THE LAW OF

MALPRACTICE LIABILITY

IN

CLINICAL PSYCHIATRY:

METHODOLOGY, FOUNDATIONS AND APPLICATIONS

by

Carel Roché Steyn

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Supervisor: Prof Dr S A Strauss

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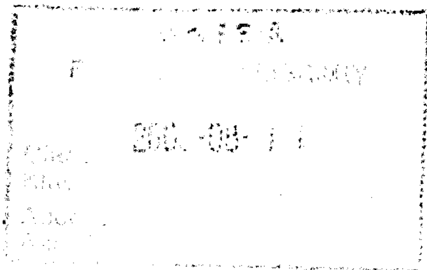
Dedication

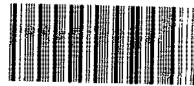
For Marina

To the Lady who taught me how to read,

I dedicate this writing

344.4121068 STEY





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Clara, for her enthusiastic help with the graphic construction of "figure 3", and Karen and Natasha for so willingly assisting in bringing that and the other figures to fruition.

Lastly, to Hilary, the lovely newly-wed lass, for sustaining the flame.

SYNOPSIS

As a point of departure in this inherently interdisciplinary endeavour, the concept "Holistic Multidisciplinary Management" ("HMM") is introduced as a macrocosmic adaption of principles of project management. In line with HMM, a number of submissions regarding terminology and definitions in the interdisciplinary context of medicine (and particularly clinical psychiatry) and law, are made, and the foundations of medical malpractice are examined.

Building on the various foundations laid, specific types of conduct that can constitute clinical-psychiatric malpractice, are addressed. A common theme that emerges in the various contexts covered, is that the psychiatrist must negotiate various proverbial tightropes, involving *inter alia* tensions between restraint and freedom, excessive and insufficient medication, becoming too involved and not being involved enough with clients, as well as client confidentiality and the duty to warn third parties.

It is concluded that law and medicine must work harmoniously together to establish appropriate balance. This can be achieved only if mutual understanding and integrated functioning are promoted and translated into practice.

Key terms:

Holistic Multidisciplinary Management (HMM); clinical psychiatry; forensic psychiatry; medical malpractice; medical law; psychiatric malpractice; *iniuria*; grounds of justification; negligence; pharmacotherapy; psychotherapy; abandonment; undue familiarity; client confidentiality; duty to warn.

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CHAPTER I

INTRODUCTION: SCOPE, AIMS AND APPROACH

1 Scope of the Dissertation

Conscientious analysis of any specific matter demands perspective on its broader context. This dissertation launches an investigation into the matter of clinical psychiatric malpractice. This has its home in the broader context of the interface between law and psychiatry. It is important, then, for the scope of the dissertation to provide an adequate introduction to this broader context, before focussing on the specific matter in question. The dissertation progresses from sketching broad context, expounding the general methodology, to narrower context, elucidating some of the foundations of the law of malpractice liability. The focus then narrows to various applications of malpractice law in the context of clinical psychiatry.

Accordingly, the dissertation first deals with the here proposed holistic multidisciplinary management (HMM) approach, which constitutes the general orientation of the investigation. This discussion provides the framework for the entire dissertation - it is the approach followed throughout. As will appear from the discussion of the HMM approach, the orientation of this dissertation is to integrate knowledge across disciplines relevant to the particular matter in question. Accordingly, particular attention is given to conceptual and terminological interdisciplinary integration. Indeed, psychiatric malpractice is an area that creates tremendous scope for multidisciplinary interaction. As will be discussed, the most relevant disciplines are management, medicine, psychology and, of course, various areas of law.[1]

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[1]Perspective on the general interactions between these disciplines is provided in the introductory discussion; hence these disciplines feature wherever relevant, at intervals

After the general introductory discussion of HMM, the elements in the interface between law and psychiatry are illuminated, highlighting the place and scope of psychiatric malpractice law, as part of medical law. Medical law is inevitably infused with the general principles of certain other areas of law, particularly the law of delict, criminal law and the law of contract. Although the general principles of especially the law of delict and criminal law go to the very core of malpractice liability, the scope of this dissertation does not allow for a comprehensive analysis of those principles. These will be featured as they are applied to the specific matter in question. Knowledge of the general principles of the law of delict, criminal law and the law of contract must therefore, of necessity, be assumed.[2]

The laws and legal literature of other countries, especially the United States, are referred to extensively, with particular sensitivity to possible application in South African law.[3]

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throughout the dissertation.

[2]It is unfortunate that scope does not allow for a comprehensive analysis of the general principles underlying malpractice liability, since it would be most desirable to provide full perspective on those principles before applying them to the matter of psychiatric malpractice. In step with the HMM approach, attention should be given to the directive that principles that are shared, for instance by the law of delict, criminal law and medical law, must be harmonious. To address these and other issues, it is hoped that this dissertation will be followed by a doctoral thesis, whose scope will allow for the aforementioned extensive analysis. The proposed title is: "The Interfaces of Law, Medicine and Psychology: An Holistic Multidisciplinary Management Approach".

[3]The specific matter of the law regarding psychiatric malpractice has not as of yet been extensively explored in South African legal literature. This necessitates a heavy reliance on foreign sources. Although there are some existing directly relevant South African sources, these are rather limited. In a fairly recent South African text, Allan A *The Law for Psychotherapists and Counsellors* Somerset West: Inter-Ed (1997), which is described as "a practical workbook, not a definitive authority on the relative [sic] aspects of law". Allan himself undertakes his overview of malpractice in the South African context with reference to general principles and case law from

The final chapter ("Conclusion") provides a synoptic perspective on the conclusions and recommendations of the dissertation, innervated, as it were, by comparative analysis and an holistic multidisciplinary management approach.[4]

2 An Holistic Multidisciplinary Management (HMM) Approach

2.1 Introduction

2.1.1 The Need for Holistic Multidisciplinary Management

The emergence of so many fields of expertise in the complex society that humankind has created, has necessitated collaboration between various specialists in their respective fields.[5] In this regard, the interface between law and

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the United States. He states: "As no case has been reported in South Africa to date in which a psychologist or a psychiatrist has been sued for malpractice (not that such cases have not occurred) little guidance can be found in [South African] case law"; see *ibid* 42. It should be noted that the South African case *Rompel v Botha* (TPD, 1953), though unreported, has been discussed by judges and jurists (see discussion *infra* chapter IV, 2.4.1); see, for instance: Neser J in *Castell v De Greef* 1994 (4) SA 408 (C) (see Neethling J, Potgieter JM & Scott TJ *Case Book on the Law of Delict* (3 ed) Juta (2000) 196; *Esterhuizen v Administrator, Transvaal* 1957 (3) SA 710 (T) 719; Snyman JL *Die Siviele Opneming van Geestesongesteldes: Regte en Regsbeskerming van die Betrokkene* (LLD thesis, Unisa, 1981) 562; Van Oosten FFW *The Doctrine of Informed Consent in Medical Law* (LLD thesis, Unisa, 1990) 47; Strauss SA *Doctor, Patient and the Law: a Selection of Practical Issues* (3 ed) Pretoria: Van Schaik (1991) 10. In line with the approach of promoting refinement through comparing systems of law, this dissertation aims *inter alia* to enrich existing South African law by detailed comparative analysis involving countries more advanced in this area. Suggestions regarding the application of principles developed in other systems, feature throughout.

[4]This approach actually incorporates comparative legal analysis, as discussed under 2.5 *infra*.

[5]In the context of mental health care, Lucas M, Pefile L, Goldstein M, Van Straten M and Allwood C "Multidisciplinary Teams - Do They Work?" *The South African Journal of Psychiatry* (1999)

psychiatry, is a prime example.[6] Although all practitioners involved in cases where various disciplines interact cannot be expected to be experts in the terminology and underlying philosophy of each field[7], professionals who specialise in

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Vol 5 No 4, allude to the importance of a multidisciplinary perspective. These authors assert that "the concept of the multidisciplinary team has become so intrinsically associated with mental health, that it is difficult to think of psychiatric treatment in any other terms". These particular teams (MDTs) would typically involve a combination of input from the fields of nursing, medicine, psychology, occupational therapy and social work. Specifically in the context of medical law, Strauss acknowledges that the development of that area of law is not exclusively the task of those in the field of law, but that a multidisciplinary approach is essential; see Strauss SA "Geneesheer, Pasiënt en die Reg: ´n Delikate Driehoek" *TSAR* 1987 1-11. The importance of knowledge and skills in management in the health-care setting was firmly demonstrated to the present author when sitting in on meetings (at the John Connelly Psychiatric Wing at Ealing, London) where a psychiatrist, social workers, a psychologist, psychiatric nurses, the client, and his or her family, deliberate. At these meetings, the psychiatrist clearly assumed a role akin to that of the project manager. He coordinated the meeting, and integrated the input from various "functions" (ie social work, psychological assessment, etc) into an holistic strategy to deal with the particular client's situation. The principles of management can clearly find fruitful application in the multidisciplinary-team context.

[6] In expressing the need for psychiatrists to learn more about the law and for lawyers to develop a better understanding of psychiatry, Alan Stone is quoted as stating: "The psychiatrist will find the law intruding on everyday practice, and the future will bring more rather than less intrusion. The psychiatrist has no choice but to become familiar with the important structures of law and psychiatry. A new generation of forensic psychiatrists, schooled in the broad constitutional questions that have added so much complexity to the field, must be developed. Most important, psychiatrists must develop working relationships with lawyers who are sensitive to the special problems attendant on the provision of mental health care..". See Maggio E *The Psychiatry-Law Dilemma: Mental Health versus Human Rights*. New York: Vantage Press (1981).

[7] The terms "field" and "discipline" will consistently be used as synonyms in this dissertation. The various areas of specialisation within a field or discipline, are then described as "sectors" within that discipline. The Encarta World English Dictionary defines a sector as "a component of an integrated system..."; see Rooney K (Ed) *The Encarta World English Dictionary* London: Bloomsbury (1999) at 1696. The word "sector" is derived from the Latin "secare", which means "to cut up".

interdisciplinary areas should make it their task to promote precise conceptual and terminological integration. If strategic multidisciplinary perspective is maintained, the process of refining concepts within a discipline not only benefits that discipline, but also potentially benefits all other disciplines with which it interacts. Moreover, proper perspective and integration improve these interactions, and produce better results.

2.1.2 Introducing HMM as a Macrocosmic Application of the Principles of Project Management

The discipline that especially has the capacity to arch across all other disciplines, and is particularly relevant where various disciplines interact, is management.[8] "Holistic Multidisciplinary

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Since every broad discipline itself is, in principle, an integrated system, it can be described as consisting of various sectors, for example criminal law within law and clinical psychology within psychology. A "field"/"discipline" would then be the superordinate areas of study and practice, eg (mainstream) medicine, psychology, law, management, economic sciences, environmental sciences, engineering, and linguistics. When exactly an area of expertise would constitute a "separate" discipline or a sector of a larger discipline is a relative matter - it would depend on which view is most practical and realistic.

[8]The general underlying theory relevant in this regard is the systems theory, which, according to Kerzner, is "a management approach that attempts to integrate and unify scientific information across many fields of knowledge."; see Kerzner H *Project Management: A Systems Approach to Planning, Scheduling, and Controlling* (7 ed) New York: John Wiley & Sons (2001) 47. In exploring the origins of this approach, Kerzner refers to the work of a biologist, Dr Ludwig von Bertalanffy, who describes systems of the human body as subsystems of the total system. According to Kerzner, Bertalanffy's contribution is important in that he "identified how specialists in each subsystem could be integrated so as to get a better understanding of the interrelationships, thereby contributing to the overall knowledge of the operations of the system" (*ibid* 48). It is here, Kerzner contends, that the foundation was laid for the evolution of project management. Therefrom actually also emerges an application of HMM. The biological sciences enrichingly impacted on the managerial sciences. A basic concept of biology was

Management" ("HMM") is the term here suggested to describe this particular application of management. Accordingly, it may be defined as "an application of adapted and refined principles of management, tailored to promote effective and efficient[9] interaction between various disciplines[10] in a manner which enriches all those involved, and identifies and implements integrative, holistic solutions". There are indeed many problems that inherently cannot be addressed in isolation but must be seen in their broader multidisciplinary context. Although this necessity presents the ideal opportunity for multilateral enrichment for all involved, there is also, unfortunately, the potential for disparity, miscommunication and incoordination. Sound HMM can obviate this negative potential.

The concept underlying HMM is akin to project management within an organisation.[11] HMM amounts to a macrocosmic[12] application of

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adapted and developed to become a fundamental philosophy underlying management: systems thinking. Today, systems thinking innervates successful management of any kind.

[9]The concepts "effective" and "efficient" are defined and discussed under 2.3 *infra*.

[10]It is particularly in the interaction between various disciplines that management has a crucial role to fulfil. At the heart of management lies the optimised coordination of various activities and processes. Correctly applied, relevant principles of management can promote collaboration between various disciplines to achieve maximum effectiveness and efficiency.

[11]Kerzner H *Project Management: A Systems Approach to Planning, Scheduling, and Controlling* (7 ed) New York: John Wiley & Sons (2001) at 4, furnishes the following definition of project management: "...the planning, organising, directing, and controlling of company resources for a relatively short-term objective that has been established to complete specific goals and objectives. Furthermore, project management utilises the systems approach to management by having functional personnel (vertical hierarchy) assigned to a specific project (the horizontal hierarchy)."

[12]The word "macrocosm" is here used in the sense of "a larger copy of a smaller system". Similarly, the Encarta World English Dictionary defines a "microcosm" as "a miniature copy of something, especially when it represents...a larger whole"; see Rooney K (Ed) *The Encarta World English Dictionary* London:

adapted principles of project management, which are generally applied to smaller systems, *viz* specific organisations. In a large organisation, there are numerous functional units, each performing specialised tasks. It is a firm principle of management that these functional units should not function in isolation, but should be harmoniously integrated with the rest of the whole organisation. There must be both vertical harmony (ie sound communication and collaboration from top management down to every employee, and vice versa) and horizontal harmony (ie sound communication between, and integrated functioning of, all the various specialised units within the organisation).[13]

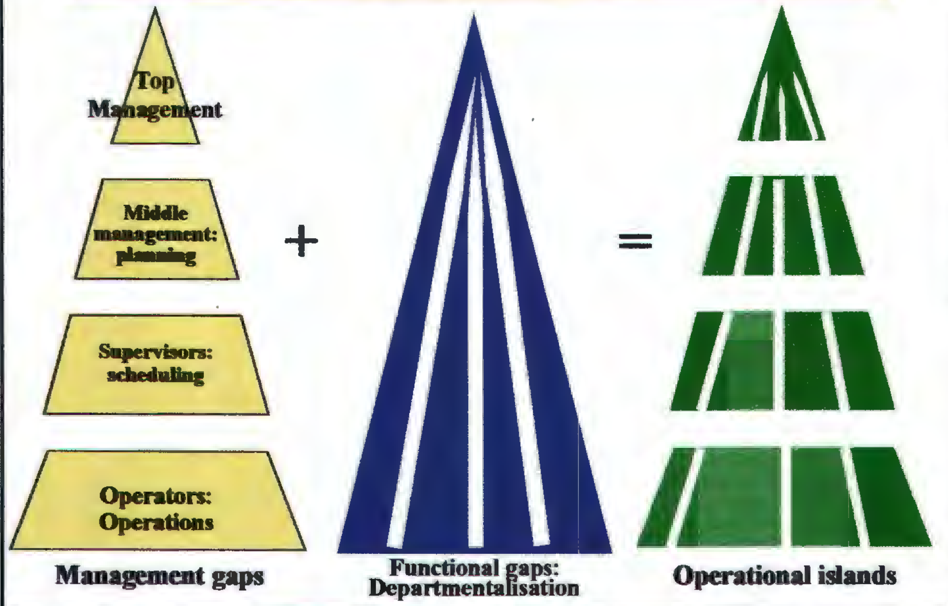
HMM is a superimposition of this imperative (ie sound systemic communication and integration) on the interaction between specialists from various disciplines. Whereas in an organisation there is invariably an appointed coordinator (manager) or group of coordinators to facilitate vertical and horizontal integration, collaboration between various independent specialists addressing issues of common concern is often initiated and coordinated by the specialists themselves. Many of these ventures lack the formal structure of an organisation (with the accompanying management structures). This is all the more reason for professionals to have a basic understanding of the general concepts and principles of management.[14] HMM aims to facilitate accessibility to the most relevant concepts and principles of management precisely for the purpose of integrating the efforts of independent specialists from diverse backgrounds.

Bloomsbury (1999) 1193.

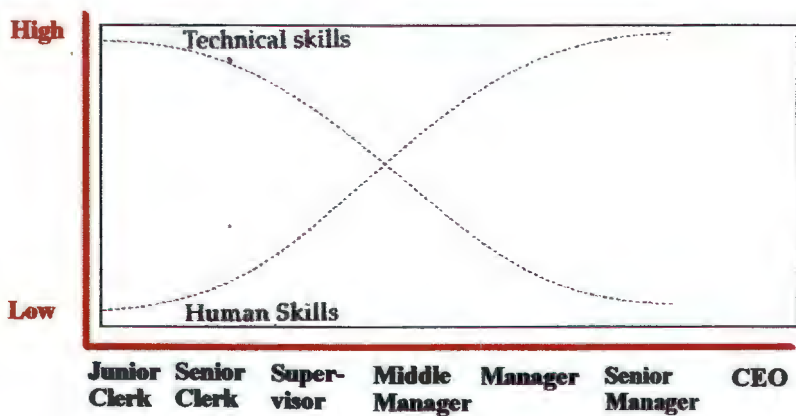
[13] Figure 1 (next page), adapted from Kerzner H *Project Management: A Systems Approach to Planning, Scheduling, and Controlling* (7 ed) New York: John Wiley & Sons (2001) 4, illustrates the operational islands that are created if sound communication and integration are lacking. It is trite that the manifestation of such isolated and dislocated operational islands precludes the smooth functioning of the organisation, and can eventually have a crippling effect. Figure 2 (on the next page) will be referred to in fn 17 *infra*.

[14] See the discussion under 2.2 *infra*.

Why are systems necessary?



Philosophy of Management



HMM is here suggested to be the way that any venture should be managed: with full regard to the relevant elements of every discipline that impacts on that venture, in a manner aimed at multilateral enrichment and refinement.[15] The more diverse the disciplines involved in a particular venture, the more pronounced the need for HMM. In the following discussion, it will be argued that refinement within fields and refinement between fields should, in a mutually reinforcing manner, promote effective multidisciplinary understanding and application, and provide the best solutions.

2.1.3 Multidisciplinary Management and the Law

It is submitted that the law is inevitably a constant facet of HMM, since the law invariably interacts with numerous other fields. The impact of the law on a multitude of disciplines is unavoidable - the law, in principle, reaches every corner of society. In turn, the impact of a multitude of disciplines on the law is also unavoidable - the field of law alone is not equipped to deal effectively and efficiently with the myriad of matters which it is compelled to encompass. Moreover, the law must allow itself to be enriched by all relevant fields in order not to stifle its development and threaten its legitimacy. HMM thus compels all disciplines to have regard to relevant law, and compels the law to have regard to the relevant aspects of all disciplines with which it interacts.

A potential enriching impact that the field of law could have on other fields, is that practitioners in other fields should be able to consult legal works (or practitioners) for guidance as to how to refine the articulation of concepts within them, since the field of law should be exemplary in the manner in which it

[15] In this way, "microcosmic" project management (ie within the various functions of an organisation) should, in turn, have regard for HMM by considering potentially vital multidisciplinary perspective when managing specific ventures.

is punctuated with sound definitions and formulations. Those in the field of law should be experts at formulation and interpretation. Language and the law are intimately intertwined: law gains its existence only through language, and there is understandably a great premium on precision in the use of language. However, the opportunity that the nature and contents of the field of law provide for exemplifying what sound formulation and interpretation are, is not currently being sufficiently utilised. Instead, the field of law is regrettably not without a certain degree of prolixity and obscurity. Accordingly, those in the field of law should pay careful attention to their use of language in defining, interpreting and conveying the law.[16]

2.1.4 **The Illustrative Example of Psychology**

The example of psychology is convenient to use to illustrate the HMM approach, due to its marked connection to management[17] and to

[16] See further the discussion under 2.3.2 and 2.3.3 *infra*.

[17] Kerzner, for instance, states that "[the] ideal project manager would probably have doctorates in engineering, business, and psychology...". An understanding of organisational psychology is indeed absolutely essential for sound business management; see Kerzner H *Project Management: A Systems Approach to Planning, Scheduling, and Controlling* (7 ed) New York: John Wiley & Sons (2001) 169. Figure 2 (*supra*) illustrates the fact that the utilisation of human skills is incrementally important in top-management positions (*ibid* 127). Not only does industrial psychology, as such, play a major role in management within an organisation, but other areas of psychology, such as health psychology, can also play a significant role. Health psychology is "the subfield of psychology concerned with the dynamic interrelationship of behaviour and psychological states with physical health"; see Bishop GD *Health Psychology: Integrating Mind and Body* Needham Heights: Allyn and Bacon (1994) 3. It goes without saying that the health of individuals within an organisation affects its productivity - a healthier workforce is a more productive workforce. The conditions under which people work, in turn, can also significantly affect their health. Thus, on the one hand the personal health context can have a significant bearing on the work context, and, on the other hand, management within the work context can have a significant impact on the personal health context. Regarding the latter, for

the law. After the general HMM approach has been discussed, psychology will be integrated into an illustration of HMM (figure 3)[18], where it is brought in relationship to (mainstream) medicine so as to demonstrate the application of HMM to those two specific interactive fields (medicine and psychology). This illustration, then, is but one example of an extract of an application of HMM, but particularly apt in the light of the topic of this dissertation.

2.2 The Ubiquitous Roles of Law and Management

2.2.1 The Impact of Law on Management within Various Fields

It is readily evident that the interaction of law with other professional disciplines is, in most cases, unavoidable. The law governs all professional endeavours where persons' interests are involved. It is submitted that most professionals, in whatever field they may operate, should ideally have knowledge of the essentials of the law that applies to that field. The more fully professionals understand the law that applies to them, the more efficiently compliant therewith they could be in practice.

From a management point of view, the cost of legal non-compliance can have a grave negative impact on the productivity and

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instance, Ogden J *Health Psychology: A Textbook* (2 ed) Buckingham: Open University Press (2000) 315, refers to a model developed by Karasek and Theorell (1990) that argues that personal control over job stress and other stressors is an important element in predicting coronary heart disease (CHD). According to the model, there are two aspects of "job strain": job demands, which reflect conditions that require performance, and job autonomy, which reflects the control over the decisions made within the job. The organisational climate (partially created by management) is obviously intimately related to these aspects. The hypothesis suggests that **high** job demands with **low** job autonomy can predict CHD. This is a clear example of how the managerial styles within organisations can impact on the health of its employees.

[18] *Infra* under 2.6.3.

profitability of the business of a particular professional or industry. It follows that sound management within any field would thus incorporate compliance with the law. The law, then, has an inevitable role to play in the management of any endeavour within most professional areas. Managing one's practice in clinical psychiatry is no exception.

2.2.2 The Impact of Management on the Law

If the law is successfully to fulfil its function of regulating a particular field, efficiently managed compliance is required. The proper functioning of the law applied to a profession is indeed dependant upon the well-managed legal compliance of professionals to whom that area of law applies. The administration of the law, itself, could also be greatly enriched by an integrative application of the principles of management. Legal process, like any process that requires planning and execution, can be improved by applying relevant principles of management.

2.2.3 The Impact of Management on All Fields

An understanding of context-appropriate principles of management, within the framework of HMM, will invariably enrich endeavours within any field. Professionals in any field should thus ideally have a sound knowledge of the principles of management that are most relevant to their particular field. Of course, some principles of management will indeed be equally applicable to all fields. For instance, the principle of continuous improvement[19] would most obviously equally apply to all fields. If professionals in all fields were to foster an orientation of striving for continuous improvement, it would be to the benefit not only of that field but also potentially all others.

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[19] This concept means basically what it states: every process in a system is endeavoured to be improved continuously, according to internal and external feedback; see Knod EM & Schonberger RJ *Operations Management: Meeting Customers' Demands* (7 ed) New York: McGraw Hill (2001) 65-71.

Two central concepts of management, which are also applicable to endeavours in all fields, are efficiency and effectiveness.[20] Efficiency and effectiveness would be promoted by good management in any context. Efficiency refers to the manner in which and the time within which a task is performed. Effectiveness refers to the end-result of the task, regardless of the cost or time of its performance.[21] It is submitted that "effectiveness" can be generally defined as "achieving the required result", and "efficiency" as "achieving a result in the most appropriate manner, maximising output and minimising expenditure of resources (including time and effort)". It is evident that in the case of effectiveness the emphasis is on "what" is achieved, whereas in the case of efficiency the emphasis is on "how" and "when" something is achieved. It is self-evident that effectiveness and efficiency should be promoted in any venture in any field of practice.

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[20] The meanings of these terms, as they are used in the general field of management, basically accord with their ordinary dictionary definitions. The Encarta World English Dictionary states that "effective" involves "having or producing the desired effect", while "efficient" involves "means or resources used in achieving a result in an economical manner"; see Rooney K (Ed) *The Encarta World English Dictionary* London: Bloomsbury (1999) at 600. These ordinary meanings have also acquired some technical guises in specific applications in management, however. See, for instance, Knod EM & Schonberger RJ *Operations Management: Meeting Customers' Demands* (7 ed) New York: McGraw Hill (2001) at 687, where efficiency is defined as "standard time divided by actual time or actual output (units) divided by standard output (units)". It is clear that this specific guise nevertheless still involves the manner in which results are achieved. General definitions of effectiveness and efficiency are furnished *statim infra*.

[21] For example, where a medical team removes a cancerous part of a patient's descending colon, using an outdated lengthy and costly procedure, the procedure is nonetheless effective when it is evident that they eventually have successfully removed all the cancer. However, their procedure would not have been very efficient at all, given the time and other costs. On the other hand, if, using the cheapest and most accurate equipment and techniques available, they perform the procedure in record time and with remarkable accuracy, only to find that they had most accurately removed the section of the ascending instead of the descending colon, the procedure, as such, shall have been extremely efficient, but obviously not at all effective.

2.2.4 The Impact of Other Fields on Management

In the same way that the field of management can enrich other fields, it can also be enriched by them. Some examples in this regard have already been mentioned.[22]

2.2.5 Conclusion: Management and Law, and Other Disciplines

As has been illustrated, not only do law and management have a reciprocal relationship, but each of them also interacts with all professional fields. Both management and law have an impact not only on the internal workings of various fields, but also on their interactions. The roles of management and law should thus be borne closely in mind in any endeavour.

Law and management provide prime media for interdisciplinary development. Those in the fields of law and management thus have a particular responsibility to maintain and promote multi-disciplinary perspective. Due to the intensive level of specialisation that occurs in today's rapidly developing professional world, those who specialise within a discipline, such as clinical psychology within the broader field of psychology, are compelled to keep abreast of developments within the specialised area, leaving little time for explorative interdisciplinary excursions.

It is especially in this light that management and legal professionals must foster collaboration between specialists, and promote interdisciplinary development. Nevertheless, as has been stated, specialists within fields must still maintain an essential working knowledge of relevant law and principles of management applicable to their fields of specialisation.

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[22]See fn 8 concerning systems thinking, and fn 17 for some comments concerning psychology in this regard, *supra*.

2.3 The Relationship between Intradisciplinary Refinement and Interdisciplinary Refinement

2.3.1 General

To facilitate efficient interdisciplinary refinement and application, it is important for professionals **within** each field to develop and refine terminology and concepts within that particular field. This process could be referred to as "intra-disciplinary"[23] as opposed to "interdisciplinary". Where different sectors within a particular discipline are involved, the internal interaction may be described as "intersectoral".[24]

As the illustration of HMM indicates[25], intersectoral refinement is a structural microcosm of interdisciplinary refinement[26], and

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[23]This word has been used, for instance, in the website http://www.ashs.edu/prog_pa.htm, and many others. Unfortunately, many different usages lead to divergent meanings and great potential confusion. The meaning presently suggested to be ascribed to "intradisciplinary" is simply: "within a particular discipline". For exactly what a "discipline" would be, see fn 7 *supra*.

[24]"Intersectoral" means "between the sectors of the integrated whole"; cf fn 7 *supra*. The term "intersectoral" is particularly apposite in a systems-thinking context (see fn 8). One could also view various disciplines as sectors of the world body of knowledge. For the sake of clarity and consistency, however, "sectors" will be used only in the intradisciplinary context. "Intersectoral" thus necessarily implies "intra-disciplinary". The sectors within disciplines/fields can then also be comparatively rated as "smaller", "medium" or "larger". In the context of law, for instance, two closely related areas of law within one particular state's legal system would have a small-system intersectoral (thus necessarily intradisciplinary) relationship, whereas the legal systems of various states would have a large-system intersectoral relationship. It should be noted that these "size ratings" are merely terms of convenience that can be used to describe various levels of interaction. The description as larger or smaller, is totally relative, depending from which perspective the interaction is viewed.

[25]See figure 3 and its explanation *infra* under 2.6.3.

[26]Intersectoral refinement enables different sectors of a discipline more efficiently and effectively to draw on one another. This not only contributes to the enrichment of the

(as part of intradisciplinary refinement) eventually contributes thereto.[27] Interdisciplinary and intradisciplinary refinement are mutually beneficial, since the latter facilitates the former, and the former is reinforcing or constructively critical of the latter.

2.3.2 **Terminological and Definitional Refinement**

It is submitted that multidisciplinary applications of concepts and terminology especially require definitional precision. The more precisely each respective field's terminology and underlying philosophy may be defined, the smoother the integrated application amongst fields would be rendered.[28]

Both law and psychology, for instance, are characteristically vulnerable to over-complex and tediously wordy formulations. This tendency results not only in internal disparity and obscurity[29],

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sectors themselves, but also promotes coherence of the entire discipline. The more congruence and mutual enrichment there can be between sectors, the greater potential there is to maximise the efficiency of the greater system.

[27]As discussed *infra* under 2.3.3.

[28]Kerzner refers, for instance, to a concern, raised in 1956 by Professor Boulding, that "subsystem specialists" (eg physicists, economists, chemists, etc) "have their own languages"; see Kerzner H *Project Management: A Systems Approach to Planning, Scheduling, and Controlling* (7 ed) New York: John Wiley & Sons (2001) 48.

[29]A shining example of obscurity in legal terminology is the use of the term *culpa*. The use of *culpa* in South African legal terminology has given rise to three possible meanings: In its broadest sense it denotes fault or culpability. In a narrower sense it is supposed to denote negligence (which is said to be one form of culpability). Finally, in its narrowest sense it has been held to denote unconscious negligence (one form of negligence); see *S v Ngubane* 1985 (3) SA 677 (A). The effect is that, when referring to *culpa*, one would have to qualify whether one means to include intent as part of culpability, and if not, whether one means to include *luxuria* (so-called conscious negligence), or whether one actually means to use it to denote only unconscious negligence. It is submitted that in a case such

but also fortifies external inaccessibility. Intradisciplinary inconsistency or obscurity can, in this way, seriously hamper interdisciplinary development, since the contents of fields must be accessible, to a viable extent, for there to be efficient interaction and successful informed integration among fields.

To promote terminological and definitional multidisciplinary accessibility and refinement, the following three general principles are advanced:

1) When attempting to discern what a word "really" means, regard should be had to its derivation - this should have special persuasive force. Due to the fact that language is by no means a static phenomenon, there are instances where the meaning of a word has developed in such a way as to be disconnected from its etymology. In some cases it may thus be impractical or lead to absurdity to hold the derivation as decisive in establishing its meaning. For the most part, however, etymology provides a solid point of reference as to the real meaning of a word, and, should, as far as reasonably possible, be decisive.

2) Generally, the use of words as terms in fields of expertise should then also have regard for the ordinary dictionary meanings of those words (provided that these are etymologically sound - dictionaries generally do well in this regard). Obviously these meanings are inevitably adapted and refined in areas of expertise, but the terms should still be firmly connected to their basic meaning, or, if development so dictates, the terms themselves should be changed, rather than assuming twisted and peculiar meanings. Peculiar usages of words are disposed to

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as this, the term *culpa* must either be accurately and consistently defined and used, or completely abandoned. The use of "*culpa*" will be avoided in this dissertation.

misunderstanding and breed obscurity. Bearing ordinary dictionary definitions in mind when developing terminology, advances common comprehensibility and more congruence across all fields.

3) Where different fields of expertise interact and share concepts, terminology and definitions attached to those concepts should be very similar if not identical. In this way collaboration and cross-pollination are facilitated. As the modern proverb states: "everyone is on the same page"; moreover, they are in a better position to improve the "text" (ie subject matter) together.

It is submitted that the above three general principles, basic as they may be, can contribute significantly to promoting the effectiveness and efficiency of multidisciplinary ventures.

2.3.3 **Smooth Interdisciplinary Integration as an Effect of Intradisciplinary Refinement**

To promote interdisciplinary collaboration and effective interactional application, management, law, psychology, psychiatry and general medicine, for instance, should endeavour towards clarity and precision so as to render their contents more readily comprehensible, and hence more accessible to capable professionals in the other fields.

Although the ideal would be to be able simply to explain the contents of complex fields to virtually anyone, it is **not** here contended that all terminology and concepts can be **simplified**[30] to the extent that any lay person can understand them. Experience

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[30]It is emphasised that the suggestion, here, is for intradisciplinary and interdisciplinary **clarification**, rather than **simplification**. It is submitted that the latter is not only difficult and sometimes impossible, but may also potentially threaten demanded precision and comprehensiveness.

teaches that the complexity of the concepts that must be articulated in the fields of psychology and law, for instance, cannot simply be circumvented. It is inevitable that complex fields will necessarily contain complicated definitions and require complex formulations to explain concepts within them. What is here suggested, is that formulations should be **clear** and **consistent** enough to be accessible to competent individuals from other fields and that unnecessarily vague or prolix formulations be avoided. In this way, concepts can at least be clearly **explained** to members of the lay public who consult professionals.

Nevertheless, it is reiterated that technical language inevitably arises in a field of expertise, and that complexity itself cannot always be avoided. It is hardly possible for outsiders readily to access all given areas of expertise. However, where the reason for this is disparity and confusion within the "area of expertise", **that** is regrettable, and, in principle, avoidable.

2.3.4 Intradisciplinary Refinement as Facilitator of Collaboration

When practitioners from various fields respect one another, their collaboration is facilitated. The overall efficiency of a field itself is a reflection of those who dwell in it and develop it. Clumsy or tautologous formulations reflect poorly on practitioners within the field.[31] Where practitioners from different fields are faced with obscurity in each other's domains, this cultivates hypercritical dispositions due to (and coupled with)

[31]Because law and psychiatry are such prime examples of fields where complex abstract concepts are sought to be defined, sound formulation, clarity and consistency are not always duly achieved. Herein lies the challenge to those who are in a position to ameliorate that situation. In this dissertation, it will be attempted, wherever possible, to promote clarity, consistency, and intersectoral harmony in the definitions and terminology relevant to both fields.

inevitable frustration.[32] Needless to say, collaboration is hampered.

2.3.5 **Interdisciplinary Integration as Contributor to Intra-disciplinary Development and Refinement**

For fields to interact efficiently in an holistic sense, their orientation must be such that they enrich one another[33], striving for harmony in terminology denoting common or related concepts.[34] Effective integration should thus be seen not only as a facilitated consequence of refinement within and across fields, but also as a causally contributing factor in the development of each respective field. Where advances are made in psychology or law, for instance, and either does not duly incorporate those, not only is disparity created between these inevitably

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[32] See, for instance, Van den Heever JA's rather uncomplimentary remarks regarding psychiatry in *R v Von Zell* 1953 (3) SA 303 (A) 311 A-B, where he refers to "the deductions of..[a].. speculative science with rather elastic notation and terminology, which is usually wise after the event".

[33] But one notable specific instance where psychology has had a generally enriching impact on law (there are numerous others), is the development of therapeutic jurisprudence. The crux of therapeutic jurisprudence is that the inevitable psychological consequences for those whom the law affects should be studied, and that the law should be developed to maximise positive "therapeutic" effects of legal rules and procedures; see Smith, SR "Symposium: Law and Psychology: From Law and Bananas to Real Law: A Celebration of Scholarship in Mental Health Law" *34 Cal W L Rev 1* (1997) 5. Therapeutic jurisprudence has been described as a "law of healing". This integrative study of the psychological impacts of law, has a special application in assessing the impact of law that pertains to individuals with mental disabilities. It "recognises that substantive rules, legal procedures and lawyers' roles may have either therapeutic or anti-therapeutic consequences". In the United States, "therapeutic jurisprudence has been embraced and endorsed by judges, by practitioners, and by mental health professionals." See Perlin ML "A Law of Healing" *68 U Cin L Rev* 407 (2000) 408.

[34] This, particularly, is an aim that features throughout this dissertation. Wherever possible, every endeavour is made to develop an acceptable common language between psychiatry and law.

interacting fields, but each field is also impoverished. Especially when the law falls behind, its use of archaic terminology[35] or concepts, threatens the respectability of the law and its real and perceived effectiveness and efficiency.

2.4 Intradisciplinary Refinement amongst Areas of Internal Law (Smaller-system Intersectoral Refinement[36])

This is a type of intersectoral refinement in the context of law: that between the different sectors of a state's internal law. Where different areas of law have common ground, it provides the opportunity for fruitful comparison. The relationship between the law of delict and criminal law, for instance, invites such comparison. Exploration of the essence of the nature and purpose of one, can be greatly enhanced by comparison with the other.

Having regard to other relevant areas of law does not detract from the focus of an investigation, but rather enriches it, creating broader perspective and more diversely informed insight.[37] The various sectors of law, as is the case with any

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[35]That South African law still, for instance, refers to "idiots" and "imbeciles" (see the **Sexual Offences Act** 23 of 1957) when these terms have long since fallen into desuetude in psychology and psychiatry, is unacceptable. In 1995, Snyman uses these terms, without any reference to their being obsolete, see Snyman C.R. *A Draft Criminal Code for South Africa.* Cape Town: Juta (1995), and for a discussion see Snyman CR *Criminal law* (3 ed) Durban: Butterworths (1995) 350-351, where these terms are erroneously described as being part of "the technical language of psychology". However, the discussion containing that statement does not appear in Snyman's latest edition. Nevertheless, the abovementioned terminology is still used without criticism; see Snyman CR *Criminal Law* (4 ed) Durban: Butterworths (2002) 365.

[36]See fn 24 *supra* for a brief explanation of this usage of these terms.

[37]Alluding to how studies within the specialised area of mental-health law can enhance an understanding of other areas of law, Smith states: "Scholarship in mental health law [is] a relatively new specialty by legal standards......Law and psychology and law and psychiatry were sometimes called "law and bananas" just a decade or two ago....[now] mental health law has

other system, do not function in isolation, but are interrelated. As in the case of operational islands within an organisation[38], numerous adverse effects can result where related areas of law become dislocated in their development.

2.5 Intradisciplinary Refinement amongst Systems of Law (Larger-system Intersectoral Refinement)

This is another type of intersectoral refinement in the context of law: that between similar sectors of different states' laws.[39] South African law may be classified as a "hybrid" system, notably containing Roman-Dutch-law and English-law elements. Indeed, as the modern "global village" expands, South African law becomes more hybrid.[40]

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become a high-quality, diverse and sophisticated contributor to our understanding of the law and legal system." With regard to the enrichment of mental health law by an understanding of other areas of law, Smith states: "Another strength of the scholars in mental health law is that they usually teach or conduct research in another substantive area of the law in addition to mental health law......criminal law, torts, and law and medicine are among the common areas of additional expertise.....this expertise brings to mental health law a very strong doctrinal understanding of almost all other areas of the law.". See Smith SR "Symposium: Law and Psychology: From Law and Bananas to Real Law: A Celebration of Scholarship in Mental Health Law" *34 Cal W L Rev 1* (1997) 1, 8.

[38]See fn 13 *supra*.

[39]These comparative-law aspects would conceptually also translate into intersectoral refinement in the context of other disciplines. Many other disciplines have diverse branches within them, just as the law does. Moreover, comparing different approaches of experts in different countries to problems within a field, would be analogous to comparative-law evaluations, and similarly fruitful.

[40]For decades now, South African law in its development has actually been quite open to the influence of foreign law. Medical law is a particularly fertile area for international cross-pollination. *Castell v De Greef* 1994 (4) SA 408 (C) is an example where American, English, German and Australian law was strongly relied upon; in fact, the "test" for disclosure (see discussion *infra* chapter IV 2.1) is based on the formulation in the Australian case, *Rogers v Whitaker* (1993) 67 ALJR 47.

The subdiscipline known as "comparative law" compares various legal systems, or parts thereof, seeking solutions and attempting to promote optimality where possible.[41] Through comparative study, the laws of different countries are able to enrich one another. Having regard to comparative law can be a valuable asset to legal development. Development in one system of law can both benefit from perspectives in other legal systems, and be of benefit to perspectives in other legal systems.

2.6 Conclusion: An HMM Approach

2.6.1 Law and Management

Any interdisciplinary analysis or multidisciplinary application would be incomplete if it does not have regard to relevant aspects of the law and relevant applied principles of management. With regard to law, conduct in the course of virtually any kind of professional practice can potentially have special legal consequences. It is thus important for those involved to understand the law in that area in order to be able to function efficiently within it. As regards management, action in the realm of any field can be rendered more efficient by the appropriate application of relevant principles of management.

The better practitioners in their fields understand relevant

Especially since 1997, with section 39 of the South African **Constitution** (Act 108 of 1996, hereafter referred to as the **Constitution**), stating that a judge may consider foreign law when giving meaning to South African law, the door is even wider open to global legal influence.

[41]Medical law generally has a strong comparative focus, and developments are shared by various states. The resultant similarities in legal principles, in turn, facilitate further mutual development. See, for instance, Carstens PA *Die Strafregtelike en Deliktuele Aanspreeklikheid van die Geneesheer op Grond van Nalatigheid* (University of Pretoria, 1996) 304-305, who, after a comprehensive analysis of the laws of various states regarding medical negligence, concludes that, on the whole, the resultant principles are virtually the same.

principles of law and management, the more effectively and efficiently they will practise. In turn, the better legal practitioners in the specialised interactive areas of the law understand the fields with which they interact, the better relevant applications from experts in those fields can be utilised by the law, and the better conduct within those fields can be regulated by the law.

2.6.2 **Sound Terminology and Definitions**

Paying careful attention to the language used to convey concepts is imperative. To avoid misunderstanding, which can often be disastrous, the meanings of concepts must be correctly and unambiguously articulated. Sound definitions are not merely a matter of theory. As discussed, unsound definitions and terminology can significantly impact on the interaction between professionals within fields and, especially, the interaction between those from various fields. Some of a proclaimed "practical disposition" might argue that "splitting hairs" about definitions and terminology is a waste of time and effort. On the contrary, in the same way that the conceptualisation phase in a project can make or break its eventual success[42], fundamental definitions and conceptualisations can facilitate or severely hamper intradisciplinary and interdisciplinary applications.

It is of great practical importance that people who are attempting to work together understand the substance of their communications. In the same way that communication is paramount in an organisation, it is paramount in effectively and efficiently solving a multidisciplinary problem. The words used, and that which is understood by them, after all, lie at the heart

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[42] Good conceptualisation facilitates smooth implementation. The better one plans and sets oneself up initially, the more smoothly one's venture will progress. Poor planning and conceptualisation are associated with unnecessary scope changes during implementation, resulting in cost and complication that could have been avoided.

of communication.

2.6.3 **Illustration Using Medicine and Psychology**

Not only those involved in interdisciplinary work, but also all those involved exclusively within fields which interact with others, can contribute to better interdisciplinary integration and refinement (for reasons discussed). Figure 3 (next page) illustrates an example of the interaction of fields and the potential for refinement that this creates. An extract of the interactive relationships between (mainstream) medicine and psychology is depicted, as encompassed by HMM. An intersectoral interactive cluster within medicine, which interacts with a similar interactive cluster within psychology, features.[43] Certain inherently interdisciplinary sciences that emerge from some of these interactions, are also indicated.[44]

On a small-system intersectoral level, the areas of (mainstream) medicine, *viz* psychiatry, paediatrics and neurology, can inform and enrich one another, and the areas within psychology, *viz*

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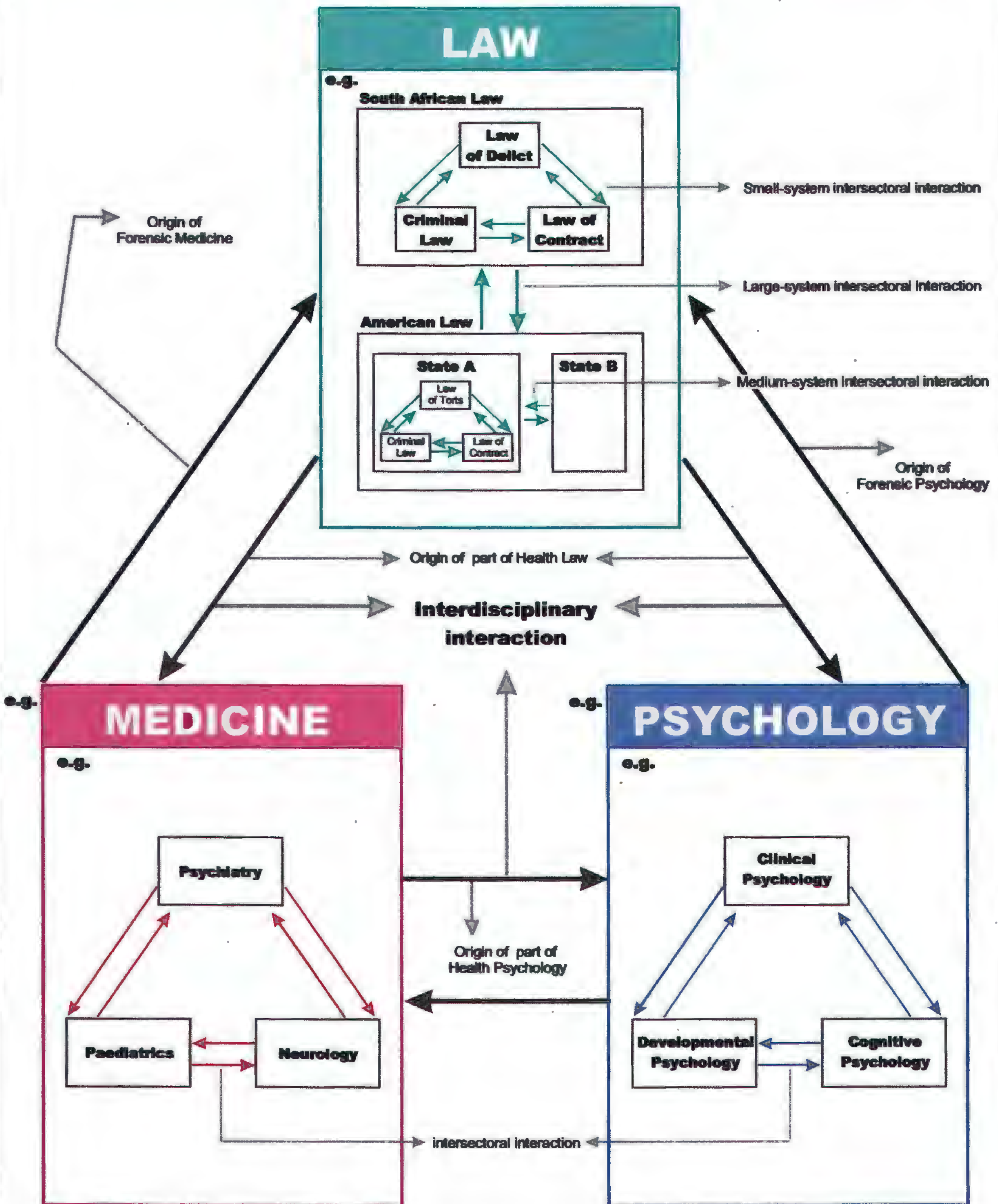
[43]The interactive relationships within the discipline, law, have been discussed *supra*. The potential for medium-system intersectoral refinement between the laws of different states within the United States of America, is also depicted, per illustration. The same principles enunciated under 2.4 and 2.5 *supra* apply to this process.

[44]The origin of forensic medicine (an application of medical expertise in the context of law) is indicated. Similarly, the origin of forensic psychology (the application of psychological expertise in the context of law) is noted. The reason for the downward arrows' representing the origin of only a part of health law, is that health law encompasses more than just law applied to the field of medicine and the field of psychology; see the discussion *infra*, chapter III under 3.2.1.3, for details. Finally, the origin of part of health psychology is reflected in the bidirectional interface between medicine and psychology. It should be noted that this interface covers more than just a part of that field, however; the interactions between clinical psychiatry and clinical psychology regarding certain aspects of psychopathology, for instance, would not necessarily involve any aspect of health psychology.



HOLISTIC MULTIDISCIPLINARY MANAGEMENT
LAW
e.g.
South African Law
Law of Delict
Criminal Law
Law of Contract
Small-system intersectoral interaction
Origin of Forensic Medicine
Large-system intersectoral interaction
American Law
State A
Law of Torts
Criminal Law
Law of Contract
State B
Medium-system intersectoral interaction
Origin of Forensic Psychology
Origin of part of Health Law
Interdisciplinary interaction
e.g.
MEDICINE
e.g.
Psychiatry
Paediatrics
Neurology
e.g.
PSYCHOLOGY
e.g.
Clinical Psychology
Developmental Psychology
Cognitive Psychology
Origin of part of Health Psychology
intersectoral interaction

clinical psychology, developmental psychology and cognitive psychology, can similarly inform and enrich one another. Then, on an interdisciplinary level, all the intersectoral enrichment that has taken place in each field, can in turn enrich the other field.

The corresponding subdisciplines especially have potential for mutual enrichment: clinical psychiatry and clinical psychology, for instance, both involve intervention in psychological/ behavioural problems; cognitive psychology and neurology have a significant overlap in so far as certain functions of the brain are concerned; developmental psychology and paediatrics have a significant overlap in so far as children at various stages of development are involved.

Nevertheless, each part in the intradisciplinary cluster can enrich any part of a cluster in the other discipline. For example, although developmental psychology and paediatrics would have the closest interactive interdisciplinary relationship, experience in the field of clinical psychology, as such, would also have the potential directly to enrich applications of paediatric medicine.[45]

In sum, although each sector in its respective position within the cluster has the most direct interdisciplinary relationship with its respective counterpart, all sectors have the potential for multilateral intra- and interdisciplinary refinement.

2.6.4 **The Crux: Continuous, Reciprocally Enriching Collaboration**

In addition to having regard to law and management, any professional field must also pay careful attention to fields related to it. The HMM approach invites professionals to maintain perspective beyond the confines of their specialised fields in

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[45] For instance, cases that involve child psychopathology.

order to promote interdisciplinary harmony and efficient specialist collaboration. Moreover, such perspective continuously creates opportunities for intradisciplinary enrichment.

One of the fundamental principles of project management is that the activities within an organisation must not lose touch with the overall strategic goals of the organisation. Projects within an organisation, apart from having their own goals and objectives, must remain aligned with the strategic aims of the organisation as a whole. This principle features in HMM in that there must be the following constant underlying strategic purpose in any multidisciplinary venture: apart from solving the specific problem at hand, the process should be aligned with the strategic purpose of interdisciplinary development and the continuous improvement of interactions and results.

It is in the interest of all to aim to develop, refine and streamline endeavours within fields and in their interactions. The more refinement there could be on the intradisciplinary level, the more efficient and effective the integration and application on the interdisciplinary level would be rendered. Sound multidisciplinary interaction, in turn, enriches all the fields of expertise involved, not to mention the experts themselves. Moreover, the most significant beneficiaries of holistic multidisciplinary development, are those whom the disciplines serve. The benefits of the effects of successful HMM are not only numerous, but also of dire importance to those who rely, sometimes with their very lives, on those to whom multidisciplinary efficiency and effectiveness have been entrusted.

CHAPTER II

CLINICAL PSYCHIATRY IN CONTEXT

1 Psychiatry: A Specialised Subfield of Medicine

In the light of the discussion in the previous chapter, it is appropriate to take the opportunity in this chapter critically to discuss and to clarify some fundamental terms and definitions relating to clinical psychiatry. Since clinical psychiatry forms part of the broader subfield of "psychiatry" within medicine, psychiatry should first be defined.

According to Dirckx *et al*[46], "psychiatry" is "the medical specialty concerned with the diagnosis and treatment of mental disorders"[47]. This definition is too narrow - it does not reflect the full scope of modern psychiatry. Although the term "psychiatry" is essentially a synthesis of the Greek *psyche* (mind) and *iatreia* (care/**treatment**), the modern field of psychiatry is broader, involving more than just the diagnosis and treatment of "mental disorders".

Anderson, Anderson and Glanze[48] define "psychiatry" as "the branch of medical science that deals with the causes, treatment and prevention of mental, emotional and behavioural problems". This definition is a more accurate reflection of the scope of modern psychiatry. "Psychiatry", in spite of the precise narrow derivational meaning of the word, has indeed grown to involve not only diagnosis and treatment, but also strategies for prevention, along with theories and research on the causes (aetiology) of

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[46] Dirckx J (Ed) *Stedman's Concise Medical and Allied Health Dictionary* (3 ed) Baltimore: Williams and Wilkens (1997).

[47] The desirability of the term "mental disorder" is discussed *infra* under 2.2.2.

[48] Anderson KN, Anderson LE and Glanze WD (Eds) *Mosby's Medical, Nursing and Allied Health Dictionary* (4 ed) St Louis: Mosby (1994) at 1296.

psychological/behavioural problems. Apart from this, the broader field of psychiatry has adopted a few different guises involving more than the diagnosis and treatment of psychopathology. Forensic psychiatry[49] is an example of one of these.

2 Clinical Psychiatry

2.1 Definition

The branch specifically dealing with the diagnosis and treatment of "mental disorders", would be "clinical psychiatry". The word "clinical" is also derived from Greek: *kline* meaning "bedside". In various professional contexts, this word has come to apply to the diagnosis and **treatment** of living persons as if "at the bedside". *Prima facie* the term "clinical psychiatry" would then appear to be etymologically tautologous. In modern reality, however, it is not, since the word "clinical" must be added when it is necessary to distinguish "clinical psychiatry" from the broader term "psychiatry". The definition that Dirckx *et al*[50] furnish for "psychiatry" would thus actually then amount to the definition of "clinical psychiatry": "the medical specialty concerned with the diagnosis and treatment of [psychopathology]".

2.2 "Psychopathology" and "Mental Disorder"

2.2.1 Definition

It is clear that the phenomenon described as a "mental disorder" is central to clinical psychiatry. "Psychopathology" is basically

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[49] Discussed in Chapter III *infra*.

[50] *Supra* 29.

a synonym for the term "mental disorder". The DSM IV-TR[51] describes rather than defines "mental disorder"[52]:

> "...it must be admitted that no definition adequately specifies precise boundaries for the concept of 'mental disorder'[53]...each of the mental disorders is conceptualized as a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present

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[51]American Psychiatric Association (APA) *Diagnostic and Statistical Manual of Mental Disorders* (4 ed - Text Revision) Washington: APA (2000). This is probably the most widely recognised and accepted classification system of "mental disorders". DSM I was first published in 1952. Since then, the many problems and shortcomings have been sought to be eradicated by numerous task groups. The DSM has made tremendous advances in the area of classification of psychopathology and has met worldwide, though not unanimous, approval. The World Health Organisation's classification system, the International Classification of Diseases (ICD), also includes a classification system for psychopathology. In South Africa, the DSM is accepted as a primary authority in the diagnosis and definition of psychopathology. See, for instance, Louw DA (Ed) *Suid-Afrikaanse Handboek van Abnormale Gedrag* Johannesburg: Southern (1989). After stating that classification is an integral part of science and human experience, Barlow DH & Durand VM *Abnormal Psychology: an integrative approach* Pacific Grove: Brooks/Cole (1995) indicate that most mental health professionals use the nosological system contained in the DSM. They describe it as the most advanced nosological system that the world has ever seen.

[52]American Psychiatric Association *DSM*-IV-TR Washington: APA (2000) xxx-xxxi.

[53]King NA "The Role of Culture in Psychology: A Look at Mental Illness and the 'Cultural Defense'" *Tulsa J Comp & Int L* (Fall, 1999) asserts that though classification of "mental illness" is not universal, the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Classification of Diseases (ICD), reflecting the official nomenclature for the classification of "mental disorders" for application in a wide variety of contexts, have received validation among numerous sectors. King states that "mental illness" has in fact been defined within the limits of the DSM and ICD: The Comprehensive Glossary of Psychiatry and Psychology defines "mental illness" as "any serious impairment of adjustment; any psychiatric disorder listed in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders or in the World Health Organization's International Classification of Diseases."

> distress...or disability...or with a significantly increased risk of suffering death, pain, disability, or important loss of freedom. In addition, this...must not be merely an expectable and culturally sanctioned response to a particular event. Whatever its original cause, it must currently be considered a manifestation of a behavioural, psychological, or biological dysfunction in the individual..."

The crux of the latter notions is that the manifestation must be a significant deviation from the norm in the particular context of the individual. It is submitted that the concept "psychopathology"/"mental disorder" may be concisely defined as "any clinically significant abnormal condition manifesting psychologically or behaviourally".[54] The inclusion of the words "clinically significant" in the furnished definition is due to the fact that, before a phenomenon can qualify as psychopathology, it must be sufficiently deviant from "normal"[55]

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[54]However, the term "psychopathology" can also be used to refer to the study of such abnormal conditions. Although that usage is actually technically closer to the etymology of the word, ie *psycho* - mind + *pathos* - disease/disorder + *logos* - study, the "-logy" suffix has developed (in medical terminology and ordinary grammar) to be often used also to denote the actual phenomenon, not only the "study thereof". Although the classification of something as psychopathology depends on a psychological/psychological-behavioural manifestation, it is, as will be discussed, inevitably related to many factors, including possible physical pathology.

[55]Adjudicating on the matter of what should be considered "normal" is a difficult task - especially in multicultural societies such as South Africa and the United States. King (*op cit* 224) points out that culture is, and indeed should be, receiving greater attention as the international arena converges. She avers that it is not until the impact of culture is universally recognised in all fields, that humankind will be able to broaden its visions and deepen its insights. In psychiatry and psychology, especially, culture is a factor that cannot be omitted from the process of interpreting behaviour. King (*ibid* 201) correctly asserts that a collection of signs and symptoms cannot simply be universally accepted as indicative of abnormality - there are immense differences in the degree of their acceptability from one culture to the next. She furnishes the example of an elderly Neapolitan cobbler who comes to a

unimpaired human behaviour to warrant clinical intervention. "Clinical" intervention then, in the present author's estimation, involves any type of integrated treatment strategy aimed at ameliorating the condition or its effects.

2.2.2 **Desirability of the Term: "Mental Disorder"**

The term "mental disorder" is in current, albeit reluctant, use. The DSM[56] itself states that "...the term mental disorder unfortunately implies a distinction between mental disorders and 'physical' disorders that is a reductionistic anachronism of mind/body dualism. A compelling literature documents that there is much physical..in mental...and much mental...in physical[.] The problem raised by the term 'mental' disorders has been much clearer than its solution, and, unfortunately, the term persists in the title of DSM-IV because we have not found an appropriate

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hospital clinic with a rambling story, wandering from headaches and listlessness to an old woman who has made him sick. The cobbler is referred to the psychiatric department. The examination reveals some detail about the perceived "enemy" and how long she has wished him ill and how "she makes his head hurt". The psychiatrist interprets this as an indication of a persecutory delusion. To be sure, an interpreter is summoned. A fluent Italian-American subsequently explains that the man is illiterate and believes the woman to be a witch who has cast the evil eye on him - the apparent delusion is nothing more than a bit of superstition typical of some parts of Neapolitan society. What constitutes a normal belief there might thus be interpreted as a psychotic symptom in an American hospital. King (*ibid* 212-213) acknowledges that distinguishing between truly pathological reactions on one hand, and behaviour sanctioned by society on the other, is a difficult endeavour - for example, according to her, Puerto Rican persons, whose culture encourages hyperverbal, hyperactive behaviour and easy expression of emotions, have sometimes been erroneously considered as manic or acutely schizophrenic. Indeed, physicians must be aware of their own potential cultural biases in their approach to psychopathology. This is particularly true in the South African context. Taking cultural factors into account should be demanded by basic standards of practice. If this were so to be established, misdiagnoses due to an unreasonable disregard of cultural factors could then form the basis of malpractice.

[56] American Psychiatric Association *DSM*-IV-TR Washington: APA (2000) xxx.

substitute."

The present author contends that the term, in addition, particularly lends itself to stigma, and does not adequately uphold the dignity[57] of those to whom it is ascribed. Moreover, it is submitted that it can have countertherapeutic effects.[58] Persons whose problems justify psychiatric intervention, are further encumbered by having to see themselves as "somebody with a mental disorder". The term "mental disorder" is indubitably not conducive to positive self-appraisal. Ironically, especially psychologists and psychiatrists should be sensitive to the impact that choice of words can have on people. These professionals should well know that the interpretation of combinations of words contains an intellectual component as well as a potentially very powerful emotional component.[59]

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[57]Upholding any person's dignity is not only important *per se*, but is also firmly entrenched as a fundamental right in section 10 of the **Constitution**: "Everyone has inherent dignity and the right to have their dignity respected and protected."

[58]The attitudes that both afflicted persons and the community have towards "mental disorders" can be extremely significant. As Dr TA Lambo, a psychiatrist who started a therapeutic village in Nigeria, stressed: "[O]ne of the most important cultural factors which influences or determines the nature of treatment is community attitudes. Community attitudes towards emotional disorder...may considerably influence what action the patient takes about his disability, and even the content and evolution of his...symptoms. They may impede free communication of his emotional (inner) experiences without the knowledge of which proper diagnosis of his condition is impossible." See King NA "The Role of Culture in Psychology: A Look at Mental Illness and the 'Cultural Defense'" *Tulsa J Comp & Int L* (Fall, 1999) 210. According to King, Lambo's experience in Africa revealed that the greater the confidence of the community with respect to both the treatment and the people who treat them, the more readily they come forward for treatment or encourage their relatives to do so.

[59]King (*ibid* 211) points out that underutilisation of mental health services is common throughout many societies. She avers that in many cultures, for example Southeast Asia, individuals are reluctant to admit to or discuss their own or family members' psychiatric problems. Stigma, which is part and parcel of the labels attached to phenomena and the words by which they are described, indeed has an impact that must not be underestimated. The present author contends that the mental health professions

This is an instance where the field of health psychology[60] should enrich clinical psychology and psychiatry. The scope of health psychology includes assessing and attempting to ameliorate the effect that the actions of health professionals have on their clients. A great part of this involves the substance and method of communication. That psychiatric clients will be exposed to commonly used terminology such as "disorder", is mostly unavoidable.[61] Apart from the controversial situation that clients may, in appropriate cases, have insight into their personal records[62], the term "disorder" is in common usage in the popular media. Conditions such as "bipolar disorder" and "obsessive-compulsive disorder" are well-known.

The word "disorder" is clearly not a friendly one - it can quite easily be perceived as having a strong negative quality that could, it is submitted, have a powerfully destructive impact on an individual's self-appraisal.[63] Moreover, the description of someone as "having obsessive-compulsive disorder" or "having bipolar disorder", for instance, compounds the risk of making the

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should evolve to a level where using insensitive and unnecessarily harsh terms to describe conditions, would constitute poor practice, and, in clear cases, even malpractice.

[60]See the discussion *infra* in chapter III, 3.2.1.3.

[61]Almost all the diagnosable conditions in the DSM contain the word "disorder"; exceptions are, for instance, "schizophrenia" and "pica".

[62]Section 32 of the **Constitution** (right of access to information) has the effect that persons have access to their medical records (see also **The Promotion of Access to Information Act** 2 of 2000). However, like all fundamental rights, the right is not absolute - it can be limited in terms of section 36 of the **Constitution**. For a discussion on access to medical records in the psychiatric context, see Coetzee LC *Medical Therapeutic Privilege* (LLM dissertation, University of South Africa, 2001) 156-164.

[63]With regard to labelling individuals, Barlow and Durand correctly assert that, once labelled, a client may be inclined to identify with the negative connotations associated with the label, negatively affecting his or her self-esteem; see Barlow DH & Durand VM *Abnormal Psychology: an integrative approach* Pacific Grove: Brooks/Cole (1995) 112.

error commonly referred to as reification of diagnostic categories.

Barlow and Durand[64] note reification as an important danger inherent in the "diagnosis" of "mental disorders". It involves seeing "mental disorders" as definite "things"[65] that exist in the same way as infectious diseases, for instance. One of the dangers, then, is that clinicians might force a manifested behavioural "disorder" into one category or another, on the mistaken assumption that everything must "fit" somewhere.[66] Instead of seeing diagnostic categories for that which they are: convenient methods for organising observations of human behaviour and emotions, some clinicians may become inclined to view the "disorders" that clinical science has created from grouping and classifying clusters of signs and symptoms, as concretely existing entities, akin to a physical disease.

Mental manifestations are inherently diverse and, although there may be many correlations in the progression of similar conditions in various individuals, people would be more aptly described as having features of a specific type of "condition", rather than one cast-in-stone, specifically diagnosable "disorder".[67]

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[64] *Ibid.*

[65] Reification literally means "making into things" (legal scholars and practitioners will immediately discern the connection to the Latin *res*): perceiving an abstract "mental disorder" as something which exists concretely in that specific form, classifiable more or less in the same way as a breed of dog or a typical-course infectious disease.

[66] Reification of diagnostic labels can result in a psychotherapist's perceiving a client's situation through distorted spectacles, unduly "observing" what he or she expects to see, while overlooking other important details.

[67] Individual differences and differences across societies and cultures lead to inevitable, striking variations in manifestations. See King NA "The Role of Culture in Psychology: A Look at Mental Illness and the 'Cultural Defense'" *Tulsa J Comp & Int L* (Fall, 1999) 206, where she acknowledges that compelling evidence exists that although "psychiatric disorders" are panhuman phenomena, the manner in which these are experienced is

Accordingly, it is submitted that it is unsound to describe someone as "having obsessive-compulsive disorder", for instance. It would be more accurate to state that someone has **"an** obsessive-compulsive condition", rather than "obsessive-compulsive disorder". The latter sounds much more like a definite specific disease with definite specific elements. The diagnostic criteria in the DSM should thus rather indicate a diagnosis of **"a** bipolar (type I) condition", for instance, rather than "bipolar I disorder".[68]

It is submitted that the word "condition" is a much "friendlier" word than the word "disorder". It is also not foreign - it has been used on many occasions in a variety of medical contexts. This dissertation will, accordingly, refer to X and Y "types of conditions", rather than X and Y "disorder". It is suggested that clinical psychiatry and psychology should evolve to do the same.[69]

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linked to the social context in which the individual lives. This is not even to mention the individual's unique personal characteristics. With regard to social context, she furnishes the following example: A study by the World Health Organisation (WHO) found a better outcome among patients with schizophrenia in developing countries, faring far better than patients in North America and Europe. There is a belief that such "major mental illness" is almost inevitably chronic and incurable. However, research has revealed that many "severe forms of mental illness" have remarkably dissimilar progressions, ranging from complete recovery, to serious disability. Social and cultural factors, not to mention individual personality, have a very significant role in the manifestation and course of any "mental disorder".

[68]Numerous scholars in psychology even contend that it is dehumanising and judgmental in any way to assign a term to a person with a particular cluster of problems. It is submitted, however, that some scholars go too far when they suggest that no psychopathology can be seen to exist in reality and that no condition can in any way be objectively assessed; see the discussion *infra* under 2.3.

[69]Strategies to avoid personal and social stigmatisation have to some extent made their way into psychotherapeutic practice. There has, for instance, emerged a tendency to refer to the person utilising psychotherapeutic services as "the client" rather than "the patient". Exactly what the impact of this is on the clients themselves and the general public, is difficult to ascertain empirically. Nevertheless, the notion of a "person making use of professional medical services" as being

Standards of practice are central to determining when there has been malpractice. This dissertation therefore must have regard to, and comment on, relevant elements of psychiatric practice.[70] The question that presently arises is then which term could replace the undesirable "mental disorder".

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a "client" accords with modern trends in health-care delivery. Moreover, if one considers the "sick" connotations to the word "patient" and that it is, after all, derived from the present participle stem *pati-* of the Latin verb "to suffer" (see Rooney K (Ed) *The Encarta World English Dictionary* London: Bloomsbury (1999) 1383), the term "client" is clearly a friendlier one. Whereas the word "patient" may be more inclined to cause a person to feel like a suffering victim with whom there is something "wrong", the term "client" is more likely to inspire feelings of autonomy and dignity - the person chooses to engage the professional services of a medical practitioner, and has "a say" and a role to play in that process. Although the use of the word "client" in some instances may lead to rather unusual results, it is submitted that its use does not give rise to any practical problems. It is, however, submitted that there is one instance in which "client" is inappropriate, *viz* where a person is treated **against** his or her will. A client is someone who chooses to take someone else's advice - an "involuntary/unwilling client" seems a contradiction in terms. Since the instances where a person is treated against his or her will are extremely limited (see chapter IV *infra*), those persons could perhaps still, proportionally exceptionally, be referred to as "patients" - after all, in addition to whatever else might ail them, they also suffer a significant curtailment of autonomy. Such a distinction in nomenclature might even augment the exceptionality of those instances. Nevertheless, it is suggested, in the interests of furthering feelings of dignity and freedom, that all voluntary health-care consumers be described as clients rather than patients. The terms by which people choose to describe concepts are intimately and inherently connected to the "feel" created within that sphere. Encouraging the use of more appropriate terminology may have a very significant contribution to make in effecting paradigm shifts. Considering that a human-rights culture, placing emphasis on dignity, equality and freedom/ autonomy, is sought to be cultivated in South Africa, encouraging health professionals to pay attention to a relatively minor detail such as using the term "client", which requires a personal mental paradigm shift, might hence contribute to the broader paradigm shift desired for the larger health-care system.

[70] If the description of someone as "having a disorder" were to be rejected in standard psychiatric practice, it would then be potentially legally actionable malpractice overtly to label someone as "having a disorder". It is here suggested that such rejection is indicated. See further the discussion *statim infra*.

2.2.3 Alternative to the Term: "Mental Disorder"

It is submitted that adding one word and a few syllables will exponentially more accurately reflect the nature and complexity of what are imprecisely and rather callously described as "mental disorders". The alternative here suggested is not particularly user-friendly, but it need not be user-friendly - it must imperatively be **psychologically** friendly.

It should be emphasised to any client who is capable of the necessary comprehension that he or she does not "have a mental disorder", but that his or her condition is a result of the complex interactions between his or her body, mind and environment - it is a biopsychosocial[71] condition. Because it warrants clinical intervention, however, the inclusion of the word "clinical" in the term is necessitated, since it is only those conditions that feature in a clinical context that would be included in a diagnostic manual.[72] The term "biospsychosocial condition" on its own would actually include virtually any condition which a person may experience. The term "clinical biopsychosocial condition" ("CBC")[73] is thus suggested as a viable

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[71]A term used, for instance, by Paris J "Personality Disorders: A Biopsychosocial Model" *Journal of Personality Disorders* 7 (3) (1993). As will shortly be elaborated, it is submitted that this term can have general application. Virtually every condition which may be classified as a "mental disorder" depends on a complex interaction between biological factors, psychological factors and social factors. Importantly, the order in which these appear is not intended to emphasise any one set of factors as more important than the others. In many conditions, it will be quite clear which factors dominate; nevertheless, other factors will invariably be involved. The clinical conditions that are so precipitated and maintained are indeed "clinical biopsychosocial conditions".

[72]If the term "clinical biopsychosocial condition" were to be adopted, the DSM would still be called the DSM (diagnostic and statistical manual); however, its full name would then be the *Diagnostic and Statistical Manual of Clinical Biopsychosocial Conditions*, rather than the *Diagnostic and Statistical Manual of Mental Disorders*.

[73]The initialism "CBC" is also used to denote other concepts. For instance, in medicine it refers to "complete blood

alternative to "mental disorder". Taking into account an individual's self-appraisal, he or she can then consider himself or herself as having a "clinical condition", rather than a "mental disorder". The term CBC is, it is submitted, more than representative of the phenomenon of psychopathology. Admittedly it is a very broad term - actually broad enough to encompass virtually any medical condition. However, it is suggested that the context of the use of CBC will distinguish it from other conditions where psychological and social factors do not play as prominent a role. Whereas "mental" is too narrow[74], it is widely accepted that that which manifests as **psycho**pathology depends on the dynamic interplay between biological, psychological and social factors. Moreover, the term "biopsychosocial" is not charged with negative connotations, as is the word "mental" as used in the context of mental illness, defect, disease or disorder.

It may take decades for the general public not to stigmatise "people with mental disorders". Professionals, on the other hand, constantly have the opportunity to improve terminology and to limit stigmatising appellations. In the present dissertation, the terms "client"[75] and "CBC"/"condition" will hence be employed wherever possible.

2.3 Desirability of Classification

Although it is evident that there are inherent dangers in classification, the need for a classification system is

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count", and in management to "cumulative budgeted cost". This is not problematic, since the context would invariably clearly reveal which usage is intended, just as ADR ("adverse drug reaction") and ADR ("alternative dispute resolution"), for instance, create no confusion in the medical-malpractice context.

[74]See also, for instance, the definition of Anderson *et al*, *supra* under 1.

[75]See fn 69 *supra*.

indisputable. Without common points of reference, terminology, definitions and clinical descriptions, it would be very difficult for research and experience regarding clinical biopsychosocial phenomena to be compiled and utilised to the benefit of all.[76] In diagnosis, one is necessarily required in some way to identify a particular possible crystallised collection of features in order to gain insight from research conducted on similar behavioural manifestations. Overtly "labeling" a client in the course of treatment should, however, be avoided.[77]

2.4 Clinical and Legal Terms

As HMM suggests, the law should also employ terminology that is sensitive to the people whom it serves, and is soundly harmonious on the interdisciplinary level. There has been much written and said regarding distinguishing clearly between legal and clinical definitions and terms.[78] However, the more congruence and mutual understanding there could be between law and the clinical sciences, the better subtle distinctions could be drawn. It is submitted that the definitions themselves should be shared as far as possible, although the purpose for which they are applied may be vastly different. There is no reason why the law should, for instance, speak of "insanity" (as is common in the United States - NGRI is the standard initialism to denote "not guilty by reason

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[76] Cultural diversity, in the context of classification, is indeed acknowledged in the DSM-IV-TR. It has "incorporated an awareness that the manual is used in culturally diverse populations in the United States and internationally." DSM-IV-TR identifies with how challenging it can be for clinicians from one ethnic or cultural background "to evaluate an individual from a different ethnic or cultural group". See King NA "The Role of Culture in Psychology: A Look at Mental Illness and the 'Cultural Defense'" *Tulsa J Comp & Int L* (Fall, 1999) 215.

[77] See fn 63 *supra*.

[78] See, for instance, Gillmer, BT, Louw DA & Verschoor T "Forensic expertise: the psychological perspective" *SACJ* (1995) 267.

of insanity")[79] when this term has long since been rejected in the clinical sciences.[80] Rather, the crux of the matter in "the insanity defense" is the person's **disability** at the time of the act: this is the extent to which the alleged CBC must affect the person - an incapacitating extent; the law defines the type of incapacity required, while psychiatry determines whether the CBC in question could have that effect. The effect is "disability" or "incapacity", and could soundly be so described without creating interdisciplinary disharmony. It is submitted that "NGRI" should rather be "ICBC" ("Incapacity due to Clinical Biopsychosocial Condition").

It is appropriate now to turn to the discussion of the interface between law and psychiatry, and the place of malpractice law therein.

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[79]It is notable that, in South Africa, the Rumpff Commission, as long ago as 1967, rejected the term "insanity"; see the *Rumpff Commission of Inquiry: Certain Views and Recommendations into the Responsiblity of Mentally Deranged Persons and Related Matters* (RP69/1967).

[80]For an example of the negative impression that the law's and/or lawyers' dislocation from clinical terminology can create, see Sevilla CM (an attorney at law in San Diego, CA) "Anti-Social Personality Disorder: Justification for the Death Penalty?" *J Contemp Legal Issues* 247 (1999, 10): "[I]f the person is mad and lacks the ability to choose to conform to societal rules, conviction and punishment for crime is [sic] not warranted; rather, treatment of the incapacitating condition seems appropriate for the truly insane person. A partially mad person, whose mental condition does not satisfy the test of insanity, can be convicted and punished, but either the degree of the crime or the harshness of the punishment should be subject to mitigation."

CHAPTER III

PSYCHIATRIC MALPRACTICE IN CONTEXT: THE INTERFACE BETWEEN LAW AND PSYCHIATRY

1 Introduction

There is a multifaceted interface between psychiatry and the law, both from psychiatry to law[81] and from law to psychiatry. From the former, in other words, psychiatry applied in legal contexts, emanates the field known as forensic psychiatry.[82] From the

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[81]Haslett *et al* aver that psychiatry has closer links with the law than most other branches of medicine, particularly due to the fact that psychiatric problems sometimes impair judgment to the extent that persons are not considered fully responsible for their actions. See Haslett C (Ed) *Davidson's Principles and Practice of Medicine* (18 ed) Edinburgh: Churchill Livingstone (1999) at 1096.

[82]According to Rieber RW and Vetter HJ *The Psychological Foundations of Criminal Justice* New York: John Jay Press (1978), the first American forensic psychiatric text (which emphasised medical causes of deviant behaviour) was published already in 1812, by Benjamin Rush. Early forensic psychiatry focussed mainly on "insanity" (now most correctly regarded as an archaic term - see *supra* 41-42) as a defence in criminal law, as well as attempting to explain criminal behaviour. The scope of forensic psychiatry has since expanded significantly. Examples of interaction and problems related thereto, both old and new, abound; see, for instance, Glueck S *Law and Psychiatry: Cold War or Entente Cordiale* Baltimore: John Hopkins Press (1962) (where he discusses some dilemmas in the "partnership" between law and psychiatry), and Freedman AM & Halpern AL "Professionalism, Mental Disability, and the Death Penalty: the Erosion of Ethics and Morality in Medicine: Physician Participation in Legal Executions in the United States" *41 N Y L Sch L Rev* (1996), where these two psychiatrists discuss what they see as an erosion of ethical standards in the practice of medicine: they refer to the report of the American Medical Association (AMA) Council on Ethical and Judicial Affairs (CEJA) that was adopted by the AMA as policy (entitled "Physician Participation in Capital Punishment: Evaluation of Prisoner Competence to be Executed; Treatment to Restore Competence to be Executed". According to Freedman and Halpern, the prior prohibition of psychiatrists' participation in legally authorised executions is virtually nullified by that CEJA Report. It declares as ethical the examination of death-row inmates for competence to be executed,

latter, in other words, law applied to the field of psychiatry, emanates a field, which, it is submitted, may be termed "psychiatric jurisprudence". These two directions of the interface will next be dealt with respectively.

2 Forensic Psychiatry

2.1 The Definition and Scope of Forensic Psychiatry

Kaplan and Sadock[83] state that "the intermix of law and psychiatry, called forensic psychiatry, includes problems of credibility of witnesses, culpability of accused persons, competency to make a will, contract, to take care of oneself or one's property, or to stand trial; compensation of injured persons; and custody of children". They also note the matter of assisting in jury selection as an instance encompassed by forensic psychiatry. It is submitted that these indeed all fall within the scope of forensic psychiatry. However, as will be discussed, strictly speaking, the "intermix of law and psychiatry" is broader than "forensic psychiatry".

In a later publication, Kaplan and Sadock (this time with Professor Jack Grebb) more accurately state that "forensic psychiatry is the branch of medicine that deals with [clinical

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and advocates the concept that "a psychiatrist is not a psychiatrist" when performing evaluations for the state. According to Freedman and Halpern, the notion that "a psychiatrist is not a psychiatrist" in the forensic setting is a recent concept in American literature. It is apparently based on an article by psychiatrist Paul Appelbaum, entitled, "The Parable of the Forensic Psychiatrist: Ethics and the Problem of Doing Harm". In this article, Appelbaum states: "The forensic psychiatrist in truth does not act as a physician. If the essence of the physician's role is to promote healing and/or to relieve suffering, it is apparent that the forensic psychiatrist operates outside the scope of that role." It is clear that the complex elements in the interface between law and psychiatry continue to lead to disparity and conflict.

[83] See Kaplan HI and Sadock BJ *Clinical Psychiatry* Baltimore: Williams and Wilkins (1988) 512.

condition]s of the mind and their relation to legal principles".[84] However, this definition is too narrow: not every matter in forensic psychiatry would necessarily involve a clinical condition as such. For example, where a psychiatrist might become involved in assisting with or evaluating a child's testimony, no clinical condition is concerned - the expertise here would involve understanding earlier stages of cognitive and emotional development.

Simon's[85] concise description is, it is submitted, correct: forensic psychiatry is "the application of psychiatry to legal issues for legal ends". The law applied to psychiatry (which is part of the "intermix of law and psychiatry") then, is not a branch of psychiatry, but rather a branch of law, namely "psychiatric jurisprudence".[86]

It is submitted that "forensic psychiatry" may be representatively defined as "the integrative branch of psychiatry where there is specialised application of psychiatry in a legal context" (forensic literally means "of the courts of law", from the Latin *forum*). In its etymologically purest form, forensic

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[84]Kaplan HI, Sadock BJ & Grebb J *Synopsis of Psychiatry* (7 ed) Baltimore: Williams and Wilkins (1994). Kaplan *et al* still, however, incorrectly discuss matters relating to the law applied to psychiatric practice under the chapter heading "Forensic Psychiatry". It is clear (also according to their definition) that these matters do not technically form part of forensic psychiatry. It is submitted that these matters would correctly fall within the realm of psychiatric jurisprudence. The first half of their chapter on forensic psychiatry deals primarily with psychiatric jurisprudence, whilst the first part of the second half deals with forensic psychiatry, returning to psychiatric jurisprudence in the form of malpractice law just before the very end. The authors then conclude with two further examples of instances involving forensic psychiatry. The present author opines that the contents of this chapter should have been separated into two chapters, the other one being entitled "Psychiatric Jurisprudence".

[85]See Simon RI *Clinical Psychiatry and the Law* (2 ed) Washington: American Psychiatric Press (1992).

[86]See discussion *infra* under 3.

psychiatry would thus involve any aspect of legal interest on which a psychiatrist might be summoned to give specialised expert testimony, or be otherwise directly or indirectly involved in the forensic (court) process.

Matters indeed covered by forensic psychiatry include mental capacity in private-law[87] and criminal-law[88] contexts; exploring the problems regarding, and assessing the value of, eyewitness testimony, offender ("line-up") identification[89] and eyewitness credibility[90]; exploring the psychological effects of emotional shock, personal insult, and physical injury; assessment following trauma for purposes of compensation for disability[91]; evaluations regarding the best interests of the child in, for instance, custody cases[92]; preparing traumatised or otherwise sensitive

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[87]This includes accountability for the purposes of a delict, and the capacity for concluding a contract or a will.

[88]This includes the capacity to commit the offence in question, see, for instance, Slovenko R *Psychiatry and Criminal Culpability* New York: John Wiley and Sons (1995). Also included is the capacity to stand trial for an alleged offence, see the **Criminal Procedure Act** 51 of 1977, s 77, and for a more elaborate perspective: Snyman CR *Criminal Law* (4 ed) Durban: Butterworths (2002) 167-176; Campbell IG *Mental Disorder and Criminal Law in Australia and New Zealand* Sydney: Butterworths (1988) 98-116.

[89]See Eysenck MW and Keane MT *Cognitive Psychology* (3 ed) East Sussex: Psychology Press (1995) 190-195; their discussion includes suggestions as to how the most accurate information can be obtained during the police interview. This type of activity is actually more likely to be encompassed by forensic psychology, rather than forensic psychiatry.

[90]Slovenko R *Psychiatry and Criminal Culpability* New York: John Wiley and Sons (1995) 259-272: In general, in the United States, psychiatric testimony as to the credibility of a witness (is he or she lying?), is not permissible; however, evidence as to the unreliability of eyewitness testimony (could he or she be making a mistake?) is permissible.

[91]See, for instance, Shapiro DL *Forensic Psychological Assessment: An Integrative Approach* Needham Heights: Allan and Bacon (1991) 239.

[92]See Berk L *Child Development* (4 ed) Needham Heights: Allan and Bacon (1997) 562-563.

witnesses for testimony.[93]

Apart from aspects of direct relevance to the courtroom, forensic psychiatry in the broader sense (but still within the furnished definition[94]) might involve explaining and predicting criminal behaviour[95], and the rehabilitation of offenders[96]. Finally, there is also some scope for psychiatrists' informing the decisions of policy-makers in law as to the psychological implications of legal policies and provisions both in evaluating existing law and the need for new law.[97]

2.2 The Acceptance of Psychiatry by the Law, and Vice Versa

2.2.1 The Acceptance of Psychiatry by the Law

Psychiatric testimony is extensively featured in courts of law

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[93]In line with the HMM approach, it is submitted that any application of psychiatry in a legal context should occur with integrative interdisciplinary perspective. It is, for instance, essential for psychiatrists to understand the legal effects of various statements. A different choice of words, which might appear to have little significance from the perspective of the ordinary clinical psychiatrist, might have great significance to the lawyer. Forensic psychiatry must therefore, of necessity, have regard to relevant legal principles in order properly to fulfil its function. Moreover, Kaplan *et al* express the view that feelings of fear on the part of the psychiatrist in the courtroom can be tempered somewhat by insights into the process; see Kaplan HI Sadock BJ and Grebb J *Synopsis of Psychiatry* (7 ed) Baltimore: Williams and Wilkins (1994). Preparing the expert clinical psychiatrist witness for the courtroom could, for instance, be the task of a specialised forensic psychiatrist or psychologist, or a psycholegal consultant.

[94]Ie "the integrative branch of psychiatry where there is specialised application of psychiatry in a legal context".

[95]See Rieber RW and Vetter HJ *The Psychological Foundations of Criminal Justice*. New York: John Jay Press (1978).

[96]See Campbell IG *Mental Disorder and Criminal Law in Australia and New Zealand* Sydney: Butterworths (1988).

[97]Once again, this is a role that is more likely to be fulfilled by a forensic psychologist or psycholegal consultant, rather than a psychiatrist, however.

around the world[98], indicating an acknowledgement of the need therefor and some acceptance of the value thereof. As might be expected, however, the value of the opinions of psychiatrists and psychologists, has also been vehemently challenged.[99] It is common cause that psychiatry and psychology are not the most concrete and exact of sciences.[100] This renders them susceptible to abstract

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[98]South African courts have relied heavily on the testimony of experts in cases such as *S v Kavin* 1977 (2) SA 731 (W). As might be expected, the American courts have featured psychiatric testimony on a considerably larger scale.

[99]The following remarks of Diemont JA, in *Stock v Stock* 1981 (3) SA 1283 (A) 1296 D-E, demonstrate some doubt as to the objective value of such expert testimony: "The overall impression gained is that the witness was not always fair and that when she was shown to be wrong she became argumentative. Counsel was in my view justified in submitting that the Court did not take a sufficiently critical view of the evidence given by the two psychologists. An expert in the field of psychology or psychiatry who is asked to testify in a case of this nature, a case in which difficult emotional, intellectual and psychological problems arise within the family, must be made to understand that he is there to assist the Court. If he is to be helpful he must be neutral. The evidence of such a witness is of little value where he, or she, is partisan and consistently asserts the cause of the party who calls him."

[100]Nevertheless, the rules of scientific evidence attempt to ensure the reliability of such evidence. See Grove WM & Barden RC "Protecting the Integrity of the Legal System: The Admissibility of Testimony From Mental Health Experts Under Daubert/Kumho Analyses" *5 Psych Pub Pol and L* (March, 1999) 225-226, where these authors comment on a leading case, *Daubert v Merrell Dow Pharms, Inc* 509 U S 579, 594-95 (1993) (setting out requirements for admissibility of scientific evidence): "In the Daubert (1993), Joiner (General Electric Co. v. Joiner, 1997), and Kumho (1999) cases, the U.S. Supreme Court has begun the long-overdue process of educating legal professionals in the essential, minimal characteristics of science. Six factors of scientific analysis, or indicia of testimonial reliability, can be distinguished in Daubert:

1. Is the proposed theory, on which the testimony is to be based, testable..?

2. Has the proposed theory been tested using valid and reliable procedures and with positive results?

3. Has the theory been subjected to peer review?

4. What is the known or potential error rate of the scientific

challenges not easily refutable with "hard evidence". It is not always easy for the expert to explain the complex basis for legitimate conclusions based on clinical judgment.[101] Nevertheless, psychiatrists are human, and make mistakes. It is also conceivable that, in a particular instance, the "mental-health opinion" of an intelligent lay person might even be superior to that of the psychiatrist.[102] Being a psychiatrist does not endow one with the quality of omniscience, nor does it confer immunity to error. There will be excellent psychiatrists and, as in any profession, relatively less competent ones.[103] However, to

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theory or technique?

5. What standards, controlling the technique's operation, maximize its validity?

6. Has the theory been generally accepted as valid in the relevant scientific community?

[T]hese features were not enumerated as an exhaustive list. Furthermore, the Daubert Court did not require trial judges to combine these factors algorithmically in deciding on admissibility, nor did they [sic] assign weights to the factors. Hence, it has been left to case law to clarify the proper application of Daubert."

[101]Indeed, however, the most competent expert would be one who can explain him- or herself; see the discussion of HMM in chapter 1 *supra*.

[102]See Slovenko R *Psychiatry and Criminal Culpability* New York: John Wiley and Sons (1995) at 226, where the work of Jay Ziskin is mentioned. Ziskin, who is both a lawyer and a clinical psychologist, is critical of the techniques employed by other psychiatrists and psychologists. He *inter alia* notes that in a study concerning the prediction of dangerousness, "the participating psychiatrists were found to be nearly always wrong". Ziskin has provided attorneys dealing with psychiatric evidence with a three-volume publication (now being expanded), "Coping with Psychiatric and Psychological Testimony". Two of the questions Ziskin suggests to be raised in court involve the basic value of psychiatric and psychological testimony: "Is the expertise shown by psychologists or psychiatrists in the court any better than the judgment of the ordinary man or woman?", and: "Are you aware of the great number of studies which show that more experienced psychiatrists are no more accurate in their assessments than inexperienced ones or even lay people?".

[103]As in any medical matter directly affecting a person's health and well-being, however, a low level of competence cannot

disregard the legitimacy of psychiatric expertise *per se*, is obviously not justified. Where someone with real interest in and, imperatively, a natural aptitude for understanding the workings of the human mind, spends years and years studying and constantly thinking about human functioning, his or her opinion can most certainly be of value. To trivialise or disregard it, would indeed be a grave loss to all involved.[104]

2.2.2 **The Acceptance of the Role of the Law by Psychiatry**

In American literature, complaints that psychiatrists are being "belegaled"[105], abound. Psychiatric malpractice law, if properly

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be tolerated. It is, appropriately, the law that must, imperatively from an informed perspective, ensure the legitimacy of the practices of professionals in society.

[104] Slovenko asks whether it is "not entirely reasonable to assume that one who has had special training in understanding people, one who spends his life studying and thinking about people, one who reputedly knows so much about the unknowable and can interpret a glance, a gesture, a slipped word, or a phrase to mean so much, is in a position to bring relevant and probative testimony on the legal regulation of behavior". The learned author also points out that when lawyers and judges say that psychiatric terms are vague, they imply that legal terms are not, and that such protest by lawyers or judges against psychiatric testimony "smacks of hypocrisy"; see Slovenko R *Psychiatry and Criminal Culpability* New York: John Wiley and Sons (1995).

[105] Ie the law intrudes too much on psychiatric practice. Simon RI "Coping Strategies for the Defensive Psychiatrist" *MedLaw* (1985) 551-552, states as follows: "It is not unusual for psychiatrists to feel that the law is heavily weighted in the favor of [cl]ients because of the numerous court decisions during the past decade that have strongly emphasized [cl]ients' rights and civil liberties. But the defensive psychiatrist goes beyond this perception and sees a potential malpractice case behind every [cl]ient, all the while feeling 'belegaled'. The legally uninformed psychiatrist [on the other hand] sees nothing, but the denial may render him even more vulnerable to liability. Defensive psychiatrists can be divided into two types - positive and negative. The positive defensive psychiatrist can be defined as one who orders procedures or treatments to prevent or limit liability. This may or may not accord with a reasonable standard of care. A negative defensive psychiatrist avoids procedures or treatments out of fear of a suit even though the [cl]ient might benefit from these interventions. This course is unconscionable and potentially legally actionable. The ubiquitous fear of

applied, should, however, be regarded very positively by psychiatrists, since it is *inter alia* this area of law which serves to ensure the respectability of their area of expertise. As is the case with any applied skill, simply studying psychiatry and psychology and achieving the required academic grade, does not afford somebody a vastly superior understanding of the human psyche. Only where natural ability is complemented by knowledge and forged by experience, can the result be a legitimate mental-health expert: the kind that the rational lay person can trust and respect. The law, in appropriate consultative interaction with the field of expertise involved, must protect the community against those who should not be trusted.

Psychiatrists should appreciate the role of the law in safeguarding the legitimacy of psychiatry. In the desirable situation where psychiatrists are held justly accountable for their actions, it would cultivate a climate of warranted trust in their conduct, and would promote the general positive perception of the field as a whole. Throughout the dissertation, it is hoped that it will become progressively clearer that the relationship between psychiatry and the law has inherent potential to be a mutually reinforcing partnership[106], rather than a competitive war

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malpractice contributes to a reactive position with [cl]ients that may have its own paradoxical legal liability consequences. The defensive psychiatrist is unaware of a fundamental truth - that in addition to an ethical (moral) and professional duty, psychiatrists possess a fundamental affirmative legal duty to provide a reasonable standard of care for their [cl]ients." The law must imperatively support good practice, and not have the opposite effect - law and psychiatry must work with each other, not against each other.

[106]Psychiatric malpractice law and sound legal regulation of psychiatry reinforce the legitimacy of psychiatric practice, whilst appropriate integrated application of psychiatry in a legal context reinforces the legitimacy of those legal applications that inherently demand psychiatric consultation. If the law were to maintain ignorance in these instances, inappropriate and unjust results would scathe its legitimacy. By the same token, if psychiatric practice were devoid of legal regulation, the flagrantly unsound practices of a minority of psychiatrists would threaten the real and perceived legitimacy of psychiatry as a whole.

of words.

3 Psychiatric Jurisprudence

3.1 Introduction

The term "psychiatric jurisprudence" is broad enough to encompass all areas where law and legal philosophy may affect psychiatry. The part of psychiatric jurisprudence on which this dissertation focusses, is "psychiatric malpractice law", which falls under "medical law". The precise position of psychiatric malpractice law in these legal divisions will next be elucidated.

3.2 Psychiatric Malpractice Law: Part of Medical Law

3.2.1 Definitions in Comparative Context

In step with the HMM approach, the definition of health law and medical law should have regard to other definitions in related fields that involve the words "medical" and "health". Moreover, the use of these words should be as close as possible to their real meanings. The place of psychiatric malpractice law in the context of medical law and health law is accordingly presently discussed with comparative reference to the divisions of health psychology and medical psychology. This is particularly appropriate, since there is considerable scope for interaction between these areas.[107]

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[107]Within the framework of sound HMM, medical law can, for instance, be informed by health psychology with great benefit. The law governs the conduct of health professionals, and, in so doing, should take cognisance of the range of psychological effects that such conduct can have on health consumers. Without an understanding of the real social/psychological impacts of the manner in which health care is delivered, the law may be impotent in ensuring the appropriate standards. This is an instance where medical law and health psychology must be properly integrated. Of course, since health-care professionals are the ones who generally guide the courts as to the establishment of the

3.2.1.1 **The Term: "Medical": A Broad Concept**

Before venturing into the brief comparative investigation, the word "medical" should be carefully examined. The word "medical" is derived from the Latin *medicus*, which broadly means "healer".[108] In this sense, "medical" actually includes all professionals involved in bringing about healing. However, although the adjective "medical" is etymologically connected to "healer" or "healing"[109], it is clear that not all areas of medical expertise necessarily involve healing. Where a pathologist, for instance, performs a necropsy in order to determine the cause of death for forensic purposes, there is obviously no healing involved. To say that a pathologist is not part of the medical profession,

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appropriate standards, it is imperative that health psychology inform all relevant areas of health care. Indeed, it should actually be trite law that all health-care providers should have training in health psychology, in order to ensure that they understand the possible psychological consequences of what they say and do, and that they consider the entire person in their treatment manner and strategy. Once again, law, medicine and psychology must work harmoniously together if the best results are to be achieved.

[108] As evidenced also by its relation to the verbs *medeor*, which means "heal, cure, remedy", and *medicare*, which means "to heal, cure.."; see Morwood J (Ed) *The Pocket Oxford Latin Dictionary* (2 ed) Oxford: Oxford University Press (1994). The Afrikaans term "geneesheer", which is commonly ascribed to a "medical doctor", actually literally means "master of healing". If one considers the word "geneesheer", it should actually be broad enough to encompass all persons who have mastered some form of the broader art of healing.

[109] The term "medicine" is also derived from Latin: *medicina*, which actually means "the art of healing"; see Morwood J (Ed) *The Pocket Oxford Latin Dictionary* (2 ed) Oxford: Oxford University Press (1994). The Afrikaans "geneeskunde", literally does mean "the art of healing", thus more accurately reflecting the meaning which is sought to be conveyed. Unfortunately, the fact that "medicine" also means "a **drug** for treating illness" and "treatment of illness or injury using drugs..", creates a very strong association in people's minds of medicine in that sense with medicine in the sense of "the art of healing". In fact, the definition "a drug for treating illness" is the first one to feature under "medicine" in the Encarta dictionary; see Rooney K (Ed) *The Encarta World English Dictionary* London: Bloomsbury (1999) at 1175.

however, would be rather absurd - the derivation of a term may provide the general preferred framework for its meaning, but cannot be applied totally literally in all instances.

What is here suggested is that at least any technique applied with the direct or indirect aim of bringing about healing would correctly fall within the ambit of "medical". It is not, however, suggested that any activity that does not *per se* involve healing should then be excluded from "medical activities".[110] All those practitioners who have been traditionally seen as medical practitioners, should still fall under the umbrella of "medical", since medical practices have evolved to encompass more activities than merely those directly or indirectly related to healing.[111] In other words, "medical" can involve **more** than merely the art of healing, but should **not** be seen as involving **less**. The point here made is that any person who provides services designed to "heal"

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[110]Where, for instance, a specialist in preventive medicine advises a perfectly healthy individual on strategies to maintain excellent health, it is also not a matter of healing, but rather of maintaining existing good health. "Preventive medicine" in the sense of "the preventive art of healing" ostensibly does not make good sense. However, the term is not, it is submitted, impermissible if one considers the fact that preventive medicine is actually the application of "medical" expertise in preventing disease. In this sense, "the healer" uses his or her expertise not to heal but to prevent. Due to the fact that it should actually be an imperative to integrate a strong preventive component into medical practice, the term "preventive medicine" is desirable. In any event, where exactly the line between prevention and healing lies would not always be readily ascertainable. Those who heal should at the same time give considerable attention to preventing, and those who are focussing on preventing, will invariably be ameliorating underlying potentially harmful conditions, thus in effect bringing about a degree of healing. Any condition within the human body or mind that disposes to the manifestation of disease, detracts from the sound whole. Any activity which restores the integrity of the whole, would amount to a form of "healing". The Encarta dictionary defines healing as follows: "to make a person or injury healthy and whole" (*ibid* 865).

[111]Therefore, even the activity of the doctor who performs a termination of pregnancy, who is quite clearly not engaging in any activity that would promote healing (unless the termination is required for therapeutic reasons), would still fall within the ambit of "medical".

in whatever way, should be seen as providing "medical services".[112]

Due to be deeply ingrained habit of using the word "medical" to refer to the traditional image of the "doctor trained in allopathic medicine", it may seem unpalatably foreign to some to describe, for instance, a homeopath, clinical psychologist or dentist as a "medical professional". Indeed, it is this conditioning that evokes, for instance, the laborious description "medical, dental, nursing and allied health sciences".[113] Actually, these can all soundly be grouped together under the single umbrella of "medical".

The term "medical practitioner" would, accordingly, actually be very broad. However, it is firmly entrenched in the minds of the members of society, both lay and professional, that when someone uses the term "medical practitioner" they would almost certainly mean to say: "a person who is trained and licensed in the field of mainstream medicine". It may also safely be accepted that someone who refers to a "medical doctor", means to exclude, for instance, a dentist, or a clinical psychologist or homeopath with a PhD. The conditioning that has led to these divisions, may take some time to undo. Nevertheless, it is submitted that the real meaning of the word "medical", as derived from its Latin roots, is broad enough to encompass all health-care professionals.[114] The

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[112] A clinical psychologist who alleviates a person's CBC, would thus be engaging in a medical activity. An industrial psychologist who in an instance advises on the optimum combination of personality types to create a high-performance work team for a particular business task, on the other hand, is clearly not engaging in a medical activity.

[113] See eg Dirckx J *Concise Medical and Allied Health Dictionary* (3 ed) Baltimore: Williams and Wilkens (1997); Anderson KN, Anderson LE & Glanze WD *Mosby's Medical, Nursing and Allied Health Dictionary* Missouri: Mosby (1994).

[114] It is merely societal conditioning that dictates that a radiologist who studies an X-ray and gives only a diagnosis, is most certainly engaging in "medical activities", whilst the aromatherapist who skilfully eradicates a chronically recurring headache caused by muscle tension, is not. There is, of course, a vast difference between these two practitioners in knowledge,

divisions within "medical" should rather then be arranged as follows:

1) Mainstream medical: the conventional "medical practitioner" as presently understood; someone trained in "western"/allopathic medicine, who "went to medical school" and has been registered as a "medical doctor".[115]

2) Allied medical: those who practise alongside the mainstream physicians, in line with the conventional "western" paradigm, such as clinical psychologists, physiotherapists and dentists.

3) Alternative medical: those who practise arts of healing that fall outside "conventionally scientific" healing arts, such as reflexology and aromatherapy.

In line with HMM, these subdivisions should endeavour not to be "divided", as in many ways they currently are, but rather to be

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skills and approach. They belong to very different "schools", and will have appropriately differing specific rules that apply to them. In the broadest sense, however, they are both still governed by medical law, as will shortly be affirmed.

[115]The term "doctor", actually literally means "teacher", as derived from the Latin *docere* (stem: doct-), which means "to teach"; see Rooney K (Ed) *The Encarta World English Dictionary* London: Bloomsbury (1999) 552. Therein lies an important lesson to "doctors" - their traditionally educative function should be upheld: in consultation, the client should not just be "treated", but should also be educated as to how best to deal with the relevant condition. Here again, professionals from mainstream medicine and health psychology ("allied medicine") should work together to make this process maximally effective and efficient. Whereas the mainstream medical doctor may not have much time to explain in lengthy detail all that a client should or should not do in the light of his or her condition, and may even find it difficult to articulate all the facets of the full spectrum, the professional health psychologist could fulfil that task and take it further. Whereas the doctor might explain the major fundamental "do's and don'ts", the health psychologist will be in a position to set up an integrated programme, incorporating all the relevant facets in the full spectrum, providing a client with strategies and techniques for putting the advice into daily practice. After all, a primary focus of health psychology is the promotion of positive health behaviours; see fn 116 *statim infra*.

collectively harmoniously "medical" - promoting optimum holistic health care. Whether one sees many different disciplines as falling under the superordinate umbrella "medical", or sees various sectors of one discipline, the more cross-pollination and holistically integrated functioning there can be among these various areas, the better the interests of health-care consumers can be advanced.

3.2.1.2 **The Definition of Medical Law**

"Medical law" should, as it ostensibly states (in the light of the meaning of "medical"), refer to "the law applied in the context of health-care provision, consumption and expertise". Psychiatrists would fall squarely under mainstream medicine, and "psychiatric malpractice law" would be "the law related to malpractice on the part of psychiatrists". Therefore, in line with the above discussion, it is clear that "psychiatric malpractice law" forms part of "medical law".

3.2.1.3 **Interdisciplinary Harmony in Related Definitions**

In step with the HMM approach, the definitions of health law and medical law should be seen in relation to the related fields health psychology and medical psychology. "Health psychology" may be defined as "the subfield of psychology concerned with the interactions of health-care professionals with consumers, and the interrelationship of behavioural and psychological factors with human health".[116] Accordingly, "health law" would be "laws and

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[116]Bishop broadly defines "health psychology" as "the subfield of psychology concerned with the dynamic inter-relationship of behaviour and psychological states with physical health"; see Bishop GD *Health Psychology: Integrating Mind and Body* Needham Heights: Allyn and Bacon (1994) 3. It is submitted, however, that the concept of health psychology is broader in that it also encompasses the dynamic interrelationship of behaviour and psychological states with resultant mental health. Moreover, the psychology of the interactions between health-care professionals and consumers is also covered by health psychology. Bishop divides the domain of health psychology into three broad areas: 1) the promotion and maintenance of health, for example

legal philosophy that concern human health".[117] It is evident that health law is extremely broad. "Medical law" ("the law applied in the context of health-care provision and expertise"[118]) is a

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by giving attention to habits such as smoking, drinking, use of safety belts, exercise and diet; 2) the prevention and manner of treatment of illness; 3) involvement with the health-care system and the formulation of health care policy. In regard to the last-mentioned area, Bishop states the following: "[O]ur interactions with health care professionals involve more than a mechanical dispensing of health care; these interactions are also personal. Health psychologists are interested in how people interact with health care professionals and institutions and the impact of these interactions on their health. For example, the relationship between people and their physicians, or other health care providers, is likely to affect their willingness to follow medical recommendations as well as their rate of recovery from illness or surgery". See *ibid* 6.

[117]"Mental-health law" would then logically encompass all areas where the law has its impact specifically on mental health. The term has, for instance, been used in South Africa, and extensively in the United States. See eg fn 37 *supra*, and Kruger A *Mental Health Law* Durban: Butterworths (1980). Psychiatric malpractice law would thus also fall within the ambit of "mental-health law".

[118]Thus, in line with the HMM approach, "medical psychology" would be defined as "psychology applied to health care provision, consumption and expertise". Bishop GD *Health Psychology: Integrating Mind and Body* Needham Heights: Allyn and Bacon (1994) asserts that the term "medical psychology" is synonymous with psychiatry in Britain, while in the United States it refers to "a subspecialty of clinical psychology concerned with the application of clinical methods from psychology to problems of the physically ill". It is submitted that neither of these descriptions is sound. In line with HMM, medical psychology should, as it ostensibly states, be defined as proposed *statim supra*. According to the proposed definition, Bishop's definition for the United States would indeed fall under medical psychology, but would more specifically be "clinical medical psychology" (see Chapter II, 2.1 *supra*, for a discussion on the meaning and application of the term "clinical"). Medical psychology is a broader concept: it covers the entire area where the principles of psychology can impact on health-care provision and consumption. A workshop to equip doctors better to deal with the impact that life-and-death decisions in the medical context can have on them personally would, for instance, still fall under medical psychology, but not clinical medical psychology. To reiterate, health psychology, then, is an even broader concept: it involves psychology not only in the health-care context, but also in individual and societal promotion and maintenance of health. Similarly, health law would also be broader than medical law in that it involves law not only in the health-care context,

narrower, more defined area of law; thus it is the term that will consistently be used in this dissertation. It is also the term most frequently used in South African law. Other countries, such as the USA and Holland[119], use the broader term "health law". Much of health law, in any event, mostly falls within the ambit of the narrower concept "medical law". Examples of areas of law that fall under health law but not medical law are: therapeutic jurisprudence[120] and public health regulations[121], eg those regarding smoking[122], and other environmental health law[123].

3.3 The Definition of Medical Malpractice

3.3.1 Different Views

As might be expected, in the light of the discussion surrounding HMM, definitions of malpractice furnished by various authors from various countries, are rather disparate. For instance, Barnes[124], an author from the United Kingdom, asserts that malpractice is "generally defined as practice or behaviour that is intentionally..abusive", and that "in medical and other settings

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but also in individual and societal promotion and maintenance of health.

[119]See, for instance, Leenen HJJ *Handboek Gezondheidsrecht, Deel I: Rechten van Mensen in de Gezondheidszorg* Houten/Diegem: Bohn Stafleu Van Loghum (2000). "Gezondheidsrecht" literally means "health law".

[120]See fn 33 *supra*.

[121]See, for instance, Nadasen S *Public Health Law in South Africa: An Introduction* Durban: Butterworths (2000) 55-56.

[122]See the **Tobacco Products Control Act** 83 of 1993.

[123]In this sense, section 24 (a) of the **Constitution** would technically be health law (but not medical law) as well as environmental law.

[124]Barnes FP *Complaints and Grievances in Psychotherapy: A Handbook of Ethical Practice* London: Routledge (1998). It is notable that Barnes has served as the chair of the Ethics Committee of the United Kingdom Council for Psychotherapy.

it would be referred to as gross professional misconduct...the act of engaging in practise with malicious intent with a specific aim of neglecting the practitioner's professional duty through intentionally unethical professional misconduct." According to Barnes, malpractice would thus necessarily involve **intentional** conduct, which is "knowingly wrong".[125]

On the other hand, in the United States, malpractice is generally defined as professional **negligence.**[126] The authors of a leading text in mental-health law[127], however, define malpractice more broadly: "[M]alpractice...encompasses all actions for substandard professional care, regardless of the specific doctrinal basis of their claim. Private actions for malpractice may be based on any of several legal grounds. Most actions are grounded in negligence doctrine, but some malpractice claims rest on the intentional tort doctrines of assault and battery, invasion of privacy, or breach of confidentiality. Additionally, occasional malpractice suits are based entirely on principles of contract law."

It is submitted that this broad conceptualisation of malpractice is correct.[128] Although it is well-established that negligence is

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[125]*Ibid* 47-57.

[126]Furrow BR, Greany TL, Johnson SH, Jost TS & Schwartz RL *Health Law* (2 ed) St Paul: West Group (2000) at 264, comment that malpractice is usually defined as unskilful practice resulting in injury to the client, where there is a failure to exercise the degree of care, skill and diligence that is required under the circumstances.

[127]Reisner R, Slobogin C. and Rai A *Law and the Mental Health System: Civil and Criminal aspects* St Paul: West Group (1999) 131.

[128]See also Strauss SA *Doctor, Patient and the Law: A Selection of Practical Issues* (3 ed) Pretoria: J L Van Schaik (1991) 243, where it is clearly stated that the concept of medical malpractice liability is **not** narrowly confined to liability flowing from professional negligence. See also Snyman JL *Die Siviele Opneming van Geestesongesteldes: Regte en Regsbeskerming van die Betrokkene* (LLD thesis, Unisa, 1981) 563, fn 4.

the most common basis for malpractice[129], it would be unsound to limit the concept of malpractice exclusively to instances of negligence. Where X performs an operation on Y, without procuring Y's consent, this would amount to intentional conduct (an assault, if no ground of justification exists)[130]. It would be absurd to say that such professional misconduct does not amount to malpractice, due to the fact that it was intentional and not merely negligent. It follows that malpractice liability could involve criminal law, the law of delict, and the law of contract. Malpractice can thus lay the foundation for an action *ex delicto* or *ex contractu*, or both, depending on the nature of the case and specific elements involved, and could, where appropriate, simultaneously give rise to criminal liability.

3.3.2 **"Malpractice" Defined**

The word "malpractice" literally refers to "poor practice".[131] In the context of liability, however, the poor practice in question would have to be of such a degree that it warrants raising the

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[129]Indeed, most claims in respect of medical malpractice are instituted *ex delicto* (ie non-contractual private-law actions for damages) on the ground of negligence. This is the case, for instance, in South African, English and American jurisdictions; see Reisner, R, Slobogin C and Rai A *Law and the Mental Health System: Civil and Criminal Aspects* (3 ed) St Paul: West Group (1999) at 131, who state: "Most actions are grounded in negligence doctrine.."; and Mason and McCall-Smith *Law and Medical Ethics* (5 ed) Butterworths: Edinburgh (1999) at 219: "Most claims in respect of medical injury are brought in tort...". "Tort" is the Anglo-American-law equivalent of the South African "delict" - the authors briefly describe it as a "non-contractual civil wrong" - their use of the Anglo-American appellation here indicates that they refer to the English law; pure Scots law would also use the term "delict", since Scotland has a Roman-law heritage; see for instance McManus F and Russell E *Delict: A Comprehensive Guide to the Law* Chichester: Wiley (1998).

[130]See Strauss SA *Doctor, Patient and the Law: A Selection of Practical Issues* (3 ed) Pretoria: J L Van Schaik (1991) 243. For a discussion of assault in the context of consent, see chapter V, 3, *infra*.

[131]The prefix "mal-" is derived from the Latin *malus*, meaning "bad" or "poor" (in the sense of bad).

issue of professional liability. In the final analysis, however, anything that clearly constitutes poor practice should actually be tantamount to malpractice.[132] It is submitted that malpractice should be defined as: "professional conduct which falls outside the limits of acceptable practice in that profession."

It is submitted that "malpractice" is limited to conduct within the course of legitimate (ie legally recognised) professional practice, as is also reflected in the definition furnished *supra*. Illegal psychiatric practice *ab initio*, in the sense of not complying with the legal requirements for being allowed to practise yet or anymore, would thus not be a case of "malpractice" as such, but rather another form of unlawful conduct, such as "illegitimate practice" (eg without being duly registered with the legally required professional body).

3.3.3 The Legal Bases for Malpractice Liability

It has already been stated that the three main legal bases for malpractice liability are delict, contract and crime.[133] These will next be dealt with in turn.

3.3.3.1 The Law of Contract

In the case of most medical interventions, there would be a

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[132] In the context of the law of delict, poor practice that results in legally significant damage would inevitably be significant enough to constitute malpractice. Similarly, in the context of criminal law, poor practice that is severe enough to amount to criminal conduct would be significant enough to constitute malpractice, and in the context of the law of contract, poor practice that amounts to a breach of contract would also be significant enough to constitute malpractice. It follows that, poor practice that attracts legal liability, would always be malpractice. In the context of liability under disciplinary committees, however, there may be cases where conduct amounts to professional malpractice but is not sufficient to form the basis of legal liability.

[133] The concept "delict" would, however, as discussed *supra*, there be referred to as "tort".

contract between doctor and client.[134] Regarding actions based on contract, the following is stated in a recent American case, *Bond v Frank*[135]: "A duty enforceable in law is one which arises out of the relationship between the parties involved. A contract is a private agreement that imposes on the parties the specific duties to which each has expressly agreed to perform. Failure to perform a duty thus owed may be a breach of the contract, for which the other party is entitled to damages or specific performance." That is also true in South African law - the duty or obligation (*vinculum iuris*: legal tie) arises *ex consensu*. Breach of contract may indeed also lead *inter alia* to an action for damages and/or specific performance in South African law.[136] The type of damage for which damages may be claimed is limited to patrimonial damage. Damages for injury to personality thus cannot be claimed *ex contractu*, but must be claimed *ex delicto*.[137]

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[134] See Strauss SA *Doctor, Patient and the Law: A Selection of Practical Issues* (3 ed) Pretoria: J L Van Schaik (1991) 3.

[135] Court of Appeals of Ohio, Second Appellate District, Miami County) 2001.

[136] See Christie RH *The Law of Contract* (4 ed) Durban: Butterworths (2001) 606-641. See also chapter VIII, 3, *infra*. As has been stated, the scope of this dissertation does not allow for a discussion of the general principles of the law of contract. These will be featured as they are applied to the specific matters dealt with in the dissertation.

[137] A leading South African case regarding damages *ex contractu* in the context of medical liability is *Administrator of Natal v Edouard* 1990 (3) SA 581 (A), which involved a claim by the father of a normal and healthy child conceived and born after an unsuccessful tubal ligation performed on his wife. In the Supreme Court of Appeal case, *Mukheiber v Raath* 1999 (3) SA 1065 (SCA), Olivier JA approvingly provides the following overview of *Edouard*: "[T]he action was based on breach of contract. Damages were claimed for (a) the cost of supporting and maintaining the child up to the age of 18 years and (b) for the discomfort, pain, suffering and loss of amenities of life suffered by the mother. This Court disallowed claim (b) on the basis that in our law general damages of the type claimed under this head are not recoverable in a breach of contract action. Claim (a) was upheld. In upholding claim (a), this Court undertook an extensive review of overseas cases and legal literature dealing with claims for 'wrongful conception', 'wrongful birth' and 'wrongful life' in the context of public policy."

3.3.3.2 **The Law of Delict and Criminal Law**

Although there would usually be a contract between doctor and client, the doctor always owes the client a duty of care, independent from the existence of any contract.[138] A doctor who undertakes a procedure on a person, whether with or without his or her consent, is obliged to perform the procedure with due care and skill. Regardless of any contract, if a procedure is performed in a substandard manner, this can give rise to delictual or even criminal liability (for example, if a procedure negligently causes the death of a person, leading to a conviction of culpable homicide).

The obligation in delict arises *ex lege*. This accords with the court's[139] further statements: "Some duties do not arise from private agreement but are instead imposed by law. That form of 'duty' is an obligation imposed by law on one person to act for the benefit of another person due to the relationship between them. When risks and dangers inherent in the relationship or incident to it may be avoided by the obligor's exercise of care, an obligor who fails to do so will be liable to the other person for injuries proximately resulting from those risks and dangers if the injuries were reasonably foreseeable." The details regarding the use of the term "duty" and approaches to the element of causation[140] are different in South African law;[141]

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[138]The establishment of a therapist-client relationship creates the professional duty of care owed to a client. See Pergament D "Internet Psychotherapy: Current Status and Future Regulation" *Journal of Law-Medicine 8 Health Matrix 233* (1998). See also Strauss SA *Doctor, Patient and the Law: A Selection of Practical Issues* (3 ed) Pretoria: J L Van Schaik (1991) 3.

[139]*Bond v Frank* Ohio App 2d (Miami County) 2001.

[140]In South African law, proximate or direct consequences and reasonable foreseeability may be taken into consideration when establishing legal causation. Courts are not obliged to adhere to any particular approach, however, but rather adhere to a "flexible approach" as formulated in the leading case, *S v Mokgethi* 1990 (1) SA 32 (A). The basic question is whether there is a "close enough" (the similarity to "proximate" is readily apparent) relationship between the act and its factual

however, the underlying idea is the same.[142] In assessing whether the "duty of care" was breached, the United States and English courts apply virtually the same general negligence tools and standards as the South African courts.[143] As has been affirmed,[144] in South Africa, England and the United States, most professional liability claims arise due to alleged negligence.

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consequence for that consequence to be legally imputed to the actor, "in view of policy considerations based on reasonableness, fairness and justice". See Neethling J, Potgieter JM and Visser PJ *Law of Delict* (4 ed) Durban: Butterworths (2001) 187.

[141]As has been stated, the scope of this dissertation does not allow for discussion of those details.

[142]In order to establish delictual liability, South African law determines that there was an unlawful (1) act (2) on the part of a culpable (3) actor which factually (4) and legally (5) caused damage (6) to another (elements in random order). These six elements are identified by Neethling, Potgieter and Visser *op cit* 4, fn 9. In order to establish tortious liability, American law determines that there was a duty of care (1) that was breached (2) and "directly" or proximately caused (3) damage (4). See, for instance, Simon RI *Clinical Psychiatry and the Law* (2 ed) Washington: American Psychiatric Press (1992). Simon describes these as the four D's: Duty, Dereliction thereof, Direct cause, and Damage. Grabois states it as follows: "The plaintiff in a malpractice action based on tort must establish four elements to make out a *prima facie* case. He or she must show (1) that there was a legal duty or obligation requiring the person to conform to a certain standard of care in treating the plaintiff; (2) that there was a failure on the person's part to conform to the standard required: a breach of the duty; (3) that there was a reasonably close causal connection between the conduct and the resulting injury. This is the proximate cause; and (4) that there was actual loss or damage resulting to the interests of another." See Grabois EW "The Liability of Psychotherapists for Breach of Confidentiality" *12 J L & Health 39* (1997/1998) 68-69.

[143]The approaches to specifically medical negligence are also fundamentally similar; for instance in *Bond v Frank* (*supra*), the court states: "[Where] a condition by its nature requires the application of knowledge and skill superior to that of the ordinary person, one who possesses that superior knowledge and skill and who fails to employ it for the benefit of another when their relation requires it will be held liable for injuries [caused by] that failure. Such persons must use the care and skill reasonable in the light of their superior learning and experience, not simply a minimum standard of care."

[144]See fn 129 *supra*.

3.3.3.2.1 **Medical Negligence**

It is trite in medical malpractice law that the doctor does not guarantee positive results. With the numerous factors involved in certain medical procedures and conditions, it is simply not possible to guarantee success.[145] The requirement is that the doctor must act in accordance with the standard with which he or she is expected to comply. Furrow *et al*[146] affirm that American law relies on the medical profession itself to set the standards of practice, while the courts enforce those standards. The situation is the same in South Africa.[147]

As with any medical speciality, the psychotherapist is held to the standard of care exercised by others in his or her field of expertise. Grabois[148] avers that when dealing with the standard of care of psychotherapists, courts have to determine the standard appropriate to those specialists. She affirms that, since there are so many schools of thought in psychotherapy, professionals practising therapy must set the legal standards of conduct by in-house expert testimony.[149] Apart from expert testimony, ethical codes of conduct can also play an important role.[150]

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[145]In respect of psychotherapy, Grabois (*op cit*) states: "In psychotherapy, the practitioner is not an insurer of a perfect cure. The practitioner is also not required to exercise the highest degree of skill possible or even extraordinary skill or care. He or she must exercise only reasonable care under the circumstances."

[146]Furrow BR, Greany TL, Johnson SH, Jost TS & Schwartz RL *Health Law* (2 ed) St Paul: West Group (2000) 265.

[147]See fn 277 *infra*.

[148]*Op cit* 71.

[149]The importance of expert testimony in proving standards of practice is echoed by Furrow BR, Greany TL, Johnson SH, Jost TS & Schwartz RL *Health Law* (2 ed) St Paul: West Group (2000) at 265. See also Strauss SA *Doctor, Patient and the Law: a Selection of Practical Issues* (3 ed) Pretoria: Van Schaik (1991) at 290.

[150]The importance of medical ethics will shortly be discussed (under 3.3.3.4 *infra*).

3.3.3.2.2 **Intentional Conduct**

As has been affirmed, intentional, wrongful conduct on the part of a medical practitioner can also give rise to malpractice liability. Once again, intentional conduct can feature in the context of the law of contract, the law of delict and criminal law. Various instances of wrongful intentional conduct in the context of psychiatric practice are highlighted in chapters V-IX of the dissertation, including sexual misconduct and assault.

3.3.3.3 **The Role of Ethics in Malpractice Liability**

Strauss[151] defines ethics as "the science of rules of moral conduct which should be followed because they are good in themselves." According to him, this involves the "rational study of preferences", providing "a general basis for the making of value judgments". Strauss further asserts that law and ethics overlap to a large extent, but that they do not coincide.[152]

The influence of ethics on the law[153], and vice versa[154], are clear.

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[151] Strauss SA "Ethics in the Treatment of Mental Patients: Some Aspects" in Van Wyk C & Van Oosten H (Eds) *Nihil Obstat: Feesbundel vir WJ Hosten/Essays in Honour of WJ Hosten* (1996) 181.

[152] *Ibid*: "There are large areas of law that are morally neutral. Yet ethical considerations can never be excluded from the administration of justice, which is the end and purpose of all civil laws. Professional ethics is part and parcel of ethics in the general sense of the term, although...it has a peculiarly legal character, in the medical context in any event. The body of professional ethics reflects the attitudes prevailing within a profession in respect of what is good and proper."

[153] See, for instance, Grabois EW "The Liability of Psychotherapists for Breach of Confidentiality" *12 J L & Health 39* (1997/1998) 72, where she avers that, in establishing standards of care, the court will point to the "Hippocratic Oath" that physicians take, and also to the "Principles of Medical Ethics" published by the American Medical Association.

[154] Pergament, for instance, comments on how civil actions establish practice guidelines for therapists. She asserts that

Ethics and law inevitably combine to set standards of practice,[155] and are potentially reciprocally reinforcing and enriching. As might be expected, there is also scope for clashes and conflict. These could, however, be seen as opportunities for positive development with a resultant deepening of mutual understanding.[156] Law and ethics both have an extremely important role to play in the lives of clinicians[157] - they function to provide guidance in dealing with dilemmas and to aim to ensure the high standards of practice that earn the trust and respect of the community - indeed crucial for all involved.

3.4 Psychiatric Malpractice

Traditionally there have been markedly fewer cases against psychiatrists compared to other medical practitioners. However,

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the impact of civil litigation on psychotherapeutic practice is significant. Indeed, case law can strongly influence the ethical standards that guide therapists in practice. See Pergament D "Internet Psychotherapy: Current Status and Future Regulation" *Journal of Law-Medicine 8 Health Matrix 233* (1998) 266.

[155] In the preface to Verschoor T *Verdicts of the Medical Council* Pretoria: Digma (1990), Strauss states: "As a jurist who has been closely involved with legal and ethical problems in medical practice, I have often been struck by how ignorant young physicians in particular are regarding the more practical side of medical ethics - not to mention legal practitioners consulted by medical practitioners. A legal practitioner may provide a physician with a thoroughly substantiated legal opinion, but if he has failed to also take the professional-ethical implications thereof into account, it will have but little practical value."

[156] The potentially developmental value of conflict is well emphasised in management, and would be applied in this context as a facet of HMM.

[157] Strauss *op cit* 189: "[T]he word of the [Health Professions Council of South Africa] is for all practical purposes law, pure and simple, to the medical practitioner." Ethical rules certainly do have a significant degree of enforceability. Strauss (189-190) points out that some of the sanctions imposed are co-enforced indirectly by the civil courts. Moreover, if a doctor whose name has been removed from the register by the Health Professions Council, continues to practise, he or she would be committing a criminal offence for which he or she may be prosecuted in court.

psychiatric malpractice suits have been on the rise in the United States and other countries. Perlin[158] reports that in 1982, 4% of malpractice suits filed were for psychiatric malpractice, which percentage had doubled by 1998.[159] Perlin discusses possible reasons why psychiatrists have been sued less than other medical practitioners. Some of those involve *inter alia* the following factors[160]:

1 Tort law had been generally reluctant to provide remedies for emotional injuries.[161]

2 It is difficult to prove the standard of care in psychotherapy.

3 Plaintiffs have been afraid of the stigmatisation following the publicisation of their psychiatric histories.

4 The complex emotional ties between therapist and client make it difficult for clients to enter into a high-conflict situation with their therapists.

5 A client is often unable to assess the efficacy or otherwise of treatment - what would his or her

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[158]Perlin ML *Mental Disability Law: Civil and Criminal* Vol 3 (2 ed) Lexis publishing (2000) 285-286.

[159]Bass *et al* discuss the growth in litigation against psychotherapists, commenting that this has not been as severe in Canada as in the United States, in which it had reached "appalling proportions". See Bass LJ, DeMers ST, Ogloff JRP, Peterson C, Pettifor JL, Reaves RP, Retflavi T, Simon NP, Sinclair C, and Tipton RM *Professional Conduct and Discipline and Psychology* American Psychological Association: Washington DC (1996) at 117.

[160]Cf Perlin *op cit* 285-286.

[161]Landmark South African cases in this regard are *Bester v Commercial Union Versekeringsmaatskappy* 1973 1 SA 769 (A) and *Barnard v Santam Bpk* 1999 1 SA 202 (SCA) (see *infra* chapter VII, 2).

condition have been if the treatment in question had not been provided?

6 Psychiatrists are often able to manipulate their clients, thereby averting suit.

7 Psychiatric medicine is "somewhat of an enigma to most trial lawyers".[162]

Some of the reasons that Perlin[163] discusses regarding the increasing frequency[164] of psychiatric malpractice suits, include the following:

1 The 1980s and 1990s have seen tort law become more receptive to emotional injury compensation.

2 Clients making use of psychiatric services are progressively "coming out of the closet", thus alleviating some of the general perception of stigmatisation.

3 Increasing litigation in psychiatric malpractice has made judges and lawyers more familiar with the "enigma" of psychiatric medicine.

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[162]Quoting Alan Wilkinson, a Californian trial lawyer (quoted in Perlin *op cit*.

[163]*Op cit*.

[164]See also Grabois EW "The Liability of Psychotherapists for Breach of Confidentiality" *12 J L & Health 39* (1997/1998) 46, where she points out that while the number of claims against therapists remains low, it is increasing for a number of reasons. She contends that one of these is a more open attitude about psychotherapeutic treatment, coupled with increased expectations of its efficacy. Another reason that she mentions is that there is more emphasis on clients' rights and new legal duties imposed on therapists (arising from the therapist-client relationship). In addition, she contends that the "larger judgments" seen in lawsuits based on psychiatric malpractice may well encourage new plaintiffs to bring suit.

4 More is known about potential side-effects of certain treatments, especially physical treatments, such as pharmacotherapy, which can *inter alia* lead to tardive dyskinesia.[165]

Psychiatry is indeed a potentially very complex, markedly more abstract medical speciality. Although the general principles of medical malpractice law will also apply to psychiatric malpractice, the issues involved in psychiatric practice are, in many cases, quite different from those involved in other areas of medical practice.[166]

Matters relating to psychiatric and clinical-psychological malpractice are to an extent addressed in the **Health Professions Act**[167] and, to a lesser degree, the **Mental Health Act.**[168] However, there is a marked paucity of legal literature on the specific matter in South Africa. According to Kruger[169], by 1980 no state psychiatric institutions had been involved in litigation involving professional psychiatric negligence. However, Kruger points out that many cases had been settled out of court without the psychiatrists' admitting liability. Kruger correctly asserts

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[165]See *infra* chapter VII under 3.1.

[166]The fundamental general principles of medical law do apply directly to psychiatrists and their clients; however, specific development is demanded by some of the unique features of this area of medicine. With regard to ethics in psychiatry, Strauss SA "Ethics in the Treatment of Mental Patients: Some Aspects" in Van Wyk C & Van Oosten H (Eds) *Nihil Obstat: Feesbundel vir WJ Hosten/Essays in Honour of WJ Hosten* (1996) at 182, states: "The ordinary set of medico-ethical rules applies to [psychiatric clients]. But because of [their] special vulnerability, certain special considerations apply in regard to [them]. A complicating factor in regard to determining ethics in the [psychiatric context] is that psychiatric intervention, representing state interests, may clash with [cl]ients' rights."

[167]56 of 1974.

[168]18 of 1973.

[169]Kruger A *Mental Health Law* Durban: Butterworths (1980) at 124.

that, because of the abstract nature of psychotherapy, it is very difficult to challenge its quality in court, as opposed to other medical treatment where concrete physical effects are usually apparent.[170]

As is the case with any medical malpractice, psychiatric malpractice is limited to conduct within the course of professional practice.[171] Various instances of clinical-psychiatric malpractice[172] are discussed in chapters V-IX. The next chapter lays the foundation for the examination of those instances by elucidating the legal bases for medical intervention.

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[170] Kruger *(ibid)* correctly maintains that psychotherapy can be as harmful as any physical treatment, and that it is merely the matter of proof that creates problems.

[171] See *supra* under 3.3.2.

[172] Matters involved in other forms of psychiatric malpractice, such as forensic-psychiatric malpractice, fall outside the scope of this dissertation. Forensic-psychiatric malpractice would, as it readily appears, involve malpractice in the course of rendering professional forensic services(see 2.1 *supra*).

CHAPTER IV

THE LEGAL BASES FOR MEDICAL INTERVENTION

1 Introduction

In the ordinary course of events, the legal relationship between doctor and client is contractual and thus based on consensus.[173] The basis for most interventions would, accordingly, be consent. A wealth of literature has emanated from attempting to define the full nature and extent of that consent. The consent required has become relatively globally known as "informed consent".[174]

Van Oosten[175] points out that it is trite law in societies subscribing to a human-rights culture that every person has the right to self-determination[176], which includes the freedom to choose to undergo or forego medical treatment, irrespective of

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[173]See Strauss SA *Doctor, Patient and the Law: A Selection of Practical Issues* (3 ed) Pretoria: J L Van Schaik (1991) 3.

[174]According to Welz D "The boundaries of medical-therapeutic privilege" *SALJ* (1999) 301, the term "informed consent" is inapplicable in Australia and England, for instance. Cf, however, Mason and McCall-Smith *Law and Medical Ethics* (5 ed) Butterworths: Edinburgh (1999) 245, and Van Oosten FFW *The Doctrine of Informed Consent in Medical Law* (LLD thesis, Unisa, 1990) 137-155; cf also Kahn M, Robson M & Swift K *Clinical Negligence* (2 ed) London: Cavendish (2002) 44, 65-66.

[175]Van Oosten FFW "Some Reflections on Emergencies as Justification for Medical Intervention" in Ahrens HJ, Bar C, Fischer G, Spickhoff A, Taupitz, J (Eds) *Festschrift für Erwin Deutsch* Köln: Carl Heymanns Verlag KG (1999) 673.

[176]With South Africa's adherence to constitutionalism, this fundamental right is now firmly entrenched as part of the Bill of Rights in the **Constitution**, the supreme law of South Africa. Section 12, which deals with "freedom and security of the person", provides as follows: "**Everyone has the right to bodily and psychological integrity**, which includes the right - (a) to make decisions concerning reproduction; (b) to security in and control over their [sic] body; and (c) not to be subjected to medical or scientific experiments without their informed consent."

its medical necessity. Every person thus has the right to refuse even life-sustaining treatment if he or she is clearly capable of making a lucid choice in that regard.[177]

Whereas consent (also known as the doctrine or defence of *volenti non fit iniuria*, in the context of justification[178]) is widely established as the first and foremost[179] basis or justification[180] for medical intervention, circumstances may exist which may justify medical interventions where consent is insufficient or absent.[181] Van Oosten classifies those grounds of justification that operate where informed consent is lacking, as emergencies, authority and duty.[182]

The various justifications, as categorised by the present author (taking into account the commentary of various authorities), are depicted in figure 4 (see next page). The first division in the flowchart (figure 4) represents the well-established principle that grounds of justification do not form a *numerus clausus* in South African law. The *boni mores* (legal convictions of the

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[177]As might be expected, this fundamental right can lead to very controversial situations. Discussions in this regard feature *infra*.

[178]See, for instance, Neethling J, Potgieter JM and Visser PJ *Law of Delict* (4 ed) Durban: Butterworths (2001) 98-104.

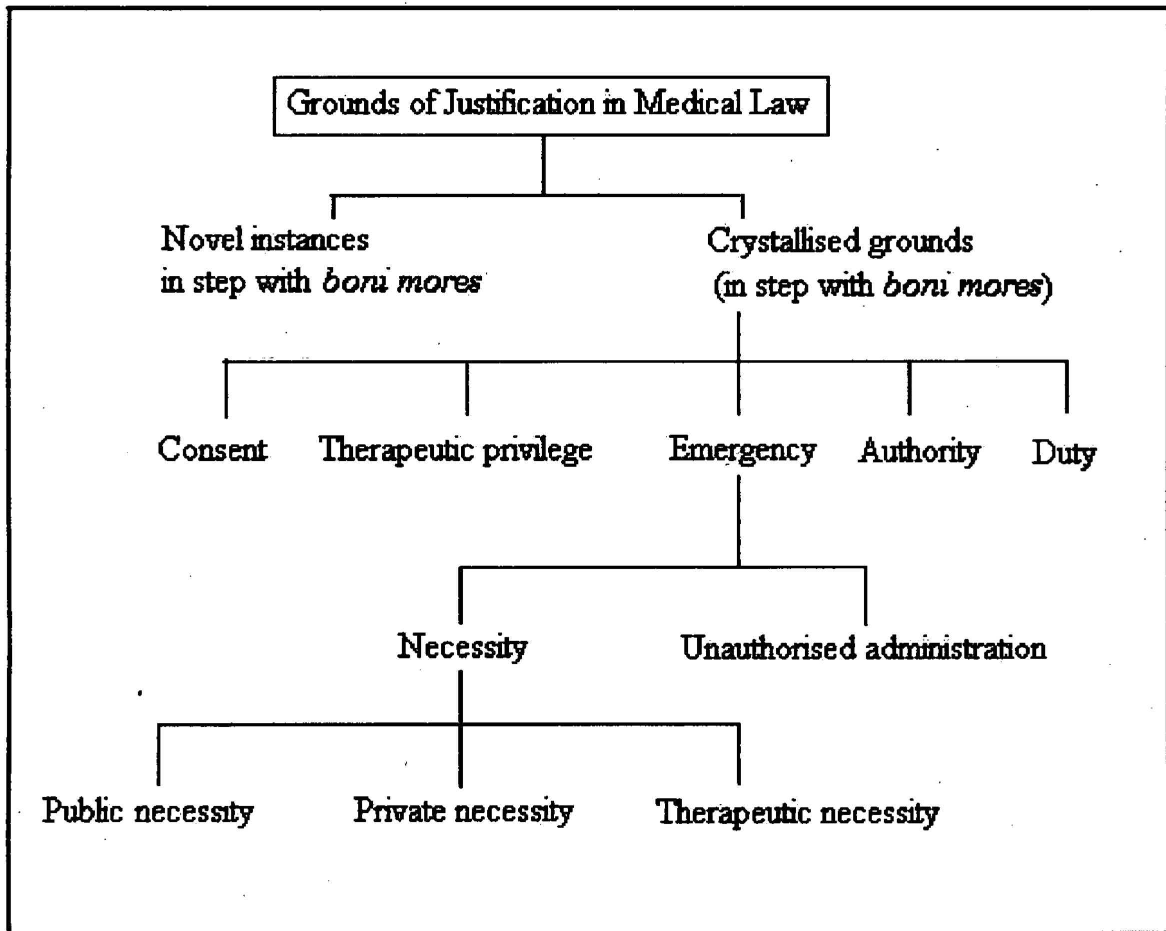
[179]Perlin also acknowledges the fundamental importance of informed consent, maintaining that informed-consent principles are the most important inquiry in virtually all negligence-based psychiatric tort litigation. See Perlin ML *Mental Disability Law: Civil and Criminal* Vol 3 (2 ed) Lexis publishing (2000) 323.

[180]Justification in law renders conduct that would have been wrongful, lawful. Medical intervention in the absence of consent or another ground of justification, is wrongful.

[181]Van Oosten FFW "Some Reflections on Emergencies as Justification for Medical Intervention". in Ahrens HJ, Bar C, Fischer G, Spickhoff A, Taupitz, J (Eds) *Festschrift für Erwin Deutsch* Köln: Carl Heymanns Verlag KG (1999) 673-674. Van Oosten considers these "exceptions to the general rule".

[182]*Ibid*. Therapeutic privilege should actually be included here, as reflected in figure 4 (next page).

Figure 4: Grounds of Justification in Medical Law



community) can create new crystallised grounds or a singular justification in a unique instance. The existing crystallised grounds, then, are merely instances that have been defined (have "crystallised") in step with the *boni mores*. The crystallised grounds of justification in medical law will next be discussed.

2 Informed Consent

2.1 Requirements for and Forms of Informed Consent

When a client consults a doctor, he or she tacitly enters into a contract with the doctor, and generally tacitly consents to such treatment as is medically indicated.[183] However, for such consent to be valid, the client must know and understand all the material elements of that to which he or she tacitly consents. The leading case in South Africa regarding which elements should be considered material for the purpose of informed consent is *Castell v De Greef*[184]. *In casu* the court held that the doctor must warn a client of all **material risks**[185]; a risk is material if:

> a) a reasonable person in the client'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 that particular client, if warned of the risk, would be

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[183] See Strauss SA *Doctor, Patient and the Law: A Selection of Practical Issues* (3 ed) Pretoria: J L Van Schaik (1991) 4.

[184] 1994 (4) SA 408 (C).

[185] Subject to "therapeutic privilege" (see discussion *infra* under 3.3), although the court did not venture to define the ambit of the so-called privilege. Some commentators contend that the attitude towards the privilege *in casu* can be construed as somewhat negative; see Coetzee LC *Medical Therapeutic Privilege* (LLM dissertation, University of South Africa, 2001) 13, fn 73.

likely to attach significance to it.[186]

Therefore, whichever form the consent of the client took, if sufficient information was not given in the course of treatment, the consent is invalid. Consent can be express, tacit or implied. Express consent would be where the client actually expresses his or her consent in words, be it vocally or in writing. According to Van Oosten[187], "tacit consent" refers to "consent communicated by the conduct of the patient", while "implied consent" refers to "consent to matters which are by necessary implication included in the subject-matter of express or tacit consent"[188]. All instances, in principle, amount to valid actual consent.

Thus, although it is not required for the client expressly to consent to every step of the indicated treatment, the client must be informed of every material step, thus giving him or her the opportunity to withdraw consent. Due to the manner in which medical treatment is generally provided, there are some who argue that informed consent in actual fact amounts to somewhat of a fiction.[189] In reality, it is not practically possible to impart

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[186]With regard to disclosure in the psychotherapeutic context (in the United States), see also, for instance, Perlin ML *Mental Disability Law: Civil and Criminal* Vol 3 (2 ed) Lexis publishing (2000) 318, who asserts that the psychotherapist must disclose all risks that are "material" - if the "reasonable person" in what the physician knows or ought to know to be a client's position would be likely to attach significance to the risk in reaching a decision.

[187]*Op cit* 680.

[188]As an example, Van Oosten (*ibid*) states that the violation of bodily integrity is a necessary concomitant of express or tacit consent to surgical intervention under general anaesthesia.

[189]According to Miller, in the United States, physicians' obligations to obtain informed consent from their clients before initiating treatment dates back to at least the 1950s. In theory, competent clients have the "right to refuse treatment" (which he maintains is more accurately called "the right to be treated only with informed consent"). Miller asserts that, despite the theoretical benefits of informed consent's supposedly enhancing client autonomy, several scholars have argued that it has had little impact on day-to-day medical practice; see Miller RD

all possibly relevant information; moreover, a doctor would not generally wait for a client's express consent (unless it involves a major intervention, such as an operation), but rather continues with the treatment as he or she sees fit, unless the client actually objects - as long as the client submits, this is considered tacit consent.

Therefore it is submitted, in practice, the "right to consent" exists more as the "right to refuse or object". Provided that a person is adequately informed, and does not refuse or object when the doctor proceeds (given the opportunity to do so before procedures are commenced[190]), he or she indeed gives tacit consent. Nevertheless, if a doctor proceeds without giving information as to the material nature of what he or she is doing, such tacit consent would not be informed, and therefore invalid. A client's right to be informed so as to be placed in a position to consent or refuse, is indeed fundamental.

2.2 Informed Consent and Health Psychology

The process involved in informed consent also provides fertile ground for the influence of health psychology.[191] The manner in which communications take place in this regard can be therapeutic or countertherapeutic. Moreover, for the client truly to exercise

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"Advance Directives for Psychiatric Treatment: A View From the Trenches" *4 Psych Pub Pol and L* (September, 1998) 728-729.

[190]Van Oosten FFW "Some Reflections on Emergencies as Justification for Medical Intervention" in Ahrens HJ, Bar C, Fischer G, Spickhoff A, Taupitz, J (Eds) *Festschrift für Erwin Deutsch* Köln: Carl Heymanns Verlag KG (1999) at 680: "One of the essentials of consent as a defence is that it must precede the act in question. Even if the [cl]ient were, subsequent to an unauthorised medical intervention, to express his or her complete satisfaction with the course of action taken by the doctor or hospital, that would at most be tantamount to concurrence or ratification, but not to consent. *Ex post facto* consent is plainly a [contradiction in terms]."

[191]Cf fn 116 *supra*.

his or her rights, the doctor must do more than pay mere lip-service to providing information - the client must essentially understand the material elements involved.

In this regard, a doctor must be sensitive to the degree to which a person is medically educated, and pitch his or her disclosure accordingly. Here the doctor should take a little time to fulfil his or her role as "teacher", building trust and rapport, providing insight into the relevant condition, and, wherever possible, emphasising basic life-style modifications for facilitating cure and preventing further problems.[192]

Not only must the doctor be sensitive to the person's level of education, but also, as alluded to above, he or she must be sensitive to the person's emotional state in the manner in which he or she communicates information.[193] Indeed, as has been stated, every health professional should have some training in health psychology in addition to the basic legal requirements involved.[194]

2.3 Advance Directives

Advance directives for medical treatment are well-known in the United States. They were designed specifically to allow individuals to specify what treatment, if any, they would desire if they were to become terminally ill and unable to express their preferences.[195] According to Miller[196], advance directives are of

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[192]Ideally, there should be an alliance with a professional health psychologist/consultant in this regard; see fn 115 *supra*.

[193]See also Coetzee LC *Medical Therapeutic Privilege* (LLM dissertation, University of South Africa, 2001) 166-169, 180.

[194]See Chapter III, 3.2.1.3 *supra*.

[195]See Miller RD "Advance Directives for Psychiatric Treatment: A View From the Trenches" *4 Psych Pub Pol and L* (September, 1998). According to him, advanced directives are a product of the trend in society to transform the doctor-client relationship from a paternalistic-fiduciary one (where physicians assume control and imperatively act in their clients' best

two types: a so-called "living will", in which individuals specify what treatments they consent to or refuse if they were to become incapacitated (and hence unable to express a treatment choice); and a proxy or "surrogate directive" or "durable power of attorney", where the individual names a person who is empowered to make the aforementioned choices in the event of the individual's becoming incapacitated.

Advance directives have not yet been formally recognised in South Africa. *Clark v Hurst NO and Others*[197] is the leading case in this regard. This case particularly concerns the so-called "right to die", involving the withdrawal of medical treatment. *In casu* C had signed a living will, declaring his wish to be allowed to die if attempts at resuscitation were to leave him in a persistent vegetative state (PVS)[198]. It subsequently so happened that C lapsed into a PVS, following complications during an operation. The court refused to give recognition to the living will as such. The court applied the ordinary criterion for wrongfulness, the *boni mores*, in determining whether the discontinuation of medical treatment (including artificial nourishment) would be lawful or not.

Interestingly then, *in casu* on the facts, in spite of not formally giving effect to the advance directive, the court found that it was not wrongful to discontinue medical care. South African law will most probably come to recognise advance directives in the future.[199] These are thus incorporated into the following discussion.

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interests), to a consensual one (where clients assume more personal control over their care).

[196] *Ibid* 730.

[197] 1992 (4) SA 630 (D).

[198] A state in which a person has no awareness of self or surroundings.

[199] In fact, the South African Law Commission has already recommended this in one of its reports.

2.4 The Existing and Potential Roles of Informed Consent and Advance Directives in Clinical Psychiatry

2.4.1 Basic Informed Consent

Although there are cases in which psychiatric clients are not competent to make decisions regarding their treatment, informed consent remains fundamental - if it is at all possible to procure a client's consent, such consent must be procured.[200] In the unreported South African case, *Rompel v Botha*[201], a psychiatrist was held liable for administering electroconvulsive therapy (ECT), during which the client sustained a bone fracture,[202] without informed consent. Strauss[203] asserts that the facts of the case clearly indicate that the client had been capable of consent and, despite that fact, had not been properly informed of the risks involved. In the context of South African law, this case, as Strauss points out, highlights the fact that it must be established whether a psychiatric client is capable of consenting and, if so, that such consent must be obtained.[204]

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[200]The consequences of not obtaining duly informed consent are discussed in the next chapter.

[201]Quoted in *Esterhuizen v Administrator, Transvaal* 1957 3 SA 710 (T) at 719.

[202]It is evident that this is a rather old case (1953). The risk of sustaining a fracture has since been eradicated by the development of muscle-relaxants (eg suxamethonium), which are administered during ECT.

[203]Strauss SA "Ethics in the Treatment of Mental Patients: Some Aspects" in Van Wyk C & Van Oosten H (Eds) *Nihil Obstat: Feesbundel vir WJ Hosten/Essays in Honour of WJ Hosten* (1996) at 188.

[204]See Mason and McCall-Smith *Law and Medical Ethics* (5 ed) Butterworths: Edinburgh (1999) 503, for a British perspective: "The mere presence of a psychiatric condition will not, of itself, be sufficient to justify compulsory treatment: a person may suffer from psychiatric [condition] and yet still be able to reach a reasoned decision as to whether or not to undergo therapy. Compulsory treatment is justified only if a person's remaining untreated poses a threat to his own health or safety or to the safety of others." Mason and McCall-Smith (at 506) further state that compulsory psychiatric treatment for those who

Significantly, Allan and Allan contend that, from a therapeutic perspective, even incompetent clients should be involved in the decision-making process as far as possible, since "this often facilitates the success of the treatment".[205] Miller[206] comments that a major benefit that is claimed for the recognition of clients' "rights to refuse treatment" is that psychiatrists are compelled to listen to them. He maintains that, although client refusals of psychotropic medications, for instance, are rarely sustained by the courts, the process of psychiatrists' attempting to explain the risks, benefits, and alternatives involved, can be beneficial.

Indeed, in most medical contexts, the process involved in obtaining consent can actually be therapeutic.[207] As has been

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pose no threat to others is based on "the notion of justified paternalism", where the intention is to protect an incapacitated person from harm. They (506-507) assert that: "ordinarily, paternalistic action will be considered wrong because it offends the principle of autonomy. It may be justified, however, when the person for whose benefit the act is performed is unable to make an informed choice for himself." They mention two approaches to the situation: 1) the American substituted-judgment test, which asks the question: "would the client, were he or she rational, consent to the treatment proposed?". If the answer is yes, treatment may be justified; 2) the "doctrine of implied consent", where someone who is not able to consent to a procedure at one time may later be able to endorse what was done, thereby providing "a form of retrospective consent". Mason and McCall-Smith note that there are serious objections to the latter approach (see also Van Oosten, fn 190 *supra*). Some objections observed by Mason and McCall-Smith include that there may be difficulty in predicting when a client's subsequent consent will be given, and that it is also possible that any *post hoc* consent "will be a product of the intervention itself - as, for example, where treatment results in increased docility, compliance or even dependence on the person providing it". Mason and McCall-Smith accordingly conclude that it is better to rely on the first-mentioned approach.

[205] Allan A & Allan M "The right of mentally ill patients to refuse treatment" *SALJ* (1997) 586.

[206] *Op cit* 735

[207] Commenting on informed consent through advance directives, Stavis asserts that building a client's trust in this manner indeed "encourages participation, reinforces a therapeutic

stated, however, there is also scope for countertherapeutic effects. It is in those few cases where the controversial "therapeutic privilege"[208] might operate. Nevertheless, in most cases, the sharing of information, and the dialogue that this stimulates, are very therapeutic. Ideally, the imperative of obtaining informed consent should provide an opportunity not only to give effect to the client's rights, but also to further his or her best interests by giving him or her insight into his or her condition, cultivating a relationship of mutual trust and respect, and promoting his or her sense of control regarding his or her situation.

2.4.2 **Advance Directives**

According to Miller[209], although the laws in the United States concerning advance directives originally developed in the context of living wills, advance directives are currently used for future medical treatment generally and also for psychiatric care.[210] Nevertheless, he contends that there are major conceptual and practical differences between advance directives for non-psychiatric medical treatment and those for psychiatric treatment. The main differences are summarised in the table on the next page.

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alliance, minimizes conflict, and maximizes cooperation where there is mutuality of trust, understanding, and appropriate treatment". See Stavis PF "The Nexum: a Modest Proposal for Self-guardianship by Contract, a System of Advance Directives and Surrogate Committees-at-large for the Intermittently Mentally Ill" *16 J Contemp H L & Pol 1* (Winter, 1999) 17.

[208]Discussed *infra* under 3.3.

[209]Miller RD "Advance Directives for Psychiatric Treatment: A View From the Trenches" *4 Psych Pub Pol and L* (September, 1998) 735.

[210]Miller (*ibid*) notes several states (in the United States) that have passed explicit statutes authorising psychiatric advance directives: Minnesota in 1991, Hawaii in 1992, Oregon in 1993, and Utah in 1995.

NON-PSYCHIATRIC MEDICAL ADVANCE DIRECTIVES	PSYCHIATRIC ADVANCE DIRECTIVES
Designed to express the wishes of clients who are, at the relevant later time, totally unable to express any wishes at all.	Express the prior wishes of clients who are rarely totally unable to express their preferences at the relevant later stage, even though they might not be technically competent to do so.
Medical directives in practice are usually negative (ie **refusing** life-sustaining treatment).	Psychiatric directives can, at least in theory, either request or refuse treatment: the choices include hospitalisation for protection of the client and others, and active treatments that have been demonstrated to be effective with the great majority of clients in controlling the symptoms of their conditions.

2.4.3 **Assessment of Advance Directives and Informed Consent in Clinical Psychiatry**

With reference to the work of Winick, a chief proponent of therapeutic jurisprudence[211], Miller[212] advances *inter alia* the following possible benefits of psychiatric advance directives:

1. Contemplating the possibility of a disabling CBC may

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[211] See fn 33 *supra*.

[212] Cf Miller *op cit* 735-736.

motivate a person to take preventive measures.

2. Taking responsibility for treatment empowers the client and counters the "infantilization typical of institutionalization".

3. The ability to determine future treatment reduces stress created by uncertainty and the experience of helplessness.

4. Addressing this important issue allows clients to "experience feelings of self-esteem and self-control that can increase their decision-making capacities and their ability to perform in other areas of their lives".

5. Psychiatrists are compelled to "negotiate with", rather than "infantilize", their clients.

6. If clients know that they have chosen their own treatments, they are more likely to comply with them.

7. As long as an incapacitated client's current wishes accord with the advance directive, it is possible to avoid formal adjudication of incompetency, which expends resources and can be stigmatising.

It is submitted that the preponderance of authority in multinational medical law is indeed correct - individual autonomy should indeed be the point of departure as far as decisions regarding medical treatment are concerned. The approach is not only sound in principle, but also, if adhered to with due care and skill, produces better results for all involved.[213] Of course,

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[213] See Stavis PF "The Nexum: a Modest Proposal for Self-guardianship by Contract, a System of Advance Directives and Surrogate Committees-at-large for the Intermittently Mentally Ill" *16 J Contemp H L & Pol 1* (Winter, 1999), where he proposes a system of informed consent that includes a form of self-

giving expression to a person's autonomy through advance directives depends on the existence of a sound administrative system that is well managed.[214] A discussion of the specifics of such a system and its management, is beyond the scope of the present dissertation. The principle is, however, here supported: advance directives, in the same manner as ordinary informed consent, should be a point of departure in decision-making; only if there is some justification to overrule the advance directive, should it so be done.[215] It is thus submitted that South Africa should come to recognise advance directives[216], especially in the light of the strong constitutional emphasis on freedom as a fundamental value. As has been stated, this includes the freedom to make choices regarding medical intervention.[217]

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guardianship by an advance directive contract, called a "Nexum." He suggests that this might further the aim of maximising client autonomy and effective treatment, while reducing costs and relieving an invariably overburdened court system.

[214]Miller (*op cit* 744-745) cautions that "psychiatric advance directives are an intriguing idea, but like other attempts to transplant procedures developed in other areas of the law into psychiatry, they run into severe problems in practice. For such directives to support true [client] autonomy..., it is not sufficient to pass laws in a vacuum. Those laws (and the regulations or procedures that operationalize them) must take into account the real-world situations in which they will be implemented."

[215]In a New York case, *In the Matter of Rosa M* 597 N Y S 2d 544 (Sup Ct 1991), cited in Miller (*op cit*), a client consented to electroconvulsive therapy (ECT), at a time when she was competent to make that decision. A short while later, she withdrew her consent and directed that she not be given ECT in the future. Subsequently, her condition deteriorated, and she became clearly incompetent to make treatment decisions. Her psychiatrist petitioned the court to authorise ECT, arguing that no other treatment would be effective. The court ruled that, in the absence of "an overriding state interest", a hospital must respect the "fundamental rights of individuals to have the final say in respect to decisions regarding their medical treatment". The court found that the petitioner had not proved that she had lacked capacity at the time that she had refused ECT.

[216]As the South African Law Commission has recommended; see fn 199 *supra*.

[217]In South Africa, the law is obliged to promote the rights in the Bill of Rights (see section 7 (2) of the **Constitution**).

In sum, in respect of any medical treatment, individual autonomy should always be the first fundamental: only if it is clear that a person is not capable of exercising his or her autonomy[218], can actual informed consent be bypassed.

This adds to the case for the recognition of advance directives, since these promote freedom of choice.

[218]In the psychiatric context, such competence would have to be constantly monitored. Stavis PF "The Nexum: a Modest Proposal for Self-guardianship by Contract, a System of Advance Directives and Surrogate Committees-at-large for the Intermittently Mentally Ill" *16 J Contemp H L & Pol 1* (Winter, 1999) at 33, contends that "rejection of clearly necessary treatment, eg, in the case of a life-threatening condition and a patient's suicidal tendency, might call for an assessment of competency. This is, of course, not to say that disagreement with clinicians is evidence of in-competence. Rather, in appropriate and substantial deviations from normal client behavior, it would naturally raise a need to consider whether further investigation is warranted. The law's recognition of the importance of personal autonomy in competency determinations is evident in requiring 'clear and convincing' evidence before autonomy is reduced or negated." As also emerges at intervals throughout his discussion, it is of cardinal importance that the process of adjudicating on competence should not interfere with urgently necessary treatment. Stavis (*ibid* 33-34) cautions that remaining untreated can prevent a person from being restored to health, and that an "untreated severe [CBC] increases the chances of suicide and death from other causes". Nevertheless, he concludes: "Although seriously impaired people should be protected, the right to make decisions for oneself should not be burdened more than is absolutely necessary. In consequentialist terms, the issue is whether the harm of incorrectly labeling autonomous agents as incompetent is outweighed by the harm of incorrectly ignoring the [client]'s autonomy, or right of self-determination. The latter is significant to the extent [that] the [client]'s well-being is at risk; no harm results from allowing an incompetent [client] to make a decision of minimal effect or one that is in keeping with his or her objective best interests. However, only [clearly] competent [persons should be allowed] to make decisions that are not in their ['objective'] best interests[.]". See also Stein MT "Decision-Making about Medical Care in an Adolescent with a Life-threatening Illness" *American Academy of Pediatrics 107 [Suppl]: 979-982* (April, 2001), where, in respect of a case of a 13-year old boy with acute lymphocytic leukemia who refuses a potentially lifesaving bone marrow transplant, Stein contends that the possibility of depression that may be impairing the adolescent's ability to be part of the decision-making process, must first be addressed: "If [J] is clinically depressed, all other medical decisions should be deferred, and he should be treated for depression. A combination of antidepressant medication and individual therapy may be needed."

3 Emergency as Justification for Intervention

According to Van Oosten[219], emergency interventions may be classified into two categories: unauthorised administration and necessity. This division is reflected in figure 4 (*supra* 75) with the suggested further subdivisions under necessity. These grounds will next be discussed.

3.1 Unauthorised Administration (*Negotiorum Gestio*)

The requirements for *negotiorum gestio* can be summarised as follows[220]:

1) The client is at the time **incapable of consenting** to a medical intervention that is

2) **urgently necessary** to save his or her life or to protect his or her health, where he or she

3) **would have consented** thereto had he or she been in a position to do so,

4) and such intervention is performed clearly in **the client's best interest.**

Point 3) above requires some discussion. Traditionally, it has been stated that the requirement is that the client must have placed **no prior prohibition** on the intervention. It is submitted, however, that the true requirement is that the client **would**

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[219] Van Oosten FFW "Some Reflections on Emergencies as Justification for Medical Intervention" in Ahrens HJ, Bar C, Fischer G, Spickhoff A, Taupitz, J (Eds) *Festschrift für Erwin Deutsch* Köln: Carl Heymanns Verlag KG (1999) 676-677.

[220] See *ibid;* cf Coetzee LC *Medical Therapeutic Privilege* (LLM dissertation, University of South Africa, 2001) 79-82.

actually have consented to the intervention at the time.[221] Van Oosten[222] advances the requirement that the client must have placed no prior prohibition on the intervention, but adds: "and would have consented to it had he or she been in a position to do so..". It is submitted, however, that it is unnecessary to advance both points as requirements. In the final "objective" (in other words, the situation actually prevailing at the time) analysis in the assessment of wrongfulness, the only relevant question is whether the client would have consented.[223] The

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[221]This also accords with its treatment as an instance of so-called "presumed consent"; see Coetzee LC *Medical Therapeutic Privilege* (LLM dissertation, University of South Africa, 2001) 82. Like any factual presumption (as opposed to certain "irrebuttable" legal presumptions), a presumption that a person would have consented can later be rebutted. It should be clarified that the question whether the person would have consented or not is a question of fact - it would most notably distinguish whether a rescuer is acting in putative unauthorised administration or (actual) unauthorised administration. The fact of whether the person would have consented or not is subject to a balance-of-probabilities (civil claims) or a beyond-reasonable-doubt (criminal charges) burden of proof, but the question remains objective (see also fn 223 *infra*). In the final analysis, if it was reasonable to believe (ie the reasonable rescuer would so have believed) that the person would have consented, the rescuer would escape liability even if it is proven that the person would not actually have consented. All that this would mean is that there was no actual valid unauthorised administration, but merely putative unauthorised administration. A court would carefully weigh the evidence, however, since invalid unauthorised administration will have the effect that the rescuer will not be able to claim remuneration; see 90-91 *infra*.

[222]*Op cit* 676-677.

[223]Which, somewhat ironically is a purely subjective test in the sense that it depends entirely on the client's will - of course, this apparent objective-subjective dichotomy is instantly resolved if one considers that persons' thought processes are also part of the objective situation actually prevailing. Suppose late on a Friday (incidently the 13th) night, X, a fairly innocently playful varsity villain, jumps from behind a bush, wearing a very scary "Scream" (the movie) suit, with the intention of scaring the wits out of a young girl who, unbeknown to him, is a 5th Dan Tae Kwon Do (a Korean martial art) expert. She interprets his actions as a life-threatening attack, considering his size and horrific resemblance to the killer in the movie "Scream". Without a sound or a hint of hesitation, she defends herself - to his dire detriment. In actual fact, he had had no intention of hurting her and was planning to turn and run

requirement that there must be no prior prohibition is thus actually irrelevant. If, for instance, the unlikely scenario would transpire that a client had placed a prior prohibition but would later actually have consented to the intervention, an objective ground of justification would be present.[224]

Considering that the test for wrongfulness is, in principle, "objective" and based on an *ex post facto* evaluation, the fact that a client would or would not have consented **at that time** is of central concern. If it appears that the client would not have consented, and thus that the intervention was **in actual fact against the client's will**, unauthorised administration cannot operate as (an objective *ex post facto*) ground of justification.[225] It is notable that, if there is justified unauthorised administration, the practitioner would be entitled to claim remuneration for his services from the person to whose aid he came.[226] Strauss[227] points out, however, that South African law

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as soon as he had secured a mental picture of her expression so that he may have a satisfying chuckle later. Needless to say, he was not to laugh. Before he could escape, he had been severely injured. From a legal point of view, the only factor that renders this a situation of **putative** private defence (thus not real **objective** private defence) is actually the fact that he had had no intention to hurt her. If he had been planning to overpower her and to kill her in the manner that she had in mind, it would have been a case of (real) private defence. It is clear that a person's subjective intentions and desires can be very important factors to consider in assessing the objective situation.

[224] Of course, a prior prohibition would create a strong presumption that the client would not have consented at the time of the unauthorised administration. Nevertheless, if he or she would have consented, the conduct will have been lawful.

[225] It is a well-established requirement of unauthorised administration that administration must not be against the will of the "beneficiary"; see Strauss S A *Doctor, Patient and the Law: a Selection of Practical Issues* (3 ed) Pretoria: Van Schaik (1991) 94: "*The treatment must not be against the will of the patient* [emphasis in original]."

[226] See Strauss SA *Doctor, Patient and the Law: a Selection of Practical Issues* (3 ed) Pretoria: Van Schaik (1991) 95.

[227] *Ibid.*

allows recovery only where at the time of the action the practitioner acted with the intention of claiming remuneration. He also notes that such remuneration is limited to the recovery of expenses incurred or any loss suffered by the practitioner as a result of the services that he or she rendered.

3.2 Necessity

3.2.1 General

In the case of necessity, the intervention must also be urgently necessary, but points 1), 3) and 4) required for unauthorised administration, are not required. It follows that the state of emergency could relate to persons other than the client, and that the intervention can, in principle, be performed against the client's will if the emergency so justifies.[228] Van Oosten[229] correctly points out that the traditional distinction between unauthorised administration and necessity does not hold any water. Traditionally, it is said that:

1) necessity involves the sacrifice of the interests of **an innocent third party**, whereas unauthorised administration involves **two parties:** the caretaker and the beneficiary;

2) necessity **protects the interests of society**, whereas unauthorised administration protects the **interests of an individual;**

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[228] This would generally be in society's best interest ("public necessity" - see fn 241 *infra*). Van Oosten furnishes the example of the inoculation of capable persons against their express refusal in order to prevent a dangerous infectious disease from spreading. See Van Oosten FFW "Some Reflections on Emergencies as Justification for Medical Intervention" in Ahrens HJ, Bar C, Fischer G, Spickhoff A, Taupitz, J (Eds) *Festschrift für Erwin Deutsch* Köln: Carl Heymanns Verlag KG (1999) 677.

[229] *Ibid* 678.

3) unauthorised administration protects a **pecuniary interest**, whereas **any legally recognised interest** may be protected in necessity.

Van Oosten refers to the "Karneades" example of necessity to refute points 1) and 2) above. In this example, two shipwrecked men fight for life over a piece of flotsam that is unable to hold both of them. This example indeed amounts to a situation of necessity, but involves neither a third person[230], nor the protection of society.[231] To refute the final point, Van Oosten contends that the medical setting clearly demonstrates that unauthorised administration can protect the interests of life or health.[232]

Van Oosten[233] concludes that, in the context of medical interventions, the essence of unauthorised administration lies in an emergency situation and the impossibility of obtaining a client's consent, while the essence of necessity lies in an emergency situation and involuntary (against the client's will) invasion of the client's bodily integrity.[234] Two further

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[230]In fact, another person *per se* is not even really required; one can violate an abstract legal provision in necessity (see Snyman CR *Criminal Law* (4 ed) Durban: Butterworths (2002) 120). An example would be where one has ingested a noxious substance and one then exceeds the speed limit so as to receive urgently necessary medical attention (cf *S v Pretorius* 1975 (2) SA 85 (SWA), which was actually a case of putative necessity - it was **thought** that the child was in grave danger due to swallowing the pills).

[231]In the context of justifying medical intervention, Van Oosten (*op cit*) acknowledges, however, that "whether or not necessity is also capable of operating, in extreme cases, as a justification where the protected legal interest is not that of society but that of the patient, is a notoriously controversial and ticklish issue." See, further, the discussion on therapeutic privilege and necessity *statim infra*.

[232]*Ibid* 679.

[233]*Ibid* 682.

[234]On the issue of the practical value of differentiating clearly between defences by their definitions, Van Oosten (*ibid*)

noteworthy requirements for the operation of necessity as a ground of justification are that the extent of the invasion must be necessary to avert the danger (in other words, it must not be more harmful than necessary) and the interest infringed must at least be commensurate with the interest protected.[235]

3.2.2 **Therapeutic Necessity and Therapeutic Privilege**

3.2.2.1 **Therapeutic Necessity**

A recognised (but controversial) instance of applying necessity as a justification to protect the client, is that of, what Van Oosten[236] terms, "therapeutic necessity": "where medical intervention is indicated, but disclosure of the information in question to the patient would be more harmful than non-disclosure". This particular situation of withholding information has also been referred to as "therapeutic privilege".[237]

In the light of the meaning of "necessity"[238] and "privilege"[239], it is, however, submitted that a distinction should be drawn

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states: "[O]ne should not overlook the consideration that the more exact the definition and requisites of a defence are, the easier it will be to establish whether or not they have been satisfied[.] [C]larification...adds practical value to the defences involved." This accords with HMM.

[235]See further Neethling J, Potgieter JM and Visser PJ *Law of Delict* (4 ed) Durban: Butterworths (2001) 86-92, and Snyman CR *Criminal Law* (4 ed) Durban: Butterworths (2002) 117-120.

[236]*Op cit* 677, fn 27.

[237]See Coetzee LC *Medical Therapeutic Privilege* (LLM dissertation, University of South Africa, 2001). See also Welz D "The boundaries of medical-therapeutic privilege" *SALJ* (1999).

[238]Generally used in the context of justifying acting positively, where an urgent situation so demands.

[239]Generally used in the context of not disclosing information, eg as in the case of attorney-client privilege; see, for instance Schmidt & Rademeyer *Bewysreg* (4 ed) Durban: Butterworths (2000) 553 *et seq*.

between therapeutic necessity and therapeutic privilege.[240] "Therapeutic necessity" should be used to describe the situation of involuntary (in the sense of "against the will") medical intervention as such[241], whereas "therapeutic privilege" should refer to the situation of withholding information.

This distinction is warranted, since there is a significant difference between performing a procedure on a client against his or her will, and withholding certain information regarding the client's condition. It is submitted that the former is most appositely classified as therapeutic necessity, whilst the latter is most appositely classified as therapeutic privilege.

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[240]These two terms have generally been seen as synonyms; see Coetzee (*op cit*) 5, fn 23. Coetzee (*ibid* 78) prefers the term "therapeutic justification", but settles on "therapeutic privilege" due to its being so firmly entrenched in medical law around the world. A valid point of criticism that he (*ibid* 77) raises against the term is that it might create the impression that the doctor can use his or her professional discretion when deciding whether to disclose certain information - it is his or her "privilege". However, it is submitted that, if one views "privilege" as simply referring to the non-disclosure of certain information (as in "privileged" information), the term should not give rise to practical problems. Health-care professionals who are aware of the privilege, if they are not negligent, will take note that the privilege is very strictly limited (see further the discussion *infra* under 3.3).

[241]This would then be a specific form of "necessity" as ground of justification in medical law. It is submitted that, where community interests are involved, this could more specifically be referred to as "public necessity". The situation where the treated individual's interests are infringed to protect another individual's (or limited group of individuals') interests, could then be referred to as "private necessity". An example of this is where a client's confidentiality is breached to warn another of imminent danger (see examples and discussion in chapter IX, 3, *infra*). It is submitted that "necessity" in medical law can, accordingly, be divided into "public necessity", where community interests are protected, "private necessity", where another individual's (or limited group of individuals') interests are protected, and "therapeutic necessity", where the treated individual's interests are protected (while at the same time infringing his or her autonomy). Just like other forms of necessity, therapeutic necessity would also require *inter alia* a real emergency and commensurability of interests.

3.2.2.2 **The Scope of Therapeutic Necessity**

It is submitted that, if there is no reason to believe that a person's judgment is in any way clouded, there can be no justification for intervening in his or her "best interests" on the ground of therapeutic necessity.[242] Consider the following contentions on the part of Strauss[243]:

> "The law will not protect the health fanatic who forcibly attempts to prevent me from using a lot of sugar in my coffee, because he maintains - quite correctly so - that in the long run it will harm my health and may even shorten my life. On the other hand, the doctrine of necessity will clearly avail the policeman who forcibly restrains me from committing

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[242] Cf Strauss SA *Doctor, Patient and the Law: a Selection of Practical Issues* (3 ed) Pretoria: Van Schaik (1991) at 91-92, who states: "It is submitted..that in regard to medical treatment of a person whose life or health is in serious danger as a result of injury, disease or ill-health, such treatment against his express will is in principle not justifiable on the basis of necessity, unless the act is directed...to protection of the community interest[.]" It is submitted that this statement is correct (cf Van Oosten FFW "Some Reflections on Emergencies as Justification for Medical Intervention" in Ahrens HJ, Bar C, Fischer G, Spickhoff A, Taupitz, J (Eds) *Festschrift für Erwin Deutsch* Köln: Carl Heymanns Verlag KG (1999) 678, fn 28). If an intervention is necessary to protect a community interest, it would be a case of "public necessity". "Private necessity" is unlikely to justify medical **treatment** as such (see fn 241 *statim supra*). If the "express will" of the person is clearly unfettered, therapeutic necessity cannot operate to protect his or her own interests. If, however, the person's judgment is significantly fettered, it can, as will shortly be discussed, be overridden in therapeutic necessity. If the reasonable practitioner would clearly have believed, with expert psychological assistance if at all possible (it is submitted, see fn 244 *infra*), that the person's judgment is fettered, putative therapeutic necessity as an excuse could operate (see chapter V, 5 *infra*). An important point of difference between it and unauthorised administration should be highlighted: in the case of unauthorised administration, the person is totally incapable of consenting, whereas in therapeutic necessity it must merely be clear that his or her judgment is fettered, not that he or she is totally incompetent.

[243] *Ibid*.

> suicide by jumping off a window-ledge in a high building. A doctor would also clearly have the right to save the life of the would-be suicide who has taken an overdose of pills, by pumping out the content of the stomach or by administering a neutralising agent. Likewise, it is submitted, medical treatment can be administered to a prisoner who, in consequence of a hunger-strike, is at death's door."

With regard to the above, the following is submitted: The first example (ie sugar use) could not amount to therapeutic necessity for two noteworthy reasons: firstly, there is no emergency situation, and, secondly, there are no circumstances to suggest that the sugar-using person's judgment is manifestly clouded. In all the last-mentioned examples, however, circumstances may indeed indicate that the person's judgment may be significantly clouded. Those are the types of situations where the person, who at the time is not thinking clearly, might be very grateful for the intervention a while after the incident. A person who is about to die of starvation does not generally have the unfettered competence to make decisions.[244] Similarly, a person who is about to commit suicide, or has attempted suicide, does not characteristically act with crystal clarity of mind - the circumstances that induce a decision to commit suicide would invariably cloud such decision-making. It is trite that consent must be given freely and voluntarily; so too refusal must be free and voluntary. If it objectively prevails that a person's judgment is impaired when he or she refuses urgently necessary treatment, therapeutic necessity as justification can operate.[245]

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[244] Such a case should nevertheless involve expert assessment, however; unless, for instance, there is a clear precedent, where numerous mental-health professionals have unequivocally and consistently concluded that a person in that situation is hardly ever capable of thinking clearly, and that it is obvious that the benefit of the doubt should be awarded to the life-saving course of action.

[245] Another example of such a situation in the psychiatric context features in Mason and McCall-Smith *Law and Medical Ethics* (5 ed) Butterworths: Edinburgh (1999) 517. They discuss *R v W*

It is submitted that an additional requirement, which is usually required in the context of unauthorised administration rather than necessity, *viz* that the intervention must clearly be in the person's best interest, should be demanded for therapeutic necessity. The essential features of therapeutic necessity are thus as follows:

1) The intervention is actually urgent.

2) There is no viable alternative to deal with the emergency.

3) Material information has been disclosed.

4) The person refuses (or has refused) treatment.

5) The refusal is clearly the product of fettered

[1992] 4 All ER 627, a case concerning a 16-year old girl suffering from anorexia nervosa, who was violent towards the staff and prone to self-injury. On account of this, she had to be "immobilised". The English Court of Appeal had no doubt that it could overrule a minor's refusal of treatment. The court held that it is a feature of anorexia that it is capable of destroying the ability to make an informed choice (as per Lord Donaldson MR): "It creates a compulsion to refuse treatment or only to accept treatment which is likely to be ineffective. This attitude is part and parcel of the disease and the more advanced the disease, the more compelling it may become." Mason and McCall-Smith (*ibid*) suggest that this case opens the door to non-consensual treatment in all instances of anorexia nervosa, irrespective of age. In another case, *Re KB* (1994) 19 BMLR 144, which involved an 18 year-old girl, Ewbank J accepted the argument that she was "suffering from anorexia nervosa...and that relieving symptoms was just as much a part of treatment as relieving the underlying cause[.]" The court held that it was clear that feeding by nasogastric tube in the circumstances constituted "treatment". The treatment that she was refusing was held to be related to her particular "mental illness" and, accordingly, she did not have the capacity to refuse the treatment. Mason and McCall-Smith conclude (at 518) that "[t]he cases as a whole...demonstrate a judicial anxiety to save lives when that is possible and some distrust of an autonomy which allows [people] to take fatal treatment decisions in circumstances in which their competence to do so is, at least, doubtful."

judgment.

6) The intervention is clearly in the unwilling person's best interests (in these cases, this would inevitably also cover commensurability).

4 Therapeutic Privilege

As has been stated, "therapeutic privilege" involves withholding material information, where disclosure thereof to the client would be more harmful than non-disclosure. Welz[246] quotes the Information Resource Manual of the American Society for Gastrointestinal Endoscopy, as follows:

> "There are times when disclosure....might be detrimental to the welfare of certain [cl]ients. The law recognizes this and has fashioned the exception of therapeutic privilege. If you believe that... disclosure would, on balance, be more harmful to a [cl]ient, you may delete it citing this exception. In reality, [however,] the law looks with a critical eye toward the use of therapeutic privilege...".

Welz[247] also refers to the important American case of *Canterbury v Spence*[248]: "[This] exception obtains when risk-disclosure poses such a threat of detriment to the [cl]ient as to become unfeasible or contraindicated from a medical point of view." Welz[249] emphasises that the court insisted that the privilege must be very carefully circumscribed, or it might devour the disclosure rule itself.

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[246] Welz D "The boundaries of medical-therapeutic privilege" *SALJ* (1999) 312.

[247] *Ibid*.

[248] 464 F 2d 772 (App DC 1972).

[249] *Op cit*.

Coetzee contends that therapeutic privilege should be seen as a separate and independent legal defence *eo nomine*.[250] It is submitted that it can indeed be seen as a ground of justification *eo nomine*. It can, for instance, operate even in instances where informed consent is not at issue, but merely information disclosure regarding a client's condition.[251] It is, however, a ground of justification that should operate only in extremely exceptional cases. Coetzee[252] offers the following cogent reasons for limiting the operation of therapeutic privilege:

1) Therapeutic privilege represents a departure from

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[250]Coetzee LC *Medical Therapeutic Privilege* (LLM dissertation, University of South Africa, 2001) 94.

[251]As is the general principle regarding therapeutic privilege, such instances would be highly exceptional. Coetzee *op cit* 179, avers as follows: "There can be no general rule in terms of which information - especially information relating to the diagnosis and prognosis of a serious or (potentially) fatal illness - may be withheld from seriously ill or dying individuals. Several factors require that honest disclosure should be the rule in most cases: the very significance of such information for [cl]ient self-determination; the likelihood that attempts to shield [cl]ients from the truth will be futile; the fact that [cl]ients who discover the truth about their disease despite efforts to conceal the truth may find themselves in isolation, unable to share their concerns and fears; the fact that the withholding of information may lead to inadequate or inappropriate medical care; the relief of uncertainty which may follow on disclosure of the truth; and the fact that the doctor's own emotional reluctance, embarrassment, fears, uneasiness and anxieties to confront the patient with the truth may make it very difficult for the doctor to be objective when deciding whether or not to disclose such information...Although it is undesirable to shower a moribund patient with upsetting information, doctors should not be allowed to escape their duty to inform by merely allowing a fatal disease to run its course without taking the time to divulge such information as would in the anticipated course of illness and treatment become necessary for the [cl]ient in making treatment decisions." Coetzee (*ibid*) makes some special remarks regarding psychotherapy clients: "It must be recognised that special considerations may apply in the case of psychiatry and psychotherapy because of the highly subjective nature of the psychiatrist-[cl]ient relationship, and because psychiatrists may be better able to predict the effect that information might have on [cl]ients."

[252]*Op cit* 37-68, 173.

the fundamental principle of self-determination.

2) A decision to withhold information may lead to other deceptions - there is the possibility of significant harm ensuing if the client were to learn the truth despite efforts to prevent this.

3) Too permissive an attitude towards therapeutic privilege may lead to a weakening of the relationship of trust that imperatively must exist between practitioner and client.

4) Lack of trust may result *inter alia* in the deterioration of health standards and concomitant costs for society if clients were to avoid or delay consulting doctors for fear that their broader personal needs might be disregarded.

5) It may legitimise doctors' natural disinclination towards being bearers of bad news - the motivation to withhold the truth from clients might sometimes originate from the doctor's unwillingness to be the bearer of bad news.

6) There is potential for abuse, including the possibility that doctors might manufacture therapeutic privilege as a defence after the fact to shield negligence.

7) There is a distinct lack of professional expertise in predicting the effect of disclosure of information on clients.

It can safely be concluded that the scope for applying therapeutic privilege should be extremely limited. Health professionals must take careful note of this, and health-care consumers must be able to rest assured that the relationship of

trust that is essential to any practitioner-client relationship (especially in the psychotherapeutic context) is held in utmost high regard. It is submitted that therapeutic privilege can never justify the giving of false information - only in certain exceptional, dire situations[253] can the withholding of information be justified.[254]

It is submitted that therapeutic privilege should be able to operate as a ground of justification for withholding information only if:

1) it is clear that disclosure will seriously harm the client;[255]

2) any proposed intervention concerning which material information is withheld, is urgently necessary (ie there is no viable alternative, and it is an emergency

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[253]Coetzee (*op cit* 177) avers that the privilege should be upheld in cases where "disclosure of information may lead to serious and not merely transient injury to a [cl]ient's health or threaten [cl]ient's life....Specifically, if disclosure would hold, or increase, the risk of suicide, for instance in the case of a severely depressed [cl]ient, information may be withheld". He states (at 88) that, in general, depression can provide a reason for invoking therapeutic privilege.

[254]The following submissions on the part of Coetzee (*ibid* 180) implicitly emphasise the role that knowledge of medical psychology (see fn 118 *supra*) can play in health-care provision (see also fn 107 *supra*): "[T]he emphasis should be shifted from 'what to tell the [cl]ient' to 'how to tell the [cl]ient' and 'when to tell the [cl]ient'. Improving the quality of communication, especially through the development of communication skills, could go a long way in overcoming the problem of avoiding harm through disclosure. Communication should be tuned in to the emotional state, fears and needs of the particular [cl]ient. Research shows that the common belief that communication skills cannot be taught is incorrect. Communication skills training [as part of medical psychology] should fulfill its rightful place on the medical curriculum."

[255]It should be clarified that withholding information regarding risks must not be with the purpose solely of obtaining consent to a medically indicated intervention to which the client is unlikely to consent - it must be clear that the disclosure *per se* will seriously harm the client.

situation);[256]

3) any such proposed intervention is clearly in the client's best interest;[257]

4) in the case of a proposed intervention, the client has not indicated that he or she would not undergo any intervention that harbours the type of risks that are now not being disclosed.[258]

It is notable that simply withholding certain material details regarding a client's condition (without any particular proposed intervention) would not necessarily involve an emergency situation. In such a case the practitioner must, it is submitted, encourage the client to utilise counselling services as part of an holistic integrated treatment plan. Such counselling should then *inter alia* be directed at placing the client in a position to be given the outstanding information. Wherever possible, individual autonomy and the right to information[259] should be respected and protected.

It is important to note that the antithetical situation, ie where a practitioner is callous and imprudently unselective as to the type of information, the timing of disclosure and the manner in which the information is conveyed, could also constitute malpractice. Law and medicine ultimately both aim to serve the client's best interests (**including** the interest of autonomy). A "defensive" practice whereby a client is indiscriminately

[256]Cf Coetzee LC *Medical Therapeutic Privilege* (LLM dissertation, University of South Africa, 2001) 95-99.

[257]Here again, autonomy should be weighed in this process; cf Coetzee (*ibid* 100), who contends that the requirement of proportionality (commensurability) should be applied.

[258]This is similar to the no-prior-prohibition requirement of unauthorised administration; cf Coetzee (*ibid* 176).

[259]See also fn 62 *supra*.

bombarded with as much information as possible (primarily so as to comply with the "legal" requirement of informed consent), regardless of the client's emotional state and the sensitivity of the communication, is medically, ethically and legally unacceptable. There are proverbial fires on both sides of the disclosure spectrum. A practitioner would do well to keep his or her client's best interests (including autonomy) as his or her primary concern. Defensive medicine is not only clinically counterproductive, but can also be legally counterproductive. There is no place for defensive medicine in a sound partnership between medicine and law - the type of partnership that is advocated in accordance with HMM.

5 Authority as a Ground of Justification

Van Oosten[260] notes the possibility of authority as a ground of justification for medical intervention, eg statutory authority or court authorisation. A recent example in South African history illustrates how a court order can be a ground of justification. A Cape court ordered the removal of a bullet from an accused's leg against his will, for the purpose of ballistic testing to be used in evidence.[261]

6 Duty as a Ground of Justification

Regarding duty as a ground of justification, Van Oosten[262] furnishes the examples of a statutory duty and common-law duty, and states: "[D]uty has, if anything, an even stronger claim

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[260] Van Oosten FFW "Some Reflections on Emergencies as Justification for Medical Intervention" in Ahrens HJ, Bar C, Fischer G, Spickhoff A, Taupitz, J (Eds) *Festschrift für Erwin Deutsch* Köln: Carl Heymanns Verlag KG (1999) 674.

[261] See *Minister of Safety and Security v Gaqa* 2002 JDR 0212 (C), not yet formally reported.

[262] *Op cit* 674, fn 8.

than authority to be treated as justification: A duty, as distinct from authority, not only creates a legal obligation to act in accordance with it, but failure to do so may result in legal liability." An example of a duty that would justify the infringement of a person's rights in the medical context is the statutory duty imposed by section 13 of the **Mental Health Act**[263], which compels practitioners to disclose information regarding dangerous persons.

7 Summary of Some Differences and Similarities between the Crystallised Grounds of Justification in Medical Law

In the light of the above discussions regarding the various grounds of justification, the following clear fundamental differences/similarities between the various grounds can be highlighted:

GROUND OF JUSTIFICATION	ROLE OF INFORMATION?	ROLE OF PERSON'S WILL?	ROLE OF EMERGENCY?	VIOLATION OF AUTONOMY?	RELATED LIABILITY ARISING FROM?
INFORMED CONSENT	All material information disclosed	Intervention with real consent	Not necessarily emergency	No	Intervention without real justification
THERAPEUTIC PRIVILEGE	Disclosure of certain material information contra-indicated	Intervention without real (full) consent	Not necessarily emergency	Yes, "for the person's own sake"	Intervention without real justification

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[263] 18 of 1973.

NEGOTIORUM GESTIO	Disclosure of information physically impossible	Rebuttably presumed consent	Emergency	No	Intervention without real justification
PUBLIC NECESSITY	Disclosure of information irrelevant	Intervention against will	Emergency	Yes, for the sake of society or the community at large	Intervention without real justification
PRIVATE NECESSITY	Disclosure of information irrelevant	Intervention against will	Emergency	Yes, for the sake of another person or limited group of persons	Intervention without real justification
THERAPEUTIC NECESSITY	Disclosure of material information has occurred	Intervention against will	Emergency	Violation of (fettered) autonomy "for the person's own sake"	Intervention without real justification
AUTHORITY	Disclosure of information irrelevant	Consent absent or insufficient	Not necessarily emergency	Not necessarily	Intervention without real justification
DUTY	Disclosure of information irrelevant	Consent absent or insufficient	Not necessarily emergency	Not necessarily	Intervening or **not** intervening without real justification

It is notable that, with regard to authority and duty, consent must be lacking (for any reason). If consent were to be sufficient, that would be the ground of justification that operates, since it is the first and foremost ground. It would thus be unnecessary to rely on any other ground. Furthermore, as indicated, the authority or duty might or might not coincide with an emergency, or might or might not violate the relevant person's autonomy. For instance, if a physician has court authorisation to attend to an unconscious person who would actually have consented to the intervention (thus also potentially meeting the requirements for *negotiorum gestio*), no autonomy would actually be violated.

It is appropriate next to examine the consequences of unjustified medical intervention, with specific applications in the context of clinical psychiatry.

CHAPTER V

LIABILITY FOR PSYCHIATRIC INTERVENTION WITHOUT JUSTIFICATION

1 Introduction: Justification and Excuse

This chapter briefly examines the legal consequences of psychiatric intervention without justification. It deals specifically with those cases not involving negligent treatment as such, but rather perfectly successful and sound treatment save for the fact that justification is lacking. The consequences of the absence of any of the various grounds of justification: consent, necessity, unauthorised administration, and therapeutic privilege, are highlighted.

Before focussing on specifics, the difference between justification and excuse must be elucidated. If something is **justified** in law, it means that the law recognises the **conduct** in question as "right".[264] In some cases, however, a person acts in

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[264]See, for instance, Eser A "Justification and Excuse: a Key Issue in the Concept of Crime" in Eser A & Fletcher G *Rechtfertigung und Entschuldigung: Rechtsvergleichende Perspektiven / Justification and Excuse: Comparative Perspectives* (Volume One) Freiburg: Max Planck Institute (1987) 19-65. Eser indicates that he considers the distinction between justification and excuse very important in the everyday life of "the law-abiding citizen: he wants, and has the right, to know what is right and wrong. Accordingly, if he engages in an activity that might be covered by the definitional elements of an offence but yet not punishable by reason of a defence, he should know whether this defence is merely providing an excuse, thus putting his act outside the law, or whether his act would be justified, thus keeping it within the boundaries of the law." To demonstrate that this is "more than mere academic speculation", Eser (*ibid* 27-28) refers to the (then) debate in Germany concerning the characterisation of defences regarding abortion: "Even though a physician who procures an abortion in order to preserve the mother from a certain state of emergency is not punishable, the medical profession, as is true for other professional activities with high social prestige, is not satisfied with being merely 'excused' but, quite understandably, wants to have the so-called 'indication' to abortion recognised as a ground of 'justification' - because otherwise the physician's conduct, though not

a manner which is not justified, but the **person** is excused by the law, based on the fact that his or her mistake was reasonable - the law does not approve of the conduct, but **excuses** the person. This means that the conduct is wrongful, but the person lacks culpability.[265]

The grounds of justification were discussed in the previous chapter; if none of those is present, a person acts without **justification**, but there is still a chance that the law will **excuse** him or her.[266] The following sections explore unjustified intervention in the context of clinical psychiatry.

2 Intervention without Justification: Violations of *Corpus* (Bodily and Psychological Integrity) and *Dignitas* (Dignity and Privacy)

2.1 General

In South African law, the personality interest known as *corpus* (bodily **and** psychological integrity[267]) is protected[268] against every factual infringement that is not of a trivial nature. Any factual infringement for which there is no justification is

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punishable, might still be considered unlawful."

[265]As has been stated (see fn 2 *supra*), due to the limited scope of the dissertation, the finer details regarding these principles cannot be ventured into.

[266]The key concept regarding the distinction between justification and excuse is a feature in both the Continental and Anglo-American systems. See, for instance, Eser (*op cit*) at 46: "[A]t least in principle, the distinction between justification and excuse is fully accepted by German criminal theory and practice."

[267]See Visser PJ "Enkele gedagtes oor die moontlike invloed van fundamentele regte ten aansien van die reg op fisies-psigiese integriteit op deliktuele remedies" *THRHR* (1997) 496.

[268]Now also by section 12(2) of the Constitution, it is reiterated. See also Visser *(ibid)*.

wrongful.[269] As will be highlighted, in the presence of the requisite culpability, such violation would give rise to delictual or criminal liability, or both.

Dignitas is a broad and rather vague[270] concept that has been said to encompass all those personality interests relating to dignity, privacy, feelings and identity. In the context of criminal law, there appears to be no separation between "dignity" and other feelings. According to Snyman[271], the exact meaning of "dignity" has never been clearly defined by the courts, but a "fair inference may be drawn from case law that 'dignity' includes both 'self-respect' and 'mental tranquillity'. To ensure inclusivity "dignity/feelings" will be used in this dissertation. The instances of violation of *dignitas* that will feature herein, will thus be divided into two categories, *viz* those affecting "dignity/feelings" and those affecting "privacy".

Privacy, apart from forming part of the concept *dignitas*, is also an independent personality right and fundamental human right.[272] Privacy can be violated by intruding on private affairs or personal areas (property or body), or through accessing personal

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[269]See Neethling J, Potgieter JM and Visser PJ *Law of Delict* (4 ed) Durban: Butterworths (2001) 332-333.

[270]In exploring its Roman-law origins, Neethling *et al* state: "*Dignitas* was not a single, clearly defined and independent personality interest as was the case with *corpus* or *fama*, and certainly was not limited to the personality interest honour or dignity. Rather it was a collective term for those personality interests which had not yet been clearly identified and defined in Roman law. It can be stated without fear of contradiction that dignity, privacy and feelings...were included in the concept *dignitas*." See Neethling J, Potgieter JM and Visser PJ *Neethling's Law of Personality* Durban: Butterworths (1996) 50.

[271]See Snyman CR *Criminal Law* (4 ed) Durban: Butterworths (2002) 455.

[272]See Neethling J, Potgieter JM and Visser PJ *Law of Delict* (4 ed) Durban: Butterworths (2001) 354; Neethling J, Potgieter JM and Visser PJ *Neethling's Law of Personality* Durban: Butterworths (1996) 33-39. Section 14 of the Constitution (Act 108 of 1996) entrenches the fundamental right to privacy.

information[273] or disclosing confidential information[274] or non-consensually acquired information[275] about the person.

2.2 Negligently Unjustified Interventions

Negligence generally consists in not foreseeing that which a reasonable person would have foreseen and/or not taking steps to prevent that foreseen.[276] In the context of medical law, however, it is most often formulated simply as "not exercising the care and/or skill that a reasonable practitioner (of the relevant category) would have exercised".[277] In the present context, the focus is on negligently unjustified interventions as such, ie where a practitioner should have known (thus "the reasonable practitioner would have known") that there was no valid ground of justification for the intervention. The following sections thus deal with negligence in respect of the unjustified intervention, and not the negligence of the actual treatment. The treatment might be superlatively administered, but, if not legally justified, it is a violation *per se*.

Where anyone negligently violates the bodily integrity of

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[273] These would fall under so-called "intrusion"; see Neethling J, Potgieter JM and Visser PJ *Law of Delict* (4 ed) Durban: Butterworths (2001) 355.

[274] So-called "disclosure", in this case where a relationship of confidence exists - the act thus also constitutes a breach of confidence (*ibid* 356).

[275] A case of disclosure where no confidential relationship exists - often intrusion followed by disclosure; see *ibid*.

[276] As classically formulated by Holmes JA in *Kruger v Coetzee* 1962 (2) SA 428 (A).

[277] See, for instance, Strauss SA *Doctor, Patient and the Law: a Selection of Practical Issues* (3 ed) Pretoria: Van Schaik (1991) 290: "The law on medical negligence is simple to state: the doctor must exercise reasonable care and skill. What is reasonable in a particular situation, is essentially a matter of expert medical evidence. It is the medical profession which lays down what the appropriate standard of care is. The courts do not make findings *in vacuo*, but strictly on the facts before them."

another, he or she can be held delictually liable.[278] Similarly, where a person negligently violates the psychological integrity of another, he or she can be held delictually liable.[279] Negligent violations can attract compensation for patrimonial loss with the *actio legis Aquiliae*, and can be the basis for the action for pain and suffering. Since intent is generally required for the *actio iniuriarum*, negligent violations do not generally give rise to that action.[280]

As regards criminal liability, if a person negligently violates the bodily integrity of another, and, in so doing, negligently causes the death of that person, he or she could be convicted of culpable homicide.[281]

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[278]This involves primarily physical harm, and the patrimonial consequences thereof; details on the range of actions available are provided when discussing psychiatric case examples *infra*.

[279]This then involves primarily psychological harm: "psigiese letsels", now fully recognised by South African law; see *Barnard v Santam Bpk* 1999 (1) SA 202 (SCA). For commentary on that landmark case, see Burchell J "An encouraging prognosis for claims of damages for negligently inflicted psychological harm" *SALJ* (1999) 697-711 and Neethling J, Potgieter JM and Visser PJ *Law of Delict* (4 ed) Durban: Butterworths (2001) 290-295. It is submitted that Burchell's translation "psychological harm", is to be preferred over "psychological lesions" (used by Neethling *et al*).

[280]Cf Neethling J, Potgieter JM and Visser PJ *Neethling's Law of Personality* Durban: Butterworths (1996) 64-65: "The question arises whether in a developed community it makes sense to persist with the intention requirement of the classical *actio iniuriarum*, and whether personality protection should not be extended to the negligent infringement of personality interests. The majority of South African writers support the latter view...The idea of delictual liability for the negligent infringement of a personality right has long been accepted in foreign legal systems. It would seem that the legislature should step in and provide for a general extension of personality protection in South African law." It is submitted that the *actio iniuriarum* should indeed be available for negligent violations - the courts can then at least have the discretion to be able to allow the action in appropriate cases, those that warrant the payment of satisfaction (*solatium*).

[281]The reason why the word "negligently" features twice in this sentence, is that it is necessary for a conviction of culpable homicide that the accused's negligence must have caused

2.3 Intentionally Unjustified Interventions

Intent consists in the direction of a person's will towards performing an act with awareness of the material facts in the situation and the wrongfulness of the act.[282] As was explained in respect of negligent violations, the focus in this chapter is on intentionally unjustified interventions as such, ie where a practitioner knows, or foresees the reasonable possibility[283], that there is no valid ground of justification for the intervention, and yet proceeds therewith.

Where a person intentionally violates the bodily integrity of another, he or she can be held delictually liable on the basis of private-law assault.[284] Depending on the severity of the case this can also constitute criminal assault.[285] Attempted assault

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the death; see Visser PJ and Maré MC *Criminal Law through the Cases* (3 ed) Durban: Butterworths (1990) 556. South African criminal law does not presently recognise "negligent assault"; cf Kahn MS "Negligent Assault" *SACJ* (1988) 470-472.

[282] See, for instance, Snyman CR *Criminal Law* (4 ed) Durban: Butterworths (2002) 174. Subjective awareness of wrongfulness was unequivocally affirmed as part and parcel of intent in *S v De Blom* 1977 (3) SA 513 (A).

[283] See the brief discussion of *dolus eventualis* fn 302 *infra*.

[284] Ie the wrongful and intentional application of force, or the immediate threat of such application, to another's person. In the context of "assault", the violation necessarily involves the physical component of *corpus*, whose infringement constitutes an *iniuria*. The wrongful and intentional violation of the psychological component of *corpus*, would also constitute an *iniuria*, but would not be termed "assault" in the absence of physical force or the immediate threat thereof.

[285] See Snyman CR *Criminal Law* (4 ed) Durban: Butterworths (2002) at 430, where he defines assault as "unlawfully and intentionally (a) applying force, directly or indirectly, to the person of another; or (b) inspiring a belief in another person that force is immediately to be applied to him or her. The elements of the crime are: 1) the application of force (Anglo-American-law "battery") or inspiring a belief that force is to be applied (Anglo-American-law "assault"); 2) wrongfulness; 3) intent (*ibid*).

(criminal) is also possible.[286] However, where a person intentionally violates the psychological integrity of another, the violation would not constitute "assault" as such[287], but rather another *iniuria*, which can take the form of emotional shock, fear, insult, embarrassment or humiliation, giving rise to the delictual *actio iniuriarum* for satisfaction (*solatium*), and, in the case of significant psychological harm[288], also the action for pain and suffering.[289] Moreover, if patrimonial loss is suffered due to the psychological harm, the *actio legis Aquiliae* is available to provide compensation.[290]

Where the psychological violation consists wholly or partly of insult, embarrassment or humiliation that is of a serious nature, the perpetrator of such violation could, in addition, be charged with *crimen iniuria*.[291] Where an intentional violation of the body

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[286] *Ibid* 434.

[287] Since there is no physical force or immediate threat thereof, see fn 285 *supra*.

[288] Expressed in Afrikaans as "Psigiese letsel": see *Barnard v Santam Bpk* 1999 (1) SA 202 (SCA).

[289] Neethling J, Potgieter JM and Visser PJ *Law of Delict* (4 ed) Durban: Butterworths (2001) 291.

[290] *Ibid*.

[291] *Crimen iniuria* is the wrongful, intentional and serious violation of the *dignitas* ("dignity" and/or "privacy") of another. Although most cases of *crimen iniuria* (on the ground of violation of "dignity" as opposed to privacy, the other major recognised component of *dignitas*) in South African law have mostly concerned situations such as persons' taking offence at insulting language or sexual impropriety, the nature of the interest protected is evidently broad enough to cover novel (eg those in the psychiatric context) instances of humiliation or injury to self-respect. Snyman (*ibid*) avers that, for there to be an infringement of "dignity", the person must (a) be aware of the perpetrator's behaviour and (b) feel degraded or humiliated by it. Although the person's subjective feelings in this regard are mostly decisive, the law applies an objective standard so as to avoid hypersensitive persons unreasonably "constituting" instances of *crimen iniuria*. Snyman (*op cit* 456, 458) affirms that "X's conduct must be of such a nature that it would offend at least the feelings of a reasonable person....[Moreover, the courts will] treat it as criminal *iniuria*....only if the *iniuria*

or mind of a person can also be construed as significantly violating that person's privacy, this can also, where appropriate, found the *actio iniuriarum* and/or constitute *crimen iniuria*.[292]

Finally, of course, where a person intentionally violates the bodily integrity of another, and, in so doing, intentionally occasions the death of that other person, such perpetrator can be charged with murder. These instances will be elucidated in the discussion of examples *infra* under 8.

3 Intervention Without Informed Consent: Assault?

Strauss[293] asserts that malpractice liability can arise from assault in the form of an operation however properly and skilfully performed, if performed without a client's informed consent. The exact nature of the legal consequence of this violation is, however, a matter of debate.

The Supreme Court of Appeal in *Broude v McIntosh*[294] makes some

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is of a sufficiently serious or reprehensible character to merit punishment in the interests of society." The last statement applies equally to *crimen iniuria* due to violation of privacy.

[292] Neethling, Potgieter and Visser aver that it is a justified approach that "unauthorised medical examinations and tests, which amount primarily to an infringement of the body (physical integrity), are often regarded as a violation of privacy". This is because there is "also an acquaintance with personal facts, mostly of a medical nature, contrary to the determination and will of the person involved". Neethling J, Potgieter JM and Visser PJ *Neethling's Law of Personality* Durban: Butterworths (1996) 38. It is submitted that this principle is not limited to instances where the primary infringement is the body (physical integrity), but applies equally to unauthorised psychological examination; see the example *infra* under 7.3.

[293] See Strauss SA *Doctor, Patient and the Law: A Selection of Practical Issues* (3 ed) Pretoria: J L Van Schaik (1991) 243.

[294] 1998 (3) SA 69 (SCA).

important remarks regarding the effect of lack of informed consent. The claim *in casu* was based upon the alleged failure on the part of M to apprise B of the risks involved in a prospective vestibular cochlear neurectomy[295] and of the existence of an alternative. In the pleadings, it was alleged that M had "wrongfully failed to obtain [B's] real or informed consent to the operation and [M] accordingly committed an assault on [B by] operating on him...". In the alternative, it was alleged that in "treating [B] and in carrying out the operation[, M] acted in a negligent and unskillful manner" in that he "failed to inform [B] prior to carrying out the operation of the risks and hazards involved and he failed to inform [B] of alternative operative treatment available". In this regard Marais JA asserts:

> "Pleading a cause of action such as this as an assault to which the [cl]ient did not give informed consent is of course a familiar and time-honoured method of doing so. However I venture to suggest with respect that its conceptual soundness is open to serious question and merits reconsideration by this court when an appropriate case arises. To the average person, and I suspect to many a lawyer, 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 [cl]ient, and who has explained to the [cl]ient what is intended to be done and obtained the [cl]ient's consent to it being done, should be pejoratively described and juristically characterised 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 [cl]ient withholding consent. It seems to me to be inherent in

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[295] A surgical intervention in which the vestibular and cochlear nerves are severed (in this case to relieve chronic tinnitus and vertigo).

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 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 characterisation 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 characterisation of the medical practitioner's act in intervening surgically as lawful or unlawful. I mention this merely by way of example to explain why I consider that the validity of causes of action framed in this manner *in circumstances similar to those which are said to exist in this case* requires re-examination. (I emphasise the latter qualification; I leave aside cases in which *mala 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.)"

Claasen and Verschoor[296] refer to the position in England, in the words of Bristow J[297]: "Once the [cl]ient 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

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[296]Claassen NJB & Verschoor T *Medical Negligence in South Africa* Pretoria: Digma (1992) at 73.

[297]In *Chatterton v Gerson* [1981] 1 All ER 257.

implications is negligence, not trespass." These authors[298] note that in 1960 the Kansas Supreme Court became the first American court to decide that a medical practitioner's liability for failure to inform a client of the risks and alternatives regarding a proposed therapy, must be based on negligence rather than battery[299]. Subsequently, they refer to the position in Canada, citing Laskin CJ[300] as follows:

> "In my opinion, actions of battery in respect of surgical or other medical treatment should be confined to cases where surgery or treatment has been performed or given to which there has been no consent at all or where, emergency situations aside, surgery or treatment has been performed.....beyond that to which there was consent.....in my view, unless there has been a misrepresentation or fraud to secure consent to treatment, a failure to disclose the attendant risks, however serious, should go to negligence rather than battery."

It is submitted that this view is correct: a distinction should be drawn between the scenario where consent is **absent** or **intentionally insufficient** (ie material information is intentionally withheld), on the one hand, and **accidently (innocently or negligently) insufficient**, on the other hand.

Accordingly, if a psychiatrist, for instance, intentionally withholds material information in obtaining a competent client's consent to treatment, this would constitute *mens rea* that could

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[298] Claassen & Verschoor *op cit* 73.

[299] See fn 285 *supra*: "battery" has been incorporated into the concept "assault" in South African law.

[300] In *Reibl v Hughes* (1981) 114 DLR 3d 1.

range from *dolus directus*[301] to *dolus eventualis*[302]. When the psychiatrist then proceeds with (physical[303]) treatment, knowing that the consent is absent or might be insufficient, such an infringement of the client's *corpus* can appropriately be classed as assault.[304] If, however, a clinician is under the erroneous impression that the consent is sufficient, in other words that all material facts have been disclosed in obtaining the client's consent, where the reasonable clinician in his or her position would have known those facts to be material and accordingly disclosed them, one is dealing with a situation of negligence. It is submitted that this infringement of the client's *corpus* lacks

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[301]Direct intent, where X **aims** to achieve something ("oogmerksopset").

[302]Where X foresees the possibility that something might be the case (eg that he or she might not have adequately informed Y), or a result (eg the death of Y), and X continues reconciling him- or herself to that possibility. See Snyman CR *Criminal Law* (4 ed) Durban: Butterworths (2002) 181-185. Botha JA in S v Beukes 1988 1 SA 511 (A) states: "[Translated from the original Afrikaans] If there was such a possibility, it is invariably inferred, from the fact that he proceeded with his conduct, that he took the consequence into the bargain. It would thus seem that the second element would normally be satisfied only if the accused foresaw the consequence as a **reasonable** possibility. Is it then necessary still to formulate two criteria for *dolus eventualis*, or does the requirement that the accused must have foreseen the possibility as reasonable, suffice? I maintain that [setting] two criteria does serve a purpose [emphasis added]." The judge then proceeds to give examples illustrating why the second criterion for *dolus eventualis* should be retained. As the law stands, *dolus eventualis* thus consists in the foresight of a reasonable possibility (cognitive criterion) with subsequent conduct that manifests a taking into the bargain or reconciliation to that possibility (volitional criterion). Jansen JA in *S v Ngubane* 1985 (3) SA 677 (A) also refers to "consenting", "reconciling" or "taking into the bargain". Some authors, such as Loubser MM & Rabie MA "Defining *dolus eventualis:* a voluntative element?" *SACJ* (1988) 435-436, contend that the second criterion is superfluous. It is tempting to comment on this debate, especially with reference to the example in fn 348 *infra;* however, the discussion of the intricacies involved is beyond the scope of the present dissertation.

[303]As has been stated, it would have to involve a physical infringement (or immediate threat thereof) to constitute assault.

[304]Unless, of course, there is some other ground of justification for the intervention.

animus iniuriandi, and should thus not be construed as assault. Rather, it is a negligent violation of bodily and/or psychological integrity, which is delictually actionable but does not attract criminal liability.[305]

4 Unauthorised Administration (*Negotiorum Gestio*)

According to the suggested clarification of the legal position regarding unauthorised administration[306], if a doctor had proceeded with an intervention against the express prior will of a client, but it later appears that the client would at the time have consented, there would be no actual assault, but only, potentially, attempted assault in criminal law.[307] The doctor could

[305] It is notable that in *Castell v De Greef* 1994 (4) SA 408 (C), Ackermann J (as he then was) emphasised that the South African situation is different from that of the Anglo-American systems - whereas breach of the duty to disclose mostly seems to raise the issue of negligence in those systems (eg in England and Australia), such a breach raises the issue of whether there is justification in terms of *volenti non fit iniuria* (see *ibid* 420, 423, 425). This does not, however, necessarily imply that the issue of negligence cannot arise after it has been established that the conduct was objectively unjustified and thus wrongful. After that finding, the culpability of the person who is the author of the wrongful conduct must still be assessed. The mere fact that *volenti non fit iniuria* is the first focus of the investigation does not mean that negligence cannot also feature - it does not mean that one can summarily also infer *animus iniuriandi*. It can thus be concluded that infringement of bodily integrity without consent does not inevitably constitute assault. In addition to lack of justification, intent (imperatively with consciousness of wrongfulness, see fn 282 *supra*) must also be established.

[306] See chapter IV, 3.1 *supra*.

[307] It is doubtful, however, that charges would be pressed if the doctor saved the life of someone who actually wanted to be saved at the time. Nevertheless, he or she could be charged and convicted to uphold the principle that one cannot attempt to violate a person's *corpus* ostensibly against his or her valid will. On the other hand, a court might regard mild disciplinary action per illustration as more appropriate, and esteem it sufficient to sound the message that the doctor would have been convicted of assault had the unlikely turn of events not ensued.

thus still incur criminal liability on the basis of attempt, but could incur no delictual liability.[308]

Van Oosten[309] points out that a doctor's erroneous belief that an emergency exists or that the client would have consented to the intervention, would result in his or her acting in putative unauthorised administration as an excuse, rather than unauthorised administration as justification. This means that the practitioner's conduct is wrongful, but he or she is excused for his or her *bona fide*[310], and reasonable, mistake of fact (*error facti*).

If the mistake is *bona fide*, but unreasonable, ie the reasonable doctor in the same position would not so have erred, he or she would have acted negligently. The doctor might then incur delictual liability on the basis of the action for pain and suffering and/or the *actio legis Aquiliae* for patrimonial loss resulting from the negligent violation. Of course, if the mistake is not *bona fide*, and thus not actually a real mistake, the practitioner's intent would also found the delictual *actio iniuriarum* and perhaps result in criminal liability for assault.

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[308] Nevertheless, from the point of view of practical proof, a prior prohibition on the part of a client would create a virtually irrefutable impression that the client would accordingly not have consented at the time. It is only the client's own honest testimony in this regard that would forfeit his or her delictual claim. As indicated, however, he or she would still not necessarily release the doctor from criminal liability.

[309] Van Oosten FFW "Some Reflections on Emergencies as Justification for Medical Intervention" in Ahrens HJ, Bar C, Fischer G, Spickhoff A, Taupitz, J (Eds) *Festschrift für Erwin Deutsch* Köln: Carl Heymanns Verlag KG (1999) 684.

[310] There would be no assault, since intent is lacking (due to a *bona fide error facti* resulting in absence of consciousness of wrongfulness).

5 Necessity

5.1 Public and Private Necessity

In the context of public and private necessity, the erroneous belief that a justifying emergency exists would similarly result in a clinician's acting in putative necessity as an excuse, rather than justification. The same principles as described above for putative *negotiorum gestio* apply to the effect of the reasonableness or *bona fides* of the alleged *error facti*.

5.2 Therapeutic Necessity[311]

It is submitted that, if in the type of situation discussed[312], it appears *ex post facto* that the person's judgment was not impaired at all or that treatment was not in fact urgently necessary, but any reasonable clinician would have been convinced of those apparent circumstances, putative therapeutic necessity can operate as an excuse.

6 Therapeutic Privilege

If a clinician errs as to being justified in withholding material information (invoking therapeutic privilege), the client's consent would not be lawfully sufficiently informed, and thus objectively invalid. As discussed above, the result is an objective violation of the client's *corpus*. The question then arises whether "putative therapeutic privilege" as excuse might operate.

It is extremely doubtful that a clinician would be successful in raising putative therapeutic privilege as excuse, since the

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[311]The meaning of therapeutic necessity (as opposed to therapeutic privilege) is discussed in chapter IV 3.2.2 *supra*.

[312]Chapter IV, 3.2.2.2 *supra*.

"privilege" itself is inherently controversial. For therapeutic privilege to justify withholding information, it would have to be clear that the disclosure would be significantly harmful.[313] There should be absolutely minimal scope for error in this regard. It is, accordingly, submitted that if it can be demonstrated that therapeutic privilege was not justified, this would necessarily imply negligence on the part of a clinician who errs in this regard. Nevertheless, the *bona fide error facti* still negatives intent.[314] The result is thus only a negligent violation of *corpus*, and not assault.

Once the issue of whether therapeutic privilege was justified or not has been resolved, the question as to negligence would thus be answered, and the plaintiff would have to prove no more. The burden of proof would initially be on the plaintiff to show that there was no informed consent. Then the defendant would raise the defence of therapeutic privilege. If he or she fails to prove its being justified, it is submitted that a **necessary inference** of negligence can be drawn.[315] If, however, the plaintiff wishes to

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[313] Cf chapter IV, 3.3 *supra*.

[314] See 2.3 *supra*.

[315] It is notable that this is not an application of *res ipsa loquitur* ("the matter speaks for itself") as featured in the courts. A thorough analysis of the application of *res ipsa loquitur* in the medical context features in Carstens PA "Die toepassing van *res ipsa loquitur* in gevalle van mediese nalatigheid" *De Jure* (1999) 19-28. According to Carstens, *res ipsa loquitur* is a rule of evidence that entitles the court to draw a **provisional inference** of negligence, based on an "absolute" (according to the *dictum* by Blum J in *Pringle v Administrator Transvaal* 1990 2 SA 379 (W)). This "absolute" apparently means that if unjustified conduct is causally connected to a certain harmful result, the situation must be such that the "only conclusion" that can be reached is that there must have been negligence involved. The anomaly that arises, it is submitted, is that the defendant then still has the opportunity to rebut (the so-called "weerleggingslas" - "onus to rebut") (Carstens *ibid*). It is submitted that the use of the term "absolute" is thus inappropriate. "Absolute" would be irrebuttable. This is clearly not the case with the application of *res ipsa loquitur*. Carstens maintains that there is not a true shift in "burden of proof", in other words, the defendant is not required to prove that he or she was not negligent; he or she

show that the defendant knew that the therapeutic privilege was not justified, the plaintiff would have to prove intent, hence establishing an assault[316] and/or other intentional violation.

7 Hypothetical Case Scenarios

To illustrate some of the above and other principles, some hypothetical scenarios are here sketched. These will then be referred to at points throughout the remainder of the dissertation (in addition to the actual cases referred to later). The basic facts are here sketched; various hypothetical outcomes (based on the present author's opinion, taking into account principles of law and the approach of the South African courts to related situations) are provided at later stages to illustrate different points.

7.1 Scenario 1

> X, a productive accountant, suffering from severe depression, consults a psychiatrist. After trying a number of antidepressant medicines to no avail, she (the psychiatrist) suggests the use of ECT (electroconvulsive therapy). She is concerned that mentioning the chance of some loss of memory and headaches around the time of the ECT, will dissuade him

merely has give a "satisfactory" explanation of his or her conduct so as to rebut the *prima facie* inference. Carstens (*ibid* 25) asserts that this "necessarily has the effect that a physician would then have to offer medical evidence to show that his conduct was, medically speaking, acceptable [translated form the original Afrikaans]". According to Carstens, if the physician fails to rebut, negligence is established. The rule here suggested for "putative therapeutic privilege" is clearly different: negligence is suggested to be a **necessary inference.** For a very extensive analysis of *res ipsa loquitur* in medical law, see Van den Heever P *The Application of Res Ipsa Loquitur to Medical Negligence Cases: A Comparative Survey* (LLD thesis, University of Pretoria, 2002).

[316] In the case of a physical intervention.

(the client) from consenting to what she esteems to be very necessary treatment. She thus conceals this information, and the client consequently consents. ECT is accordingly performed a number of times.

7.2 Scenario two

Suppose the same set of facts, except that the client has some cardiovascular problems, creating a risk of myocardial infarction (and hence death) during the ECT. The psychiatrist is almost certain that if she were to reveal this risk, the client would not consent to the treatment. She harbours the reasonable medical opinion that the need for the treatment outweighs the fairly remote risk[317] involved, considering the marked deterioration in the client's depressive condition.

7.3 Scenario three

X consults a psychiatrist regarding what he (the psychiatrist) subsequently identifies as a dysthymic condition.[318] The psychiatrist strongly suspects that

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[317]In terms of South African law, however, if a risk of a significant consequence (such as death) is present, it must be disclosed even if it is fairly remote. See Van Oosten FFW *The Doctrine of Informed Consent in Medical Law* (LLD thesis, Unisa, 1990) 48-50.

[318]To provide an idea of the nature of a dysthymic condition, the following from the American Psychiatric Association's *Diagnostic and Statistical Manual of [Clinical Biopsychosocial Conditions]* IV-TR Washington: APA (2000): "The essential feature of [a] [d]ysthymic [condition] is chronically depressed mood that occurs for most of the day more days than not for at least 2 years (Criterion A). Individuals with [a] [d]ysthymic [condition] describe their mood as sad or 'down in the dumps'. During periods of depressed mood, at least two of the following additional symptoms are present: poor appetite or overeating, insomnia or hypersomnia, low energy or fatigue, low self-esteem, poor concentration or difficulty making decisions, and feelings of hopelessness (Criterion B). Individuals may note the prominent presence of low interest and self-criticism, often seeing themselves as uninteresting or incapable. [T]hese symptoms...

significant events that took place during her (the client's) childhood precipitated and are sustaining her condition. She does not seem to recall any such "major" events, apart from her childhood being "relatively unhappy". She acknowledges that she does become quite anxious when talking about her childhood. She expresses that she is not ready to discuss all the emotions that she experiences in her relationships with various family members. She maintains that she wants to focus on the problems which she is experiencing in current relationships with friends and colleagues. To her mind, her reservations and tensions regarding those relationships are a major source of continuing despair. The psychiatrist surmises that she probably harbours repressed memories of childhood sexual abuse, but does not disclose this suspicion so as to avoid placing suggestions in her mind. He believes that the only way to discover the source of the problem is to recover those repressed memories. During a session, he offers her a "sedative" to "ease her anxiety" while talking about the past weekend's interactions with certain family members. In actual fact, he administers a recently developed drug akin to sodium amytal, designed to facilitate revealing repressed material in a trance-like state. He fears that this is the only way, since he knows that she would not be comfortable enough with this to consent to it. During the session, it clearly emerges that she was sexually abused on numerous occasions by her father.

7.4 **Scenario four**

A client consults a psychiatrist regarding his specific phobia involving dogs. She is convinced that flooding

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become much a part of the individual's day-to-day experience (eg 'I've always been this way', 'that's just how I am')."

is the most suitable technique to use.[319] She does not mention an alternative technique, systematic desensitisation, to him. She also omits to warn him that this technique may be quite traumatic, since she does not want him to enter therapy with that idea in mind. She explains as much as she sees fit. On the basis of the information, he "consents".

7.5 Scenario five

In a state in which active euthanasia is lawful in accordance with statutory provisions, a physician administers a lethal dose of a substance, causing a suffering, terminally ill person a painless death. *Ex post facto* it emerges that there was no valid consent for the active euthanasia.

8 Examples Illustrating the Consequences of Intervention without Justification in terms of South African Law

8.1 Introduction

The table under 8.3 illustrates some of the legal consequences of intervention without justification in the various hypothetical situations described above. In addition to the delictual and criminal consequences there indicated, some general remarks regarding contractual liability are indicated.

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[319] This technique encourages the client "to confront the feared situation directly, without a gradual build-up as in systematic desensitization or graded exposure. No relaxation exercises are used, as in systematic desensitization. The [client] experiences fear, which gradually subsides after a time...Many [cl]ients refuse flooding because of the psychological discomfort involved." See Kaplan HI, Sadock BJ and Grebb J *Synopsis of Psychiatry* (7 ed) Baltimore: Williams and Wilkins (1994) 854.

8.2 **Contractual Liability**

Every non-consensual intervention that materially affects the consensus that is essential to the establishment of any contract, will render void *ab initio,* or voidable[320], any contract that might have existed between the parties.[321] If the contract is null and void, the client would not be liable for payment of fees. If he or she has already paid, he or she could claim restitution.[322] If other patrimonial damage has been suffered, he or she could not claim for that *ex contractu*, however, since there legally never was a contract. If, on the other hand, the contract is voidable, the client can choose to uphold it, and can then sue in terms thereof for patrimonial loss.[323] Since a claim *ex delicto* provides wider compensation, however, this would invariably be the better option.

Nevertheless, claims should be instituted providing for both options, *viz* a claim based on contract and/or a claim based on delict. In this way, one can accommodate the possibility of the failure of the delictual claim. Moreover, it is also possible to recover different losses with contractual and delictual remedies concurrently.[324] A client could, for instance, recover the money he or she paid for the treatment in step with contractual

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[320] If a there has been a material misrepresentation, it is general contract law that the person in respect of whom the misrepresentation was made has the option of enforcing or voiding the contract; see Nagel CJ (Ed) *Commercial Law* Johannesburg: *Lex Patria* (1994) 50.

[321] It is notable that reimbursement of one acting in unauthorised administration would also not be forthcoming if he or she was not actually justified in doing so.

[322] Ie contractual negative *interesse*, see fn 325 and chapter VIII, 3, *infra*.

[323] Cf chapter VIII, 3 *infra*.

[324] See Van Aswegen A "Concurrence of Contractual and Delictual Claims and the Determination of Delictual Wrongfulness" *THRHR* (1994) at 150.

negative *interesse*[325] while the remainder of his or her loss could be claimed for in step with delictual negative *interesse*.[326]

It is appropriate now to turn to the table reflecting the possible delictual and criminal consequences of unjustified intervention.[327]

8.3 Delictual and Criminal Liability

The following column headings apply throughout:

Status of Inter-vention	**Legal effect where the intervention is intentionally non-consensual (or otherwise unjustified), and does not result in the death of the client**	**Legal effect where the intervention is intentionally non-consensual (or otherwise unjustified), and does result in the death of the client**	**Legal effect where the intervention is negligently non-consensual (or otherwise unjustified), and does not result in the death of the client**	**Legal effect where the intervention is negligently non-consensual (or otherwise unjustified), and does result in the death of the client**

[325] Ie (s)he is placed in the position in which (s)he would have been had the contract never been concluded (thus the money would not have been paid).

[326] Ie (s)he is placed in the position in which (s)he would have been, had the delict never been perpetrated. The actions can be combined, provided that they are used to claim for different losses; see Van Aswegen (*op cit*).

[327] Based on the present author's opinion, taking into account principles of law and the approach of the South African courts to related situations.

Violates psychological integrity (but is medically perfectly successful)	<u>Delictual:</u> *actio iniuriarum* available for intentional violation of psychological integrity and invasion of privacy[328]; <u>Criminal:</u> *Crimen iniuria*[329]	Not a reasonable possibility[330]	<u>Delictual:</u> action for pain and suffering might be available for negligent violation of psychological integrity[331]; <u>Criminal:</u> None	Not a reasonable possibility

[328] Suppose, in scenario 3 *supra*, the client endures the trauma of confronting her father, has many disturbing thoughts and feelings around that time, but within a month has adjusted and makes a full recovery from her dysthymic condition. Her relationships flourish and she becomes more productive than she ever thought she could be. Due to the fact that consent was lacking, she could still avail herself of the *actio iniuriarum* to satisfy her for the violation of her psychological integrity and privacy. However, because her patrimonial position improved and she endured less pain and suffering than she would have but for the intervention, the action for pain and suffering and the *actio legis Aquiliae* would not be viable.

[329] Suppose, in scenario 3 *supra*, she initially suffers considerable embarrassment/humiliation at the psychiatrist's laying bare of her sexual encounters with her father (nevertheless the outcome is as in fn 328 *statim supra*). As discussed, the intentional invasion of her privacy, and the humiliation that she suffered might constitute *crimen iniuria*, due to the violation of "privacy" and/or "dignity". See fn 291 *supra*.

[330] It is inconceivable that the successful outcome of any psychiatric intervention would be death.

[331] Suppose, in scenario 4 *supra*, he experiences considerable discomfort during repeated sessions, but eventually conquers his specific phobia in good time. When telling a new friend, who happens to be a psychologist, she mentions the alternative treatment. He feels that he would much have preferred that process, and feels "wronged" by the fact that no mention of this was made to him. Assuming that the reasonable psychiatrist would have made the disclosure, the psychiatrist negligently violated his psychological integrity. If it is conceivable that the alternative treatment could have been efficacious without the pain and suffering, the action may be viable.

Violates bodily integrity (but is perfectly successful)	Delictual: *actio iniuriarum* available for assault[332]; Criminal: Assault[333]	Delictual: action avails dependants for the death of their breadwinner[334]; Criminal: Murder[335]	Delictual: action for pain and suffering might be available for negligent violation of bodily integrity[336]	Delictual: action avails dependants for the death of their breadwinner[337]; Criminal: Culpable homicide[338]

[332]Suppose, in scenario 1 *supra*, the client merely suffers some mild headaches and hardly any memory loss surrounding the ECT, and his depression is alleviated. He could still avail himself of the *actio iniuriarum* to satisfy him for the assault. Due to the fact that his patrimonial position improves (he is able to work more, free from depression) and he endured less pain and suffering than he would have but for the intervention, the action for pain and suffering and the *actio legis Aquiliae* would, however, not be viable.

[333]With reference to scenario 1, it is unlikely but not impossible that such intentional violation of his *corpus* could warrant a charge of criminal assault. Nevertheless, technically it has all the elements of criminal assault. See fn 285 *supra*.

[334]The only conceivable "successful" intervention that results in death, would be euthanasia. Hence, with reference to scenario 5, suppose the state is South Africa, and the person had dependants for whom he or she was a breadwinner; those dependants can claim compensation for *damnum iniuria datum* due to the loss of their breadwinner. See Neethling J, Potgieter JM and Visser PJ *Law of Delict* (4 ed) Durban: Butterworths (2001) 282-289.

[335]Without valid consent and with the requisite intention, the physician commits murder. Of course, since South Africa does not at this time accept active euthanasia as lawful, informed consent in this regard could never be valid (being legally *contra bonos mores)*, thus intentional active euthanasia would inevitably constitute murder; see eg *S v Hartmann* 1975 (3) SA 532 (C).

[336]Suppose, in scenario 1 *supra*, she *bona fide* (but unreasonably) believes that she has disclosed all material facts regarding the ECT. She then negligently violates his psychological integrity (due to negligently not obtaining informed consent). It is inconceivable that the action for pain and suffering would be available for the minor headaches, however. If negligence were sufficient for the *actio iniuriarum*, satisfaction would have been appropriate in this case (see fn 280 *supra*).

[337]With reference to scenario 5 and fn 335, suppose the doctor *bona fide* (but unreasonably) believed that the consent is valid, he or she shall have negligently occasioned the wrongful death. The action for dependants is viable.

Violates psycho-logical integri-ty (is up to medical standard but is unsuc-cessful)	<u>Delictual:</u> *actio iniuriarum actio legis Aquiliae;* and action for pain and suffering[339] <u>Criminal:</u> *Crimen iniuria*[340]	<u>Delictual:</u> action might avail dependants for the death of their breadwinner[341]; <u>Criminal:</u> *Crimen iniuria*[342]	<u>Delictual:</u> action for pain and suffering; *actio legis Aquiliae*[343];	<u>Delictual:</u> action might avail dependants for the death of their breadwinner[344];

[338]With reference to fn 335: suppose the doctor *bona fide* (but unreasonably) believes that the consent is valid. Although he acts intentionally, in the colourless sense (ie without awareness of wrongfulness) in respect of the death, he is negligent in respect of its wrongfulness - it is submitted that the result could be a verdict of culpable homicide.

[339]With reference to fn 328 *supra*, suppose the dysthymic condition persists. Since the dysthymic condition is now coupled with additional trauma, her productivity decreases tremendously, and she suffers patrimonial loss. All patrimonial loss due to the wrongful treatment is recoverable with the *actio legis Aquiliae*. Moreover, the additional pain and suffering she has endured can give rise to the action for pain and suffering. It is submitted that the fact that the treatment as such was not negligent offers no defence. Of course, the *actio iniuriarum* is still (cf fn 328) available.

[340]The situation is the same as in fn 329 *supra*.

[341]Still with reference to scenario 3, suppose the trauma coupled with subsequent major depression clearly causes the client, who is a breadwinner, to commit suicide. Even though the suicide might not have been reasonably foreseeable and the treatment as such was not negligent, it is submitted that the action is still viable due to the fact that his intentional violation factually and legally (let it be assumed - a court may regard the connection as too remote or the suicide as a *novus actus interveniens*) caused her death.

[342]However, a charge of murder is unlikely due to the likely problems in respect of establishing legal causation. The fact that the victim has died does not extinguish the charge of *crimen iniuria*.

[343]Suppose, with reference to scenario 4, that she *bona fide* (but unreasonably) believes that the consent was valid. The treatment is unsuccessful and the trauma causes him to become so phobic that he cannot leave his home. He suffers tremendous despair and patrimonial loss. These actions clearly avail him, even though the treatment itself was not negligently administered (let it be assumed).

[344]The situation is the same as in fn 341 *supra*, except that it is here his negligence that is factually and legally causally connected to her death.

Violates bodily integrity (is up to medical standard but is unsuccessful)	Delictual: *actio iniuriarum* available for assault; also *actio legis Aquiliae*; and action for pain and suffering[345] Criminal: Assault[346]	Delictual: action avails dependants for the death of their breadwinner[347]; Criminal: Murder[348], or assault[349]	Delictual: *actio legis Aquiliae*; action for pain and suffering for negligent violation of bodily integrity[350];	Delictual: action avails dependants for the death of their breadwinner

[345]Suppose, in scenario 1 *supra*, the client suffers severe headaches and marked memory loss, and his depressive condition is virtually unchanged. He could not only avail himself of the *actio iniuriarum* to satisfy him for the assault, but also, due to the fact that his patrimonial position worsens (he is unable to work due to the headaches and memory loss, coupled with depression), the *actio legis Aquiliae* would be available. Moreover, he endures considerably more pain and suffering than he would have but for the intervention; thus, the action for pain and suffering would be viable.

[346]Due to the increased gravity of harm (compared to the situation in fn 332), a charge of criminal assault would be more likely.

[347]With reference to scenario 2, suppose that he had two dependants for whom he was the breadwinner. Even assuming that the treatment itself was not negligent, the intentional non-disclosure is nevertheless causally connected to the wrongful death of their breadwinner. The action would be available.

[348]With reference to scenario 2, she foresaw the reasonable possibility that he might die as a result of the treatment, and nevertheless proceeded. Of course, she did everything she could to guard against that occurrence, however. Whether this is a case of murder would depend on the formulation of *dolus eventualis*. If the volitional criterion (see fn 302 *supra*) is "consenting", "reconciling" or "taking into the bargain", then she quite possibly complies therewith. Normally, it would be the client's consent that justifies her conduct; without that consent, what remains is her subjective foresight of the possibility of death and continued conduct regardless. If one omits the volitional criterion altogether, as some contend should be the case (see fn 302 *supra*), she would certainly act with *dolus eventualis*.

[349]If the court finds that the requirements for murder have not been met, assault might be a competent verdict. The possibility of culpable homicide, however, demands some debate, the intricacies involved in which are beyond the scope of the present dissertation.

[350]With reference to scenario 1, suppose the damage he suffers is that in fn 345, these actions would certainly avail him.

Violates psycho-logical integri-ty (is not up to medical standard and is unsuc-cessful)	Delictual: *actio iniuriarum*, *actio legis Aquiliae*; action for pain and suffering all available Criminal: *Crimen iniuria*	Delictual: action certainly avails dependants for the death of their breadwinner; Criminal: *Crimen iniuria* and culpable homicide[351]	Delictual: *actio legis Aquiliae* and action for pain and suffering available due to negligent violation of psychological integrity;	Delictual: action avails dependants for the death of their breadwinner; Criminal: Culpable homicide[352]
Violates bodily integri-ty (is not up to medical standard and is unsuc-cessful)	Delictual: all mentioned actions available Criminal: assault	Delictual: action avails dependants for the death of their breadwinner; Criminal: Murder, culpable homicide or assault	Delictual: *actio legis Aquiliae* action for pain and suffering	Delictual: action avails dependants for the death of their breadwinner;

[351]It is not impossible that, in addition to *crimen iniuria*, a court might, depending on the severity of the negligence of the treatment, establish culpable homicide. Once again, the intent in respect of unjustified intervention is probably not sufficiently closely connected to the death to warrant a conviction of murder. The court would then have to find negligence in respect of the death to be able to convict of culpable homicide.

[352]Due to the fact that the treatment is not up to medical standard, it is not impossible that a court might find that the negligence in respect of justification and treatment (if gross), and also in respect of the resultant death, warrants a conviction of culpable homicide.

CHAPTER VI

LIABILITY FOR FAILURE TO INTERVENE

1 Introduction

According to Strauss[353], a doctor in private practice[354] is an independent contractor who may (apart from in emergency situations) accept or refuse clients at his or her discretion.[355] However, failing to perform an operation agreed upon (breach of contract), which failure has caused financial loss[356] for the client, can found a malpractice claim.[357] Where a psychiatrist has agreed on a certain intervention, and fails to honour such agreement, it might thus constitute malpractice. Moreover, especially[358] in the light of section 27(3) of the **Constitution**, which states that no one may be refused emergency treatment, even private practitioners[359] may be expected not unreasonably to refuse

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[353] Strauss SA *Doctor, Patient and the Law: a Selection of Practical Issues* (3 ed) Pretoria: Van Schaik (1991) 189.

[354] Doctors at state facilities cannot ordinarily refuse persons who present there; see *ibid*.

[355] Pergament echoes that: "As a general rule, a therapist in private practice may choose whomever she wishes to treat." Pergament D "Internet Psychotherapy: Current Status and Future Regulation" *Journal of Law-Medicine 8 Health Matrix 233* (1998).

[356] *Administrator of Natal v Edouard* 1990 (3) SA 581 (A).

[357] See Strauss SA *Doctor, Patient and the Law: A Selection of Practical Issues* (3 ed) Pretoria: J L Van Schaik (1991) 243.

[358] Before the **Constitution**, the common law had already compelled practitioners to act positively in certain situations; see *ibid* 23-27. See also the *locus classicus* regarding the legal duty to act positively, *Minister of Police v Ewels* 1975 (3) SA 590 (A).

[359] Section 8(2) of the **Constitution** has the effect that natural and juristic persons (ie not just the state and its organs) are, "where appropriate", bound by the fundamental rights in its chapter 2 - so-called "horizontal functioning".

to attend to someone in dire need.[360]

Other notable instances where psychiatrists may be held liable for not intervening in the appropriate manner in respect of their existing clients[361], are: not preventing a suicidal client from committing suicide by commitment, supervision and/or restraint, and not preventing a dangerous client from harming members of the public by commitment, supervision and/or restraint. These instances will be discussed in this brief chapter.

2 Suicide or Self-injury on the Part of the Client

2.1 Grounds for Liability

Kruger[362] asserts that, in terms of South African law, the hospital and treating psychiatrist of a particular client, owe a special legal duty to him or her if he or she is suicidal. Should there be a dereliction of such a duty, liability for the death of such a client will follow if the hospital and/or psychiatrist is/are found to have been negligent in omitting to prevent his or her death.

According to Perlin[363], it is established law in the United States that a psychiatrist (or facility) has a duty to apply reasonable care and skill to prevent a client, whom a psychiatrist knows or ought to know may injure himself or herself, from doing so. He cautions that keeping too close an eye or too tight a rein on clients might, on the other hand, conflict with the right to

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[360] Such practitioners do still have the right to be remunerated, of course.

[361] In other words, those in respect of whom they have already undertaken treatment on a continuous basis.

[362] Kruger A *Mental Health Law* Durban: Butterworths (1980).

[363] Perlin ML *Mental Disability Law: Civil and Criminal* Vol 3 (2 ed) Lexis publishing (2000) 383-385.

treatment in the least restrictive alternative setting.[364] Still in the context of the United States, Reisner *et al*[365] aver that where a client commits suicide, the next of kin may assert a claim against the therapist for malpractice, alleging, for instance, that the therapist elected an improper mode of therapy[366] or that he or she did not commit the client or place him or her under close supervision.

Liability for suicide may be particularly appropriate where a therapist fails to take necessary precautions when he or she has clear knowledge of a client's suicidal propensities.[367] Reisner *et al*[368] caution, however, that "suicide prediction is notoriously unreliable. Various studies have shown that suicide prediction by experts is likely to grossly overpredict suicide, resulting in numerous 'false positives', ie prediction that individuals will commit suicide, when in fact they would not. Thus, the widespread use of civil commitment to prevent suicide would, as one court has noted, result in numerous [cl]ients who are not suicide risks being subjected to a loss of freedom."

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[364]In this regard he refers to the case of *Youngberg v Romeo* 50 US LW 4681 (US June 18 1982). The principle of 'the least restrictive alternative' is a commonly referred to and generally accepted one. Reisner R, Slobogin C and Rai A *Law and the Mental Health System: Civil and Criminal Aspects* (3 ed) St Paul: West Group (1999) 719 note, however, that it is "[s]till unresolved, at least by the United States Supreme Court,..whether the least restrictive alternative doctrine has constitutional status".

[365]*Ibid* 165.

[366]This would technically not, however, be failure to intervene, but rather negligent treatment. According to Reisner *et al* (*ibid*), such a claim might follow the negligent treatment of a client who entered therapy having suicidal impulses coupled with depression, where the negligence manifested in the therapist's failure to consider antidepressant medication, instead relying entirely on psychotherapy. See *Osheroff v Chestnut Lodge* 62 Md App 519, 490 A2d 720 (1985) in Reisner *et al ibid* 148 *et seq*.

[367]See Reisner R, Slobogin C and Rai A *Law and the Mental Health System: Civil and Criminal Aspects* (3 ed) St Paul: West Group (1999) 165.

[368]*Ibid*.

It is notable that this may be somewhat of a proverbial tightrope for a psychiatrist to walk: depriving a person of his or her freedom constitutes a significant curtailment of basic rights.[369] If a psychiatrist unjustifiably facilitates the commitment of an apparently dangerous or suicidal person, who should actually not have been committed, that could also constitute malpractice.[370] Moreover, if a psychiatrist unjustifiably and unreasonably restrains an individual under his or her care, it violates *corpus*[371] and also *libertas*, constituting malpractice.[372] In the context of preventing harm, there may thus be a risk of being too cautious in that regard and unjustifiably committing an individual. The matter of improper commitment hence warrants brief attention.

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[369] Apart from the fact that freedom is one of the cornerstones of the South African **Constitution** and democracy, the personality interest *libertas* has long enjoyed legal protection. See Neethling J, Potgieter JM and Visser PJ *Law of Delict* (4 ed) Durban: Butterworths (2001) 335-336.

[370] See, for instance, Kruger A *Mental Health Law* Durban: Butterworths (1980), who states: "[I]f it appears that the magistrate *bona fide* believed that the necessary medical grounds were present for commitment - in other words where the magistrate was misled by the reports of medical practitioners - an action in delict may lie against the practitioner." Kruger notes that a client detained under the **Mental Health Act** 18 of 1973, or a relative or guardian of such client, may at any time request a court to investigate the grounds of his or her detention. The court may subsequently make such order as it deems fit.

[371] See chapter V, 2.2 *et seq, supra,* regarding assault and negligent violation of *corpus*. Perlin ML *Mental Disability Law: Civil and Criminal* Vol 3 (2 ed) Lexis publishing (2000) at 370, also mentions assault and battery constituted by using excessive force to restrain or control a client. In South African law the psychiatrist would have to have at least *dolus eventualis* in respect of the fact that the force is excessive and thus wrongful, for that to constitute an assault. Nevertheless, in the absence of *dolus* or *animus iniuriandi,* he or she could still be held delictually liable for negligent violation of *corpus* and wrongful deprivation of liberty (where the form of restraint renders this appropriate).

[372] See Neethling *et al* (*op cit* 335): "The *libertas* (bodily freedom) is protected not only against the total deprivation of liberty but against any limitation of a person's freedom of movement or action."

2.2 The Consequences of Improper Commitment

Both inappropriate voluntary[373] and involuntary[374] commitment can be very harmful to the client and can attract legal liability. As has been stated,[375] an action *ex delicto* could lie against a

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[373]This can be problematic if an incompetent person is allowed "voluntarily" to commit himself or herself. At the time a person considers signing the "voluntary" admission document, the psychiatrist authorising admission (in South Africa the responsible person is the "superintendent", who is not necessarily a psychiatrist; see section 3 of the **Mental Health Act** 18 of 1973) must ensure that the person is competent. In the American case *Zinermon v Burch* 494 US 113 (1990), the hospital staff noted that upon "voluntarily" admitting himself, Darrell Burch was confused, unable to give reasons for his hospitalisation, and believed that he was "in heaven". Progress reports by psychiatrist Marlus Zinermon reflected his condition upon admission, describing him as "disoriented, semi-mute, confused, and bizarre in appearance and thought, uncooperative at the initial interview, extremely psychotic, and apparently paranoid and hallucinating"; see the discussion of this case in Stone DH "The Benefits of Voluntary Inpatient Psychiatric Hospitalization: Myth or Reality?" *9 B U Pub Int L J* (Fall, 1999) 25, 35-36. He reports: "Darrell E. Burch, the named patient in the case, alleged that the Florida state mental hospital violated state law by admitting him as a voluntary patient when they 'knew or should have known that [he] was incapable of voluntary, knowing, understanding and informed consent' to his admission. Burch further alleged that the hospital's failure to initiate Florida's involuntary placement procedure denied him constitutionally guaranteed procedural safeguards. The Court held that the hospital should have only allowed patients who were competent to consent to voluntary admission....The Court recognized that Mr Burch was confined, imprisoned, and subjected to involuntary commitment and treatment for 149 days without the benefit of counsel or a hearing... Burch's five-month stay, without hearing or attorney consultation, demonstrates an obvious due process violation."

[374]Ie where a person is committed against his or her will or without his or her consent. Some issues in the context of primary and secondary health care, involving involuntary admissions to psychiatric hospitals, are discussed in Allan A, Allan MM and Van der Merwe PL "Inappropriate Involuntary Admissions to Psychiatric Hospitals" *The South African Medical Journal* (1999) 89 1303-1307. These authors theorise about the factors that might contribute to inappropriate involuntary admissions in South Africa, but assert that more research is required before clear conclusions can be reached.

[375]See fn 370 *supra*.

practitioner and/or institution negligently (or intentionally[376]) allowing improper commitment.

Under the influence of English law, South African law has adopted the specific form of *iniuria*, "wrongful deprivation of liberty".[377] The effect of the influence of English law is that the courts do not require intent or negligence to found liability.[378] It is submitted, however, that in the context of wrongful commitment, it would be unreasonable to apply strict liability.[379] Especially considering that liability can arise on both sides of the spectrum,[380] it is doubtful that a court would hold a practitioner or institution liable without there having been at least

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[376]Intentional improper commitment is also not impossible - this would be even more serious an act.

[377]See Neethling J, Potgieter JM and Visser PJ *Law of Delict* (4 ed) Durban: Butterworths (2001) 335. They note that "[t]he existence of such deprivation must be judged objectively. Where a person thinks or believes that he is being held captive while this is not in fact the case, infringement of his physical liberty does not occur. On the other hand, a person need not be aware of the fact he is being deprived of his liberty for the personality infringement to be present." This would be relevant in cases where a psychotic person may well be "unaware" of the deprivation.

[378]*Ibid* 336.

[379]The psychiatric context is different from the context in which the action would usually feature. The rationale for strict liability for wrongful deprivation of liberty involves the inequalities between private individuals and public servants, normally in the context of "false imprisonment" or "wrongful arrest". See *ibid* 335, 372.

[380]Ie if a person is unreasonably not committed, and causes damage to himself or herself or others, liability can also arise. It is notable that where a client is prematurely released and causes harm to a third party, the releasing institution may be held liable, as Kruger (*op cit*) asserts, if it can be shown that the client should not have been released, and had proper care been taken, he or she would not have been released. In respect of both commitment and discharge, Kruger emphasises that practitioners should not be so "afraid" of lawsuits that they refuse to certify persons who should really be certified or detain persons unnecessarily. In both cases, such "defensive" conduct could attract liability for not preventing harm to the public or the client, or wrongful detention, respectively.

negligence involved. The threat of strict liability would do nothing more than encumber an already difficult task. Liability on the ground of negligence would be sufficient to sound the importance of taking care in this regard. The South African courts have the discretion to develop the common law taking such policy considerations into account, especially in novel instances[381] - as this would be.

Returning specifically to the commitment of a client who discloses suicidal ideation or displays suicidal tendencies: apart from the possible legal perils just discussed, on a therapeutic level, the invocation of civil commitment poses the risk that "the client-therapist relationship, which relies on trust, may be ruptured, making it less likely that the therapist will be in a position thereafter to provide effective treatment".[382]

2.3 Conclusion

2.3.1 The Crux: Due Professional Care and Skill

Successfully negotiating the tension between not keeping close enough supervision or physical control (such as commitment or restraint[383]) on the one hand, and keeping too close control on the

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[381]See, generally, Van Aswegen A "Policy Considerations in the Law of Delict" *THRHR* (1993) 171.

[382]See Reisner R, Slobogin C and Rai A *Law and the Mental Health System: Civil and Criminal Aspects* (3 ed) St Paul: West Group (1999) 165.

[383]It is notable that "chemical restraint" is also possible. This involves the use of medication to restrain a person who might pose a threat of harm to himself or herself or others. Serious violations of *corpus* and *libertas* can be perpetrated where this mechanism is abused, eg to "punish" a difficult committed person or for the mere sake of convenience. All persons working in such institutions should consider it their duty to be sensitive to the possibility that a frustrated colleague might be applying more restraint than necessary. The law cannot protect people if their plights are not brought to its attention; it is

other (resulting in a wrongful deprivation of liberty and/or violation of *corpus*), depends simply[384] and entirely on the application of the care and skill that a reasonable practitioner in the same position would have applied.

2.3.2 **An Application**

With reference to scenario 3[385], suppose informed consent had been duly obtained, and the treatment was performed up to medical standard. Still, the treatment is unsuccessful, and the trauma coupled with subsequent major depression clearly causes the client to become suicidal. Suppose also that there are a number of threats of suicide, and one or two attempts. If the suicide is reasonably foreseeable and the reasonable psychiatrist would have taken steps to prevent it, it is submitted that the *actio legis Aquiliae* avails her dependants, provided also that the court adjudicates affirmatively on the matter of legal causation.[386]

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imperatively up to those who are "on the ground" to assist the law (and professional bodies) in safeguarding the integrity of their practices and profession.

[384]It may be simple to state (cf fn 277 *supra*), but certainly not so simple to establish or prove. It is precisely this fact that urges practitioners to insure themselves against malpractice suits.

[385]Chapter V, 7.3 *supra*.

[386]Cf fn 341 *supra*. In the American case *Weathers v Pilkinton* T App S W 2d 75 (1988), the matter of "proximate cause" and liability for suicide is featured. The following extract from that case may have some value in guiding a South African court: "[Majority judgment:] [W]e conclude that where a defendant injures another either wilfully or negligently and as a result of the injury, the injured person commits suicide the act of suicide is, as a matter of law, an intervening independent cause if the decedent knew and understood the nature of his or her act or the act resulted from a moderately intelligent power of choice....Therefore, we are of the opinion that the result in this case turns on the question of whether there is evidence in the record from which the jury might conclude that on the date of his death Mr Weathers did not know and understand the nature of his suicidal act and, therefore, did not have a wilful and intelligent purpose to accomplish it..." Tatum, Special Judge, dissenting, contends as follows: "I agree with the majority that there was evidence of negligence on the part of the defendant.

CHAPTER VII

MALPRACTICE IN DIAGNOSIS AND TREATMENT

1 Introduction

The basic meanings of intent and negligence have already been discussed[387], and those concepts have featured in the context of unjustified interventions, and also negligence in respect of a client's suicide. Intent or negligence relating to the actual quality of diagnosis and treatment will be focussed on in this chapter.

2 Misdiagnosis

2.1 Intentional Misdiagnosis

According to Haroun and Morris, there may be a financial incentive for a psychiatrist intentionally to misdiagnose a

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I disagree that such negligence could not be found by a jury to be the proximate cause of the death of the decedent. The history of the previous attempts of the decedent to commit suicide is strong evidence that he was afflicted with a [CBC] that caused suicidal compulsions. It was for this reason that the decedent was placed in the care of the defendant, a health provider. It was the duty of the defendant to attempt to prevent the decedent from committing suicide...In my view, suicide is not an intervening independent cause that will relieve a physician of liability or negligence when the patient had no power of choice. There was evidence in this case that the decedent acted with compulsion and not through a power of choice. As stated, the history of the decedent's previous attempts to commit suicide is circumstantial evidence sufficient to make a jury question as to whether the suicide was committed by 'intelligent power of choice' or by compulsion due to [CBC]. I repeat that this suicidal tendency or compulsion was specifically the ailment which the defendant was entrusted to treat." See Reisner R, Slobogin C and Rai A *Law and the Mental Health System: Civil and Criminal Aspects* (3 ed) St Paul: West Group (1999) 168-170.

[387] Chapter V *supra* under 2.2 and 2.3.

condition. They aver that "a common diagnostic confusion surrounds individuals who present in a psychotic state".[388] The problem is that the psychosis may be a manifestation of a **primary** biological-psychological-social condition (such as schizophrenia) or may be a **secondary** substance-induced psychosis due to, for instance, amphetamines, cocaine, PCP (phencyclidine), or hallucinogens, such as LSD (lysergic acid diethylamide)[389].

According to these clinicians,[390] the symptoms and signs are identical: "A psychiatrist, relying on a clinical interview alone, will not be able to distinguish a primary psychosis from a secondary psychosis. The most objective method to resolve this differential is to do a urine toxicology screen. But frequently the test is not ordered. The treating psychiatrist may have a financial incentive in not knowing so that he or she maintains diagnostic flexibility. Without a urine test, the doctor can diagnose the [cl]ient with psychotic disorder not otherwise specified (NOS). If a urine test is ordered and the [cl]ient tests positive, the doctor may have to report that the psychosis was drug induced - and potentially not reimbursable through the [cl]ient's insurance."

In terms of South African law, a psychiatrist who, in that situation, does not order the toxicology screen, acts with *dolus eventualis* in respect of misdiagnosis. The psychiatrist would *inter alia*[391] be committing fraud against the client's insurer.[392]

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[388]See Haroun A M & Morris G H "Weaving a Tangled Web: The Deceptions of Psychiatrists" *10 J Contemp Legal Issues* (1999) 235.

[389]See Kaplan H Sadock B and Grebb J *Synopsis of Psychiatry* (7 ed) Baltimore: Williams and Wilkins (1994) 429.

[390]Haroun & Morris *op cit* 235-236.

[391]Ie apart from ethical violations and potential harm to the client.

[392]The elements required for fraud are all present; see Snyman CR *Criminal Law* (4 ed) Durban: Butterworths (2002) 520-529.

2.2 Negligent Misdiagnosis

Slawson[393] reports that the American Psychiatric Association authorised a study of more than 700 closed cases of psychiatric malpractice between 1974 and 1984. The most common complaints involved improper medication, improper treatment, and failure to diagnose a physical condition.[394] The last-mentioned type of error will here feature as an example of negligent misdiagnosis.

In the South African context, Kruger[395] notes, with reference to the American situation, that claims based on faulty diagnosis often involve neglecting to identify an underlying physical ailment. Perlin[396] points out that there is a high percentage of undetected physical conditions in psychiatric clients, because *inter alia* they are likely to be in poorer physical health and receive poorer medical care. He contends that it is inevitable that there will be increased future litigation regarding psychiatrists' failure to perform an appropriate physical examination.

It is submitted that psychiatrists must constantly be aware of the possibility that there might be a causative or merely concomitant physical condition, and must be sensitive to the possibility that another practitioner might need to be consulted. In line with HMM, specialists must know enough about one another's areas of expertise to be able to collaborate efficiently and effectively. The psychiatrist does not have to have the skill to make a detailed diagnosis of every possible physical condition. He or she must, however, be able to recognise where an investigation into a possible physical condition is

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[393] Slawson PF "Psychiatric malpractice: ten years loss experience" *MedLaw* (1989).

[394] *Ibid* 422.

[395] Kruger A *Mental Health Law* Durban: Butterworths (1980)

[396] See Perlin ML *Mental Disability Law: Civil and Criminal* Vol 3 (2 ed) Lexis publishing (2000) 341.

indicated, and, hence, must refer the client to the relevant specialist. Failure to exercise due care and skill in this regard, would constitute malpractice.

3 Improper Treatment

3.1 Improper Pharmacotherapy

Slawson[397] reports improper medication as the most common psychiatric-malpractice complaint. According to Reisner *et al*[398] all classes of psychotropic medications can have side-effects, which commonly include dystonia (involuntary contraction or muscle spasm) and akathisia (restlessness sometimes associated with continuous leg movement). They assert that approximately ten to fifteen percent of persons treated with such medication develop one or both of these conditions, which, fortunately are reversible when the use of the medication is terminated. More troublesome is the fact that approximately ten to twenty percent of clients who are treated for more than one year with certain medications develop a condition known as "tardive dyskinesia" (TD)[399], which is sometimes irreversible.[400]

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[397] *Op cit.*

[398] Reisner R, Slobogin C and Rai A *Law and the Mental Health System: Civil and Criminal Aspects* (3 ed) St Paul: West Group (1999) 47.

[399] TD is a condition that is "characterized by involuntary movements of the face, trunk, or extremities, and is often associated with the prolonged exposure to dopamine receptor drugs such as antipsychotic drugs. Involuntary movements include: frowning, blinking, grimacing, puckering, chewing, smacking, rolling of the tongue, foot tapping, and rocking of the hips... The term "tardive" refers to the fact that the condition usually develops only after a prolonged antipsychotic drug regimen of at least six months, whereas "dyskinesia" refers to the involuntary movements resulting from the actual drug use." See Baker J "Tardive Dyskinesia: Reducing Medical Malpractice Exposure Through a Risk-benefit Analysis" *DePaul J Health Care L* (Summer, 1997) 800.

[400] *Ibid.*

Baker[401] reminds that a truism accepted by most clinicians, but often disregarded by both the lay and legal communities[402] is that "few drugs that help anybody will not hurt somebody, and all potent drugs, no matter how skillfully administered can cause untoward effects in some [cl]ients". He affirms that one of the more serious possible side-effects of antipsychotic medication is TD. Mentioning some of the typical antipsychotic drugs used in treatment, he reports that a study revealed that no one antipsychotic drug is superior, and that there are few data identifying specific drugs or drug classes in the development of TD. Some drugs, however, are believed not to cause TD, such as clozapine.[403]

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[401]Baker J "Tardive Dyskinesia: Reducing Medical Malpractice Exposure Through a Risk-benefit Analysis" *DePaul J Health Care L* (Summer, 1997) 799.

[402]Baker (*ibid* 824-823) makes some averments in this regard that once again highlight the importance of HMM: "[D]ivergent perception of the risks involved in the treatment of antipsychotic medication is yet another reason for the perceived medical malpractice crisis and the tensions between the medical and legal communities. Thus, judges may tend to view clinicians' treatment decisions as reckless. The differences in risk perception are magnified by 'hindsight bias', as judges in malpractice suits seek outcomes inevitably in retrospect. Judges become more risk adverse because they address treatment decisions retrospectively, while psychiatrists must make treatment decisions prospectively. Judges also become more risk adverse because the side effects of antipsychotic medication are visible in a courtroom, while the benefits of antipsychotic medication are not readily apparent. The anti-medicine rhetoric often found in legal literature, and the judicial misunderstanding of those medical facts involved in antipsychotic medication and tardive dyskinesia, must be altered. The legal community should be educated on the real risks of antipsychotic medication and TD and must also be informed of the great benefits provided by such medication. Judges and juries can learn through expert witnesses the true medical facts in order to make reasoned decisions, and the medical community should approach the problem of TD honestly in order to develop an educational dialogue between the two professions."

[403]Clozapine may, on the other hand be associated with many other side-effects; see, for instance, Sher L "Pharmacogenetics and Antipsychotic Drugs" *Lancet* 356 (9226): 342 7/22 (2000): "Clozapine has been held up as the best antipsychotic drug for the management of resistant schizophrenia. However, clozapine has been a difficult drug for both [cl]ient and physician. The use

Baker[404] furnishes some examples, based on American law, of bases for liability in this context:

(1) Administering dosages of antipsychotic medication for the wrong reason or time period.

(2) Negligent misdiagnosis resulting in the wrong prescription of antipsychotic medication.

(3) Failure to monitor the client's condition

(4) Negligent treatment of TD when it has developed.

(5) Failure appropriately to reduce or discontinue medication.

(6) Dangerous polypharmacy (the dangerous combination of multiple drugs).

(7) Failure to seek expert consultation.

(8) Failure to take heed of a client's medical history.

(9) Failure to take into account risk factors such as

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of clozapine has been associated with multiple side effects including: agranulocytosis, leucopenia, increase in liver enzymes, neuroleptic malignant syndrome, delirium, seizures, tachycardia, hypotension, myocarditis, cardiomyopathy, and sudden death. Clinically relevant side effects occur in 73% of [cl]ients treated with clozapine. Also, white-blood-cell monitoring is necessary - ie [cl]ients need frequent blood tests. Safer antipsychotic drugs that do not require frequent blood testing are coming onto the market. It is not likely that clozapine will be widely used in the future. When we treat a severe [CBC] with a drug that can improve the [cl]ient's quality of life, we should not, at the same time, put the [cl]ient's physical health and life in danger. I suggest that pharmacogeneticists should focus on drugs that are likely to be used in the future."

[404] *Op cit* 818.

age and gender[405]

10) failure to obtain informed consent prior to administering antipsychotic medication.

Perlin[406] contends that improper pharmacotherapy is a potential minefield for the psychiatrist. He recommends[407] that, at the very least, the dosage guidelines set forth in the physicians' desk reference (PDR) will be given considerable weight by the courts. Once again, the standard for negligence (both in South Africa and the United States) is the same, *viz* that of "the reasonable psychiatrist". The following American cases, discussed by Baker[408], reflect instances where this standard was not met:

1) *Faigenbaum v Oakland Medical Center*[409]

"The plaintiff in Faigenbaum was...suffering from depression and schizophrenia. Between the years of 1964 and 1966, she was hospitalized for what may have been manic psychoses caused by marital difficulties. At this time, she responded favorably to low doses of

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[405] Baker (*op cit* 807) notes the following: "The most implicated risk factor for TD, especially the more severe and persistent forms, is increased age. Many studies indicate there is a strong correlation between a [cl]ient's age and the prevalence and severity of TD. Therefore, clinicians must be extremely cautious when administering antipsychotic drugs to elderly [cl]ients and any side-effects should be carefully monitored. Clinicians should also warn [cl]ients of the following risk factors associated with TD: smoking, alcohol use, and the use of antidepressants. Diabetes mellitus has similarly been identified as a possible risk factor."

[406] Perlin M L *Mental Disability Law: Civil and Criminal* Vol 3 (2 ed) Lexis publishing (2000) 350.

[407] *Ibid* 353.

[408] *Op cit* 830-832.

[409] 373 N W 2d 161 (Mich Ct App 1985).

chlorpromazine. She was again hospitalized in 1976, suffering from 'manic-depression', chronic undifferentiated schizophrenia, and 'hysterical neurosis', and she was prescribed chlorpromazine. Hospitalized for nearly one year, the [cl]ient developed a movement disorder, incorrectly diagnosed by a staff neurologist as Huntington's Chorea, rather than TD. As a result of the misdiagnosis, the hospital physicians continued to administer antipsychotic drugs for one year until the [cl]ient's family demanded the medication be discontinued. In determining whether the hospital was negligent in treating the [cl]ient, the Faigenbaum court concluded that the hospital physicians incorrectly diagnosed the [cl]ient's condition, failed to monitor the [cl]ient's condition properly, and negligently continued to administer antipsychotic medication after she displayed clear symptoms of TD. The trial court, therefore, awarded a $ 1 million judgment in favor of the [cl]ient."

2) *Hedin v United States*[410]

"[T]he plaintiff received...treatment from a VA hospital for a period of seventeen months, during which time he saw no physician and continued to receive antipsychotic drugs through the mail. In determining whether the VA physicians were negligent in failing to monitor the plaintiff's condition, the court noted that the physicians prescribed an excessive amount of antipsychotic drugs over a prolonged period of time. As it turned out, however, the VA ultimately admitted that the prescribed doses were excessive, the plaintiff's condition was not adequately monitored, and the plaintiff's condition had been previously diagnosed as

[410] No 5-83-3 (D Minn Jan 4, 1985).

untreatable. Therefore, the sole issue before the court was the amount of damages. The court thereafter awarded the plaintiff nearly $ 3 million, including a $ 30,000 loss of consortium award to his ex-wife."

3) *Vincent v Walz*[411]

"[T]he plaintiff was prescribed Mellaril for menopausal symptoms and maintained the prescription for seven years until she developed symptoms of TD. Trial proceeded on the sole issue of damages, after a default judgment was entered against the defendant-physician for failing to answer the complaint in a timely manner. The jury ultimately awarded the plaintiff $ 1.25 million in damages."

It is evident that the awards in these cases were rather high. Such high awards are not featured in the South African courts. The focus in the awarding of damages in South African law is on compensating a person for the actual loss suffered, and where appropriate, providing *solatium* (satisfaction) to "satisfy" the aggrieved plaintiff for damage to his or her personality interests (for which real compensation cannot be provided). *Solatium* does not reach the proportions of the amounts awarded as "punitive damages" in the United States, however. Nevertheless, psychiatrists in South Africa must exercise great care in their use of medication. Both too much[412] and too little (or none)[413] can give rise to liability. Once again, the reasonable psychiatrist must carefully and skilfully negotiate the proverbial tightrope.

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[411]No 86-3710 (DeKalb Ct Sup Ct, Jan 14, 1988).

[412]As the above cases illustrate.

[413]Where the reasonable psychiatrist would have provided the necessary dosage of medication, and it is not provided, causing the client to suffer damage, it would constitute malpractice.

3.2 Improper Psychotherapy

3.2.1 Introduction

Unlike most medical interventions, psychotherapy involves no (or, imperatively, little[414]) physical contact with the client. The "abstract" nature of psychotherapy has been said to have made it more difficult to base malpractice claims thereon.[415] Perlin[416] opines, however, that verbal psychotherapy now appears to be a fertile field for future psychiatric malpractice litigation.

3.2.2 Negligence and the Respectable-Minority Doctrine

Once again, the yardstick for determining negligence in psychotherapy would be that of the reasonable psychotherapist in the class of practitioners to which he or she belongs. A matter that is of particular relevance in this regard is the so-called "respectable-minority doctrine". Reisner *et al*[417] introduce this doctrine as follows:

> "A [cl]ient who has received treatment involving the use of a particular technique may, if the outcome is unsatisfactory, claim that the physician or therapist was negligent in not utilizing a more effective treatment modality. Such claim of negligence in the selection of treatment may be advanced, moreover, even where the physician or therapist obtained the informed consent of the [cl]ient... Generally, claims that physicians or therapists have utilized the wrong

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[414] See *Hammer v Rosen* (discussed *statim infra*) and the discussion on undue familiarity in chapter VIII *infra*.

[415] Perlin ML *Mental Disability Law: Civil and Criminal* Vol 3 (2 ed) Lexis publishing (2000) 361.

[416] *Ibid* 363.

[417] Reisner R, Slobogin C and Rai A *Law and the Mental Health System: Civil and Criminal Aspects* (3 ed) St Paul: West Group (1999) 147.

> therapeutic technique or failed to use the most effective one will, as with all other aspects of performance, be measured by the standard of due care, ie, what members of the profession would customarily do under the circumstances. While a finding that the therapeutic approach used was not 'customary' does not necessarily lead to liability, proof of conformity to custom generally precludes a finding of liability. Thus, whether a particular treatment is 'customary' or 'accepted' by the profession may well be dispositive of the issue of liability. Proof that a particular procedure is customary does not, however, require that it be used by a majority of practitioners. In fact, in a number of jurisdictions, a defense is established by a showing that a particular treatment approach is supported by a 'respectable minority' of those in the field."

An example of where an uncustomary technique did not meet the respectable-minority criterion is the American case of *Hammer v Rosen*[418], where the psychiatrist, Dr J N Rosen, had earned a reputation for success in the treatment of schizophrenic persons using a technique, which "...was highly personalized, but which was consented to by the spouse, next of kin, or legal guardian of each patient...Dr. Rosen might touch certain patients from time to time with differing degrees of force, depending upon the mental condition and needs of the patient, in order to effectively and fully explore and utilize the possibilities and potentialities which his method offered."[419] The court heard no evidence by which to conclude that this technique was acceptable. A claim for malpractice was sustained.[420]

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[418] 7 NY 2d 76, 198 N Y S 2d 65, 165 N E 2d 756 (1960).

[419] See Reisner *et al* (*op cit* 155).

[420] See also Snyman JL *Die Siviele Opneming van Geestesongesteldes: Regte en Regsbeskerming van die Betrokkene* (LLD thesis, Unisa, 1981) 569-570.

3.2.3 High-risk Psychotherapy

3.2.3.1 Introduction: Recovered Memory Therapy

Though a certain therapy might be accepted in psychiatry/ psychology, it might still be potentially problematic in the negligence context - some techniques are inherently more risky than others. Reisner *et al*[421] discuss one such therapy, recovered memory therapy.[422] They report that in the United States, since 1990, the use of this technique has led to 105 malpractice suits, of which forty-two were settled out court (notably with one settlement leading to the payment of 10,2 million dollars to the client and her family). Moreover, it is notable that of the nine cases that went to trial, all resulted in a verdict for the plaintiff, and forty-three cases were still pending by July 1998.[423]

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[421] *Op cit* 156-165.

[422] Also featured in the hypothetical scenario 3 *supra*. Bowman CG "The Manipulation of Legal Remedies to Deter Suits by Survivors of Childhood Sexual Abuse" *92 NW U L Rev 1481* (Summer, 1998) 1482-1483, explains as follows: "'Discovery' in the sexual abuse context can occur in one of two ways, depending upon whether the plaintiff's memory of the abuse was continuous or recovered. Courts and commentators have styled these 'Type I' and 'Type II' situations: in Type I cases, the victim never forgot the sexual abuse, but either failed to understand the connection between the abuse and her injuries or was not psychologically able to sue until much later; in Type II cases, on the other hand, the victim's memory of the abuse was repressed and then later recovered. In both of these situations, most victims of abuse had no legal remedy in the past, and consequently most perpetrators were never held accountable for their actions unless they were caught and criminally prosecuted at the time of the abuse - a vast minority of all cases. Reacting to this perceived injustice, the majority of states now provide by statute some form of delayed discovery rule for victims of childhood sexual abuse. As a result, numerous suits have entered the legal system that previously would have been barred by the statute of limitations." She cautions that "[t]here is substantial debate within both the scientific and legal communities as to the existence and reliability of delayed-recall memories".

[423] Reisner *et al* (*op cit* 156).

3.2.3.2 **Malpractice Claims on the Part of the Client in the Context of Recovered Memory Therapy**

The recent American case, *Bloom v Braun and Others*[424], involves the therapy in question. The plaintiff, Rhonda Bloom, based her claim on the following (as per Bronstein J[425]):

> "In her complaint, Bloom alleged that Dr Braun was involved with a unique psychotherapy program specializing in diagnosing a multiple personality disorder [termed 'Dissociative Identity Disorder' by the DSM since 1994 (DSM-IV[426]), partly due to the fact that it is not an axis-II 'personality disorder' but an axis-I 'dissociative disorder']. She also alleged that Dr Braun was an expert in uncovering repressed memories of satanic ritual abuse...Bloom alleged that defendants misrepresented as fact that satanic ritual abuse was proven to exist and that since her mother had recovered memories of participating in such rituals, she was also a victim/participant in the activity...She also alleged that defendants were aware that the imagery she experienced was confabulated and a product of their therapy, yet they did not inform her that the memories and the resultant [dissociative condition] were actually caused by their therapy. She also alleged that she was lulled into not discovering her psychiatric injuries inflicted...by defendants' misrepresentations...Bloom's complaint identified her injuries as: aggravation of preexisting depression; great humiliation and embarrassment; a belief [that] she was a product of incest between her mother and grandfather; self-hatred and a pattern of self-mutilation and

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[424] No 1-99-3992, 317 Ill App 3d 720; 739 N e 2d 925 (2000).

[425] *Ibid* 722-724.

[426] American Psychiatric Association *Diagnostic and Statistical Manual of Mental Disorders* IV Washington: APA (1994).

cutting; abortion of a fetus because she believed it would be promised to the cult; irrational paranoid fear for her safety; sleep dysfunction, including sleeping with weapons under her pillow; severance of her relationship with her mother; and living in emotionally abusive and violent relationships."

In casu the court found that the statute of limitations had run - thus it did not entertain the merits of the case. Nevertheless, the case illustrates the type of cause of action to which such therapy may give rise. In this case, the focus was on the injuries endured by the client herself.[427] Under 3.2.3.3 *statim infra*, a case illustrating liability towards third parties in this context is briefly discussed.

As a further illustration of actions on the client's part, with reference to Scenarios 3 and 4[428], suppose that valid informed consent had been obtained. If the techniques were subsequently applied negligently, such malpractice would, in terms of South African law, potentially give rise to the *actio legis Aquiliae* and action for pain and suffering.[429]

3.2.3.3 **Malpractice Claims on the Part of Third Parties in the Context of Recovered Memory Therapy**

To illustrate the type of malpractice suit that could be brought by accused third persons against therapists, a summary[430] of the

[427]It is clear that liability for "psychological harm" would be a major factor in such a case in the South African context. See chapter V, 2 *supra*.

[428]*Supra* chapter V, 7.3 and 7.4.

[429]See *supra* chapter V.

[430]Combining the accounts of Bowman CG "The Manipulation of Legal Remedies to Deter Suits by Survivors of Childhood Sexual Abuse" *92 NW U.L. Rev 1481* (Northwestern University Law Review) (Summer, 1998) 1486-1487 and Slovenko R "The Duties of Therapists to Third Parties" in Joubert JJ (Ed) *Essays in Honour of - Huldigingsbundel vir SA Strauss* Pretoria: Unisa (1995) 218.

well-known American case *Ramona v Isabella, Rose & Western Medical Center*[431] is provided:

> Holly Ramona had sought therapy for an eating problem. Her therapists suggested that her problem might be caused by childhood sexual abuse that she had repressed. She was told that if she recovered memories of abuse under sodium amytal, these would be accurate. Such memories were subsequently "uncovered". Her father, G, the alleged abuser, was summoned to a meeting where a confrontation and the presentation of a charge against him occurred. Subsequently he was granted standing to sue the therapist even though Holly (the client) was completely satisfied with the therapy. He claimed for damages based on: the accusation of abuse, causing his wife to divorce him, causing his other daughters to become estranged from him, and causing his employer to terminate his employment. Slovenko reports that, in their verdict, the jury concluded that "(1) the defendants were negligent in providing health care to Holly Ramona by implanting or reinforcing false memories that the plaintiff [G] had molested her as a child; (2) the defendants caused the plaintiff to be personally confronted with the accusation that he had molested Holly Ramona; (3)...the plaintiff suffered [damage] that [was] caused by the negligence of the defendants".[432]

In the United States, the question has subsequently been asked whether the decision opens the door to litigation by any person who is aggrieved by an interpretation made by a therapist in respect of a client. In this regard, Slovenko emphasises the fact

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[431] *Ramona v Isabella, Rose & Western Medical Center* case no C 61898 (1994).

[432] See Slovenko *op cit* 220.

that, in the *Ramona* case, the "therapists operated on the basis of unsupported beliefs and urged the [cl]ient to blame someone for her problems".[433] Indeed, a major factor leading to liability *in casu* was the manner in which the confrontation and legal action against G was encouraged and arranged. Slovenko notes that a resolution of the American Medical Association requires "external validation" to establish the authenticity of the history of a client's trauma. He asserts that in "revival" of memory of sexual abuse, it is incumbent upon therapists, given its impact on others, to secure corroborating evidence. He further reports that "Dr Paul Appelbaum, representing the American Psychiatric Association, opined that it might be salutary if therapists were found liable in negligence to serve as a chastening lesson".[434]

Once again, the reasonable psychotherapist finds the balance between going to the lengths required by therapy in the client's best interest, and not going too far, exceeding the boundaries of prudent practice and jeopardising the interests of third parties or, inadvertently, those of the client. The reasonable psychotherapist will not be so "defensive" as to compromise a client's path to wholeness, which may perhaps require a confrontation with a third party, nor will he or she irresponsibly make suggestions to the client.[435] The reasonable psychotherapist must bear the interests of all in mind and be cautious in exercising the considerable influence that he or she may have on the lives of others.

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[433]See Slovenko *op cit* 219.

[434]*Ibid* 220. Bowman (*op cit*) contends that "[e]ven where the client's best interest seems to dictate a confrontation with her abuser, a therapist abreast of the latest legal developments may be reluctant to encourage a confrontation or to be present if it does take place (as happened in the *Ramona* case), and may counsel against the filing of any legal action".

[435]Thus not impetuously urging a client to engage in confrontations based on dubious facts. If, for instance, a client elects to confront the possible abuser, the therapist can only but assertively urge against it (if appropriate).

CHAPTER VIII

UNDUE FAMILIARITY AND ABANDONMENT

1 Introduction

This brief chapter examines potential liability on two poles of yet another set of extremes. On the one hand, if a psychiatrist becomes too intimately involved with a client, it could constitute malpractice. On the other hand, if a psychiatrist is not involved enough (or unreasonably terminates involvement), it could likewise constitute malpractice.

2 Undue Familiarity

This could range from innocently inappropriate conduct to intentional sexual exploitation of clients. The transference phenomenon has often been implicated as a major factor in this context.[436] The types of instances involving negligent undue

[436] In the context of psychiatric malpractice in the form of sexual exploitation, Sanbar *et al* note the following: "As therapy progresses, unconscious feelings of conflict, fears, and desires originating from important relations in the [cl]ient's past are said to be 'transferred' to the therapist in the present. Known as the 'transference' phenomenon, this experience is a common occurrence in psychotherapy and often provides a therapist with valuable information to analyze and interpret. Because of the transference phenomenon, a [cl]ient becomes vulnerable to the emotions being experienced, for example, love feelings. The therapist, therefore, must conduct the treatment with sensitivity and care. A similar phenomenon, known as 'countertransference' also may occur in therapy. This occurs when a therapist experiences unconscious conflicts and feelings toward a [cl]ient. As with [cl]ient transferences, countertransference feelings should be recognized as important therapeutic information and analyzed in order to gain insight into how to better understand the [cl]ient." These authors note that "in addition to sexual activity, other types of behavior that demonstrate a manipulation of the transference phenomenon or therapeutic relation may be subject to civil liability". See Sanbar S, Gibovsy A, Firestone MH *Legal Medicine* (3 ed) St Louis: Mosby (1995) 604, 605.

familiarity and intentional undue familiarity will next be dealt with respectively.

2.1 Negligent Undue Familiarity

Strauss and Strydom[437] discuss the much-referred-to older English case of *Landau v Werner*[438], where a psychiatrist's client had "fallen in love with him" (a product of transference) and told him that, for this reason, she did not want to continue her therapy. The psychiatrist, however, believed that she was in need of further therapy, and repeatedly took her to restaurants and visited her at her home. After a few months, her condition deteriorated to such an extent that she could not work. The authors[439] report that, confirming the judgment of the lower court, the court of appeal held the psychiatrist liable to pay damages of £6000 for "negligent psychotherapy".

Any situation in which a psychiatrist becomes inappropriately closely involved with a client might constitute negligent therapy on the basis of undue familiarity. The question would once again be whether the reasonable psychotherapist would have erred in blurring the imperative therapeutic boundaries. If expert evidence convinces a court that the reasonable psychotherapist would have applied caution and skill in avoiding the blurring of boundaries, and a defendant did not, that defendant will be found to have been negligent.

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[437] Strauss SA & Strydom MJ *Die Suid-Afrikaanse Geneeskundige Reg* Pretoria: Van Schaik (1967) at 300.

[438] 105 Sol J 257, appeal dismissed, 105 Sol J 1008 (QB 1961). See Snyman JL *Die Siviele Opneming van Geestesongesteldes: Regte en Regsbeskerming van die Betrokkene* (LLD thesis, Unisa, 1981) 580. See also Claassen NJB & Verschoor T *Medical Negligence in South Africa* Pretoria: Digma (1992) at 24, where the case is erroneously referred to as being American.

[439] Strauss & Strydom *op cit* 300.

2.2 Intentional Undue Familiarity

In the United States, a leading case in this regard is *Roy v Hartogs*[440]. *In casu* R alleged that she was induced to have sexual intercourse with H as part of her prescribed therapy. R claimed that, as a result, she was so emotionally injured that she had to seek hospitalisation. In their discussion of the case, Reisner *et al*[441] report that the trial court's award of damages was upheld: "By alleging his client's mental and emotional status was adversely affected by this deceptive and damaging treatment, plaintiff's counsel asserted a viable cause of action."

In *Roy v Hartogs*[442] expert testimony affirmed that there are "absolutely no circumstances which merit a psychiatrist to engage in sex with his [client]". Sanbar *et al*[443] maintain that there still remain some therapists who attempt to rationalise their actions. They note that some of the most common arguments, all of which have thus far been rejected by the American courts, include that the client consented to the sexual activity, that the sexual activity was not a part of treatment (thus an independent relationship) or that the treatment had been terminated before the sexual relationship commenced.

Any situation, even after termination of treatment, where a therapist abuses his or her influence, taking sexual advantage of a client or ex-client, is unacceptable. Presently, in South African law, one would have to argue along the lines of invalid consent (due to its not being "free and voluntary", but rather, in fact, heavily influenced) to establish delictual or criminal

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[440] 85 Misc 2d 891, 381 N Y S 2d 587 (1976).

[441] Reisner R, Slobogin C and Rai A *Law and the Mental Health System: Civil and Criminal Aspects* (3 ed) St Paul: West Group (1999) 174.

[442] *Supra*.

[443] Sanbar S, Gibovsy A & Firestone MH *Legal Medicine* (3 ed) St Louis: Mosby (1995) 605.

liability. Labuschagne[444] points out that South African statutory law does not cover sexual contact between psychotherapist and client (apart from instances where the client is more than mildly mentally retarded[445]). Such contact has been statutorily criminalised in some countries, such as Germany. Labuschagne generally concludes that, in view of the relationship of dependency of a client with his or her therapist and the scope for abuse that this creates, South Africa should statutorily criminalise the intentional abuse of that relationship for sexual gain. The absence-of-consent concept is, to his mind, insufficient. Indeed, it would simplify matters and be more realistic if such provisions were to be incorporated.

3 Abandonment

Perlin[446] asserts that it is standard malpractice law that a physician who abandons a client who is in need of further treatment, without giving that client reasonable time to find an alternative provider, has breached his or her duty to the client. Strauss[447] affirms that once a client has been accepted for medical

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[444] Labuschagne JMT "Seksuele Kontak Tussen Psigoterapeut en Patient: Opmerkinge oor die Strafregtelike Beskerming van Psigoseksuele Outonomie" *TRW* 25 2 (2000) 59-60.

[445] Presently, "mild mental retardation" would be the correct term for what more or less used to amount to a "moron". The **Sexual offences Act** 23 of 1957 criminalises sexual intercourse with a female "imbecile or idiot". These two remarkably archaic categories used to represent individuals whose intellectual abilities would now be placed in three categories: moderate, severe and profound mental retardation, which categories cover IQ below 50-55. Labuschagne (*ibid* 59) contends that the fact that only female persons are protected is unconstitutional. This contention is indubitably valid. Moreover, as has been stated (fn 35 *supra*), the continued use of such archaic (and colloquially laughable) terminology mocks the fitness of law.

[446] Perlin ML *Mental Disability Law: Civil and Criminal* Vol 3 (2 ed) Lexis publishing (2000) 368.

[447] Strauss SA "Ethics in the Treatment of Mental Patients: Some Aspects" in Van Wyk C & Van Oosten H (Eds) *Nihil Obstat: Feesbundel vir WJ Hosten/Essays in Honour of WJ Hosten* (1996)

treatment on a continuous basis, he or she may not simply be abandoned. He[448] contends that the psychiatric situation is largely the same as the general medical one just described, with the following two possible points of difference, however:

(a) the psychiatric client may be emotionally more dependant on the therapist than other medical clients;

(b) the condition of the client may be such as to render a contractual relationship between the psychiatrist and the client impossible. In this case, Strauss asserts, a reasonable arrangement in the best interest of the client should be negotiated with his or her spouse, parent, *curator personae* or other legal representative.

Depending on the circumstances, abandonment could constitute a breach of contract and/or professional negligence.[449] Unlike in the situation in chapter 5, where voiding the contract would result in a restitution action only[450], in the case of abandonment, the action in contract would arise from breach of contract. In this case, the contract is not voided, but upheld. The client can thus choose to sue in terms of the contract, availing himself or herself of one of the following contractual remedies: specific performance[451] or cancellation[452], and, in both cases, also

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[448] *Ibid.*

[449] *Ibid* 188.

[450] This is a case of contractual negative *interesse*: the law attempts to place the plaintiff in the position in which he or she would have been, had no contract been concluded and acted on. As has been indicated, the recovery is limited to patrimonial loss.

[451] Where the practitioner would be compelled to perform properly in terms of the contract, as he or she undertook to do. It would be ill-advised, however, considering the fragility of the therapeutic alliance, to opt for this contractual remedy in the case of abandonment. Indeed, specific performance involving

damages[453], where compensable damage has been suffered. With cancellation, the client could claim restitution, thus the sum total of his or her performance (ie all moneys paid to the psychiatrist) and claim for other patrimonial damage suffered due to the breach of contract (such as loss of earnings due to deterioration in his or her condition caused by the abandonment). Once again, it is advisable that the client should base his or her claim on both contract and delict, concurrently or in the alternative.[454]

Instances that may give rise to actions for malpractice based on abandonment, include: where the therapist is absent and fails to

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highly personal services is at the best of times not a very effective remedy.

[452]This option would entitle the client to cancel the contract and claim for all patrimonial loss due to the breach of contract. Here a plaintiff can choose to rely on positive or negative *interesse*. Viljoen JA remarks in *Sommer V Wilding* 1984 (3) SA 647 (A) that negative *interesse* is normally claimed in the case of fraud or misrepresentation in a contractual context (as indeed was the case in some examples in chapter V). Nienaber J, in *Probert v Baker* 1983 (3) SA 229 (D), argues as follows: "Can a claim for restitutionary damages be advanced for breach of contract in contradistinction to, say fraudulent misrepresentation? In my opinion it can, provided only that the contract has been duly cancelled by the aggrieved party. Cancellation of the contract does not of course preclude a claim for damages computed on the basis of positive *interesse*. That much is trite. The aggrieved party is perfectly entitled to cast his eyes forward to the position he would have occupied had the contract been fulfilled. But it may suit his purpose to look backwards instead, to the position in which he would have been if no contract had been entered into at all. By the very act of cancelling the contract the aggrieved party is trying to sever all contractual links and to divest himself of the consequences of the contract. There would be no inconsistency in granting him the right, at his election, to turn the clock backward instead of forward in an effort to restore the status quo by means of a claim for damages." See Visser PJ and Potgieter JM *The Law of Damages through the Cases* (2 ed) Cape Town: Juta & Co Ltd (1998) 138, 150.

[453]See Nagel CJ (Ed) *Commercial Law* Johannesburg: *Lex Patria* (1994) 108.

[454]As discussed *supra*, chapter V, 8.2.

provide adequate backup services[455], and where the therapist fails to respond to his or her client's emergency calls[456], thinking, for instance that the client is manipulating him or her, and that he or she has to keep his or her distance and "not get too involved". This once again illustrates the tightrope of not being too involved and not being involved enough.

Perlin[457] points out that the corollary to the psychotherapist's duty of not abandoning his or her client is to terminate treatment when it appears to be ineffective or dangerous.[458] If a psychotherapist unreasonably continues treatment where the reasonable psychotherapist would have referred the client to someone else, that, on the other hand, would be psychotherapeutic malpractice.

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[455]Perlin M L *Mental Disability Law: Civil and Criminal* Vol 3 (2 ed) Lexis publishing (2000) 369.

[456]*Ibid.*

[457]*Ibid.*

[458]There are other circumstances in which a therapist may (rather than must) terminate treatment where the client would like to continue. One notable instance would be breach of contract on the part of the client, eg where the client over a fairly lengthy period of time fails to pay the therapist's fees. Nevertheless, the termination must be effected in an appropriately sensitive manner that is legally and ethically acceptable. The exact measures required would inevitably depend on the circumstances.

CHAPTER IX

BREACH OF CONFIDENTIALITY AND THE DUTY TO WARN

1 Introduction

This chapter addresses yet another tightrope that the reasonable psychiatrist has to negotiate. On the one hand, liability can arise from breach of confidentiality and/or an action for defamation, whilst on the other hand, liability can arise from not disclosing information necessary to warn a person or group of persons of imminent danger. The various factors involved in this potentially treacherous balancing act, are here examined.

2 The Importance of Confidentiality

Confidentiality involves information shared by one person with another when there is a relationship of trust between them. The duty of professionals to maintain confidentiality is of ancient origin, and is recognised in numerous modern declarations.[459] According to Clark[460], in considering American case law and judicial commentaries, it is clear that the extent to which a professional may be held liable in certain situations for disclosure or non-disclosure of confidential information, is a controversial issue. Nevertheless, there has emerged a clear duty to warn persons of danger in certain situations[461], and it is trite

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[459] Strauss SA "Ethics in the Treatment of Mental Patients: Some Aspects" in Van Wyk C & Van Oosten H (Eds) *Nihil Obstat: Feesbundel vir WJ Hosten/Essays in Honour of WJ Hosten* (1996) 185. See also, for instance, the *International Code of Medical Ethics* (as amended in Venice, 1983).

[460] Clark JW "Confidential Communications in A Professional Context: Attorney, Physician, and Social Worker" *The Journal of the Legal Profession* (2000) 80.

[461] As firmly established in the landmark American case *Tarasoff v Regents of the University of California*, which has

that a judicial officer can order a psychotherapist to disclose certain information in court.[462]

A concern raised in respect of this "relative" nature of confidentiality is that unless clients are assured of confidentiality, they may be reluctant to communicate salient

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been referred to in South Africa (see *infra* under 3), and also in other countries around the world; see, for instance, Tomkin D & Hanafin P *Irish Medical Law* Dublin: Sweet & Maxwell (1995) 57. Slovenko asserts that no decision has caused more concern in the psychiatric community than that decision of the California Supreme Court. He points out that the case was actually heard twice: "*Tarasoff* I" 118 Cal Rptr 129, 529 P 2d 334 (1974) (vacated) and "*Tarasoff* II" 17 Cal 3d 425, 131 Cal Rptr 14, 551 P 2d 334 (1976); see Slovenko R "The Duties of Therapists to Third Parties" in Joubert JJ (Ed) *Essays in Honour of - Huldigingsbundel vir SA Strauss* Pretoria: Unisa (1995) 211. Grabois EW "The Liability of Psychotherapists for Breach of Confidentiality" *12 J L & Health 39* (Cleveland State University Journal of Law and Health) (1997/1998) 72-73, notes that "in the case of McIntosh v Milano, in which a psychiatrist failed to warn the plaintiff that his [cl]ient had murderous intentions toward his deceased daughter, the court discussed confidentiality between the psychiatrist and the [cl]ient. The court said 'a [cl]ient is entitled to freely discuss his symptoms and condition to his physician in confidence' and the court refers to Section 9 of the Principles of Medical Ethics and the Hippocratic Oath. The court discusses that a psychiatrist must keep the [cl]ient's thoughts and feelings confidential, but may have to disclose those thoughts and feelings when the [cl]ient or the community needs to be protected from imminent danger." For a statutory duty to warn in South Africa, see section 13 of the **Mental Health Act** 18 of 1973.

[462] See Harms LTC, Galgut B & Faris JA in Joubert WA (Ed) *The Law of South Africa* (Vol 17) Durban: Butterworths (1999) 187: "[A] practitioner must, under protest, give information regarding a [cl]ient in a court of law if so instructed by the presiding judicial officer." Clark (*op cit*) reports that, in 1973 the American Medical Association's (AMA) Code of Ethics was revised to state as follows: "A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of [cl]ients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community." Clark affirms that "[t]he governing body of the American Medical Association is the AMA's Council on Ethical and Judicial Affairs. The council's main responsibility is to interpret the AMA principles with most recent revision of the AMA Code of Ethics adopted in 1981. The statements on confidentiality are still maintained."

personal information and thoughts. According to Grabois[463], this silence can then all but totally defeat the purpose of psychotherapeutic treatment, and render it ineffectual. She contends that communications between a client and psychotherapist are, by their very nature, confidential, with clients often revealing thoughts that they have revealed to no one else. She further maintains that clients who "express hidden thoughts and desires generally expect that such information will be kept confidential".[464] The thought of having such deeply personal information revealed may well discourage clients from the free and open expression so essential to efficacious therapy.

3 Instances in Which Confidence May or Must Be Overridden

The first and foremost situation in which confidence may be overridden is with the consent of the person whose confidence is kept. Although it is theoretically possible for a court to order disclosure (without consent) in a particular case, it can, as will be discussed, do so only under limited circumstances. The chances that the information that any given client discloses during therapy will end up being revealed in a court of law, are actually very remote. In both South Africa and the United States[465], the clinician is ethically required to urge upon the court his or her confidential relationship to his or her client, and strenuously to object to his or her disclosing any information - only if the court rejects his or her objection,

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[463]Grabois (*op cit* 50). See also Harms LTC, Galgut B & Faris JA in Joubert WA (Ed) *The Law of South Africa* (Vol 17) Durban: Butterworths (1999) 187: "Ethically and legally psychiatrists and psychologists are required to keep their [cl]ients' confidences and it has been said that secrecy is the *sine qua non* of the practice of psychiatry. A psychiatrist must have a [cl]ient's complete confidence, otherwise he cannot help the [cl]ient."

[464]*Ibid*.

[465]Clark JW "Confidential Communications in A Professional Context: Attorney, Physician, and Social Worker" *The Journal of the Legal Profession* (2000) 80.

does he or she have to reveal the information.[466]

The instances in which a therapist would be justified in disclosing information to protect the interests of third parties, are similarly limited. The typification of the justification in terms of South African law would be (private[467]) necessity[468], or duty[469]. Due to the high premium placed on confidentiality, the instances in which confidence may be broken must be appropriately extreme in nature. The following cases illustrate some situations in which breach of confidentiality was justified and one in which it was not.

1) Case 1:

Strauss[470] mentions a 1994 South African disciplinary case, whose facts are as follows: Dr X had been separately consulted by a divorcee, Mrs L, and her ex-husband Mr L. At one stage, she presented with a black eye after allegedly having been assaulted by her ex-husband. She handed Dr X a letter by her ex-husband to her, which featured allegations that she had been

[466]The consequence in both civil and criminal proceedings of then still refusing to reveal the information is that the psychiatrist will be guilty of contempt of court. In criminal matters he or she may be sentenced to continuous periods of imprisonment of two years or five years, depending on the nature of the crime allegedly perpetrated by the accused. See Harms LTC, Galgut B & Faris JA in Joubert WA (Ed)*The Law of South Africa* (Vol 17) Durban: Butterworths (1999) 188.

[467]See fn 241 *supra*.

[468]This would be an instance where the interests of one party are infringed (the client's right to privacy and/or good name) for the protection of those of another. See *supra* chapter IV.

[469]See chapter IV, 3.5 *supra*.

[470]Strauss SA "Ethics in the Treatment of Mental Patients: Some Aspects" in Van Wyk C & Van Oosten H (Eds) *Nihil Obstat: Feesbundel vir WJ Hosten/Essays in Honour of WJ Hosten* (1996) 185.

grossly promiscuous during their married life and after the divorce. Dr X gave her a brief note to the effect that her ex-husband appeared to be suffering from a paranoid disturbance and probably had to be certified. The note was apparently intended for use by the district surgeon with a view to an eventual application for a committal order. The disciplinary committee found that Dr X had made no attempt to make contact with Mr L before issuing the note, and recommended that Dr X be found guilty of disgraceful conduct in the form of breach of confidentiality. In her submission to the (then) South African Medical and Dental Council, Dr X's attorneys attacked the committee's finding on the ground that her conduct had been reasonable; although there had been a conflict of interest between her two clients (Mr and Mrs L), she had acted reasonably in an emergency situation by disclosing information in order to avert a danger to Mrs L. Dr X's attorneys referred to *Tarasoff v Regents of the University of California* in support of her case. The SAMDC, accordingly, set aside the committee's finding.

2) *Tarasoff v Regents of the University of California*[471]

"[P] had met weekly for a total of eight sessions with Dr Laurence Moore [M], a clinical psychologist at...the University hospital. He revealed thoughts of harming even killing, a young woman, readily identifiable as Tatiana Tarasoff, who had rejected him. [M], with the concurrence of a colleague, concluded that [P] should be committed for observation...and...notified the campus police that [P] was dangerous and should be

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[471] *Supra* (fn 461); here as summarised by Slovenko R "The Duties of Therapists to Third Parties" in Joubert JJ (Ed) *Essays in Honour of - Huldigingsbundel vir SA Strauss* Pretoria: Unisa (1995) 211.

> committed. The campus police questioned [P] and they also talked to other people familiar with him. They warned him to stay away from the girl. They concluded that commitment was not necessary. [P] never returned to the clinic, perhaps because he felt his trust with [M] had been betrayed. Two months later, when Tatiana returned from vacation he stabbed her to death."

Slovenko affirms that the effect of the *Tarasoff* ruling is that there is a duty on therapists to protect potential third-party victims, provided that they are "readily identifiable".[472] It is not possible for the psychiatrist readily to predict dangerous behaviour in any given client.[473] Only where there is a reasonably foreseeable risk to a readily identifiable third party (such as the one brought to light by the direct statement of intention as in the *Tarasoff* case), the therapist must take reasonable steps to prevent that harm form eventuating.[474] The *Tarasoff* court conceded that what is reasonably necessary to protect such third parties, can be determined only on a case-by-case basis.[475]

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[472] It is notable that the case as such was eventually actually settled out of court. Slovenko (*op cit* 212) contends that, had it gone to trial, the court could have found that [M] had in fact discharged the duty by notifying the campus police.

[473] See Mason and McCall-Smith *Law and Medical Ethics* (5 ed) Butterworths: Edinburgh (1999) 504: "[T]he prediction of dangerousness is an imprecise - and, perhaps, fruitless - exercise." See also Strauss S A "The Person with Schizophrenia and Criminal Justice: Some Aspects" *CILSA* (1996) 286, who echoes that the prediction of violence is extremely difficult. Pergament D "Internet Psychotherapy: Current Status and Future Regulation" *Journal of Law-Medicine 8 Health Matrix 233* (1998) at 257, contends that "[g]enerally the courts conclude that the interests of society to be protected against the violent acts of [cl]ients outweigh the concerns of confidentiality, overcommitment, and difficulty of predicting violent acts".

[474] The similarity to the general formulation of the test for negligence in South African law (see chapter V, 2.2 *supra*), is readily evident.

[475] *Ibid* 214.

3) *MacDonald v Clinger*[476]

"[T]he plaintiff sued his psychiatrist, from whom he had received psychotherapeutic treatment, for disclosing personal information to the plaintiff's wife without his consent. The court held the parties had a relationship that gave rise to an implied covenant which, when breached, was actionable. The court found the breach of contract action of the plaintiff inadequate for a recovery for his mental distress, loss of employment and deterioration of his marriage...[T]he court held that the [cl]ient who was the plaintiff should not be limited to a breach of contract action. Otherwise, the plaintiff would be limited to damages of an economic loss flowing directly from the breach, and could not recover for 'mental distress, loss of employment, and for the deterioration of his marriage'. The court believed that the relationship of a psychotherapist and his [cl]ient is not just a contractual one, but there is 'an additional duty springing from but extraneous to the contract and that the breach of such duty is actionable in tort'. It is an action in tort for a breach of a duty of confidentiality and trust."[477]

From the above cases, it is clear that in both South Africa and the United States, the psychiatrist may be caught between two fires, as it were: he or she must disclose information in certain situations, or he or she may be held liable; on the other hand,

[476] 446 N Y S 2d 801 (Sup Ct 1982); as discussed by Grabois (*op cit* 67-70).

[477] Apart from illustrating an instance in which breach of confidentiality was not justified, this case reflects some similarities in the principles governing contractual damages in the United States and South Africa.

if he or she is unjustified in disclosing confidential information, he or she may be held liable.

Harms *et al*[478] affirm that a psychiatrist who breaches a client's confidence may be guilty of malpractice. Instances that they cite in which the law recognises that a psychiatrist may "breach"[479] a client's confidence, include:

1) The client consents to disclosure.

2) A court of law orders the disclosure.[480]

3) An Act of parliament requires the disclosure.

4) There is a legal obligation on the practitioner to make a disclosure.[481]

4 The Consequences of Unjustified and Culpable Disclosure of Information in terms of South African Law

The ordinary delictual principles governing infringement of *dignitas* based on disclosure apply to breach of confidentiality

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[478]Harms LTC, Galgut B & Faris JA in Joubert WA (Ed)*The Law of South Africa* (Vol 17) Durban: Butterworths (1999) 185.

[479]It is submitted that the use of the term "breach" in respect of the first instance listed, is inappropriate. If a client consents to disclosure, it seems unsound to state that one "breaches" his or her confidence upon disclosure.

[480]Harms *et al* (*ibid* 187) expand on this as follows: "[W]here psychiatric evidence resulting in a breach of confidence is essential to the administration of justice, the court will require such evidence to be led; for instance:..where the [cl]ient puts his mental condition in issue as part of a claim or defence;...where it is necessary to establish the mental capacity of a testator; or...in child custody suits."

[481]This is where the *Tarasoff*-type situation would feature.

in the psychiatrist-client situation. Once again, contractual remedies are available for breach of contract. The same principles discussed *supra*[482] apply.

Where information concerning a client is distributed in a manner which infringes his or her *fama* (reputation or good name)[483], such an infringement could also constitute defamation.[484] The ordinary defences to a claim based on defamation apply.[485]

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[482]See chapter V, 8 and chapter VIII, 3.

[483]See Neethling J, Potgieter JM and Visser PJ *Law of Delict* (4 ed) Durban: Butterworths (2001) 337.

[484]Once again, if the infringement is significant enough, it could constitute criminal defamation in addition to private-law defamation; see Snyman CR *Criminal Law* (4 ed) Durban: Butterworths (2002) 459-461. The elements of the crime are as follows: "(a) the publication (b) of a defamatory allegation concerning another which is (c) serious and which is made (d) unlawfully and (e) intentionally" (*ibid* 459). With regard to private-law defamation, see Neethling J, Potgieter JM and Visser PJ *Law of Delict* (4 ed) Durban: Butterworths (2001) 338-350.

[485]See *ibid*.

CHAPTER X

CONCLUSION

1 Synoptic Overview

In chapter I, the concept "Holistic Multidisciplinary Management" ("HMM") is introduced as a macrocosmic adaption of principles of project management.[486] This approach provides the framework for the dissertation.

The HMM approach places particular emphasis on the fact that sound terminology and definitions facilitate and enhance interdisciplinary communication and collaboration. A central submission is that, where practically possible, terms and definitions should be shared and contemporaneously developed with reference to the advancements in various fields. At the heart of the approach lies interdisciplinary cross-pollination. There should be the underlying strategic purpose in any multidisciplinary venture that, apart from solving the specific problem at hand, the process should be aligned with the general aim of interdisciplinary development and continuous improvement of interactions and results.

In chapter II, clinical psychiatry is placed in context.[487] The concept central to clinical psychiatry, "psychopathology"/"mental disorder" is examined. For various reasons[488], the term "clinical biopsychosocial condition" ("CBC") is suggested as a viable

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[486] It is there ventured that this may be defined as "an application of adapted and refined principles of management, tailored to promote effective and efficient interaction between various disciplines in a manner which enriches all those involved, and identifies and implements integrative, holistic solutions".

[487] It is concluded that clinical psychiatry may be defined as "the medical speciality concerned with the diagnosis and treatment of clinical biopsychosocial conditions".

[488] See chapter II, 2.2.

alternative to "mental disorder". Moreover, the use of the term "client" is suggested to be better for an individual's sense of well-being than "patient".[489] It is concluded that psychiatry and law should both employ terminology that is sensitive to the people whom they serve, and is soundly harmonious on the interdisciplinary level. The more congruence and mutual understanding there could be between law and the clinical sciences, the better subtle distinctions could be drawn. The definitions themselves should be shared as far as possible, although the purpose for which they are applied may be vastly different.

In chapter III, the interface between law and psychiatry is briefly elucidated. It is concluded that the interface houses forensic psychiatry[490] and psychiatric jurisprudence. The term "psychiatric jurisprudence" is broad enough to encompass all areas where law and legal philosophy may affect psychiatry. The part of psychiatric jurisprudence on which this dissertation focusses, is "psychiatric malpractice[491] law", which falls under "medical law". After careful analysis of the meaning of the word "medical"[492], medical law is defined as "the law applied in the context of health-care provision, consumption and expertise". This definition is subsequently brought into interdisciplinary perspective so as to ensure that it is harmonious, in step with HMM. It is concluded that the general principles of medical malpractice law apply to psychiatric malpractice, although the issues involved in psychiatric practice are, in many cases, quite

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[489] See fn 69.

[490] Defined as "the integrative branch of psychiatry where there is specialised application of psychiatry in a legal context".

[491] Malpractice is defined as "professional conduct which falls outside the limits of acceptable practice in that profession".

[492] It is concluded that "medical" is broad enough to encompass all health-care professionals. See chapter III 3.2.1.1, where "medical" is subdivided into "mainstream medical", "allied medical" and "alternative medical".

different from those involved in other areas of medical practice, and thus demand special attention.

In chapter IV, the grounds of justification for medical intervention are examined. Informed consent is maintained as fundamental, and it is suggested that advance directives be recognised in principle. It is further submitted, however, that the system involved in advance directives must be managed well. Next, emergency as justification for intervention, is discussed. Two main categories are advanced: unauthorised administration and necessity. The latter category is suggested to be divided into three subcategories, *viz* public necessity, private necessity and therapeutic necessity.[493]

The last-mentioned concept is suggested to refer to the involuntary (in the sense of "against the will") medical intervention as such, whereas "therapeutic privilege" should refer to the situation of withholding information. It is submitted that this distinction is warranted, since there is a significant difference between performing a procedure on a client against his or her will, and withholding certain information regarding the client's condition. It is concluded that the former is most appositely classified as therapeutic necessity, whilst the latter is most appositely classified as therapeutic privilege. Therapeutic privilege as a possible justification in extreme cases, is then discussed. Subsequently, authority and duty as grounds of justification are briefly touched upon. Finally, a table that synoptically highlights some of the differences and similarities between the various grounds of justification, is provided.

In chapter V, the consequences of intervention without justi-

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[493] "Public necessity" being where community interests are protected, "private necessity" being where another individual's (or limited group of individuals') interests are protected, and "therapeutic necessity" being where the treated individual's interests are protected (while at the same time infringing his or her autonomy). See chapter IV, 3.2.

fication are explored. In respect of consent for a physical intervention, it is concluded that a distinction should be drawn between the scenario where consent is absent or intentionally insufficient (ie material information is **intentionally** withheld), on the one hand, and **negligently** insufficient, on the other hand. The former infringement of the client's *corpus* can appropriately be classed as assault, whilst the latter[494] does not amount to assault - it is a situation of negligence.[495]

In the latter part of chapter V, a number of hypothetical case scenarios in the psychiatric context are sketched to be used to illustrate the legal consequences of lack of justification in various instances. The available contractual and delictual actions are dealt with, and possible criminal liability discussed. It is suggested that (private-law) claims be instituted based on both contract and delict, in appropriate circumstances, to maximise potential recovery for loss suffered.[496]

Chapters VI to IX deal with specific types of conduct that can constitute psychiatric malpractice. A common theme that emerges in the various contexts covered, is that the psychiatrist must negotiate various therapeutic tightropes, as it were.

In chapter VI, the following tightrope is investigated: If a psychiatrist unjustifiably facilitates the commitment of a person who should not have been committed, that could constitute malpractice. Moreover, if a psychiatrist unjustifiably and unreasonably restrains an individual under his or her care, it could constitute malpractice. On the other hand, if a

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[494] Ie a clinician is under the erroneous impression that the consent is sufficient, in other words that all material facts have been disclosed in obtaining the client's consent, where the reasonable clinician in his or her position would have known those facts to be material and accordingly would have disclosed them.

[495] See chapter V, 3.

[496] See chapter V, 8.2 and chapter VIII, 3.

psychiatrist fails to commit or restrain an individual who could harm himself or herself (especially in the case of potential suicide), or harm others, that could give rise to liability.

Chapter VII examines the tightropes involved in negligent therapy as such. In respect of medication (pharmacotherapy), both too much and too little (or none) can give rise to liability. Where the reasonable psychiatrist would have provided the necessary dosage of medication, and it is not provided, causing the client to suffer damage, it would constitute malpractice. On the other hand, administering excessive medication can cause conditions such as tardive dyskinesia[497], and give rise to liability. In respect of psychotherapy, using recovered memory therapy as an example, it is illustrated how the reasonable psychiatrist must find the balance between going to the lengths required by good therapy in the client's best interest, and not going too far, exceeding the boundaries of prudent practice and jeopardising the interests of third parties or, inadvertently, those of the client.

Chapter VIII examines the tension between being too close or being too distant, undue familiarity and abandonment, respectively. On the one hand, if a psychiatrist becomes too intimately involved with a client, it could constitute malpractice. On the other hand, if a psychiatrist is not involved enough (or unreasonably terminates involvement), it could likewise constitute malpractice. Moreover, if a psychiatrist does **not** terminate therapy where the therapy is clearly not progressing in the client's best interests[498], that could constitute malpractice.

Chapter IX addresses the two fires - metaphorically speaking - represented by breach of confidentiality and the duty to warn

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[497] See chapter VII, 3.1.

[498] Such termination must, of course, occur in the appropriate manner, including possibly referring the client to someone best suited to his or her needs.

third parties. On the one hand, liability can arise from breach of confidentiality and/or an action for defamation, whilst on the other hand, liability can arise from not disclosing information necessary to warn a person or group of persons of imminent danger.

2 Conclusion

In all the above instances, the standard with which a psychiatrist must comply is that of "the reasonable psychiatrist". The law can establish and enforce that standard only with the assistance of the specialists in psychiatry - they are the ones who determine the standard. The reasonable psychiatrist is expected to be just that: reasonable.[499] Psychiatric malpractice law should actually be regarded very positively by psychiatrists, since it is *inter alia* this area of law which serves to ensure the respectability of their area of expertise. In the desirable situation where psychiatrists are held justly accountable for their actions, it would cultivate a climate of warranted trust in their conduct, and promote the general positive perception of the field as a whole.

Many consumers of psychiatric services do not have the capacity to protect their interests with sufficient competence. They, more than any other medical consumers, must be protected from harm by both the medical community and the law.[500] In step with HMM, this

[499]Practically, it should be borne in mind that a client bringing suit against a therapist will generally bear the burden of proof. He or she would have to prove "on a balance of probabilities" that the psychiatrist acted unreasonably, leading expert testimony in that regard. Similarly, the state would, in criminal cases, have to prove "beyond reasonable doubt" the elements of the crime with which the therapist is charged (one of which may be negligence). It should be noted that it is very important that careful records of treatment be kept at all times. When it comes to responding in defence, inadequate records can place a practitioner in a very vulnerable position indeed.

[500]Indeed, the law cannot protect people if their plights are not brought to its attention; it is imperatively up to those who

should not be a situation of "law v medicine", where medicine and law work **against** each other to find balance and best serve the community. Rather, law and medicine must work **together** to the benefit of all, including the psychiatric specialists themselves. The potential impact of defensive medical practices can be avoided only if mutual understanding and integrated functioning are promoted and translated into practice.

To reiterate one of the core conclusions of HMM: the most significant beneficiaries of holistic multidisciplinary development and integrated practice are those whom various disciplines serve. The benefits of the effects of successful HMM can be of dire importance to those who rely, sometimes with their very lives, on those to whom multidisciplinary efficiency and effectiveness have been entrusted. Law and psychiatry must imperatively work together to fulfil the roles with which the community has entrusted them, and must cohesively endeavour to further their inevitable common cause: the interests of society and its members.

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are "on the ground" to assist the law (and professional bodies) in safeguarding the integrity of their practices and profession.

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LIST OF ABBREVIATIONS AND LATIN TERMS

Cf: *confer* (compare)

Ibid: *Ibidem* ("the same"; herein used as meaning "the same source as cited directly above")

In casu: in the present case

Infra: below

Inter alia: among others

Op cit: opus citatem (herein used to indicate that the source referred to has been cited no less recently than two pages back)

Statim: immediately

Supra: above.

Viz: videlicet ("it is permitted to see"; generally used as "namely")

ABBREVIATIONS OF JOURNAL NAMES

B U Pub Int L J: Boston University Public Interest Law Journal

Cal W L Rev: California Western Law Review

CILSA: Comparative and International Law Journal of Southern Africa

Contemp H L & Pol: Journal of Contemporary Health Law & Policy

J Contemp Legal Issues: University of San Diego School of Law Journal of Contemporary Legal Issues

J L & Health: Cleveland State University Journal of Law and Health

N Y L Sch L Rev: New York Law School Law Review

NW U L Rev: Northwestern University Law Review

Psych Pub Pol and L: Journal of Psychology, Public Policy and Law

SACJ: The South African Journal of Criminal Justice

SAJP: The South African Journal of Psychiatry

SAMJ: The South African Medical Journal

SALJ: The South African Law Journal

THRHR: Tydskrif vir Hedendaagse Romeins-Hollandse Reg

TRW: Tydskrif vir die Regswetenskap

TSAR: Tydskrif vir die Suid-Afrikaanse Reg

Tulsa J Comp & Int L: Tulsa Journal of Comparative and International Law

U Cin L Rev: University of Cincinnati Law Review