The interaction between medical ethics, case law and the National Health Insurance: A discussion of the South African health care crisis

By

Eunette Beukes ,27232418

prepared under supervision of

Prof P.A. Carstens

at the University of Pretoria

November 2016

Table of Content

1. Chapter 1:

a. Introduction

Law and Medicine – these two professions have been involved, for a substantial amount of years, in an intricate and intertwined relationship. However, the relationship for these two paternalisms has become more complicated with the development of human rights and a society that wants to see the fulfilment of socio-economic rights. This dissertation will assess the four ethics in the Beauchamp/Childress model in the context of South African case law and legislation.[1] It will then proceed to discuss how South African case law has written the history for socio-economic rights. Thereafter will be a discussion on the National Health Insurance as means to give balance to the lack of health care for those in an underprivileged position.

b. Problem Statement

The profession of law and medicine has a relationship that has existed to the detriment of the disadvantaged groups in South Africa – therefore the primary objective would be to discuss how law has protected medicine whilst it has been violating socio-economic rights in terms of the basic right of access to health as it is guaranteed in the Constitution of South Africa: section 27 (1) Everyone has the right to have access to (1) health care services, including reproductive health care.[2] This dissertation will determine in which manner medical ethics has been present in the layered approach in South Africa - the constitution, legislation, case law precedents, common law and the policies created by medical councils. It will then determine to what extent the legal profession has protected the medical profession in terms of case law and also whether the implementation of the NHI will correct this destructive relationship .

[1] Beauchamp and Childress (2009) Principles of Biomedical Ethics 6th Edition New York: Oxford University Press.
[2] Constitution of South Africa 1996.

c. Methodology

This dissertation's main aim is to analyse the relationship between the legal profession and the medical profession in context of ethics, case law and to look at the NHI as a possible means to correct this relationship and the effect that it has had on South African society's disadvantaged.

The first analysis will be with regard to the four medical ethical principles as set out in the Beauchamp/Childress model: Autonomy, beneficence, non-maleficence and justice. The second analysis pertains to case law that discusses socio-economic rights in a medical context. The third analysis will be pertaining the case of S v Tembani [3] and Oppelt v Head: Health, Department Of Health, Provincial Administration: Western Cape[4] and will state the courts' perception on the quality of health care in both the private and the public health care sector as well as a discussion into the NHI.

d. Proposed structure and hypotheses

In chapter one, there will an outline of each of the chapter to follow. Each chapter will discuss the following hypothesis:

- There is an intricate relationship between the profession of law and medicine. Both of these professions can be considered paternalistic in nature – law being a hard paternalism and medicine being a soft paternalism. The essence of their relationship is in the four principles of medical ethics as proposed by the Beauchamp/Childress model and each of these principles has a strong engagement and root in the South African Constitution. Certain aspects such as informed consent and the paternalism paradigm shift remain controversial.

[3] S v Tembani 2007 1 SACR 355 (SCA).
[4] Oppelt v Head: Health, Department Of Health, Provincial Administration: Western Cape (CCT185/14) [2015] ZACC 33; 2016 (1) SA 325 (CC); 2015 (12) BCLR 1471 (CC) (14 October 2015).

- The legal profession protects the medical profession through court judgments. The law takes legislation and Constitutional sections and interprets it in such a manner that it is to the benefit of the medical profession, and to the disadvantage of persons that are already in a position - whom are not able to afford a privatised medical health insurance plan. It specifically protects it under the notion that limited resources can be an excuse for medical negligence.
- The National Health Insurance is a possible solution for the problem of substandard health care specifically in public health care institutions. The National Health Insurance is only in a white paper stage at the time of completion of this dissertation, and all progress that has been made on relies on the Office of Health Safety Compliance (OHSC).

Chapter one is an introduction of the problem statement, the methodology used, the hypotheses and the chapter layout.

In Chapter Two, there is a discussion of the four principles as developed by Beauchamp and Childress which includes autonomy, non-maleficence, beneficence and justice. These principles are discussed in a South African context. Under autonomy is a discussion about informed consent - from the applicable legislation, to problematic aspects as discussed by Carstens and Pearmain and also case law that have deemed informed consent to be a controversial topic.[5] Under non-maleficence is a discussion of the case of Stransham – Ford v Minister of Correctional Services and Others and[1] Minister of Justice and Correctional Services and Others v Estate Late James Stransham-Ford and Others to discuss the topic of voluntary active euthanasia.[6] Under beneficence is a discussion of the medicine as well as law, the former being a soft paternalism and the latter as hard paternalism, and the interaction involved with each other. The final principle, concept of justice, there is a discussion around the allocation of medical resources as well as the different theories of justice.

[5] Carstens and Pearmain (2007)Foundational Principles of South African Medical Law Durban: LexisNexis.
[6] Stransham – Ford v Minister of Correctional Services and Others (27401/15) [2015] ZAGPPHC 230; 2015 (4) SA 50 (GP); [2015] 3 All SA 109 (GP) (4 May 2015) ; Minister of Justice and Correctional Services and Others v Estate Late James Stransham-Ford and Others (531/2015) [2016] ZASCA 197 (6 December 2016).

In Chapter Three, case law pertaining to the development of socio – economic rights will be discussed as developed by Marius Pieterse.[7] The purpose of this discussion would be to show the difference in opinion by different courts regarding what type of quality health care the disadvantaged can expect. It is also to see if the courts are obliged or not to enforce these socio – economic rights as stated in the Constitution and pressure the State to make more funding available for resources or if the courts distances themselves from that type of policymaking.

The fourth chapter is a discussion on two prominent cases that reflect the view on how medical negligence can be excused in the private and public health care institutions as there is a shortage of resources. It also reflects on the full development, til thus far, on the National Health Insurance and the implementation thereof. Various policy papers and the official white paper are discussed.

My fifth and final chapter will be a summary of all chapters as well as recommendation on a paradigm shift that needs to develop in the medical and health care profession.

[7] Pieterse (2014) Can rights cure? The impact of human rights litigation on South Africa's health system Pretoria " Pretoria University Law Press.

2. Chapter 2: Principles of medical ethics in a South African Context

a. Introduction

In this chapter, there is a discussion on the four principles of medical ethics as it has been developed by the Beauchamp/Childress model. The importance of this discussion is to understand how the medical profession and the ethics related to it, is intertwined in several aspects with the legal profession such as the Constitution, legislation and the development of case law. One needs to understand how intertwined it is, because the two professions should not be viewed separately, but as one complex and intricate relationship, where one (law) protects the other (medicine). This chapter will discuss respect for the autonomy, whilst specifically focusing on informed consent as a controversial topic in South African law. It will also discuss non-maleficence and the case of Stransham- Ford v Minister of Correctional services and others and its approach on active voluntary euthanasia. Thereafter is a discussion on beneficence and paternalism and how medicine (as the soft paternalism) and law (as the hard paternalism) work together. The final principle is the principle of justice as well as the theories of justice, of which the egalitarian theory will be emphasized.

b. Respect for the autonomy

Autonomy refers to the rule or the governance of one's self –

> Personal autonomy encompasses, at a minimum, self-rule that is free from both controlling interference by others and from certain limitations such as an inadequate understanding that prevents meaningful choice. The autonomous individual acts freely in accordance with a self-chosen

> plan, analogous to the way an independent government manages its territories and establishes its policies.[8].

For Beauchamp and Childress, an action will be considered autonomous if there is a 'substantial degree of understanding and freedom of constraint…'[9] Both of these consideration need not be taken to its fullest degree. The problem arises with autonomy between the fact that the patient is in a dependant condition and the doctor is in the authority to help that person. The boundaries of what the patient intended is compromised by the boundaries that the doctor can breach as the one, in a position of authority.

Beauchamp and Childress state that

> …respect for the autonomy can be stated as a negative and positive obligation. As a negative obligation: Autonomous actions should not be subjected to controlling constraints by others…As a positive obligation, this principle requires both respectful treatment in disclosing information and actions that foster autonomous decision making.'[10]

Respect for the autonomy is also recognised by the Constitution in the following sections: Section 12(2) the right to bodily and psychological integrity (which includes the right to make decisions about reproduction and security and control over their body); section 14 the right to privacy (in the sense that all communication between doctor and patient needs to remain private)[11]; section 11 the right to life ; section 21(1) the right to freedom of movement and section 15(1) right to freedom of religion and belief.[12] Even before the Constitution reflected the principles of autonomy were stated in Stoffberg v Elliot in 1923 that:

---

[8] Beauchamp and Childress (2009) 99; Moodley (2011) Medical ethics, Law and Human Rights Pretoria: Van Schaik 41 – 42; Dhai and McQuoid – Mason (2011) Bioethics, Human Rights and Health Law Claremont: Juta and Company Ltd. 14.
[9] Beauchamp and Childress (2009) 103.
[10] Beauchamp and Childress (2009) 104.
[11] Dhai and McQuoid-Mason (2011) 40. The right to privacy also include not have blood tested if it was given voluntary, but without informed consent to test it as in the case of C v Minister of Correctional Services 1996(4) SA 292 (T).
[12] Dhai and MQuoid-Mason (2011) 39. The authors also refer to the right of mentally competent patients not to live by refusing treatment (Section 6(1)(d) of the National Health Act 61 of 2003) in context of the right to life as well as the right of mentally competent patients to voluntary discharge themselves (Section 19(1) of the National Health Act) in context of the right of freedom of movement.

> In the eyes of the law every person has certain absolute rights which the law protects. They are not dependent on statute or contract, but they are rights to be respected, and one of the rights is absolute security to the person … Any bodily interference or restraint of man's person which is not justified in law, or excused in law or consented to is a wrong…[13]

i. Informed consent

Informed consent will be discussed in a South African context as the case law is inconclusive and controversial. Informed consent is the most common ground of justification or defence for medical interventions.[14] Informed consent forms part of the rules of the Health Professions Council of South Africa (HPCSA)[15] and the National Health Care Act 61 of 2003.[16] Before we discuss informed consent, it is important to know that the person that signs the informed consent needs to have the capacity to do so.[17]

The right to freedom of religion and belief does not always extend to children in the case of life-threatening situations.

[13] Stoffberg v Elliot 1923 CPD 148.

[14] Carstens and Pearmain (2007) 875: Moodley (2011) 43-47.

[15] HPCSA Ethical And Professional Rules Of The Health Professions Council Of South Africa As Promulgated In Government Gazette R717/2006 2nd Edition Booklet 2 (2007) Rule 13 : Professional confidentiality 13. (1) A practitioner shall divulge verbally or in writing information regarding a patient which he or she ought to divulge only - (a) in terms of a statutory provision; (b) at the instruction of a court of law; or (c) where justified in the public interest. (2) Any information other than the information referred to in sub rule (1) shall be divulged by a practitioner only - (a) with the express consent of the patient; (b) in the case of a minor under the age of 14 years, with the written consent of his or her parent or guardian; or (c) in the case of a deceased patient, with the written consent of his or her next-of-kin or the executor of such deceased patient's estate.

[16] National Health Care 61 of 2003: User to have full knowledge
6. (1) Every health care provider must inform a user of- (a) the user's health status except in circumstances where there is substantial evidence that the disclosure of the user's health status would be contrary to the
best interests of the user;(b) the range of diagnostic procedures and treatment options generally available
to the user;(c) the benefits, risks, costs and consequences generally associated with each option; and (d) the user's right to refuse health services and explain the implications, risks, obligations of such refusal. (2) The health care provider concerned must, where possible, inform the user as contemplated in subsection (1) in a language that the user understands and in a manner which takes into account the user's level of literacy.

[17] In terms of S 78(1) (a) & (b) of the Criminal Procedure Act 51 of 1977, capacity is the defined as (a) the ability to distinguish between right and wrong and (b) the ability to act in accordance of such appreciation. Children's capacity is in terms of the Child Justice Act 75 of 2008, section 7(1) under the age of 10, there is no criminal capacity; section 7(2 between 10 and 14 – there is presumed to lack criminal capacity unless it is proven that he or she has capacity in terms of section 11.Burchall (2013) Principles of Criminal Law Cape Town: Juta 256 states that criminal proceedings, children over the age of 14, have the same capacity as that of an adult.

Carstens and Pearmain state various reasons why the doctrine of informed consent is controversial. The first reason is that it is deemed the foundation of the relationship between doctor and patient in terms of the 'law of obligations and underscored by ethical considerations'.[18] This can either be a harmonious relationship or one strained with animosity if there is a miscommunication regarding consent. The next reason is important for this dissertation and it is that informed consent introduced a paradigm shift from medical paternalism to patient autonomy.[19] This is a controversial step to take in the medical profession which is still very based in a traditional paternalism mind-set. The third reason relates to blame shifting in a hospital setting and who is held responsible for informed consent: the nurse or the doctor?[20] The fourth reason is that with regard to positive law. There are so many sources that need to be taken into account – the Constitution, common law, legislation, professional policy and guidelines, case law – and one needs to obtain a balance between all these sources.[21] Relating to this is the fact that courts have not been able to provide a definitive decision that will assist in this regard. A further consequence of the introduction of patient autonomy and the move away from medical paternalism is that there needs to be a balance between the power which the medical practitioner has and the respect that they need to the opinion of the patient and that there needs to be shared decision-making between the two.[22] Informed consent has also challenged the doctor to '…as it were "rise to the occasion" and to "humanise" the doctor/patient relationship by establishing a rapport with the patient…'[23] Another problem is that informed consent relates to a specific procedure and the form on which the informed consent needs to be obtained is generic and laid in a specific format, which makes the differentiation between various procedures, difficult.[24]

Another reason that can be emphasized is the fact that in South Africa, there is a major difference between the public and private health care sector and therefore

[18] Carstens and Pearmain (2007) 877.
[19] Carstens and Pearmain (2007) 877.
[20] Carstens and Pearmain (2007) 877.
[21] Carstens and Pearmain (2007) 877.
[22] Carstens and Pearmain (2007) 877.
[23] Carstens and Pearmain (2007) 877.
[24] Carstens and Pearmain (2007) 878.

informed consent is often compromised as there are not enough resources to follow the procedure.[25]

Intertwined with the principle of beneficence, is the fact that doctors consider their patients as too illiterate to fully grasp the content of informed consent and therefore the doctor overrides the patients' wishes and perform medical procedures in the best interests of the patient.[26] If a claim then should arise based on the lack of informed consent, the Particulars of Claim '…are often principally flawed due to the fact that cause of action, is not reflective of the applicable legal principles…which persuasively illustrate that medical law trul transcends the traditional boundaries of law.'[27] Also in the of applying the law to informed consent various difficult concepts have arisen such the "reasonable patient", "the reasonable prudent doctor", "wrongfulness" and "material risk" – the concept are difficult as the cannot be plainly interpreted.[28] The most important reason for the difficulty in informed consent, for purposes of this dissertation is the fact that courts are weary to medical professional did not adequately inform the patient.[29]

One aspect that also requires a brief discussion in the context of informed consent is that if a medical practitioner fails to inform the patient, it regarded as assault on the patient, rather than negligence.[30] The *locus classicus* for this statement is found in the Castell v De Greef the following statements came through: (a) It rejected the "reasonable –doctor" (in essence rejected Richter v Estate Hammann) standard as it implies that that the medical practitioner to inform a patient cannot be left to the medical profession and rather establishing the "reasonable patient"[31]; (b) it regarded lack of informed consent as an element of wrongfulness (assault) and not

[25] Carstens and Pearmain (2007) 878.
[26] Carstens and Pearmain (2007) 878.
[27] Carstens and Pearmain (2007) 878.
[28] Carstens and Pearmain (2007) 878.
[29] Carstens and Pearmain (2007) 878 refer to case law: Castell v De Greef (claim failed), Broude v McIntosh (claim failed), Jacobson v Carpenter – Kling (claim failed), Louwrens v Oldwage (claim failed). The claim on succeeded in McDonald v Wroe.
[30] Carstens and Pearmain (2007) 679 refers to Strauss Doctor, Patient and the Law: '…The essence of negligence in the medical context is unskilful treatment…'
[31] Castell v De Greeff 1994 (4) SA 408 (C) and Richter v Estate Hammann 1976 (3) SA 80 (C) as referred to in Carstens and Pearmain (2007) 680.

negligence.[32] After Castell, Broude v McIntosh did not over rule Castell, but found this type of claim odd. As Carstens and Pearmain describes it as

> The court held that it was a strange notion that the surgical intervention of a medical practitioner whose sole object had been to alleviate the pain or discomfort of the patient, and who explained to the patient what was 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 had 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. It was inherent in the notion that, even if the risk did to eventuate and the operation was successful, the practitioner's conduct would nonetheless have constituted an assault.[33]

In Jacobson v Carpenter – Kling, the court relied on Castell v Greeff and held that …'it was sufficient for a doctor to indicate the body parts on which the operation would be performed and to indicate the "danger areas" which might be affected together as an indication that the required care would be excised.'[34]

Then there was the case of Louwrens v Oldwage which further contributed to the controversial aspects of informed consent. In this case, the Supreme Court of Appeal relied on the case of Richter v Estate Hammann.[35] This is problematic as Richter v Estate Hammann relies on the "reasonable doctor" approach (which supports medical paternalism) in context of informed consent and Castell v De Greeff rejects the "reasonable doctor" approach in favour of the "reasonable patient" approach (which supports patient autonomy) . The case of Louwrens v Oldwage relied on both cases and as shown, these two cases cannot be reconciled with each other.[36] Another reason why the judgment is disappointing is the fact that not many cases make it to the Supreme Court of Appeal, therefore it would have been the perfect opportunity to develop the doctrine of informed consent in light of Castell v de Greeff

[32] Carstens and Pearmin (2007) 680 -681.
[33] Broude v McIntosh 1998 (3) SA 60 (SCA) as referred to in Carstens and Pearmain (2007) 681 -682
[34] Jacobson v Carpenter – Kling 1998 (TPD) unreported as referred to in Carstens and Pearmain (2007) 682.
[35] Louwrens v Oldwage 2006 (2) SA 161 (SCA) as referred to in Carstens v Pearmain (2007) 686
[36] Carstens and Pearmain (2007) 686.

as well as Broude v McIntosh.[37] It could have also interpreted the common law in light of Carmichele v Minister of Safety and Security[38] as it was in McDonald v Woe (in this case the court found that the failure of a medical practitioner to warn the plaintiff if possible damage with reference to extraction of wisdom, violated her Constitutional right to bodily integrity in terms of section 12 (2) of the Constitution).[39]

c. Non-maleficence

This principle can be described as a principle to not inflict harm onto others.[40] Non-maleficence is also incorporated in the Constitution in the following sections: Section12(1)(e) Right no to be treated or punished in a cruel, inhuman or degrading manner; Section 12(2)(c) Right not to be subjected to medical or scientific experiments without their informed consent; Section 31(1) Right not to be denied the right to practice their religion or culture or to speak their language[41]; Section 24(a) Right to an environment that is not harmful to health or wellbeing; Section 27(3) Right not to be refused emergency medical treatment and most important is section 10 Right to dignity.[42]

Beauchamp and Childress refers to the Hippocratic Oath expression " I will use treatment to help the sick according to my ability and judgment, but I will never use it to injure or wrong them"[43] As harm can be defined in very broad terms and can cause an infringement of various Constitutional and human rights, Beauchamp and Childress attempt to narrow it down to '…physical harms, especially pain, disability, suffering and death, while still affirming the importance of mental harms and other setbacks to one's interests. In particular, we concentrate on intending, causing and permitting death or the risk of death.'[44] A major theme that this dissertation will focus on in context of non-maleficence is assisted dying - the situation where a medical practitioner assists a person in his/her own death. Beauchamp and Childress refer to

[37] Carstens and Pearmain (2007) 685.
[38] 2002(1) SACR 79 (CC).
[39] McDonald v Woe (CPD) unreported case 7975/03 as referred to in Carstens and Pearmain (2007) 686 – 687.
[40] Beauchamp and Childress (2009) 151; Moodley (2011) 63 -71.
[41] In section 6(2) of the National Health Act 61 of 2003 states that healthcare personnel needs to communicate with patients in a language they understand. Dhai and McQuoid- Mason (2011) 44.
[42] Dhai and McQuoid – Mason (2011) 44.
[43] Beauchamp and Childress (2009) 151.
[44] Beauchamp and Childress (2009) 153.

this situation as awkward for medicine and law, since if the patient was on life-sustaining treatment, there would be a right to withdraw.[45] However, if a person is not in that position, then they can '…refuse nutrition and hydration or give you the palliative care until you die a natural death, however painful, undignified and costly.'[46] Beauchamp and Childress regard it as infringing the ethic of autonomy if a patient's wishes to be assisted in death and there is a refusal thereof.

In light of this, there needs to be a discussion on the case of Stransham – Ford v Minister of Correctional Services and Others.[47] In this case, the applicant was a male advocate that had terminal stage 4 cancer and who had no cognitive impairment. He had a few weeks to live.[48] The applicant requested that a medical practitioner would end his life and not be held accountable of any civil, criminal or disciplinary liability.[49] He also requested that this conduct be developed in light of the common law. It has been declared by expert evidence that the cancer was terminal and the applicant had a short time to live.[50] The court proceeded to discuss the deterioration of the applicant's quality of life, the variety of treatments that have been utilised as well as the progression of the disease, the fact that the applicant has accepted death and does not fear it, but rather the fear of suffering.[51] The applicant relief on the following sections in the Constitution for common law development: Section 1, Section 7(1) & (2), Section 8(3) (a), section 10 (Human Dignity) and Section 12 (1) & (2) Freedom and security of the person. The court proceeded to discuss dignity in the current Constitutional dispensation – '

> Although it is difficult to capture in precise terms, the concept requires us to acknowledge the value and worth of all individuals as members of society. It is the source of a person's innate rights to freedom and to physical integrity, from which a number of other rights flow, such as the right to bodily integrity. It is my view also that persons must be regarded

[45] Beacuhamp and Childress (2009) 180.
[46] Beauchamp and childress (2009) 180.
[47] Stransham – Ford v Minister of Correctional Services and Others (2015).
[48] Stransham – Ford v Minister of Correctional Services and Others [2 – 3].
[49] Stransham – Ford v Minister of Correctional Services and Others [4.2 – 4.4].
[50] Stransham – Ford v Minister of Correctional Services and Others [6].
[51] Stransham – Ford v Minister of Correctional Services and Others [7 – 9.5].

> as recipients of rights and not objects of statutory mechanisms without any say in the matter.[52]

Reference was also made to O'Reagan J as cited in S v Makwanyane about having a right to life, must be a life that is worth living : '

> Without life in the sense of existence, it would not be possible to exercise rights or to the bearer of them. But the right to life was included in the Constitution not simply to enshrine the right to existence. It is not life as mere organic matter that the Constitution cherishes, but the right to human life: the right to share in the experience of humanity… So the rights to dignity and to life are intertwined. The right to life is more than existence; it is a right to be treated as a human being with dignity: without dignity, human life is substantially diminished.[53]

The court also further assessed the concept of euthanasia in light of authors Carstens and Pearmain stated that if one looks at the values, spirit and purport of the Constitution, it supports voluntary active euthanasia, but that it needs to be strictly regulated and monitored to ensure the autonomy of the competent terminally ill patients in order to guard against the abuse of such a practice.[54] Fabricious J agreed with this view. He also agreed with the Sachs J submission on Soobramoney vs Minister of Health, KwaZulu-Natal that dying is part of living and therefore one needs to die with dignity as one needs to live with dignity.[55]

Fabricious J criticised society that it tolerates death in various forms (wars, malnutrition, AIDS) and he also criticises the state:

> The State says that it cannot afford to fulfil all socio-economic demands, but it assumes the power to tell an educated individual of sound mind who is gravely ill and about to die, that he must suffer the indignity of the severe pain, and is not allowed to die in a dignified, quiet manner with the assistance of a medical practitioner.[56]

---

[52] Stransham – Ford v Minister of Correctional Services and Others [12] page 14.
[53] Stransham – Ford v Minister of Correctional Services and Others [12] page 16.
[54] Stransham – Ford v Minister of Correctional Services and Others [13].
[55] Stransham – Ford v Minister of Correctional Services and Others [14] page 18.
[56] Stransham – Ford v Minister of Correctional Services and Others [14] page 19.

He proceeds to discuss the aspect, relevant for this section, personal autonomy:

> The irony is, they say, that we are told from childhood to take responsibility for our lives but when faced with death we are told we may not be responsible for our own passing. There are many other ironic considerations in this context. One can choose one's education, one's career, one can decide to get married, one can live according to a lifestyle of one's choice, one can consent to medical treatment or one can refuse it, one can have children and one can abort children, one can practice birth control, and one can die on the battlefield for one's country. But one cannot decide how to die'[57]

The court takes note thereof that although the applicant's counsels as well as the SA Law commission propose that active voluntary euthanasia be legalised, it does not consider it an issue in the current application as the Fabricious J stated that each case should be decided on its facts and that future courts should determine their own safeguards.[58] It referred to the case of Clarke v Hurst and reasoned that even though the case context is different in each case, human rights still not to be given effect where the common law does not provide a solutions as it '...in effect, totally negates the rights that every human being is entitled to.'[59] In light of considering foreign law, the court specifically looked at Canadian law and also took extract from the case of Carter v Canada (Attorney General 2015 SCC5), which also emphasized the concept of dignity and autonomy.[60] The agreed with this case on two grounds; firstly, that a complete ban on assisted suicide does not protect vulnerable persons and secondly, that it deprived individuals to determine what to do with their bodies and that it could lead to suicide by themselves rather than with the assistance of a medical practitioner's assistance. The court proceeded to look at the opposing affidavits of the respondents. With regard to why the Minister of Correctional services

[57] Stransham – Ford v Minister of Correctional Services and Others [14] page 19.
[58] Stransham – Ford v Minister of Correctional Services and Others [17] page 22.
[59] Stransham – Ford v Minister of Correctional Services and Others [17] page 23.
[60] Stransham – Ford v Minister of Correctional Services and Others [18] page 25:' I wish to quote from par. 66 of this judgment: "…an individual's response to a grievous and irremediable medical condition is a matter critical to their dignity and autonomy. The law allows people in this situation to request palliative sedation, refuse artificial nutrition and hydration, or request the removal of life sustaining medical equipment, but denies them to request their 26 physicians' assistance in dying. This interferes with their ability to make decisions concerning their bodily integrity and medical care and thus trenches on liberty. And, by leaving people like Ms Taylor to endure intolerable suffering, it impinges on their security of the person."

had not made any progress regarding the commission report, the counsel stated that the conduct of the medical doctor who would assist with the euthanasia would amount to a criminal offence and he denied that right to dignity was involved in the case. The opposition also stated that if the application is granted it would lead to the inequality and discrimination of the poor as it would limit the access to the courts.[61] The court did not find this argument relevant. The third respondent, HPCSA, disputed whether the applicant's condition violated his right to dignity or that that he was being treated in an inhumane and degrading manner.[62] The respondent also stated that the applicant's view is subjective and therefore his right to dignity had not been infringed. These statements met a disapproving response of unjust from the court as Fabricious J had indicated, if it had not been for the 40 years in litigation and the fact that he was not shocked easily, this would have shocked him.[63] The court also agreed with a LLM by LB Grové that stated that there is no distinction between the withdrawal of life sustaining treatment and active voluntary euthanasia.[64] The main intention behind both procedures is that the medical practitioner needs to ensure that the patient has his/her quality of life and dignity intact. In light of the Constitution, the court decided to grant the application.

This case is in line with the principles of medical ethics as Beauchamp and Childress agree that:

> To make our overall position on the legitimacy of physician – assisted dying clear, principles of respect for autonomy and beneficence – as well as justice and virtues of care and compassion all offer strong reasons for recognising the legitimacy of physician – assisted death.[65]

In a disappointing, Supreme Court of Appeal decision, the judgment of the high court was turned around in the case of and The Minister of Justice and Correctional Services and Other v Estate Late Robert James Stransham-Ford and Others. The court begins its judgment by distinguishing between physician assisted suicide (PAS) which is '…the patient should be permitted to obtain a prescription for lethal drugs that they may use to terminate their own lives.' and physician administered

[61] Stransham – Ford v Minister of Correctional Services and Others [21] page 29.
[62] Stransham – Ford v Minister of Correctional Services and Others [21] page 30.
[63] Stransham – Ford v Minister of Correctional Services and Others [21] page 30.
[64] Stransham – Ford v Minister of Correctional Services and Others [21] page 30 -31.
[65] Beauchamp and Childress (2009) 185.

euthanasia (PAE) which falls under voluntary euthanasia and that is that 'the medical practitioner should be permitted at their request to administer such lethal drugs to them'.[66]

The court proceeded to state that the judgment of the High Court should have failed on three grounds: The first is that Adv. Stransham – Ford died two hours before the judgment was handed down and therefore his cause of action had ceased to exist.[67]Secondly, it was stated that there was no sufficient examination of local and international law, the Constitution and the Bill of Right and the common law on the subject.[68] The last reason is that the order did not comply with the Uniform Rules of Court and therefore interested parties were not allowed to be heard.[69]

With regard to the first reason, the court stated that Stransham- Ford only referred to his own human rights and not the rights of the general public or as a member of a class or group. The court stated that he wanted to have the common law developed for him, which meant a personal relief as he would have needed to involve other parties that suffer from similar circumstances. Also with regard to the medical doctor that would have needed to assist him and had the potential of being guilty of murder or culpable homicide, when Stransham – Ford ceased to live, the need for the development of those two common laws ceased to exist as no action would have taken place.[70] The court also confirmed this under rule 42(1) of the Uniform Rules and in terms of common law, under the *Justus* error.[71] The court also considered the fact that it is a constitutional issue and came to the conclusion with National Gay Coalition for Gay and Lesbian Equality and other v Minister of Home Affairs and others , that there was not more an 'existing or live controversy' which Fabricious J has to decide upon as the case became moot.[72]It further stated that: 'The courts have not plenary power to raise legal issues and make and shape the common law.

[66] Minister of Justice and Correctional Services and Others v Estate Late James Stransham-Ford and Others [2]page 4.
[67] [5]page 7.
[68] [5]page 7.
[69] [5]page 7.
[70] [14] –[15] page 12-13 .
[71] In terms of this rule, an order may be rescinded where it was erroneously sough or granted in the absence of a party and where it was made on the basis of a mistake common to the parties.
[72] [21] at page 17. In a late paragraph the court defines mootness as 'the term used to describe the situation where events overtake matters after judgment has been delivered, so that further consideration of the case by way of appeal will not produce a judgment having any practical effect.' [26] at page 20.

They must wait for litigants to bring appropriate cases before them that warrant such development.'[73]

With regard to the second reason, the court criticized the fact that the High court assumed that the position on active voluntary euthanasia or assisted suicide is clear, as the cases on which the high court relied upon did either not deal with voluntary euthanasia or assisted suicide (S v De Bellocq and S v Marengo)[74] and the third was facilitating in a domestic situation that is 'far removed from the matters with which we are concerned.'[75] The high court stated 'The current legal position is that assisted suicide or active voluntary euthanasia is unlawful.'[76] The court mentioned the medical principle of autonomy in its relation to the Constitution:

> A person may refuse treatment that would otherwise prolong life. This is an aspect of personal autonomy that is constitutionally protected and would not ordinarily be regarded as suicide. Medical treatment without the patient's consent is regarded as an assault so that the patient is always entitled to refuse medical treatment.[77]

The court set aside that question of Physician Assisted Suicide as there was no mentioned made of doctor who was willing to administer the final dose. The court regarded the possibility of PAE as academic and stated that 'The high court was not in a position to consider whether and subject to what condition the law in regard to consent as a defence to a charge of murder needed to be altered. Even had Mr. Stransham – Ford not die when he did, the court should have refused to enter into this academic question.'[78] Further, it held, with a reliance on Grotjohn case, that the court (in Grotjohn) did not decide that it is a criminal offence whenever any person (including and excluding medical practitioners) encourages or enables someone to commit suicide or the attempt to do so. [79] The court further stated that when one needs to determine if a person will be guilty of a criminal offence depends on the

[73] [24] at page 19.
[74] S v De Bellocq 1975 (3) SA 538 (T) at 539 d; and S v Marengo 1991 (2) SACR 43 (W) 47 A – B
[75] Ex parte Minister van Justisie: In re S v Grotjohn 1970 (2) SA 355 A. [28] – [29] 21 -22.
[76] [28]page 21.
[77] [31]page 22.
[78] [41]page 30.
[79] [54]page 37.

facts, intention, unlawfulness and causation and therefore the high court went too far to state that all circumstances of Physician Assisted Suicide is unlawful.[80]

When the court considered foreign law, the court also warned that jurisdictions that permitted PAE and PAS, had to answer difficult questions in terms of their own legislation or constitution and that this 'stand as a cautionary warning against any too ready assumption that the approach in a foreign court can readily be transplanted to South African soil.'[81]

It also confirmed that the right to commit suicide or aspects related thereto such as the date and the manner is prescribed or embodied by the constitution.[82] The court further held that nothing in common law, nor the Constitution, permits a law to be developed for an individual, but it does not apply to society.[83] It criticized the high court on various other aspects such as reducing that PAE and PAS are simple terms; not distinguishing the two; too little regard was paid to international jurisprudence and it also based its judgment on a case basis without application to all future cases, but without indicating how it can be controlled.[84]

Other aspects were also scrutinized is the fact that Stransham – Ford had reservation about whether he wanted to proceed with the euthanasia and this had not been made available to the judge.[85] There was also the issue that there is no person for whom the relief needs to be sought – as Stransham –Ford died 2 hours before his judgment and there were no specific doctors that sought to be excused from criminal proceedings or possible sanctions.[86]The court also raised concerns the fact that South Africa has a different economy and a diverse population and therefore the framework around the PAS and PAE needs to be completely functional.[87] There was also great emphasis placed on the cultural values and attitudes of this diverse population as the court did not consider the impact it has on various groups ' The notion of a dignified death must be informed by a rounded view

[80] [54]page 37.
[81] [58]page 40.
[82] [62]page 42.
[83] [68]page 46.
[84] [70]page 47.
[85] [85]–[88]page 56.
[86] [89]page 56-57.
[87] [98]page 61.

of society, not confined to a restricted section of it'.[88] Connected to this statement, is the judge's concluding remarks which state that 'In general, whilst recognizing the role that the Constitution confers upon the courts, it is desirable in my opinion that issues engaging profound moral questions beyond the remit of judges to determine, should be decided by the representatives of the people of the country as a whole.'[89]

d. Beneficence

Moodley defines beneficence as '…to doing good and the active promotion of goodness, kindness and charity. All doctors have a responsibility to provide beneficial treatment and to avoid and minimise harm.'[90] The beneficial treatment of the patient has historically been determined by the medical practitioner.

This paradigm is medical paternalism and will be the focus of this section for this dissertation. Beauchamp and Childress define paternalism as '

> the intentional overriding of one person's preference or action by another person, where the person who overrides justifies this action by appeal to the goal of benefitting or of preventing or mitigating harm to the person whose preferences or actions are overridden.[91]

The trend is that patient autonomy has increased, while medical paternalism has decreased, which lead to conflicting attitudes in the patient-doctor relationship.[92] A distinction can be made between soft and hard paternalism. Soft paternalism is where '…an agent intervenes in the life of another person on grounds of beneficence

---

[88] [100]page 62.
[89] [101]page 63. Refer to S v Makwanyane and Another (CCT3/94) [1995] ZACC 3;1995 (6) BCLR 665; 1995 (3) SA 391; [1996] 2 CHRLD 164; 1995 (2) SACR 1 (6 June 1995) 87 -89 : where the court regarded public opinion as having some relevance, but it would still be up to the Constitutional Court to adjudicate the matter : 'The question before us, however, is not what the majority of South Africans believe a proper sentence for murder should be. It is whether the Constitution allows the sentence.
Public opinion may have some relevance to the enquiry, but in itself, it is no substitute for the duty vested in the Courts to interpret the Constitution and to uphold its provisions without fear or favour. If public opinion were to be decisive there would be no need for constitutional adjudication… The very reason for establishing the new legal order, and for vesting the power of judicial review of all legislation in the courts, was to protect the rights of minorities and others who cannot protect their rights adequately through the democratic process. Those who are entitled to claim this protection include the social outcasts and marginalised people of our society. It is only if there is a willingness to protect the worst and the weakest amongst us, that all of us can be secure that our own rights will be protected.
This Court cannot allow itself to be diverted from its duty to act as an independent arbiter of the Constitution by making choices on the basis that they will find favour with the public.'
[90] Moodley (2011) 57.
[91] Beauchamp and Childress (2009) 208.
[92] Moodley (2011) 59.

or nonmaleficence with the goal of preventing substantially nonvoluntary conduct.'[93] Hard paternalists '…restrict forms of information available to the person or will otherwise override the person's informed and voluntary choices. The intended beneficiary's choices need not be fully informed or voluntary, but for the interventions to qualify as hard paternalism, these choices must be substantially autonomous.'[94]

Beauchamp and Childress state that there are reasons to be wary of the two types of paternalisms. The first is the ethical disadvantage – the policies that paternalism enforce can be reconciled with the values of individuals '…if they did not encounter internal limits of rationality and control.'[95] Paternalism uses methods to enforce policies, that will not face opposition and therefore a space of abuse can exists if these policies are not scrutinized by the public. The second is that paternalism stigmatizes conduct which changes behaviour. The example is given that of smoking – as smoking is more common among lower socio-economic groups and there are policies and legislation that prevent it, the stigma surrounding those groups attracts hostility.[96] The third reason for caution is the fact that soft paternalism can lead to hard paternalism – it is a matter of perspective of how far the autonomy is limited.[97] It is easy to start a campaign of soft paternalism, if the example of smoking is used, because there is a gradual support for campaigns that reconcile with social norms. The warning of the doctor becomes a law of the government – from disclosing information regarding smoking to makings law that tax cigarettes and restricts smokers from public areas. Beauchamp and Childress that these actions, while beneficent, violate respect for the autonomy.[98]

e. Concept of Justice

It can be argued that the concept of justice is embraced in the existence of the Constitution, as all rights, even when they are limited against each other in terms of section 36 of the Constitution, exist to achieve justice. Dhai and MacQuoid – Mason specify that these are the most prominent rights in the Constitution that enshrine justice: Section 9 Right to equality and non- discrimination; Section 10 Right to

[93] Beauchamp and Childress (2009) 209.
[94] Beauchamp and Childress (2009) 210.
[95] Beauchamp and Childress (2009) 212.
[96] Beauchamp and Childress (2009) 212.
[97] Beauchamp and Childress (2009) 212.
[98] Beauchamp and Childress (2009) 213.

dignity and Section 33 (1) Right to lawful, reasonable and procedurally fair administrative action.[99]

Beauchamp and Childress states that the 'Standards of Justice are needed whenever persons are due benefits or burdens because of their particular properties or circumstances, such as being productive or having harmed by another person's acts.'[100]

In light of medical ethics and its overlap to legal principles, one needs a clear understanding of distributive justice this is defined as '…fair, equitable and appropriate distribution determined by justified norms that structure the terms of social cooperation.'[101] Beauchamp and Childress proceed to give an example of what distributive justice means in context of medical research done on human subjects. Up until the 1990s, an ethical concern pertaining to human subjects was that they should not be exploited to medical research that will lead to harm and abuse. After 1990, the focus shift from this point to view, to a view that human subjects became more concerned with having access to the research and less with the risks involved.[102]

Beauchamp and Childress further proceed to differentiate between formal justice and material justice. Formal justice is defined by the Aristotle's 'Equals must be treated equally and unequals must be treated unequally.'[103] The problem with this type of justice is its lack of definition or criteria –

> it identifies no particular respects in which equals ought to be treated equally and provides no criteria for determining whether two or more individuals are in fact equals. It merely asserts that persons equal in whatever respects are the relevant respects should be treated equally.[104]

Beauchamp and Childress argue that it does not express the term 'equality' and it does not define how far equality should extend in a specific group. They state that a typical problem is 'Virtually all accounts of justice in health care hold that delivery

[99] Dhai and Macquoid – Mason (2011) 46.
[100] Beauchamp and Childress (2009) 241.
[101] Beauchamp and Childress (2009) 241.
[102] Beauchamp and Childress (2009) 241.
[103] Beauchamp and Childress (2009) 242.
[104] Beauchamp and Childress (2009) 242.

programs and services designed to assist persons of a certain class, such as the poor, the elderly, or the disabled should be made available to all members of *that class.* To deny benefits to some when others in the same class receive benefits is unjust. But is it also unjust to deny access to equally needy persons outside of the delineated class, such as workers with no health insurance?'[105]

The problem with this statement, in its application to South Africa, is that all disadvantaged groups are denied quality health care services as given by the public health care sector. Although it is a concern that certain groups would be excluded in the range of vulnerable groups as referred to by the problem, a far bigger problem South Africa has is the lack of resources that is needed to provide quality health care for the majority of the disadvantaged.

Related to this is the second type of justice which is referred to material justice – 'they identify the substantive properties for distribution. One such principle is the principle of need, which declares that social resources, including health care, should be distributed according to need.' [106] Beauchamp and Childress state that the obligation to provide will be limited to 'fundamental needs'.[107]

In South Africa, there is a multi – layered problem with the distribution of sources. The first problem is the fact that there are different groups of disadvantage in South Africa – the poor, the elderly, the disabled and these groups are also placed in situations (which are not necessarily deemed to be at a disadvantage, but can be deemed as such when contextualised under the theme of 'Insufficient resources in the public health care') such as uneducated, living in rural areas, living in overpopulated areas etc. Even if it can be argued that these different groups are receiving an equal share of health care resources, it is still disproportionality less than those who have access to private health care services. Another layer added to those who can access private health care services, is that even in private health care, there is a shortage of resources that compromise quality service delivery.[108]

[105] Beauchamp and Childress (2009) 242.
[106] Beauchamp and Childress (2009) 242.
[107] Beauchamp and Childress (2009) 242.
[108] Refer to Oppelt case (n 4).

The same can also be said of those that can only access public health care services, except their 'equal share' of resources are stretched so thin that health care institutions are very rarely held accountable for medical negligence.[109]

i. Theories of Justice

These are theories that have attempted to deal with the distribution of aspects relating to socio –economic rights such as health care.

The first of these theories is Utilitarian Theory, which Beauchamp and Childress state is '…the standard of justice on the principle of utility, which demands that we seek to maximize social welfare… These rights are strictly contingent upon social arrangements that maximize net social utility.'[110]

The second theory is the Libertarian theory. This theory is very capitalist driven as the rights of property and liberty are emphasized and people need to make it their own initiative to advance themselves. Under this theory, health care is not a right and the entire health care system needs to be privatized.[111]

The third theory is the Communitarian theory which focuses on aspects of pluralistic and diverse communities. [112] There is a reciprocal understanding between community and the individuals and the fact there is a sense of responsibility between the two. Beauchamp and Childress state that communitarians '… adopt the language of solidarity, which is both a personal virtue of commitment and a principle of social morality.[113]

The fourth theory, and the one, that will be emphasised in this dissertation is the Egalitarian theory. This theory was develop by John Rawls' Theory of Justice and it states that there needs to be equal distribution of sources (for example health care), but it must be done in such a way that it benefits the least advantage –

> the first requires equality in the assignment of basic rights and duties, while the second holds that social and economic inequalities, for example inequalities of wealth and authority, are just only if they result in

[109] Refer to S v Tembani (n 2).
[110] Beauchamp and Childress (2009) 245.
[111] Beauchamp and Childress (2009) 245.
[112] Beauchamp and Childress (2009) 246.
[113] Beauchamp and Childress (2009) 246.

> compensating benefits for everyone, and in particular for the least advantaged members of society.[114]

Rawls's theory entails two principles of justice: The first principle is that each person has an equal right to the basic liberties which will include the right to vote, freedom of speech, freedom from psychological oppression and physical assault, the right to have property and freedom from arbitrary arrest.[115] The second principle is split into two parts – the first part is that social and economic inequalities must be arranged that every person obtains an advantage. The second part states that social and economic inequalities need to be arranged to be attached to positions and open offices to all (in other words Rawls explains that positions of authority must be open to all).[116] Beauchamp and Childress make the observation that even if Rawls did not consider healthcare to be a one of the basic liberties there have been writers, such as Norman Daniels, that extends these rights to include healthcare and that each person should receive their share of equal opportunity where resources of health care are concerned.[117] If one takes the theory of Rawls and adds health care as a basic right that must be to advantage of each person and you make it a system that works in real life – then you get a system on which the National Health Insurance is based on.[118]

Although it is futile to discuss arguments that support the right to health care, as it is already a Constitutional right in terms of the South African Constitution, these arguments can also be used in the context of providing health care that is of a certain quality. The first reason is that health care can be regarded as a collective responsibility, which according to Beauchamp and Childress '…makes an appeal to coherence. If the government has an obligation to provide one type of essential service, then it must have an obligation to provide another relevantly similar service.'[119] The second argument is that institutions need to compensate for those people who are in a disadvantaged position for any specific reason, as they are normally the individuals that need health care the most, but who lacks it more than

[114] Rawls (1991) Theory of Justice: Revised Edition Cambridge Massachusetts: The Belknap Press of Harvard University Press13; Beauchamp and Childress (2009) 247.
[115] Rawls (1991) 53; Beauchamp and Childress (2009) 247.
[116] Rawls (1991) 53; Beauchamp and Childress (2009) 247.
[117] Beauchamp and Childress (2009) 247 -248.
[118] Chapter 4 is the full discussion of the National Health Insurance and its progress up until now.
[119] Beauchamp and Childress (2009) 259.

others because of the costs involved.[120] Beauchamp and Childress state that 'Insofar as injury, disability or diseases creates profound disadvantages and reduces agent's capacity to function properly, justice requires that we use the societal health care resources to counter these effects and to restore to persons a fair chance to use their capacities.'[121]

f. Conclusion

All of the medical principles have a basis in the South African constitution and therefore all principles can be validated in this regard.

There are however conflicting and controversial aspects of each of the principles. The underlying subtext of these problems is the fact that there are still very much conflicting feelings to give up medical paternalism under the guise of beneficence and non-maleficence, even while patient autonomy needs to be a consideration. It is conflicting as case law has shown that patient autonomy needs to be respected, but on the other hand law assists in maintaining the paternalism by making laws of aspects that the medical sector would prescribe.

This dissertation will now proceed to analyse South African case law that discuss the stance of socio-economic rights in context of the medical profession.

[120] Beauchamp and Childress (2009) 259.
[121] Beauchamp and Childress (2009) 259.

3. Chapter Three: An analysis of case that discussed socio-economic rights in a South African medical context

a. Introduction

The development of socio-economic rights in South African legislation has proven to be a difficult as will be illustrated by the case law below. This led to the intricate relationship that the medical profession and the legal profession have as the judgments do not only take medical principles and legal principles into account, but there are other factors that weigh in on this relationship such as policy considerations and case law that are extremely politically loaded. [122]

b. History of case law

i. Van Biljon v Minister of Correctional Services

The applicants of the case were four inmates from Pollsmoor Prison and the respondents were the Minster of Correctional Services, the Commissioner of Correctional Services, the Commander of Pollsmoor Prison and the Minister of Health and Welfare of the Province of the Western Cape. The applicants were all HIV positive. They sought declaratory order in which they could enforce section 35(2)(e) of the Constitution which states that 'Everyone who is detained, including every sentenced prisoner, has a right…(e) to condition of detention that are consistent with human dignity, including at least exercise and the provision, at state expense, of adequate…medical treatment'. [123] They wanted to use this right for prisoners with a CD4 count of less than 500/ml – that the state needs to provide the appropriate anti-viral medication.

For purposes of this dissertation, there will only be a discussion on the issue of, if the antiretroviral has been prescribed to the prisoners, whether it is an infringement on the prisoner's constitutional right, if these prescriptions are 'withheld' from the prisoners?

There are two main issues, with regards to socio-economic rights and the protection of the legal system over that of the health care system. These two issues are

[122] Pieterse (2011) 60.
[123] Van Biljon v Minister of Correctional Services 1997 (4) SA 441 (C) 445.

separate and also related to each other and will be discussed, separately and related to each other.

The first issue pertains to when the Court stated that:

> I do not, however, agree with the proposition that financial conditions and budgetary constraints are irrelevant in the present context. What is 'adequate medical treatment' cannot be determined in vacuo. In determining what is 'adequate', regard must be had to, inter alia, what the State can afford. If the prison authorities should, therefore, make out a case that as a result of budgetary constraints they cannot afford a particular form of medical treatment or that the provision of such medical treatment would place an unwarranted burden on the State, the Court may very well decide that the less effective medical treatment which is affordable to the State must in the circumstances be accepted as 'sufficient' or 'adequate medical treatment'. After all, as was pointed out by Mr Scholtz, s 35(2)(e) of the Constitution does not provide for 'optimal medical treatment' or 'the best available medical treatment', but only for 'adequate medical treatment'.[124]

In this paragraph, the issue is the fact that the court referred to 'adequate medical treatment' and had not continued to define the term.

The second issue relates to when the court stated:

> If a proper case was made out by out by respondents that, due to the constraints of its own budget, the Department of Correctional Services simply cannot afford the medical treatment claimed by applicants, I might have come to the same conclusion as the English Court of Appeal in R v Cambridge Health Authorities ([1995] 2 All ER 129 (CA)) or I might have found that "adequate medical treatment" for applicants is dictated by such budgetary constraints. From what I have already stated, it appears, however, that on the facts of this case it is not necessary for me to make a definite finding in these difficult issues.[125]

[124] Van Biljon v Minister of Correctional Services 1997 (4) SA 441 (C) 445[49].
[125] Carstens and Pearmain (2007) 111 – 112 with reference to Van Biljon.

This issue in this paragraph is the fact that the court admits that if circumstances had been different and the respondent did make out a case of budgetary constraints, it would not have made the order to provide the applicants with anti-viral therapy.

In this case, there was a declaratory order made, which ordered that the first and second applications be provided with the anti-viral therapy as it had been prescribed for them.[126]

Carstens and Pearmain states that in spite of the fact that it seems to be a beneficial judgment for the disadvantaged, such as the imprisoned (and the poor), this is actually not the case, as

> …"adequate" might be "…reasonable legislative and other measures within the available sources…" The right of the poor with regard to access to health care services, when expressed in practical terms seem different to those of the rich who can afford to pay for health care services or who do not have the same disease profile.[127]

The court remained hesitant to define 'adequate' as it will put an obligation onto the state/health sector to specifically adhere to 'adequate' medical treatment. Currently, there is no subminimum standard that needs to be complied with, and therefore the health sectors has leniency regarding the decisions it makes about the quality it provides. Also, there is always a secondary excuse that covers all aspects in the greater scheme of inadequate healthcare and that is budgetary constraints. In this case, it was not used, but as the court stated, if the respondents did use it, its order would have been different. In making this statement, the courts also provide a hint for future respondents on what to use in a similar case (as a precedent has been set that hints towards this outcome).

ii. Soobramoney v Minister of Heath, KZN

In this case, the applicant was a 41-year old, unemployed man with ischaemic heart disease and cerebro-vascular disease and he was in the final stages of chronic renal failure. As means to prolong his life, he sought treatment at a state hospital, but they were not able to assist him as they could only provide renal dialysis to a number of

[126] Van Biljon [61].
[127] Carstens and Pearmain (2007) 114.

patients, some of the machines were generally in a poor condition and there was a lack of funds to assist in his illness. Further, there were also guidelines that stipulated that if a patient suffered from an irreversible chronic renal failure, as the applicant, they would not be given treatment. Also the applicant was not free from 'vascular and cardiac' diseases and therefore could not be eligible for a kidney transplant.[128] The applicant had made use of private healthcare facilities, but his finances were depleted and this led him to rely on public healthcare facilities.

From the start of the judgment, Chaskalson P commented on the great divide in wealth in South Africa and how it existed from before the Constitution and how this divide needs to be closed, by means of transformation and if this not happen, it all seems but a futile process.[129]

The right to life argument had been rejected. Chaskalson P had stated that:

> If section 27(3) were to be construed in accordance with the appellant's contention it would make it substantially more difficult for the state to fulfil its primary obligations under sections 27(1) and (2) to provide health care services to "everyone" within its available resources. It would also have the consequence of prioritising the treatment of terminal illnesses over other forms of medical care and would reduce the resources available to the state for purposes such as preventative health care and medical treatment for persons suffering from illnesses or bodily infirmities which are not life threatening. In my view much clearer language than that used in section 27(3) would be required to justify such a conclusion.[130]

It moves on then to state that the socio-economic rights, in general (housing, healthcare, food, water etc.) are limited due to a lack of resources. It specifically referred to the budget of 1996 – 1997, as well as 1998, and how overspending had taken place and resources had been stretched out.

The Constitutional Court, again, distances itself from the interference politics and administration regarding healthcare where it stated that issues regarding budget lies at a political level and ' A court will be slow to interfere with rational decision taken in

[128] Soobramoney v Minister of Health, KZN 1998 (1) SA 765 (CC) [4].
[129] Soobramoney v Minister of Health, KZN [8].
[130] Soobramoney v Minister of Health, KZN [19].

good faith by political organs and medical authorities whose responsibilities it is to deal with such matters.'[131] Carstens and Pearmain also agrees that 'It is clear from the judgment in Soobramoney that there are boundaries beyond which the law should not interfere in matters involving the allocation of resources.'[132]

A particularly prominent stance that is taken in this judgment is the notion of the many-versus-the-few. With the scarcity of resources, there is an understanding that resources will allocated to society as a whole, rather than spending it on the few/individuals. This is evident, where the court states that: 'The state has to manage its limited resources in order to address all these claims. There will be times when this requires it to adopt a holistic approach to the larger needs of society rather than to focus on the specific needs of particular individuals within society,'[133]

The court also takes a particular stance on death and the extension thereof where Sachs J states:

> However the right to life may come to be defined in South Africa, there is in reality no meaningful way in which it can constitutionally be extended to encompass the right indefinitely to evade death. As Stevens J put it: dying is part of life, its completion rather than its opposite. We can, however, influence the manner in which we come to terms with our mortality. It is precisely here, where scarce artificial life-prolonging resources have to be called upon, that tragic medical choices have to be

[131] Soobramoney v Minister of Health, KZN [29].
[132] Carstens and Pearmain (2007) 48. A point to ponder is the case of where different resources are involved. In the Bato Star Fishing v The Minister of Environmental Affairs and Tourism and Others (CCT 27/03) [2004] ZACC 15; 2004 (4) SA 490 (CC); 2004 (7) BCLR 687 (CC) (12 March 2004) (hereinafter referred to as Bato Star Fishing case) the issue was with regard to the allocation of natural resources (fish - hake) and the fact the quotas handed down were too small to be considered in light with the transformation policy that is set out in the Marine Living Resources Act, 18 0f 1998 (section 2). In this case, there was a balancing of two interests: on the one hand were natural resources, who has been a decline for the past 40 years and on the other hand is the issue of transformation in a Constitutional Era. Both sides are extremely important for sustainability and transparency of the fishing industry in South. Yet, the court was willing to make a 'trade-of', in a manner of speaking and made a judgment on the allocation of natural resources in light of transformation. In the Soobramoney case, the resource is different (financial). The court was willing to get involved in the allocation of natural resources (a resource that can become extinct.), but not on financial resources (which a more flexible resource that can be created again if compared to nature, which is a volatile and uncontrolled resource).
[133] Soobramoney v Minister of Health, KZN [31]; Carstens and Pearmain (2007) 47.

> made. Courts are not the proper place to resolve the agonising personal and medical problems that underlie these choices.[134]

The court makes a point that is not their choice to prolong life as it is not the correct institution where these choices are made. This statement has to read together with the fact that courts decide to keep patients from using euthanasia as means to terminate life, on voluntary basis.[135] It is only in the very recent case of Stransham-Ford v Minister of Justice and Correctional Services and Others that Fabricious J used the same quote from Sachs J to state that living is indeed part of dying and Fabricious J agreed with the counsel's argument that is a human right to die with dignity in terms of the Constitution.[136]

In the case of of Stransham-Ford v Minister of Justice And Correctional Services and Others, the courts also criticised the State's role in excusing itself from fulfilling its socio –economic duties in light and blaming it on the lack of resources, yet they still control the manner in which people die, by not allowing them to die.[137]

iii. Minster of Health v Treatment Action Campaign

In the Minster of Health v Treatment Action Campaign an issue regarding the government which had to make nevirapine available to mothers and new-born babies, as public healthcare facilities to prevent transmission of HIV/AID from mother-to-baby.[138] The government placed restriction on the use of these drugs and the respondents stated that is affected the following sections in the Constitution: section 27(1(a) Everyone has access to health care services, including reproductive health care; section 27(2) The state must take reasonable and other measure, within its available resources, to achieve the progressive realisation of these rights ' and section 28(1)(c) Every child has the right basic nutrition, shelter, basic health care services and social services.

---

[134] Soobramoney v Minster of Health, KZN [57] &[58].
[135] Carstens and Pearmain 2007) 49 referring to S v Hartmann 1975 (3) SA 532 (C); s v de Bellocq 1975 (3) SA 538 (T); Clarke v Hurst NO 1992 (4) SA 630 (D).
[136] (27401/15) [2015] ZAGPPHC 230; 2015 (4) SA 50 (GP); [2015] 3 All SA 109 (GP) (4 May 2015).
[137] Refer to Chapter 2 page 14 of this dissertation.
[138] (No 2) (CCT8/02) [2002] ZACC 15; 2002 (5) SA 721; 2002 (10) BCLR 1033 (5 July 2002).

In this judgment, they court makes an affirmative statement that socio-economic rights are justiciable.[139] The question was 'whether the applicants have shown that the measures adopted by the government to provide access to health care services for HIV-positive mothers and their newborn babies fall short of its obligations under the Constitution.'[140] The court attempts to set a standard of what the minimum requirement would be to ensure that individual rights have been met, by referring to the minimum core.[141] Without setting up precise borders, the court states:

> This minimum core might not be easy to define, but includes at least the minimum decencies of life consistent with human dignity. No one should be condemned to a life below the basic level of dignified human existence. The very notion of individual rights presupposes that anyone in that position should be able to obtain relief from a court.[142]

It referred to the case of Grootboom and the judgment by Yacoob J, that measures by the state must be reasonable, and it proceeded to state that '…the socio-economic rights of the Constitution should not be construed as entitling everyone to demand that the minimum core be provided to them. Minimum core was thus treated as possibly being relevant to reasonableness under section 26(2), and not as a self-standing right conferred on everyone under section 26(1).'[143] This statement is creates a reality check to any notion that any person whose rights are protected under the Constitution has a right to healthcare.[144]

The court also referred to Soobramoney and stated that it could not control the finances of the State and distanced itself as it reaffirms the role of the Court to:

> …restrained and focused role for the courts, namely, to require the state to take measures to meet its constitutional obligations and to subject the reasonableness of these measures to evaluation. Such determinations of

[139] Minister of Health v TAC [25].
[140] Minister of Health v TAC [25].
[141] Minister of Health v TAC [26].
[142] Minster of Health v TAC [28].
[143] Minister of Health v TAC [34].
[144] Pieterse (2014) 68.

> reasonableness may in fact have budgetary implications, but are not in themselves directed at rearranging budgets.[145]

The court ordered the government four provisions that it had to remove the restriction that prevent nevirapine from being available, it has to facilitate the use thereof, make provisions for counsellors where necessary and take reasonable measures to extend testing and counselling facilities.[146]

This case serves as an example that if courts proceed to make order that serves as a catalyst for the implementation of socio- economic rights. Since its judgment more pregnant mothers that make use of public health care facilities have had access to Nevirapine.[147]

iv. N and others v Government of RSA and others

In the case of N and others v Government of RSA and others, the case evolved once again around prisoners and the access to anti-retroviral treatment. The applicants wanted to have restrictions removed that prevented them from obtaining anti-retroviral treatments and also have the respondents, be ordered to provide ARV treatment in terms of the National Treatment Plan.

The court agreed with the applicants. The Court stated that the implementation was unreasonable, inflexible and that there was an unjust and unexplained delay to implement the plan.[148] In addition, to have all restrictions removed and providing ARV to prisoners who meet the criteria, a structural interdict was also granted in which the respondent had to set out the manner (in terms of a time frame) in which they would set out how they would comply with the order.

This is an important case for courts and their approach on whether or not they can interfere with policy, politics and government. This case has shown that medical access can be enforced on the individual as well as the group by a court judgment and that the courts needs not necessarily take a distant approach as it did with

[145] Minister of Health v TAC [38].
[146] Minister of Health v TAC [135].
[147] Pieterse (2014) 70.
[148] N and others v Government of RSA and Others 2006(6) SA 543 (D) (No 1) [30] as referred to by Pieterse (2014) 74.

Soobramoney v Minister of Health, KZN and Minister of Health v Treatment Action campaign.[149]

v. Law Society of South Africa v Minister of Transport

In the case of the Law Society of South Africa v Minister of Transport, the Law Society sought to have section 21 of the Road Accident Fund (which abolishes a motor accident's common law right to claim compensation from a wrongdoer for losses which are not compensable under the RAF Act); section 17(4) which limits the amount of compensation that the Road Accident Fund (Fund) is obliged to pay for claims for loss of income or a dependant's loss of support arising from the bodily injury or death of a victim of a motor accident and Regulation 5(1) in which the Minister for Transport (Minister) has, pursuant to section 17(4B)(a) of the Act, prescribed tariffs for health services which are to be provided to accident victims by public health establishments.[150] Although the applicants used various sections to challenge the constitutionality of these section, only section 27(1) Access to Healthcare Services, was successful.

The court considered the expert evidence of 6 medical doctors and it was gathered that the Uniform Patient Fee Schedule (UPFS), made the tariff so low that it would not be possible for a patient to receive treatment from a private healthcare institution.[151] The National Health Reference Price List (NHRPL) is a set of rules that the Department of Health uses as reference prices. Medical schemes also determine their payment for medical services based on these prices. The NHRPL is said to be 300 – 500% higher than the UPFS rates. The other rating that the UPFS has been compared to is the Health Professions Council Ethical Tariff for Medical Practitioners (HPCMP). This tariff is not used anymore, but it is still used as a guideline. The difference between UPFS and the HPCMP also varies 120%.[152]

The expert evidence also showed a list of needs that a quadriplegic patient would need, not covered by the UPFS such as home-based caring. This was also considered where the quadriplegic person lived in a rural area, where there is no

[149] Pieterse (2014) 75.
[150] Law Society of South Africa v Minister of Transport 2011 (2) BCLR 150 (CC) [3].
[151] Law Society of South Africa v Minister of Transport [88].
[152] Law Society of South Africa v Minister of Transport [89].

immediate access to healthcare facilities and home-based caring is essential for sustaining life. [153] As a final remark, the court also stated that evidence was given that showed that public healthcare facilities were not able to rehabilitate quadriplegic and paraplegic victims.[154] Four of the expert witnesses also testified to the lack of resources in the public healthcare facilities and how it will negatively affect the disabled patient.

The court proceeded to state that there are situations, where the restriction can be justified, however, in the case of quadriplegics and paraplegics, the public healthcare system will not be able to sufficiently treat their medical needs.[155]

vi. Lee v Minister of Correctional Services

The final case that will be discussed is the case of Lee v Minister of Correctional Services.[156]This case also deals with a prisoner that wanted to claim damages from the state, as the Correctional Services failed to take preventative and cautionary measures to assure that those in detention do not contract TB.[157] The applicant's rights to dignity (section 10), right to life (section 11), freedom and security of the person(section 12(1), be detained in conditions that are consistent with human dignity, including at least exercise and the provision, at state expense, of adequate accommodation, nutrition, medical treatment (section 35(2)(e) as well as provisions (section 2(a) The purpose of the correctional system is to contribute to maintaining and protecting a just, peaceful and safe society by— (a) enforcing sentences of the courts in the manner prescribed by this Act) and section 12 of the Correctional Services Act.[158] The prison had shortages of resources, including nursing staff and

[153] Law Society of South Africa v Minister of Transport [92].
[154] Law Society of South Africa v Minister of Transport [93].
[155] Law Society of South Africa v Minister of Transport [96].
[156] (CCT 20/12) [2012] ZACC 30; 2013 (2) BCLR 129 (CC); 2013 (2) SA 144 (CC); 2013 (1) SACR 213 (CC) (11 December 2012).
[157] Lee c Minister of Correctional Services [2].
[158] Section 12 provides:
"(1) The Department must provide, within its available resources, adequate health care services, based on the principles of primary health care, in order to allow every inmate to lead a healthy life.(2)(a) Every inmate has the right to adequate medical treatment but no inmate is entitled to cosmetic medical treatment at state expense.
(b) Medical treatment must be provided by a correctional medical practitioner, medical practitioners or by a specialist or health care institution or person or institution identified by such correctional medical practitioner except where the medical treatment is provided by a medical practitioner in terms of subsection (3).

this led to the failure of measures to identify persons with TB and separate them from the others. The Constitutional court agreed that 'there was a negligent breach on the part of the responsible authorities for failing to maintain an adequate system for management of TB'[159] By using the *conditio sine qua non* test, the court had to determine the causation.[160]

The court stated that the evidence suggested that there was factual causation as the risk of contagion would have been reduced if the correct systems were put in place.[161] The claim succeeded.

Pieterse refers to this case as well as an article by Annelize Nienaber, that discusses whether the state will be held liable for HIV/AIIDS where the transmission was based on omissions in the detention facilities (such as the failure to provide condoms in prison/ lack of protection in the case of sexual assault) or a lack of resources (such as sufficient space to keep prisoners).[162] He mentions specific points that are relevant: Firstly, the fact that the state can be liable for an individual for a failure in healthcare.[163] Secondly, since courts have admitted that damages can be claimed and it has been confirmed with valid legal principles, there is a question of how far the umbrella of constitutional obligations can reach in respect of healthcare in South Africa?[164] In the Lee v Minister of Correctional Services case, there is an obligation to protect vulnerable, detained persons by making sure that all procedures surrounding health care are put in place. This case opens up the obligations of the state pertaining to different groups of vulnerable persons: disabled, the poor, the elderly, children, the uneducated, the homeless etc.

---

(3) Every inmate may be visited and examined by a medical practitioner of his or her choice and, subject to the permission of the Head of the Correctional Centre, may be treated by such practitioner, in which event the inmate is personally liable for the costs of any such consultation, examination, service or treatment.

[159] Lee v Minister of Correctional Services [37].

[160] In Lee v Minister of Correctional Services [40] the court referred to the International Shipping case for the definition: 'may involve the mental elimination of the wrongful conduct and the substitution of a hypothetical course of lawful conduct and the posing of the question as to whether upon such an hypothesis plaintiff's loss would have ensued or not. If it would in any event have ensued, then the wrongful conduct was not a cause of the plaintiff's loss; [otherwise] it would not so have ensued. If the wrongful act is shown in this way not to be a causa sine qua non of the loss suffered, then no legal liability can arise'.

[161] Lee v Minister of Correctional Services [60].

[162] Pieterse (2014) 78.

[163] Pieterse (2014) 78.

[164] Pieterse (2014) 78.

c. Summary and Conclusion

- In Van Biljon, the court states that the level of medical treatment that the State provide needs to 'adequate', but does not define 'adequate'. The court also stated that if the State used budgetary constraints as an excuse for not being able to provide medical treatment, then it would not have granted the treatment.
- In Soobramoney, the court takes a definite stance that it will not interfere regarding aspects such as budget and the allocation of resources. The court also makes a statement that it will not make a choice on extending the span of an individual's life as it is not the correct institution. This can be contrasted with the Stransham – Ford case, where it criticised the State for not being able to fulfil the scarcity of medica resources, yet it still controls how people die.
- In the Minister of Health v TAC case, the court attempts to set a very broad, minimum standard for health rights as a minimum core which 'includes the minimum decencies of life consistent with human dignity'. The court confirmed that court should not control the finances of the State by referring to Soobramoney, yet it did make the order that nevirapine should granted for pregnant mothers, there indirectly interfering with the manner in which allocates its resources.
- In N and Others v Government of RSA and others, the court took a much different stance than the cases before it – a stance much more aggressive and assertive against the State than the diplomatic judgments before it. The court order in terms of making ARVs more accessible and it even granted an interdict by which the State had to set out how they would comply within a time frame.
- In Law Society of SA v Minister of Transport, the court stated that public health care facilities are not adequate for quadriplegics and paraplegics. This is an interesting statement to make as it begs the question to what extents of disability can this be applied to?
- In Lee v Minister of Correctional Services case, it was held that there was causation to show that the state can be held liable if there are scenarios, in which the state did not use its resources to prevent the contagion of certain

viruses. This case also opens up the possibility to how wide can the net be cast for State obligation in the context of medical prevention if it pertains to protection of vulnerable groups?

If one looks at various case law, certain conclusions can be drawn: The first is that the court, in some instances, does not want to interfere in how the State makes decisions in the context of the medical and health profession. It distances itself, in spite of the fact that it can lead to the detriment of disadvantaged groups' socio – economic rights. The second is that the court in certain circumstances reacts very paternalistic and conservative in issues pertaining to death. This paternalism is to a certain extent also seen in the medical profession and it creates this idea that both fathers know best. There are judgments that rebel against this notion of protecting the State and the medical profession.

This dissertation will now proceed to the judgments that specifically address the issue of resource allocation and medical negligence and the NHI as a possible answer to ensure socio-economic fulfilment of the right to health.

4. Chapter 4: An analysis of S v Tembani and Oppelt case in context of resource allocation and medical negligence and NHI as possible answer for the lack of right of health

a. Introduction

In the previous chapter, there was a discussion on various judgments that have influenced the state of socio-economic rights in the sphere of South African health care. In this chapter, the two most prominent cases on the view of medical negligence and the lack of resource allocation in the public and private health care institutions will be discussed. In light of these case law, will follow a discussion of the development of the NHI as possibility to assist in the crisis of deteriorating health care services and those that are being affected.

b. S v Tembani and Oppelt: a public and private affair

Although the S v Tembani case is a case that discussed criminal liability, specifically causality, it is also the case that set the standard for the quality of healthcare provided by public healthcare institutions. This is a 'negative' standard as the court stated that even if this standard was present, the public healthcare facility would still not be liable for the death of the victim (in the case where the final acts of death resulted from medical negligence).

The facts in S v Tembani are as follow: The accused shot his girlfriend in her chest and it penetrated her lung, diaphragm and abdomen. The second bullet entered her calf. She was admitted to Tembisa Hospital. She died fourteen days later, from septicaemia caused by the wound in the chest and the abdomen. The accused's defence was that the hospital was grossly negligent and this severed the link of causation, therefore he is not liable for murder.[165] Initially, her wound was drained and she was given antibiotics, but then she was left for four days unattended. All

[165] S v Tembani 2007 (n 2 above) [4]; See also Carstens (2008) Judicial recognition of substandard medical treatment in South African public hospitals : the slippery slope of policy considerations and implications for liability in the context of criminal medical negligence. S v Tembani 2007 1 SACR 355 (SCA) http://hdl.handle.net/2263/10492 (date accessed: 07-11-2016); Pieterse (2014) 8.

procedures and admission to ICU had been a futile exercise as her wounds became septic.[166]

The court decided that based on policy considerations that the appeal will be dismissed. Cameron J based this on the fact that the accused does not have diminished moral and legal culpability, because there were others that fail to save the victim.[167] In the second reason, Cameron J, excuses the state of public healthcare in South Africa based on the scarcity of resources by stating that:

> 'In a country where medical resources are not only sparse but grievously maldistributed, it seems to me quite wrong to impute legal liability on the supposition that efficient and reliable medical attention will be accessible to a victim, or to hold that its absence should exculpate a fatal assailant from responsibility for death. Such an approach would misrepresent reality, for it presumes levels of service and access to facilities that do not reflect the living conditions of a considerable part, perhaps the majority, of the country's population. To assume the uniform availability of sound medical intervention would impute legal liability in its absence on the basis of a fiction and this cannot serve the creation of a sound system of criminal liability.'[168]

The court proceeded to set a standard, which will still not be considered, to excuse the accused of his criminal liability.

Cameron J stated that:

> I should add *that I do not consider that even gross negligence in the administration of medical treatment* [my emphasis] should be sufficient to relieve the original perpetrator of criminal liability for an ensuing death… It is not necessary to determine whether 'substantial' absence of reasonable proficiency connotes the presence of gross negligence, since I am prepared to assume in favour of the appellant that a finding of gross negligence may be warranted. Even so, while the wound remains

[166] S v Tembani (n2) [5].
[167] S v Tembani [26].
[168] S v Tembani [27].

> intrinsically fatal, even gross negligence should not permit escape from legal liability for its consequences.[169]

This was then taken further when in the Oppelt v Head: Health, Department of Health Provincial Administration Western Cape case, the court felt that this standard also extends to private healthcare industries based on the scarcity of resources that they encounter. [170] In this case the applicant was a 17 – year old rugby player, who sustained a spinal cord injury that led to him being a quadriplegic. He based his claim on the fact that too much time had lapsed in the transfer from one hospital to the next and this time lapse gave rise to the fact that the blood supply was not restored in time. The applicant sought a delictual claim of which causation was the main attack and then court held that there was a causal link by referring to the expert evidence given as well as the use of the" but-for" test in Lee v Minister of Correctional Services.[171] The court also found, that the respondent had been wrongful and had acted unlawful – this was based on the fact that the respondent did not react promptly to a medical emergency (within the four hours required).[172] Negligence was also present and therefore the applicant's claim succeeded.

In the minority judgment given by Cameron J, there are differences based on causation. The first difference is the fact that Cameron J stated that it cannot be concluded that the applicant was refused emergency medical treatment:

> …the majority judgment places insufficient weight on the circumstances in which the doctors and medical personnel worked on the critical day… Moreover, Groote Schuur's trauma unit register for the crucial day, which was proved in evidence, confirms that the unit was burdened with acute trauma cases…] Given these circumstances, I find it impossible to conclude that Mr Oppelt was refused emergency medical treatment. In light of the desperate situation of resource scarcity and pressure on the medical personnel, we cannot say he was inappropriately treated.[173]

---

[169] S v Tembani [29].
[170] Oppelt v Head: Health, Department Of Health, Provincial Administration: Western Cape 2015 (n 3 above).
[171] Oppelt v Head: Health, Department Of Health, Provincial Administration: Western Cape [34], [48]-[50].
[172] Oppelt v Head: Health, Department Of Health, Provincial Administration: Western Cape [51] – [68].
[173] Oppelt v Head: Health, Department Of Health, Provincial Administration: Western [100] - [103].

He based this claim on the fact that there were insufficient staffs for the trauma unit and answers that the wrongfulness has not been proven.

Turning to negligence, Cameron J, refers to the question of 'whether a reasonable medical professional would have foreseen the damage and would have taken steps to avoid it.'[174] The first part of the question was an obvious, yes, because of the expert evidence that was given by the respondent and applicants' witnesses.[175] The court at the expert evidence of two doctors – one doctor testified that there was a four-hour period in which all procedures had to be done, while another did not follow this rule. The court looked at the theory of the four-hour rule and whether the doctors that attended to the applicant was supposed to adhere to the theory, as part of the scope of 'reasonable' practice. The court found that there was no obligation to follow this rule, as it was not a generally accepted theory in the medical community.[176]

In both cases, the court has stated medical negligence can be excused in both public and private health care institutions based on the lack of resources.

c. National Health Insurance

i. Introduction

It seems as if the difficulty at this stage, South African health care has various dimensions: On the one hand, it seems as if the health care institutions (both private and public) have a severe lack of resources and therefore they struggle to give patients quality health care. This phenomenon is less observant in the private health care than in the public health care sector as there is more pressure on the public health care system to treat more patients that in the private health care system. Disadvantaged groups are more severely affected as they already come from a disadvantaged background, and now have less access to resources when it comes to their health and well – being. As disadvantaged groups cannot necessarily be taken out of their disadvantaged position, the alternative would be to at least make sure that the medical services on which they rely on, are adequate. Therein, lies the

[174] Oppelt v Head: Health, Department Of Health, Provincial Administration: Western Cape [107].
[175] Oppelt v Head: Health, Department Of Health, Provincial Administration: Western Cape [110].
[176] Oppelt v Head: Health, Department Of Health, Provincial Administration: Western Cape [131].

possibility of the NHI – as a system that has the potential to guarantee quality health care for more South Africans.

ii. The development thus far: NHI

As a result of the large gap in economy, the NHI, is aimed at providing ' *quality* [my emphasis], affordable health services for all South Africans based on their health needs, irrespective of their socio – economic status.'[177]

In light of the cases mentioned previously and the precedents that have been create in terms of the quality of healthcare that can be expected from public, and also private healthcare institutions, it presents an interesting dilemma of what standard 'quality' health care would refer to.

The main focus of the NHI is to close the gap of the current 'two-tiered' system divided along socio-economic lines.'[178] This idea of a system such as the NHI is not a new idea – from 1928 there was a Commission of Old Age and National Insurance that 'recommended that a health insurance scheme should be established to cover medical, maternity and funeral benefits for all low income sector employees in urban areas' and in 1935 a similar proposal was made by the Committee of Enquiry into NHI. [179] The National Health Service Commission of 1942 – 1944 'recommended the implementation of a National Health Tax to ensure that health services could be provided free at the point of service for all South Africans. The aim was to bring health services "within reach of all sections of the population, according to their needs, and without regard to race, colour, means or station in life".' [180] These proposals were accepted by General Jan Smuts; however any progress to it was curbed after the election of the National Party led by General DF Malan. Only in 1994, the Heath Care Finance Committee was established 'where several policy initiatives were considered to form a social or national health insurance.'[181] After this committee, various others were formed: Committee of Inquiry on National Health

[177] National Health Insurance for SA: Toward Universal Health Coverage Version 40 Notice 1230 of the Government Gazette Number 39506 11 December 2015 paragraph 12.
[178] National Health Insurance for SA: Toward Universal Health Coverage Version 40 Notice 1230 of the Government Gazette Number 39506 11 December 2015 paragraph 5.
[179] National Health Insurance in South Africa: Policy Paper (2011) paragraph 39.
[180] National Health Insurance in South Africa: Policy Paper (2011) paragraph 41.
[181] National Health Insurance in South Africa: Policy Paper (2011) paragraph 43.

Insurance in 1995, which supported the Health Care Finance Committee; The Social Health Insurance Working Group in 1997 in which the framework for the Medica Schemes Act was developed[182];The Committee of Inquiry into a Comprehensive Social Security for South Africa in 2002 which argued 'that there must be mandatory cover for all those in the formal sector earning above a given tax threshold and that contributions should be income-related and collected as a dedicated tax for health. The Committee also recommended that the State should create a national health fund through which resources should be channelled to public facilities through the government budget processes.' [183] The Ministerial Task Team on Social Health Insurance in 2002 that had to draft an implementation plan for a social health insurance plan (as it was not widely supported the proposal was stalled) and then in 2009 The Advisory Committee on National Health Insurance was created after the ANC Conference in Polokwane in 2007, in which Resolution 53 was passed that called for the establishment of the NHI. As there has never been a national health insurance plan, the South African health care sector developed racially and therefore the principles of the NHI has been developed in line with the Constitution. Firstly, it fulfils section 27 which is the Right to access health care.[184] Other principles include social solidarity, equity, and health care as a public good, affordability, efficiency, effectiveness and appropriateness. [185] The White Paper foresees a variety of problems in terms of Structural Problems of the Health System as well as the Burden of Disease. For purposes of this dissertation, some aspects with be dealt with in more detail than others.[186] One of the aspects that is discussed under Structural Problems is the Quality of Health Care Services and it states that:

> Quality of healthcare must be adequately addressed in both the public and private sectors. Public sector facilities are regularly assessed against core quality standards. This has revealed that there are quality problems in the areas of staff attitudes, waiting times, cleanliness, drug stock outs,

[182] The policy criticises the Act as it state that in spite of the Act's intention the make healthcare more accessible, the outcome was that there are still only less than 16% of the population that has medical coverage.
[183] National Health Insurance in South Africa: Policy Paper (2011) paragraph 47.
[184] National Health Insurance in South Africa: Policy Paper (2011) paragraph 52(a).
[185] National Health Insurance in South Africa: Policy Paper (2011) paragraph 52(b) – 52(g).
[186] In terms of Structural problems, the following can be considered: Cost drivers in the public healthcare sector, costly private health sector, poor quality of health services, curative hospi-centric focus of the health system, mal-distribution and inadequate human resources, fragmentation in funding pools, out-of pocket payments and financing systems that punish the poor.

> infection control and safety and security of staff and patients. In addition, significant increases in utilisation due to the high burden of disease and increased patient loads have further compromised the quality of care.[187]

Another problem that can be emphasised is 'Out-of Pocket Payment' that South Africans are currently exposed to. In terms of using public healthcare, users pay a facility-based fee in accordance with the UPFS. These amounts are determined by their income level. In terms of this practice, the South African Human Right Commission made an observation about vulnerable users:

> Primary health care is provided free of charge. Children under six years of age, pregnant women, the disabled and the indigent do not pay user fees for higher levels of care, and the National Health Act allows for free health care to be extended to other categories of users. However, in research presented to the public hearing, it was found that only half of those who visited a public hospital obtained an exemption despite all being eligible. The research also found that general private facilities were more popular than public hospitals despite the costs involved with the former. Of the households interviewed, 20% incurred "unaffordable" costs.'[188]

A major, final problem is that South Africa has financing systems in place, which punish the poor. In terms of the GDP, South Africa spends 8.5% on health of which 4.1 of the GDP is spent on 84% of the (poorer) population and 4.4% is spent on 16% of the population.[189] The expenditure of medical schemes in South Africa is more than any other OECD country - it is six times more than the OECD average.[190] As healthcare insurance is a form a financing, it is a form that disadvantages the poor. 20% of the richest population receive 36% of total benefits whilst having a health

[187] National Health Insurance in South Africa: Policy Paper (2011) paragraph 22.
[188] National Health Insurance for SA: Toward Universal Health Coverage Version 40 Notice 1230 of the Government Gazette Number 39506 11 December 2015 paragraph 88 referred to the 2009 Report and recommendation based on Submission and Proceedings of the Public Hearing conducted in 2007 – Public Inquiry: Access to Health Care Services.
[189] [189] National Health Insurance for SA: Toward Universal Health Coverage Version 40 Notice 1230 of the Government Gazette Number 39506 11 December 2015 paragraph 92.
[190] Organisation for Economic Co-operation and Development (OECD). National Health Insurance for SA: Toward Universal Health Coverage Version 40 Notice 1230 of the Government Gazette Number 39506 11 December 2015 paragraph 92.

need share of less than 10%. 20% of the poorest receive 12.5% of the benefits, whilst have a health need share of more than 25%.[191]

The rationale behind the NHI is based in elements of offering better public health care services by attempting to restore the absence of understaffed hospitals and providing a sustainable solution with its roots in the betterment of social and economic welfare. This is evident where it states that:

> The introduction of NHI is premised on a number of key interrelated elements, namely: a) to strategically introduce a single funding pool for meeting the health and healthcare needs of the population. This single funding pool of resources will be used to support the strategic purchasing and procuring of health resources i.e. facilities and human resources through properly articulated contracting mechanisms to supplement government's health services provision and delivery capacities; b) To better and more effectively mobilise and control the key financial resources in the health sector so as to adequately and sustainably enhance the strengthening of the under-resourced and strained public sector. This is directly linked to the State's responsibility to progressively realise the right of all to access affordable health care services and the need for improved efficacy in the delivery of healthcare; and c) To enhance the role of the health sector in improving the social and economic welfare of the population.[192]

Although all South Africans, as well as all legal permanent residents, will be granted insurance under the NHI, prioritization will be granted for more vulnerable groups.[193] This will be done through registration of residents and the issuing of NHI card, which will be linked to the Department of Home Affairs' smart ID.[194] When residents utilise the card, they will not need to pay at the point where they access the healthcare resources as services will be provided through the NHI fund. UPFS will also be

[191] National Health Insurance for SA: Toward Universal Health Coverage Version 40 Notice 1230 of the Government Gazette Number 39506 11 December 2015 paragraph 93.
[192] [192] National Health Insurance for SA: Toward Universal Health Coverage Version 40 Notice 1230 of the Government Gazette Number 39506 11 December 2015 paragraph 108.
[193] [193] National Health Insurance for SA: Toward Universal Health Coverage Version 40 Notice 1230 of the Government Gazette Number 39506 11 December 2015 paragraph 118.
[194] [194] National Health Insurance for SA: Toward Universal Health Coverage Version 40 Notice 1230 of the Government Gazette Number 39506 11 December 2015 paragraph 120.

abolished, which means that no fees will be levied at the public healthcare hospitals.[195] Certain fees that will not be included by the coverage such as the elective cosmetic surgery as well or fees utilised that individuals that are not covered under the NHI (such as tourists) have to be paid for directly or via an alternative medical scheme.[196]

The NHI will make use of both private and public hospitals – 'Certified and accredited hospitals and specialised services in the private sector will be contracted to address the health needs of the population in line with the requirements of NHI.'[197]

An interesting statement is the one where the White Paper specifically mentions a factor as

> One of the most identifiable factors that contribute to poor quality in our public Institutions is inappropriate, weak or poor management. Management of public hospitals has been characterised by over-centralisation, with hospital managers having almost no authority to manage their own institutions. Instead, hospitals are simply administered by provincial health department head offices, rather than being actively managed at facility level. This has led to under-development of management systems and capacity at hospital level and demoralisation of hospital managers, exacerbated by poor remuneration, limited training and support and inadequate career paths for managers. This makes it difficult for the public system to attract and retain skilled managers. Overcentralisation has also undermined the legitimacy and functioning of Hospital Boards, diminishing public accountability and trust in the hospital system.[198]

[195] National Health Insurance for SA: Toward Universal Health Coverage Version 40 Notice 1230 of the Government Gazette Number 39506 11 December 2015 paragraph 147.
[196] [196] National Health Insurance for SA: Toward Universal Health Coverage Version 40 Notice 1230 of the Government Gazette Number 39506 11 December 2015 paragraph 149.
[197] [197] National Health Insurance for SA: Toward Universal Health Coverage Version 40 Notice 1230 of the Government Gazette Number 39506 11 December 2015 paragraph 189.
[198] [198] National Health Insurance for SA: Toward Universal Health Coverage Version 40 Notice 1230 of the Government Gazette Number 39506 11 December 2015 paragraph 190.

The White Paper also attempts to solve this problem by stating that there needs to be a change in the role, functions and responsibilities of the management. [199] The White Paper states that accountability, quality of health service, performance and effectiveness must improve and this will be done by allowing managers to make more decisions in delegation of human resources, finances, supply chain management, facility management, cost centre as well as infrastructure.[200]

The standard for quality health establishments will be dealt with by the Office of Health Standard Compliance (OHSC). In 2011, the Department of Health also released the National Core Standards for Health Establishment in SA policy document for the improvement of health services and the quality thereof.[201] There are seven domains which need to be focused on as these domains are the ones that could lead to a risk in lower quality: (1) Patient rights; (2) Patient safety, Clinical governance and care; (3) Clinical Support Services; (4) Public Health; (5) Leadership and Corporate Governance; (6) Operation Management and (7) Facilities and Infrastructure. This policy document was developed by the Office of Standard Compliance and these seven standards are also included in the White Paper.[202]

In terms of the White Paper on National Health Insurance the Office of Health Standard Compliance 'will be the key in the certification of health establishments throughout the country'.[203] The Office of Health Safety Compliance has had some challenges in its inspections and ratings phases which included: (a) insufficient progress on the number of facilities inspected[204]; (b) there are no measures that

[199] [199] National Health Insurance for SA: Toward Universal Health Coverage Version 40 Notice 1230 of the Government Gazette Number 39506 11 December 2015 paragraph 209.
[200] [200] National Health Insurance for SA: Toward Universal Health Coverage Version 40 Notice 1230 of the Government Gazette Number 39506 11 December 2015 paragraph 209.
[201] Department of Health (2011) National Core Standards for Health Establishments in SA http://www.rhap.org.za/wp-content/uploads/2014/05/National-Core-Standards-2011-1.pdf (date accessed: 07/06/2016) 10.
[202] National Health Insurance for SA: Toward Universal Health Coverage Version 40 Notice 1230 of the Government Gazette Number 39506 11 December 2015 40; Department of Health (2011) National Core Standards for Health Establishments in SA http://www.rhap.org.za/wp-content/uploads/2014/05/National-Core-Standards-2011-1.pdf (date accessed: 07/06/2016) 8.
[203] National Health Insurance for SA: Toward Universal Health Coverage Version 40 Notice 1230 of the Government Gazette Number 39506 11 December 2015 paragraph 12.
[204]SAMED (2016) 16 March 2016: Public Health Facilities audit results: Office of Health Standards Compliance (OHSC) briefing http://www.samed.org.za/Filemanager/userfiles/Public%20Health%20Facilities%20audit%20results_Office%20of%20Health%20Standards%20Compliance%20briefing.pdf (date accessed: 08/06/2016) 2. The Office of Health Standard Compliance held a meeting on 16 March 2016 and presented 2014/15 results. They had inspected 10% of healthcare facilities – their aim was 25%.

have been put in place for non-compliant healthcare establishments of which the most common challenges were 'safety being compromised, good pharmacy practice (GPP) not being adhered to, waste mismanagement, lack of cleanliness, as well as poor maintenance of grounds and equipment'[205] and (c) lack of human resources in the Office of Health Standard Compliance are planning an increase from 96 in 2015/16 to 137 in 2017/18.[206]

iii. Conclusion

Although not a plan without its faults, the NHI does hold great potential for the current economic health care crisis in South Africa. It has the potential to give quality health care to all South Africans and to exclude the possibility of gross medical negligence and possibly decline the amount of medical negligence incidents. If there is a decline in medical negligence incidents, there will be fewer opportunities where the courts have to refuse to comment on policy makers and their budgetary behaviour. There is the possibility of having more hands-on management in all hospitals and a hospital can be singled out as a specific problematic hospital that needs additional assistance.

[205] SAMED (2016) 16 March 2016: Public Health Facilities audit results: Office of Health Standards Compliance (OHSC) briefing http://www.samed.org.za/Filemanager/userfiles/Public%20Health%20Facilities%20audit%20results_Office%20of%20Health%20Standards%20Compliance%20briefing.pdf (date accessed: 08/06/2016) 1-3. The system of inspection worked from A to F (A being the best and F being the worst). All facilities that rated E and F indicated non-compliance.

[206] OHSC (2015) Annual Performance Plan: for the Fiscal Year 2015/16 to 2019/2020.

5. Chapter 5: Conclusions and Recommendations

The three previous chapters contain an analysis of the relationship between the medical and legal profession in terms of medical ethics and judgments. This relationship has indeed contributed to the health care crisis in South Africa.

The second chapter dealt with the medical principles as given by the Beauchamp/Childress model. These medical principles are applied in a Constitutional contextualisation. The first principle of autonomy, which focused on the concept of informed consent as it is a controversial topic that needs further clarification. As consent needs to be obtained in the public and the private health care sector, the resources are limited and therefore the procedure is signed, without the proper transfer of knowledge from doctor to patient. Informed consent has not been developed in terms of the Constitution as shown in the case of Louwrens v Oldwage. The second principle is non-maleficence and the discussion of the Stransham – Ford v Minister of Correctional Services and Others case, in which the high court granted the applicant to be active and voluntary euthanized. This case showed how the concept of non – maleficence can be interpreted in Constitutional principles. The third principle is beneficence and it can be deemed as a problematic principle as it supports the idea of paternalism, which is often seen in the medical profession (soft paternalism) and the legal profession (hard paternalism). This is a difficult principle to reconcile with the principle of autonomy as well as justice. A final discussion is the concept of justice that discussed the theories of justice. The preferred theory is the egalitarian theory, as developed by John Rawls, as it supports the stance of socio- economic development and the NHI.

The third chapter analyses judgments of South African case law that have engage with the socio-economic rights in South Africa. The case law show that the courts are hesitant to set out a minimum standard for health care and are hesitant to interfere in the allocation of resources. There is also uncomfortableness in the theme of death and to what regards the State wants to interfere with it. On the one hand, there is a shortage of resources to keep patients alive and the court translates it as, that death is part of lying and it has to go its course. On the other hand, there is a conservative, beneficence and non – maleficence view that people are not allowed to partake in

active, voluntary euthanasia, even though their health has deteriorated to such an extent that they have mere weeks to live and those weeks will be painful and undignified. There have also been judgements that have taken a more pertinent stance with the state and the medical health sector and have forced to them to make medical resources more readily accessible or have stated that there can be causation between a person's health and the State's actions.

The fourth chapter discussed the case of S v Tembani as well Oppelt as the two cases that have excused medical negligence in the public and the private health care sector based on the shortage of medical resources. In S v Thembani, it went so far as to state that not even gross negligence would be regarded as sufficient for the avoidance of medical negligence. In the case of Oppelt, the court held the situation of resource scarcity to be a desperate one, therefore laying a standard on how the courts view the absence of resources. As a possible solution to the problem of resource allocation is the implementation of the NHI, which is currently at a White Paper stage. The major aim of this insurance is quality and inclusive medical treatment to all South Africans.

In this chapter, recommendations will be submitted for aspects that have been seen as problematic:

- The first recommendation relates to informed consent. As informed consent is a process or a discussion, not only a signature, medical staff needs to receive education or training on informed consent. The suggestion would be to make it a requirement that all staff needs to attend a workshop prior to the renewal of their registration of their medical licences, where a medico-legal advisor will explain and re-affirm the principles pertaining to informed consent. There also needs to be more awareness created in the general population that they need to understand and sign an informed consent before any procedure has commenced.
- As there is a precedent in case law, there needs to be a clarification made on the position on voluntary, active euthanasia. These circumstances will apply in a strict manner to avoid it relating to assisted suicide. The circumstances will be that a patient will give the instruction (not his/her family or his doctor) to receive medical treatment that will end his life. His/her medical condition must

be either be of a 'intractable and unbearable illness' or a ' terminal illness' as is defined by the Bill prescribed by the South African Law Commission Report Project 86: Euthanasia and the Artificial Preservation of Life.[207] The patient must be mentally competent and must be able to show understanding and appreciation of death. Voluntary active euthanasia can be developed along the lines of Netherlands and State of Oregon legislation.[208]

- A recommendation regarding paternalism would be to change the attitude toward ethics in a manner that certain ethics are not to seen as more prevalent than others for example that beneficence trumps patient autonomy. One possibility is to teach this paradigm shift from university stage onwards. The difficulty lies in the fact that one does not want to force medical staff to attend workshops about being less paternalistic, as this would be paternalistic towards them and would defeat the purpose thereof. The ideal would be that doctors need to focus more on aspects of professionalism and ethics as a whole, rather than only focusing on medical paternalism.
- A recommendation that is crucial in this crisis is the implementation of the NHI for various reasons, that also rely on a lot of 'ifs': If all public health care facilities are upgraded to a minimum quality standard or better, there will be improvements in terms of medical negligence, which will mean that there will be less court cases that will lead to court taking unsure standpoints on the medical profession and policy makers thereof. If there is a detachment of between the legal profession and the medical profession, the medical profession will gain more independence as its standard of quality would have improved. Once its quality has improved, it will be able to fulfil its Constitutional obligation to ensure the right to health to disadvantaged groups. Unfortunately, implementation takes time and a lot of water still needs to go under the bridge before the NHI will come to a realisation. Step-by-step smaller action plans need to be set in place and funds need to be made

[207] South African Law Commission Report Project 86 (1998) Euthanasia and the Artificial Preservation of Life defines 'intractable and unbearable illness' means an illness, injury or other physical or mental condition, but excluding a terminal illness, that- (a) offers no reasonable prospect of being cured; and (b) causes severe physical or mental suffering of a nature and degree not reasonable to be endured and 'terminal illness' means an illness, injury or other physical or mental condition that-
(a) in reasonable medical judgement, will inevitably cause the untimely death of the patient concerned and which is causing the patient extreme suffering; or(b) causes a persistent and irreversible vegetative condition with the result that no meaningful existence is possible for the patient.
[208] Carstens and Pearmain (2007) 203 -204.

available for aspects such as recruiting more inspectors in order to achieve their goals for institution inspection completion.

6. Bibliography

a. Primary Sources

i. Case Law

- In the Bato Star Fishing v The Minister of Environmental Affairs and Tourism and Others (CCT 27/03) [2004] ZACC 15; 2004 (4) SA 490 (CC); 2004 (7) BCLR 687 (CC) (12 March 2004)
- Broude v McIntosh 1998 (3) SA 60 (SCA)
- Carmichele v Minister of Safety and Security 2002(1) SACR 79 (CC)
- Castell v De Greef 1994 (4) SA 408 (C)
- Clarke v Hurst NO 1992 (4) SA 630 (D)
- Jacobson v Carpenter – Kling 1998 (TPD) unreported
- Law Society of South Africa v Minister of Transport 2011 (2) BCLR 150 (CC)
- Lee v Minister of Correctional Services(CCT 20/12) [2012] ZACC 30; 2013 (2) BCLR 129 (CC); 2013 (2) SA 144 (CC); 2013 (1) SACR 213 (CC) (11 December 2012)
- Louwrens v Oldwage 2006 (2) SA 161 (SCA)
- McDonald v Woe (CPD) unreported case 7975/03
- Minster of Health v Treatment Action Campaign No 2) (CCT8/02) [2002] ZACC 15; 2002 (5) SA 721; 2002 (10) BCLR 1033 (5 July 2002)
- Minister of Justice and Correctional Services and Others v Estate Late James Stransham-Ford and Others (531/2015) [2016] ZASCA 197 (6 December 2016)
- N and others v Government of RSA and Others 2006(6) SA 543 (D)(No1)
- Oppelt v Head: Health, Department Of Health, Provincial Administration: Western Cape (CCT185/14) [2015] ZACC 33; 2016 (1) SA 325 (CC); 2015 (12) BCLR 1471 (CC) (14 October 2015)
- Richter v Estate Hammann 1976 (3) SA 80 (C)
- S v de Bellocq 1975 (3) SA 538 (T)
- S v Hartmann 1975 (3) SA 532 (C)
- S v Makwanyane and Another (CCT3/94) [1995] ZACC 3; 1995 (6) BCLR 665; 1995 (3) SA 391; [1996] 2 CHRLD 164; 1995 (2) SACR 1 (6 June 1995)
- S v Tembani 20071 SACR 355 (SCA)
- Stransham – Ford v Minister of Correctional Services and Others (27401/15) [2015] ZAGPPHC 230; 2015 (4) SA 50 (GP); [2015] 3 All SA 109 (GP) (4 May 2015)

- Soobramoney vs Minister of Health, KwaZulu-Natal 1998 (1) SA 765 (CC) [4]
- Stoffberg v Elliott 1923 CPD 148
- Van Biljon v Minister of Correctional Services 1997 (4) SA 441 (C) 445

ii. South African Legislation

- National Health Care Act 61 of 2003
- Constitution of South Africa 1996
- Criminal Procedure Act 51 of 1977
- Child Justice Act 75 of 2008

ii. South African Policy Papers

- National Health Insurance for SA: Toward Universal Health Coverage Version 40 Notice 1230 of the Government Gazette Number 39506 11 December 2015
- National Health Insurance in South Africa: Policy Paper (2011)

b. Secondary Sources

i. Books

- Beauchamp and Childress (2009) Principles of Biomedical Ethics 6th Edition New York Oxford University Press
- Burchell (2013) Principles of Criminal Law 4th Edition Cape Town: Juta
- Carstens and Pearmain (2007)Foundational Principles of South African Medical Law Durban: LexisNexisDhai and McQuod – Mason (2011)
- Dhai and McQuoid – Mason (2011) Bioethics, Human Rights and Health Law Claremont: Juta and Company Ltd
- Moodley (2011) Medical ethics, Law and Human Rights Pretoria: Van Schaik
- Pieterse (2014) Can Rights Cure? The impact of human rights litigation on South Africa's health system Pretoria: Pretoria university Law Press
- Rawls (1991) Theory of Justice: Revised Edition Cambridge Massachusetts: The Belknap Press of Harvard University Press

ii. Booklets

- HPCSA Ethical And Professional Rules Of The Health Professions Council Of South Africa As Promulgated In Government Gazette R717/2006 2nd Edition Booklet 2 (2007)

iii. Journal Articles on websites

- Carstens (2008) Judicial recognition of substandard medical treatment in South African public hospitals: the slippery slope of policy considerations and implications for liability in the context of criminal medical negligence. S v Tembani 2007 1 SACR 355 (SCA) http://hdl.handle.net/2263/10492 (date accessed: 07-11-2016)

iv. Reports

- OHSC (2015) Annual Performance Plan: for the Fiscal Year 2015/16 to 2019/2020
- South African Law Commission Report Project 86 (1998) Euthanasia and the Artificial Preservation of Life

v. Websites

- Department of Health (2011) National Core Standards for Health Establishments in SA http://www.rhap.org.za/wpcontent/uploads/2014/05/National-Core-Standards-2011-1.pdf (date accessed: 07/06/2016) 10
- SAMED (2016) 16 March 2016: Public Health Facilities audit results: Office of Health Standards Compliance (OHSC) briefing http://www.samed.org.za/Filemanager/userfiles/Public%20Health%20Facilities%20audit%20results_Office%20of%20Health%20Standards%20Compliance%20briefing.pdf (date accessed: 08/06/2016)