

**Rising medical negligence litigation: The importance of
legislative and ethical knowledge**

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205513053

Submitted in fulfilment of the degree of

LLMMED (MEDICAL LAW)

At the

COLLEGE OF LAW & MANAGEMENT STUDIES

HOWARD COLLEGE CAMPUS UNIVERSITY OF

KWAZULU-NATAL

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June 2021

DECLARATION

I, Dr Siyabonga Hopewell Ngcobo, student number: 205513053, hereby declare that this mini-dissertation, submitted for the degree Master's in Medical Law at the University of KwaZulu-Natal, is my original work in execution and style and all sources that contributed to this work are, where possible, cited by means of references and/or footnotes.

A black rectangular box redacting the signature of Dr Siyabonga H. Ngcobo.

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ACKNOWLEDGEMENTS

I wish to express my deepest gratitude and appreciation to my Supervisor at the University of KwaZulu-Natal, Mr. Ntokozo S Mnyandu, for his input, guidance, support, and patience with this mini dissertation.

My wife, Londiwe, who supported and encouraged me throughout the endeavour, taking over many other chores and duties at home so I would be free to research and write. My two handsome boys, Melokuhle andENZOKUHLE, and their sister, Ayabonga, who were patient with me while I was absent, busy working, and would be so happy when I took breaks to spend time with them.

I must also mention my brother, Mr Dumisani Mngadi and his family; a Certified Director of the Institute of Directors of Southern Africa, and an Analyst at the Parliament of the Republic of South Africa. He worked tirelessly and meticulously in research mentoring and coaching. He was also the one encouraging me to not give up when I felt I was not coping with schooling and working at the same time; worse in my line of work during the difficult time when the whole world is facing the COVID-19 pandemic. Dumisani, I could not have done it without you! Thank you very much.

ABSTRACT

There has been an increase in medical negligence litigation in the country, both in value and in the number of claims. Health departments, establishments and professionals are facing the financial burden of these increases. The study offers an examination of the legislation and ethical guidelines that govern medical practice. It further elaborates through case law and research what the law and guidelines mean and what they require during the provision of health care.

The research argues that the rise in litigation is caused, among others, by the failure to follow appropriate procedure and guidelines when obtaining informed consent, maintaining patient confidentiality and when providing care. Consequently, the research highlights the importance of having good knowledge and understanding of the law and the relevant ethical and practical guidelines as provided for by the Health Professions Council of South Africa and the four pillars of bioethics. When medical professionals follow the guidelines, they will be able to justify their actions and will be able avoid claims of medical negligence. This is because ethical guidelines give medical professionals an established framework of values which serves as a reference point from which they can determine which course of action is most justifiable in the circumstances. Furthermore, medical professionals must realize that the law is not just for lawyers. Being aware of the provisions that regulate the provision of healthcare will enable them to act in a manner that will help them avoid damages claims.

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CHAPTER ONE: INTRODUCTION AND BACKGROUND

1.1 INTRODUCTION

The South African Constitution states that everyone has the right to access to healthcare services, including emergency and reproductive health.¹ The Constitution of the Republic of South Africa further provides that there must be a provision of basic healthcare for children, and medical services for detained persons.² The enactment of these provisions has meant that people have greater latitude in requesting and in getting healthcare services. This has resulted in a greater demand for healthcare services. The demand is further exacerbated by an increase in both communicable and noncommunicable diseases in the country.³ This increase must be considered against the backdrop which is that health care is a social good which is regulated in terms of a number of different laws, this means that despite the increase in demand, it must still be provided in a manner that is of an acceptable standard and which is consistent with the rights of patients. Those who provide the service must do so in a manner that is responsible, and which respects the rights of patients.⁴

However, medical professionals and health establishments are frequently challenged with litigations related to medical negligence, leading to several challenges.⁵ This has put a huge burden on the budget of the department of health and as it will appear in the research, insurance costs have also increased.⁶ The research discusses how this ‘medical litigation storm’⁷ can be averted. It argues that in order to solve the problem medical professionals must know and understand the legal framework from which they operate. The legal framework which informs the right to healthcare services. They must also understand various ethical principles which come to play when healthcare is provided and how they should balance these

¹ The Constitution of the Republic of South Africa, 1996 section 27(1).

² Idem, section, 27(1), 28(1)(c) and 35(2)(e).

³ R Hiller ‘Designing a Precision Medicine Center of Excellence – Concept for Discussion Purposes’ *Center for Proteomic & Genomic Research* (5 April 2018), available at <https://cpgr.org.za/designing-a-precision-medicine-center-of-excellence-concept-for-discussion-purposes/>, [accessed 09 January 2020].

⁴ EJ Mills, S Gruskin, D tarantola ‘History, principles, and practice of health and human rights’ (2007) 370 *Lancet* 449.

⁵ L. Pienaar ‘Investigating the Reasons behind the Increase in Medical Negligence Claims’ (2016) *PELJ/PER* 19.

⁶ South African Law Reform Commission Discussion Paper 154 ‘Medico-Legal Claims (October 2021), available at <https://www.justice.gov.za/salrc/dpapers/dp154-prj141-Medico-Legal-Claims.pdf>, 19, [Accessed 20 March 2022].

⁷ S Pepper and M Slabbert ‘Is South Africa on the verge of a medical malpractice litigation storm?’ (2011) 4 *SAJBL* 29.

principles so that their actions are justified, and potential damages claims are avoided.

1.2 BACKGROUND TO THE STUDY

A medical issue can sometimes become a legal issue. For example, where complications arise in performing a routine procedure and a patient is injured;⁸ parents of a gravely ill child refuse to consent to a blood transfusion for cultural or religious reasons;⁹ or a public hospital with limited resources denies renal dialysis to a patient with chronic renal failure.¹⁰ Doctors are not lawyers and often not equipped, either by training or experience, to deal with medical negligence claims. Any qualified medical practitioner with vast experience of solid practice will probably face a medical lawsuit in his or her career.

The number of claims against the health sector has grown exponentially and continues to grow.¹¹ Reasons for the surge include the degenerating state of some provincial healthcare facilities and services; patients becoming more aware of their rights and a shift from a paternalistic to a more assertive ‘patient autonomy’ approach.¹² While acknowledging these reasons, the research postulates that another cause may be a failure on the part of medical professionals to apply the necessary skill and care when treating patients. The research argues that this is due to a lack of knowledge and understanding of important ethical and legal provisions which regulate the health profession. Doctors have a real and growing need to understand and adhere to this rapidly developing branch of law, the objective being to improve patient care and avoid negligence litigations.

1.3 OBJECTIVES OF THE STUDY

This study seeks to provide work that is useful and accessible to doctors searching for practical insights into applicable law and how it works, to avoid becoming involved in damages for medical negligence. Negligence is understood to refer to a breach of a duty of care that results in damage. In medical negligence cases the breach is usually a result of a

⁸ *Pringle v Administrator, Transvaal* 1990 (2) SA 379 (W).

⁹ *Hay v B* 2003 (3) SA 492 (W).

¹⁰ *Soobramoney v Minister of Health, KwaZulu-Natal* 1998 (1) SA 765 (CC).

¹¹ According to the medical Protection Society, the cost of reported claims have increased by a hundred percent over the 24 months, see Malherbe J ‘Counting the Cost. The Consequences of Increased Medical Malpractice Litigation in South Africa’ (2013) *SAMJ* 84.

¹² L Pienaar ‘Investigating the Reasons behind the Increase in Medical Negligence Claims’ (2016) *PELI/PER* 2.

failure to exercise a certain degree of skill and care which is expected in the circumstances.¹³ Legally, to establish negligence it has to be proved that the defendant had a duty of care to the patient, breached that duty, through failure to conform to the stipulated standard of conduct; this negligent conduct led to the harm incurred, by the claimant who was in fact harmed.¹⁴ For medical doctors to know what conduct the law regards as malpractice or negligent, is to be armed against incurring litigations and liability. The outcome of the content analysis and resulting framework will empower doctors and medical practitioners with key indicators of litigation and the defense thereof.

1.4 LITURATURE REVIEW

Incidences of medical negligence have profound consequences for medical professionals as it tends to dent their reputation and professionalism. Furthermore, medical ‘negligence is ultimately and inevitably an accusation of unprofessional conduct.’¹⁵ The reason for this is that like medical negligence, unprofessional conduct points to a failure to abide by the code of conduct which sets out the boundaries and requirements of medical practice. However, there are those who are of the view that the current rise in medical negligence claims is not due to preprofessional conduct. In two separate works, Malherbe and Bateman argue that the standard of care which is provided by medical professionals has not dropped.¹⁶ This cannot be entirely reflective of the situation at hand. Even by its own admission the Health Professions Council of South Africa stated that there is ‘a decline in professionalism among healthcare practitioners.’¹⁷

In 2012, the Health Professions Council of South Africa created a campaign with the idea of educating patients about their rights should they experience a decline in professionalism. In fact, the campaign was motivated by this decline in professionalism among its healthcare

¹³ D McQuoid-Mason ‘What constitutes medical negligence: A current perspective on negligence versus malpractice’ (2010) 7(4) *SA Heart* 249.

¹⁴ LM Sykes, WG Evans and HD Dullabh ‘Negligence versus Malpractice: The “Reasonable Man”’ (2017) 72(9) *South African Dental Journal* 430.

¹⁵ P Carstens and D Pearmain *Foundational Principles of South African Medical Law* (2007) 942.

¹⁶ C Bateman ‘Medical negligence pay-outs sour by 132% - subs follow’ (2011) *SAMJ* 216; J Malherbe ‘Counting the cost: The Consequences of increased medical malpractice litigation in South Africa’ (2013) *SAMJ* 83.

¹⁷ Malherbe J ‘Counting the Cost: The Consequences of Increased Medical Malpractice Litigation in South Africa’ (2013) *SAMJ* 84; According to Malherbe, HPCSA’s CEO was reported as having said this in March of 2012.

practitioners.¹⁸ Furthermore in the 2012 Medico-Legal Summit, it was highlighted that the increase in claims is due to professional negligence and medical malpractice. The latter is about intentional and negligent acts which causes harm whereas the former is limited to negligent conduct.¹⁹ Both professional negligence which is sometimes referred to as medical negligence and professional negligence often arise because of a failure to follow provisions in the law or provisions in ethical guidelines. In cases of medical malpractice, there is often a failure to obtain informed consent.²⁰ In mitigation, medical malpractice which is due to the failure to provide informed consent can be attributed to the shift in medical law from an overly paternalistic approach to the current position which is centered around individual autonomy. Previously, patients were expected to make a choice based on the information which they receive from the medical practitioner if any. The current position requires that the patient be fully informed.²¹ Giesen states that we have moved from paternalism to self-determination to shared decision-making.²² This shift requires that health care practitioners be sufficiently responsive and understanding of the current legal and ethical guidelines dealing with the rights of patients.

Medical practitioners may not be aware of the extent of the information which they must relay to the patient about a proposed treatment or operation. This has been evident in a number of cases. This is discussed in the coming chapters.

1.5 RESEARCH QUESTIONS

- a) What is causing the rise in medical negligence claims?
- b) What are the legal provisions that aim to ensure that a patient's right to healthcare is protected?
- c) What are the ethical provisions that aim to ensure that the course of action a medical professional takes is justified?
- d) How can we prevent medical negligence?

¹⁸ Malherbe J 'Counting the Cost: The Consequences of Increased Medical Malpractice Litigation in South Africa' (2013) *SAMJ* 83.

¹⁹ D McQuoid-Mason 'What constitutes medical negligence? A current perspective on negligence versus malpractice.' (2010) 7(4) *SA Hart* 248.

²⁰ SA Strauss 'Doctor, patient and the law: A delicate triangle' (2008) *SA Orthopaedic Journal* 10.

²¹ NV Dokkum 'The evolution of medical malpractice law in South Africa' (1997) 41 *Journal of African Law* 175.

²² D Giesen 'From paternalism to self-determination to shared decision-making' (1998) *Acta Juridica* 107.

1.6 METHODOLOGY

A qualitative study in the form of desktop research is undertaken. The research relies on primary sources such as the Constitution, legislation, and case law. Ethical guidelines which provide practical guidance to health professionals are also used. Secondary sources are used for a persuasive purpose and to contextualize the research. Consulted secondary sources include, textbooks, journal articles and web pages.

1.7 STRUCTURE OF THE RESEARCH

Chapter One: This chapter provides an introduction, a general background to the study. It sets out the aims and objective of the research the research design and provides important research questions.

Chapter Two: The purpose of this chapter is to highlight the different legal provisions which are applicable to medical practice. The chapter looked at the responsibilities of healthcare practitioners that result from the right to access to health as provided for in the Constitution, legislation and the common law. In doing so, the discussion focuses on the different ways in which the health sector can make sure that the right to access to health is protected and it showed that to do this the law requires respect for the confidentiality of patients; obtaining informed consent and providing the patient with full knowledge of their health status

Chapter Three: The purpose of this chapter is to reflect on the relevant expectations that are born out of the Constitution and legislation that aims to give effect to it. In particular, it focuses on how the law informs the standard of care and how when regard to these standards is had, the number of medical negligence claims may be reduced. That is, to know what conduct the law regards as falling short of the required standard of care is to be armed against incurring liability.

Chapter Four: The chapter looks at the universal codes of ethics which medical practitioners can use when faced with an ethical dilemma. The chapter also considers the ethical guidelines provided by the HPCSA which help medical practitioners to act within acceptable standards of health care provisions.

Chapter Five: This chapter looks at a few recommendations and gives a conclusion.

CHAPTER TWO: LEGISLATION RELEVANT TO MEDICAL PRACTICE

2.1 INTRODUCTION

Since the dawn of a democratic era, South African has achieved several milestones which are considered to extremely progressive to world standards.²³ In the years that followed, it adopted a Constitution, the cornerstone of which is the Bill of Rights which affirms the democratic values and enshrines the rights of all people in the country.²⁴ In short, Pius Langa described it as a guiding document that tells us ‘what our rights and entitlements are and also our responsibilities or obligations are.’²⁵ Although our Constitution is celebrated the world over, it requires of each and every one of us to act in a manner that is consistent with its vision, section 7 tells us this much.²⁶

In the arena of medical practice, the same standards are expected from healthcare institutions, medical professionals and patients. In specific terms, the medical professional is expected to provide the patient with medical treatment. They must do so in a manner that will not cause undue harm to the patient. This means that they must not act carelessly or negligently when they exercise the knowledge and skills which they have acquired.²⁷ This is a basic principle of the common law which medical negligence claims are based, and the relevant legislations including the Bill of Right merely inform the principles of delict.

The purpose of this chapter is to reflect on the relevant expectations that are born out of the Constitution and legislation that aims to give effect to it. In particular, it focuses on how the law informs the standard of care and how when regard to these standards is had, the number of medical negligence claims may be reduced. That is, to know what conduct the law regards as falling short of the required standard of care is to be armed against incurring liability.²⁸ In short, the Constitution and its attended legislation provides a blueprint of the type of medical

²³ P Langa ‘A new Constitution and a Bill of Rights’ (2000) 4(2) *Law, Democracy and Development* 115.

²⁴ The Constitution of the Republic of South Africa, 1996, section 7.

²⁵ P Langa ‘A new Constitution and a Bill of Rights’ (2000) 4(2) *Law, Democracy and Development* 115.

²⁶ The Constitution of the Republic of South Africa, 1996, section 7

²⁷ M Pandit and S Pandit ‘Medical negligence: Coverage of the profession, duties, ethics, case law, and enlightened defence – A legal perspective’ (2009) *Indian Journal of Urology* 327.

²⁸ J Saner *Medical Malpractice in South Africa* (2021) 1-1.

care and standards we as a country should aspire to provide for every citizen.

While clinical standards continue to improve considering the requirement of the various sources of law and ethics guidelines, it must be accepted that the complete elimination of medical negligence will forever remain an unachievable goal. Saner goes on to explain that it is ‘universally acknowledged that a qualified doctor in possession of a solid practice will probably face a medical lawsuit at some time in his or her career.’²⁹

In such cases of negligence, it is usually the health institutions particularly the hospitals which become vicariously liable for the acts of the employees which has fallen short of the required standard of care.³⁰ It is argued in this study that if health professionals are aware of the legal implications of their negligence conduct and the source of law that informs these then there will be fewer cases of litigation. This will provide much needed relief as the country is currently facing a surge in the number of medical negligence claims.³¹

2.2 COMMON LAW

2.2.1 Delict

The Constitution and its Bill of Rights did not replace the common law. Thus, the principles of delict that inform medical negligence still apply. The only shift that is provided by the Bill of Rights is that these principles must now be applied in the manner that is consistent with the Constitution.³² Therefore, the conduct of the medical professional will be tested against that of a reasonable medical professional to determine if he is negligence.³³ Those who fall within the medical profession must be aware of what the patient will need to prove if they are to successfully claim for damages. The law is not just for lawyers. Being aware of the law will give the medical professional the power to act in a manner that will avoid claims for damages.

The question in regard to negligence is not usually that the medical professional did not

²⁹ J Saner *Medical Malpractice in South Africa* (2021) 1-1.

³⁰ Vicarious liability is described as a strict form of liability of one person, usually an employer for the delict of another person when in fact there was no fault on the part of the employer.

³¹ L Pienaar ‘Investigating the reasons behind the increase in medical negligence claims’ 2016 (19) *PELJ* 1.

³² The Constitution, of the Republic of South Africa, section 2.

³³ *Dube v Administrator, Transvaal* 1963 (4) SA 260 (T) AT 261.

possess the required skills and competencies, the claim usually revolves around the fact that applying the same, he or she did so in a manner that is blameworthy.³⁴

McQuoid-Mason writes that in terms of the common law, ‘medical negligence by doctors occurs where a patient is harmed because a doctor that failed to exercise the degree of skill and care of a reasonably competent doctor in his or her branch of profession.’³⁵ Provided all other delictual elements are proved, the medical professional will incur damages.³⁶ In law negligence is proved by meeting the requirement of negligence as provided for in *Kruger v Coetzee*.³⁷ That is, negligence arises if:

- (a) A reasonable person in the position of the defendant:
 - (i) Would foresee the reasonable possibility of his conduct injuring another in his personal property and causing him patrimonial loss; and
 - (ii) Would take reasonable steps to guard against such occurrence; and
- (b) The defendant failed to take such steps.

McQuoid-Mason gives further meaning to the test, by saying that the enquiry is whether a reasonably competent practitioner in the same circumstances would have foreseen the likelihood of harm and if so, would have taken steps to guard against it.³⁸ If yes, then the practitioner would be negligent. These principles have been dissected and given content and meaning in cases that deal with medical negligence which the research turns to next.

One thing to note is that the reasonable person is not expected to apply exceptional skills, he is merely required to apply reasonable care and knowledge.³⁹ This principle can be traced to the Appellate Division where the court in *Van Wyk v Lewis*⁴⁰ held that ‘the cases are agreed upon the foregoing main propositions that a reasonable and not the highest or greatest amount of care... is required of a medical man.’⁴¹ In determining the level of expertise that is required

³⁴ *Van Wyk v Lewis* 1924 AD 438.

³⁵ D McQuoid-Mason ‘What constitutes medical negligence? A current perspective on negligence versus malpractice.’ (2010) 7(4) *SA Hart* 248.

³⁶ Wrongfulness, causation and harm.

³⁷ *Kruger v Coetzee* 1966 (2) SA 428 (A) 430E.

³⁸ D McQuoid-Mason ‘What constitutes medical negligence? A current perspective on negligence versus malpractice.’ (2010) 7(4) *SA Hart* 249.

³⁹ JC Walt and JR Midgley *Principles of Delict* (2016) 169-170.

⁴⁰ *Lee v Schonberg* 1877 (7) Buch 136.

⁴¹ *Wan Wyk v Lewis* 1924 AD 438 at 456.

the court will have regard to the circumstances of that case. In some instances, the medical professional will be expected to exercise a greater degree of care than in others.⁴² Generally, the greater the danger or risk arising from a particular procedure the greater the care that will be required.⁴³

Medical professionals should also be aware they are not always around to give constant care for the patient as such patients have to be discharged and left to their own devices. In such cases it is important that they give patients proper advice as to the specific dangers of certain medication in combination with other substances. In some instances, there is a need for the medical professional to warn the patient about certain symptoms that they may have and to give clear advice as to what to do in those circumstances. The one case that speaks of this is *Dube v Administrator Transvaal*,⁴⁴ where the court held that the doctor was negligent for failing to give clear instructions to the patient. The doctor should have told the patient to return immediately to hospital if he observed any persistent swelling or pain.⁴⁵ Given the site of the fracture, there was a risk of the hand being deformed and leading to amputation if not attended to. It was thus material for the doctor to advise the patient accordingly which he did not do.

Courts are also alive to the fact that doctor's work in different environments. In some cases, the resources available to one doctor in a public hospital may not be available to another who is at a public institution. It is said that the standard of care expected, cannot be beyond the final resources of that health establishment within which the professional is based.⁴⁶ This means that the court will consider the standard of care that is applied at that establishment or in establishments which are of a similar nature, example, public or private.⁴⁷ However, this is not to say that the court will be bound by that practice if it is unreasonable.

Medical professionals must also be kept abreast with the changing practical guidelines. This is because, when determining negligence, courts will assess the actions of the professional

⁴² *R v Van Schoor* 1948 (4) SA 349 (C) 350.

⁴³ *Mitchell v Dixon* 1914 AD 519.

⁴⁴ *Dube v Administrator, Transvaal* 1963 (4) SA 260 (W).

⁴⁵ *Idem*, at 269.

⁴⁶ J Saner *Medical Malpractice in South Africa* (2021) 2.

⁴⁷ J Saner *Medical Malpractice in South Africa* (2021) 2.

against the accepted and practiced guidelines at the time of the alleged negligence.⁴⁸ This is why in *Durr v ABSA Bank Ltd*, the court said ‘it is not negligent to be a lawyer. But those who undertake to advise clients on any matter including an important legal component do so at their peril if they have not informed themselves sufficiently on the law.’⁴⁹

The following quote from Carstens apply summarises the discussion above:

‘The standard that is required is thus not on what can be expected of the exceptionally able doctor, but on what can be expected of an ordinary or average doctor in view of the general level of knowledge, ability, experience, skill and diligence possessed and exercised by the profession, bearing in mind that a doctor is a human being and not a machine and that no human being is infallible.’⁵⁰

2.2.2 Contract

The line of division between contractual and delictual liability where negligence is an issue is not always easy to draw.⁵¹ According to Innes CJ, the reason for this is that negligence and the duty of care are fundamental to both the law of delict and of contract.⁵² Both contract and delict fall under the law of obligation.

According to Carstens, a patient who wishes to make a claim using the law of contract will be required to prove; that he or she suffered damages; there was a breach of terms agreed on; a factual connection between damages caused and the practitioner’s breach; the damages caused should be sufficiently close enough to the breach in that it must have been reasonably foreseeable.

Medical professionals are often unaware that when they treat a patient, they are doing so under a contractual obligation. When a patient requests medical treatment and a medical professional accepts, a contractual relationship is formed.⁵³ They are often unaware because the terms are implied and there is no written contract. Generally, the contract terms are that

⁴⁸ *Van Wyk v Lewis* 1924 AD 438.

⁴⁹ *Durr v ABSA BANK LTD* 1997 (3) SA 448 (SCA) at 462.

⁵⁰ P Carstens and D Pearmain *Foundational Principles of South African Medical Law* (2007) 622.

⁵¹ *Van Wyk v Lewis* 1924 AD 438.

⁵² *Idem*; P Carstens and D Pearmain *Foundational Principles of South African Medical Law* (2007) 62.

⁵³ I Fahrenhorst ‘Civil liability arising from medical care – principles and trends’ (1984) 9 *International Legal Practitioner* 84.

the medical professional will exercise the care and skill that a reasonable medical professional would also apply in that field of medicine.⁵⁴ This therefore makes the practitioner a debtor in terms of the contract.⁵⁵ Where there is a failure on the part of the practitioner to meet his obligation, they may be required to pay compensation for the breach in contract.⁵⁶ A breach of contractual terms could arise from a failure to carry out the agreed procedure or a carrying it out in an unreasonable manner which causes harm to the patient.

The most important factors which medical professionals must be aware of is whether one is obliged to contract in the context of emergency medical treatment.⁵⁷ This is an important consideration for healthcare professional since section 27(3) of the Constitution states that no one may be refused emergency medical treatment.⁵⁸ To respond, one must first ascertain what would be seen as constituting emergency medical treatment. The case of *Soobramoney v Minister of Health*,⁵⁹ provides some guidelines. In that case, the court defined it to mean treatment that is urgent, and which is required when a person experiences unexpected and sudden trauma.⁶⁰ In regards to the obligation to provide emergency medical treatment, the court held that, the purpose behind the section is to ensure that a patient who finds himself in such a situation is not frustrated by 'bureaucratic requirements or other formalities.' Meaning, the idea behind the section is to limit the rights of other stakeholders such as doctors and private institutions to refuse a patient treatment. This is to say that the medical professional is not free to refuse to contract in instances of 'emergency medical treatment'.⁶¹ Any action on the part of the health institution and medical practitioner may mean that they are in breach of contract.

However, this is not to say that the medical professional may not refuse to treat patients who do not fall within the definition of emergency medical treatment. The common law right of healthcare professional to refuse to accept a patient remains valid. Where the patient has been

⁵⁴ *Richter and Another v Estate Hamman* 1976 (3) SA 266 (C) at 232.

⁵⁵ R Ahmed 'The standard of the reasonable person in determining negligence – comparative conclusions' (2021) 24 *PELJ* 29.

⁵⁶ N van Dokkum 'The Evolution of Medical Malpractice Law in South Africa' (1997) 41(2) *Journal of African Law* 178.

⁵⁷ For a detailed discussion see, D Bhana 'The implications of the health rights in section 27 of the Constitution for our common law of contract' (2015(3) *Stell LR* 532-549.

⁵⁸ The Constitution of the Republic of South Africa, 1996, section 27.

⁵⁹ *Soobramoney v Minister of Health* 1998 (1) SA 765 (CC).

⁶⁰ *Idem*, para 20.

⁶¹ D Bhana 'The implications of the health rights in section 27 of the Constitution for our common law of contract' (2015(3) *Stell LR* 539

accepted, there is a contractual duty to treat the patient and discontinuation of treatment may only occur if:

‘...treatment can feasibly be left to another health care professional who is willing to treat; where sufficient instructions for further treatment are issued; where further treatment is medically unnecessary, futile or likely to do more harm than good; where the patient refuses further treatment; or where the practitioner gives the patient reasonable notice of her intention to discontinue treatment while simultaneously ensuring that alternative treatment options are available.’⁶²

2.3 STATUTES

2.3.1 The Constitution

The Constitution is the supreme law of the country, all acts of Parliament and actions of and all actions of the executive and citizens must be consistent with it.⁶³ One of the reasons why litigation against healthcare facilities and its personnel has increased is because the public has come to understand better the rights enshrined in the Constitution which is very protective of the rights of patients.⁶⁴ Pienaar describes the health sector legal environment as one which is patient centered.⁶⁵ Section 27(1) unequivocally states that everyone has the right to healthcare services. In some ways this has led to an increasing number of people presenting themselves at hospital to enforce their rights. The increase means that there will be a greater strain on the system and more mistakes.

Furthermore, the Bill of Rights provides for further rights of citizens which are directly related to the right to healthcare services. Included in these are the right to human dignity,⁶⁶ the right to life,⁶⁷ bodily integrity and psychological integrity.⁶⁸

⁶² M Pieterse ‘Enforcing the right not to be refused emergency medical treatment: Towards appropriate relief’ (2007) *Stell LR* 386.

⁶³ The Constitution of the Republic of South Africa, 1996, section 2 read with section 7.

⁶⁴ L Pienaar ‘Investigating the reasons behind the increase in medical negligence claims’ (2016) 19 *PELJ* 1.

⁶⁵ *Idem*.

⁶⁶ The Constitution of the Republic of South Africa, section 10.

⁶⁷ The Constitution of the Republic of South Africa, section 11.

⁶⁸ *Idem*, section 12.

Through the Constitution in general and section 27(1) in particular, the state has a duty to provide access to health care services. Section 27(2) provides that the state must ensure that it realises this right by enacting reasonable legislative measures. It therefore becomes necessary to engage with various statutes that aim to give effect the right to health care services. Medical professionals need to be aware of some of the provisions of these statutes as breach of them could result to a denial of the right of access to health care services and could give rise to claims of medical negligence. It must be noted that whiles medical negligence is a common law offence in terms of either delict or contract law, however, in deciding these matters the court has regard to provisions of the legislation and the values and rights in the Constitution.

Furthermore, the common law also provides for the protection of subjective rights such as the right to privacy, bodily integrity and dignity. Where these are infringed, these may and has led to claims against medical professionals. Where these rights are engaged, the court will look to the Constitutional provisions for guidance as to how to interpret them.

2.3.2 The National Health Act

The National Health Act (hereafter referred to as ‘the NHA’)⁶⁹ is arguably the most important legislation that deals with the provision of healthcare services. The NHA provides a framework for a uniform health system in South Africa based on its obligations to the Constitution and other laws regulating health services. The main objective of the NHA is to regulate national health and provide uniformity in respect of health services across the country. It does so by establishing a system that sets out the rights and duties of doctors, other healthcare workers, facilities, and users; and protecting, promoting, respecting, and fulfilling the rights of the people of South Africa, including children and vulnerable groups.⁷⁰ Medical professionals must be aware of the relevant provisions of the NHA that affect their practices, particularly those that deal with the rights and duties of healthcare users and provides. These include the right to informed consent, confidentiality and access to medical records.

⁶⁹ The National Health Act 63 of 2001.

⁷⁰ Idem, preamble and section 2.

The rights and duties of users and health care personnel are written under chapter two of the NHA. First, the NHA requires the patient to be provided with full knowledge of their health status, treatment and alternative treatments, the risks and benefits of the same as well as their right to refuse treatment.⁷¹ However, a healthcare professional may refuse to provide all the details in respect of the health of that patient if the disclosure would be contrary to their best interest.⁷² This is because, although patients have certain rights, however, these can be limited as long as that limitation is justifiable and reasonable.⁷³ It cannot be denied that this section creates intrusion into the right to autonomy and self-determination, however, medical professional must be reminded that they can only refuse to provide the user, knowledge about their health status if there is a risk in doing so.⁷⁴ This gives medical professional therapeutic privilege which is a defence that they may use for withholding relevant medical treatment.⁷⁵ However, the NHA does not provide details about when it will be in the best interest to not give this information to the patient. Rubin is of the view that the most common justifications for not disclosing information would be where it would create incapacitating emotional distress.⁷⁶ However, there are certain things that the medical professional must be aware of in order to ensure that when they raise it as a defence it is successful. According to Van den Heever, they should;

- (a) do clinical assessment of the psychological status of the patient.
- (b) should provide information of a general nature in a manner companionate way to see if the patient is emotionally ready to receive such information.
- (c) document the clinical assessment.⁷⁷

Giving or refusing to give the patient information about their health records is also directly related to another right of patients which is to give informed consent. Section 7 of the NHA states that ‘health service may not be provided to a user without the user’s informed

⁷¹ The National Health Act 63 of 2001, section 6.

⁷² *Idem*, section 6(1)(a).

⁷³ The Constitution of the Republic of South Africa, section 36.

⁷⁴ R Thomas ‘Where to from *Castell v de Greef*? Lessons from recent developments in South Africa and abroad regarding consent to treatment and the standard of disclosure’ (2007) *SALJ* 208.

⁷⁵ *Idem*.

⁷⁶ EB Rubin ‘Professional conduct and misconduct’ in *Handbook of Clinical Neurology* (2013) 103.

⁷⁷ P van den Heever ‘Pleading the defence of therapeutic privilege’ (2005) 95 *SAMJ* 421.

consent.’⁷⁸ Consent is key to all medical law regulations that are mentioned in this chapter. Obtaining informed consent is now established as a distinguished legal and ethical requirement in the medical profession. The NHA provides a protocol for obtaining consent and the procedure that is followed is usually dependent on the mental capacity and age of the patient. McQuoid-Mason says that informed consent means:

‘Knowledge of the nature and extent of the harm or risk; an appreciation and understanding of the nature of harm or risk; consented to the harm or assumed the risk of harm; and consented to the entire transaction, including all its consequences.’⁷⁹

However, there are many risks involved in any medical treatment or operation. A medical professional may be of the view that telling the patient all the risks may be time consuming. The court in *Castell v De Greeff*⁸⁰ provides some useful guidance on when the risk is material enough to warrant the medical professional informing the patient about it. The court said:

‘...a risk is material if, in the circumstances of the particular case: (a) a reasonable person in the patient’s position, if warned of the risk, would be likely to attach significance to it; or (b) the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it.’⁸¹

*Esterhuizen v Administrator Transvall*⁸² is one example of where these rules were applied. In that case, the court held that mere consent to undergo an X-ray treatment, under the belief that it is innocuous or undergoing it without being aware of the attendant risks cannot amount to effective consent to undergo the risk.⁸³

Although it has often been said that obtaining informed consent is a time consuming and it is a ‘diversion from work for which a surgeon is uniquely qualified’,⁸⁴ however, the NHA

⁷⁸ The National Health Act 63 of 2001, section 7.

⁷⁹ D McQuoid-Mason ‘What constitutes medical negligence: A current perspective on negligence versus malpractice’ (2010) 7(4) *SA Heart* 247-248.

⁸⁰ *Castell v De Greeff* 1994 (4) SA 408 (C).

⁸¹ *Idem* at 426.

⁸² *Esterhuizen v Administrator, Transvaal* 1957 (3) SA 710 (T).

⁸³ *Idem* at 719.

⁸⁴ D McQuoid-Mason ‘What constitutes medical negligence: A current perspective on negligence versus malpractice’ (2010)

creates a legal obligation to obtain it.⁸⁵ Failure to obtain it may expose the doctor to litigation. The advantage ensuring that informed consent is obtained is that it creates a defence for the medical professional and the hospital against litigation. The most strategic decision a medical professional can adopt is to indicate the risk and benefits of the treatment. Failure to obtain informed consent is seen as a violation of the patient's right to physical or bodily integrity. In other words, it can be seen as amounting to assault.⁸⁶

Medical professionals must be aware that merely agreeing to be admitted at a health facility, or giving consent to a particular treatment, does not also imply that further treatment which is considered to be of benefit to the patient is also consented to. However, the NHA makes provision for health service without consent. Under section 9 of the NHA, it is identified that where a user is admitted to a health establishment in the absence of their consent, within two days, the head of the provincial department must be made known of that fact.⁸⁷

Medical professionals must be aware of the fact that patients are entitled to confidentiality. In *Jansen van Vuuren v Kruger* the court held that 'The duty of a physician to respect the confidentiality of his patient is not merely ethical but is also a legal duty recognised by the common law.'⁸⁸ In the case between *Ash Worth Security Hospital v MGN LTD*,⁸⁹ the court affirmed that medical practitioners should always keep their patient's confidential information secret. It is a duty placed upon all medical practitioners by section 14 of the NHA.⁹⁰ Furthermore, their professional relationship with the patient requires them to keep all information relating to a patient's treatment or health status confidential. Medical confidentiality is central to the trust between medical professionals and patients. If the patient does not feel assured that their confidentiality will be protected, then they may be hesitant to provide medical professionals with key information.⁹¹ All patients have a legitimate expectation that their medical information will be kept confidential. Where medical professionals fail to

7(4) SA Heart 247-248.

⁸⁵ The National Health Act 63 of 2001, section 7.

⁸⁶ P Mahery 'Consent laws influencing children's access to health care services' (2006) *South African Health Review* 169.

⁸⁷ The National Health Act 63 of 2001, section 9.

⁸⁸ *Jansen van Vuuren v Kruger* 1993 (4) SA 842 (AD) 14.

⁸⁹ *Ash Worth Security v MGN LTD* [2002] 1 W.L.R 2033.

⁹⁰ The National Health Act, section 14.

⁹¹ P Carstens and D Pearmain *Foundational Principles of South African Medical Law* (2007) 1453.

live up to section 14 of the NHA, this may result in a breach of privacy and therefore a delictual claim against the doctor or the health establishment as the act of disclosure would be considered to be unlawful.⁹²

However, the NHA does provide for some exception to the rule. This is because all rights, including that of that of privacy may be limited in certain circumstances. These exceptions may be used as defences to any charge against the medical professional. Among these it is noted that the health status, treatment of a patient may be disclosed where:⁹³

- (a) the user consents to that disclosure in writing.
- (b) a court order or another legislation or regulation requires a disclosure; or
- (c) non-disclosure of that information would create a significant threat to public health.

The common law also provides an exception to the confidentiality rule in terms of which it is only lawful to publish information in the discharge of one's duty or if the person is exercising a right to a person who has a right or duty to receive the information.⁹⁴

A patient's right to privacy and ultimately confidentially cannot be respected unless their medical records are kept in an appropriate manner. The NHA specifically provides for the protection of health records. Under section 17 of the NHA, there are detailed provisions on the subject matter.⁹⁵ It is required that there be control measures to ensure the safety of the records and to prevent access which is not warranted. Good data handling and resource management aid as reference when a hospital or an employee is sued. If it was not written down, it did not happen. Improving the management of data reliability and protection of confidential information pertaining to patients is a good base for defence in case a doctor or hospital is sued. A good case is Inkosi Albert Luthuli Central Hospital in the province of KwaZulu-Natal (KZN), currently the only paperless state hospital in South Africa, with

⁹² Health Professions Council of South Africa 'Confidentiality: Protecting and providing information' (September 2016), available at https://www.hpcsa.co.za/Uploads/Professional_Practice/Conduct%20%26%20Ethics/Booklet%20%20Confidentiality%20Protecting%20and%20Providing%20Information%20September%202016.pdf.

⁹³ Idem.

⁹⁴ *Jansen van Vuuren v Kruger* 1993 (4) SA 842 (AD) para 17.

⁹⁵ The National Health Act 61 of 2003, section 17.

renewed efforts to expand the adoption and use of electronic health records to other state hospital facilities.⁹⁶

The NHA provides that it is an offence to break any of these rules:⁹⁷

- a) Falsify the records;
- b) Temper with the records without an authority to do so;
- c) Fail to create or change the records when required;
- d) Copy any information on the records while the requisite authority to do so is absent;
- e) Gain access to the records while the authority to do so is absent. Gaining access may also refer to connecting or modifying online storage systems where the records are kept.

However, this is not to say that the patient's health information may not be accessed or that it may not be shared with others. Access to the information may be gained for the purpose of treatment, study and research with the patient's authorization.⁹⁸ Once a medical professional has access to these records, he or she may share the same with others provided that it is in the best interest of the patient to do so.⁹⁹ While in most instances it may be obvious whether the disclosure is in the interest of the patient, however, in other cases it may be difficult, cases such as in the context of HIV where one partner is positive and the other would like to know the result. In fact, the Health Professions Council of South Africa (HPCSA) general ethical guidelines, HIV examples are 'particularly perplexing'.¹⁰⁰ The HPCSA guidelines on the management of patient with HIV infections or AIDS state that health practitioners should encourages HIV positive patients to disclose their health status to their partners.¹⁰¹ Where there is refusal to disclose, the health practitioner is advised to use his or her discretion taking into account the risks of infection.¹⁰²

⁹⁶ 'Our Vision & History' IALCH, available at <https://www.ialch.co.za/our-vision-history/#:~:text=The%20Inkosi%20Albert%20Luthuli%20Central%20Hospital%20is%20the%20ONLY%20FULLY,organisations%2C%20both%20nationally%20and%20internationally.>

⁹⁷ The National Health Act 61 of 2003, section 17(2).

⁹⁸ The National Health Act 61 of 2003, section 16.

⁹⁹ P Carstens and D Pearmain *Foundational Principles of South African Medical Law* (2007) 1453.

¹⁰⁰ HPCSA 'General guidelines for good practice in the health care professions' (September 2016) 5.

¹⁰¹ HPCSA 'Guidelines for the management of patients with HIV infection or AIDS' (September 2016) 5.

¹⁰² *Idem*, 5.

2.3.2 The Children's Act

Medical professionals should be aware of the laws that govern children. This is because there are certain rules and procedures that are created to protect person who are under the age of 18. One of the most vital statutes that speaks to the way in which we should interact with children is the Children's Act.¹⁰³ Medical professionals are expected to perform their duties and responsibilities in accordance with the Children's Act when dealing with minors and their guardians. Essentially, doctors should have thorough knowledge of the Children's Act. The Constitution specifically says that children have the right to basic health care services, and the Children's Act, aims to provide protective measures which will ensure that this right is not infringed.¹⁰⁴ Therefore, medical professionals who are not aware of the provisions of the Children's Act may inventively infringe on the Constitutional rights of children. One of the most important parts of this Act is Part 3 of Chapter 3 which is about protective measures relating to the health of Children.

It is important for medical professional to know that children have a right to information about their health so as to enable them to make informed decisions about treatment. And just like adults, section 13 of the Children's Act affirms that children have a right to confidentiality.¹⁰⁵ The same rules and principles that govern an adults right to confidentiality will apply to children. The right to receive information is important for the child in order for them to give consent to treatment. Section 129 of the Children's Act holds that children above the age of twelve can consent to medical treatment and procedures. Children may also consent to the medical treatment and procedure of their children. There is a requirement which the medical professional needs to be aware of in order for section 129 to hold. In terms of that section the child must be sufficiently mature and have the mental capacity to understand the benefits, risks, social and other implications of the treatment or procedure.¹⁰⁶ In law, sufficient maturity and mental capacity has specific meaning. Pillay and Singh define what these terms mean in relation to children's health. They write that in health care, capacity relates to 'a clinical evaluation of an individual's functional ability to make autonomous, authentic decisions

¹⁰³ The Children's Act 38 of 2005.

¹⁰⁴ The Constitution of the Republic of South Africa, section 28(1)(c).

¹⁰⁵ The Children's Act 38 of 2005, section 13.

¹⁰⁶ *Idem*, section 129.

about his or her own life.¹⁰⁷ To determine this the medical professionals must see if the child has the ability to assimilate relevant facts and is able to appreciate their situation to as it relates to the facts.¹⁰⁸ This is because a decision-making capacity is incomplete until the nature of the choice and the circumstances in which it is made are detailed.¹⁰⁹

Further guidance can be gleaned from section 3 of the United Kingdom's Mental Capacity Act¹¹⁰ which states that having mental capacity means being able to:

- (a) Understanding the information relevant to the decision, including the purpose of any proposed cause of action, the main benefits, risks, and alternatives, and the consequences of refusing to follow the proposed course of action and failing to make a decision.
- (b) Retain that information for long enough to make a decision.
- (c) Use or weigh that information as part of the process of making the decision.
- (d) Communicate his or her decision, whether by speech, sign language or any other means.¹¹¹

Because there are no clear guidelines in terms of any of the health regulations about what is mental capacity, Pillay and Singh suggest that medical professionals should use the above criteria when making a determination.¹¹² Among the factors that influence a child's capacity is their age, personal experience to health care and the magnitude and complexity of treatment or procedure.¹¹³

Sufficient maturity is linked to sufficient capacity in that it is about the ability to appreciate the implication of their decision.¹¹⁴ Maturity is aligned to whether the child is sufficiently developed in terms of their physical, moral and emotional characteristics.¹¹⁵

¹⁰⁷ B Pillay and A Singh 'Mental capacity', sufficient maturity' and 'capable of understanding in relation to children: how should health professionals interpret these terms? (2018) 48(4) *South African Journal of Psychology* 541.

¹⁰⁸ Idem.

¹⁰⁹ H Kruger 'The protection of children's right to self-determination in South African law with specific reference to medical treatment operations' (2018) 21 *PELJ* 7.

¹¹⁰ Mental Capacity Act of 2005.

¹¹¹ Idem, section 3.

¹¹² B Pillay and A Singh 'Mental capacity', sufficient maturity' and 'capable of understanding in relation to children: how should health professionals interpret these terms? (2018) 48(4) *South African Journal of Psychology* 541.

¹¹³ Idem, 544-545.

¹¹⁴ Pillay and Singh 'Mental capacity', sufficient maturity' and 'capable of understanding in relation to children: how should health professionals interpret these terms? (2018) 48(4) *South African Journal of Psychology* 541

¹¹⁵ Y Havenga and M Temane 'Consent by children: Considerations when assessing maturity and mental capacity' (2016) 58(1) *South African Family Practice* 43.

Havenga writes that medical professional should make a clinical judgment determine to determine the child's mental capacity and maturity. Such a clinical judgment is crucial in getting consent.¹¹⁶ Greater maturity and capacity to consent is needed when the risks involved are significant.¹¹⁷ In fact, the Children's Act requires above and beyond the requirement of being over twelve years, and sufficiently maturity and mental capacity but also that in cases where there is a need for a surgical operation on them, the child must be duly assisted.¹¹⁸ It is important for medical practitioners to be aware of the difference between parental assistance and parental consent and to know in what circumstances are these two things needed.¹¹⁹ Parental assistance refers to the parents input which enables the child to make a decision about a particular procedure. Meaning that the parent helps the child to understand and appreciate the benefit, risk and importance of the decision.

However, despite any amount of maturity or mental capacity that the child may have, they cannot consent to any medical treatment or procedure if they are under the age of twelve years.¹²⁰ In such a case, the parent or guardian of a child may provide consent to the medical treatment or surgical operation. However, the Children's Act dictates that a parent or guardian of a child may not: (i) refuse to assist a child who consents to surgical procedure, or (ii) withhold consent for medical treatment or a surgical operation solely on religious grounds. Unless such parent or guardian can show a medically accepted alternative to the prescribed operation or treatment.¹²¹ The issue of when can a parent refuse consent has received much attention and has produced precedent. The one case where this was discussed involved a patient who is of the Jehovah's Witness faith. In that case of *Hay v B*¹²² the judged concluded the best interest of a child in determining whether to validate the refusal to consent of the parents. The parents in this case refused to consent to a blood transfusion due to religious belief.¹²³ The judged conclude the parent's refusal was neither reasonable nor was it in the child's best interest. It was found that in this case, the beliefs of the parent could not operate

¹¹⁶ Y Havenga and M Temane 'Consent by children: Considerations when assessing maturity and mental capacity' (2016) 58(1) *South African Family Practice* 43.

¹¹⁷ *Idem*, 45.

¹¹⁸ The Children's Act 38 of 2005, section 129(3).

¹¹⁹ P Mahery 'Consent laws influencing children's access to health care services' (2006) *South African Health Review* 169.

¹²⁰ The Children's Act 38 of 2005, section 4 and 5.

¹²¹ *Idem*, section 129(10)

¹²² *Hay v B* 2003 (3) SA 429 (W).

¹²³ *Idem* at 424.

to override the child's right to life.¹²⁴ This is not to say that a parent's reasons for refusal should be ignored but in all cases there must be proper consideration of those reasons.

In circumstances where the treatment or operation necessary to save life of the child or to prevent lasting injury or there is great urgency to provide the same, the superintendent of the hospital may provide consent.¹²⁵ The Minister of Social Development may also provide consent if the parents or guardian or even the child unreasonably refuse to give consent.¹²⁶ Furthermore, medical professionals need to be aware of the ability of children to consent to termination of pregnancy. This topic is discussed next.

2.3.4 Choice on Termination of Pregnancy Act

Medically induced termination of pregnancy, common referred to as an abortion, is governed by the Choice on Termination of Pregnancy Act (hereafter referred to as the 'Pregnancy Act').¹²⁷ The Pregnancy Act provides for the circumstances in which the pregnancy of a woman may be terminated. The Pregnancy Act is the result of the Constitution and the NHA which provides that woman must be provided with termination of pregnancy services which must be free in the public sector.¹²⁸ The right to termination of pregnancy is considered to be an exercise of a reproductive right and of the right to freedom of bodily integrity.¹²⁹ Thus, a failure to provide termination of pregnancy as per the Pregnancy Act may give rise to a delictual claim. However, the Pregnancy Act also provides penalties for any person, including a medical professional who prevents the lawful termination of pregnancy or who prevents access to a facility.¹³⁰ Under section 10 it provides that such a person will be guilty of an offence and would be liable to a prison sentence of 10 years or less or to a fine.¹³¹ It is therefore important for health establishments and medical professionals to be aware of the provisions of the Pregnancy Act, in particular they need to be aware of the circumstances in which a pregnancy may be terminated so as to ensure that they do not obstruct access to these services.

¹²⁴ *Hay v B* 2003 (3) SA 429 (W) at 495.

¹²⁵ The Children's Act 38 of 2005, section 6.

¹²⁶ *Idem*, section 7 and 8.

¹²⁷ Choice on Termination of Pregnancy Act 92 of 1996.

¹²⁸ The National Health Act, 2003, section 4(3)(c)

¹²⁹ P Carstens and D Pearmain *Foundational Principles of South African Medical Law* (2007) 942.

¹³⁰ Choice on Termination of Pregnancy Act 92 of 1996, section 10(c).

¹³¹ *Idem*, section 10(c).

The Pregnancy Act provides that up to the first 12 weeks of the gestation period, the termination may be done upon request by a pregnant woman.¹³² When pregnancy has reached the 13th to the 20th week, termination may be done by a medical doctor, on conditions that; the physical or mental health of either the woman or foetus would be compromised should pregnancy continue; the pregnancy resulted from rape or incest, or socio-economic circumstances of the woman would be significantly affected by the pregnancy.¹³³ In cases where pregnancy is beyond the 20th week, induced termination may only take place should the life of the woman would be endangered or where it would lead to severe malformations of the fetus.¹³⁴

Regarding consent, a female of any age may consent to a termination of pregnancy without her parent or guardian's consent.¹³⁵ In cases where the woman is a minor, they must be advised to consult with their guardian or parent, or friend, or family member.¹³⁶ However, medical professionals and establishments cannot refuse to terminate pregnancy on the basis that the minor has not consulted.¹³⁷ The constitutionality of the rule was affirmed in *Christian Lawyers Association v Minister of Health*.¹³⁸ In that case, the rule was challenged on the basis that children under the age of 18 are incapable of giving informed consent without parental consent or control.¹³⁹ However, the court declared that the approach failed to recognize the individual differences of woman and that they were just as mature as those above the age of 18.¹⁴⁰

McQuoid-Mason provides much needed clarity on whether doctors may refuse to terminate pregnancy as a result of their freedom of conscience.¹⁴¹ He writes that in emergency situations, the medical professional may refuse to terminate on the basis of conscience if another medical practitioner is available.¹⁴² In cases which are not of an emergency, the medical professional

¹³² Choice on Termination of Pregnancy Act 92 of 1996, section 2(1)(a).

¹³³ *Idem*, section 2(1)(b).

¹³⁴ *Idem*, section 2(1)(c).

¹³⁵ The Children's Act 38 of 2005, section 5(1) read with section 1.

¹³⁶ *Idem*, section 5.

¹³⁷ The Children's Act 38 of 2005, section 5.

¹³⁸ *Christian Lawyers Association v Minister of Health* 2005 (1) SA 509 (T).

¹³⁹ *Idem*, at 510.

¹⁴⁰ *Idem*, at 518.

¹⁴¹ D McQuoid-Mason 'State doctors, freedom of conscience and termination of pregnancy revisited' (2010) 3(2) *SAJB* 75.

¹⁴² D McQuoid-Mason 'State doctors, freedom of conscience and termination of pregnancy revisited' (2010) 3(2) *SAJB* 78.

must refer the woman to someone who is prepared to provide the service. This means that there must be active assistance in finding another medical professional. Failure to do so may be seen as obstructing access to termination services and may attract liability.¹⁴³ However, as seen from the discussion above, private medical practitioners may refuse to provide treatment to any person, provided the decision is reasonable and it is not an emergency.

2.3.5 The Mental Health Care Act

The Mental Health Care Act¹⁴⁴ governs the law concerning the protection and treatment of a mental health care user. The term ‘mental health care user’ refers to persons receiving care, treatment, and rehabilitation services at a health establishment, aimed at enhancing the mental health status of a user.¹⁴⁵ In addition, depending on the circumstances, the term may also include (a) the patient; (b) the person’s next of kin; (c) a person authorised by other law or court to act on the patient’s behalf; and an administrator appointed in terms of the act.¹⁴⁶ A healthcare provider or health facility may provide care, treatment and rehabilitation services to or admit a mental health care user only when; the user has given informed consent or on authority of a court order or should any delay in providing care, treatment and rehabilitation services result in adverse implications due to mental illness.¹⁴⁷

Doctors, as health practitioners, must understand the content and limitations of the Mental Health Care Act. When a doctor is dealing with the case of a mental health care user who does not have the necessary mental capacity to give consent, certain safeguards need to be followed, with proper consent obtained from the person with legal capacity to give such consent.

¹⁴³ *Idem*, 78.

¹⁴⁴ Mental Health Care Act 17 of 2002.

¹⁴⁵ *Idem*, section 1.

¹⁴⁶ *Idem*, section 1.

¹⁴⁷ Mental Health Care Act 6 of 2002, section 9(1)(c).

2.3.6 Consumer Protection Act

The Consumer Protection Act¹⁴⁸ is seen as an important law which ensures that the rights of all consumers are protected and that they are not exploited. A patient, who is at a health establishment, would be considered as a consumer and the hospital would be a supplier and the Act would apply to them.¹⁴⁹ Through the Act, patients can demand quality service and they have a right to goods that are safe.¹⁵⁰ In the medical context this would be medication and the use of medical equipment which abides by these requirements. Furthermore, where the goods are defective or hazardous, the patient may have a recourse in terms of the Act if there is harm that occurs as a result of this.¹⁵¹

Medical professionals must also be aware that general notices of indemnity against liability would not always suffice. These clauses will need to comply with the provisions of the Act. McQuoid-Mason goes into great detail regarding this. He writes that the provision of the common law of delict which allows for persons to escape liability based on indemnity clauses save for when there is gross negligence has been affected by the Consumer Protection Act.¹⁵² The Act achieves this by providing that suppliers of services cannot impose clauses which are unjust or unreasonable such as requiring a consumer to waive the liability of the supplier.¹⁵³

2.3.7 Protection of Personal Information Act

In the age where information can be sold and bought for a fee, it is important for governments around the world to do everything they can to protect personal records. South Africa has taken up this mantle by having a number of laws which aim to ensure that the right to privacy is not infringed. One such measure is the Protection of Personal Information Act (hereafter referred to as POPI).¹⁵⁴ POPI provides a number of mechanism or requirements to ensure that personal information is protected. Medical professionals need to be aware of this as a breach in any of them could make them liable for a penalty under POPI. In terms of POPI no one is allowed to

¹⁴⁸ The Consumer Protection Act 68 of 2008.

¹⁴⁹ D McQuoid-Mason 'Hospital exclusion clauses limiting liability for medical malpractice resulting in death or physical or psychological injury: What is the effect of the Consumer Protection Act?' (2012) 5(2) *SAJBL* 66.

¹⁵⁰ The Consumer Protection Act 68 of 2008, section 54 and 55.

¹⁵¹ *Idem*, section 60(2).

¹⁵² D McQuoid-Mason 'Hospital exclusion clauses limiting liability for medical malpractice resulting in death or physical or psychological injury: What is the effect of the Consumer Protection Act?' (2012) 5(2) *SAJBL* 68.

¹⁵³ The Consumer Protection Act 68 of 2008, section 48.

¹⁵⁴ Protection of Personal Information Act 4 of 2013.

process information about, among others, a person's health.¹⁵⁵ Such information may only be processed with the explicit consent of the person or if the provisions of POPI allow for the same. One such exception to the requirement of consent is when medical professionals and health establishment, process the information in order to provide treatment of the patient.¹⁵⁶

Medical professionals as well as health establishments need to be aware of the following when handling patient information. They must ensure that the patient is notified about the fact that they hold their information and that should they require such information that it is made available to them and that where there are discrepancies, that they be allowed to amend it.¹⁵⁷

2.3.8 The Health Professions Act

Although the practice of medical care has to conform to the Constitution, national legislation and the common law, however, in a strict sense, it is regulated by a statutory body called the HPCSA. The HPCSA is regulated in terms of the Health Professions Act (hereafter referred to as the Professions Act).¹⁵⁸ The purpose of the Professions Act is to provide for control over training, registration, education and the practicing of the health professions in South Africa.¹⁵⁹ As it will appear in the next chapter the HPCSA provides for a number of ethical guidelines to which medical professionals need to follow in order to ensure that the country is able to provide good professional practice. The guidelines help the HPCSA to achieve this by setting out various ethical standards and values which must be followed by those who are registered with it.¹⁶⁰ However, the guidelines go further than this, in that they also provide practical advice on how medical professionals can ensure that the rights of patients are given effect to within different circumstances.

Medical professionals need to be aware of the provisions of the Professions Act, as it gives the HPCSA certain powers which are crucial in ensuring that it is able to carry out its mandate. A critical aspect of the Professions Act is under section 10 which gives the HPCSA the power

¹⁵⁵ Protection of Personal Information Act 4 of 2013, section 32.

¹⁵⁶ *Idem*, section 32(1).

¹⁵⁷ *Idem*, section 24.

¹⁵⁸ Health Professions Act 56 of 1974.

¹⁵⁹ *Idem*, long title.

¹⁶⁰ HPCSA 'General guidelines for good practice in the health care professions' (September 2016) 2.

to establish disciplinary committees so as to prosecute those who are alleged to have committed unprofessional conduct.¹⁶¹

Further to this, through the Professions Act, the HPCSA is open for complaints from the public who feel they are charged.¹⁶² The Professions Act also regulates the dispensing of medicine by medical professionals.¹⁶³

The one important provision which medical professionals need to be aware of is section 56 of the Professions Act. In terms of this provision, if a patient dies while undergoing or as a result of a procedure which is palliative, diagnostic or therapeutic, the medical professional is obliged to report the death so that an inquest may be opened.¹⁶⁴

Breaches of the provisions of the Professions Act by a medical practitioner may result in a criminal offence and/or disciplinary proceedings by the HPCSA. What becomes clear from the Professions Act is that the HPCSA is responsible for ensuring that there is a high quality of health standards in the country.¹⁶⁵

2.4 CONCLUSION

The chapter has highlighted the different legal provisions which are applicable to medical practice. The chapter looked at the responsibilities of healthcare practitioners that result from the right to access to health as provided for in the Constitution, legislations and the common law. In doing so, the discussion focused on the different ways in which the health sector can make sure that the right to access to health is protected and it showed that to do this the law requires respect for the confidentiality of patients; obtaining informed consent and providing the patient with full knowledge of their health status.

¹⁶¹ Health Professions Act 56 of 1974, section 10.

¹⁶² *Idem*, section 53.

¹⁶³ *Idem*, section 52.

¹⁶⁴ *Idem*, section 56.

¹⁶⁵ P Carstens and D Pearmain *Foundational Principles of South African Medical Law* (2007) 395.

CHAPTER THREE: ETHICAL GUIDELINES

3.1 INTRODUCTION

‘It would not be correct to say that every moral obligation involves a legal duty, but every legal duty is founded on a moral obligation.’¹⁶⁶

The conduct of medical professionals is not only regulated by various provisions in law, it is also informed and regulated by ethical guidance. Medical ethics refers to fundamental moral principles which govern the way in which we practice medicine.¹⁶⁷ Medical ethics are often globally applied and accepted.¹⁶⁸ In Europe, medical ethics have roots in ancient guidelines relating to the duty of medical professionals as influenced by the Hippocratic Oath and Christian doctrines.¹⁶⁹ The last hundred years has seen an increase in conversations on medical ethics, this is the result of an advances in medicine and medical technology.¹⁷⁰ This is because many of the advances touches on peoples most dear interest such as human mortality and reproduction.¹⁷¹

This chapter provides insight into the ethical principles and guidelines which inform medical practice. It is known that medical professionals encounter various ethico-legal dilemmas in their medical practice. An ethical dilemma takes place when there are various courses of action which may be justifiable in any given situation, possibly resulting in contradictory outcomes.¹⁷² In such a situation, whiles the medical professional must act with a degree of care and skill, this does not necessarily help him to decide the best course of action. Ethical guidelines give medical professionals an established framework of values which serve as a reference point from which to determine which course of action is justifiable.¹⁷³ Childress

¹⁶⁶ *R v Instan* [1893] 1 QB at 543.

¹⁶⁷ M Davidson ‘Medical Ethics’ (1959) 5(8) *The Central African Journal of Medicine* 425.

¹⁶⁸ D Thaller et al ‘An optimistic vision for biosciences in South Africa: A response to the ASSAf report on human genetics and genomics’ (2019) 115(7) *South African Journal of Science* 1.

¹⁶⁹ Z Zondo ‘Reopening the debate on medical malpractice claims in South Africa: Examining the intersection between quality health and professional training and bioethics.’ [Unpublished LLM, UKNZ] 19.

¹⁷⁰ *Idem*.

¹⁷¹ T Laurie, S Harmon and G Porter *Mason & MaCall Smith Law and Medical Ethics* 10th ed (2016) 1.

¹⁷² *Idem*, 5.

¹⁷³ *Idem*.

and Beauchamp are of the opinion that the medical professional should consider the four pillars of bioethics such as the principle of respect for individual autonomy, non-maleficence, beneficence and justice.¹⁷⁴ As will be discussed in this chapter medical professionals may also rely on the various code of conduct guidelines as provided for by the Health Professional Council of South Africa. These professional guidelines reflect the core ethical values such as those identified by Childress and Beauchamp. However, as it will appear they also reflect values of integrity, confidentiality, professional competence, respect for persons, human rights, truthfulness and compassion.¹⁷⁵

3.2 THE FOUR PILLARS OF BIOETHICS

As stated in the introduction, the four principles of bioethics are: respect for autonomy, justice, non-maleficence and beneficence. Childress and Beauchamp argue that by balancing the four principles of ethics, medical professionals will be able to resolve health care dilemmas. However, it may be that at any given time, there is uncertainty about which principle to apply in the circumstances. If there is more than one which is applicable, then medical professionals must balance them. This means that a particular principle will apply unless there is a different principle which has more weight in the circumstances. The dominant principle that is applied depends on the situation.¹⁷⁶ This approach to providing solutions to ethical dilemma is widely accepted. Van Niekerk is of the view that the approach ‘provides a simple and versatile apparatus that has attained enormous acclaim with people who have to make everyday practical decisions all over the world.’¹⁷⁷ These principles will provide a framework from which medical practitioners can take decisions and from which they can justify their actions.¹⁷⁸ The following discussion provides an overview of the different principles.

¹⁷⁴ JF Childress and T Beauchamp *Principles of Biomedical Ethics* 7th ed (2012)

¹⁷⁵ P Carstens and D Pearmain *Foundational Principles of South African Medical Law* (2007) 942.

¹⁷⁶ A van Niekerk ‘Ethics theories and the principlist approach in bioethics’ in K Moodley *Medical Ethics, Law and Human Rights: A South African perspective* 2nd ed (2017).

¹⁷⁷ Idem.

¹⁷⁸ D van der Reyden ‘The right to respect for autonomy Part 1 – What is autonomy all about?’ (2008) 38 *South African Journal of Occupational Therapy* 28.

3.2.1 Respect for individual autonomy

As seen from the previous chapter, respect for individual autonomy is at the heart of some of the rights and duties of patients and medical professionals. The Constitution and the various forms of laws aim to protect a patient's right to individual autonomy. It was shown that failure to provide a patient with information regarding his or health status can be seen as an intrusion into the patients right to autonomy. The reason for this is that when there is no sharing of information then the patient is not able to exercise his or her right to choose how to be treated. Furthermore, therapeutic privilege is also an intrusion albeit a justifiable one. The right to respect for autonomy also finds application in confidentiality and consent.

However, beyond being a legal principle, respect for individual autonomy is also an ethical principle which medical professionals should know and follow in their medical practice. Respect for autonomy speaks to the issues of confidentiality, informed consent, truth telling and communication. This is because, the principle of autonomy is about the right to live one's own life, to make one's own decision.¹⁷⁹ In the health context, it requires professionals not to conduct themselves in a manner that will interfere with the exercise of the autonomy of the patient.¹⁸⁰ Some aspects of this may be clear to medical professionals, however, a few important points are worth mentioning so that they are aware of the full meaning of respecting the autonomy of the patient. This principle requires that medical practitioners act positively to ensure that the patient is able to exercise their autonomy, to this extent, van der Reyden says that health practitioners must enable 'effective exercise' of patient autonomy.¹⁸¹

The principle further presupposes that the medical practitioner is alive to the capacity of the individual patient. It presupposes that they have knowledge and understanding of the various provisions, discussed under chapter two, which relate to one's capacity to consent among others. The medical professional should know which patients are not autonomous because of their age and wellbeing. The group of patients who usually lack autonomy are those who

¹⁷⁹ D van der Reyden 'The right to respect for autonomy Part 1 – What is autonomy all about?' (2008) 38 *South African Journal of Occupational Therapy* 28.

¹⁸⁰ Idem.

¹⁸¹ K Moodley 'Respect for patient autonomy' in K Moodley *Medical Ethics, Law and Human Rights: A South African Perspective* (2017).

have suicidal ideation, extreme psychiatric illness and infants.

It should become evident that respect for autonomy is not unqualified. As discussed, if a principle is in conflict with another, there must be a balancing act which is done to see which principle should apply. In *Castell v De Greef*¹⁸² the court had to balance autonomy with paternalism. This case provides an example where the court had to consider the right to respect autonomy of a patient, albeit in its legal form and paternalism which can be used to override the moral obligation to respect autonomy on the basis of beneficence.¹⁸³ The court found that in order to give effect to a patient's autonomy, the medical professional has to warn them of the material risk involved in the proposed treatment. The medical professional must also seek informed consent.¹⁸⁴ If this is done, the patient will have enough information to be able to effectively exercise his or her autonomy. In that case, the court went on to say that it is wholly irrelevant that in the eyes of the medical practitioners the patient's decision to refuse treatment was 'grossly unreasonable'.¹⁸⁵ It reasoned this way having said that her right to autonomy entitled her to refuse medical treatment.¹⁸⁶

What is interesting to observe from the case is that the court recognised that South Africa and the world seems to be moving away from paternalism towards individual autonomy.¹⁸⁷ A specific form of paternalism, which is the principle of beneficence is discussed next.

3.2.2 Beneficence

The essence of beneficence is that a person should aim to do good where it is possible.¹⁸⁸ The reason for the rider is that beneficence does not require severe sacrifice.¹⁸⁹ In the health context, it means acting in a manner which will benefit the patient. According to Childress,

¹⁸² *Castell v De Greef* 1994 (4) SA 408 (C).

¹⁸³ 'The principle of beneficence in applied ethics' *Stanford Encyclopedia of Philosophy* (11 February 2019), available at [¹⁸⁴ *Castell v De Greef* 1994 \(4\) SA 408 \(C\) at 409.](https://plato.stanford.edu/entries/principle-beneficence/#:~:text=(Both%20%E2%80%CBenefiting%E2%9D%20and%2%E280%9C,choice%20on%20grounds%20of%beneficence,[accessed 20 April 2022].</p></div><div data-bbox=)

¹⁸⁵ *Idem*, at 421.

¹⁸⁶ *Idem*, at 421

¹⁸⁷ *Idem* at 426.

¹⁸⁸ JF Childress and T Beauchamp *Principles of Bioethics* (2013) 203

¹⁸⁹ *Idem*, 204.

the principle provides support for various forms of obligations such as:¹⁹⁰

- (a) Protecting and defend the rights of others.
- (b) Prevent harm from occurring to others.
- (c) Removing conditions that will cause harm to others.
- (d) Help persons with disabilities.
- (e) Rescue persons in danger.

Medical professionals must be aware that they all have an obligation to minimize or avoid harm and provide beneficial treatment.¹⁹¹ It is not enough for the doctor to simply say that they avoided harm, the principle requires positive steps to help the other person.¹⁹² In order to ensure that harm is minimised and acts of negligence are avoided, doctors must ensure that there are competent to do good. The following is a discussion of the ways in which this can be achieved:¹⁹³

- (a) One way of ensuring this is by keeping medical records that are complete and legible. Anything contrary may lead to a wrong prescription being given or the wrong treatment or procedure being taken.
- (b) Another way of enabling medical professionals to ensure that they do good is to ensure that they have good medical training, skills and knowledge. They must keep themselves abreast of clinical developments in their area of expertise.
- (c) It is further suggested that medical professionals should be aware of significant changes in law resulting from court judgements.

Beneficence underpins medical practice, Dhai and McQuoid-Mason are of the view that beneficence is 'inherent in the role of the practitioner.'¹⁹⁴ Failure to abide by the beneficence principle may result in the violation of the first and foremost medical principle, not to do harm. The following discussion looks at this principle which is commonly referred to as non-maleficence.

¹⁹⁰ JF Childress and T Beauchamp *Principles of Bioethics* (2013) 204.

¹⁹¹ K Moodley *Medical Ethics, Law and Human Rights: A South African Perspective* 2nd ed (2017) Chapter 6.

¹⁹² A Dhai and D McQuodi-Mason *Bioethics, Human Rights and Health Law* 2nd ed (2020) 18.

¹⁹³ *Idem*.

¹⁹⁴ *Idem*.

3.2.3 Non-maleficence

Medical practice as a whole is firmly rooted in the principle, first do no harm. It is incumbent on all medical professionals to abide by this principle. In this particular instance, the harm that must be avoided has two meanings. The first is the ordinary grammatical one which is about ensuring that there is no physical, emotional or psychological injury that is caused by the medical professional. In the second instance it refers to ensuring that that there is no wrong or injustice that is caused. Childress outlines five rules of non-maleficence that the medical professional needs to adhere to:¹⁹⁵

- (a) Do not cause pain or suffering to others.
- (b) Do not incapacitate others.
- (c) Do not deprive others of the goods of life.
- (d) Do not cause offence to others.

These rules are non-exhaustive and are not absolute. This is why Childress refers to the weighing and balancing of the different ethical principles. To determine whether the medical professional is observing any of the rules, they must perform a risk-benefit exercise. They must determine whether the proposed cause of treatment has risks that outweigh the benefit. Invariably, most medical interventions have risks, and in most of these instances the benefit are of a greater proportion. This is especially true for treatment such as surgery, which often inflicts harm. As long as the medical professional ensures that the proposed treatment has benefits that outweigh the harm.¹⁹⁶

What is beneficial to the patient should not only be measured in scientific or medical terms. Medical professionals need to consider the patient's autonomy when determining the benefits of proposed treatment. This requires input from the patient and input from their own values and preferences.¹⁹⁷ This is especially true in decisions that involve preservation of life.

Medical professionals will have to decide where the benefit of medical treatment ends and

¹⁹⁵ JF Childress and T Beauchamp *Principles of Bioethics* (2013) 204.

¹⁹⁶ M Brazier and E Cave *Medicine, Patients and the Law* (2016) 65.

¹⁹⁷ K Moodley *Medical Ethics, Law and Human Rights: A South African Perspective* 2nd ed (2017) 249.

where the harm begins. This line is not always easy to draw. However, South African courts have drawn a clear line in the context of withholding or withdrawing treatment. The court in *S v Williams*¹⁹⁸ held that medical professionals would not be liable if treatment is withheld or withdrawn in circumstances where further medical intervention would be futile, and the burden outweighs the benefits.¹⁹⁹

Medical professionals need to also learn that the principle of non-maleficence also requires of them to not engage in omissions that will cause injury to their patients.²⁰⁰ Freedman makes the point that refusing to provide an emergency blood transfusion to a patient for reasons which are not medically justified would be in contravention of the principle of do no harm.²⁰¹ This is particularly true where the medical professional is the only one at the time who can give such treatment. In essence, Freedman is saying that medical professionals need to be aware that they can cause harm by omitting to prevent harm. The reasons for not doing something must be medically sound or otherwise there must be an alternative which is available for the patient.

One of the greatest concerns which medical professionals may have is what happens in the case of accidental adverse events such as the failure of equipment or individual human error. In such situations it is firstly advised that health establishments should ensure that procedures for ensuring maintaining equipment is followed. This will require that the requirement is checked and served at regular intervals.²⁰² Provided this is done, the medical professional and the health establishment would have acted in line with the principle of non-maleficence.

In the case where the medical professional causes harm due to his or her individual mistake, a few points are worth noting. It is firstly important to note to err is human and therefore it is quite likely that mistakes will happen from time to time. However, a medical professional should strive to ensure that this does not occur. It is noted that they must ensure that those

¹⁹⁸ *S v Williams* 1986 (4) SA 1188 (A).

¹⁹⁹ *Idem*, para 23.

²⁰⁰ W Freedman 'May doctors for religious reasons refuse to give patients blood transfusions under any circumstance?' (2019) 82 *THRHR* 481.

²⁰¹ *Idem*.

²⁰² K Moodley *Medical Ethics, Law and Human Rights: A South African Perspective* 2nd ed (2017) 255.

working with patients are update themselves and their skills in the provision of treatment.²⁰³ This will help to minimize risks and errors. It must be ensured that were an error has taken place, the medical professional should disclose it in a manner that is sensitive and in a meaningful manner as the patient may feel angry about what has happened.²⁰⁴ They should also not become defensive when the patient reacts in this manner, and instead, they should provide a detailed analysis of the error and the events that led to it. Such a disclosure would ensure that the doctor-patient relationship which is built on trust is maintained. An apology is both helpful and appropriate.²⁰⁵

3.2.4 Justice

As a principle in medical ethics, justice requires that when balancing the ethics of a decision, we must enquire as to whether it is in line with the law and that it is fair.²⁰⁶ Moodley writes that there are three obligations which arise from the principle. She writes that there is an obligation to have: ‘

- (a) Respect for morally acceptable laws – legal justice.
- (b) Respect for people’s rights – rights-based justice.
- (c) Fair distribution of limited resources – distributive justice.’²⁰⁷

The form of justice which is often regarded as most important is distributive justice. This form requires that there be an equitable and fair distribution of health care resources.²⁰⁸ In the South African context, distributive justice is especially relevant.²⁰⁹ This is because, as a country we have limited resources to cater for the entire population. In response to our very unequal system, the government has tabled the National Health Insurance Bill.²¹⁰ Its main

²⁰³ JF Childress and T Beauchamp *Principles of Bioethics* (2013) 309.

²⁰⁴ R Manscur, Ammar, A Al-Tabba, et al ‘Disclosure of medical errors: physicians’ knowledge, attitudes and practices (KAP) in an oncology center’ (2020) 21(74) *BMC Medical Ethics* 2.

²⁰⁵ T Beauchamp and JF Childress *Principles of Bioethics* (2013) 310.

²⁰⁶ K Moodley *Medical Ethics, Law and Human Rights: A South African Perspective* 2nd ed (2017) 200.

²⁰⁷ Idem.

²⁰⁸ B Varkey ‘Principles of clinical ethics and their application to practice’ (2021) 30(17) *Med Princ Pract* 20.

²⁰⁹ K Moodley *Medical Ethics, Law and Human Rights: A South African Perspective* 2nd ed (2017) 249.

²¹⁰ R Rensburg ‘Healthcare in South Africa: how inequity is contributing to inefficiency’ *The Conversation* (6 July 2021) available at <https://theconversation.com/healthcare-in-south-africa-how-inequity-is-contributing-to-inefficiency-163753>, [Accessed 20 February 2022]; The National Insurance Bill GN 40955 GG 627 (30 June 2017).

aim is to ensure that there is ‘access to quality, affordable personal healthcare services for all South Africans based on their health needs, irrespective of their socioeconomic status.’²¹¹ According to Dhali and McQuoid-Mason, distributive justice requires equals to be treated equally. Varkey provides greater context by explaining how this can be achieved. He writes that there must be an equal share of resources, and which must be distributed according to contribution, effort, need, and free-market exchanges.²¹²

Failure to provide emergency treatment to patients may result in the violation of distributive justice. Olejarczyk and Young amplify this by stating that the right to emergency treatment is derived from justice and beneficence.²¹³ Another example which would prove to be contrary to the principle is where the medical professional chooses expensive treatment over affordable one, merely for his or her benefit or for the benefit of the hospital. In such a case the medical professional may be hindering equal access to treatment.

Distributive justice requires a discussion on aspects of national policy which is outside the ambit of this research. However, it is important for medical professionals to be aware that there is a substantial shift in policy which is necessitated by, among other, the principle of distributive justice.²¹⁴ The research provided a few examples of how the principle would apply to a local setting such as a health establishment.

An aspect of justice which is more relevant to the research is that of legal justice. In terms of legal justice, medical professional need to have respect for morally acceptable laws.²¹⁵ This means that they are obliged to respect laws which are morally justifiable even if doing so may be in conflict with the patient’s wishes. Equally, medical professionals may decide to ignore morally unjustifiable laws when providing treatment to a patient. However, Gillon observes that while one may use the principle of legal justice to justify their actions, it does not mean that they will not face legal consequences for their actions.²¹⁶ In fact, medical

²¹¹ The National Insurance Bill GN 40955 GG 627 (30 June 2017), 16.

²¹² B Varkey ‘Principles of clinical ethics and their application to practice’ (2021) 30(17) *Med Princ Pract* 20

²¹³ J Olejarczyk and M Young ‘Patient rights and ethics’ *Stat Pearls* (5 May 2022), available at <https://www.ncbi.nlm.nih.gov/books/NBK538279/>, [Accessed 14 May 2022].

²¹⁴ This is reflected on page 20 of the National Insurance Bill GN 40955 GG 627 (30 June 2017), 29.

²¹⁵ R Gillon ‘Medical ethics: four principles plus attention to scope’ (1994) 309 *BMJ* 189.

²¹⁶ *Idem*.

professionals must be prepared to face them. In essence, legal justice requires healthcare be aware of the potential conflict which their conduct may have with established laws.²¹⁷ It therefore means that they must have proper understanding of the various laws which may have an impact on the provision of healthcare.²¹⁸

Another important aspect of justice is rights justice. This form of justice refers to the medical professional's obligation to respect the rights of his or her patient. A right is an entitlement to something which is valuable to the holder of the rights. When a patient is being treated or consulted by a medical professional, a patient is entitled to have his or her rights to be respected. The NHA lists some of these rights and these include:²¹⁹

- a) Emergency treatment.
- b) Full knowledge of health status, diagnostic procedures and treatment options as well as be informed of the right to refuse treatment.
- c) Informed consent.
- d) Participation in decisions which affect the patient's personal health and treatment.
- e) Confidentiality.
- f) Protection of health records.
- g) Discharge report.

A health practitioner has an obligation to treat a patient in a manner that is consistent with their rights. Gillon makes the example that a doctor has the obligation to provide a patient with a sicknote even if the patient's irresponsible lifestyle led them to being sick.²²⁰ Health practitioners need to be aware of the rights of patients and their responsibilities towards these rights.

The principles of bioethics provide useful guidance for medical professionals to use when engaging with patients. These principles ensure that they act ethically and that their conduct is justified.²²¹

²¹⁷ 'What are the basic principles of medical ethics?' *Medical Ethics* 101, available at <https://web.stanford.edu/class/siw198q/websites/reprotech/New%20Ways%20of%20Making%20Babies/EthicVoc.htm>, [Accessed 22 April 2022].

²¹⁸ K Moodley *Medical Ethics, Law and Human Rights: A South African Perspective* 2nd ed (2017) Chapter 6.

²¹⁹ The National Health Act 61 of 2003, Chapter 2.

²²⁰ R Gillon 'Medical ethics: four principles plus attention to scope' (1994) 309 *BMJ* 186.

²²¹ W Freedman 'May doctors for religious reasons refuse to give patients blood transfusions under any circumstance?

3.3 THE HEALTH PROFESSIONS COUNCIL OF SOUTH AFRICA: ETHICAL GUIDELINES FOR GOOD PRACTICE

The principles of bioethics provide useful guidance for medical professionals to use when engaging with patients. These principles ensure that they act ethically and that their conduct is justified.²²² Although the principles are universally accepted, South Africa has amplified them by creating its own sets of ethical codes. In addition to those outlined in the previous discussion, the HPCSA has added a number of core ethical values and standards to which medical practitioners should abide by. The set of standards and ethical values include:

- a) Truthfulness: health practitioners' professional relationship with clients should be based on truth telling.
- b) Confidentiality: Unless therapeutic privilege applies, health practitioners should keep the patient's personal or private information confidential.
- c) Integrity: the character of health professionals should be based on these ethical values and standards.
- d) Compassion: health professionals should be sensitive to, and empathise with, the individual and social needs of their patients. Where it is appropriate to do so, they should provide support and care.
- e) Community: health professionals should strive to use their professional abilities to provide a valuable contribution to their communities.
- f) Self-improvement and competence: health professionals should ensure that they are always engaging with various trainings to ensure that their level of skills and knowledge is up to date with the best practice.
- g) Tolerance: it is required that health professionals will respect the various beliefs that patients may have owing to their personal, cultural or religious convictions.
- h) autonomy, justice, non-maleficence, beneficence: these have been discussed.

What appears from these ethical values and standards is that they are an amplified version of the four pillars of bioethics. Their amplification allows medical professional to know exactly what is required from them. What also appears from the various ethical codes which the HPCSA has adopted is that some of them cater for the South African context. It is known that in the African context, communitarianism is very important, it is a way of life. This way

(2019) 82 *THRHR* 481.

²²² *Idem*.

of life is expressed in the maxim of ubuntu 'Umuntu ngumuntu ngabantu' which essentially means that a person exists because the community exists.²²³ As an ethical consideration, ubuntu encompasses, group solidarity, compassion, justice, respect and survival.²²⁴ In the context of health care, ubuntu means that a medical professional must participate in the life of his patients not just in the operating theatre but also by striving towards making a positive contribution to their community. This is in line with the ethical principle of community as expressed in the HPSCA guidelines. The principle of ensuring that there is a contribution to the community is bolstered by the fact that the Health Professions Act²²⁵ requires medical professionals who are registered with the HPSCA to do remunerated community service for a period of 12 months.²²⁶ The search suggests that ubuntu should have been expressly stated as a core principle.

Furthermore, South African courts have pronounced on what the principle of tolerance means. In *Ryland v Edros*,²²⁷ the court expressed that the value of (equality and) tolerance of diversity and the understanding of the plurality of our society is one which underpins our Constitution.²²⁸ Although the case dealt with proprietary obligations that flow from Muslim marriages, the case explains the importance of this value in our society.

Health professionals who are registered with the HPCSA must adhere to these values and principles. The HPCSA uses these values to enhance the quality of the provision of health in the country. In doing so, it has created a set of guidelines to help medical professionals to need to refer to. The guidelines 'reflect the spirit of medical professionalism' by making reference to core ethical values and standards for good practice as well as ethical reasoning and general ethical duties.²²⁹ The research makes reference to some of the booklets which are provided by the HPCSA. The booklets which are discussed are those which are in keeping with the general theme of the research which relates to informed consent, confidentiality and keeping safe records."

²²³ JY Mojoro 'Ubuntu and the law in South Africa' (1998) 4 *PELJ* 15.

²²⁴ L Mbigi *Ubuntu: The African Dream in Management* (1997) 110.

²²⁵ Health Professions Act 56 of 1974.

²²⁶ *Idem*, section 24A.

²²⁷ *Ryland v Edros* 1997 (2) SA 690 (C).

²²⁸ *Idem*, at 709.

²²⁹ 'HPCSA: Ethical guidelines for good practice in the health care professions'.

a) Booklet 1: *General ethical guidelines for the health care professionals*

- The booklet is the first one in the series and it provides groundwork for the other books. It provides the core ethical values and standards that health professionals must abide by.
- It provides for the duties to patients, colleagues, society, health care profession and the environment.
- Importantly it sets out a procedure for resolving ethical dilemmas: it requires that health professionals use ethical reasoning which can be achieved in four steps:

Analysing ethical issues

Step 1. *Formulate the problem:* Determine whether the issue at hand is an ethical one, then ascertain if there is a better way of understanding it.

Step 2. *Gather information:* All the relevant information, including clinical, personal and social data, must be collected.

Step 3. *Consult authoritative sources:* Sources such as the HPCSA guidelines, practitioner associations and respected colleagues should be consulted. Check how practitioners generally deal with such matters.

Step 4. *Consider the different options:* Consider alternative solutions in light of the principles and values they uphold.

Step 5. *Make a moral assessment:* The ethical content of each option should be weighed by asking the following questions:

- (a) What are the likely consequences of each option?
- (b) What are the most important values, duties and rights involved? Which weighs the heaviest?
- (c) What are the weaknesses of the practitioner's individual view concerning the correct option?
- (d) How would the practitioner want to be treated under similar circumstances – that is, apply the Golden Rule?
- (e) How does the practitioner think that the patient would want to be treated in the particular circumstances?
- (f) Discuss your proposed solution with those whom it will affect.
- (g) Act on your decision with sensitivity to others affected.
- (h) Evaluate your decision and be prepared to act differently in the future.

Figure 1: ANALYSING ETHICAL ISSUES

b) Booklet 2: *Ethical and professional rules of the Health Professions Council of South Africa as promulgated in government gazette R717/2006*

- The booklet provides a set of rules regarding the professional conduct of health practitioners. It also provides that complaints against health practitioners will be evaluated against these rules.

c) Booklet 3: *National Patients' Right Charter*

- Both the Department of Health and health practitioners are required to refer to this booklet which aims to ensure that the right to access to health is realized. The Patient's Rights Charter provides a standard for achieving the realization of this right. These have already been discussed in the previous headings.

d) Booklet 4: *Seeking patient's informed consent: The ethical considerations*

- The purpose of this booklet is to provide what is expected from a health practitioner when attempting to obtain a patient's informed consent.

e) Booklet 5: *Confidentiality: Protecting and providing information*

- The guidelines provided in this booklet are meant to ensure that the information which is obtained while consulting a patient is kept confidential and is only disclosed for the purpose ensuring that the patients' rights to access to health is given effect to.

f) Booklet 6: *Guidelines for the management of patients with HIV infections or AIDS*

- Although this guideline provides special attention to HIV and Aids, however, the guidelines are also relevant to other communicable diseases and to those which have similar burdens of discrimination and stigma.
- The booklet provides information on the responsibility of patients to patients infected with HIV. It also provides guidance on occupational transmission of HIV, compensation and insurance.
- Among other things, it also gives a guidance to health practitioners on how they can encourage patients to disclose their status to their partners.

g) Booklet 7: *Guidelines on withholding and withdrawing treatment*

- This booklet defines practical procedures which health care professionals should follow when they have to withhold or withdraw treatment. It also provides that a health establishment may limit access to life-sustaining

interventions in cases that meet the national agreed criteria for admonition to these specialized units or interventions.

h) Booklet 8: *Guidelines on Reproductive Health Management*

- The Constitution unequivocally states that everyone has the right to access to reproductive health care.²³⁰ By doing so, the Constitution underscores the importance of good practice on reproductive health. The booklet serves as a guide for medical practitioners on how to approach reproductive health to ensure that woman have the best chance of having a health infant.
- The booklet establishes that medical practitioners should see themselves as advocates for women's health care. According to the booklet, being an advocate is an ethical duty of medical practitioners. There are a number of attended responsibilities that medical practitioners should be aware of which arise from their role such as:
 - o Ensuring intimate examinations are done in an appropriate manner.
 - o Assisting as best as they can in matters involving domestic violence and violence against women.
 - o The guide to reproductive health management provides for specific ethical considerations in sterilizations. It is important for practitioners to familiarize themselves with guidelines as the process has lasting implication not just for those requesting it but for others around them as well. It reminds medical practitioners that sterilization may give rise to certain biases arising from personal values and it thus provides for best practice in such cases. The importance of approaching the procedure in an appropriate manner is highlighted by Strode who has written about the heavy impacts of forced sterilizations on women.²³¹ One thing to be highlighted is that there is no minimum or maximum number of children which may be used as a criteria for access to the procedure and no one must be forced into it.

²³⁰ The Constitution, section 27(1)(a).

²³¹ A Strode and Z Essack 'I feel like half a woman all the time': The impact of coerced and forced sterilizations on HIV-positive woman in South Africa.' (2012) 20(39) *PMID* 61.

- The guide also provides some guidelines on termination of pregnancy which also encompasses ethical conflicts. Much of the discussion on this topic has been alluded to in the previous discussion on the Termination of Pregnancy Act.

i) Booklet 9: *Guidelines on patient records*.

- This guideline describes what constitutes a health record and why such information should be retained. It also speaks to how long health records should be kept for and who and in what instances may held records be accessed.
- Importantly, the guidelines provide a checklist for record-keeping which will allow the medical practitioner to that patient's records are kept in manner which aligns with their rights.

3. 4 SOUTH AFRICAN MEDICAL ASSOCIATION

It must be noted that the HPCSA is not the only custodian of morals or ethical conduct in South Africa. Health practitioners must refer to the South African Medical Association (SAMA) for ethical guidance. Medical professionals need to have due regard to the various ethical guidelines which are provided by SAMA. In most instances, the guiding documents provide practical steps to ensuring that medical professionals do not break ethical rules. Below is a discussion of some of these guidelines:

a) *Guideline for medical practitioners taking blood samples in drunken driving cases:*

- In terms of section 37(2) of the Criminal Procedure Act, a medical practitioner may be required to take blood samples in certain situations.
- Practitioners should receive a written request for examination of the person who has been arrested.
- Practitioners should attempt to obtain consent of the person if it is possible do so.
- Practitioners should understand that the arrested person is entitled to legal advice or to be examined by his own doctor but the detail in getting the same

should not be more than two hours.

- Practitioners should ascertain and record in writing that the arrested person is being examined because of alcohol consumption.

b) *Guidelines on maintaining patient confidentiality in wards*

- This guideline provides a discussion of the challenges which medical professionals may face when maintaining patient confidentiality. Among others it requires that:
 - Greeting the patient.
 - Getting informed consent.
 - Speaking in a tone that will ensure that the discussion is not heard by others.
 - Curtains around the bed of the patient must be closed.
 - Patient's file to be filled near the patient not anywhere else where confidentiality may be compromised.
 - Practitioners are not to discuss the patient's treatment or health status with another practitioner in elevators or in similar situations. This is particularly important as it seems that not all practitioners are aware of this. In the landmark case of *Jansen van Vuuren v Kruger*,²³² the HIV status of a patient was disclosed by a medical practitioner to a colleague. The disclosure had occurred the two practitioners were playing a game of golf. The court held that the confidentiality should always be honored. It found that respecting a patient's right not to have their information disclosed to others is important in order to protect their right to privacy and to ensure trust in the doctor-patient relationship. It found that there was no justifiable disclosure of the information and nor did the other practitioner have a duty to receive the information. Finally, it held that the patient has a right to expect compliance by health practitioner of his ethical duty.
- The guideline also discusses how to obtain informed consent for minors who

²³² *Jansen van Vuuren v Kruger* 1993 (4) SA 842 (AD).

are under 12 or those who lack maturity. Procedures and requirements when obtaining consent of minors has already been discussed. However, it seems that the guideline has made an error as the heading is about confidentiality whereas the discussion is about informed consent.

c) *Rights and responsibilities of doctors and patients*

- The guidelines reflect on the various rights which are provided for in the Constitution and which have a bearing on the treatment of patients. Some of these are listed below:
 - A right to equal treatment and benefit of the law including provisions relating to medical care, medical schemes.
 - Non to be unfairly discriminated against.
 - To have his or her life protected by means of the benefits of treatment.
 - To be free from cruel or degrading treatment. To be free from being subjected to medical experiments without consent.
 - To have privacy protected.
 - To have their beliefs, religion and opinion to be respected by doctors.
 - To petition or demonstrate in relation to health care issues.
 - To be subjected to medical treatment by suitably qualified medical practitioners.
 - To have access to health care including a second opinion.
 - To obtain copies of their health information.

3.5 CONCLUSION

The principles of bioethics provide useful guidance for medical professionals to use when engaging with patients. These principles ensure that they act ethically and that their conduct is justified.²³³

What appears from these ethical values and standards is that they are an amplified version

²³³ W Freedman 'May doctors for religious reasons refuse to give patients blood transfusions under any circumstance?' (2019) 82 *THRHR* 481.

of the four pillars of bioethics. Their amplification allows medical professional to know exactly what is required from them in medical practice. The lack of proper application of bioethics principles leads to medical negligence. Medical ethicists use these four principles in determining whether their actions are morally or motivationally ethical or not.

CHAPTER FOUR:

CAUSES AND DEFENCES OF MEDICAL NEGLIGENCE

4.1 INTRODUCTION

The previous two chapters delved into the various legal and ethical considerations that arise during the provision of healthcare services. The chapters looked at the responsibilities of healthcare practitioners that result from the right to access to health as provided for in the Constitution and legislations. In doing so, the discussion focused on the different ways in which the health sector can make sure that the right to access to health is protected and it showed that to do this the law requires respect for the confidentiality of patients; obtaining informed consent and providing the patient with full knowledge of their health status. It was also revealed that while providing healthcare, several ethical dilemmas may arise which cannot be solved by looking at the law. The reasons for this is that the law ‘moves more slowly than either medical or public mores.’²³⁴ In such instances the medical professional may rely on the balancing of medical ethics in order to justify a cause of action.

Despite medical practitioners being able to rely on the law and principles of ethics there is still an increase in medical negligence cases.²³⁵ The thrust of this chapter is to argue that part of this increase is because of ignorance of the law and of these ethical principles. This is the reason why the previous chapters spoke to the various provisions and principles which doctors need to know in order to minimize the extent of medical negligence. There seems to be a lack of professionalism among medical practitioners, and this is due to their failure to have good understanding and knowledge of the different provisions that apply to them and ethical guidelines which they are meant to rely on in order to ensure good professional practice. As stated by McQuoid-Mason, to maintain good professional practice one must be grounded in core ethical values and standards.²³⁶ Furthermore, as reflected in the previous chapters, a medical practitioner may be required to update their skills and knowledge and keep abreast of changing emerging approaches to medicine and case laws.

²³⁴ T Laurie, S Harmon and G Porter *Mason & MaCall Smith Law and Medical Ethics* 10th ed (2016) 18.

²³⁵ S Pepper and M Slabbert ‘Is South Africa on the verge of a medical malpractice litigation storm?’ (2011) 4 *SAJBL* 29.

²³⁶ Bioethics, human rights and Health Law.

The chapter will look at possible defences for medical practitioners who find themselves on the wrong side of what is expected from them.

4.2 MEDICAL NEGLIGENCE AND WHY IT HAPPENS

It is recognised that just like in any other complex system which involves humans, errors will also occur in the provision of healthcare.²³⁷ However, it is expected that those who practice medicine will sufficiently inform themselves of good practices in order to ensure that harm is minimized or is avoided. At the back of a substantial increase in medical negligence claims, it is questioned as to whether medical practitioners have taken all the necessary steps to inform themselves and to apply professional competence.

There is no discord among commentators on the idea that medical negligence cases are on the rise. Pienaar makes the point that there has been an increase in both the value and the number of claims in South Africa.²³⁸ To illustrate the effect of this, he writes that it costs obstetricians about R330 000 a year just to be insured against claims.²³⁹ Another prominent writer is of the view that South Africa is on the brink of a medical malpractice litigation storm.²⁴⁰ The Department of Health has also accepted that there is cause for concern. Former Minister of Health, Dr Aaron Motsoaledi expressed during an address at a Medico Legal Summit, that medico-legal litigation had reached a crisis of epic proportions.²⁴¹ These claims are supported by empirical evidence. In a discussion paper of the South African Law Reform Commission, it was stated that the total value of claims in the country for 2018 and 2019 was at R2 billion rands.²⁴²

There are several reasons why there is such an exponential increase in medical negligence claims. Among others, it is said that the dramatic shift in law that was brought in by the Constitution and patient centered legislation has had a huge part in the increase.²⁴³ According

²³⁷ MS Donaldson 'An overview of *To Err is Human*: Re-emphasizing the message of Patient Safety' in RG Hughes *Patient Safety and Quality: An Evidence-Based Handbook for Nurses* (2008) 2.

²³⁸ L Pienaar 'Investigating the reasons behind the increase in medical negligence claims' 2016 (19) *PELJ* 1.

²³⁹ L Pienaar 'Investigating the reasons behind the increase in medical negligence claims' 2016 (19) *PELJ* 1.

²⁴⁰ S Pepper and M Slabbert 'Is South Africa on the verge of a medical malpractice litigation storm?' (2011) 4 *SAJBL* 29.

²⁴¹ Malherbe J 'Counting the Cost: The Consequences of Increased Medical Malpractice Litigation in South Africa' (2013) *SAMJ* 83.

²⁴² South African Law Reform Commission Discussion Paper 154 'Medico-Legal Claims (October 2021), available at <https://www.justice.gov.za/salrc/dpapers/dp154-prj141-Medico-Legal-Claims.pdf>, 19, [Accessed 20 May 2022].

²⁴³ NV Dokkum 'The evolution of medical malpractice law in South Africa' (1997) 41 *Journal of African Law* 175.

to the South African Law Reform Commission, our constitutional democracy has resulted in increased awareness of rights and thus an upsurge in litigation as patients attempt to give effect to their rights.²⁴⁴ Patients are simply becoming more aware of enforcing their rights. Other reasons which have been sighted include opportunities by lawyers and a decline in professionalism.²⁴⁵ It is this latter aspect which is discussed in greater detail below.

In 2012, the HPCSA created a campaign with the idea of educating patients about their rights should they experience a decline in professionalism. In fact, the campaign was motivated by this decline in professionalism among its healthcare practitioners.²⁴⁶ Furthermore, in the 2012 Medico-Legal Summit, it was highlighted that the increase in claims is due to professional negligence and medical malpractice. The latter is about intentional and negligent acts which causes harm whereas the former is limited to negligent conduct.²⁴⁷ Both professional negligence which is sometimes referred to as medical negligence and medical malpractice often arise because of a failure to follow provisions in the law or provisions in ethical guidelines. In cases of medical malpractice, there is often a failure to obtain informed consent.²⁴⁸ In mitigation, medical malpractice which is due to the failure to get informed consent can be attributed to the shift in medical law from an overly paternalistic approach to the current position which is centered around individual autonomy. Previously, patients were expected to make a choice based on the information which they receive from the medical practitioner if any. The current position requires that the patient be fully informed.²⁴⁹ Giesen states we have moved from paternalism to self-determination to shared decision-making.²⁵⁰ This shift requires that health care practitioners be sufficiently responsive and understanding of the current legal and ethical guidelines dealing with the rights of patients.

Medical practitioners may not be aware of the extent of the information which they must relay to the patient about proposed treatment or an operation. This has been evident in a number of cases. As discussed in the previous chapter, informed consent requires that the

²⁴⁴ South African Law Reform Commission Discussion Paper 154 'Medico-Legal Claims (October 2021), available at <https://www.justice.gov.za/salrc/dpapers/dp154-prj141-Medico-Legal-Claims.pdf>, 19, [Accessed 20 May 2022].

²⁴⁵ L Pienaar 'Investigating the reasons behind the increase in medical negligence claims' (2016) 19 *PELJ* 1.

²⁴⁶ Malherbe J 'Counting the Cost: The Consequences of Increased Medical Malpractice Litigation in South Africa' (2013) *SAMJ* 83.

²⁴⁷ D McQuoid-Mason 'What constitutes medical negligence? A current perspective on negligence versus malpractice.' (2010) 7(4) *SA Hart* 248.

²⁴⁸ SA Strauss 'Doctor, patient and the law: A delicate triangle' (2008) *SA Orthopaedic Journal* 10.

²⁴⁹ NV Dokkum 'The evolution of medical malpractice law in South Africa' (1997) 41 *Journal of African Law* 175.

²⁵⁰ D Giesen 'From paternalism to self-determination to shared decision-making' (1998) *Acta Juridica* 107.

doctor has to warn a patient of all material risks. Furthermore, case law has put specific requirements on what would constitute a material risk. Medical practitioners need to be aware of these. The following examples provide an illustration of what happens when practitioners fail to have due regard of the ethical and legal requirements.

In *Castell v De Greeff*²⁵¹ a patient had successfully sued her plastic surgeon for failing to disclose the risks which were inherent in the procedure.²⁵² *Esterhuizen v Administrator Transvaal*²⁵³ is another example of a case where the healthcare practitioner failed to obtain informed consent. In that case, the court held that mere consent to undergo an X-ray treatment, under the belief that it is innocuous or undergoing it without being aware of the attended risks cannot amount to effective consent to undergo the risk.²⁵⁴ The issue of consent was also raised in the case *Petse v Health Professions Council of South Africa*, where the medical practitioner had been found by the Professional Conduct Committee of the HPCSA to have removed the fallopian tubes of Mr's S without her consent.²⁵⁵

There have also been several claims which have occurred as a result of a breach of a patient's confidentiality. As explained in the previous discussion, confidentiality is a cornerstone of healthcare ethics. It informs the trust on which the doctor-patient relationship depends on. The Hippocratic Oath considers it to be a shameful act to disclose confidential information.²⁵⁶ However, despite this and despite the right to confidentiality appearing either directly or indirectly in the Constitution, health legislation and in the HPCSA, SAMA guidelines, medical practitioners still struggle to apply it successfully. The widely reported case of *Jansen van Vuuren v Kruger*,²⁵⁷ provides a classical example of confidentiality breach. In this case, the HIV status of a patient was disclosed by a medical practitioner to a colleague. The disclosure had occurred between two practitioners who were playing a game of golf. The court held that confidentiality should always be honored.²⁵⁸ It found that respecting a patient's right not to have their information disclosed to others is important in order to protect their right to privacy and to ensure trust in the doctor-patient relationship. The court found

²⁵¹ *Castell v De Greeff* 1994 (4) SA 408 (C).

²⁵² *Castell v De Greeff* 1994 (4) SA 408 (C) para 12.

²⁵³ *Esterhuizen v Administrator, Transvaal* 1957 (3) SA 710 (T).

²⁵⁴ *Esterhuizen v Administrator, Transvaal* 1957 (3) SA 710 (T) at 719.

²⁵⁵ *Petse v Health Professions Council of South Africa* (91234/2020) ZAGPPHC 631 (15 October 2020).

²⁵⁶ O Temkin and CL Temkin *Ancient Medicine: Selected Papers of Ludwig Edelstein* (1967) 6.

²⁵⁷ *Jansen van Vuuren v Kruger* 1993 (4) SA 842 (AD).

²⁵⁸ *Jansen van Vuuren v Kruger* 1993 (4) SA 842 (AD) para 40.

that there was no justifiable disclosure of the information and nor did the other practitioner have a duty to receive the information. Finally, it held that the patient has a right to expect compliance by a health practitioner of his ethical duty.²⁵⁹

In some instances, medical negligence results from a failure by the attending physician to apply sufficient skill, care and experience. This form of negligence usually arises in relation to cases that involve surgery. An example of such a case is that of *Van den Berg v MEC for Health, North West*.²⁶⁰ In this recent case, the court was asked to award the plaintiff damages which he sustained when he had a hip replacement surgery done on him. Experts of both parties agreed that the members of the defendant were negligence in the treatment of the plaintiff in that they failed to diagnose and correct the badly inserted femoral neck into the hip.²⁶¹

Other types of medical negligence cases include among others:²⁶²

- a) Wrongful diagnoses
- b) Incompetent anesthesia;
- c) Incompetent procedures;
- d) 'baby-swaps' in maternity wards; delay in providing treatment;
- e) Failed abortions;
- f) Failure to warn a pregnant woman about the risk of having a defective child;
- g) Overdose of medicine;
- h) Wrongful blood transfusions;

What the discussion of the cases above reveals is that the rise of medical negligence claims can be attributed (in part) to unprofessional conduct on the part of the treating medical practitioner. As Carsten and Pearmain write that 'an accusation of medical negligence is ultimately and inevitably an accusation of unprofessional conduct.'²⁶³ The discussion relieved that medical negligence may arise because of a failure to follow professional code of conduct as set out in the law and or in the various ethical guidelines provided. Medical practitioners

²⁵⁹ *Jansen van Vuuren v Kruger* 1993 (4) SA 842 (AD) para 38.

²⁶⁰ *Van den Berg v MEC for Health, North West*, Unreported, [2020] ZANWHC 50, 17 September 2020, available online at <http://www.saflii.org/za/cases/ZANWHC/2020/50html>, [Accessed 24 May 2022].

²⁶¹ *Van den Berg v MEC for Health, North West*, Unreported, [2020] ZANWHC 50, 17 September 2020, available online at <http://www.saflii.org/za/cases/ZANWHC/2020/50html>, para 5.9[Accessed 24 May 2022].

²⁶² *Bioethics, Human Rights and Health Law: Principles and Practice* 2nd ed 128.

²⁶³ P Carstens and D Pearman *Foundational Principles of South African Medical Law* (2007) 681.

need to be kept abreast of the legal and ethical requirements for securing informed consent, maintaining confidentiality and where possible to update their skills and knowledge to meet best practices. The following sentiments of Leslie London aptly conclude the point of this discussion:

‘Healthcare providers have many opportunities to facilitate the realization of the right to health. Whether in terms of documenting and, if necessary, providing testimony for those whose rights have been violated or improving the quality and accessibility of healthcare services, health workers can support the attainment of the full range of health rights [and avoid litigation]. By becoming aware of the provisions in the South African Constitution, in international human rights legislations as well as in ethical codes of conduct.’²⁶⁴

4.3 THE GOOD SAMARITAN

The ‘good Samaritan’ is an ideal of Christian ethics.²⁶⁵ It represents a moral demand to help others. Although its foundation can be traced back to a parable by Jesus, the idea behind the ethical principle bears relevance in everyday life and especially in medical care. Its use in the delivery of health care ranges from the idea that healthcare practitioners should provide care for those who are unable to pay for it provided it is an emergency.²⁶⁶ It may also be used to refer to a duty on governments to provide basic health care for all its citizens.²⁶⁷ However, in this discussion, the ethics of the ‘good Samaritan’ is restricted to whether there is a moral duty to provide care when there is no doctor-patient relationship.

Up until this point, the research has discussed the legal and ethical provisions that arise from a contract between a medical professional and a health user. A discussion of the applicable principles arising from a situation where there is no doctor-patient relationship is important as medical professionals are increasingly finding themselves in such situations. In brief, the research will outline the applicable law and suggest ways in which the medical professional may act in these situations. The research also suggests law reform.

²⁶⁴ Leslie London ‘Human Rights: The Relevance for South African Health Professionals’ in K Moodley *Medical Ethics, Law and Human Rights: A South African Perspective* 2nd ed (2017) Chapter 6

²⁶⁵ R Zimmermann ‘The etho-poetic of the parable of the good Samaritan (Lk 10:25-37): The ethics of seeing in a culture of looking the other way’ (2008) 29 *Verbum ET Ecclesia* 270.

²⁶⁶ N Jecker ‘Contemporary ethics of care’ in S Post (ed) *Encyclopedia of Bioethics* 3rd ed (2004) 372.

²⁶⁷ N Jecker ‘Contemporary ethics of care’ in S Post (ed) *Encyclopedia of Bioethics* 3rd ed (2004) 372.

In South African law, there is currently no duty on a reasonable man or professional to behave as a good Samaritan.²⁶⁸ The reason for this principle is that if we require such persons to have this duty, then it will place a heavy burden on individuals and the community.²⁶⁹ However, the law does recognise that in certain circumstances, there may be a duty which is incumbent on a person to act positively to prevent loss. This is often referred to as a legal duty to act. A person has a duty to act if there is a statutory provision which requires that person to do so. A legal duty to act may also arise from one's own negligence conduct, in such a case a doctor will be required to act to prevent further loss. In *CF Coronation Brick (Pty) Ltd v Strachan Construction Co (Pty) Ltd*,²⁷⁰ the court explained that a reasonable person would realise that he is obliged to regulate his conduct so as to prevent loss which he foresees as a likely result of his actions.²⁷¹

Although there is no principle or law that states that there is a legal duty that exists on the part of a medical professional, however, they must be mindful that a determination of such will depend on the ever-changing legal convictions of the community. This means that a medical practitioner may be deemed to have had a legal duty to attend to a patient outside of a doctor-patient relationship. Saner explains the law's approach by stating the following:

‘... to convert the failure of a doctor to render treatment into an actionable wrong, the court must decide that policy considerations point to an existing duty and consequently to the liability of the defendant. Liability will result when the legal convictions of society regard the conduct (failure to act) as unlawful’²⁷²

The net result of the statement is that depending on the circumstances of the failure to act, the court will have to determine whether the medical professional was in fact required to act. There are a number of considerations which professionals should be aware of which may indicate that in those particular circumstances they had a legal duty to act. The court will also look at both available policy considerations and laws in coming to a determination.

²⁶⁸ *Minister van Polisie v Ewels* 1975 (3) SA 590 (A) at 586H.

²⁶⁹ P Boberg *The Law of Delict Vol 1: Aquilian Liability* (1984) 55.

²⁷⁰ *Cf Coronation Brick (Pty) Ltd v Strachan Construction Co (Pty) Ltd* 1982 (4) SA 317 (N).

²⁷¹ *Cf Coronation Brick (Pty) Ltd v Strachan Construction Co (Pty) Ltd* 1982 (4) SA 317 (N).

²⁷² J Saner *Medical Malpractice in South Africa* (2021) 4-2.

The Constitution and the HPCSA general ethical guideline place a duty on healthcare practitioners to provide emergency treatment in appropriate circumstances.²⁷³ The right to health is also considered to be a fundamental human right. In the same breath, humans regard health as an essential asset which is fundamental in ensuring that we live a dignified life.²⁷⁴ From this it seems that the right to access to health is vital to life as we know it and it is further heightened in cases of emergency treatment. Thus, it is argued that in cases where there is an emergency, a medical professional may be required to assist if he or she has the required competence.²⁷⁵

The duty to assist may be heightened by the fact that the person requiring medical treatment is at the consulting room of a private doctor. The community sense of justice would frown upon a medical professional who does not come to the aid of such a patient even if it is just to put them in a stable condition. Carstens submits that there would be different considerations if the medical professional was required to assist while he or she is away on holiday.²⁷⁶ It is argued in this research that the reason why such a doctor may not be regarded as having a duty to act is because his right to liberty, to be left alone would prove to be insurmountable in such cases. Requiring a medical professional to act in such a situation would place too heavy a burden on him and it would be intruding on freedom to act. However, it must be noted that the legal convictions of the community are ever changing and that it may be such that in future a medical professional may be required to act in all instances.

The researcher suggests that the law must be changed to reflect this. It must provide that medical professionals have a duty to assist a person who requires emergency medical treatment even if they are on holiday. However, the law should also provide safety net measures for such persons. The reason for this is that, where a doctor intervenes to provide assistance, he or she will not be protected against a claim for damages should the same arise. The chances of there being negligence are greater in instances where the medical professional is not in the consulting room. The only time, a medical practitioner should face a lawsuit in such cases is when there is gross negligence on his or her part.

²⁷³ The Constitution of Republic in South Africa, 1993, section 27(3).

²⁷⁴ 'The Right to Health' *Office of the United Nations High Commissioner for Human Rights* 1.

²⁷⁵ J Saner *Medical Malpractice in South Africa* (2021) 4-5.

²⁷⁶ P Carstens and D Pearmain *Foundational Principles of South African Medical Law* (2007) 324.

4.4 GROUNDS OF JUSTIFICATION

Just because the patient feels aggrieved by the care and treatment they received; this does not necessarily mean that the claim for medical negligence will succeed. A medical practitioner may raise grounds of justification to defend himself against liability even if harm has been caused. The following discussion will represent some of the traditional grounds which may be raised in most instances. However, the ground raised will need to be context specific.

In the previous chapters it was highlighted that a failure to follow due care and skill may result in the infringement of rights to bodily integrity, or privacy which is protected in terms of the common law. As such a medical practitioner may attempt to refute the wrongfulness of his action by stating that there was a lawful reasoning for the harm caused. One such ground is consent. In *Castell v De Greeff* it was held that a medical procedure which is done without informed consent would amount to assault.²⁷⁷ It is also negligence to do a procedure without the required consent.²⁷⁸ It is negligent in that the practitioner would have failed to act with due care and skill. However, as discussed previously, the consent must be informed. *Castell v De Greeff* held that in consent would only constitute a justification which excludes unlawfulness if the medical practitioner warns the patient of the material risk of the proposed treatment.²⁷⁹ Consent is essentially a 'legal act that restricts the injured person's right.'²⁸⁰ The requirements for informed consent have already been discussed.

Another ground of justification which may be used is that of necessity. Necessity justifies the conduct of a person who act a particular way in order to protect the interest of others or to protect his own interest. In order for necessity to work, the interest which is to be protected must be endangered by a threat of harm.²⁸¹ Further requirements are such that the threat must have commenced or must have been imminent and there must be no other way of averting it. In the medical context, necessity would only work in the case of a medical emergency.²⁸² The reason why necessity only works in a medical emergency is because the patient must be

²⁷⁷ *Castel v De Greeff* 1994 (4) SA 408 (C) 409.

²⁷⁸ 'Consent in South African Medical Law' *Lyons & Brivik Inc* (14 May 2015), available at <https://www.lyonsbriviklaw.com/article/medical-law/>, [Accessed 31 May 2022].

²⁷⁹ *Castell v De Greeff* 1994 (4) SA 408 (C) at 409.

²⁸⁰ J Neethling *The Law of Delict* (2020) 130.

²⁸¹ P Carstens and D Pearmain *Foundational Principles of South African Medical Law* (2007) 666.

²⁸² *Cf Philips v De Klerk* 1983 (T).

incapable of consenting and getting consent in the particular case from next of kin or relevant authorities would amount to a delay which would put the life of the patient in jeopardy. An example of where the defence of necessity would work is where a surgeon operates on an unconscious patient. His or her action which would otherwise be seen as an assault would be justified based on necessity.²⁸³ A medical practitioner would be acting to avert the imminent harm to the patient. The defence of necessity can only be successfully applied when: there is an emergency; the patient must be unaware of the medical intervention or be incapable of consenting; the medical intervention must not be expressly prohibited by the patient through things such as an advanced will and it must be in the best interest of the patient.²⁸⁴

While a number of other grounds of justification exist, there one which is most relevant to medical practice is that of an error of professional judgment. This defence may only be raised if the medical practitioner had made a reasonable error of professional judgment that another reasonable competent physician in the same circumstances would have made.²⁸⁵ What it means is that the physician was simply using his best judgment and that the outcome was just a matter of probability.²⁸⁶ This defence was first considered in 1989 where the court in *Pike v Honsinger* held that a medical practitioner would not be 'liable for a mere error of judgement, provided he does what he thinks is best after careful examination.'²⁸⁷ This is a powerful defence which is under used in South African.²⁸⁸ It may prove very useful if medical practitioners were to be aware of it. The error of professional judgment defence works by

Within necessity, a medical practitioner may also rely on therapeutic privilege. This defence allows a medical practitioner to not reveal certain information regarding the health status of a patient so as to protect the patient.²⁸⁹ Rubin states that the most common justifications for not disclosing information would be in cases where it would lead to incapacitating emotional distress.²⁹⁰ However, there are certain things that the medical professional must be aware of

²⁸³ B Bal and L Brenner 'The judgment defense in medical malpractice' (2013) 471(11) *Clin Orthop Relat Res* 3405.

²⁸⁴ CR Steyn 'Liability for misdiagnosis and negligent therapy in psychiatry' (2005) 30(2) *Journal of Juridical Science* 105.

²⁸⁵ P Carstens and D Pearmain *Foundational Principles of South African Medical Law* (2007) 1000.

²⁸⁶ B Bal and L Brenner 'The judgment defense in medical malpractice' (2013) 471(11) 3405.

²⁸⁷ *Pike v Honsinger* 155 N.Y 201.

²⁸⁸ P Carstens and D Pearmain *Foundational Principles of South African Medical Law* (2007) 1000.

²⁸⁹ R Thomas 'Where to from *Castell v de Greef*? Lessons from recent developments in South Africa and abroad regarding consent to treatment and the standard of disclosure' (2007) *SALJ* 208.

²⁹⁰ EB Rubin 'Professional conduct and misconduct' in *Handbook of Clinical Neurology* (2013) 103.

in order to ensure that when they raise it as a defence it is successful. According to Van den Heever, they should;

- (a) do clinical assessment of the psychological status of the patient.
- (b) should provide information of a general nature in a manner companionate way to see if the patient is emotionally ready to receive such information.
- (c) document the clinical assessment.²⁹¹

4.5 CONCLUSION

This chapter has provided insight into the causes of medical negligence claims South Africa. It has observed that medical negligence claims are on the rise because there is unprofessional conduct from medical professionals. There is a failure to follow legal and ethical principles which are necessary for good practice. Although this has been disputed by certain authors, however, the HPCSA itself has acknowledged the same. Cases which were referred to in this chapter also provide empirical evidence of this failure by medical practitioners.

The chapter has also discussed the principle of a 'good Samaritan'. It has shown that medical practitioners may find themselves being called upon to assist people in instances where there is no doctor-patient relationship. This is yet another ethical dilemma which requires close attention. The chapter discussed how the court would determine a medical practitioner should have assisted in the particular situation. It has been shown that it is not necessarily safe for medical practitioner to simply fold their arms. The duty to act will be inferred from the facts as well as from a consideration of policy. It seems that on the side of policy, South Africa is leaning towards making it unlawful for medical practitioners not to assist those who are not in their care, especially in circumstances where there is an emergency. This can be inferred from the many patients centered legislations. The research has suggested that in order to avoid medical practitioners finding themselves in an ethical dilemma of whether to help or not considering that, if they are negligence, they may face lawsuit. The research has suggested medical professionals who assists in such situations should be protected from prosecution, save for instances of gross negligence.

²⁹¹ P van den Heever 'Pleading the defence of therapeutic privilege' (2005) 95 *SAMJ* 421.

The research further accepted that just because there is a claim for damages, it does not mean that the medical practitioner was negligence. There is thus a need for them to be aware of the various grounds of justifications which relate to medical care. Knowing such grounds will help medical practitioner to act in a manner which they will be able to justify.

CHAPTER FIVE: CONCLUSION AND RECOMMENDATIONS

5.1 INTRODUCTION

There seems to be an evolution of medical malpractice in South Africa. The country seems to be moving towards a patient centered legislative approach. This can be seen from the enactment of the Constitution and the National Health Act which provide for a number of rights of patients which must be respected. The idea behind this legislation is not only to give effect to the right of citizens to have access to health, but it also is a way of ensuring that rights such as the right to privacy, autonomy and bodily integrity are not infringed. In its attempts to ensure that the rights of patients are respected, the South African government has also enacted the Health Professions Act. This Act allows for the creating of the Health Professions Council of South Africa which sets a number of ethical standards and values which must be adhered to in professional practice. The idea behind these is to ensure that medical professionals provide the best care and skill when providing medical practice.

However, despite the many measures in place to protect the rights of patients, there seems to be a rise in medical negligence claims. A number of reasons have been proffered to explain the increases. The research focused on the fact that there seems to be a failure to follow the various legislative and ethical provisions which are provided. The evidence of this is in the cases which have been decided. From the cases, it is observed that part of the reason for the rise is that medical practitioners are not following the rules that aim to give effect to the rights of patients. Such rules include obtaining patient confidentiality, informed consent and safe keeping of medical records. Medical practitioners need to be aware that there is a change in approach to medical practice from a purely paternalistic approach to one which aims to give effect to individual autonomy. This means that decisions relating to the patients have to be taken with the patient. Although it is the medical practitioner who provides medical care, however, it is the patient who is driving how that medical care should be provided.

5.2 RECOMMENDATIONS

Health care professionals are responsible for the delivery of health care. Accordingly, an

understanding of the law, the legal system and the various ethical guidelines is necessary for the provisions of safe and competent patient care. Such understanding will enable health professionals to engage in informed decision making about health provisions and service delivery thereby avoiding an increase in medical negligence claims.

Below is a list of the more specific recommendations that arise from this research:

A) Due care and skill

In medical practice there is no guarantee given by any medical practitioner that the patient would be cured. However, the medical practitioner should, according to the common law guarantee that he or she will apply all the necessary skills and competences that a reasonable medical practitioner in the medical community would have applied. That may not be the highest skill. It is thus required that medical practitioners update themselves in terms of training whenever possible.

B) Respect for patient autonomy

The right to autonomy means the right to refuse treatment. The right of autonomy also means that any decision that is taken by medical practitioners should be taken with the patient. This requires that the medical practitioner obtains informed consent from the patient. Informed consent is discussed below. Medical practitioners need to be aware that the medical fraternity is moving towards an a patient centered approach which aims to give effect to a patient's rights to autonomy.

C) Proper record keeping

Public hospitals should adopt an electronic data management system, as this system will help with a defence to litigation. It will integrate all related cases in a much more coordinated and comprehensive manner, ensuring doctors have ease of access to patient information prior to continuing with medical care. This will ensure fewer cases of negligence, as doctors will be aware of the condition of the patient including any susceptibilities.

D) Informed consent

Medical professionals must warn patients about the risks at every step and the same has been documented. The patient has the right to be informed about the treatment options so that he or she can be an informed participant in decision-making regarding treatment. The medical professional must inform the patient about every risk which is material while keeping in mind that he or she has a right to therapeutic privilege.

5.3 CONCLUSION

There has been an increase in medical negligence litigation in the country, both in value and in the number of claims. Health departments, establishments and professionals are facing the financial burden of these increases. The study offers an examination of the legislation and ethical guidelines that govern medical practice. It further elaborates through case law and research what the law and guidelines mean and what they require during the provision of health care.

The research argues that the rise in litigation is caused, among others, by the failure to follow appropriate procedure and guidelines when obtaining informed consent, maintaining patient confidentiality and when providing care. Consequently, the research highlights the importance of having good knowledge and understanding of the law and the relevant ethical and practical guidelines as provided for by the Health Professions Council of South Africa and the four pillars of bioethics. When medical professionals follow the guidelines, they will be able to justify their actions and will be able to avoid claims of medical negligence. This is because ethical guidelines give medical professionals an established framework of values which serve as a reference point from which they can determine which course of action is most justifiable in the circumstances. Furthermore, medical professionals must realise that the law is not just for lawyers. Being aware of the provisions that regulate the provision of healthcare will enable them to act in a manner that will help them avoid damages claims.

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