

CHAPTER 4

Medical law and ethics



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Outcomes

At the end of this chapter you will be able to:

- Understand the basic principles of medical ethics
- Explain the difference between ethical and legal obligations
- Explain how health care practitioners can promote and protect human rights
- Describe the relationship between doctor and patient
- Explain the law concerning informed consent and confidentiality
- Explain the meaning of medical malpractice and professional negligence
- Understand the rights and obligations arising from a patient's bill of rights
- Explain certain legal and ethical aspects of HIV/AIDS
- Explain certain legal and ethical aspects of scarce resources in health care
- Explain certain legal and ethical aspects of dual loyalty in health care.

4.1

Basic principles of medical ethics

Definition

MEDICAL ETHICS

Medical ethics are the moral principles that govern the practice of medicine by doctors and other health care practitioners.

When dealing with patients or health care users health care practitioners are governed by ethical principles and the law. Breaches of ethical rules may result in disciplinary action by employers and professional bodies. Breaches of the law may result in similar disciplinary action as well as criminal or civil legal action against the health care practitioners concerned.

Medical ethics are the moral principles that govern the practice of medicine by doctors and other health care practitioners. Basic principles of medical ethics are usually regarded as being:

- a) respect for patient autonomy
- b) not inflicting harm on patients
- c) a positive duty to contribute to the welfare of patients and
- d) justice or fair treatment of patients.

The KwaZulu-Natal Health Act 2 of 2000 acknowledges most of these principles.

4.1.1

Patient autonomy

The principle of patient autonomy recognises the capacity of mentally and legally competent patients to think and decide independently, to act on the basis of their decisions, and to communicate their wishes to doctors and other health care practitioners. This is in line with the right to freedom and security of the person in accordance with the provisions of the Constitution. [Section 12]

4.1.2

Not inflicting harm on patients ('non-maleficence')

The principle of not inflicting harm on patients is based on the idea that doctors and other health care practitioners should not deliberately inflict harm on their patients. The principle is used to justify, for example, the difference between killing and letting die (active and passive euthanasia), or withholding or withdrawing life-sustaining treatment.

Contributing to the welfare of patients ('beneficence')

The principle of contributing to the welfare of patients requires doctors and other health care practitioners to help patients further their health interests. This not only requires providing patients with the benefits of the treatment concerned, but also requires a balancing of the benefits that may be received from the treatment against any possible harm which may result from such treatment. For example, in cases of withholding or withdrawing life-sustaining treatment it is necessary to weigh the chances of success should such treatment be instituted or continued, against the probable costs or risks to the patient.

Justice or fairness

The principle of justice or fair treatment of patients requires that doctors and health care practitioners should treat all patients equally irrespective of race, gender, colour and ethnic origin. In other words there should be no unfair discrimination against patients. This accords with the right to equality in the Constitution. [Section 9]

4.1.3



EQUALITY OF TREATMENT

Health care practitioners should treat all patients equally.

4.1.4

4.2

Ethical and legal obligations

Ethical obligations are based on the moral principles that underpin the practice of the different health care professions. A breach of such principles in themselves may not necessarily lead to legal action where they have not been given the force of law by publication in a statute. Some of these moral principles may be incorporated in the ethical rules of the different professions. For example, regulations passed by the health professions council concerning the rules of conduct for medical practitioners and dentists impose certain obligations on such practitioners. Although medical and dental practitioners breaching these rules may be disciplined by the council, their conduct may not necessarily result in legal action in the courts.



ETHICAL OBLIGATIONS

Ethical obligations are based on the moral principles that underpin medical practice.



PROVING A CIVIL WRONG

In order for a civil wrong to be proved it would have to be shown that the health professional's conduct was also a breach of a legal obligation.

Medical malpractice and professional negligence

A breach of an ethical principle or of an ethical rule or regulation promulgated by a professional council may be used to establish medical malpractice or professional negligence [See pg 93, para 4.7], even though the breach itself may not constitute a crime or civil wrong. In order for a civil wrong to be proved it would have to be shown that the health professional's conduct was also a breach of a legal obligation. For example, if the doctor or other health care practitioner negligently caused the death of a patient by breaching an ethical rule he or she may face a criminal charge of culpable homicide or a civil action by the deceased's dependents.

4.3

The promotion and protection of human rights



ADVOCATES FOR PATIENTS

Ethical principles require health care practitioners to become advocates for their patients.

The ethical principles of autonomy, not inflicting harm, contributing to the welfare of patients and justice and fairness would seem to require doctors, other health care practitioners, and where applicable, the professional bodies concerned, to become advocates for their patients where the latter's constitutional human rights are being violated. This duty has also been clearly set out in certain international declarations and codes of ethics.

The principle of autonomy requires medical personnel to ensure that their patients' constitutional and common law human rights to freedom and security of the person are respected. [Section 12 of the Constitution]

This is safeguarded by the ethical and legal requirements of an informed consent. [See pg 86]

Respect of a patient's right to freedom of religion, belief and opinion is legally required in terms of the Constitution. [Section 15]

Their right to privacy [Section 14 of the Constitution] is safeguarded by the ethical and legal rules regarding confidentiality.

The principle of not inflicting harm requires medical personnel to ensure that their patients' constitutional human rights to dignity [Section 10], life [Section 11], emergency treatment [Section 27(3)] and an environment that is not harmful to health [Section 24(a)] are upheld.

The principle of contributing to the welfare of patients requires medical personnel to ensure that the constitutional imperative of

access to health care services [Section 27(1)], including reproductive health care [Section 27(1)(a)] (e.g. the right to have a pregnancy terminated in accordance with the Choice on Termination of Pregnancy Act of 1996), within the available resources of the state, is honoured by the public health facilities concerned.

The principle of justice or fairness requires medical personnel to ensure that their patients enjoy the constitutional right to equal treatment and freedom from unfair discrimination [Section 9].



EQUALITY

Medical personnel ensure that their patients enjoy equal treatment and freedom from unfair discrimination.

International Codes of Ethics

Doctors are specifically enjoined by the International Code of Medical Ethics, the Declaration of Tokyo (dealing with prisoners and detainees), and Regulations in Time of Armed Conflict, to stand up for the rights of their patients by putting the patient's interests first, before those of anyone else.

4.4

Relationship between practitioner and patient

The relationship between health care workers and patients may take the form of a contract or a duty of care imposed by the law because of the special relationship between health care workers and patients. This section will deal mainly with the doctor-patient relationship, but similar principles apply to other health care workers.

The contract between health care practitioners and patients

A patient who consults a doctor or other health care practitioner in private practice enters into a contractual relationship with the practitioner but the latter also owes the patient a duty of care (see below 'medical malpractice'). However, a patient who goes for medical treatment by the staff at a hospital or health care establishment enters into a contract with the relevant hospital authority, e.g. a private or provincial hospital authority. The hospital authority will be contractually liable for the negligent conduct of its employees, but staff doctors and other members of staff will also be liable in their personal capacities.

In the doctor-patient relationship the contract usually takes the form of an implied agreement that the doctor will diagnose the

4.4.1



DUTY OF CARE

Health care practitioners owe their patients a duty of care.



LIABILITY

Doctors and other members of staff are liable in their personal capacities.

4.4.2

Is there a duty to treat?

patient's complaint and treat the person in the normal manner according to generally accepted medical procedures. Any procedures to be used by the doctor should first be discussed with patient and the necessary consent to treatment obtained. [See pg 86]

When taking on a case a medical practitioner does not guarantee that the patient will be cured, unless he or she specifically says so.

If a doctor departs from his or her patient's express instructions, or fails to treat a patient for no good reason, the doctor will be guilty of a breach of contract and may be denied the right to claim a fee. Once treatment has commenced the doctor may not abandon a patient, but if the treatment has been completed the agreement ends and the doctor need no longer attend to the patient. Patients must also perform their part of the agreement by making themselves available for treatment.

The Constitution provides that everyone has the right to have access to health care services which the state must provide within its available resources. [Section 27]

Therefore in the case of state run health care facilities health care practitioners are required to treat everyone who presents and qualifies for treatment. This does not apply to privately run facilities except in the case of emergency medical cases. In the case of emergency medical treatment nobody may be turned away by either public or private facilities. [Section 27(3) of the Constitution]

In this context the Constitutional Court has defined an 'emergency' as 'a dramatic, sudden situation or event which is of passing nature in terms of time'. [See *Soobramoney* case, pg 105]

Apart from emergency situations there is generally no duty on a private doctor to treat a person who is not his or her patient. This is because in law there is usually no liability for a mere omission. However a duty to act will be imposed by the law where the circumstances are such that society would regard the failure to act as unlawful (e.g. where somebody pushes another into a river and does not rescue the person). There may however be a contractual duty, for example, a casualty officer at a state hospital is obliged to treat patients brought in for treatment.



NO TURN-AWAYS

In the case of emergency medical treatment nobody may be turned away by either public or private facilities.

Definition

EMERGENCY

An emergency is 'a dramatic, sudden situation or event which is of passing nature in terms of time'.

Definition

ACTS AND OMISSIONS

An act is some positive conduct by a person (e.g. treating a patient). An omission is a failure to do something by somebody (e.g. failing to treat a patient.)

Assessing the failure to treat

According to Strauss in *Doctor, Patient and the Law*, when determining whether or not the failure to treat by the doctor is unreasonable the court will probably take into account the following factors:

- a) the doctor's actual knowledge of the patient's condition
- b) the seriousness of the patient's condition
- c) the professional ability of the doctor to do what is asked
- d) the physical state of the doctor, for example, the doctor may have been physically exhausted at the time
- e) the availability of other health care practitioners, or nurses or paramedics
- f) the interests of the other patients of the doctor, and
- g) considerations of professional ethics.

The bus accident

A doctor works in a mission hospital in a rural part of the country where the incidence of HIV-positive people is very high. She leaves to drive to the city on the weekend to attend her son's wedding. As she is off duty and expecting to relax she leaves behind her medical bag which contains universal precautions against HIV infection. While she is still in the high risk area, an hour's drive away from the mission hospital, she comes across a bus accident with bodies lying scattered in the road. She is feeling overworked, and also needs to hurry to reach the city in time for her son's wedding. She decides not to stop but uses her cell phone to call the mission hospital with a request that they send help immediately. Three people die from loss of blood which could have been prevented had she stopped and assisted.



1. Did the doctor act ethically? Why or why not?
2. Did the doctor act legally? Why or why not?



4.5

Informed consent



CONSENT

Consent generally takes the form of a request made by a patient for a specific treatment or operation, and is usually in writing.

Consent, in medical cases, means that a patient:

- has knowledge of the nature or extent of the harm or risk
- appreciates and understands the nature of the harm or risk
- has consented to the harm or assumed the risk and
- understands that the consent is comprehensive, i.e. extends to the entire procedure, including its consequences.

The person giving the consent must be legally capable of doing so (e.g. not a minor or insane person). The consent will only be valid if the act consented to is in accordance with public policy (e.g. not consent to reckless medical experiments). Patients may consent expressly to treatment, (e.g. in words or in writing), or by conduct. Consent generally takes the form of a request made by a patient for a specific treatment or operation, and is usually in writing.

Failure to obtain a proper informed consent may result in the doctor being sued for assault (e.g. where the doctor knowingly fails to get a consent) or invasion of privacy (e.g. where a blood test is done without consent).

4.5.1

Consent by spouses

Spouses have the right in terms of Section 12 of the Constitution of 1996 to consent independently to medical treatment or operations (e.g. sterilisation or abortion). Furthermore, one spouse has no right to compel the other to undergo an operation against his or her will or even to submit to a medical examination.

4.5.2

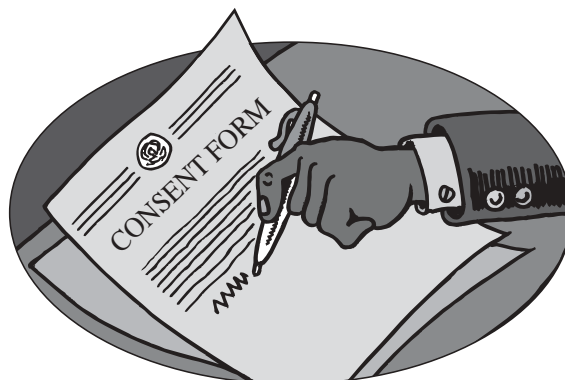
Consent in the case of minors

A minor is usually regarded as a person under the age of 21 years who requires the consent of his or her parent or guardian to enter into certain legal agreements. However, the Child Care Act 74 of 1983 provides for a number of exceptions with regard to age and medical treatment.



EXCEPTIONS TO CONSENT RULE

The Child Care Act provides for a number of exceptions to the consent rule with regard to age and medical treatment.



Circumstances where consent of parent or guardian is not required

- a) Minors over 18 years of age are competent to consent, without the assistance of a parent or guardian, to the performance of any medical operation.
- b) Minors over the age of 14 years are competent to consent to medical treatment.
- c) If the parents or guardian cannot be found, or refuse permission for treatment or an operation to a minor under the age of 14 years, the Minister of Health may, if satisfied after due inquiry that the treatment or operation is necessary, consent to it instead of the parents or guardian of the child.
- d) If the medical superintendent of a hospital is of the opinion that an operation or medical treatment is necessary to preserve the life of the child or to save the child from physical injury or disability, and that the need is so urgent that there is no time to postpone the operation or treatment for the purpose of consulting the person who is legally competent to consent to such operation or medical treatment, the superintendent may give the necessary consent.



Where the Minister or medical superintendent gives consent the person whose duty it is to maintain the child in question is liable for the cost of any treatment or operation carried out upon the child as if it had been authorised by him or her.

Consent to abortion

In the case of abortion the Choice on Termination of Pregnancy Act of 1996 provides that a girl-child of any age may consent to a termination of pregnancy without the consent of anyone else provided she gives an informed consent. This means that she must be sufficiently mentally mature to understand the nature, extent and consequences of the procedure to which she consents.

The child, however, must be advised to consult with her parents, guardian, family members or friends, but if she refuses to do so she cannot be denied an abortion.



ABORTION

A girl-child of any age may consent to a termination of pregnancy without the consent of anyone else provided she gives an informed consent.

In the case of minors in institutions (e.g. reform school or children's home) or training institutions (e.g. a special school) the right of control and custody over them may be given to the head of the institution. The head of the institution may consent to medical operations or treatment to minors in cases of emergency or in urgent cases

where there is no time to postpone an operation or treatment to consult the parents or guardian. The head, however, may not give consent without first consulting the parents or guardian in non-urgent cases, or where the medical treatment or operation pose a serious danger to the child's life.

In all cases the high court as the upper guardian of minors in South Africa can give an order granting consent, and overruling the refusal to give consent on the part of a parent or guardian, where such consent is necessary in the best interests of a minor.

4.5.3

Consent in the case of mentally ill persons

The Mental Health Act of 1973 makes provision for certain persons to consent, on behalf of mental patients held in institutions, to an operation or medical treatment where such patients are unable to give the necessary consent.

Definition

CURATOR

A curator is a person appointed by the court to look after the affairs or goods of a mentally incapable person.



MENTALLY ILL PATIENTS

Special additional statutory safeguards have been introduced to protect mentally ill persons who are unable to consent.

Definition

LEUCOTOMY

A leucotomy is a surgical operation in which areas of the white nerve fibres of the brain are severed.

Persons who may consent on behalf of mental patients

The persons who may consent are listed in order of priority as follows:

- a) The curator appointed by the court to the person or property of the patient and
- b) The patient's spouse, parent, major child or brother or sister. These persons have precedence in the order in which they are mentioned. If however one of them unreasonably withholds consent, or the operation or treatment is urgent and the person having precedence cannot be found timeously, the person following in precedence may consent.

In the case of patients in institutions, if none of the persons mentioned above exist, or if such persons cannot be found after reasonable inquiry, the superintendent of the institution may consent if he or she is of the opinion, on reasonable grounds, that the life of the patient is endangered or that the patient's health is seriously threatened. Where mental patients are living outside institutions consent must, in accordance with the common law, be given either by a parent or guardian, (in the case of a minor), or by a curator appointed by the high court.

Special additional statutory safeguards have been introduced to protect mentally ill persons who are unable to consent and are required to undergo sterilisation or termination of pregnancy operations, or may require a leucotomy.

Consent to research

The South African Constitution states that everyone has the right to bodily and psychological integrity, which includes the right not to be subjected to medical or scientific experiments without their informed consent. Likewise, according to common law a medical practitioner who wishes to carry out an experiment or research on a person will have to obtain an 'informed consent' before carrying out any research procedure. The *Guidelines on Ethics for Medical Research* published by the Medical Research Council (MRC) provide that patients should not only know that they are participating in research but should also consent to such participation.

It has been suggested that consent on behalf of mentally ill or defective patients should only be sanctioned in respect of therapeutic research. Consent to non-therapeutic research on mentally ill and defective patients should only be allowed if it involves no risk or danger to the subjects. The MRC *Guidelines* suggest that consent should only be given on behalf of mentally ill or defective persons for therapeutic research that will benefit them directly. However, an ethics committee may sanction non-therapeutic research if it is convinced that the research is acceptable, and it is specifically directed at patients who might be incompetent.

Informed consent and material risks

A consent will only be 'informed' if it is based on substantial knowledge concerning the nature and effect of the act consented to. Because of the technical nature of most forms of medical treatment and surgical operations, there is a duty upon the practitioner to inform the patient in a language he or she can understand about the procedures to be followed, the risks involved and their consequences.

A doctor is obliged to warn a patient of 'material risks' inherent in the proposed treatment.

What are material risks?

A risk is material if:

- a) A reasonable person in the patient's position, if warned of the risk, would regard it as important, and
- b) The medical practitioner should reasonably be aware that the patient, if warned of the risk, would regard it as important. Thus a doctor need not tell the patient about all the remote risks, but should at least mention the probable and possible risks of harm, particularly where they are serious.

4.5.4



RESEARCH

Patients should not only know that they are participating in research but should also consent to it.

4.5.5



RISKS

There is a duty upon the practitioner to inform the patient about the risks involved.

Usually doctors inform their patients about their diagnosis but this is not an absolute rule. For example, where the information concerning the diagnosis or the potential effect of treatment may have an extremely harmful effect on the patient which will undermine the treatment, the doctor may be justified in not informing the patient of the diagnosis. Where, however, the patient insists that his or her consent is dependent upon being given a diagnosis of the condition, such diagnosis must be made known to the patient otherwise the consent will not be legal. The doctor must weigh up the risk of inhibiting treatment against the need to obtain an informed consent.

4.5.6

Medical treatment without consent in cases of emergency

Where a person whose life or health is in serious danger as a result of injury, disease or ill-health is unable to give consent to medical treatment or an operation he or she may be given emergency treatment provided it is not against the patient's will.



EMERGENCIES

Emergency treatment may be given without consent provided it is not against the patient's will.

When is emergency treatment justified?

According to Strauss such treatment is justified where:

- a) there is an emergency
- b) the patient is or has been unable to communicate
- c) the treatment is not against the patient's will, and
- d) the treatment is in the best interests of the patient.

Where an operation is extended to save the patient's life while he or she is unconscious and unable to consent, the defence of necessity will also succeed.



TALKING POINT

No to blood

A doctor at a provincial hospital is treating an eight year old boy who requires a blood transfusion. For religious reasons his parents are not prepared to give consent.



- What should the doctor do?

Depression vs information

A doctor has diagnosed her patient as suffering from cancer. She knows that her patient is subject to bouts of depression and that if she informs the patient that she is suffering from cancer, she will go into a deep depression that will undermine the treatment.



- Should the doctor reveal the diagnosis in order to obtain an informed consent to treat the condition?



Risk of amputation

A doctor informs the parents of a 14-year-old girl suffering from cancer that she will need superficial radium treatment which may result in minor pigmentation changes to her arms and legs. The parents sign a consent to such treatment 'together with such other or additional operations and treatments necessarily incidental thereto'. The superficial treatment does not work and she now requires deep radium treatment which may result in shortening of the limbs and the risk of their amputation.

- Does the doctor require a further consent or is the original consent sufficient? Why or why not?



4.6

Confidentiality

Patients discuss intimate and personal details about themselves with health care workers and have a right to expect that their disclosures will remain in confidence.

If this was not the case patients would be frightened into non-disclosure and this would greatly inhibit their treatment. A breach of such confidence may result in an action for invasion of privacy or defamation. The ethical rules of the Health Professions Council provide that there is an ethical duty on doctors not to divulge information about their patients without the latter's consent if they are over 14 years of age, or the written consent of their parents or guardians if they are minors under 14 years of age. In the



CONFIDENTIALITY
There is an ethical duty on doctors not to divulge information about their patients without the latter's consent.

case of a deceased patient the written consent of his or her next-of-kin or the executor of his or her estate must be obtained. [Rule 20]

4.6.1



WHEN CONFIDENTIALITY MAY BE BREACHED:

- Court order
- Act of Parliament
- Moral or legal obligation
- Consent by patient

When confidentiality may be breached

There is a professional duty on doctors to maintain confidentiality unless:

- a) A court of law orders them to make a disclosure, (e.g. in a paternity dispute)
- b) An Act of Parliament requires them to make a disclosure, (e.g. reporting child abuse in terms of the Child Care Act of 1983)
- c) There is a moral or legal obligation on the doctor to make a disclosure to a person or agency that has a reciprocal moral or legal obligation to receive the information, (e.g. where a patient threatens to kill someone), or
- d) The patient consents to the disclosure being made.

4.6.2



BREACHING CONFIDENTIALITY

A doctor who unlawfully breaches the confidentiality rule may be sued for breach of contract, defamation or invasion of privacy.

Confidentiality and evidence in court

A doctor may be ordered by a court of law to give evidence concerning treatment of a patient. A doctor who discloses such information when ordered to do so by a court cannot be held liable for breaching the confidentiality rule. If the doctor refuses to comply with a court order he or she may be prosecuted for contempt of court.

The courts have exercised a discretion as to whether they will permit a medical witness to refuse to give evidence. For example, in criminal cases the courts have admitted evidence by a psychiatrist concerning whether an accused was mentally able to understand what he or she was doing when the crime was committed, but have refused to admit evidence to prove that what the accused said to the psychiatrist conflicted with what he or she had said in an earlier statement to a magistrate.

4.6.3



HIV/AIDS

Doctors may be required to disclose HIV status.

Confidentiality and HIV-positive or AIDS patients

Generally patients who are HIV-positive or suffering from AIDS are entitled to have their right to confidentiality respected. However, if they are a threat to the health and life of others it may be necessary to disclose their HIV or AIDS status.

The Health Professions Council requires doctors to breach the confidentiality rule in cases where their HIV-positive patients, or patients suffering from AIDS, put other health care practitioners or the patient's spouse or sexual partner at risk. In such cases the

doctor should try to persuade the patient to consent to the disclosure being made. If the patient refuses consent the doctor should counsel the patient and explain that he or she is ethically bound to warn the other parties on a confidential basis.

The selfish lover

A doctor is consulted by a patient who has been diagnosed as HIV-positive. The patient is married but is having sexual intercourse with another woman with whom he is having an affair. The doctor advises the patient that the latter should tell both his wife and the other woman that he is HIV-positive and to ensure that precautions are taken. For religious reasons the patient is not prepared to use a condom. He also does not wish to inform his wife because she may divorce him, and does not want the other woman to know in case she ends their relationship.



- What should the doctor do?



4.7

Medical malpractice and professional negligence

Medical malpractice consists of wrongful acts on the part of doctors and health care workers which cause injuries or harm to patients. Such acts may be done intentionally or negligently. Where malpractice is done intentionally the wrongdoer directs his or her will to do the wrongful act and knows at the time that the conduct is wrongful. Where the malpractice is negligent the wrongdoer does not do the act intentionally, but fails to act like a reasonable doctor or health care practitioner would have acted in similar circumstances. Most medical malpractice takes the form of professional negligence.

Professional negligence

A doctor or other health care practitioner is expected to exercise the degree of skill and care of a reasonably skilled person in his or her field. In deciding reasonableness the court will have regard to, but is not bound by, the general level of skill and care possessed and exercised by members of the branch of the profession to which the person belongs.



MALPRACTICE

Medical malpractice consists of wrongful acts on the part of doctors and health care workers which cause injuries or harm to patients.

4.7.1

Greater skill and care is expected of a specialist than a general practitioner, and is also required where more complicated medical procedures are used. A doctor will be negligent if he or she undertakes work which requires specialist skill which the doctor does not have.

4.7.2

The standard of care

The test for the standard of care is: How would a reasonably competent practitioner in that branch of medicine have acted in a similar situation? Would a reasonable doctor have foreseen the likelihood of harm to the patient and taken steps to guard against its happening? If so, the doctor will have acted negligently.



TALKING POINT

The unobservant doctor

[Blyth v van den Heever 1980 (1) SA 191 (A)]

A patient broke his arm when his horse fell on him during a polo game. He suffered a transverse fracture of the ulna and a fracture of the radius. A general practitioner operated on him and put his arm in plaster. The next day the patient complained that the plaster cast was too tight, his fingers were 'very stiff' and he experienced pain. A day later the doctor made the hospital staff remove the plaster cast and apply a crepe bandage but did not check or test the the arm. The wool beneath the plaster was not cut and continued to constrict the arm. The arm became septic and the patient suffered extensive muscle necrosis and nerve lesion. His arm was reduced to 'a shrunken, claw-like appendage of extremely limited functional value'. The doctor said that he could not have reasonably been expected to detect any significant ischemia as he was treating the sepsis in the forearm.



- Did the doctor act negligently in the circumstances? Why or why not?



SUDDEN EMERGENCY

In cases of 'sudden emergency' the same degree of skill and care may not always be required.

As negligence is determined by the criterion of reasonableness, there may be no liability where a highly unusual complication occurs in the treatment of the patient, (e.g. due to idiosyncrasy or hypersensitivity), unless it could have been tested for beforehand. A greater degree of care will be required where a person works with substances that are inherently dangerous (e.g. poison), and where the doctor has special knowledge of circumstances that increased the risk.

In cases of 'sudden emergency' the same degree of skill and care may not always be required, provided the emergency was not created by the health professional concerned. Failure to obtain a patient's consent through carelessness may be regarded as negligent conduct.

Intentional failure to get consent for treatment or an operation will be regarded an assault. The courts have been reluctant to draw an inference in favour of patients in cases where there would otherwise be scope for the maxim 'the facts speak for themselves', (e.g. a swab left inside a patient during an operation).

Vicarious liability for professional negligence

Hospitals

As a general rule hospital authorities are vicariously liable for the unlawful acts of persons employed by them, (e.g. doctors or nurses), where such acts occur during the course and scope of the work of their employees. Hospital authorities may even be liable in cases where they have warned their employees against using certain procedures, provided that such acts fall within the general scope of their employment. However, a standard of excellence cannot be expected which is beyond the financial resources of the hospital authority concerned.

4.7.3

4.7.3.1

Definition

VICARIOUS LIABILITY

Vicarious liability means that hospitals are liable for the unlawful acts of persons employed by them where such acts occur during the course and scope of their work.

The zealous security guard

[Zungu v Administrator, Natal 1971 (1) SA 284 (D)]

A security guard was employed at King Edward VIII Hospital to prevent unauthorised persons from entering the hospital premises. Mr Zungu tried to enter the premises without having a good reason for doing so. He began arguing with the security guard who beat him with a knobkerrie and chased him into Francois Road where he was struck by a motor car and injured.



1. Was the security guard acting within the scope of his employment?
2. Was the security guard acting within the course of his employment?
3. Should the hospital be held vicariously liable for the injuries suffered by Zungu?



Doctors

Whether a doctor is liable for the acts of his or her assistants depends upon whether they are 'servants' (i.e. under his or her control as to the manner in which they do their work). Where the doctor employs his or her own assistants the doctor is clearly liable where they act as servants. However, where the doctor has assistants provided by a hospital or nursing home the doctor's vicarious liability will depend

4.7.3.2



DOCTOR NEGLIGENCE

If the doctor is in a position to intervene in order to prevent harm, and fails to do so, he or she may also be liable for negligence.

upon whether or not such assistants are under the doctor’s control, (i.e. he or she can tell them what to do and how to do it). For instance, it has been held that a qualified theatre sister is not the servant of a doctor as she has ‘independent duties to discharge’.

Generally it seems that nurses would be regarded as under the control of the medical practitioner concerned. However, whenever an assistant performs an independent task properly entrusted to him or her, which is left to the person’s own discretion, the assistant is not acting as the servant of the doctor.

This applies even if the assistant is exercising an independent task. If the doctor is in a position to intervene in order to prevent harm, and fails to do so, he or she may also be liable for negligence. In any event while an employer, (e.g. a hospital), is vicariously liable for the wrong of a doctor or nurse, the latter will also be personally liable for any harm caused, (i.e. both are legally responsible). Generally a surgeon is not liable for the negligence of an anaesthetist, but may be personally liable if he or she negligently failed to prevent the harm to the patient.



TALKING POINT

The anaesthetist who froze

[State v Kramer 1987 (1) SA 887 (W)]

An anaesthetist mistakenly places an intra-tracheal tube down the throat (oesophagus) instead of the wind-pipe (trachea) of a patient during an operation to remove his tonsils. The surgeon begins operating after being given permission by the anaesthetist, but notices that the patient is blue in the face (cyanosed). The anaesthetist panics and ‘freezes’. The anaesthetist had been chosen by the surgeon to assist him even though he knew that she had only recently qualified. The surgeon takes over and unsuccessfully tries to rectify the matter by re-inserting the tube. The patient dies from lack of oxygen.



1. Who was factually responsible for the death of the patient?
2. Who should be held legally responsible for the death of the patient?
3. Who was medically in control of the operation?

4.8

Patient’s bill of rights

The Constitution enshrines several health-related rights which form the foundation on which national and provincial health policy must be built.

Section 27 of the Constitution establishes a right to 'have access to... health care services including reproductive health care', with respect to which the state 'must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights'. Section 28 of the Constitution establishes the rights of children to 'basic nutrition, shelter, basic health care service and social services'. Section 24 of the Constitution outlines a right to an environment 'not harmful to health or well being'. Thus the Constitution does not guarantee a right to health, but it guarantees a right of access to health care services, within available resources.

The health of an individual, however, is first and foremost an individual responsibility. The role of government is to ensure that an individual facing health problems, has access to basic health care treatment in the form of primary health care services. None of the rights listed in the Bill of Rights is absolute. Rights may be limited to accommodate limited human and financial resources and to give effect to competing rights in society.

Benefits of the patient's bill of rights

The introduction of a patient's bill of rights or charter will result in:

- a) Improved consumerism within the state health system
- b) Raised awareness amongst consumers and providers of health care
- c) Raised expectations of patients, and their empowerment in terms of participating in health matters
- d) Changes in attitudes of health care practitioners
- e) Strengthened partnerships between consumers and providers
- f) An improvement in the quality of health care provided.

At present there is a tendency towards passive acceptance of health services by consumers. Patients will get the best from the health service only when they know what is reasonable to expect of it, what their rights and responsibilities are, and when they have the confidence and skill to exercise them. Patients clearly need more and better information about what services are available: how to gain access to them, what choice they have in terms of doctors and services, how they can influence decision-making in the health services, and how they can make a complaint when something goes wrong. [See pg 78, para 3.6.1]

The national department of health is considering introducing a patients' bill of rights. However, as has been mentioned, a bill of rights is not of much benefit to patients if the latter do not know what their corresponding duties are. A proposed patient's bill of rights and responsibilities might look like the following: [See pg 98]



ACCESS TO HEALTH CARE

The Constitution establishes a right to 'have access to ... health care services including reproductive health care'.



RESPONSIBILITY

Health is first and foremost an individual responsibility.



INFORMATION

Patients need more and better information about what services are available.

PATIENT'S BILL OF RIGHTS

Rights	Responsibilities
<ul style="list-style-type: none"> • To be exposed to a non-harmful environment • To have access to health care • To have access to timely emergency medical care • To have access to medical records • To exercise reproductive rights • To be informed of health services in the official languages of the Province • To obtain a second opinion • To give an informed consent or refusal regarding medical treatment • To know what local health services there are • To participate in the development of health policies • To exercise their right to a second opinion if not satisfied • To ask their health care practitioner to explain in more detail if they do not understand • To choose not to be informed of the nature and state of the illness if they so wish • To exercise the right to die • To be treated holistically • To receive palliative care for terminal diseases • To receive appropriate drugs and information for their safe and correct usage • To have confidentiality of information respected • To be given clearly set out complaint procedures • To be treated with courtesy, dignity, empathy and tolerance • To be interviewed and examined in a dignified and supportive manner during a medico-legal investigation • To receive or decline spiritual and moral support • To be required to consent to participation in medical research • To refuse to be seen by medical students • To lodge a complaint when things go wrong 	<ul style="list-style-type: none"> • Care for the environment • Live a healthy life • Not to abuse the health system and competently trained health care workers • Not to damage health care establishments • Pay fees stipulated by law • Not to leave health problems too late • Not to burden emergency services with minor problems that can be handled routinely • Give an accurate history • Exercise their reproductive choices in a responsible manner • Make sure that they understand the nature of the disease and treatment • Accept responsibility for refusal to accept treatment • Advise their health care worker on their personal views and expectations regarding death and dying. • Consider making a living will • Tell their health care worker about their physical and mental state of health • Inform their health care worker whether or not they wish to receive palliative care • Comply with prescribed treatment procedures agreed upon • Store drugs in a safe place • Check with their health care worker about confidentiality and advise about what may be disclosed to a third party • Respect the similar rights of health care practitioners and fellow patients • Advise the health care practitioner if they are uncomfortable with the procedures being followed • Advise health care workers accordingly • Ensure that they know the nature and extent of the research and what they are consenting to

4.9

Legal and ethical aspects of HIV/AIDS

A person who intentionally or negligently infects another with HIV/AIDS may be liable to criminal or civil sanctions. In such situations health personnel, hospitals and patients may be held liable for infecting people with HIV/AIDS. The Constitution protects HIV/AIDS survivors against unfair discrimination.

Murder and culpable homicide

A person who unlawfully and intentionally infects another with HIV/AIDS which results in the latter's death will be guilty of murder. A person who recklessly infects another with HIV/AIDS, not caring whether or not that other person contracts the disease and dies will also be guilty of murder if the person dies. A person who intentionally or recklessly exposes another to HIV/AIDS without infecting them may be guilty of attempted murder.

A person who negligently infects another with HIV/AIDS which results in the latter's death may be found guilty of culpable homicide. Negligence means that the person foresaw the likelihood that he or she would infect another with HIV/AIDS but did not take any steps to prevent such infection from occurring. For instance, an HIV/AIDS survivor who has sexual intercourse with a person without using a condom and without warning that person, with the result that the person contracts the disease and dies will be guilty of culpable homicide.

Assault

A person who unlawfully and intentionally infects a person with HIV/AIDS or threatens to infect them with HIV/AIDS will be guilty of assault if the person is still alive. A person who intentionally or recklessly infects another with HIV/AIDS may be guilty of assault where the victim has contracted the disease but has not died. A person knowingly suffering from HIV/AIDS who does not warn a sexual partner that he or she has the disease and has intercourse with that person will be guilty of assault if that person becomes infected with the disease.

One of the major problems with criminal prosecutions for infecting others with HIV/AIDS is the question of causation. Causation means that there is a direct link between the wrongful conduct or failure to act by the wrongdoer and the injury suffered by the person harmed. In some American and Australian states and in Zimbabwe it is a crime to 'knowingly and wilfully expose another to HIV/AIDS' – even if the person does not become infected.

4.9.1



MURDER

A person who unlawfully and intentionally infects another with HIV/AIDS which results in the latter's death will be guilty of murder.

4.9.2



ASSAULT

A person knowingly suffering from HIV/AIDS who does not warn a sexual partner and has intercourse with that person will be guilty of assault if that person becomes infected.

Civil actions

There are two types of civil actions which may arise from:

- a) intentional or negligent acts which result in physical injuries or death, and
- b) intentional acts which result in infringements of a person's dignity, privacy or reputation, that cause sentimental damages.

4.9.3.1

Damages for physical injuries

In the case of damages for physical injuries and/or death the infected person or his or her dependents must prove intention or negligence by the wrongdoer. The requirement of intention or negligence is the same as in criminal actions.

In cases where an HIV/AIDS survivor has negligently infected another, the former must have foreseen the possibility of harm and taken steps to guard against the other person contracting the illness. For example, this could be done by avoiding exchanging body fluids, using a condom, informing the other party about the disease, subjecting themselves to a blood test after high risk activities, or monitoring the foetus of a mother with HIV/AIDS.

It would be a good defence if persons infected by the HIV/AIDS survivor knew that the survivor had HIV/AIDS and consented to the risk (e.g. by not insisting on the use of a condom), or were themselves negligent (e.g. sharing a needle for drug injections, sharing razors, or using untested blood).

Where the HIV/AIDS survivor causes the death of the infected person the dependents (e.g. widow and children) could sue the survivor for loss of support, and the deceased's estate could sue for funeral and hospital expenses.

4.9.3.2

Sentimental damages for personality infringements

Where a person has intentionally infringed the dignity, reputation or privacy of another person the latter will be entitled to sue them for sentimental damages. For instance, a person's dignity or reputation may be affected where he or she is falsely accused of being an HIV/AIDS survivor. Their privacy may be infringed if there is no good reason for such a disclosure to be made. [See pg 91, para 4.6]



LOSS OF SUPPORT

Where the HIV/AIDS survivor causes the death of the infected person the dependents (e.g. widow and children) could sue the survivor for loss of support.



REPUTATION

A person's dignity or reputation may be affected where he or she is falsely accused of being an HIV/AIDS survivor.



The case of the talkative doctor

[Jansen van Vuuren v Kruger 1993 (4) SA 842 (A)]

A doctor who was playing golf with two colleagues – one a doctor the other a dentist – disclosed to them that one of his patients was HIV positive. The second doctor had also once treated the patient while acting as a locum for the first doctor and the dentist had also once treated the patient. Neither of them was treating the patient at the time the disclosure was made. The patient sued the first doctor for invasion of privacy.



1. Was there any good reason for the first doctor to make the disclosure? Why or why not?
2. Did the first doctor invade the privacy of his patient? Why or why not?



A person's privacy may be invaded by disclosures that he or she is infected with HIV/AIDS when it is not in the interests of anybody, or if a person's blood is tested for HIV/AIDS without their consent.

A case of invasion of privacy

[C v Minister of Correctional Services 1996 (4) SA 292 (T)]

C, a prisoner at Westville prison, consented to having a number of tests being conducted on his blood. He was not however informed that his blood would be tested for HIV. The prison had a special protocol concerning the testing of blood of prisoners but this was not followed in C's case. C sued the Minister of Correctional Services for invasion of privacy.



- Do you think that C succeeded in his action? Why or why not?



Health care practitioners and hospitals

4.9.4

Health care practitioners who negligently or intentionally infect others with HIV/AIDS will be liable in a criminal or civil action depending on the circumstances. If medical personnel infect other people with HIV/AIDS while they are acting in the course and scope of their employment, their employers as well as themselves will be liable to the person who is infected with the illness. Hospitals,



NEGLIGENCE

Health care practitioners who negligently or intentionally infect others with HIV/AIDS will be liable in a criminal or civil action depending on the circumstances.

4.9.5



DISCRIMINATION

The Constitution requires that the state should not discriminate unfairly against people living with HIV/AIDS.



NOTIFICATION

So far AIDS has not been made a 'notifiable disease' because of the fear of driving it underground.

doctors and blood banks will be liable for the wrongs of their employees and servants acting in the course and scope of their employment.

Conversely health care practitioners or hospitals that negligently test the blood or body fluids of HIV/AIDS survivors and do not take 'universal precautions' in situations where their staff or patients may be subject to the risk of HIV/AIDS will be liable to people infected as a result of such negligence. There is a duty on hospitals working under conditions where health care practitioners or staff are at risk concerning HIV/AIDS to take proper precautions (e.g. protect staff and patients from contaminated needles and equipment).

Hospitals and health care practitioners should not test the blood of patients without their consent as this would be regarded as an interference with the patient's personality rights, more particularly with their right to privacy. [See pg 86]

As has been mentioned [See pg 92] if a medical practitioner knows that a person is infected with HIV/AIDS and that the person will not allow the doctor to warn a fellow health care practitioner or a spouse or sexual partner then there is an ethical duty on the doctor to do so. The doctor should first attempt to obtain the consent of the patient by counselling the person.

Discrimination and people living with HIV/AIDS

As has been mentioned the Constitution requires that the state should not discriminate unfairly against people on a number of stipulated grounds, including disability. [Section 9(3)] Disability would include people living with HIV/AIDS.

Therefore, according to the Constitution, state health employees cannot refuse to treat HIV/AIDS-related diseases simply because patients are HIV positive or have full-blown AIDS. Any decision not to treat must be reasonable and justifiable and based on good medical grounds. For instance, the prognosis may be so hopeless that nothing can be done to cure the patient and only palliative treatment can be offered. In any event, the ability to admit HIV/AIDS patients to public hospitals often depends upon the resources available. [See pgs 103-104]

HIV/AIDS: 'communicable' but not 'notifiable'

HIV/AIDS is a 'communicable disease' like cholera and chickenpox and must be reported to the Regional Director of Health. So far it has not been made a 'notifiable disease' because of the fear of driving it underground.

4.10

Legal and ethical aspects of scarce medical resources



Health care practitioners will be expected to maintain their ethical standards even in an environment of reduced resources.

Scarcity of medical resources gives rise to a number of ethical and legal dilemmas for health care professionals and institutions.

Medical ethics and scarce medical resources

The general rule regarding the provision of health care services in an environment of reduced medical resources is that the ethical rules of the health care professions cannot be compromised. Health care practitioners will be expected to maintain their ethical standards even in an environment of reduced resources. Failure to do so may result in disciplinary action by the relevant health care professional board or council. Furthermore, if the breach of ethics results in an invasion of a patient's constitutional or common law rights the health care practitioner may also face legal action. Decisions about reducing the resources available to health care practitioners and their patients are usually made by public health authorities and the managers of health care institutions.

Constitutional rights of patients

As has been mentioned the Constitution specifically provides for the provision by the state of access to health care services *within its avail-*

4.10.1



NO COMPROMISE

The general rule is that the ethical rules of the health care professions cannot be compromised.

4.10.2



LIMITATION OF RIGHTS

The rights to equality, dignity, life and freedom are not absolute and may be limited in terms of the Constitution.

able resources. In addition, in terms of the Constitution nobody may be refused emergency treatment [See pg 84, para 4.4.2]. When considering the question of scarce medical resources other provisions of the Constitution such as the rights to equality, dignity, life and freedom and security of the person must also be taken into account. These rights are not absolute and may be limited in terms of the Constitution provided the limitation is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom. Where the state has the power to regulate (e.g. by introducing health care regulations), it must ensure that there is a ‘rational connection’ between the *method* of regulation and the *purpose* of such regulations.

The courts will take into account the financial resources available to the hospital concerned when judging the standard of care required of health care practitioners. However, when allocating resources proper weight should be given to the clinical advice of doctors and health care practitioners and not just the financial advice of accountants. Usually the courts will not interfere with the allocation of resources to medical facilities by the state, but may consider individual cases and review allocation of resources on clinical grounds.



4.10.3

EQUIPMENT

Health care managers will be held liable for negligently failing to repair or replace medical equipment or obtain the required medical items when resources are available.

Health care managers and clinicians

Health care managers will be held liable for negligently failing to repair or replace medical equipment or obtain the required medical items (including drugs) when resources are available. Where there are limited or no resources to repair or replace equipment or the required medical items such managers may have to set up alternative referral systems and to restrict patient intake. Except in emergencies it would be negligent for a health care manager to allow the acceptance of patients for procedures which cannot be done at the facility concerned. Health care managers may allocate resources within a facility but should do so in consultation with the clinicians.

4.10.4



CLOSURE

The decision to close down a facility or reduce services should be made in consultation with managers and clinicians.

Closing down of facilities or reduction of health services

When health authorities decide to close down a facility or reduce services provided by a facility the decision should be made in consultation with the managers and the clinicians, taking into account the following:

- The material, human and financial resources provided by the governing authority
- The cost of the particular services
- The demand for the particular services
- The priority rating of the services by the authorities, the clinicians and the community
- The impact of such closure or reduction of services on the community.

Where a public authority makes a decision to close down or reduce the services provided by a state-funded facility two issues are involved:

- If the closure or reduction is being done to bring it within available resources the authority will have to show that there is a rational connection between the aims to be achieved and the means to achieve them.
- If the closure or reduction affects a fundamental right in the Constitution (e.g. the right to life), the authority will have to show that the decision is reasonable and justifiable in terms of the limitation clause in the Constitution.

Reduced services and patients' rights

If a patient's treatment will be affected by a shortage of resources at a medical facility the patient has a right to be informed. Patients must be provided with sufficient information about the treatment and options available so that they can give an informed consent.

Private patients who are referred to state hospitals because their medical aid or financial resources have run out are not entitled to better treatment than other state-aided patients. They must be treated in the same way as other state-aided patients who are being treated within the state's available resources.

4.10.5



REDUCED SERVICES

If a patient's treatment will be affected by a shortage of resources at a medical facility the patient has a right to be informed.

The kidney patient who was refused treatment

[Soobramoney v Minister of Health, KZN 1998 (1) SA 765 (CC)]

Mr Soobramoney suffered from chronic kidney failure which required him to have regular kidney dialysis treatment in order for him to survive. He could not afford private hospital treatment and approached a state hospital for dialysis treatment. The hospital refused treatment because dialysis was only available to renal patients who were eligible for a kidney transplant. In order to qualify for a kidney transplant a patient had to be free from other significant disease which Mr Soobramoney was not. The hospital justified its policy on the basis that dialysis treatment was very expensive and it only had limited resources. A clinical decision was made by doctors as to who were good candidates for a kidney transplant.

Mr Soobramoney brought an urgent application in the high court for an order directing the hospital to provide him with dialysis treatment because without such treatment he would die. He based his application on Section 27(3) of the Constitution which states: 'No one may be refused emergency medical treatment'. His application failed and he appealed to the Constitutional Court where his application was again refused.



TALKING POINT





1. What is meant by 'emergency medical treatment'?
2. Why do you think the Constitutional Court refused Mr Soobramoney's application?
3. Do you think he may have succeeded if he had based his application on the 'right of access to health care services'? Why or why not?
4. If Mr Soobramoney had based his application on the 'right to life' what would the hospital have had to show?

4.11

Legal and ethical aspects of dual loyalty



DUAL LOYALTY

Dual loyalty arises where conflicts of interest arise between the interests of the employers and those of the patient.

4.11.1

International ethical codes

International ethical codes require complete loyalty to patients and imply that such loyalty should extend above the interests of third parties. It does not matter whether a patient is a dangerous criminal, detainee, prisoner, gangster, terrorist, unpopular political activist or wartime enemy, once a patient-health care practitioner relationship is established, the interests of the patient must come before those of the state or anyone else.

The World Medical Association's Declaration of Geneva of 1948 (the modern Hippocratic Oath) requires doctors to pledge that 'the health of my patient shall be my first consideration'. It also states that a doctor shall provide medical services in 'full technical and moral independence'. The World Medical Association's Code of Medical Ethics of 1983 likewise states that 'a physician shall owe his patients complete loyalty and all the resources of his science'.



LOYALTY

A physician shall owe his patients complete loyalty and all the resources of his science'.

4.11.2

Prisoners and detainees

The United Nations Principles of Medical Ethics of 1982 specifically state that health care practitioners should provide prisoners and



Even if the patient is a dangerous criminal, the patient-health care practitioner relationship must come before those of the state or anyone else.

detainees with physical and mental treatment ‘of the same quality and standard as is afforded to those who are not imprisoned or detained’ [Principle 1]. It further states that health care practitioners must not engage in any professional relationships with prisoners or detainees ‘the purpose of which is not to solely evaluate, protect or improve their physical and mental health’ [Principle 3].

Clinical independence

The World Health Organisation’s Declaration of Tokyo of 1975 states that: “A doctor must have complete clinical independence in deciding upon the care of a person for whom he or she is medically responsible. The doctor’s fundamental role is to alleviate the distress of his fellow men, and no motive, whether personal, collective or political, shall prevail against this higher purpose”.



CLINICAL INDEPENDENCE

A doctor must have complete clinical independence in deciding upon the care of a person for whom he or she is medically responsible.

Indicators of dual loyalty

It has been suggested that the determining features of a dual loyalty situation are:

- a) Simultaneous conflicting professional or social obligations (e.g. whether a part-time district medical officer consulted in his private capacity by one of his patients should report to the police that the patient has bullet wounds)
- b) Internal or external pressures or constraints (e.g. the police may have asked the public to report the whereabouts of a suspected murderer wounded in a shoot-out)

4.11.3



DUAL LOYALTY

Certain employment situations give rise to dual loyalty situations.

- c) An obligation to third parties (is there an obligation on medical officers to protect the public by assisting the police?), and
- d) Actual or threatened interference with the patient's human rights (a disclosure by the district medical officer will be a breach of confidentiality infringing the patient's right to privacy).

Employment situations giving rise to dual loyalty situations are those involving: prison medicine; police medicine; military or wartime medicine; immigration medicine; occupational medicine; public health; mental health; and forensic medicine.



TALKING POINT



The Biko Case

Mr Steve Biko was arrested by the apartheid security police and died in detention on 12 September 1977. The only evidence given at the subsequent inquest concerning his physical condition while in detention was given by the security police and the district surgeons who attended to him whilst in custody. The evidence indicated that Mr Biko had:

- a) Died of brain injuries inflicted 'in a scuffle' with the police
- b) Been kept naked in his cell
- c) Been chained to a grille at night
- d) Been left lying in a urine-stained blanket on a rubber mat on the floor
- e) Been taken naked in the back of a police vehicle on a 1 250 kilometre journey from Port Elizabeth to Pretoria while ill, unattended by medical personnel, and
- f) Been left dying in his cell with an empty drip bottle attached to his arm. The district surgeons consulted by the security police to attend to Mr Biko were Dr Ivor Lang and Dr Benjamin Tucker.

Dr Lang, when called to see Mr Biko:

- a) Issued an incorrect medical certificate and a misleading bed letter (medical record)
- b) Failed to examine the patient properly
- c) Failed to inquire into and ascertain the possibilities of a head injury
- d) Failed to obtain a proper medical history of the patient, and
- e) Failed to observe the patient and keep proper notes.

Likewise, Dr Tucker:

- a) Failed to object to Mr Biko's transportation in the back of a police vehicle from Port Elizabeth to Pretoria
- b) Did not insist upon transportation by ambulance with proper medical attendants and the patient's medical records, and
- c) Failed to make a proper medical check before stating that the patient's central nervous system had shown no changes between examinations.

Dr Lang stated that he and Dr Tucker had no option but to agree to the



demands of the security police because they “could not buck the security police.” Dr Tucker said that he accepted the theory of Colonel Goosen of the security police that Mr Biko was ‘shamming’. He did not know that he could “override the decisions made by a responsible police officer” when Colonel Goosen refused to allow Mr Biko to be transferred to a provincial hospital. Dr Lang examined Mr Biko in the presence of Colonel Goosen and had found that Mr Biko suffered from:

- a) A laceration on his upper lip which was oedematous
 - b) A superficial bruise over the sternum at approximately the level of the second rib
 - c) A ringmark about each wrist
 - d) Oedema of his hands, feet and ankles, and
 - e) That he walked with an ataxic gait and spoke in a slurred manner.
- None the less Dr Lang had signed a certificate that read: “This is to certify that I have examined Steve Biko as a result of a request from Colonel Goosen of the security police who complained that the abovementioned would not speak. I have found no evidence of any abnormality or pathology on the patient.”

1. What common law rights of Mr Biko were violated by the security police?
2. If the incident had occurred after 27 April 1994, what Constitutional rights of Mr Biko would have been violated by the security police.
3. What legal rights of Mr Biko were violated by the district surgeons?
4. What ethical rules were violated by the district surgeons in their treatment of Mr Biko?
5. What should the district surgeons have done in this case?
6. What should the district surgeons have done if the security police had persisted in their conduct?



Dual loyalty in cases of emergency

In cases of emergency it may not be open to health care practitioners to refuse to treat the patient because of conflicts of interest. In such instances they will have to put the patient’s interests first and take the consequences of any pressure exerted on them by third parties also claiming to have a legitimate interest that should be protected.



Dual loyalty guidelines

The following guidelines may assist health professionals faced with dual loyalty situations. Where this occurs health care practitioners should:

- a) Reaffirm that their primary obligation ethically and legally is to promote the health and well-being of their patients.
- b) Inform the patient that they are also acting on behalf of a third party but reassure them that ethically the patient's interests will come first otherwise they will refer the patient to someone else who can deal exclusively with his or her interests.
- c) Identify the conflicting interests and determine if they can be resolved without compromising their ethical duty to the patient. If not, explain to the patient why they are withdrawing from the relationship and refer the patient to another competent health care practitioner.
- d) Examine whether the pressures being felt are real or perceived and legitimate. If so, explain to the patient why they are withdrawing from the relationship and refer the patient to another competent health care practitioner.
- e) Examine whether the third party has a legitimate claim on them. If so, explain to the patient why they are withdrawing from the relationship and refer the patient to another competent health care practitioner.
- f) Examine whether the conflict of interest will result in the patient's human rights being violated. If so, explain to the patient why they are withdrawing from the relationship and refer the patient to another competent health care practitioner.