The application of the doctrine of informed consent in South African medical law: Reflections on significant developments in the case law

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Abstract

The doctrine of informed consent is the foundation of the physician–patient relationship. This doctrine remains controversial despite its importance, and issues involving consent are frequently litigated. This article examines the application of the doctrine of informed consent in South African medical law as it has developed in South African case law. This examination first sets a normative background for consent as a ground of justification against a wrongful act in either contract or delict (or both) that is significantly influenced by the Constitution of the Republic of South Africa, 1996. Against this normative background, a selected anthology of nine significant judgments by South African courts is analysed, with specific attention paid to the critical shift prompted by the promulgation of the Constitution. Finally, the analyses of the nine judgments are consolidated and collated to draw conclusions about the triumphs and failings of the South African courts, based on the normative background. This analysis reveals which aspects of the doctrine of informed consent have crystallised in South African medical law and which remain unclear.

Informed consent — patient autonomy — volenti non fit iniuria — duty to disclose

I Introduction

The prerequisite that lawful consent be given before a healthcare provider administers treatment or performs a procedure is a cornerstone principle of medical law. [1] Nevertheless, informed consent, as a doctrine of medical law, remains controversial, consisting of several (often complicated) facets. [2]

This doctrine is the core and foundation of the relationship between a patient and a physician. It stems from the law and is regulated by the ethical rules of the healthcare professions. [3] The importation of this doctrine into South African medical law resulted in a paradigm shift from medical paternalism to patient autonomy. [4] Although several established legal and ethical rules underpin this doctrine, there is often a gap between the normative ideal endorsed by it and the actual state of affairs as it appears in practice. [5] This is especially true for vulnerable patients, such as those with an intellectual disability that reduces their capacity. [6] Dhai & McQuoid-Mason argue that the successful interplay between human rights and the rules of medical ethics is crucial in providing adequate healthcare services in a democratic and caring society. [7] Consequently, a burden rests on healthcare providers to ensure that their actions conform to the requirements of professional ethics and human rights and to interject

(in their capacity as advocates for and guardians of their patients) when the actions of others within their field do not conform to those standards. [8]

This article will examine the medico-legal doctrine of informed consent — as South African courts have articulated it — as a manifestation of human rights and the rules of medical ethics. [9] First, we contextualise the importance of consent as a defence against a wrongful act within the realm of the physician–patient relationship, after which we discuss the ethico-legal rules sustaining the doctrine. Secondly, we undertake an in-depth discussion of South African case law, analysing important judgments on the doctrine before and after the promulgation of the Constitution of the Republic of South Africa, 1996. Thirdly and finally, we analyse the case law to expose our courts' triumphs and failings.

This article will examine the doctrine of informed consent in South Africa through a multi-level but integrated approach. [10] Thus, the regulating framework (with the supreme provisions of the Constitution at its core) will be distilled, facilitating the bridging, in future court decisions, of the gap between the normative ideal of this doctrine and the actual state of affairs.

II The doctrine of informed consent as a defence or ground of justification against a wrongful Act

In this part of the article, the doctrine of informed consent in South African medical law will be put into context by briefly examining the legal nature of the relationship between physician and patient and by analysing the ethico-legal development away from medical paternalism in favour of patient autonomy. Subsequently, the constitutional rights underpinning this doctrine will be examined to set the legal background against which the case law will be analysed.

(a) The relationship between physician and patient

The relationship between physician and patient was traditionally viewed as a subject matter situated in the realm of private law and belonging exclusively to the law of obligations. [11] The law of obligations, consisting

primarily of the law of contract and the law of delict, is a subdivision of proprietary rights and still constitutes the foundation of the physician–patient relationship. [12] However, the adoption of the Constitution and several pieces of national legislation on healthcare in terms of the Constitution added a prominent public-law dimension to this relationship. [13]

The relationship between physician and patient thus falls primarily within the law of obligations (contract and delict), but, in certain instances, human rights, constitutional law and criminal law also substantively influence this relationship. [14]

(i) A professional obligation to treat

Under South African law, a physician has no professional right to treat a patient. [15] However, in certain circumstances, an obligation rests on physicians to apply their skills (derived from their profession) to benefit their patients. [16] This is more than a moral or an ethical obligation — it is a legal obligation, which arises in different ways. [17] The obligation for a physician in private practice arises after a contract — known as an obligationary agreement — has been concluded with the patient. [18] In contrast, a physician's obligation in the civil service derives from the

employment agreement between the physician and the relevant provincial health administration. [19] These are thus obligations ex contractu. The relationship between physician and patient will mostly be contractual, with several aspects being tacit or implied. [20]

Stemming from a physician's professional obligation (independent from the clauses of the contractual agreement), a physician will always have a duty of care toward their patients. [21] In terms of the duty of care, all treatment must be administered with reasonable, professional skills to prevent the patient from suffering harm. [22] Should a physician fail in their duty of care, the patient can institute a delictual claim for a wrongful act, in terms of which the patient can claim damages. [23] This obligation thus arises ex delicto and is always relevant when a physician treats a patient.

(ii) Contract

A contract is often the source of physicians' obligations toward their patients. [24] When examining the contractual obligations of the physician–patient relationship, it is essential to distinguish between a physician in private practice and one in civil service.

The contract between the physician in private practice and the patient is generally regarded as the legal foundation of their relationship. [25] In terms of the obligationary agreement, patients request a physician to examine, diagnose and treat them in exchange for monetary remuneration for the professional service rendered.[26] However, in the context of the physician–patient relationship, these contracts are rarely reduced to writing, and the specific clauses are seldom negotiated before the conclusion. [27] It is trite that the verbal nature of these contracts does not detract from their validity, but it does render it significantly more difficult to prove specific agreements. [28]

When a patient uses public healthcare services, the contractual relationship between the physician and the patient is more complicated. The uncertainty in this regard arises partially because matters involving public healthcare services are rarely decided based on contract law — judgments are usually based on the law of delict. [29] Nevertheless, it is generally possible for the state to conclude contracts for rendering services. This general principle also applies to rendering health services,

as is evident from a handful of reported decisions. [30] It remains uncertain, though, whether a physician in civil service is contractually bound to their patients in all circumstances. [31]

The doctrine of informed consent is specifically relevant when a contract is concluded to render health services, as the absence thereof will constitute either a misrepresentation or an error. [32] Under these circumstances, a contract will be either voidable or void, respectively, and an aggrieved party will have the standard remedies in terms of contract law for these outcomes. Informed consent is thus a requirement for consensus — the first element for a lawful contractual relationship to arise. [33]

(iii) Delict

A delict refers to an act perpetrated wrongfully and culpably that causes harm. [34] Where this occurs, the disadvantaged party can claim proven damages from the person who caused it. [35] The relationship between physician and patient ex delicto is thus the result of a physician's wrongful act that culpably (intentionally or negligently) harmed the patient.

In the law of delict, the doctrine of informed consent relates to the element of wrongfulness and is generally not a manifestation of culpability. [36] In essence, the wrongfulness lies in the infringement of a legally protected interest (or an interest that is legally worthy of protection) in a manner that is not lawfully permitted. [37] Wrongfulness thus includes the violation of a person's physical body and the infringement of their various personality rights — that is, a patient's right to autonomy and self-determination. [38] The test to determine whether an infringement is lawful is the boni mores. [39] In healthcare, medical interventions to which a patient

did not consent have since 1923 been regarded by the South African courts as contra bonos mores. [40]

(b) Patient autonomy and the doctrine of informed consent

Traditionally, the practice of medicine was paternalistic. [41] Strauss states that it consisted of three distinct components: first, the component of wisdom, namely the knowledge of human illnesses; secondly, a moral component, which stems from the belief that a physician is an embodiment of good, as envisaged by the Hippocratic oath; and, thirdly, a charismatic component, which was a clear indication of the historical relationship between medicine and religion. [42] In the twentieth century, healthcare technology developed by leaps and bounds, which brought about change, [43] such as the tendency to move away from a religiously oriented morality towards an increasing emphasis on personal freedom and permissiveness. [44] Strauss indicates that the '[sage-physician-counsellor]' [45] paternalism had to make room for a cold, contractual relationship through which the patient obtained their sovereignty. [46]

Although the principle of patient autonomy does not fully encompass the doctrine of informed consent, this principle remains central to obtaining proper, informed consent from a patient. It also determines how the consent should be obtained. [47] Obtaining informed consent requires various actions and a specific social disposition, which the practitioner must employ to respect a patient's autonomy and right to self-determination. [48] The effective application of the doctrine of informed consent is a tangible manifestation of empowerment and respect for a patient's autonomy. [49]

The following discussion will briefly explain how the once patently paternalistic relationship between physician and patient evolved into a relationship with 'sovereign' patients. Thereafter, the ethical and legal foundations supporting patient autonomy in South Africa will be examined.

(i) From medical paternalism to patient autonomy

Previously, the notion of 'doctor knows best' was the primary approach to medical decision-making. Consequently, physicians, rather than patients, made treatment decisions. [50]

The meaning of 'paternalism', especially 'medical paternalism', is often uncertain. [51] Beauchamp & Childress define 'paternalism' as 'the principle and practice of paternal administration; government as by a father; the claim or attempt to supply the needs or to regulate the life of a nation or community in the same way a father does those of his children'. [52]

Paternalism thus refers to those actions that limit individual freedom (seemingly) for the benefit of the individual. [53] The common defence for paternalistic actions is either that they are done in favour of the individual or that they prevent the individual from harming themselves. [54] In healthcare, paternalism manifests itself in different forms, from blatant takeovers to more subtle persuasion and coercion — especially in cases involving vulnerable patients. [55]

Over the past fifty years, the idea that a patient should have the right to decide about their own body garnered support among bioethicists, whilst support for a model of medical paternalism congruently waned. [56] After the Nuremberg Trials, the Universal Declaration of Human Rights and several other codes and regulations published by international organisations such as the World Medical Association established the principle of patient autonomy as decisive [57] — something replicated in South Africa. [58]

The principle of autonomy, from the Greek 'outos', meaning self, and 'nomos', meaning to rule or govern, [59] states that persons are born free — at least supposedly — and therefore should be entitled to determine how they wish to arrange their lives. [60] This principle requires that a physician equip the patient with the knowledge and understanding of the (intended) intervention necessary for rendering a patient's decisions informed. [61]

The principle of patient autonomy is thus twofold. First, a physician is obliged to empower patients with knowledge of their medical condition and possible interventions. Secondly, the physician is expected to respect and, within reason, carry out the informed decisions taken by the patient.

In South African jurisprudence, the principle of patient autonomy has been recognised since 1923. In *Stoffberg v Elliot*, [62] Watermeyer J instructed the jury (used at the time) as follows:

> '[A] man, by entering a hospital, does not submit himself to such surgical treatment as the doctor in attendance upon him may think 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 purposes of vivisection; he remains a human being, and he retains his rights of control and disposal of his own body; he still has the right to say what operation he will submit to, and, unless his consent to an operation is expressly obtained, any operation performed upon him without his consent is an unlawful interference with his right of security and control of his own body, and is a wrong entitling him to damages if he suffers any.' [63]

Since then, this principle has been confirmed and expanded upon numerous times by the supreme courts of the Republic, and several legislative provisions now underscore it. [64]

(ii) Ethical foundations for patient autonomy

Respecting a person's autonomy is very important in liberal and plural communities. [65] Put simply, people generally dislike being told what they can and cannot do. Respecting a patient's right to self-determination is arguably the most important principle of bioethics. [66]

Beauchamp & Childress state that respecting a patient's autonomy first requires from the physician a disposition that respects a patient's choices, and secondly requires the physician to act in accordance with the patient's will. [67] These authors indicate that respect for a patient's autonomy creates five ethical rules: (i) always tell the truth; (ii) respect the privacy of others; (iii) protect confidential information; (iv) obtain the patient's consent before the medical intervention; and (v) when asked, assist the patient in making important decisions. [68]

Nevertheless, the rules of autonomy are only prima facie and not absolute. [69] A prima facie rule must be followed unless it contradicts a rule of equal or greater importance. [70] Moodley states that respecting patient autonomy obligates a physician to obtain informed consent, handle a patient's information confidentially, speak the truth, and communicate effectively with the patient. [71]

The Health Professions Council of South Africa ('the HPCSA'), which is obliged by statute to regulate physicians and other healthcare providers, has adopted specific codes of ethics to ensure that patients can exercise their right to self-determination. [72] The ethical guidelines for healthcare providers endorse respecting patient autonomy as a core value and standard for rendering good and ethical medical services. [73] The HPCSA's definition of 'autonomy' requires that physicians respect and honour a patient's right to self-determination — that is, to make their own informed decisions and to live their lives according to their own beliefs, values and preferences. [74]

(iii) The legal foundations supporting patient autonomy

The principle that the perpetrator is not liable if the victim has consented to the harm or the risk thereof stems from the Roman maxim volenti non fit iniuria. [75] This maxim may be translated into English as 'a person who consents cannot receive an injury'. [76] In terms of this, a defence is created against wrongfulness, which is generally regarded as the most important defence against a physician's liability in the typical performance of their duties. [77]

Consent is essential in the daily interactions between physicians and patients. The foundational requirements for lawful consent deal with the knowledge, appreciation and acceptance of the risks and consequences of the medical treatment by the patient. [78] These requirements presuppose

that the patient can consent to the medical intervention. [79] As most medical patients are laypersons without medical training, the knowledge of the procedure and appreciation of the information will be quintessential for raising the defence of consent. [80] In *Esterhuizen v Administrator, Transvaal*, [81] Bekker J worded the position as follows:

> 'Generally speaking, all the numerous authorities without exception, indicate that, to establish the defence of *volenti non fit iniuria*, the plaintiff must be shown not only to have perceived the danger, for this alone would not be sufficient, but also that he fully appreciated it and consented to incur it.' [82]

After the indirect protection of a person's autonomy provided by the maxim of volenti non fit iniuria, several statutory provisions now protect a person's bodily integrity and right to self-determination. With the promulgation of the Constitution, a sovereign clause was incorporated into the Bill of Rights in s 12, thereby explicitly confirming the principle of autonomy in general and particularly in the practice of medicine. [83]

Section 12(2) of the Constitution determines that everyone has the right to bodily and psychological integrity, security in and control over their bodies, and the right not to be subjected to medical or scientific experimentation without their express informed consent. [84] It is important to note that s 12(2) of the Constitution protects both bodily and psychological integrity. [85] In medical law, this is important, as medical interventions against a patient's wishes will not necessarily result in bodily harm. In fact, the intervention will (objectively viewed) enhance a patient's physical well-being in some cases. [86] Nevertheless, such actions will infringe on s 12(2) when they violate the patient's psychological integrity. [87] In this way, the principle of autonomy is also closely linked to the constitutional right to human dignity, as encompassed by s 10 of the Constitution, as the

right to make decisions about one's own body is part of a person's inherent dignity. [88] This aspect will be elaborated upon below.

The right to privacy, as articulated in s 14 of the Constitution, has also been interpreted by the courts in a manner that encompasses the principle of autonomy. [89] In *Case & Curtis v Minister of Safety and Security*, [90] the Constitutional Court extended the right to privacy beyond information protection to the so-called 'substantive or personal autonomy privacy right'. [91] This broad interpretation allows people to make decisions about the private sphere of their lives (their families, home and sexual lives) without interference by other parties — especially the state. [92]

In addition to the constitutional provisions, several pieces of national legislation promote respect for patient autonomy, either explicitly or by requiring informed consent. The National Health Act, in s 6, requires that patients have full knowledge of the nature, extent and dangers associated with an intervention before consenting to it. [93] Section 7 of the Act further bars a healthcare provider from rendering a healthcare service to a patient without their informed consent. [94] Similar provisions are also contained in the Mental Health Care Act. [95]

Several judgments since *Stoffberg* [96] in 1923 have confirmed the principle of patient autonomy in South African case law, [97] and it has been consistently applied since then — even in the context of children. [98] In *Christian Lawyers Association v Minister of Health*, [99] the court contextualised informed consent within South African common law and concluded that the doctrine — as it stems from volenti non fit iniuria — rests on the three independent legs of knowledge, appreciation and consent. [100] The most

recent reported judgment is the matter of *Beukes v Smith*, [101] where a full bench of the Supreme Court of Appeal ('SCA') stated:

> '[C]ourts employ a patient based approach. The reasoning is that a patient's freedom to self-determination includes the right to decide whether

she wants to undergo surgery. A patient is entitled to refuse medical treatment. If she consents to surgery or medical treatment, she accepts responsibility for unintended harm in the medical treatment, in the sense envisaged in the principle *volenti non fit injuria.*' [102]

From the above, it is apparent that respecting a patient's right to self-determination and autonomy is a legal imperative.

(c) Human dignity and the doctrine of informed consent

For McQuoid-Mason, bioethics principles, human rights and South African law are intrinsically linked. [103] Several rights in chap 2 of the Constitution encompass the doctrine of informed consent. [104] This part of the article will focus on the right to human dignity as the anchor norm of human rights in so far as patient autonomy is concerned. [105]

(i) Human dignity as the anchor norm of human rights

In the South African constitutional dispensation, dignity is acknowledged as a founding value and an enforceable right. [106] As a founding value, the recognition and protection of human dignity are the touchstone of the South African political order and are fundamental to our Constitution. [107] As a fundamental right, dignity is frequently referred to as the foremost right, which should particularly enjoy protection. [108]

Human dignity, as a foundational value and human right, links directly to the right to freedom and security of the person (s 12), as the

infringement of this right will also violate a person's inherent dignity. [109] Haysom considers dignity also to be directly implicated when the equality clause is interpreted to determine unfair discrimination, as enshrined in s 9(3) of the Constitution. [110]

It is, therefore, evident that human dignity as both a foundational value and fundamental right is central and guiding when adjudicating constitutional rights contained in the Bill of Rights. Although human dignity is a right in and of itself, it is also intrinsically linked with the process that is followed to determine whether a constitutional right is infringed. [111] Chaskalson thus argues that the right to human dignity is implicit in almost all of the fundamental rights in our constitutional dispensation. [112]

This article typifies it as the 'anchor norm' of human rights owing to the implicit, guiding centrality of the right to human dignity. [113]

(ii) Patient autonomy and the doctrine of informed consent as an expression of human dignity

In part II(b), we indicated those ethical and legal provisions that directly underpin patient autonomy. Thereafter, we indicated that the right to human dignity is a founding value and right so fundamental to the South African constitutional dispensation that it is the touchstone by which the lawfulness of all action is measured and through which all other constitutional rights should be interpreted. [114] From this, it follows that respecting a patient's right to self-determination and dignity, as encompassed by the doctrine of informed consent, is a manifestation of human dignity. However, the reverse is perhaps more critical: a physician failing to obtain a patient's informed consent for medical intervention amounts to an infringement of the patient's right to human dignity.

From a bioethical viewpoint, Foster argues that human dignity is the all-important value, principle and right in healthcare research [115] — when applied correctly, dignity is the key that unlocks all issues in medicine and bioethics. Foster calls it the 'bioethical Theory of Everything'. [116] In analysing any medical or bioethical issue, one should always ask:

'Which solution best protects and develops the human dignity of the relevant parties?' [117]

Although several legal and ethical instruments protect a patient's autonomy — that is, their right to self-determination [118] — it is submitted that, more than any other value, human dignity underscores the doctrine of informed consent. From this discussion, it is evident that every person's inherent dignity is of cardinal importance. The right to command one's own body — to make autonomous decisions and for those decisions to be respected — is fundamental to a patient's dignity. Therefore, this article's premise is that human dignity, as the anchor norm of human rights, also underlies and confirms the doctrine of informed consent.

III Overview of South African case law

It is trite that case law is an important, primary source of South African law. [119] In the context of medical law, Carstens & Pearmain describe case law as a guiding source of positive law that frequently shines a light on complex and otherwise uncertain provisions. [120] Indeed, the pertinence of the doctrine of informed consent, as South African scholars and courts articulate it, transcends South African borders, as is clear from seminal decisions in neighbouring countries. [121]

Respecting a patient's right to self-determination and the view that medical interventions without the necessary consent are contra bonos mores were, importantly, established by our courts in *Stoffberg v Elliot* [122] a century ago (as indicated in part II). In this part of the article, nine decisions about patient autonomy and informed consent will be examined, indicating how they have contributed to the application and development of the doctrine in South Africa. The purpose is not to discuss the facts of each matter thoroughly but rather to provide a sort of anthology regarding the South African courts' development of this doctrine. Every judgment was purposefully chosen to provide a concise overview from the earliest recognition of a physician's disclosure duty to the SCA's most recent reported judgment.

(a) Before the promulgation of the Constitution

As indicated above, the principle of patient autonomy precedes the Constitution. [123] Ackermann indicates that South Africa has a rich personality rights jurisprudence predating the promulgation of the Constitution. [124] These judgments, which are still binding, provide an important interpretative basis from which we view constitutional rights such as human dignity, privacy, and the right to freedom and security of the person. It is, however, crucial to scrutinise these judgments carefully through the prism of the Bill of Rights and to ensure that they conform to the provisions thereof before relying on them as an authority.

Part III(a) will give an overview of four essential judgments on patient autonomy and the doctrine of informed consent delivered before the promulgation of the Constitution.

(i) *Stoffberg v Elliot*[125]

In the infamous matter of *Stoffberg*, Mr Stoffberg instituted action against Dr Elliot for what he alleged was the unlawful amputation of his penis when he consented only to surgery removing cancerous growths. [126] It is trite that upon instructing the jury, Watermeyer J articulated a strong medical paternalism and strongly propagated patient autonomy. [127] Of course, it must be noted that the 'absolute rights which the law protects, . . . [which include] the right [to] absolute security of the person', [128] can be limited in terms of the general limitation clause of the Constitution and are not, as Watermeyer J states, absolute. [129] Another important aspect of this judgment is the determination that

> '[a]ny bodily interference or restraint of man's person which is not justified in law, or excused in law or consented to is a wrong, and for that wrong the person whose body has been interfered with has a right to claim such damages as he can prove he has suffered owing to that interference'. [130]

This indicates that a lack of informed consent relates to the wrongfulness component of a delict or crime. [131]

This foundational judgment provided a robust legal basis for the principle of patient autonomy and marked a decisive move away from medical

paternalism in South African medical-law jurisprudence. [132]

(ii) *Esterhuizen v Administrator, Transvaal*[133]

The decision in *Esterhuizen v Administrator, Transvaal* is a similarly early decision — decided in 1957 — about a physician's duty to disclose all essential risks and the consequences of the medical treatment envisaged to the patient to establish the defence of volenti non fit iniuria.[134] A ten-year-old girl had a small nodule on her foot, which was diagnosed as Kaposi's haemangiosarcoma. [135] She was referred to the Johannesburg General Hospital (as it was then known) for X-ray treatment. After receiving radiation treatment some years after the initial diagnosis, the girl, then almost 15, suffered extensive radiation injuries, resulting in the loss of her legs and right hand. [136] The likelihood seemed great that she would lose her left hand as well. [137] When questioned on why he did not inform the patient and her legal guardians of the risks, Dr Cohen, the treating physician, stated:

> 'It was my function to cure the disease if possible. . . . I was fully aware that there would be cosmetic changes . . . after radiotherapy. I did not consider it necessary to discuss these details with the patient and I had never met the patient's parents. . . . It is not the usual procedure in the radiotherapy department to ask the parents to come.' [138]

In his judgment, Bekker J approvingly referred to Neser J's judgment in the unreported matter of *Rompel v Botha*, [139] where he said:

> 'There is no doubt that a surgeon who intends operating on a patient must obtain the consent of the patient. In such cases, where it is frequently a matter of life and death and I do not intend to express any opinion as

> to whether it is the surgeon's duty to point out to the patient all the possible injuries which might result from the operation, but in a case of this nature, which may have serious results to which I have referred, in order to effect a possible cure for a neurotic condition, I have no doubt that a patient should be informed of the serious risks he does run. If such dangers are not pointed out to him then, in my opinion, the consent to the treatment is not in reality consent — it is consent without the knowledge of possible injuries.' [140]

In light of the abovementioned decision, Bekker J expanded as follows:

> '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.' [141]

Moreover, in agreement with the position taken in *Rompel v Botha*, [142] Bekker J rejected the notion that it would be 'intolerable' for healthcare workers if a duty is placed on them to inform the patient of all the consequences, dangers and details of the risks associated with the medical intervention. [143] Bekker J stated:

> 'I do not pretend to lay down any such general rule; but it seems to me, and this is as far as I need to go for purposes of a decision in the present case, that a therapist, not called upon to act in an emergency involving a matter of life and death, who decides to administer a dosage of such an order and to employ a particular technique for that purpose, which he knows beforehand will cause disfigurement, cosmetic changes and result in severe irradiation of the tissues to an extent that the possibility of necrosis and a risk of amputation of the limbs cannot be excluded, must explain the situation and resultant dangers to the patient – no matter how laudable his motives might be – and should he act without having done so and without having secured the patient's consent, he does so at his own peril.' [144]

From this judgment, it is clear that mere consent to a medical procedure, without knowledge of the possible (and essential) risks that the intervention entails, will not be regarded as sufficient — at least not in so far as the defence of volenti non fit iniuria is concerned. This judgment confirms a patient's right to act autonomously and contains a strong disdain for medical paternalism.

(iii) *Richter v Estate Hammann*[145]

Richter v Estate Hammann is a most ill-fated tale of unexpected medical consequences. The plaintiff, Ms Richter, instituted a claim against the estate of the late Dr Hammann, a revered neurological surgeon. [146] The plaintiff had consulted with the physician following an injury to her coccyx that caused her great pain and discomfort. [147] He administered a unilateral phenol block to the plaintiff's right side, which had the unfortunate consequences of leaving Ms Richter permanently incontinent, chronically constipated, without sexual feeling, and with a loss of strength in her right foot. [148]

Coincidentally, like *Stoffberg* [149] in 1927, [150] this judgment was penned by a different Watermeyer J in the same Cape Provincial Division of the High Court (as it was then known). But, unlike in *Stoffberg* some 50 years earlier, the same weight was not afforded to patient autonomy. [151] Instead, Watermeyer J stated:

> 'A doctor whose advice is sought about an operation to which certain dangers are attached — and there are dangers to most operations — is in a dilemma. If he fails to disclose the risks he may render himself liable to an action for assault, whereas if he discloses them he might well frighten the patient into not having the operation when the doctor knows full well that it would be in the patient's interests to have it. It may well be that in certain circumstances a doctor is negligent if he fails to warn a patient, and, if that is so, it seems to me in principle that his conduct should be tested by the standard of the reasonable doctor faced with the particular problem.' [152]

It is important to note, though, that this passage was explicitly rejected by the full bench in *Castell* (discussed below), [153] with Ackermann J stating (immediately after quoting the same passage):

> 'I am, with respect, unable to agree.
>
> . . .
>
> I am also unable, with respect, to agree with the conclusion that the "reasonable doctor" test does not "leave the determination of a legal duty to the judgement of doctors." In *Sidaway's* case, also reported in *Sidaway v Bethlehem Royal Hospital Governors & others* [1985] 1 All ER 643 (HL),

> which report will hereinafter be referred to (for purposes of citation) at 658–9, Lord Diplock held that:
>
> > ". . . To decide what risks the existence of which a patient should be voluntarily warned and the terms in which such warning, if any, should be given, having regard to the effect that the warning may have, is as much an exercise of professional skill and judgment as any other part of the doctor's comprehensive duty of care to the individual patient, and expert medical evidence on this matter should be treated in the same way. The *Bolam* test should be applied."
>
> Lord Diplock was, therefore, of the view that although the law imposed the duty of care, the standard of care to be enforced was a matter of medical judgment. Giesen *Malpractice Law* at 282 comments as follows:
>
> > "One has to consider this result carefully. Should the medical profession really be appointed judge in its own cause? Carried to its ultimate logical conclusion, Lord Diplock's opinion would mean that the function of English Courts would be limited to determining whether the defendant physician had acted in accordance with a responsible body of medical opinion, unless the plaintiff was a member of the judiciary (a reference by Giesen to the singular observation at 659 *a–b* that members of the judiciary have the right to be informed as patients apparently because they are aware of their right of self-determination) or had specifically demanded information which the physician then failed to disclose. A standard of disclosure which allows the medical profession to be judge in its own cause and physicians in deciding what is best for the patient to override the patient's right to decide for himself is 'medical imperialism' at its worst. We cannot but agree with Lord Scarman's criticism of that stance.'" [154]

It is submitted, with respect, that Ackermann J's criticisms of the *Richter* decision are sound and that the test of the 'reasonable doctor' smacks of medical paternalism. Still, it is peculiar to note that several judgments since *Richter* have quoted this passage approvingly despite its having been overturned by a full bench of the same division; what is even more peculiar is the fact that *Richter* and *Castell* have both been cited approvingly by the SCA, despite the opposing views they take, with no explanation given for this. [155]

Richter's inappropriate application will be discussed in more detail below.

(iv) *Castell v De Greef*

Despite several later judgments by the SCA, [156] the locus classicus for informed consent remains a decision by a full bench of the Cape Provincial Division of the High Court (as it was then known) in *Castell v De Greef*. [157] In this matter, the plaintiff underwent a subcutaneous mastectomy as a preventative measure, as she had lumps in her breasts and a history of breast cancer in her family. [158] After consideration, it was decided that the defendant would implant a prosthesis and reconstruct the plaintiff's breasts. [159] This was done, but the plaintiff was unhappy with the procedure's outcome for several reasons. [160]

Through this judgment, Ackermann J, for the first time, imported the doctrine of informed consent by name into South African law and added a new dimension to consent in medical interventions that, despite some controversy later, is still the lodestar for physicians and jurists. [161] Regarding the doctrine of informed consent and a physician's onus of disclosure, the court stated:

> 'It is in accord with the fundamental right of individual autonomy and self-determination to which South African law is moving. This formulation also sets its face against paternalism, from many other species whereof South Africa is now turning away. It is in accord with developments in common law countries like Canada, the United States of America and Australia, as well as the judicial views on the continent of Europe. . . .
>
> I therefore conclude that, in our law, for a patient's consent to constitute a justification that excludes the wrongfulness of medical treatment and its consequences, the doctor is obliged to warn a patient so consenting of a material risk inherent in the proposed treatment; a risk being material if, in the circumstances of the particular case:
>
> *(a)* a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it; or
>
> *(b)* the medical practitioner would be likely to attach significance to it.' [162]

According to Carstens & Pearmain, the importance of this judgment for the doctrine of informed consent in South Africa can be summarised in four points: (i) in this decision, the doctrine was for the first time

identified to be a facet of South African medical law; (ii) an unequivocal recognition of patient autonomy above medical paternalism was given; (iii) a lack of informed consent relates to the element of wrongfulness and not negligence; and (iv) the 'reasonable patient' and not the 'reasonable physician' was held to be the test for informed consent. [163]

Although this decision was penned before the promulgation of the Constitution, the formulation of the argument very much aligns with the now supreme constitutional provisions. [164] Although more recent decisions by the SCA have muddied the water regarding especially points (iii) and (iv) — regrettably so — this decision has never been expressly overturned or set aside. [165] It is hoped that the SCA or the Constitutional Court will unequivocally confirm these principles at the next opportunity.

(b) After the promulgation of the Constitution

The South African legal system received a complete overhaul in 1994; we now view all actions and laws through the prism of the sovereign Bill of Rights. [166] The Constitution neither operates in a vacuum nor is it self-executing. [167] Realizing our constitutional ideals requires active and wilful implementation by politicians, public administrators, jurists and the private sector. The direct application of human rights in subject areas such as medical law — referred to as the 'medicalisation of civil rights' — accords with the rule of law. [168]

In this part, we examine five judgments. What is particularly important is that these judgments — building on the solid foundation of our common law, discussed in part III(a) — were all decided after the promulgation of the Constitution. As noted above, old-order jurisprudence remains an essential source of (binding) precedent. [169] Nevertheless, courts have

to scrutinise those judgments to assess their applicability within the framework of the (now) constitutional state. The influence of the relevant constitutional provisions in these judgments (or the lack thereof) will be considered.

(i) *Broude v McIntosh* [170]

The facts of *Broude v McIntosh* are complex and somewhat contentious. [171] The appellant, a physician by profession, suffered paralysis of the left side of the face caused by the (alleged) negligent conduct of the respondent — an ear, nose and throat surgeon — who had operated on his left ear. [172] The court a quo declared absolution of the instance, as Broude could not discharge the burden of proof and prove his case on a preponderance of probabilities. [173] On appeal, Marais JA ruled: 'All things considered, I am unable to conclude that the trial judge has been shown to have been wrong in granting absolution from the instance.' [174] The appeal was subsequently dismissed with costs. [175] The bulk of this judgment deals with contradicting evidence, which has little relevance for the present discussion save for one critical remark by Marais JA, where he stated (obiter):

> 'Pleading a cause of action such as this as an assault to which the patient did not give informed consent is, of course a familiar and time-honoured method of doing so. However I venture to suggest with respect that its conceptual soundness is open to serious question and merits reconsideration by this court when an appropriate case arises. To the average person, and I suspect to many a lawyer, it is a strange notion that the surgical intervention of a medical practitioner whose sole object is to alleviate the pain or discomfort of the patient, and who has explained to the patient what is intended to be done and obtained the patient's consent to it being done, should be pejoratively described and juristically characterised as an assault simply because the practitioner omitted to mention the existence of a risk considered to be material enough to have warranted disclosure and which, if disclosed, might have resulted in the patient withholding consent. . . . I consider that the validity of causes of action framed in this manner *in circumstances similar to those which are said to exist in this case* requires re-examination. . . . However, re-examination would be inappropriate in the present case.' [176]

It is respectfully submitted that Marais JA's statement illustrates the danger of obiter dicta, as it neither conforms to the notion of patient autonomy nor is it in line with the constitutional values and rights

that underpin the doctrine of informed consent. [177] As argued above, it violates a patient's inherent human dignity and right to bodily autonomy to perform a medical intervention upon the patient without their full and proper informed consent. In this judgment, the court seems to have lost sight of the essential final requirement for an actionable delict, namely damage. [178]

Neethling & Potgieter indicate that the law of delict has two distinct functions in alleviating the damage caused by a wrongful act. [179] First, there is monetary compensation for the (patrimonial and certain types of non-patrimonial) damage suffered, intending to eliminate (as far as possible) the damage incurred retrospectively and into the future — money is thus equated to the damage. [180] Secondly, moral damages are claimed when the damage suffered is to a personality right — meaning that money cannot compensate for the damage suffered (ie to a person's dignitas, fama, or for pain and suffering). [181] It is submitted that medical interventions without a patient's informed consent violate their constitutional rights to dignity and autonomy of the body. [182] The fact that no physical harm followed the impugned intervention is of no consequence concerning whether a wrong was committed. The patient subjected to medical treatment — however laudable the physician's intention might be — without their express and informed consent (when they can give it) suffers a violation of their personality rights. This, it is submitted, can take the form of either a medical intervention that (objectively viewed) enhances the patient's health but to which they did not consent or a situation where a physician did not adequately explain the risks inherent in a specific medical intervention. It must be conceded, however, that — as is the case with all delictual claims based on personality rights — the proof and calculation of damages is a difficult task [183] and a topic that falls outside the scope of the present article. Nevertheless, the complexity does not detract from such an action's lawfulness or soundness.

The view above also conforms to the legal position in comparable jurisdictions. In English law, for example, a casuist approach is followed, which consists of a group of individual wrongful acts known as torts, each

with its own elements and rules. [184] Trespass to the person — in the context of medical interventions, specifically battery and assault — is particularly relevant. [185] In the context of civil medical malpractice, battery will be committed when a healthcare provider touches a patient without their 'real' consent. [186] In this regard, Jackson states:

> 'It is no defence to a charge of battery that the doctor was acting in the best interest of her patient, or that she exercised all reasonable care and skill. Evidence of accepted medical practice is also irrelevant: if the failure to provide information to a patient vitiates her consent, the fact that the defendant can point to the other doctors who would have acted in the same way will not absolve her of responsibility. There could be no "therapeutic exception" [if] the cause of action is battery. If information is necessary for consent to be real the doctor cannot decide not to mention it in order to shield the patient from distress.' [187]

It is imperative to note that no physical harm caused by inadequate disclosure has to be established for an action in battery to succeed. [188] Instead, following a successful action in battery, patients can be compensated for the dignitary harm they suffered from being treated without their valid consent. [189] Where physical harm is present, it would be more suitable in English law to bring an action on the tort of negligence. [190]

Similarly, in German law, a physician can be held liable criminally and civilly for Körperverletzung (a violation of a patient's personality rights)

regardless of whether the medical intervention was done with the necessary skill and diligence required of physicians. [191]

Marais JA's comment was made obiter and therefore cannot constitute a binding dictum. [192] It is vital that negative connotations regarding an 'assault', primarily as it is understood in the criminal context, do not lead jurists astray in medical-law cases. The wrong lies in the lack of informed consent, founded upon various constitutional rights. It should — at least as a foundational understanding of our normative law — be regarded as an actionable delict if patient autonomy is to be truly respected.

(ii) *Louwrens v Oldwage*[193]

In the matter of *Louwrens v Oldwage*, the appellant, Dr Louwrens, appealed a decision by the Cape of Good Hope Provincial Division (as it was then known) to the SCA. [194] In this matter, the respondent, Mr Oldwage, approached the appellant on referral from his general practitioner, as he was suffering from severe pain in his leg and lower back. [195] The central factual issue of this matter was whether the origin of the pain was vascular — as diagnosed and treated by Dr Louwrens — or neuralgic. [196] The court a quo found the latter to be the case, which consequently meant that Dr Louwrens had made an incorrect diagnosis. [197] The respondent, having undergone surgery for both vascular and neuralgic conditions by the time a claim was instituted, came to suffer from what is termed as 'steal syndrome' and exhibited symptoms of claudication (blockage of the arteries with resultant cramping), which he alleged was the result of the appellant's surgical intervention. [198] In its order, the SCA upheld the appeal with costs, set the order of the court a quo aside, and dismissed the suit against Dr Louwrens. [199]

In the judgment, Mthiyane JA dealt extensively with the evidence presented to the court a quo regarding the finding of an incorrect diagnosis. [200]

This analysis is not relevant to the present discussion. What is relevant, though, is the court's discussion about whether Mr Oldwage's consent to the vascular surgery was informed, specifically concerning the risk of steal syndrome as a possible side effect. [201]

The court indicated that the respondent relied on the authority of *Castell*, [202] where that court said:

> 'For consent to operate as a defence the following requirements must, *inter alia*, be satisfied:
> (a) the consenting party "must have had knowledge and been aware of the nature and extent of the harm or risk";
> (b) the consenting party "must have appreciated and understood the nature and extent of the harm or risk";
> (c) the consenting party "must have consented to the harm or assumed the risk";
> (d) the consent "must be comprehensive, that is extend to the entire transaction, inclusive of all its consequences."' [203]

The SCA in *Louwrens* did not expressly state that it accepted these requirements as a sound authority, but they would seem to be the benchmarks against which they measured the appellant's actions. Thus, their appellate approval can be inferred. It is common cause that Mr Oldwage was not warned of the possibility of steal syndrome as an adverse effect of the operation that Dr Louwrens performed. On the probability of the occurrence of steal syndrome, two experts gave evidence. First, Mr Oldwage called Professor De Villiers. [204] Relying on so-called 'Veteran Administration Studies' from 1976, De Villiers indicated that about four per cent of patients suffered from steal syndrome as an adverse effect. [205] Professor Immelman for Dr Louwrens disputed this figure, indicating that, for various reasons, [206] it was not applicable to the matter before the court. [207] Without a clear indication of the authority upon which he relied, Immelman placed the risk of steal syndrome at no higher than two per cent, which estimation the court accepted. [208]

In its reasoning, the court held that '[i]f there was only a two per cent chance of "steal" occurring then the risk to the plaintiff was so negligible that it was not unreasonable for [Dr Louwrens] not to mention it'. [209] For this finding, the court relied on *Richter*, [210] where it was held that the test for informed consent is that of the reasonable physician. [211]

It is respectfully submitted that the court's finding that a two per cent probability is negligible enough not to have warranted disclosure appears to be arbitrarily made. In no way did the court consider that, for example, Mr Oldwage led an active lifestyle in which he enjoyed cycling, swimming and hiking, nor did it give any guidance on how a court should assess whether or not a risk is significant enough to warrant mentioning. The court also did not indicate whether four per cent is a probability that would amount to a risk worth mentioning, should Professor De Villiers' version have been accepted. If risk should be expressed as a percentage (which is not always attainable), at which fraction will it become material? The finding seems plucked from the air, and how the court reached this finding was unfortunately not set out in the judgment.

Moreover, the authority relied on for this decision (*Richter*) was effectively overturned by the decision in *Castell*. [212] As indicated above, *Richter* did not conform to the principle of patient autonomy and was expressly rejected by a full bench of the same division. [213] The court also does not explain this, nor does it rule that the decision in *Castell* was incorrect for reversing *Richter*'s ratio.

(iii) *McDonald v Wroe*[214]

In *McDonald v Wroe*, the plaintiff, Ms McDonald, consulted the defendant, Dr Wroe, a general dental practitioner in Green Point, Cape Town. [215] Ms McDonald had suffered from an infection in her wisdom teeth. [216] After examining her, Dr Wroe advised the plaintiff that three of her impacted wisdom teeth would require surgical extraction under general anaesthesia. [217] Dr Wroe undertook the extraction, but, unfortunately,

Ms McDonald's inferior alveolar nerve on the left side of the mandible was damaged. [218] This led to chronic numbness and 'pins and needles' to the left side of Ms McDonald's face. [219] The plaintiff, in her particulars of claim, alleged that first, the defendant was negligent in failing to offer to refer her to a specialist maxillo-facial and oral surgeon, and secondly, that the defendant negligently failed to inform her of the possible complications and risks of the planned procedure. [220] It is the second claim that is of relevance to this article.

In an articulate judgment, Fourie J stated that

> '[f]or the consent to the planned procedure to constitute a justification that excludes wrongfulness of the medical treatment and its consequences, the medical practitioner is obliged to warn a patient so consenting of a material risk inherent in the treatment'. [221]

To answer the question as to when a risk is regarded as material, the learned judge favourably referred to *Castell* regarding the test of the reasonable patient to determine whether or not consent was informed. [222] Fourie J ruled that the 'plaintiff's right to bodily integrity is

entrenched in section 12(2) of our Constitution, Act No. 108 of 1996 [sic], which right the defendant has violated by subjecting her to surgery without obtaining her informed consent'. [223]

Although this order was later overturned by a full bench of the same division, the element of causation led to this decision's demise, not the question of whether or not Ms McDonald's consent was informed. [224] The court's judgment at first instance thus remains a proper authority on aspects of informed consent.

(iv) *Sibisi v Maitin*[225]

The SCA decision in *Sibisi v Maitin* is perplexing. [226] Ms Sibisi instituted a claim on behalf of her minor daughter, Yandiswa, against Dr Maitin. [227] She alleged that Dr Maitin's negligent conduct in delivering Yandiswa, who was a macrosomic baby (a very large baby), resulted in injury to her brachial plexus, which in turn resulted in Erb's palsy — defined as

a weakness or paralysis of the shoulder and arm caused by injury to the upper routes of a baby's brachial plexus during birth. [228]

In this matter, the court — in its own words — was tasked with deciding several legal questions, including about a physician's duty to disclose information regarding remote risks to a patient, the test to determine whether a physician discharged their duty to disclose and, if a physician is not found to be negligent in their failure to disclose a remote risk, on what basis liability arises. [229]

Rather than providing a definitive answer to any of these crucial questions, the court, per Lewis JA, stated:

> '[T]he question of informed consent goes to the wrongfulness element of the Aquilian action. Negligent conduct on the part of the doctor will be wrongful if the patient has not given informed consent. Negligence is still a requirement, and in *Castell* it was established. [sic] Where there is no negligence proved, however, the test for wrongfulness does not even arise.' [230]

In this regard, Zwart correctly indicates that the court here failed to acknowledge that unlawfulness is an element of a delict (or a crime) that must be adjudicated separately from the element of fault; and that fault, in the absence of informed consent, frequently manifests as dolus rather than culpa. [231]

Moreover, in paras 46 and 47–9, Lewis JA referred approvingly to two judgments that directly contradict one another regarding the test of a physician's duty to disclose. [232] In para 46, the court cited *Richter*, [233] where the test of the reasonable physician was set as the standard. [234] In contrast, the court in paras 47–9 indicated that the test is that of the reasonable patient, as determined in *Castell.*[235] The court also did not explain or reconcile this patent contradiction.

In this regard, Van Loggerenberg states that the court was merely paying lip service to *Castell* by not applying it. [236] Lewis JA stated that informed consent, as a ground of justification, would exclude the element of wrongfulness — the act would automatically have been wrongful as it amounts to assault in terms of the actio iniuriarum — but then incorrectly applied *Castell*, as she required negligence to constitute a

delict, in terms of the actio legis Aquiliae. [237] The judgment ends with the sentence: 'On the facts, therefore, it cannot be found that the conduct of Dr Maitin was wrongful. And since he was not negligent, liability cannot be established.' [238] Based on authority that does not support the premise, the court thus determined that the absence of informed consent does not in itself lead to liability and (seemingly) inadvertently amended the approach to this doctrine. [239]

Where the error lies — whether the court meant to reject *Castell* or to accept it but simply misapplied it — remains unclear. What is certain, though, is that this judgment did not expressly invalidate *Castell*, and the actual state of affairs is uncertain.

(v) *Beukes v Smith*[240]

The SCA's most recent reported judgment addressing the informed-consent doctrine is *Beukes v Smith*. In this matter, the appellant, Ms Beukes, underwent a laparoscopic hernia repair during which her colon was perforated. [241] Ms Beukes argued that the surgeon, Dr Smith, did not adequately inform her of the procedure's risks (as well as laparotomy as an alternative), rendering her consent uninformed and insufficient. [242]

Although the doctrine of informed consent was the core of the legal question in this matter, the court had to answer two (other) central questions. The first question related to the degree of and the circumstances under which the ethical rules for professional practice for healthcare workers should influence the element of wrongfulness. [243] The second question dealt with how courts consider evidence within the context of medical negligence — specifically when contradicting versions regarding informed consent are presented to the court. [244]

In *Beukes,* the court referred to both *Castell* [245] and *Sibisi* [246] regarding a physician's duty of disclosure for surgical medical interventions and stated:

> 'In claims for damages based on negligence for failure to warn a patient of material risks or complications attendant in a treatment or surgical procedure, courts employ a patient based approach. The reasoning is that a patient's freedom to self-determination includes the right to decide whether she

> wants to undergo surgery. A patient is entitled to refuse medical treatment. If she consents to surgery or medical treatment she accepts responsibility for unintended harm in the medical treatment, in the sense envisaged in the principle *volenti non fit iniuria.* However, a patient must have had knowledge and must have appreciated the nature and extent of such harm or material risk. Therefore, for a patient's consent to constitute justification that excludes wrongfulness, a doctor is obliged to warn a patient of the attendant material risks in such procedure. A risk is regarded as material when a reasonable person in the patient's position, if warned of the risk, would likely attach significance to it; or where the medical practitioner is aware that the patient, if warned, would likely attach significance to it.' [247]

Although Navsa JA approvingly referred to the patient-based approach of informed consent, as framed in *Castell*, he also — on an equal basis — referred to the confusing decision in *Sibisi.*[248] In contrast to *Sibisi*, however, the court's application of the law to the facts leads one to believe that the court intended to give effect to the test of the reasonable patient (rather than the reasonable physician) in so far as a physician's duty of disclosure is concerned.

Over and above the critique levelled at the judgment by Townsend & Thaldar, [249] the court made a regrettable statement toward the end of the decision: 'It could therefore not be said that there was *negligence* in relation to obtaining the informed consent from Mrs Beukes.' [250] This directly contradicts the court's earlier statement, only a few paragraphs before this, that volenti non fit iniuria as a ground of justification is a defence against wrongfulness and not fault (in the form of negligence). [251]

Although the SCA resolved some of the confusion created in *Sibisi* [252] — especially in so far as the patient-based approach is concerned — the manifestation of medical interventions without the necessary consent was again typified only as negligence (rather than wrongfulness). This notion does not align with the decision in *Castell*, regardless of the court's apparent approval of this judgment. [253]

IV An assessment of the South African case law

In part III of this article, nine significant judgments were dissected in light of the normative ethico-legal background sketched in part II.

In this part, the part III analysis will be consolidated and collated into two groups: those elements of the doctrine of informed consent that have crystallised and those that remain uncertain. By doing this, the triumphs and failings of the South African courts will become evident, and we hope that the position regarding any shortcomings might be rectified — in line with the normative framework — when similar matters come

before the bench again.

(a) What is certain

As indicated in the discussion above, the doctrine of informed consent has evolved as a notion within the broader realm of medical law and the South African legal landscape. Although some aspects remain unclear from the case law, other aspects have been distilled and confirmed.

(i) Patient autonomy is recognised over medical paternalism

As indicated, the physician–patient relationship shifted from medical paternalism to patient autonomy during the twentieth century. [254] The notion that patients ought to have the right to decide over their bodies — even when it might ostensibly be to their detriment — was recognised by South African courts as early as 1923. [255] Since then, numerous authorities have confirmed the applicability of this principle in South African medical law. [256]

Of the matters considered, it was only in *Richter* that Watermeyer J made certain claims contrary to this principle's quintessence. [257] Still, it is submitted that the various decisions after *Richter* confirmed this principle and thus superseded those aspects of the dicta in *Richter* that can be considered as favouring medical paternalism. [258] This position is also solidified by the various legislative provisions since enacted, chief among them ss 10 and 12 of the Constitution. [259] Ousting medical paternalism in favour of patient autonomy also aligns with global tendencies [260] and is a positive development in South African case law.

(ii) The doctrine of informed consent applies in South Africa

Carstens & Pearmain indicate that it was only in 1994, through the decision in *Castell*, that this doctrine was named and formally imported into South African case law. [261] Since this decision, the doctrine has been applied by name in several cases. [262]

This is significant, as the doctrine of informed consent is a subject of international relevance, [263] with new research being published annually. As medical technology continues to develop, the doctrine has to evolve to create a sound foundation for medical research and advances in, for example, telemedicine and robotic surgery. [264] Similarly, research continually develops our understanding of informed consent for the particularly vulnerable, such as persons with intellectual disabilities, children, the elderly, and the illiterate. [265] Most of the latter aspects have not yet been adjudicated by our courts, but recognising the doctrine opens a wealth of research in this field for litigants to submit to the courts in their heads of argument. It also enables our courts to compare positions in relevant jurisdictions more easily. [266]

Consequently, the express recognition of the doctrine of informed consent is a significant development in South African medical law jurisprudence.

(iii) The test of informed consent

Judgments regarding a physician's duty to disclose pertinent aspects of medical intervention to the patient mainly deal with the required threshold to allow the defendant to call upon the defence of volenti non fit iniuria. [267] In this regard, the question arose as to whether the test should be subjective (what the reasonable patient would want to know) or objective (what the reasonable physician would disclose). [268]

In *Richter*, it was held that the test should employ the standard of the reasonable physician faced with the particular dilemma. [269] This position was rejected in *Castell*, where it was found to be an example of medical paternalism. [270] Still, the impugned passage was — incorrectly, it is respectfully submitted — cited favourably by the SCA in both *Louwrens* [271] and *Sibisi*, [272] whilst — perplexingly — these decisions held the opposing judgment in *Castell* in high esteem. [273]

However, in *Beukes*, the SCA seems to have both accepted and applied the test for informed consent as a subjective — reasonable-patient — test, in line with the decision in *Castell*.[274] Based on the ruling in *Beukes*, we believe that the ousting of the paternalistic reasonable-physician test should be welcomed as a triumph for patient autonomy within the South African medico-legal landscape.

(b) What remains uncertain

From the discussion of case law under part III of this article, it was clear that no consensus has yet been reached on two aspects of informed consent, namely that a lack of informed consent speaks to the wrongfulness element of a delict or crime and that the violation of bodily autonomy constitutes an assault. These two aspects conflict with the normative description of the doctrine described under part II of this article.

(i) A lack of informed consent and the element of wrongfulness

Neethling & Potgieter indicate that the community's sense of justice — encapsulated by the boni mores — determines whether or not an impugned action amounts to a wrong. [275] The test for wrongfulness is thus objective. [276] Hence, if a physician administers an intervention to a patient without their informed consent, this will be wrongful because it is contra bonos mores to do so. [277] The objectively assessed question should thus be whether the reasonable patient would likely have wanted to be informed of the intervention and any material risk associated with it. [278]

The courts, however, seem to confuse (or at the very least blur) the distinction between the delictual elements of wrongfulness and fault (specifically in the form of negligence) when confronted with a case of uninformed consent. [279] In this regard, we make the following three points. First, an actionable delict may still be constituted where a physician encroached on the patient's bodily autonomy, even where no *physical* harm was caused. [280] This is because the harm can constitute a violation of the patient's psycho-social autonomy and human dignity. [281] Secondly, in medical malpractice cases based on a lack of informed consent, the fault element can manifest as either negligence or intent. Thirdly, if the action by the physician is assessed and found to have been wrongful, it would still have to be *culpable* through the subjective test of the reasonable physician at the time of the impugned action. [282] Culpability is determined ex post facto in light of all the facts and circumstances that were genuinely present, viewed in light of all the consequences that followed the act. [283]

As Neethling & Potgieter emphatically state, the elements of wrongfulness and culpability must not be telescoped into one. [284] If this were to happen, the element of wrongfulness would no longer serve

as a kind of 'long-stop' excluding liability within the law of delict. [285] This distinction is also important in criminal law. In the event of the death of a patient, the assessment of the culpability (intent or negligence) translates to verdicts of either murder or culpable homicide. Similarly, assault is a crime of intent and cannot be committed negligently (although negligently committed, such an act could still amount to an actionable delict). [286]

From a constitutional-rights perspective, with the rights of bodily autonomy and human dignity at the forefront, the SCA or the Constitutional Court must provide clear guidance on how a lack of informed consent manifests itself under the elements of both wrongfulness and culpability.

(ii) The notion of 'assault' and a recognition of the violation of bodily autonomy

It is a time-honoured principle of South African law to plead that a physician's treating a patient without informed consent constitutes an assault. [287] Assault can only be criminally prosecuted if it was committed intentionally. [288] In civil suits, however, a delictual claim can arise

where a physician *negligently* failed to obtain informed consent from the patient. In this circumstance, it is submitted that the lack of informed consent would speak to the wrongfulness of the delict, whilst the fault (in the form of negligence) would be founded on the basis that no ground excluding fault was present.

As indicated above, Marais JA drew this notion into question in *Broude.*[289] It is important to recall that although the court expressed its reservations about the conceptual soundness of holding that a physician who failed to inform a patient is liable for assault, it made this observation obiter. [290] Although Marais JA found *Broude* not to be the appropriate matter for re-examining this question, he did indicate that this principle requires re-examination. [291]

As indicated in the discussion of *Broude*, other jurisdictions have similar principles through which a lack of informed consent is treated as an actionable trespass of the body. On English judicial hostility toward convicting physicians on a battery charge for lack of informed consent, Jackson emphasises the importance of protecting a patient's right to information regarding medical interventions. [292] Assault, in the context of a lack of informed consent, must be understood as a violation of the patient's bodily integrity and dignity — a violation of the trust relationship between physician and patient. Respecting these rights is crucial in any caring, democratic society. It would be incorrect to argue that the patient experienced no harm without suffering physical damage. It should also be noted that quantifying the harm and proving the causal link will be difficult; thus, the fear of multifarious malpractice suits is unfounded. It is submitted that maintaining the status quo aligns with the notion of patient autonomy and the normative legal framework in part II.

Although the SCA in *Broude* cast serious doubts on our assertion because of Marais JA's obiter remark, it did not set aside this principle. Consequently, this aspect of the doctrine of informed consent remains uncertain and hopefully the SCA or the Constitutional Court will adjudicate upon it soon.

V Conclusion

Although informed consent is the foundation and core of the physician–patient relationship, our analysis of the relevant literature on this doctrine has indicated that it is fraught with controversy. [293] The shift from the sanctified '[sage-physician-counsellor]' [294] approach to a contractual service agreement has led to many dilemmas in medical law and ethics. In this article, nine significant cases were evaluated to provide an overview of the development of the doctrine of informed consent in South African medical law. These cases were evaluated through a normative analysis of the law that we submit underlies this doctrine.

The final analysis indicates — beyond contest — that the case of *Castell v De Greef* [295] is the most influential matter in the context of the doctrine of informed consent in South African medical law. No court in South Africa has explicitly overruled it and it has been cited as the leading authority on the subject. This benchmark decision was, in hindsight, ahead of its time. Although it was decided before the advent of the Constitution, it could

easily fit into and resonate with the constitutional paradigm, with specific reference to patient autonomy [296] and the comparative approach. [297]

We hope this contribution to the vibrant worldwide debate might assist patients, physicians, scholars and litigants to understand and apply correctly the doctrine of informed consent in the South African medico-legal framework.

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‡ BLC LLB LLD (Pretoria).

1 Imogen Goold & Jonathan Herring *Great Debates in Medical Law and Ethics* 2 ed (2018) 29; Dieter Giesen *International Medical Malpractice Law: A Comparative Law Study of Civil Liability Arising from Medical Care* (1988) 252–4.

2 See for example Ames Dhai & David McQuoid-Mason (eds) *Bioethics, Human Rights and Health Law: Principles and Practice* 2 ed (2020) 96; Goold & Herring op cit note 1 at 29; Pieter Carstens & Debbie Pearmain *Foundational Principles of South African Medical Law* (2007) 877; N J B Claassen & T Verschoor *Medical Negligence in South Africa* (1992) 57; F F W van Oosten *The Doctrine of Informed Consent in Medical Law* (LLD thesis, University of South Africa, 1989) 11; Giesen ibid at 252–3; S A Strauss & M J Strydom *Die Suid-Afrikaanse Geneeskundige Reg* (1967) 182.

3 Dhai & McQuoid-Mason ibid at 95–6; Carstens & Pearmain ibid at 877; Giesen op cit note 1 at 252–3.

4 Dhai & McQuoid-Mason ibid at 95; Carstens & Pearmain ibid at 877. For a general discussion of this shift see Goold & Herring op cit note 1 at 11–12.

5 See for example Ebenezer Durojaye 'Involuntary sterilisation as a form of violence against women in Africa' (2018) 53 *Journal of Asian and African Studies* 721; Carstens & Pearmain ibid at 877–8; Nanci Palmer & Mark Kaufman 'The ethics of informed consent: Implications for multicultural practice' (2003) 12 *Journal of Ethnic and Cultural Diversity in Social Work* 1.

6 See for example in the context of South Africa: Durojaye op cit note 5 at 1; Willene Holness 'Informed consent for sterilisation of women and girls with disabilities in the light of the Convention on the Rights of Persons with Disabilities' (2013) 27 *Agenda* 36; Sumaya Mall & Leslie Swartz 'Sexuality, disability and human rights: Strengthening healthcare for disabled people' (2012) 102 *SA Medical Journal* 792. Internationally see Anwuli Irene Ofuani 'Protecting adolescent girls with intellectual disabilities from involuntary sterilisation in Nigeria: Lessons from the Convention on the Rights of Persons with Disabilities' (2017) 17 *African Human Rights Law Journal* 551; Ronli Sifris 'The involuntary sterilisation of marginalised women: Power, discrimination, and intersectionality' (2016) 25 *Griffith Law Review* 45; John Tobin & Elliot Luke 'The involuntary, non-therapeutic sterilisation of women and girls with intellectual disability: Can it ever be justified?' (2013) 3 *Victoria University Law and Justice Journal* 27; Laurent Servais 'Sexual health care in persons with intellectual disabilities' (2006) 12 *Mental Retardation and Developmental Disabilities Research Reviews* 48; Douglas S Diekema 'Involuntary sterilization of persons with mental retardation: An ethical analysis' (2003) 9 *Mental Retardation and Development Disabilities Research Reviews* 22; Palmer & Kaufman ibid at 9; Elizabeth Kingdom 'Consent, coercion and consortium: The sexual politics of sterilisation' (1985) 12 *Journal of Law and Society* 19.

7 Dhai & McQuoid-Mason op cit note 2 at 43.

8 Ibid.

9 This doctrine is underpinned by several human rights, as will be discussed below. See for example David McQuoid-Mason 'An introduction to aspects of health law: Bioethical principles, human rights and the law' (2008) 1 *South African Journal of Bioethics and the Law* 7.

10 See the explanation and importance of this approach in Carstens & Pearmain op cit note 2 at 1–2.

11 Tracy Humby & Louis Kotzé (eds) *Inleiding tot die Reg en Regsvaardighede in Suid-Afrika* (2013) 174; Carstens & Pearmain ibid at 283; S A Strauss *Doctor, Patient and the Law: A Selection of Practical Issues* 3 ed (1991) 3.

12 Humby & Kotzé ibid; Carstens & Pearmain ibid.

13 Carstens & Pearmain ibid. This view is also supported by the plethora of constitutional jurisprudence handed down since the promulgation of the interim Constitution.

14 Daniel Keevy *A Critical Analysis of the Doctor–Patient Relationship in Context of the Right to Adequate Health Care* (LLM dissertation, University of Pretoria, 2012) 39.

15 Dhai & McQuoid-Mason op cit note 2 at 80–1; Liezl Zwart *An Analysis of Informed Consent and Clinical Aspects Regarding Mental Capacity in Context of the Mental Health Care Act 17 of 2002* (LLM dissertation, University of Pretoria, 2015) 63; F F W van Oosten 'Informed consent: Patient rights and the doctor's duty of disclosure in South Africa' (1988–1989) 7 *Medicine and Law* 449; P C Smit ''n Beroepsplig om te genees!' (1983) 63 *SA Medical Journal* 282; Strauss & Strydom op cit note 2 at 178.

16 Dhai & McQuoid-Mason ibid at 79; J A Singh 'Law and the health professional in South Africa' in Keymanthri Moodley (ed) *Medical Ethics, Law and Human Rights* 2 ed (2017) 133–4; Smit op cit note 15 at 282.

17 Carstens & Pearmain op cit note 2 at 283–4; Smit op cit note 15 at 282; Strauss & Strydom op cit note 2 at 175–6.

18 *Friedman v Glicksman* 1996 (1) SA 1134 (W); Dhai & McQuoid-Mason op cit note 2 at 77; Smit ibid; Strauss & Strydom ibid at 104.

19 Carstens & Pearmain op cit note 2 at 379; Smit ibid.

20 Dhai & McQuoid-Mason op cit note 2 at 78; Singh op cit note 16 at 133; Carstens & Pearmain op cit note 2 at 283.

21 Strauss op cit note 11 at 3.

22 Ibid.

23 Carstens & Pearmain op cit note 2 at 489; Strauss ibid.

24 A contract is an agreement between two or more persons with the purpose of creating a relationship that is legally binding and enforceable. See Dale Hutchison & Chris-James Pretorius (eds) *The Law of Contract in South Africa* 4 ed (2022) 6.

25 Singh op cit note 16 at 133; Carstens & Pearmain op cit note 2 at 413.
26 Hutchison & Pretorius op cit note 24 at 260–1; Smit op cit note 15 at 282; Strauss & Strydom op cit note 2 at 104.
27 Singh op cit note 16 at 133; Carstens & Pearmain op cit note 2 at 413; Strauss & Strydom ibid at 105.
28 Hutchison & Pretorius op cit note 24 at 177; Carstens & Pearmain ibid; Strauss & Strydom ibid at 105–6.
29 Carstens & Pearmain ibid at 284.
30 See for example *Administrator, Natal v Eduard* 1990 (3) SA 581 (A).
31 Carstens & Pearmain op cit note 2 at 284.
32 Hutchison & Pretorius op cit note 24 at 126 and 88 respectively; Carstens & Pearmain ibid at 313.
33 Hutchison & Pretorius ibid at 6; Carstens & Pearmain ibid at 322.
34 J Neethling & J M Potgieter *Neethling-Potgieter-Visser Deliktereg* 7 ed (2015) 4.
35 Ibid at 3; Strauss & Strydom op cit note 2 at 159.
36 See especially the thorough explanation by Carstens & Pearmain op cit note 2 at 676–700; Strauss op cit note 11 at 267–9; Claassen & Verschoor op cit note 2 at 71–4; Strauss & Strydom ibid at 168–9 as well as the various judgments that these authors discuss.
37 Neethling & Potgieter op cit note 34 at 35.
38 See among others *H v Fetal Assessment Centre* 2015 (2) SA 192 (CC) para 69; F F W van Oosten '*Castell v De Greef* and the doctrine of informed consent: Medical paternalism ousted in favour of patient autonomy' (1995) 28 *De Jure* 178–9.
39 Neethling & Potgieter op cit note 34 at 38–9.
40 See the instruction of Watermeyer J to the jury (as was employed in South African courts at the time) in *Stoffberg v Elliot* 1923 CPD 148 at 149–50: 'Any bodily interference or restraint of man's person which is not justified in law, or excused in law or consented to is a *wrong*, and for that wrong the person whose body has been interfered with has a right to claim such damages as he can prove he has suffered owing to that interference' (emphasis supplied).
41 S A Strauss 'Geneesheer, pasiënt en die reg: 'n Delikate driehoek' 1987 *TSAR* 1.
42 Ibid.
43 Ibid.
44 Ibid.
45 Originally in Afrikaans: 'wysgeer-geneesheer-raadgewer'.
46 Strauss op cit note 41 at 1–2.
47 Ruth R Faden & Tom Beauchamp *A History and Theory of Informed Consent* (1986) 13.
48 Palmer & Kaufman op cit note 5 at 5.
49 Ibid.
50 Goold & Herring op cit note 1 at 11.
51 Tom L Beauchamp & James F Childress *Principles of Biomedical Ethics* 8 ed (2019) 231; Alasdair Maclean *Autonomy, Informed Consent and Medical Law* (2009) 10.
52 Beauchamp & Childress ibid at 231.
53 Dhai & McQuoid-Mason op cit note 2 at 95; Goold & Herring op cit note 1 at 11.
54 Goold & Herring ibid.
55 Ibid; see also Kingdom op cit note 6 at 19–34 for a thorough discussion.
56 Beauchamp & Childress op cit note 51 at 99–100; Goold & Herring ibid.
57 Dhai & McQuoid-Mason op cit note 2 at 95–6.
58 Several statutory provisions require that physicians respect patients' autonomy. See inter alia ss 11, 12(2) and 14 of the Constitution, as discussed in Dhai & McQuoid-Mason ibid at 50–1.
59 Beauchamp & Childress op cit note 51 at 99.
60 Goold & Herring op cit note 1 at 4.
61 Ibid.
62 Supra note 40.
63 Ibid at 149–50.
64 This will be discussed in part III.
65 Goold & Herring op cit note 1 at 2.
66 Ibid.
67 Beauchamp & Childress op cit note 51 at 104.
68 Ibid.
69 K Moodley 'Respect for patient autonomy' in Keymanthri Moodley (ed) *Medical Ethics, Law and Human Rights* 2 ed (2017) 54.
70 Ibid.
71 Ibid at 55.
72 The HPCSA is a statutory body in terms of s 15 of the Health Professions Act 56 van 1974 that serves as the overarching body for the professional councils of the different healthcare professions.
73 Health Professions Council of South Africa *Guidelines for Good Practice in the Healthcare Professions: Booklet 1* (2016) para 2.3.5.
74 Ibid.
75 Neethling & Potgieter op cit note 34 at 113; Strauss & Strydom op cit note 2 at 182.
76 V G Hiemstra & H L Gonin *Drietalige Regswoordeboek/Trilingual Legal Dictionary* 3 ed (1992) 306–7.
77 Carstens & Pearmain op cit note 2 at 875.
78 Dhai & McQuoid-Mason op cit note 2 at 98; Van Oosten op cit note 2 at 31.
79 Dhai & McQuoid-Mason ibid at 98–9; Carstens & Pearmain op cit note 2 at 879.
80 In *Lymbery v Jeffries* 1925 AD 236, a South African court for the first time emphasised a physician's duty to inform a patient fully of the risks and consequences of a medical intervention. In this regard see also Carstens & Pearmain op cit note 2 at 879; Van Oosten op cit note 15 at 445.
81 1957 (3) SA 710 (T).
82 Ibid at 719.
83 Section 12 of the Constitution.
84 Section 12(2) of the Constitution.
85 Ignatius M Rautenbach & Roxan Venter *Rautenbach-Malherbe Constitutional Law* 7 ed (2018) 361.
86 For example, where a Jehovah's Witness is given a blood transfusion against their will, or where an elderly patient prefers to die, rather than be resuscitated, once their heart stops beating.
87 Rautenbach & Venter op cit note 85 at 361. See also *Van der Merwe v Road Accident Fund* 2006 (4) SA 230 (CC) para 40.
88 Holness op cit note 6 at 41.
89 Johan Neethling 'Die reg op privaatheid en outonomie: *Prince v Minister of Justice and Constitutional Development* 2017 (4) SA 299 (WCC); [2017] 2 All SA 864 (WCC)' (2018) 15 *Litnet Akademies* 486.
90 1996 (3) SA 617 (CC).
91 Ibid at 656–7, discussed by Neethling op cit note 89 at 489.
92 Neethling ibid at 489.
93 Section 6 of the National Health Act 61 of 2003.
94 Section 7 of the National Health Act.
95 See for example s 9 of the Mental Health Care Act 17 of 2002.
96 *Stoffberg* supra note 40.
97 See inter alia the decisions in *Castell v De Greef* 1994 (4) SA 408 (C); *Broude v McIntosh* 1998 (3) SA 60 (SCA); *Lourens v Oldwage* 2006 (2) SA 161 (SCA); *Sibisi v Maitin* 2014 (6) SA 553 (SCA); *Beukes v Smith* 2020 (4) SA 51 (SCA).
98 See *Christian Lawyers Association v Minister of Health* 2005 (1) SA 509 (T), in which a minor girl's right to consent unilaterally to the termination of preg-nancy was confirmed.
99 Ibid.
100 Ibid; see also the discussion in Carstens & Pearmain op cit note 2 at 983.
101 *Beukes* supra note 97.
102 Ibid para 25.
103 McQuoid-Mason op cit note 9 at 7.

104 Rights such as the right to freedom and security of the persons (s 12), the right to privacy (s 14), the right to life (s 11), the right to freedom of movement (s 21) and the right to freedom of religion, belief and opinion (s 15). See McQuoid-Mason ibid.

105 See the discussion in Theresia Degener 'Disability in a human rights context' (2016) 35 *Laws* 3.

106 Human dignity as a foundational value is entrenched in s 1*(a)* of the Constitution, while the right to human dignity is enshrined in s 10. See also Laurie Ackermann *Human Dignity: Lodestar for Equality in South Africa* (2012) 95.

107 See for example O'Regan J's judgment in *S v Makwanyane* 1995 (3) SA 391 (CC) para 329.

108 See specifically Nick Haysom 'Dignity' in Halton Cheadle, Dennis Davis & Nicholas Haysom *South African Constitutional Law: The Bill of Rights* 2 ed (2019) 5-1, as well as Arthur Chaskalson 'The third Bram Fischer Lecture: Human dignity as a foundational value in our constitutional order' (2000) 16 *SAJHR* 193.

109 Haysom ibid at 5-2 to 5-3.

110 Ibid. See also Ackermann's discussion op cit note 106 at 182–8 in this regard.

111 Ibid.

112 Chaskalson op cit note 108 at 197–8.

113 This name is given to human dignity for the reasons set out in this para, but it was originally coined by Degener op cit note 105 within the context of disability rights.

114 See the discussion in part II(c)(i).

115 Charles Foster *Human Dignity in Bioethics and Law* (2011) 1.

116 Ibid.

117 Ibid.

118 See the discussion in part II(c)(i).

119 Bernard Bekink *Principles of South African Constitutional Law* 2 ed (2016) 224–9.

120 Carstens & Pearmain op cit note 2 at 1.

121 See for example the seminal decisions on the doctrine of informed consent for Namibia in *LM v Government of Namibia* [2012] NAHC 211 as well as the subsequent decision in the Supreme Court in *Government of Namibian v LM* [2014] NASC 19, which heavily relied on the research and decisions of South African scholars and courts in the formulation their decisions.

122 *Stoffberg* supra note 40.

123 The interim Constitution came into force on 27 April 1994, whilst the Constitution was promulgated on 4 February 1997. It is trite that *Stoffberg* ibid first recognised the principle of patient autonomy in 1923, more than seven decades earlier.

124 Ackermann op cit note 106 at 87.

125 *Stoffberg* supra note 40.

126 *Stoffberg* ibid at 153.

127 See *Stoffberg* ibid at 149–50, quoted in part II(b)(i) above.

128 *Stoffberg* ibid at 148.

129 It is trite that no rights — not even those enshrined in the Constitution — are absolute. See Iain Currie & Johan de Waal *The Bill of Rights Handbook* 6 ed (2013) 150; Rautenbach & Venter op cit note 85 at 350. In the context of medical law, situations of emergency especially provide for two grounds of justification where medical interventions can be administered without consent, namely unauthorised administration (negotiorum gestio) and necessity. For a thorough discussion of these grounds of justification see Carstens & Pearmain op cit note 2 at 906–17.

130 *Stoffberg* supra note 40 at 48.

131 See the discussion in part II(a)(iii) above.

132 The locus classicus of informed consent, *Castell* supra note 97 at 418–19, relied inter alia on Watermeyer J's judgment.

133 *Esterhuizen* supra note 81.

134 *Esterhuizen* ibid at 719.

135 *Esterhuizen* ibid; Carstens & Pearmain op cit note 2 at 803.

136 *Esterhuizen* ibid; Carstens & Pearmain ibid at 803–5.

137 *Esterhuizen* ibid.

138 Carstens & Pearmain op cit note 2 at 805.

139 (TPD) unreported judgment of 15 April 1953.

140 Ibid, quoted in *Esterhuizen* supra note 81 at 719.

141 *Esterhuizen* ibid.

142 *Rompel* supra note 139.

143 Van Oosten op cit note 15 at 448.

144 *Esterhuizen* supra note 81 at 721.

145 1976 (3) SA 226 (C).

146 Ibid at 228.

147 Ibid at 227.

148 Ibid.

149 *Stoffberg* supra note 40.

150 See the discussion of *Stoffberg* in part III(a)(i) above. *Stoffberg* was decided in 1927, whilst *Richter* was decided in 1976, both in the Cape Provincial Division.

151 See part III(a)(i).

152 *Richter* supra note 145 at 232.

153 *Castell* supra note 97.

154 Ibid at 418–19.

155 See for example *Lourens* supra note 97 paras 22 and 25; *Sibisi* supra note 97 paras 46–9. In terms of the principle of stare decisis, the decision in *Castell* would have overturned the position of *Richter*, as a full bench in the same division overrules a decision by a single judge. This is the position unless a superior court (such as the SCA) expressly rejects *Castell* and confirms *Richter* — which, as will be discussed below, has not happened. See Humby & Kotzé op cit note 11 at 218; H R Hahlo & Ellison Kahn *The South African Legal System and its Background* (1973) 237–60.

156 See, among others, the judgments of *Broude* supra note 97; *Lourens* supra note 97; *Sibisi* supra note 97; *Beukes* supra note 97.

157 Mzukisi Niven Njotini 'Preserving the integrity of medical-related information — How "informed" is consent?' (2018) 21 *PER/PELJ* 1 at 2–3; Anton van Loggerenberg 'An alternative approach to informed consent' (2018) 135 *SALJ* 57–8; Carstens & Pearmain op cit note 2 at 891.

158 *Castell* supra note 97 at 428; Carstens & Pearmain ibid at 711.

159 *Castell* ibid at 430; Carstens & Pearmain ibid at 711–12.

160 *Castell* ibid at 412; Carstens & Pearmain ibid at 713.

161 Carstens & Pearmain ibid at 891–2.

162 *Castell* supra note 97 at 426.

163 Carstens & Pearmain op cit note 2 at 892.

164 Ackermann J, who authored the judgment, was later elevated by former President Mandela to the Constitutional Court of South Africa. He also authored the influential monograph on the right to human dignity; see Ackermann op cit note 106.

165 Van Loggerenberg op cit note 157 at 65.

166 Reference can be made here to s 2 of the Constitution: 'The Constitution is the supreme law of the Republic; law or conduct inconsistent with it is invalid, and the obligations imposed by it must be fulfilled.' See in general also Rautenbach & Venter op cit note 87 at 21–2; Bekink op cit note 119 at 244–6 and, in the context of medical law, Carstens & Pearmain op cit note 2 at 7–10.

167 Carstens & Pearmain ibid at 7.

168 See Pieter Carstens 'Commentary on an essay by Konnoth CJ. Medicalization and the new civil rights' (2020) 12 *Ethics, Medicine and the New Civil Rights* available at *https://doi.org/10.1016/j.jemep.2019.100445*; Craig Konnoth 'Medicalization and the new civil rights' (2020) 12 *Ethics, Medicine and Public Health* available at *https://doi.org/10.1016/j.jemep.2019.100435*.

169 See the discussion in part III(a).

170 *Broude* supra note 97.

171 Ibid paras 2–3.

172 Ibid.

173 Ibid para 3.

174 Ibid paras 49–50.

175 Ibid para 50.

176 Ibid paras 20–2.
177 See the discussion in part I above.
178 The element of damage or harm is essential to constitute a delictual action. See Neethling & Potgieter op cit note 34 at 227 as well as, for example, *Jowell v Bramwell-Jones* 2000 (3) SA 274 (SCA) at 283; *Road Accident Fund v Krawa* 2012 (2) SA 346 (ECG) at 366–7.
179 Neethling & Potgieter op cit note 34 at 227–8.
180 Ibid.
181 Ibid.
182 See the discussion in part I(b) above.
183 See for example the discussion by Neethling & Potgieter op cit note 34 at 261–72.
184 Ibid at 4–5, as well as Mark Lunney, Donald Nolan & Ken Oliphant *Tort Law: Text and Materials* 6 ed (2017) 1–5.
185 Lunney, Nolan & Oliphant ibid at 53–7; Emily Jackson *Medical Law: Text, Cases and Materials* 6 ed (2022) 216–17.
186 Jackson ibid at 214.
187 Ibid at 215.
188 Ibid at 214. It must be noted in the context of English law that in *Chatterton v Gerson* [1981] QB 432, Bristow J held that consent would be real for claims of battery where the patient was informed in 'broad terms' about the nature of the procedure.
189 Ibid at 214–15.
190 Ibid at 215. Jackson notes the reluctance by the English courts to use battery in medical cases due to the connotation of such a charge. She states op cit note 185 at 216: 'A doctor who fails to tell a patient about a small risk inherent in a proposed treatment does not intend to injure her. Because a battery will also often be an assault, judges have been reluctant to criminalize by association well-meaning but misguided decision to withhold information from patients.' Still, several reported decisions by English courts have confirmed the lack of informed consent as trespass of the body (battery). See for example in the criminal context *R v Richardson* (1998) 43 BMLR 21 (CA); *R v Tabassum* [2000] 2 Cr App R 328 (CA); and in the civil context *Chatterton v Gerson* supra note 188; *Appleton v Garrett* (1995) 34 BMLR 23 (QB); *The Creutzfeldt-Jakob Disease Litigation* [1995] 54 BMLR 1 (QB).
191 See for example the discussion in Pieter Carstens *Die Strafregtelike en Deliktuele Aanspreeklikheid van die Geneesheer op grond van Nalatigheid* (LLD thesis, University of Pretoria, 1996) 279–81; as well as Karl Engisch 'Ärztlicher eingriff zu heilzwecken und einwilligung' in Albin Eser (ed) *Recht und Medizin* (1990) 136.
192 Marais JA stated that examining the validity of assault in the context of consent which was not fully informed would be inappropriate in the present matter: *Broude* supra note 97 para 22. Yekiso J in *Oldwage v Lourens* [2004] 1 All SA 532 (C) para 99 also accepted this statement as obiter only.
193 *Louwrens* supra note 97.
194 The decision by the court a quo is also a reported judgment: see *Oldwage* supra note 192.
195 *Louwrens* supra note 97 para 4.
196 Ibid.
197 Ibid.
198 Ibid paras 3 and 22.
199 Ibid para 28.
200 Ibid paras 6–19.
201 Ibid paras 22–5.
202 *Castell* supra note 97 at 409. See the discussion of this matter in part III(a)(iv) above.
203 *Louwrens* supra note 97 para 22.
204 Ibid paras 22–4.
205 Ibid para 22.
206 These reasons included, inter alia, that the study was dated; the case was before the court in 2000 whilst the study was conducted in 1976; the Veteran Administration Hospitals were not well-equipped; the Veteran Administration studies were not highly regarded as scientific studies; and the patients treated in these hospitals were typically unhealthy. Ibid para 24.
207 Ibid.
208 Ibid paras 24–5.
209 Ibid para 25.
210 *Richter* supra note 145. See the discussion of this matter in part III(a)(iii).
211 *Louwrens* supra note 97 para 25.
212 As discussed above in part III(a)(ii), both *Richter* and *Castell* were heard by the Cape Provincial Division of the High Court (as it was then known), the former by a single judge and the latter by a full bench. In accordance with the rule of stare decisis, the ratio of *Richter* should have been voided by the full bench of *Castell*.
213 See part III(a)(iii). See also *Castell* supra note 97 at 420.
214 [2006] 3 All SA 565 (C).
215 Ibid para 1.
216 Ibid.
217 Ibid.
218 Ibid para 2.
219 Ibid.
220 Ibid.
221 Ibid para 7.
222 Ibid.
223 Ibid para 39.
224 *Wroe v McDonald* [2011] JOL 29733 (C).
225 *Sibisi* supra note 97.
226 See Van Loggerenberg op cit note 157 at 65; Liezl Zwart '*Sibisi NO v Maitin*: A dual burden of proof?' (2015) 553 *De Rebus* 33.
227 *Sibisi* supra note 97 para 4.
228 Ibid.
229 Ibid para 1.
230 Ibid para 50.
231 Zwart op cit note 226 at 33.
232 The patent contradiction between *Richter* and *Castell* was discussed in part III(a)(iii) above. In fact, Ackermann J in *Castell* expressly rejected the test formulated in *Richter*: see *Castell* supra note 97 at 419–20.
233 *Richter* supra note 145.
234 Ibid.
235 *Castell* supra note 97 at 426.
236 Van Loggerenberg op cit note 157 at 65.
237 Ibid.
238 *Sibisi* supra note 97 para 52.
239 Ibid.
240 *Beukes* supra note 97.
241 Ibid para 1.
242 Ibid.
243 Beverly Townsend & Donrich Thaldar 'Informed consent in medical malpractice suits: An analysis of *Beukes v Smith*' (2020) 137 *SALJ* 13.
244 Ibid.
245 *Castell* supra note 97, as discussed in part III(a)(iv).
246 *Sibisi* supra note 97, as discussed in part III(b)(iv).
247 *Beukes* supra note 97 para 25, footnotes omitted.
248 *Sibisi* supra note 97.
249 See the discussion by Townsend & Thaldar op cit note 243 at 13–25, where these authors criticise the SCA's prejudice against patients regarding evidence given in the matter of *Beukes* supra note 97.
250 *Beukes* ibid para 32 (emphasis supplied).

251 Ibid para 25.

252 *Sibisi* supra note 97, as discussed in part III(b)(iv).

253 *Castell* supra note 97 at 420 and 425.

254 See part II(b)(i).

255 *Stoffberg* supra note 40 and part (III)(a)(i).

256 See for example the Transvaal Provincial Division in *Esterhuizen* supra note 81 at 721; the full-bench matter in the Cape of Good Hope Provincial Division of *Castell* supra note 97 at 418–19; and the SCA judgment in *Sibisi* supra note 97 paras 47–9.

257 *Richter* supra note 145 at 232.

258 As indicated above, the dictum in *Castell* supra note 97 at 419–20 effectively overturned the decision of *Richter* as it was decided by a full bench of the same division. This is also confirmed by the SCA judgment in *Sibisi* supra note 97 paras 47–9.

259 See parts II(b)(ii) and II(c).

260 See for example General Principle 1 of the World Medical Association's International Code of Medical Ethics, which states: 'The physician must provide care with the utmost respect for human life and dignity, and for the *autonomy and rights of the patient*' (emphasis supplied) available at *https://www.wma.net/policies-post/wma-international-code-of-medical-ethics/*, accessed on 9 November 2022.

261 Carstens & Pearmain op cit note 2 at 892. It should be noted that the court in *Castell* relied heavily on the works of various scholars, most notably, within the South African context, Van Oosten and his influential doctoral thesis: Ferdinand van Oosten *The Doctrine of Informed Consent in Medical Law* (LLD thesis, University of South Africa, 1989). The doctrine was thus already prevalent among scholars of medical law; the decision in *Castell* was merely the first court case to acknowledge its applicability.

262 See for example *Broude* supra note 97 paras 19–20; *Louwrens* supra note 97 para 21; *McDonald* supra note 214 para 39; *Sibisi* supra note 97 para 2; *Beukes* supra note 97 para 1.

263 World Medical Association op cit note 260.

264 See for example Himel Mondal et al 'Informed consent for telemedicine' (2020) *Journal of Family Medicine and Primary Care* 5402; Steven C Shallhorn et al 'Informed consent in refractive surgery: In-person vs telemedicine approach' (2018) 12 *Clinical Ophthalmology* 2459; Sean Ryan et al 'How informed is "informed consent" for robotic cardiothoracic surgery?' (2009) 4 *Innovations* 307; Allessia Ferrarese et al 'Informed consent in robotic surgery: Quality of information and patient perception' (2016) 11 *Open Medicine* 279.

265 See for example Teresa Iaconon & Vanessa Murray 'Issues of informed consent in conducting medical research involving people with intellectual disability' (2003) 16 *Journal of Applied Research in Intellectual Disabilities* 41; Mahnaz Alei et al 'Obtaining informed consent in an illiterate population' (2013) 5 *Middle East Journal of Digestive Diseases* 37. This relates also to the uncertain question (at least in South African law) of the applicability of the concept of therapeutic privilege, on which see Margaux Beard & J R Midgley 'Therapeutic privilege and informed consent: A justified erosion of patient autonomy?' (2005) 68 *THRHR* 51.

266 Courts have an express authority in terms of s 39(1)*(c)* of the Constitution to consider foreign law when interpreting rights in the Bill of Rights.

267 See for example *Esterhuizen* supra note 81 at 719; *Castell* supra note 97 at 420; *Christian Lawyers' Association v Minister of Health* supra note 98 at 515; *Beukes* supra note 97 para 25.

268 See the discussion in *Castell* supra note 97 at 421–2.

269 *Richter* supra note 145 at 232.

270 *Castell* supra note 97 at 426.

271 *Louwrens* supra note 97 para 25.

272 *Sibisi* supra note 97 para 46.

273 See *Louwrens* supra note 97 para 22 and *Sibisi* ibid paras 48–50. This inexplicable contradiction was also discussed above.

274 *Beukes* supra note 97 para 25.

275 Neethling & Potgieter op cit note 34 at 44–5.

276 Ibid.

277 This statement is supported by the express legislative requirement of informed consent in ss 6 and 7 of the National Health Act and s 9 of the Mental Health Care Act. It is further supported by the right to human dignity (s 10), and freedom and security of the person (s 12) in the Constitution.

278 Carstens & Pearmain op cit note 2 at 893–5.

279 See the discussion above, with specific reference to the cases of *Sibisi* supra note 97 and *Beukes* supra note 97.

280 This is because it might still infringe on the patient's personality rights. See, among others, *H v Fetal Assessment Centre* supra note 38 para 69; Van Oosten op cit note 38 at 178–9.

281 Ibid.

282 Neethling & Potgieter op cit note 34 at 168–71.

283 Ibid at 170.

284 Ibid. See also Johann Neethling & Johan Potgieter 'Deliktuele aanspreeklikheid weens 'n late: Onregmatigheid en nalatigheid — *Za v Smith* 2015 (4) SA 574 (HHA)' (2016) 13 *LitnetAkademies* 491.

285 Neethling & Potgieter op cit note 34 at 171. This position flows from the SCA judgment in *Roux v Hattingh* 2012 (6) SA 428 (SCA) at 439–40 where the court stated: '[The distinction between wrongfulness and culpability] serves as a "long-stop" to exclude liability in situations where most right minded people, including judges, will regard the imposition of liability as untenable, despite the presence of all other elements of the Aquilian action.'

286 C R Snyman *Strafreg* 6 ed (2012) 481.

287 See for example *Stoffberg* supra note 40; *Lampert v Hefer* 1955 (2) SA 507 (A); *Esterhuizen* supra note 81; *S v Sikunyana* 1961 (3) SA 549 (E); *Richter* supra note 145; *Burger v Administrateur, Kaap* 1990 (1) SA 483 (C); *S v Kiti* 1994 (1) SACR 14 (E); *Castell* supra note 97; and *Broude* supra note 97.

288 The definition of the crime of assault requires it to be both intentional and unlawful. See Snyman op cit note 286 at 475.

289 See the discussion in part III(b)(i).

290 *Broude* supra note 97 para 22. See also Carstens & Pearmain op cit note 2 at 685–7.

291 *Broude* ibid.

292 Jackson op cit note 185 at 244.

293 Carstens & Pearmain op cit note 2 at 877.

294 Strauss op cit note 41 at 1–2.

295 Supra note 97.

296 Se ction 12(2)*(b)* of the Constitution.

297 Section 39 of the Constitution.