INFORMED CONSENT TO MEDICAL TREATMENT

THE BASIS OF A CLAIM AND THE STANDARD OF DISCLOSURE

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By

Maria Catherine Ivy Wilson
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Study Leaders: Professor H Oosthuizen and Prof T Verschoor

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FOREWORD

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To my parents, Anne and Peter: thank you for your encouragement.

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CHAPTER 1

INTRODUCTION

The legal vision of informed consent, based on *self-determination*, is still largely a mirage.
Yet a mirage, since it not only deceives but can also sustain hope, is better than no vision at all.

-J Katz *The Silent World of Doctor and Patient* 84-

1.1 Consent to medical treatment and consent to the consequences of treatment

In South African law, *volenti non fit iniuria* is a justification ground, both in civil and criminal law, excluding the wrongfulness of conduct.[1] One translation reads 'No-one can complain of an act which he has expressly or impliedly assented to',[2] and another 'an injury is not done to one who consents'.[3] In turn, a pre-requisite for consent is knowledge of the full nature and extent of the act or consequence.[4]

In the context of consent to medical treatment, the operation of the maxim potentially incorporates a number of forms of consent:

- Consent to an act involving actual harm, for example a doctor performing an operation.[5]

[1] Van Oosten 1989:14-15.
[2] McKerron 1971:67.
[3] Burchell 1993:68.
[4] Neethling *et al.* 2006:93-94.
[5] Neethling *et al.* 2006:90; *Santam Insurance Co Ltd v Vorster* 1973 4 SA 764 (A): 775 A; Snyman 2006:124.

- Consent to the consequences inherent in an act, for example the risk of negative side-effects resulting from the operation.[6]

- Consent to consequences attached to the act/operation through the quality of the treating doctor, for example a surgeon who is a carrier of the Hepatits B virus.[7]

- Consent to potentially negligent act/s,[8] related to the quality of the treating doctor, for example, a surgeon who has no experience, who is a drug addict or who has uncontrolled epilepsy.

In terms of one interpretation of the *volenti* principle, consent to the act can be clearly separated from consent to the consequences of the act. As a result, there may well be a valid consent to the treatment, although there is no consent to the consequences of the medical intervention. However, the question is whether it is always possible to draw a bright line between knowledge required for consent to the medical treatment and knowledge required for consent to its consequences.[9]

For example, is it only knowledge of the bare removal of wisdom teeth by a dentist, that is required for a valid consent to what would otherwise be an assault, or is knowledge also required of the inevitable consequences (moderate pain for a few days), virtually inevitable consequences (visible swelling on the face for a few days), probable consequences (slight bleeding for a few hours) or even possible consequences (facial paralysis or transmission of the Hepatitis B virus)? Furthermore, who decides which information is essential for a valid consent to medical treatment - the doctor, the fictitious reasonable man or the patient?

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[6] Neethling *et al.* 2006:90; *Santam Insurance Co Ltd v Vorster:*775 B-D; Burchell 2005:333-334.
[7] One study puts the risk of transmission of the HIV virus at about 0.3% after percutaneous exposure to the infected surgeon's blood. The risk of exposure was estimated at 6.9%. However, the risk of transmission of Hepatitis B after exposure was estimated at 30%. www.cdc.gov/mmwR: August 2007.
[8] Strauss 1961:55-57,111,119; *Santam Insurance Co Ltd v Vorster:*782F-H.
[9] See for example, Somerville 1981:742-743 and Feng 1987:154, who question the distinction. Feng 1987:154 states that 'it is generally conceded that there is really no logical way of drawing the distinction.'

1.2 Knowledge of the general nature and the consequences of medical treatment

1.2.1 England and Australia

The English and Australian courts have separated consent to medical treatment from the consequences of the treatment. The courts have accepted that there is a valid consent if the patient has consented to the 'general nature' of the medical treatment, even though there has been no disclosure of the implications and risks of the treatment.[10] In other words, the English and Australian jurisdictions have mirrored the traditional approach to consent to sexual intercourse, which provides that it only an *error in negotio* and *error in persona*, as traditionally defined, which is capable of vitiating consent to the act.[11]

The courts enquire whether a risk should have been disclosed to a patient, by using the following method:

a. Information relating to the general nature of medical treatment is regarded as part of the essential nature of the treatment. Such information is considered crucial for the patient to be able to consent to treatment. In

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[10] *Chatterton v Gerson and Another* [1981] 1 QB 432:443 A; *Sidaway v Bethlehem Royal Hospital Governers and others* [1984] 1 All ER 1018 (CA):1029C-E; In *Rogers v Whitaker* (1992) 109 ALR 625 (HCA):633, the court held that 'Anglo-Australian law has rightly taken the view that an allegation that the risks inherent in a medical procedure have not been disclosed to the patient can only found an action in negligence and not in trespass; the consent necessary to negative the offence of battery is satisfied by the patient being advised in broad terms of the nature of the procedure to be performed'.

[11] The Australian author Devereux 2007:166, states that 'the test as to what amounts to the nature of treatment is derived from the test used in criminal law in order to determine whether someone has consented to a battery (or in the case of rape, as sexual battery); In *Sidaway v Bethlem Royal Hospital Governers and others*:1029C-E, the Court, per Lord Dunn, held that if there is consent to the nature of the act then there is no trespass to the person and justified this approach with reference to *Clarence* (1888) 22 QBD 23, [1886-90] All ER Rep 133. In this case a conviction of rape was quashed where the woman did not know that the accused, her husband, was suffering from a venereal disease, which he transmitted to her. If she had known, she would not have consented to sexual intercourse, but as she had consented to the act of sexual intercourse, even though without the knowledge of the risk of infection, there was no rape. Strauss 1961:110-111, states that there may be a valid consent to the act of sexual intercourse, although there is no consent to the risk of transmission of a venereal disease; Snyman 2006:126, also points out that consent to sexual intercourse may be valid although one party to sexual intercourse mistakenly thinks it will cure him/her of an illness.

turn, consent justifies the wrongfulness of an assault.[12]

b. On the other hand, knowledge of consequences of medical treatment is not considered an essential element of consent to the treatment[13] and the relevance of the consequences is instead determined with reference to the tort of negligence. Under this tort, instead of asking whether the patient consented to the touching, it is asked whether the doctor breached a duty to disclose the risks of treatment.[14]

c. The courts determine whether the doctor had a duty to disclose relevant risk information, by fusing the enquiries into wrongfulness and fault and choosing one particular standard or test to determine the boundaries of the duty of care. In England, the professional practice standard has traditionally been used to determine whether the doctor complied with a duty to disclose the relevant consequences of treatment.[15] In *Sidaway,*[16] the court adopted the 'Bolam' test with minor variations. The court held as follows in *Bolam v Friern Hospital Management Committee:*[17]

> a doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art ...[and] a doctor is not

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[12] In English law, a trespass to the person can be both a tort, known as battery, or a crime, known as assault. Jackson 2006:274; Pattinson 2006:108. Likewise, in Australian law, treatment for which no consent is obtained is known as battery in tort and criminal battery or assault in criminal law. Devereux 2007:694.

[13] This information threshold means that an action in battery is only available if the doctor treats the patient against that patient's will, administers a different treatment, or obtains the patient's consent by fraud. Pattinson 2006:104.

[14] An action in negligence for damages in English law comprises three elements. Firstly, that the doctor owed the patient a duty of care; secondly that he/she was in breach of that duty (ie, that he/she failed to provide care of an adequate standard/that there was negligence) and thirdly the harm of which the victim complains was caused by that breach of duty. McHale and Fox 2007:152-153; Pattinson 2006:62.

[15] However, the majority of the court in the House of Lords in *Chester v Afshar* [2005] 4 All ER 587(HL):593h-594b, accepted the majority decision in *Pearce v United Bristol Healthcare NHS Trust* [1999] PIQR 53:59, in which Lord Woolf held that 'In a case where it is being alleged that a plaintiff has been deprived of the opportunity to make a proper decision as to what course he or she should take in relation to treatment, it seems to me to be the law...that if there is a significant risk which would affect the judgment of a reasonable patient, then in the normal course it is the responsibility of a doctor to inform the patient of that significant risk, if the information is needed so that the patient can determine for him or herself as to what course he or she should adopt.' Therefore, it appears that the reasonable patient standard of disclosure has been accepted into English law and has effectively displaced the traditional reasonable doctor test in *Sidaway* and *Bolam.* Meyers 2006:270.

[16] *Sidaway v Bethlem Royal Hospital Governors and Others* [1984]:1030g-h; (1985) 1 All ER 480 (HL):498D-E.

[17] *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118:122B-C.

negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion that takes a contrary view.[18]

However, in the Australian case of *Rogers v Whitaker,*[19] the court applied a more patient-orientated test:

> A doctor has a duty to warn a patient of a material risk inherent in the proposed treatment; a risk is material if, in the circumstances of the particular case, a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it or if 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.[20]

1.2.2 South Africa

South Africa stands apart from England and Australia in that, for consent to medical treatment to be regarded as real, the patient must not only be informed of the general 'nature' of the treatment, but must also be given information regarding the consequences of proposed treatment.[21] When considering whether a risk of medical treatment should have been disclosed to a patient, the following procedure is used:

a) The issue of disclosure of consequences of medical treatment may arise in the context of consent to medical treatment in a claim based on criminal

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[18] *Bolam v Friern Hospital Management Committee:*122B-C; Kian 2003:394, states that 'On a proper application of the *Bolam* test, an expert view from a responsible body of medical opinion, must satisfy the threshold test of logic. Even a minority respectable view of a medical expert that satisfies the logic test will suffice'.

[19] *Rogers v Whitaker* (1992) 109 ALR 625.

[20] *Rogers v Whitaker:*634; The combined patient test comprises a combination of the average patient's minimum informational needs followed by the requirements of the particular patient in the circumstances. Giesen 1988:303.

[21] See for example, *Castell v De Greef* 1994 (4) SA 408:417B-I, 425C-F; *Esterhuizen v Administrator, Transvaal* 1957 3 SA 710 T:719C-H, 722H; *Rompel v Botha* 1953 T unreported; Milner 1957:385-386; Simons 1978:130-131 states that 'uninformed consent is tantamount to no consent, and treatment, by which I mean some bodily interference, without consent is an assault'; Strauss 1961:123-124 states that if A consents to Dr B operating but Dr C operates instead, there is no consent.

or civil assault[22] on the one hand, or it may arise in the context of liability for the failure to disclose the risks/consequences of medical treatment in a delictual claim on the other.[23]

b) When the claim is brought as assault, the courts have departed from a strict application of *volenti non fit iniuria* to determine whether consent justifies an otherwise unlawful touching. Full knowledge of the nature and extent of medical treatment is not required. In *Castell v De Greef,*[24] the court adopted the Australian test set out in *Rogers*[25] and held that when determining the boundaries of consent to medical treatment, a doctor is obliged to warn a patient of the material risks inherent in the proposed treatment, a risk being material if in the particular circumstances:

> a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it; or the doctor is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it. [26]

c) However, in delict, the courts more often use the English breach of a duty of care than assault as a cause of action. In so doing, the courts fuse the determination of wrongfulness and fault and apply a negligence-based test in the form of the professional standard test, similar to the English *Bolam* test, to determine whether a risk of medical treatment should have been disclosed. This test was set out in *Richter and Another v Estate Hammann:* [27]

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[22] For examples of claims based on assault in delict, see for example, *Oldwage v Louwrens* [2004] 1 All SA 532 (C); *Esterhuizen v Administrator of Transvaal*; See also Amerasinghe 1967:57-61; Strauss 1991:268, states that 'Where there has been no consent to a medical procedure – or what is legally the same, where the consent in fact given was so 'uninformed' as to the nature of the procedure or the consequences thereof that may well manifest themselves, this it cannot be said that there was a 'real' consent – the patient will have an action based upon assault'.

[23] See, for example, *Richter and Another v Estate Hamman* 1976 (3) SA 226 (C).

[24] *Castell v De Greef* 1994 (4) SA 408.

[25] Although the court in *Rogers v Whitaker* applied this test in the context of a breach of the duty of care.

[26] *Castell v De Greef* 1994:426G-H.

[27] *Richter and Another v Estate Hammann*:232G-H; The test was also applied in *Castell v De Greef* 1993 (3) SA 501:517G-J, 518A-D; The Supreme Court of Appeal in *Louwrens v Oldwage* [2006] 1 All SA 197 (SCA):209f-h also referred to the professional practice standard as set out in *Richter*, with approval.

> In reaching a conclusion a Court should be guided by medical opinion as to what a reasonable doctor, having regard to all the circumstances of the particular case, should or should not do.

The only exception to the English approach in dealing with liability for an omission to disclose risks of medical treatment, was the court in *McDonald v Wroe*,[28] which separated the enquiry into wrongfulness and fault. At the wrongfulness stage of the enquiry, the court applied the combined patient test as set out in *Castell*, but at the fault stage of the enquiry, the court applied the test for negligence as set out in *Kruger v Coetzee*.[29]

1.3 Problems and proposals

1.3.1 Assault or negligence

In South Africa, claims that a doctor treated a patient without disclosing relevant information are predominantly brought in negligence by using the English breach of a duty of care, rather than as an assault.[30] However, it will be suggested that assault should be the primary cause of action[31] for, *inter alia*, the following reasons:

a. Assault is a particular type of *iniuria* in South African law.[32] The fundamental principle underlying assault is that physical force, of whatever sort and in whatever degree, should not be applied to the body of

[28] *McDonald v Wroe* [2006] 3 All SA 565 (C).
[29] *McDonald v Wroe*:568 b-d; The test for negligence as stated in *Kruger v Coetzee* 1966 2 SA 428 (A):430 is as follows: 'For the purposes of liability *culpa* arises if- (a) a *diligens paterfamilias* in the position of the defendant - (i) would foresee the reasonable possibility of his conduct injuring another in his person or 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.'
[30] See the detailed discussion of South African case law in Chapter Four.
[31] With the exception of dependants claims, because a claim based on assault, as an *iniuria*, is actively or passively transmissible only when *litis contestatio* has been reached. Neethling et al. 2005:78; *Argus Printing and Publishing Co Ltd v Esselen's Estate* 1994 2 SA 1 (A); *Potgieter v Rondalia assurance Corporation of SA Ltd* 1970 1 SA 705 (N).
[32] An *iniuria* is the wrongful and intentional infringement of an interest of personality and the body is one such interest. Carstens and Pearmain 2007:504; *Minister of Justice v Hofmeyr* 1993 (3) SA 131 (A):154C.

another.[33] The right to bodily integrity is not only regarded as an absolute common law right, but it is also a fundamental constitutional right [34] and one of the foundational constitutional values.[35] Therefore, the slightest infringement of bodily integrity is sufficient to found a cause of action based on assault.[36] On the other hand, under the Aquilian action and action for pain and suffering, the infringement of bodily integrity has no special significance. [37] The action for pain and suffering lies because of actual physical injury to the body[38] and the Aquilian action lies because of infringement of a patrimonial interest.[39]

b. Unlike English law relating to assault,[40] in South African law the infringement of the right to bodily integrity may take place through a broad range of conduct. For example, it is not always necessary for there to be direct or indirect physical contact between the parties[41] and the infringement may take place directly or indirectly,[42] by commission or by omission,[43] and externally or internally.[44]

c. The application of force in assault is regarded as a consequence. Viewed in this way, consent must cover not only the general nature of medical treatment, but also the consequences of medical treatment.[45]

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[33] Milton 1996:407 47.
[34] Section 12 of the Constitution of the Republic of South Africa, 1996.
[35] *Ex parte Minister of Safety and Security: In re S v Walters* 2002 (4) SA 613 (CC):631.
[36] Subject to the *de minimis non curat lex* rule, which provides that the infringement must not be of a trivial nature. *Bester* 1971 (4) SA 28 (T).
[37] Amerasinghe 1967:62.
[38] *Matthews & Others v Young* 1922 AD 492:504.
[39] For example, a dependant's claim for loss of maintenance following the death of a breadwinner.
[40] In order to hold a person liable for battery, there must be direct physical contact between the parties. Jackson 2006:276; McHale and Fox 2007:358; Trindade FA 1982:216, 218-219, 225-226; Kenny 1958:197.
[41] Strydom 1962:216.
[42] *Marx* 1962 (1) SA 848 (N); *Matthews* 1950 (3) SA 671 (N); Burchell 2005:684-685; Snyman 2006:433-434.
[43] *B* 1994 2 SACR 237 (E); *A* 1991 (2) SAV 257 (N).
[44] An example of an assault by omission which results in internal infringement of bodily integrity is if a doctor does not tell a patient about the availability of a more appropriate treatment option and, as a result, the patient decides to have no treatment at all rather than choose one of the unacceptable options set out by the doctor. As a result, there is application of force through the progression of a disease, which could have been halted if the doctor had disclosed the option in question. Jackson 2006:276. Another example is a nurse whose duty it is to give pain medication to a patient at certain times, but omits to do so and, as a result, the patient feels pain. Snyman 2004:46.
[45] Subject to the new test for consent introduced by *Castell v De Greef* 1994 (4) SA 408 (C). In this regard, see Chapter Four, Section 4.4.2.1 and 4.4.2.3.

d. Where an infringement of bodily integrity takes place by commission, either directly or indirectly, it is regarded as *prima facie* wrongful.[46] On the other hand, under the duty of care approach, the claim is always based on an omission to disclose risks of medical treatment, which is *prima facie* lawful.[47] In this regard, Carstens and Pearmain point out that converting to the idea that medical interventions are *prima facie* lawful undermines the value of consent as a justification ground to *prima facie* wrongful medical treatment and potentially undermines the realization of fundamental common law and constitutional rights such as the right to bodily integrity.[48]

e. In a delictual claim based on assault, once the plaintiff proves the application of force, the right to bodily integrity is further strengthened by the presumption of intention or *animus iniuriandi*, which the defendant must rebut.[49] In addition, while consciousness of wrongfulness is an important part of intention in criminal assault, it will respectfully be proposed that consciousness of wrongfulness has very limited relevance to delictual assault in South African medical law.[50] On the other hand, the test for negligence includes the professional practice standard and requires that the reasonable doctor would not only foresee the reasonable possibility of his conduct injuring another in his person or property and causing him patrimonial loss; but, in addition, would take reasonable steps to guard against such occurrence.[51] It therefore has the potential to severely curtail protection of the patient's right to bodily integrity

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[46] Neethling *et al.* 2006:302.
[47] Neethling 2006:211; Neethling and Potgieter 2007:122.
[48] Carstens and Pearmain 2007:499, 687, 501; See further the discussion in Chapter Six, Section 6.6.2.2.
[49] *Walker v Van Wezel* 1940 W L D 66:67; *Bennett v Minister of Police* 1980:34-35; *Groenewald v Groenewald* 1998 (2) SA 1106 (SCA):1111-1112.
[50] See, for example, *Stoffberg v Elliott*:150-151 and *Layton and Layton v Wilcox and Higginson* 1944 SR 48:50-51. In these cases, because the doctor had directed his will to applying force to the plaintiff, the fact that the touching was not accompanied by consciousness of the wrongfulness of the touching, was regarded as irrelevant in determining liability for assault. However, in the later case of *Castell v De Greef* 1994, the court required that in order to hold the defendant liable for assault, he/she must have possessed subjective or objective consciousness that the undisclosed risk was material to the particular patient in deciding whether to consent to the treatment. In other words, a particular type of mistake of fact, if reasonable, now excludes liability.
[51] *Kruger v Coetzee* 1966 2 SA 428 (A):430.

f. Where a claim is based on assault in delict, it is not only satisfaction but also patrimonial damages which may be claimed, where applicable.[52]

g. The National Health Act 61 of 2003 came into force in South Africa on 2 May 2005. Section 7 of the Act is titled 'Consent of user' and provides, *inter alia*, that a health service may not be provided to a user without the user's informed consent. The courts still need to interpret and apply the provisions of the Act.

The writer will respectfully suggest that the interpretation of the provisions of the Act will be influenced by the principles and rules that have been laid down by one or both of the conflicting standards which limit the amount of information which must be provided to a patient. The first is the patient standard, which is rooted in the justification ground of consent or *volenti non fit iniuria* and operates with reference to the informational requirements of the patient. The second is the professional practice standard, which functions at the fault, specifically negligence, stage of the enquiry into delictual liability and reflects the usual disclosure practice of doctors.

The writer is respectfully of the view that a major problem with the concurrent use of the above two methods in South Africa, is that the underlying values of the patient standard are incompatible with those underlying the professional practice standard encompassed in the negligence determination. Consequently, the use of contradictory methods through the use of assault and the justification ground of consent as the standard on the one hand, and the breach of the duty of care with negligence as the standard on the other, leads to contradictory outcomes and an unacceptable level of uncertainty as to what should be disclosed in practice. Therefore, one standard needs to be selected as the only

[52] Boberg 1989:18-20; *GA Fichardt Ltd v The Friend Newspapers Ltd* 1916 AD 1:7.

applicable standard.[53]

Secondly, when deciding which method to choose, it is important that a method of limiting disclosure is chosen which least infringes on a patient's right to self-determination.[54] It has often been argued that the professional practice standard does not adequately protect the right of a patient to self-determination.[55] The conclusion will be drawn that a patient-centered standard is more appropriate.

1.3.2 The fusion of wrongfulness and fault in the patient standard

A pre-requisite for *volenti non fit iniuria* is full knowledge of all the final negative consequences, whether probable or possible or highly unlikely.[56] However, the court in *Castell v De Greef*[57] introduced a new test for consent and, in so doing, limited the amount of information which must be disclosed to a patient to that information which the reasonable patient requires or that which the doctor actually or ought to foresee is significant to the particular patient.

The writer is respectfully of the view that the problem with the current construction of the test for consent in South Africa, is that the second leg of the test, being the individual patient standard, is not purely a subjective standard, which would require the doctor to disclose information which the patient in fact needs.[58] There is an additional requirement that the doctor is or should foresee the relevance of the information to the patient. The writer will respectfully

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[53] See the discussion and comparison of the competing standards in Chapter Five.
[54] The right to security and control over the body is regarded as an absolute right in South African common law. *Stoffberg v Elliott*:149-150; South African patients also have Constitutional rights, which protect their right to self-determination, such as the right to privacy, bodily integrity and security of the person and dignity. For example, section 12(2)(b) of the Constitution of the Republic of South Africa 1996, provides that 'Everyone has the right to bodily and psychological integrity, which includes the right to security in and control over their body', section 14 provides that all people have a right to privacy and section 10 protects the right to dignity.
[55] See for example, Giesen 1988:272, who argues that the more weight is attached to professional determination of the patient's welfare, the more paternalistic and elitist the standard of disclosure becomes, even to the exclusion of any right to self-determination.
[56] Strauss 1961:137.
[57] *Castell v De Greef* 1994:426G-H.
[58] Giesen 1988:297.

illustrate that, in so doing, the presence or absence of consent is made dependent on the state of mind of the defendant and, in effect, a form of the reasonable doctor standard for consent has been established.

The writer will respectfully propose that the fault of the defendant should have no impact on the determination of consent. The proposed standard will also be referred to as the combined patient-centered standard. This standard is not subject to the point of view of the defendant, rather it is strongly based on the informational requirements of the individual person and therefore on the right to self-determination. It is therefore a subjective enquiry related to the particular plaintiff.[59] The writer will respectfully suggest that this approach is more consistent with constitutional values and the law in relation to consent or *volenti non fit iniuria* in South Africa.[60]

1.3.3 Specific proposals in relation to South African law

The main proposals will be as follows:

a. Assault (criminal and/or delictual assault) as the primary cause of action, rather than the English breach of duty of care and negligence, when the claim is that the doctor treated the patient without disclosing the risks of treatment.
b. A combined patient-centered standard as the method for determining whether there was consent to the application of force. The test is modified in that it contains no reference to the state of mind of the defendant.

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[59] Pattinson 2006:102; Lubbe and Murray 1988:109; *Sidaway v Bethlem Royal Hospital Governors and Others* [1985] AC 871:894; *Malherbe v Eskom* 2002 (4) SA 497 (O); *Fourie v Naranjo* 2007 (4) All SA 1152 (C):1157b; *Castell v De Greef* 1994 (4) SA 408 (C):425H-I; *Waring and Gillow Ltd v Sherborne* 1904 TS 340:344.

[60] Innes J in *Waring and Gillow Ltd v Sherborne*:344, set out the elements of *volenti non fit iniuria*: '[I]t must be clearly shown that the risk was known, that it was realized, and that it was voluntarily undertaken. Knowledge, appreciation, consent – these are the essential elements; but knowledge does not invariably imply appreciation, and both together are not necessarily equivalent to consent.'

c. Consciousness of wrongfulness as an element of liability in criminal assault, but a limited requirement of consciousness of wrongfulness in delictual assault. By moving the requirement of reasonable foresight from the combined patient test for consent to the fault element in assault, the effect is that only a reasonable mistake of a particular type of fact is relevant. In other words, consciousness of wrongfulness is relevant to a limited extent in medical assault in delict.

1.4 Scope and outline of the study

The legal consequences of a medical intervention performed without the patient's consent are that the doctor may incur liability for breach of contract, civil or criminal assault (a violation of physical integrity), civil or criminal *iniuria* (in the sense of a violation of *dignitas*/privacy), negligence, or that the doctor may be unable to recover a professional fee.[61] Further, there may be constitutional liability because of violation of the constitutional right to bodily integrity, set out in section 12(2) of the Constitution of the Republic of South Africa.[62]

The dissertation will focus on informed consent to medical treatment as it is applied in South African case law, with particular emphasis on the failure to disclose risks of medical treatment in delictual assault. In addition, for purposes of comparison, criminal assault will also be discussed.

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[61] Van Oosten 1995:166.

[62] Act 108 of 1996. Section 8(1) of the Constitution provides that 'the Bill of Rights applies to all law, and binds the legislature, the executive, the judiciary and all organs of state' and section 8(2) provides that 'a provision of the Bill of Rights binds a natural or a juristic person.' Further, section 172(2)(a) provides that the Supreme Court of Appeal, a High Court or a court of similar status may decide a constitutional matter and section 172(1) provides that 'When deciding a constitutional matter within its power, a court –(a) must declare any law or conduct that is inconsistent with the Constitution is invalid to the extent of its inconsistency ... and (b) may make an order that is just an equitable...' However, Currie and De Waal 2001:189 point out that the Bill of Rights should be applied indirectly, through development of common law remedies, before it is applied directly. See also Van der Walt and Midgley 2005:18 and *Fose v Minister of Safety and Security* 1997:826B-D, 827H-828B. Section 8(3) of the Constitution confirms this approach: 'When applying a provision in the Bill of Rights to a natural or juristic person ... a court ... in order to give effect to a right in the Bill, must apply or if necessary develop, the common law...'

In the following chapter, delict and crime in South African law will be introduced, with particular reference to the various elements of a delict or crime.

In chapter three, delictual and criminal assault in South African law will be discussed, with particular reference to the nature of a cause of action based on assault, the justification ground of *volenti non fit iniuria* or consent and the requirement of *dolus* or intention and consciousness of wrongfulness.

In the fourth chapter, South African case law on informed consent will be examined in detail, with particular reference to the distinction between the cause of action based on assault and breach of duty of care. The standard of disclosure required under each cause of action will also be discussed. Attention will be paid to the elements of each cause of action.

In the fifth chapter, the competing standards of disclosure in South Africa in light of the National Health Act will be discussed.

In the sixth chapter, the doctrine of informed consent both within and outside South Africa will be discussed, with particular emphasis on the merits and feasibility of excluding assault as a cause of action where risks of medical treatment are in issue.

The final chapter will set out the writer's conclusions and submissions.

CHAPTER 2

CRIME AND DELICT

2.1 Crime and delict distinguished

A crime consists of unlawful, blameworthy conduct, punishable by the state. On the other hand, a delict is unlawful, blameworthy conduct resulting in damage to another and a right on the part of the injured party to compensation.[63]

A primary object of criminal proceedings is the punishment of the accused. Criminal law aims to promote the welfare of society and its members by establishing and maintaining peace and order. A crime is therefore almost invariably injurious to the public interest.[64] On the other hand, the main object of civil proceedings is the enforcement of a right claimed by the plaintiff against the defendant.[65] A delict aims to compensate the plaintiff and, in so doing, put him/her in the position he/she would have been had the delict not been committed.[66] It is therefore usually injurious only to private or individual interests.[67]

Crimes may consist of a circumstance, for example, driving over the speed limit, or a consequence, for example, murder, which requires a causal link between the act and a certain situation (the result).[68] However, because in delict there is no liability for a circumstance, delict and crime only overlap where the forbidden

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[63] Snyman 2006:5-6; Neethling *et al.* 2006:3.
[64] Burchell 2005:9, 68; McKerron 1971:1; Neethling *et al.* 2006:6; Snyman 2006:12.
[65] McKerron 1971:1; Van der Walt and Midgley 2005:31, point out that 'the law of delict still has a strong individualistic character. In effecting a compromise between conflicting interests, the interests of the particular individuals involved are primarily taken into account.'
[66] Delictual remedies are compensatory in nature, compensating or indemnifying the aggrieved party for the harm the defendant has caused. Neethling *et al.* 2006:6.
[67] Snyman 2006:6.
[68] Snyman 2006:77 classifies circumstance and consequence crimes as 'conduct' and 'result' crimes, or 'formally' and 'materially' defined crimes.

conduct involves consequences.[69] For example, if X assaults Y, X may be punished for assault by the state and, in addition, Y may claim damages in delict.[70] In each case, however, X's conduct must meet the particular requirements laid down by the crime or delict.

2.2 Delict

2.2.1 The generalizing approach

South African law of delict embraces a generalizing approach to delictual liability. In other words, general principles or requirements regulate the law of delict.[71] There are a number of delictual elements, which must all be proved, for the defendant to be held liable in delict, that is, the conduct, wrongfulness, fault (in the form of intention and/or negligence), causation and damage.[72]

In a delictual claim, the question of which party bears the burden of proof is determined as a matter of substantive law.[73] The plaintiff will, in the ordinary course of events, lead evidence to establish a *prima facie* case[74] against the defendant and the defendant must raise and prove a justification ground or other defence.[75] The standard of proof in a civil action is a balance of probabilities.[76]

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[69] Burchell 2005:185-186; *A* 1991 (1) SACR 257 (N):273c-d; Neethling *et al.* 2006:31; Milton 1991:383.
[70] Snyman 2006:6; Snyman 2004:450, 462-463, points out that assault is a consequence crime. See also, Strydom 1962:216.
[71] In *Minister of Finance and Others v EBN Trading* 1998 (2) SA 319 (N):324B-C, the court pointed out that 'In Roman law...the principles of the law developed from various types of actions; but today we deal essentially in principles rather than actions'.
[72] Neethling *et al.* 2006:vii-ix.
[73] Schwikkard and Van der Merwe 2002:537, 544; *Woerman and Schutte v Masondo* 2002 (1) SA 811 (SCA):819 A. The onus of proof is also affected by the allegations in the pleadings. *Klaassen v Benjamin* 1941 TPD 80. In actions for damages relating to delicts impacting on the plaintiff's bodily integrity or personality, the defendant usually raises a justification ground, which he/she then bears the onus to prove. *Mabaso v Felix* 1981 3 SA 865 (A). *Minister of Justice v Hofmeyr* 1993 (3) SA 131 (A). However, sometimes, the nature of the pleadings may place the onus on the plaintiff to negative the justification. *Minister of Law and Order v Monti* 1995 (1) SA 35 (A):37.
[74] A '*prima facie*' case means that the plaintiff has led enough evidence upon which a court, applying its mind reasonably, might find for him/her when he/she closes his/her case. Schwikkard and Van der Merwe 2002:542.
[75] Schwikkard and Van der Merwe 2002:537.
[76] Schwikkard and Van der Merwe 2002:544.

2.2.2 Elements

The first element is the act or conduct, which is the damage-causing event and consists of a voluntary human act or omission.[77] Furthermore, the conduct must be wrongful. However, Boberg[78] points out that it would be more accurate to speak of a wrongful consequence than wrongful conduct, because conduct is only delictually wrongful if it has as its consequence the infringement of an individual interest.[79]

Legally recognized interests or subjective rights consist of a dual relationship: firstly the relationship between the holder of the right, who has the power to use, enjoy and dispose of the legal object, for example, a corporeal thing.[80] Secondly the relationship between the holder of the right and the persons against whom it lies, in terms of which there is a duty on others to refrain from infringing the holder's relationship with the legal object.[81] Therefore, a right and a duty are correlative concepts and the one implies the other.[82]

Consequently, the question of wrongfulness may be approached by asking whether the defendant breached a legal duty or whether he/she infringed a recognized interest of the plaintiff.[83] However, Boberg[84] points out that wrongfulness is concerned less with the defendant's breach of duty than the plaintiff's interest it protects:

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[77] Neethling *et al.* 2006:23-24.
[78] Boberg 1989:31.
[79] Neethling *et al.* 2006:32 states that the act and its consequence are always separated by time and space, although the division may be negligible. For example, if X assaults Y by slapping Y in the face, the consequence (infringement of physical integrity or honour) follows immediately upon the act (the slap).
[80] Legally recognized interests or subjective rights are classified according to different legal objects, for example corporeal things, interests of personality, such as reputation, bodily integrity, dignity and privacy, immaterial products of the human intellect and spirit and performances, that is doing something or refraining from doing something. A right to a corporeal object is known as a real right and the right to an interest of personality is known as a personality right. Van der Walt and Midgley 2005:76
[81] Van der Walt and Midgley 2005:76.
[82] The affirmation of the defendant's duty implies the existence of the plaintiff's right and, if it is found that the plaintiff has a right, it implies there was a legal duty not to infringe it. Boberg 1989:31-32.
[83] Boberg 1989:32.
[84] Boberg 1989:31-32.

> The question is not "What acts are wrongful?" but "Which interests enjoy legal protection?" Those who define wrongfulness as the infringement of a legal right ... therefore place the emphasis where it belongs and focus attention upon the true enquiry...[85]

Further, at the heart of the wrongfulness enquiry is the criterion for determining whether the subjective right was infringed in a legally reprehensible manner. Therefore, crucial to the wrongfulness enquiry is: (a) the existence of an interest falling within the definable categories of rights and (b) a criterion for determining when an interference with the subject-object relationship is justified.[86]

In modern law, the general criterion used to determine whether a particular infringement of interests took place in a legally reprehensible or unreasonable manner, is the *boni mores* or the legal convictions of the community.[87] The infringement of the person or property of another by positive conduct is regarded as *prima facie* wrongful and, consequently, the determination of wrongfulness is seldom contentious.[88] On the other hand, an omission to avoid harm to others is *prima facie* lawful.[89] Wrongfulness will only be present when, according to the legal convictions of the community, there is a legal duty to prevent harm to others

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[85] An act is delictually wrongful if it has as its consequence the infringement of an individual interest. If the consequence is absent, the act cannot be wrongful. Boberg 1989:31; Neethling *et al.* 2006:31.

[86] Van der Walt and Midgley 2005:77. In *Universiteit van Pretoria v Tommie Meyer Films (Edms) Bpk* 1977 4 SA 376 (T):383, the court accepted and applied the doctrine of subjective rights in order to determine the wrongfulness of conduct. However, this approach does not exclude the existence or development of other criteria for determining wrongfulness. Van der Walt and Midgley 2005:76.

[87] Neethling *et al.* 2006:33-34; Neethling and Potgieter 2006:609. The act will only be wrongful if the infringement of the individual interest took place in a legally reprehensible or unreasonable manner. Neethling *et al.* 2006:33-34; Originally it was held that a duty to act only arises where the omission is connected with some prior positive act. *Cape Town Municipality v Paine* 1923 AD 207:217, 229. However, in time the categories of duties widened to include other criteria, such as control over dangerous things and public office or calling. McKerron 1971:14-2. Finally, in *Minister van Polisie v Ewels* 1975 (3) SA 590 (AD):597A-C, the court, per Rumpff CJ (Jansen JA, Trollip JA, Muller JA and Van Zijl AJA concurring) adopted a flexible approach and held that an omission will be regarded as unlawful if the circumstances of the case are of such a nature that the omission does not only evoke moral indignation but also the legal convictions of the community require that the omission is regarded as unlawful and that the damage ought to be borne by the person who omitted to act positively. This flexible criterion does not, however, negate the categories already established, but rather adds to them. Boberg 1975:363-364.

[88] *Minister of Justice v Hofmeyr* 1993 (3) SA 131 (A):153D-E; *Gouda Boerdery BK v Transnet* 2005 (5) SA 490 (SCA):498; *Telematrix v Advertising Standards Authority* SA 2006 (1) SA 461 (SCA):468; Boberg 1989:32; Neethling and Potgieter 2007:122; Neethling *et al.* 2006:41; Neethling 2006:210; *Trustees, Two Oceans Aquarium Trust v Kantey & Templer* 2006 (3) 138 (SCA):143-145.

[89] Neethling 2006:211; Neethling and Potgieter 2007:122.

through positive conduct.[90] This depends on the reasonableness or *boni mores* criterion whereby there is a weighing and a balancing between the interests of the parties and that of the community.[91]

There are various factors which the courts have traditionally considered relevant in determining whether a defendant had a legal duty to act positively to prevent harm to another:[92]

a. Statutory obligations.[93]
b. Knowledge or foreseeability on the part of the defendant.
c. A special relationship or proximity between the plaintiff and the defendant.[94]
d. A contractual undertaking to protect the plaintiff.
e. Factual control by the defendant over a dangerous situation.
f. A representation that the plaintiff would be protected.
g. Prior conduct (the *omissio* per *commissionem* rule).[95]
h. The possible or probable extent of harm the plaintiff could have suffered.
i. Preventative measures which could reasonably and practicably have been successful and whether the costs of taking the measures would have been proportional to the damage the plaintiff would have suffered.
j. Whether the public interest would be served by imposing a legal duty.
k. Whether a multiplicity of actions could result from placing the legal duty upon the defendant.

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[90] *Trustees, Two Oceans Aquarium Trust v Kantey & Templer (Pty) Ltd* 2006 (3) 138 (SCA):143-145; Society's reluctance to extend delictual liability to omissions is closely linked to the individualistic character of private law, reflected in the notion that as long as people do not cause harm to others, they are entitled to mind their own business even when they can morally and reasonably be expected to help someone else. Another reason for this position is that it may be too burdensome for society to shoulder a general duty to act to prevent harm to others. Brand 2007:76-77; See also Carstens and Pearmain 2007:506-507.

[91] Neethling 2006:211; *Van Eeden v Minister of Safety and Security (Women's Legal Center Trust as Amicus Curiae)* 2003 (1) SA 389 (SCA):395-6.

[92] Neethling 2005:583-585; Neethling *et al.* 2006:35, 62, 69; Neethling 2006:207-208.

[93] Non-compliance with a statutory duty, such as the provisions of the National Health Act, Act 61 of 2003, discussed in Chapter Five, is an indication that the violation of the plaintiff's interests took place wrongfully. However, it is not the violation of the norm which constitutes wrongfulness, rather the violation of the plaintiff's interests in a legally reprehensible manner. Neethling *et al.* 2006:69.

[94] Such as a doctor-patient relationship, for example. Neethling *et al.* 2006:62.

[95] A person acts *prima facie* wrongfully when he/she creates a new source of danger by means of positive conduct (*commissio*) and subsequently fails to eliminate the danger (*omissio*), with the result that harm is caused to another person. Neethling *et al.* 2001:58-59.

Neethling[96] points out that, in particular instances, the existence of a legal duty may be ascribed to one of the factors listed above, but in other cases a combination of several factors play a role. All the relevant circumstances of a particular case must be considered to determine whether a legal duty to act is present.

Further, once conduct is regarded as *prima facie* wrongful, it may nevertheless still be found to be lawful if justified by a ground of justification. Grounds of justification, such as private defence, necessity and consent, are crystalised expressions of the *boni mores* criterion, with reference to typical factual circumstances that occur regularly in practice.[97]

However, the determination of wrongfulness must now take place in light of the Constitutional rights and values. In *Carmichele v Minister of Safety and Security*,[98] the Constitutional Court emphasized that the common law determination of the *boni mores* of society must be re-evaluated in light of section 39(2) of the Constitution,[99] which provides that when interpreting any legislation, and when developing the common law or customary law, every court, tribunal or forum must promote the spirit, purport and objects of the Bill of Rights.[100]

In *Carmichele*,[101] an accused assaulted and injured the complainant while he was on bail. The plaintiff sued the state in delict, alleging that the state owed her a legal duty to prevent her from being harmed, that the state had negligently failed to comply with that duty and as a result she had suffered damage. The court held that the determination of wrongfulness has changed in the Constitutional era:

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[96] Neethling 2005:585-586.
[97] Neethling *et al.* 2006:70-71; It is seldom necessary to use the *boni mores* criterion directly as precise methods have developed to determine the legal convictions of society. Only in exceptional circumstances does it need to be applied.
[98] *Carmichele v Minister of Safety and Security* 2001 (4) SA 938 CC.
[99] The Constitution of the Republic of South Africa, 1996.
[100] Pieterse 2002:36, also states that 'the *boni mores*, which are instrumental to a finding of wrongfulness or otherwise in founding a duty to act, must necessarily incorporate the values of the Bill of Rights.'
[101] *Carmichele v Minister of Safety and Security* 2001 (4) SA 938 CC.

> [The common law determination of wrongfulness] had to reflect the wishes, often unspoken, and the perceptions, often but dimly discerned, of the people. A balance had to be struck between the interests of the parties and the conflicting interests of the community according to what the court conceives to be society's notions of what justice demands ...[However] under s 39(2) of the Constitution concepts such as policy decisions and value judgments ... might well have to be replaced, or supplemented and enriched by the appropriate norms of the objective value system embodied in the Constitution. Following this route it might be easier to cast the net of unlawfulness wider...[102]

Carstens and Pearmain,[103] also point out that the Constitution now reflects the *boni mores* of society:

> [The Constitution] now spells out the values of society in a more definite way so that there is now no doubt as to the nature of the public policy that must be taken into consideration in questions of wrongfulness for the purposes of the law of delict.[104]

In Chapter One, the Constitution states that South Africa is founded, *inter alia*, on the values of 'human dignity, the achievement of equality and the advancement of human rights and freedoms.'[105] Further, the fundamental human rights are spelt out in Chapter two in the Bill of Rights.

An infringement of a fundamental right, such as the right to bodily integrity, may give rise to a claim directly under the Constitution[106] including, in principle,

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[102] *Carmichele v Minister of Safety and Security* 2001 (4) SA 938 CC:962-963. For detailed commentary on this case see, for example, Leinius and Midgley 2002:17-39; Van der Walt 2002:148-221; Pieterse 2002:27-39; Van der Walt 2003:517-540.

[103] Carstens and Pearmain 2007:530.

[104] Christie 2001:411-412 also states that the Constitution represents a reliable statement of public policy. On the other hand, Neethling and Potgieter 2007:122-123 are of the view that it is not only constitutional norms which must be considered in the determination of wrongfulness. They state that the value judgment depends upon an examination of the circumstances of the particular case, where the interplay of various factors, including constitutional norms, must be considered. See also, Lenius and Midgley 2002:20-21 for the latter view.

[105] Section 1(a).

[106] Section 8(1) of the Constitution provides that 'the Bill of Rights applies to all law, and binds the legislature, the executive, the judiciary and all organs of state' and section 8(2) provides that 'a provision of the Bill of Rights binds a

damages.[107] In terms of this enquiry, it must firstly be asked whether there was an infringement of the right and, secondly, whether the infringement was justified with reference to section 36(1) of the Constitution, that is, the limitation clause.[108]

However, Currie and De Waal[109] point out that the Bill of Rights should be applied indirectly, through development of common law remedies, before it is applied directly.[110] Section 8(3) of the Constitution confirms this approach:

> When applying a provision in the Bill of Rights to a natural or juristic person ... a court ... in order to give effect to a right in the Bill, must apply or if necessary develop, the common law...[111]

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natural or a juristic person.' Further, section 172(2)(a) provides that the Supreme Court of Appeal, a High Court or a court of similar status may decide a constitutional matter and section 172(1) provides that 'When deciding a constitutional matter within its power, a court –(a) must declare any law or conduct that is inconsistent with the Constitution is invalid to the extent of its inconsistency ... and (b) may make an order that is just an equitable...'

[107] Whereas common law damages are traditionally compensatory in nature, constitutional damages are aimed at vindicating the rights offended and deterring their future violation. Varney 1998:340-341. In *Fose v Minister of Safety and Security* 1997(3) SA 786 (CC):798-789, the Constitutional Court held that whilst the primary purpose of the common law of delict is to regulate relationships between parties, the main aim of a constitutional claim is to protect the constitutional rights of individuals from state intrusion. Further, the law of delict seeks to compensate one party because of the wrongful actions of another. Under the law of delict, compensatory damages include compensation for pain and suffering and patrimonial loss. In addition, occasionally punitive damages are awarded, for example, in cases concerning defamation and adultery. See, for example, *Salzmann v Holmes* 1914 AD 471:480, 483 and *Bruwer v Joubert* 1966 (3) SA 334 (A):338C-D. On the other hand, a constitutional remedy not only has as its objective the compensation for harm caused to a plaintiff for infringement of his/her fundamental rights, but also vindication of the right itself, deterrence and prevention of future infringements of fundamental rights and the punishment of those who have infringed fundamental rights.

[108] Neethling *et al.* 2006:19 fn 154.

[109] Currie and De Waal 2001:189. The authors point out that this is in accordance with the principle of avoidance of constitutional issues. In *Fose v Minister of Safety and Security* 1997 (3) SA 786 (CC), 1997 (7) BCLR 851 (CC), the complainant alleged that several of his fundamental rights, including his right to human dignity, freedom and security of the person and privacy, had been infringed by the South African police when they allegedly assaulted and tortured him. He claimed 'constitutional damages' over and above the common law damages which were awarded to him. The court held that, in the circumstances, the common law relief in the form of compensatory damages suffered was sufficient vindication of the plaintiff's constitutional rights. Further, the court held that punitive constitutional damages were not appropriate in a country where there is a great demand on public resources and such funds could be better used in structural and systemic ways to eliminate or reduce the cause of the infringements. The court also held that, in the circumstances of the case, if a violation of a fundamental right gives rise to a common law claim for damages in delict, then the plaintiff cannot claim an additional amount for breach of the fundamental right unless there are widespread and persistent similar infringements of fundamental rights. *Fose v Minister of Safety and Security* 1997:826B-D, 827H-828B.

[110] Van der Walt and Midgley 2005:18, explain the procedure when applying the Constitution indirectly to the common-law as follows: 'First, courts must consider whether the common law is deficient when measured against the objectives of section 39(2); and, if it is, then they have to determine what ought to be done to meet those objectives and to ensure that the common law reflects proper values. In so doing they should give content to common law principles and concepts, not by applying and giving effect to any specific provision in the bill of rights, but by having regard to the "spirit purport and objects" of the bill of rights.' However, the authors add that 'a specific constitutional right does of course articulate constitutional values and could be considered in that sense.' Van der Walt and Midgley 2005:19 fn 12.

[111] Section 8(3) also provides that the courts may develop rules of common law to limit fundamental rights, provided that the limitations are in accordance with section 36(1). Section 36(1) provides that "The rights in the Bill of Rights may by limited only in terms of a law of general application to the extent that the limitation is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom, taking into account all relevant factors, including- (a) the nature of the right; (b) the importance of the purpose of the limitation; (c) the nature and extent of the limitation; (d) the relation between the limitation and its purpose; (e) less restrictive means to achieve the purpose.

In *Fose v Minister of Safety and Security*,[112] the Constitutional Court held that common law remedies must be developed in order to be effective in upholding the Constitutional values and fundamental rights:

> An appropriate remedy must be an effective remedy, for without effective remedies for breach [of a fundamental right], the values underlying and the rights entrenched in the Constitution cannot properly be upheld or enhanced...The courts have a particular responsibility in this regard and are obliged to *forge new tools and shape innovative remedies*, if need be, to achieve this goal.[113]

2.2.3 Common law remedies

In Roman law there were two forms of action. The first was the action based on *iniuria* or injury, in which damages were claimed for personality infringement.[114] The aim of the *actio iniuriarum* was retribution/satisfaction sought for by way of pecuniary penalty in order to satisfy the sufferer's injured feelings, caused by another inflicting pain or distress on the mind or body.[115] Fault in the form of *animus iniuriandi* or intention was required.[116]

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[112] *Fose v Minister of Safety and Security* 1997:826G-I.

[113] My emphasis. Van der Walt and Midgley 2005:19, point out that 'the possibilities for indirect application are endless. The Constitution could (a) affect the structural aspects regarding the nature of delictual liability, specifically the nature and role of the fault element, the development of new remedies, and procedural issues; (b) influencing the nature of the rules by promoting the creation of new substantive rights, by extending or restricting the ambit of current provisions, by creating new defences or reformulating existing ones, or by revisiting the content of rules and concepts, particularly open-ended standards or principles, such as objective reasonableness, legal causation or negligence; and (c) it could radiate upon the manner in which rules are applied to factual situations, and their ultimate effect on parties – how conflicting rights ought to be balanced, or restricted, or how rules should be applied to specific facts so that the result does not conflict with constitutional values.'

[114] Thomas 1976:369. The rights protected by the *actio iniuriarum* were those which every person has as a matter of natural right. Rights such as dignity are absolute in that they are not created by, nor dependent for their being upon any contract. De Villliers 1899:24.

[115] *Iniuria* included the infringements of *corpus*, *fama* and *dignitas*. Thomas 1976:369.

[116] Thomas 1976:370. Intention in this regard means that the defendant directs his/her will to the infringement of the plaintiff's right to physical-mental integrity in the knowledge that such an infringement is possibly wrongful. Neethling *et al.* 2005:106-107. *Dolus* or wrongful intent is virtually identical in meaning with the *animus iniuriarum*. Amerasinghe 1967:194. Roman and Roman-Dutch law required intent as an element of liability for an *iniuria*. The concept of *contumelia* was used in connection with *iniuria*, but indicated only the intentional violation of another's personality, or conduct which demonstrated contempt for a person's personality and did not mean that the intent to insult or to violate a person's honour had to accompany every *iniuria*. Neethling *et al.* 2006:12-13.

The second was the *actio legis Aquiliae*[117] in which pecuniary loss was claimed for physical damage to economic interests.[118] It was an action to recover actual damages for actual economic loss sustained. However, in addition to damage to property, the *actio legis Aquiliae* was also made available to a free man for patrimonial loss resulting from personal injuries.[119] Fault in the form of *dolus* or *culpa* was required.[120] Further, the patrimonial damages had to have been caused by the unlawful and culpable conduct.[121]

In addition, in Roman-Dutch law, an injured person could claim non-patrimonial damages for pain and suffering, independently of both the *actio legis Aquiliae* and the *actio iniuriarum.*[122] The action for pain and suffering did not fall under the *actio iniuriarum* and consequently negligence on the part of the defendant was sufficient for liability.[123] It was not aimed primarily at satisfaction as in the case of the *actio iniuriarum,* but had a compensatory function in that the law attempted in an imperfect way to restore the impairment of physical integrity.[124]

The *actio iniuriarum,* the *actio legis Aquiliae* and the action for pain and suffering are now the three pillars of the South African law of delict.[125] Within the structure

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[117] The *acio legis Aquiliae* is based on an Act from 286/287 BC known as the *Lex Aquilia*. For a discussion see Van der Walt and Midgley 2005:8-10.
[118] Thomas 1976:363-369.
[119] As well as to a father for patrimonial loss suffered as a result of injury to his child. Van der Walt and Midgley 1997:10; Neethling *et al.* 2006:8. In modern South African law, physical injury to person or property is not necessary to found Aquilian liability, because compensation may also be awarded for pure economic loss through the Aquilian action. *Coronation Brick v Strachan Construction Co* 1982 (4) SA 371 (D):377.
[120] Van der Walt and Midgley 2005:9; Thomas 1976:365. It is not enough that the defendant has wrongfully infringed the plaintiff's rights; the law must also be prepared to hold him/her accountable. Boberg 1989:268; Neethling *et al.* 2006:21, 23, 31-33. *Dolus* or Intention is a subjective enquiry into the mind of the defendant. The *factum probandum* is the defendant's actual state of mind. Boberg 1989:271. *Dolus* may take the form of *dolus directus* (the defendant's primary object was to produce the consequence. Boberg 1989:268), *dolus indirectus* (the consequence was a necessary and foreseen consequence of attaining the defendant's primary object. Boberg 1989:268) or *dolus eventualis* (which represents the minimum requirement for intention, which is that the defendant, while not desiring the result, subjectively foresees the possibility that he/she may cause the result and reconciles him/herself to this, by performing the act, which brings about the consequence in question. Neethling *et al.* 2006:113). On the other hand, *culpa* or negligence is an objective enquiry into the blameworthiness of the conduct of the defendant. The two traditional legs of the enquiry into negligence are reasonable foresight and reasonable preventability of damage. Neethling *et al.* 2006:126. Neethling and Potgieter 2007:123.
[121] Boberg 1989:475-476. Roman law also required a causal connection between the wrongful act of the defendant and the harm, but it did not develop a theory of causation. Van der Walt and Midgley 2005:9.
[122] *Government of the RSA v Ngubane* 1972 (2) SA 601 (A):606; *Administrator Natal v Edouard* 1990 (3) SA 581 (A):595.
[123] However, the intentional causing of bodily harm is also sufficient for the action for pain and suffering in South African law. Neethling *et al.* 2001:5.
[124] Neethling *et al.* 2005:48-49.
[125] Boberg 1989:20, accepts that the weight of authority regards the action for pain and suffering as *sui generis*, but proposes that it is treated as part of the Aquilian action, particularly as he points out that the action's departure from Aquilian principles is confined to compensating for non-patrimonial loss.

provided by these three actions, the modern South African law of delict embraces a generalizing approach to delictual liability. In other words, general principles or requirements regulate the law of delict.[126] Certain forms of delict, which occur often in practice have become known as separate delicts with specific names, for example, invasion of privacy and insult.[127] However, they are essentially a species of the *genus* delict and may give rise to a claim under one or more of the three pillars of South African law of delict.[128]

2.3 Crime

2.3.1 The presumption of innocence

The constitutional and common-law presumption of innocence[129] and the principle that the burden of proof rests on the person making a positive allegation, casts on the state the burden of proving the guilt of an accused beyond reasonable doubt.[130] However, as Dlamini[131] observes 'this leads to the question of what facts or incidents, if proved, comprise the guilt of the accused? Or is guilt a single incident which, if proved, will lead to the punishment of the accused?' He points out that criminal law solves this problem for procedural law by dividing the crime into various elements, which the state must prove beyond reasonable doubt.[132]

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[126] Neethling *et al.* 2006:4-5.
[127] Neethling *et al.* 2006:4-5.
[128] In *Minster of Finance and Others v EBN Trading (Pty) Ltd* 1998 (2) SA 319 (N):324B-D.
[129] Section 35(3)(h) of the Constitution of the Republic of South Africa, 1996, states that 'Every accused person has a right to a fair trial, which includes the right ...to be presumed innocent ...'
[130] *Coetzee* 1997 (3) SA 527 (CC) (1997) (1) SACR 379 (CC):383b-c; Schwikkard and Van der Merwe 2002:526. In *Kubeka* 1982 1 SA 534 (W) 538G, Slomowitz AJ observed: 'The rule that the state is required to prove guilt beyond a reasonable doubt has on occasion been criticized as being anomalous. On the other hand, the vast majority of lawyers (myself included) subscribe to the view that in the search for truth it is better that guilty men should go free than that an innocent man should be punished.'
[131] Dlamini 2001:23.
[132] Dlamini 2001:23.

The presumption of innocence requires the state to prove all elements of the offence charged as well as the absence of any defence raised by the accused.[133] Once the prosecution establishes a *prima facie* case, the accused carries an evidential burden if he/she raises a defence, for example, a justification ground such as consent. However, the onus remains on the State to prove all the elements of the offence, including unlawfulness.[134]

2.3.2 Elements of a crime

The principle of legality requires that it must first be established that the human conduct forming the basis of the charge is recognized in South African law as a crime, in clear, unambiguous terms, and that it was recognized as a crime before the conduct took place.[135]

The voluntary conduct, in the form of an act or omission, is the first element of a crime that must be proved.[136] Burchell,[137] states that the conduct element of a crime involves not only a physical aspect, but also a consequence. On the other

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[133] Schwikkard 1999:19. The author refers to, *inter alia*, *Ndlovu* 1986 (1) SA 510 (N); *Ngomane* 1979 (3) SA 859 (A); *Mtetwa* 1977 (3) SA 628 (E); *Van Rensburg* 1987 (3) SA 35 (T); *Viljoen* 1992 (1) SACR 601 (T); *Potgieter* 1994 (1) SACR 61 (A); *Adams* 1981 (1) SA 187 (A); *Chretien* 1981 (1) SA 1097 (A); *Hlongwane* 1959 (3) SA 337 (A); *Mhlongo* 1991 (2) SACR 207 (A) and *Zwayi* 19997 (2) SACR 772 (CkHC) in support. If the act complies with the definitional elements, it can be described as *prima facie* unlawful or provisionally unlawful. However, it can only be conclusively stamped as unlawful if it is clear that it cannot be justified. Snyman 2006:94-95. In *Engelbrecht* 2005 (2) SACR 41 (WLD):137c-d, the court emphasized that in a criminal trial, the burden of proof rests with the state to prove the guilt of the accused beyond reasonable doubt. The accused must discharge an evidential burden in respect of a ground of justification for her actions. However, the onus remains on the state to prove all the elements of the offence, including unlawfulness.

[134] In *Scagell v Attorney-General of the Western Cape* 1997 (2) SA 368 (CC), the court pointed out that an evidentiary burden requires sufficient evidence to give rise to a reasonable doubt to prevent conviction. The evidentiary burden refers to one party's duty of producing sufficient evidence for a judge to call on the other party to answer and it also encompasses the duty cast upon a litigant to adduce evidence in order to combat a *prima facie* case made by his opponent. In certain circumstances the burden of proof and the evidentiary burden will coincide. At the beginning of a criminal trial, the prosecution bears both the burden of proof and the evidentiary burden. The evidentiary burden is discharged once the prosecution has established a *prima facie* case. The evidentiary burden then shifts to the accused to adduce evidence or run the risk of conviction. However, it is possible that even if the accused does not lead evidence, he will not be convicted if the court is satisfied that the prosecution has not proved guilt beyond a reasonable doubt. Unlike the shifting of the evidential burden, the burden of proof remains with the prosecution. Schwikkard and Van der Merwe 2002:525; Schwikkard 1999:19.

[135] Burchell 2005:94-96; Snyman 2006:41.

[136] In a consequence crime, it is not only a positive act, but also an omission where there is a duty to act, which can give rise to criminal liability. Burchell 2005:178, 185-186, states that a concept of the act that is limited to a bodily movement, whether voluntary or involuntary, is inadequate in that it does not accommodate a failure to act (or omission) and may have to be unnaturally extended to cover the utterance of words.

[137] Burchell 2005:185-186.

hand, Snyman[138] states that the causal link is a specification of the circumstances in which the act is unlawful.[139]

If the act complies with the definitional elements, it can be described as *prima facie* unlawful or provisionally unlawful.[140] However, it can only be conclusively stamped as unlawful if it is clear that there are no circumstances which justify the performance of the conduct and render it lawful.[141] As in law of delict, various justification grounds have crystallized over time, such as private defence, necessity and consent.[142]

Further, the conduct of the accused must not only be unlawful but it must also be culpable, unless the crime imposes strict liability. However, since the advent of the Constitution, courts very seldom construe statutory provisions as creating offences of strict liability and there are only a few examples of the application of this exception to the requirement that fault is an essential element of liability.[143] Where intention is an element of the particular crime, *dolus directus*,[144] *dolus indirectus*[145] or *dolus eventualis*[146] is generally required.[147]

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[138] Snyman 2006:69-70, 95 points out that whereas all crimes require conduct, not all crimes require causation. He states that the conduct is the basic element and all the other elements are attributes or qualifications of the act.

[139] See also Paizes 1996:239.

[140] A *prima facie* case is 'one in which the prosecution case is complete on all inculpatory elements of the offence and sufficient in the sense that a reasonable trier of fact could find that the evidence comes up to proof beyond a reasonable doubt.' Schwikkard 2002:534.

[141] Snyman 2006:94-95.

[142] Snyman 2006:95.

[143] For example, parking and speeding offences. Burchell 2005:549-550. O'Regan J in *Coetzee* 1997 (3) SA 527 (CC) (1997) (1) SACR 379 (CC):442:h-i, emphasized that it is a fundamental principle of democratic communities that 'people who are not at fault should not be deprived of their freedom.' Strict liability relieves the prosecution of proving the fundamental element of fault and therefore could lead to a conviction despite a reasonable doubt of guilt. Burchell 2005:550.

[144] The accused's aim and object is to perpetrate the unlawful conduct or cause the unlawful consequence. Burchell 2005:152; *Sigwahla* 1967 (4) SA 566 (A):569-570; *De Bruyn* 1968 (4) SA 498 (A):505, 510.

[145] The accused foresaw the unlawful conduct or consequence as certain or substantially certain to occur. Burchell 2005:152. In *Kewelram* 1922 AD 213, the accused set fire to stock in a store. His aim was to destroy the stock (*dolus directus*) in order to claim insurance money. However, he foresaw the destruction of the store as virtually certain, or an inevitable consequence of burning the stock (*dolus indirectus*).

[146] The accused foresees the possibility of the circumstance or consequence occurring and reconciles him/herself to the possibility/consents to the possibility/takes the possibility into the bargain. *Sethoga* 1990 (1) SA 270 (A); *Campos* 2002 (1) SACR 233 (SCA). In *Jolly* 1923 AD 176:181-182, the appellants derailed a train unlawfully and intentionally. No-one was seriously injured. However, the court held that the appellants had intended to kill as they had foreseen the possibility of death of the passengers as a result of the derailing, yet were content to cause the risk in order to achieve their main object.

[147] Snyman 2006:183-186. Furthermore, fault in the form of negligence is sufficient for some crimes, for example, culpable homicide. Du Plessis 2000:33. For a successful conviction of culpable homicide the prosecution must prove beyond reasonable doubt that a reasonable person, in the same circumstances as the accused, would have foreseen the death of the victim as a consequence of his/her conduct, would have taken steps to guard against this consequence and the accused failed to take these steps. Burchell 2005:160.

Further, the common-law definitions of criminal conduct and the scope of the defences to such conduct are, as in law of delict, susceptible to scrutiny under the South African Constitution. When directly applied, the Bill of Rights overrides legislation and conduct that is inconsistent with it. However, when indirectly applied, the Constitution and Bill of Rights establish an objective, normative value system which provides the matrix within which the common law must be developed.[148]

[148] *Carmichele v Minister of Safety and Security* 2001 (4) SA 938 (CC):961; The judgment in *Engelbrecht* 2005 (2) SACR 41 (WLD): 132a-b, 134c-d, is an example of indirect application of the Bill of Rights which resulted in the development of the justification ground of self-defence. A woman killed her husband after planning and buying a gun for this purpose, because the deceased husband had physically and mentally abused the woman over a number of years. The court applied the justification ground of self-defence to the facts of the case. In so doing, the court considered Constitutional principles, in particular the duty of the court to have regard to the values of human dignity, equality and freedom underpinning the Constitution. The court held that where there is a cycle of abuse, the requirement of 'imminence' in self-defence, should be extended to include abuse which is 'inevitable'. As a result, premeditation of the defensive act is not necessarily inconsistent with the justification ground.

CHAPTER 3

CRIMINAL AND DELICTUAL ASSAULT

3.1 English law

In contrast to the generalising approach in South African law, English law is casuistic. The law of delict consists of a group of separate delicts (torts), each with its own rules, and liability will only follow if the plaintiff satisfies the requirements of the specific delict.[149]

Battery, assault and false imprisonment comprise what the English common law calls trespass to the person, which is any type of activity that infringes the bodily integrity or liberty of another.[150] Battery can be defined as the intentional application of physical contact to the person without consent or other lawful justification.[151] On the other hand, the unlawful inspiring of fear in another person that he/she is going to be attacked (that is, experience a battery) is known as 'assault'.[152]

In order to hold a person liable for battery, there must be direct physical contact between the parties.[153] Kenny explains that 'it is essential to a battery that there should be a personal exertion of force by the assailant.'[154]

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[149] Neethling *et al.* 2006:4-5.
[150] McHale and Fox 2007:352.
[151] Kenney and Grubb 1998:110 fn 3.
[152] Pattinson 2006:98. However, in practice, a trespass to the person is called 'trespass to the person' 'battery' in tort and 'assault' in criminal law. Jackson 2006:274; Pattinson 2006:104; McHale and Fox 2007:352. Likewise, in Australian law, treatment for which no consent is obtained is known as battery in tort and criminal battery or assault in criminal law. Devereux 2007:694.
[153] Jackson 2006:276; McHale and Fox 2007:358; Trindade FA 1982:216, 218-219, 225-226; Kenny 1958:197. McLean 2006:76. Kennedy and Grubb 1998:110 fn 7, point out that there is no battery if the medical intervention did not involve a touching, for example, if a doctor causes a patient to take a drug where he/she is not aware that he/she is part of a research project. In *Hanson* (1849) 2 Car & Kir 912; 4 cox CC 138, it was held that the administration of poison to a woman was not an assault in common law. Further, in *Clarence* (1889) 22 QBD:23, it was held that a man who transmitted a sexually transmitted infection to his wife after he had sexual intercourse with her without disclosing that he was infected with gonorrhoea, could not be held liable for assault.
[154] Kenny 1958:197.

Furthermore, the consent of the plaintiff is a complete defence to battery[155] and the information threshold for consent is very low.[156] For example, no battery is committed when a patient understands the broad nature of the medical treatment.[157] Therefore, in practice, when a patient consents to a medical procedure, he/she is just about always aware of its 'nature.'[158] Furthermore, the plaintiff must prove the absence of consent. In other words, the application of force is *prima facie* lawful.[159]

The defendant must also act intentionally. However, intention only relates to the physical contact and it is not necessary for the defendant to intend or foresee the plaintiff's harm.[160] Further, in medical cases, the hostility requirement, if required at all, is satisfied where a competent adult is subjected to unauthorised treatment.[161]

The actionable harm is the uninvited contact rather than the consequences of that contact. Therefore, in establishing a cause of action the plaintiff does not have to prove causation and damage.[162] Consequently, a patient does not have to prove that he/she would not have had the operation if he/she had been informed of the risk in question.[163] A patient may also sue where a doctor performs an operation without consent, even if the operation was medically required and improves the patient's health.[164]

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[155] Martin 1985:151-152; Trindade 1982:228.
[156] Pattinson 2006:103, 107.
[157] Pattinson 2006:104; McHale and Fox 2007:360. The information requirement for the criminal law of assault is the same as that for battery. In other words, conduct giving rise to a claim for battery will usually also amount to the crime of assault. Pattinson 2006:105.
[158] Pattinson 2006:104. Therefore, an action for battery will only be available if, for example, a doctor treats a patient against the patient's will, administers a different treatment or obtains a patient's consent by misrepresentation or fraud. Pattinson 2006:104. Geisen 1988:28. A complaint regarding the failure to disclose the risks of medical treatment must be brought in negligence. Pattinson 2006:107.
[159] Kennedy and Grubb 1998:112; Pattinson 2006:100 who refers to *Freeman v Home Office* [1984] 1 QB 524 in support. However, for criticism of this position, see Trindade 1982:229.
[160] Trindade 1982:219; Pattinson 2006:99, who refers to *Wilson v Pringle* [1987] QB 237:249 in support. McHale and Fox 2007:353.
[161] Pattinson 2006:99-100; Kennedy and Grubb 1998:111.
[162] Pattinson 2006:98. However, damage is relevant to the amount of compensation that will be awarded.
[163] *Chatterton v Gerson* [1981] QB 432:442H-443A; Pattinson 2006:104; Martin 1985:153.
[164] McHale and Fox 2007:363; Pattinson 2006:104.

The defendant is liable for the consequences that flow directly from his/her unlawful and intentional act. Therefore, damages may be recovered in the modern tort of battery for the unforeseen medical complications of an unlawful procedure, even though damages would not be recoverable in negligence.[165]

3.2 South Africa

3.2.1 The nature of assault

In Roman law, conduct which would today constitute an assault, was pursued under the much wider wrong of *iniuria.*[166] An *iniuria* is the wrongful and intentional infringement of an interest of personality.[167] In *Umfaan*,[168] Innes CJ explained:

> If we look at the essentials of an *iniuria* we find ... that they are three. The act complained of must be wrongful; it must be intentional; and it must violate one or other of those real rights, those rights *in rem*, related to personality, which every free man is entitled to enjoy.[169]

In common law, *iniuria* was wide enough to embrace a number of infringements of the body, honour, dignity and good name. Similarly, the rights to personality that are protected in modern South African law are the rights to physical integrity (*corpus* or body and *libertas* or liberty), the right to *fama* (good name) and *dignitas* (a collective term for the rights to dignity, privacy, feelings and

[165] Pattinson 2006:98. McHale and Fox 2007:363-364; Martin 1985:153.
[166] De Villiers 1899:78-80; *R v Kumalo* 1952 1 SA 381 (A):388-391. In Roman-Dutch law authorities fall into two broad categories: those who, like the Romans, treated assault as one form of *iniuria* and those who regarded assault as an independent substantive crime punishable largely in accordance with the numerous local statutes. Hunt and Milton 1982:463.
[167] Carstens and Pearmain 2007:504; *Minister of Justice v Hofmeyr* 1993 (3) SA 131 (A):154C.
[168] *Umfaan* 1908 TS 62. The accused in this case verbally threatened to kill another person in a private place.
[169] *Umfaan*:66.

identity).[170] A criminal prosecution or a civil action following an *iniuria* is possible.[171]

The right to physical integrity protects the physical-psychological aspect of the personality and comprises a number of elements: (a) the body, through which the person is protected against physical infringement, (b) health, including mental well-being and (c) bodily freedom, which not only comprises protection against imprisonment, but also protection against restriction of movement and freedom of action.[172]

Under the influence of English law, in particular during the nineteenth century, an *iniuria* committed against the bodily integrity (*corpus*) of another developed into a separate substantive crime or delict, known as assault.[173] However, in South Africa, the definition of assault does not distinguish between the English law concepts of 'assault' and 'battery'. Instead, the concepts are fused together, into the single offence of assault.[174] A number of forms of assault also evolved under the influence of English law, for example, assault with intent to do grievous bodily harm, indecent assault and common assault. All are chargeable independently.[175]

The majority of South African academic authors accept assault as a cause of action in delict when there is an intentional infringement of bodily integrity.[176] Most authors also hold the view that assault is an *iniuria* against the *corpus* of another.[177] Further, most case law expressly treats assault as an *iniuria,*[178]

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[170] Neethling *et al.* 2006:297. In *Umfaan:66*, Innes J pointed out that 'An *iniuria* ... infringes [a person's] dignity, his person or his reputation.

[171] This was also the position in Roman law. In the later classical period criminal redress was always available for any *iniuria* but especially where the wrongdoer would not have been worth suing, by reason of lack of means. Thomas 1976:371-372. In modern criminal law, an *iniuria* committed against another's dignity is prosecuted as a *crimen iniuria*, whereas an *iniuria* against someone's good name is punished as defamation. Snyman 2004:449.

[172] Joubert 1953:131.

[173] Snyman 2004:449. Hunt and Milton 1982:465 point out that 'there is no doubt that from early in the nineteenth century it was so regarded in South African practice.'

[174] Burchell 2005:680-682.

[175] Burchell 2005:162; Hunt and Milton 1982:465.

[176] Amerasinghe 1967:57-75, 194-208; McKerron 1971:153; Boberg 1989:19; Carstens and Pearmain 2007:499; Van der Walt and Midgley 2005:110.

[177] See for example, Carstens and Pearmain 2007:500-501; Snyman 2004:449.

whereas some case law appears to impliedly treat assault as an *iniuria,* in that it only refers to a cause of action in assault, but the requirements for a cause of action remain the same.[179]

The definition of common assault is the same in both criminal law and law of delict[180] and an action based on assault may be brought in both criminal law[181] and civil law.[182] Assault is defined as 'unlawfully and intentionally applying force to the person of another or inspiring a belief in that other that force is immediately to be applied'.[183] Therefore, the essential elements are a) applying force or inspiring apprehension of it, b) unlawfully and c) intentionally.[184]

3.2.2 Applying force or inspiring the apprehension of it

The plaintiff must prove the facts necessary to establish the act of assault.[185] The fundamental principle underlying assault is that physical force, of whatever sort and in whatever degree, should not be applied to the body of another.[186] Therefore, subject to the *de minimis* rule,[187] even the slightest contact with another person's body is sufficient.[188] Further, the application of force to the body need not be accompanied by *contumelia* in the sense of insult.[189]

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[178] See, for example, *Marx* 1962 (1) SA 848 (N):853; *Jack* 1908 TS 132:132-133; *Brandon v Minister of Law and Order* 1997 (3) SA 68 (C)*; Bennett v Minister of Police* 1980 (3) SA 24 (C):35; *Brown v Hoffman* 1977 (2) SA 556 (NC):557A-B.
[179] For example, in *Mthimkhulu and Another v Minister of Law and Order* 1993 (3) SA 432 (E), the court decided the matter as an assault, but did not refer to assault as an *iniuria.*
[180] Amerasinghe 1967:57 fn 2, states that the South African criminal law definition serves for the civil law as well, as 'it is difficult to see why the delict of assault should differ in its initial *factum.'*
[181] See for example, *Bester* 1971 (4) SA 28 (T); *Jolly* 1923 AD 176; *B* 1994 (2) SACR 237 (E); *A* 1991 (2) SACR 257 (N); *Marx* 1962 (1) SA 848 (N); *Collett* 1978 (3) SA 206 (RA); *Sibanyone* 1940 JS 40 (T); *Miya* 1966 (4) SA 274 (N).
[182] See for example, *Broude v McIntosh* 1998 (3) SA 60 (SCA); *Castell v De Greef* 1994 (4) SA 408 (C); *Layton and Layton v Wilcox and Higginson* 1944 SR 48; *Esterhuizen v Administrator Transvaal* 1957 3 SA 710 T; *Oldwage v Louwrens* [2004] 1 All SA 532 (C).
[183] Burchell 2005:161; This approach is in harmony with the common law *iniuria*, which recognized both forms of the modern day assault. Snyman 2004:449.
[184] Burchell 2005:161.
[185] *Jackson v SA national Institute for Crime Prevention* 1976 (3) SA 1 (A); *Mthimkhulu*:441F.
[186] Milton 1996:407.
[187]The *de minimis non curat lex* rule, which provides that the infringement must not be of a trivial nature. *Bester* 1971 (4) SA 28 (T); The law will not punish trifles. The *de minimis non curat lex* rule is, strictly speaking, not a defence which excludes the unlawfulness of the accused's conduct, but rather a decision of the court to allow the unlawful conduct to go unpunished on account of its triviality. Burchell 2005:355
[188] Burchell 2005:685; Snyman 2006:434; Amerasinghe 1967:62.
[189] Amerasinghe 1967:60-61; Neethling *et al* 2006:302; Boberg 1989:746 states that 'Assault is *per se* contumelious.' Amerasinghe 1967:60-62, 205 points out that the Romans did not regard interference with bodily integrity as an

In English law there must be a direct application of actual physical force by one person to the body of the other. However, Snyman[190] points out that the application of force to the person of another is interpreted much more widely in South African law. The concept of force or violence encompasses many other forms of conduct and the application of force may be direct or indirect, may be committed through an act or an omission and may be external or internal.

The line between direct and indirect force is not watertight.[191] Snyman[192] regards examples of direct application of force when X touches Y's body either by using his own body to do so or by using an instrument such as a knife or a harmful drink. On this view, direct force is also applied if Dr X administers a harmful substance to patient Y or instructs Y to take the substance.[193] On the other hand, force is indirect when there is no contact between X and Y, either by a part of X's body or through the medium of an instrument.[194] For example, where X pulls away a chair that Y was going to sit on, causing Y to fall on the floor.[195]

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aggression upon *dignitas* for purposes of the *actio iniuriarum*, but regarded interference with bodily integrity as a violation of an interest in *corpus*, which affected a person's feelings. It is possible that an assault involved violation of dignity as well, but this would be an added element in the *iniuria*; Amerasinghe 1967:62 also notes that a separate element of *contumelia* did not have to be established, because the mere interference of the *corpus per se* imported *contumelia;* In *Matthews v Young* 1922 AD 492:503, *De Villiers JA* stated that 'there is an element of *contumelia,* insult, in every *iniuria* ...' It is however, unclear from some case law as to whether *contumelia* can automatically be awarded once the cause of action for assault is established even though *contumelia* has not specifically been alleged (see for example, *Mthimkhulu v Minister of Law and Order* 1993 (3) SA 432 (E) and *Brown v Hoffman* 1977 (2) SA 556 (NC):557H-558A, 558H where the court automatically awarded *contumelia*) or whether *contumelia* has to be separately proved if the plaintiff is claiming damages in this regard (see, for example, *Bennett v Minister of Police* 1980 (3) SA 24 (C):37c-e).

[190] Snyman 2004:448-463.

[191] Snyman 2004:450. In *Jolly*, 1923 AD 184, Innes CJ held that the application of force is indirect when a person causes force to be applied to the body of another without him/herself touching that other. See also Burchell 2005:684-685 and Snyman 2006:433-434.

[192] Snyman 2004:450-452; Burchell 2005:684-685; Snyman 2006:433-434. In *Marx* 1962 (1) SA 848 (N), an adult was held liable for assault after he administered alcohol to young children which intoxicated them. For comment on this case, see Lansdown 1962:133-135 and Strydom 1962:214-216. The fact that the person drinks the poison themselves voluntarily, does not mean that force has not been applied. Burchell 2005:685. An assault may be committed where a poisonous substance is administered to children or where supplied to a willing adult victim to take him/herself. *Matthews* 1950 (3) SA 671 (N); Lansdown 1962:134-135. Snyman 2004:452, also gives the example of a person who secretly gives another a medication which causes nausea. In *A* 1993 1 SACR 600 (A), the court held that it is an assault if a person forces another through threats to drink clean water against his/her will.

[193] *Matthews* 1950 (3) SA 671 (N); Lansdown 1962:134-135; De Wet and Swanepoel 1960:234. In English law, on the other hand, as the prescription of drugs does not involve any physical contact, the tort of battery is not available as a remedy to a patient who was inadequately informed about the medicine's side-effects. Jackson 2006:276.

[194] In Roman law, the use of indirect force was also recognized, for example the causing of a bad smell or the contaminating of water was regarded as an *iniuria*. Snyman 2004:453, who refers to Joubert 1953:77, 83-84 in support

[195] Snyman 2004:452-453; However, see *Marx*: 853H, 854A, where the court held that indirect force includes the placing of a harmful substance in the drink of another person and force is consequently applied from within another person's body; Further, in *Jolly* 1923 AD 184, Innes CJ held that the application of force is indirect when a person causes force to be applied to the body of another without him/herself touching that other.

Furthermore, an omission may give rise to liability for assault. For example, a mother who fails to prevent her partner from physically abusing her child in circumstances where she was able to intervene, commits an assault[196] and a nurse whose duty it is to give pain medication to a patient at certain times, but omits to do so and, as a result, the patient feels pain, also commits an assault.[197]

Snyman[198] and Strydom[199] both hold the view that the test for assault should not focus on whether there was an application of force in the literal sense. They point out that the crucial issue is what right is infringed rather than how it is infringed. In other words, if the rights to bodily integrity and self-determination are infringed as a result of the defendant's conduct, then the fact that there was no direct or indirect contact with the plaintiff's body, or the infringement took place by omission, is irrelevant.[200]

The writer is respectfully of the view that the authors' emphasis on infringement of bodily integrity in assault is strengthened by the enactment of a written Constitution in South Africa, because the starting point in constitutional law is also the infringement of a fundamental right.[201] The right to bodily integrity is regarded as an absolute right in South African common law,[202] but, in addition,

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[196] *B* 1994 (2) SACR 237 (E); In *A* 1991 (2) SAV 257 (N):273, a policeman A failed to prevent a colleague B from assaulting a detainee C. The question was whether A could also be held liable for assault. The court regarded the omission by A to prevent the force to the body of C, as the physical conduct for purposes of assault. Furthermore, the court held that the omission to act was unlawful as A had a legal duty to prevent harm to B and A should and could have prevented the harm. In addition, the court regarded the application of force to the body of C as the consequence of A's unlawful conduct. The court therefore concluded that the requirement of application of force in assault contains elements of a consequence crime.

[197] Snyman 2004:461.

[198] Snyman 2004:452, 462-463.

[199] Strydom 1962:216; Snyman 2004:463, concludes that although in practice South African courts have interpreted the wording in the definition of assault widely, nevertheless for the sake of clarity, the wording in the definition of assault should read as follows: Assault is any unlawful and intentional act or omission which has the result that (a) Another person's bodily integrity is infringed either directly or indirectly; or (b another person believes that an infringement of his/her bodily integrity will immediately occur.

[200] Carstens and Pearmain 2007:687, are also of the view that although assault is a valid cause of action in South African law, 'the concept of assault should not be assessed in its strict literal sense, but as a violation of the patient's right to bodily or physical integrity'.

[201] The Constitution of the Republic of South Africa, No. 200 of 1993, replaced by No. 108 of 1996.

[202] *Stoffberg v Elliott*:149-150. The right to bodily integrity creates a sphere of individual inviolability and also includes ideas of autonomy and self-determination. Currie and De Waal 2005:308. At common law, bodily integrity is regarded as so important that, in some circumstances, even if the complainant has given his/her consent to the invasion of their bodily integrity, the consent itself will be regarded as *contra bonos mores*. Burchell 2005:334-335. Dada and McQuoid-Mason 2001:8. Rights such as dignity are absolute in that they are not created by, nor dependent for their being upon any contract. De Villliers 1899:24. In *Minister of Justice v Hofmeyer* 1993 (3) SA 131 (A):145 I, 153E, Hoexter JA emphasised that 'One of an individual's absolute rights of personality is his right to bodily integrity'. In this case, the plaintiff claimed that he had been unlawfully separated from all other prisoners for months in circumstances amounting to solitary

the right is now also entrenched in the Constitution.[203] Section 12(1)(c) states that 'Everyone has the right to freedom and security of the person, which includes the right...to be free from all sorts of violence from either public or private sources' and section 12(2)(b) provides that 'everyone has the right to bodily and psychological integrity, which includes the right to security in and control over their body.'[204]

3.2.3 Unlawfully

It is accepted that because the body is regarded as one of the most valuable assets a person has, every factual infringement of the body is, in principle, *per se* wrongful or *contra bonos mores*.[205] However, in common law, conduct in the form of a commission, which infringes bodily integrity, is *prima facie* wrongful, but an omission to act positively to prevent the infringement of bodily integrity is *prima facie* lawful.[206] Therefore, where an omission is in issue, the plaintiff must first prove that the defendant owed the plaintiff a duty to act positively to prevent the harm to the plaintiff and, secondly, that the defendant breached the duty.[207]

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confinement. Further, during his isolation, he was denied access to basic services such as exercise and reading material. The court held that the detention to which the plaintiff was subjected constituted an infringement of his basic rights and, in particular, of his right to bodily integrity.

[203] Section 12 of the Constitution of the Republic of South Africa, 1996.

[204] It also finds expression in the Constitutional rights to life (section 11), health care (section 27), privacy (section 14) and dignity (section 10).

[205] Neethling *et al.* 2006:302.

[206] Boberg 1989:32. See also, for example, the judgments in *A* 1991 (2) SAV 257 (N); *Minister van Polisie v Ewels* 1965 (3) SA 590 (A); *Minister of Law and Order v Kadir* 1995 (1) SA 303 (A); *Knop v Johannesburg City Council* 1995 (2) SA 1 (A).

[207] Further, Pieterse 2002:36-37, states that the common law 'requires significant development to bring it into line with the values associated with s 12(1)(c) of the Constitution. He is of the view that section 12(1)(c) of the Constitution requires a 'somewhat radical departure' from the traditional common law position, in that the provision 'seems to mandate a presumption of a duty to prevent violence, especially when there is a special relationship between the parties. However, he also points out that while the 'special relationship' construct is useful in determining private liability for omissions to prevent violations of s12(1)(c), it should not be viewed as anything more than one of several factors which may be taken into account when establishing the reasonableness of an omission to prevent violent conduct. In this regard, he criticizes the Constitutional Court judgment of *Carmichele,* which he interprets as establishing the 'special relationship' as a separate criterion for establishing the existence of a duty to act. See also Carpenter 1998:151 for criticism of the 'special relationship' criterion. On the other hand, despite views to the contrary, under the common law, a special relationship is sometimes a determining factor in deciding whether there is a duty to act positively to prevent harm to another person. For example, in *A* 1991 (2) SACR 257 (N):271f-j, 272g-I, the court held that the policeman's omission to prevent another policeman from assaulting a prisoner was wrongful because (1) there was a legal duty to prevent harm to the prisoner because of the special relationship between the policeman and the prisoner in terms of which the policeman was under an obligation to guard and protect the accused from harm and (2) the policeman breached this duty because she did not stop the other policeman from assaulting the accused when she should have and could have done so.

Various grounds of justification exist which negate the unlawfulness of a *prima facie* assault, for example, defence of person or property,[208] necessity[209] and consent.[210] However, in *Ex parte Minister of Safety and Security: In re S v Walters,*[211] the Constitutional Court, per Kriegler J emphasized that the Constitution does not lightly recognize a justification ground when the right to bodily integrity is infringed:

> ...The right to life, to human dignity and to bodily integrity are individually essential and collectively foundational to the value system prescribed by the Constitution. Compromise them and the society to which we aspire becomes illusory. It therefore follows that any significant limitation of any of these rights would for its justification demand a very compelling countervailing public interest.[212]

3.2.4 ***Volenti non fit iniuria***

Volenti non fit iniuria means 'to one who consents, no harm is done'.[213] One translation also reads 'No-one can complain of an act which he has expressly or impliedly assented to'.[214]

Consent in South African law is a defence, both in criminal and in civil law. It is a ground of justification, excluding the wrongfulness of the conduct in question.[215] The defence may apply in a number of different situations:

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[208] *Mokoena* 1976 (4) SA 162 (O).
[209] *Goliath* 1972 (3) SA 1 (A).
[210] *Stoffberg v Elliott*:149.
[211] *Ex parte Minister of Safety and Security: In re S v Walters* 2002 (4) SA 613 (CC):631.
[212] The case concerned the constitutionality of statutory provisions that permit force to be used when carrying out an arrest. The court held that the use of force raises constitutional misgivings regarding the 'three elemental rights contained in the Bill of Rights', which are 'the right to life, dignity and bodily integrity' (at 620F). Further, the court pointed out that these three fundamental rights are introduced by the Constitution in s 7(1) which provides that 'This Bill of Rights is a cornerstone of democracy in South Africa. It enshrines the rights of all people in our country and affirms the democratic values of human dignity, equality and freedom' (*Ex parte Minister of Safety and Security: In re S v Walters*:620 fn 5). Section 1 of the Constitution states that 'The Republic of South Africa is one, sovereign, democratic state founded on the following values: (a) human dignity, the achievement of equality and the advancement of human rights and freedoms...'. Section 39(1) requires that the rights in the Bill of Rights must be interpreted in such a way that the values that underlie an open and democratic society based on human dignity, equality and freedom are promoted'.
[213] Or 'an injury is not done to one who consents.' Burchell 1993:68.
[214] McKerron 1971:67.

- Consent to an act involving actual harm, for example, the body contact involved in contact sports such as rugby.[216]

- assuming a known and already existing danger, for example, an aggressive ostrich.[217]

- assuming a risk of danger inherent in the activity, for example, the risks inherent in a 'dicing' contest.[218]

- assuming a risk of negligent conduct by the defendant, for example, getting into a car with a clearly drunk driver.[219]

In the context of consent to medical treatment, the maxim also potentially incorporates a number of forms of consent:

- Consent to an act involving actual harm, for example consent to the performance of an operation by a doctor.[220]

- Consent to a danger of harm, for example the risk of negative side-effects resulting from an operation.[221]

- Consent to consequences attached to the act/operation through the quality of the treating doctor, for example a surgeon who is a carrier of the Hepatits B virus.[222]

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[215] Van Oosten 1989:15; Neethling *et al.* 2006:90 fn 410, point out that the term 'voluntary assumption of risk' may refer to consent to a risk associated with the defendant's conduct, or it may refer to contributory intention. These two concepts must furthermore be distinguished from contributory negligence. All three are defences, which exclude or reduce the liability of the defendant. However, whereas consent to the risk of harm excludes the wrongfulness of the defendant's conduct, contributory intention excludes the fault of the defendant and contributory negligence partially excludes the fault of the defendant. Contributory negligence in medical law usually relates to a patient's failure to follow the instructions given by the treating doctor, or failure to report for further treatment. Carstens and Pearmain 2007:938.
[216] *Santam Insurance v Vorster* 1973 (4) SA 764 (A):775A.
[217] *Santam Insurance v Vorster*:775C.
[218] *Santam Insurance v Vorster*:775E-F.
[219] *Santam Insurance v Vorster*:782F-G.
[220] Neethling *et al.* 2006:90; *Santam Insurance v Vorster*:775A.
[221] Neethling *et al.* 2006:90.

- Consent to potentially negligent act/s, related to the quality of the treating doctor, for example, a surgeon who has no experience, is a drug addict or who has uncontrolled epilepsy.[223]

The essential elements of the defence are knowledge, appreciation and consent.[224] Innes CJ in *Waring and Gillow Ltd v Sherborne*[225] explained:

> [I]t must be clearly shown that the risk was known, that it was realized, and that it was voluntarily undertaken. Knowledge, appreciation, consent – these are the essential elements; but knowledge does not invariably imply appreciation, and both together are not necessarily equivalent to consent.[226]

3.2.4.1 Knowledge

A pre-requisite for *volenti non fit iniuria* is knowledge of the full nature and extent of the act or consequence.[227] A person can only consent to that which they have knowledge of. For example, if a person consents to being slapped on the head, they do consent to some pain. However, a person does not consent to consequences they are not aware of.[228] Full knowledge is required of all the final negative consequences, whether probable or possible or highly unlikely.[229] In

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[222] In a 1991 study titled 'Recommendations for Preventing Transmission of Human Immunodeficiency Virus and Hepatitis B Virus to Patients During Exposure-Prone Invasive Procedures', the Centers for Disease Control and Prevention put the risk of transmission of the HIV virus at about 0.3% after percutaneous exposure to the infected surgeon's blood, the risk of exposure being 6.9%. However, the risk of transmission of Hepatitis B after exposure was estimated at 30%. www.cdc.gov/mmwR; August 2007.

[223] Strauss and Strydom 1967:324, argue that consent to exclude or limit the liability of the doctor for negligence, should be regarded as null and void as being contrary to public policy, because it is the interest in bodily integrity which is at stake and not merely a patrimonial interest.

[224] *Santam Insurance v Vorster*:779B; Dada and McQuoid-Mason 2001:116.

[225] *Waring and Gillow v Sherborne* 1904 TS 340. The plaintiff in this case sued the defendant for damages following the death of her husband during the course of his employment as a workman at a construction site for the defendant. On Appeal, the defendant raised the defence of *volenti non fit iniuria*, arguing that the deceased voluntarily assumed the risk of injury or death by engaging in dangerous employment. However, the court rejected the defence, holding that none of the elements of knowledge, appreciation and consent had been satisfactorily established. The defence of contributory negligence also failed. *Waring and Gillow v Sherborne*:345-347.

[226] *Waring and Gillow v Sherborne*:344.

[227] Neethling *et al.* 2006:93-94.

[228] Strauss 1961:116-117, 137. The requirements of consent also apply to consequences, as it is also a manifestation of the will. Strauss 1961:63.

[229] Strauss 1961:137.

addition, the consenting party must have knowledge of the particular details of the act or consequence.[230]

In English law of battery, the knowledge required for consent is limited. The courts draw a line between the general nature of the medical treatment and the other consequences.[231] In *Sidaway v Bethlehem Royal Hospital Governers and others*,[232] the Court, per Lord Dunn, explained:

> The first argument was that unless the patient's consent to the operation was a fully informed consent the performance of the operation would constitute a battery on the patient by the surgeon. This is not the law of England. If there is consent to the nature of the act then there is no trespass to the person. So in *R v Clarence* (1888) 22 OBD 23 [18886-90] All ER Rep 133 a conviction of rape was quashed where the woman did not know that the prisoner was suffering from a venereal disease which he communicated to her. If she had known, she would not have consented to sexual intercourse, but as she had consented to the act of sexual intercourse, even though without the knowledge of the probable risk of infection, there was no rape.[233]

The Australian author Devereux,[234] also states that 'the test as to what amounts to the nature of treatment is derived from the test used in criminal law in order to determine whether someone has consented to a battery (or in the case of rape,

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[230] Strauss 1961:62.

[231] *Chatterton v Gerson and Another* [1981] 1 QB 432:443A; *Sidaway v Bethlehem Royal Hospital Governers and others* [1984] 1 All ER 1018 (CA):1029C-E. In the Australian case of *Rogers v Whitaker* (1992) 109 ALR 625 (HCA):633, the court held that 'Anglo-Australian law has rightly taken the view that an allegation that the risks inherent in a medical procedure have not been disclosed to the patient can only found an action in negligence and not in trespass; the consent necessary to negative the offence of battery is satisfied by the patient being advised in broad terms of the nature of the procedure to be performed'.

[232] *Sidaway v Bethlehem Royal Hospital Governers and others* [1984]:1029C-E.

[233] In the same case, Donaldson MR held that: 'I am wholly satisfied that as a matter of English law a consent is not vitiated by a failure on the part of the doctor to give the patient sufficient information before the consent is given. It is only if the consent is obtained by fraud or by misrepresentation as to the *nature* of what is to be done then it can be said that an apparent consent is not a true consent. This is the position in criminal law (see *R v Clarence* (1988) 22 QBD 23:43, [1886-90] All ER Rep 133:44) and the cause of action based on trespass to the person is closely analogous.' *Sidaway v Bethlehem Royal Hospital Governers and others* [1984] 1 All ER 1018 (CA):1026F-G. My emphasis. In *Chatterton v Gerson* [1981] 1 QB 432:443A-B, Bristow J held that 'In my judgment once a patient is informed in broad terms of the nature of the procedure which is intended, and gives her consent, that consent is real, and the cause of action on which to base a claim for failure to go into *risks and implications* is negligence, not trespass.' My emphasis.

[234] Devereux 2007:166.

as sexual battery).

However, the writer is respectfully of the view that it is doubtful whether the reasoning which is applied to consent in the context of rape, can be transplanted, without further ado, to medical assault and, in so doing, separate consent to the medical procedure from the other consequences of the procedure. Where sexual assault in the form of the crime of rape is concerned, the application of force is specifically restricted in the definition of rape to penetration.[235] Therefore, if, through consensual penetration, the accused inflicts bodily injury in the form of a venereal disease on the complainant without consent, there is no rape because sexual penetration was consensual.[236]

On the other hand, in South African law, common assault is viewed as a consequence crime and the requirement of application of force in assault is regarded as a consequence.[237] Viewed in this way, consent must cover the consequence in its entirety.[238] Full knowledge is required of all the final negative consequences, whether possible or probable or highly unlikely.[239] In other words, the writer is respectfully of the view that the nature, type and degree of the application of force is relevant to the consent enquiry in South African law.

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[235] Under the common law, rape is a specific form of assault and consists in the intentional, unlawful sexual intercourse with a woman without her consent. Burchell 2005:162. However, Section 3 of the Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007, has repealed the common law and provides that 'any person ("A") who unlawfully and intentionally commits an act of sexual penetration with a complainant ("B"), without the consent of B, is guilty of the offence of rape.' It is applicable to all forms of sexual penetration, irrespective of gender. It also includes the offence of 'compelled rape', which emphasizes that rape also has features of a consequence crime. Section 4 provides that 'Any person ("A") who unlawfully and intentionally compels a third person ("C"),without the consent of C, to commit an act of sexual penetration with a complainant ("B"), without the consent of B, is guilty of the offence of compelled rape.'

[236] However, there may be liability for assault, because the wrongful omission by the accused to disclose the risk of transmission of the venereal disease may be viewed as the physical conduct and the consequence as the infliction of the venereal disease. Burchell 1997:139, states that if X is infected with HIV he/she would be obliged, in terms of the legal convictions of the community, to inform his/her intended partner Y of the risks of contracting a serious disease. If X omits to inform Y, X will be liable for assault if Y does have sexual intercourse with X and contracts the disease. This liability for assault is independent of Y's consent to sexual intercourse. Furthermore, there may be liability for fraud, for the making of a false representation, or *iniuria* if there was intentional injury to the honour and dignity of the injured party through sex. Strauss 1961:129-130. In *Venter v Nel* 1997 (4) SA 1014 (D), the South African court accepted that an unopposed claim for infection with the HIV virus through sexual intercourse founded a valid claim for damages resulting from the infection. However, the court did not discuss the legal basis of such claim.

[237] See the discussion in Chapter Three.

[238] Strauss 1961:62, 63,116-117,137.

[239] Strauss 1961:62, 63,116-117,137; Neethling *et al.* 2006:93-94.

In the next chapter it will be illustrated through a discussion of case law, that in South African law of medical assault, no bright line is drawn between the act and its consequences for purposes of consent to medical treatment. Further, in chapter six, it will be illustrated that, in practice, it is not possible to divide the nature of medical treatment and its consequences.

3.2.4.2 Understanding

It is essential that, in addition to knowledge, the knowledge is grounded in understanding of the act and appreciation of the nature and extent of the harm and the risk involved.[240]

3.2.4.3 Consent

The essential elements of consent are as follows:

3.2.4.3.1 Capacity to consent

Consent must be given by a person capable in law of consenting. Factors such as youthfulness, mental disorder, intoxication and unconsciousness may impact on the legal capacity to give an effective consent. The essential question is whether the person purportedly giving consent has the mental capability and maturity to understand the nature, extent and implications of the consent.[241]

[240] Strauss 1961:108; Van der Walt and Midgley 1997:114; Van Oosten 1989:18.
[241] Van der Walt and Midgley 1997:117.

3.2.4.3.2 Voluntary

Consent must have been freely and voluntarily given and not constitute a mere submission. Therefore, even if the consent appears valid, because the patient has full capacity and has been given adequate information on which to make a choice, it may be invalid if it was obtained by fraud, force or undue influence.[242]

Whether consent has been free and voluntary depends on the circumstances of the particular case and, in particular, on the moral, social and economic pressures restricting the plaintiff's freedom of choice.[243]

3.2.4.3.3 Consent must not be contrary to public policy

The law of delict, in principle, protects individual interests.[244] However, criminal law also protects the public interest and, as a result, consent does not ordinarily justify criminal conduct. This renders the application of the defence more limited in criminal law than in law of delict.[245]

Consent can only operate as a ground of justification in respect of certain crimes, for example, it is not available in crimes against the community or state, such as treason, or contravening the speed limit.[246] On the other hand, in respect of crimes against the individual, consent is sometimes allowed and can be divided into a number of categories:

- Crimes in respect of which consent by the injured party is never recognized as a defence, for example, murder.

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[242] McHale and Fox 2007:397; Burchell 1993:68.
[243] Van der Walt and Midgley 1997:115.
[244] Snyman 2006:124.
[245] Snyman 2006:124; Van Oosten 1989:15 fn 7. On the other hand, there are certain policy exceptions to the rule that the patient must consent to treatment, for example in the interests of public health, the patient may be forced to submit him/herself to inoculation or treatment, or where the patient is unconscious and needs urgent assistance. Claasen and Verschoor 1990:57-58.
[246] Snyman 2006:122-124.

- Crimes where consent forms part of the definitional elements of the crime, for example, rape.

- Crimes where consent operates as a ground of justification, for example, theft.

- Crimes in respect of which consent is sometimes regarded as a ground of justification and sometimes not, for example, assault. It is often difficult to pinpoint the dividing line between harm to which one may and harm to which one may not consent. The criterion to be applied in this respect is the general criterion of unlawfulness, that is, the community's perception of justice or public policy.[247] For example, if a patient consents to medical treatment and the purpose of the operation is curative or therapeutic, the operation will be lawful unless the law provides otherwise. However, where the essential objective of the medical intervention is scientific and without direct therapeutic value to the person subjected to the research, and serious risk to life, health or person is involved, the procedure will not be lawful, despite consent of the patient.[248]

  Under civil law, the fact that the act complained of was a criminal act, does not, in principle, exclude the operation of consent.[249] However, the giving of consent under civil law must also not be contrary to public policy or *contra bonos mores.*[250] For example, Strauss and Strydom[251] are of the view that where a patient enters into an agreement to exclude or limit the liability of the doctor for negligence, it should be regarded as null and void

[247] Snyman 2006:122-124.
[248] Burchell 2005:334-335; Dada and McQuoid-Mason 2001:8. For this reason, Carstens and Pearmain 2007:Annexure R on CD enclosed with the book, suggest that a particulars of claim based on assault should allege either that the plaintiff did not give informed consent or that the procedure was not clinically indicated. However, Van Oosten 1995:166, states that the notion that the intervention must be therapeutic for consent to be regarded as valid, loses sight of the fact that lawful consent is sufficient justification for certain non-therapeutic interventions, such as purely diagnostic, experimental and cosmetic interventions.
[249] McKerron 1971:73.
[250] Boberg 1989:740.
[251] Strauss and Strydom 1967:324. Another example is if an employee consents to being beaten by an employer as a form of discipline, this would be regarded as contrary to public policy. *Collett* 1978 (3) SA 206 (RA).

as being contrary to public policy, because it is the patient's interest in bodily integrity which is at stake and not merely a patrimonial interest.[252]

3.2.4.3.4 The subjective nature of consent

The maxim is *volenti* not *scienti non fit iniuria.* Therefore, knowledge and appreciation will not suffice. The plaintiff must also have consented to the infliction of the harm or assumed the risk implicit in the defendant's conduct.[253]

The Collins English Dictionary gives one definition of consent as 'accordance or harmony in opinion; agreement'.[254] Therefore, consent, in its most general meaning, relates to the concurrence of a number of wills and is a precursor to a contract for treatment.[255] On the other hand, another definition of consent provided by the Collins English Dictionary is 'acquiescence to or acceptance of something done or planned by another, permission'.[256] Consent in this sense is unilateral and has the same meaning as *voluntas*/will.[257]

Neethling *et al*[258] point out that consent is a unilateral act and it therefore does not have to be made known to the perpetrator. However, for consent to be a legal act, which restricts the complainant's rights, consent must be made known or manifested outwardly. Consent implies that the plaintiff intended his/her rights to be limited, and therefore he/she must not only have consented to the physical

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[252] See also Claasen and Verschoor 1990:60, who state that consent to reckless medical experiments is *contra bonos mores*.
[253] Van der Walt and Midgley 1997:114; Van Oosten 1989:18; *Lampert v Hefer* 1955 (2) SA 507 (A):509E.
[254] Hanks *et al.* 1979:320.
[255] Carstens and Pearmain 2007:313-314; Strauss 1961:18-19.
[256] Hanks *et al.* 1979:320.
[257] Strauss 1961:17-19. Burchell 1993:69, does not exclude the possibility of the existence of a contract, but argues that 'consent does not have to involve mutual agreement between the parties'. Neethling *et al.* 2006:90-91, argue that the presence of a contract is not necessary for the operation of consent as it is a unilateral act. McKerron 1971:72, points out that the defence of *volenti non fit iniuria* need not have a contractual basis. Strauss 1961:157-158, opines that it is unjust to confine consent as a defence to contract and that the consent principle should be strongly separated from contract law. Van der Walt and Midgley 1997:118, argue that in South African law *volenti non fit iniuria* is not founded on an agreement between the parties in the form of a *pactum de non petendo* or any similar contract, but on a unilateral legal act.
[258] Neethling *et al.* 2006:90-91.

harm or risk, but also to the legal risk of injury. Consent requires the clear intention of restricting one's rights.[259]

Strauss[260] also distinguishes between the concepts of 'will' and 'consent'. He points out that consent rests upon the inner will and that the outward consent, whether in words or behaviour, is a manifestation of the will. He notes the argument that consent can exist in the direction of the will of the consenting party, without manifestation thereof and confirms that this approach is in accordance with the general use of speech. However, he is of the view that the problem with this interpretation of consent, is that there is the practical problem of proof of inner psychological workings.

On the other hand, Roemer[261] favours an interpretation of consent which rests in the inner direction of the will and submits that it is unjust to mix the question of law with the question of proof or to make the question of law dependant on the question of evidence. Lubbe and Murray[262] also hold that the means of proof must not be confused with that which has to be proved. In other words, in principle, it is the inner, subjective will which represents consent and the objective proof thereof falls under the law of evidence.[263]

Strauss,[264] despite distinguishing between the will and consent, at the same time does acknowledge that there is a difference between inner consent and evidence of consent. He states that 'bewys van toestemming' is to be found in the

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[259] Van der Walt and Midgley 1997:115.
[260] Strauss 1961:5-6. In declaring the will, Strauss 1961:33, 41-42 states that either express consent (words or writing) or implied consent (behaviour) is sufficient. Furthermore, deeds speak louder than words and in the event of a conflict implied consent overrules express consent. However, in the context of consent to medical procedures, in *Stoffberg v Eliott* 1922 CPD 148:149, where a doctor cut off a patient's penis without his consent, the court held that a doctor must ensure that 'consent to an operation is expressly obtained'.
[261] Referred to in Strauss 1961:31.
[262] Lubbe and Murray 1988:109.
[263] In the context of the requirement for fault in the form of intention, Boberg 1989:271, explains the difference between the inner subjective state of a defendant's mind and the proof thereof as follows: 'When the enquiry into intention is described as 'subjective', it means that the *factum probandum* is the actor's actual state of mind. Nevertheless, the impossibility of delving into a person's mind to discover its content, compels the court to infer intention from all the circumstances.' Boberg 1989:271, further emphasizes that the test for intention is not objective: "If 'test' means 'criterion', it remains subjective. The point is simply that this subjective phenomenon – intention – has to be proved by circumstantial evidence. This does not make the phenomenon itself or the measure of its existence 'objective'..."
[264] Strauss 1961:38.

behaviour of the party in the light of all the surrounding circumstances – that the party had knowledge of the nature of it, understood it and wished for the committing of the deed or reconciled themselves to the advent of the consequence.

South African law generally accepts the direction of the will theory in principle, but for purposes of proof or evidence of the will, looks to the circumstances, including the testimony of the complainant.[265] The question of the presence or absence of consent is a subjective enquiry, in which the court determines whether an inference arises from all the evidence that plaintiff must have understood and accepted such risk'.[266]

On this view, consent is, in essence, an internal state of mind.[267] It is 'a state of mind personal to the victim'.[268] Consent to the harm or risk of harm, which caused the supervening injuries is a subjective enquiry related to the particular plaintiff.[269] Mere reconciliation is not consent.[270] The mental position is that the person wills or wishes the event particulars or approves or at least does not disapprove, in other words, they are satisfied that it is so.[271] Further, consent must be given in advance – *ex post facto* consent is invalid.[272] The requirements

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[265] Lubbe and Murray 1988:109; *Fourie v Naranjo*:1157b. Van Oosten 1989:455-456, states that signed disclosure documents should be afforded evidential value, but should not be considered conclusive proof that the requisite disclosure actually did occur.

[266] *Rosseau v Viljoen* 1970 (3) SA 413 (C):418A-C per Van Winsen J. In *Fourie v Naranjo:*1157-1159 , the plaintiff entered the premises of another and was attacked by a dog. The court considered the evidence in order to determine whether the plaintiff subjectively consented to the risk of harm. The court accepted the plaintiff's testimony as to his subjective state of mind when entering the premises where the dog was, as decisive of the issue of consent. In *Santam Insurance v Vorster:*781, the Appellate Division per Ogilvie Thompson CJ, also clearly distinguished between consent in principle, which it regarded as a subjective enquiry into the mind of the complainant and proof or evidence of consent. The court therefore accepted that consent is a subjective direction of the will rather than an outward declaration of the will. However, the court held that for purposes of proof of the inner workings of the complainant's mind, it would not only rely on a complainant's testimony but would draw an inference from the facts of the case in order to decide for itself whether the complainant did in fact foresee the risk in question. In this regard, the court held that a finding that the complainant foresaw the risk in question, was sufficient to hold that the complainant consented to the risk. Newman and McQuoid-Mason 1978:266, interpret the latter as authority for the holding that 'when considering voluntary assumption of risk the test for knowledge and appreciation may be subjective, but the test for consent is objective'.

[267] Pattinson 2006:102.

[268] Per Lord Diplock in *Sidaway v Bethlem Royal Hospital Governors* [1985]:894.

[269] *Santam Insurance v Vorster*:781B-C, 778F-G; Neethling *et al.* 2006:94.

[270] De Wet 1985:95; For example, if a father jumps in front of a car to rescue his child, which is driving on a pavement, he may have reconciled himself to the danger of injury but he cannot be said to have approved of or be satisfied with the situation. Strauss 1961:46.

[271] Strauss 1961:22.

[272] De Wet 1985:95.

for consent were neatly summed up by Cleaver J in *Fourie v Naranjo*[273], when he held that the complainant must have:

a. Full knowledge of the nature and extent of the possible prejudice to which he was exposing himself.[274]

b. Realise or appreciate fully what the nature and extent of the harm might be.[275]

c. In fact subjectively consents to the risk.[276]

3.2.5 Fault

In addition to wrongfulness, it must also be determined whether the conduct of the accused/defendant was blameworthy or culpable. In Roman and classical Roman-Dutch law, the interference with *corpus* was *per se* or *prima facie* an unlawful act involving *iniuria*.[277] Roman and Roman-Dutch law, required fault in the form of the *animus iniuriandi* or intention for purposes of an *iniuria*. Intention, in relation to the *animus iniuriarum,* means that the defendant directs his/her will to the infringement of the plaintiff's right to physical integrity in the knowledge that such an infringement is possibly wrongful.[278] *Dolus* or wrongful intent is therefore virtually identical in meaning with the *animus iniuriarum*.[279]

Neethling[280] points out that the concept of *contumelia* or insult was used in connection with *iniuria*, but indicated only the intentional violation of another's

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[273] *Fourie v Naranjo* 2007 (4) All SA 1152 (C).
[274] *Fourie v Naranjo*:1157a. The court referred to *Castell v De Greef* 1994 (4) SA 408 (C):425 and *Santam Insurance v Vorster*:781 in support.
[275] *Fourie v Naranjo*:1157b. The court referred to *Castell v De Greef* 1994:425 and *Durban City Council v SA Bondmills* 1961 (3) SA 397 (A) in support.
[276] *Fourie v Naranjo*:1157b. The court referred to *Malherbe v Eskom* 2002 (4) SA 497 (O) in support.
[277] Amerasinghe 1967:62.
[278] Neethling et al. 2005:106-107. The subjective element of the *iniuria* is the *animus iniuriandum*. Amerasinghe 1967:205.
[279] Amerasinghe 1967:194.
[280] Neethling et al. 2006:12-13.

personality, or conduct which demonstrated contempt for a person's personality and did not mean that the intent to insult or to violate a person's honour had to accompany every *iniuria*.[281]

3.2.5.1 Criminal law

Mens rea, in the form of *dolus*, must be proved[282] and *dolus eventualis* is sufficient.[283] X must foresee the possibility that his/her conduct may result in unlawful direct or indirect force to Y's body, or that it might inspire in Y the fear that such force will immediately be applied, and X must reconcile him/herself to such possibility.[284]

However, ignorance or mistake excludes intention,[285] as long as the ignorance or mistake[286] relates to the act, the definitional elements or unlawfulness. In other

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[281] Amerasinghe 1967:62, 194; Neethling *et al*. 2006:12-13. A malicious motive was not necessary, because the motive of the wrongdoer is not an element of the *animus iniuriandi* or intent. Amerasinghe 1967:57, 194, 203; Carstens and Pearmain 2007:504-505; Neethling *et al* 2006:115; Snyman 2006:190; Burchell 2005:463. Neethling *et al*. 2005:106-107, point out that *dolus* or wrongful intent is virtually identical in meaning with the *animus iniuriarum*. Intention in this regard means that the defendant directs his/her will to the infringement of the plaintiff's right to physical integrity in the knowledge that such an infringement is possibly wrongful.

[282] Criminal law does not know the offence of negligent assault. *Steenkamp* 1960 (3) SA 680 (N): 684; Snyman 2006:438.

[283] In South African law *dolus eventualis* is sufficient for the intention element in crimes such as assault. Du Plessis 2000:6; Snyman 2006:438; Burchell 2005:466, 688; *Sethoga* 1990 (1) SA 270 (A); *Campos* 2002 (1) SACR 233 (SCA); *Ngubane* 1985 (3) SA 677 (A):685, 686A-B.

[284] Subjective foresight of the possibility of the occurrence of a consequence or the existence of a circumstance is not sufficient for *dolus eventualis*. The accused must also reconcile him/herself to the possibility/consent to the possibility/take the possibility into the bargain. *Sethoga* 1990 (1) SA 270 (A); *Campos* 2002 (1) SACR 233 (SCA). Snyman 2006:184-186 states that just because the accused proceeds with his/her conduct, it does not automatically follow that he/she reconciled him/herself to the possibility of the circumstance or consequence. However, Burchell 2005:484, regards the second volitional part of the test to determine *dolus eventualis* as redundant. In other words, as long as the accused foresaw the possibility as a reasonable, real or concrete possibility, then if he/she acts on the possibility, he/she has reconciled him/herself to the possibility. In *Ngubane* 1985 (3) SA 677 (A):685, 686A-B, the court held that the more concrete or real the possibility of the consequence ensuing the more likely, if the accused persists with their conduct, that the inference will be drawn that the accused reconciled themselves to the possibility of the result occurring. The judgment does not, therefore, rule out *dolus eventualis* where there is foresight of a remote possibility. However, both Burchell 2005:484 and Snyman 2006:185 are of the opinion that if X foresees the possibility as only far-fetched or remote, *dolus eventualis* is absent.

[285] Snyman 2006:191, 203-205; *De Blom* 1977 (3) SA 513 (A):532H, 533B-D, 544B.

[286] The South African position is that although there is a difference in meaning between ignorance and mistake, for the purpose of criminal law, the two concepts are not distinguished. Burchell 2005:502, points out that "Ignorance implies a total want of knowledge in reference to the subject-matter. Mistake admits knowledge but implies a wrong conclusion and is virtually a species of ignorance." Williams 1961:151-152, points out that mistake is a kind of ignorance and concludes that 'ignorance is the genus of which simple ignorance and mistake are the species'. However, some authors do distinguish between mistake and ignorance, arguing that mistake negates intention, but ignorance does not. The reason for this is that a person acting under mistake of law is acting under a positive state of mind, whereas someone acting in ignorance of the law has a vacuum in his/her mind, which must be filled before a determination can be made as to his/her guilt or innocence. Amirthalingam 1995:15-16. There is also sometimes uncertainty when a mistake will qualify as a mistake of fact or law. Rabie 1994:95, argues that distinguishing between fact and law is misleading because it focuses on the nature of the ignorance or mistake rather than its effect. He points out that it is only when such ignorance or

words, it must be material.[287] For example, on a charge of assault, ignorance or mistake in relation to consent is material, because consent relates to unlawfulness.

An example of ignorance or mistake of a material fact is as follows: Dr X thinks that Dr Z obtained consent from patient Y for the operation to be performed by Dr X and Dr Z, whereas in fact no consent was obtained. In this example, intention is excluded, even if Dr X's thoughts and conclusions are unreasonable, because the test for intention is purely subjective.

On the other hand, in the above example, Dr X may have been negligent. In the first place, there may be unconscious negligence[288] if Dr X ought reasonably to have foreseen that Dr Z did not obtain consent from patient Y for the operation to be performed by Dr X and Dr Z. There may also be conscious negligence,[289] if Dr X did foresee the possibility that Dr Z did not obtain consent from Y, but Dr X then concluded that consent was obtained, when he/she ought reasonably to have concluded otherwise. In addition, when determining whether there was negligence, after establishing what the state of mind of the accused ought reasonably to have been, it must also be asked whether a reasonable person would nevertheless have taken steps to act differently in the circumstances.[290]

In the present example, even if Dr X was negligent, he/she will escape liability for assault, because fault in the form of intention is required for assault and South African criminal law is firmly based on the psychological theory of fault, that is

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mistake relates to an element in the definition of proscription (the *actus reus*) or the unlawfulness of the accused's conduct, that the mistake or ignorance of fact or law is relevant. He states that all instances of mistake or ignorance concern either an element contained in the definition of proscription or the unlawfulness of the conduct in question. Therefore, ultimately the common denominator is that the accused mistakenly believes that his conduct is lawful or, conversely, is ignorant of the unlawfulness of such conduct.

[287] Snyman 2006:192.

[288] For a discussion of unconscious negligence, see Snyman 2006:187-188.

[289] For a discussion of conscious negligence, see Snyman 2006:187-188.

[290] Paizes 1996:238 states that 'An accused can be blamed for his actions if, on the one hand, he either intended to do wrong in the sense that it was his aim and object to do so, or he foresaw the real possibility of doing so, or, on the other hand, he did so negligently in the sense that he ought to have foreseen the possibility of doing wrong and failed to take the steps that he ought to have taken to guard against that possibility.'

that *mens rea* in the form of *dolus* is purely a subjective matter.[291] In other words, the enquiry is limited to the state of mind of the accused and negligence is irrelevant.

In addition to mistake of fact, mistake of law may also negate *dolus*. In 1977, the landmark Appellate Division decision of *S v De Blom*[292] firmly established that knowledge on the part of the accused of the unlawfulness of his/her conduct, in particular, knowledge of the law which governs his/her particular conduct, is a requirement of *mens rea* in the form of intention.[293]

A mistake of law can be illustrated through the following example: Dr X does not foresee the possibility that the law requires that he/she must obtain consent from Y for surgery and blood tests as he/she is under the impression that if Y admits

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[291] Amirthalingham 1995:14. The psychological theory separates the objective enquiry into wrongfulness from that of the subjective enquiry into *dolus*. It is only once wrongfulness has been decided, that the fault of the accused is considered. On the other hand, under the normative theory, it is asked whether, despite the absence of subjective intention, the accused deserves to be blamed. This assessment involves a value judgment. Snyman 2006:206-2008. Various other South African authors support the normative theory in various contexts. See, for example Wolhuter 1996:443-462 and Le Roux 1997:13-17. See also Paizes 1996:238-266, who argues that in the same way that the test for negligence involves an investigation into the reasonableness of the accused's conduct, where *dolus* is in issue there should also be an examination of the reasonableness of the conduct of the accused after it is determined what his/her actual state of mind was. However, in *Engelbrecht*:41-163, the court, per Satchwell J, emphasised that the psychological theory applies in South African law. The court refused to develop a new approach to culpability based on the normative theory, in terms of which culpability is based on reasonableness. The court held that this would interfere with the subjective test of intention and have the superfluous effect of the issue of reasonableness being considered twice. The court pointed out that the reasonableness of the accused's conduct had already been dealt with at the stage of wrongfulness. The court also referred with approval to Van Oosten 1995:583, who also rejects the normative theory: 'First, it confuses and identifies criminal fault with the various other elements of crime and the aims and objects of criminal punishment; secondly, it confuses and identifies criminal fault with criminal liability, thus rendering the fault requirement tautologous and redundant and leaving intention and negligence hanging in the air; thirdly, it transforms and expands crimes of intention to crimes of negligence and substitutes the specific notions of intention and negligence with a general notion of fault; and finally, it subverts or abandons the fault requirement by partially or wholly substituting it with policy considerations and general prevention. The present position in South African criminal practice is in any event that, generally speaking, both concepts of fault are accommodated to a large extent ..., in so far as intention has a purely psychological content, while negligence has a predominantly normative content. Forcing both intention and negligence under a single normative fault umbrella ... goes as much against the grain of South African criminal practice as forcing both intention and negligence under a single psychological umbrella ...'.

[292] *De Blom* 1977 (3) SA 513 (A).

[293] Prior to *De Blom*, the maxim *'ignorantia juris neminem excusat'* prevailed, with some exceptions, in South African law. In this case, the Appellant, Mrs De Blom, was convicted of taking jewellery and money out of the country contrary to the relevant regulations. In a unanimous decision, the court, per Rumpff CJ, held that the regulations required *mens rea* for liability in the form of either intention or negligence. In respect of the money, the woman had *mens rea* in the form of *dolus* as she knew that she needed permission to take money out of the country and that the permission had not been obtained. However, the court held that the prosecution had failed to prove beyond reasonable doubt that the woman had knowledge of unlawfulness in respect of the jewellery. The court accepted the woman's testimony that she did not know she needed permission to take jewellery out of the country. The court held that the accused's testimony was 'reasonably possibly true' as she wore more jewellery than the average woman, she had on previous occasions taken jewellery out of the country and returned it and she intended returning with the jewellery. *De Blom* 1977 (3) SA 513 (A): 532H, 533B-D, 544B. Therefore, ignorance or mistake of law may negate *mens rea* in respect of the unlawfulness element and excludes liability: *De Vicenzo* 2003 (3) SA 572 (C); *International Computer Broking and Leasing* (Pty) Ltd 1996 (3) SA 582 (W); Burchell 2005:493-496; Du Plessis 2000:9; *Mini* 1963 (3) SA 188 (A):192; *Malinga* 1963 (1) SA 692 (A):694; *Modise* 1966 (4) SA 680 (GW).

him/herself to hospital, the law is that Y is considered to have impliedly consented to whatever medical treatment and investigations the doctor feels is necessary.[294] Once again, Dr X does not have the required *mens rea* for assault, because he/she does not have consciousness of wrongfulness.

However, there is a debatable qualification to the requirement of consciousness of wrongfulness. In *S v De Blom*[295] the Appellate Division held that if a person works in a particular sphere of activity, he/she ought to know the law relating to that sphere of activity and ignorance of the law is no excuse.[296] In other words, in the present example, even if Dr X did not have consciousness of wrongfulness, nevertheless if he/she ought to have known the law relating to consent in his/her specialized field as a doctor, liability may follow.

South African courts have applied the 'specialised activity' rule, by relying on the reasoning in *De Blom*. For example, in the later case of *S v Molubi,*[297] the court confirmed the accused's conviction of common assault (of which intention is an element), despite the fact that the accused thought that his conduct was legally justified. The court held that because the accused ought to have known that his conduct was unlawful, he could not rely on ignorance of the law.[298]

Therefore, on the above interpretation of *De Blom*, in effect the objective negligence standard is applied in cases where a person is involved in a specialised activity and seeks to rely on ignorance of the law. However,

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[294] It is not necessary to prove that he knew the detailed requirements of the offence with which he/she is charged, or the penalty of the offence, but merely that he/she knew, or foresaw the possibility that what he/she was doing was a contravention of the law in a broad sense. Burchell 2005:497-498; Snyman 2006:204-205.
[295] *De Blom* 1977 (3) SA 513 (A):531-532.
[296] *De Blom*:531-532.
[297] *Molubi* 1988 (2) SA 576 (B).
[298] The case concerned a tribal chief, who imposed corporal punishment on a person who had failed to pay a fine. The court held the caning was an assault without justification, because in terms of the legislation applicable to traditional courts, the traditional court had no power to inflict strokes on the complainant in question. Furthermore, the accused was a professional officer of the traditional authority and ought to have known he was expected to have the knowledge of the law applicable to his particular functions and interest. He was therefore convicted of assault. *Molubi* 1988 (2) SA 576 (B):578F, 580H-581B, 581F-G. However, Snyman disagrees with the judgment and argues that Rumpff J in *De Blom*, could not have intended the 'specialised activity' rule to mean that even if the accused did not know that the conduct was wrongful, he should nevertheless be held liable for assault on the basis of negligence, because such an interpretation of the judgment constitutes a confusion of the subjective test for intention with the objective test for negligence. Snyman 1994:1-3; Snyman 2006:208

Dlamini[299] is of the view that it 'is unacceptable to superimpose this requirement of reasonableness, which is tested objectively, on a case where the form of *mens rea* required is intention, since intention is tested subjectively'. In addition, it has been argued that a correct interpretation of the *De Blom*[300] judgment is that it is only where negligence is an element of the crime that the specialized activity rule applies.[301]

On the other hand, there are a number of potential objections to applying the subjective theory of intention without qualification, for example:

a. If people know that ignorance or mistake of the law will be an acceptable excuse, this will be an incentive to deliberately refrain from gaining knowledge, leading to a lax society, which lacks incentive to familiarize itself with the applicable criminal provisions.[302]

   In response, it has been argued that there is little risk that an accused would deliberately refrain from acquiring knowledge of his/her legal obligations, because in such instances it would almost invariably be possible to prove *dolus eventualis*.[303] The prosecution need not prove that the accused actually knew that his/her conduct was unlawful. It is sufficient if the prosecution proves that the accused foresaw the possibility

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[299] Dlamini 1989:15.
[300] At *De Blom:* 531H.
[301] Snyman points out that Rumpff J in *De Blom*, could not have intended the 'specialised activity' rule to mean that even if the accused did not know that the conduct was wrongful, he should nevertheless be held liable for assault on the basis of negligence, because such an interpretation of the judgment constitutes a confusion of the subjective test for intention with the objective test for negligence. Snyman 1994:1-3; Snyman 2006:208. See also, Burchell 2005:496; Amirthalingam 1995:13; Snyman 2006:205, opines that although it is correct that the test for *mens rea* in the form of *dolus* is subjective, a normative limitation should be placed on the scope of this defence in criminal law, in that the law should not recognize ignorance of the law as a defence if the ignorance was avoidable. In *Myburgh* 2002 (2) All SA 603 (C):609-610, the accused, allegedly as a joke, poured methylated spirits on the complainant and flicked his lighter near the complainant, apparently thinking that his lighter was not working. However, a flame from the lighter set the complainant on fire and he sustained serious burns. Msimang AJ dismissed an appeal by the State against the accused's acquittal and held that as the accused had subjectively believed it was a joke, it followed that he was unaware of the wrongfulness of his action and accordingly could not be held liable for common assault. Furthermore, in response to the State's argument that the specialized-activity rule applied to the accused, who was a policeman who had arrested the complainant, the court held that the rule only applies to a person who is involved in a specialist activity and makes a mistake of law relating to that specialist activity. In *casu*, the court held that the accused had made a mistake of fact to which the specialist activity rule does not apply. Further, the court pointed out that this rule should apply to offences requiring *mens rea* in the form of *culpa* and not to those requiring *mens rea* in the form of *animus*.
[302] Rabie 1994:102.
[303] Rabie 1994:102.

that the conduct was unlawful, yet proceeded, reckless as to whether it was unlawful or not.[304]

b. If ignorance or mistake of the law is admitted as an excuse, the accused will be treated as though the law were in fact as he/she mistakenly supposed it to be and, in so doing, each person is made a law unto themselves. The resultant collapse of the law's objectivity will be in conflict with the principle of legality.[305]

   In response it has been argued that the principle of legality and the validity of legal norms remain unaffected by the accused's knowledge or ignorance regarding such norms. The fact that the accused successfully relies on ignorance or mistake does not mean that his/her conduct is rendered lawful. Although the conduct remains unlawful, the accused is discharged in respect of a crime for which intention is required, because he/she was unaware of the unlawfulness of the conduct.[306]

c. Accepting an unqualified subjective theory of intention, will lead to a flood of unwarranted acquittals, because it will be too difficult to prove that the accused was not ignorant or mistaken.[307]

   In response, it has been argued that the state will not be burdened with insurmountable evidentiary problems leading to unjustified acquittals, because courts often have to deal with aspects of an accused's thought process and come to a decision in this regard. It should therefore be no more difficult to investigate an accused's averment of ignorance or mistake.[308]

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[304] *Hlomza* 1987 (1) SA 25 (A):31-32; *Bezuidenhout* 1979 (3) SA 1325 (T):1330H; *Russel* 1980 (2) SA 459 (C); *Magidson* 1984 (3) SA 825 (T). However, in *Aitken* 1988 (4) SA 394 (C), a theft case, it was held that knowledge of unlawfulness cannot exist in the form of *dolus eventualis*. Burchell 2005:497 fn 37, states that this decision is out of step with the general approach to *mens rea*. Oosthuizen 1990:681-96 and Labuschagne 1989:14, also criticize the approach in *Aitken*.
[305] Rabie 1994:103.
[306] Rabie 1994:104.
[307] Stassen 1977:261; Whiting 1978:95; Rabie 1994:97; Amirthalingam 1995:2-13.
[308] Rabie 1994: 97-98.

In determining whether the accused did have knowledge of wrongfulness at the time of the commission of the offence, a combination of, *inter alia*, the following factors may be relevant:

i. The testimony of the accused as to his/her state of mind at the relevant time. However, the court will treat this evidence with caution and will also look to outside factors, which prove or disprove the accused's testimony.[309]

ii. The nature of the prohibited conduct, for example, certain core crimes are generally known in general by the public to be unlawful, such as murder or assault.[310]

iii. The surrounding circumstances and the way in which the crime was committed is also relevant.[311]

iv. The fact that the accused ought to know the law. [312]

v. The reasonableness of the mistake or ignorance often indicates that there was a genuine mistake or ignorance.[313]

Therefore, although *mens rea* in the form of intention is a subjective state of mind in criminal law, the distinction between intention and proof of intention must be borne in mind. For example, if Dr X testifies that he/she did not foresee that the law required that he obtain consent from Y for the surgery and investigations, the

[309] *Rosseau v Viljoen* 1970 (3) SA 413(C):418A-C; Lubbe and Murray 1988:109; *Fourie v Naranjo*:1157b.
[310] Rabie 1994:98.
[311] Rabie 1994:99.
[312] Burchell 2005:496, points out that when intention is an element of an offence the fact that the accused should have been aware of the law is one factor of evidential value in determining whether the accused's ignorance or mistake of law was genuine or not.
[313] Dlamini 1989:15-16; Rabie 1994:99, points out that unreasonableness is only one factor in *proving* intention and is not a *requirement* for intention. Therefore, he argues that it does not undermine the subjective concept of intention and introduce the objective criterion under the guise of subjective intention.

court might not actually believe Dr X and instead may find that Dr X did have the required consciousness of wrongfulness.

In conclusion, the dominant position in South African criminal law is that *dolus* is present if Dr X foresees the possibility that his/her *unlawful* conduct may result in the direct or indirect force to patient Y's body and Dr X then reconciles him/herself to such possibility. A mistake of fact or law is therefore relevant.[314]

3.2.5.2 Delict

In a claim based on assault, once it has been shown that the defendant applied force to the body of the plaintiff, there is ordinarily a presumption, not only that the assault was wrongful, but also that the defendant acted *animo iniuriandi.*[315] The defendant must then prove that the act was lawful, or that he/she did not have the required intention to injure the plaintiff's right of personality.[316]

Mens rea, in the form of *dolus*, is required[317] and *dolus eventualis* is sufficient.[318] Therefore, under the *actio iniuriarum*, the defendant must foresee the possibility

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[314] Although the 'specialised activity' rule is a recognised exception since *De Blom.*

[315] *Walker v Van Wezel* 1940 WLD 66:67; *Bennett v Minister of Police* 1980:34-35; *Groenewald v Groenewald* 1998 (2) SA 1106 (SCA):1111-1112.

[316] Amerasinghe 1967:194, 205; Carstens and Pearmain 2007:500 fn 31, state that 'any aggression upon the person of another is *prima facie* an *iniuria*.' The interference with *corpus* in Roman and Roman-Dutch law was *per se* an unlawful act involving *iniuria*. Amerasinghe 1967:60-61; In *Whittaker v Roos and Bateman* 1912 AD 92:124, Innes J stated that 'when an unlawful aggression... has been proved, the law presumes that the aggressor had in view the necessary consequence of his conduct; that is, that he had the intention to injure, the *animus iniuriandi.*'

[317] The rule that negligence is not sufficient for an action based on the *actio iniuriarum*, is related to the idea that a private penalty is obtainable with the *actio iniuriarum* as punishment. Neethling *et al* 2005:58 fn 218. However, Van der Walt 1979:6, argues that this position 'is not justifiable in a modern system of law', because '[t]he basic purpose of a civil action in delict is to compensate the victim for the actual harm done ...It is for criminal law to punish and thereby discourage such conduct'.

[318] Boberg 1989:268-269; Neethling *et al.* 2006:113. The subjective element of the *iniuria* is the *animus iniuriandum*. It denotes the intention of committing an *iniuria*, of subjecting another to an *iniuria*. McKerron 1971:56. In *Whittaker v Roos*:131, Solomon J stated that "It is sufficient [for the *animus iniuriandi*] that the injuries suffered by the plaintiffs were inflicted by the defendants, not accidentally or negligently, but with deliberate intention." A malicious motive is not necessary. Amerasinghe 1967:57, 194; Carstens and Pearmain 2007:505. The motive of the wrongdoer is not an element of the *animus iniuriandi* or intent. Amerasinghe 1967:203; Neethling *et al.* 2006:115; Snyman 2006:190; Burchell 2005:463; Carstens and Pearmain 2007:504. Motive indicates the reason for someone's conduct, that is his/her desire or the facts behind the formation of his/her will. On the other hand, intent denotes a technical legal term that indicates willed conduct that the wrongdoer knows is wrongful. Therefore, even if a person has a good motive, he/she may act with intent, for example when X kills Y because of sympathy for Y's suffering. However, motive may serve as evidence that someone had consciousness of wrongfulness. A bad motive generally indicates knowledge of wrongfulness, while a good motive indicates the opposite. Neethling *et al.* 2006:115-116.

of the wrongful application of force to the body of the plaintiff. On the other hand, it is debatable whether, in delictual assault, a mistake of fact or law, whether reasonable or unreasonable, which leads the defendant not to desire or foresee the wrongfulness of assault, is available as a defence. In other words, on this view, as long as the defendant foresees the possibility of the application of force to the body of the plaintiff, then whether or not he/she foresees that it may be unlawful, is irrelevant for purposes of determining liability.

McKerron[319] agrees with this approach and points out that in modern law, where the *actio iniuriarum* no longer performs a purely penal function, it is 'repugnant to the ordinary man's ideas of justice and good sense' that a defendant should escape liability for assault because of a *bona fide* mistake that he/she was not injuring the plaintiff's personality right. He elaborates on this approach by quoting from Wessels JP in *Cohen Lazar & Co v Gibbs*[320]*:*

> If the law were otherwise an innocent third person whose person is wrongfully arrested or whose goods are wrongfully seized would be wholly unprotected. Such a state of affairs is inconceivable.[321]

McKerron[322] explains further:

> A person who knowingly and intentionally invades another's rights of personality does so at his own peril; it is no defence for him to plead that he *bona fide* believed that the invasion was justified, however reasonable such belief may have been, if in fact no justification existed.

On the other hand, Neethling *et al*[323] state that, in accordance with developments in criminal law in South Africa, it must be accepted as a general rule that, for

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[319] McKerron 1971:56-57.
[320] McKerron 1971:57. *Cohen Lazar & Co v Gibbs* 1922 TPD 142.
[321] *Cohen Lazar & Co v Gibbs*:145.
[322] McKerron 1971:57.
[323] Neethling *et al.* 2006:115; Boberg 1989:271–272, states that consciousness of wrongfulness is not a separate requirement, but is part of intention. The actor's will is directed at causing an unlawful consequence and not merely a consequence. He reasons that if consciousness of wrongfulness is removed, then intention falls away altogether and, as a result, there is strict liability or liability in negligence only. See also Van der Walt 1997:38, for the same views. Van Oosten 1989:454, states that where assault or *iniuria* is the cause of action, the non-disclosure must have been

purposes of delictual liability, any mistake with regard to either a relevant fact or law excludes intent.

However, Dlamini[324] disagrees and is of the view that the defence of ignorance of the law is rightly applied to criminal proceedings, because criminal proceedings are concerned with the punishment of an individual for an offence and the state imposes punishment. Punishment amounts to an extreme violation of the rights of the individual, because it involves a deliberate infliction of pain and suffering on the individual or a deprivation of the individual's property or freedom. On the other hand, in a civil suit, the court has to determine which of the two individuals should bear the loss. As a result, it may be more just to shift the loss to the person who infringed the right and caused the damage.

Further, Carstens and Pearmain[325] point out that there is current South African common law authority for the view that consciousness of wrongfulness is not necessary in order to be held liable for medical assault.[326] In addition, they reason in a similar fashion to McKerron and argue that in certain comparable delicts, such as false imprisonment, *dolus* is an ingredient of the cause of action, but it is not necessary for the plaintiff to establish consciousness on the part of the wrongdoer of the wrongful character of his/her act.[327]

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intentional in the sense that the doctor actually foresaw and reconciled himself with the possibility of the unlawful non-disclosure.

[323] Dlamini 1989:13,19.

[324] Dlamini 1989:13,19.

[325] Carstens and Pearmain 2007:501-506.

[326] See, for example, *Stoffberg v Elliot* 1922 CPD 148; *Layton and Layton v Wilcox and Higginson* 1944 SR 48; *Esterhuizen v Administrator Transvaal* 1957 3 SA 710 T.

[327] Carstens and Pearmain 2007:504-506; The authors refer, *inter alia*, to *Ramsay v Minister van Polisie* 1981 (4) SA 802 (A); *Whittaker v Roos* 1912 AD 131 and *Smit v Meyerton Outfitters* 1971 (1) SA 137 (T) in support. See also, *Boswell v Union Club of SA (Durban)* 1985 (2) SA 162 (D):166-168; *Donono v Minister of Prisons* 1973 (4) SA 259 (C):262; *Smith and Lardner-Burke v Wonesayi* 1972 (3) SA 289 (RA); *Norton v Ginsburg* 1953 (4) SA 537 (A):551 and *C v Minister of Correctional Services* 1996 (4) SA 292 (T). In *Minster of Justice v Hofmeyer* 1993 (3) SA 131 (A):137A, 146C, 154H, a prisoner was separated from the other inmates in isolated conditions for extended periods of time. The court held that the segregation of the plaintiff involved an aggression upon his absolute right to bodily integrity. The court further held that knowledge of wrongfulness is not required in delicts involving false imprisonment and the wrongful attachment of goods. In *Minister of Finance and Others v EBN Trading*:329B-C, a case involving unlawful detention of goods, the court held that, in line with the human rights culture stressed in the Constitution of South Africa, in cases involving wrongful imprisonment or wrongful detention of goods, the plaintiff need not establish consciousness of wrongfulness of the wrongful character of the act on the part of the wrongdoer.

In order to succeed in an action based on wrongful deprivation of liberty (arrest or detention), the plaintiff must prove that the defendant deprived him/her of his/her liberty. However, once the arrest or imprisonment has been admitted or proved, it is for the defendant to allege and prove the existence of a ground of justfication. Further, consciousness of wrongfulness is not required and a *bona fide* mistake is therefore not available as a defence.[328] In *Minister of Correctional Services v Tobani,*[329] Jones J pointed out that this position fits comfortably with the principles of constitutional legality:

> So fundamental is the right to personal liberty that the lawfulness or otherwise of a person's detention must be objectively justifiable, regardless of the *bona fides* of the gaoler and regardless even of whether or not he was aware of the wrongful nature of the detention

The writer respectfully agrees with Dlamini, McKerron and Carstens and Pearmain and is of the view that in delict the same rule relating to consciousness of wrongfulness should be applied, whether an invasion of bodily integrity takes place through deprivation of liberty or assault. Both false imprisonment and assault are concerned with the closely intertwined and fundamental common-law and Constitutional rights to bodily integrity and freedom. Further, the right to physical integrity embraces both *corpus* (body) and *libertas* (liberty).[330]

This position can be illustrated by the following hypothetical examples:

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[328] Neethling 2004:712.

[329] *Minister of Correctional Services v Tobani* 2003 (5) SA 126 (E):133F-G.

[330] Neethling *et al.* 2006:297; In *Ex parte Minister of Safety and Security: In re S v Walters* 2002(4) SA 613 (CC):631, the court held that the use of force to effect an arrest raises constitutional misgivings regarding the 'three elemental rights contained in the Bill of Rights', which are 'the right to life, dignity and bodily integrity.' The court also pointed out that the fundamental rights to life, dignity and bodily integrity are introduced by the Constitution in s 7(1), which provides that 'This Bill of Rights ... affirms the democratic values of human dignity, equality and freedom'. *Ex parte Minister of Safety and Security: In re S v Walters*:620:F, 620 fn 5. Furthermore, the right to bodily integrity finds expression in section 1 of the Constitution, which states that South Africa is founded on the values of human dignity, the achievement of equality and the advancement of human rights and freedoms...'. In addition, section 39(1) requires that the rights in the Bill of Rights must be interpreted in such a way that the values that underlie an open and democratic society based on human dignity, equality and freedom are promoted'.

a. Dr X thinks that Dr Z obtained consent from Y for surgery to be performed by Dr Z with Dr X assisting, whereas in fact no consent was obtained (mistake of fact).

b. The law requires that Dr X obtain separate, express consent from Y for the particular surgery and blood tests that he/she proposes. However, Dr X does not foresee the possibility that he/she must obtain consent from Y for surgery and blood tests, as he/she is under the impression that if Y admits him/herself to hospital, it follows that Y impliedly consents to whatever medical treatment and investigations the doctor feels is necessary (mistake of law).

c. Dr X does not disclose a risk of surgery to Y. Dr X is not aware of the risk and therefore does not foresee that he/she must disclose the risk to Y in order for consent to the procedure to be regarded as legally valid (mistake of fact).

d. Dr X does not disclose a risk of surgery to Y. Dr X is aware of the risk of harm, but does not think that the law requires him/her to disclose the risk to Y in order for consent to the procedure to be valid (mistake of law).

e. Dr X foresees a risk associated with surgery, but mistakenly concludes that Y will not suffer any harm as a result of the risk and therefore does not disclose the risk to Y (mistake of fact).

In all of the above examples, as long as Dr X intended to apply force to Y, then even a *bona fide* or reasonable mistake with regard to fact or law will not negate culpability. Therefore, if Dr X does not obtain consent from Y and does not successfully invoke one of the other justification grounds, such as necessity,[331]

[331] In *Stoffberg v Elliott*:150, Watermeyer J stated: 'Supposing a man is picked up unconscious in the street, and you cannot get his consent, and it is necessary for the doctor to perform some operation to save his life, then I think clearly the doctor could do so without consent.'

then, irrespective of whether Dr X knew or ought to have known of or foreseen the unlawfulness of the outcome, he/she will be at fault.[332] Dr X will therefore be held liable for assault even if Dr X did not possess consciousness of wrongfulness, due to a mistake of fact or law.

3.3 English battery and South African assault

Although English law influenced the development of assault as a separate cause of action in South Africa in the nineteenth century, there are some important differences between English law on the one hand, and South African law, on the other, for example:

a. In order to hold a person liable for battery in English law, there must be direct physical contact between the parties,[333] whereas in South African law the emphasis is on infringement of the right to bodily integrity.

b. In English law, a sharp line is drawn between the nature of the application of force and the rest of the consequences, whereas in South Africa, assault is regarded as a consequence crime/delict. In principle, the doctrine of *volenti non fit iniuria* requires full knowledge of the consequences for valid consent.[334]

c. In English law the plaintiff must prove the absence of consent, but in South Africa, the defendant bears the onus to prove the presence of the justification ground.[335]

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[332] *Layton and Layton v Wilcox and Higginson* 1944 SR 48:50-51; *Stoffberg v Elliott*:150-151.
[333] Jackson 2006:276; McHale and Fox 2007:358; Trindade FA 1982:216, 218-219, 225-226; Kenny 1958:197. Therefore, in *Hanson* (1849) 2 Car & Kir 912, it was held that the administration of poison to a woman was not an assault in common law.
[334] See the discussion in Chapter Two.
[335] *Minister of law and order v Monti* 1995 (1) SA 35 (A):39G-I; In *Fourie v Naranjo* 2007 (4) All SA 1152 (C):1157a-c, it was also held that the defendant (the appellant in this case) bears the onus of proof in respect of consent to an otherwise unlawful assault.

d. In English law, intention only relates to the physical contact.[336] However, in South African law, consciousness of wrongfulness is a requirement in criminal law, although it is debatable whether subjective consciousness of wrongfulness is required where the accused is involved in a specialized activity or where delictual assault is in issue.

e. In English law, for purposes of a claim based on assault, it does not matter that the medical treatment was indicated and therapeutic or that the plaintiff would have consented to the treatment if he/she had been properly informed. The position is the same in South African law. Van Oosten[337] states that in South African law a doctor may be held liable for assault, irrespective of whether or not the intervention was administered with proper care and skill and eventually proves to be beneficial to the patient. In addition, Van der Heever,[338] commenting on South African law of assault, states that the plaintiff does not have to show what he/she would have done if he/she had been properly informed, since this requirement is not an element of the delict of assault.

3.4 Conclusion

In Chapters Two and Three the basic elements of a crime and a delict in South African law were explained in the context of assault. In particular, it was pointed out that consent or *volenti non fit iniuria* is a justification ground, which negates the wrongfulness element of a crime or delict and it is a subjective test, which focuses on the actual state of mind of the plaintiff. Furthermore, subjective consciousness of wrongfulness is a requirement for intention in criminal assault, but the position in respect of delictual assault is debatable.

[336] Trindade 1982:219; Pattinson 2006:99, who refers to *Wilson v Pringle* [1987] QB 237:249 in support.
[337] Van Oosten 1995:167 states that the reason for this is because 'the violation perpetrated by the doctor who performs the wrongful or unlawful intervention is one against the patient's physical integrity or *dignitas*/privacy rather than one against his health'.
[338] Van der Heever 2004:55.

In the following chapter, leading South African case law relating to disclosure of information prior to administering medical treatment, will be examined in detail. The two main causes of action in delict will be discussed and compared, that is assault and breach of duty of care. In so doing, the boundaries of consent, the requirement of consciousness of wrongfulness as applied in South African case law, and the claiming of damages for assault will also be considered.

CHAPTER 4

CONSENT TO MEDICAL TREATMENT IN SOUTH AFRICA

4.1 Introduction

The chapter is divided into various types of disclosure and the delictual causes of action which were brought by patients relating to each form of disclosure. Prominent case law relating to the various delictual causes of action is discussed and the focal points of the judgments are highlighted. Following a discussion of case law, the elements of the different causes of action are interpreted and summarized through an analysis of case law.

4.2 Disclosure of the general nature of medical treatment

4.2.1 Assault

4.2.1.1 *Stoffberg v Elliott* 1922 CPD 148

A surgeon cut off a patient's penis without his consent. In response, the patient instituted a civil action against the doctor for assault.

The doctor put forward two arguments in his defence, the first relating to wrongfulness and the second relating to fault:

a. The patient did consent to the operation, because by submitting himself to treatment at the hospital the patient had impliedly agreed to whatever treatment as was immediately necessary.[339]

b. Alternatively, the doctor was under the impression that consent had been obtained by the hospital staff. He was a visiting honorary surgeon and the usual practice at the hospital was that the hospital staff obtained the consent.[340]

In response to the first argument, the court, per Watermeyer J, held that consent must be expressly obtained before treating the patient:[341]

> By going into hospital [the patient] does not consent to such surgical treatment as the doctor may consider necessary. By going into hospital he does not give up or waive his right of absolute security of the person; he cannot be treated in hospital as a mere specimen, or as an inanimate object which can be used for the purposes of vivisection; he remains a human being and he retains his rights of control and disposal of his own body; he still has a right to say what operation he will submit to, and, unless his consent to an operation is expressly obtained, any operation performed upon him without his consent is an unlawful interference with his right of security and control of his own body, and is a wrong entitling him to damages if he suffers any.

In response to the second argument, the court held that, although no 'moral blame' attached to the defendant, and that he was 'quite justified' in assuming that consent had been obtained (in other words, his mistake was reasonable), nevertheless his mistake did not justify treating the patient without his consent:

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[339] *Stoffberg v Elliott*:149-151.
[340] *Stoffberg v Elliott*:149-151.
[341] *Stoffberg v Elliott*:149-150; Strauss 1961:33, 41-42, states that consent may be obtained either expressly or by implication; Van Oosten 1989:35 fn 7, states that 'Since lawful consent need not be express, but can also be implied, Watermeyer J's statement goes too far'.

> I want first of all to explain to you what, in law, an assault is. In the eyes of the law, every person has certain absolute rights, which the law protects. They are not dependant upon a statute or upon a contract, but they are rights to be respected, and one of those rights is the right of absolute security of the person. Nobody can interfere in any way with the person of another ... ...in law if a man commits an assault, or if he is one of a number who commits an assault, then it does not matter whose duty it was to ask for consent to that assault. If the consent is not obtained then all the persons concerned in that assault are liable to the plaintiff...[342]

In other words, according to Watermeyer J, the element of consciousness of wrongfulness, or knowledge that the conduct is wrongful, is not part of the enquiry where the cause of action is delictual assault. Further, even a reasonable mistake will not exclude liability for assault. [343]

The court noted that the patient was claiming patrimonial damages and damages for pain and suffering flowing from bodily injury and was brought through the Aquilian action and action for pain and suffering. In this regard, Watermeyer J stated, *obiter*, that the plaintiff has to prove actual loss, either pecuniary or pain and suffering, in order to succeed in an action based on a civil wrong. In other words, the plaintiff must prove bodily injury, causation and damage where patrimonial loss and pain and suffering are claimed in the action based on assault.[344]

Further, Watermeyer emphasized that actual loss must be proved "unless the wrong was committed under such circumstances that it can be taken to be an insult, which is called in law, *contumelia*, or unless the action is brought to

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[342] *Stoffberg v Elliott*: 148-151.
[343] However, according to Boberg 1989:746, the doctor in *Stoffberg* was without fault, because his subjective mistake that the plaintiff had consented excluded consciousness of wrongfulness and therefore intention, while the reasonableness of his belief excluded negligence. He states that, in effect, the court held the doctor strictly liable for assault. See also Price 1953:9 for the same views.
[344] *Stoffberg v Elliott*:152.

establish some right."[345] Neethling *et al*[346] interpret this as meaning that *contumelia* must be separately established in order to claim satisfaction for assault under the *actio iniuriarum*. They disagree, stating that the primary infringement of bodily integrity on its own may be considered an *iniuria,* despite the absence of *contumelia*.[347] Further, they point out that *contumelia* need not be interpreted exclusively to mean insult or injury to a person's honour.[348] Further, Amerasinghe[349] notes that a separate element of *contumelia* does not have to be established, because the mere interference of the *corpus per se* imports *contumelia.*[350] If this reasoning is accepted, the plaintiff in this case could have claimed satisfaction through the *actio iniuriarum.*

Finally, the court directed the jury that in spite of the fact that there was a wrong done to the plaintiff, he must also suffer patrimonial loss and/or pain and suffering, which he would not otherwise have suffered, in order to satisfy the causative element required to successfully claim damages under the Aquilian action. The court noted that the operation was necessary to save the plaintiff's life as he would have died a painful death of cancer within two years if he did not have the operation. The court therefore directed the jury to carefully consider whether the plaintiff had suffered any damage at all. The jury found for the defendant by a majority.[351]

However, the writer is respectfully of the view that there would still have been a

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[345] *Stoffberg v Elliott*:152.
[346] Neethling *et al*. 2005:85.
[347] On the other hand, Van Oosten 1989:451-452, states that the infringement of bodily integrity without consent is sufficient to give rise to a claim for assault. However, where there is an added element of *contumelia,* in that it is not only the patient's bodily integrity which is infringed but also his/her dignity, the doctor may also be held liable for *iniuria.*
[348] Neethling *et al*. 2005:85; Neethling *et al*. 2006:12-13.
[349] Amerasinghe 1967:60-62
[350] See also, Neethling *et al* 2006:302; Carstens and Pearmain 2007:500 fn 31, state that 'any aggression upon the person of another is *prima facie* an *iniuria*'; Boberg 1989:746 states that 'Assault is per se contumelious.' Amerasinghe 1967:60-62,205 points out that the Romans did not regard interference with bodily integrity as an aggression upon *dignitas* for purposes of the *actio iniuriarum*, but regarded interference with bodily integrity as a violation of an interest in *corpus*, which affected a person's feelings. It is possible that an assault involved violation of dignity as well, but this would be an added element in the *iniuria*. It is however, unclear from case law as to whether *contumelia* can automatically be awarded once the cause of action for assault is established even though *contumelia* has not specifically been alleged. (*Mthimkhulu v Minister of Law and Order* 1993 (3) SA 432 (E); *Brown v Hoffman* 1977 (2) SA 556 (NC):557H-558A, 558H), or whether *contumelia* has to be separately proved if the plaintiff is claiming damages in this regard (*Bennett v Minister of Police* 1980 (3) SA 24 (C):37c-e).
[351] *Stoffberg v Elliott*:152-153; See also Boberg 1989:746 for comment.

valid claim for satisfaction under the *actio iniuriarum*. As Carstens and Pearmain[352] point out:

> The nature of medical treatment is such that it affects the patient's 'personhood'. It affects much more than his life or physical well-being... If a patient who is suffering from an incurable disease is forcibly treated against his will in order to save his life and this objective is achieved but in the process his suffering is prolonged and his rights to human dignity and to bodily and psychological integrity have been violated it is submitted that there may well be arguments on the basis of public policy that clearly favour the wrongfulness of such an act and that would support a significant award of damages. Life is not everything. It is rather the lowest common denominator in being human as the matrix of other rights in the constitutional Bill of Rights indicates.

4.2.2 Assault and breach of duty of care

4.2.2.1 *Layton and Layton v Wilcox and Higginson* 1944 SR 48

Doctors performed an operation on a child without obtaining consent from the parents. The child died as a result of the operation.

The parents based their claim for damages on both assault and negligence. The claim based on assault alleged that the operation was unlawfully performed, without the consent of the plaintiffs, and the alleged negligence consisted in the failure to notify and obtain the consent of the parents.[353] The father claimed special damages and the mother claimed damages for nervous shock flowing from the death of her child.

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[352] Carstens and Pearmain 2007:506.
[353] *Layton and Layton v Wilcox*:49.

The court held that in the first place there was an assault because the operation had been performed without consent.[354] The court accepted that the defendant doctors genuinely believed that the question of consent was purely an administrative function of the nursing sister and, in addition, the court considered the mistake reasonable.[355] However, despite the mistake, the court confirmed the magistrate's award to the father of special damages flowing from the assault.[356]

Having decided the assault question, the court turned to the alternative cause of action, based on the English tort of negligence, which comprises three elements. Firstly, that the doctor owed the patient a duty of care; secondly that he/she was in breach of that duty (ie, that he/she failed to provide care of an adequate standard/that there was negligence) and thirdly the harm of which the victim complains was caused by that breach of duty.[357]

Hudson C J[358] pointed out that a finding of an assault by no means proves that there was also negligence in not obtaining consent.[359] In the first place, the court held that the doctors owed no duty of care to the mother as the doctors were only obliged under South African law to obtain consent from the father.[360] Therefore, the mother's claim for nervous shock failed. However, as far as the father's claim was concerned, the court held that (1) the doctors had a duty to obtain consent, which (2) they negligently breached by failing to obtain the consent of the patient's father who was readily accessible, or not taking reasonable steps to obtain the father's consent.[361]

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[354] *Layton and Layton v Wilcox*:50.
[355] *Layton and Layton v Wilcox*:51.
[356] *Layton and Layton v Wilcox*:50.
[357] McHale and Fox 2007:152-153; Pattinson 2006:62.
[358] Blakeway J concurring.
[359] *Layton and Layton v Wilcox and Higginson*:50.
[360] *Layton and Layton v Wilcox and Higginson*:50.
[361] *Layton and Layton v Wilcox and Higginson*:50.

4.2.3 Analysis

Stoffberg[362] and *Layton*[363] are both early South African cases dealing with assault in the context of consent to an operative procedure. Both claims were based on delictual assault, which was treated as a separate cause of action to the three pillars of South African law of delict. In both cases it was found that the defendant intentionally operated on the plaintiff without the plaintiff's consent. Neither court required that the defendant possess consciousness of wrongfulness. In other words, neither case accepted that a mistake, whether reasonable or unreasonable, is capable of excluding liability for assault and the intention to touch the patient was sufficient.[364]

In neither case was a claim for satisfaction under the *actio iniuriarum* pursued. The plaintiff in *Stoffberg*[365] claimed damages through the Aquilian action and action for pain and suffering and the plaintiff in *Layton*[366] also claimed patrimonial damages flowing from the assault. Further, the court in *Layton* went on to consider a separate cause of action based on the English duty of care or tort of negligence.[367]

English law is casuistic - the law of delict consists of a group of separate delicts (torts), each basically with its own rules, and liability will only follow if the plaintiff satisfies the requirements of the specific delict.[368] The tort of negligence is one such example and, as stated above, it consists of three elements, which explicitly conflate the requirements of wrongfulness and fault into a single enquiry into the defendant's conduct.[369]

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[362] *Stoffberg v Elliott* 1922 CPD 148.
[363] *Layton v Wilcox* 1944 SR 48.
[364] See the discussion on these cases in 4.2.1.1 and 4.2.2.1.
[365] *Stoffberg v Elliott*:152.
[366] *Layton and Layton v Wilcox*:50.
[367] See the discussion on these cases in 4.2.1.1 and 4.2.2.1.
[368] Neethling *et al.* 2006:4-5.
[369] Brand 2007:80; Neethling *et al.* 2006:138, argue that by confusing wrongfulness and fault 'the theoretical foundations of our law of delict are undermined, and this inevitably leads to legal uncertainty.'

On the other hand and in contrast to English law, in South Africa general principles regulate the law of delict.[370] A number of elements must all be proved, for the defendant to be held liable in delict, that is, the conduct, wrongfulness, fault (in the form of intention and/or negligence), causation and damage.[371] Further, in principle, the determination of fault, in the form of intention or negligence, only takes place once it has been established that a person has acted wrongfully.[372] The South African courts have repeatedly emphasized that the enquiry into wrongfulness and fault is separate.[373]

In South African law, wrongfulness is seldom contentious in cases of a positive act causing damage to person or property, as such conduct is *prima facie* wrongful.[374] However, omissions are *prima facie* lawful and wrongfulness will only be present when there was, according to the reasonableness or *boni mores* criterion, a legal duty to prevent harm through positive conduct.[375] This depends on the reasonableness or *boni mores* criterion whereby there is a weighing and a balancing between the interests of the parties and that of the community.[376]

However, in determining the question of wrongfulness for an omission, South African courts sometimes use the English term 'duty of care' as a synonym for the term 'legal duty'.[377] The courts have also often conflated the elements of wrongfulness and negligence, not only by utilizing the two legs of the test for negligence (foreseeability and preventability of harm) separately in the

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[370] See the discussion in Chapter Two.
[371] Neethling *et al.* 2006:vii-ix.
[372] Neethling *et al.* 2006:109, states that 'Fault can only be present if a person has acted wrongfully; it would be illogical to blame someone (that is to find fault on his part) who has not acted for purposes of the law of delict or who has acted lawfully.'
[373] See, for example, *Local Transitional Council of Delmas v Boshoff* 2005 (5) SA 514 (SCA):521-522; *Telematrix (Pty) Ltd t/a Matrix Vehicle Tracking v Advertising Standards Authority* SA 2006 (1) SA 461 (SCA):468-469; *Gouda Boerdery BK v Transnet*:498-499; *Road Accident Fund v Mtati* 2005 (6) SA 214 (SCA):227-228; *Minister of Safety and Security v Van Duivenboden* 2002 (6) SA 431 (SCA):441-442; See also, Neethling *et al.* 2006:109; Neethling and Potgieter 2007:120-130; In *Telematrix*:468B-C, Harms JA said that 'the fact that the act is negligent does not make it wrongful ...to elevate negligence to the determining factor confuses wrongfulness with negligence'. However, for a contrary view, see Fegan 2005:90-141.
[374] *Trustees, Two Oceans Aquarium Trust v Kantey & Templer* 2006 (3) 138 (SCA):143-145.
[375] See the discussion in Chapter Two and Three.
[376] Neethling 2006: 211; *Van Eeden v Minister of Safety and Security (Women's Legal Center Trust as Amicus Curiae)* 2003 (1) SA 389 (SCA):395-6.
[377] Therefore, Neethling *et al.* 2006:137-138, are of the opinion that to avoid confusion it would be better to describe the duty involved in the test for wrongfulness as a 'legal duty' and not as a duty to take care.

application of the test for wrongfulness but also by applying the whole test for negligence to determine wrongfulness.[378] Furthermore, the courts have also sometimes applied the English duty of care doctrine wholesale,[379] as occurred in the present case.[380]

The relationship between wrongfulness and fault in the context of an omission to disclose information will be discussed further when the more recent cases of *Castell v De Greef*[381] and *McDonald v Wroe*[382] are discussed below.

4.3 Disclosure of the general nature of treatment and the risks of treatment

4.3.1 Assault

4.3.1.1 *Esterhuizen v Administrator, Transvaal* 1957 3 SA 710 T

The plaintiff, a young woman, alleged that the doctor had failed to warn her that she would be receiving radium treatment, a more radical form of 'X-ray treatment' than she had previously received from the hospital for her skin cancer. She also alleged that he had failed to warn her of the inevitable and possible serious consequences of the more radical X-ray treatment.[383]

The plaintiff alleged that the failure to obtain her consent meant that there was a wrongful, unlawful and intentional assault, which caused her to sustain inevitable serious injuries in the form of burns, deformity and cosmetic changes. Furthermore, a 10% risk of amputation of her limbs eventuated and the plaintiff's

[378] Neethling 2006:209.
[379] Dendy 1988:395; Van der Merwe and Olivier 1989:129-130; Boberg 1989:274.
[380] *Layton and Layton v Wilcox and Higginson*:50.
[381] *Castell v De Greef* 1994 (4) SA 408 (C).
[382] *McDonald v Wroe* [2006] 3 All SA 565 (C).
[383] *Esterhuizen v Administrator, Transvaal*:715E-G.

right leg was amputated above the knee, her left leg amputated below the knee and both her hands were eventually amputated.[384]

4.3.1.1.1 Application of force

The application of force in this case was arguably direct. The defendant used an instrument, the X-ray machine, to apply X-rays to the plaintiff's body.[385]

4.3.1.1.2 Consent

The court began its legal findings by referring to *Stoffberg v Elliott*.[386] The court considered the ambit of the defence of consent or *volenti non fit iniuria* and, in this regard, quoted Schriener JA in *Lampert v Hefer*:[387]

> It is usual to include in the defence of *volenti non fit iniuria*, or, as I call it for convenience, consent, cases of voluntary assumption of risk as well as cases of permission to inflict intentional assaults upon oneself, as in the case of surgical operations.[388]

The court further explained the requirements for establishing the defence of *volenti non fit iniuria*:

> to establish the defence of *volenti non fit iniuria* the plaintiff must be shown not only to have perceived the danger, but also that he fully appreciated it

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[384] *Esterhuizen v Administrator, Transvaal*:717D-F, 726B.
[385] See the discussion on direct and indirect application of force in Chapter Three.
[386] *Esterhuizen v Administrator, Transvaal*:718A-D. The defendant argued, *inter alia*, that the radium treatment was essential, a matter of 'life and death'. In response, the court held that the doctor will only be justified in proceeding without consent where the treatment is so urgently necessary that it cannot be delayed in order to obtain consent. The court held that, in the present case, there was sufficient time to obtain consent. *Esterhuizen v Administrator, Transvaal*:718E-D, 722D-E. The court relied on the reasoning of Millin J in *Ex parte Dixie* 1950 (4) SA 748 (W):751:'Such an operation cannot lawfully be performed without the consent of the patient, or, if he is not competent to give it, that of some person in authority over his person. The fact that he is a patient in this hospital does not entitle those in charge of it to perform any surgical operation upon him which they may consider beneficial. They would only be justified in performing a major operation without consent where the operation is urgently necessary and cannot with due regard to the patient's interests be delayed.'
[387] *Lampert v Hefer* 1955 (2) SA 507 (AD):508.
[388] *Esterhuizen v Administrator, Transvaal*:719B.

and consented to incur it.[389]

Bekker J expressly stated that he associated himself with the following views and remarks of Neser J in *Rompel v Botha*:[390]

> I have no doubt that a patient should be informed of the serious risks he does run. If such dangers are not pointed out to him then, in my opinion, the consent to the treatment is not in reality consent – it is consent without knowledge of the possible injuries. On the evidence defendant did not notify plaintiff of the possible dangers, and even if plaintiff did consent to shock treatment he consented without knowledge of injuries which might be caused to him. I find accordingly that plaintiff did not consent to the shock treatment.[391]

However, the defendant's counsel argued that it would render the position of the medical profession 'intolerable' if they had to inform patients of all the consequences accompanying the operation or treatment. In response, Bekker J refused to lay down a general principle as to whether there should be a limitation on the amount of information provided on policy grounds. Instead, he expressly confined his comments to the facts of the particular case and concluded that the consequences in this case, that is the inevitable consequences and the possible, but serious consequences should have been disclosed.[392] The court concluded that the patient had not consented to the X-ray treatment, as it was 'vastly different in form, substance and more dangerous than the earlier treatments'.[393]

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[389] *Esterhuizen v Administrator, Transvaal*:719C.
[390] *Rompel v Botha* TPD 15 April 1953, unreported.
[391] *Esterhuizen v Administrator, Transvaal*:722C. The court also referred to American law in support of the view that consent to an invasion of a personal interest without knowledge of the dangers involved is not in reality consent *Esterhuizen v Administrator, Transvaal*:719F-G. Simons 1978:130-131, relying on the judgments of *Stoffberg v Elliott* and *Esterhuizen v Administrator Transvaal*, states that 'uninformed consent is tantamount to no consent, and treatment, by which I mean some bodily interference, without consent is an assault'.
[392] *Esterhuizen v Administrator, Transvaal*:719:721A-D.
[393] *Esterhuizen v Administrator, Transvaal*:720H, 722H.

4.3.1.1.3 Fault

As in the *Stoffberg*[394] and *Layton*[395] cases, the court did not consider the question of whether the defendant possessed consciousness of wrongfulness relevant. It was sufficient that the defendant intended to apply the X-ray treatment to the patient.[396]

However, the defendant argued that the required *dolus* had not been proved as the doctor had administered the treatment to the plaintiff with the laudable motive of attempting to cure her. In response, the court pointed out that there is a difference between the concepts of intent and motive and the fact that the motive for an assault might be laudable does not negative the fact that the intention to assault or that the assault itself might nevertheless be wrongful.[397]

4.3.1.1.4 Causation and quantum

The plaintiff claimed patrimonial damages and pain and suffering. The court therefore considered whether, on a balance of probabilities, if the X-ray treatment had not been administered, the patient would have remained in remission without the need for this radical form of treatment and the consequent risk of losing her limbs.[398] The court found in favour of the plaintiff in this regard and awarded her damages for future medical expenses and for loss of amenities, disfigurement and pain and suffering.[399]

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[394] *Stoffberg v Elliott* 1922 CPD 148. See the discussion on this case in 4.2.1.1 and 4.2.3.
[395] *Layton v Wilcox* 1944 SR 48. See the discussion on this case in 4.2.2.1 and 4.2.3.
[396] *Esterhuizen v Administrator, Transvaal*:719:722F-G.
[397] *Esterhuizen v Administrator, Transvaal*:719:722F-G.
[398] *Esterhuizen v Administrator, Transvaal*:726C-H. See also *Stoffberg v Elliott*:152-153.
[399] *Esterhuizen v Administrator, Transvaal*:719:726C-H. Naidoo 2004:8, comments on the *Esterhuizen* judgment and states that 'Although the ultimate goal of treatment will be to rid the patient of the disease, it must not be taken for granted that the patient is willing to take the risk. A patient may prefer to live with the disease rather than without limbs...'. The writer is respectfully of the opinion that, as in the *Stoffberg* case, the plaintiff may well have successfully claimed satisfaction under the *actio iniuriarum*.

4.4 Disclosure of the risks of medical treatment

4.4.1 Breach of a duty of care

4.4.1.1 *Lymbery v Jefferies* 1925 AD 236

The respondent doctor diagnosed the appellant patient with fibrosis of her uterus. He recommended that she have deep-seated X-ray treatment, but he did not advise her that the treatment carried a risk of burns. The patient sustained severe burns and alleged in the particulars of claim that the doctor was negligent, *inter alia*, in not informing her that the X-ray treatment was dangerous.[400]

A radiologist testified that there is no need to warn a patient of the danger of submitting to X-ray treatment for fibrosis of the uterus, because as a rule there is no danger attending this treatment and burns are a rare complication. The Appellate Division accepted this evidence and held that no duty was imposed upon the respondent doctor to point out to the patient that severe burns might result from the X-ray treatment. [401]

The court formulated a general principle from the radiologist's evidence and held that there might well be a duty on a surgeon to tell the patient that the operation is dangerous and might end in death, or that there might be great pain. However, the surgeon does not have to meticulously point out all the complications that may arise. All he is obliged to do is give some 'general idea' of the consequences of surgery.[402]

Therefore, the court based its decision on the evidence of a single radiologist, who testified as to the standard of disclosure expected of doctors. Furthermore,

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[400] *Lymbery v Jefferies*:238-239.
[401] *Lymbery v Jefferies*:240.
[402] *Lymbery v Jefferies*:240.

based on the radiologist's evidence, the court formulated a general principle of law.[403]

4.4.1.2 *Richter and another v Estate Hammann* 1976 (3) SA 226 (C)

The defendant doctor advised the plaintiff to undergo a phenol block of the lower sacral nerves to alleviate backache. However, he allegedly did not advise her of the risks of this procedure, which manifested in her case as loss of control of the bladder and bowel, loss of sexual feeling and loss of power in her right leg and foot.[404]

The court acknowledged that the patient may base a claim on assault if the doctor fails to disclose the risks of medical treatment.[405] However, the plaintiff in this case based her claim on the English tort of negligence, rather than on assault.[406] Therefore, the court pointed out that where negligence is the cause of action, the professional practice standard applies to the doctor's conduct:

> ...his conduct should be tested by the standard of the reasonable doctor faced with the particular problem. The court must, of course, make up its own mind, but it will be assisted in doing so by medical evidence.[407]

The experts all testified that the risks, which manifested, were extremely unusual, one expert going so far as to say that they 'could not have been expected by any

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[403] Strauss 1991:269 is of the opinion that the court in *Lymbery v Jefferies* did not conclusively decide that the failure to adequately inform constitutes negligence; Carstens and Pearmain 2007:677, agree with Strauss and quote from the judgment in support, where Wessels JA held: 'It may well be that it is the duty of the surgeon before operating to tell the patient that the operation is dangerous and may end in death, or that it will be accompanied with great pain.' *Lymbery v Jefferies*:240.

[404] *Richter v Estate Hammann*:227D-F.

[405] *Richter v Estate Hammann*:232G. Watermeyer J stated that 'A doctor whose advice is sought about an operation to which certain dangers are attached...is in a dilemma. If he fails to disclose the risks he may render himself liable to an action for assault, whereas if he discloses them he might well frighten the patient into not having the operation, when the doctor knows full well that it would be in the patient's interests to have it.'

[406] *Richter v Estate Hammann*:227F-G.

[407] *Richter v Estate Hammann*:232G-H. However, Strauss 1991:268, is of the view that the court in *Richter* did not conclusively decide that failure of the doctor to adequately inform the patient would in fact constitute negligence, presumably on the basis that the court stated that 'It may well be that, in certain circumstances, a doctor is negligent if he fails to warn a patient ...' *Richter v Estate Hammann*:232H. My emphasis.

stretch of the imagination.'[408] The combined expert opinion was that there was no obligation to disclose the risks and the court therefore held that there was no duty to disclose the risk in question.[409] In addition, Watermeyer J noted that even if the doctor was under a duty to disclose the risks in question:

> Plaintiff would of course have had the further problem of having to show that her disabilities were caused by the failure to warn, and this would have entailed proof at least of the fact that if Dr Hammann had told her that the incidence of risk was as low as that set out above she would still have refused to have the operation. She did say that if she had been told that there was any risk she would have refused to be treated, but I feel that very little weight should be attached to an *ex post facto* statement of that nature, and this attitude is in striking contrast to her attitude when she subsequently underwent a hysterectomy. On that occasion she says she was not warned and she did not ask if there was any risk.[410]

Therefore, the court considered the fact that a patient asks questions as important evidence that the patient is concerned about the risks of treatment and would not have consented to the treatment had she been advised of the risks. Further, the court regarded the test for causation as subjective.[411] However, this part of the judgment was *obiter*, as the court had already held that there was no obligation on the defendant to disclose the unforeseen risks of the phenol block to the plaintiff.

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[408] *Richter v Estate Hammann*:229A, 230E-F, 233C.

[409] *Richter v Estate Hammann*:232H-233C. Van Oosten 1989:45-46, 50 interprets the case as confirming a principle that a remote risk, even if it is serious, does not need to be disclosed. However, another possible interpretation supports the concrete approach to foreseeability, that is that a defendant will not be held liable in negligence in circumstances where a reasonable person would not have foreseen the particular adverse consequences of the conduct in question. The problem in this case was that the defendant performed a unilateral phenol block, yet the risks manifested on both sides of the patient instead of only on one side, hence the expert testimony that the risks as they manifested 'could not have been expected by any stretch of the imagination'. *Richter v Estate Hammann*:230F. There are two diverging views as to the nature of the foreseeability test in negligence. In terms of the abstract approach, the question is whether the harm was in general reasonably foreseeable. It is not a requirement under this approach that the extent of the damage or a particular consequence that actually occurred is reasonably foreseeable, because this question is answered with reference to legal causation. On the other hand, in terms of the concrete approach, the particular consequence must be reasonably foreseeable. A strict application of this approach obviates the need for an enquiry into legal causation. It is submitted that under the latter approach it could not be said that the defendant in Richter foresaw the particular harm, which manifested. However, under the former approach, it is submitted that harm in general was foreseen.

[410] *Richter v Estate Hammann*:233D-E.

[411] English law essentially adopts a subjective approach to causation. Khoury 2005:252; Jones 2003:6-154. See also, for example, the judgments in *Chester v Afshar* [2004] 4 All ER 587(HL) and *Chappel v Hart* (1998) 195 CLR 232.

4.4.1.3 *Castell v De Greef* 1993 (3) SA 501 (C)

A doctor advised a patient with lumps in her breasts to have a total mastectomy with a simultaneous breast reconstruction. Following the reconstruction she developed severe infection and necrosis leading to the need for further hospitalisation and operations.

The plaintiff alleged that arising from the agreement between herself and the defendant, the defendant was under a duty to advise her of the material risks and complications which might arise from the operation and, in breach of the defendant's duty, he did not advise her of the high risks inherent in the procedure (a more than 50% risk of necrosis), nor did he advise her of the safer alternative two-step procedure, whereby the reconstruction would have been performed some time after the mastectomy.[412] The plaintiff further alleged that she would not have undergone the reconstruction procedure suggested by the defendant had he informed her of the risks and therefore, she would not have suffered *sequelae* and damages she was claiming.[413]

The court rejected the doctrine of informed consent, which the court understood to incorporate the reasonable patient standard to determine whether the risk should have been disclosed and to vitiate consent if pleaded successfully. Unfortunately the court did not give reasons for rejecting this test, other than that it had been rejected in England, but merely stated that 'in my view there can be no justification for adopting it in our law'.[414] Instead, the court adopted the professional practice standard and referred with approval to the test employed in the *Richter* case.[415] The court was of the opinion that 'the test is flexible and does not, as has been argued on occasion, leave the determination of a legal duty to the judgment of doctors.'[416]

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[412] *Castell v De Greef* 1993:502-506.
[413] *Castell v De Greef* 1993:507G-508F.
[414] *Castell v De Greef* 1993:518B-D.
[415] *Castell v De Greef* 1993:517G-H.
[416] *Castell v De Greef* 1993:517H- 518A.

In determining the ambit of the duty to disclose under the professional practice standard, the court held that the doctor must 'present his patient ...with a fair and balanced picture of the material risks involved.'[417] In so doing, the court confirmed the principle laid down in *Lymbery v Jefferies*[418] (based on negligence and the professional practice standard), that the doctor is only obliged give a general idea of the consequences of surgery.

The court warned that disclosing risks of treatment carries its own risks:

> To do so could well result in the risk of complications and their possible further *sequelae* assuming an undue and even distorted significance in the patient's assessment of whether to proceed with the operation or not. Nor is the doctor obliged to educate his patient to the extent of bringing him up to the standard of his own medical knowledge.[419]

The court concluded that the evidence of the defendant was more reliable than the plaintiff, particularly as the plaintiff was unable to recall everything that had been discussed at the consultation. Furthermore, the court drew an adverse inference against the plaintiff, because her husband, who was present with her at the consultations with the defendant, did not testify.[420] The court accepted the defendant's evidence that he did notify the patient that there was a high degree of risk involved in the proposed procedure.[421]

Further, the court accepted the defendant's evidence that the one-step procedure performed by the defendant did not carry more of a risk than the alternative two-step procedure, which had not been disclosed to the patient. However, the court held that even if the proposed procedure did carry more risk, the defendant was under no obligation to disclose the increased risk to the patient, as long as the

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[417] *Castell v De Greef* 1993:518G-H. The court held that a risk need not be disclosed to a patient in percentages and, for example where in the present case the risk of necrosis was 50%, as long as the patient was aware that there was a high degree of risk, then the defendant had fulfilled his duty. In this regard, the court accepted the defendant's version that the plaintiff had been so informed.
[418] *Lymbery v Jefferies*:240.
[419] *Castell v De Greef* 1993:518F-H. See also 519G-H.
[420] *Castell v De Greef* 1993:516F-H.
[421] *Castell v De Greef* 1993:520A-B; 519I-J.

procedure constituted 'acceptable practice'[422] and the surgeon regarded his decision 'as being in the overall interests of the patient.'[423]

4.4.1.4 Analysis

The three cases discussed above, provide a useful indication of the approach of the courts, where the claim is that the doctor did not disclose the consequences of treatment and the cause of action is negligence.[424] In *Castell*,[425] the court considered that the delictual duty of care arose from the contract between the doctor and patient, whereas the other two cases did not refer to the origin the duty. All of the cases appear to have applied the English duty of care approach which fuses the elements of wrongfulness and fault.[426] Further, when determining whether there was a breach of the duty of care, the courts applied the professional practice standard, a version of which has also traditionally been applied in England, to determine the degree of disclosure expected of the doctor.[427]

In applying the professional practice standard, the courts relied on expert evidence as to what the risks of the procedure are and were also guided by the opinion of doctors as to whether the risks should have been disclosed to the patient.[428] In turn, the doctors formulated their opinions with reference to usual medical practice[429] and their view as to the best interests of the patient.[430]

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[422] *Castell v De Greef* 1993:519G.
[423] *Castell v De Greef* 1993:519G.
[424] However, the cases discussed above are not the only cases to be decided in negligence. For example, in *Dube v Administrator Transvaal* 1963 (4) SA 260 (W), the hospital was held liable in negligence, *inter alia*, because a doctor failed to inform the patient about the symptoms and complications following a plaster of paris application. Had the patient been properly informed, he would have returned to the hospital as soon as he experienced the symptoms. See further, for example, the discussion of *McDonald v Wroe* in this Chapter below.
[425] *Castell v De Greef* 1993:505-508.
[426] *Richter v Estate Hammann*:227F-G, 232G-H; *Lymbery v Jefferies*:238-240; *Castell v De Greef* 1993:518B-D, 517G-H.
[427] However, see the discussion of more recent developments in English law in Chapter One, footnote 15.
[428] *Richter v Estate Hammann*:232G-H.
[429] *Lymbery v Jefferies*:240.
[430] *Castell v De Greef*:519G; *Richter v Estate Hammann*:232G. In *SA Medical and Dental Council v McLoughlin* 1938 (2) SA 355 (A):366-367, Watermeyer CJ observed that 'it may sometimes even be advisable for a medical man to keep secret from his patient the form of treatment which he is giving him'. In addition, the court held that one of the reasons for withholding information, would be if it 'would serve no purpose because the patient would simply not understand'. Henley *et al.* 1995:1273-1278, conducted an empirical study of the reasons why doctors in South Africa tend not to obtain

In *Lymbery* and *Richter*, both courts based their final conclusions directly and exclusively on the evidence of medical experts.[431] This was so, despite the court in *Richter* emphasizing that the court should make up its own mind.[432] Furthermore, the court in *Castell*, although emphasizing that the professional practice standard is not dependant on the views of the doctor, nevertheless accepted as the general starting point when applying the professional practice standard, the principle laid down in *Lymbery*, which was decided on the basis of the opinion of the single medical expert in the case.[433] In *Lymbery* it was held that if a risk is remote, it need not be disclosed, even if it is a serious risk.[434] In addition, the court in *Castell* held that the doctor may limit the information disclosed to the patient, as long as the treatment, in his/her opinion, is in the overall interests of the patient.[435]

On the other hand, where the claim is based on assault, the requirements of the defence of *volenti non fit iniuria* must be met. The court in *Esterhuizen*[436] pointed out that where a claim is based on assault:

> to establish the defence of *volenti non fit iniuria* the plaintiff must be shown not only to have perceived the danger, but also that he fully appreciated it and consented to incur it...[and] if such dangers are not pointed out to him then, in my opinion, the consent to the treatment is not in reality consent – it is consent without knowledge of the possible injuries.

The court in *Richter*[437] recognized the conflict between a cause of action based on negligence on the one hand and assault on the other:

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informed consent. The reason most frequently cited by doctors for not doing so was that the doctor assumed that he/she must 'tell' the patient what he/she intended to do. Another common belief held by doctors was that patients expected the doctor to know best. Warren 2000:922-923, states that the belief among doctors that a paternalistic and authoritarian approach is in the patient's best interests is based on three assumptions: (1) that the patient is not able to understand medical matters, (2) the passive, childlike behaviour of people who are ill makes them incapable of making rational decisions on their own behalf and (3) the patient can rely on the doctor's commitment to altruism to protect the patient's interests.

[431] *Richter v Estate Hamman*:233C; *Lymbery v Jefferies*:240.
[432] *Richter v Estate Hamman*:233C.
[433] *Castell v De Greef* 1993:518G-H.
[434] *Lymbery v Jefferies*:240.
[435] *Castell v De Greef* 1993:519G.
[436] *Esterhuizen v Administrator, Transvaal*:719C, 722C.

> A doctor whose advice is sought about an operation to which certain dangers are attached...is in a dilemma. If he fails to disclose the risks he may render himself liable to an action for assault, whereas if he discloses them he might well frighten the patient into not having the operation, when the doctor knows full well that it would be in the patient's interests to have it.

In other words, where the claim is based on assault, the test for informed consent is whether the requirements of *volenti non fit iniuria* have been met, that is full knowledge, appreciation and consent.[438] On the other hand, where negligence is the cause of action, the professional practice standard is used to determine the required disclosure and the yardstick for knowledge is therefore usual medical practice, which limits disclosure to the probable risks and that which the doctor considers to be in the best interests of the patient.

4.4.2 Assault

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

The plaintiff appealed the *a quo* judgment of Scott J.[439] Three judges heard the appeal[440] and Ackermann J delivered the unanimous judgment, which overturned the ruling of the trial court.

The court stated that in the South African context, the doctor's duty to disclose a material risk must be seen in the contractual setting of consent to the operation and its *sequelae* and thereafter referred with approval to Van Oosten:[441]

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[437] *Richter v Estate Hammann*:232G; Van Oosten 1989:448, also compares the judgments of *Rompel v Botha* and *Esterhuizen v Administrator Natal* on the one hand with *Lymbery v Jefferies* and *Richter v Estate Hammann* on the other, and concludes that the principles laid down in respect of risk disclosure 'can easily lead to diametrically opposite results'.
[438] The *ratio decedendi* of the case was confined to the facts of the case, which concerned serious, but remote risks.
[439] *Castell v De Greef* 1993 (3) SA 501.
[440] Friedman JP, Ackermann J and Farlam J.
[441] *Castell v De Greef* 1994:420H, 425E-G. The court referred to Van Oosten 1989:14-15.

> South African law generally classifies *volenti non fit iniuria*, irrespective of whether it takes the narrower form of consent to a specific harm or the wider form of assumption of the risk of harm, as a ground of justification ... that excludes the unlawfulness or wrongfulness element of a crime or delict.

The court emphasised that the issue of consent is not treated as one of negligence, arising from the breach of a duty of care, but as one of consent to the injury involved and assumption of an unintended risk. Therefore, the expression 'informed consent' is appropriate in South African law.[442] The enquiry is whether the defence of *volenti non fit iniuria* has been established and, in particular, whether the patient's consent has been a properly informed consent.[443]

In determining the ambit of *volenti non fit iniuria*, Ackermann J agreed with Bekker J in *Esterhuizen v Administrator Transvaal*[444] and Neser J in *Rompel v Botha,*[445] that consent to medical treatment is dependent on knowledge of the consequences.[446] Therefore, the court held that for consent to operate as a defence to 'the operation and its *sequelae*', the following requirements must, *inter alia,* be satisfied:

a. the consenting party must have had knowledge and been aware of the nature and extent of the harm or risk;
b. the consenting party must have appreciated and understood the nature and extent of the harm or risk;
c. the consenting party must have consented to or assumed the risk;
d. the consent must be comprehensive, that is extend to the entire transaction, inclusive of its consequences.[447]

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[442] *Castell v De Greef* 1994:425E-F, 426A-B. The court referred to *Van Wyk v Lewis* 1924 AD 438:451, *Correira v Berwind* 1986 (4) SA 60 (ZH) and *Verhoef v Meyer* 1975:unreported AD:26-9, in support.
[443] *Castell v De Greef* 1994:423B-C.
[444] *Esterhuizen v Administrator, Transvaal*:722C
[445] *Rompel v Botha* TPD 15 April 1953, unreported.
[446] *Castell v De Greef* 1994:417F-H.
[447] *Castell v De Greef* 1994:425H-I.

Ackermann J held that whether the question of what must be disclosed to a patient is approached on the basis of breach of duty of care in the context of negligence, or on the basis of consent to medical treatment, the same or virtually identical matters of legal policy are involved, that is:

> The conflict between autonomy and self-determination on the one hand and the right of the medical profession to determine the meaning of reasonable disclosure, flowing from the duty of the doctor to act in what he conceives to be the best interests of the patient, on the other.[448]

Ackermann J held that he could not conceive how the 'best interests of the patient' (as seen through the eyes of the doctor or the entire medical profession) could justify treatment that the patient was vehemently opposed to, even if foregoing the treatment would mean death for the patient[449] and emphasized that the right to self-determination lies at the heart of informed consent:

> It is clearly for the patient to decide whether he or she wishes to undergo the operation, in the exercise of the patient's fundamental right to self-determination... It is, in principle, wholly irrelevant that her attitude, in the eyes of the entire medical profession, is grossly unreasonable, because her rights of bodily integrity and autonomous moral agency entitle her to refuse medical treatment. It would ... be equally irrelevant that the medical profession was of the unanimous view that ... it was the duty of the surgeon to refrain from bringing the risk to the patient's attention.[450]

The court emphasised that the professional practice standard, which it called 'the reasonable doctor test', is not well-established in South African law and, in addition, is problematic in that it leaves the determination of the legal duty to the judgment of doctors.[451] Further, although expert medical evidence would be relevant to determine what risks inhere in or are the result of a particular treatment and might also have a bearing on their materiality, nevertheless

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[448] *Castell v De Greef* 1994:418G.
[449] *Castell v De Greef* 1994:421A-B.
[450] *Castell v De Greef* 1994:420I-J, 421C-E.
[451] *Castell v De Greef* 1994:418G-419C.

ultimately the decision as to whether a risk is material must be judged by a standard demanded by law, rather than according to the standards set by the medical profession.[452]

Ackermann J concluded that there is not only a justification but in fact a necessity for adopting a patient-centered test into South African law,[453] and, in this regard approved the patient-centered test applied in the Australian case of *Rogers v Whitaker*.[454] In the latter case, the court held that in determining the boundaries of the duty of care in negligence:

> A doctor has a duty to warn a patient of a material risk inherent in the proposed treatment; a risk is material if, in the circumstances of the particular case, a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it or if 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.[455]

The court in *Castell* adopted substantially the same test, but in the context of consent:

> ... In our law, for a patient's consent to constitute a justification that excludes the wrongfulness of medical treatment and its consequences, the doctor is obliged to warn a patient of the material risks inherent in the proposed treatment, a risk being material if in the particular circumstances:
>
> 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 doctor is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it. [456]

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[452] *Castell v De Greef* 1994:426H-J.
[453] *Castell v De Greef* 1994:420G.
[454] *Rogers v Whitaker*:634:5.
[455] *Rogers v Whitaker*:634:5.
[456] *Castell v De Greef* 1994:426G-H.

The court explained that a risk is of significance to a patient if the patient would not have undergone the proposed treatment had he/she been informed of the risk in question.[457] However, the plaintiff testified that if she had been informed of the risk in question 'it is quite likely that I would have gone back to my gynaecologist and rethought everything, or maybe sought another opinion'.[458] However, she also testified that she would still have gone ahead with the operation but that it 'might have' taken a different form.[459] In a civil case, the standard of proof is that of a reasonable degree of probability.[460] Therefore, because the plaintiff testified that she would have still have had the operation, which only 'might have' taken a different form, the court rejected the plaintiff's evidence, concluding that 'there is no convincing evidence that she would have adopted a different course ...'[461]

The court also ultimately preferred the doctor's evidence that the plaintiff had in fact been informed of the risks of the proposed procedure and that the alternative option carried a lower risk, but that the patient had chosen the procedure with a higher risk.[462] In addition, the court held that the trial court had correctly drawn an adverse inference against the plaintiff for failing to call her husband to testify on her behalf as he had been present at the consultations.[463] Therefore, the court decided in favour of the doctor and dismissed the plaintiff's claim based on informed consent.

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[457] *Castell v De Greef* 1994:430:C-G.
[458] *Castell v De Greef* 1994:430F.
[459] *Castell v De Greef* 1994:430F-G. My emphasis.
[460] Schwikkard and Van der Merwe 2002:544.
[461] *Castell v De Greef* 1994:430G. It is debatable as to whether, if the plaintiff had testified that she 'probably' would have had a different operation, rather than 'might' have, the court may have decided in her favour.
[462] *Castell v De Greef*:430A-I.
[463] *Castell v De Greef*:428A-B.

4.4.2.2 *Oldwage v Louwrens* [2004] 1 All SA 532 (C)

The plaintiff consulted with the defendant, a vascular surgeon, after he fell and experienced severe pain in his right leg. The defendant diagnosed vascular disease and recommended an arterial bypass procedure. Following the procedure, the symptoms persisted and the patient also suffered from claudication in his left leg.[464] The persistence of the symptoms and the claudication were both risks of the proposed procedure.

The plaintiff sued the defendant, claiming *inter alia* that (1) in breach of the defendant's contractual obligations he had failed to obtain informed consent from the plaintiff and, (2) in the alternative, that the defendant had failed to obtain informed consent to the operation and the operation therefore constituted an assault on the plaintiff. [465] The plaintiff claimed that the defendant had failed to advise the plaintiff of the risk of claudication and persistence of pre-operative symptoms and that he had failed to advise the plaintiff of alternative options to the proposed operation.[466]

The court held that in order for consent to operate as a ground of justification, the patient must not only consent to the injury and medical intervention, but also to the risks and consequences of the medical intervention.[467] The court explained the concepts of consent and informed consent:

> Consent will ... only be valid where it is based on essential knowledge of the nature and effect of the proposed treatment ... [and] will only be "informed" if it is based on substantial knowledge concerning the nature and the effect of the act consented to.[468]

The court held that the object of informed consent is to enable the patient to

[464] The court noted that 'intermittant claudication' which was the symptom that the plaintiff was experiencing, is pain or cramp in the calf muscle after exercise. *Oldwage v Louwrens*:560c.
[465] *Oldwage v Louwrens*:540-541.
[466] *Oldwage v Louwrens*:536-542.
[467] *Oldwage v Louwrens*:555a-b.
[468] *Oldwage v Louwrens*:555b-c.

decide whether or not to run the risk of consenting to the recommended treatment or procedure and that the administration of treatment without informed consent is an assault.[469]

In deciding which test should be used to determine consent to medical treatment, the court rejected the professional practice standard and instead adopted the patient-centered test as set out in *Castell.*[470] The court emphasized that it was bound to follow the approach in *Castell* because it 'focuses on patient autonomy rather than the views of the medical profession' and 'is in conformity with the fundamental right of individual autonomy and self-determination'.[471]

The defendant doctor testified that informed consent was given to the proposed procedure after a lengthy discussion as to costs.[472] However, the court drew an adverse inference against the doctor because he failed to call a hospital employee to testify who was also present at the consultation with the plaintiff. The court accepted the plaintiff's evidence and held that the defendant did not properly counsel the plaintiff prior to the operation in that (1) he did not properly discuss other options, in particular that the plaintiff did not have to undergo the vascular operation immediately, and (2) he did not advise the plaintiff of material risks of the proposed operation.[473]

The court, *per* Yekiso J, concluded that the defendant acted in breach of his contractual obligations, in particular as he had not obtained informed consent to the medical procedure, which, in the absence of informed consent, constituted an assault. The court held that as a result of the breach of contractual obligations the plaintiff suffered damages as claimed. Finally, the court was of the opinion that if the conduct of a doctor 'falls short of assault, it nonetheless could amount

[469] *Oldwage v Louwrens*:555f-g; 557i.
[470] *Castell v De Greef* 1994:426G-H.
[471] *Oldwage v Louwrens*:555g-556b.
[472] *Oldwage v Louwrens*:556d-h.
[473] *Oldwage v Louwrens*:555f-g.

to a violation of the right to privacy'.[474] However, in the instant case, the court held:

> I find that the defendant's conduct, to the extent that whatever consent which may have been given was not properly informed, constitutes assault.[475]

4.4.2.3 Analysis

4.4.2.3.1 Introduction

The legal relationship between a doctor and patient is governed by the contract between the parties as well as by the law of delict. In terms of both contract and delict, the patient's lawful consent is fundamental to a medical intervention.[476] Furthermore, a contractual undertaking may give rise to a legal duty in delict.[477]

The legal consequences of a medical intervention performed without the patient's lawful consent are that the doctor may incur liability for breach of contract, civil or criminal assault (a violation of physical integrity), civil or criminal *iniuria* (a violation of *dignitas*/privacy), or negligence, or that the doctor may be unable to recover a professional fee.[478]

In *Oldwage*,[479] the court distinguished between a claim for breach of contractual obligations and a claim based on assault. The court held that by not obtaining informed consent to the medical procedure, the doctor had both breached contractual obligations and had assaulted the patient. The writer respectfully agrees with this approach. The contract between a doctor and patient, in terms of

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[474] *Oldwage v Louwrens*:557a-f, 558a, 558c-d, 562.
[475] *Oldwage v Louwrens*:558:b-d.
[476] Van Oosten 1995:166.
[477] For the factors that are relevant in determining whether there is a legal duty see Neethling 2005:583-585, Neethling *et al.* 2006:35, 62, 69 and Neethling 2006:207-208.
[478] Van Oosten 1995:166.
[479] *Oldwage v Louwrens*:562d-e.

which the doctor-patient relationship is formalized, is wider than the obtaining of consent to a medical procedure. One of the contractual obligations is that the doctor will obtain informed consent to any proposed procedure and the failure to do so is therefore a breach of contract. Furthermore, if a doctor applies force to a patient without obtaining consent, there may be liability for delictual or criminal assault.

The court in *Oldwage* expressly relied on *Castell* to justify holding the defendant liable for assault.[480] However, the court in *Castell* did not use the word 'assault' in the judgment, save at one point when it quoted from *Richter*:

> If [the doctor] fails to disclose the risks he may render himself liable to an action for assault ...[481]

The court in *Castell* referred to two causes of action, one based on contract and one in criminal law and delict.[482] The only reference to contract was when Ackermann J stated that in the South African context, 'the doctor's duty to disclose a material risk must be seen in the contractual setting of consent to the operation and its *sequelae*.' Thereafter the court emphasized that:[483]

> South African law generally classifies *volenti non fit iniuria*, irrespective of whether it takes the narrower form of consent to a specific harm or the wider form of assumption of the risk of harm, as a ground of justification ... that excludes the unlawfulness or wrongfulness element of a crime or delict.

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[480] *Oldwage v Louwrens*:558:b-d.
[481] *Castell v De Greef* 1994:417I-418A.
[482] Van Oosten 1995:178, comments that insofar as the court in *Castell* appears to suggest that the doctor is *also* under a contractual obligation to furnish the patient with information, it raises the question of whether for purposes of contracts between doctors and patients, the patient's consent is synonymous to *volenti non fit iniuria* as a defence to wrongfulness and whether a patient's personality rights of bodily integrity are also protected contractually. However, the author points out that even if personality rights are protected contractually, protection would be incomplete, because breach of contract on the doctor's part which violates the patient's personality rights would entitle the patient to no more than an award of pecuniary damages. On the other hand, Van Oosten states that breach of contract may constitute an appropriate cause of action in particular cases, for example, where a patient specifically contracts with the doctor for disclosure of all the consequences to the proposed intervention and the doctor fails to keep his side of the bargain. In such a case, a claim for patrimonial loss is quite conceivable.
[483] *Castell v De Greef* 1994:420H, 425E-G. The court referred to Van Oosten 1989:14-15.

It appears that, although the court did not use the term 'assault', the court regarded assault as the appropriate cause of action for, *inter alia*, the following reasons:

- The court made it clear that consent or *volenti non fit iniuria* operates as a justification ground, negating the unlawfulness of medical treatment and its consequences.[484]

- The court expressly rejected negligence as a cause of action and instead quoted approvingly from a number of cases, which were based on assault, such as *Esterhuizen* and *Rompel*.[485]

- Carstens and Pearmain[486] state that the *Castell*[487] decision was of importance to South African medical law, because not only did it import and accept the doctrine of informed consent into South African medical law, but it also treated the lack of informed consent as an issue of assault and not negligence.

- The later case of *Oldwage v Louwrens*[488] expressly relied on *Castell* to justify holding the defendant liable for assault.

The court in *Castell*[489] also introduced a new test for consent into South African law. The writer is respectfully of the view that the way in which this test is interpreted, has important implications not only for determining the boundaries of consent, but also for determining the boundaries of the some of the other elements in a claim based on assault, such as fault and causation. The impact of this test on these elements will now be considered:

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[484] *Castell v De Greef* 1994:426F.
[485] *Castell v De Greef* 1994:417F-H.
[486] Carstens and Pearmain 2007:892, 716.
[487] *Castell v De Greef* 1994.
[488] *Oldwage v Louwrens*:558b-d.
[489] *Castell v De Greef* 1994:426G-H.

4.4.2.3.2 The meaning of 'significance'

The defence of *volenti non fit iniuria* requires full knowledge in order for consent to be valid. The principle is that a person cannot consent to something that they are unaware of.[490] However, the question is whether a patient must be informed of all the possible consequences in order for consent to medical treatment to be regarded as lawful. The court in *Esterhuizen*[491] accepted the doctrine of *volenti non fit iniuria* and refused to lay down any general rule that allows for a limitation on the information which must be provided to the patient.[492]

However, in *Castell*[493] the court accepted a new test, in terms of which consent to medical treatment may be valid, even if the patient does not have knowledge of a particular risk or a potentially large number of risks of medical treatment. This is so, because the doctor does not have to disclose *all* the consequences of medical treatment in order for consent to the act of medical treatment to be valid. Rather, it is only those risks, which a doctor foresees or ought reasonably to foresee are likely to be of 'significance' to the particular patient.[494]

The court in *Castell*[495] interpreted 'significance' as meaning that the risk must be of such great significance to the plaintiff that he/she subjectively would not have consented to the treatment had he/she been informed of the risk. The plaintiff testified that if she had been informed of the risk in question 'it is quite likely that I would have gone back to my gynaecologist and rethought everything, or maybe sought another opinion'. However, she also testified that she would still have

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[490] See the discussion on *volenti non fit iniuria* in Chapter Three.
[491] See the discussion of this case in 4.3.1.1 and 4.4.1.4.
[492] However, on the facts of the case the *ratio decedendi* was that consent to the serious although remote risks is necessary for consent to the act to be valid.
[493] *Castell v De Greef* 1994.
[494] *Castell v De Greef* 1994:426G-H.
[495] *Castell v De Greef* 1994:430C-G; Seidelson 1976:332 supports a subjective standard of disclosure based on what the patient would have decided; Beyleveld and Brownsword 2007:147, argue that, in the context of consent to sexual intercourse, if the defendant was under a duty to disclose the risk to the complainant and the complainant would not have consented to sexual intercourse if informed of the defendant's status, then the defendant may be liable for rape. On the other hand, if the complainant would have had sexual intercourse with the defendant but would have refused to have unprotected intercourse, then the defendant would be able to rely on the complainant's consent to sex. However, he would not be able to rely on the complainant's consent to a charge of knowingly exposing the complainant to a risk of HIV infection.

gone ahead with the operation but that it 'might have' taken a different form.[496] However, in a civil case, the standard of proof is that of a reasonable degree of probability.[497] Therefore, because the plaintiff testified that she 'maybe' would have sought another opinion and would have still have had the operation, which only 'might have' taken a different form, the court concluded that 'there is no convincing evidence that she would have adopted a different course ...'

However, the question is whether a 'different course' includes the scenario where the Plaintiff would have had the operation but only at a later date than that which she actually underwent the operation. It is unclear from the Plaintiff's evidence whether the fact that she would have gone back to her gynaecologist and obtained a second opinion would have meant that she would in all probability not have had the operation at the time that she had it, but would only have had the operation at a later date. The evidence and the decision of the court did not specifically deal with this issue.

The writer is respectfully of the opinion that, for purposes of determining whether there was consent to the touching, although the Plaintiff might well have been likely to have consented to the touching at a later date, nevertheless the pertinent question is whether the Plaintiff did in fact consent to the touching at the time it occurred. In other words, if the Plaintiff did not consent to the operation which was actually performed, there is an assault.[498]

Further, in the later case of *Oldwage,*[499] although the court accepted the test for consent laid down in *Castell*[500], nevertheless it did not require that the patient

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[496] *Castell v De Greef* 1994:430F-G. My emphasis.
[497] Schwikkard and Van der Merwe 2002:544.
[498] In English law, for purposes of a claim based on assault, it does not matter that the medical treatment was indicated and therapeutic or that the plaintiff would have consented to the treatment if he/she had been properly informed. *Chatterton v Gerson* [1981] QB 432:442H-443A; Pattinson 2006:104; Martin 1985:153. The position is the same in South African law. Van Oosten 1995:167 states that in South African law a doctor may be held liable for assault, irrespective of whether or not the intervention was administered with proper care and skill and eventually proves to be beneficial to the patient. In addition, Van der Heever 2004:55 commenting on South African law of assault, states that the plaintiff does not have to show what he/she would have done if he/she had been properly informed, since this requirement is not an element of the delict of assault.
[499] *Oldwage v Louwrens*:555g.

would subjectively not have undergone the operation had he/she been informed of the risk in question, but rather regarded the object of informed consent as ensuring that the patient is able to make a decision as to whether to run the risk of consenting to the treatment or not. Crisp[501] agrees with the approach in *Oldwage* and states that the fact that the patient would not have agreed to the operation, is completely irrelevant to consent where a claim is based on assault. He points out that an assault consists of the violation of bodily integrity and autonomy, and autonomy is the exercise of the capacity to make decisions, rather than the drawing of any practical conclusion. Further, the violation of autonomy lies in the failure to provide the patient with relevant information so that he/she can properly exercise the capacity to make a decision in running his/her life. Therefore, how the patient would actually have decided is irrelevant and is also not relevant when assessing damages.[502]

The writer is respectfully of the view that the reasoning in *Oldwage*[503] and of Crisp[504] is the more acceptable view, as long as the element of 'significance' continues to be interpreted by the court as a subjective element. In *Castell*,[505] the court regarded the test for 'significance' as subjective in that the question was whether the particular patient would subjectively not have undergone the operation had she been informed of the consequences in question. Therefore, in terms of the alternative interpretation, 'significance' centers on whether the information was significant to the patient in the sense that, *from the patient's point of view*, it would probably have impacted on her capacity to arrive at a decision.[506]

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[500] *Castell v De Greef* 1994.
[501] Crisp 1990:78-79.
[502] Maclean 2004:400, states that 'the disclosure of risks, alternative treatments and any other similar information is necessary to allow the patient to decide whether or not to give consent [to the medical treatment].' Kirby 1995:6 writes that under the doctrine of informed consent, if a patient is not informed of the material risks, complications and side-effects of treatment, the patient is considered to be incapable of giving the consent that is necessary to authorise the medical procedure in the first place. Therefore, the treatment is unlawful.
[503] *Oldwage v Louwrens*:555g.
[504] Crisp 1990:78-79.
[505] *Castell v De Greef* 1994:430C-G.
[506] Ost 1984:305-306, states that patients do not have a right to waive their right to information as it would involve a right to avoid responsibility to act as an autonomous agent. However, for the view that the right to autonomy does allow for a right not to know, see Strasser 1986:265-278 and Andorno 2004:435-439.

Further, on Crisp's interpretation of 'significance' it ultimately also does not matter that the plaintiff would have decided to have the operation at the time she had it. What is important is that the undisclosed information affected the Plaintiff's capacity to arrive at a decision. The writer is respectfully of the view that if this interpretation of 'significance' had been adopted, the court may well have found for the plaintiff in this case. The Plaintiff's evidence was that if she had been informed of the information in question she would probably have gone back to her gynaecologist, sought a second opinion and rethought everything.

4.4.2.3.3 Inherent risks

In terms of the test adopted by the court in *Castell*,[507] it is those risks which are 'inherent' in the procedure which must be disclosed to the patient. According to the Collins English Dictionary, to 'inhere' means 'to be an inseparable part of'. The word 'inhere' derives from the Latin '*inhaerere*', which means 'to stick in' and from '*habere*' which means 'to stick'. Further, 'inherent' means 'existing as an inseparable part'.[508]

Therefore, a question which arises is whether risks relating to the treating doctor also need to be disclosed, particularly as the quality of a doctor may not only introduce risks to the procedure, such as the risk of transmission of the hepatitis B virus, but may also increase the chance of existing risks of the procedure occurring. The writer is respectfully of the view that to interpret the section restrictively to exclude risks of the procedure, which arise because of the quality of the treating doctor, would be to artificially attempt to divide the definition of the treatment from the reality that treatment never exists in abstract isolation but is always performed by a particular person.[509]

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[507] *Castell v De Greef* 1994:426G-H.
[508] Hanks *et al.* 1979:752.
[509] For example, a doctor with no experience who performs a complicated removal of wisdom teeth and, in so doing, damages the nerves supplying the face. In *McDonald v Wroe*:570-571, the court accepted that there was an inherent risk of nerve damage associated with the operative procedure, no matter which doctor performed the procedure, but found

4.4.2.3.4 Intention

The writer is respectfully of the view that although 'significance' is a subjective element, the test for consent is, in effect, a type of 'reasonable doctor' test.[510] This is so because even if a risk is subjectively material to a particular patient in deciding whether to undergo the proposed treatment, the question of consent is also dependant on whether the defendant was or ought to have been aware that the undisclosed risk of treatment was likely to be of significance to the patient.[511]

In other words, the doctor's foresight that the patient would probably not undergo the procedure if he/she was informed of the risk in question, is material in deciding whether there was consent. Put another way, a particular type of mistake of fact, if reasonable, excludes the unlawfulness of the conduct. In other words, even if the patient would have refused treatment if he/she had been informed of the risk in question, nevertheless, if a reasonable doctor would have made a mistake and concluded that the patient would have probably undergone the procedure, despite not knowing of the risk, he/she escapes liability.[512]

Therefore, in order to meet the foresight requirement, the doctor should either actually subjectively have foreseen the possibility that the risk was likely to be of significance to the patient, or if the court accepts the defendant's testimony that he/she did not foresee this, then it will be asked whether he/she ought reasonably to have foreseen that the risk was likely to be of significance to the patient. Practical examples are as follows:

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that the risk of nerve damage increased when performed by someone who was inexperienced. However, the court discussed this issue in the context of causation, rather than in the context of the obligation to disclose the risks associated with inexperience. It is submitted that if inexperience increases the chance of inherent risks manifesting then it should be disclosed. Further, the general practitioner in this case undertook to do surgery normally performed by a specialist surgeon and the standard expected of him was therefore that of a specialist surgeon. Strauss and Strydom 1967:324 argue that where a patient enters into an agreement to exclude or limit the liability of the doctor for negligence, it should be regarded as null and void as being contrary to public policy, because it is the patient's interest in bodily integrity which is at stake and not merely a patrimonial interest.

[510] However, Carstens and Pearmain 2007:892, also state that the court in *Castell* established the yardstick of the 'reasonable patient' as the test for informed consent and not the 'reasonable doctor.' Dreyer 1995:532-539, also regards the test as a 'reasonable patient' test.

[511] *Castell v De Greef* 1994:430:C-G.

[512] See the discussion of consciousness of wrongfulness in the context of assault in criminal law and delict in Chapter Three.

i. Dr X subjectively foresees that a risk of treatment is likely to be material to patient Y in deciding whether to undergo the treatment, but a reasonable doctor would not have foreseen this.

ii. Dr X subjectively foresees that a risk of treatment is likely to be material to Y in deciding whether to undergo the treatment and a reasonable doctor would also have foreseen this.

iii. Dr X does not subjectively foresee that a risk of treatment is likely to be material to Y in deciding whether to undergo the treatment, but a reasonable doctor would have foreseen this.

iv. Dr X does not subjectively foresee that a risk of treatment is likely to be material to Y in deciding whether to undergo the treatment and a reasonable doctor would also not have foreseen this.

In all of the above examples, the risk is likely to be material to Y but Dr X does not disclose the risk to Y before carrying out the treatment.

In the first two examples, the fact that Dr X subjectively foresaw that the risk was likely to be material to Y is sufficient to find that there was no consent, irrespective of whether or not a reasonable doctor would also have foreseen this. In the third example, Dr X ought to have foreseen that the risk was likely to be material to Y and consent is therefore absent. However, in the last example, a reasonable doctor would also have made the mistake of fact and consent is therefore present. In other words, if a court accepts the doctor's allegation that he/she did not foresee that the undisclosed risk was likely to be material to the patient, then his/her assertion will also be judged according to the standard of the

reasonable doctor. It is only a particular type of *reasonable* mistake of fact, which excludes liability.[513]

Therefore, it is clear from the above examples, that liability is not excluded on the basis that the defendant lacked the required *mens rea*, but rather because the patient is deemed to have consented to the treatment, on the basis of the state of mind of the defendant, even if the undisclosed risk was of significance to the patient in deciding whether to undergo the treatment. The doctor therefore escapes liability on the basis that the treatment rendered to the patient was lawful.

Therefore, the second leg of the test, being the individual patient standard, is not purely a subjective standard, which requires the doctor to disclose information, which the patient in fact needs, whether or not the doctor is, or reasonably should be aware of it.[514] The writer is respectfully of the view that by adding the requirement that the doctor is or should be aware of the relevance of the information to the patient, the court in *Castell*[515] fused a determination of consent with elements relating to fault and made the presence or absence of consent dependent on the state of mind of the defendant. In other words, a doctor standard rather than a patient standard in effect, became the standard of disclosure.

The writer is also respectfully of the opinion that the conflation of elements of consent and fault in the combined patient-centered test, has occurred partly because, although the court in *Castell* expressly emphasised that the issue of consent is not treated as one of a negligent omission, but as a justification ground that excludes the wrongfulness of the medical treatment and its

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[513] As discussed above, in earlier cases, consciousness of wrongfulness, whether subjective or objective, was not an element of liability All that was required was that the defendant intentionally applied force to the plaintiff. *Stoffberg v Elliott*:150-151; *Layton and Layton v Wilcox and Higginson*:50-51.
[514] Giesen 1988:297.
[515] *Castell v De Greef* 1994:426G-H.

consequences,[516] at the same time the court adopted the patient-centered test wholesale from the *Rogers* judgment. However, the *Rogers* case concerned an omission to disclose information and the case was decided under the English duty of care doctrine, where elements of wrongfulness and fault are explicitly fused into one negligence enquiry.[517]

The writer is respectfully of the view that the conflation of the elements of consent and fault, in the context of the justification ground of consent to what would otherwise be an assault, is contrary to established principles in South African law.[518] As already indicated, the application of force by commission is *prima facie* wrongful unless justified by a ground of justification such as consent.[519] Further, *volenti non fit iniuria,* as a justification ground, is a subjective enquiry into the state of mind of the plaintiff and the *mens rea* of the defendant plays no role in the determination of consent.[520] Therefore, for purposes of establishing whether there was consent, the writer is respectfully of the view that the second leg of the combined patient-centered test should be limited to the subjective state of mind of the plaintiff.

4.4.2.3.5 Equality and intention

The writer is respectfully of the opinion that by allowing the defendant's point of view to define acceptable mistakes which preclude consent, it is not conducive to the attainment of equality in the doctor-patient relationship. The writer is respectfully of the view that the power imbalance in the doctor-patient relationship can be broadly compared to gender inequality in the context of sexual assault.

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[516] *Castell v De Greef* 1994:425E-F, 426G-H.
[517] See the discussion of this case in Chapter One.
[518] See the discussion of *volenti non fit iniuria*, as well as the basic elements of a delict in Chapter Two and Three.
[519] See the discussion in Chapter Two, Three and in the present chapter.
[520] Lubbe and Murray 1988:109; *Fourie v Naranjo*:1157b; *Sidaway v Bethlem Royal Hospital Governors and Others* [1985]:894; Pattinson 2006:102.

MacKinnon[521] points out that, as with the contract fiction, consent to sexual intercourse relies on a fiction that the sexes begin on equal terrain. The law presents consent as a free exercise of sexual choice under conditions of equality of power, without exposing the underlying structure of constraint and inequality. She argues that the legal construction of consent should reflect the reality that consent is given within the context of unequal sexual relationships. Typically the man initiates the sexual encounter and the woman is relegated to the more passive role of responder to initiatives.[522] This role makes women particularly vulnerable to pressure as well as the use of deception.[523]

In the same way, it has often been argued that the relationship between a doctor and patient reflects an unacceptable imbalance of power. Since time immemorial the medical profession has clung to the Hippocratic tradition of emphasising the patient's welfare at the expense and often to the exclusion of their right to self-determination.[524] The history of medical practice allows the doctor to determine the relevance and weights of benefits and harms to the patient. Ironically, the doctor seeks the best interests of the patient, sometimes even in isolation of the value priorities of the particular patient.[525]

Wolhuter[526] argues that the attainment of substantive equality necessitates the recognition of women's different experiences of and responses to violence and the accommodation of these differences. In the same way, it can be argued that in order to break out of the power imbalance in the doctor-patient discourse, we need to more substantively and explicitly recognize patients' difference experiences of and responses to illness and to accommodate these differences.
Le Roux[527] argues, in the context of consent to sexual intercourse, that limiting mistakes which are regarded as capable of precluding consent, to pre-defined

[521] MacKinnon 1989:174-176.
[522] MacKinnon 1989:174.
[523] Le Roux 1997:14-15.
[524] Giesen 1988:278.
[525] Giesen 1988:275.
[526] Wolhuter 1998:445.
[527] Le Roux 1997:14-15.

categories, effectively perpetuates the domination of men over women. In the same way, it can be argued that excluding mistakes which invalidate consent or limiting mistakes to a category of mistakes ultimately defined by the state of mind of the defendant, perpetuates the domination of one view of illness and health over another. The writer is respectfully of the view that in order to break this cycle, it is necessary to adopt a subjective patient test for consent, which explicitly recognizes and directly proclaims that the doctor ought to disclose the information, which the particular patient in fact needs.

However, a widespread criticism of the subjective test in the context of medical assault is that it is inevitable that the patient will testify that it is likely that he/she would not have undergone the procedure had they been informed of the risk in question (or in terms of the suggested test – it is likely that the information would have impacted on the patient's decision-making process). This is because in addition to the plaintiff's self-interest, his/her testimony that he/she would have withheld consent is made after-the-fact, subsequent to having endured the adverse consequences of the medical procedure.[528]

However, as pointed out by Seidelson,[529] who supports a subjective standard of disclosure, the above factors should alleviate any judicial concern that the judge, without appropriate reflection and discrimination, will accept the plaintiff's testimony. Seidelson[530] also emphasizes that the court, whilst acting with caution when considering a patient's testimony, must also always bear in mind that to the extent that the plaintiff would have declined the proposed treatment and a reasonable person in similar circumstances would have consented, the patient's right of self-determination is 'irrevocably lost'. Arguing in a similar

[528] 'It places the physician in jeopardy of the patient's hindsight and bitterness'. *Canterbury v Spence* 464 F2d 772 (1972):790-791; King and Moulton 2006:444; Seidelson 1976:332; King and Moulton 2006:444-445, also point out that adopting the subjective standard as the sole test might preclude recovery for failure to provide informed consent if the patinet died as a result of an undisclosed risk.
[529] Seidelson 1976:332.
[530] Seidelson 1976:329.

fashion, Ackermann J in *Castell*[531] states that the right of the patient to decide what to do with their own body must be 'guaranteed':

> Even where the individual patient differs from what the medical profession or anyone else considers to be a 'reasonable' person. The patient has a right to be different. The patient has a right to be wrong.

Therefore, in deciding whether to accept a plaintiff's testimony the judge will inevitably exercise caution, but at the same time it is incumbent on the judge to consider the individuality of the patient and the right of the patient to think differently to the so-called 'reasonable' person, to be 'wrong'. Therefore, the writer agrees with Seidelson, who emphasizes that the law must preserve the patient's right to self-determination through the application of a subjective patient-centered standard.[532] King and Moulton[533] highlight the criticisms of the subjective standard but at the same time acknowledge that:

> A subjective-based standard... best reflects the ethical and legal foundations of informed consent and should represent the ultimate goal of an informed consent system.

4.4.2.3.6 'Floodgates' and intention

However, in addition to the objections to the subjective test for consent discussed above, a prominent objection is the 'floodgates' argument. It can be argued that the subjective approach leads to injustice because it causes like cases not to be treated alike, making the law unpredictable. In the face of similar circumstances, one complainant might be said to have consented, while another might not, because of the difference in their reaction. On the other hand, under an approach focused on 'reasonableness', it is arguably more predictable as to what

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[531] *Castell v De Greef* 1994:421I-J.
[532] Seidelson 1976:329.
[533] King and Moulton 2006:445.

circumstances will and will not lead to liability and the outcome will not vary excessively from one case to another.[534]

On the other hand, it can be argued that paying attention to the individual complainant does not in itself entail that the impact of the law will be unpredictable, in a way that will cause injustice. If the construction of consent remains constant, then there is no question of like cases not being treated alike, because the doctor will only be liable for assault if he treats the patient without his/her consent.[535] As Gardner states, albeit writing in the context of consent to sexual assault, differences in how this comes about or likenesses between cases where it does come about and cases where it does not, are irrelevant to the point.[536]

In addition, the unpredictability problem is also specifically raised in the question of whether, in a particular case, a doctor will be able to work out whether the patient's consent is of a quality, which counts as consent. In other words, the test can be stretched to what can be argued is the point of absurdity. For example, a patient sues a doctor for assault, stating that a risk of a temporary body rash for a few hours following administration of a local anaesthetic, was material to her in deciding whether to accept the treatment. She argues that if she had known about the side-effect she would not have consented to the treatment at that time due to her work schedule.

However, in response it can be argued that, if foresight is part of the *mens rea* requirement, then if the defendant is unaware of the factor that the plaintiff considers material to his/her decision and a reasonable doctor would also not have been aware of this factor or, even if the doctor does have knowledge of the factor, nevertheless if the doctor is unaware that the factor is material to the patient and a reasonable doctor would have also have been unaware of the

[534] Gardner 1996:293.
[535] Gardner 1996:293.
[536] Gardner 1996:293.

significance to the plaintiff, the doctor will escape liability. In other words, there can be no liability unless the reasonable doctor could have predicted that the patient might not be consenting.[537] Therefore, although the conduct remains unlawful, the doctor nevertheless escapes liability on grounds of the absence of culpability.

4.4.3 Assault or breach of duty of care

4.4.3.1 *Broude v McIntosch* 1998 (3) SA 60 (SCA)

A patient became paralysed on the left side of his face after undergoing an operation on the nerves supplying his ear to correct tinnitus and vertigo. The appellant alleged that the doctor had wrongfully failed to obtain his 'real or informed consent' to the operation and therefore the doctor had committed an assault. Secondly, and in the alternative, the appellant also alleged that the doctor had carried out the operation in a negligent manner in that he had failed to inform the patient prior to carrying out the operation of the risks and hazards involved and the alternative operative treatment available.[538]

Both of the above claims failed on the facts. The Supreme Court of Appeal, per Marais J, dismissed the appeal,[539] holding that it was unlikely that the appellant, who was a medical doctor, would have been unaware of the risks he alleged were not disclosed. The court also accepted the trial court's finding that it was improbable that the respondent doctor had not informed the patient of the risks and alternatives.

The court also commented at some length on the suitability of pleading a claim for failure to disclose the risks of treatment as an assault, but did not decide the

[537] Gardner 1996:293-294.
[538] *Broude v McIntosh*:67G-H.
[539] *Broude v McIntosh*:68F-69E.

issue. The court's criticism of this cause of action will be dealt with in more detail in chapter six.

4.4.4 Breach of a legal duty and negligence

4.4.4.1 *McDonald v Wroe* [2006] 3 All SA 565 (C)

4.4.4.1.1 Facts and decision

The plaintiff sued a dentist for, *inter alia*, failing to advise her of a risk of less than 1% of permanent nerve damage following removal of her wisdom teeth.[540] The risk eventuated leaving the plaintiff with numbness and a feeling of pins and needles on the left side of her face.[541]

The plaintiff based her claim on a wrongful and negligent omission to disclose the risk in question.[542] The defendant conceded that his failure to warn the plaintiff of the risk of permanent nerve damage was both wrongful and negligent.[543] This concession rendered the court's findings as to the determination of wrongfulness and negligence *obiter*.

In the first place, the court held that in South African law 'a doctor has a duty to disclose a material risk of a planned procedure to a patient. This duty must be seen in the contractual setting of an unimpeachable consent to the procedure and its *sequelae*.'[544] However, the court did not adopt the English duty of care doctrine, but instead separated the enquiries into wrongfulness and fault and held as follows:

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[540] *McDonald v Wroe*:570b-c.
[541] *McDonald v Wroe*:566i-567a.
[542] *McDonald v Wroe*:567d-e, 570c.
[543] *McDonald v Wroe*:570c.
[544] *McDonald v Wroe*:568a.

a. The omission to warn the patient of the risk of nerve damage from the planned procedure was wrongful[545] in that

   i. The doctor had a duty to disclose the material risks of the planned procedure;[546] and

   ii. he breached this duty in that he did not obtain consent to the planned procedure.[547]

b. The doctor's omission was not only wrongful but was also negligent.[548]

c. The doctor's omission was directly linked to the plaintiff's damage, which was the nerve damage to her face.[549]

d. The doctor also violated the plaintiff's Constitutional right to bodily integrity, by subjecting her to surgery without her informed consent. [550]

4.4.4.1.2 Breach of the duty to disclose a material risk

The court stated that at the wrongfulness stage of the enquiry, the combined patient-centered test, as set out in *Castell v De Greef*[551] should be used.[552]

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[545] *McDonald v Wroe*:570c-d, 575f-j.
[546] *McDonald v Wroe*:568a.
[547] *McDonald v Wroe*:568a-c.
[548] *McDonald v Wroe*:570d.
[549] *McDonald v Wroe*:575f-h.
[550] *McDonald v Wroe*:575h.
[551] *Castell v De Greef* 1994:426G-H.
[552] *McDonald v Wroe*:568b-d.

4.4.4.1.3 Fault

After considering the wrongfulness of the omission, the court turned to the question of fault and held that the requirements as set out in the test for negligence in *Kruger v Coetzee*,[553] had been met.

4.4.4.1.4 Causation and damage

The court held that even if the defendant had advised the plaintiff of the risk in question, the plaintiff would probably still have had the operation. However, she would probably have sought a second opinion and would have had the operation done at a later date by a specialist. Further, if the operation was done by a specialist, the risk of nerve damage would probably have been less than when it was done by the defendant, a general practitioner. Therefore, the plaintiff would have been less likely to have suffered nerve damage if she had been operated on at a later stage. For these reasons, the court found that the defendant's wrongful and negligent failure to disclose the risk of nerve damage, was causally linked to the nerve damage actually suffered by the plaintiff.[554]

4.4.4.1.5 Violation of the Constitutional right to bodily integrity

The court held that the defendant had violated the plaintiffs right to bodily integrity, entrenched in section 12(2) of the Constitution, because he subjected her to surgery without her informed consent.[555]

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[553] *Kruger v Coetzee* 1966 2 SA 428 (A). The court stated that because the requirements as set out in the test for negligence in *Kruger v Coetzee*, were met, the conduct was negligent. However, the court did not state what the test was, discuss it or expressly apply the facts of the current case to the test for negligence, but merely stated that the defendant's concession of negligence was correct in view of the requirements in *Kruger v Coetzee* 1966 2 SA 428 (A).
[554] *McDonald v Wroe*:570-571.
[555] *McDonald v Wroe*:575h.

4.4.4.1.6 Conclusion

For the above reasons, the court concluded that the defendant was liable for the damages that the plaintiff could prove she had suffered resulting from the surgical extraction of her wisdom teeth by the defendant.[556]

4.4.4.1.7 Analysis

4.4.4.1.7.1 Wrongfulness

The court in *McDonald*[557] regarded the cause of action as a delictual duty of the doctor to disclose information to a patient, arising from a contractual relationship between the doctor and patient.

Further, unlike the approach in *Layton,*[558] *Richter,*[559] *Lymbery*[560] *and Broude*,[561] discussed above, the court did not adopt the English duty of care approach, but instead separated the enquiries into wrongfulness and fault. The court opined that at the wrongfulness stage of the enquiry, the combined patient-centered test should be used:[562]

> For the consent to the planned procedure to constitute a justification that excludes the wrongfulness of the medical treatment and its consequences, the medical practitioner is obliged to warn a patient so consenting of a material risk inherent in the proposed treatment. A risk is regarded as being material if in the circumstances of the particular case:

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[556] *McDonald v Wroe*:575j-576a-b.
[557] *McDonald v Wroe*:568a.
[558] *Layton and Layton v Wilcox*:49-50.
[559] *Richter v Estate Hammann*:227F-G, 232G-H.
[560] *Lymbery v Jefferies*:238-240.
[561] *Broude v McIntosh*:67G-H.
[562] *McDonald v Wroe*:568b-d.

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 doctor is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it.[563]

However, it is respectfully submitted that the court in *McDonald*[564] erroneously described the test for determining the wrongfulness of an omission to disclose information, as a justification ground of consent to medical treatment. As discussed above, the application of force to the body of another by commission, either directly or indirectly, is regarded as *prima facie* wrongful or unreasonable unless justified by a justification ground such as consent. The question of wrongfulness is therefore seldom contentious. On the other hand, an omission to disclose is regarded as *prima facie* lawful and the plaintiff must establish a *prima facie* case of the wrongfulness of the omission.[565]

As discussed in Chapter Three, the Constitutional Court[566] has made it clear that the Constitution is not merely 'a formal document' but it also embodies an objective, normative value system that provides the value structure within which the common law must be developed. Therefore, the common-law test for

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[563] *McDonald v Wroe*:568b-d. This approach appears consistent with the approach of Lord Scarman in *Sidaway v Governor of Bethlem Royal Hospital* [1985]:494A-C who, in his *obiter dictum*, focused on the rights of the patient where a duty to disclose information was in issue:'In a medical negligence case where the issue is as to the advice and information given to the patient as to the treatment proposed, the available options and the risk, the court is primarily concerned with the patient's rights. If one considers the scope of the doctor's duty by beginning with the right of the patient to make his own decision whether he will or will not undergo the treatment proposed, the right to be informed of significant risk and the doctor's corresponding duty are easy to understand: for the proper implementation of the right requires that the doctor be under a duty to inform the patient of the material risks inherent in the treatment.'

[564] *McDonald v Wroe*:570c-d.

[565] For example, the writer is respectfully of the view that one way of approaching the situation is that in terms of the prior conduct rule (*omissio* per *commissionem* rule) a plaintiff will only establish *prima facie* wrongfulness if he/she leads sufficient evidence that the doctor created a new source of danger by, for example, suggesting an operation with dangers attached (*commissio*) and subsequently failed to eliminate the danger by informing the patient of the risk in question (*omissio*), with the result that harm is caused to the patient. However, in order to show that the plaintiff suffered harm, he/she will have to lead evidence that the risk was material. For the prior conduct rule, see Neethling *et al.* 2001:58-59, 65-66; Brand 2007:76-77 states that society's reluctance to extend delictual liability to omissions is closely linked to the individualistic character of private law, reflected in the notion that as long as people do not cause harm to others, they are entitled to mind their own business even when they can morally and reasonably be expected to help someone else. Another reason for this position is that it may be too burdensome for society to shoulder a general duty to act to prevent harm to others.

[566] In *Carmichele v Minister of Safety and Security* 2001 (4) SA 938 (CC). In this case, a private citizen A sued the state for damages, after being attacked and assaulted by a man B who had previously been convicted of house-breaking and indecent assault had been released on bail by the state. A had requested the police and public prosecutor in charge of the case to keep B detained.

wrongfulness of an omission must now be carried out in accordance with the 'spirit, purport and objects of the Bill of Rights' and the relevant factors must be weighed in the context of a Constitutional State founded on dignity, equality and freedom.[567] Further, when determining the wrongfulness of an omission, concepts such as 'policy decisions' and 'value judgments' might have to be replaced, supplemented or enriched by constitutional norms.[568]

The *McDonald*[569] judgment, in effect, established that the combined patient-centered test now represents the current *boni mores* or legal convictions of the community as to when an omission to disclose information to a patient is unreasonable or wrongful. This is the same test which is used to determine whether there was consent to *prima facie* unlawful application of force by commission in assault. However, in a claim based on an omission to disclose information the plaintiff must establish a *prima facie* case of wrongfulness.

4.4.4.1.7.2 Fault

After considering the wrongfulness of the omission, the court in *McDonald*[570] turned to the question of fault and held that the requirements as set out in the test for negligence in *Kruger v Coetzee*,[571] had been met. However, the court did not state what the test was, or discuss it. The test for negligence as stated in *Kruger* is as follows:

> For the purposes of liability *culpa* arises if- (a) a *diligens paterfamilias* in the position of the defendant - (i) would foresee the reasonable possibility of his conduct injuring another in his person or property and causing him

[567] *Carmichele v Minister of Safety and Security*:957b-c, 961e-g.
[568] *Carmichele v Minister of Safety and Security*:962d-e.
[569] *McDonald v Wroe*:568b-d.
[570] *McDonald v Wroe*:570d.
[571] *Kruger v Coetzee* 1966 2 SA 428 (A).

patrimonial loss; and (ii) would take reasonable steps to guard against such occurrence; and (b) the defendant failed to take such steps.[572]

Therefore, where negligence is in issue, the doctor must meet the standard of conduct expected of a reasonable doctor in his/her position. The writer is respectfully of the view that this test incorporates and elaborates on the reasonable doctor test or professional practice standard as described in *Richter*,[573] that is that the doctor's conduct should be tested by the standard of a reasonable doctor faced with the particular problem.[574]

The effect is that where liability for an omission to disclose information is in issue, the combined patient-centered test is applied at the wrongfulness stage of the enquiry, but the professional practice standard is applied thereafter if fault in the form of negligence is alleged.[575]

It is also clear from the above that the first leg of the test for negligence comprises a reasonable foresight criterion, a version of which is also contained in the combined patient-centered test for the wrongfulness of the omission. The court in *McDonald*[576] adopted the combined patient-centered test wholesale from *Castell*,[577] which in turn imported the test from *Rogers*.[578] However, the latter case concerned the determination of liability for an omission, by explicitly conflating the elements of wrongfulness and negligence, whereas in *McDonald*,[579] the two elements were considered separately.

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[572] *Kruger v Coetzee*:430.
[573] *Richter v Estate Hammann*:232G-H.
[574] However, Strauss 1991:268, is of the view that the court in *Richter* did not conclusively decide that failure of the doctor to adequately inform the patient would in fact constitute negligence, presumably on the basis that the court stated that '*It may well be* that, in certain circumstances, a doctor is negligent if he fails to warn a patient ...' My emphasis.
[575] Dreyer 1995:533 explains: 'Eerstens die vraag of die verweerder die eiser na behore ingelig of gewaarsku het rakende die wesenlike risiko's en komplikasies verbonde aan die operasie wat hy op haar uitgevoer het. Hierdie vraag hou verband met die stelreel *volenti non fit iniuria* en bepaal of die toestemming deur die patient (eiser) aan die dokter (verweerder) gegee, regsgeldige toestemming was wat onregmatigheid en derhalwe ook aanspreeklikheid, aan die kant van die dokter utigesluit het. Tweedens word die "redelike dokter-toets" aangewend om to bepaal of die dokter se optrede as nalatig aangemerk kan word'.
[576] *McDonald v Wroe*:568b-d.
[577] *Castell v De Greef* 1994:426G-H.
[578] *Rogers v Whitaker* (1992) 109 ALR 625:634.
[579] *McDonald v Wroe*:568a-c, 570d.

The writer is respectfully of the view that, faced with a choice of where to place the foresight requirement in this case, it is more suited to the negligence enquiry.[580] Although foresight may be one of the many factors, which are considered at the wrongfulness stage of the enquiry into liability for an omission, it is one of the two essential elements in the test for negligence.[581] Further, wrongfulness is often described with reference to the infringement of a subjective right,[582] whereas negligence is never described as such, but is determined with reference to the standard of conduct expected of the defendant in the circumstances.[583]

4.4.4.1.7.3 Causation

A question which arises is, if an undisclosed risk associated with the treatment manifests, in circumstances in which the plaintiff cannot be said to have consented to the treatment which was actually performed, but would probably have consented to the same treatment carrying the same risks at a later date, whether the plaintiff can be said to have suffered patrimonial loss and/or pain and suffering.

The court in *McDonald*[584] held that the damages claimed by the plaintiff were causally linked to the wrongful and negligent omission of the defendant, because even though the plaintiff would still have had the operation, but at a later date, she would probably have been operated on by a specialist and this would have decreased the risk of the bodily injury and resultant damages occurring.

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[580] However, Neethling 2006:212 states that if the foresight criterion is applied at the wrongfulness stage of a delictual enquiry then there is no need to apply it when determining whether the conduct was negligent.
[581] Neethling *et al.* 2006:126.
[582] Neethling *et al.* 2006:69.
[583] Boberg 1989:270.
[584] *McDonald v Wroe*:570-571.

In the English case of *Chester v Afshar*,[585] a patient underwent surgery to her lumbar spine and, as a result, a 1-2% risk of partial paralysis inherent in the surgical procedure manifested. The plaintiff alleged that although she could not say for certain that she would have refused the surgery, nevertheless she would definitely not have consented to the surgery on that particular day, as she would have sought further opinions. She brought her claim in negligence and an important question was therefore whether the failure to warn was causally linked to the damage that the plaintiff had suffered.

The three majority decisions of the House of Lords held that the required causal connection was present. Lord Steyn held that if the surgeon had warned the patient of the risk in question, the injury would not have occurred when it did and the chance of it occurring on a subsequent occasion was very small. He stated that the fact that the risk on the subsequent occasion would also be 1-2%, meant that the probabilities were that the risk would not have occurred during the later hypothetical surgery.[586] Lord Hope also noted that if the patient had been given the warning she would not have had the operation on that day and the chances of her being injured in that way if she had had the operation later would have been very small.[587]

The writer respectfully agrees with the reasoning of Lord Steyn. In other words, even if the patient would probably have consented to the same treatment with the same inherent risks, but at a later stage, nevertheless if the probabilities are that the risk would not have manifested (ie, the possibility of the risk occurring is under 50%), then the plaintiff has a valid claim in terms of the principles relating to the Aquilian action and action for pain and suffering for the loss resulting from the current manifestation of the risk.

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[585] *Chester v Afshar* [2004] 4 All ER 587(HL).
[586] *Chester v Afshar*:592j, 594j.
[587] *Chester v Afshar*:604h-j.

However, on 2 March 2007, the full bench of the High Court,[588] reversed the trial court's finding in *McDonald v Wroe* when it held:

> The harm which the plaintiff suffered, is harm she might equally probably have suffered in any event if the surgery had been performed by a specialist surgeon ...there is ... no direct causal link between the defendant's negligence (in failing to warn the plaintiff of the risk) and occurrence of the harm, unless it is shown that the plaintiff, upon being warned of risk, would not have undergone the procedure at all. That is not the plaintiff's case.'[589]

This appeal has not, however, been reported to date.[590]

4.4.4.1.7.4 Conclusion

The writer is respectfully of the view that the plaintiff in *McDonald v Wroe* could have proceeded from the outset on the basis of assault and a *prima facie* unlawful commission which infringed the plaintiff's bodily integrity. Alternatively, the court could have held that the failure to obtain informed consent to the procedure constituted a breach of the defendant's contractual obligations and, in addition, an assault. In *Oldwage*,[591] the court held that the breach of a contractual obligation by failing to obtain informed consent to the procedure, also constituted an assault.

The writer is also respectfully of the view that if, at the wrongfulness stage of a delictual enquiry into an omission to disclose information, it is found that there was no consent to the procedure which was in fact performed, as occurred in this case, then there is also a *prima facie* assault. The defendant may then raise a

[588] Comprised of HJ Erasmus J Thring J and Wagley J.
[589] *Wroe v McDonald*: para 34.
[590] For commentary on the Appeal, see also www.bowman.co.za.
[591] *Oldwage v Louwrens*:557a-f, 558a-d, 562.

justification ground.[592] However, as the court in *McDonald* had already applied the combined patient-centered test to determine the wrongfulness of the omission, the writer is respectfully of the view that it would have been superfluous to apply it again as a justification ground to the *prima facie* unlawful assault.

Further, where assault is the cause of action, the next enquiry will relate to fault in the form of intention, rather than whether the defendant was negligent.

4.5 The English approach

4.5.1 *Louwrens v Oldwage* [2006] 1 All SA 197 (SCA)

The defendant in *Oldwage v Louwrens*,[593] discussed above, appealed the judgment, which was decided in favour of the plaintiff.

The Supreme Court of Appeal in *Louwrens v Oldwage*[594] set out as one of the issues on appeal the question of whether 'the plaintiff gave informed consent to the surgical procedure performed by the defendant, in the absence of which consent such intervention would have amounted to assault'.[595] In dealing with this issue, the court divided the judgment into two questions, namely (1) 'Was there informed consent?' and (2) 'Was the plaintiff warned of the risks involved and was his current claudication caused by the defendant's surgical intervention?'[596]

Under the first heading 'Was there informed consent?' the court held that:

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[592] Neethling *et al.* 2006:70-71. See also page 18.
[593] See 4.4.2.2 and 4.4.2.3 for a discussion of the case.
[594] The judgment was delivered by Mthiyane JA (Mpati DP, Streicher JA, Lewis JA and Ponnan JA concurring).
[595] *Louwrens v Oldwage*:200d-e.
[596] *Louwrens v Oldwage*:207g, 208b.

> The defendant explained in detail to the plaintiff the surgical procedure he planned to do and which was eventually done. In the circumstances I am satisfied that the plaintiff gave informed consent to the operation.[597]

The second heading is, 'Was the plaintiff warned of the risks involved and was his current claudication caused by the defendant's surgical intervention?' The court initially referred to the four requirements set out in *Castell v De Greef*:[598]

a. the consenting party must have had knowledge and been aware of the nature and extent of the harm or risk;
b. the consenting party must have appreciated and understood the nature and extent of the harm or risk;
c. the consenting party must have consented to or assumed the risk;
d. the consent must be comprehensive, that is extend to the entire transaction, inclusive of its consequences.

However, it is striking that the court did not go on to refer to the combined patient-centered test. Instead the court went on to consider the expert evidence and held that, based on the evidence of the defendant's medical expert, the likelihood of the risk of claudication occurring was 2% (the court did not accept the evidence of the plaintiff's expert that the risk was 4%).[599] The court thereafter referred to the professional practice standard with approval[600] and quoted the following passage of Watermeyer J:

> A doctor whose advice is sought about an operation to which certain dangers are attached...is in a dilemma. If he fails to disclose the risks he may render himself liable to an action for assault, whereas if he discloses them he might well frighten the patient into not having the operation, when the doctor knows full well that it would be in the patient's interests to have it. It may well be that in certain circumstances a doctor is negligent if he fails to warn a patient, and, if that is so, it seems to me in principle that his

[597] *Louwrens v Oldwage*:207g-208a.
[598] *Castell v De Greef* 1994:425H-I.
[599] *Louwrens v Oldwage*:208i-209d.
[600] *Louwrens v Oldwage*:209f-h.

> conduct should be tested by the standard of the reasonable doctor faced with the particular problem. The court must, of course, make up its own mind, but it will be assisted in doing so by medical evidence[601]

However, the court did not then go on to consider the views of the medical experts as to whether the risk should have been disclosed, but went straight on to hold that:

> If there was only a two percent chance of [the risk] occurring then the risk to the plaintiff was so negligible that it was not unreasonable for the defendant not to mention it.[602]

and

> [i]n my view of the evidence, the likelihood of [the risk occurring] ... was so negligible that no duty arose on the defendant to mention it and his omission to do so did not constitute negligence.[603]

The court justified this finding by referring to the judgment in *Richter*,[604] stating that it held that a doctor is not negligent in failing to warn the patient where 'there was only a remote possibility of the complications arising'.[605] The court also justified its decision by holding that the defendant's expert had said that if the risk occurred 'it can be rectified by a minor operation'.[606] The court went on to hold that the harm the plaintiff had suffered had not in any event been caused by the risk and the harm had not been caused by the defendant.[607]

Therefore, the court appears to lay down a general principle that if a risk of harm is statistically remote, then even if the harm caused by the risk is significant, nevertheless if it can be reversed by a further 'minor' operation, it need not be disclosed to a patient.

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[601] *Richter v Estate Hamman*:232G-H.
[602] *Louwrens v Oldwage*:209e.
[603] *Louwrens v Oldwage*:209i.
[604] *Richter v Estate Hamman*:232G-H.
[605] *Louwrens v Oldwage*:209e.
[606] *Louwrens v Oldwage*:210a-b.
[607] *Louwrens v Oldwage*:210a-b.

Even more importantly, however, the court appears to have adopted the English approach to consent to medical treatment in that the court indicated that consent to the surgical procedure was valid as long as the doctor had explained to the patient the general nature of the treatment.[608] Further, it appears that the court decided the question of which risks should be disclosed as an issue relating to negligence.[609] Although the court referred to the four guidelines set out in *Castell,* the court did not refer to or rely on the combined patient-centered test, but instead used the professional practice standard and a case decided under the reasonable doctor standard as a basis for concluding that the doctor's omission to disclose the risk to the patient was reasonable.

Carstens and Pearmain express concern about the judgment, stating that it is disappointing in that it was not well-considered and failed to deal with the applicable principles as laid down in previous cases, in a logical, thorough and principled fashion.[610]

4.6 Summary

It is clear from the above discussion of case law that one of two causes of action is consistently used when it is alleged that a doctor has not disclosed the risk/s of treatment. – assault or the English breach of duty of care. Further, in *McDonald*, the court introduced a third approach, and split up the enquiry into wrongfulness and fault, in the form of negligence, when determining liability for an omission to disclose information.

What follows is a summary and comparison of the main elements of these causes of action reflected in the law examined above.

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[608] *Louwrens v Oldwage*:209e-i.
[609] *Louwrens v Oldwage*:209i.
[610] Carstens and Pearmain 2007:686 state that 'the judgment is, with respect, principally flawed as it does not take cognizance (it is in fact oblivious) of the legal debate and flies in the face of contemporary legal developments in this regard.'

4.6.1 Conduct

4.6.1.1 Assault

The infringement of bodily integrity in assault may take place by commission or omission.[611] However, all of the claims of medical assault reported in South African case law so far have been based on a positive act or commission and most relate to surgery.[612]

4.6.1.2 Breach of duty of care

The conduct is in the form of an omission to disclose information and the claim is either brought as a breach of a duty of care to obtain consent, where there was a complete failure to disclose even the general nature of the treatment,[613] or, more commonly, as a breach of a duty of care to disclose information, where the risks of treatment as well as other treatment options are in issue.[614]

4.6.1.3 Breach of a legal duty

The conduct is in the form of an omission to disclose information.[615]

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[611] *B* 1994 (2) SACR 237 (E); *A* 1991 (2) SAV 257 (N):273; Snyman 2004:461. See further Chapter Three, Section 3.2.2.
[612] See for example, *Stoffberg v Elliott*, *Layton and Layton v Wilcox and Higginson*, *Castell v De Greef* 1994, *Oldwage v Louwrens* and *Broude v McIntosh*, all discussed above.
[613] *Layton and Layton v Wilcox and Higginson.*
[614] See, for example, *Richter v Estate Hammann*; *Lymbery v Jefferies; Castell v De Greef 1993; McDonald v Wroe*, all discussed above.
[615] See *McDonald v Wroe*, discussed above.

4.6.2 Wrongfulness

4.6.2.1 Assault

Consent, also known as *volenti non fit iniuria,* is a ground of justification that excludes the *prima facie* unlawfulness or wrongfulness element of a crime or delict.[616]

A patient must have knowledge of and consent to the procedure which is to be performed.[617] In addition, consent must be comprehensive, that is, it must extend to the entire transaction, inclusive of its consequences. For consent to medical treatment to be valid there must not only be consent to the treatment but also to the dangers and risks of the treatment.[618] The dangers include the possible dangers.[619] Consent will only be informed if it is based on substantial knowledge of the nature and effect of the act consented to.[620] Further, consent includes not only knowledge but also appreciation, understanding and finally consent.[621]

However, the court in *Castell v De Greef*[622] introduced the combined patient-test into South African law, in terms of which a risk is material if it is of significance to the patient. Further, a risk is of significance to the particular patient if the patient would be likely to not have undergone the proposed treatment had he/she been informed of the risk in question. On the other hand, in the later case of *Oldwage*[623] the court placed emphasis on whether the patient is able to make a decision as to whether to run the risk of consenting to the treatment or not, rather than on the outcome of the decision.

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[616] *Castell v De Greef*:425G.
[617] *Stoffberg v Elliott* :149-150; *Layton and Layton v Wilcox and Higginson*:50.
[618] *Esterhuizen v Administrator, Transvaal*:719F-G; *Castell v De Greef* 1994:425H-I.
[619] *Rompel v Botha*; *Esterhuizen v Administrator, Transvaal*:719F-G; *Castell v De Greef* 1994:417F-H.
[620] *Oldwage v Louwrens*:555b-c.
[621] *Castell v De Greef* 1994:425H-I.
[622] *Castell v De Greef* 1994:430C-G.
[623] *Oldwage v Louwrens*:555g.

However, either way, consent will only be absent if the doctor foresaw the possibility that the risk was likely to be of significance to the particular patient, or ought to have foreseen that the risk was likely to be of significance to the patient.[624] In other words, a particular type of mistake of fact, if reasonable, excludes the unlawfulness of the conduct.

The writer respectfully made the following observations and proposals regarding the combined patient test:

- Risks inherent in the treatment include those risks which inhere in the treatment through the quality of the treating doctor.

- For purposes of consent, it is not necessary that the risk in question was definitely of significance to the plaintiff. It is sufficient if it was likely to have been or probably is of significance to the plaintiff.

- A risk is of significance to a patient if the information would have subjectively impacted on decision-making process as to whether to undergo the proposed treatment, rather than subjectively causing the patient to refuse the proposed treatment.

- The fact that the plaintiff would probably have consented to the proposed treatment with the same risks attached to it, but only at a later stage, does not mean that there was consent to the treatment that was actually administered.

- A modified combined patient-centered test to measure consent was proposed. Under this test, the requirement of actual or reasonable foresight of the defendant is considered at the fault stage of the enquiry

[624] *Castell v De Greef* 1994:426G-H; *Oldwage v Louwrens*:555g-556b.

and the consent determination reflects a purely subjective test, which is more in line with the *volenti* principle.

However, the Supreme Court of Appeal in *Louwrens v Oldwage*[625] appeared to imply that as long as the patient has knowledge of the general nature of the treatment, it is sufficient for consent to medical treatment, and the failure to disclose the risks of treatment falls to be determined under a breach of duty of care.

4.6.2.2 Breach of duty of care

In order to determine whether there is liability for an omission to disclose information to the patient, the English duty of care approach is adopted[626] and is specifically referred to as 'negligence', which is the name given to the English tort of negligence. The determination of wrongfulness and fault are rolled into one enquiry into whether an omission to disclose information was wrongful and culpable. Further, the professional practice standard is used to determine both wrongfulness and fault.

As opposed to the broad principle laid down by the combined patient test in *Castell*, some rules which have been laid down through the application of the reasonable doctor standard are as follows:

- The essential question is whether a reasonable doctor, in the circumstances of the defendant, would have disclosed the risk.

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[625] *Louwrens v Oldwage*:207g-208a, 208i-209d, 209f-h.
[626] See for example, *Layton and Layton v Wilcox and Higginson*:49; *Lymbery v Jefferies*:240; *Richter v Estate Hammann*:227F-G; *Castell v De Greef* 1993:507G-508F.

- The court must make up its own mind, but will be guided in doing so by medical evidence as to the nature of the risk and materiality of the risk.[627]

- The evidence of a single doctor as to the usual practice of doctors is acceptable.[628]

- A doctor is only obliged to give the patient a 'general idea' of the consequences of surgery.[629]

- Even if a risk is serious, if it is remote it does not need to be disclosed.[630]

- if a risk of harm is statistically remote, then even if the harm caused by the risk is significant, nevertheless if the harm can be reversed by a further 'minor' operation, it need not be disclosed to a patient.[631]

- It is not necessary to disclose alternative procedures as long as the recommended procedure constitutes 'acceptable practice' 'and is in the 'overall interests of the patient.'[632]

4.6.2.3 Breach of a legal duty

In the more recent case of *McDonald v Wroe*,[633] the English duty of care approach was not used to determine liability for an omission to disclose information. Instead, the determination of wrongfulness and negligence were split up in accordance with South African delictual principles and the

[627] *Richter v Estate Hammann*:232G-H.
[628] *Lymbery v Jefferies*:240.
[629] *Lymbery v Jefferies*:240.
[630] *Lymbery v Jefferies*:240.
[631] *Louwrens v Oldwage*:209i, 209e, 210a-b.
[632] *Castell v De Greef* 1993:519G.
[633] *McDonald v Wroe*:568a-c, 570c-d, 575f-j.

wrongfulness of an omission to disclose information was determined according to the combined patient-centered test as set out in *Castell v De Greef*.[634]

4.6.3 Fault

4.6.3.1 Assault

The doctor must direct his/her will to touching the patient, but consciousness of wrongfulness is not necessary and a mistake of law or fact, whether unreasonable or reasonable, is irrelevant. Furthermore, motive is irrelevant.[635] As soon as the plaintiff has proved the application of force, there is a presumption of intention, or *animus iniuriandi*, which the defendant must rebut.[636]

However, the writer was also respectfully of the opinion that the elements presently included in the combined patient-centered test for consent, which relate to fault, should be considered under the fault element of the delict. In *Castell*, [637] the court required that in order to hold the defendant liable for assault, he/she must have had subjective or objective consciousness that the undisclosed risk of treatment in question was likely to be significant to the patient. In other words, a particular type of mistake of fact, if reasonable, now excludes liability, although it appears that the position in respect of mistake of law is unchanged.

4.6.3.2 Breach of a legal duty

The court in *McDonald*[638] held that where liability for an omission to disclose information is in issue, the combined patient-centered test is applied at the wrongfulness stage of the enquiry and the negligence test as applied in *Kruger v*

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[634] *Castell v De Greef* 1994:426G-H.
[635] *Esterhuizen v Administrator, Transvaal*:722 F-G.
[636] See Chapter Three, Section 3.2.5.2 fn. 309.
[637] *Castell v De Greef* 1994:426G-H.
[638] *McDonald v Wroe*:568a-c, 570c-d, 575f-j.

Coetzee[639] was used thereafter. The writer was respectfully of the view that the test for negligence includes the professional practice standard.

Further, although negligence was alleged in the case law examined, fault may take the form of negligence or intention. The plaintiff must prove that the defendant acted with the requisite fault in the form of negligence (including objective consciousness of wrongfulness), or intention (including subjective consciousness of wrongfulness).[640] The defendant must therefore subjectively or objectively foresee the unlawful consequences, including the bodily injury and patrimonial loss.[641] In addition, where negligence is in issue, the plaintiff must not only prove foresight, but must also prove that the reasonable doctor would take reasonable steps to guard against such occurrence; and that the defendant failed to take such steps.[642]

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[639] *Kruger v Coetzee* 1966 2 SA 428 (A):430.

[640] *Matthews v Young* 1922 AD 492:503-506; Neethling *et al.* 2006:115; Neethling *et al.* 2005:106-107; Boberg 1989:271–272, states that consciousness of wrongfulness is not a separate requirement, but is part of intention. The actor's will is directed at causing an unlawful consequence and not merely a consequence. He reasons that if consciousness of wrongfulness is removed, then intention falls away altogether and, as a result, there is strict liability or liability in negligence only.

[641] Boberg 1989:274-279; Amerasinghe 1967:205; There are two main views as to what damage the defendant or reasonable defendant should foresee in order to satisfy the culpability requirement. The first is the abstract or absolute approach. Van der Walt 1964:506 explains that the defendant does not have to foresee a particular consequence or a certain type of damage for purposes of culpability. Rather, the defendant should foresee harm in general, no matter the nature or the type of harm. See also McKerron 1961:283-292. On the other hand, in terms of the concrete or relative approach the defendant must foresee the particular damage that the plaintiff is claiming compensation for. Dean 1974:48; Neethling *et al.* 2006:127-128. Both the abstract and the concrete approaches have found support in South African law. For example, the concrete approach was applied in *Mukheiber v Raath* 1999 3 SA 1065 (SCA):1077 and *Van der Spuy v Minister of Correctional Services* 2004 2 SA 463 (SE):472-473, whereas the abstract approach was applied in *Groenewald v Groenewald* 1998 2 SA 1106 (SCA):1112. However, Neethling *et al* 2006:127-129, point out that the wide abstract approach has been narrowed down, in some cases, so that the general nature of the harm must be foreseeable or the general manner in which it occurred, although not the specific harmful consequence or the precise manner in which it has occurred (for example, *Ocean Accident and Guarantee Corporation Ltd v Koch* 1963 4 SA 147 (A):152; *Sea Harvest Corporation (Pty) Ltd v Duncan Dock Cold Storage (Pty) Ltd* 2000 1 SA 827 (SCA):840. The authors conclude that because both the concrete and abstract approaches require foreseeability of the general nature of the consequences and the general manner in which it occurred, both approaches should produce the same result.

[642] *Kruger v Coetzee*:430.

4.6.4 Causation

4.6.4.1 Assault

The court in *Stoffberg*[643] appeared to be of the view that a separate element of *contumelia* must be established for liability under the *actio iniuriarum*. However, there is authority in South African law for regarding proof of this additional element as unnecessary in order to claim satisfaction.[644]

In order to claim patrimonial loss and pain and suffering, *Esterhuizen*[645] and *Stoffberg*[646] required that the treatment was not necessary to save the patient's life or limbs. It must be asked whether the patient would have suffered the loss even if the defendant did not assault him/her.[647]

In *Stoffberg*,[648] the court held that a claim for patrimonial damages and pain and suffering arises from the Aquilian action, but in *Esterhuizen*,[649] the court awarded patrimonial damages and pain and suffering once the cause of action based on assault was established, without referring to the Aquilian action or action for pain and suffering.

4.6.4.2 Breach of duty of care and breach of a legal duty

The plaintiff must show that his/her disabilities were caused by the failure to warn. It follows that he/she must show that the harm was caused by the

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[643] *Stoffberg v Elliott*:152.
[644] See the discussion in 4.2.1.1.
[645] *Esterhuizen v Administrator, Transvaal*:726C-H.
[646] *Stoffberg v Elliott*:152-153;
[647] *Esterhuizen v Administrator, Transvaal*:726C-H.
[648] *Stoffberg v Elliott*:152.
[649] *Esterhuizen v Administrator, Transvaal*::726C-H.

manifestation of the undisclosed risk. The plaintiff must also show that he/she would not have had the treatment had he/she been informed of the risk in question. Causation is a subjective test, but the fact that the patient asks questions is evidence that the risk is material to him/her in deciding whether to have the treatment.[650]

In *McDonald*,[651] the court held that, on the facts of the particular case, causation is established where the plaintiff would subjectively have consented to the proposed treatment at a later stage, but the risk in question would have had less of a chance of manifesting, because the treatment would have been administered by a specialist instead of a general practitioner. However, on Appeal the court held that causation is only established if the plaintiff would not have had the treatment in question at all.[652]

Further, the writer was respectfully of the view that the approach to causation laid down by the English House of Lords in *Chester*[653] should be adopted, whereby causation is present even if the plaintiff would probably have consented to the same treatment with the same risks, but at a later stage.[654]

However, the Full Bench in *Wroe v McDonald*[655] held that if the harm which the plaintiff suffered, is harm she might equally probably have suffered in any event if the operation was performed at a later stage, then the fact that she did not consent to the operation at the time it was performed, is irrelevant to the question of causation. Therefore, it is only if the Plaintiff would not have consented to the operation at all that the claim for patrimonial damages will succeed. However, this Appeal is unreported to date.

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[650] *Richter v Estate Hammann*:233D-E.
[651] *McDonald v Wroe*:570-571; See also *Richter v Estate Hammann*:233D-E.
[652] *Wroe v McDonald*: para 34.
[653] *Chester v Afshar* [2004] 4 All ER 587(HL):592j, 594j, 604h-j. See also Section 4.4.4.1.7.3.
[654] As long as the risks are 50% or less.
[655] *Wroe v McDonald*: para 34.

4.6.5 Onus of proof

4.6.5.1 Assault

In *Esterhuizen*[656] the court refused to decide whether the defendant or the plaintiff bears the *onus* of proof in respect of consent. The other cases discussed above do not deal with this issue expressly. However, the general rule in South African law under the *actio iniuriarum* is that the application of force to the body of the plaintiff, establishes not only *prima facie* wrongfulness but also a presumption of intention, which the defendant must rebut.[657]

4.6.5.2 Breach of duty of care and breach of a legal duty

In general, the plaintiff proves all the elements of the delict, that is the omission, that it was unlawful, fault in the form of negligence or intention and the causal connection between the failure to warn and the damages.[658]

4.6.6 Justification for the cause of action

4.6.6.1 Assault

The right to self-determination lies at the heart of informed consent.[659] The patient has a fundamental right of individual autonomy and self-determination'.[660]

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[656] *Esterhuizen v Administrator, Transvaal*:718E-F, 721A.
[657] See the discussion in chapters Two and Three.
[658] . The plaintiff will, in the ordinary course of events, lead evidence to establish a *prima facie* case against the defendant. A '*prima facie*' case means that the plaintiff has led enough evidence upon which a court, applying its mind reasonably, might find for him/her when he/she closes his/her case. Schwikkard and Van der Merwe 2002:542. In *McDonald v Wroe*:568d-f, 571f, 575f, the court held that the plaintiff proves the causal nexus between the failure to warn and the harmful consequences. See further Chapter Two, Section 2.2.1.
[659] *Castell v De Greef* 1994:420I-J, 421C-E.
[660] *Oldwage v Louwrens*:555g-556b.

The patient has an absolute right of control and disposal of his/her own body,[661] which overrides the view of anyone else as to the person's best interests.[662]

The decision as to whether a risk is material is judged by a standard demanded by law, rather than according to the standards set by the medical profession.[663] Therefore, the issue of consent, in South African law, is not treated as one of negligence, arising from the breach of a duty of care, but as one of consent to the injury involved and assumption of an unintended risk'.[664]

The object of the doctrine of informed consent is so that the patient can decide whether to run the risk of consenting to the treatment.[665] Under this approach the combined patient-centered standard is applied to determine the applicable level of disclosure. The focus in this test is on the state of mind of the plaintiff, subject to the reasonable foresight of the defendant.

4.6.6.2 Breach of duty of care

The doctrine of informed consent does not apply, because it has been rejected in England.[666] In England, the omission to disclose risks of treatment is dealt with under the law of negligence.

In practice, medical practitioners tend to regard the best interests of the patient as an important factor in deciding whether to whether to withhold information regarding the risks of treatment.[667] The question is whether, from the doctor's point of view, disclosure might result in the risks assuming a distorted

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[661] *Stoffberg v Elliott*:148-149.
[662] *Castell v De Greef* 1994:420I-J, 421C-E.
[663] *Castell v De Greef* 1994:426H-J.
[664] *Castell v De Greef* 1994:425E-F.
[665] *Oldwage v Louwrens*:555f-g.
[666] *Castell v De Greef* 1993:518B-D.
[667] *Castell v De Greef* 1993:519G. A right to cure has also been put forward as a justification for medical interventions. However, in this regard Claasen and Verschoor 1992:58, refer to Smit 1983:282, who points out that the right to cure may lead to a denial of the patient's right to self-determination and to Strauss and Strydom 1967:178, who assert that this would lead to a doctor having a licence to kill.

significance in the mind of the plaintiff and, in so doing interfere with the patient's ability to decide whether to proceed with the procedure. The doctor must also consider whether the patient might be frightened into not having the procedure when the doctor thinks that the treatment is in the overall best interests of the patient.[668]

4.6.6.3 Breach of legal duty

The test for whether there was a breach of a legal duty is the same as that for consent laid down in *Castell*,[669] that is, the combined patient test. However, thereafter, the test for negligence is applied. Therefore, the determining standard is the professional practice standard.

4.7 Conclusion

In South Africa, the courts apply both the professional practice standard and a more patient-centered standard to determine whether risks of medical treatment should have been disclosed to a patient:

a. When a commission, which causes the infringement of bodily integrity, comprises the conduct in a delictual cause of action, then a patient-orientated test is used to determine the boundaries of the justification ground of consent to the *prima facie* unlawful touching.[670]

b. Where the conduct is in the form of an omission to disclose information, the courts use the English duty of care approach by fusing the elements of wrongfulness and fault, in the form of negligence, and applying the

[668] *Richter v Estate Hammann*:232G.
[669] *Castell v De Greef* 1994:426G-H; *McDonald v Wroe*:568b-d.
[670] *Castell v De Greef* 1994 (4) SA 408 (C).

professional practice standard to determine whether there was a breach of the duty of care.[671]

c. However, in one case concerning liability for an omission to disclose information, *McDonald*,[672] the court split up the elements of wrongfulness and fault and used both standards - the combined patient-centered standard at the wrongfulness stage of the enquiry and the professional practice standard at the negligence stage of the enquiry.

In other words, when the claim is decided on the basis of assault with intention as the fault element, then the conduct is in the form of a commission. However, when the claim is decided with negligence as the fault element, then the conduct is dealt with in the form of an omission to disclose information, and either the English breach of duty of care is used, or the elements of wrongfulness and fault are split up and decided separately.

The difference between proceeding on the basis of a commission which causes the infringement of bodily integrity, on the one hand, and an omission to disclose information on the other, is not insignificant. When the claim is based on a commission, it is usually easy for the plaintiff to prove that the conduct caused the infringement of bodily integrity and the conduct is regarded as *prima facie* wrongful,[673] but where the claim is based on an omission to disclose information, the conduct is regarded as *prima facie* lawful.[674]

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[671] *Lymbery v Jefferies 1925 AD 236; Richter and another v Estate Hammann* 1976 (3) SA 226 (C); *Castell v De Greef* 1993 (3) SA 501.
[672] *McDonald v Wroe* [2006] 3 All SA 565 (C).
[673] For example, where a surgeon operates on a patient.
[674] Boberg 1989:32.; *A* 1991 (2) SAV 257 (N); *Minister van Polisie v Ewels* 1965 (3) SA 590 (A); *Minister of Law and Order v Kadir* 1995 (1) SA 303 (A); *Knop v Johannesburg City Council* 1995 (2) SA 1 (A). For example, the writer is respectfully of the view that in terms of the prior conduct rule (*omissio* per *commissionem* rule) a plaintiff will only establish *prima facie* wrongfulness if he/she leads sufficient evidence that the doctor created a new source of danger by, for example, suggesting an operation with dangers attached (*commissio*) and subsequently failed to eliminate the danger by informing the patient of the risk in question (*omissio*), with the result that harm is caused to the patient. However, in order to show that the plaintiff suffered harm, he/she will have to lead evidence that the risk was material. For the prior conduct rule, see Neethling *et al.* 2001:58-59, 65-66.

The writer is respectfully of the view that where an omission to disclose information is in issue, then one way of approaching the matter is that in terms of the prior conduct rule (*omissio* per *commissionem* rule)[675] a plaintiff will only establish *prima facie* wrongfulness if he/she leads sufficient evidence that the doctor created a new source of danger by, for example, suggesting an operation with dangers attached (*commissio*) and subsequently failed to eliminate the danger by failing to inform the patient of the risk in question (*omissio*), with the result that harm was caused to the patient. Where a cause of action is based on assault, the harm is the infringement of bodily integrity.[676] However, in order for the plaintiff to show that he/she suffered harm as a result of the omission to disclose, the plaintiff will have to lead evidence that the undisclosed information was material or significant to him/her.[677]

All of the reported South African cases discussed above relating to medical assault, have concerned an assault by commission and most concern surgery. On the other hand, all of the reported South African cases discussed above and decided on the basis of breach of duty of care and negligence have relied on conduct in the form of an omission. However, the writer is respectfully of the opinion that all of the latter cases could also have been pursued on the basis of conduct in the form of a commission and as an assault. In all of these cases there was a direct application of force through surgery, with the exception of *Lymbery*,[678] which involved the infringement of bodily integrity by commission in the form of X-ray treatment.

Further, conduct in the form of an omission may also form the basis of assault as a cause of action.[679] For example, a doctor assaults a patient if he/she advises the patient, but does not tell the patient about the availability of a more

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[675] For the prior conduct rule, see Neethling *et al.* 2001:58-59.
[676] Snyman 2004:452, 462-463; Strydom 1962:216.
[677] However, where a claim is based on the Aquilian action the harm is the infringement of a patrimonial interest (For example, a dependant's claim for loss of maintenance following the death of a breadwinner.)
and where the claim is based on the action for pain and suffering the harm is in the form of bodiliy injury (*Matthews & Others v Young* 1922 AD 492:504.) See also the discussion in Chapter 4, Section 4.7.
[678] *Lymbery v Jefferies* 1925 AD 236.
[679] *B* 1994 (2) SACR 237 (E); *A* 1991 (2) SAV 257 (N):273.

appropriate treatment option and, as a result, the patient decides to have no treatment at all rather than submit to the doctor's unacceptable suggested option. Consequently, there is application of force through the progression of a disease, which could have been halted if the doctor had disclosed the option in question.[680] Another example is a nurse whose duty it is to give pain medication to a patient, but omits to do so and, as a result, the patient feels pain.[681]

Therefore, the writer is respectfully of the view that assault, with intention as the fault element, may be used in most claims concerning the disclosure of information to patients, which results in the infringement of bodily integrity, whether the conduct is in the form of a commission or omission.[682] However, where the conduct is in the form of a commission which infringes bodily integrity, it is regarded as *prima facie* wrongful. On the other hand, where the conduct is in the form of an omission to disclose information, the conduct is regarded as *prima facie* lawful.

In the following Chapter, the competing standards of disclosure in South African law will be compared in more detail, that is the professional practice standard which operates at the negligence stage of an enquiry into liability and the more patient-orientated standard which operates at the wrongfulness stage of an enquiry into liability. Particular attention will be paid to the conflicting principles and rules which have been laid down through the application of these conflicting standards.

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[680] In English law, a claim based on battery would not lie, because an action in battery is only possible if there has been some sort of physical contact between the doctor and patient. Jackson 2006:276.
[681] Snyman 2004:461.
[682] However, a claim based on assault, as an *iniuria*, is actively or passively transmissible only when *litis contestatio* has been reached. Neethling et al. 2005:78; *Argus Printing and Publishing Co Ltd v Esselen's Estate* 1994 2 SA 1 (A); *Potgieter v Rondalia assurance Corporation of SA Ltd* 1970 1 SA 705 (N).

CHAPTER FIVE

THE COMPETING STANDARDS OF DISCLOSURE

5.1 Introduction

The discussion in this Chapter begins with a summary and comparison of the *ratio decedendi* of the cases discussed in Chapter Four, in order to determine whether there is any difference in outcome when the different causes of action and standards of disclosure are used.

Thereafter, the specific principles and rules of disclosure which have emerged through application of the different causes of action and disclosure standards are compared and contrasted in table form.

Finally, the National Health Act[683] is discussed, with particular reference to the question of which of the conflicting principles and rules relating to disclosure of information apply when interpreting the provisions of the Act concerning informed consent.

[683] The National Health Act 61 of 2003.

5.2 The *ratio decedendi* of reported cases

5.2.1 Assault

In *Stoffberg*,[684] the doctor conceded that he had not obtained consent from the patient. The court concluded that the patient had been assaulted, but the plaintiff failed to prove causation under the Aquilian action.

In *Layton*,[685] the doctors conceded that they had not obtained consent from the father of the child and the court held that there was an assault. The court awarded special damages to the father.

In *Esterhuizen*,[686] the defendant admitted that the risks of the treatment had not been disclosed in respect of the particular X-ray treatment that had been administered. The court held the doctor liable for assault and awarded damages.

In *Castell*,[687] the court believed the doctor's evidence that he had in fact disclosed the disputed risks to the patient and had disclosed other options to the patient, but that the patient had nevertheless decided on the proposed option. The court also agreed with the trial court that an adverse inference was correctly drawn against the plaintiff for failing to call her husband to testify, as he had been present at the relevant consultations. The plaintiff's claim in respect of informed consent was accordingly dismissed.

In *Oldwage*,[688] the defendant doctor testified that the patient gave informed consent to the proposed procedure after a lengthy discussion as to costs. However, the court drew an adverse inference against the doctor because he failed to call a hospital employee to testify, who was also present at the

[684] *Stoffberg v Elliott*:149-153.
[685] *Layton and Layton v Wilcox*:50-51.
[686] *Esterhuizen v Administrator, Transvaal*:719:721 A-D, 722F-G.
[687] *Castell v De Greef*:428A-B, 430A-I.
[688] *Oldwage v Louwrens*:556d-h, 555f-g, 557a-f.

consultation. The court held that the defendant had not informed the patient of the elective nature of the procedure and no other options were discussed with the patient other than the proposed procedure. The court believed the plaintiff's version and held that informed consent was not obtained.

In *Broude*,[689] the court did not believe the patient's evidence that he was not aware of the risk in question, as he was a medical practitioner. Further, the court believed the defendant's version that he had disclosed the risk to the patient.

In *Louwrens*,[690] the court held that there was informed consent because the doctor had disclosed the general nature of the treatment to the patient. The court dealt with the issue of risk disclosure as a question of negligence.

5.2.2 Breach of duty of care

In *Lymbery*,[691] the doctor admitted that the risks of serious burns had not been disclosed to the patient. However, the court accepted the defendant's expert's evidence that remote risks, even if serious, do not have to be disclosed to a patient.

In *Richter*,[692] the risk was held to be unforeseeable, on the basis of medical expert evidence, and therefore the court held that it did not need to be disclosed.

In *Layton*,[693] the doctors conceded that they did not take steps to obtain consent from the father of the child and the court held that they were negligent in not doing so. However, the court held that the doctors were not legally obliged to

[689] *Broude v McIntosh*:68F-69E.
[690] *Louwrens v Oldwage*:207g-208a.
[691] *Lymbery v Jefferies*:240.
[692] *Richter v Estate Hammann*:229 A, 230 E-F, 233 C.
[693] *Layton and Layton v Wilcox and Higginson*:50.

obtain consent from the mother. Therefore, the mother's claim for nervous shock failed.

In *Castell*,[694] the court drew an adverse inference against the plaintiff for failing to call her husband to give evidence, who had been present at the relevant consultations with the defendant. The court believed the doctor's evidence that the high risk of the proposed procedure had been disclosed to the patient. Furthermore, the court concluded that a doctor is not under a duty to disclose alternative options if the proposed option constitutes acceptable practice and is in the overall interests of the patient.

In *McDonald v Wroe*,[695] the doctor conceded wrongfulness and negligence. Although the defendant disputed causation, the plaintiff's claim succeeded *a quo*, but failed on Appeal.[696]

In *Broude*,[697] as stated above in the context of the cause of action based on assault, the court did not believe the patient's evidence that he was not aware of the risk in question. Further, the court believed the doctor that he had disclosed the risk to the patient.

In *Louwrens*,[698] the defendant admitted that he did not mention the risk in question to the patient. However, the court found that the defendant did not have a duty to disclose the risk to the patient, because although it was a serious risk, it was remote (2%) and could be rectified by 'a minor operation'.

[694] *Castell v De Greef* 1993:516F-H, 519I-J, 520A-B.
[695] *McDonald v Wroe*:570c-571.
[696] *Wroe v McDonald*: para 34.
[697] *Broude v McIntosh*:68F-69E.
[698] *Louwrens v Oldwage*:210a-b.

5.2.3 Analysis

Where assault is the cause of action, the combined patient-centered test is used and the question must be asked whether the doctor was or ought to have been aware that the risk was material to the particular patient in deciding whether to undergo the treatment. However, none of the cases discussed above ultimately turned on this question.

The judgments confirm that where assault is the cause of action, the cases generally turn on the factual question of whether the risk in question was actually disclosed to the patient or not. Where the doctor concedes that the risk was not disclosed, he has been held liable for assault. However, where the doctor insists that he has disclosed the information to the patient, the court must decide whether to accept the plaintiff's or the defendant's evidence. In one of these cases an adverse inference was drawn against the doctor for failing to call a witness to give evidence and in another case, an adverse inference was drawn against the plaintiff for failing to call a witness to give evidence. In the remaining case, the plaintiff was a medical doctor and the court did not believe that he was not, in any event, aware of the risk in question.

The case of *Louwrens*[699] stands apart from all of the other cases in that it only requires knowledge of the general nature of the treatment to satisfy the requirement of informed consent. However, the writer is respectfully of the view that this judgment does not overrule the traditional approach to informed consent, because it was litigated before the National Health Act came into force, which confirms the holistic approach to informed consent in South Africa. [700]

On the other hand, where the cause of action was breach of duty of care and negligence and the professional practice standard were in issue, the judgments

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[699] *Louwrens v Oldwage*:207g-208a.

[700] *Louwrens* was decided without reference to the requirements of the National Health Act, because the case originally went to trial in the Cape High Court in 2004, before the Act took effect in 2005. See Section 5.4 for further discussion.

confirm that although the parties do sometimes dispute the facts and the court may decide the matter on this basis, the case more often turns on the question of whether, as a matter of law, the risk should have been disclosed. In one case, although the doctor admitted he had not disclosed a serious risk to the patient, the court held that the risk did not need to be disclosed to the patient as it was remote. In a later case, the defendant also admitted that he did not disclose a serious risk to a patient, but the court held that the risk did not need to be disclosed to the patient as it was remote and, in addition, the defendant's expert had testified that the harm could be corrected by 'a minor operation'. However, where the doctor conceded that his failure to disclose was both wrongful and negligent, this was accepted by the court, and the matter was ultimately decided in favour of the plaintiff.

In summary, where the case has been decided on the basis of assault, the court has accepted that the information should have, as a matter of law, been disclosed to the individual patient. However, where the case has been decided in negligence, the courts have laid down rules restricting the amount of information which must, as a matter of law, be disclosed to patients as a group.

5.3 Competing standards of disclosure in South Africa

The table below summarises and compares some of the principles which have been laid down in case law by the combined patient-centered test in the context of *volenti non fit iniuria* on the one hand, and by the professional practice standard in the context of negligence, on the other:

Case law application of the competing standards in South African law

PATIENT STANDARD	PROFESSIONAL PRACTICE STANDARD
Principles laid down in common law through application of the principle of *volenti non fit iniuria* and by the patient-centered standard: • For consent to medical treatment to be valid there must not only be consent to the treatment but also to the dangers and risks of the treatment.[701] • The dangers include the possible dangers.[702] • Consent will only be informed if it is based on substantial knowledge of the nature and effect of the act consented to.[703] • Consent includes not only knowledge but also appreciation, understanding and finally consent.[704] • It is not necessary to inform a patient of a risk in percentages.[705] • Informed consent requires that the patient be advised of the alternatives to the proposed treatment option.[706] • In addition to the above disclosure requirements, the court must also consider the informational requirements of the reasonable patient in the circumstances of the particular case as well as the particular patient.[707]	Principles laid down in common law by the professional practice standard: • The court must make up its own mind, but will be guided in doing so by medical evidence as to the nature of the risk and materiality of the risk.[708] • A doctor is only obliged to give the patient a 'general idea' of the consequences of surgery.[709] • Even if a risk is serious, if it is remote, it does not need to be disclosed to the patient.[710] • if a risk of harm is statistically remote, then even if the harm caused by the risk is significant, nevertheless if it can be reversed by a further 'minor' operation, it need not be disclosed to a patient.[711] • It is not necessary to disclose alternative procedures as long as the recommended procedure constitutes 'acceptable practice' 'and is in the 'overall interests of the patient.'[712] • The evidence of a single doctor as to the usual practice of doctors is acceptable.[713] • It is not necessary to inform a patient of a risk in percentages.[714]

[701] *Esterhuizen v Administrator, Transvaal*:719F-G; *Castell v De Greef* 1994:425H-I.
[702] *Rompel v Botha*; *Esterhuizen v Administrator, Transvaal*:719F-G; *Castell v De Greef* 1994:417F-H.
[703] *Oldwage v Louwrens*:555b-c.
[704] *Castell v De Greef* 1994:425H-I.
[705] *Castell v De Greef* 1994:430C.
[706] *Oldwage v Louwrens*:557e-f.
[707] In other words, the combined patient-centered test.
[708] *Richter v Estate Hammann*:232G-H.
[709] *Lymbery v Jefferies*:240.
[710] *Lymbery v Jefferies*:240.
[711] *Louwrens v Oldwage*:209i, 209e, 210a-b.
[712] *Castell v De Greef* 1993:519G.
[713] *Lymbery v Jefferies*:240.
[714] *Castell v De Greef* 1993:519I-J.

It is clear from the above that under the professional practice standard, specific limitations on the amount and type of information that must be disclosed to patients as a group have been laid down in case law, whereas the combined patient test adopts a more principled approach, which focuses on the informational requirements of the particular patient.

5.4 The National Health Act 61 of 2003

The National Health Act (The Act) came into force on 2 May 2005. Chapter 1 of the Act sets out the objects of the Act, which are, *inter alia*, to protect, respect, promote and fulfill the rights of the public to health care services, to ensure an environment not harmful to health and to ensure the protection and development of vulnerable groups such as women, children, older persons and persons with disabilities. Furthermore, Chapter 1 explains that the Act sets out rights of and duties of health care providers, health workers, health establishments and users.[715]

Section 7 of the Act is titled 'Consent of user' and provides, *inter alia*, that a 'health service' may not be provided to a user without the user's informed consent.[716] In terms of s7(3), 'informed consent' means consent which is informed as contemplated in s6. Section 6 of the Act provides that:

> Every health care provider must inform a user of –
>
> a. the user's health status except in circumstances where there is substantial evidence that the disclosure of the user's health status would be contrary to the best interests of the user;

[715] Chapter 1 also states that the Act was passed in order to regulate national health and provide uniformity in respect of health services across South Africa, by establishing one national health system encompassing public and private providers of health.

[716] Further, s8 is headed 'Participation in decisions' and provides that the patient 'has a right to participate in any decision affecting his or her personal health and treatment'. The Act therefore confirms the doctrine of informed consent, including the right not only to participate in decision-making, but also the right to refuse health services. s8(1) and s6(1)(d) respectively.

b. the range of diagnostic procedures and treatment options generally available to the user;

c. the benefits, risks, costs and consequences generally associated with each option; and

d. the user's right to refuse health services.[717]

An interpretation of the Act that favours a broad application of the right to information is *inter alia* compatible with:

a. the title of s6 of the Act 'User to have Full Knowledge';

b. the values acknowledged in the Preamble to the Act. The Preamble *inter alia* recognizes the need to:

i. respect, promote and fulfill the rights enshrined in the Bill of Rights;

ii. establish a society based on democratic values and fundamental human rights;

iii. establish a health system based on a spirit of enquiry and advocacy which encourages participation; and

iv. free the potential of each person.

[717] Non-compliance with a statutory duty, such as the provisions of the National Health Act, is an indication that the violation of a plaintiff's interests took place wrongfully. However, it is not the violation of the norm which constitutes wrongfulness, rather the violation of the plaintiffs interests in a legally reprehensible manner. Neethling *et al.* 2006:69.

c. Section 39(2) of the Bill of Rights, which provides that 'when interpreting any legislation and when developing the common law or customary law, every court, tribunal or forum must promote the spirit, purport and objects of the Bill of Rights'.

In terms of section 6 of the Act, it is not only the benefits, risks and costs of the proposed treatment which must be disclosed, but also the other options and the benefits, costs and consequences of the various options.[718] In addition, prior to the Act, leading academic opinion endorsed a general rule that a doctor does not have to disclose the diagnosis to the patient.[719] However, the Act now makes it clear that the patient's health status must be disclosed, but it is subject to 'the best interests of the patient' or therapeutic privilege.[720] In addition, although under the common law, risks of diagnostic procedures and treatment options are subject to therapeutic privilege,[721] the Act is silent in this regard.[722]

The doctrine of therapeutic privilege or best interests of the patient, allows the doctor to withhold information that he/she would otherwise be obliged to disclose if disclosure would be 'harmful' or have a detrimental effect on a particular

[718] In *Oldwage v Louwrens*:557e-g, the court held that informed consent includes the requirement that other options should be properly discussed with the patient.
[719] Strauss 1991:6-7; 13-14; Van Oosten 1989:431-432. However, certain exceptions were recognized, for example where the patient insists that he/she be informed and where the disclosure of the risks of treatment render disclosure of the health status necessary. Van Oosten 1989:433, 440.
[720] S6(1)(a). Van Oosten 1989:450, states that if the patient insists on being told his/her health status, the therapeutic privilege defence does not apply and the doctor is obliged to inform the patient of his health status. Further, Mulheron 2003:210-211 states that if it is possible to defer treatment until the patient is in a mental position to hear his health status, for example, in the case of an elective procedure, then as much information as possible should be given and the treatment delayed until the patient is ready for full disclosure.
[721] *SA Medical and Dental Council v McLoughlin* 1948 2 SA 355 (A):336; *Richter v Estate Hammann*:232G; *Castell v De Greef* 2004:426H. Mulheron 2003:210-211 states that if it is possible to defer treatment until the patient is in a mental position to hear his health status, for example, in the case of an elective procedure, then as much information as possible should be given and the treatment delayed until the patient is ready for full disclosure.
[722] The latin maxims *'noscitur a socius'* and *'expressio unius, exclusio alterius'* support the limitation of the defence to the health status – s6(1)(a) refers to the therapeutic exception, but subsections (b), (c) and (d) do not. On the other hand, if the defence of therapeutic privilege justifies non-disclosure of the patient's health status, the doctor may not, at the same time, be able to meet the requirements of the Act regarding disclosure of the benefits, risks, costs and consequences of the treatment options, without disclosing the health status to the patient. For example, a patient has cancer and needs radiation therapy. If the doctor discloses to the patient that a particular treatment option, being X-ray treatment, is a form of radiation therapy, then the health status of the patient will inevitably have to be revealed. Further, under the Act, the doctor will have to explain the benefits of the 'X-ray treatment', for example to prevent recurrence of the cancer or its spread. In addition, in describing the risks and consequences, the doctor would have to disclose the implications of declining treatment, for example, a probability of hastened death. In so doing, he would be disclosing the health status to the patient in the form of his prognosis. It therefore appears that in practice it may not be possible to restrict the application of the therapeutic defence to the health status.

patient.[723] The boundaries of therapeutic privilege in South Africa are vague and unsettled[724] and the dearth of judgments in South Africa has led to much debate by academic writers as to the boundaries of the defence.[725]

Whilst the 'best interests' of the patient is an integral part of the test for disclosure in cases based on breach of duty to disclose and the professional practice standard,[726] in a claim based on assault, the therapeutic privilege is an exception and a separate justification ground to consent.[727] To the writer's knowledge, none of the South African cases based on assault, have applied therapeutic privilege. In *Castell v De Greef*, Ackerman J,[728] in his only reference to therapeutic privilege in the judgment, set out the justification ground of consent embodied in the combined patient test and thereafter stated that the test is 'subject to the therapeutic privilege,' but dismissed the exception stating 'whatever the ambit of the so-called "privilege" may today still be.'[729]

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[723] *VRM v The Health Professions Council of South Africa* TPD 1679/2002 (10 October 2003) unreported, Paginated Index of Court Papers: 37.

[724] When confronted with a claim based on a lack of informed consent, doctors often raise unsubstantiated concerns that disclosure may, for example, (1) lead to anxiety which will impact negatively on the positive outcome of treatment (*Canterbury v Spence* 464 F.2d 772 (1972):778 II; *VRM v The Health Professions Council of South Africa* TPD 1679/2002 (10 October 2003) unreported, Paginated Index of Court Papers, 37) and (2) cause the patient to refuse the treatment the doctor recommends (*Richter v Estate Hammann* 1976 (3) SA 226 (C):232G. In this regard, see ss6(1)(d) of the National Health Act which specifically provides that the patient has a right to refuse health services).

[725] See for example, Beard 2005:51-68; Coetzee 2004:464-481; Coetzee 2003:269-287; Van der Heever,1993:624-626; Van Oosten 1991:31-41; Welz 1999:164-179.

[726] However, Mulheron 2003:209, points out that where the common law notion of therapeutic privilege and a statutory obligation on health professionals to disclose information conflict, the latter will prevail.

[727] Mulheron 2003:208-209, questions the applicability of the thereapeutic privilege defence to the disclosure of risks of medical treatment under a subjective patient-centered standard. One of his arguments is that the very fact that a patient is unusually anxious and nervous would require disclosure of the risk under the subjective patient-centered test because the risk would probably be significant to such a patient. There is therefore an inherent conflict between the defence of therapeutic privilege and the subjective patient test. Coetzee 2004:477, argues that the therapeutic defence should be regarded as a separate and independent justification ground to the common law grounds of justification and that the requirements of the necessity defence should apply.

[728] *Castell v De Greef*:426G-H.

[729] Coetzee 2001:79-82,122,176, states that it is possible to interpret the concept of therapeutic privilege in accordance with the principles and requirements of the necessity defence. Therefore, he argues that the defence of therapeutic privilege must meet the requirements for the necessity justification ground. In addition, he is of the view that if the doctor knows, or has reason to believe that the patient would not consent to the treatment if he knew of the risks, then the defence of therapeutic privilege may not be raised. He points out that as it is possible to act against the patient's will under the defence of necessity, it is necessary to add this element, which is part of the defence of *negotorium gestio*. The requirements for necessity are, *inter alia*, that the threat of harm must have commenced or be imminent (*S v Mtewtwa* 1977 (3) SA 628 (E):631) and that it is necessary (to withhold information) to avert the danger (*R v Mahommed* 1938 AD 30:34). If the doctor infringes a legal interest of lesser value than the legal interest protected then usually the conduct will be regarded as justified. Burchell 2005:162. Informed consent is a legislative right and it protects the Constitutional rights to dignity, life, privacy and freedom and security of the body (Sections 10, 11, 14 and 12 of the Bill of Rights respectively). It also ensures the autonomy of the patient without which it can be argued that a person is not able to exercise any of their rights (Ost 1984:304, 309). Therefore, the writer respectfully in agreement with Coetzee 2001:147-50, that the justification of non-disclosure and the consequent infringement of autonomy and a host of Constitutional rights should be limited to serious injury. For example: (1) Development of a new, chronic and serious mental illness, such as post-traumatic stress disorder, (2) permanent and serious worsening of an existing mental illness, or (3) serious physical harm, for example, suicide attempts. Coetzee 2001:120, 147-150, points out that even where the

However, despite strong arguments for a broad interpretation of the Act, s6 of the Act makes it clear that it is only mandatory for the doctor to disclose to the patient the options that are 'generally available' to the patient as well as the consequences (whether inevitable or potential) which are 'generally associated' with each option.[730] The ambit of these provisions have not yet, to the writer's knowledge, been tested in the courts and it is therefore not certain how they will be applied to concrete situations. However, the writer is respectfully of the view that the ordinary meaning of the words 'generally associated' do point to a restrictive disclosure of information. According to the Collins English Dictionary, 'generally' means 'usually, as a rule', 'commonly or widely', 'without reference to specific details or facts' and 'broadly'.[731]

On the other hand, it may well be that the courts will interpret the Act's provisions against the background of common law, embodied in case law and academic writings, which have, over time, set out the information that the law considers to be 'generally associated' with each option.[732] However, the principles laid down by the courts when consent to a *prima facie* touching is in issue, are different to the principles laid down when the professional practice standard is applied in the context of a negligent omission to disclose information. Therefore, it appears that the interpretation of the Act's provisions may differ depending on which standard of disclosure and consequently which principles are applied in interpreting the Act.

However, the writer is respectfully of the view that the reference to 'Informed

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fear of suicide exists, sensitive disclosure might sometimes provide an alternative to non-disclosure. In addition, he argues that hiding the truth may actually cause harm. Kubler-Ross 1974:52, points out that the fear of many health professionals that if they tell their patient they have a serious illness they will become suicidal, is unfounded. She proposes that a suicidal reaction can be avoided by taking the time to break the news gently and truthfully but in a manner that does not cause the patient to lose all hope. Coetzee 2003:287, proposes that a doctor should only be allowed to exercise the therapeutic defence when he possesses some expertise in predicting the effect of disclosure on patients. Coetzee 2001:120, is also of the opinion that the argument that a psychiatrist should judge whether the disclosure of certain information may make the patient suicidal, is compelling. However, Mulheron 2003:203-204, points out that overreliance on the opinion of doctors' evidence to determine the applicability of the therapeutic privilege defence effectively reintroduces the medical paternalism which the introduction of the subjective patient test has sought to remove.

[730] Under s6, the doctor 'must' disclose the information set out in the section. This disclosure is therefore mandatory (subject to therapeutic privilege in the context of the health status).

[731] Hanks *et al.* 1979:605.

[732] A statutory provision can by implication itself grant a delictual obligation, or it can justify a conclusion that a common-law legal duty exists. Neethling *et al.* 2006:59.

Consent' and 'Consent' in Section 7 of the Act lends weight to the argument that the principles of disclosure relating to consent or *volenti non fit iniuria* are applicable, rather than principles of disclosure relating to negligence. Further, the writer is respectfully of the view that a constructive interpretation of the Act, lends weight to the proposition that the Act, in broad outline, gives partial effect to the first leg of the modified combined patient-centered test, that is, the information that a reasonable patient would expect to be informed of. In other words, it provides a skeleton outline for a minimum level of disclosure, which should be interpreted in light of the requirements laid down in common law.

Furthermore, the writer is respectfully of the view that under the reasonable patient leg of the combined test, it may be that more or less information than that referred to in the Act and common law, should be disclosed to the reasonable patient, because disclosure under the reasonable patient leg of the test is also dependant on the circumstances of the particular case and, in particular, the reasonable person is assessed in the position of the particular plaintiff.

In addition, the reasonable patient test is also subject to the second leg of the test, being the subjective standard. It is therefore possible that a risk that is 'generally associated' with a treatment option under common law, or is of significance to the reasonable patient in the circumstances of the particular case, was not in fact material to the particular plaintiff in deciding whether to undergo the treatment. On the other hand, even if a risk is not 'generally associated' with a particular treatment option, or is not deemed to be significant to the reasonable patient in the circumstances of the case, the risk might well be significant or material to the particular plaintiff.

5.5 Conclusion

Consent in South African law is based on the principle of *volenti non fit iniuria*, which is essentially a subjective enquiry into the state of mind of the plaintiff and consequently the question is asked whether the particular patient did in fact consent. The writer is respectfully of the view that the proposed modified combined patient-centered test, which is ultimately a subjective test, fits in well with the consent enquiry. It introduces some potential limitations to the amount of information which must be disclosed to a patient, but it does so by focusing on the right to self-determination of the patient[733] and allows for broad principles to be applied to the specific circumstances of each case.

On the other hand, the writer is respectfully of the view that the professional practice standard fits in well with the negligence determination, which is a conduct-based enquiry focusing on the standard of practice expected by members of the medical profession when exercising duties in practice.[734] In this regard, the judgments reveal that courts are strongly influenced by what the medical profession regards as reasonable disclosure in practice.[735]

The National Health Act is in its infancy and it is unclear how the courts will interpret and apply the provisions relating to disclosure of risks and informed consent. It has been indicated that there is a difference between the disclosure principles which have been established by the courts when determining the boundaries of consent to what would otherwise be an assault, on the one hand, and the more specific disclosure rules which have been laid down through the application of the professional practice standard in negligence, on the other.

The application of the different standards in South African law has given birth to conflicting principles and if both standards are applied to interpret the provisions

[733] Carstens and Pearmain 2007 state that the court in *Castell* 'ousted medical paternalism in favour of patient autonomy'.
[734] Boberg 1989:269 states that 'Negligence is ... an attribute of conduct: when the actor's conduct falls short of the standard that the law demands of him, we describe that conduct as negligent...'
[735] A higher standard of care may be required of someone possessed with special knowledge or skills. The courts will consider expert evidence in this regard. Boberg 1989:280, 346.

of the National Health Act, then the problem of conflicting principles will continue. The writer is respectfully of the view that this can only lead to confusion in medical practice as to what must be disclosed, as well as to uncertainty in litigation. It does, however, appear that the clear reference in Section 7 of the Act to 'Informed consent' and 'consent', indicate that the principles of the justification ground of consent or *volenti non fit iniuria* apply, rather than the principles relating to fault in the form of negligence.

A further question is whether a doctor can be held liable for assault at all if he/she fails to disclose the consequences of treatment. In *Broude* the Supreme Court of Appeal expressed reservations about using assault as a cause of action.[736] Further, in the later case of *Louwrens,* the Supreme Court of Appeal considered that the patient has given informed consent if he/she has been informed of and consented to the general nature of the treatment, and the court dealt with the issue of non-disclosure of consequences under the breach of duty of care in negligence and under the professional practice standard. On the other hand, *Louwrens* was decided without reference to the requirements of the National Health Act, because the case originally went to trial in 2004, before the Act took effect in 2005. The Act expressly includes the consequences of treatment as part of the informed consent determination. However, the courts still have to interpret and apply the provisions of this Act.

[736] This aspect of the judgment is discussed in Chapter Six.

CHAPTER SIX

THE EXCLUSION OF ASSAULT AS A CAUSE OF ACTION

6.1 The development of the doctrine of informed consent

Initially the law in South Africa as well as in foreign jurisdictions such as the United States, Canada, the United Kingdom and Australia, concerned itself with the failure to obtain any consent to medical treatment and actions were brought as assault.[737] For example, in *Schloendorff v Society of New York Hospital,*[738] after the patient had consented to an abdominal examination under anaesthesia, but had specifically requested that no surgery be carried out, the doctor performed an operation. Cardozo J stated that:

> Every human being of adult years and sound mind has a right to determine what shall be done with his own body and a surgeon who performs an operation without his patient's consent commits an assault for which he is liable in damages.[739]

The doctrine of consent was then extended to include the doctrine of informed consent. From at least the early 1950's, the South African courts began treating the failure to disclose the risks of treatment also as vitiating formal consent.[740] The first reported South African case is the 1957 case of *Esterhuizen v Administrator, Transvaal.*[741] The court found that the patient had, *inter alia*, not consented to the risks of the proposed treatment and held the defendant liable

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[737] Or battery. For example, in English law, a trespass to the person can be both a tort, known as battery, or a crime, known as assault. Jackson 2006:274. Pattinson 2006:108. Likewise, in Australian law, treatment for which no consent is obtained is known as battery in tort and criminal battery or assault in criminal law. Devereux 2007:694.
[738] *Schloendorff v Society of New York Hospital* 211 N.Y. 125, 105 N.E. 92 (1914).
[739] *Schloendorff v Society of New York Hospital*:129-130.
[740] *Rompel v Botha* TPD 15 April 1953, unreported.
[741] *Esterhuizen v Administrator, Transvaal* 1957 3 SA 710 T.

for assault on the basis that there was no consent to the treatment.[742]

In the late 1950's the American and Canadian courts also began treating the failure to disclose the risks of treatment as relevant to the consent enquiry in a claim based on assault.[743] However, almost immediately, from the 1960's, jurisdictions in the United States started allocating claims based on the failure to disclose risks of treatment to the law of negligence,[744] and limiting claims for assault to the failure to disclose the general nature of the treatment. Canada followed the trend in the United States in 1980.[745] In 1957 the United Kingdom recognized that the failure to warn of risks of treatment falls to be determined under the law of negligence.[746] Australia followed the trend in America, Canada and the United Kingdom in 1983.[747]

Presently, in most jurisdictions, with the exception of a few such as South Africa, a distinction is drawn between medical information claims sounding in assault on the one hand and in duty of care in negligence on the other, depending on the type of information in question.[748]

6.2 The rejection of the doctrine of informed consent

English courts have accepted that there is a valid consent to treatment even though there has been no disclosure of the risks of medical treatment. In *Sidaway v Bethlehem Royal Hospital Governers,*[749] the court *per* Donaldson MR held that:

> I am wholly satisfied that as a matter of English law a consent is not vitiated by a failure on the part of the doctor to give the patient sufficient

[742] *Esterhuizen v Administrator Transvaal*:719C-E, 721A.
[743] *Salgo v Leland Standford Jr University Board of Trustees* 154 Cal App 2d 560, 317 P 2d 170 (1957).
[744] *Natanson v Kline* 354 P 2d 670 (1960).
[745] *Reibl v Hughes* (1980) 114 DLR (3d) 1, (Can SC) 2 SCR 880.
[746] *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118:122B-C.
[747] *F v R* (1983) 33 SASR 189 SC (SA).
[748] Giesen 1988:262-263.
[749] *Sidaway v Bethlehem Royal Hospital Governers* [1984] 1 All ER 1018 (CA):1026F-G.

information before the consent is given. It is only if the consent is obtained by fraud or by misrepresentation as to the *nature* of what is to be done then it can be said that an apparent consent is not a true consent. This is the position in criminal law (see *R v Clarence* (1988) 22 QBD 23 at 43, [1886-90 All ER Rep 133 at 44) and the cause of action based on trespass to the person is closely analogous.

In *Chatterton v Gerson,*[750] Bristow J held:

> In my judgment once a patient is informed in broad terms of the nature of the procedure which is intended, and gives her consent, that consent is real, and the cause of action on which to base a claim for failure to go into *risks and implications* is negligence, not trespass.[751]

In other words, the consequences of treatment are excluded from the consent determination and are instead dealt with under the law of negligence, which is traditionally defined in terms of a doctor's responsibility, or duty of care, not to injure another person, rather than in terms of the patient's right not to be injured. Therefore, the issue of consent is regarded as irrelevant.[752]

For these reasons, English law does not recognize the doctrine of informed consent. In *Sidaway,*[753] Lord Browne-Wilkinson LJ held:

> The position therefore in English law is this. The plaintiff in fact consented to the operation actually performed. This consent provides a complete answer to any claim in trespass since, whether or not she was fully informed of the risks attendant on the operation, the doctrine of informed consent is not part of the law of England.

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[750] *Chatterton v Gerson* [1981] 1 QB 432:443 A-B. My emphasis.
[751] However, in *Chatterton:*443A, Bristow J held further that 'of course if information is withheld in bad faith, the consent will be vitiated by fraud.'
[752] Feng 1987:150.
[753] *Sidaway v Bethlehem Royal Hospital Governers and others* [1984]:1032H-J.

In *Rogers,*[754] the Australian High Court also categorically rejected the term 'informed consent':

> The phrase "informed consent" is apt to mislead as it suggests a test of the validity of the patient's consent. Moreover, consent is relevant to actions framed in trespass, not in negligence.

Canada and most jurisdictions in America[755] also distinguish between assault and negligence claims with reference to the essential nature of the treatment and its risks. However, contrary to the position in England and Australia, they continue to use the term 'informed consent' when claims are dealt with in negligence, even though it has also generally been accepted in these jurisdictions that the test for negligence has nothing to do with consent.

In the Canadian case of *Reibl v Hughes,*[756] the patient suffered a massive stroke whilst undergoing surgery. He was not informed of the ten percent risk of stroke inherent in the surgical procedure. The Supreme Court of Appeal acknowledged 'the temptation to say that the genuineness of consent to treatment depends on proper disclosure of the risks which it entails.'[757] However, the court was reluctant to accept this notion of consent:

> I do not understand how it can be said that the consent was vitiated by the failure of disclosure so as to make the surgery or other treatment an unprivileged, unconsented to and intentional invasion of the patient's bodily integrity.[758]

However, whilst the English House of Lords expressly rejected the term 'informed consent', the court in *Reibl v Hughes*[759] merely felt that it would be 'better' to abandon it:

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[754] *Rogers v Whitaker*:633.
[755] Warren 2000:927.
[756] *Reibl v Hughes* (1980) 114 DLR (3d), 1 (Can SC) 2 SCR 880.
[757] *Reibl v Hughes*:891.
[758] *Reibl v Hughes*:891-892.
[759] *Reibl v Hughes*:889.

> The popularization of the term 'informed consent' for what is, in essence, a duty of disclosure of certain risks of surgery or therapy appears to have had some influence in the retention of battery as a ground of liability, even in cases where there was express consent to such treatment and the surgeon or therapist did not go beyond that to which consent was given. It would be better to abandon the term when it tends to confuse battery and negligence.

The court held that a failure to disclose the attendant risks, however serious, should go to informed consent in negligence rather than to consent in battery.[760] Once the patient has consented to the general nature of the treatment, the doctor's failure to inform of the risks of the treatment, however serious, does not invalidate the patient's consent to the treatment so as to give rise to battery.

In short, in England and Australia, the courts have rejected the term 'informed consent', holding that it has no relevance to the determination of the duty of care in negligence. On the other hand, in most jurisdictions of the United States and in Canada, the courts have retained this term when determining whether there has been a breach of the duty of care to disclose.

However, in all of the above jurisdictions, a bright line is drawn between the essential 'nature' of the treatment and other information. Where consent to the general 'nature' of the treatment is in issue, the cause of action is assault or battery, but where consent to the risks and implications of treatment is concerned, the cause of action is negligence, where the issue of consent is regarded as irrelevant.

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[760] *Reibl v Hughes*:891-892.

6.3 The blurred line between the nature and the consequences of medical treatment

Some of the difficulties in attempting to divide the essential nature of the act of medical assault from its consequences have been discussed in chapter three. It was submitted that it is doubtful whether the reasoning which is applied to sexual assault in the context of rape, can be transplanted, without further ado, to medical assault and, in so doing, separate consent to the medical procedure from the consequences of the procedure. It was submitted in chapter three, that where sexual assault in the form of the crime of rape is concerned, it is possible to draw a line between consent to the act and consent to the consequences of the act. This is so, because the application of force in the crime of rape is specifically restricted to penetration without consent. However, it was submitted that the same reasoning cannot be applied to assault, *inter alia*, because assault is a consequence crime or delict. Viewed in this way, there is no clear line between the general 'nature' of the act and the consequences of the act.

The practical difficulty of distinguishing between the nature of the treatment and its consequences has been vigorously debated. In the Canadian case of *Kelly v Hazlett,*[761] the court distinguished between the 'nature of the act' as opposed to other 'collateral matters' but acknowledged the difficulty in doing so:

> In some cases it may be difficult to distinguish and separate out the matter of consequential or collateral risks from the basic nature and character of the operation or the procedure to be performed.

In the criminal matter of *Burrell v Harmer,*[762] the defendant tattooed the arms of two boys of 12 and 13 years of age, causing them pain and inflammation, which lead to their claim. The court convicted the defendant of causing bodily harm, holding that the boys did not give their real consent as they were unable to understand the nature of the act. However, the question is whether the boys did

[761] *Kelly v Hazlett* (1976) 15 OR (2d) 290:559.
[762] *Burrell v Harmer* [1967] Crim LR 169 208 C.

not understand the nature of the act with regard to tattooing or tattooing with the pain and inflammation[763] or tattooing with the degree of pain and inflammation, which they suffered. Pain and inflammation are inevitable temporary consequences of tattooing, but the degree and permanence to which they may manifest, is arguably a question of risk.

This case illustrates the often artificial distinction between the nature of the treatment and its consequences in the form of inevitable, probable and possible consequences and the difficulty in drawing a clear line between the essential nature of the act and its associated information. There are a number of questions which arise:

1. Do inevitable consequences form part of the nature of the act?
2. Do risks form part of the nature of the act?
3. If risks are included, is it all risks of treatment or only some risks?
4. If some risks are included then how is the line to be drawn between those risks that do form part of the nature of the treatment and those which do not?

Somerville[764] submits that inevitable consequences of treatment are part of the essential nature of the act. She states that it is not only the touching that must be consented to, but also the touching 'in that manner'.[765] However, if it is accepted that inevitable consequences form part of the nature of the act, the next question is whether risks which are almost certain to manifest, such as a risk that has a 99% chance of occurring, also form part of the nature of the act? Further, if such a risk is regarded as part of the nature of the act, then the question is where is the line to be drawn? Are risks that have a greater than 90% chance of occurring or a greater than 80% chance of occurring also regarded as part of the

[763] *Burrell v Harmer* [1967] Crim LR 169 208 C.
[764] Somerville 1981:740-808.
[765] Somerville 1981:750.

essential nature of the treatment? What about risks that have a greater than 50% chance of occurring?

In addition, the question is whether it is it every risk, even a very minor risk, which has a high probability of occurring that forms part of the essential nature of the act. For example, the 90% risk of slight sneezing for an hour after taking a particular medication? On the other hand, if a risk has a low probability of occurring but will cause very serious harm if it manifests, should it be regarded as forming part of the basic nature and character of the act?

Somerville argues that some risks are so serious that most people would regard them as an essential part of the description of the basic nature and character of the procedure.[766] If so, then the risk does form part of the basic nature of the act. On the other hand, the court in *Kelly v Hazlett*,[767] did not adopt the 'most people' approach. The court opined that 'the more probable the risk the more it could be said to be an integral feature of the nature and character of the operation.' However, the court also held that:

> Even if a risk is truly collateral, but still material, it could be said that its disclosure is so essential to an informed decision to undergo the operation that lack of such disclosure should vitiate the consent.[768]

In other words, the court is of the opinion that even if the risk is not probable and therefore not part of the essential nature of the act, it might still be material if it is essential for the patient to be able to validly consent to the procedure.

Feng[769] also states that when the risk is high it is definitely part of the knowledge needed by the reasonable patient to give full consent to the treatment, particularly in low benefit but high risk procedures. However, he argues that in final analysis it is not the degree of probability of the risk occurring which is

[766] Somerville 1981:747, 750-751.
[767] *Kelly v Hazlett*:559.
[768] *Kelly v Hazlett*:559.
[769] Feng 1987:156.

decisive, rather the question is whether the patient is able to give consent with the knowledge that he/she has.

On this approach, the central question is whether the patient has been given sufficient information about the particular procedure to be able to decide whether to accept or refuse the treatment. However, the question which inevitably follows is, how is it to be determined whether the patient has received sufficient information to be able to validly consent to treatment?

Feng[770] adopts the 'reasonable person' yardstick. If a reasonable patient would be denied sufficient knowledge to give due consideration to the matter at hand to exercise his/her free will and make a considered decision as to whether to accept or refuse the treatment, then consent will be vitiated. On the other hand, Lord Diplock,[771] in *Sidaway*, made it clear that he did not agree with the reasonable person standard when determining what information is necessary for the patient to consent to treatment. He pointed out that it is the individual or the subjective patient centered standard, which determines the knowledge required for consent:

> Consent to battery is a state of mind personal to the victim of the battery and any information required to make his consent qualify as informed must be relevant information...actually possessed by him...There is no room in the concept of informed consent for the 'objective' patient...On what logical or juristic basis can the need for informed consent be confined to some risks and not extended to others that are also real – and who decides which risk falls into which class?

The above discussion illustrates that it is not as easy as is sometimes supposed to divide information pertaining to medical treatment into watertight groups. In debating the issue, the focus inevitably shifts from the nature of the information to the question of *who* is to decide which information is necessary for a person to

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[770] Feng 1987:161.
[771] *Sidaway v Bethlem Royal Hospital Governors and Others* [1985]:894.

make an informed and considered decision– is it the doctor, the fictitious reasonable person or the person themselves?

However, in spite of the confusion that attempts to separate the 'nature' of medical treatment from its 'consequences' have created, most jurisdictions maintain the distinction and allocate claims to different causes of action, based on the type of information in question. The general nature of the treatment is allocated to assault and the consequences of medical treatment are dealt with as a breach of duty of care in negligence, where the courts apply one of a number of standards of disclosure, in order to determine whether the undisclosed information was material and should have been disclosed.

6.4 The standard of disclosure in negligence

'Standard' can be defined as

> an accepted or approved example of something against which others are judged and measured;
> a level of excellence or quality;
> of recognized authority, competence or excellence.[772]

A standard therefore not only represents an ideal to which society strives but it is also of practical and tested value or use to the community.

A number of jurisdictions use the professional practice standard, with its reference to accepted medical practice, to determine whether a doctor was negligent in not disclosing the risks of medical treatment to a patient. This standard is effective in twenty five States in America.[773] Traditionally it was also

[772] Hanks *et al.* 1979:1417.
[773] King and Moulton 2006:430.

the applicable standard in England.[774] In some jurisdictions, it is accepted by the courts as conclusive, but in others it is subject to the ultimate discretion of the court to determine whether it falls short of the standard required by law.[775]

However, the reasonable patient standard is also used in many jurisdictions to determine the question of negligence. Under the reasonable patient standard, disclosure is limited to the requirements of the average reasonable patient in the circumstances. This standard is effective in twenty three American States and the District of Columbia.[776] Canada has also adopted this standard.[777]

In a few jurisdictions, the subjective patient standard is used to determine whether the failure to disclose risks of medical treatment was negligent. Under the subjective patient standard, the scope of disclosure is tailored to the requirements of each individual patient, in his or her particular situation. Only two American States maintain this standard.[778]

Finally, the combined patient-centered test is also sometimes used. This standard is a combination of the reasonable patient and the individual patient test. The reasonable patient test is followed by the requirements of the particular patient in the circumstances. Australia has embraced a modified form of this test.[779]

Giessen[780] states that at the heart of the debate regarding the applicable standard are two basic and competing values - on the one hand is the best

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[774] However, the majority of the court in the House of Lords in *Chester v Afshar* [2005] 4 All ER 587(HL):593h-594b, accepted the majority decision in *Pearce v United Bristol Healthcare NHS Trust* [1999] PIQR 53:59, in which Lord Woolf held that 'In a case where it is being alleged that a plaintiff has been deprived of the opportunity to make a proper decision as to what course he or she should take in relation to treatment, it seems to me to be the law...that if there is a significant risk which would affect the judgment of a reasonable patient, then in the normal course it is the responsibility of a doctor to inform the patient of that significant risk, if the information is needed so that the patient can determine for him or herself as to what course he or she should adopt.' Therefore, it appears that the reasonable patient standard of disclosure has been accepted into English law and has effectively displaced the traditional reasonable doctor test in *Sidaway* and *Bolam*. Meyers 2006:270.

[775] This is the theoretical position in South Africa. *Richter and Another v Estate Hammann* 1976 (3) SA 226 (C).

[776] King and Moulton 2006:430.

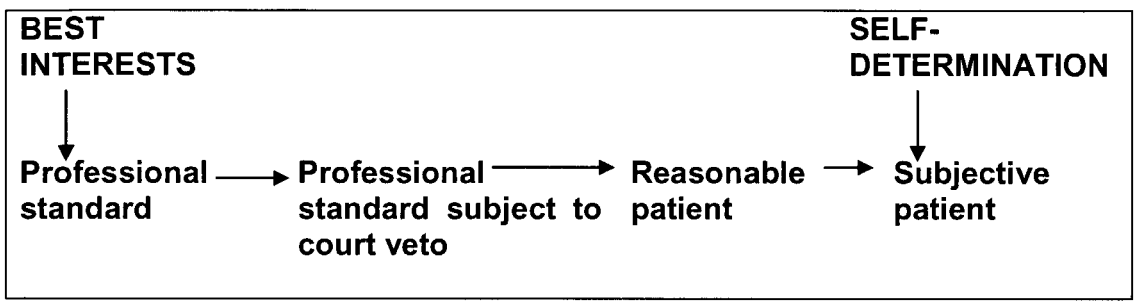
[777] In *Reibl v Hughes* (1980) 114 DLR (3d), 1 (Can SC) 2 SCR 880.

[778] King and Moulton 2006:445.

[779] *Rogers v Whitaker* (1992) 109 ALR 625:634.

[780] Giesen 1988:272-3.

interests or welfare of the patient and on the other is the patient's own will to determine what shall be done with their body. The outcome depends on which value is emphasised. Giessen[781] points out that courts use the professional standard where the patient's best interests are accepted as the only or decisive criterion. On the other hand, courts use the subjective patient standard when self-determination of the patient is decisive. Between these two extremes are the professional standard subject to court veto and the reasonable patient standard. The relationship between the different values and standards can be represented on the following continuum:



According to Giessen,[782] the more weight is attached to professional determination of the patient's welfare, the more paternalistic and elitist the standard of disclosure becomes, even to the exclusion of any right to self-determination. On the other hand, the more the particular patient's own will is emphasised, the more patient-centered the approach becomes, sometimes to the exclusion of objectively beneficial medical care.

There are at least two moral rationales underlying policies of disclosure to a patient regarding their diagnosis, options and prognosis:

a. The consequentialist approach is orientated towards patients' best interests and depends on a calculation of risk and benefit. For example, a policy of generally disclosing risks to patients can be defended by doctors

[781] Giesen 1988:271-273.
[782] Giesen 1988:272-273; Earle 1995:642 states that 'when it comes to informing patients of inherent risks, the professional standard falls short of the ethical premise of autonomy'.

on the basis that there is scant evidence that it harms patients and because patients can contribute more to their care. In other words, on balance, the benefits of disclosure outweigh the risks. This perspective is paternalistic because disclosure is based on an analysis of patients' needs, not because of what patients want or are entitled to. Disclosure is, at best, contingent.[783]

b. The deontological perspective is orientated towards patients' rights and depends on what patients want and prefer. Doctors respond to what patients want because they acknowledge that patients have a right to information. Disclosure does not depend mainly on a risk-benefit calculation.[784]

Therefore, in determining the question of whether there was negligent non-disclosure of risks of medical treatment, a central question is whether the patients' interests (as perceived by the doctor) define the content of doctors' duties, or whether the patients' preferences determine the content of the doctors' acts.[785]

However, the writer is respectfully of the view that even if the test for negligence is infused with a more rights-based standard in the form of a patient-centered test, nevertheless the doctrine of therapeutic privilege remains an inherent part of the negligence standard.[786] Therapeutic privilege is based on a medical assessment of the best interests of the patient and the result is an inherent conflict between the doctrine of therapeutic privilege in the negligence determination on the one hand and the patient standards on the other.[787]

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[783] Childress 1982:145.
[784] Childress 1982:145.
[785] Childress 1982:33.
[786] See the discussion in Chapter Five, Section 5.4.
[787] Mulheron 2003:208-209, questions the applicability of the thereapeutic privilege defence to the disclosure of risks of medical treatment under a subjective patient-centered standard. One of his arguments is that the very fact that a patient is unusually anxious and nervous would require disclosure of the risk under the subjective patient-centered test because the risk would probably be significant to such a patient. There is therefore an inherent conflict between the defence of therapeutic privilege and the subjective patient test.

Further, the test for negligence is a conduct-based enquiry focusing on the standard of practice expected by members of the medical profession when exercising duties in practice.[788]

On the other hand, consent is a justification ground to the *prima facie* wrongfulness of the infringement of the right to bodily integrity. The question of whether or not the plaintiff consented to the touching is a subjective test which focuses on the state of mind of plaintiff.[789] Further, the doctrine of therapeutic privilege forms no part of the test for consent,[790] thereby allowing the subjective patient-centered standard to sit comfortably with the doctrine of *volenti non fit iniuria* or consent in South African law.

6.5 Reasons for restricting the cause of action to negligence

Most jurisdictions have abolished assault as a cause of action where the consequences of medical treatment are concerned for, *inter alia*, the following reasons:

6.5.1 Policy

a. Assault has a counterpart in criminal law, which could potentially leave a doctor open to criminal charges for the unconsented to touching.[791]
b. Assault allows for very few defences, unlike negligence.[792]

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[788] Boberg 1989:269 states that 'Negligence is ... an attribute of conduct: when the actor's conduct falls short of the standard that the law demands of him, we describe that conduct as negligent...'
[789] *Fourie v Naranjo* 2007 (4) All SA 1152 (C):1157a-b; *Rosseau v Viljoen* 1970 (3) SA 413 (C):418A-C. See the discussion in Chapter Three, Section 3.2.4.3.4.
[790] Coetzee 2004:477, argues that the therapeutic defence should be regarded as a separate and independent justification ground to the common law grounds of justification and that the requirements of the necessity defence should apply. See the discussion in Chapter Five, Section 5.4.
[791] King and Moulton 2006:445.
[792] King and Moulton 2006:445.

c. The negligence standard permits judges to defer to the wisdom of the medical profession, so that doctors are only liable for failing to disclose information that other doctors would have provided.[793]

d. Judges prefer to base the legal standard for doctor behaviour on actual medical practice rather than legal theory.[794]

e. Negligence law places a larger burden of proof on plaintiffs so as to deter frivolous claims that assault would have allowed.[795]

f. It is unduly prejudicial to a doctor that even if a risk does not eventuate and the treatment is successful, the doctor's conduct would nevertheless be characterized as assault.[796]

g. It is unduly prejudicial to a doctor to describe his actions as assault if his motive is to alleviate pain and discomfort of the patient and he has explained the procedure in general, yet has omitted to mention a material risk of the treatment.

6.5.2 Legal Theory

a. If there is consent to the essential nature of the act there is no liability for assault. For example, consent to sexual intercourse but not to the concomitant risk of venereal disease does not constitute rape. In the same way, if there is consent to the medical treatment, then failure to advise of risks should not render the doctor liable for assault.[797]

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[793] King and Moulton 2006:445.
[794] Katz 1977:165.
[795] King and Moulton 2006:445; Katz 1977:166.
[796] *Broude v McIntosh*:67-68.
[797] Dunn L J in *Sidaway v Bethlem Royal Hospital* 1984:1029c-e.

b. It is difficult to see how plaintiffs can maintain informed consent claims against their doctors for prescribing a drug, because there is no touching.[798]

6.6 Assault as a cause of action in South Africa

6.6.1 Criticisms by the Supreme Court of Appeal

In the South African case of *Broude v McIntosh*,[799] the Supreme Court of Appeal raised some of the policy arguments noted above. The court acknowledged that pleading a cause of action as assault 'is a familiar and time-honoured method of doing so', but doubted its conceptual soundness and suggested that the issue should be reconsidered by the Supreme Court 'when a suitable case arises.'

The court was of the opinion that if the motive of the doctor was to help the patient, then the touching of the patient should not be regarded as an assault, even if there was no consent to the treatment:

> ... it is a strange notion that the surgical intervention of a medical practitioner whose sole object is to alleviate the pain or discomfort of the patient, and who has explained to the patient what is intended to be done and obtained the patient's consent to it being done, should be perjoratively described and juristically characterized as an assault simply because the practitioner omitted to mention the existence of a risk considered to be material enough to have warranted disclosure and which, if disclosed, might have resulted in the patient withholding consent.[800]

However, the writer is respectfully of the view that there is a difference between intention and motive and that motive is irrelevant when determining whether the

[798] Merz 1993:231; Warren 2000:917.
[799] *Broude v McIntosh*:67H-I.
[800] *Broude v McIntosh*:67I-68A.

defendant possessed the relevant intention in assault.[801] In *Esterhuizen*,[802] the court pointed out that there is a difference between the concepts of intent and motive and the fact that the motive for an assault might be laudable does not negative the fact that the intention to assault or that the assault itself might nevertheless be wrongful. Further, Carstens and Pearmain observe that the views of Marais J are based on somewhat emotional grounds rather than the importance of the right to bodily and psychological integrity.[803]

Marais J approved of allowing assault as a cause of action if the doctor possessed a particular motive or mode of deception:

> I leave aside cases in which *male fides* is involved such as cases of deliberate fraud and deliberate misrepresentation of what is entailed in order to obtain consent which would otherwise not be forthcoming.[804]

In the same vein, in the English case of *Chatterton v Gerson,*[805] Bristow J held that the failure to disclose consequences of treatment should be determined in negligence, but 'if information is withheld in bad faith, the consent will be vitiated by fraud'. The court in *Reibl*[806] also held that 'unless there has been misrepresentation or fraud to secure consent to the treatment, a failure to disclose the attendant risks, however serious, should go to negligence rather than battery'.

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[801] Snyman 2006:190; Neethling *et al.* 2006:115; Burchell 2005:463-464.
[802] *Esterhuizen v Administrator, Transvaal*: 719:722 F-G.
[803] Carstens and Pearmain 2007:502.
[804] *Broude v McIntosh*:68D-68E. In *Sidaway v Bethlem Royal Hospital Governers and others* [1984] 1 All ER 1018 (CA):1026F-G, Lord Dunn stated that 'it is only if the consent is obtained by fraud or by misrepresentation as to the *nature* of what is to be done then it can be said that an apparent consent is not a true consent.' my emphasis. However, Pattinson 2006:105, refers to a number of cases where fraud as to the 'quality' rather than the nature of the act has invalidated the complainant's consent. For example, he refers to the criminal case of *Tabassum* [2000] 2 Cr App R 328, where a man was convicted of indecent assault, having carried out breast examinations in such a way as to mislead the women into believing that he had medical qualifications or training. The women testified that they would not have consented to the examination had they known that he was not medically qualified.
[805] *Chatterton v Gerson*:443A.
[806] *Reibl v Hughes*:891-892.

It appears that the court in *Broude* as well as the English and Canadian courts, tend to equate intention with a bad motive or deliberate deceit and trickery, where intention in medical assault is concerned. However, as Feng[807] points out:

> There is no magic in the character of the conduct concealing or distorting the medical advice for purposes of the defence of consent. The misconduct only gives occasion to the concealment. What is material is the content of medical advice that is concealed, not the mode of concealment.

Further, where the element of fault is in issue, Feng[808] emphasizes that the concealment of the risk in question need not arise out of fraud or trickery, but could well be as a result of indifference, particularly common in medical practice.

In South African law, consent is a justification ground negating the wrongfulness of an assault, and is considered separately to the element of intention, both in criminal law and in law of delict.[809] Further, fault in the form of intention is required for liability for criminal assault and it may take the form of *dolus directus*, *dolus indirectus* and *dolus eventualis*. In this regard, motive in the form of bad faith, is irrelevant. However, where delictual assault is concerned, as long as the defendant directed his/her will to touching the patient, the requirement of intention is satisfied, unless the defendant can show that he/she made a reasonable mistake of a particular type of fact.

The court in *Broude*[810] was also of the opinion that the assault cause of action is unsound when applied to non-disclosure of risks of treatment:

> It seems to me to be inherent in the notion that, even if the risk does not eventuate and the surgical intervention is successful, the practitioner's conduct would nonetheless have constituted an assault. That strikes me

[807] Feng 1987:156.
[808] Feng 1987:156.
[809] In South African law, fraud is a separate common law crime, which consists in unlawfully making, with intent to defraud, a misrepresentation, which causes actual prejudice or which is potentially prejudicial to another. Burchell 2005: 833. There is also the delict of misrepresentation and, as in the crime of fraud, the question of whether there was a misrepresentation involves the *act* as delictual element. Neethling *et al.* 2006:275. On the other hand, the act in assault is the application of force to the body of another.
[810] *Broude v McIntosh*:68A-68D.

> as a bizarre result which suggests that there is something about the approach which is unsound. There is no principle of law of which I am aware by which the characterization as lawful or unlawful of an intentional act objectively involving the doing of bodily harm to another can be postponed until its consequences are known. Either it was an assault at the time of its commission or it was not. Events occurring *ex post facto* can logically have no bearing on the question. It is no answer to say that if the undisclosed risk does not eventuate no damage will have been caused. That has nothing to do with the characterization of the medical practitioner's act in intervening surgically as lawful or unlawful.

However, the writer is respectfully of the view that no person, including a doctor, has the right to infringe another person's right to bodily and psychological integrity without obtaining that patient's consent or relying on another justification ground. If the doctor does so, subject to the *de minimus non curat lex* rule, it is indeed correct that the patient may lay a criminal charge of assault or bring a civil claim of assault for compensation in the form of satisfaction, even if the patient suffered no physical harm as a result of the assault.

In *Oldwage v Louwrens*,[811] which was decided after the present case, the court referred to the above criticisms of Marais J and concluded:

> In my view these remarks are no more than an *obiter dictum* so that, bound as I am by the *ratio* of the Full Bench of this division in *Castell v De Greef* (*supra*) I therefore find that the defendant's conduct, to the extent that whatever consent which may have been given was not properly informed, constitutes assault.

Unfortunately, the Supreme Court of Appeal in the later case of *Louwrens v Oldwage*,[812] did not follow the request of Marais J to take the

[811] *Oldwage v Louwrens*:558:b-d.
[812] *Louwrens v Oldwage* [2006] 1 All SA 197 (SCA).

opportunity to discuss the merits of pleading a case as assault. The writer is therefore respectfully of the opinion that the *obiter* comments in *Broude*[813] still need to be addressed by the Supreme Court when another opportunity arises.

6.6.2 Academic opinion

6.6.2.1 Assault or 'infringement of bodily integrity'

Neethling *et al*[814] prefer to use the term 'infringement of bodily integrity' in delict instead of assault. The authors are of the opinion that the criminal law definition of assault should not be used in delict, because it ignores the fact that there are common law *iniuriae* against the body where there is no physical violence.[815]

However, as stated above, the requirement of 'application of force' in South African law of criminal and delictual assault is not limited to the direct, external application of force, may not involve physical violence and is not limited to the external body of the plaintiff. Rather, the application of force may occur directly or indirectly, by commission or by omission, externally or internally and, subject to the *de minimis* rule,[816] even the slightest contact with another person's body is sufficient.[817] As Snyman points out, it is the infringement of bodily integrity which is the focus of the enquiry in assault, rather than the manner in which it occurs.[818]

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[813] *Broude v McIntosh*:67H-I.
[814] See, Neethling *et al.* 2005:84, 88, where the authors discuss the delictual case of *Stoffberg v Eliott* 1922 CPD 148:151-152; Although the judgment refers to 'assault' as the cause of action, the authors use the term 'infringement of *corpus*' instead when discussing the judgment.
[815] McKerron 1971:154 also states that a claim based on bodily injury covers those cases where there has been no infliction of bodily harm.
[816] The *de minimis non curat lex* rule, which provides that the infringement must not be of a trivial nature. *Bester* 1971 (4) SA 28 (T). The law will not punish trifles. The *de minimis non curat lex* rule is, strictly speaking, not a defence which excludes the unlawfulness of the accused's conduct, but rather a decision of the court to allow the unlawful conduct to go unpunished on account of its triviality. Burchell 2005:355
[817] Burchell 2005:685; Snyman 2006:434. Amerasinghe 1967:62.
[818] Snyman 2004:448-463.

In addition, Neethling *et al*[819] object to the use of the term 'assault' on grounds that certain physical infringements, which found the *actio iniuriarum* do not necessarily amount to criminal offences. The authors do not give any specific examples of assault in delict which do not amount to assault in criminal law. However, the writer is respectfully of the view that both criminal and delictual assault are specific types of *iniuria* and the elements of assault remain the same whether the claim is brought in criminal law or delict, it is merely their scope and application which may vary.[820]

Finally, McKerron[821] points out that a claim based on infringement of bodily integrity also covers the negligent infliction of bodily harm under the *actio legis Aquiliae,* whereas fault in the form of intention is required for a claim under the *actio iniuriarum.*[822] However, the writer is respectfully of the view that the unlawful infringement of bodily integrity is an assault, which also requires intention in the form of *animus iniuriandi.* In so doing, the right to bodily integrity, which is not only regarded as an absolute common law right, but is also a fundamental constitutional right[823] and one of the foundational constitutional values,[824] is protected. On the other hand, the violation of bodily integrity has no special significance for actions under the *lex Aquilia*, or for pain and suffering.[825] The action for pain and suffering lies because of actual physical injury to the body and the Aquilian action lies because of infringement of a patrimonial interest.[826] Therefore, the writer is respectfully of the view that a claim brought under the Aquilian action or the action for pain and suffering, should not be referred to as 'infringement of bodily integrity', but should rather be called 'the causing of patrimonial loss' or 'the causing of bodily injury'. Intention or

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[819] Neethling *et al.* 2005:88.
[820] For a discussion of the elements of criminal and delictual assault see Chapter Three.
[821] McKerron 1971:154.
[822] However, Anerasinghe is of the view that the infringement of bodily integrity in delict is an assault, which can be committed negligently Amerashinghe 1967:205-206
[823] Section 12 of the Constitution of the Republic of South Africa, 1996.
[824] *Ex parte Minister of Safety and Security: In re S v Walters* 2002 (4) SA 613 (CC):631.
[825] Amerasinghe 1967:62.
[826] *Matthews & Others v Young* 1922 AD 492:504. For example, a dependant's claim for loss of maintenance following the death of a breadwinner.

negligence is sufficient for the Aquilian action as well as for the action for pain and suffering.[827]

The writer is therefore respectfully of the view that the term 'assault' is appropriate, both in criminal law and law of delict. It reflects the seriousness of an infringement of the fundamental common-law and Constitutional right to bodily integrity.[828]

6.6.2.2 Assault or negligence?

Van Oosten[829] is of the view that although assault and not negligence is the appropriate form of action where the medical intervention was performed without informed consent but proved to be beneficial to the patient's health, nevertheless where the medical intervention was performed with due care and skill but the undisclosed risks of danger materialized, the negligence action is appropriate.

However, Milner[830] is of the view that if the non-disclosure of risks nullifies the patient's consent, it would also rank as negligence and it is at this point that the twin questions of negligence on the doctor's part and lack of consent on the patient's part merge into a single issue. He emphasizes however, that the enquiry into the patient's consent should not take place by way of the surgeon's duty as this would be 'devious in the extreme and very likely to distort the issue through false emphasis'.

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[827] Van der Walt and Midgley 2005:9; Thomas 1976:365. The intentional causing of bodily harm is also sufficient for the action for pain and suffering in South African law. Neethling *et al.* 2001:5.

[828] The right to bodily integrity is regarded as an absolute right in South African common law (*Stoffberg v Elliott*:149-150) and, in addition, the right is also entrenched in Section 12(1)(c) of the South African Constitution.
Ex parte Minister of Safety and Security: In re S v Walters 2002 (4) SA 613 (CC):631 the Constitutional Court, per Kriegler J emphasized that '...The right to life, to human dignity and to bodily integrity are individually essential and collectively foundational to the value system prescribed by the Constitution. Compromise them and the society to which we aspire becomes illusory'.

[829] Van Oosten 1989:451-452; Van Oosten 1989:51 states that the administration of treatment to a patient without obtaining their consent is tantamount to a civil or criminal assault. Furthermore, non-disclosure of the nature and consequences of treatment may also constitute an assault.

[830] Milner 1957:389.

On the other hand, Burchell[831] rejects a cause of action based on negligence:

> It involves a distortion of the law relating to the defence of consent to say that a person has consented to an operation where all he knows is the broad nature of the operation and is oblivious to the material or likely risks attendant upon such an operation...It is not a sufficient answer to the problem to say that the correct course of action for a patient who is not told of the risks involved in an operation is to sue the doctor for negligence.

Strauss[832] is also of the view that the breach of duty of care should not be used as a cause of action:

> Traditionally our courts have dealt with non-compliance of doctors with the duty to obtain an informed consent on the basis of assault...where there has been no consent to a medical procedure – or what is legally the same, where the consent in fact given was so 'uninformed' as to the nature of the procedure or the consequences thereof that may well manifest themselves, that it cannot be said that there was a 'real' consent – the patient will have an action based upon assault...It is submitted that to consider failure to inform as negligence would not be in accordance with the Roman-Dutch concept of *culpa* which until now has been defined as the failure to foresee the damaging consequences and to take reasonable measures to avoid it. The essence of negligence in the medical context is unskillful treatment.

Boberg[833] is of the view that where the patient is not adequately informed of the risks attendant upon a medical procedure, the consent of the patient is invalid and the liability of the doctor is not based on negligence.

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[831] Burchell 1986:298-299.
[832] Strauss 1991:268.
[833] Boberg 1984:751.

Carstens and Pearmain[834] are of the view that 'the lack of informed consent amounts to an assault (in context of wrongfulness/unlawfulness) and not negligence (in context of the element of fault)'. They point out that in assault, if a patient has validly consented to the application of force, there is no need to ask whether, in spite of the consent, there was still a duty on the doctor to disclose, because consent is the primary legitimizing factor in our law.

Carstens and Pearmain[835] point out that rejecting assault as a cause of action has negative implications for the doctrine of informed consent:

> To the extent that the *obiter dictum* of Marais J in *Broude v McIntosh* 1998 (3) SA 60 (SCA), that it is not appropriate for a doctor to be accused of assault, with all its perjorative connotations, for mere lack of patient consent can be interpreted as meaning that South African law should convert to the idea that medical interventions are *prima facie* lawful, the writers submit that this is not supported by constitutional principles. Given the history of the South African people and the past disregard for the rights of human dignity, bodily and psychological integrity and freedom and security of the person it is submitted that to diminish the value of consent in this context would be wholly inappropriate and could potentially undermine the realization of fundamental rights in the Bill of Rights for South Africans. The current system of dealing with medical interventions on an exception or justification basis and on the circumstances of each individual case is far preferable.

Carstens and Pearmain[836] therefore reject the approach adopted in the majority of South African cases, which begins from the premise that the conduct is in the form of an omission to disclose information and is therefore *prima facie* lawful:

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[834] Carstens and Pearmain 2007:499, 687.
[835] Carstens and Pearmain 2007:501. The authors state that the view that a doctor who fails to adequately inform a patient will be liable for assault is compatible with the general principles of South African law Carstens and Pearmain 2007:679.
[836] Carstens and Pearmain 2007:501.

> To exclude medical interventions from the definition of assault and render them *prima facie* lawful demonstrates the value of the current approach in South African law that they are *prima facie* unlawful violations of well-established and long recognized rights. If one starts from the premise that they are lawful it starts to become extremely difficult to define just what it is that is lawful and where lawfulness begins and ends. In South African law this problem does not arise because the intervention is *prima facie* unlawful.

Furthermore, Carstens and Pearmain[837] argue that if the approach is adopted that medical interventions are *prima facie* lawful then 'the importance of consent becomes greatly diminished since the consent of the individual is presently the primary legitimizing factor in South African law.'[838] They conclude that:

> The maxim *volenti non fit iniuria* provides a key element of this system of legal principle in that it both recognizes and supports the fundamental importance of such 'absolute' human rights as the rights to life, to human dignity, to freedom and security of the person and to bodily and psychological integrity. It also places squarely in the hands of the individual the right to self- determination. The pivotal importance of the principle of consent in the South African system can therefore not be overstated and should be bolstered rather than undermined.

However, in taking the view that all medical interventions are *prima facie* wrongful, it appears that Carstens and Pearmain have in mind conduct in the form of a commission rather than an omission. When the claim is based on a commission, it is usually easy for the plaintiff to prove that the conduct caused the infringement of bodily integrity and the conduct is regarded as *prima facie* wrongful,[839] but where the claim is based on an omission to disclose information,

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[837] Carstens and Pearmain 2007:501.
[838] Carstens and Pearmain 2007:501.
[839] For example, where a surgeon operates on a patient.

the conduct is regarded as *prima facie* lawful.[840] The writer is respectfully of the view that where an omission to disclose information is in issue, one way of approaching the matter may be to say that in terms of the prior conduct rule (*omissio* per *commissionem* rule)[841] a plaintiff will only establish *prima facie* wrongfulness if he/she leads sufficient evidence that the doctor created a new source of danger by, for example, suggesting an operation with dangers attached (*commissio*) and subsequently failed to eliminate the danger by failing to inform the patient of the risk in question (*omissio*), with the result that harm was caused to the patient. Where a cause of action is based on assault, the harm is the infringement of bodily integrity.[842] However, in order for the plaintiff to show that he/she suffered harm as a result of the omission to disclose, the plaintiff will have to lead evidence that the undisclosed information was significant to him/her.[843]

6.6.3 Patrimonial damages and damages for pain and suffering

In South African law assault is an *iniuria*. Therefore the question arises as to whether compensation is limited to satisfaction, or whether other damages can be claimed once the cause of action for assault has been established. The question is whether the plaintiff will have to institute a separate claim based on the *actio legis Aquiliae* and action for pain and suffering and, in addition, meet all the requirements for these actions separately to the *actio iniuriarum*, if he/she wishes to claim patrimonial damages and pain and suffering, in addition to satisfaction.[844]

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[840] Boberg 1989:32.; *A* 1991 (2) SAV 257 (N); *Minister van Polisie v Ewels* 1965 (3) SA 590 (A); *Minister of Law and Order v Kadir* 1995 (1) SA 303 (A); *Knop v Johannesburg City Council* 1995 (2) SA 1 (A). For example, the writer is respectfully of the view that in terms of the prior conduct rule (*omissio* per *commissionem* rule) a plaintiff will only establish *prima facie* wrongfulness if he/she leads sufficient evidence that the doctor created a new source of danger by, for example, suggesting an operation with dangers attached (*commissio*) and subsequently failed to eliminate the danger by informing the patient of the risk in question (*omissio*), with the result that harm is caused to the patient. However, in order to show that the plaintiff suffered harm, he/she will have to lead evidence that the risk was material. For the prior conduct rule, see Neethling *et al.* 2001:58-59, 65-66.

[841] For the prior conduct rule, see Neethling *et al.* 2001:58-59.

[842] Snyman 2004:452, 462-463; Strydom 1962:216.

[843] See also the discussion on this issue in Chapter 4, Section 4.7.

[844] In *Minister of Finance and Others v EBN* 1998 (2) SA 319 (N):326F-G, the plaintiff sued the Minister of Finance for damages for the alleged wrongful detention of its goods. The court held that the plaintiff's claim was based upon the *actio iniuriarum* as it arose out of the wrongful seizure and detention of the plaintiff's goods. However, the court held that in an

Amler's Precedents of Pleadings[845] confirm that 'the case law is not clear or consistent' in this regard. Some case law expressly requires that pain and suffering and patrimonial loss flowing from an assault is claimed under the Aquilian action,[846] whereas other case law awards pain and suffering and satisfaction flowing from an assault without requiring that a separate cause of action be established.[847] In *Stoffberg*,[848] the court held that a claim for patrimonial damages and pain and suffering arises from the Aquilian action, but in *Esterhuizen*,[849] the court awarded patrimonial damages and pain and suffering once the cause of action based on assault was established, without referring to the Aquilian action or action for pain and suffering. Further, in *Layton*,[850] the court awarded special damages flowing from the assault, without mentioning the Aquilian action or requiring that the treatment was not life or limb-saving.

Neethling *et al.*[851] point out that there is authority in South African law that the *actio iniuriarum* can be used to claim both satisfaction and patrimonial damages. However, they prefer the view that when an *iniuria* causes patrimonial damage, the prejudiced person should institute a claim based on the *actio iniuriarum* and another based on the *actio legis Aquiliae*. Further, the authors are of the view that although the two actions are kept separate in theory, in practice damages

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action based on *iniuria* in which the plaintiff claims special damages, the requisites for a claim under the *actio legis Aquiliae* must be alleged and proved.

[845] Amler's Precedents of Pleadings 1999:46.

[846] *Brandon v Minister of Law and Order* 1997 (3) SA 68 (C):78E-F. See also *Stoffberg v Elliott*, discussed in Chapter Four above.

[847] For example, in *Mthimkhulu* 1993 (3) SA 432 (E) the court awarded the plaintiff damages for pain and suffering and *contumelia*, which the court held were caused by the assault, but did not refer to the *actio iniuriarum* or action for pain and suffering as causes of action.

[848] *Stoffberg v Elliott*:152.

[849] *Esterhuizen v Administrator, Transvaal*:719:726C-H.

[850] *Layton and Layton v Wilcox*:50.

[851] Neethling *et al.* 2005:65-68; Neethling *et al.* 2006:238-239, fn42; For example, in *GA Fichardt Ltd v The Friend Newspapers Ltd* 1916 AD 1:7, the defendant, during the First World War, falsely reported that the plaintiff was a German or pro-German business. The plaintiff instituted an action based on defamation and claimed patrimonial damages. The court held that the statement was not defamatory, but if it had been, the action to claim patrimonial loss is the *actio iniuriarum*. See also *Wessels v Bosman* 1918 TPD 431, *Carelse v Van der Schyff* 1928 CPD 91 and *Goodhall v Hoogendoorn* Ltd 1926 AD 11:16, where the approach in *Ficardt* was confirmed by Innes CJ in an *obiter dictum*. However, Neethling *et al.* 2005:67, emphasise that the view in *Fichardt* has also been directly criticized in South African case law. In *Universiteit van Pretoria v Tommie Meyer Films (Edms) Bpk* 1977 4 SA 376 (T):385 and *Bredell v Piennaar* 1924 CPD 203, the courts held that that it is not correct to use the *actio iniuriarum* to claim patrimonial damage and that the *actio legis Aquiliae* is the appropriate action in such a case. In *Minister of Finance and Others v EBN* 1998 (2) SA 319 (N), the plaintiff sued the Minister of Finance for damages for the alleged wrongful detention of its goods. The court held that the plaintiff's claim was based upon the *actio iniuriarum* as it arose out of the wrongful seizure and detention of the plaintiff's goods. However, the court held that in an action based on *iniuria* in which the plaintiff claims special damages, the requisites for a claim under the *actio legis Aquiliae* must also be alleged and proved. *Minister of Finance and Others v EBN*:326 F-G.

and satisfaction are claimed simultaneously and the two actions are hardly ever mentioned by name.[852]

On the other hand, Boberg,[853] states that where there is intentional infringement of a personality right, both satisfaction for *iniuria* and damages for pecuniary loss may be recovered, whether one regards the basis as the Aquilian action and *actio iniuriarum* rolled into one, or whether it is said that both forms of redress are recoverable under the *actio iniuriarum*. He emphasizes that if the intention necessary to constitute an actionable *iniuria* is established, then there is no objection to awarding mere pecuniary loss flowing from it, because it is only negligently inflicted pecuniary loss that invokes the law's misgivings.[854]

The writer is respectfully of the view that that a cause of action based on assault must comply with the requirements for the *actio iniuriarum*. Therefore, in criminal law, the plaintiff must prove all the elements of the assault beyond reasonable doubt. Furthermore, fault in the form of intention, including consciousness of wrongfulness, must be proved. On the other hand, in a delictual action, the plaintiff must meet the requirements for the *actio iniuriarum* and prove the claim on a balance of probabilities, with the defendant carrying the onus if he/she raises a justification ground such as consent. Further, there is a presumption of *animus iniuriandi*, which the defendant must rebut. It is debateable whether consciousness of wrongfulness is required. Having established the cause of action based on assault, the plaintiff is entitled to satisfaction. If, however, the plaintiff wishes to claim patrimonial damages and pain and suffering, then he/she must prove that the loss has been caused by the assault,[855] without having to separately institute a claim based on the *Actio Legis Aquiliae.*

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[852] A concurrence of two or all three actions is also quite possible. Amerashinghe 1967:57-75, 194-208. However, Van der Merwe and Olivier 1989:465 argue that the *actio iniuriarum* and the action for pain and suffering cannot concur, because when the *actio iniuriarum* is instituted for intentional bodily infringement, the action for pain and suffering loses its meaning. In response, Neethling *et al.* 2006:238-239, argue that since the function of the *actio iniuriarum* is satisfaction, but the function of the action for pain and suffering is compensation, a concurrence of the two actions is acceptable.

[853] Boberg 1989:19-20.

[854] Where both sentimental damages and patrimonial damages arise from a single act, there is no need to bring separate actions, because redress may be obtained in a single action Boberg 1989:18; *Matthews v Young* 1922 AD 492:505.

[855] Boberg 1989:475. In *Esterhuizen v Administrator, Transvaal*:726C-H, when assessing whether the infringement of bodily integrity caused the plaintiff's patrimonial loss, the court considered whether, on a balance of probabilities, if the X-

CHAPTER SEVEN

CONCLUSION

7.1 South African case law on the failure to inform patients of the risks of medical treatment

A patient who alleges that a doctor did not provide him/her with adequate information prior to administering treatment, has a number of potential causes of action at his/her disposal in South African law of delict and the following were identified through an examination of case law:

a. When a commission, which causes the infringement of bodily integrity, is regarded as the conduct element of the delict, the courts use assault as the cause of action. The test for consent set out in *Castell*[856] is used to determine the boundaries of the justification ground of consent to the *prima facie* unlawful touching.

b. Where the conduct is in the form of an omission to disclose information, the courts use the English duty of care approach by fusing the elements of wrongfulness and fault, in the form of negligence, and applying the professional practice standard as set out in *Richter*[857] to determine whether there was a breach of the duty of care.

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ray treatment had not been administered, the patient would have remained in remission without the need for the X-ray treatment and the consequent risk of losing her limbs; In *Stoffberg v Elliott*:152-153, the court directed the jury that the plaintiff must suffer patrimonial loss and/or pain and suffering, which he would not otherwise have suffered, in order to satisfy the causative element required to successfully claim damages.

[856] *Castell v De Greef* 1994 (4) SA 408 (C).

[857] *Richter and another v Estate Hammann* 1976 (3) SA 226 (C).

c. However, in one case concerning liability for an omission to disclose information, that is, *McDonald*,[858] the generalizing approach to delictual liability was used. The court split up the elements of wrongfulness and fault and used both of the above-mentioned standards - the *Castell* standard was applied at the wrongfulness stage of the enquiry and the professional practice standard was applied at the negligence stage.

In other words, when the claim is decided on the basis of assault with intention as the fault element, then the conduct is in the form of a commission. On the other hand, when the claim is decided with negligence as the fault element, then the conduct is dealt with in the form of an omission to disclose information, and either the English breach of duty of care is used, or the elements of wrongfulness and fault, in the form of negligence, are split up and decided separately.

All of the South African cases discussed in this thesis relating to medical assault, have concerned an assault by commission and most concern surgery. On the other hand, all of the cases decided on the basis of breach of duty of care and negligence relied on conduct in the form of an omission. However, the writer is respectfully of the opinion that all of the latter cases could also have been pursued on the basis of conduct in the form of a commission and as an assault. Further, the writer has noted that conduct in the form of an omission may also form the basis of assault as a cause of action.

The difference between proceeding on the basis of a commission and an omission to disclose information on the other, is not insignificant. When the claim is based on a commission, the conduct is regarded as *prima facie* wrongful, but where the claim is based on an omission to disclose information, the conduct is regarded as *prima facie* lawful.

[858] *McDonald v Wroe* [2006] 3 All SA 565 (C).

7.2 Assault as the ideal cause of action

The writer was respectfully of the view that assault may ideally be used in most claims[859] concerning the failure to disclose information to patients, which results in the infringement of bodily integrity, whether the conduct element is in the form of a commission or omission, for *inter alia*, the following reasons:

a. Assault is a particular type of *iniuria* in South African law. The fundamental principle underlying assault is that physical force, of whatever sort and in whatever degree, should not be applied to the body of another. The slightest infringement of bodily integrity is sufficient to found a cause of action based on assault. Further, the infringement of the right to bodily integrity may take place through a broad range of conduct. The infringement may take place directly or indirectly, by commission or by omission, and externally or internally.

b. The application of force in assault is regarded as a consequence. Viewed in this way, consent must cover not only the general nature of medical treatment, but also the consequences of medical treatment.

c. In a delictual claim based on assault, once the plaintiff proves the application of force, the right to bodily integrity is further strengthened by the presumption of intention or *animus iniuriandi*, which the defendant must rebut. In addition, while the writer is respectfully of the view that consciousness of wrongfulness is an important part of intention in criminal assault, the writer has also respectfully proposed that consciousness of wrongfulness has very limited relevance to delictual assault in South African medical law.

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[859] However, a claim based on assault, as an *iniuria*, is actively or passively transmissible only when *litis contestatio* has been reached. Neethling et al. 2005:78; *Argus Printing and Publishing Co Ltd v Esselen's Estate* 1994 2 SA 1 (A); *Potgieter v Rondalia assurance Corporation of SA Ltd* 1970 1 SA 705 (N).

d. Where a claim is based on assault in delict; it is not only satisfaction but also patrimonial damages which may be claimed, where applicable.

Therefore, this action provides strong protection for the right to bodily integrity, which is not only regarded as an absolute common law right, but it is also a fundamental constitutional right and one of the foundational constitutional values.

Further, the writer has respectfully suggested that the use of the English breach of a duty of care as well as negligence as the fault element is not ideal in most medical information cases for, *inter alia*, the following reasons:

a. The negligence standard is concerned with the standard of conduct expected of a reasonable doctor when obtaining consent in the circumstances of the case. Therefore, informed consent is only indirectly relevant. On the other hand, in the cause of action based on assault, informed consent plays a central and pivotal role.

b. The South African law of delict embraces a generalizing approach to delictual liability. Consent is a justification ground which functions at the wrongfulness stage of an enquiry into delictual liability and is a subjective test, which focuses on the state of mind of the plaintiff. On the other hand, fault in the form of negligence is a separate delictual element, which follows the determination of wrongfulness and focuses on the reasonableness of the conduct of the defendant. Therefore, the fusion of the elements of wrongfulness and fault is not appropriate.

c. Under the negligence standard, which incorporates the professional practice standard, the best interests of the patient plays an important role and the doctrine of therapeutic privilege is an integral part of the standard. The standard is therefore inherently paternalistic. On the other hand, under the consent determination, therapeutic privilege is not relevant and

the Constitutional rights to equality and self-determination play a much more important role.

d. The negligence standard develops and lays down specific rules restricting the information that must be disclosed by a doctor, through application of the professional practice standard, rather than applying a broader and more principled approach, which is evident in the consent standard.

e. The test for negligence requires that the reasonable doctor would not only foresee the reasonable possibility of his conduct injuring another in his person or property and causing him patrimonial loss; but, in addition, would take reasonable steps to guard against such occurrence. It therefore has the potential to severely curtail protection of the patient's right to bodily integrity. On the other hand, assault requires intention but it is only a particular type of mistake of fact which is relevant, that is, if the doctor is unaware that the information is material to the patient or a reasonable doctor would have have been unaware of the significance to the patient.

7.3 The National Health Act 61 of 2003

The National Health Act requires that a doctor must obtain informed consent from a patient. In terms of the Act, informed consent includes not only the general nature but also the consequences of medical treatment.

However, two standards of disclosure relating to medical information apply in South African law and have resulted in the formulation of conflicting principles and rules of disclosure. The first is the doctrine of informed consent or *volenti non fit iniuria* and the second is the professional practice or negligence standard. It is unclear at this stage which standard and therefore which principles and rules will be used to interpret the provisions of the Act relating to informed consent.

The writer has respectfully proposed that the Act provides for a minimum level of disclosure, which must be supplemented by the common law principles in relation to informed consent or *volenti non fit iniuria*. In particular, increased or even decreased disclosure may be required, depending on the informational requirements of the reasonable patient in the particular circumstances of the plaintiff or the requirements of the plaintiff in the circumstances of the case.

7.4 The combined patient-centered test for consent

A pre-requisite for *volenti non fit iniuria* is full knowledge of all the final negative consequences, whether probable or possible or highly unlikely. However, the court in *Castell* introduced a new test for consent and, in so doing, limited the amount of information which must be disclosed to a patient. The writer has has respectfully suggested that the test for consent set out in *Castell*[860] in effect creates a form of a reasonable doctor standard.

The writer has respectfully suggested that in order to more closely give effect to the subjective nature of the common law doctrine of *volenti non fit iniuria* and, in addition, in order to enhance the Constitutional right to equality, we need to more substantively and explicitly recognize patients' difference experiences of and responses to illness and to accommodate these differences. Therefore, at the wrongfulness stage of the enquiry the doctor should disclose to the patient the information that the patient in fact and subjectively needs in order to decide for him/herself what course of action to take. The writer has therefore proposed a modified combined patient-centered standard, in terms of which, a risk of medical treatment is material if:

a). a reasonable person in the patient's position, if warned of the risk of such treatment, would be likely to attach significance to it; or

[860] *Castell v De Greef* 1994 (4) SA 408 (C).

b). the particular patient, if warned of the risk of treatment, would be likely to attach significance to it.

The writer is respectfully of the view by removing the criterion that the doctor did or ought reasonably to have foreseen that the risk was material to the patient from the consent determination and placing it as part of the fault enquiry, the test for consent is now firmly based on the right to self-determination. Further, by moving the foresight of the doctor to the fault element of assault, the writer acknowledges the generalizing approach to delictual liability, in terms of which wrongfulness and fault are separate elements of the delict. In terms of this approach, a particular type of reasonable mistake of fact will now negate intention in civil assault.

The writer is respectfully of the view that this proposal is in line with the recommendation of the Constitutional Court in *Carmichele v Minister of Safety and Security.*[861] The Constitutional Court has acknowledged the important role of common law remedies and has recognized the different roles of the elements of wrongfulness and fault. The Constitutional Court has held that the influence of the Constitutional values on common law remedies may mean that on the one hand the net of wrongfulness should be cast wider and, on the other, the fault element of a delict should be developed in order to rein in liability. The writer is respectfully of the view that by adopting the writer's proposal, the net of wrongfulness in assault will be cast wider, but the fault element will be developed in order to rein in liability there.

The cause of action based on assault is deeply rooted in South African law. However, where failure to obtain informed consent to the application of force in the medical context is in issue, it has largely been ignored in favour of negligence. Now that the Constitution has added new emphasis to the importance of the right to bodily integrity, by entrenching the absolute common

[861] *Carmichele v Minister of Safety and Security* 2001 (4) SA 938 CC:962C-E – 963A-B.

law right to bodily integrity in the Bill of Rights and requiring that the common law take cognizance of constitutional values, it is hoped that assault will be allowed take its place as an important cause of action in South African medical law.

SUMMARY

The right to security and control over the body is described as an absolute right in South African common law. It is also regarded as one of the essential and foundational constitutional rights, together with the right to life and dignity. The importance that the *boni mores* or legal convictions of the community place on the right to bodily integrity and self-determination are reflected in the requirements for the justification ground of *volenti non fit iniuria*. The essential elements of *volenti non fit iniuria* are knowledge, appreciation and, finally, consent, which is a personal and subjective state of mind.

When a doctor applies force to the body of a patient without the patient's informed consent, the use of assault, a specific type of *iniuria* in South African law, as a cause of action, reflects the importance that society places on the right to bodily integrity and self-determination. On the other hand, where the English breach of duty of care and negligence is used, the rights to bodily integrity and self-determination are undermined. It is recommended that South Africa adopts assault as a primary cause of action.

OPSOMMING

Die reg tot sekuriteit en beheer oor die liggaam word beskryf as 'n absolute reg in die Suid-Afrikaanse reg. Dit word ook as 'n noodsaaklike en fundamentele konstitusionele reg beskou tesame met die reg op lewe en waardigheid. Die belangrikheid wat die *boni mores* of wetlike oortuigings van die gemeenskap plaas op die reg tot liggaamlike integriteit en selfbehoud word weergegee in die vereistes vir die regverdiging van *volenti non fit iniuria*. Die noodsaaklike elemente van *volenti non fit iniuria* is kennis, waardering en, finaal, toestemming, wat 'n persoonlike en onafhanklike bewustheid teweeg bring.

Wanneer 'n dokter geweld gebruik teenoor n pasiënt se liggaam sonder ingeligte toestemming, aanranding, 'n spesifieke tipe *iniuria* in die Suid-Afrikaanse reg, as 'n aksie, die belangrikheid wat die gemeenskap plaas op die reg tot liggaamlike integriteit en selfbehoud, weerspieël. Aan die anderkant, waar die Engelse plig van versorging en nalatigheid gebruik word, word die reg tot ligaamlike integriteit en selfbehoud ondermyn. Dit word aanbeveel dat Suid-Afrika aanranding as 'n primêre aksie, aanvaar.

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