THE SOUTH AFRICAN HEALTH CARE SYSTEM

In South Africa we distinguish between practitioners who are employed by the State and those who practice for their own account.

Private practices and hospitals attend to those who can afford to pay for their services, by their own funds or their medical aid scheme.

A patient, who seeks the services of a private practitioner, enters into a direct relationship with him and must remunerate him privately = FREE ENTERPRISE SYSTEM and the state isn't a party to the agreement. BUT this contract is limited as the law puts certain limits on the contract between the doctor and the patient (e.g. where the patient assumes risk for negligent treatment). Thus we can't be called a free enterprise system.

Besides S27 of the Constitution – no one has an absolute right to health care.

There is NO National Health care service in SA, but provision has been made for state and provincial hospitals and clinics.

The National Health Act (S4(1)): empowers the minister of health to prescribe conditions, regarding which people are eligible for free health care services at a public health establishment.

S4 (3): of the NHA: state clinics and health centers provided by the state must provide:

- Pregnant and lactating woman and children under 6 who aren't members of a medical aid with free health care
- All people (except members of medical aid schemes) and their dependents and all people getting compensation for an occupational disease with free primary health care services
- Woman, subject to the Choice of Termination of Pregnancy Act, with free terminations of pregnancy.

The National Health Department hopes to make membership of medical aid schemes more affordable by introducing a National Health Insurance system. This will however, be expensive to implement.

The NHIS is aimed at ensuring that all South Africans have access to health care.
This system will be funded from the taxes paid by the higher income earners in society and administered by the public sector.

THE CONTRACT BETWEEN DOCTOR AND PATIENT

A patient in consulting a doctor enters into a contractual relationship with him.
A doctor in private practice is a free agent or independent consultant and can accept or refuse patients as he chooses. The exception to this is S27, dire emergency.

The contract entered into is in a tacit agreement where the doctor undertakes to diagnose and treat the patient in a normal way. Any unusual procedures must firstly be discussed with the patient. The undertaking of this agreement does not mean that the doctor will treat the patient personally. He can refer the patient to a specialist.
By undertaking a case, a doctor does not guarantee that the patient will be cured.

A medical practitioner can refuse to treat anyone who is physically or verbally abusive subject to section 27.
Once a treatment has commenced a doctor may not simply abandon the patient.

Medical fees

Medical fees must be reasonable. The doctor must furnish the patient with a detailed account within a reasonable period even where an account was rendered to a medical scheme.

MUTUAL CONTRACTUAL RELATIONS BETWEEN DOCTORS – HOW DOCTORS PRACTICE TOGETHER

Partnership

Partners share profits and losses.

Advantage is that if a partner falls ill he does not lose his income because he continues to share in the income generated by the other partners.

Disadvantages are that relations may become strained if one of the partners does not pull his weight and the insolvency of one of the partners may also create problems.

Associate Practice

An agreement by which facilities are shared (an alternative).
Doctors are not sharing in both profit and loss but each practices for his own profit, yet they share certain facilities, e.g. rooms, equipment etc.

Doctors in "association" are mutually available for each other's patients.

Company

In terms of the Act, corporate practice, that is, a registered company is generally prohibited for doctors. The Minister of Health may, on the recommendation of the Health Professions Council, exempt any juristic person, from any of the provisions.

Requirements

- The company must be incorporated and registered as a profit company.
- The company's memorandum must provide that directors shall be liable, together with the company, for the debts and liabilities of the company incurred during their term of office.
- Only doctors and members of supplementary health service professions registered, can be shareholders.
- A greater measure of continuity as far as possession.
- There could also be some tax advantages.

Collaborative Agreement

Companies, have come into being to facilitate coordination of services in the field of primary health care = may own, lease or sublease rooms to, for e.g. a clinic. This has become as a medical and health network.

Objective: is to facilitate the access of patients to a variety of medical practitioners and related health-care providers located in one center. The doctors are not employed by the company itself (illegal) but will lease rooms.

Such a company will then enter into agreements with medical schemes in terms of which the members of the medical scheme will have access to health-care providers at the centre at a fixed reduced rate. These agreements are known as "capitation". This means that the medical scheme pays to the company a pre-negotiated fixed fee.

RESTRAINT OF TRADE

When a medical practitioner employs a professional assistant and insists on including a condition in the agreement, that upon termination, the assistant cannot practice for a certain period within the general area in which the medical practitioner practices.

Object: to protect practitioners and prevent future competition including the drawing of new patients.

Past: The courts had a marked unwillingness to allow these clauses as they restricted ones right to free trade.

Today: A clause restricting trade is not invalid and unenforceable. A covenant which restricts someone's freedom to trade is not always against public policy. It is valid if it is reasonable. (Magna Alloys)

The factors that the courts look at to determine the reasonableness:
- the area in which the restraint operates,
- the period and the scope of the activities,
- the court will have regard to the availability of similar, alternative services.

What is reasonable is determined by asking the following:
- Does the party in whose favour the restraint operates have an interest that deserves protection?
- Is the interest affected by the party against whom the restraint lies?
- Is the restraint of one party's freedom of trade needed to protect another party's interest?
- Is there any aspect of public interest that requires the restraint not to be upheld?

Examples
1. *Locum tenens* restrained from practicing as a general practitioner within 5miles / 8km for 5 years. Upheld. Estate Matthews
2. Professional assistant restrained for two years within 4 miles / 6km. Upheld. Rogaly v Weingarts
3. Partner leaving general practice restrained from practicing in any capacity for 3 years within 50km. Period held unreasonably long. Scaled down to 12 months. Ntsanwisi v Mbombi
4. In Kleynstruber v Barr the court held that a restraint is unreasonable where the service supplied (superior physiotherapy) was of a unique nature and not available anywhere else in South Africa.

REGULATION OF THE MEDICAL PROFESSION BY THE LAW

HEALTH PROFESSIONS COUNCIL OF SOUTH AFRICA (HPCSA)

The objects of the HPCSA include:

- Co-ordinate the activities of the professional boards
- Promote and regulate interprofessional liaison between registered practitioners and the public
- To determine strategic policy with regard to the professional boards and registered professions for matters including finance, education, ethics, registrations, etc.
- Consult and liaise with relevant authorities.
- Assist in the promotion of health of the population
- Control and exercise authority in respect of all matters affecting the training of persons for diagnosis, treatment or prevention.
- Advise the Minister on any matter falling within the scope of the Act
- Communicate to the Minister information of public importance

PRACTICE BY UNREGISTERED PERSONS PROHIBITED

- It is a criminal offence for an unregistered person to practice for gain. This excludes registered nurses and pharmacists etc.
- The Act also declares punishable a series of individual acts preformed for gain:
    (a) physically examining someone
    (b) perform any acts of diagnosis, treatment or prevention
    (c) advising someone on their physical state
    (d) on information obtained from the person, diagnosing, supplying, selling or prescribing medicine or treatment
    (e) prescribe or supply any medicine or substance
    (f) performing any act pertaining to a medical practitioner's profession
- It's an offence to diagnose, treat or prevent any physical defect, illness or deficiency in any person, by virtue to obtain any benefit.
- It is an offence where an unregistered person, whether for gain or not, to diagnose, treat, prescribe a cure, treatment or medicine for cancer.
- It is an offence to pretend to be a medical practitioner or to use the name.

A conviction can lead to a fine or 12months imprisonment.

UNPROFESSIONAL CONDUCT

This is improper, disgraceful, dishonourable or unworthy conduct.

Section 41: A professional board is rested with the power of instituting an inquiry into alleged unprofessional conduct.

Either this comes to the board as a complaint by a patient or it is referred to the board by a court.

A complaint by a patient must be in writing to a professional board, HPCSA or registrar.

The registrar or the investigating officer must compile a report of the investigation (section 41A). If the report shows *prima facie* evidence of unprofessional conduct and no complaint has been laid, such report shall serve the purpose of the complaint.

The registrar must refer complaints and matters which are not within the jurisdiction of the HPCSA to the ombudsman for mediation.
The ombudsman must then:
- mediate any minor transgression in aim of resolving same
- refer matters which can't be solved to the registrar for a preliminary investigation
- refer a matter to an appropriate board or tribunal

<u>Procedure:</u>

- Complaint is received and registered
- Inform the respondent of the complaint
- The respondent to give a written response within 40 days (even if it is just the right to remain silent), as a practitioner whose conduct is subject to an enquiry shall have the opportunity of answering to the charge. (Section 42)
- All documents, whether including a response or not, must be submitted to a preliminary committee of inquiry.

If the respondent didn't respond	**If the respondent did respond**
He will be issued with a written notice instructing him to appear before the committee. The committee has to then: - find the respondent guilty and impose a penalty (a warning or reprimand or a prescribed fee) - order the respondent to submit his written response	The committee may make one of the following findings: - there are no grounds for taking any further action - the respondent acted unprofessionally but the conduct is only a minor transgression – impose punishment

- and direct the registrar to confirm its decision in writing to the respondent. If the respondent fails to attend the meeting, the committee may: - find the respondent guilty and impose a penalty for contempt - order the respondent to submit his written response - and direct the registrar to confirm its decision in writing.	- there are grounds for a professional enquiry into the conduct of the respondent Do the enquiry and then impose a punishment.

A professional board may impose one / more penalties such as:

1. a caution or reprimand
2. suspension for a specific period from practicing or performing acts
3. removal of name from the register
4. fine not exceeding R10 000
5. compulsory period of professional service
6. payment of the costs of the proceedings or restitution

PREFORMANCE ASSESSMENT

If the committee finds that the evidence points to poor performance by the respondent, it may impose practice restrictions and refer the matter to a performance assessment committee.

The respondent is then required to submit reports in order to make a final determination.

If on the grounds submitted in the report, the performance committee is satisfied that the respondent has acquired the required skill it may lift any practice restrictions but if they are not satisfied the committee must determine the skills required and request further assessments.

APPEAL AND REVIEW

Appeal: There are two types of appeals (1st appeal internal):
1. Internal – to an appeal committee.
2. External – to the high court.

De Bruin held that this is an appeal in the normal sense and is based solely on the evidence upon which the decision was made (confirmed in De Beer).

Review: to the high court by virtue of common-law powers of review.

DISPENSING OF MEDICINES

GR: A licensed practitioner may not keep an open shop or pharmacy (the supply of medicines to the public is not done by prescription)

Requirements and limitations include:
- practitioner must have completed a supplementary course by SA Pharmacy Council.
- a license may be issued "on the prescribed conditions"
- an application fee is payable
- the license is valid for a prescribed period (3 years) and must be renewed periodically by way of application. A fee is also payable
- the Director-General can revoke or suspend a license on grounds such as failure to comply with the conditions imposed

GENERIC SUBSTITUTION

Ethical medicines are medicines which patented and may not be manufactured and marketed by anyone other than the holder of the patent. Once the patent has expired other manufactures may make and market similar products under a different trademark, these are known as generic medicines and are considerably cheaper than their original.

A pharmacist has a duty to:
1. inform all patients presenting a prescription of the benefits of the generic
2. dispense a generic, unless the patient has expressly forbidden substitution.

A pharmacist may not dispense a substitute if:
1. the doctor has written, "no substitution".
2. the retail price of the generic is higher than the original
3. if the generic has been declared "non-substitutable"
4. if the patient requests the ethical

Commissions: A medical practitioner may not accept or get from any pharmacist any commission or reward in connection with any prescription given = An offence and will lead to disciplinary action.

Bonusing: supply of medicines according to a bonus system, rebate system or any other incentive system".

Sampling is "the free supply of medicines by a manufacturer or wholesaler or its agent to a pharmacist, medical practitioner, etc." The prohibition does not include a free supply of medicines for the purpose of clinical trials.

LEGISLATION AND ITS EFFECT ON MEDICAL LAW

THE PROHIBITION OF UNFAIR DISCRIMINATION

S9 of the Cn (equality clause)**:** Prohibits unfair discrimination on numerous grounds including:
- "disability", e.g. epilepsy

This includes denying a disabled person any supporting facility necessary for her functioning in society.

The Promotion of Equality and Prevention of Unfair Discrimination Act (S34) – HIV/AIDS is considered a disability and is a prohibited ground of discrimination.

NHA – Section 20 prohibits unfair discrimination against health care personnel on the grounds of their health status.

THE RIGHT TO LIFE – S11 of Cn

In Christian Lawyers Association the court held that the Termination of Pregnancy Act governing abortion was not in conflict with the constitutional right to life.

THE RIGHT TO FREEDOM AND SECURITY – S12 of the Cn

Bodily and psychological integrity and it includes:
- The right to make decisions about reproduction: *(including sterilization and abortion – as found support in the Choice on Termination of Pregnancy Act)*
- Security and control over your body
- Not to be subject to medical experimentation without informed consent

THE RIGHT TO PRIVACY

S14 of the Cn deals with one's right to privacy in general terms. Common law: a patient has a right to expect that the doctor doesn't disclose his ailments and treatment

S14 National Health Act: all information regarding a patients health, treatment and stay at an institution is private unless:
1. Patient consents in writing
2. Court order allows for it
3. It amounts to a threat to public health

Publication of names and HIV status = breach of this right (NM v Smith).

Disclosure in the newspaper of the minister of health's records = infringement of s17 NHA and privacy (Tshabalala-Msimang).

THE RIGHT TO HEALTH CARE

S27 of the Cn:
(1) everyone has the right to have access to health-care services, including reproductive health care (public)
(2) the state must take reasonable legislative and other measures within its available resources to achieve progressive realization of these rights.
(3) no one may be refused emergency medical treatment (public or private)

In Soobramoney the court held, when a person suffers a sudden catastrophe which calls for immediate medical attention. – Here, the patient suffered from kidney failure which could be prolonged by means of regular rental dialysis. The cost would be too high and the patient's condition was not serious enough.

In Treatment Action Campaign and others v Minister of health and others, the applicants wanted Nevirapine dispensed in all hospitals to mothers who are pregnant with HIV. The High Court held that with Nevirapine it is affordable if the programme is properly planned. On confirmation in the Constitutional Court, it was held that it was not a complex task and that reasonable measures would need to be taken to extend testing and counseling and that by making it available to reduce the risk of mother-to-child transmission of HIV. This was confirmed by the Constitutional court.

S5 NHA states that "A health care provider, health worker or health establishment may not refuse a person emergency medical treatment". – there is nothing in this provision which entitles a patient to such treatment free of charge.

THE RIGHTS OF CHILDREN – S28 of the Cn

The Cn states that any matter involving a child must be in a child's best interest. (*Hay v B*)

Section 28(1)(c) refers to the child's right to health care services and section 28(1)(b) refers to the child's right to parental care or if removed from same to appropriate alternative care.

Grootboom stated that these two sections should be read together.

THE RIGHT TO INFORMATION – S32 of the Cn

Everyone has the right of access to:
(a) any information held by the state
(b) any information held by another and is required for protection of any rights.

This clearly entitles patients access to their medical records.

Medical And Health Records

NHA:
S10: a patient must be supplied with a discharge report
S13: requires that hospitals and other health establishments keep detailed records
S14: requires confidentiality of patient information.
S15: deals with ones rights to access to health records
S16: deals with access to health records by health care providers. The rights given to doctors to see the health care records for:
- Treatment of the patient
- Study, teaching or research with authorization of the patient unless no information as to the patients identity is revealed.

S17: Protection of medical records.
S19: If a patient refuses treatment, he must sign a certificate of release of liability

THE RIGHT TO JUST ADMINISTRATIVE ACTION – S33 of the Cn

The right to administrative action that is lawful, reasonable and procedurally fair, including the right to be given written reasons.

THE RIGHTS OF PRISONERS – S35 of the Cn

This includes the rights of arrested, detained or accused, which includes the right to medical treatment at state expense and the right to be visited by a chosen medical practitioner.

In Van Biljoen and others v Minister of Correctional Services, it was held that the state has a higher duty of care to HIV prisoner's than to citizens. Once a prisoner has been prescribed an anti-viral treatment for AIDS, he is entitled to continue receiving medication, but the decision to originally prescribe it is a medical not a legal question.

S37 says that in a state of emergency the detainee has the right to choose and be visited at any reasonable time by a medical practitioner.

THE LEGAL BASIS OF MEDICAL INTERVENTION

A doctor is under a general duty to act – with an omission look if the person can be legally expected to interfere.

A doctor will be liable if he has a legal duty to act positively and fails to do so – this is tested by using the objective *boni mores* test.

Doctor wouldn't be liable if:

- Specialized knowledge is required
- He doubts his ability
- Too many patients
- Drunk, exhausted

What establishes a legal duty to act?

Prior conduct	**Control of dangerous object**	**Statutory authority**	**Contractual liability**
This is where a positive act creates a dangerous situation and the person then fails to prevent harm to others. e.g. start treatment and fail to complete it e.g. blood transfusion	Where you have a dangerous situation / object and fail to exercise proper control e.g. In Seema a gravely disturbed patient escaped from the hospital, kidnapped the plaintiff's daughter and raped her. The court held that there was a legal duty to protect the boarder public against unlawful conduct by patients and the court awarded damages to the Plaintiff. In Magware the court held that the staff had a duty to complete the treatment once commenced.	S27 (3) on the constitution states that no one can be refused emergency medical treatment = doctor expected to act in this situation	Employed by hospital: the scope of his duties depends on his employment contract. Private practice: duty arises when the doc contracts with the patient

Right to heal:

Consent justifies medical treatment: *volenti non fit inuria* = no injustice is done to he who is willing

When treatment takes place against the will of the patient = UNLAWFUL. This is the case even if such treatment cures him = it still violates his personality rights

Requirements for consent:
- Must not violate the good morals of society
- Must be given in the proper form as prescribed by law
- Be given voluntarily
- Be clear and unambiguous
- Be comprehensive
- Encompass all three elements of consent
- Be given by someone legally capable of consenting

In Castell v De Greef the question was asked how much information must a patient be told. It was held that informed consent is needed.

A medical intervention against the will of the patient will be legally justifiable only where the interests of the state or society are involved. E.g. administration of a vaccination in order to prevent the spreading of an infectious disease.

A DOCTOR'S DUTY TO INFORM THE PATIENT

The question asked is how much must a doctor tell his patient about the risks involved in the treatment.

Although there is no need for the doctor to point out all the conceivable complications that may arise, he should at least inform the patient of the serious risks involved in the operation. E.g. amputate his penis (Elliot).

Our law requires informed consent be given with regards to any medical treatment. It is a serious offence should a practitioner act without informed consent.

In McDonald v Wroe the court stated that subjecting a patient to surgery without his informed consent is a violation of one's bodily integrity.

The question that then arises is how do we determine what is sufficient for informed consent:

Before: Richter: the courts were guided by the reasonable doctor test = look at the opinion of the reasonable doctor – often this required expert evidence.

Castell v De Greef: look at a **material test** = look at if there are material risks inherent in the kind of treatment proposed

The courts were guided by:

1. Would a reasonable person in the patient's position, if warned of the risk, would likely attach significance to the risks
2. Was the doctor reasonably aware, or should he have been, that the patient would attach such significance to the risks

They no longer used the reasonable doctor test but look to the interests of the reasonable patient.

In Broude v McIntosh and Others, the court declined to express itself on the correctness of the judgment in Castell. They held that they could not use the reasonable doctor or patient test because the patient was a doctor and one could assume he would have a certain percentage of knowledge and would know what to ask. However, the court still followed Castell but did not want to confirm it as the correct way.

UNISA: informed consent is needed; therefore the reasonable patient test was preferred.

Louwrens: the court confirmed the use of the reasonable patient test ('material risk' test as used in Castell)
On appeal, the court refrained from unequivocally confirming the correctness of the test.
It is decided that the wise doctor will ensure that he does not overestimate the patient's intellectual level, and will avoid technical terminology in describing to the patient the nature and scope of the operation and any serious consequences or complications that may result from it.

In McDonald v Wroe confirmed the criterion of materiality as the standard to be applied.

The Doctrine of informed consent is covered by common law and statutory law.

NHA: reinforced the common law position: S6: a doctor must inform the patients of the benefits, risks, costs and consequences of the treatment.
There is also a duty on the doctor to inform a patient who refuses treatment on the implications and risks inherent in his refusal

The doctor has however no obligation to inform the patient when:

- The patient already has the requisite information
- The patient waives his right to information expressly or tacitly
- Disclosure is physically impossible in the circumstances
- The damage caused by disclosure would be greater than the damage caused by withholding it (therapeutic privilege)

DEFENCE: therapeutic privilege – the doctor will look at any harmful side effects on the patient (suicidal tendencies)
VRM: the doctor didn't tell a 8 month pregnant woman that she was HIV positive.

Section 13(3) of the Mental Health Care Act provides that a mental health care provider may temporarily deny a mental health care user access to information contained in his health records if disclosure of that information is likely to seriously prejudice the user or the health of other people.

The NHA has given express but limited statutory recognition to therapeutic privilege in requiring the doctor to inform the patient unless it would be contrary to the best interests of the patient.

HIV testing in the work place

In Rand Water Board v SAMWU Others the court ruled that HIV testing of employees was permitted for a restricted time under the following:

a. On a voluntary basis with informed consent
b. Testing will not be requested as a condition of employment
c. Testing will not be a job requirement
d. No prejudicial inference will be drawn from a refusal to be tested
e. Testing will only be done after pre-test counseling has been given and will be followed by post-test counseling
f. The contractors conducting the testing will at no time reveal the results of the test to anyone but the employee
g. Contractors will be required to sign a confidentiality agreement
h. The result of any testing will not be made known to any decision-maker required to decide on any employment policy or practice concerning such employee

Doctor deviating from operation consented to

GR: a doctor will not be entitled to materially deviate from treatment agreed upon, in any event not where the treatment given is far more radical than that consented to unless it proved:

1. That such extension of the operation is in accordance with good medicine
2. That the extension takes place in good faith in order to alleviate the patient's complaint

3. That the risk to the patient is not materially increased
4. That it would be contrary to the patient's medical interests to first allow him to recover from the anesthetic in order to give consent to the operation's being extended.

Treatment without consent

S7 NHA confirms treatment without consent in the case of dire emergency provided that the patient has never expressly refused such treatment.
Section 7(1) of the NHA allows for medical intervention without a party's consent where:

- It is authorized by any law
- It is authorized by a court
- failure to treat might result in a serious risk to public health
- any delay might result in the person's death or irreversible damage.

In Minister of Health, Western Cape v Goliath an application was brought in public interest where the respondents had been diagnosed with a highly infectious drug resistant tuberculosis. They argued that such detention would infringe their right to freedom. The court found that such limitation was justifiable.

Doctor can act without the consent of the patient if he can prove:

Presumed consent: The patient would have consented if he could have.

Necessity "Emergency": in necessity the interests of an innocent 3rd party are sacrificed to protect the interest of the person threatened. When a doctor acts in this situation no innocent 3rd parties rights are affected. This could be a defence when the treatment is done in the interests of the community = vaccination / outbreak

Negotiorum Gestio: This is generally used for a patrimonial interest but can be extended to a situation where the party who is threatened is physically present but unconscious

Requirements:
1. Necessity
2. Patient (dominus) is incapable of consenting
3. Doctor promote the interests of the patient without his knowledge
4. Cannot be against his wishes

If the doctor does what is reasonable he cannot be held liable if the patient dies

Substituted consent

Minors:

GR: consent from the parent or guardian is required (Esterhuizen)
EXCEPT in the following:

1. Where parents refuse - the Minister of Health may then consent.
2. The procedure to be performed may be so urgent that it would be unrealistic to first seek ministerial consent. The high court, as the upper guardian can consent. (Hay v B)
3. A medical superintendent of a hospital, in emergency circumstances, can consent.
4. In cases of absolute emergency where it is impractical or dangerous to request consent. Example: cardiac arrest, CPR. The doctor, nurse or paramedic can take immediate action.
5. Heads of institutions (e.g. in reform schools) are vested with the powers of authorizing medical operations.

A child can refuse treatment if they are the correct age and comply with the maturity level but if their refusal is unreasonable then substituted consent can occur.

HIV Tests: S130 of the Children's Act states that children under 7 may consent to a test if he is of sufficient maturity to understand the benefits, risks and social implications of such a test.

Contraceptives: Children over 12 are entitled to purchase condoms.

Virginity tests: are prohibited on a child below 16 and may only be performed on children over 16 if their written consent is obtained.

Circumcision: is prohibited on a male child under 16 unless:

- It is performed for religious purposes
- It is performed for medical reasons

Circumcision of female children is prohibited.

Medical examination of victims of a sexual or violent nature: A magistrate or a certain senior police officer may give consent where a parent or guardian

- Can't be traced within a reasonable time
- Can't grant consent
- Is a suspect in respect of the offence
- Unreasonably refuses to consent
- Is incompetent due to a mental disorder
- Is deceased

Abortion: a female of any age may consent independently to abortion. (Christian Lawyers Association).

Mentally ill patients:

Consent can be given on behalf of mental patients by:

1. The curator
2. The patients spouse
3. The patients parent
4. The patients major child
5. The patients brother or sister
6. The superintendent of the institution where the patient is
7. In cases of dire emergency, hospital doctors may consent.
8. In the case of frail, aged persons, it is sufficient for relatives consent, after consultation with them.

Mental Health Care Act

Voluntary care: provision of health interventions to a person who gives consent to such interventions.

Assisted care: provision of health interventions to a person who is incapable of making informed decisions due to their mental health status and who do not refuse the intervention.

Involuntary care: provision of health interventions to a person who is incapable of making informed decisions due to their mental health status and who refuse the intervention but require such service for their own protection or the protection of others.

Section 9(1) states that care may be provided to a health care user only if:

- the user has consented
- the intervention is authorized by court (Ex Parte Dixie)
- due to the mental illness, the delay in providing such intervention may result in:
    - death or irretrievable harm of the user
    - user inflicting serious harm to himself or others
    - user causing serious damage or loss of property.

LEGALLY RECOGNISED MEDICAL PROCEDURES

Two kinds of medical procedure can be distinguished:

1. a healing (therapeutic) procedure, that is treatment of an ailing person with the view of curing him (normal medical procedures)
2. a non-therapeutic procedure which is preformed on a healthy person by the application of medical science (experiments and cosmetic surgery)

THERAPEUTIC PROCEDURES

ACTIVE EUTHANASIA

Euthanasia is unlawful whether it takes placed at the request of the sufferer or otherwise. Consent to homicide is no defence – contra boni mores. If a medical practitioner were to take positive steps so as to cause the hastening or immediate death, he would consequently be guilty of murder. **TO HASTEN DEATH IS TO CAUSE IT.**

R v Dawidow, the accused was found not guilty of murder where he shot his painfully suffering mother to release her from her suffering.

S v De Bellocq: no request or desire on the part of the sufferer. Here, a mother, in a state of emotional shock and deep depression, drowned her child who was suffering from an incurable disease. She was accused and found guilty of murder but was not sentenced.

In S v Hartmann, a medical practitioner took the life of his ailing father. The court held that the accused was guilty of murder because it was unlikely that the father ad expressed a wish to die. The judge held that there were strong mitigating factors and sentenced the accused to a suspended term of imprisonment of one year.

According to South African judgment, to hasten death is to cause it. In R v Makali, the court declared that the true enquiry is whether the deceased would have died when he did but for the accused's unlawful act (factual causation).

Can a physician shorten a patient's life?

- A patient is suffering from an incurable disease accompanied by excruciating pain. The physician administers the minimum dosage of drugs necessary to make the pain endurable knowing that such minimum dosage will probably also cause death.
- A patient is suffering from a painful and incurable disease and a drug is administered. Due to the resistance of habitual administering of the drug, steadily increasing doses have to be administered. This means that unless the patient dies beforehand

owing to another cause, a point must be reached when dosage becomes lethal
- Where a patient is suffering and no treatment can avert death but his life may be slightly prolonged by the administering of drugs, the failure of the physician's conduct to administer the drugs will not be unlawful.

ASSISTED SUICIDE:

If a physician makes the harmful medicine available in the circumstances, which would make death a likely consequence, the existence of a causal connection ought to be accepted, and the liability of the practitioner ought to depend on his fault.
It CANNOT be argued that, since suicide is not a crime, it is not unlawful to assist a person to commit suicide.

In S v Gordon, the accused was acquitted on the charge of murder where he and his mistress had entered into a "suicide pact". He gave her the drugs; she took the tablets and subsequently died. Her act was, according to the court a novus actus interveniens. This decision was, in Unisa's respectful opinion, open to criticism and the perpetrator should have been found guilty of murder or CH.

In R v Matthews, the accused was found guilty of culpable homicide where he supplied the deceased, who was already under the influence of liquor, three glasses of sherry, and persuaded him to drink them in quick succession. As a result of this, the deceased died.

In Grotjohn the court supported the view that a person, who assists another in committing suicide, may be guilty of murder or CH.

"Dr Death": In 1999, by the time Kevorkian had assisted 130 suicides he was charged with murder once again after giving an ailing patient who desired to die, a lethal dosage of drugs. He had injected the patient himself while the procedure was recorded on videotape. He was convicted of second-degree murder.

During the 1990s the legislature of the Australian Northern Territories state enacted legislation to legalize doctor-assisted suicide within certain narrow limitations.

In 2001 the Dutch parliament passed an Act, which declares doctor-assisted suicide in extreme cases lawful. The requirements are very strict:
1. The doctor must be satisfied that the patient's suffering is unbearable and
2. There is no prospect of improvement.

PASSIVE EUTHANASIA

Where a person is kept alive artificially by medical means, and the doctors in attendance decide that there is no purpose in continuing resuscitative or life-sustaining measures and where such treatment is discontinued, resulting in the patient's death = **right to die debate**

Clarke v Hurst NO and Others. Dr Clarke, a member or the SA Voluntary Euthanasia Society, signed a Living Will before his last illness in which he suffered irreversible brain damage. He became comatosed and remained in that condition permanently.

His wife approached the court for an order appointing her as curator of her husband's person, with powers to authorize the discontinuance of any treatment, including any non-natural feeding or hydration.

The Attorney general opposed the application on a number of grounds: The discontinuance of the artificial feeding would hasten the patient's death, thus causing it =liable for murder. He was in a persistent vegetative state and that the damage was irreversible but he was not brain-dead.

His wife and the *curator ad litem*, argued that an adult, while of sound mind, is entitled to refuse to undergo medical treatment, irrespective of whether such refusal would lead to his death. Clarke, while he was in sound mind, directed that should he lapse into a persistent vegetative state with no prospect of recovery, he should be allowed to die and not be kept alive by artificial means and therefore there is no reason why his curator should not have the power to give effect to his direction.

Court looked to the boni mores test: The judge said that artificial feeding did not have any significance for the simple reason that the patient was quite unaware of it and would be equally unaware of it if it was withheld.
In S v Williams, the victim had suffered severe brain damage and was coupled to a ventilator. The court held that the uncoupling of the ventilator could not be regarded as the cause of her death; it was no more than the termination of an unsuccessful attempt to save her life. The doctor had not killed her, but had merely allowed her to die.

Another judge observed that the uncoupling of the ventilator had accelerated the patient's death and therefore in a sense caused it but it is clear that a factual causal connection is not enough to entitle legal liability.
JUDGMENT: Mrs. Clarke was appointed as curator with the power to authorize the discontinuance of any treatment.

A NEW APPROACH TO EUTHANASIA

The South African Law Commission made no recommendation on voluntary active euthanasia but proposed the following three options:

- that the present provision of prohibiting voluntary active euthanasia be confirmed
- that voluntary active euthanasia be regulated by legislation and a doctor be allowed to comply with the request of a terminally ill but mentally competent patient to end his unbearable pain
- that active euthanasia be regulated by legislation where the final decision rests with a panel or committee who have to comply with a specific criteria

The SA Law Commission also proposed that a living will enjoy legal recognition with regards to passive euthanasia.

It seems as if the underlying values and spirit of the Constitution support the acceptance of voluntary active euthanasia based on a person's rights to dignity, freedom of a person, privacy and access to emergency medical care.
Recognition of voluntary active euthanasia recognizes the right of freedom of choice but this choice should only be given to terminally ill patients who are mentally competent and not suffer from depression.

BEHAVIOUR MODIFICATION

THE OBJECTIVE BEHAVIOUR MODIFICATION OR CHANGE OF PERSONALITY

This is a brain operation performed on a healthy individual who is suffering from a mental illness or personality disorder, which results in antisocial or dangerous behaviour. An example is a leucotomy.

In S v V, a convicted rapist wanted brain surgery to be performed on him, which may have the effect of destroying the sexual drive.

With the introduction and increasing use of a growing number of antipsychotic drugs recently, the performance of leucotomies has declined drastically.

NON-THERAPEUTIC PROCEDURES INVOLVING HEALTHY PERSONS

Three kinds of procedures are conceivable here:

1. prophylactic measures applied to a healthy person (vaccination)
2. procedures involving a healthy person with the object of eventually curing an ailing person (experiments)
3. operations performed without any curative purpose whatsoever (plastic surgery)

DONATIONS

Anatomical donations by living persons

Governed by the Human Tissue Act. It defines "tissue" as "any human tissue, including any flesh, bone, organ, gland or body fluid, but excluding any blood or gamete". "Gamete" is defined as "either of the two generative cells essential for human reproduction (sperm and ovum)".

Who cannot donate what:
Mentally ill: tissue and organs that are not replaceable, e.g. kidney, gamete.
Minor: gamete (but may donate blood and skin).
Habitual criminal: gamete.

The removal may be effected only with the consent of the donor (a minor – his parents consent). Where donors are fourteen or older and mentally competent, no parental consent is required before replaceable tissue and blood may be removed.

Consent must be in writing except in the case of blood or tissue replaceable by natural processes.

The use of a gonad (testicle and ovary) for transplantation is illegal, unless the Minister's written consent has been obtained in advance.

The removal of tissue from dead bodies

Governed by the Human Tissue Act.
An organ is an independent part of the body that performs a special function, e.g. hearts, lungs. Removal of an organ must take place immediately after the death and transplanted without delay.
A tissue, e.g. corneae or skin, need not be removed or transplanted immediately but may be stored for an indefinite period.

The "donor" must be deceased: NHA says that "Brain death" is sufficient.
The death must be established by two doctors, one who has been practicing for at least five years and neither may be a member of the transplantation team.
Eye tissue is excluded from this provision. In respect of eye tissue an ordinary death certificate will suffice. (S v Williams).

To whom donations may be made:
A donation of a whole body or parts there of may be made to a hospital, university or technikon or any other institution authorized by the Minister. If no donee (a type of institution) is nominated, the donation is of no effect.

Consent: may be given in one of the following ways:

1. By the deceased prior to his death in a will or statement.
2. By the spouse, major child, parent, guardian or major brother or sister of the deceased after his death.
3. If none of the persons mentioned can be traced, the Director-general. There are two conditions:
    a. The deceased must not have given a contrary instruction
    b. The Director-General must be satisfied that all reasonable steps have been taken to trace the family members.

The question arises whether the official concerned may make such a donation if the identity of the deceased is unknown. = NO!!

Removal of tissue during post mortem examination:
No such removal may be carried out if the medical practitioner involved (S9).

1. Is not satisfied that the removal of tissue will in no way affect the outcome of the post mortem.
2. At the time of the examination, has reason to believe that the body or tissue has been donated, or that the removal would be contrary to any direction given by the deceased before his death.

Time: must be done within 24 hours

Sale: of tissue prohibited

Genetic manipulation: is prohibited (S39A)

Secrecy: The Act prohibits the publication of the identity of the donor of the body or tissue, unless consent, in writing, is given by the deceased, living donor, relatives or district surgeon who donated the tissue.

Offences: Are punishable by a fine of R2000 or imprisonment for a period not exceeding one year (or both).

LEGALLY RECOGNISED MEDICAL PROCEDURES

CASTRATION

Castration will be permissible in the following situations:

1. A child is born with the sexual organs of both sexes (hermaphrodite). The child's parents may decide that the male organs been removed allowing the child to grow up as a female.
2. A transsexual who has the sexual organs of a male but psychologically orientated as a female, may wish to be surgically "converted" into a female.
3. There may be a sound medical reason for the castration (testicular cancer).

Castration, the surgical removal of the testicles must be distinguished from "chemical castration", the administration of a drug, which inhabits both sexual performance and desire. Surgical is generally irreversible.

In S v V, the accused could also have argued for castration but it is said that it would probably not have been granted any way.

Although the courts are reluctant to authorize surgical castration they will authorize chemical castration. In 2003 a Durban magistrate, Sharon Marks, sentenced a convicted paedophile, school teacher and ex-scout master, Deon Foster, to chemical castration.

STERILISATION

Section 11 guarantees the right to life and section 12 to make decisions concerning reproduction, which includes the right to be sterilized.

No person is prohibited from having sterilization performed on him or her if he or she is:

1. Capable of consenting
2. 18 years or above

Such consent must be given freely and voluntarily (informed consent) The patient or other person giving the required consent must have been given a clear explanation of:

1. the proposed plan of the procedure and
2. the consequences, risks and the reversible or irreversible nature of the sterilization procedure (informed consent)

Such a person must have been informed that consent may be withdrawn any time before the treatment.
A married spouse can consent to sterilization independently.

Minors: Sterilization may not be performed on a minor, except where failure to do so would jeopardize the person's life or seriously impair their physical life.

Mentally ill patients: Sterilization may only be performed on the request of a parent, guardian, spouse or curator of the patient. A panel must be convened to consider all relevant information, including that the patient is at least 18 years of age and that there is no other safe and effective method of contraception except sterilization.

Contravention of this law could amount to 5 years imprisonment.

ABORTION

Abortion is governed by the Choice of Termination of Pregnancy Act. The foetus's right of life claim was rejected in Christian Lawyers Association of SA and Others v Minister of Health and Others.

When may a pregnancy be terminated:

first 12 weeks	**13 to 20 weeks**	**After the 20th week**
No age limit Medical practitioner or registered midwife or a registered nurse.	1. Risk to the woman's physical health 2. Risk to the woman's mental health 3. Risk that the foetus will suffer from a severe physical abnormality 4. Risk that the foetus will suffer from a severe mental abnormality 5. Resulted from rape 6. Resulted from incest 7. Affect the social or economic circumstances of the woman Only a medical practitioner may carry out the termination.	1. Endanger the woman's life 2. Will result in severe malformation of the foetus 3. Pose a risk of injury to the foetus A medical practitioner must, after consultation with another doctor or a midwife. Only a doctor may carry out the termination.

There is a duty on the state to promote the provision of non-mandatory and non-directive counseling, before and after the termination of any pregnancy.
For termination the informed consent of the woman is required. No age limit (G v Superintendent + Christian Lawyers Association).

An abortion can only take place at a facility which:
- gives access to nursing and medical staff
- gives access to an operating theatre
- has appropriate surgical equipment
- supplies drugs for intravenous injection
- has emergency resuscitation equipment
- give access for appropriate transport to arrive in an emergency
- has facilities and equipment for clinical observation
- has appropriate infection control measures
- gives access to safe waste disposal
- has telephonic means of communication
- has been approved by notice in the Government Gazette

For a termination within the first 12 weeks, a facility that complies with the above requirements may terminate a pregnancy without the consent of a Member of the Executive Council.

A criminal abortion: 10 years
Section 10 makes it a criminal offence to prevent the lawful termination of a pregnancy or to obstruct access to a facility.
Section 10 doesn't exactly criminalize lack of informed consent.

PREGNANCY CLAIMS

"**Wrongful pregnancy / conception"** = a healthy child is born, following negligent contraceptive advice, sterilization or abortion, and the parents claim damages.

"**Wrongful birth":** where a claim is brought by the parents of an abnormal or disabled child.

"**Wrongful life":** where a claim is brought by or on behalf of the abnormal or disabled child himself.

Wrongful Pregnancy / Conception Claims

In Thake and Another v Maurice, a married man had a vasectomy and then a sixth child was born = action for damages based on negligence on the grounds of the practitioner's failure to comply with the contractual agreement and to exercise delictual duty to take care Entitled to damages for parental stress, pain and suffering, as well as the reasonable cost for rearing the unplanned child.

In Eyre v Measday, a woman who had undergone sterilization gave birth to a child. She could not prove that the operation had been performed negligently and her claim was rejected.

The first decision on "wrongful conception" in South Africa was handed down in Behrmann and Another v Klugman. The plaintiffs instituted an action for damages for the birth of a normal child after Mr. B had had a vasectomy. The action was based on the alleged breach of contract and alternatively negligence. Found in favour of the doctor.

In Edouard v Administrator of Natal, parents had agreed with a provincial hospital that a tubular ligation was to have been formed on the woman at the time of giving birth to her third child. She fell pregnant, gave birth to a normal child. The woman had requested the procedure because she and her husband could not afford to support any more children.

The plaintiff averred that he was entitled to receive further compensation, namely:

1. General damages for the discomfort, pain and suffering, and the loss of amenities suffered by his wife (they were married in community and it affected their joint estate).
2. The cost of maintaining the child until she attains the age of 18

Doctor claimed it was contrary to public policy to allow the parents of a healthy, normal but unplanned child to recover the costs of the upbringing of the child where the parents refuse to give the child up for adoption.

Compensation would not be awarded for the fact that a child was allowed to be born. It would be awarded for the loss which the parents would suffer in having to support the child whose conception the doctor had negligently failed to avoid and whom they weren't able to support.

It would not be contrary to public policy to recover damages in respect of the child's maintenance but the court was not prepared to award general damages for the pain and suffering.

This case was taken on appeal and confirmed by a five-judge bench. They held that to sue for maintenance but to refuse to give up the child for adoption would not be against public policy because it is that burden and not the child that is unwanted.

The Appellant division dealt in length with the argument that as a matter of law, the birth of a normal child is such a blessed event that the benefits flowing from parenthood outweigh the financial burden brought on by the obligation to maintain the child. The judge state that the wrong done was not that the birth was unwanted but that it was such a burden that was unwanted. He further held that a normal birth doesn't always constitute a blessing as the child may become a drug addict, criminal etc.

In countering the argument that it would be inhuman for a child to later find out that his parents were awarded damages because his birth was a mistake, the court held that by the parents wanting to keep the child and not put him up for adoption shows that the child was not unwanted. The court thereby confirmed the decision of the court in favour of the child's father.

In Raath and Another v Mukheiber, a married couple claimed damages, when after giving birth to a normal child the doctor told them that he had performed a sterilization operation. As a result of the doctor's statement the couple did not use contraceptives and another child was conceived and born in due course.

The court found that the Plaintiffs had not proven that the doctor had made a misrepresentation.

On appeal, the court (full bench and SCA) held that the plaintiffs were entitled to recover damage and be compensated by the doctor for pure economic loss in respect of

1. confinement costs and
2. maintenance of the child until it becomes self supporting.

The next question that arises is whether, in the case of alleged negligence in performing an abortion, resulting in the non-prevention of the birth of a normal child, there may be liability on the part of the doctor.

Chalk v Fassler, an unmarried woman sued the doctor for damages in consequence of the birth of a normal, healthy child. She alleged that Dr F had agreed to perform a legal abortion on her but failed to do so properly or at all. She claimed damages in the form of loss of earnings while caring for the child and costs of maintaining the child until it reached majority.
Dr F contended that it had been a term of their agreement that if the pregnancy was not terminated, Ms C had to return to him for further steps to perform the abortion properly. According to him she chose not to come in when he suggested she may still be pregnant and elected to continue with the pregnancy.

The known risk of failure in the abortion would be sufficient to deter a surgeon from making a guarantee because even with the requisite degree of care and skill, abortions do occasionally fail.

Wrongful Birth Claims

Friedman v Glicksman: The plaintiff instituted action after she had consulted the doctor during her pregnancy to advise her on the risk of being pregnant with a disabled infant and stated that she wished to terminate the pregnancy if the situation were so. Mrs. F alleged that

the doctor had carried out certain tests and advised her that there was no greater risk than the normal risk of having an abnormal child and that it was safe to proceed to full term. She later gave birth to a defective child, Alexandra. She accordingly brought two claims:

1. A claim in her personal capacity for the expenses of maintaining and rearing Alexandra as well as for future medical expenses and hospital treatment and other special expenses (**wrongful birth)**
2. A claim in her representative capacity on behalf of Alexandra for general damages as well as a claim for future loss of earning **(wrongful life)**

The doctor argued that it would be against public policy to enforce the contract entered into between Mrs. F and himself because it would encourage abortion.

The judge held that the "wrongful pregnancy" and "wrongful birth" claims are not contrary to public policy and ruled in favour of the mother.
They however held that "wrongful life" claims are not recognized in our law.

Such claims have since been discussed as an action in South Africa in accordance with the recent Supreme Court decision but our courts have still found against such a claim.

In Sonny v Premier, Kwazulu-Natal (2010), a pregnant woman was not fully advised on the inconclusive results of a test for Down syndrome. On birth it was discovered that the baby was Down-syndrome.

Two claims were instituted:

1. Wrongful birth claim for damages resulting from the birth of a child with Down syndrome based on both breach of contract and delict.
2. A claim for damages as a sterilization was performed during the caesarean without her informed consent.

The plaintiffs alleged that the staff had been negligent in not conducting the tests earlier as the woman was a high risk (aged 37) and they owed her a higher degree of medical care.

The court found that the doctor at the hospital had a duty to inform her and this negligence could be causally linked to the birth of the baby. On a delictual claim, there was no contributory negligence on the part of the mother. Contributory negligence could be considered in the contractual claim

This case was taken on appeal to the SCA and dismissed.

Wrongful Life Claims

The first South African decision on "wrongful life" was handed down in Friedman v Glicksman.

In this case the court found that wrongful claims cannot succeed.

In doing so, the court gave the following reasons:

1. It would be contrary to public policy to hold that it would be better not to have an unquantifiable blessing of life rather than have such life marred.
2. Allowing such a claim would open the door for such a child to be able to sue its parents.
3. Granting damages would be against the measure of damage allowed for by the law of delict.

In Stewart v Botha (2008) the SCA rejected the appeal and confirmed the judgment of the court a quo, where a child, Brian, was born with numerous serious defects.

Two claims were instituted:

1. a claim against the Defendants for damages resulting from the birth for special education and past and future medical expenses. (wrongful birth)
2. a delictual claim on behalf of the child for compensation for the same harm (wrongful life)

The Plaintiffs alleged that the Defendants had been negligent in that they failed to diagnose the defects and inform the Plaintiffs. Had they been informed, the Plaintiffs would have opted for a termination of pregnancy.

The Defendants noted an exception against the claim as it did not reveal a cause of action and that such a claim would be against public policy. The high court confirmed the exception and rejected the Plaintiffs claim.

On appeal the SCA recognized the claim for the harm flowing from the child's disability but distinguished between the parent's claim and the child's claim.
The court stated that the crux of this case was the question of whether it would have been better – from the child's perspective – not to have been born? However to choose no life as a disabled person violates the sanctity of human life.
The court stated that the question goes so deeply into the heart of what it is to be human that it should not even be asked of the law.

SCIENTIFIC EXPERIMENTATION

Section 12 (2) (a) enshrines the right of everyone not to be subjected to medical or scientific experiments without their informed consent.

Reckless experimentation which is not directed at gaining scientific knowledge is illegal. This also applies to experiments, which cause bodily harm.

Section 11 and 71 of the NHA govern research and experimentation with human subjects. The provision for experimental or research purposes must be authorized beforehand by the user, the healthcare provider primarily responsible for the user, the head of the health establishment and the relevant health research ethic committee.

Research can only be conducted on a living person in terms of s71(1):
(a) In a prescribed manner
(b) And with informed written consent of the person.

Research on a minor for non-therapeutic purposes can only be conducted in terms of s71(3)(a):
(i) In a manner and on conditions as prescribed
(ii) With the Minister of Health's consent
(iii) With the parent or guardian's consent and
(iv) The consent of the minor if they are capable of understanding

Section 73(b) states that a Minister may not consent where:
(i) The objects of the research can be achieved by conducting it on an adult
(ii) The research is not likely to significantly improve the scientific understanding of the minors condition
(iii) The reasoning behind the parents' consent is contrary to public policy
(iv) The research poses a significant risk to the minor
(v) There is some risk to the health and well-being of the minor & the potential benefit doesn't significantly outweigh the risk

Artificial insemination:

There are different types:
1. AID (artificial insemination donor)
2. AIH (artificial insemination husband)
3. IVF (in vitro fertilization)

Artificial insemination is defined as the introduction by other than natural means of a male gamete into internal reproductive organs of a female person for the purpose of human reproduction, including

1. the bringing together outside the human body of a male and a female gamete with the view to placing the product of a union of such gamete in the womb of a female person, or
2. the placing of a product of a union of a male and a female gamete which have been bought together outside the human body, in the womb of a female person for such purpose.

Human Tissue Act = the artificial insemination regulations generally are not applicable to AIH but only to AID.

AID: donor file: A doctor intending to obtain gametes for the purpose of artificial insemination must open a personal donor file. Comprehensive written consent must be obtained from the donor for the following:

- Physical examination and interview
- Taking of samples of gametes for the purpose of testing analyzing or processing
- Certain personal details (except: name, id number, date of birth) being made available to the ultimate recipient
- Certain personal details including his family history being made available to the doctor who will perform the operation
- Certain confidential details regarding himself being made available to the Director-General of Health.
- The information relating to the Gamete donor must be relayed to a central data bank.

If the doctor has reasons to believe that at least six children have been artificially produced from the donor, the donor must be informed that no further donation may be made by him.

A married donor needs to obtain their spouses consent in writing.

A doctor who intends to artificially inseminate a recipient must open a personal **recipient's file.**

A doctor who affected an artificial insemination must report the birth within 30 days to the doctor who handled the donation and must record such birth in the central data bank within 3 months of the birth.

The legal position of the AID child

Section 40(1)(a) of the Children's Act states that if the fertilization done was not the husband's sperm then his consent is needed for the child to be a child born of married parents. Paragraph (b) contains the presumption in our law that both parents granted consent.

The potential liability of the doctor

- Performing artificial insemination upon an unmarried girl under the age of 16 can possibly make the physician liable in terms of the Sexual Offences Act.
- If a semen donor is HIV positive - may be held liable for damages.
- If a doctor is negligent in using semen, so that a defective child is born, there is a possibility of liability on the basis of wrongful birth.

In vitro fertilization (IVF)

This was done for the first time with the so called "test-tube" baby in 1978 - Mrs. Lesley Brown.

There is no ethical objection that can be raised against such a procedure, and it is lawful, provided that the practitioner complies with the provisions of the Human Tissue Act.

Surrogacy agreements and legal status of the child

A Surrogate mother is a woman who bears a child on behalf of another woman, either from her own egg fertilized by the other woman's partner, or from the implantation in her womb of a fertilized egg from the other woman.

In the past such an agreement was unenforceable as compensating the hostess for her "services" - contra bonos mores.

Surrogacy agreements are now governed by The Children's Act 38 of 2005, Chapter 19, Section 292 – Section 303.

- A surrogate agreement will be valid if it is in writing and is signed by all the parties. It must be entered into in the Republic and must be confirmed by the High Court (S292).
- Consent of the commissioning parents as well as the surrogate and her husband, wife or partner has to be obtained (S293).
- No surrogate agreement is valid unless the gametes of both or at least one of the commissioning parents is used (S294).
- The court may only confirm such agreement if the commissioning parents are unable to give birth and if they comply with the requirements for suitable parenthood. The agreement must be for altruistic reasons and the surrogate must have had at least one

pregnancy and viable delivery and has a living child of her own. (S295)
- Artificial fertilization may only take place after the contract has been confirmed by the court and within 18 months thereof. (S296)
- The effect is that the child is for all purposes the child of the commissioning parent or parents from the moment of the birth and the surrogate mother or her husband, partner or relatives have no right of contact with the child unless provided for in the agreement. If the agreement is not valid the child is deemed to be the child of the woman that gave birth to that child. (S297)
- An agreement can terminate where the surrogate mother, who is a genetic parent cancels the agreement within 60 days of the birth, or the court can terminate the agreement (S298).
- The effect of termination and parental rights and responsibilities are contained in S299. - Any child born of a surrogate mother in accordance with a valid agreement is for all purposes the child of the commissioning parent or parents from the moment of its birth. Conversely, a child born as a result of an invalid agreement will be deemed to be the child of the woman that gave birth to that child.
- A child can be aborted in a surrogacy if it is done in terms of the Choice on Termination of Pregnancy Act. The decision is that of the surrogate but she must inform the commissioning parents. (S300)
- Payments in respect of surrogacy prohibited but the surrogate can claim compensation for expenses that relate directly to the artificial fertilization and pregnancy, the birth of the child and the confirmation of the surrogate motherhood agreement. She can also claim loss of earnings and insurance to cover the surrogate mother for anything that may lead to death or disability. (S301)
- No person may publish any facts that reveal the identity of a person born as a result of a surrogate motherhood agreement. (S302)
- It is an offence for a person to artificially fertilize a woman without a court authorized agreement. (S303)
- An offence is punishable with a fine or imprisonment not exceeding 10 years or both.

<u>Ex Parte Applications for the Confirmation of three Surrogate Motherhood Agreements (2011)</u> brought to for the problems surrounding such applications.

The case laid down the following guidelines:
- Applications should not be brought to court on an urgent basis
- The courts confirmation on such agreements is not merely a rubber stamp
- The court has an obligation to ensure the child's best interest is of paramount importance and must take this responsibility as serious
- The success of the application is based on evidence before the court
- All expert reports must be compiled with care and must be reliable

On 27 September 2011 the North-Gauteng High court, in the case of WH and Others, approved and confirmed a surrogacy agreement.

Experimentation on embryos

Research into the selection of foetal sex may be inappropriate if it could result in a request for an abortion because the sex of the foetus is unacceptable to parents. On the other hand, gender selection may be beneficial in sex-linked genetic diseases and may be justified under exceptional circumstances.

"SEX-CHANGE" (transsexualism or intersexuality)

transsexual – a person who has a normal male physique but feels emotionally like a woman or visa versa
hermaphrodite – a person born with the sexual organs of both sexes

Two opinions:
a. "sex-change operation" is misleading because the sex of a person is determined at conception and is dictated by chromosomes. Therefore it is contended that a change of sex is physically impossible.
b. sex is primarily a question of psychological orientation and not so much a psychological appearance.

In Unisa's opinion, consent to a "sex-change" by an unmarried person with the view of relieving grave psychoneurotic problems is allowed.

In Jonker, a divorce order was granted to a married female transsexual.

W v W, the court, in an undefended divorce action, considered the marital status of a married transsexual in a detailed judgment. The court refused to grant a decree of divorce and ordered absolution from the instance. The judge held that the plaintiff's evidence did not show that the operation which she had undergone had converted her into a female.

The Constitutional Court judgment in *Minister of Home Affairs v Fourie (2006)* in which the constitutionality of same-sex unions was upheld, has greatly diminished the importance of the legal recognition of a sex change operation.

Society has had a change of attitude towards sex-changes which is evident in the Alteration of Sex Description and Sex Status Act which allows a person to alter their sex description in the births register where they have undergone a sex-change surgery which resulted in gender reassignment.

GENETIC ENGINEERING

There are various ethical acceptable and legal forms of genetic engineering.

Gene therapy

Curing patients with serious ailments by means of gene therapy is deserving of praise and is lawful, provided no unacceptable and unlawful experimentation with persons of human embryos takes place.

Genetic counseling

Genetic testing and counseling of individual patients or potential parents of a baby with a severe genetic disorder is accepted as beneficial.

Genetic Manipulation

We are now able to manipulate hereditary material to the extent that with cloning it is possible to make identical copies of cells and individuals.
Curing by means of gene therapy is lawful provided that there was no unlawful experimentation on embryos or persons.

Cloning

Section 57 of the NHA recognizes that there is a difference between reproductive cloning and therapeutic cloning. The difference lies in the object behind the cloning. Reproductive cloning is aimed at the creation of a child whereas therapeutic cloning is aimed at using stem cells from a cloned embryo for a person suffering from a disease.

S57(1)(b) provides that no person may engage in any activity for the purpose of reproductive cloning of a human being.
The Act allows the Minister of Health with the authority to permit therapeutic cloning under prescribed conditions.
Contravention of this section is punishable by a fine or max 5 years imprisonment.

DELICTUAL LIABILITY

The elements of a delict: act (omission or commission), wrongfulness (based on what is *contra boni mores*), fault (intention / negligence), causation and damages

There are actions available to a party in a delictual law suit:

- ***Actio legis Aquiliae**:* to claim compensation for patrimonial loss caused unlawfully and with fault.
- ***Action for pain and suffering:*** to claim compensation for non-patrimonial loss caused unlawfully and with fault including claims for: disfigurement, loss of amenities of life, pain, suffering, emotional shock and the loss of life expectancy.
- ***Actio iniuriarum**:* to claim compensation and satisfaction for non-patrimonial loss resulting intentionally and unlawfully from an infringement of a personality interest (physical integrity, privacy or dignity).

Invasion of privacy

S14 National Health Act: all information regarding a patients health, treatment and stay at an institution is private unless:

1. Patient consents in writing
2. Court order allows for it
3. It amounts to a threat to public health

Doctor-patient relationship = duty of the doctor to maintain confidentiality. If he breaches this, a doctor will be liable under the *actio iniuriarum.*
A doctor can escape liability only if he can prove a recognized ground of jurisdiction, e.g. consent or public interest.

In Jansen van Vuuren and Another NNO v Kruger: a homosexual man who was a well-known resident of a small Transvaal town. He later moved to another town where he applied for life insurance and was required to have a medical. He went to a doctor in the new town and requested that Dr K keep it (his HIV status) confidential. The following day during a game of golf, Dr K told another doctor and dentist about his condition. The doctor was sued for damages based on breach on doctor-patient relationship and infringement of privacy. The doctor pleaded that he had the defence of truth and public interest.

In determining whether Dr K had a social or moral duty to make the disclosure and the other two doctors's had a reciprocal social and moral duty to receive it, the standard of the reasonable man applies. On appeal, the court ruled there had been no such duty and the plaintiff was awarded damages for R5000.

In C v Minister of Correctional Services the court had to deal with the issue of taking a blood sample in order to test for HIV without the relevant persons consent where C claimed damages for invasion of privacy after a blood sample was taken from him while in prison. The court found that no informed consent was given. The Correctional Service alleged that the requirements to prove the *actio iniuriarum* were not proven as the employee drawing the sample was unaware of the wrongful act. Court held this case falls into a limited class of delict and fault was not required. C's right was infringed.

MEDICAL NEGLIGENCE

The standard of care

In the medical context the question arises whether failure by a doctor to inform a patient in advance of the possible risks involved in a particular medical procedure would constitute negligence even if the procedure as such was not performed in a negligent manner. In Richter, the court held that such failure could constitute negligence. This view was rejected in Castell v De Greeff.

The standard of care required of a medical practitioner who undertakes the treatment of a patient is not the highest possible degree of professional skill, but reasonable skill and care. This principle was reaffirmed in Buls and Another v Tsatsarolarkis.

The principle that reasonable skill and care are required and not a higher degree, was reaffirmed in Castell and in Van der Walt v De Beer.

LOCALITY RULE: Van Wyk v Lewis: is the area of where the doctor practices a factor in assessing whether the doctor complied with the reasonable doctor test?

Objective test: the locality where an operation is performed is an element in judging whether or not reasonable skill, care, skill and judgment have been exercised. = in a situation like this you need to look at the objective circumstances in which the doctor operates (facilities, equipment and staff)

Subjective test: the same degree of care is required wherever the doctor may practice: the standard and uniformity of medical education in the Republic - you look at the subjective knowledge of the medical practitioner no matter where he is practicing to determine if he acted with the required degree of care and skill

Objective and subjective test: a distinction should be drawn between the subjective abilities (skill, education and knowledge) and the objective circumstances. He argued that a lack of medical facilities and infrastructure should be considered in the assessment of his conduct.

In Collins v Administrator, the court held that when it concerns a claim against a hospital authority for harm suffered by a patient in consequence of the negligence of its staff, a standard of excellence which is beyond its financial resources cannot be expected.

The proof of negligence: res ipsa loquitur

The ordinary rule concerning the burden of proof is that the burden rests with the plaintiff. Because expert evidence is necessary, the plaintiff is usually confronted by a problem.

A single aspect, namely whether in endeavouring to prove negligence, the plaintiff may rely on the evidentiary principle of *res ipsa loquitur* ("the thing speaks for itself").

This means that by proof of the harmful event and that it was caused by the defendant, a factual presumption of negligence on the part of the defendant arises. The plaintiff will not be relieved the onus which he bears, but if the defendant does not succeed in offering an acceptable explanation for what happened, the court may readily come to the conclusion that he had been negligent. The principle is often invoked in negligence cases.

Our courts have displayed a marked unwillingness to apply the *res ipsa loquitur* doctrine in cases of alleged medical negligence. The leading case is Van Wyk v Lewis, where following a surgical operation there was a failure to remove a surgical swab from the patient's body, causing painful consequences. The court refused to find that the doctor was negligent on the basis of *res ipsa loquitur* - the mere fact that a swab is left in the patient is not conclusive of negligence. It may have been better for the patient to leave the swab in rather than to waste time in exploring whether it is there or not.

In Pringle v Administrator Transvaal, the patient's vena cava was torn during an operation. She lost 2l of blood and suffered brain damage as a result of it. After the operation her employment was terminated and the court found the doctor to be negligent.
In cross examination it was put to Dr S that he had "tugged" and pulled the vena cava. His answer was: "in retrospect I would say that I tugged to hard."
The judge said that "negligence is not established by merely showing that the occurrence happened."
Here the doctor the doctor did not use the care and skill required and damages of approximately R90 000 were awarded to the plaintiff.

Damage

Apportionment of damage is possible in medical law where more than one party is liable.

In the appeal judgment of Wright v Medi-Clinic Ltd, where negligence during birth left the baby brain damaged, the doctor had to pay 20% and the Medi-Clinic 80% of the damages.

Proof of causal connection

In Pearce v Fine and Others, a man who had a problem with his prostate went into x-rays, was injected with contrast medium in order to take better pictures of the internal organs. The doctor took the x-rays and both the doctor and the radiologist, G, left the room. On G's return she found the patient unconscious and quickly summoned the doctor and an emergency team. They attempted resuscitation but the patient later died. Expert evidence said that the cause of the death was the drop in blood pressure. It was alleged that Dr L had been negligent because he left the patient before it was safe to do so. It was held that even if there had been negligence, it had not been established that the negligence was causally connected to the patient's death.
The patient had cardiomyopathy and evidence indicated that chances of survival were very slim.

In Silver v Premier of the Gauteng Provincial Government, the patient went in for treatment of pancreatitis but by the time that he was discharged, his ability to walk properly had been permanently impaired. He sued the hospital for negligence because he got bedsores which became infected resulting in paralysis of the lower limbs. There were several risk factors present predisposing the patient for bedsores. When he went into hospital he was obese, diabetic, had to go for dialysed and had low blood pressure.

Evidence was led by the defendant that the standard of nursing care received by P in the hospital had measured up to the required standards. The court concluded that there had been no proof of a causal connection between any act or omission (bedsores) on the part of the hospital staff. Therefore the court held that the staff was not liable.

In Michael and Another v Linksfield Park Clinic (Pty) Ltd and Another, a 17 year old underwent corrective nasal surgery after a sports injury. During the operation the patient went into cardiac arrest. The nurse had difficulty operating a defibrillator in an attempt to normalize the heart and the patient suffered serious and permanent brain damage. The court found that regardless of the circumstances the brain damage was unavoidable even if there had been no delay in starting the defibrillation and there was no negligence on the part of the anaesthetist.

VICARIOUS LIABILITY

A person can be held delictually liable if he has ordered or authorized another to commit a wrongful act.

Requirements:
1. There must be an employment relationship
2. The employee must have committed a delict
3. Must have been committed within the scope of his employment

One partner is vicariously liable for the wrongful act of another when such act falls within the scope of a partnership business (Lindsay v Stofberg NO and Mdletshe v Litye).

If a partner goes beyond the scope of the business then the other partner is not vicariously liable.

In Dube v Administrator, Transvaal, the hospital authority was held liable for negligence on the part of two plastermen and a doctor in the service of the hospital, in regard to the treatment of a patient's broken forearm, where the plaster had been applied too tightly and the patient's arm ha to be amputated.

In Mtetwa v Minister of Health, the judge stated that the degree of supervision and control which is exercised by the person in authority over him is no longer regarded as the sole criterion to determine whether someone is a servant or something else. The deciding factor is the intention of the parties to the contract, which is to be gathered from a variety of facts and factors

Independent contractor: A person is not vicariously liable, for the wrongful act of an independent contractor engaged by him. Such a contractor undertakes a specific job and in the execution thereof acts in accordance with his own judgment.

Direct hospital liability: A hospital authority incurring direct liability for its own negligence, i.e. not via the conduct of an employee. E.g. faulty equipment.

A DOCTOR / HOSPITAL PROTECTING THEMSELVES AGAINST NEGLIGENT CLAIMS BY PATIENTS - DISCLAIMER

The question asked is whether a doctor, hospital or other health-care provider protect themselves against liability for possible negligence in treating the patient or for some other form of malpractice, by getting the patient to sign a waiver of claims, indemnity form or so called "disclaimer" prior to the intervention?

Private hospitals have waiver clauses in their admission or consent forms which they require to be signed prior to treatment = they seek to protect the hospital against mishaps occurring in connection with nursing or handling the patient.

In Edouard v Administrator, Natal, there is an obiter suggesting that a doctor could "contract out of liability". But there is no indication in the judgment that this would be possible where the doctor had been negligent.

Burger v Medi-Clinic Ltd, a patient after an operation tried to go to the bathroom, slipped and fractured his cheekbone = He suffered from pain, depression, concussion and permanent disfigurement.
On entering the hospital he signed a consent form with an indemnity clause. He argued that the hospital was only indemnified for the actual operation and that the clause did not protect the hospital from gross negligence. The judge found that the consent form was not just for the operation but included admission to the clinic and after treatment care. The court found in favour of the hospital.

On appeal, the court ruled that a disclaimer of liability by a hospital is null and void. The court found that the actions complained about were not covered in the ambit of specific waiver clauses.

In Afrox Healthcare Bpk v Strydom, the patient alleged that treatment by the hospital had been negligent and the indemnity clause signed by him was contra boni mores or alternatively that the clause should have been pointed out to him.
The judge upheld these contentions and found in favour of the patient. The supreme court of appeal set aside the judgment and came to the conclusion that the indemnity clause was indeed legally enforceable.

The court in Napier v Barkhuizen confirmed that the inequality of bargaining power could be a factor in striking down a contract on public policy and constitutional grounds. The court in this case however left open the possibility that an indemnity clause will not be upheld as a defence to gross negligence.
As the patient knew that he was signing the contract which included the waiver clause, he could not rely on the argument that he wasn't

made aware of it when he signed without reading it. There was no duty on the staff to point out the indemnity clause to the patient.

The Consumer Protection Act 68 of 2008

Section 48 and 49 state that not only must indemnity clauses now be pointed out to the consumer but that the consumer be awarded the opportunity to consider these.

Section 49 requires that a prospective consumer be informed of any conditions in a proposed contract that purports to:
- limit in any way the risk or liability of the supplier or any other person;
- constitute an assumption of risk or liability by the consumer;
- impose an obligation on the consumer to indemnify the supplier or any other person for any cause;

The provisions have to be brought to the attention of the consumer,
- written in plain language,
- in a conspicuous manner and form that is likely to attract the attention of an ordinarily alert consumer, having regard to the circumstances

Had these provisions been in force when the above matters (Afrox and Napier) went to court, then the outcome would surely have been different.

Section 51(1)(c) makes it clear that any term excluding gross negligence is void.

CRIMINAL LIABILITY OF THE DOCTOR: MURDER AND CULPABLE HOMICIDE

DOCTOR IN GOOD FAITH, SUPPLIES MEDICINE TO A PATIENT AND HE DIES

The test for causation must be applied, that is was the death a reasonable and probable consequence of the perpetrator's conduct and not the result of a new independent or intervening occurrence. If the medicine were made available in circumstances where the death of the receiver was not a likely consequence of such availability, then the existence of a causal connection will not be recognized by the courts.

THE DEGREE OF NEGLIGENCE

The doctor must be grossly negligence.
The general test is based on the reasonable person.

Overdosage of medicine

In R v Van Schoor, an inexperienced doctor used ten times the recommended amount of a drug as he did not read the instruction and did not do any research. Two patients died. Guilty of CH.

In R v Van der Merwe, the doctor gave a prescription without indicating the dosage the pharmacist was unable to reach him, so he gave his own dosage. The woman started to deteriorate and inspite of blood transfusions died. It was held that an experienced doctor should not be able to hide behind the pharmacist. Guilty of CH.

In S v Mkwetshana, a woman was suffering from asthma, there were complications in the hospital when the doctor administered a recognized drug for the treatment of asthma, there was no improvement so he then decided it could be epilepsy. He administered 20cc of another drug and the patient died. Later expert evidence showed that only 5cc should have been used. Guilty of CH.

Blood transfusion to the wrong patient

In S v Berman, there were two women in the same hospital with the same surname. The wrong woman received the blood transfusion. She died and the doctor was convicted of CH.

Radiology: excessive amount of contrast medium

In S v Bezuidenhout, a radiologist caused the death of a 6 week old baby because of the medium used for x-rays. 125ml was administered to the child and according to expert evidence it should only have been 30ml. the doctor and radiologist were guilty of CH.

Incorrect procedure during anesthesia

In S v Kramer and Another, a relatively inexperienced anaesthetist, working with a surgeon to remove a ten-year-old's tonsils, failed to insert a tube correctly. The patient became cyanosed and the surgeon noticed this. He came to the conclusion that the tube was not in the trachea. The patient was ventilated and her colour improved. She suddenly became cyanosed again and attempts were made to stimulate her heart but she died in theatre. Magistrates court: both the surgeon and the anaesthetist were convicted of CH.
On appeal the court held that the surgeon had acted swiftly and reasonably. The anaesthetist had been negligent – CH.

Failure of general practitioner to call in a specialist

In S v Nel, Dr N, a general practitioner, was attending to a woman giving birth to her third child. Immediately after the birth, Dr N experienced problems with the removal of the placenta.

Shortly after the birth, Dr N pushed his hand into the patient's vagina and pulled on the umbilical cord so that it broke and blood splashed all over a nursing sister. A heated argument followed. By 19:00 Dr N left the maternity ward. Mr. H learnt from the matron that there was a specialist on the premises and told Dr N. He told H that he was "not a monkey" and that he would call in a specialist if needed.

Between 19:00 and 19:20 Dr N called in anaesthetist. The anaesthetist arrived at 19:40 and noticed that there had already been a massive loss of blood and no blood specimen had been taken or blood plasma been ordered and that no intravenous infusion of fluid had been done. He immediately took the patient's blood pressure, commenced an infusion and administered anaesthesia. At the request of the matron, Dr N then called in a specialist, Dr S, with the remark that "a second opinion would do no harm".

At 20:10, Dr S arrived. He removed the placenta tissue and began to suture the incision, which had remained unsutured up to that stage. Before he could complete this the patient died at 20:20.

Dr N was charged with culpable homicide.

Failure by a doctor to care for a patient post-operatively

In S v Van Heerden, a patient went in for a hysterectomy and after the operation the staff noticed her blood pressure was extremely low and her pulse very high. They contacted the accused and gave the doctor the relevant information.
The doctor gave the nursing sister instructions but did not visit the patient immediately and she died later that from internal bleeding.

The court held that the moment the doctor was informed about the readings he had a legal duty to go and see her and was therefore negligent.
Expert evidence further revealed that the patient's life could have been saved had the doctor been present and acted immediately.
The court found the link between the negligence of the accused and the death and both the accused was found guilty of culpable homicide.

On appeal the court set both the conviction and the sentence aside as they found that the nursing sisters evidence was unreliable.