistic responses to strategic questions.\footnote{Wright & Wright 1975 \textit{Arch Otolarygol Head Neck Surg} 148-50; Peterson & Topazian “Psychological Considerations in Corrective Maxillary and Midfacial Surgery” 1976 \textit{Journal of Oral Surgery (J Oral Surg)} 157, Simon 1978 \textit{Ariz L Rev} 671.} Regardless of the patient’s ability to camouflage underlying motivations, a cosmetic surgeon should at the very least make reasonable inquiries in order to identify danger signs widely recognised in the practice of cosmetic surgery.\footnote{Simon 1978 \textit{Ariz L Rev} 673.} Questions should focus on the decision-making process of the patient, family and marital relations, support shown by friends and family and the autonomy of the patient’s decision.\footnote{Book “Psychiatric Assessment for Rhinoplasty” 1971 \textit{Archives Otolaryngology Head and Neck Surgery (Arch Otolaryngol Head Neck Surg)} 54; Reich 1975 \textit{PRS} 11; Peterson & Topazian 1976 \textit{J Oral Surg} 162; Simon 1978 \textit{Ariz L Rev} 683.} The cosmetic surgeon must be wary of great enthusiasm, vague or disproportionate expectations, personal stress and paranoia.\footnote{Honigman \textit{et al} 2004 \textit{PRS} 1236.}

Studies have shown that a person with a history of depression, anxiety or a personality disorder is not an ideal candidate for cosmetic surgery in terms of surgical and psychological outcomes.\footnote{Honigman \textit{et al} 2004 \textit{PRS} 1236.} The patient should therefore be questioned regarding his or her psychiatric history and current mental state.\footnote{Reich 1975 \textit{PRS} 9; Simon 1978 \textit{Ariz L Rev} 682.} The cosmetic surgeon should rather not proceed with the surgery if the patient is significantly depressed, psychotic or suffers from body dysmorphic disorder.\footnote{Honigman \textit{et al} 2004 \textit{PRS} 1236.} It is neither a cosmetic surgeon’s duty to diagnose a patient with a psychiatric or personality disorder, nor does it fall within their scope of practice, however as part of the
screening process the cosmetic surgeon should at least be aware of signs that a patient might be suffering from body dysmorphic disorder. Although psychiatric treatments for the disorder can be effective, many patients who suffer from body dysmorphic disorder do not seek psychiatric help, instead they vehemently pursue a surgical solution for a psychological problem. The cosmetic surgeon should inquire as to the amount of time spent each day worrying about the cosmetic defect, how much distress the perceived imperfection causes and whether concern over the imperfection has had any behavioural consequences such as social avoidance. If the patient is preoccupied with the perceived imperfection to the extent that it causes significant distress or impairment in functioning, body dysmorphic disorder may be present. Furthermore, if the flaw in the patient’s appearance is far more insignificant than the patient perceives it to be, this might also be indicative of body dysmorphic disorder.

Most problem patients can be handled effectively by the cosmetic surgeon by being gentle, but completely candid during the counselling interview. If the cosmetic surgeon believes that there might be present or potential psychological disturbances, he or she should candidly confront the patient and recommend that the patient arranges a psychiatric consultation prior to surgery. The cosmetic surgeon is under no duty to cure the patient, but he or she must at least refer the patient to a specialist for counselling before even considering the possibility of proceeding with the surgery.

851 Ibid.
852 Ibid.
5 6 A Physician’s Legal Liability Concerning Patient Selection: Application of General Delictual Principles

A psychological or psychiatric injury can be described as any recognisable harmful infringement of the brain or nervous system of a person. Psychological injury can be sustained in a variety of ways, including nervous shock, fright or other forms of mental suffering. Thus far courts have been primarily concerned with delictual liability due to the infliction of nervous shock, however there is no reason why psychological or psychiatric harm caused in ways other than emotional shock would not be actionable. Delictual liability is primarily determined with reference to the requirements of wrongfulness, fault and legal causation. The brain or nervous system is as much a part of the physical body as any limb and any infringement of a person's physical-psychological integrity is regarded as prima facie wrongful and therefore actionable. The cosmetic surgeon’s duty to screen patients in order to prevent psychological harm is rooted in the fiduciary relationship that exists between a physician and patient. This duty can be legally enforced by applying the general principles of negligence. In order to establish negligence, the reasonable foreseeability and preventability of the psychological harm must be ascertained. The essence of negligence lies in the foreseeability of harm that may give rise to a duty to take reasonable steps to prevent the harm. The foreseeability of emotional harm resulting from the performance of an elective surgery (particularly cosmetic surgery) without prior screening is well documented.

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856 Bester v Commercial Union Versekeringsmaatskappy van SA Bpk 1973 1 SA 769 (A) 775; Barnard v Santam Bpk 1999 1 SA 202 (HHA) 208-9; Majiet v Santam Ltd 1997 4 All SA 555 (K) 567; Neethling “Deliktuele Aanspreeklikheid Weens die Veroorsaking van Psigiese Letsels” 2000 Journal of the South African Law 1.
857 Minister of Justice v Hofmeyr 1993 3 SA 131 (A) 145-6; Neethling 2000 TSAR 1.
858 Neethling 2000 TSAR 1; Barnard v Santam Bpk 208-9.
859 Neethling 2000 TSAR 4; Bester v Commercial Union Versekeringsmaatskappy van SA Bpk 779; Barnard v Santam Bpk 209.
860 Nugent “Cosmetic Surgery on Patients with Body Dysmorphic Disorder: the Medical, Legal and Ethical Implications” <http://works.bepress.com/cgi/viewcontent.cgi?article=1004&context=Kristen_nugent> (accessed 14 February 2012); Panfilov & Larkin 6.
862 Neethling et al 125; Kruger v Coetsee 1966 2 SA 428 (A) 430.
within the medical research. This is partly due to the fact that, in the case of cosmetic surgery, underlying psychological considerations will always be present.

When applying the reasonable foreseeability test it is impossible to formulate exact legal criteria for the determination of the reasonable foreseeability of the harm. There are however a few broad and flexible guidelines that can be followed in order to determine the foreseeability of the harm. The general guideline is that the foreseeability of the harm is dependent upon the degree of probability of the manifestation of the harm. If there was a very strong possibility of harm occurring, then it is highly likely that the resulting harm was reasonably foreseeable. As far as the preventability of foreseeable harm is concerned, four factors must be taken into consideration. These factors relate to the probability of harm, the gravity of potential harm, the importance and object of the wrongdoer’s conduct and the gravity of the burden of preventing the harm. These factors help determine how a reasonable cosmetic surgeon would act under similar circumstances. When the burden of taking steps to prevent the harm is light and the probability and gravity of harm is great, a legal duty to take steps to prevent the harm exists. The probability of harm may be relatively small, but the burden of making reasonable inquiries and referring doubtful cases to psychologists or psychiatrists to avoid serious harm is negligible. Therefore, the cosmetic surgeon carries a legal duty to take these precautions and performing cosmetic surgery without paying any attention to the emotional fitness of the patient will constitute negligence.

865 Van der Walt & Midgley 177-8; S v Bochris Investments 1988 1 SA 861 (A); Visser et al General Principles of Criminal Law through the Cases (1990) 541-63; Butters v Cape Town Municipality 1993 3 SA 521 (K); Deysel v Karsten 1994 1 SA 447 (A); Cape Town Municipality v Butters 1996 1 SA 473 (K).
866 Ibid.
867 Ibid.
868 Simon 1978 Ariz L Rev 685; Neethling et al 139-40; Van der Walt & Midgley 179.
In general the magnitude of the risk must be balanced against the utility of the conduct and the difficulty, expense or other disadvantage of desisting from the conduct or taking a particular precaution. If the magnitude of the risks outweighs the utility of the conduct, the reasonable person would take measures to prevent the occurrence of harm; if the actor failed to take such measures he or she acted negligently. On the other hand, if the burden of eliminating a risk of harm outweighs the magnitude of the risk, the reasonable person would not take any steps to prevent the occurrence of foreseeable harm.872

A cosmetic surgeon’s decision to perform cosmetic surgery on a psychologically and emotionally unfit patient could even sometimes, in rare cases, be seen as a misdiagnosis.873 For example, further cosmetic surgery will not cure the patient suffering from body dysmorphic disorder. Such a patient needs psychiatric help, not additional surgery. That being said, a misdiagnosis will not always constitute negligence. An erroneous diagnosis per se is not necessarily negligent, but the failure to adequately examine a patient in order to formulate an accurate diagnosis is indeed negligent.874

The patient plaintiff would also have to prove that a reasonably close nexus existed between the cosmetic surgeon’s breach of duty and the ultimate harm suffered by the patient.875 The cosmetic surgeon’s breach of duty must therefore be the proximate cause of the harm suffered by the patient. In the case of psychological harm following surgery, the patient plaintiff would have to prove that had the surgeon refused surgery or warned of the imminent risks of psychological harm, the surgery would never have been performed and the resulting psychological harm would not have been incurred by the patient. The patient plaintiff would not have to prove that he or she had no pre-existing psychological problems. Cause includes substantial or material factors contributing to ultimate injury, therefore a plaintiff would only have to prove that the surgeon’s conduct had been a precipitating and significant factor that triggered new problems or substantially worsened existing problems.876

872 Van der Walt & Midgley 179.
874 Ibid.
875 Id 688.
876 Id 689.
As far as the nexus between the defendant’s conduct and harm suffered by an abnormally psychologically vulnerable patient is concerned, the *talem qualem* rule also becomes relevant. This is a well-established legal principle and is commonly referred to as the egg-skull rule.\(^{877}\) This rule is traditionally expressed in the maxim “the wrongdoer must take the victim as he finds him”.\(^{878}\) Egg-skull cases arise where the plaintiff, because of one or other physical, psychological or economic weakness, suffers a worse injury or loss as a result of the wrongdoer’s conduct than would have been the case had the plaintiff not suffered from the particular weakness.\(^{879}\) The egg-skull rule has its origin in the English case of *Dulieu v White and Sons*\(^{880}\) where the court held that: “If a man is negligently run over or otherwise negligently injured in his body, it is no answer to the sufferer’s claim for damages that he would have suffered less injury, or no injury at all, if he had not had an unusually thin skull or an unusually weak heart.”\(^{881}\) Legal scholars generally agree that in such a case the wrongdoer should be held liable for all the harm which may be ascribed to the existence of the weakness.\(^{882}\) Just as a defendant who injures a plaintiff with an egg-skull is not entitled to use the abnormal vulnerability of the plaintiff’s skull as a defence, it could be argued that a cosmetic surgeon cannot use the extraordinary psychological vulnerability or the egg-skull psyche of an unstable cosmetic surgery patient as a defence.\(^{883}\)

There are several theories on how the liability of the wrongdoer should be justified, or which test for legal causation should be used to express liability in egg-skull cases.\(^{884}\) Suffice it to say that the most acceptable approach to egg-skull cases is a flexible test for legal causation.

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\(^{877}\) Neethling *et al* 191.

\(^{878}\) *Hay or Bourhill v Young* 1943 AC 92 109-10.

\(^{879}\) Neethling *et al* 191.

\(^{880}\) *Dulieu v White and Sons* 1901 2 KB 669.

\(^{881}\) *Id* 679.

\(^{882}\) Neethling *et al* 192.

\(^{883}\) Simon 1978 *Ariz L Rev* 690; Neethling 2000 *TSAR* 10; Van der Walt & Midgley 173 state that: “The doctrine of direct consequences has exerted its strongest influence on the question of liability for personal injuries. One a defendant has been proved to have acted wrongfully and negligently, his or her responsibility embraces any harm flowing from a latent physical condition of the plaintiff, however unforeseeable or abnormal. This principle, inherent in the theory of direct consequences, is usually expressed by stating that the tortfeasor ‘must take the victim as he finds him’.”

\(^{884}\) For more information on the different theories of justification see Neethling *et al* 192-3.
as illustrated in the case of *Smit v Abrahams*\(^885\) where Farmal J investigated the rule and came to the conclusion that the fact that a plaintiff has a proverbial egg-skull is just one more fact that needs to be considered when applying all the other facts of the particular case in terms of the flexible test for causality. One must therefore determine whether, on the basis of reasonableness, fairness and justice, and in the light of all the circumstances of the case, the damage should be reasonably be imputed to the defendant.\(^886\) Other existing tests for legal causation may also play a secondary role when determining legal causality in terms of the flexible approach.\(^887\) In particular, the direct consequences test may be one of several factors taken into account in egg-skull cases.\(^888\) In terms of the direct consequences test, a wrongdoer is liable for all direct consequences of his negligent conduct, irrespective of whether these consequences were reasonably foreseeable.\(^889\) The fact that the psychological harm to an abnormally vulnerable cosmetic surgery patient was not reasonably foreseeable would in terms of this test not constitute a defence. The direct consequences test cannot be applied as a general test for causality.\(^890\) It may simply, along with all the other tests for causality, play a subsidiary role. It may be a particularly relevant factor, but not the only factor when determining legal causality in egg-skull cases.

### 561 A Physician’s Legal Liability Concerning Patient Selection: Assault Due to a Lack of Informed Consent

The cosmetic surgeon’s duty to screen patients could also be enforced by applying the doctrine of informed consent. As a patient with a psychiatric disorder might possibly lack autonomy or the capacity to consent to treatment, he or she could be incapable of giving his or her informed consent to the treatment or surgery. Such a lack of informed consent due to a lack of capacity on the part of the patient could give rise to an action for assault against the surgeon. Capacity refers to competence; which is the functional ability to meet the demands of the decision-making situation by evaluating the potential consequences.\(^891\) The fact that a  

\(^885\) *Smit v Abrahams* 1994 4 SA 1 (A).  
\(^886\) Neethling *et al* 193.  
\(^887\) Neethling *et al* 181; *Standard Chartered Bank of Canada v Nedperm Bank Ltd* 1994 4 SA 747 (A) 765.  
\(^888\) Neethling *et al* 187; Van der Walt & Midgley 207.  
\(^889\) Neethling *et al* 185; Van der Walt & Midgley 206.  
\(^890\) Neethling *et al* 187 ; Boberg 442 ; Visser *et al* 112.  
\(^891\) Carstens & Pearmain 879.
patient's choice seems irrational, or does not accord with the cosmetic surgeon’s view of what is in the patient's best interests *per se*, is not evidence that the patient lacks competence.\textsuperscript{892} Furthermore, patients who have psychological problems or who are vulnerable to such problems are generally not mentally ill or incompetent to give consent.\textsuperscript{893} Even mentally ill persons are generally able to consent to medical treatment as mental illness *per se* does not render a person unable to consent.\textsuperscript{894} Mentally ill patients are only incapable of giving informed consent if their disorder prevents them from understanding what they are consenting to.\textsuperscript{895} It is possible that severe psychological problems could render an individual incompetent to give consent to surgery.\textsuperscript{896} This would be the case if the mental disorder prevents the patient from making definitive decisions, communicating his or her consent or accepting the need for medical intervention.\textsuperscript{897}

\textbf{5 6 1 1 A Physician’s Legal Liability Concerning Patient Selection, Informed Consent and Body Dysmorphic Disorder: the Case of *Lynn G v Hugo* 96 NY2d 306 2001}

An example can be found in the New York case of *Lynn G v Hugo*.\textsuperscript{898} In this case, the plaintiff had visited the defendant, her cosmetic surgeon, nearly fifty times over a six year period to discuss various cosmetic surgery procedures. During that period, she underwent several cosmetic surgeries, including eyelid surgery, facial liposuction, eyebrow tattooing and wrinkle and skin growth removals. At some stage the plaintiff elected to undergo liposuction on her stomach. When the liposuction failed to produce the desired results, the plaintiff decided to undergo a full abdominoplasty to tighten her abdomen. Prior to the surgery, the

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\item \textsuperscript{892} Par 9.2 of the HPCSA’s “Guidelines for Good Practice in the Health Care Professions, Seeking Patient’s Informed Consent: The Ethical Considerations”.
\item \textsuperscript{896} Simon 1978 *Ariz L Rev* 691.
\item \textsuperscript{897} Carstens & Pearmain 901.
\item \textsuperscript{898} *Lynn G v Hugo* 96 NY2d 306 2001.
\end{itemize}
\end{footnotesize}
The defendant informed plaintiff of the risks associated with an abdominoplasty, including ugly scarring. The plaintiff acknowledged, in writing, her understanding of the risks and signed a consent form. Following her surgery, the plaintiff complained of an unsightly scar on her abdomen. The plaintiff then instituted legal action against the defendant, alleging a lack of informed consent and medical malpractice. Specifically, plaintiff claimed that she lacked capacity to consent to the procedures because she suffered from body dysmorphic disorder. The crux of her argument was that if a patient suffers from a mental disorder that is directly related to the procedure to which he or she is consenting, the validity of that patient’s informed consent should be called into question.899 The plaintiff claimed that her unusually high demand for surgical correction of minimal defects, together with the defendant's awareness of her use of antidepressant medication, should have alerted him to her condition, and that the defendant was negligent in not referring her to a psychiatrist before performing the surgeries. Furthermore, she asserted that body dysmorphic disorder had diminished her capacity to provide valid informed consent. The plaintiff neither contended that body dysmorphic disorder had made her incapable of concluding any contracts, nor that it had rendered her incapable of providing informed consent to surgery in general. The plaintiff simply claimed that body dysmorphic disorder had impacted her ability to properly evaluate risks and benefits of cosmetic surgery, as it had caused her to irrationally exaggerate her perceived physical imperfections. The court held that there was insufficient evidence to establish that the plaintiff actually suffered from body dysmorphic disorder. Consequently the court was silent on whether body dysmorphic disorder could potentially invalidate a patient’s ability to provide informed consent to cosmetic surgery. Regardless, the case is still significant as the court’s review of the adequacy of evidence to establish whether the plaintiff suffered from body dysmorphic disorder indicates that body dysmorphic disorder might potentially influence the validity of a cosmetic surgery patient’s informed consent.900 The court of appeal avoided making a pronouncement on the lower court’s holding that cosmetic surgeons should be aware of established psychiatric conditions that affect body image and could impair a patient’s ability properly to evaluate and consent to cosmetic surgery. The lower court’s analysis of the surgeon’s method to obtain informed consent was also sidestepped on appeal. The consequence of the lower court’s opinion, never rejected at appellate level, is that when a patient suffers from compromised judgment, the determination

899 Mantese et al 2006 MIBJ 27; Pitts-Taylor 131; Newell 2011 J Leg Med 328.
900 Id 325.
whether or not to undergo surgery cannot exclusively be left with the patient.\textsuperscript{901} Despite the fact that the court of appeal did not apply the doctrine of informed consent, the case is still significant as it is indicative of the fact that claims regarding informed consent by cosmetic surgery patients suffering from body dysmorphic disorder are beginning to emerge, that courts are starting to recognise that body dysmorphic disorder could potentially influence the validity of patient’s consent and that cosmetic surgeons must take a more proactive role in determining whether a patient should undergo cosmetic surgery when that patient’s judgment is possibly impaired.\textsuperscript{902}

\section*{5 6 2 A Physician’s Legal Liability Concerning Patient Selection: Can a Physician Be Held Contractually Liable?}

As far as a cosmetic surgeon’s contractual liability for operating on a patient suffering from body dysmorphic disorder is concerned, courts are unlikely to hold a surgeon who operated in accordance with reasonable care and skill liable in contract for such a patient’s poor physical or psychological outcome after surgery. That being said, if the court determines that the cosmetic surgeon, in operating on a patient ostensibly suffering from body dysmorphic disorder, did not treat the patient with a reasonable degree of professional skill and care and to a standard required by the professional and ethical rules of the profession, such a patient may have a claim based on a breach of contract. It is an implied or tacit term in healthcare contracts that the physician will treat the patient with a reasonable degree of professional skill and care and to a standard required by the professional and ethical rules of the profession.\textsuperscript{903} Furthermore, as far as the formation and conclusion of a contract is concerned, informed consent is usually a precursor to the contract, but it may also form part of the terms of the contract itself.\textsuperscript{904} It is generally an implied or tacit term in health care contracts that the patient’s informed consent will be obtained in regard to treatment that is administered or surgery that is performed on the patient prior to the administration or performance of such

\textsuperscript{901} Ibid.
\textsuperscript{902} Ibid.
\textsuperscript{903} Carstens & Pearmain 364. See Carstens & Pearmain 362 where it is said that there are a number of terms, including that a patient will be treated with a reasonable degree of professional care and skill, which may be inferred in a healthcare contract on the grounds of public policy, fairness and reasonableness. These terms are derived as much from the law of delict, constitutional law and administrative law as from the law of contract.
\textsuperscript{904} Id 313.
treatment or surgery.\footnote{Carstens & Pearmain 364; \textit{Castell v De Greef}; \textit{Broude v McIntosh}.} It is also worth noting that if the cosmetic surgeon had made a contractual promise of a certain surgical outcome to the patient, the issue of negligence and whether or not the patient had otherwise been competent to give informed consent is inconsequential in relation to the determination of the cosmetic surgeon’s liability.\footnote{Nugent “Cosmetic Surgery on Patients with Body Dysmorphic Disorder: the Medical, Legal and Ethical Implications” <http://works.bepress.com/cgi/viewcontent.cgi?article=1004&context=Kristen_nugent> (accessed 14 February 2012).} A representation which occurs during pre-contractual negotiations can be made part of the consensus between the parties and as such might become a term of the ensuing contract.\footnote{Van der Merwe et al \textit{Contract General Principles} (2007) 106.} This is relevant in the case of patients suffering from body dysmorphic disorder as such patients are more likely to interpret statements of opinion made by the cosmetic surgeon with some optimistic colouring, in their own minds thereby transforming such statements into promises and guarantees.\footnote{Nugent “Cosmetic Surgery on Patients with Body Dysmorphic Disorder: the Medical, Legal and Ethical Implications” <http://works.bepress.com/cgi/viewcontent.cgi?article=1004&context=Kristen_nugent> (accessed 14 February 2012).}

A claim based on breach of contract might be particularly attractive in cosmetic surgery cases where the plaintiff has trouble recovering on other grounds. When courts are permitted to infer contractual guarantees from speculative oral statements made by the cosmetic surgeon during consultation, the cosmetic surgeon's scope of liability is broadened by allowing an action for breach of contract.\footnote{Bonebrake “Contractual Liability in Medical Malpractice - Sullivan v O’Connor” 1974 \textit{DePaul Law Review (DePaul L Rev)} 217.} From the plaintiff's perspective, the possibility of pleading a case in contract is attractive since it renders his or her burden of proof significantly lighter as there is no need to prove negligence on the part of the cosmetic surgeon.\footnote{Ibid.} This suggests that the cosmetic surgeon’s potential liability is increased under the contractual theory, while under negligence theory it is limited to actions where fault can be proven.
An action in contract is also particularly attractive if the cosmetic surgeon advertised or engaged in puffery during consultation in a manner that vulnerable individuals, such as those suffering from body dysmorphic disorder, might have interpreted as an express guarantee of satisfaction or of a certain aesthetic result.\textsuperscript{911} Given the high percentage of individuals opting for cosmetic surgery who suffer from body dysmorphic disorder, telling a patient that he or she can surgically achieve the same appearance as a model or a celebrity, or even using computerized digital imaging software is not recommended as patients may accuse surgeons of warranting the surgeon’s ability to achieve that particular result.\textsuperscript{912} Not even the most skilled cosmetic surgeon can make a patient look identical to the prognostic virtual image, and the patient suffering from body dysmorphic disorder’s distorted perspective will focus on any deviations from the aesthetic ideal he or she had hoped to achieve.\textsuperscript{913} A disillusioned patient could easily grab on to what he or she understood as a guarantee of perfection and complete satisfaction to initiate litigation against the surgeon. Recovering under a contract claim under these circumstances might require a strained interpretation of the surrounding facts and will probably only be used as a cause of action as a last resort when the assault due to a lack of informed consent and medical negligence charges have failed.\textsuperscript{914} If however the court believes that the patient could have reasonably interpreted the cosmetic surgeon’s statements during consultation, the surgeon’s advertising materials or the surgeon’s use of computer imaging as a promise to attain a certain result, the court may allow the patient to recover damages.

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\item \textsuperscript{911} Nugent “Cosmetic Surgery on Patients with Body Dysmorphic Disorder: the Medical, Legal and Ethical Implications” \texttt{<http://works.bepress.com/cgi/viewcontent.cgi?article=1004&context=Kristen_nugent>} (accessed 14 February 2012).
\item \textsuperscript{913} \textit{Ibid}.
\item \textsuperscript{914} Nugent “Cosmetic Surgery on Patients with Body Dysmorphic Disorder: the Medical, Legal and Ethical Implications” \texttt{<http://works.bepress.com/cgi/viewcontent.cgi?article=1004&context=Kristen_nugent>} (accessed 14 February 2012).
\end{itemize}
5.7 Conclusion

Like all physicians, cosmetic surgeons carry certain ethical and moral duties toward their patients and society as a whole. However, as illustrated above, cosmetic surgeons face certain unique ethical dilemmas and are burdened by equally unique ethical and moral duties due to the particular, and arguably at times peculiar, nature of their practice. An ethical cosmetic surgeon is careful and vigilant about employing only the most ethical, honest and neutral advertising methods. The ethical cosmetic surgeon’s duties toward his or her patient therefore commence before he or she even meets the patient and continue throughout the first consultation, any additional consultations, the process of informed consent and the operation itself and last well beyond the removal of the last suture. An ethical cosmetic surgeon should feel compelled to do whatever he or she can in order to address some of the ethical challenges faced by the profession. As illustrated above, many of these ethical concerns can be adequately addressed by enriching interactions between cosmetic surgeons and their patients and by slightly adjusting the existing practice of informed consent. An ethical cosmetic surgeon therefore also considers the process of informed consent to be something more than just the once off signing of a legal document by the patient and the discharge of a legal duty in the most convenient way possible. An ethical cosmetic surgeon obtains the patient’s informed consent in person, by means of a series of open and honest conversations, well ahead of the date of the operation, with full and detailed disclosure and with a constant awareness of the underlying psychological factors and suspect norms of appearance that influence a request for cosmetic surgery.
Chapter 6  
Final Conclusions

6 1 Conclusions

6 1 1 Hypothesis

At the beginning of this dissertation, the question was asked whether wish-fulfilling medicine, extreme forms of cosmetic surgery in particular, should be legal. With reference to the South African Constitution, the South African common law, legislation, foreign law and medical ethics it can be concluded that cosmetic surgery, even extreme forms thereof, should be legal. However, this pro-cosmetic surgery stance should not be understood to be without exceptions, conditions and certain reservations.

6 1 2 Conclusions Regarding Common Law Perspectives on Wish-Fulfilling Medicine

In chapter 2, the phenomenon of wish-fulfilling medicine was examined in context of the common law with reference to the maxim of *volenti non fit iniuria*, otherwise known as consent to harm. An investigative discourse was conducted on whether a patient’s consent is sufficient justification for the performance of ethically suspect and radical non-therapeutic surgery. It was concluded that in terms of the common law consent *per se* is not sufficient justification for any sort of bodily harm, including surgery. A wide variety of wish-fulfilling medical procedures are available, but not everything that is medically possible and would happily be privately paid for, should be allowed.\(^915\) Consent must not be *contra bonos mores*. In this regard, individual autonomy is limited by considerations of individual and social responsibility and public interests necessitate that reasonable limits be placed on the capacity to limit one’s own rights.\(^916\) However, the common law does not require a therapeutic objective for a medical intervention to be lawful. Essentially, the common law relating to a patient’s consent to bodily harm occasioned by a physician is the same as the law governing other relationships between human beings. If individuals have such dominion over their


\(^{916}\) Van der Walt & Midgley 143; Burchell & Milton 324.
bodies that they may prohibit life-saving surgery where an emergency exists, there is no reason why they should not be allowed to consent to efforts to beautify it.  

Whether cosmetic surgery is lawful or not should not depend on the therapeutic or non-therapeutic nature thereof, but rather on whether the objective of the surgery is legally sanctioned or at the very least justifiable. When evaluating the ethical aspects of a particular medical intervention, we should therefore not concern ourselves with the therapy-enhancement distinction, but rather with the question whether the intervention poses substantial risks, offers considerable benefits, violates or promotes human dignity etc. It was conceded that it could be very difficult to determine whether a non-therapeutic operation serves some or other socially acceptable objective. Decisions would have to be based on the court’s perception of the social acceptability and utility of the particular activity and would have to be made on a case-by-case basis. This would allow the changing boni mores to determine which activities should be classified as unlawful. It would be a delicate question of public policy in order to identify those non-therapeutic surgeries that are socially acceptable, particularly when fundamental human rights such as the patient’s right to human dignity and privacy and bodily integrity are involved.

6.1.3 Conclusions Regarding Constitutional Perspectives on Wish-Fulfilling Medicine

In chapter 3 it was concluded that the practice of wish-fulfilling medicine, extreme forms of cosmetic surgery in particular, involve very important fundamental human rights. It was illustrated how human dignity, privacy and bodily integrity relates to a patient’s decision to undergo elective surgery. The close relationship between dignity and autonomy in the context of healthcare played an important role in the final conclusion regarding the definition of human dignity. Dignity is a wide and all-encompassing concept; as such no single conception of dignity is correct or incorrect. When referring to the dignity of a patient seeking wish-fulfilling surgery, it was concluded that it would be more appropriate to refer to the classic liberal conception of dignity with an emphasis on autonomy as opposed to a communitarian sense of dignity rooted in ubuntu. This is because autonomy is so important in personal decisions regarding healthcare. In the context of privately paid for wish-fulfilling procedures such as cosmetic surgery, the broader social and material dimensions of the

917 Smith 1942 Rocky Mtn L Rev 286.
918 Resnik 2000 Camb Q Healthc Ethics 374.
pursuit of health was found to be less relevant. As such, the emphasis on autonomy is warranted. It was found that even though cosmetic surgery is generally dignity enhancing, some transgressive forms of surgery could infringe dignity. These forms of cosmetic surgery should be prohibited if they infringe dignity to a serious degree. Consent is not an ultimate value, but only a substitute for something else. Making legal rights and duties dependent on consent usually serves human dignity. Dignity and consent are commonly linked, but they are not indistinguishable or interchangeable concepts and they may therefore come into conflict with one another. Consenting individuals get what they want and desire, but the law should not blindly and uncritically serve an individual’s subjective whims, wishes and desires. A patient’s consent can therefore not be a defense against a charge of assault in the case of extreme elective surgery if it degrades human dignity to a serious degree. Human dignity is a more fundamental value, as it is central to humanity and it is what makes us human. As important as personal autonomy is to the law and our constitutional order, human dignity is equally or more important. Certain forms of harmful conduct should therefore be prohibited even if it is consensual. Besides the patient’s human dignity, it was found that his or her constitutionally enshrined right to privacy and bodily and psychological integrity also comes into play in the case of extreme wish-fulfilling surgeries. Should a surgeon refuse to perform a procedure that does not violate the patient’s dignity to a serious degree, the patient’s right to dignity, bodily integrity and privacy will be infringed upon. Such a limitation would require an extremely convincing justification rooted in public interests. Such a compelling countervailing public interest will be difficult to identify in the case of the personal realm of wish-fulfilling surgery. It is difficult to imagine how an idiosyncratic decision, made by an individual in his or her private sphere, could disadvantage the interests of society to such an extent that it needs to be prohibited. However, from a bioethical perspective some broader ethical arguments can be made against the practice of cosmetic surgery. These arguments are based on several ethical concerns.

6 1 4 Conclusions Regarding Bioethical Concerns and Recommendations for Reform

Some of these broader ethical concerns were discussed in chapter 4, where it was concluded that these concerns, although serious, do not warrant an overall ban on cosmetic surgery. Many of these concerns were repudiated, whilst solutions were suggested for others. The

objections related to the goals of medicine and the disease-enhancement dichotomy, complicity arguments, arguments regarding human nature and naturalness, justice and accessibility, concerns regarding the autonomy of the patient’s wish and concerns regarding the application of Principilism. It was found that cosmetic surgeons themselves can adopt certain practical guidelines, as set out in chapter 5, to address at least some of these problem areas. Holding cosmetic surgeons legally liable under certain circumstances would also help address and prevent unethical practices. It was found that concerns regarding medicine’s complicity in the conceptualisation of the body and the possibility of medicine’s exploitation of destructive norms of appearance for the sake of financial gain, can to some extent be addressed by following ethical advertising guidelines and by allowing a true appreciation of the injustices that underlie norms of appearance to influence and enhance the process of informed consent. The true value of a person cannot be reduced to appearance, and cosmetic surgeons must resist these ideologies and help patients have a more realistic view of themselves.920 Furthermore, ethical cosmetic surgeons should allow a true appreciation of the injustices that underlie norms of appearance to influence and enhance the process of informed consent.921 Cosmetic surgeons should speak out against the pressures women face, whilst still using surgical skills in cases where there seems to be no other path out of suffering.922 Cosmetic surgeons should be solely motivated by the genuinely noble goal of relieving human suffering and any act of complicity should be done reluctantly.923

6.1.4.1 Impact on Advertising
As far as advertising is concerned, it was found that despite the fact that medical advertising is legal, it is certainly not ethically unproblematic and that there are moral boundaries that should not be crossed. Patients experience subtle, but undue influence in the form of demand stimulating advertising by cosmetic surgeons. The vulnerability of cosmetic surgery patients as well as the imbalance of power and knowledge between cosmetic surgeons and patients necessitate that cosmetic surgery advertising be approached with caution. Mainstream advertising techniques not only erode trust in the physician-patient relationship, it also wears

921 Little 174; Amadio 2010 JAMA 402.
922 Little 174; Davis (2003) 77; Bogdanoski 2009 Griffith L Rev 504.
923 Little 171; Parens 20.
away at the public’s confidence in the medical profession. The increased use of mainstream advertising techniques such as price information and promotional tactics in cosmetic surgery adversely affect the reputation of the medical profession and compromise professional integrity. This results in the performance of multiple elective procedures that put healthy patients at physical risk. In this regard, some cosmetic surgeons should refrain from promoting their own commercial interests over the patient’s best interest. Cosmetic surgery advertising says as much about the surgeon as it does about his or her product.

6 1 4 2 Impact on Informed Consent and Disclosure
It was found that it is also by means of a careful process of informed consent, patient selection and evaluation that any misgivings regarding autonomous decision-making by cosmetic surgery patients can be adequately addressed. It was illustrated why there are certain unique considerations regarding informed consent in cosmetic surgery. There are no medical indications for cosmetic surgery. It was concluded that this means that the scope of risk information provided to the cosmetic surgery patient should be wider, as there is no obvious medical reason for the patient to run those risks. In light of new medical technologies, it was concluded that it is unlikely that standard informed consent procedures still adequately serve their original intention. Medical treatments were far simpler and there were far fewer elective procedures when the doctrine of informed consent was developed. It was therefore recommended that informed consent be contextualised by creating different categories of informed consent for different procedures. Withholding information that might scare a patient cannot be justified on the basis of non-maleficence, as cosmetic surgery isn’t medically necessary. If a patient decides to forego the cosmetic procedure after hearing comprehensive explanation of possible risks, it won’t do any harm to his or her health. Cosmetic surgery might have both psychological and functional benefits for the patient, but it is not an essential operation in the sense that it treats a life threatening condition. In the case of cosmetic surgery, where the decision to be made by the patient is more subjective and personal than therapeutic, the cosmetic surgeon therefore has a duty to be especially careful to disclose all the risks as well as the consequences for the patient, should such risks

924 Devereaux 170.
925 Miller et al 2000 Camb Q Healthc Ethics 360; Hennink-Kaminski & Reichert 2011 Sexuality and Culture 42.
materialise. In matters of this kind, there is no real urgency. The relevant problems must therefore be explained to the patient, and the patient can weigh the medical risks against his own non-medical desires and priorities. Since there is no therapeutic need for the operation, a patient might well decide that he would prefer to live with a blemish rather than take the risk.

In addition to adopting a broader duty of disclosure, this study suggested a few additional guidelines for obtaining proper informed consent in the case of elective surgery, specifically cosmetic surgery. The informed consent should preferably be obtained by the cosmetic surgeon him- or herself, as it is advisable that the person obtaining the informed consent should be capable of performing the procedure themselves. Furthermore, the consent should be obtained well ahead of the date of the surgery. Consent will not be valid if it is obtained under duress. In practice, this will usually relate to the timing of the informed consent. If the consent is only obtained upon the day of the surgery the patient may feel under duress to proceed with the operation as all the arrangements have been made.\textsuperscript{926} The cosmetic surgeon’s duty to obtain informed consent should not be regarded as a once-off duty. As circumstances may change, it is a continuing duty.\textsuperscript{927} If patients are unable to recall important aspects of the risks and benefits of surgery, then this continuing duty of informed consent remains unfulfilled.\textsuperscript{928} It was concluded that a second consultation is therefore advisable. A second consultation during which the cosmetic surgeon can check the patient’s comprehension of the meaning of the forms is therefore one more way in which a cosmetic surgeon can further ensure adequate patient understanding. Such a policy would not only demonstrate the cosmetic surgeon’s commitment to obtaining the patient’s subjective informed consent, as opposed to simply discharging a legal duty in the most convenient way possible, but it would also give him or her an opportunity to observe the patient a second time for any symptoms of psychological disorder.\textsuperscript{929}

\textsuperscript{926} Anderson & Wearne 2007 JRSM 97.
\textsuperscript{929} Nugent “Cosmetic Surgery on Patients with Body Dysmorphic Disorder: the Medical, Legal and Ethical Implications” <http://works.bepress.com/cgi/viewcontent.cgi?article=1004&context=Kristen_nugent> (accessed 14 February 2012).
6 1 4 3 Impact on Patient Selection

It was found that there are unique challenges regarding cosmetic surgery patient selection. The challenge that cosmetic surgeons face is how to identify, prior to surgical intervention, those patients who may have a poor result in terms of psychological adjustment and psychosocial functioning in spite of a technically acceptable result.\textsuperscript{930} As psychological factors are at the root of most requests for cosmetic surgery, it was submitted that a legal duty on the part of the cosmetic surgeon to remain sensitive to widely recognised dangerous symptomology should exist. Cosmetic surgeons, more so than most other specialists, need to be careful listeners with clinical acumen that extends beyond the typical borders of medical illness.\textsuperscript{931} As far as autonomous decision-making is concerned, it was found that ultimately there is no strong empirical information available to deny or assert the autonomy of patients choosing wish-fulfilling procedures and any misgivings regarding autonomous decision-making can be adequately addressed by careful evaluation of patient motivation and quality of information in each individual case.\textsuperscript{932}

6 1 5 Conclusions Regarding Physician Liability and Ethics

As far as physician liability is concerned, it was found that a cosmetic surgeon’s duty to screen patients can be legally enforced by applying the general principles of negligence, the principles of informed consent and/or general contractual principles. A cosmetic surgeon’s decision to perform cosmetic surgery on a psychologically and emotionally unfit patient could even sometimes, in rare cases, be seen as a misdiagnosis. The cosmetic surgeon’s duty to screen patients in order to prevent psychological harm is rooted in the fiduciary relationship that exists between a physician and patient.\textsuperscript{933} In order to establish negligence, the reasonable foreseeability and preventability of the psychological harm must be ascertained. The essence of negligence lies in the foreseeability of harm that may give rise to a duty to take reasonable steps to prevent the harm. The foreseeability of emotional harm resulting from the performance of an elective surgery (particularly cosmetic surgery) without

\textsuperscript{930} Honigman \textit{et al} 2004 PRS 1230; Sykes 2009 \textit{Curr Opin Otolaryngol Head Neck Surg} 322.
\textsuperscript{931} Sykes 2009 \textit{Curr Opin Otolaryngol Head Neck Surg} 321.
\textsuperscript{932} Buyx 2008 \textit{Med Healthc Philos} 139.
\textsuperscript{933} Nugent “Cosmetic Surgery on Patients with Body Dysmorphic Disorder: the Medical, Legal and Ethical Implications” <http://works.bepress.com/cgi/viewcontent.cgi?article=1004&context=Kristen_nugent> (accessed 14 February 2012); Panfilov & Larkin 6.
prior screening is well documented within the medical research. This is partly due to the fact that, in the case of cosmetic surgery, underlying psychological considerations will always be present. As a patient with a psychiatric disorder possibly lacks autonomy or the capacity to consent to treatment, he or she might be incapable of giving his or her informed consent to the treatment or surgery. It was concluded that a lack of informed consent, due to a lack of capacity on the part of the patient, should give rise to an action for assault against the surgeon if a patient suffers from a mental disorder that is directly related to the procedure to which he or she is consenting. The validity of that patient’s informed consent should be called into question. It was found that the duty to screen patients can also be legally enforced by applying contractual principles. Should the court determine that the cosmetic surgeon, in operating on a patient ostensible suffering from a psychiatric disorder, did not treat the patient with a reasonable degree of professional skill and care and to a standard required by the professional and ethical rules of the profession, such a patient should have a claim based on breach of contract. Furthermore, if the cosmetic surgeon had made a contractual promise of a certain surgical outcome to the patient, the cosmetic surgeon should be held contractually liable. An action in contract is also applicable if the cosmetic surgeon advertised or engaged in puffery during consultation in a manner that vulnerable individuals, such as those suffering from a psychiatric disorder, might have interpreted as an express guarantee of satisfaction or of a certain aesthetic result.

6 1 6 Final Thoughts

It was found that most of the concerns regarding cosmetic surgery can be addressed in the everyday practice of medicine. Most of the concerns do not relate to the practice of cosmetic surgery per se, but rather the effect that cosmetic surgery has on patients if taken to the extreme and not regulated properly and ethically. It was found that the practice of cosmetic surgery per se is actually relatively uncontroversial. What contributes to the controversy and negative public perceptions surrounding cosmetic surgery, is the unethical behaviour of a small group of surgeons. The unethical behaviour relates to irresponsible patient selection, financial exploitation, surgeons placing their own egos before the welfare of their patients,

displays of ostentatious behaviour not suited to physicians etc. Unfortunately, some cosmetic surgeons boast that they chose to become cosmetic surgeons just to become rich aesthetic surgeons.936 Currently, this is the image they project.937 These problems can be addressed and rectified by cosmetic surgeons themselves. In this regard, the performance of cosmetic surgery necessitates a degree of ethical conduct on the part of the cosmetic surgeon that surpasses the level of ethical conduct normally required between a physician and patient, as the relationship between a cosmetic surgeon and a patient differs from the traditional physician-patient relationship. An ethical cosmetic surgeon should feel compelled to do whatever he or she can in order to address some of the ethical challenges faced by the profession. Concerns should be addressed by cosmetic surgeons internally by going back to Hippocrates and to the basics of being a physician.938 The solution is not to place an overall ban on extreme forms of cosmetic surgery. The solution is grounded in the medicalization of cosmetic surgery, in other words, cosmetic surgery should first and foremost always be treated and practiced as a true form of medicine.939 By positioning itself as part of a beauty industry focused on market requirements, cosmetic surgery is running the risk of losing its status as a profession.940 Perhaps the most important conclusion of all made by this study is the following: cosmetic surgeon is still medicine and should be treated as such. Surgeons should therefore, to some extent, act as gatekeepers. It is their profession and therefore it is their duty to safeguard its reputation. However, this does not imply that cosmetic surgeons should act as moral gatekeepers. Such a stance would not be conducive to patient autonomy. Patients should be free to make controversial choices concerning their health and appearance. Essentially it goes back to basic medical ethics. Cosmetic surgeons must do no harm, but in the least paternalistic way possible. This does not mean that cosmetic surgeons should refuse a patient request that seems strange. It means that they must take a journey with that patient, prepare them, ensure that they have given proper informed consent etc. In this regard, the process of informed consent should consist of more than the mere exchange of information. It should be a process of shared decision-making. The process of informed consent should be a therapeutic process during which the cosmetic surgeon helps the patient to establish a sense

936 Atiyeh et al 2008 Aesth Plast Surg 829.
937 Ibid.
940 Ibid.
of control, develop realistic expectations and prepare emotionally for the surgery. Only in the case of surgeries that violate human dignity to an extreme degree, not merely in the case of surgeries that are strange or unconventional, should surgeons refuse treatment. The Hippocratic Oath calls for physicians to apply their skill according to their ability and judgement, not just their technical skill; and to protect patients from harm and injustice, not just from unfair business practices. Cosmetic surgery faces its current identity and ethical crisis, due to the fact that it has lost sight of these ethical standards. Cosmetic surgeons must keep in mind that the practice of cosmetic surgery is medicine; therefore it will essentially always be a moral enterprise. Cosmetic surgeons must also keep in mind that being a physician is all that a cosmetic surgeon should ever be. If cosmetic surgeons fail to think about these implications, cosmetic surgery will finally and irreversibly lose its identity as medicine.

942 Ringel 1998 Arch Derm 430.
944 Ibid.
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