A LEGAL PERSPECTIVE ON THE POWER IMBALANCES IN THE DOCTOR-PATIENT RELATIONSHIP

Andra le Roux-Kemp

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Promotor: Prof LM du Plessis
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SUMMARY

The unique and intimate relationship that exists between a medical practitioner and his/her client is possibly one of the most important relationships that can come into being between any two people. This relationship is characterised and influenced by the qualities and attributes specific to the nature and historical development of medical care, as well as medical science in general. The doctor-patient relationship is also influenced by the social dynamics of a particular community, environmental factors, technological advances and the general social and commercial evolution of the human race. With regard to medical care and health service delivery, the doctor-patient relationship is furthermore vital to the quality of the care provided, as well as to the outcomes and relative success of the specific medical intervention or treatment.

One of the distinct characteristics of the doctor-patient relationship is the power imbalance inherent in this relationship. The medical practitioner has expert knowledge and skill, while the patient finds himself or herself in an unusually dependent and vulnerable position. It is because of this important role that the doctor-patient relationship still plays in health service delivery today; the susceptibility of the relationship to a variety of influences, and the characteristic power imbalances inherent in this relationship, that a study of the doctor-patient relationship in South African medical- and health law is necessary. The characteristic power imbalances will be considered from a legal perspective in this dissertation.

This study provides a comprehensive source of the doctor-patient relationship from a legal perspective. Where relevant, references are made to theories and principles from other disciplines, including sociology, economy and medical ethnomethodology. The prevalence and consequences of power imbalances in the doctor-patient relationship are identified and discussed with the aim of bringing these to the attention of both the legal fraternity, and medical practitioners.

Specific problem areas are identified and solutions are offered, including the following:

- The adverse consequences of power imbalances inherent in the doctor-patient relationship on the medical decision-making process are considered from various perspectives. With regard to these adverse consequences, the doctrine of informed consent is analysed and evaluated in great detail.

- The influence of paternalistic notions in health service delivery; the business model of health service delivery and the effects of managed care and consumer-directed health care on the doctor-patient relationship and health service delivery in general are also analysed from a legal perspective, and specifically with regard to the power imbalances inherent in this relationship.

- The role of autonomy, self-determination and dignity, as well as the principles of beneficence in medical practice, are reconsidered in an attempt to provide a solution for redressing the power imbalances inherent in the doctor-patient relationship.

- The fiduciary nature of the doctor-patient relationship and the special role of trust in the relationship are emphasised throughout the dissertation as the focal point of departure in the doctor-patient relationship and the main constituent in any legal endeavor to redress the power imbalances inherent in it.

OPSOMMING

Die unieke en intieme verhouding wat bestaan tussen 'n mediese praktisyn en 'n pasiënt is wêreldwyd waarskynlik een van die belangrikste verhoudings wat tussen twee persone tot stand kan kom. Hierdie verhouding word gekenmerk en beïnvloed deur kwaliteite en eienskappe eie aan die besonderse aard en historiese ontwikkeling van gesondheidsorg, sowel as die mediese wetenskap in die algemeen. Die dokter-pasiënt verhouding word verder beïnvloed deur die sosiale dinamika van 'n bepaalde gemeenskap, omgewingsfaktore, tegnologiese vooruitgang en die algemene sosiale en kommersiële ontwikkeling van die mensdom. Op die terrein van gesondheidsorg en mediese dienslewering is die dokter-pasiënt verhouding voorts ook sentraal tot die kwaliteit van die mediese sorg wat verskaf word, sowel as die uitkomste en relatiewe sukses van die spesifieke mediese behandeling.

Een van die kenmerkende eienskappe van die dokter-pasiënt verhouding is die magswanbalans wat daar tussen dokter en pasiënt bestaan. Die mediese praktisyn beskik oor deskundige kennis en vaardighede, terwyl die pasiënt hom- of haarself in 'n ongewone, afhanklike en kwesbare posisie bevind. Dit is dan veral weens die besondere rol wat hierdie verhouding steeds in hedendaagse gesondheidsorg speel, die beïnvloedbaarheid van hierdie verhouding deur 'n verskeidenheid faktore, sowel as die kenmerkende magswanbalans inherent in die verhouding, dat 'n ondersoek na die dokter-pasiënt verhouding in die Suid-Afrikaanse mediese reg noodsaaklik is. Hierdie kenmerkende magswanbalans sal vanuit 'n regsperspektief verder in hierdie proefskrif ondersoek word.

Hierdie studie bied 'n omvattende bron van die dokter-pasiënt verhouding benader vanuit 'n regsperspektief, terwyl verwysings na teorieë en beginsels van ander dissiplines soos die sosiologie, ekonomie en mediese etnometodologie ook waar nodig ingesluit word. Die voorkoms en gevolge van 'n magswanbalans in die dokter-pasiënt verhouding word verder geïdentifiseer en bespreek ten einde dit onder die aandag te bring van beide regslui en medici.

Spesifieke probleemareas wat geïdentifiseer is en die oplossings wat daarvoor aan die hand gedoen is sluit die volgende in:

- Die nadelige gevolge van die bestaan van 'n magswanbalans in die dokter-pasiënt verhouding op die mediese-besluitnemingsproses word bespreek vanuit verskillende persepktiewe. Met betrekking tot hierdie nadelige gevolge, word die leerstuk van ingeligte toestemming in besonder geanaliseer en geëvalueer.

- Die invloed van 'n paternalistiese benadering tot gesondheidsorg, die besigheids-model van gesondheidsorg, en die effek van bestuurde- en verbruikersgedrewe gesondheidsorg inisiatiewe op die dokter-pasiënt verhouding en die verskaffing van gesondheidsdienste in die algemeen word ook vanuit 'n regsperspektief ge-analiseer. Spesifieke aandag word in dié verband gegee aan die invloede van hierdie benaderings en perspektiewe op die magswanbalans inherent aan die dokter-pasiënt verhouding.

- Die besondere rol van autonomie, selfbeskikking en menswaardigheid, asook die beginsels van weldadigheid in gesondheidsorg, word heroorweeg in 'n poging om 'n meer gelyke distribusie van mag in die dokter-pasiënt verhouding te verseker.

- Die fidusiêre aard van die dokter-pasiënt verhouding en die besondere rol wat vertroue in hierdie verhouding speel, word in hierdie proefskrif beklemtoon en word voorts as die basis van die dokter-pasiënt verhouding beskou. Vertroue, as 'n kenmerk van die dokter-pasiënt verhouding, behoort ook die fokuspunt te wees van enige poging om die magswanbalans in die dokter-pasiënt verhouding aan te spreek.

Table of Contents

Chapter 1: Introduction 1
1.1. Background 1
1.2. Identifying the doctor and the patient in health service delivery 5
1.3. When does a doctor-patient relationship come into being? 9
1.4. Aim and methodology 14
1.5. Research question and underlying assumptions 16
1.6. Outline of study 17
1.6.1. Chapter 2 17
1.6.2. Chapter 3 17
1.6.3. Chapter 4 18
1.6.4. Chapter 5 19
1.6.5. Chapter 6 19
1.6.6. Chapter 7 20
1.6.7. Chapter 8 20

PART A

Chapter 2: The historical development of the doctor-patient relationship and the culture of medical care 23
2.1. The historical development of the doctor-patient relationship 24
2.1.1. Primitive society 25
2.1.2. The Greek medical tradition (± 600 – 100 B.C.) 28
2.1.3. Classical, medieval and early modern societies (1200 – 1600 A.D.) 30
2.1.4. Modern western societies (1700 – 1900 A.D.) 32
2.1.5. Postmodern societies 33
2.2. The culture of medical care 35
2.2.1. Professionalism and the regulation of the medical profession 35
2.2.2. Social roles and the doctor-patient relationship 42
2.2.2.1. The physician's role 43
2.2.2.2. The sick role 45
2.2.3. Professionalism, authority and the doctor-patient relationship 46
2.2.4. Power and the doctor-patient relationship 53
2.3. Conclusion 57

Chapter 3: Medical decision-making and the doctor-patient relationship in a paternalistic setting.....59
3.1. Defining medical paternalism 60
3.2. Medical decision-making in a paternalistic medical setting........ 65
3.3. Autonomy, dignity, self-determination and beneficence in medical decision-making........ 72
3.4. A juridical response to traditional paternalism in medical decision-making 80
3.4.1. Informed consent 82
3.4.1.1. The origin of informed consent........ 83
3.4.1.2. The development of the doctrine of informed consent 89
3.4.1.3. The current status of the doctrine of informed consent 95
3.5. An evaluation of medical decision-making and the doctor-patient relationship 104
3.5.1. Standards of disclosure 106
3.5.2. Historical attributes 112
3.5.3. Practical considerations........ 113
3.5.4. The efficiency of the doctrine of informed consent 116
3.5.5. Recommendations........ 118
3.6. Conclusion 123

PART B

Chapter 4: The doctor-patient relationship in the medical marketplace 126
4.1. Defining the business model in medical practice........ 127
4.2. The relevance of the business model to medical practice and the doctor-patient relationship........ 133
4.3. The business model and the power imbalances in the doctor-patient relationship 140
4.3.1. Informed consent 140
4.3.2. Patients' rights, patient autonomy and the defiance of beneficence 147
4.3.3. The erosion of trust in the doctor-patient relationship........ 151
4.4. Conclusion 155

Chapter 5: The fiduciary nature of the doctor-patient relationship 159
5.1. The doctor-patient relationship as a fiduciary relationship 160
5.2. The legal content of the fiduciary relationship between doctor and patient 168
5.3. The doctor as a fiduciary in the doctor-patient relationship........ 172
5.3.1. The duty of loyalty 173
5.3.2. The duty to act in the patient's best interest 176
5.4. The patient as a beneficiary in the doctor-patient relationship 179

5.4.1. Right or entitlement to a benefit enforceable against the fiduciary 179
5.5. An evaluation of the doctor-patient relationship as a fiduciary relationship 183
5.6. Conclusion 189

PART C

Chapter 6: The doctor-patient relationship in an era of managed care...192
6.1. The history and development of managed care in health service delivery 195
6.2. The influence of managed care practices on the doctor-patient relationship....................... 202
6.2.1. Access to health care 205
6.2.2. The new role of the physician in the doctor-patient relationship................................. 211
6.2.3. Trust in the doctor-patient relationship and trust in managed care institutions 214
6.2.4. Informed consent in an era of managed care 219
6.2.5. Patient advocacy in an era of managed care 223
6.3. Conclusion 225

Chapter 7: Consumerism and the doctor-patient relationship 228
7.1. Consumer choice, patient autonomy and the ethical limits of consumer responsibility 232
7.2. Consumer protection in the doctor-patient relationship 237
7.3. Consumer empowerment and the doctor-patient relationship 241
7.4. Conclusion 243

Chapter 8: A proposed re-conceptualisation of the doctor-patient relationship to redress power imbalances...246
8.1. Are there power imbalances in the doctor-patient relationship? 247
8.2. Can the doctor-patient relationship be re-conceptualised, from a legal perspective, to redress the power imbalances inherent in the relationship?.. 251
8.2.1. The role of autonomy, dignity, self-determination and beneficence in the doctor-patient relationship 251
8.2.2. The doctrine of informed consent and the power imbalances in the doctor-patient relationship 253
8.2.3. The fiduciary nature of the doctor-patient relationship and the power imbalances inherent in the relationship 255
8.2.4. The role of trust in the doctor-patient relationship 256
8.3. Concluding remarks 259

Table of cases **261**
Bibliography **265**
Index **281**

CHAPTER ONE: Introduction

1.1. Background
1.2. Identifying the doctor and the patient in health service delivery
1.3. When does the doctor-patient relationship come into being?
1.4. Aim and methodology
1.5. Research question and underlying assumptions
1.6. Outline of study
1.6.1. Chapter 2
1.6.2. Chapter 3
1.6.3. Chapter 4
1.6.4. Chapter 5
1.6.5. Chapter 6
1.6.6. Chapter 7
1.6.7. Chapter 8
1.7. Conclusion

1.1. Background

Good health is universally valued, and variations of the saying "as long as you have your health" exist in almost every language and culture.[1] When illness strikes, anxiety, desperation and fear are experienced by both the weakest and strongest in society.[2] For this reason the medical profession is one of the most important vocations, elevated to a special status, and with corresponding privileges and rights. The unique interaction between members of a profession as reputable as the medical one, and vulnerable patients with essential health needs makes the doctor-patient relationship complicated. It is not only one of the most important, but also one of the most unequal social relationships.

"Power in the doctor-patient relationship is distributed unequally. This structural inequality affects all transactions within the relationship, including decision-making by

[1] Yamin, Alicia Ely "Defining Questions: Situating issues of power in the formulation of a right to health under international law" *Human Rights Quaterly* 18.2 (1996) 398 – 438.
[2] Mahlati, Malixole Percival *The Medical Profession in a Transforming South African Society; Ideals, Values and Role* Thesis presented in partial fulfilment of the requirements of the degree M Phil (Applied Ethics) at Stellenbosch University March 2000 (Supervisor: Prof AA van Niekerk), 18.

the doctor and the patient, the construction of knowledge, and the doctor's performance of legal obligations to the patient."[3]

The historical and social context of the distribution of power and inequality affects the nature of power in the doctor-patient relationship. However, this maldistribution of power and the inequality inherent in the doctor-patient relationship are rarely considered in judgements concerning medical law as well as health law.[4] Such a narrow approach to health law in general, and the doctor-patient relationship in particular, is regrettable for the following reasons:

- An unequal distribution of power in the doctor-patient relationship undermines the vulnerable patient's effective participation in and control over decision-making. The constitutional rights to life,[5] to bodily and psychological integrity,[6] privacy,[7] freedom of religion, belief and opinion,[8] and freedom of movement[9] are consequently not recognised or encouraged. In addition, sections 6 – 12 of the National Health Act 61 of 2003 are also not duly adhered to in such situations.
- Without power, patients have difficulty giving effect to their own values, whether founded on personal, cultural, religious or any other group-defined basis. The constitutional rights to freedom of religion, freedom of belief and opinion,[10] as well as the right to freedom of association[11] in the Bill of Rights are thereby also not honoured.
- Patients' sense of self and dignity, as envisioned in the constitutional rights to human dignity,[12] freedom and security of the person[13] and the right to privacy[14] are undermined.

[3] Peppin, Patricia Power and Disadvantage in Medical Relationships *Texas Journal of Women and Law* Vol 3 (Spring 1994) 221 – 263, 221.
[4] Peppin, Patricia Power and Disadvantage in Medical Relationships *Texas Journal of Women and Law* Vol 3 (Spring 1994) 221 – 263, 221; See below for a discussion on the concepts "medical law"and "health law".
[5] Constitution of the Republic of South Africa, 1996, section 11.
[6] Constitution of the Republic of South Africa, 1996, section 12(2).
[7] Constitution of the Republic of South Africa, 1996, section 14.
[8] Constitution of the Republic of South Africa, 1996, section 15(1).
[9] Constitution of the Republic of South Africa, 1996, section 21(1).
[10] Constitution of the Republic of South Africa 1996, section 15.
[11] Constitution of the Republic of South Africa, 1996, section 18.
[12] Constitution of the Republic of South Africa, 1996, section 10.
[13] Constitution of the Republic of South Africa, 1996, section 12.
[14] Constitution of the Republic of South Africa, 1996, section 14.

- Personal effectiveness and an authentic representation of the self, as described in the right to freedom of expression[15] in the Bill of Rights, is undermined.
- The inability to control medical decision-making increases the likelihood that unwanted risks will fall on patients.[16]

In this dissertation, the ordinary doctor-patient relationship, as opposed to other specialist relationships like the relationship between a psychologist and a patient, will be examined.[17] The collective concepts of power and equality as well as an affirmation of difference will be considered in terms of the ordinary, universally accepted notion of the relationship between doctor and patient and the dynamics unique to doctor-patient interaction.

In addition, reference will be made to both medical law and health law. To date there has been no agreement on a clear and universally accepted definition and distinction of these two concepts.[18] While medical law was, at the outset, primarily engaged with aspects of medical malpractice and negligence, its scope has now been enlarged to cut across the traditional compartments of law (such as delict-, contract-, criminal-, family- and public law) with which most lawyers have become familiar.[19] The term "health law,"on the other hand, overlaps with the term "medical law"and has a wider meaning than the latter concept. Health law concerns a complex group of professions, applies to a wide range of professionals and extends beyond the established medical and nursing practices and communities.[20] As the primary focus of this dissertation will be on the historical and social context of the distribution of power and inequality, as well as on the nature of power in the doctor-patient relationship, it will be necessary to consider relevant areas of both medical law and health law. Note, however, that were the term "medical law" is used in this

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[15] Constitution of the Republic of South Africa, 1996, section 16.

[16] Peppin, Patricia Power and Disadvantage in Medical Relationships *Texas Journal of Women and Law* Vol 3 (Spring 1994) 221 – 263, 223 - 224.

[17] See the discussion in 1.2. below.

[18] Cartens, P & Pearmain, D *Foundational principles of South African Medical Law* LexisNexis Durban 2007 3 – 5; Strauss, SA Medical Law – South Africa in International Encyclopaedia of Laws (eds Blanpain R and Nys H) (2006) para 42.

[19] Cartens, P & Pearmain, D *Foundational principles of South African Medical Law* LexisNexis Durban 2007 3 – 5; Strauss, SA Medical Law – South Africa in International Encyclopaedia of Laws (eds Blanpain R and Nys H) (2006) para 42; Van Oosten FFW Medical Law – South Africa in International Encyclopaedia of Laws (eds Blanpain R and Nys H) (1996) 26 – 27.

[20] Cartens, P & Pearmain, D *Foundational principles of South African Medical Law* LexisNexis Durban 2007 4.

dissertation, it is not meant to refer to or to be limited by the traditional subdivisions of law (especially the law of obligations) with which this term had historically been associated.

The question of power in the doctor-patient relationship will be the focal point of this dissertation. Power in any relationship is essentially about control and authority, and due analysis of power relations and interests is consequently called for. The research question is: *How can the doctor-patient relationship be conceptualised, from a legal perspective, to redress power imbalances in this relationship?* The inherent inequality in the doctor-patient relationship is therefore central to the *legal* analysis that follows, and not the traditional subdivisions of the law on which medical- and health law have historically been founded. It is submitted that a true analysis of power relations in the doctor-patient relationship cannot sensibly be confined to the traditional juridical model on which medical law is traditionally founded.[21] A socio-legal perspective is called for instead, conceiving of the law as inseparable from, and indeed imbedded in, the social dynamic that informs the doctor–patient relationship.

In the South African context, it is also particularly important to investigate how this relationship between doctor and patient developed from a relationship governed by common law principles to a relationship now informed and shaped by the Constitution and, more specifically, the Bill of Rights. The new legal environment, fundamentally (re)-shaped by the advent of two successive, justiciable, supreme constitutions since 1994, calls for a multilayered approach to health law, taking into account relevant legislation, case law, medical ethics and common law principles while incorporating relevant constitutional values, principles and rights.[22] However, a mainstream human rights analysis with a special focus on social and economic rights will also not fully appreciate how "…*social relations constitute structures of choices within which people perceive, evalute and act*."[23]

[21] London, Leslie What is a Human-Rights-based Approach to Health and does it matter? *Health and Human Rights* Vol 10, No 1 65 – 80, 67.
[22] Cartens, P & Pearmain, D *Foundational principles of South African Medical Law* LexisNexis Durban 2007 25 – 26.
[23] Yamin, Alicia Ely Suffering and Powerlessness: The Significance of Promoting Participation in Rights-based Approaches to Health *Health and Human Rights* Vol 11, No 1, 5 – 22, 17.

The topic of this study is vast and its scope will therefore be limited for the purposes of this dissertation. The ordinary relationship between doctor and patient in the private health care sector will serve as the point of departure, while the additional power imbalances that exists between a doctor and patient in the context of public health care (especially in the South African context) will also be referred to where applicable. An in-depth constitutional investigation of socio-economic rights will not be undertaken, nor will the question whether or not the South African Constitution provides for a right to health care (and the effect of the Constitution on health service delivery in general) be addressed, as this dissertation is primarily concerned with the power-imbalances in the doctor-patient relationship and how such disparities influence the nature and consequences of doctor-patient interactions in practice. However, a conceptualisation of what power in the doctor-patient relationship means and how power imbalances in the relationship influence health service delivery and its outcomes, as is envisaged in this dissertation, can inevitably lead to a better understanding of health rights in general. The focus will consequently be the doctor-patient relationship and how the Constitution could possibly *inform* it.

1.2. Identifying the doctor and the patient in health service delivery

Since this dissertation will comprehensively analyse the power imbalances in the doctor-patient relationship, it is important to determine when exactly a doctor-patient relationship comes into existence. First, however, it is necessary to identify the two main protagonists in this relationship. A health practitioner, in terms of the Health Professions Act,[24] is any person, including a student, registered with the council in a profession registrable in terms of this particular Act, while a medical practitioner is any person registered in terms of the Health Professions Act. The National Health Act,[25] on the other hand, refers to health care providers rather than health practitioners and describes a health care provider as any person providing health services in terms of law, and "law" includes the Health Professions Act,[26] the Allied Health Professions Act,[27] the Nursing Act,[28] the Pharmacy Act[29] and the Dental Technicians Act.[30]

[24] 56 of 1973.
[25] 61 of 2003.
[26] 56 of 1973.

A health care user, according to the definition in section 1 of the National Health Act,[31] refers to a person receiving treatment in a health establishment, including receiving blood or blood products, or using a health service, and if the person receiving treatment or using a health service is below the age contemplated in section 39 (4) of the Child Care Act,[32] then the 'user' includes the person's parent or guardian or another person authorised by law to act on the firstmentioned person's behalf. Further, if the health care user is incapable of taking decisions, 'user' also includes the person's spouse or partner or, in the absence of such spouse or partner, the person's parent, grandparent, adult child or brother or sister, or another person authorised by law to act on the firstmentioned person's behalf.

Noteworthy in the South African context are also the definitions relating to the understanding of who a doctor is and who a patient is in *traditional health practice,*[33] and in terms of the Traditional Health Practitioners' Act.[34] This Act defines a traditional health practitioner as a person registered under this particular Act in one or more of the categories of traditional health practitioners. The categories of traditional health practitioners, as identified in the act, are based on thetraditional health care practice and philosophy,[35] as well as on the particular functions, activities, processes and/or services, traditionally associated with what health practitioners may do. These functions, activities, processes and/or services must furthermore have the following as their objects:

- the maintenance or restoration of physical or mental health or function; or
- the diagnosis, treatment or prevention of a physical or mental illness; or

[27] 63 of 1982; This includes practitioners of the profession of ayurveda, Chinese medicine and acupuncture, chiropractic, homeopathy, naturopathy, osteopathy, phytotherapy, therapeutic aromatherapy, therapeutic massage therapy or therapeutic reflexology, or any other profession contemplated in section 16 (1) of the Act.
[28] 50 of 1978.
[29] 53 of 1974.
[30] 19 of 1979.
[31] 61 of 2003.
[32] Child Care Act 74 of 1983.
[33] Traditional medicine refers to an object or substance used in traditional health practice for the diagnosis, treatment or prevention of a physical or mental illness; or any curative or therapeutic purpose, including the maintenance or restoration of physical or mental health or well-being in human beings.
[34] 35 of 2003.
[35] According to the act, traditional philosophy means indigenous African techniques, principles, theories, ideologies, beliefs, opinions and customs and uses of traditional medicines communicated from ancestors to descendants or from generations to generations, with or without written documentation, whether supported by science or not, and which are generally used in traditional health practice.

- the rehabilitation of a person to enable that person to resume normal functioning within the family or community; or
- the physical or mental preparation of an individual for puberty, adulthood, pregnancy, childbirth and death,

but excludes the professional activities of a person practising any of the professions contemplated in the Pharmacy Act,[36] the Health Professions Act,[37] the Nursing Act,[38] the Allied Health Professions Act,[39] or the Dental Technicians Act,[40] and any other activity not based on traditional philosophy.

Just as the scope of traditional medical practice, as referred to above, determines the nature of the relationship between traditional health practitioners and their patients, the scope of the profession of medicine, as understood in terms of the Health Professions Act and the Health Professions Council of South Africa, also influences the doctor-patient relationship and the understanding of who the doctor is and who the patient is in health service delivery. The following acts have been identified as acts, which shall for the purposes of the Health Professions Act,[41] be deemed to be acts pertaining to the medical profession:

- the physical medical and/or clinical examination of any person;
- performing medical and/or clinical procedures and/or prescribing medicines and managing the health of a patient (prevention, treatment and rehabilitation);
- advising any person on his or her physical health status;
- on the basis of information provided by any person or obtained from him or her in any manner whatsoever—
    - diagnosing such person's physical health status;
    - advising such person on his or her physical health status;
    - administering or selling to or prescribing for such person any medicine or medical treatment;

[36] Pharmacy Act 53 of 1974.
[37] Health Professions Act 56 of 1974.
[38] Nursing Act 50 of 1974.
[39] Allied Health Professions Act 63 of 1982.
[40] Dental Technicians Act 19 of 1979.
[41] Health Professions Act 56 of 1974.

- prescribing, administering or providing any medicine, substance or medical device as defined in the Medicines and Related Substances Act, 1965 (Act No. 101 of 1965);
- any other act specifically pertaining to the medical profession based on the education and training of medical practitioners as approved by the board from time to time.[42]

These actions will, however, not be construed as prohibiting other actions, authorised by and regulated in terms of the Health Professions Act[43] and the Health Professions Council. Such actions, which may also be deemed necessary and relevant actions in the practice of medicine, include:

- the performance of any act specified in any legislation regulating health care providers and in accordance with the provisions of such legislation and regulation, by a person registered under that legislation;
- actions by interns working at an institution recognised by the council performing any function or issuing any certificate or other document which in terms of any law, other than this Act, that may be or is required to be performed or issued by a medical practitioner, whether described in such law as a medical practitioner or by any other name or designation, or describing himself or herself as a medical practitioner in connection with the performance of any such function or the issuing of any such certificate or document;
- actions by student interns performing any act specified in a specific regulation under the supervision of a medical practitioner in the course of his or her training;
- the performance of any act by a dentist as specified in a specific regulation in the course of performing any act falling within the scope of dentistry, including the prohibition of using any name, title, description or symbol normally associated with his or her profession; or
- actions by any person specified in a specific regulation in the course of bona fide research at any institution approved for that purpose by the Minister.

[42] Section 2, Regulations defining the scope of the profession of medicine GN R237 in Government Gazette 31958 of 6 March 2009.
[43] Health Professions Act 56 of 1974.

It is evident from these definitions provided for in legislation, as well as the legislative demarcation of the scope of the profession of medicine (as it is referred to in the relevant notice published in the Government Gazette) that the two main role players in any health service relationship will depend on the type of health service involved, as well as the scope of that particular medical discipline's actions. This will, in turn, also influence the dynamics of the said relationship as well as the power-imbalances in that relationship. As, due to the practical limitations of this study, it is impossible to discuss the nuances and power-imbalances in all health service relationships, the doctor in the doctor-patient relationship as referred to in this dissertation, will be limited to any person providing health services in terms of law, including in terms of the Health Professions Act,[44] the Allied Health Professions Act,[45] the Nursing Act,[46] the Pharmacy Act[47] and the Dental Technicians Act.[48] The context of the doctor-patient relationship, as herein further referred to, will moreover be limited to the general and universal characteristics unique to the relationship between a healthcare practitioner and a patient. Particular nuances and power dynamics attributed to specific medical diciplines and specialist areas of practice will not be discussed. Similarly, the patient in the doctor-patient relationship, as considered and referred to in this dissertation, will be limited to the ordinary, reasonable and competent patient. Patients with special and additional vulnerabilities and needs, including legally incompetent patients, will not be discussed.

1.3. When does a doctor-patient relationship come into being?

The discussion will now focus on the doctor-patient relationship and the question when this relationship can be regarded to come into existence. Generally speaking, it is assumed that this happens when a doctor and a prospective patient have come to an agreement (usually implicit and after a consultation) that the doctor will accept the said person as his/her

[44] 56 of 1973.
[45] 63 of 1982; This includes practitioners of the profession of ayurveda, Chinese medicine and acupuncture, chiropractic, homeopathy, naturopathy, osteopathy, phytotherapy, therapeutic aromatherapy, therapeutic massage therapy or therapeutic reflexology, or any other profession contemplated in section 16 (1) of the Act.
[46] 50 of 1978.
[47] 53 of 1974.
[48] 19 of 1979.

patient and will treat this patient.[49] There is no implicit agreement to cure the patient, though, unless the practitioner committed himself or herself to this explicitly.[50] Although the legal basis of the relationship between a doctor and a patient have been discussed in South African medical law sources and related case law, the exact moment when such a relationship commences has not been intensively discussed in the South African context.[51] There are, however, a few cases from the United States of America dealing specifically with the establishment of the doctor-patient relationship in circumstances relevant to the present discussion.

In *Clanton v Von Haam*[52] Eldrige J ruled that when a physician who previously treated a patient for a different ailment returns this patient's phone calls about another condition and listens to the patient's account of symptoms, a (new) doctor-patient relationship is not created. The court based its decision on the fact that the patient herself in this particular case interpreted the conversation with the specific medical practitioner as a refusal of medical services. However, not all patients would interpret such a telephone conversation as a refusal of medical treatment and it is clear from the judgement that the question whether a doctor-patient relationship was established as a result of such a telephonic enquiry would largely depend on the particular circumstances in each case. Another example is the case of *Bienz v Central Suffolk Hospital*[53] where the court had to decide "*…whether a telephone call to a physician's office for the purpose of initiating treatment is*

[49] Le Roux, Andra Telemedicine: A South African Legal Perspective *Tydskrif vir Suid-Afrikaanse Reg* (2008) 1, 99 – 114, 111.

[50] Le Roux, Andra Telemedicine: A South African Legal Perspective *Tydskrif vir Suid-Afrikaanse Reg* (2008) 1, 99 – 114, 111.

[51] For a general discussion on the formation of the doctor-patient relationship see: Gordon, Turner & Price Medical Jurisprudence (1953) 69ff; Strauss & Strydom Die Suid-Afrikaanse Geneeskundige Reg (1967) 104ff; Strauss Doctor Patient and the Law (1991) 3ff; Claassen & Verschoor Medical Negligence in South Africa (1992) 115ff; Strauss & Van Oosten International Encyclopaedia of Laws: South Africa (2007) 59ff; Carstens & Pearmain Foundational Principles of SA Medical Law (2007) Chapters 5 – 8; Lerm A Critical Analysis of Exclusionary Clauses in Medical Contracts (unpublished LLD-thesis) UP (2008); Van Wyk v Lewis 1924 AD 438ff; Correira v Bewind 1986 (4) SA 60 (Z) 63ff; Edouard v Administrator, Natal 1989 (2) SA 368 (D); Allot v Paterson & Jackson 1936 SR 221 224; Magware v Minister of Health 1981(4) SA 472 (Z); Dube v Administrator Transvaal 1963 (4) SA 260(W); Mtetwa v Minister of Health 1989 (3) SA 600 (D); Jansen van Vuuren v Kruger 1993(4) SA 842 (A) 848 – 849; Friedman v Glickman 1996 (1) SA 1134 (W); Clinton-Parker v Administrator Transvaal 1996 (2) SA 37 (W) 58, 68. Le Roux, Andra Telemedicine: A South African Legal Perspective *Tydskrif vir Suid-Afrikaanse Reg* (2008) 1, 99 – 114, 111.

[52] *Clanton et al v Von Haam* 70991 (177 Ga App 694) (340 SE2d 627) 1986.

[53] *Bienz v Central Suffolk Hospital* 163 AD 2d 269, 557 NYS 2d 139 (1990).

sufficient to create a physician-client relationship".[54] In this case, the court held that it is important to know what advice or information the physician gave the patient during the telephone conversation and what reliance the patient placed on the conversation.[55] Thus, from the judgements in these two cases, it can be concluded that whether or not a telephone conversation between a doctor and a patient will establish a relationship between them will depend on the particular circumstances in each case.[56]

The case of *Dougherty v Gifford*[57] is also important as it deals with the establishment of a doctor-patient relationship where there is no personal contact between the doctor and the particular patient. The patient, Gifford, developed a hernia of the oesophagus that worsened to the point that his family practitioner referred him to a specialist, Dr Williams. The specialist took a biopsy of the hernia and sent it to the regional pathology department directed by the appellant. (The appellant's department had a contract to perform all the pathology work for the medical centre where the specialist had his practice.) The actual pathology work in this particular case, however, was not performed by the appellant himself but by a pathologist who worked under an arrangement with the relevant department directed by the appellant. The pathologist diagnosed cancer and as a result, Gifford was ordered to undergo radiation and chemotherapy. After six weeks of treatment, a second biopsy was taken and this time it revealed that no malignancy was present. The original biopsy slides were then re-evaluated and it was established that these original slides also showed no sign of cancer. On learning of this misdiagnosis, the patient and his spouse brought an action for negligence against the treating specialist, the laboratory of the appellant as well as the pathologist who examined the tissue. The appellant and the pathologist argued that they had no doctor-patient relationship with the patient, as they conducted the pathology work exclusively for other doctors, did not see the patient themselves and the patient had not personally opted for their services. The court in this case, however, ruled that the absence of personal contact between a patient and medical practitioner does not preclude the formation of a doctor-patient relationship. A doctor-

[54] *Bienz v Central Suffolk Hospital* 163 AD 2d 269, 557 NYS 2d 139 (1990).
[55] Le Roux, Andra Telemedicine: A South African Legal Perspective *Tydskrif vir Suid-Afrikaanse Reg* (2008) 1, 99 – 114, 112.
[56] Le Roux, Andra Telemedicine: A South African Legal Perspective *Tydskrif vir Suid-Afrikaanse Reg* (2008) 1, 99 – 114, 112.
[57] *Dougherty v Gifford* 826 SW.2d 668, 674 (Tex App – Texarkana 1992).

patient relationship was said to exist in this particular case between the patient, Gifford, and the pathologist who examined the tissue, because the pathologist performed the services for the patient's benefit, and with both the treating physician's and the patient's implied consent.[58] In this decision, special emphasis was placed on the fact that the services performed by the pathologist were to the benefit of the patient.

A different point of view was espoused in the case of *Lotspeich v Chance Vought Aircraft*.[59] Lotspeich worked for Chance Vought Aircraft on two occasions and, according to company policy, had to undergo a physical examination by company doctors on company premises for each term of employment. These examinations included X-rays of the torso. Three years after the appellant's last employment term with the defendants, X-rays of her chest revealed active tuberculosis. Re-examination of the previous X-rays showed that this was actually already visible on the chest X-rays taken three years earlier. The appellant submitted that the defendants and the company doctors employed by the defendants had a duty to disclose this information to her. The court, however, found that there was no doctor-patient relationship between the appellant and the company doctors and that the company doctors consequently had no duty to disclose or to diagnose the appellant, since they had only acted on orders of and for the benefit of the defendant.[60] But in the Canadian case of *Parslow v Masters,*[61] with similar facts, the court held that such a medical examination was for both the patient and the company's benefit. In addition, although the company paid for the medical examination, the patient had disclosed personal information during the examination process so that the medical practitioner could compile a complete medical report. This, according to the court, created a doctor-patient relationship.

In German law, it is said that a separate doctor-patient relationship is formed between a patient and a third party if the primary medical practitioner asks a third party for advice or

[58] Le Roux, Andra Telemedicine: A South African Legal Perspective *Tydskrif vir Suid-Afrikaanse Reg* (2008) 1, 99 – 114, 112.
[59] *Lotspeich v Chance Vought Aircraft* 369 SW 2d 705 (1963).
[60] Le Roux, Andra Telemedicine: A South African Legal Perspective *Tydskrif vir Suid-Afrikaanse Reg* (2008) 1, 99 – 114, 112.
[61] *Parslow v Masters* [1993] 6.W.W.R. 273, 15 C.C.L.I. (2d) 13, 110 Sask. R. 253.

assistance in the patient's specific case.[62] And even in situations where the particular patient does not know about, or did not directly consent to the third party being involved or providing assistance, it is generally acknowledged that a doctor-patient relationship is also formed.[63] Generally speaking, when a particular patient's case is referred to another medical practitioner for an opinion, it does not matter who contracted for the service, but rather whether it was contracted for with the express or implied consent of the patient and/or for the patient's benefit.[64]

This foregoing, brief analysis of foreign case law confirms that a doctor-patient relationship comes into existence once a person and a doctor have come to an agreement (also an implicit agreement after a consultation) that the doctor will accept and treat that person as a patient. However, much depends on the particular circumstances of each case. Personal contact between doctor and patient is not necessarily a prerequisite for the establishment of a doctor-patient relationship. Instead, the fact that a particular medical practitioner performs medical services to the benefit of a patient is significant.

In this dissertation, the finding of the court in the case of *Lopez v Aziz*[65] with regard to the formation of a doctor-patient relationship will be adhered to. In the Lopez case the following three requirements for the formation of a doctor-patient relationship were laid down:

- the physician should agree directly or indirectly to counsel the patient;
- there should be a medical evaluation of the symptoms; and
- the patient should rely on the physician's opinion.[66]

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[62] Le Roux, Andra Telemedicine: A South African Legal Perspective *Tydskrif vir Suid-Afrikaanse Reg* (2008) 1, 99 – 114, 113.

[63] Le Roux, Andra Telemedicine: A South African Legal Perspective *Tydskrif vir Suid-Afrikaanse Reg* (2008) 1, 99 – 114, 113.

[64] Le Roux, Andra Telemedicine: A South African Legal Perspective *Tydskrif vir Suid-Afrikaanse Reg* (2008) 1, 99 – 114, 113.

[65] *Lopez v Aziz* 852 SW 2d 303 305 – 306 (Tex App – San Antonio 1993).

[66] *Lopez v Aziz* 852 SW 2d 303 305 – 306 (Tex App – San Antonio 1993); Le Roux, Andra Telemedicine: A South African Legal Perspective *Tydskrif vir Suid-Afrikaanse Reg* (2008) 1, 99 – 114, 113.

1.4. Aim and methodology

This research project is significant in that it aims to make a contribution to South African medical law and health law.[67] The main objective is to reconsider the doctor-patient relationship with due regard to the context in which this relationship operates, the variety of influences affecting it, and the inherent power imbalances in this relationship. In order to identify and discuss these power imbalances from a legal perspective it will be necessary to look at different approaches to or styles of health service delivery.[68] The approaches or styles thus identified will provide a thematic structure and framework for the discussion. The approaches to health service delivery that will be discussed can not be regarded as theoretical constructs or models per se, but rather as general approaches to health service delivery, based on the particular social context and the situation of medical science and available medical knowledge and technology. These approaches are important for another reason too. The language used to describe the practice of medicine in each approach, and the metaphors employed to describe the relationship between patients and physicians, not only establish conceptual boundaries for this discussion, but it will become evident that they also affect the practice of medicine itself.[69]

The doctor-patient relationship is complex and can be approached from various points of view, resulting in different theoretical approaches to health service delivery.[70] Starting from the actual meeting between a doctor and a patient, their relationship can be considered as a continuous exchange of information.[71] But doctors and patients do not meet each other in a vacuum, and it will become evident from the discussion and the structural framework of this dissertation that the suggested approaches to health service delivery do not exclude each other but rather permit elaboration on different aspects of the complex structure of the

[67] *"…there is presently no in-depth, authorative examination of and an integrative commentary on the new legal environment in which providers / funders / users of health care services in South Africa are operating, nor in the broader context of medical law*." Carstens, P & Pearmain, D *Foundational principles of South African Medical Law* LexisNexis Durban 2007 vi.

[68] Also see the following article for examples on how doctor-patient relationship models have been identified and used in various analysis: Meinhardt, Robyn & Landis, Kenneth W Bioethics Update: The changing Nature of the Doctor/patient Relationship *Whittier Law Review* (1995) Vol 16, 177 – 186.

[69] Siegler, Mark The Progression of Medicine: From Physician Paternalism to Patient Autonomy to Bureaucratic Parsimony *Archives of Internal Medicine* (1985) Vol 145, 713 – 715.

[70] Pierloot, R.A. Different Models in the Approach to the Doctor-Patient Relationship *Psychotherapy and Psychosomatics* Vol 39 (1983) 213 – 224, 213.

[71] Pierloot, R.A. Different Models in the Approach to the Doctor-Patient Relationship *Psychotherapy and Psychosomatics* Vol 39 (1983) 213 – 224, 214.

doctor-patient relationship.[72] In Chapter Three the doctor-patient relationship in the context of medical paternalism will be considered. The business model of health service delivery will be considered in Chapter Four and the rhetoric of this approach (which includes autonomy, freedom, liberty and patient sovereignty) will become evident from the analysis and discussion. In Chapter Five the fiduciary nature of the doctor-patient relationship will be dealt with and in Chapter Six, both the doctor-patient relationship, as well as the institution-patient relationship in an era of managed care will be discussed. Chapter Seven, the final thematic chapter of this dissertation, will consider the power imbalances in the doctor-patient relationship in the context of consumer-directed health care.

The aim of the analyses in Chapters Three to Seven is to identify and evaluate the power imbalances in the doctor-patient relationship from a legal perspective. The power imbalances identified in this dissertation are omni-present in doctor-patient relationships. Some of the power imbalances identified in a particular chapter may also feature again in other chapters. This may be necessary since the specific power imbalance may present different perspectives, relevant to this research, with reference to each approach. In Chapter Eight the dissertation will be concluded with recommendations that the potentially precarious consequences of extreme power imbalances in the doctor-patient relationship be addressed from a legal point of view to ensure greater protection of the interests of both parties and also to ensure that the applicable constitutional rights of the parties are upheld. Most importantly, it will be shown that by addressing the said power imbalances, the interests of the patient can best be protected, ultimately resulting in a new, enriched understanding of the doctor-patient relationship.

This dissertation will include a legal comparison of the medical law and health law of South Africa, the United Kingdom and the United States of America, with occasional references to other jurisdictions where relevant. The United Kingdom was specifically selected for the purposes of legal comparison in this dissertation, since the medical law and health law of South Africa and the United Kingdom share, in many respects, the same historical, substantial and procedural foundation. The medical case law and general jurisprudence of

[72] Pierloot, R.A. Different Models in the Approach to the Doctor-Patient Relationship *Psychotherapy and Psychosomatics* Vol 39 (1983) 213 – 224, 216 & 222.

the United States of America will also be relied on, since social justice,[73] and economic and health problems, transcend distance and borders, even the vast geo-political disparities between South African and the USA.[74] United States case law offers interesting comparative examples of dealing with the themes and issues discussed in this dissertation and serves as a catalyst for further critical analysis. The USA is a wealthy country with a well developed health care system and much litigation on the themes and issues aforesaid yielding informative and helpful case law in the field.

1.5. Research question and underlying assumptions

The research question guiding the discussion in this dissertation is the following: *How can the doctor-patient relationship be conceptualised, from a legal perspective, to redress the power imbalances in this relationship?*

Assumptions underlying this research question include the following:

- There are power imbalances inherent in the doctor-patient relationship.
- The doctor-patient relationship is influenced by the social and legal context in which it functions.
- The general spirit and letter of the Constitution of the Republic of South Africa, 1996 have influenced this relationship and have resulted in considerable(actual and potential) development of the common law applicable to medical- and health law.
- There is a tendency to move from a paternalistic approach to health service delivery towards a more individualistic approach.
- South African medical- and health law and specifically the doctor-patient relationship are usually regarded in isolation from external influences and dynamics, which does not allow for a complete understanding of doctor-patient relations in South African legal discourse.

[73] Here specifically power and empowerment.

[74] Lanier, MM Epidomiological Criminology: A Critical Cross-cultural Analysis of the Advent of HIV/AIDS *Acta Criminologica* (2009) 22(2) 2009 60-73.

I am convinced that there is a viable, alternative characterisation and conceptualisation of the doctor-patient relationship which will allow for a better understanding of the uniqueness of this relationship, address the power imbalances inherent in it, and which will ensure that the constitutional principles and values are realised, promoted and developed in health service delivery.

1.6. Outline of study

1.6.1. Chapter 2

The historical and social context of the doctor-patient relationship and society's perceptions and attitudes towards the medical profession, as well as the valuation of health and illness, will form the foundation of the discussion in this chapter. It will become evident from the discussion that human interaction, such as that between doctor and patient, is determined by prevailing cultural standards and influenced by historical factors. The culture of medical care, which refers to the general nature of the medical profession and practice, as well as the distinguishing characteristics of health care delivery, will also be discussed. An analysis of these distinguishing features will provide a better understanding of the doctor-patient relationship.

The following aspects will receive special attention in this chapter: professionalism and the regulation of medical practice as well as the ensuing power associated with professionalism; the medical anthropological theories on the institutionalisation of various role relationships between the medical profession in itself and other parts of society; and the notions of power and authority as natural consequences of professionalism.

1.6.2. Chapter 3

Medical paternalism is rooted in the historical development of the medical profession, the unique characteristics and special status associated with the medical profession and the power and authority consequently attributed to it. Despite critique, changing social and cultural dynamics and centuries' long developments in the practice of medicine, medical paternalism has continued to remain the template frame of mind of many a physician. Medical paternalism as the dominant approach in health service delivery will form the foundation of the discussion in Chapter Three.

In Chapter Three, the first power imbalance in the doctor-patient relationship will be identified and discussed. In a medical paternalistic practice, medical practitioners are assumed to have internalised the interests of their patients and patients are consequently not active participants in the medical decision-making process. Physicians are regarded as custodians of abstruse knowledge, not communicable to the lay person and, as a result, the responsibility of decision-making is assigned solely to medical practitioners, given their expert skill and knowledge.

The use and value of the available legal instruments to address this power imbalance will also be considered in this chapter, more specifically informed consent. Sections 3.4. and 3.5. will deal comprehensively with the origin, development and current practice of informed consent in the three jurisdictions identified for legal comparative purposes. Reference will be made to other jurisdictions where applicable. The discussion will include an evaluation of medical decision-making and informed consent.

The vital role of autonomy and self-determination in modern medical practice, as well as beneficence and the historic service and altruistic motivation generally associated with the medical profession, will be detailed in section 3.3. The concepts of autonomy, self-determination and beneficence will be discussed in the context of the rights and values contained in the Constitution of the Republic of South Africa, 1996, especially the Bill of Rights, as well as in the National Health Act 61 of 2003. The theories of Beauchamp on autonomy and beneficence in medical practice and the Pellegrino-Thomasma beneficence model will also be discussed in this section.

1.6.3. Chapter 4

Today, health care is increasingly seen as an ordinary commodity to be bought and sold in the medical marketplace and the doctor-patient relationship as an ordinary business relationship based on contract. This business model will be discussed in Chapter Four. The discussion will focus on whether this perspective on health service delivery — which is in stark contrast to the paternalistic approach to medical practice described in Chapter Three — can assist in ensuring a more equal distribution of power in the doctor-patient relationship.

The importance of trust in the doctor-patient relationship will also be considered with regard to the power imbalances identified in the relationship and in preparation for the discussion and analysis in Chapter Five, dealing with the fiduciary nature of the doctor-patient relationship. In this chapter, it will also be considered whether or not the business ethic in health service delivery has transformed the underlying reality of the traditional doctor-patient relationship.

1.6.4. Chapter 5

The unique qualities and dynamics of the doctor-patient relationship, as identified and discussed in Chapter 4, will be the point of departure in Chapter 5 which will deal with the distinctive fiduciary nature of this relationship. The doctor-patient relationship will first be analysed in terms of fiduciary principles and values, since it will be evident from the analyses of and references to case law that this relationship displays many hallmarks of a fiduciary relationship. In section 5.2. the legal content of the doctor-patient relationship as a fiduciary relationship will be considered. The concepts of trust, altruism, morality and justice will receive special attention, as well as the theories of Rainbolt and Dworkin. In section 5.3. the duties of the physician as the fiduciary and the patient as beneficiary will be considered. The chapter will conclude with an evaluation of the doctor-patient relationship as a fiduciary relationship.

1.6.5. Chapter 6

The continuing commercialisation of health service delivery, now organised and controlled in a manner similar to the corporate environment, necessitates that the institution-patient relationship be considered in addition to the traditional doctor-patient relationship. Section 6.1. will provide a limited account of the history and development of managed care initiatives in health care, including the development of medical schemes and health insurance plans, as well as definitions and clarifications of the most important terms and practices. Section 6.2. will provide an introduction to the most important managed health care organisations to illustrate how the delivery of health care services has evolved. An analysis of how these developments in health service delivery have influenced the doctor-patient relationship, specifically with regard to the distribution of power, will be given.

Trust in the doctor-patient relationship in a managed care era of health service delivery will also be considered in this chapter. The notion that managed care practices create a conflict of interest for medical practitioners in the doctor-patient relationship and may lead to an erosion of trust in that relationship will be investigated. It will be concluded that health care delivery is a moral endeavour, whether undertaken by an individual medical practitioner or an institution.

1.6.6. Chapter 7

While the main objective of managed care practices has been to contain and lower the escalating cost of health care, this has again risen rapidly in recent years. In this post-managed care era, market advocates are now endorsing consumer-directed health care which has at its aim to better inform patients (consumers) about health care spending in order to curb the escalating cost of health care services. It also provides consumers with more control and responsibility in medical decision-making by giving them incentives to consider both the cost and quality considerations when making a health care decision.

This chapter will focus on the critical role that patients, as consumers of health care services, can play in ensuring a more equal balance of power in the doctor-patient relationship. Another fundamental concern addressed in this chapter is whether or not it is appropriate to view patients as consumers in the medical marketplace. This question is closely linked to the distinctive characteristics of the doctor-patient relationship and the unique nature of medical practice described and commented on in the preceding chapters.

The chapter will conclude with commentary on and some recommendations for consumer protection and empowerment in the new era of health care delivery. The pivotal role of the medical practitioner in the doctor-patient relationship with regard to both consumer protection and empowerment will be emphasised.

1.6.7. Chapter 8

The objective of the final chapter is to concentrate on and answer the research question presented in section 1.3. The discussion will refer to selected arguments and analyses of previous chapters and a proposed re-conceptualisation of the doctor-patient relationship,

from a legal perspective, will be recommended to redress the power imbalances in the doctor-patient relationship.

PART A

In this part, the historical and social context of the doctor-patient relationship will serve as the foundation and framework of the discussion. Medical paternalism as an approach to health service delivery in general is also rooted in the historical development of medical practice and will therefore also form part of this particular part.

Chapter 2: **The historical development of the doctor-patient relationship and the culture of medical care**

Chapter 3: **Medical decision-making and the doctor-patient relationship in a paternalistic setting**

CHAPTER TWO: The historical development of the doctor-patient relationship and the culture of medical care

2.1. The historical development of the doctor-patient relationship

2.1.1. Primitive society

2.1.2. The Greek medical tradition (±600 – 100 B.C.)

2.1.3. Classical, medieval and early modern societies (1200 – 1600 A.D.)

2.1.4. Modern western societies (1700 – 1900 A.D.)

2.1.5. Postmodern societies

2.2. The culture of medical care

2.2.1. Professionalism and the regulation of the medical profession

2.2.2. Social roles and the doctor-patient relationship

2.2.2.1. The physician's role

2.2.2.2. The sick role

2.2.3. Professionalism, authority and the doctor-patient relationship

2.2.4. Power and the doctor-patient relationship

2.3. Conclusion

The history of medicine is a complex and multi-layered narrative; the result of various influences and perspectives. The commonly known history of the medical profession and science of medicine is founded in paleopathology, which is the study of human disease and ailments from the earliest civilisations to date.[75] Medical science has consequently always been concerned with disease and is mostly written from this point of view. Based on paleopathology, the history of medicine may be divided into three periods: the mythological period which refers to the period from the earliest times to about 400 BC; the dogmatic period or empirical age which dates from the Hippocratic period (around 400 BC) to the end of the eighteenth century; and the final period, the rational age in medicine, which refers to the period from the end of the eighteenth century to the beginning of the nineteenth century.[76] In this dissertation the paleopathological point of view on the history of medicine will not form the foundation of the discussion. Rather, the historical and social context of the doctor-patient relationship and societies' perceptions and attitudes towards the medical

[75] Carstens, Pieter and Pearmain, Debbie *Foundational Principles of South African Medical Law* LexisNexis: Durban 2007, 608.

[76] Carstens, Pieter and Pearmain, Debbie *Foundational Principles of South African Medical Law* LexisNexis: Durban 2007, 608.

profession will form the basis of this research. However, the history of medicine and the medical profession is also shaped by the perceptions and attitudes of societies towards the human body and the valuation of health and disease.[77] In addition to the various historical perspectives, one should therefore also take into account that most professions promote their historical development and formation, creating a legendary past which is usually not true to the authentic historical reality.[78] And for the medical profession, with its distinctly complex and multi-layered historical narrative, the authentic historical reality will depend on the particular point of view one chooses to adopt. The end result is therefore a composite of perspectives which, while mostly written from a medical point of view, clearly cannot be separated from its historical and particular social context.

The aim of this chapter will not only be to provide the necessary background to the historical development of the doctor-patient relationship, but also to highlight and elaborate on some distinguishing characteristics of the medical profession and the doctor-patient relationship. Important questions which this chapter will address include: Was the medical practitioner always regarded as a reputable physician? Has this profession always enjoyed a good standing amongst the general public? What is the status of this profession today? How has the relationship between doctor and patient changed? And fundamental for the purposes of this dissertation: what is the importance of this historical development of the doctor-patient relationship for the present culture of medical care?

2.1. The historical development of the doctor-patient relationship

Most sources on the history of the medical profession deal primarily with the science of medicine itself or approach the subject from a medical point of view.[79] Very few sources investigate and report on the historical development of this profession and the social dynamics between doctors and patients across time and civilisations. However, studies on the conditions of health and disease in any particular time and geographical area may provide some information on the historical development of the doctor-patient relationship and the medical profession. Everybody experiences disease and each society develops social

[77] Sigerist, Henry E The Physician's Profession through the Ages *Bulletin of the New York Academy of Medicine* Vol. IX, No. 12 December 1933.

[78] Sigerist, Henry E *Medicine and Human Welfare* Yale University Press: New Haven 1941, 105; Dormany, Thomas *Four Creators of Modern Medicine Moments of Truth* Wiley 2003, 1.

[79] Sigerist, Henry E *A History of Medicine* Oxford University Press: New York 1951, 4.

practices to respond to sickness and injury in ways that promote healing. Societies also construct disease and injury eventuations as socially meaningful phenomena, like illness, which refers to the individual's perception of a medical problem.[80] Not only is it necessary to understand the physician as a practitioner and decision maker in his/her historical and social context, but also what the position of the sick person was in that particular community and how disease was generally perceived.[81]

In the exposition that follows I will sketch the historical development of the doctor-patient relationship by looking at the general evolution of civilisations with regard to the diseases they were confronted with, whether and how they reacted against these and also the role of the sick person and the medical practitioner in that particular context. Reference is specifically made to "civilisations" thereby to indicate that I will be dealing only with the concept of modern, western medicine throughout this dissertation and will not discuss other cultures with their alternative medical practices – for there are many. Only the general practice of medicine will furthermore be discussed, and not the historical development of specialisation areas in medicine, like psychiatry and surgery. Lastly, exceptional doctor-patient relationships, such as the relationship between specialist medical practitioners and the mentally ill, will also not be discussed. The exposition will be limited to serve the aim and objectives of this dissertation and it is not an attempt to provide a comprehensive account of how medicine has evolved and changed across pre- and recorded history.

2.1.1. Primitive societies[82]

Sickness and healing was initially family- and small-group oriented and medical knowledge was not systematized. During the Paleolithic period any form of social organization was extremely limited. Only one household lived and worked together to gather food and complete other tasks necessary for daily survival. The eldest member of such a family was

[80] Sickness refers to the social construct of a condition of illness, and disease or pathology refers to the existing physical or organic condition. Fàbrega, Horacio Jr *Evolution of sickness & healing* University of California Press: Los Angeles 1999 3, 32.

[81] Sigerist, Henry E *A History of Medicine* Oxford University Press: New York 1951, 15.

[82] Section 2.1.1. is based on a reading of Sigerist, Henry E *A History of Medicine* Oxford University Press: New York 1951, especially pages i to 51 and chapter one, *The Genesis of Medicine* and chapter two, *The First Known Medical Men*.

trusted and respected and acted as advisor, priest, magician and physician. Any illnesses were dealt with according to the directions of this family member and with the limited and primitive resources available. However, despite this important medical role which the eldest of a family played in the family's survival, he/she did not have any special position in the family structure. Furthermore, the diagnosis, prognosis and treatment were solely based on the transcendental beliefs of the household as well as their general expertise with diseases and treatment thereof.

The Neolithic period that followed was probably one of the most important evolutions of civilization as we know it today. Communities developed with more families living together or in closer proximity to one another, compared to the Palaeolithic period. The social life of communities became more complex: a food-producing economy rather than a food-gathering mindset developed, improved tools and housing emerged, and domestic arts and crafts developed. The communities were able to protect themselves more efficiently from dangers and forces of nature and the supply of food also improved. The Neolithic civilization was also confronted with disease and other ailments and due to its communal nature, also contagious diseases. Communities' perception of disease, where it came from and how to treat it was also very primitive and based on their particular beliefs, transcendental ideas as well as their general expertise with illnesses and treatment thereof. Although this knowledge was more specialised, medicine was still not regarded as a profession and the knowledge remained unsystemised. It is interesting to note that serious illnesses in this period were usually explained in terms of the magical or religious beliefs of the group or regarded as a consequence of the individual's or his/her family's behaviour. This contributed to the notion of disease as a social sanction. The physician was usually a wise and elderly person from the particular community or surroundings and there were more possible agents with the required knowledge to diagnose and treat illnesses than in the Paleolithic period. Such wise men also acted as priests, magicians and advisors of the community. They were paid according to the success of the treatment but were still not elevated to any special position.

The sick also had no special position in this society. They were treated with domestic remedies, without isolating them from the community.[83] In the case of serious illnesses however, the sick role was expanded. The sick person received a special position in society based on his/her condition and the society's attitude towards the particular disease.[84] Such a seriously ill person could not contribute to the normal day to day activities and tasks, which were of great importance and necessary for the group's day to day survival. Such a patient found him- or herself isolated from the community and a burden on the immediate family. Literature suggests that the sick person in this civilization was usually eliminated if the social economy of the particular community could not sustain him/her any longer or if the fear of the particular disease and the patient's condition warranted the action. In some cultures the sick, aged and crippled were killed in the name of respect and compassion – mercy killings.

Pre-state and state societies had a higher level of social organisation and systemised knowledge, the number of physicians increased and so did the level of competition among them. Although it is impossible to indicate when the practice of medicine ceased to be primitive, it was the systemisation of knowledge which was largely responsible for the advancement of the practice as a profession.[85] The recorded history of medicine can be traced back to about 3200 BC, when Egyptian physicians assembled medicine compounds from written instructions.[86] The Code of Hammurabi from 2000 BC in Babylon is an example of the early systemisation of the practice of medicine and is regarded as the oldest rule book of the profession. It is interesting to note that this code was the first to define the civil and criminal liability of members of the medical profession.[87]

[83] Sigerist, Henry E *A History of Medicine* Oxford University Press: New York 1951, 154.
[84] Sigerist, Henry E *A History of Medicine* Oxford University Press: New York 1951, 154.
[85] The word "profession" stems from the Latin *professio*, a public oath of fealty or turning over one's obedience and loyalty to another.
[86] Broekmann, Reginald J *Power in the Physician-patient Relationship* Thesis presented in partial fulfillment of the requirements of the degree M Phil (Applied Ethics) at Stellenbosch University March 2000 (Supervisor: Prof AA van Niekerk), 6.
[87] Inglis, Brian *A History of Medicine* Weidenfeld and Nicolson: London 1965, 13; Broekmann, Reginald J *Power in the Physician-patient* Relationship Thesis presented in partial fulfillment of the requirements of the degree M Phil (Applied Ethics) at Stellenbosch University March 2000 (Supervisor: Prof AA van Niekerk), 6.

2.1.2. The Greek medical tradition (±600 – 100 BC)

When considering the historical development of the medical profession, most medical practitioners look back to the Greek medical tradition and the era of Hippocrates as the legendary foundation and origin of a humble profession. But, it seems as though "*we tend to look back at Greek medicine through the distorting lens of legend*."[88] The Greek physician can be described as a craftsman, wandering from door to door and offering his services.[89] Only the large cities had their own doctor(s) employed in the city service. Wandering physicians had to win a community's trust with their appearance and their ability to make a correct diagnosis without even asking the patient any questions or physically examining him or her. Patients came or were brought to a central spot in the town or city and there was relatively little privacy and confidentiality between doctor and patient. Although the Greek physician did not have any important status — since the Greeks despised people who worked for money — the physician was highly esteemed, mainly because of the attitude of the Greeks towards the human body and the importance which was placed on good health.[90] Although the empirico-rational approach, which relies more on naturalistic observations enhanced by a practical trial and error experience, gained acceptance during this period, most Greek physicians, like their predecessors, also had a superstitious approach to healing.[91] Asclepius was the Greek god of healing.[92] Asclepius had two daughters: Panacea, who was the goddess of healing (today referred to as clinical medicine) and Hygeia, (health or hygiene) who was the goddess of good health and preventive medicine.[93] According to literature Hygeia's teaching required people to eat less, drink less, smoke less, fornicate less, avoid excess and exercise prudently or they would fall into the

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[88] Bloom, Samuel W *The doctor and his patient: A sociological interpretation* Russell Sage Foundation NY: USA 1963, 85.

[89] Sigerist, Henry E The Physician's Profession through the ages *Bulletin of the New York Academy of Medicine* Vol. IX, No. 12, December 1933, 664.

[90] Sigerist, Henry E The Physician's Profession through the ages *Bulletin of the New York Academy of Medicine* Vol. IX, No. 12, December 1933, 665; Sigerist, Henry E *Medicine and Human Welfare* Yale University Press: New Haven 1941, 114.

[91] Kaba, R & Sooriakumaran, P The evolution of the doctor-patient relationship *International Journal of Surgery* (2007) 5, 57 – 65, 58.

[92] Lawson, Russell M Medicine in Science in the Ancient World: Any Encyclopedia Santa Barbara, CA: ABC-CLIO http://www.credoreference.com.ez.sun.ac.za/entry/7921350 [Accessed on 4 October 2008].

[93] Staum, Martin S 7 Larsen, Donald E (eds) *Doctors, Patients and Society: Power and Authority in Medical Care* Wilfrid Laurier University Press: Canada 1981, 198.

hands of Panacea, Hygeia's sister, and her physicians. Hygeia's teaching is very similar to notions of preventive medicine which is a main focus of current day health care services.[94] Hippocrates, who is said to have lived from 460 to 361 BC, was by far the most important figure in Greek medicine. It is believed that Hippocrates was responsible for the eradication of medical beliefs based on magic or religious philosophies, for establishing the first systematic differentiation of diseases and for setting up standards for doctors, later referred to as the Hippocratic Oath.[95] However, very little is known of Hippocrates and it is doubted whether all the writings attributed to him were actually his own work. But he remains an important figure in medical history and the writings (a collection of about 50 – 70 essays and texts) have made a tremendous contribution to the development of western medical science, especially with regard to the doctor-patient relationship.[96] Dignity in medicine and respect for patients were, for example, advocated in these texts and the greatest objective for the physician was also described as the benefit his/her actions would have for the patient.[97]

The wandering Greek physicians were also present and sought-after in Rome, where the first physicians were slaves with a very primitive conception of medical science. In Rome, as in Greece, the profession of a physician was also not very highly regarded.[98] However, it was in Rome that the physicians were in time afforded extensive privileges. In 46 BC Julius Caesar granted all free-born Greek physicians on Roman soil the right to Roman citizenship. Physicians were exempt from taxes, compulsory military service and from taking in lodgers. Systems were also put in place to regulate these physicians and, depending on its size, only a limited number of physicians were granted these privileges in each city. To attain this

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[94] See the discussion in Chapter Six with regard to the objectives of managed health care practices.

[95] The original version of the Hippocratic Oath is also no longer used in medical faculties. The Oath requires of graduates to swear by pagan gods like Apollo, Asclepius and Panaceia. It requires those who take the oath to share their wealth with their professors and adopt their professors' children; not to practice surgery and not to assist in abortive remedies. The purpose of the oath is explained in the final sentence: if the oath is fulfilled and honoured the practitioner will be honoured with fame. http://www.pbs.org/wgbh/nova/doctors/oath_classical.html [Accessed on 3 September 2008].

[96] The *Corpus Hippocraticum* is the first set of Western writings about medical professional conduct.

[97] Inglis, Brian *A History of Medicine* Weidenfeld and Nicolson: London 1965, 25-29; Magner, Lois N *A History of Medicine* New York Marcel Dekker Inc, 1992; See chapter 3 for a discussion on the effect that this principle of beneficence has on the dynamics of the doctor-patient relationship.

[98] Sigerist, Henry E The Physician's Profession through the ages *Bulletin of the New York Academy of Medicine* Vol. IX, No. 12, December 1933, 666; Sigerist, Henry E *Medicine and Human Welfare* Yale University Press: New Haven 1941, 115; Carstens, Pieter and Pearmain, Debbie *Foundational Principles of South African Medical Law* LexisNexis: Durban 2007, 611.

status, physicians had to prove that they possessed the required medical knowledge.[99] In addition to this first version of a licence system for physicians and state control of this profession, the first medical societies were also established in Rome, and at the end of the empire, medical specialists were recognised.[100] Galen of Perganum (130 A.C. – 200 AC), a follower of Hippocrates, is regarded as the most important Roman physician.[101] By the time of the fall of the Roman Empire medical knowledge was more elaborate, specific, conceptually organized and systematized than ever before. Physicians also had more prestige and power.[102]

2.1.3. Classical, medieval and early modern societies (1200 – 1600 AD)

The following general developments during the period between 1200 – 1600 AD are noteworthy for the purposes of this limited exposition of the historical development of the medical profession: improved literacy, the further systematisation and standardisation of social practices, more economic activity, the production of knowledge, the spread of new diseases from other parts of the world, plagues,[103] an increased lifespan and the growth of science and technology.[104] However, after the demise of the Roman Empire religious and mystical approaches to the practice of medicine were again the order of the day. During the Middle Ages the principles of Greek medicine were still applied but the element of religion was stronger than before.[105] In the early Middle Ages most physicians were monks and all physicians were directed by the church.[106] The profession of the physician was regarded as a

[99] Sigerist, Henry E The Physician's Profession through the ages *Bulletin of the New York Academy of Medicine* Vol. IX, No. 12, December 1933, 666.

[100] Sigerist, Henry E The Physician's Profession through the ages *Bulletin of the New York Academy of Medicine* Vol. IX, No. 12, December 1933, 667, 673; Sigerist, Henry E *Medicine and Human Welfare* Yale University Press: New Haven 1941, 116.

[101] Lawson, Russell M Medicine in Science in the Ancient World: Any Encyclopedia Santa Barbara, CA: ABC-CLIO http://www.credoreference.com.ez.sun.ac.za/entry/7921350 [Accessed on 4 October 2008].

[102] Fàbrega, Horacio Jr *Evolution of sickness & healing* University of California Press: Los Angeles 1999, 102.

[103] In 1354 a Genoese ship brought the plague (yersinia pestis) to Europe. This permanently changed the social structure of Europe. Mayeaux, EJ A History of western medicine and surgery http://lib-sh.lsuhsc.edu/fammed/grounds/history.html [Accessed on 30 May 2007].

[104] Fàbrega, Horacio Jr *Evolution of sickness & healing* University of California Press: Los Angeles 1999, 112.

[105] Sigerist, Henry E The Physician's Profession through the ages *Bulletin of the New York Academy of Medicine* Vol. IX, No. 12, December 1933, 670.

[106] Sigerist, Henry E The Physician's Profession through the ages *Bulletin of the New York Academy of Medicine* Vol. IX, No. 12, December 1933, 668.

vocation, a divine mission with definite duties towards God and fellowmen.[107] The position of the sick person and the physician was profoundly changed by Christianity.[108] Christianity appealed to the sick and promised healing, both spiritually and physically.[109] Hospitals were built, like the hospital in Asia Minor by St Basil in Caesarea 362 AC, and convents and monasteries were devoted to caring for the sick.[110] Healing was grace, science was subordinate to theology and the experience of cure became spiritual for both the sick person and the physician. Women also started to play an increasingly important role by assisting in hospitals and other institutions devoted to health care.[111] (It was only much later, during the nineteenth century, that nursing was transformed from a religious to a secular vocation, especially due to the influence of Florence Nightingale who lived from 1820 to 1910 and who raised public awareness for the importance of nursing as a vocation.)[112]

Furing the late tenth century the first medical faculty in the occidental world was established in Salerno, Italy, followed by the institution of universities all over Europe and the establishment of an elitist academic tradition of medicine and the early professionalization of medicine.[113] From here on, the physician was a scholar and a doctor and has been so ever since.[114] Physicians had a shared social identity and started to form distinctive groups differentiated as to their mode of training.[115] The profession was also

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[107] Sigerist, Henry E The Physician's Profession through the ages *Bulletin of the New York Academy of Medicine* Vol. IX, No. 12, December 1933, 671; Sigerist, Henry E *Medicine and Human Welfare* Yale University Press: New Haven 1941, 119.
[108] Sigerist, Henry E The Physician's Profession through the ages *Bulletin of the New York Academy of Medicine* Vol. IX, No. 12, December 1933, 667.
[109] Sigerist, Henry E The Physician's Profession through the ages *Bulletin of the New York Academy of Medicine* Vol. IX, No. 12, December 1933, 667.
[110] Some sources indicate that the hospital was actually built in 370 A.C. and not 362 A.C.; Peppin, John F Business Ethics and Health Care: The Re-Emerging Institution-Patient Relationship *Journal of Medicine and Philosophy* Vol 24, No 5 (1999) 535 – 550, 539.
[111] Inglis, Brian *A History of Medicine* Weidenfeld and Nicolson: London 1965, 58.
[112] Millar, D & Millar, I & Millar, J & Millar M *The History of Medicine* in *The Cambridge Dictionary of Scientists* Cambridge: Cambridge University Press http://www.credoreference.com.ez.sun.ac.za/entry/5714410/ [Accessed on 4 October 2008].
[113] The first medical school was established in Alexandria in the time of Hierophilus and Erasistratus, but no written records of this school remained and the medical faculty of Salerno is therefore generally regarded as the first; Inglis, Brian *A History of Medicine* Weidenfeld and Nicolson: London 1965, 67.
[114] Sigerist, Henry E The Physician's Profession through the ages *Bulletin of the New York Academy of Medicine* Vol. IX, No. 12, December 1933, 671; Fàbrega, Horacio Jr *Evolution of sickness & healing* University of California Press: Los Angeles 1999, 114.
[115] Fàbrega, Horacio Jr *Evolution of sickness & healing* University of California Press: Los Angeles 1999, 119.

commercialized to a certain extent and subjected to even more state regulation.[116] The nature of medical knowledge and the economic contingencies of healing created a culture and society in which sickness and healing were more prominent.[117] Medical licensure also became a permanent institution at the beginning of the Middle Ages and the establishment of universities and medical faculties.[118] The writings of Henri de Mondeville (ca 1260 – 1325), a medieval surgeon and teacher of anatomy, can here be singled out as significant. Mondeville overtly embraced the beneficence model in fully accepting traditional Hippocratic authoritarianism.[119] He also believed that patients should obey their physicians at all times and that the deception of a patient was justified if it was for the benefit of the patient's health.

Although the Renaissance and seventeenth century is characterised by enlightenment and scientific curiosity, it was relatively uneventful with regard to the development of the medical profession, and magical and religious beliefs again influenced medical techniques and thoughts. However, dissatisfaction with traditional theories paved the way for new insights and development.[120] The eighteenth century saw great advancements in the area of preventative medicine (inoculations) as well as mental health.[121]

2.1.4. Modern western societies (1700 – 1900 AD)

During the rise of capitalism and with an increased emphasis on economics, which started already during the late 16th century, the medical profession became a means to earn a living. This, together with the rise of democracy at the end of the eighteenth century and the great advances in medical research and technology during the nineteenth century revolutionised medical service. The nineteenth century saw the development of the germ theory of disease and the discovery of anaesthesia. Improved sanitation curbed the horrors

[116] See Chapter Four for an analysis of the commercialisation of health service delivery. The analysis is limited to the ambit of the dissertation's research question and the context of the power imbalances in the doctor-patient relationship.
[117] Fàbrega, Horacio Jr *Evolution of sickness & healing* University of California Press: Los Angeles 1999, 132.
[118] Sigerist, Henry E *Medicine and Human Welfare* Yale University Press: New Haven 1941, 127.
[119] Faden, Ruth R & Beauchamp, Tom L *A History and Theory of Informed Consent* Oxford University Press: NY 1986, 63.
[120] Inglis, Brian *A History of Medicine* Weidenfeld and Nicolson: London 1965, 96-103.
[121] Inglis, Brian *A History of Medicine* Weidenfeld and Nicolson: London 1965, 111-117.

of the infectious diseases of the Middle Ages.[122] Chronic diseases of affluence, like obesity and heart disease, started to emerge. Advances in medical technology and changes in the prevailing diseases of the time are very important since the relationship between doctor and patient is very closely related to the model of illness that dominates at any given period in history.[123] By this stage, medical service had changed to such an extent that the humble beginning of this profession in the Paleolithic period was hardly recognisable, although some characteristics of primitive society's concept of medicine remained in our modern society as superstitions.[124]

Medical concepts were universalised and secularised during this period and cultural, political and economic advances as well as social developments influenced the development of medical science. The medical profession emerged as the dominant profession and was accorded great social prestige. The profession was also unified, formalized and organised with appropriate regulations enforced. Medical knowledge was controlled by the physician and sponsored by the state. The doctor-patient relationship during this period can be described as socially and emotionally distant, impersonal with the physician as an authoritarian and the patient in a sub-ordinate position.[125] During this period, health was still regarded only as the absence of disease; the focus on preventative medicine only emerged in postmodern society.

2.1.5. Postmodern societies

Medical service in the postmodern society of today is characterized by escalating cost, pervasive medicalisation, increased abilities and knowledge, the expansion of sickness definitions to include morale, stress, appearance and various psychological states, prolonged life, commercialisation, more personal responsibility for both the physician and the patient, commoditisation, the vulnerability of both the physician and patient in the medical marketplace, consumerism, distrust, increased state regulation and also managed

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[122] Swedin, Eric G *Medicine* in *Science in the Contemporary World: An Encyclopedia* Santa Barbara, CA: ABC-CLIO http://www.credoreference.com.ez.sun.ac.za/entry/0818288/ [Accessed on 4 October 2008].

[123] Kaba, R & Sooriakumaran, P The evolution of the doctor-patient relationship *International Journal of Surgery* (2007) 5, 57 – 65, 59.

[124] Sigerist, Henry E *Medicine and Human Welfare* Yale University Press: New Haven 1941, 111.

[125] Fàbrega, Horacio Jr *Evolution of sickness & healing* University of California Press: Los Angeles 1999, 135-137; This paternalistic approach to health service delivery will be discussed in Chapter Three of this dissertation.

care.[126] Health in the postmodern society is actively sought, with the main focus on prevention while death is regarded as a manageable eventuation. The doctor-patient relationship can be described as a partnership. Medical intervention in the absence of disease is also common.[127]

It is clear from this short exposition that although the physician's primary task has remained the same throughout history – i.e. to treat and prevent illness and disease – the physician's position in society is always determined by society itself and by the economic and social structure as well as the available technical and scientific means of that time.[128] The physician's success or failure depends on the response of society, and the responsiveness of society depends on social, economic, religious, philosophical and political factors. [129] It can be concluded that medicine is a social institution constructed around sickness and healing.[130] And at all times through the evolution of civilisations the physician's profession provided him or her with power.[131] It has therefore always been necessary to regulate the medical profession and prevent and manage the potential misuse of this power by setting definite standards.

But of what importance is the historical development of the medical profession and the tremendous strides medical science has made for the present culture of medical care? How can it help one to better understand the unique relationship between doctor and patient? In section 2.2. I will discuss particular concepts noted in this section in order to better describe and define the doctor-patient relationship, to comment on the roles of the parties involved and to identify the most important characteristics of this relationship. This section is

[126] See Chapters Four, Six and Seven; Fàbrega, Horacio Jr *Evolution of sickness & healing* University of California Press: Los Angeles 1999, 137-138.
[127] The doctor-patient relationship in this postmodern context will form the basis of the discussion in Chapters Four, Six and Seven.
[128] Sigerist, Henry E The Physician's Profession through the ages *Bulletin of the New York Academy of Medicine* Vol. IX, No. 12, December 1933, 676; Sigerist, Henry E *Medicine and Human Welfare* Yale University Press: New Haven 1941, 106.
[129] Sigerist, Henry E *Medicine and Human Welfare* Yale University Press: New Haven 1941, 109; Fàbrega, Horacio Jr *Evolution of sickness & healing* University of California Press: Los Angeles 1999, 14.
[130] Fàbrega, Horacio Jr *Evolution of sickness & healing* University of California Press: Los Angeles 1999, 30.
[131] Sigerist, Henry E The Physician's Profession through the ages *Bulletin of the New York Academy of Medicine* Vol. IX, No. 12, December 1933, 663.

important since the concepts identified here will be discussed in all the approaches of health service delivery which will be introduced in the chapters to follow.

2.2. The culture of medical care

The culture of medical care refers to the general nature of the medical profession and practice, as well as those unique and distinguishing characteristics of health care service which form the foundation of the doctor-patient relationship. The aim of the discussion in this section is to identify and discuss these distinguishing features in order to provide a better understanding of this unique doctor-patient relationship and also to establish a foundation for further discussion in Chapters Three to Seven.

The first concept to be discussed is professionalism and the regulation of medical practice. It is important to understand how a profession differs from any other occupation and how the distinguishing feature of professionalism in medical practice and the ensuing power of members of this profession influence the doctor-patient relationship. The roles of the physician and patient in the doctor-patient relationship will be examined in section 2.2.2. The medical anthropological theories of the physician's role and the sick role illustrate how each of these role players is perceived and what functions and behaviour is attributed to each. These roles form the foundation of the doctor-patient relationship. Section 2.2.4. will provide an in-depth investigation of the influences of professionalism and autonomy on the doctor-patient relationship and in section 2.2.4, the concepts "power" and "authority", as natural consequences of professionalism and self-regulation, will be discussed in the context of the doctor-patient relationship. The chapter will conclude with a clarification of the importance of the historical development of medical practice and the culture of medical care.

2.2.1. Professionalism and the regulation of the medical profession

Professionalism has not always been a distinguishing feature of the medical fraternity, but dates back to medieval times.[132] It was in the medieval university where the title of doctor

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[132] The earliest use of the term "profession" dates from 1453 according to the Oxford English Dictionary; Katz, Jay *The Silent World of Doctor and Patient* Johns Hopkins University Press: Baltimore (2002) 32.

was created.[133] During the twelfth century provision was made for regulations on curricula, state examinations, licenses, fee structures etc.[134] With the title and state of professionalism came status in society, education and important affiliations in organisations. The professionalisation of medicine has, however, also been described in terms of the dominance members of this profession have over the health care system, also referred to as a strategy of occupational control and limitation over its members and the occupation's resources, knowledge and skill.[135] The unequal relationship between doctor and patient is another source of power or dominance for this profession: The patient needs assistance with the most valued attribute in life, namely health, while the doctor is regarded as the most important and knowledgeable provider to assist with this particular need. The professionalisation of medicine, the ensuing power of the profession and the needs of vulnerable patients, together with the subject matter – the universally valued quality of health - therefore necessitates some form of state regulation in addition to the profession's self-regulation.

It is necessary to understand what is meant by the distinctive category called professions. The word "trade" is etymologically derived from Germanic and Anglo-Saxon noun roots, "footstep" or "track", derivatively meaning the course, manner or way of life; a regular habitual course of action. The word "profession", on the other hand, can be traced to an act of self-conscious and public – even confessional – speech.[136] A profession would therefore be an activity or occupation to which its practitioner publicly professes his/her devotion. Since the 1970s historians have defined a so-called profession as either a highly ethical agent of the community or as a vehicle of monopoly and self-interest.[137] This has resulted in three approaches to professionalism. The normative approach suggests that the high ethical standards associated with such a group and their highly developed ethical code are

[133] Bloom, Samuel W Chapter 3: *The doctor and his patient: A sociological interpretation* Russell Sage Foundation NY:USA 1963, 86.
[134] Bloom, Samuel W Chapter 3: *The doctor and his patient: A sociological interpretation* Russell Sage Foundation NY:USA 1963, 86.
[135] Harrington, John A Between the state and civil society: Medical discipline in Tanzania *Journal of Modem African Studies* Vol 37 No 2 (1999) 207 – 239, 211.
[136] See the discussion in Chapter Four with regard to the business model of health service delivery and the distinction between a trade and a profession; Kass, Leon R Medicine: Profession or Trade? *Medicine on the Midway* Spring 1989, 8 – 11, 8.
[137] Loeb, Lori Doctors and Patent Medicines in Modern Britain: Professionalism and Consumerism *Albion: A Quaterly Journal Concerned with British Studies* Vol 33, No 3 (2001) 404-425, 404.

indicators that a particular occupation can be classified as a profession.[138] However, there are two objections against the identification of professions according to this approach: Not only does it make the profession's evaluation of itself definitive, but it also fails to provide for a very good solution to differentiate between professions and other occupations, since most occupations already have some sort of ethical code or code of conduct.[139] The trait approach provides an alternative to this narrow focus by submitting that a unique combination of a range of characteristics makes an occupation a profession.[140] But what should these characteristics or traits be? Can consensus be reached? Even in the area of health service delivery numerous occupations, among them nursing, chiropody and homeopathology claim to be professions. This alone is a clear indication that uncertainty within the profession itself with regard to the particular traits and characteristics necessary to establish a profession will be conclusive in an investigation of professionalism in medical practice. The third approach, the occupational approach, is closely related to the above submission. This approach focusses on the highly desired status of professionalism. Many occupations claim to be professions or try to attain this status. This status will not only raise the standing of the members of the profession in the eyes of the public and other occupations, but will also provide the particular occupation with more control and power. For example, control over the medical marketplace, power over their clients and control over their rewards as well as the entry and exit regulations of their occupation. According to the occupational approach, professionalism is a mode of occupational control *"A profession is not, then an occupation but a means of controlling an occupation"*.[141]

Based on these three approaches I believe one can conclude that the practice of medicine is a profession. Medical practitioners do not only have high ethical standards and a code of conduct dating back to the Hippocratic Oath, but their occupation also displays a unique range of characteristics which certainly makes it distinguishable from others. One of the

[138] Moran, Michael & Wood, Bruce *States, Regulation and the Medical Profession* Open University Press: Buckingham 1993, 24.
[139] Moran, Michael & Wood, Bruce *States, Regulation and the Medical Profession* Open University Press: Buckingham 1993, 24.
[140] Moran, Michael & Wood, Bruce *States, Regulation and the Medical Profession* Open University Press: Buckingham 1993, 25.
[141] Moran, Michael & Wood, Bruce *States, Regulation and the Medical Profession* Open University Press: Buckingham 1993, 25; Johnson, T *Professions and Power* Macmillan: London 1972, 45; Montgomery, Jonathan Medicine, Accountability and Professionalism Journal of Law and Society Vol 16, No 2 (1989) 319 – 339.

core characteristics of a profession is the required extended formal training of its members. This is regarded as the cornerstone of professionalism: professions are occupations which have a monopoly on an esoteric and difficult body of knowledge.[142] This body of technical knowledge is not accessible to lay persons and can not be applied mechanically.[143] A second characteristic is the occupation's orientation of service towards the community and the functional specificity of its members. Altruism is central to the ideology of professionalism and specifically to the medical profession.[144] The concept of altruism in the medical profession is safeguarded by the ancient command of *primum non nocere* – above all, do no harm.[145] The members of this profession also form a distinct social group based on their professional activity and the social group is then organised into an association with formal rules and informal practices. The association disciplines its own members, thereby securing their independence, and also determines its own standards of education, ethical codes, licensing, admission, norms of practice and other matters of control and regulation. Every physician is not only trained in the skills and knowledge of his/her profession but also in its values and attitudes. This is also referred to as the socialisation of the medical student in the particular culture of the medical profession. There is a high degree of integration of the doctor into his/her profession and the physician is consequently extremely dependent on the professional group.[146] The members are relatively free from lay evaluation and control and due to the profession's high income, power and prestige ranking, it can demand a higher caliber of students for training.[147] Finally, as regards the occupational approach, the medical profession is certainly an excellent example of a profession with extensive self-regulatory powers. Some of these powers are licensing that allows the profession to maintain a virtual monopoly on the right to provide health care services; practice etiquette

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[142] Katz, Jay *The Silent World of Doctor and Patient* Johns Hopkins University Press: Baltimore (2002) 88; Montgomery, Jonathan Medicine, Accountability, and Professionalism *Journal of Law and Society* Vol 16, No 2 (1989) 319 – 339, 326.

[143] Montgomery, Jonathan Medicine, Accountability, and Professionalism Journal of Law and Society Vol 16, No 2 (1989) 319 – 339, 326.

[144] Katz, Jay *The Silent World of Doctor and Patient* Johns Hopkins University Press: Baltimore (2002) 89.

[145] Katz, Jay *The Silent World of Doctor and Patient* Johns Hopkins University Press: Baltimore (2002) 93; See Chapter Three, section 3.3. for a comprehensive discussion on the principle of beneficence and the doctor-patient relationship.

[146] Bloom, Samuel W Chapter 3: *The doctor and his patient: A sociological interpretation* Russell Sage Foundation NY: USA 1963, 78.

[147] Bloom, Samuel W Chapter 3: *The doctor and his patient: A sociological interpretation* Russell Sage Foundation NY: USA 1963, 88-89.

and rules that discourage overt or public criticism limits competition between practitioners, and the profession's own disciplinary guidelines and procedures.

The particular nature of medicine as an occupation makes the status of professionalism a necessity. Medical practitioners are entrusted with very personal information about their patients. In many cases they are entrusted with the patients' life. Patients on the other hand are vulnerable and in need of assistance with the most important aspect of their life, their health. Medicine is an intrusive and intimate business, a unique and private affair between doctor and patient, the nature of professionalism assists in the justification of the nature of the profession's functional specificity.[148]

As a result of this professionalisation of medicine and the ensuing power and control, as well as the comprehensive methods of self-regulation which the profession exhibits, external regulation of the profession's extensive authority is also necessary and important. The exposition on the historical development of the doctor-patient relationship in section 2.1 clearly showed how dependent the profession's external regulation is on the historical and social context of a particular state and that history, political institutions, assumptions about the role of medicine and the significance of medicine itself in any particular society all reflect distinct national/state experiences. Thus, although the scientific heritage of medicine is shared across all boundaries, the role of the medical profession and its regulation has a national character. External attempts to regulate a profession are significant since such warranted attempts to intervene will only be found in professions whose functional specificity is such that it is vitally important for society to ensure that self-regulation is complemented by external regulation.

State regulation of the profession usually deals with the remuneration of the profession's members, market entry and exit control, the control of competitive practices and also market organization.[149] Although such regulations may be viewed as a restriction on the profession and as patient centered, they actually provide opportunities of control for the

[148] Moran, Michael & Wood, Bruce *States, Regulation and the Medical Profession* Open University Press: Buckingham 1993, 25.
[149] Moran, Michael & Wood, Bruce *States, Regulation and the Medical Profession* Open University Press: Buckingham 1993, 25.

profession. For instance, controlling competitors and organizing the labour market may serve the doctors' interests rather than the patients'. The medical profession also acquires much of its power and authority from the state and through state regulation. The state establishes and maintains the profession's dominance and professionalism. This self-regulation is achieved with the agreement of the state because it is argued that models of comprehensive external regulation, like state regulation, are not suitable for a profession since the discretion such professional judgement requires falls beyond the understanding of those outside the profession.[150] Another argument in favour of extensive self-regulation is that it will ensure accountability to peers and that such peer pressure will result in higher standards.[151] These arguments are based on three premises:

- medical practice is based on a body of technical knowledge which is not readily accessible to lay persons;
- this knowledge cannot be applied mechanically because every patient is different; and finally
- due to the first two claims medicine is an indeterminate process and it is impossible to lay down rigid rules to govern its application and that special skills of interpretation are therefore needed.[152]

Although a degree of self-regulation is certainly warranted for professions it is doubtful whether self-regulatory methods are really effective. Freidson submitted that it is actually due the profession's comprehensive autonomy that the self-regulatory methods of the profession is failing, since autonomy results in a self-deceiving vision of the objectivity and reliability of the profession's knowledge and the virtues of its members.[153]

Even in the sphere of the law the medical profession has succeeded in having its own standards accepted and its self-regulatory attempt at disciplinary action extended. In South

[150] Moran, Michael & Wood, Bruce *States, Regulation and the Medical Profession* Open University Press: Buckingham 1993, 26; Davies, Mark *Medical Self regulation: Crisis and change* Ashgate Publishing 2007, 5.
[151] Davies, Mark *Medical Self regulation: Crisis and change* 2007 Ashgate Publishing, 11.
[152] Montgomery, Jonothan Medicine, Accountability and Professionalism *Journal of Law and Society* Vol 15, No 2, 1989 319-339.
[153] Wolinsky, Fredric D The professional dominance perspective, revisited *The Milbank Quaterly* Vol 66, Supplement 2: The changing character of the medical profession (1988) 33-47, 37.

African[154] and English law[155], as well as the law of the United States of America[156], (in this dissertation these three jurisdictions will primarily be considered, with reference to other jurisdictions where relevant) it is generally accepted that the primary test in judging whether a medical practitioner has been negligent is one which measures a doctor's actions against the standards of his/her peers. A doctor will only be found guilty of negligence if it can be proved that he/she did not act in accordance with the accepted standards of practice. These standards against which all action is measured are determined by members of the medical profession – doctors, in other words, set the legal standard of care.

Whether comprehensive self-regulation and sanctioned state regulation are regarded as justified and an ordinary characteristic of professionalism or as an enforcement of the profession's monopoly over health services and as a source of unwarranted power, it seems clear that the root of the profession's power certainly lies in its status and the ensuing occupational control.[157] Another source of power for the medical profession is the unique doctor-patient relationship itself. As stated previously, the patient is in need of assistance with the most valued attribute in life, health, while the doctor is regarded as the most important and knowledgeable provider to meet this particular need. The patient is a vulnerable and dependent agent in this relationship.

The distinguishing features of the medical profession and the doctor-patient relationship discussed in this section clearly show that a profession embodies the institutionalisation of various role relationships between itself and other sections of society.[158] The medical profession can therefore be described as a type of social institution, teaching and regulating the norms – patterns of prescribed behaviour - which are conveyed through medical faculties, hospitals and the profession itself. A discussion of these role relationships

[154] *Richter and another v Estate Hammann* 1967 (3) SA 226 (C) ; *Esterhuizen v Administrator, Transvaal* 1957 (3) SA 710 (T); *Van Wyk v Lewis*1924 AD 438 at 444; *Broude v McIntosh and others* 1998 (3) SA 60 (SCA) ; *Castell v De Greef* 1994 (4) SA 408 (C) ; *Louwrens v Oldwage* 2006 (2) SA 161 (SCA).

[155] *Bolam v Friern Hospital Management Committee* [1957] 1 W.L.R. 582; *Sidaway v Bethlem Regional Health Authority* [1985] A.C. 871; *Gold v Haringey* [1988] Q.B. 481.

[156] *Canterbury v Spence* (1972) 464 F.2d 772 (D.C. Cir. 1972).

[157] Moran, Michael & Wood, Bruce *States, Regulation and the Medical Profession* Open University Press: Buckingham 1993, 136.

[158] Bloom, Samuel W Chapter 3: *The doctor and his patient: A sociological interpretation* Russell Sage Foundation NY: USA 1963, 90.

between the profession and the society, more specifically the physician's as well as the sick role will now follow.

2.2.2. Social roles and the doctor-patient relationship

The application of the social role system in medical practice was first introduced by sociologist, Talcott Parsons. His functionalist, role-based approach defines the doctor and patient in the doctor-patient relationship in terms of the social context of sickness and health.[159] A social role is a pattern of expected behaviour which is regulated by cultural norms or rules of behaviour and organized into rights and obligations which have general acceptance within a group.[160] The professionalisation of medicine also provides the physician and patient with very specific social roles, referred to as the physician's role and the sick role respectively. The physician's role refers to society's perceptions and beliefs regarding physicians.[161] An example of an attribute society usually associates with the physician's role is the high regard for the physician's education as intellectually exacting and demanding of skill. An example of the obligations and privileges attached to the physician's role is the privilege of physicians to examine patients - a highly intimate and confidential practice. A corresponding obligation of the physician would be to treat all information about the patient as confidential and private. Similarly the patient, in the sick role, also has what society normally perceives as privileges and obligations in this unique doctor-patient relationship.

These role descriptions are internalised and incorporated in our behaviour, since medicine is a social and cultural configuration of societies, as was established in section 2.1.[162] These general conceptions of the roles also influence the profession's policies, patients' expectations and the actions of physicians. They form the foundation of the doctor-patient relationship and are especially important in the context of this dissertation since these roles

[159] Also referred to as the structural-functionalist school, an approach that listed distinctive characteristics of professions and sought to delineate socially desirable rationales for each characteristic; McKoy, June M, Karsjens, Kari L & MacDonald-Glenn, Linda Is Ethics for sale?...Juggling Law and Ethics in Managed Care *DePaul Journal of Health Care Law* (2005) Vol 8, 559 – 613, 561.

[160] Bloom, Samuel W Chapter 2: *The doctor and his patient: A sociological interpretation* Russell Sage Foundation NY: USA 1963, 67.

[161] Bloom, Samuel W Chapter 3: *The doctor and his patient: A sociological interpretation* Russell Sage Foundation NY: USA 1963, 92.

[162] Bloom, Samuel W Chapter 3: *The doctor and his patient: A sociological interpretation* Russell Sage Foundation NY: USA 1963, 95.

are also associated with status and power. This association with power and status is maintained because in order to function, society organises behaviour into reciprocal patterns, and behaviour is always conceived with reference to the behaviour of another.[163] This assigned status is a source of power in the doctor-patient relationship and presupposes a set of rights and duties associated with this status.

2.2.2.1. The physician's role

The doctor's role or pattern of behavior in our society entails a stable set of general obligations and privileges. The doctor achieves his/her status through elaborate education. Society has specific expectations of the doctor and grants the doctor unusual rights and privileges to enable the doctor to be effective in his/her occupation. This, however, also provides the doctor with obligations towards society and his/her patients. Since these are normative patterns of behaviour in society the doctor does not need to explain the physician's privileges and obligations to every patient. Society has already learned about the physician's social role through an internalisation of society's cultural norms.[164] Talcott Parsons found that society has a tendency to characterise professional behaviour as atypical in terms of its motivation; society believes that the service aspect of professional behaviour should be stronger than self-interest. [165] Society therefore attributes a service motive to professions while a profit motive is allowed for other industries and sections of the community. It is for this reason that society tends to criticise the medical profession for excessive financial self-interest.[166] Are similar charges made against other occupations, like manufacturers or officials working in commerce and can the medical profession really be expected to be so unusually altruistic? Parsons believes that it should be, since altruism legitimates the protectionist attitudes which the law and the state display towards the

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[163] Bloom, Samuel W Chapter 2: *The doctor and his patient: A sociological interpretation* Russell Sage Foundation NY: USA 1963, 68.

[164] Bloom, Samuel W Chapter 2: *The doctor and his patient: A sociological interpretation* Russell Sage Foundation NY: USA 1963, 67.

[165] Bloom, Samuel W Chapter 3: *The doctor and his patient: A sociological interpretation* Russell Sage Foundation NY: USA 1963, 92-93; Parsons, Talcott *The Social System* The Free Press Glencoe Illnois, 1951, 434.

[166] Bloom, Samuel W Chapter 3: *The doctor and his patient: A sociological interpretation* Russell Sage Foundation NY: USA 1963, 92.

medical profession. Without this protection the medical profession would be put at the mercy of the free market.[167]

Parsons identified four important attributes of the physician's role. He indicated that this role is functionally specific. Within this specific role the physician is given unusual privileges based on his/her specific functions; privileges necessary for the physician to be effective in his occupation, such as having access to private and intimate information about the patient and the right to examine the patient. The physician's specialisation or technical competence is consequently linked to his/her unique status. This attribute is referred to as the *functional specificity* attribute.[168] The second attribute, *affective-neutrality* refers to the expectation that physicians should remain scientifically objective about the particular medical problem and emotionally detached from the patient. This requires a very fine balance between empathy and affective-neutrality, as well as between objectivity and self-interest, which includes ideals of commercial gain.[169] The third attribute is called the *orientation to the collectivity* as opposed to self-orientation. This attribute dictates that the welfare of the patient should dominate the doctor-patient relationship and not self-interest. The fourth and final attribute is that the physician is subject to the universal rules of this profession and not the requirements of the particular relationship with the patient.[170] Jeffrey Berlant explained the physician's role as follows: "*Fundamentally, the physician gains access to the patient's private life by maximising trust, emphasising competence, asking health related questions and segregating the context of professional practice from other contexts*".[171]

The physician experiences strain and frustration in the performance of his specific function due to the limits of medical science at the time and his/her own assimilation of it, but also due to the elements of uncertainty and impossibility which may lead to unpredictable results. This places immense strain on the balance of need, skill, effort and expectations of

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[167] See Chapter Four for a discussion on health service delivery in the medical marketplace; Montgomery, Jonathan Medicine, Accountability and Professionalism *Journal of Law and Society* Vol 16, No 2 (1989) 319 – 339, 327; The nature of the doctor-patient relationship in such a free market will be discussed in Chapter Four.

[168] Bloom, Samuel W Chapter 3: *The doctor and his patient: A sociological interpretation* Russell Sage Foundation NY: USA 1963, 93-94; Parsons, Talcott *The Social System* The Free Press Glencoe Illnois 1951, 434.

[169] Parsons, Talcott *The Social System* The Free Press Glencoe Illnois 1951, 434 - 435.

[170] Bloom, Samuel W Chapter 3: *The doctor and his patient: A sociological interpretation* Russell Sage Foundation NY: USA 1963, 93-94.

[171] Brennan, Troyen *Just Doctoring: Medical Ethics in the Liberal State* Berkeley: University of California Press (1991) 28.

result. The primary definition of the physician's responsibility is to do everything possible and this is also institutionalised in terms of society's expectations.[172]

2.2.2.2. The sick role

The existence of a specific social role depends on the existence of a set of institutionalised expectations and corresponding sentiments and sanctions. According to this test the patient in the doctor-patient relationship also has a specific social role.[173] The following institutionalised expectations are associated with the patient/sick role: the first is the patient's exemption of normal social role responsibilities. This usually requires legitimation from a physician. The second is that the sick person cannot be expected to get well by an act of decision or will. Here, the patient is clearly also exempt from responsibility and must seek the assistance of another, like a physician. The third is concerned with the state of being ill, which is an undesirable state with its corresponding obligation to do what is necessary to get well. Finally, the patient is obligated, depending on the severity of the condition, to seek assistance from a legitimate source such as a physician.[174]

The sick role can be described as a contingent, temporary role in which anyone in society, regardless of their status, may find himself or herself.[175] It is also an inherently universal role, since generalised scientifically objective criteria determine whether one is sick, how sick and with what kind of illness. Functional specificity is also a characteristic of the sick role because the sick role is confined to the sphere of health and in this role one aspires to be healthy or get well. As in the physician's role, affective neutrality is also a factor here since the expected behaviour patterns are focused on an objective problem, the illness. One should bear in mind that physicians, too, have these expectations and an internalised idea of the patient / sick role in general. They are therefore also influenced by these role expectations and this may influence the way in which they deal with their patients.

According to Parsons, the institutional definition of the sick role is that the sick person is helpless and in need of assistance. With regard to the different illnesses and their degree of

[172] Parsons, Talcott *The Social System* The Free Press Glencoe Illnois 1951, 449.
[173] Parsons, Talcott *The Social System* The Free Press Glencoe Illnois 1951, 437.
[174] Parsons, Talcott *The Social System* The Free Press Glencoe Illnois 1951, 437.
[175] Parsons, Talcott *The Social System* The Free Press Glencoe Illnois 1951, 438.

seriousness one can generally say that the patient will also be anxious about his/her health. This need for assistance is therefore very different from most other needs. Situations of illness also require patients and those close to them to deal with complex problems and emotional adjustments. Sickness creates a situation of strain and frustration. This combination of helplessness, lack of technical competence and emotional strain make patients extremely vulnerable. The situation furthermore makes it very difficult for patients to behave rationally when making decisions about their health.[176] However, sick role performance – the way in which the patient actually behaves — may differ from person to person since it is influenced by socio-economic and ethnic/cultural factors, personal experiences and how the particular illness is viewed in society. The patient's personality also largely determines how he/she reacts to illness and the willingness with which such a patient will assumes the sick role.[177]

Unfortunately, Parsons's theory neglects to look at the power imbalances in the doctor-patient relationship. It also ignores those who are patients, but who are not sick, like plastic surgery patients and pregnant women. There is no reference to patients who cause their own illnesses, like lung cancer patients who continue to smoke. Parsons's patrician model of health care, is also out of date with present day concepts of consumer-driven health care which will be discussed in Chapter Seven. Nevertheless, the social role theory does provide one with a better understanding of the social dynamics between doctor and patient. The discussion on the physician's role and the sick role illustrate that the doctor-patient relationship is built on mutual trust and the technical competence of the physician. The physician is doing everything he/she can, while the patient is cooperating because he/she has the will to get well. This results in privileges and obligations for both the patient and the physician and acts as a mechanism of social control.[178]

2.2.3. Professionalism, authority and the doctor-patient relationship

Throughout the discussion in sections 2.2.1. and 2.2.2., the theme of power and authority in both the profession as well as the doctor-patient relationship was central. It was established

[176] Parsons, Talcott *The Social System* The Free Press Glencoe Illnois 1951, 440 - 446.
[177] Leigh, Hoyle & Reiser, Morton F *The Patient: Biological, Psychological and Social Dimensions of Medical Practice* Plenum Medical Book Company: New York and London, 1980, 18, 253.
[178] Parsons, Talcott *The Social System* The Free Press Glencoe Illnois 1951, 464 – 465, 477.

that the status of professionalism confers power and authority on the members of a profession, and that the social roles of the doctor and the patient, as well as the consequent expected behaviour patterns, result in privileges and obligations for both parties. These privileges and obligations are inherent to professional authority and power and also relate to mutual trust between doctor and patient. In this section the investigation of power and authority in the doctor-patient relationship will be continued.

First, it is necessary to understand what is meant by authority in the medical profession as well as in the doctor-patient relationship. Authority is a source of power but power is essential to exercise authority.[179] Authority generally refers to the control of the behaviour of others for the promotion of collective goals, based on some form of knowledge or consent.[180] Authority can also be described as the possession of some status, quality or claim that compels voluntary trust and obedience.[181] Two sources of effective control ensure and maintain authority: legitimacy and dependence.[182] In the doctor-patient relationship patients generally accept their physicians' superior competence and obey them.

This authority the physician has over the patient is called the Asclepian authority. Asclepian authority can be sapiential, moral or charismatic.[183] Sapiental authority refers to the right to be heard based on knowledge and expertise. This type of authority resides in the person and not in the position which that person may occupy. Someone with this type of authority may advise, inform or instruct, but may not order. The moral authority of doctors, which is expressed in the Hippocratic Oath, stems from the service motive attributed to the medical profession and the expectation that doctors do what is expected of them for the benefit of the particular patient as well as society. Moral authority provides the physician with the right to control and direct. Charismatic authority refers to the right to control and direct as a God-given grace and stems from the original unity of religion and medicine, described in

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[179] Staum, Martin S 7 Larsen, Donald E (eds) *Doctors, Patients and Society: Power and Authority in Medical Care* Wilfrid Laurier University Press: Canada 1981, 29.

[180] Broekman, Reginald J *Power in the Physician-patient Relationship* Thesis presented in partial fulfillment of the requirements of the degree M Phil (Applied Ethics) Stellenbosch University March 2000 (Supervisor: Prof AA van Niekerk), 32.

[181] Starr, Paul *The Social Transformation of American Medicine* Basic Books Inc Publishers: New York 1982, 9.

[182] Starr, Paul *The Social Transformation of American Medicine* Basic Books Inc Publishers: New York 1982, 10.

[183] Osmond, Humphry God and the Doctor *The New England Journal of Medicine* (March, 1980) Vol 302, No 10, 555 – 558, 556.

section 2.1. The charismatic element of authority is also connected to the possibility of death and the universal value of good health and physicians are therefore accorded the authority to not always act reasonably; a degree of arbitrariness is allowed since life and death is also arbitrary and medicine may not always be amenable to reason. Based on this Aesclepian idea of authority, the patient entrusts certain of his/her freedoms to the physician in order to obtain the benefits the physician has to offer.[184] Although the unequal distribution of power and authority in this relationship may seem unwarranted, it must be remembered that professionalism is necessary for the medical profession in its functional specificity. It can therefore be argued that power and authority are important components of medical practice and benefit society and the patient.[185]

Eliot Freidson however disagrees.[186] He distinguishes between the technical aspects of medical practice which requires professional autonomy, and professional authority in the doctor-patient relationship, which is a mask for the exercise of power.[187] He submits that professional autonomy was needed during the historical development of medical practice for protection from ignorance, sub-standard competitors and other potential harms for an *infant discipline*. But while professionalism did protect the discipline, facilitate scientific development and improve knowledge, it has impeded the improvement of the social application of this scientific knowledge.[188] I agree with Freidson that the general nature of professionalism in medical practice does protect the profession and certainly also places strain on the social dynamics of the doctor-patient relationship. However, Freidson oversimplifies the concept of professionalism and erroneously believes that medical practice only recently acquired the status of a profession, thereby referring to it as an *infant discipline*. It is clear from the discussion in sections 2.1. and 2.2.1. that the scientific tradition of medical practice and the development of medicine as a profession have a very long and rich history and that the special status and power of the medical profession is, to a

[184] Staum, Martin S 7 Larsen, Donald E (eds) *Doctors, Patients and Society: Power and Authority in Medical Care* Wilfrid Laurier University Press: Canada 1981, 194.
[185] Staum, Martin S 7 Larsen, Donald E (eds) *Doctors, Patients and Society: Power and Authority in Medical Care* Wilfrid Laurier University Press: Canada 1981, 201.
[186] The structuralist-functionalist conception of Parsons came under attack from sociologists Elliot Friedson and Paul Starr in the 1960's; McKoy, June M, Karsjens, Kari L & MacDonald-Glenn, Linda Is Ethics for sale?...Juggling Law and Ethics in Managed Care *DePaul Journal of Health Care Law* (2005) Vol 8, 559 – 613, 561.
[187] Montgomery, Jonathan Review: Medical Law in the Shadow of Hippocrates *The Modern Law Review*, Vol 52, no 4, (Jul 1989) 566- 576, 568.
[188] Jacob, Joseph M *Doctors and Rules: A Sociology of professional values* Transaction Publishers 1999, 110.

certain extent, necessary for the functional specificity of physicians. Nevertheless, Freidson's theory on professional dominance need to be investigated, since the general nature of professionalism and self-regulation does provide for an unequal distribution of power and authority in the doctor-patient relationship which cannot be ignored.

Eliot Freidson was the first sociologist who recognised the complexities and conflict in the doctor-patient relationship. According to his professional dominance theory the unique characteristics of a profession, like the medical profession, are not the reason for, nor the source of the occupation's status as a profession.[189] Rather, the medical profession's dominance over its sphere of work is the only distinguishing characteristic.[190] Such professional dominance entailed a dominant position in a division of labour, so that the profession gained control over the determination of the substance of its own work.[191] This dominance[192] is established by the profession's autonomy over its work, control over the work of others in the profession, institutional power and the cultural beliefs and deference of society towards physicians.[193] Institutional power in this context refers to the profession's claim to valuable and complex knowledge which has been internalised in society as cultural and legal authority and hence also in institutional authority.[194] The theory of professional dominance also explains why other occupations in the health care industry can not be classified as a profession. An occupation like nursing, for instance, does not have absolute dominance over the division of their specific labour and is not autonomous.

Freidson also rejected Parsons's social role theory, which was discussed in section 2.2.2. According to Freidson, practitioner behaviour is not guided by internalised motives, values

[189] Freidson, Eliot *Professional Dominance: The Social Structure of Medical Care* Aldine Publishing Company, New York, 1979.

[190] Light, Donald & Levine, Sol The Changing character of the Medical Profession: A Theoretical Overview *The Milbank Quaterly* Vol 66, (2) 1988, 10-32, 11.

[191] Wolinsky, Fredric D The Professional Dominance Perspective, Revisited *The Milbank Quarterly*, Vol 66, Supplement 2: The changing character of the medical profession (1988) 33-47, 33 34.

[192] Dominance describes a state of consensually validated authority, as opposed to domination which refers to arbitrary use of power and authority.

[193] Light, Donald & Levine, Sol The Changing character of the Medical Profession: A Theoretical Overview *The Milbank Quaterly* Vol 66, (2) 1988, 10-32, 12.

[194] Light, Donald & Levine, Sol The Changing character of the Medical Profession: A Theoretical Overview *The Milbank Quaterly* Vol 66, (2) 1988, 10-32, 12.

or knowledge unless these are continually reinforced by the social environment.[195] Various problems result from this situation of professional dominance. Two examples are the maldistribution of health care, since physicians tend to practise where they want to and the collective protection physicians sometimes afford one another, which impede any attempt at disciplinary action. Freidson continued to believe in his theory despite the changing social dynamics of the profession and the emergence of alternative theories like Marie Haug's de-professionalisation theory and Vincente Navarro's proletarianisation theory. These alternative theories are based on the suggestion that the profession's autonomy is declining.

In 1973, Marie Haug claimed that de-professionalisation would be the trend of the future.[196] Haug anticipated that the medical profession would lose its monopoly over knowledge, that the public's belief in the service ethos will decline and that the corresponding expectations of work autonomy and authority will fade, due to the diffusion of knowledge through computors, increased literacy as well as the rising dissatisfaction of society with professionals who are self-serving.[197] (See Chapter Four for a discussion on these developments in health service delivery.) Haug also believed that the following factors would contribute to de-professionalisation: increasing specialisation which would make the physician more dependent on other role players, the emergence of consumer self-help groups and allied health care practitioners, and the rising cost of health care which tarnished the altruistic image of the medical profession.[198] Freidson dismissed much of the de-professionalisation argument and maintained that the institutional dominance of the profession would remain intact. He believed that the consumer health movement and its consequent culture shift will not affect the dominance of the profession and that the great advances in technology and knowledge would counter the dissemination of knowledge in

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[195] Turk, Herman Review: Professional Dominance: The Social Structure of Medical Care by Eliot Freidson *American Sociological Review* Vol 36, No 6, (Dec 1971) 1168-1169, 1168.

[196] Light, Donald & Levine, Sol The Changing character of the Medical Profession: A Theoretical Overview *The Milbank Quaterly* Vol 66, (2) 1988, 10-32, 14; Haug, Marie R The Erosion of Professional Authority: A cross-cultural inquiry in the case of the physician *The Milbank Quaterly* Vol 54, No 1 (1976) 83 – 106.

[197] See Chapter Four; Light, Donald & Levine, Sol The Changing character of the Medical Profession: A Theoretical Overview *The Milbank Quaterly* Vol 66, (2) 1988, 10-32, 14.

[198] Wolinsky, Fredric D The professional dominance perspective, revisited *The Milbank Quaterly*, Vol 66, Supplement 2: The changing character of the medical profession (1988), 33 – 47, 37.

the information age.[199] (For a discussion on the emergence of consumerism in health service delivery see Chapter Seven.)

Proletarianisation[200] (Marxist) theorists of the 1970s focused on the process by which an occupation is divested of control and subordinated to the broader requirements of production, due to the rise of capitalism and the increased dependency of professions on advanced capitalism.[201] The term "proletariat" refers to supervised manual workers who do not have control over the means or organisation of production. In the context of the medical profession, it refers to medical practitioners who have settled in salaried positions in bureaucratic institutions where regulatory norms and administrative hierarchy shape the delivery of medical care — a medical-industrial complex.[202] This is an extremely important development in the practice of medical care, since this definition clearly shows that proletarianisation de-professionalises medical practice by taking away the control members of this profession have over their work. A new form of social control over the medical profession has arrived. Three very important changes form the basis of the proletarianisation theory:

- modern medicine have become increasingly technical and organisationally complex, making the physician more dependent on other people/specialists to function effectively;
- investor-owned health care corporations – especially hospital chains - have increased; and
- the revolt and influence of institutional buyers who want to control the rising cost of health care services.[203]

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[199] Light, Donald & Levine, Sol The Changing character of the Medical Profession: A Theoretical Overview *The Milbank Quaterly* Vol 66, (2) 1988, 10-32, 14 - 15.

[200] "*Proletarianisation refers to the process by which an occupational category is divested of control over certain prerogatives relating to the location, content and essentiality of its task activities and is thereby subordinated to the broader requirements of production under advanced capitalism*."; McKinlay John B and Arches, Joan Towards the Proletarianisation of Physicians *International Journal of Health Services* Vol 15, No 2 (1985) 161 – 195, 161.

[201] See Chapter Four; McKinlay, John B & Arches, Joan Towards the Proletarianisation of Physicians *International Journal of Health Services*, Volume 15, Number 2 (1985) 161 – 195, 161.

[202] See Chapter Six; Light, Donald & Levine, Sol The Changing character of the Medical Profession: A Theoretical Overview *The Milbank Quaterly* Vol 66, (2) 1988, 10-32, 15 - 19.

[203] Light, Donald & Levine, Sol The Changing character of the Medical Profession: A Theoretical Overview *The Milbank Quaterly* Vol 66, (2) 1988, 10-32, 17; These developments in medical practice will be discussed in Chapter Six.

The result, according to this theory, is that the medical profession is reduced to a common service level within the broader interest of capitalism and it is therefore no longer professionally dominant.[204] The most important advocate of this argument is Vincente Navarro.[205] Freidson acknowledged that capitalism has reduced the autonomy of the individual practitioner but maintained that the autonomy of the medical profession remained intact.[206] He views the changes identified in the de-professionalisation and proletarianisation theories as part of the ever changing medical profession and not as changes happening outside the profession. The medical profession, according to Freidson, dynamically preserves its dominance by adapting to changing circumstances.[207] It is furthermore argued that the social organisation of medicine or proletarianisation of the profession is not driven by capitalist notions, but rather by socio-economic beliefs to provide economic support for health care services, to provide optimal service delivery for all and to ensure quality by means of social management.[208]

It is also necessary to take note of a theory referred to as the corporatisation of the medical profession. Corporatisation, in the context of proletarianisation, refers to the subjection of the medical profession to structures of corporate control e.g. quality review, incentive pay structures, restrictions and organisation of practice patterns and the restructuring of the marketplace to multi-institutional complexes.[209] Although the medical profession is also dependent on such complex organisations, these institutions may de-professionalise the practice of medicine by controlling the work of medical practitioners and influencing the manner of health care delivery, their autonomy and independence to such an extent that

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[204] Wolinsky, Fredric D The professional dominance perspective, revisited *The Milbank Quaterly*, Vol 66, Supplement 2: The changing character of the medical profession (1988), 33 – 47, 39.

[205] Hughes, James J *Organisation and information at the bed-side: The experience of the medical division of labour by University Hospitals' inpatients* Doctoral Dissertation submitted for fulfillment of the degree D Phil at the University of Chicago, March 1995 (Supervisor: Prof Ed Laumann), 8; Navarro, Vicente Professional Dominance or Proletarianisation?: Neither *The Milbank Quaterly*, Vol 66, Supplement 2: The Changing character of the medical profession (1988) 57 – 75.

[206] Wolinsky, Fredric D The professional dominance perspective, revisited *The Milbank Quaterly*, Vol 66, Supplement 2: The changing character of the medical profession (1988), 33 – 47, 40.

[207] Larkin, GV Medical dominance in Britain: Image and Historical Reality *The Milbank Quaterly*, Vol 66, Supplement 2: The changing character of the medical profession (1988) 117 – 132, 119 – 120.

[208] Roemer, Milton I Proletarianisation of Physicians or organisation of health services? *International Journal of Health Services*, Vol 16, No 3 (1986), 467 – 471.

[209] See Chapters Four and Six; Light, Donald & Levine, Sol The Changing character of the Medical Profession: A Theoretical Overview *The Milbank Quaterly* Vol 66, (2) 1988, 10-32, 19 - 20.

the doctor-patient relationship is ultimately revolutionised to fit this new mode of health care delivery.

Irrespective of one's personal view on these sociological theories on the position and future of the medical profession, it remains clear that power and authority remain distinguishing features and a central theme of the doctor-patient relationship. Even though the roles of those involved in the relationship may change, professional authority and power has a sociological structure and is not based on a superior status or a manifestation of superior wisdom.[210] A patient is, for instance, not obliged to obey the physician's instructions. Professional authority and power is based on the superior technical competence of the relevant professional and irrespective of the mode of health care delivery, this distinguishing factor will always be present in the doctor-patient relationship.[211]

2.2.4. Power and the doctor-patient relationship

It has already been established that the doctor-patient relationship is probably one of the most unequal relationships in society and that where power imbalances exist, the potential for abuse is also present.[212] Power is an integral component of all social relationships and is inherently neutral, neither good nor evil. It is also not a finite commodity; one person's gain is not necessarily due to another's loss. When the source of power is knowledge, the potential exists for both parties to be empowered by the exchange.[213] The word "power" is derived from the Latin word *potere* which means "to be able". For the purposes of this dissertation the definition by Foucault will be used: Power is a general matrix of force relations at a given time in a given society; a vehicle through which discourses about knowledge unfold through the actions of subjects (individual or collective) upon others.[214] It is also helpful to consider the following definition by Cassell: Power is the ability to do or act

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[210] Parsons, Talcott *Essays in Sociological Theory* (Revised edition) The Free Press, Glencoe Illnois 1958, 38.

[211] See Chapter Five, especially section 5.2. dealing with the characteristics of a fiduciary relationship; Parsons, Talcott *Essays in Sociological Theory* (Revised edition) The Free Press, Glencoe Illnois 1958, 38.

[212] Broekman, Reginald J *Power in the Physician-patient Relationship* Thesis presented in partial fulfillment of the requirements of the degree M Phil (Applied Ethics) Stellenbosch University March 2000 (Supervisor: Prof AA van Niekerk), 27.

[213] Goodyear-Smith, Felicity and Buetow, Stephen Power Issues in the Doctor-patient relationship *Health Care Analysis* (2001) 9 : 449 – 462, 449.

[214] Córdoba, José *Foucault on power and ethics: implications for information systems planning*, Paper presented at the UKAIS annual conference in Warwick, April 2003.

so as to affect something, a potential capacity, an influence, a dominion, an authority, a right or ability to control, a legal authority of authorisation.[215]

In addition to all the sources of power in the doctor-patient relationship that have already been identified in section 2.2. the following types of power as identified by Lewicki are also relevant to this relationship and merit closer attention:[216]

- Informational power is based on the imbalance of knowledge in this relationship and the persuasive and influential value of information itself.
- Expert power is a special form of informational power.[217] In the doctor-patient relationship the doctor possesses advanced scientific knowledge and technical skill on which the patient is dependent. Advanced education and knowledge have been identified as attributes of the physician's role in Parsons's social role theory in section 2.2.2. and a source of authority in section 2.2.3.
- Legitimate power requires people to respond to the directions from another, because it is proper and expected of them to obey.[218] Legitimate power exists in the doctor-patient relationship and is also identified in Parsons's social role theory as a pattern of expected behaviour which is attached to a particular role. Parsons's social role theory also indicates that the patient has legitimate power or expectations regarding the physician's behaviour. In the doctor-patient relationship both the physician and patient are expected to respond in a particular manner based on their corresponding privileges and obligations. The need for social ordering and structure forms the basis of this legitimate power.[219]
- Resource power is described as follows: If one can offer a service required by another, one has a resource and consequent resource power. In the doctor-patient

[215] Cassell's English Dictionary 1962 Cassell and Co London.
[216] Lewicki, R and Litterer, J *Negotiation* Irwin: Homewood Ill 239 – 257.
[217] Broekman, Reginald J *Power in the Physician-patient Relationship* Thesis presented in partial fulfillment of the requirements of the degree M Phil (Applied Ethics) Stellenbosch University March 2000 (Supervisor: Prof AA van Niekerk), 30.
[218] Broekman, Reginald J *Power in the Physician-patient Relationship* Thesis presented in partial fulfillment of the requirements of the degree M Phil (Applied Ethics) Stellenbosch University March 2000 (Supervisor: Prof AA van Niekerk), 32.
[219] Broekman, Reginald J *Power in the Physician-patient Relationship* Thesis presented in partial fulfillment of the requirements of the degree M Phil (Applied Ethics) Stellenbosch University March 2000 (Supervisor: Prof AA van Niekerk), 32.

relationship the physician possesses the required knowledge and skills to assist the patient's health. Resource power is therefore a source of power for the physician.

- Principle-centered power is also present in the doctor-patient relationship. This type of power is derived from leadership power based on an honourable character and the exercise of certain power tools and principles and is related to moral authority as described in section 2.2.3. Principle-centered power is therefore also another source of power for the physician in the doctor-patient relationship based on their good standing in the public, the status which professionalism confers on its members, as well as the high regard placed on the ethical conduct of members of this profession.

By this stage the existence of power in the doctor-patient relationship, its historical background as well as the sources of these powers should be clear. Talcott Parsons's social role theory and its premise that deference and submission to the medical authority by patients assigned a sick role is necessary for the doctor-patient relationship to function effectively is an example of the necessity of power in the said relationship.[220] From the discussion on the characteristics of professionalism it would seem that medical practitioners do require a certain degree of power in order to perform their duties in the unique doctor-patient relationship and for patients to benefit from their professional expertise.[221]

Before continuing the examination on power imbalances in the doctor-patient relationship from a legal perspective, it is necessary to look at the research of the philosopher, Michel Foucault. A great deal of Foucault's research deal with power relationships. He believed that power is everywhere, not because it embraces everything, but because it comes from everywhere.[222] According to Foucault power in the doctor-patient relationship is heavily weighted in favour of the physician and that this type of power is based on an old power technique developed in Christian institutions, the technique of pastoral power.[223] Pastoral

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[220] See Chapter Two, section 2.2.2.; Goodyear-Smith, Felicity and Buetow, Stephen Power Issues in the Doctor-patient relationship *Health Care Analysis* (2001) 9 : 449 – 462, 450.

[221] Chapter Two, sections 2.2.1. and 2.2.3.

[222] Broekman, Reginald J *Power in the Physician-patient Relationship* Thesis presented in partial fulfillment of the requirements of the degree M Phil (Applied Ethics) Stellenbosch University March 2000 (Supervisor: Prof AA van Niekerk), 39; Foucault, M The History of Sexuality Vol I: An Introduction Allen Lane: London; Foucault, M *The Birth of the Clinic: An Archaeology of Medical Perception* Routledge 1973, 52.

[223] Broekman, Reginald J *Power in the Physician-patient Relationship* Thesis presented in partial fulfillment of the requirements of the degree M Phil (Applied Ethics) Stellenbosch University March 2000 (Supervisor: Prof

power assured individuals of their salvation, was coupled with sacrificial stewardship and in the final instance had a subject matter which was of universal concern, not only for the whole community but also for each individual throughout his/her life. This power can also not be exercised without intimate knowledge about the subject and implies knowledge of the conscience and the ability to direct it the power of the confessional.[224] In the doctor-patient relationship the benefit of salvation is replaced with health and the objective of the power is therefore changed to a more concrete reality. Foucault also recognises the dual nature of power relationships in the obligations and privileges of both the physician and the patient in Parsons's social role theory.

In the early 1970s Foucault began writing on how power and knowledge shape the relationships among legal, medical and social science discourses.[225] For Foucault knowledge cannot be analysed purely as an expression of power or as an instrument of power. Discursive knowledge requires forms of power that enable classification, record keeping, accumulation and systematic communication; while power and the exercise of power require the formation of useful knowledge. According to Foucault, power and knowledge are therefore mutually dependent.[226]

In order to restore these power imbalances in the doctor-patient relationship, which are mainly based on the physician's expert knowledge, Foucault suggests that the theory of right should be employed. The essential role of the theory of right, since the medieval times, was to "fix" the legitimacy of power. The discourse of rights addresses the intrinsic dominance of power in order to present power as the legitimate right of authority as well as

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AA van Niekerk), 41, 73; Foucault, M *The Birth of the Clinic: An Archaeology of Medical Perception* Routledge 1973, 52, 62 & 89.

[224] Broekman, Reginald J *Power in the Physician-patient Relationship* Thesis presented in partial fulfillment of the requirements of the degree M Phil (Applied Ethics) Stellenbosch University March 2000 (Supervisor: Prof AA van Niekerk), 41, 73.

[225] This is important for the purposes of this dissertation as it was already pointed out in sections 2.2.1. and 2.2.3. that expert knowledge is a distinguishing factor of the medical profession and in this section Lewicki's concept of expert power was also discussed; Turkel, Gerald Michael Foucault: Law, Power and Knowledge *Journal of Law and Society* Vol 17, No 2 (1990) 170 – 193, 178; Foucault, M *The Birth of the Clinic: An Archaeology of Medical Perception* Routledge 1973, 89.

[226] Turkel, Gerald Michael Foucault: Law, Power and Knowledge *Journal of Law and Society* Vol 17, No 2 (1990) 170 – 193, 178; Foucault, M *The Birth of the Clinic: An Archaeology of Medical Perception* Routledge 1973, 51 & 67.

a legal obligation which must be obeyed.[227] In essence Foucault suggests that such power relationships should be placed in a legal framework of rights and obligations in order to recognise and justify the imbalances but also to ensure that parties to this relationship are protected, rights are honoured and obligations are met. This is also the aim of this dissertation.

2.3. Conclusion

This Chapter established that the perceptions and attitudes of societies towards the human body and the valuation of health and disease influence the status of the medical profession and the mode of health care delivery. It is clear that the practice of medicine cannot be separated from the social and cultural context in which it operates. Parsons's social theory also confirmed that medicine is a social institution constructed around sickness and healing. This is important because despite all the advances in modern medical technology and knowledge, medicine is still grounded in a social and cultural dimension. When seeking medical help today, people want all the benefits of modern technology while also receiving specific attention to their emotional and personal attributes as ordinary and vulnerable people.[228] However, it is also clear that the medical profession plays a substantial role in defining those values associated with the physician and the sick role. It is said that *"[p]rofessionals profess. They profess to know better than others the nature of certain matters and to know better than their clients what ails them or their affairs. They presume to tell society what is good and right for the individual and for society at large in some aspect of life…The medical profession, for instance, is not content merely to define the terms of medical practice. It also tries to define for all of us the very nature of health and disease*."[229]

Section 2.2. of this chapter focused on the distinguishing features of the medical profession that influence the doctor-patient relationship, including: professionalism, self-regulation,

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[227] Foucault, M *The Birth of the Clinic: An Archaeology of Medical Perception* Routledge 1973, 199. Compare this arguement with the right's ethic proposed by the business model of health service delivery discussed in Chapter Four; Freeman, M.D.A. *Lloyd's Introduction to Jurisprudence (*6th ed) London Sweet & Maxwell Ltd 1994, 891.

[228] Leigh, Hoyle & Reiser, Morton F *The Patient: Biological, Psychological and Social Dimensions of Medical Practice* Plenum Medical Book Company: New York and London, (1980), viii.

[229] Meisel, Alan The "Exceptions" to the Informed Consent Doctrine: Striking a balance between competing values in medical decision-making *Wisconsin Law Review* 2 (1979) 413 – 488, 428.

state-sanctioned regulation, specific social roles with expected patterns of behaviour and comprehensive power, authority and autonomy. Relatively recent developments in the medical profession which may alter the scope of the profession's autonomy, power and authority were identified in section 2.2.3. The autonomy of the patient will form the basis of the discussion in Chapter Three, which deals with medical decision-making and the doctor-patient relationship in a medical paternalistic setting.

CHAPTER THREE: Medical decision-making and the doctor-patient relationship in a paternalistic setting

3.1. Defining medical paternalism

3.2. Medical decision-making in a paternalistic medical setting

3.3. Autonomy, dignity and self-determination and beneficence in medical decision-making

3.4. A juridical response to traditional paternalism in medical decision-making

3.4.1. Informed consent

3.4.1.1. The birth of informed consent

3.4.1.2. The development of the doctrine of informed consent

3.4.1.3. The current status of the doctrine of informed consent

3.5. An evaluation of medical decision-making and the doctor-patient relationship

3.5.1. Standards of disclosure

3.5.2. Historical attributes

3.5.3. Practical considerations

3.5.4. The efficiency of the doctrine of informed consent

3.5.5. Some recommendations

3.6. Conclusion

In this chapter power imbalances in the doctor-patient relationship will be identified and analysed from a legal perspective. The discussion will be structured according to the suggested approaches to health service delivery identified in Chapter One of this dissertation. Medical paternalism as an approach to health service delivery will form the basis of the discussion. Medical paternalism refers to the traditional beneficence-based mode of health service delivery that has dominated orthodox medical practice for the past 2500 years.[230] This approach is the first of five approaches which will be used to facilitate the analysis and discussion in the dissertation. It was selected not only because it is regarded as the dominant approach in health service delivery, and the characteristics and traits of professionalism in medical practice actually enable this approach, but also because this discussion will show that a paternalistic approach to the doctor-patient relationship generally results in far-reaching unwarranted power imbalances between the parties and potentially negative consequences, especially for the patient.

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[230] Katz, Jay *The Silent World of Doctor and Patient* Johns Hopkins University Press: Baltimore (2002), ix; Teff, Harvey *Reasonable Care: Legal Perspectives on the Doctor-patient Relationship* Clarendon Press Oxford (1994) 69; Buchanan, Allen Medical Paternalism *Philosophy and Public Affairs* Vol 7, No 4 (1978) 371 – 390, 371.

Section 3.1. of the chapter will provide a definition and general oversight of medical paternalism as one specific mode of health service delivery. Next, in sections 3.2. to 3.4., the first power imbalance in the doctor-patient relationship will be identified and evaluated. This power imbalance is the lack of parity that exists between doctor and patient with regard to medical decision-making in a medical paternalistic setting. The discussion will include a comprehensive analysis of the relevant case law, legislation and/or other legal instruments from the three jurisdictions which were identified in Chapter One of this dissertation and were selected for discussion in terms of the specific purposes and aim of this research - South Africa, the United Kingdom and the United States of America (USA). Reference will also be made to other jurisdictions where relevant and helpful. The analysis will not take the form of a typical legal comparison where the jurisdictions are extensively compared with one another since the power imbalances discussed in this dissertation are generally neutral and omni-present in all doctor-patient relationships. The chapter will conclude with commentary on the use and value of the available legal instruments to address the power imbalances identified in this chapter.

3.1. Defining medical paternalism

Medical paternalism refers to the traditional beneficence-based mode of health service delivery which has dominated orthodox medical practice for the past 2500 years. In spite of far-reaching social and cultural changes as well as great advances and developments in medical science, paternalism has remained the preferred and dominant ethos in medical practice. Paternalism requires that a person's liberty be restricted for his/her own good in circumstances that would normally be perceived as violating that person's autonomy. Motivated and justified by an allegedly beneficent concern for the welfare of patients, paternalism expects them to act in a certain way, employing mechanisms and means other than reasoned persuasion to reach its objectives and assuming that medical practitioners internalise the interests of patients.[231] The patient is not considered as an active participant in decision-making. That responsibility is assigned to the medical practitioner instead, given

[231] Scoccia, Danny In defense of hard paternalism *Law and Philosophy* (2008) 27:351 – 381, 351 – 352; For a comprehensive discussion of paternalism in general, see http://plato.stanford.edu/entries/paternalism/#1 [Accessed on 12 December 2008].

his/her expert medical knowledge.[232] The notions of beneficence and non-maleficence are, as a matter of fact, in themselves paternalistic[233]

The paternalistic doctor-patient relationship is actually akin to the relationship between a parent and a child. The doctor does have obligations towards the patient but is as the holder of expertise and knowledge, assumed to be dominant while the patient is submissive. The doctor disciplines and controls the decision-making process, the patient is expected to cooperate, and their shared goal is said to be the preservation and protection of the patient's health.[234] In medical practice and specifically in doctor-patient relationships, there is both direct and indirect evidence for the existence of this approach described by Katz as the conspiracy of silence that exists in the consulting room.[235] Direct evidence can be found in surveys, articles and other academic literature in which patients and physicians attest to the existence of paternalistic practices in medicine. Indirect evidence can be found in the language used to describe doctor-patient interactions.[236] The plaintiff in the case of *Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital,*[237] for example, described her neurosurgeon as "*a man of very, very few words*". The trial judge later described this neurosurgeon as "*reserved, slightly autocratic and of the old school*".[238] And in the South African landmark decision of *Castell v De Greef*[239] the court pointed out that medical paternalism "*stems largely from a bygone era predominantly marked by presently outmoded patriarchal attitudes".*[240]

Medical paternalism is rooted in the historical development of the medical profession and the doctor-patient relationship as described in Chapter Two, and more specifically in the

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[232] Gindes, Daniel Judicial Postponement of Death Recognition: The tragic case of Mary O'Conner *American Journal of Law and Medicine* (1989) 15, 301 – 331, 317.
[233] Rich, Ben A Medical Paternalism v Respect for patient autonomy: The more things change the more they remain the same *Michigan State University Journal of Medicine & Law* 10 (2006) 87-124, 92.
[234] Rees, Charlotte E et al Doctors being up there and we being down here: A metaphorical analysis of talk about student/doctor-patient relationships *Social Science & Medicine* 65 (2007) 725 – 737, 725.
[235] Katz, Jay *The Silent World of Doctor and Patient* Johns Hopkins University Press: Baltimore (2002), 56; Buchanan, Allen Medical Paternalism *Philosophy and Public Affairs* Vol 7, No 4 (1978) 370 – 390, 372.
[236] Buchanan, Allen Medical Paternalism *Philosophy and Public Affairs* Vol 7, No 4 (1978) 370 – 390, 372.
[237] *Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital* [1985] A.C. 871 HL.
[238] Teff, Harvey *Reasonable Care: Legal Perspectives on the Doctor-patient Relationship* Clarendon Press Oxford (1994) 69.
[239] *Castell v De Greef* 1994 (4) SA 408 (C).
[240] *Castell v De Greef* 1994 (4) SA 408 (C), 422.

unique characteristics and special status associated with the medical profession and the consequent power and authority attributed to its members. Assumptions underlying this unquestionable deference to professional authority are the following:

- A single best treatment for most illnesses exists and physicians are generally informed about the latest treatment options.
- Physicians can be trusted always to apply their expert knowledge and skill when deciding on treatment for their patients.
- Physicians' skills and expert knowledge qualify them to make the most appropriate treatment decisions.
- Since physicians always act in the best interest of their patients, they have a legitimate interest in each treatment decision.[241]

Specifically associated with these assumptions are: non-disclosure, deference, and an impersonal and detached relationship between doctors and patients; the ability of physicians to persuade rather than discuss, to advise rather than explain; extensive self-regulatory powers, and legislative endorsements of these powers and far-reaching powers with regard to discretionary decision-making.[242]

From about the 1960s this approach has been severely critiqued. The following count among the numerous sources of resistance to medical paternalism:

- the political and ethical philosophy of individual rights;
- higher education levels among the general public;
- public awareness of the powers and dangers of medical technology;
- a general distrust of experts;
- the rise of consumerism; and
- the moral challenges of wars.[243]

It has also been argued that paternalism prevents doctors from appreciating how illness is experienced.[244] Physicians can, in other words, not relate to the attributes and needs of the

[241] Charles Cathy, Gafni Amiram, Whelan Tim Decision-making in the physician-patient encounter: revisiting the shared treatment decision-making model *Social Science & Medicine* 49 (1999) 651 – 661, 652.
[242] Teff, Harvey *Reasonable Care: Legal Perspectives on the Doctor-patient Relationship* Clarendon Press Oxford (1994) 69, 71.
[243] Stauch, Marc; Wheat, Kay; Tringle John *Text, Cases and Materials on Medical Law* 3rd ed Routledge: Cavendish (2006) 35.

sick role as described by Talcott Parsons.[245] Physicians furthermore have not respected the autonomy of patients and therefore have not actively encouraged their participation in the consulting room, and paternalistic physicians usually focus too much on relieving specific physical symptoms without paying attention to the individual patient's overall needs. Kantianism offers a non-consequentialist and philosophical objection to paternalism: it harms rather than benefits its intended beneficiaries, for even though it may benefit those whom it targets, its negative side-effects outweigh that benefit. And even if it benefits those whom it targets, and harms no one else, it still violates some deontological side-constraint on permissible action.[246] A generation critical of unjust claims to power that regards physicians' defense of professional power and autonomy as self-interested authoritarianism (a notion also supported by Eliot Freidson and his theory of professional dominance) has thus allegedly caused the demise of the traditional paternalistic approach as an appropriate model for the doctor-patient relationship.[247]

However, despite this critique, changing social and cultural dynamics, and centuries long developments in the practice of medicine, medical paternalism has continued to remain the template frame of mind of many a physician. The unique characteristics of professionalism in general, and the practice of medicine in particular, may possibly explain the resilience of the paternalistic model of health care: authority and prestige are attributed to the profession; the expert knowledge of its members is admired; patients as beneficiaries of health care are vulnerable; and medical practitioners exercise strong occupational control over their own profession.[248] In particular, expertise acquired through education and

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[244] Teff, Harvey *Reasonable Care: Legal Perspectives on the Doctor-patient Relationship* Clarendon Press Oxford (1994) 69.

[245] See Chapter Two, section 2.2.2 for a complete discussion of Talcott Parsons's sick role; The bio-medical model of disease that drives the curative paradigm of modern medical education also does not make provision for the consideration of the patient's individual experience of illness, which includes the social and cultural dynamics of disease and the attributes attached to the sick role. The curative paradigm is an approach based on one-dimensional medical values and prioritises diagnostic and clinical interventions and projects the goals of these priorities onto the patient; Rich, Ben A Medical Paternalism v Respect for patient autonomy : The more things change the more they remain the same *Michigan State University Journal of Medicine & Law* 10 (2006) 87 – 124, 97.

[246] Scoccia, Danny In defense of hard paternalism *Law and Philosophy* (2008) 27:351 – 381, 354.

[247] See Chapter Two, section 2.2.3.

[248] For a complete discussion of the distinguishing features of professionalism see Chapter Two, section 2.2.1.

research is relied on as justification for paternalistic practices.[249] According to Montgomery the juxtaposition of the physician's competence and the patient's "non-competence" creates distance, conducive to paternalistic practices, between them.[250] Moreover, ready deference to the evidential judgements of medical professionals in lawsuits invests them with extensive discretionary powers, enabling them to determine their own standards of care.[251]

Another possible reason for the dominance and resilience of medical paternalism in medical relationships is to be found in the historical development of the doctor-patient relationship as described in Chapter Two.[252] The religious character of this relationship, dating back to the Greek medical tradition and also early modern societies, as well as the magical undertones of the doctor-patient relationship, especially evident in primitive societies and medieval times, may very well still be real and present in the doctor-patient relationship of the twenty-first century. It was clear from the exposition in Chapter Two that the modern doctor-patient relationship is still accorded a special status and is regarded as distinctive due to the intimate and intrusive nature of the relationship, the vulnerability of the patient and the valued quality of health which forms the reason for and subject matter of the relationship. These factors bestow on the doctor-patient relationship a sacrosanct quality, almost like a one-to-one pastoral bond, which also enables paternalistic practices.[253] The subsequent paternalistic approach of medical practitioners promotes the welfare of an exclusive patient, creating an archaic, self-indulgent vision of medical practice far removed from the realities of health service delivery.[254]

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[249] Teff, Harvey *Reasonable Care: Legal Perspectives on the Doctor-patient Relationship* Clarendon Press Oxford (1994) 85 - 86.

[250] Montgomery, Jonathan Medicine, Accountability and Professionalism *Journal of Law and Society* Vol 16, No 2 (1989), 319 – 339, 319.

[251] Teff, Harvey *Reasonable Care: Legal Perspectives on the Doctor-patient Relationship* Clarendon Press Oxford (1994) 85 - 86.

[252] For a comprehensive discussion of the historical development of the doctor-patient relationship see Chapter Two, section 2.1; Strauss, SA Geneesheer, pasiënt en die reg: 'n delikate driehoek *TSAR* 1 (1987) 1 – 11, 1.

[253] Teff, Harvey *Reasonable Care: Legal Perspectives on the Doctor-patient Relationship* Clarendon Press Oxford (1994) 93.

[254] Teff, Harvey *Reasonable Care: Legal Perspectives on the Doctor-patient Relationship* Clarendon Press Oxford (1994) 93.

However, not only physicians, but patients, too, are responsible for keeping paternalism in medicine alive. Physicians may resort to paternalism due to sheer work pressure, to avoid potentially stressful dialogues, to project an image of confidence and reassurance or simply because they feel comfortable with it. Many patients, on the other hand, choose to relinquish their autonomy and own responsibility when faced with a medical problem and to place trust in the expert instead.[255] This attitude corresponds with the attributes of the sick role which Talcott Parsons identified in his social role theory.[256] According to Parsons, the institutional definition of the sick role is that the sick person is helpless and in need of assistance. The combination of helplessness, lack of technical competence and emotional strain results in a vulnerable patient who cannot perform at a high level of rational judgement when making decisions about his/her health.[257] The patient's preferred role as passive recipient of treatment may also be due to the "magical" qualities historically attributed to the practice of medicine and the patient's ignorance and blind trust in this science.[258]

Clearly medical paternalism accords the physician great power and authority *vis-à-vis* the patient, based on the expert knowledge and skill that medical professionals have. Altruistic motives attributed to members of the medical profession also play a role in determining the dynamics of a paternalistic doctor-patient relationship. These characteristics, as well as the other distinguishing practices of medical paternalism highlighted in the discussion above, profoundly influence medical decision-making and make for a power imbalance in a doctor-patient relationship.

3.2. Medical decision-making in a paternalistic medical setting

Historically, disclosure, consent and participatory decision-making have never been important objectives in medical practice.[259] Hippocrates once said that "*Life is short, the Art*

[255] Teff, Harvey *Reasonable Care: Legal Perspectives on the Doctor-patient Relationship* Clarendon Press Oxford (1994) 53, 71; Wilson-Barnett, Jenifer Limited autonomy and partnership: professional relationships in health care *Journal of medical ethics* 15 (1989) 12 – 16.

[256] For a discussion of Talcott Parsons' social role theory see Chapter Two, section 2.2.2.2.

[257] Parsons, Talcott *The Social System* The Free Press Glencoe Illnois 1951, 438.

[258] Teff, Harvey *Reasonable Care: Legal Perspectives on the Doctor-patient Relationship* Clarendon Press Oxford (1994) 73.

[259] Katz, Jay *The Silent World of Doctor and Patient* Johns Hopkins University Press: Baltimore (2002) 1; For an argument to the contrary see Pernick, Martin S *The Patient's Role in Medical Decision-making: A Social History*

is long, Opportunity fleeting, Experiment treacherous and Judgement difficult". And since the art is long and life short, the undertaking to share knowledge and information with patients, to explain opportunities, experiments and the rationale underlying judgements have never been regarded as part of the Hippocratic task.[260] In fact, the only reference made to communication between doctor and patient in the Hippocratic Corpus advises against disclosure.[261] During medieval times this viewpoint on disclosure and conversations with patients was upheld and interactions between physicians and patients were based on three principles: patients must honour physicians since the latter received their authority from God, patients must have faith in their physicians and patients must promise obedience.[262] Greater importance was consequently placed on beneficence and the physician's opinion in medical decision-making than on patient autonomy, dignity and self-determination. It was permissible for the physician (rather than the patient) to decide what action (or inaction) would be in the patient's best interest, based on expert knowledge regarded as objective, scientific and value-free, while the patient's welfare was defined in clinical terms excluding any normative dimension reaching beyond the physician's clinical expertise. The participation of patients in the medical decision-making process was therefore not only regarded as unnecessary but actually also as unfeasible.[263] In summary there are three main arguments for the justification of withholding information from a patient or misinforming a patient about the particulars of his/her condition. The first is that

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of Informed Consent in Medical Therapy in President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioural Research, *Making Health Care Decisions*, (Washington: US Government Printing Office, 1982) Vol 3.3; Faden, Ruth R & Beauchamp, Tom L *A History and Theory of Informed Consent* Oxford University Press: NY 1986, 56 - 60.

[260] Katz, Jay *The Silent World of Doctor and Patient* Johns Hopkins University Press: Baltimore (2002) 1.

[261] Katz, Jay *The Silent World of Doctor and Patient* Johns Hopkins University Press: Baltimore (2002) 4; Teff, Harvey *Reasonable Care: Legal Perspectives on the Doctor-patient Relationship* Clarendon Press Oxford (1994) 73; In *Decorum XVI in 2 HIPPOCRATES 297 – 277 (W. Jones trans. 1923)*: "*perform these duties calmly and adroitly, concealing most things from the patient while you are attending to him. Give necessary orders with cheerfulness and serenity, turning his attention away from what is being done to him; sometimes reprove sharply and emphatically, and sometimes comfort with solicitude and attention, revealing nothing of the patient's future or present conditions*"; Beauchamp, Tom L The promise of the Beneficence model for medical ethics *Contemporary Health Law and Policy* 6 (1990) 145 – 155.

[262] See Chapter Two, section 2.2.3. of this dissertation: "The moral authority of doctors, which is expressed in the Hippocratic Oath stems from the service motive attributed to the medical profession and the expectation that doctors do what is expected of them for the benefit of the particular patient as well as society. Moral authority provides the physician with the right to control and direct." Katz, Jay *The Silent World of Doctor and Patient* Johns Hopkins University Press: Baltimore (2002) 7 - 8.

[263] Rich, Ben A Medical Paternalism v Respect for patient autonomy: The more things change the more they remain the same *Michigan State University Journal of Medicine & Law* 10 (2006) 87-124, 91; Rich, Ben A Medical Paternalism v Respect for patient autonomy: The more things change the more they remain the same *Michigan State University Journal of Medicine & Law* 10 (2006) 87-124, 95.

physicians have a duty to prevent harm or to minimise harm to patients and it is therefore permissible for the physician to withhold information from patients. The second argument is that the physician-patient relationship is a contractual relationship and that the terms of the contract are such that the patient authorises the physician to minimise harm to the patient by whatever means the physician deems necessary.[264] Finally, it is argued that physicians are justified in withholding information from patients when the patient is unable to understand the information.[265]

It was only during the Age of Enlightenment (the eighteenth century) that some physicians started contending that the public in general and patients in particular should be informed about medical matters, but few medical professionalists took notice as the traditional approach was too ingrained.[266] The British and American medical associations drafted their first codes of ethics without acknowledging this enlightened view. Instead they adhered to the writings of Thomas Percival, an advocate of custody and not of patients' liberty.[267] Percival followed tradition and urged restraint in the disclosure of information to patients. Physicians were regarded as the custodians of abstruse knowledge not communicable to the lay person.[268] Medical training and institutionalisation helped to sustain and promote this attitude.[269] The authority and prestige of the medical profession as well as extensive privileges and legislative endorsement of self-regulation also aided the maintenance of these traditional views and practices.[270] Discretionary decision-making powers and the right of the medical profession to determine its own standards became its trademark.[271]

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[264] See Chapter Four for a complete discussion on the business model and the notion that the doctor-patient relationship is a contractual relationship.
[265] Buchanan, Allen Medical Paternalism *Philosophy & Public Affairs* Vol 7 No 4 (1978) 370 – 390.
[266] Katz, Jay *The Silent World of Doctor and Patient* Johns Hopkins University Press: Baltimore (2002) 13 - 14.
[267] See Percival's Medical Ethics written by the end of the eighteenth century and published in 1803. Originally it was intended to be titled: Powers, Privileges and Employments of the Faculty; Katz, Jay *The Silent World of Doctor and Patient* Johns Hopkins University Press: Baltimore (2002) 13 – 14; Teff, Harvey *Reasonable Care: Legal Perspectives on the Doctor-patient Relationship* Clarendon Press Oxford (1994) 74; The first code of ethics in the USA was adopted by the American medical Association in 1847; Beauchamp, Tom L The promise of the Beneficence model for medical ethics *Contemporary Health Law and Policy* 6 (1990) 145 – 155.
[268] Teff, Harvey *Reasonable Care: Legal Perspectives on the Doctor-patient Relationship* Clarendon Press Oxford (1994) 74.
[269] Teff, Harvey *Reasonable Care: Legal Perspectives on the Doctor-patient Relationship* Clarendon Press Oxford (1994) 76.
[270] Teff, Harvey *Reasonable Care: Legal Perspectives on the Doctor-patient Relationship* Clarendon Press Oxford (1994) 84.
[271] Teff, Harvey *Reasonable Care: Legal Perspectives on the Doctor-patient Relationship* Clarendon Press Oxford (1994) 85.

A telling example of the attitude of an early twentieth century physician towards – as well as his point of view on – his obligations and rights regarding disclosure and consent is to be found in the case of *Pratt v Davis*.[272] The physician, Dr Pratt, bluntly told the court that "*[h]e did not deem her [the patient] worthy [of an explanation]*;" that he had "*worked her deliberately, systematically, taking chances which she did not realise the full aspect of [and that he had] deliberately and calmly deceived the woman*". He also stated that "*when a patient places herself in the care of a surgeon for treatment without [express limitations] upon his authority, she thereby in law consents that he may perform such operation as in his best judgement is proper and essential to her welfare*". In the English case, *Bolam v Friern Hospital Management Committee*[273] the physician unselfconsciously admitted that he would not divulge any information on material and catastrophe risks unless he was directly asked about this by the patient. And even then, he would only disclose slight risks since he did not want to drive his patients away. This sentiment on disclosure was also echoed by medical practitioners in the South African case of *Richter and another v Estate Hammann*.[274] And in the case of *Esterhuizen v Administrator, Transvaal*[275] the medical practitioner stated that he did not consider it necessary to discuss the details of radiation therapy with the patient (then aged 10) nor with the patient's parents.

However, to completely deny the authority of medical professionals in the decision-making process would be to ignore the nature of medical practice.[276] According to Dr Arnold Relman the "*responsibility [of the physician] for the welfare of his patients often requires that he deal with technical medical issues which are of vital importance to his patients but which they are unable to comprehend fully, if at all, and which they must therefore delegate to him. Unless he is willing to assume this decision-making role on the patients' behalf he is not really doing his job*".[277] He elaborated on this statement by providing three justifications for the extensive decision-making powers by physicians. First he claimed that life and death decisions are and have always been medical decisions, traditionally made by medical

[272] *Pratt v Davis* 118 Ill. App 161 (1905); Also see the discussion of this case on page 47 of this dissertation.
[273] *Bolam v Friern Hospital Management Committee* [1957] 1 W.L.R. 582, 589.
[274] *Richter and another v Estate Hammann* 1976 (3) SA 226 (C), 233.
[275] *Esterhuizen v Administrator, Transvaal* 1957 (3) SA 710 (T), 718.
[276] Baron, Charles H Medical Paternalism and the Rule of Law: A reply to Dr Relman *American Journal of Law and Medicine* Vol 4, No 4 (1979) 337 - 365, 338.
[277] Baron, Charles H Medical Paternalism and the Rule of Law: A reply to Dr Relman *American Journal of Law and Medicine* Vol 4, No 4 (1979) 337 - 365, 338.

practitioners. Such decisions should be made by physicians since they usually involve technical-medical detail which cannot be properly apprehended by a lay person. He also stated that courts are incapable of handling such decisions since they do not have the necessary medical expertise.[278] He furthermore believed that physicians are justified in having this extensive power in medical decision-making since patients have delegated this power to their doctors, believing that only their doctors can decide for them in an informed and rational manner.[279]

But can doctors really make informed and rational decisions about the health of their patients on their own? And if so, how can such decisions be justified in the light of the vital role that autonomy and self-determination play in modern medical and ethical practice?[280] In the case of *Pratt v Davis*[281] the physician removed the patient's ovaries and uterus in order to cure her epilepsy. Although Dr Pratt submitted that he had informed the patient's husband of this medical intervention he self-righteously pointed out that "*when a patient places herself in the care of a surgeon for treatment without [express limitations] upon his authority, she thereby in law consents that he may perform such operation as in his best judgment if proper and essential to her welfare*".[282] Dr Pratt's statement is a good example of the sentiments and beliefs of physicians who adhere to the paternalistic approach in medicine. In the case of *Mohr v Williams*[283] the plaintiff consented to an operation on her right ear, but under anaesthetic the defendant examined her left ear and found the condition of the left ear to be more serious and more in need of an operation than the right ear. The defendant continued to operate on the plaintiff's left ear without obtaining her consent. In this case the defendant also submitted that he acted in the interest and welfare of the patient and that he could not be held liable for this medical judgement, nor for the skillfully performed operation. The medical practitioner in this case clearly believed that he

[278] Baron, Charles H Medical Paternalism and the Rule of Law: A reply to Dr Relman *American Journal of Law and Medicine* Vol 4, No 4 (1979) 337 - 365, 339.
[279] Baron, Charles H Medical Paternalism and the Rule of Law: A reply to Dr Relman *American Journal of Law and Medicine* Vol 4, No 4 (1979) 337 - 365, 342.
[280] Wilson-Barnett, Jenifer Limited autonomy and partnership: professional relationships in health care *Journal of Medical Ethics* 15 (1989) 12 – 16.
[281] *Pratt v Davis* 118 Ill. App 161 (1905).
[282] *Pratt v Davis* 118 Ill. App 161 (1905).
[283] *Mohr v Williams* 104 N.W. 12 (Minn 1905).

had the authority to decide on behalf of his patient, without obtaining her consent, since he had acted in the best interests of the patient.

Although the consent to or refusal of surgical interventions was generally accepted and required as an ancient legal necessity, this right was extremely narrow in scope and did not include the right to be properly and fully informed of all risks, benefits and alternatives.[284] In the *Mohr*-case,[285] for example, the court confirmed that a patient should explicitly agree to or refuse medical interventions but the court also held that the judiciary should not lay down rules which would unreasonably interfere with the exercise of the physician's discretion. And in the case of *Bennan v Parsonnet*[286] the court concluded that when a person elected to continue with surgery and did not appoint another person to represent him/her during the period of unconsciousness the law would regard the surgeon to be the patient's representative, authorised to act in the patient's welfare as long as the surgeon did not perform an operation different to – and especially more risky than – the operation to which the patient had initially consented. An eighteenth century English judge observed that "*a patient should be told what is about to be done to him, that he may take courage and put himself in such a situation as to enable him to undergo the operation*".[287] Patients merely had an elementary right to be free from uninvited contact and therefore only needed to be informed of the nature of the medical intervention, nothing more.[288]

[284] The law's concern for bodily integrity can be traced to writ of trespass for battery; Katz, Jay *The Silent World of Doctor and Patient* Johns Hopkins University Press: Baltimore (2002) 49; *Haskins v Howard* 16 S.W. 2d 20 (Tenn 1929); *Schloendorff v Society of New York Hospitals* 211 N.Y. 125 (1914); *Ex parte Dixie* 1950 (4) SA 748 (W); Meisel, Alan The "Exceptions" to the Informed Consent Doctrine: Striking a balance between competing values in medical decision-making *Wisconsin Law Review* 2 (1979) 413 – 488, 419; Earle, Murray 'Informed Consent': Is there room for the reasonable patient in South African law? *South African Law Journal* (1995) 629 – 642, 630.

[285] *Mohr v Williams* 104 N.W. 12 (Minn 1905).

[286] *Bennan v Parsonnet* 83 A. 948 (N.J. 1912).

[287] *Slater v Baker & Stapleton* 95 Eng Rep 860 (K.B. 1767); Katz, Jay *The Silent World of Doctor and Patient* Johns Hopkins University Press: Baltimore (2002) 49.

[288] Katz, Jay *The Silent World of Doctor and Patient* Johns Hopkins University Press: Baltimore (2002) 50; Also see *Haughian v Paine* (1987) 55 SaskR 99 at 114 where an expert medical witness said: "*..for doctors of European training and this is anywhere on the continent, the surgeon was considered to be omnipotent, and as a result, the patients dutifully did what they were told. They never inquired, most of them were never told. It was the agreed-upon-sociological way of handling this.*"

A final case illustrating the disregard of disclosure and consent which dominated health service delivery for nearly 2500 years is the case of *Hunt v Bradshaw*.[289] In this case Dr Bradshaw advised the patient that a small sharp-edged piece of steel lodged in the patient's neck after an unfortunate work injury needed to be removed. Upon the patient's enquiry about the seriousness of the operation Dr Bradshaw allegedly responded that "*it wasn't nothing to it (sic), it was very simple*". After the operation, however, the patient found that he had lost the use of his fingers of his left hand and that this left hand was contracted in a claw like state. With regard to an alleged lack of disclosure in this case the court stated: "*It is understandable [that] the surgeon wanted to reassure the patient so that he would not go to the operating room unduly apprehensive. Failure to explain the risk involved, therefore, may be considered a mistake on the part of the surgeon, but under the facts cannot be deemed such want of ordinary care as to import liability*".[290] It is clear from this judgement that the court did not want to challenge the medical professionals' disclosure practices.[291]

The medical profession justifies such non-disclosure and lack of consent in an essentially paternalistic manner. They submit that patients are not able to understand the complex medical jargon and information and are too emotionally distressed and dependent on medical practitioners to make rational decisions regarding their health.[292] This second argument is directly linked to Talcott Parsons's also inherently paternalistic sick role and its attributes. None of these cases referred to above involved a sophisticated enquiry into the relationship between disclosure, consent and self-determination. The hesitance of the judiciary to address the general disregard for full disclosure and consent in medical practice, on the other hand, was based on judges' unfamiliarity with medical science, their respect for the medical profession's authority and expertise as well as a desire to maintain the profession's independence, as a core characteristic of professionalism.[293] The extensive power and authority of physicians in medical decision-making, due to this disregard for full disclosure and consent has created a power imbalance in the doctor-patient relationship.

[289] Katz, Jay *The Silent World of Doctor and Patient* Johns Hopkins University Press: Baltimore (2002) 53; *Hunt v Bradshaw* 88 S.E. 2d 762 (N.C. 1955).
[290] *Hunt v Bradshaw* 88 S.E. 2d 762 (N.C. 1955), 766.
[291] Katz, Jay *The Silent World of Doctor and Patient* Johns Hopkins University Press: Baltimore (2002) 55.
[292] Rich, Ben A Medical Paternalism v Respect for patient autonomy: The more things change the more they remain the same *Michigan State University Journal of Medicine & Law* 10 (2006) 87-124, 103.
[293] Katz, Jay *The Silent World of Doctor and Patient* Johns Hopkins University Press: Baltimore (2002) 59; *Natanson v Kline* 186 Kan. 393, 350 P.2d 1093, 1102; Woolley v Henderson 418 A.2d 1123 (Maine 1980), 1131.

However, criticism of physicians' customary exercise of paternalistic sovereignty and the increased emphasis on patient autonomy and self-determination could no longer be ignored. But before analysing the legal reaction to the paternalistic approach in medical decision-making, the conflicting underlying values in the medical decision-making process need to be considered.

3.3. Autonomy, dignity, self-determination and beneficence in medical decision-making

From the discussion in this chapter it is clear that medical practitioners' obligations and virtues have traditionally been understood in terms of fundamental obligations of beneficence. However, the human rights movement with its increased focus on human rights in general and patient autonomy and rights in particular, has called for a new perspective, moving away from the traditional beneficence-based model of medical ethics to a model of autonomy. According to the autonomy model, a physician's obligations towards the patient are primarily established by the moral principle of respect for autonomy.[294] The aim of this section is not to discuss the conflict between autonomy and beneficence in general, but to provide sufficient, if limited, background to these concepts in the context of medical paternalism and specifically with regard to medical decision-making in the doctor-patient relationship.

Autonomy means that a person has sovereignty over his/her life.[295] This sovereignty protects privacy as well as rights to control what happens to one's person and property.[296] This concept related to self-determination was articulated in the case of *Natanson v Kline*: "*A doctor might well believe that an operation or form of treatment is desirable or necessary, but the law does not permit him to substitute his own judgement for that of the patient by any form of artifice or deception*".[297] Self-determination refers to the rights of

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[294] Beauchamp, Tom L The promise of the beneficence model for medical ethics *Journal of Contemporary Health law & policy* 6 (1990) 145 – 155, 149.

[295] According to Beauchamp the word 'autonomy' is a legacy from ancient Greece, where *autos* (self) and *nomos* (rule or law) were joined to refer to political self-governance in the city-state; Faden, Ruth R & Beauchamp, Tom L *A History and Theory of Informed Consent* Oxford University Press: NY 1986, 8.

[296] Stauch, Marc; Wheat, Kay; Tringle John *Text, Cases and Materials on Medical Law* 3rd ed Routledge: Cavendish (2006) 35.

[297] Stauch, Marc; Wheat, Kay; Tringle John *Text, Cases and Materials on Medical Law* 3rd ed Routledge: Cavendish (2006) 36; *Natanson v Kline* 186 Kan. 393, 350 P.2d 1093.

individuals to make decisions without interference by others (*voluntas*).[298] In its extreme forms, paternalism, the adverse sibling of self-determination, requires a total surrender of a patient's decision-making capacity to the will of others.[299] The principle of autonomy requires that competent[300] persons must be allowed to make their own decisions regarding every aspect of their life and that these decisions must be based on their own beliefs, principles, preferences and conceptions. Autonomy, in short, means self-rule.[301] Known as "autonomy of will" in Immanuel Kant's deontology autonomy[302], autonomy emanates from the rational human will and exists prior to action. According to Kant, to be autonomous is to govern oneself, and this includes the right to make one's own choices in accordance with universal moral principles.[303] In John Stuart Mill's dissimilar conception autonomy does not originate from a prior will to act but rather from the action itself, as "autonomy of action".[304] He believed that autonomy is the freedom of actions and worthwhile only to the extent that people respect one another's autonomy.[305] Autonomy is moreover neither permanent nor immutable, but rather dynamic in nature.[306]

Both autonomy and self-determination are recognised in the Constitution of the Republic of South Africa, 1996, in the provisions regarding the right to bodily and psychological integrity,[307] the right to privacy,[308] the right to life,[309] the right to freedom of movement,[310]

[298] Katz, Jay *The Silent World of Doctor and Patient* Johns Hopkins University Press: Baltimore (2002) 110; For a comprehensive discussion on the psychoanalysis of self-determination see Katz, Jay *The Silent World of Doctor and Patient* Johns Hopkins University Press: Baltimore (2002), a psychoanalytical view of self-determination does not however fall within the ambit of this dissertation; Giesen, Dieter From Paternalism to Self-determination to shard Decision making *Acta Juridica* (1988) 107 – 127, 107.

[299] Katz, Jay *The Silent World of Doctor and Patient* Johns Hopkins University Press: Baltimore (2002) 110.

[300] It is important to remember that this dissertation will only deal with the general and ordinary doctor-patient relationship, as was submitted in Chapter One of the dissertation. Exceptions, for example the case of an incompetent patient, a minor or mentally ill patient as well as specialised relationships, for instance the relationship between a psychiatrist and his/her patient, do not fall within the ambit of this discussion.

[301] Dworkin, Roger B Getting what we should from doctors: Rethinking patient autonomy and the doctor-patient relationship *Health Matrix: Journal of Law-Medicine* 13 (2003) 235 – 296, 238.

[302] Kantian deontology is a major theoretical framework underlying bioethical argumentation developed by the German philosopher, Immanuel Kant. The Kantanian concept of autonomy emphasises individual rights – it is a rights based view. Secker, Barbara The Appearance of Kant's deontology in contemporary Kantanianism: Concepts of Patient Autonomy in Bioethics *Journal of Medicine and Philosophy* (1999) Vol 24, 43 – 66, 44.

[303] Devereux, John *Australian Medical Law* (Second Edition) Cavendish Publishing, Australia Sydney 2002, 4.

[304] Komrad, Mark S A defence of medical paternalism: maximising patients' autonomy *Journal of Medical Ethics* (1983) 9, 38 – 44.

[305] Devereux, John *Australian Medical Law* (Second Edition) Cavendish Publishing, Australia Sydney 2002, 5.

[306] Komrad, Mark S A defence of medical paternalism: maximising patients' autonomy *Journal of Medical Ethics* (1983) 9, 38 – 44, 41.

[307] Section 12(2) of the Constitution of the Republic of South Africa, 1996.

and the right to freedom of religion and belief.[311] The values of dignity, integrity, individuality, independence, responsibility and self-knowledge constitute the foundation of a person's right to autonomy, and among these values, dignity is singled out as having a particularly close connection with a person's health. Health is seen to be essential for life and human dignity; dignity is a founding value of the South African Constitution and is also protected as a fundamental right in the Bill of Rights.[312] Autonomy and self-determination are also recognised in the National Health Act 61 of 2003, more specifically in sections 6, 7, 8, and 12.[313]

Section 10 of the Constitution, forming part of the Bill of Rights (Chapter Two) states that everyone has an inherent dignity and the right to have his/her dignity respected and protected. The Constitutional Court has emphasised that this right signals respect for the intrinsic worth of all human beings and that dignity as a constitutional value informs the interpretation of all other rights.[314] Section 12(2) of the Constitution is also relevant to the present discussion. The value underlying this provision which also protects everyone's right to bodily and psychological integrity is the right to self-determination. It also includes the right to security in and control over a person's body (section 12(2)(b)) and the right not to be subjected to medical or scientific experiments without his/her informed consent (section

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[308] Section 14 of the Constitution of the Republic of South Africa, 1996.

[309] Section 11 of the Constitution of the Republic of South Africa, 1996; And which includes the right of mentally competent patients not to live by refusing medical treatment.

[310] Section 21(1) of the Constitution of the Republic of South Africa, 1996; E.g. the right of mentally competent patients to voluntarily discharge themselves.

[311] Section 15(1) of the Constitution of the Republic of South Africa No 108 of 1996; E.g. respecting a mentally competent patient's right to refuse medical treatment for themselves on religious grounds – but not necessarily to refuse treatment for their children in life-threatening situations. See Hay v B 2003(3) SA 492 (W) in this regard; McQuoid-Mason, David An introduction to aspects of health law: bioethical principles, human rights and the law *South African Journal of Bio-ethics and Law* Vol 1, No 1, (June 2008) 7 – 10, 7; Thomas, Rhiannon Where to from Castell v De Greef? Lessons from recent developments in South Africa and abroad regarding consent to treatment and the standard of disclosure *South African Law Journal* (2007) 188- 215, 205; Section 12(2); Also see Pieterse, Marius The Interdependence of rights to Health and Autonomy in South Africa *South African Law Journal* 2008 (3) 553 – 572, 558.

[312] Thomas, Rhiannon Where to from *Castell v De Greef*? Lessons from recent developments in South Africa and abroad regarding consent to treatment and the standard of disclosure *South African Law Journal* (2007) 188- 215, 204; *S v Makwanyane and another* 1995 (3) SA 391 (CC) para 328; Carstens, Pieter and Pearmain, Debbie *Foundational Principles of South African Medical Law* LexisNexis: Durban 2007, 29; Section 1(a) and section 10 of the Constitution of the Republic of South Africa.

[313] National Health Act 61 of 2003.

[314] Thomas, Rhiannon Where to from Castell v De Greef? Lessons from recent developments in South Africa and abroad regarding consent to treatment and the standard of disclosure *South African Law Journal* (2007) 188- 215, 193; *Dawood, Shalabi, Thomas and others v Minister of Home Affairs* 2000 (3) SA 936 (CC) para 35.

12(2)(c)). The origin of this right to self-determination as an ethical principle reflected in legal rules is explained in various ways. Some claim that it is based on inherent natural rights, others say that it is a political notion expressing the importance of the individual, and still another perception is that it is based on a patient's right to dignity.[315] The reiteration of these rights and underlying values in various instruments and judicial decisions will now be discussed.

In health law, autonomy refers to either liberal individualism or physical essentialism. Liberal individualism in this context (also referred to as the procedural quality of individualism) refers to the right to *all* relevant information, while physical essentialism (also referred to as the substantive quality of individualism) means that one's body is the essence of oneself and autonomy thus means that one has exclusive rights over and the final say in what happens to one's body. In the rhetoric of modern medical ethics patient autonomy and self-determination are clearly values of considerable significance. As such, they trace their origin to Judge Cardoza's famous dictum in the case of *Schloendorff v Society of New York Hospital*: "*Every human being of adult years and sound mind has a right to determine what shall be done with his own body*".[316] In South African medical law the concept of patient autonomy was first recognised in the case of *Stoffberg v Elliott,* with Justice Watermeyer explaining that: "*in the eyes of the law every person has certain absolute rights which the law protects. They are not dependent on statute or contract, but they are rights to be respected, and one of the rights is absolute security of the person…*".[317] Consent expresses the primacy of autonomy and individualistic values in our society, as well as in medical practice. The significance of consent to an individual as well as to the greater community, which must decide whether to give effect to it, depends on each particular situation and its circumstances.[318]

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[315] Kirby, MD Informed consent: what does it mean? *Journal of Medical Ethics* (1983) 9, 69 – 75.

[316] Dworkin, Roger B Getting what we should from doctors: Rethinking patient autonomy and the doctor-patient relationship *Health Matrix: Journal of Law-Medicine* 13 (2003) 235 – 296, 239; *Schloendorff v Society of New York Hospital* 105 N.E. 92, 129 (N.Y. 1914); Kottow, W The battering of informed consent *Journal of Medical Ethics* 30 (2004) 565 – 569.

[317] *Stoffberg v Elliott* 1923 CPD 148 - 150.

[318] Shuck, Peter H Rethinking Informed Consent *The Yale Law Journal* (1993) Vol 103: 899 – 959, 900 and 906.

The principle of autonomy is, however, not absolute and the truly independent and self-determining self is but a theoretical construct.[319] There is also a conflict between the principle of autonomy and the principle of beneficence, which underlies medical paternalism. The principle of beneficence requires a decision on what is good for others made in a way that is temporally neutral with regard to the person's present and future.[320] Beneficence may also involve the prevention of harm, the removal of harm, benevolence or compassion.[321] As mentioned in Chapter Two, section 2.2., this principle forms the foundation of medical paternalism and centers on an allegedly altruistic commitment of the doctor to the patient (*salus aegroti*).[322] Society also regards such altruistic commitment or beneficence as the moral foundation of the physician's role.[323] Medical practitioners are generally regarded as having a positive duty to do good and some believe that it is a duty of supererogatory benevolence that goes beyond what can reasonably be expected from the rest of the population.[324] This belief rests on a combination of assumptions: the expert knowledge of medical professionals; the vulnerability of patients; the sacredness of health; and the consequent unique relationship that exists between doctors and their patients. The principle of beneficence has four elements:

- a medical practitioner should not inflict evil or harm;
- evil or harm should be prevented;
- evil or harm should also be removed if it is present; and
- medical practitioners ought to do good and/or promote good.[325]

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[319] Thomas, Rhiannon Where to from Castell v De Greef? Lessons from recent developments in South Africa and abroad regarding consent to treatment and the standard of disclosure *South African Law Journal* (2007) 188- 215, 205.

[320] *Scoccia, Danny* In defense of hard paternalism *Law and Philosophy (2008) 27:351 – 381, 361.*

[321] Devereux, John *Australian Medical Law* (Second Edition) Cavendish Publishing, Australia Sydney 2002, 5.

[322] Scoccia, Danny In defense of hard paternalism *Law and Philosophy* (2008) 27:351 – 381, 354; Brennan, Troyen *Just Doctoring: Medical Ethics in the Liberal State* Berkeley: University of California Press (1991) vii.

[323] Stauch, Marc; Wheat, Kay; Tringle John *Text, Cases and Materials on Medical Law* 3rd ed Routledge: Cavendish (2006) 19 – 20, 24 – 25; Brennan, Troyen *Just Doctoring: Medical Ethics in the Liberal State* Berkeley: University of California Press (1991) 31; This was also evident in Talcott Parsons' physician role where it was submitted that society perceives professional behaviour to be atypical in terms of its motivation; For a comprehensive discussion of Parsons' physician role see Chapter Two, section 2.2.2.1.

[324] Stauch, Marc; Wheat, Kay; Tringle John *Text, Cases and Materials on Medical Law* 3rd ed Routledge: Cavendish (2006) 19 – 20, 21.

[325] Faden, Ruth R & Beauchamp Tom L *A History and Theory of Informed Consent* Oxford University Press: NY 1986, 10.

Beneficence is regarded as the *raison d'être* of the medical profession.[326] It was first suggested by Hippocrates as the moral purpose of the medical profession and was later elaborated on by others like Dr John Gregory who defined medicine as being "*the art of preserving health, of prolonging life and of curing diseases"*.[327] The service and altruistic motivation associated with the physician's role also contributes to the notion that beneficence is the moral foundation of this role/profession. However, in return for this altruistic commitment the patient must accept that the physician will at times act paternalistically and must also recognise that illness will decrease his/her autonomy.[328] Beneficence is also recognised in the provisions of the Constitution, which state that everyone has the right to life,[329] access to health care within available resources,[330] including reproductive health care,[331] that children have a right to basic health care services,[332] and that everyone has the right of access to information.[333] The principle of non-maleficence, doing no harm, is closely linked to the principle of beneficence. Non-maleficence is also invoked in constitutional provisions dealing with everyone's right to an environment that is not harmful to health or well-being,[334] the right of people not to be treated or punished in a cruel, inhuman or degrading manner,[335] not to be subjected to medical or scientific experiments without their informed consent,[336] or not to be denied the

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[326] Devereux, John *Australian Medical Law* (Second Edition) Cavendish Publishing, Australia Sydney 2002, 5; Pellegrino, Edmund D & Thomasma, David C *For the Patient's Good: The Restoration of Beneficence in Health Care* Oxford University Press: NY (1988) 73.

[327] Devereux, John *Australian Medical Law* (Second Edition) Cavendish Publishing, Australia Sydney 2002, 6.

[328] Brennan, Troyen *Just Doctoring: Medical Ethics in the Liberal State* Berkeley: University of California Press (1991) vii.

[329] Section 11 of the Constitution of the Republic of South Africa 108 of 1996; E.g. patients should be provided with life-saving treatment where this is necessary.

[330] Section 27(1)(a) of the Constitution of the Republic of South Africa, 1996; E.g. HIV-positive patients should be provided with access to proper medication if they cannot afford it.

[331] Section 27(1)(a) of the Constitution of the Republic of South Africa, 1996; E.g. the right to obtain a legal termination of pregnancy.

[332] Section 28(1)(c) of the Constitution of the Republic of South Africa, 1996; E.g. babies born of HIV-positive mothers should be provided with prophylactic treatment.

[333] Section 32(1) of the Constitution of the Republic of South Africa, 1996; E.g. access to their health records; McQuoid-Mason, David An introduction to aspects of health law: bioethical principles, human rights and the law *South African Journal of Bio-ethics and Law* Vol 1, No 1, (June 2008) 7 – 10, 7 - 8;

[334] Section 24(a) of the Constitution of the Republic of South Africa, 1996.

[335] Section 12(1)(e) of the Constitution of the Republic of South Africa, 1996.

[336] Section 12(2)(c) of the Constitution of the Republic of South Africa, 1996.

right to practise their religion or culture or to speak their language,[337] and the provision that nobody may be refused emergency medical treatment.[338]

Despite the significant role that autonomy and self-determination are said to play in a free and liberal state, and even though autonomy has been hailed as the most important principle of bio-ethics, both are continuously being subjected to restrictions in medical practice based on the principle of beneficence.[339] But is this restriction of autonomy, liberty and self-determination in the doctor-patient relationship acceptable? Feinberg contends that "*every person's moral right to govern himself surely outweighs the "right" of benevolent intermeddlers to manipulate him for his own advantage, whether that advantage is health, wealth, contentment, or freedom*".[340] The more private the choice to be made the more robust should autonomy be protected and promoted. Since few choices are more private and intimate than those concerning a person's health, society should therefore not permit any interference with this choice.[341] Beauchamp suggests that the autonomy model and the beneficence model should be understood as two polar opposites, but that it is possible to adopt principles from each of the models without resultant inconsistency.[342] This much was acknowledged by the USA President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioural Research: "*The primary goal of health care in general is to maximise each patient's well-being. However, merely acting in a patient's best interest without recognising the individual as the pivotal decisionmaker would fail to respect each person's interest in self-determination…When the conflicts that arise between a competent patient's self-determination and his or her apparent well-being remain unresolved after adequate deliberation, a competent patient's self-determination is and*

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[337] Section 31(1) of the Constitution of the Republic of South Africa, 1996.

[338] Section 27(3) of the Constitution of the Republic of South Africa, 1996; McQuoid-Mason, David An introduction to aspects of health law: bioethical principles, human rights and the law *South African Journal of Bio-ethics and Law* Vol 1, No 1, (June 2008) 7 – 10, 8;

[339] Kottow, M The battering of informed consent *Journal of Medical Ethics* 30 (2004) 565 – 569.

[340] Teff, Harvey *Reasonable Care: Legal Perspectives on the Doctor-patient Relationship* Clarendon Press Oxford (1994) 94.

[341] Schuck, Peter H Rethinking Informed Consent *The Yale Law Journal* (1993) Vol 103, 899 – 959.

[342] Beauchamp, Tom L The promise of the beneficence model for medical ethics *Journal of Contemporary Health Law and Policy* 6 (1990) 145 – 155, 149 – 150.

surely should be given greater weight than other people's views on that individual's well-being".[343]

Another attempt at resolving the conflict between the principle of autonomy and beneficence in medical decision-making is the Pellegrino-Thomasma Beneficence Model.[344] Edmund Pellegrino and David Thomasma promoted the preeminence of beneficence by reconstructing the traditional beneficence model to accommodate some of the concerns of the autonomy model.[345] They submit that neither contemporary law nor contemporary medical ethics provides sufficient reason for or proof of the supremacy of autonomy above beneficence in medical decision-making: "*None of [the court cases favouring patient autonomy] can be seen as an objection to the beneficence model. It might be tempting to think that these cases give precedence to patient wishes or presumed wishes over physician paternalism, but that is not so. Instead, they emphasise patient wishes…as a means for protecting the patient's best interests. This is a critical point. While autonomy is not a clear winner in these cases, neither is paternalism. Rather, the best interests of the patients are intimately linked with their preferences. From these are derived our primary duties toward them*".[346] Pellegrino-Thomasma's theory is mainly founded on the principle of beneficence, submitting for example that technically correct decisions may not necessarily be in the patient's best interest as defined in the patient's own terms.[347] Pellegrino even suggests that there are no absolute moral principles in the doctor-patient relationship, except the injunction to act in the patient's best interest, since all illness represents a state of diminished autonomy.[348] Both Beauchamp and Pellegrino-Thomasma therefore suggest a

[343] Beauchamp, Tom L The promise of the beneficence model for medical ethics *Journal of Contemporary Health Law and Policy* 6 (1990) 145 – 155, 149.
[344] Beauchamp, Tom L The promise of the beneficence model for medical ethics *Journal of Contemporary Health Law and Policy* 6 (1990) 145 – 155, 151; Pellegrino, Edmund D & Thomasma, David C *A Philosophical Basis of Medical Practice* Oxford University Press: NY 1981; Pellegrino, Edmund D & Thomasma, David C *The virtues in Medical Practice* Oxford University Press: NY 1993; Pellegrino, Edmund D & Thomasma, David C *For the patient's good: The restoration of Beneficence in Health Care* Oxford University Press: NY 1988.
[345] Beauchamp, Tom L The promise of the beneficence model for medical ethics *Journal of Contemporary Health Law and Policy* 6 (1990) 145 – 155, 151.
[346] Beauchamp, Tom L The promise of the beneficence model for medical ethics *Journal of Contemporary Health Law and Policy* 6 (1990) 145 – 155, 151.
[347] Pellegrino, Edmund D & Thomasma, David C *A Philosophical Basis of Medical Practice* Oxford University Press: NY 1981, 214.
[348] Beauchamp, Tom L The promise of the beneficence model for medical ethics *Journal of Contemporary Health Law and Policy* 6 (1990) 145 – 155, 152; Komrad, Mark S A defence of medical paternalism: maximising patients' autonomy *Journal of medical ethics* 9 (1983) 38 – 44, 38.

combination of the principles of these two models in medical decision-making, Beauchamp from the autonomy model as starting point and Pellegrino-Thomasma from the point of view that beneficence supersedes both autonomy and paternalism in medical decision-making.[349]

From the discussion above it appears that the conflict between autonomy and beneficence in medical decision-making is historically rooted in the nature of medical care. The discussion has also demonstrated that a paternalistic approach in medical decision-making infringes on the patient's autonomy and right to self-determination on the grounds of beneficence. Since the principle of beneficence is so ingrained in the doctor-patient relationship, and sometimes also necessary due to the functional specificity of the medical profession, it is no a simple task to find a balance between these conflicting values. It is therefore necessary to recognise the limits of both beneficence and autonomy in medical practice. Excessive claims by patients dictating treatment cannot be justified in the name of patient autonomy, but at the same time physicians cannot be allowed to decide exclusively and unilaterally. They can also not simply withhold their guidance, lest patients forfeit the benefit of the professional expertise of the physician in medical decision-making.[350] A balance between patient autonomy and beneficence in medical decision-making is therefore needed. The discussion in section 3.4. will show that the current legal valuation of patient autonomy in medical decision-making is not successful.

3.4. A juridical response to traditional paternalism in medical decision-making

Few concepts are more sensitive to a dynamic social context and the changing values of society than the notion of consent.[351] With an increased recognition of human rights and the value of patient autonomy, as well as physicians being trained in a new patient-centred approach, the doctor-patient relationship and medical decision-making have been

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[349] Beauchamp, Tom L The promise of the beneficence model for medical ethics *Journal of Contemporary Health Law and Policy* 6 (1990) 145 – 155, 152; Pellegrino-Thomasma

[350] Bagheri, Alireza Regulating Medical Futility: Neither Excessive Patient's Autonomy nor Physician's Paternalism *European Journal of Health Law* 15 (2008) 45 – 53, 51; See Chapter Two, section 2.2.1. and 2.2.3. of this dissertation for a discussion on the functional specificy of members of the medical profession and the attributes, which include power and authority, necessary to fulfill their function.

[351] Shuck, Peter H Rethinking Informed Consent *The Yale Law Journal* (1993) Vol 103, 899 – 959.

remodeled.[352] This was necessary since the traditional paternalistic approach to medical decision-making, based on the principle of beneficence, provided the physician with great power over the patient and with the potential of abuse. Various reasons for this rights-based perspective exist, including revelations of the atrocities committed by Nazi doctors during World War II, the international and national guidelines and ethical codes drawn up as a consequence of this, a growing commitment to human rights in general, the highlighting of power imbalances, discrimination and the social disadvantages of minorities, and the medical malpractice crises in the USA during the 1970s.[353]

In medical law, this shift of focus to patient autonomy and self-determination was facilitated, politically and legally, by abstract principles enshrined in foundational texts, like ethical codes[354] and guidelines,[355] legislation[356] and the Constitution of the Republic of South Africa.[357] But the impetus for more informed and participatory decision-making in health care first came with the doctrine of informed consent, formerly articulated and implemented in case law by the judiciary. The discussion that follows will include a comprehensive consideration of all these legal instruments which have made informed and participatory decision-making in health care possible. The discussion will commence with the doctrine of informed consent, a concept which also forms the foundation of present medical ethics. However, no attempt will be made to provide an exhaustive exposition on this doctrine of informed consent. The focus will be on the relevance of this doctrine for a

[352] Bagheri, Alireza Regulating Medical Futility: Neither Excessive Patient's Autonomy nor Physician's Paternalism *European Journal of Health Law* 15 (2008) 45 – 53, 48; Silverman, William A The myth of informed consent: in daily practice and in clinical trials *Journal of Medical Ethics* 15 (1989) 6 – 11.

[353] Teff, Harvey *Reasonable Care: Legal Perspectives on the Doctor-patient Relationship* Clarendon Press Oxford (1994) 96; Brennan, Troyen *Just Doctoring: Medical Ethics in the Liberal State* Berkely: University of California Press (1999) 53.

[354] See the National Patients' Rights Charter issued in 2001 by the Department of Health.

[355] See the Medical Research Council's guidelines – *Guidelines on Ethics for Medical Research* (1993). These guidelines are currently being reviewed; Also see the guidelines, codes of conduct and ethical codes of the Health Professions Council of South Africa, these ethical guidelines are binding on members of the HPCSA; These guidelines will not be discussed in this dissertation since they are ethical considerations, although important in medical practice, not legal obligations or instruments to consider. The duty to follow these guidelines is ethical and not legal and does not fall within the ambit of this research.

[356] Chapter 9 of the National Health Act 61 of 2003, also see section 71 of the act; Mental Health Care Act 17 of 2002; Children's Act 38 of 2005; Choice on Termination of Pregnancy Act 92 of 1996; Sterilisation Act 44 of 1998.

[357] Constitution of the Republic of South Africa 108 of 1996, section10 and 12.

discussion of the power imbalances in the doctor-patient relationship within the framework of medical paternalism.[358]

3.4.1. Informed consent

The doctrine[359] of informed consent was formulated to address the general lack of importance placed on disclosure and consent in medical decision-making, as well as the ensuing power imbalance this creates in the doctor-patient relationship. This doctrine is inherently about patient autonomy and self-determination and theoretically in line with the underlying values of the South African Constitution.[360] The doctrine of informed consent requires that medical practitioners explain to a patient what is involved in an intended diagnostic or therapeutic procedure before such procedure is carried out. This is necessary in order to secure the understanding consent of the patient before proceeding.[361] The purpose of the doctrine is therefore to ensure that the patient's rights to self-determination and freedom of choice are respected and also to encourage rational decision-making by enabling the patient to make an informed decision.[362] Cases where a lack of informed consent is alleged are usually based either on the submission that a physician failed to fulfill the duty to supply the patient with all material information about risks and alternatives for the proposed medical procedure or on the submission that a physician administered treatment beyond what was authorised by the patient.[363] This doctrine is usually held to have originated on 22 October 1957, when judgement in the case of *Salgo v Leland Stanford Jr. University Board of Trustees, USA* was handed down.[364]

[358] This discussion will for example not include the exception of therapeutic privilege since this dissertation will only deal with the general and ordinary doctor-patient relationship as was submitted in Chapter One of this dissertation.
[359] A legal doctrine is a body of legal theory applied to a particular topic.
[360] Carstens, Pieter and Pearmain, Debbie *Foundational Principles of South African Medical Law* LexisNexis: Durban 2007, 687; Earle, Murray 'Informed Consent': Is there room for the reasonable patient in South African law? *South African Law Journal* (1995) 629 – 642, 630.
[361] Kirby, MD Informed consent: what does it mean? *Journal of Medical Ethics* 1983, 9, 69 – 75, 69.
[362] Carstens, Pieter and Pearmain, Debbie *Foundational Principles of South African Medical Law* LexisNexis: Durban 2007, 883.
[363] *Culbertson v Mernitz* 602 N.E.2d 98 (Ind. 1992), 105
[364] Katz, Jay *The Silent World of Doctor and Patient* Johns Hopkins University Press: Baltimore (2002) 60; *Salgo v Leland Stanford Jr. University Board of Trustees* 317 P.2d 170 (Cal. Dist. Ct. App. 1957); Although some writers claim that the first case in which informed consent in medical care was an issue was the 1767 English case of *Slater v Baker and Stapleton* 95 Eng Rep 860, 2 Wils. K.B. 359 (1767).

3.4.1.1. The origin of informed consent

In the *Salgo* case the plaintiff was referred to one Dr Gerbode for continued and worsening cramping pains in his legs.[365] Dr Gerbode diagnosed the plaintiff with advanced arterial insufficiency and subsequent advanced arteriosclerosis. This was a serious diagnosis and a disease which could cause a stroke or coronary occlusion to the vessels of the heart. Dr Gerbode suggested further tests at an inpatient hospital, including an aortography. The plaintiff remained in hospital and seemed to recover well from the procedures. However, when the plaintiff woke up the following morning his lower extremities were paralysed. This condition was permanent. The plaintiff claimed that this permanent paralysis was due to the negligent performance of the aortography by the doctors and staff of the Stanford University Hospital. He later claimed that the physicians had failed to warn him of the risks of paralysis inherent in this procedure.[366]

One paragraph at the end of Judge Bray's judgement in the ensuing case introduced the doctrine of informed consent. This paragraph was adopted verbatim and without attribution from the *amicus curiae* brief submitted by the American College of Surgeons to the California Court of Appeals.[367] Judge Bray stated: "*A physician violates his duty to his patient and subjects himself to liability if he withholds any facts which are necessary to form the basis of an intelligent consent by the patient to the proposed treatment… In discussing the element of risk a certain amount of discretion must be employed consistent with the full disclosure of facts necessary to an informed consent".*[368] Although this introduction to informed consent stimulated debate on the subject, the paragraph quoted above did very little to clarify the conflict between disclosure, consent and the far-reaching authority of physicians with regard to their discretion in such matters. Nor did it offer an effective solution for the conflict between beneficence and self-determination in medical decision-making. Judge Bray held that physicians should always place the welfare of their patient above all else, but should also be aware that each patient's case presents unique problems

[365] Katz, Jay *The Silent World of Doctor and Patient* Johns Hopkins University Press: Baltimore (2002) 60; *Salgo v Leland Stanford Jr. University Board of Trustees* 317 P.2d 170 (Cal. Dist. Ct. App. 1957).
[366] Katz, Jay *The Silent World of Doctor and Patient* Johns Hopkins University Press: Baltimore (2002) 61.
[367] Katz, Jay *The Silent World of Doctor and Patient* Johns Hopkins University Press: Baltimore (2002) 60.
[368] *Salgo v Leland Stanford Jr. University Board of Trustees* 317 P.2d 170 (Cal. Dist. Ct. App. 1957), paragraph 12.

and that physicians should therefore employ their discretion in each individual case.[369] It is evident from Judge Bray's dictum that he believed that physicians' and patients' interests are one and the same and that physicians can therefore decide on their patients' behalf.[370] It is also clear from the dictum that he viewed the principle of beneficence as the starting point in medical decision-making and the patient's autonomy as secondary thereto. Although the court introduced new elements into the relationship of trust between doctors and their patients, its hesitance to interfere in medical practice was evident. In juxtaposing disclosure and discretion the medical and legal fraternity avoided the real issue at hand, namely the value of patient autonomy and self-determination versus the doctor's obligation to disclose.

Three years later the doctrine was affirmed and further developed in the case of *Natanson v Kline*.[371] Judge Schroeder based his judgement on the following fundamental principle: "*Anglo-American law starts with the premise of thorough-going self-determination. It follows that each man is considered to be master of his own body, and he may, if he be of sound mind, expressly prohibit the performance of life-saving surgery, or other medical treatment....[H]e [the doctor] may not substitute his own judgement for that of the patient by any artifice or deception*."[372] Although this was a great leap forward from the *Salgo*-judgement, this pronouncement of informed consent also had its limitations. Judge Schroeder did not, for instance, deal with the crucial fact that the plaintiff's consent was meaningless since the dangers of cobalt radiation had not been communicated to her.[373] He furthermore limited his pronouncement on informed consent by stating that the duty of physicians to disclose is limited to those disclosures which a reasonable medical practitioner would make under the same or similar circumstances. The notion of informed consent consequently remained a question of medical judgement in which thorough-going patient self-determination had no place.

[369] *Salgo v Leland Stanford Jr. University Board of Trustees* 317 P.2d 170 (Cal. Dist. Ct. App. 1957), paragraph 12.

[370] Katz, Jay *The Silent World of Doctor and Patient* Johns Hopkins University Press: Baltimore (2002) 64.

[371] *Natanson v Kline* 186 Kan. 393, 350 P.2d 1093 [1960]; In this case the plaintiff suffered burn injuries from radiation cobalt therapy used to reduce the risk that her breast cancer would recur or spread. The plaintiff brought a malpractice action against the hospital and the physician in charge of the radiology department for these injuries allegedly resulting from the negligence in administering the therapy. She also claimed that he had failed to advise her of the nature of the proposed treatment and its hazards.

[372] *Natanson v Kline* 186 Kan. 393, 350 P.2d 1093 [1960], 1104.

[373] Katz, Jay *The Silent World of Doctor and Patient* Johns Hopkins University Press: Baltimore (2002) 68.

It was only in 1972 that the doctrine of informed consent was sufficiently developed and pronounced in medical jurisprudence in the United States in the case of *Canterbury v Spence*.[374] The plaintiff suffered from back pain and submitted to an operation without being informed of a risk of paralysis incidental thereto. A day after the operation he fell from his hospital bed when left unattended and suffered an almost immediate setback. The lower half of his body became paralysed and despite extensive medical care he never fully recovered. Years later he hobbled on crutches [*sic*] and also suffered from paralysis of the bowels and urinary incontinence. The complaint in this case stated several causes of action but for the purposes of this discussion the focus will only be on the defendant's alleged failure to inform the plaintiff beforehand of the risk involved in the operation. As in the *Natanson* case the judgement commenced with the root premise of self-determination first pronounced by Judge Cardozo in the *Schloendorff* case.[375] Judge Robinson added to this that "*true consent to what happens to one's self is the informed exercise of a choice, and that entails an opportunity to evaluate knowledgeably the options and the risks attendant upon each*". He elaborated that the patient's right to self-decision is central and shapes the boundaries of the duty to reveal. The right to self-determination can only be exercised if the patient possesses enough information to enable an informed choice. The test for determining whether particular facts and information should therefore be disclosed is the materiality of the disclosure to the patient's eventual decision. All risks potentially affecting the decision must therefore be disclosed.[376]

However, Judge Robinson also recognised the role of the medical practitioner's judgement in this disclosure, since the content of the disclosure rests in the first instance with the particular medical practitioner who is the only one in a position to decide what information is materially important and necessary to divulge. He stated that the focus of attention is more upon the nature and content of the physician's divulgence than on the patient's understanding of consent. The vital inquiry regarding the duty to disclose relates to the physician's obligation to disclose; the subjective degree of the patient's comprehension is

[374] *Canterbury v Spence* 464 F. 2d 772 (D.C. Cir. 1972).
[375] Teff, Harvey *Reasonable Care: Legal Perspectives on the Doctor-patient Relationship* Clarendon Press Oxford (1994) 84.
[376] *Canterbury v Spence* 464 F. 2d 772 (D.C. Cir. 1972), 786.

mostly secondary thereto.[377] The judge concluded that it is material and necessary to disclose a risk or information when a reasonable person in what the physician knows or should know to be the patient's position, would likely attach significance to when making an informed decision.[378] This calls for an objective test for disclosure based on the reasonableness of the physician's divulgence and not a subjective test of materiality based on an individual patient's needs.[379]

Judge Robinson furthermore addressed the ability of the medical profession to establish its own standards, especially the ability of making use of expert medical witnesses to establish the professional standard of care in respect of disclosure: "*We do not agree that the patient's cause of action is dependent upon the existence and non-performance of a relevant professional tradition*."[380] Robinson here rejected the professional standard of practice in disclosure disputes based on respect for a patient's right to self-determination which requires a standard set by law and not a standard set by the medical profession. He explained that ordinary disclosure does not involve a physician's expert knowledge and skills and therefore does not require a standard set by members of the medical profession (a medical judgement), but rather a standard set by the law. He acknowledged that non-disclosure by itself cannot establish liability to the patient.[381] An unrevealed risk must materialise for otherwise the omission is legally without consequence. Negligence unrelated to injury is non-actionable. In addition, there must be a causal relationship between the physician's failure to disclose and the patient's injury.[382] Such a causal relationship can only exist when disclosure of a significant risk would have resulted in a decision against running such risk. Since a hypothetical investigation of what the patient would have decided if the information/risk was disclosed would have resulted in a subjective determination, Judge Robinson voiced his preference for a more objective approach by asking what a prudent person in the patient's position would have decided if suitably informed of all significant

[377] *Canterbury v Spence* 464 F. 2d 772 (D.C. Cir. 1972), 780.
[378] *Canterbury v Spence* 464 F. 2d 772 (D.C. Cir. 1972), 787.
[379] Katz, Jay *The Silent World of Doctor and Patient* Johns Hopkins University Press: Baltimore (2002) 75.
[380] *Canterbury v Spence* 464 F. 2d 772 (D.C. Cir. 1972), 783; *Culbertson v Mernitz* 602 N.E.2d 98 (Ind 1992), 100, 106; *Matthies v Mastromonaco* 709 A.2d 238 (N.J. Super. Ct. App. Div. 1998), 249; *Cobbs v Grant* 502 P.2d 1 (1972), 9.
[381] *Canterbury v Spence* 464 F. 2d 772 (D.C. Cir. 1972), 790.
[382] The difficulty of proving causation in medical negligence cases does not fall within the ambit of this research and will consequently not be elaborated on in this dissertation.

perils.[383] However, the non-disclosure of a material risk already violates the patient's right to self-determination and autonomy, even without (or before) any injury may follow as a result of this non-disclosure.

The doctrine of informed consent in the legal system of the United States of America, as it was articulated in the *Canterbury* case therefore required an objective reasonable patient test to determine what information should be disclosed to the patient. The determination of what information and risks a reasonable patient would have found material for the decision and what a reasonable physician would have disclosed is furthermore a matter to be decided by the courts and not by a professional standard of practice. Finally, the test for causation adopted in this case was also an objective test, asking what a reasonable person in the patient's position would have decided if the particular information and risks had been divulged.

In English medical law the notion of "informed consent" was not adopted with much enthusiasm. The first medical law case in which the phrase "informed consent" was used was in the case of *Re D (A minor) (Wardship: Sterilisation)*.[384] Thereafter the phrase was only used in explaining the English law's rejection of this American concept.[385] It was also described by Kennedy and Grubb as an "*unfortunate phrase and one prone to mislead*".[386] English courts prefer the concept, "real consent". In the case of *Chatterton v Gerson*[387] it was submitted that once the patient is informed in broad terms of the nature of the intended procedure and gives her/his consent, that consent is real.

The case of *Bolam v Friern Hospital Management Committee*[388] was heard earlier during the same year as the landmark *Salgo* case in the USA. In the former case the plaintiff sustained injuries during the course of electro-convulsive-therapy treatment administered at the

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[383] *Canterbury v Spence* 464 F. 2d 772 (D.C. Cir. 1972), 791.
[384] *Re D (A minor) (Wardship: Sterilisation)* [1976] Fam 185, 193.
[385] Skegg, P.D.G. English medical law and 'Informed Consent': An Antipodean Assessment and Alternative *Medical Law Review* Vol 7 (1999) 135 – 165, 136.
[386] Skegg, P.D.G. English medical law and 'Informed Consent': An Antipodean Assessment and Alternative *Medical Law Review* Vol 7 (1999) 135 – 165, 136; Grubb, Andrew *Principles of Medical Law* (Second edition) Oxford University Press 2004, 180; Teff, Harvey *Reasonable Care: Legal Perspectives on the Doctor-patient Relationship* Clarendon Press Oxford (1994) 196.
[387] *Chatterton v Gerson* [1981] Q.B. 432, 442B-C.
[388] *Bolam v Friern Hospital Management Committee* [1957] 1 W.L.R. 582, QBD.

defendant's mental hospital. The plaintiff claimed that the defendants had been negligent in several respects, including that they had failed to inform him of the risks involved in the treatment and that they had not provided him with the opportunity to decide whether or not he was willing to take those risks. Justice McNair instructed the jury to decide whether the practice adopted by the defendants not to divulge any material information but only to answer specific questions from the plaintiff fell below the proper standard of competent professional opinion. With this instruction Justice McNair opted for an objective test for disclosure based on a medical judgement and standards set by the medical profession – a professional practice standard, in other words. McNair also added that should the jury find that proper practice does require that material information about the procedure should be divulged, the jury must also decide whether such disclosure would have made any difference in this particular case. It is clear from Justice McNair's instructions that the significance of patient autonomy and self-determination in medical decision-making were not regarded as critical to an eventual decision. McNair's direction to the jury in this case has become known as the Bolam test according to which medical practitioners are not negligent if they act in accordance with a practice accepted at the time as proper by a responsible body of medical practitioners.[389] This test championed medical paternalism and has been described as an outdated keepsake of a hierarchical English society.[390]

In South Africa the doctrine of informed consent was first introduced in 1976 in the case of *Richter and another v Estate Hammann,*[391] although the groundwork for the acceptance of this doctrine in the South African medical- and health law had been laid by the preceding cases reaffirming the judiciary's commitment to patient autonomy.[392] In the *Richter* case Justice Watermeyer stated that the standard of the reasonable doctor should be used to determine the required nature and scope of disclosure in the doctor-patient relationship. He

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[389] Skegg, P.D.G. English medical law and 'Informed Consent': An Antipodean Assessment and Alternative *Medical Law Review* Vol 7 (1999) 135 – 165, 144; See *Rogers v Whitaker* 175 CLR 479 [1992] for comprehensive critique on the Bolam test.

[390] Bradfield, Owen At the heart of Chappel v Hart: a warning about warning! Australian Law Students' Association: Academic Journal http://www.alsa.asn.au.files/acj/2000/chappel_hart.html ; The Bolam test was reaffirmed in *Maynard v West Midlands Regional Health Authority* [1984] 1 W.L.R. 634 HL and *Whitehouse v Jordan* [1981] 1 W.L.R. 246 HL.

[391] *Richter and another v Estate Hammann* 1967 (3) SA 226 (C).

[392] Carstens, Pieter and Pearmain, Debbie *Foundational Principles of South African Medical Law* LexisNexis: Durban 2007, 891; *Esterhuizen v Administrator Transvaal* 1957 (3) SA 710 (T); *Richter and another v Estate Hammann* 1967 (3) SA 226 (C).

also stated that medical opinion is necessary to determine what a reasonable doctor, having regard to all the circumstances of the particular case, should or should not disclose, but added that the court would ultimately decide on the question.[393] This test proposed in the *Richter* case corresponds to the Bolam test in English law.

It is clear from these early decisions on the doctrine of informed consent that the courts have failed to provide for real self-determination. In the *Salgo* and *Natanson* cases the doctor-patient relationship was framed in terms of an encounter between right-bearing individuals, but both these cases ended up exaggerating the physician's authority without allowing for thorough-going self-determination on the part of the patient.[394] In the *Canterbury* case an apparently decided commitment to self-determination at the beginning of the judgement got weaker as Judge Robinson moved from jurisprudential theory to the realities of medical practice.[395] Patient autonomy and self-determination do not even feature in the English Bolam and the South African Richter decisions. In both of these instances the courts opted for a professional practice standard, reinforcing the authority of the medical profession in medical decision-making. All these cases rhetorically professed self-determination, but left considerable scope for medical paternalism.[396] According to Katz the courts continue to deal inadequately with the concepts of patient autonomy and self-determination because they have their doubts about patients' decision-making capacity and they fear that meddling with patients' unquestioning faith could undermine cure.[397]

3.4.1.2. The development of the doctrine of informed consent

The cautious introduction of the doctrine of informed consent to medical- and health law just described was followed by many inconsistent rulings, which added very little to its analytical development and offered no extension of either the patient's or physician's rights

[393] *Richter and another v Estate Hammann* 1967 (3) SA 226 (C), 233.
[394] Brennan, Troyen *Just Doctoring: Medical Ethics in the Liberal State* Berkeley: University of California Press (1991) 106.
[395] Katz, Jay *The Silent World of Doctor and Patient* Johns Hopkins University Press: Baltimore (2002) 71.
[396] Teff, Harvey *Reasonable Care: Legal Perspectives on the Doctor-patient Relationship* Clarendon Press Oxford (1994) 200.
[397] Katz, Jay *The Silent World of Doctor and Patient* Johns Hopkins University Press: Baltimore (2002) 71; *Natanson v Kline* 186 Kan. 393, 350 P.2d 1093, 1102; Teff, Harvey *Reasonable Care: Legal Perspectives on the Doctor-patient Relationship* Clarendon Press Oxford (1994) 30; Thomas, Rhiannon Where to from Castell v De Greef? Lessons from recent developments in South Africa and abroad regarding consent to treatment and the standard of disclosure *South African Law Journal* (2007) 188- 215, 195.

and obligations.[398] Some judgements reasserted faith in the capacity of medical practitioners to set adequate disclosure standards themselves, thereby opting for a *medical judgement* and standard of care, rather than a standard *set by law*.[399] In the case of *Collins v Meeker,*[400] for example, the court submitted that expert testimony from the medical profession is required to establish that disclosures were made in accordance with what is expected of a reasonable medical practitioner. In the case of *Bly v Rhoads*[401] the plaintiff's contention that the standard of disclosure should be determined by the patient's need to know and not by the standards of the medical community, was also rejected in favour of an approach placing more importance on the medical judgement – a professional disclosure standard.[402] In *Woolley v Henderson*[403] the court stated that since a medical practitioner is not an insurer of his medical interventions (a material risk standard), liability for a risk that was not disclosed but later materialised, can never be allowed. The court also concluded that legal principles designed to provide compensation to persons injured by bad professional practice should not unduly intrude on the intimate physician-patient relationship. The court believed that this would place good medical practice in jeopardy.[404] Furthermore, in *Malloy v Shanahan*[405] the court ruled that the doctrine of informed consent is not applicable to therapeutic treatment. A final example is the English case of *Gold v Haringey Health Authority.*[406] Here, the plaintiff alleged that the defendants had been negligent in failing to disclose to her that the sterilisation operation which she had undergone had a failure rate and that its success could not be guaranteed. The defendants had also failed to discuss alternatives to the operation, such as a vasectomy, with her. The court in this case applied the Bolam test and emphasised that expert medical testimony is necessary to determine whether particular facts, risks and information should be divulged.[407]

[398] Katz, Jay *The Silent World of Doctor and Patient* Johns Hopkins University Press: Baltimore (2002) 80.
[399] Katz, Jay *The Silent World of Doctor and Patient* Johns Hopkins University Press: Baltimore (2002) 80.
[400] *Collins v Meeker* 424 P.2d 488 (Kan. 1967), 495.
[401] *Bly v Rhoads* 222 S.E. 2d 783 (Virg. 1976).
[402] *Bly v Rhoads* 222 S.E. 2d 783 (Virg. 1976), 787; *Woolley v Henderson* 418 A.2d 1123 (Maine 1980), 1129.
[403] *Woolley v Henderson* 418 A.2d 1123 (Maine 1980), 1129.
[404] *Woolley v Henderson* 418 A.2d 1123 (Maine 1980), 1131.
[405] *Malloy v Shanahan* 421 A.2d 803 (Penn 1980).
[406] *Gold v Haringey Health Authority* [1988] Q.B. 481 CA.
[407] The Bolam-test was also applied in *Blyth v Bloomsbury Area Health Authority* HA [1993] 4 Med LR 151.

There were, however, other cases where the doctrine of informed consent was developed to provide greater protection for patient autonomy and to extend the patient's right to self-determination. The USA case of *Scott v Bradford*[408] is a case in point. The plaintiff suffered from fibroid tumours on her uterus. The defendant admitted her to hospital, where she signed a routine consent form, and the defendant then performed a hysterectomy. After the surgery the plaintiff experienced problems with incontinence, which is an inherent risk of the procedure performed by the defendant. The plaintiff's action against the defendant was based on the defendant's failure to advise her of the risks involved in the procedure and to inform her of available alternatives. The plaintiff maintained that if she had been properly informed, she would not have elected to continue with the surgery. The court applied the doctrine as articulated in *Canterbury* but also added that the objective reasonable man approach used in *Canterbury* backtracks on its own theory of self-determination and limits the protection granted to an injured patient.[409] The application of a reasonable man approach in deciding whether a patient would have declined the medical intervention based on the disclosed information, was therefore rejected in this case. The court thought that the patient's testimony as to her reaction to a full disclosure should be accepted. Such a subjective approach provides greater protection of patient autonomy and self-determination.

The minority judgement of Lord Scarman in the English case *Sidaway v Board of Governors of Bethlem Royal Hospital and the Maudsley Hospital* is another example of a decision favouring the protection of patient autonomy and the realisation of self-determination in medical decision-making.[410] The plaintiff allegedly suffered injuries as a result of surgery performed by a neuro-surgeon. The plaintiff claimed that had she been properly informed of all the material risks inherent in this operation she would not have consented to it. The majority decision in this case, based on professional judgement criteria, found in favour of the defendants, holding that a doctor should act in accordance with a practice accepted at the time as proper by skilled and experienced medical practitioners. In addition, where there is a substantial risk of grave consequences which no reasonably prudent doctor would

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[408] *Scott v Bradford* 606 P.2d 554 (Okla. 1980).
[409] *Scott v Bradford* 606 P.2d 554 (Okla. 1980), 559.
[410] *Sidaway v Board of Governors of Bethlem Royal Hospital and the Maudsley Hospital* [1985] A.C. 871 HL.

fail to disclose without having a compelling clinical reason, the court may deem its disclosure to be necessary.[411] Lord Diplock submitted that the Bolam test should apply to cases concerning disclosure and that the duty to disclose is part of a doctor's normal duty of care. Lord Donaldson in turn added that the courts cannot stand idly by when the profession by an excess of paternalism denies patients real choice.[412]

Of considerable significance for the present discussion, however, is the previously referred to minority judgement of Lord Scarman, reaffirming that the duty of a doctor to warn a patient is part of the duty of care and skill that the former owes the latter. He also pointed out that the patient's right to make his/her own decision regarding medical treatment is a basic human right protected by the common law and that the courts should not allow medical opinion to override the patient's right to self-determination. He acknowledged that in many cases factors other than purely medical considerations may play a significant part in a patient's decision-making. It should therefore be acknowledged that a doctor's objective opinion and a particular patient's needs, personal beliefs and values might not always be the same. Lord Scarman consequently held that an objective approach should be applied to determine whether all material information was divulged – if a reasonable person in the patient's position would be likely to attach significance to the information/risk. He found that the Bolam test is not applicable to cases concerning disclosure and consent and suggested that the USA doctrine of informed consent be accepted for this purpose instead. The majority was fearful, however, that informed consent would threaten the professional authority of medical practitioners and the doctrine was therefore not accepted in English medical law. Decisions like *Scott v Bradford* and Lord Scarman's effort in *Sidaway* are unfortunately few and far between and disappear amongst the numerous contradicting judgements on informed consent.

In South Africa however, the landmark decision in *Castell v De Greef,*[413] about 17 years after the *Richter* case, can generally be viewed as the impetus for a paradigm shift in South

[411] Teff, Harvey *Reasonable Care: Legal Perspectives on the Doctor-patient Relationship* Clarendon Press Oxford (1994) 212.
[412] Teff, Harvey *Reasonable Care: Legal Perspectives on the Doctor-patient Relationship* Clarendon Press Oxford (1994) 30.
[413] *Castell v De Greef* 1994 (4) SA 408 (C).

African medical- and health law from medical paternalism to an approach focusing on patient autonomy.[414] The plaintiff had a history of breast cancer in her family and on discovery of malignant lumps in her breasts, she decided on a treatment plan that included a mastectomy followed by reconstructive surgery. After the reconstructive surgery the plaintiff experienced a discolouration of the areolae, necrosis of tissues and a discharge that exuded an offensive odour due to a *staphylococcus aureus* infection. She suffered extreme pain, embarrassment, and psychological trauma and underwent numerous surgical procedures to rectify the damage. One of the causes of action submitted by the plaintiff was that the defendant neglected to inform her of the material risks and complications inherent in the procedure treatment plan. The plaintiff's claim, which was based on the lack of informed consent, was dismissed, but the judgement nonetheless had a significant impact on the doctrine of informed consent in South African medical- and health law in that it clearly opted for patient autonomy at the expense of medical paternalism. Justice Ackermann held that self-determination and the rights to bodily integrity and autonomous moral agency are fundamental rights of each patient and that a doctor is therefore under a legal duty to obtain the patient's informed consent for any medical intervention.[415] He also stated that "the best interests of the patient" can never prevail above patient autonomy and self-determination.[416] Informed consent requires that a patient fully appreciates the nature and extent of the harm or risk inherent in the intervention.[417] The court also treated lack of informed consent as an issue of assault rather than negligence. In this case, a subjective patient-centred test for disclosure was used – a medical practitioner should disclose all information and risks that a reasonable person in the patient's position, if warned of these risks, would be likely to attach significance to; or that a reasonable practitioner in this situation should be aware that the particular patient, if warned of these

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[414] Carstens, Pieter and Pearmain, Debbie *Foundational Principles of South African Medical Law* LexisNexis: Durban 2007, 877 *Castell v De Greef* 1994 (4) SA 408 (C), 421; Pieterse, Marius The Interdependence of Rights to Health and Autonomy in South Africa *South African Law Journal* 2008(3) 553 – 572, 559.

[415] *Castell v De Greef* 1994 (4) SA 408 (C), 420J, 421C-D & 427D-E; Thomas, Rhiannon Where to from Castell v De Greef? Lessons from recent developments in South Africa and abroad regarding consent to treatment and the standard of disclosure *South African Law Journal* (2007) 188- 215, 188; Pieterse, Marius The Interdependence of Rights to Health and Autonomy in South Africa *South African Law Journal* 2008(3) 553 – 572, 559.

[416] *Castell v De Greef* 1994 (4) SA 408 (C), 420J – 421D.

[417] Thomas, Rhiannon Where to from Castell v De Greef? Lessons from recent developments in South Africa and abroad regarding consent to treatment and the standard of disclosure *South African Law Journal* (2007) 188- 215, 188.

risks would be likely to attach significance to.[418] By opting for this subjective patient-centered test the court clearly placed patient autonomy before traditional medical paternalistic beliefs and practices. The court furthermore required that the consent be comprehensive, meaning that informed consent requires ongoing dialogue between a patient and a doctor.[419] It also required that the patient be supplied with relevant information about post-operative / treatment aspects as well as matters of significance after her/his discharge from hospital.[420] The court also pointed out that expert medical evidence is necessary to determine what information about risks is material and should be disclosed, but that the court, and not expert evidence alone, will ultimately decide the question.

According to Van Oosten the court in the *Castell* case actually introduced the patient's right to self-determination or freedom of choice as a separate and distinct category of personality rights in South African medical- and health law.[421] But true self-determination did not fully materialise in this landmark judgement for the development of patient autonomy and self-determination, because the court neglected to provide guidelines for the implementation and application of this approach in the South African medical- and health law.[422] Furthermore, the test for disclosure in this judgement appears to be a subjective patient-centred test, but the court did not allow thorough-going self-determination to realise. The starting point of the test is still the practitioner's and not the individual patient's perspective. The court actually did not apply the test it formulated, but asked whether the

[418] Carstens, Pieter and Pearmain, Debbie *Foundational Principles of South African Medical Law* LexisNexis: Durban 2007, 892; Thomas, Rhiannon Where to from Castell v De Greef? Lessons from recent developments in South Africa and abroad regarding consent to treatment and the standard of disclosure *South African Law Journal* (2007) 188- 215, 188; In the court a quo the reasonable doctor test was preferred by Scott J.
[419] Thomas, Rhiannon Where to from Castell v De Greef? Lessons from recent developments in South Africa and abroad regarding consent to treatment and the standard of disclosure *South African Law Journal* (2007) 188- 215, 188; *Castell v De Greef* 1994 (4) SA 408 (C), 425.
[420] Thomas, Rhiannon Where to from Castell v De Greef? Lessons from recent developments in South Africa and abroad regarding consent to treatment and the standard of disclosure *South African Law Journal* (2007) 188- 215, 188; *Castell v De Greef* 1994 (4) SA 408 (C), 426.
[421] Van Oosten, FFW Castell v De Greef and the Doctrine of Informed Consent: Medical Paternalism ousted in favour of patient autonomy *De Jure* 164 – 179, 178 – 179.
[422] Thomas, Rhiannon Where to from Castell v De Greef? Lessons from recent developments in South Africa and abroad regarding consent to treatment and the standard of disclosure *South African Law Journal* (2007) 188- 215, 191;

plaintiff would have made a different decision if information about the risk had been fully disclosed.[423]

In *Broude v McIntosh*[424] the test formulated in the *Castell* case was implicitly accepted but the court failed to realise that lack of disclosure already violates a patient's right to self-determination, irrespective of whether it results in injury or damage.[425] Carstens suggests that the legal uncertainty ensuing after *Broude* will revive the "regressive spirit of medical paternalism".[426] In *McDonald v Wroe*[427] the test as articulated in *Castell* was recently applied, the court holding that a lack of disclosure violated a plaintiff's right to bodily integrity entrenched in section 12(2) of the Constitution.[428] Thus, as in English and USA law, the purpose and aims of this informed consent are obscured by numerous contradicting judgements, each opting for a different approach or standard and with courts mostly still believing that doctors know best.

3.4.1.3. The current status of the doctrine of informed consent

The doctrine of informed consent is well developed in civil law countries such as France, Germany and Switzerland.[429] In Germany the right to give informed consent (*ärztliche Aufklärungspflicht*) has long been recognised and is directly linked to a constitutionally entrenched guarantee of individual self-determination.[430] Much of the impetus towards the

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[423] Thomas, Rhiannon Where to from Castell v De Greef? Lessons from recent developments in South Africa and abroad regarding consent to treatment and the standard of disclosure *South African Law Journal* (2007) 188- 215, 192; Here the court clearly erred in confusing the test for disclosure and informed consent with the test for causation.

[424] *Broude v McIntosh and others* 1998 (3) SA 60 (SCA).

[425] Thomas, Rhiannon Where to from Castell v De Greef? Lessons from recent developments in South Africa and abroad regarding consent to treatment and the standard of disclosure *South African Law Journal* (2007) 188- 215, 188; *Broude v McIntosh and others* 1998 (3) SA 60 (SCA), 68 – 69.

[426] Carstens, Pieter and Pearmain, Debbie *Foundational Principles of South African Medical Law* LexisNexis: Durban 2007, 686.

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

[428] Carstens, Pieter and Pearmain, Debbie *Foundational Principles of South African Medical Law* LexisNexis: Durban 2007, 687.

[429] Shaw, Josephine Informed Consent: A German Lesson (1986) Vol 35, No 4 *International and Comparative Law Quaterly* 864 – 890; Van Oosten, FFW *The Doctrine of Informed Consent in Medical Law* (unpublished LLD thesis) UNISA 1989, Supervisor: Prof SA Strauss, 414; Giesen, Dieter and Hayes, John The Patient's right to know – a comparative view *Anglo-American Law Review* (1992) 101 – 122, 111; Moumijd, Nora and Callu, Marie-France Informed Consent and Risk Communication in France *BMJ* Vol 327 (27 Sep 2003), 734 – 735.

[430] Shaw, Josephine Informed Consent: A German Lesson (1986) Vol 35, No 4 *International and Comparative Law Quaterly* 864 – 890, 865; Van Oosten, FFW *The Doctrine of Informed Consent in Medical Law* (unpublished LLD thesis) UNISA 1989, Supervisor: Prof SA Strauss, 190.

development of this doctrine in Germany can be traced to experiences and human rights violations under the Third Reich.[431] Physicians are required to disclose all that a patient needs to know in order to decide whether to run the risks of a particular form of treatment. The disclosure should include the following: details about the diagnosis, proposed treatment, alternatives to the treatment, attendant risks and prospects of recovery.[432] Where an operation is for diagnostic purposes, is not an emergency and has no therapeutic goal, the doctor is still required to disclose all risks including extremely remote risks.[433] For therapeutic operations the patient must be informed *im grossen und ganzen*.[434] In addition, the disclosure must take into account each patient's individual circumstances.[435] A subjective standard of disclosure is therefore used.

In Swiss law the starting point in informed consent cases is also the patient's basic human right of autonomy and self-determination, and this principle is not reduced or limited by any considerations that will allow the medical profession to override the patient's own will based on beneficence.[436] In Japan however, the right of patients to take part in the medical decision-making process to a large extent remains ignored, even though the West German legal concept of informed consent was introduced into Japanese academic legal theory in 1970.[437]

In the 1992 Code of Medical Ethics, prepared by the Council on Ethical and Judicial Affairs of the American Medical Association, the medical profession's standard for informed consent

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[431] Shaw, Josephine Informed Consent: A German Lesson (1986) Vol 35, No 4 *International and Comparative Law Quaterly* 864 – 890, 870.
[432] Shaw, Josephine Informed Consent: A German Lesson (1986) Vol 35, No 4 *International and Comparative Law Quaterly* 864 – 890, 875; BGH [1984] NJW 1397, 1398; BGH [1980] NJW 633; Giesen, Dieter From Paternalism to Self-determination to shard Decision making *Acta Juridica* (1988) 107 – 127, 108.
[433] Shaw, Josephine Informed Consent: A German Lesson (1986) Vol 35, No 4 *International and Comparative Law Quaterly* 864 – 890, 876; OLG Hamm [1981] VersicherungsRecht (VersR) 68.
[434] Shaw, Josephine Informed Consent: A German Lesson (1986) Vol 35, No 4 *International and Comparative Law Quaterly* 864 – 890, 876.
[435] Shaw, Josephine Informed Consent: A German Lesson (1986) Vol 35, No 4 *International and Comparative Law Quaterly* 864 – 890, 876.
[436] *Castell v De Greef* 1994 (4) SA 408 (C), 423.
[437] Annas, George J and Miller, Frances H The Empire of Death: How Culture and Economics Affect Informed Consent in the US, the UK and Japan *American Journal of Law and Medicine* Vol XX No 4 (1994) 357 – 394, 373; The case of *Makino v The Red Cross Hospital* May 29 1989 Chisai [Nagoya District Court] is cited as Japan's leading informed consent decision.

was codified in the USA.[438] According to this document the patient's right of self-decision can only be effectively exercised if the patient possesses enough information to make an intelligent choice. The physician's obligation is to present the medical facts accurately and to make recommendations for the management of the medical condition in accordance with good medical practice. This obligation is also viewed as an ethical obligation to assist the patient in making choices from the available therapeutic alternatives, consistent with good medical practice. This code furthermore describes informed consent as a basic social policy and the only two exceptions allowed are in cases of emergency where the patient is unconscious or otherwise incapable of consent and in risk-disclosure situations where disclosure will result in serious psychological harm. In addition to this code various different versions of the doctrine of informed consent have also been enacted in informed consent legislation in about 24 of the 51 USA states.[439] Some examples of these statutes include the Wisconsin informed consent law,[440] the New York Public Health Law §2805-d,[441] the Florida Statute Ann. §768.132(3)(a)[442] and the Georgia statute.[443] These statutes were created in response to the medical malpractice "crises" experienced in the USA between 1975 and 1977 and generally attempt to limit the liability of medical practitioners. (See Chapter Six for a discussion on the consequences of the medical malpractice "crises" in the context of managed health care interventions.)

The doctrine of informed consent was recently also codified in South African law in the National Health Act 61 of 2003.[444] In section 6 of this act the nature and scope of

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[438] *Culbertson v Mernitz* 602 N.E.2d 98, (Ind 1992), 103 - 104.

[439] Katz, Jay *The Silent World of Doctor and Patient* Johns Hopkins University Press: Baltimore (2002) 81; Also compare with the Patients' Rights Act of Norway, passed on 1 January 2001.

[440] *Schreiber & Krueger v Physicians Insurance Company of Wisconsin* 579 N.W. 2d 730 (Wis. 1998) 734.

[441] Meisel, Alan and Kabnick, Lisa D Informed Consent to Medical Treatment: An Analysis of Recent Legislation *University of Pittsburgh Law Review* Vol 41 (1980) 407 – 564, 421; This particular statute requires a professional standard of disclosure but without the locality rule – compare with the Florida Statute footnote 306.

[442] *Laskowitz v CIBA Vision Corporation* 215 A.D.2d 25 (N.Y. 1995); Annas, George J et al *American Health Law* Little Brown and Company, Boston 1990, 611; the standard of disclosure in this statute for example requires a professional standard with a locality rule; Meisel, Alan and Kabnick, Lisa D Informed Consent to Medical Treatment: An Analysis of Recent Legislation *University of Pittsburgh Law Review* Vol 41 (1980) 407 – 564, 421.

[443] GA Code Ann §31-9-6.1 (1991); For a comprehensive discussion and analysis of the common law and the statutory law of informed consent in the 24 states see Meisel, Alan and Kabnick, Lisa D Informed Consent to Medical Treatment: An Analysis of Recent Legislation *University of Pittsburgh Law Review* Vol 41 (1980) 407 – 564, 421.

[444] This act is applicable to all health care providers and users, both from the public health system as well as the private health care system.

information that should be disclosed to a patient are provided for.[445] Section 6(1) of the act is premised on an extensive understanding of informed consent, requiring that the diagnosis and alternatives to the proposed treatment be divulged as well as the risks, costs and consequences inherent in the procedure. Section 6(1)(a) also provides for an exception, namely where disclosure would be contrary to the patient's best interests.[446] Section 6(2) furthermore requires that this information be divulged in a language that the patient understands and in a manner that takes into account the patient's level of literacy. This section should be read in conjunction with sections 7, 8 and 9. While section 7 of the act makes provision for the exceptions to the general requirement of informed consent, section 8 provides health care users with the right to participate in decisions affecting their health, thereby advocating an approach of shared decision-making. The right to self-determination has also been extended considerably in section 8, which provides that a patient's informed consent is required even though he/she has previously been treated and the necessary consent was obtained. The section also provides for participatory decision-making of individuals who cannot give the consent themselves but who can participate in the decision-making process to a certain extent.[447] Strauss believes that these statutory requirements with regard to informed consent now supersede the common law in South Africa.[448] Since the act came into effect only recently, this remains to be seen.

The relevant sections in the National Health Act[449] referred to above should be read together with section 12 of the Constitution. Section 12 affirms that everybody has the right to bodily and psychological integrity, which includes the right to security and control over his/her body. All patients in South Africa therefore have the right to free choice, and

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[445] S 6 National Health Act 61 of 2003: "*Every health care provider must inform a user of –*

a) *The user's health status except in circumstances where there is substantial evidence that the disclosure of the user's health status would be contrary to the best interests of the user;*
b) *The range of diagnostic procedures and treatment options generally available to the user;*
c) *The benefits, risks, costs and consequences generally associated with each option; and*
d) *The user's right to refuse health services*."

[446] Carstens, Pieter and Pearmain, Debbie *Foundational Principles of South African Medical Law* LexisNexis: Durban 2007, 672.

[447] Carstens, Pieter and Pearmain, Debbie *Foundational Principles of South African Medical Law* LexisNexis: Durban 2007, 694.

[448] Carstens, Pieter and Pearmain, Debbie *Foundational Principles of South African Medical Law* LexisNexis: Durban 2007, 672; Strauss, SA Medical Law – South Africa in *International Encyclopaedia of Laws* (eds Blanpain R and Nys H) 2006, 130.

[449] National Health Act 61 of 2003.

informed consent and refusal in the health care context.[450] But autonomy is not absolute. Section 36 of the Constitution limits all rights in the Bill of Rights on condition that the limitation is reasonable and justifiable in an open and democratic society.[451]

In 1999/2001 a National Patients' Rights Charter was launched in terms of the constitutional mandate to set a common standard for achieving the right of access to health care services and as an endorsement of a human rights approach in medical practice.[452] This charter provides "*an officially sanctioned baseline standard*" and "*can be used as a tool of accountability by patients, health workers broader civil society and institutions*".[453] The rationale for this charter was to assist in the transformation of the South African health care system which was described by the Minister of Health as indifferent, arrogant, negligent, in the business of covering up, and with total disregard for human dignity, respect and privacy.[454] The charter recognises the doctrine of informed consent and states that: "*Everyone has the right to be given full and accurate information about the nature of one's illnesses, diagnostic procedures, the proposed treatment and the costs involved for one to make a decision that affects any one of these elements*". But no reported cases have referred to this charter. The provisions of both the National Health Act as well as the Patient's Charter accord with the constitutional values and principles, specifically the right to bodily integrity in section 12(2)(b) of the Constitution as well as the right of access to information in section 32.[455]

[450] Dhai, A Informed Consent 2008 *South African Journal on Bio-ethics and Law* Vol 1, No 1, (June 2008) 27 – 29.

[451] Dhai, A Informed Consent 2008 *South African Journal on Bio-ethics and Law* Vol 1, No 1, (June 2008) 27 – 29.

[452] Section 27(2); Thomas, Rhiannon Where to from Castell v De Greef? Lessons from recent developments in South Africa and abroad regarding consent to treatment and the standard of disclosure *South African Law Journal* (2007) 188- 215, 209; See http://www.hpcsa.co.za/hpcsa/UserFiles/File/Patient'sRightsCharter.pdf .

[453] Liebenberg, Sandra Human Development and Human Rights South African Country Study Human Development Report 2000 at 19, available at www. Communitylawcentre.org.za/ser/docs_2002/South_African_Country_Study_HDR2000.doc; Thomas, Rhiannon Where to from Castell v De Greef? Lessons from recent developments in South Africa and abroad regarding consent to treatment and the standard of disclosure *South African Law Journal* (2007) 188- 215, 209.

[454] Thomas, Rhiannon Where to from Castell v De Greef? Lessons from recent developments in South Africa and abroad regarding consent to treatment and the standard of disclosure *South African Law Journal* (2007) 188- 215, 209.

[455] Carstens, Pieter and Pearmain, Debbie *Foundational Principles of South African Medical Law* LexisNexis: Durban 2007, 674.

The National Patients' Rights Charter can be compared to the New Zealand Code of Health and Disability Consumers' Rights (1996) in terms of the Health and Disability Commissioner Act of 1994.[456] The code and the act set out consumers' rights and impose obligations relevant to the doctor-patient relationship. Clause 1 of the code, for example, provides that every provider should take action to inform consumers of their rights and enable consumers to exercise these rights.[457] An enormous range of providers, situations and activities are covered by the code which together with the act have the effect of creating a new form of civil liability.[458] The code is also widely available and providers are required to bring its content to the notice of consumers.[459] One of the functions of the code and the act is to promote, educate and market relevant particulars regarding informed consent to all consumers of health care services.[460] The code also attempts to strike a fair balance between the sometimes conflicting interests of the providers and users of health care services.[461] However, the main differences between the New Zealand Code and the South African National Patients' Rights Charter as well as the United Kingdom Patient's Charter is that the New Zealand Code is enacted as law and accompanied by the statutory structure of the New Zealand Code of Rights, while the same is not true of the South African and UK Charters.[462]

Although no judgement on informed consent has been handed down since the enactment of the National Health Act, both of the most recent cases in South African medical law, *McDonald v Wroe*[463] and *Louwrens v Oldwage,*[464] did not pay any attention to the National Patient's Charter nor to the provisions of the National Health Act (then bill). In the case of *Louwrens v Oldwage* the subjective patient-centred test for disclosure was accepted in the

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[456] Also compare with the Patients'Rights Act 2 No 63 (1999) of Norway and see Angell, Marcia Patients'Rights Bills and Other Futile Gestures *New England Journal of Medicine* Vol 342, Issue 22 1663 – 1667.
[457] New Zealand Code of Health and Disability Consumers' Rights (1996), clause 1(3).
[458] Skegg, P.D.G. English medical law and 'Informed Consent': An Antipodean Assessment and Alternative *Medical Law Review* Vol 7 (1999) 135 – 165, 151 - 165.
[459] New Zealand Code of Health and Disability Consumers' Rights (1996), clause 1(3).
[460] New Zealand Code of Health and Disability Consumers' Rights (1996), clause 30.
[461] Skegg, P.D.G. English medical law and 'Informed Consent': An Antipodean Assessment and Alternative *Medical Law Review* Vol 7 (1999) 135 – 165, 149; New Zealand Code of Health and Disability Consumers' Rights (1996), clause 3(1) – (2).
[462] Skegg, P.D.G. English medical law and 'Informed Consent': An Antipodean Assessment and Alternative *Medical Law Review* Vol 7 (1999) 135 – 165, 163.
[463] *McDonald v Wroe* [2006] 3 All SA 565 (C).
[464] *Louwrens v Oldwage* 2006 (2) SA 161 (SCA).

court a quo but the court of appeal by contrast applied the dictum from the *Richter* case which required a professional standard for disclosure.[465] This is problematic since these two opposing tests can obviously not co-exist in South African medical- and health law. It is also regrettable that the Supreme Court of Appeal did not make use of the opportunity to develop the doctrine of informed consent to provide certainty regarding the required standards and application of a more patient-centred approach.[466]

Real protection for self-determination in medical decision-making has not yet materialised in the USA and the majority of states still adhere to the professional practice standard.[467] However, the relatively recent and controversial case of *Arato v Avedon*[468] is noteworthy. The plaintiffs (the widow and children of a pancreatic cancer victim) claimed for the physician's failure to disclose information concerning the statistical life expectancy of pancreatic cancer patients. They claimed that due to this failure to disclose such information the physician consequently failed to obtain the patient's informed consent. The plaintiffs alleged that the patient would not have consented to the treatment if all material information had been disclosed and that the patient would have averted the economic losses that resulted from his failure to put his business and financial affairs in order. Although the court acknowledged a patient-centred standard for disclosure, the court also held that the disclosure of information beyond that implicated by the risks of death or serious harm and the potential complications from the treatment, should be defined by a professional standard and that in specific cases expert testimony is essential to determine the standard of disclosure.[469] It was also accepted in the court a quo that in cases like these,

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[465] *Louwrens v Oldwage* 2006 (2) SA 161 (SCA), 174 – 175; In this case the defendant, a surgeon, performed vascular surgery on the plaintiff following complaints of excruciating pain from the plaintiff's right leg. Following the surgery, the plaintiff suffered from claudication in his left leg. The plaintiff submitted that he would not have consented to the surgery if he was told of the inherent risk of claudication occurring; Thomas, Rhiannon Where to from Castell v De Greef? Lessons from recent developments in South Africa and abroad regarding consent to treatment and the standard of disclosure *South African Law Journal* (2007) 188- 215, 188; *Broude v McIntosh and others* 1998 (3) SA 60 (SCA), 68 – 69; *Richter and another v Estate Hammann* 1967 (3) SA 226 (C).

[466] Carstens, Pieter and Pearmain, Debbie *Foundational Principles of South African Medical Law* LexisNexis: Durban 2007, 685.

[467] Grubb, Andrew *Principles of Medical Law* (Second edition) Oxford University Press 2004, 193; Shaw, Josephine Informed Consent: A German Lesson (1986) Vol 35, No 4 *International and Comparative Law Quaterly* 864 – 890, 869; McPherson v Ellis 287 S.E. 2d 892 [North Carolina 1982]

[468] *Arato v Avedon* 23 Cal. Rptr. 2d 131 (1993).

[469] *Arato v Avedon* 23 Cal. Rptr. 2d 131 (1993), 143 – 144.

the primary duty of a physician is to do what is best for his/her patient.[470] Although Justice Hanssen in the case of *Scaria v St Paul Fire and Marine Ins Co*[471] (USA) submitted that the rights of a patient and the duties of a physician are standards recognised and circumscribed by the law and are not entirely dependent upon self-created customs of the profession, he concluded in his dissenting judgement that he still had more confidence in the standards of the professional group involved than in a court deciding what disclosures needed or ought to be made. "*Children play at the game of being a doctor, but judges and juries ought not to*".[472]

The decision of the House of Lords in the case of *Bolitho v City and Hackney Health Authority*[473] is regarded by some as the death knell of the Bolam test in English law.[474] This case did not deal with the duty to inform but rather the quantum of care expected from a doctor. In this case it was reaffirmed that the content of the duty of care is determined by the courts whilst mindful of technical medical matters for which expert medical testimony from a responsible medical body may be necessary, but the Bolam test was also modified by requiring that the medical testimony or opinion should be capable of withstanding logical analysis. The current orthodox position in English law with regard to the standard of disclosure can also be found in the case of *Pearce v United Bristol Health Care HNS Trust*[475] where a broader patient-centred approach was embraced.[476] In this case Lord Woolf held that a medical practitioner should normally inform a patient of the relevant risks involved in order for the patient to make an informed decision. This test was furthermore also applied in *Chester v Afshar,*[477] a case in which the court of appeal described the doctrine of informed consent as onerous.[478] In this case the English law with regard to informed

[470] *Arato v Avedon* 23 Cal. Rptr. 2d 131 (1993), 136.
[471] *Scaria v St Paul Fire & Marine Ins. Co*. 227 N.W. 2d 647 (Wis. 1975).
[472] *Scaria v St Paul Fire & Marine Ins. Co*. 227 N.W. 2d 647 (Wis. 1975), 659.
[473] *Bolitho v City and Hackney Health Authority* [1997] 1 WLR 1151.
[474] Mason, Kenyon Bolam, Bolam – Wherefore Art Thou Bolam? *Edinburgh Law Review* 9 (2005) 298 – 306, 301.
[475] *Pearce v United Bristol Health Care HNS Trust* [1999] PIQR P53 (CA).
[476] In this case however the plaintiff's action failed because evidence suggested that even if the information regarding the risk of still birth had been disclosed, the plaintiff would still have gone ahead with a natural delivery; Thomas, Rhiannon Where to from Castell v De Greef? Lessons from recent developments in South Africa and abroad regarding consent to treatment and the standard of disclosure *South African Law Journal* (2007) 188- 215, 198.
[477] *Chester v Afshar* [2002] 3 All ER 552.
[478] *Chester v Afshar* [2002] 3 All ER 552, 568 par 33.

consent was developed further. The court gave due recognition to the aim of the doctrine of informed consent to protect patient autonomy and choice.[479] In his majority judgment Lord Steyn elaborated on this aim and held that patient autonomy should always be the starting point in situations of disclosure and obtaining consent.[480] Although all rights are not equal, he believed that a patient's right to receive appropriate warning required effective protection where possible.[481] Lord Steyn emphasised that the doctrine of informed consent does not only assist in avoiding injury for which the patient is not prepared, but that this doctrine also has another purpose; it respects the autonomy and dignity of each patient.[482] The court furthermore established that the judiciary has the ultimate say and the medical profession is not the final arbiter of the required standard for disclosure.[483] Although the court did not embrace an absolutely subjective patient-centred standard, it did recognise that various considerations will influence a patient's decision.

As in the USA, the focus on patient autonomy and self-determination suffered due to numerous contradicting judgements. The Bolam test furthermore does not seek to achieve a fair balance between the sometimes conflicting interests of the health care providers and the users of health care services, and standards of disclosure are preferably left to the medical profession to determine.[484] An analysis of English case law shows that relatively little emphasis is placed on the fact that other medical alternatives should also be disclosed and discussed with patients.[485] According to Teff, the legal characteristics of the doctor-patient relationship in England are shaped by a judiciary generally well-disposed towards

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[479] Thomas, Rhiannon Where to from Castell v De Greef? Lessons from recent developments in South Africa and abroad regarding consent to treatment and the standard of disclosure *South African Law Journal* (2007) 188- 215, 200.
[480] *Chester v Afshar* [2002] 3 All ER 552, 594 para 16.
[481] *Chester v Afshar* [2002] 3 All ER 552, 594 para 17.
[482] *Chester v Afshar* [2002] 3 All ER 552, 594 para 18; Thomas, Rhiannon Where to from Castell v De Greef? Lessons from recent developments in South Africa and abroad regarding consent to treatment and the standard of disclosure *South African Law Journal* (2007) 188- 215, 200.
[483] *Chester v Afshar* [2002] 3 All ER 552, 593 para 14.
[484] Skegg, P.D.G. English medical law and 'Informed Consent': An Antipodean Assessment and Alternative *Medical Law Review* Vol 7 (1999) 135 – 165, 148.
[485] Skegg, P.D.G. English medical law and 'Informed Consent': An Antipodean Assessment and Alternative *Medical Law Review* Vol 7 (1999) 135 – 165, 148 - 149.

the medical profession.[486] Consequently, while the rate of medical malpractice litigation in the USA is excessive, the rate in Britain is too low to be realistic.

3.5. An evaluation of medical decision-making and the doctor-patient relationship

It is clear from the discussion above that patient autonomy and self-determination dominate the rhetoric in the law regarding medical decision-making, but they are definitely not being served by the law. The law, and especially case law, still fails to deliver on its promise of patient-centred decision-making and patients' freedom of choice, and is not effective in addressing the power imbalance in the doctor-patient relationship.[487] Furthermore, the conflict between autonomy and beneficence still remains, since patients seek medical assistance not merely to exercise their right to self-determination but also to ask medical practitioners to act for their benefit; based on their expert knowledge and skill and during times when patients are vulnerable and generally uninformed of matters relating to medical science.[488]

Although it is seems as if very little has changed since the *Salgo* case first introduced the doctrine of informed consent, according to Katz this lack of progress should not be viewed as failure. It will take much more time and effort to change a 2500 year old tradition of silence.[489] However, Katz believes that those who look for evidence of committed implementation of patient self-determination and autonomy will be sadly disappointed, as the doctrine of informed consent can merely be regarded as an inspiration of patient's rights, autonomy and self-determination at common law.[490] The words of Justice Frankfurter can furthermore be applied to the current status of this doctrine: "*…it is an excellent illustration of the extent to which uncritical use of words bedevils the law. A phrase begins life as a literary expression; its felicity leads to its lazy repetition; and repetition soon*

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[486] Teff, Harvey *Reasonable Care: Legal Perspectives on the Doctor-patient Relationship* Clarendon Press Oxford (1994) 57.

[487] Dworkin, Roger B Getting what we should from doctors: Rethinking patient autonomy and the doctor-patient relationship *Health Matrix: Journal of Law-Medicine* 13 (2003) 235 – 296, 274.

[488] Bagheri, Alireza Regulating Medical Futility: Neither Excessive Patient's Autonomy nor Physician's Paternalism *European Journal of Health Law* 15 (2008) 45 – 53, 51.

[489] Katz, Jay *The Silent World of Doctor and Patient* Johns Hopkins University Press: Baltimore (2002) 76.

[490] Katz, Jay *The Silent World of Doctor and Patient* Johns Hopkins University Press: Baltimore (2002) 84.

establishes it as a legal formula, undiscriminatingly used to express different and sometimes contradictory ideas".[491]

The reason for this lack of development and progress in the law of informed consent as well as the perceived ambiguity of the doctrine is generally due to the diverse perceptions that surround it. To illustrate this, it is useful to distinguish between three different perceptions of the informed consent doctrine. The first perception is the ideal, true doctrine in service of real patient autonomy and self-determination. The second perception is the doctrine as it is imagined, feared and often caricatured by some members of the medical profession who believe that the ultimate outcome of this doctrine is the de-professionalisation of the medical profession. Some also fear that the doctrine of informed consent will open the floodgates to medical negligence cases. However, this fear is definitely unfounded and in no jurisdiction where the doctrine of informed consent has been accepted, either at common law level or in statute law, can it be proven that the incidence of medical negligence cases has increased. The USA state of Kentucky is an ironic example of this. No plaintiff has ever succeeded with a common law action based on informed consent, as the main goal of the Kentucky statute is in fact to minimise a plaintiff's chances of success in light of the USA medical malpractice crises.[492] The final perception of this doctrine is a consequence of the gap between the first two perceptions and it pertains to the doctrine as it is actually practiced by clinicians – the doctrine in action.[493] These different perceptions of this doctrine are partially responsible for the numerous contradicting judgements on informed consent and the lack of agreement on the standards that should apply.

In addition, those who have commented on the doctrine can be divided into two camps. The idealists advocate a relatively expanded conception of patients' rights and physicians' obligations. Idealists emphasise the qualitative dimension of the doctor-patient interactions and argue for a subjective patient-centred approach.[494] The realists are usually medical

[491] *Tiller v Atlantic Coast Line Railroad Company* (1943) 318 U.S. 54, 68, in this case Judge Frankfurter referred to the assumption of risk; Skegg, P.D.G. English Medical Law and 'Informed Consent': An Antipodean Assessment and Alternative *Medical Law Review* Vol 7 (1999) 135 – 165, 135.

[492] Meisel, Alan and Kabnick, Lisa D Informed Consent to Medical Treatment: An Analysis of Recent Legislation *University of Pittsburgh Law Review* Vol 41 (1980) 407 – 564, 497.

[493] Schuck, Peter H Rethinking Informed Consent *The Yale Law Journal* (1993) Vol 103:899 – 959.

[494] Schuck, Peter H Rethinking Informed Consent *The Yale Law Journal* (1993) Vol 103:899 – 959, 903.

professionals and they doubt whether patients really desire the kind of dialogue proposed by the doctrine. They also question the alleged gains of this doctrine — autonomy and self-determination — and lastly, they emphasise the impracticality of the doctrine.[495] The perceptions and comments on informed consent which are relevant for the aims and purposes of this research, will now be discussed, with specific focus on the value of informed consent in addressing power imbalances in the doctor-patient relationship.

3.5.1. Standards of disclosure

Clearly, the doctrine of informed consent is currently not effective in ensuring patient autonomy and self-determination in medical decision-making. The first weakness of the doctrine pertains to uncertainty regarding the appropriate standard or test that should be used for determining what information concerning risks should be disclosed. Few jurisdictions agree on the standard or test for disclosure, and even within a particular jurisdiction various contradicting judgements exist. Generally, three standards of disclosure can be identified: The professional practice standard uses the customary practices of the medical professional community to determine what information should be disclosed. The standard therefore appeals to the profession's technical skill and competence. According to this standard, disclosure and treatment are functions that belong to the medical profession by virtue of its professional expertise, role and commitment.[496] This is not a reliable standard, however, since physicians' technical judgements are often infused with values traditionally considered to be central to medical practice, such as the principle of beneficence and the commitment to clinical freedom.[497] Their judgements will also be coloured by personal beliefs and values and this standard in the main also reflects a philosophy of paternalism and is tantamount to denying the patient's right to self-determination.[498] The professional practice standard furthermore assumes that all medical decisions require technical expertise and that there is a certain degree of professional

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[495] Schuck, Peter H Rethinking Informed Consent *The Yale Law Journal* (1993) Vol 103:899 – 959, 904.

[496] Faden, Ruth R & Beauchamp, Tom L *A History and Theory of Informed Consent* Oxford University Press: NY 1986, 30.

[497] Teff, Harvey *Reasonable Care: Legal Perspectives on the Doctor-patient Relationship* Clarendon Press Oxford (1994) 199.

[498] Giesen, Dieter From Paternalism to Self-determination to shard Decision making *Acta Juridica* (1988) 107 – 127, 119.

agreement on what should be disclosed and what not.[499] The professional practice standard was used in the cases of *Bolam v Friern Hospital Management Committee*,[500] *Richter and another v Estate Hammann,*[501] *Louwrens v Oldwage*[502] and the test is currently used in the informed consent statutes of most USA states.[503]

The reasonable person/patient standard requires that the information and risks which a reasonable person would find significant in making his/her decision be disclosed. This objective test is the default position employed by the judiciary to strike a balance between medical paternalism and patient autonomy and self-determination. The test was used in *Salgo v Leland Stanford Jr. University Board of Trustees*,[504] *Natanson v Kline*,[505] *Canterbury v Spence,*[506] as well as the Canadian case *Reibl v Hughes.*[507] The trial judge in this last case held that the duty to disclose arises primarily from the special relationship between physician and patient. The test established in this case is based on what a reasonable person in the patient's position would want to know, coupled with another objective test for causation – whether a reasonable person in the patient's position would have consented to the treatment had the information been disclosed. This case rejected the paternalistic approach in determining what should be disclosed and emphasised a patient's right to know. But, by using an objective test, it also helped to ensure that the medical system would enjoy protection against liability claims while accommodating a reasonable patient's concerns and needs.[508]

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[499] Grubb, Andrew *Principles of Medical Law* (2nd ed) Oxford University Press 2004, 182.
[500] *Bolam v Friern Hospital Management Committee* [1957] 1 W.L.R. 582, QBD.
[501] *Richter and another v Estate Hammann* 1967 (3) SA 226 (C).
[502] *Louwrens v Oldwage* 2006 (2) SA 161 (SCA).
[503] Grubb, Andrew *Principles of Medical Law* (Second edition) Oxford University Press 2004, 193; Shaw, Josephine Informed Consent: A German Lesson (1986) Vol 35, No 4 *International and Comparative Law Quaterly* 864 – 890, 869; McPherson v Ellis 287 S.E. 2d 892 [North Carolina 1982]; Meisel, Alan and Kabnick, Lisa D Informed Consent to Medical Treatment: An Analysis of Recent Legislation *University of Pittsburgh Law Review* Vol 41 (1980) 407 – 564, 423, 487, 537; Some of the states, for example Texas and Hawaii even created administrative agencies to prescribe what information should be disclosed for specific procedures, while some states like Nevada require that all treatment alternatives be disclosed and other states like Alaska only require that reasonable treatment alternatives be disclosed etc; Krause, Joan H Reconceptualising Informed Consent in an Era of Health Care Cost containment *Iowa Law Review* 85 (1999 -2000) 260 – 386, 323.
[504] *Salgo v Leland Stanford Jr. University Board of Trustees* 317 P.2d 170 (Cal. Dist. Ct. App. 1957).
[505] *Natanson v Kline* 186 Kan. 393, 350 P.2d 1093 [1960].
[506] *Canterbury v Spence* 464 F. 2d 772 (D.C. Cir. 1972).
[507] *Reibl v Hughes* [1980] 2 S.C.R. 880.
[508] *Arndt v Smith* [1997] 2 S.C.R. 539, par 15.

In the Australian case of *Rogers v Whitaker*[509] the reasonable patient standard was also used. The patient, who was almost blind in one of her eyes, consented to an operation in order to improve her eyesight. Although the patient questioned the surgeon on the possible complications she did not enquire whether the operation could adversely affect her other eye. The surgeon also did not offer any information on this, even though there was a 1 in 14 000 chance of sympathetic ophthalmia occurring. This risk was furthermore slightly higher in this patient's case since the eye to be operated on had previously been injured by penetration. Though the operation was conducted with the required skill and care, the patient did develop sympathetic ophthalmia and became almost completely blind after one year. In this case, the court found that the failure to disclose the risk constituted a breach of the duty of care.[510] The court repudiated the Bolam test and submitted that it is for the courts to adjudicate on what is the appropriate standard of care.[511] As to what information and risks should be divulged Justice Gaudron also stated that this is not a matter exclusively within the province of medical knowledge and expertise but often simple commonsense.[512] In this case the Canterbury test was used, namely whether a reasonable person in the patient's position would have attached significance to the information/risk. This reasonable patient test was reaffirmed in the cases of *Chappel v Hart*[513] as well as *Rosenberg v Percival.*[514] However, the reasonable patient standard is unrepresentative of the vast numbers of individuals who have varying levels of experience and knowledge using different levels of health care services. This is especially problematic in a country like South Africa were a great discrepancy between public and private health care exists, where the differences between public and private health care services are vast, and the population also represents a vast number of individuals with varying levels of education, literacy and access to health care services.[515] The test fails to protect a particular patient's right to self-determination since every patient has the right to be his/her own self, even though the

[509] *Rogers v Whitaker* 175 CLR 479 [1992].

[510] Teff, Harvey *Reasonable Care: Legal Perspectives on the Doctor-patient Relationship* Clarendon Press Oxford (1994) 222.

[511] *Rogers v Whitaker* 175 CLR 479 [1992], 484.

[512] *Rogers v Whitaker* 175 CLR 479 [1992], 493.

[513] *Chappel v Hart* (1998) 72 ALJR 1344, [1999] Lloyd's Rep Med 223, Aust HC.

[514] *Rosenberg v Percival* [2001] HCA 18.

[515] See the Canadian case of *Ciarlariello v Schacter* [1993] 2 S.C.R. 119 for an example of the requirement that information should be disclosed to a patient in a language which the patient understands.

patient may be wrong, unreasonable or irrational in the medical practitioner's eyes.[516] The test may cause the informed consent process to be compromised in public health care due to a lack of infrastructure and resources.[517] This test also does not allow for real self-determination in medical decision-making.

The subjective personal standard, which has been adopted in Germany and Switzerland, refers to the particular patient's personal need for information and what information such a patient would consider significant.[518] It was introduced in the late 1970s and early 1980s when the courts held that the reasonable patient standard does not live up to the ideals of patient autonomy.[519] The subjective patient standard was used in *Scott v Bradford,*[520] *Castell v De Greef,*[521] *Broude v McIntosh and others*[522] and *Arato v Avedon.*[523] The standard is mainly criticised for the suspect nature of the testimony given by injured and bitter patients with the benefit of hindsight.[524] It is also suggested that this standard is out of step with standards of liability in other areas of the law and that it places an unfair burden on medical practitioners since they are expected to read each patient's mind.[525] However, it can be argued that the relationship between a doctor and patient is a very intimate relationship and it should therefore generally be possible for medical practitioners to assess the amount

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[516] Giesen, Dieter From Paternalism to Self-determination to shard Decision making *Acta Juridica* (1988) 107 – 127, 120; Giesen, Dieter and Hayes, John The Patient's right to know – a comparative view *Anglo-American Law Review* (1992) 101 – 122, 115 - "*To apply a 'prudent patient' test to an individual patient and his needs and worries is to ask him to behave 'reasonably' according to value-judgements others impose on him*." *McPherson v Ellis* 287 SE2d 892 (NC. 1982); In *Chester v Afshar* [2002] 3 All ER 552, 612 para 86 it was submitted that various considerations may influence a patient's decision re medical treatment and only the patient is in a position to rank these concerns according to his/her priorities – even if medical considerations are the only ones to be considered.

[517] Carstens, Pieter and Pearmain, Debbie *Foundational Principles of South African Medical Law* LexisNexis: Durban 2007, 878.

[518] Kottow, M The battering of informed consent *J Med Ethics* 30 (2004) 565 – 569.

[519] Olufowote, James Olumide A Structural Analysis of Informed Consent to Treatment: Societal Evolution, Contradiction and Reproductions in Medical Practice *Health Communication* 23 (2008) 292 – 303, 299; Giesen, Dieter From Paternalism to Self-determination to shard Decision making *Acta Juridica* (1988) 107 – 127, 121.

[520] *Scott v Bradford* 606 P.2d 554 (Okla. 1980).

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

[522] *Broude v McIntosh and others* 1998 (3) SA 60 (SCA).

[523] *Arato v Avedon* 23 Cal. Rptr. 2d 131 (1993).

[524] Teff, Harvey *Reasonable Care: Legal Perspectives on the Doctor-patient Relationship* Clarendon Press Oxford (1994) 203; *Cobbs v Grant* 104 Cal. Rptr. 505, 515; *Richter and another v Estate Hammann* 1976 (3) SA 226 (C), 234; Thomas, Rhiannon Where to from Castell v De Greef? Lessons from recent developments in South Africa and abroad regarding consent to treatment and the standard of disclosure *South African Law Journal* (2007) 188- 215, 195; Broude v McIntosh and others 1998 (3) SA 60 (SCA), 61; Arndt v Smith [1997] 2 S.C.R. 539, par4.

[525] Katz, Jay *The Silent World of Doctor and Patient* Johns Hopkins University Press: Baltimore (2002) 77; *Culbertson v Mernitz* 602 N.E.2d 98 (Ind 1992), 103; Teff, Harvey *Reasonable Care: Legal Perspectives on the Doctor-patient Relationship* Clarendon Press Oxford (1994) 203.

and quality of information patients need.[526] English courts in particular are hesitant to include subjective considerations, since they do not want to open the proverbial floodgates of malpractise actions, place too heavy a burden on medical practitioners, require doctors to second-guess their patients and finally, because it is difficult to quantify these types of claims.[527]

In most of the cases discussed an objective test was allowed to determine what information is material for the patient's decision rather than a subjective test based on what an individual patient would have considered a significant risk. However, an objective test limits the role and importance of autonomy and self-determination in the doctor-patient relationship. While the courts tried to strike a balance between physician paternalism and patient sovereignty by requiring a reasonable patient as the standard, this objective standard for disclosure actually contradicts each individual's right to decide what will be done to his/her body, since there is no one reasonable response for every situation.[528] This objective test also contradicts the aim of the doctrine, to preserve individual choice. While accepting that to ascertain a patient's informational needs is very difficult and that it is an art that needs to be learned, it must be remembered that the aim of the doctrine of informed consent is not to encourage uniform medical treatment.[529] And since there is no custom reflecting a consensus on the communication of information and risk, exactly how this art of ascertaining each individual patient's information needs can be learned remains uncertain.[530] It is for this reason that Katz submits that the medical judgement necessary to ascertain what information should be divulged and what information is material to the specific patient's needs and decisions (the objective test) actually allows the medical

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[526] Giesen, Dieter From Paternalism to Self-determination to shard Decision making *Acta Juridica* (1988) 107 – 127, 121.
[527] Thomas, Rhiannon Where to from Castell v De Greef? Lessons from recent developments in South Africa and abroad regarding consent to treatment and the standard of disclosure *South African Law Journal* (2007) 188- 215, 203.
[528] Katz, Jay *The Silent World of Doctor and Patient* Johns Hopkins University Press: Baltimore (2002) 76; Rich, Ben A Medical Paternalism v Respect for patient autonomy : The more things change the more they remain the same *Michigan State University Journal of Medicine & Law* 10 (2006) 87-124, 106; *Culbertson v Mernitz* 602 N.E.2d 98 (Ind 1992), 104; *Matthies v Mastromonaco* 709 A.2d 238 (N.J. Super. Ct. App. Div. 1998), 249.
[529] Katz, Jay *The Silent World of Doctor and Patient* Johns Hopkins University Press: Baltimore (2002) 76; *Scott v Bradford* 606 P.2d 554 (Okla. 1979).
[530] *Matthies v Mastromonaco* 709 A.2d 238 (N.J. Super. Ct. App. Div. 1998), 249.

practitioner's own subjectivity to determine the extent of the disclosure.[531] The strongest consideration should rather be the patient's right to self-determination, a right independent of medical custom and practice.[532]

While courts should guard against returning to the older reasonable doctor test and the current duty to disclose should be expanded, an absolutely subjective test is also not advisable.[533] In the Canadian case of *Arndt v Smith*[534] Justice Cory held that neither a purely objective nor a subjective test could ensure a reasonable balance of the underlying values in medical decision-making. While an objective test would unduly favour the medical profession, a completely subjective test would place an unfair burden on physicians. The test of *Reibl* was consequently applied but extended to require that the particular concerns and special considerations affecting the specific patient must also be divulged.[535] Canadian jurisprudence therefore allows for the consideration of a patient's particular concerns as well as any special considerations that might affect the patient.[536]

Thomas suggests a more precise and appropriate standard for disclosure in South Africa:

> "*Recognising the importance of the rights to dignity and bodily integrity, the duty of disclosure requires that the patient must be informed of the material risks and benefits as well as any other special or unusual risks and benefits that the particular patient would have considered material. In determining which risks and benefits the patient would have considered material, the medical practitioner should have regard to the particular patient's concerns, that is, those that the patient volunteered and those discovered through questioning. The patient must also be apprised of the alternatives, with their risks and benefits, and the costs involved. The risks to the particular patient of sustaining the injuries, the inherent risks of injury that arise from rare and random*

[531] Katz, Jay *The Silent World of Doctor and Patient* Johns Hopkins University Press: Baltimore (2002) 78; *Culbertson v Mernitz* 602 N.E.2d 98 (Ind 1992), 106.

[532] *Matthies v Mastromonaco* 709 A.2d 238 (N.J. Super. Ct. App. Div. 1998), 249.

[533] Thomas, Rhiannon Where to from Castell v De Greef? Lessons from recent developments in South Africa and abroad regarding consent to treatment and the standard of disclosure *South African Law Journal* (2007) 188- 215, 202.

[534] *Arndt v Smith* [1997] 2 S.C.R. 539.

[535] Thomas, Rhiannon Where to from Castell v De Greef? Lessons from recent developments in South Africa and abroad regarding consent to treatment and the standard of disclosure *South African Law Journal* (2007) 188- 215, 195.

[536] Thomas, Rhiannon Where to from Castell v De Greef? Lessons from recent developments in South Africa and abroad regarding consent to treatment and the standard of disclosure *South African Law Journal* (2007) 188- 215, 193; Arndt v Smith para 6.

causes in every surgical procedure, those unavoidable risks that cannot be eliminated by the exercise of reasonable care and those risks, though slight, with serious consequences, such as death or paralysis, should also be disclosed. The duty should begin when the patient walks into the consulting room and end when the whole course of treatment is complete".[537]

3.5.2. Historical attributes

A second weakness of the current doctrine of informed consent stems from the historical attributes that are attached to both the sick role and the physician's role in the doctor-patient relationship. While informed consent was a desirable goal in all the cases discussed, pragmatic considerations made the full realisation of self-determination in the doctor-patient relationship nearly impossible.[538] This was generally due to the attributes of both the sick role and the physician's role as explained by Talcott Parsons in his social role theory.[539] (See Chapter Two, section 2.2.2.) It is also clear from the discussion on informed consent that the legal doctrine and its commitment to self-determination and shared decision-making challenges this core of professionalism, the power and authority physicians have based on their expert knowledge and experience. The allowance of such paternalistic attitudes, based on the historical attributes attached to doctor and patient in the doctor-patient relationship, is unwarranted for the following two reasons: It prejudices the sick by implying that they are not fully autonomous; and secondly, the medical professional's expert knowledge and skill are elevated to include the ethical qualifications and the prerogative to decide on behalf of others.[540]

Katz proposes that more attention should be given to these historical attributes and specifically the sick role and physician's role in the doctor-patient relationship, as described by Parsons.[541] An exploration of these complex roles and interaction of caretaking and being-taken-care-of can shed light on the nature and quality of the process, which can then

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[537] Thomas, Rhiannon Where to from Castell v De Greef? Lessons from recent developments in South Africa and abroad regarding consent to treatment and the standard of disclosure *South African Law Journal* (2007) 188- 215, 214.
[538] Kottow, M The battering of informed consent *J Med Ethics* 30 (2004) 565 – 569.
[539] See Chapter Two, section 2.2.2.
[540] Kottow, M The battering of informed consent *J Med Ethics* 30 (2004) 565 – 569.
[541] See Chapter Two, section 2.2.2.; Katz, Jay *The Silent World of Doctor and Patient* Johns Hopkins University Press: Baltimore (2002) 84.

be translated into meaningful legal and medical prescriptions based on mutual trust and respect.[542] The basis of the doctrine should also be that physicians have a legal, ethical and moral duty to respect patient autonomy.[543] And in addition to their duty to disclose all material information, physicians also need to respect patient choice and the right to self-determination.

3.5.3. Practical considerations

The application of the doctrine of informed consent was the very first attempt of the judiciary to get involved in and comment on medical decision-making. Unfortunately this attempt initially had very little effect.[544] The courts relied on this doctrine to try and encourage shared decision-making, but most judges did not realise how deeply rooted the traditional approach to health service delivery was.[545] In some informed consent cases it was held that the doctrine served the value of patient autonomy,[546] while other cases explicitly excoriated paternalism.[547] There are strong reasons to suspect that informed consent is honoured in the breach but almost impossible to enforce in practice and that the traditional paternalistic approach to medical decision-making consequently prevails.[548]

Social science evidence demonstrates that informed consent in action is often ritualistic, formalistic and hollow.[549] For example, medical practitioners who are currently taught that autonomy is the dominant value in doctor-patient communication now act in a more passive manner. Some provide patients with a full range of choices but do not give recommendations, or their own opinion, fearing that they may overstep the mark in the

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[542] Katz, Jay *The Silent World of Doctor and Patient* Johns Hopkins University Press: Baltimore (2002) 84.
[543] *Schrieber v Physicians Ins. Co. of Wis.* 579 N.W.2d 730, 734 (Wis. Ct. App. 1998)
[544] More disputes are reaching courts and presents the judiciary with the opportunity to establish new principles and refine existing doctrines; Teff, Harvey *Reasonable Care: Legal Perspectives on the Doctor-patient Relationship* Clarendon Press Oxford (1994) 29.
[545] Katz, Jay *The Silent World of Doctor and Patient* Johns Hopkins University Press: Baltimore (2002) 3; Schuck, Peter H Rethinking informed consent *The Yale Law Journal* (1993) Vol 103, 899 – 959, 937.
[546] *Matthies v Mastromonaco* 709 A.2d 238, 249 (N.J. Super. Ct. App. Div. 1998); *Schrieber v Physicians Ins. Co. of Wis.* 579 N.W.2d 730, 734 (Wis. Ct. App. 1998); *Bankert v United States*, 973 F.Supp. 1169, 1173 (D. Md. 1996)
[547] *Perez v Wyeth Labs Inc* 734 A.2d 1245, 1255 (N.J. 1999); *Culbertson v Mernitz* 602 N.E.2d 98, 104 (Ind 1992).
[548] Schuck, Peter H Rethinking informed consent *The Yale Law Journal* (1993) Vol 103, 899 – 959; Little is known about what physicians tell their patients and even less is known about what patients truly understand - Krause, Joan H Reconceptualising Informed Consent in an Era of Health Care Cost containment *Iowa Law Review* 85 (1999 -2000) 260 – 386, 275.
[549] Schuck, Peter H Rethinking Informed Consent *The Yale Law Journal* (1993) Vol 103, 899 – 959, 934; Morris, Grant H Dissing Disclosure: Just What the Doctor Ordered *Arizona Law Review* 44 (2002) 313 – 371, 315.

decision-making process.[550] Others make use of various other mechanisms, including non-disclosure and persuasive tactics to ensure that their patients make the decision they want them to make.[551] These examples make a mockery of what patient autonomy in medical- and health law should involve. Clearly, the commitment to autonomy needs to be rethought without returning to unbridled paternalism and giving medical practitioners authority that exceeds their expertise.[552]

The cases pertaining to informed consent that reach the courts are furthermore believed to be just the tip of the iceberg. It can be argued that neither the medical profession nor the judiciary has fully realized the actual problem regarding consent and informed decision-making in medical practice.[553] In this regard it must be noted that South Africa is largely a non-litigious society since litigation is very expensive and certainly beyond the means of the ordinary person.[554] In developing countries like South Africa, with eleven official languages and a great diversity of cultures and customs, medical practitioners are not always able to communicate with patients in their first language, nor do they always understand and support patients with differing customs and beliefs about sickness and healing. Furthermore, they tend to have a highly paternalistic approach towards those who are illiterate or have a low level of education.[555] Nevertheless, surveys and empirical research indicate that medical practitioners are now more careful about obtaining consent and most say that they also provide more information to patients than before. Unfortunately, these actions do not necessarily improve the quality of patient decision-making.[556]

On the other hand, medical practitioners complain that informed consent wastes valuable time and is impracticable and unnecessary; patients are unable to understand the technical

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[550] Bagheri, Alireza Regulating Medical Futility: Neither Excessive Patient's Autonomy nor Physician's Paternalism *European Journal of Health Law* 15 (2008) 45 – 53, 48.

[551] This is also referred to as therapeutic disclosure. See Van Oosten, FF Castell v De Greef and the Doctrine of Informed Consent: Medical Paternalism ousted in favour of Patient Autonomy *De Jure* (1995) 164 – 179, 169.

[552] Dworkin, Roger B Getting what we should from doctors: Rethinking patient autonomy and the doctor-patient relationship *Health Matrix: Journal of Law-Medicine* 13 (2003) 235 – 296, 275.

[553] Kirby, MD Informed consent: what does it mean? *Journal of Medical Ethics* (1983) 9, 69 – 75, 73.

[554] Carstens, Pieter and Pearmain, Debbie *Foundational Principles of South African Medical Law* LexisNexis: Durban 2007, 503; Skegg, P.D.G. English medical law and 'Informed Consent': An Antipodean Assessment and Alternative *Medical Law Review* Vol 7 (1999) 135 – 165, 150.

[555] Carstens, Pieter and Pearmain, Debbie *Foundational Principles of South African Medical Law* LexisNexis: Durban 2007, 502.

[556] Jones, Michael A Informed Consent and other Fairy Stories *Medical Law Review* Vol 7 (1999) 103-134, 125.

complexities; doctors' ethical duty to heal ranks above a legal duty to inform; the doctrine undermines the trust which patients should have for their physicians and consequently has an adverse effect on the doctor-patient relationship; it requires the disclosure of risks which if known to the patient may lead to a psychologically self-fulfilling prophecy; the disclosure may frighten the patient from undergoing necessary treatments; the goal of disclosure is illusionary since it is possible for medical practitioners to disclose information in such a way as to ensure that the patient agrees to the treatment; and in some instances the patients have already made up their minds and the disclosure does not change their decision.[557] In addition Shuck identifies the following three impediments to the implementation of informed consent: first, most doctor-patient interactions are perfunctory and reinforce physician control; second, the clinical setting of medical practice discourages the meaningful exchange of information; and third, the nature of the legal system (as the discussion on the case law illustrates) makes it difficult for patients to establish an effective legal claim.[558]

Regarding this last impediment it must also be noted that non-disclosure of a material risk violates the patient's right to self-determination and autonomy even without (or before) any injury following as a result of this non-disclosure However, under the doctrine of informed consent the only kind of injury that can constitute a compensable harm is an adverse medical outcome.[559] The principles of the applicable law of delict require that the undisclosed risk must materialise and cause the patient harm in order to establish liability and for a claim to realise.[560] The patient must also prove that the lack of informed consent was the cause of the adverse medical outcome.[561] There are many intricate elements which must be proven in order to establish legal liability, among them, the standards of disclosure,

[557] Carstens, Pieter and Pearmain, Debbie *Foundational Principles of South African Medical Law* LexisNexis: Durban 2007, 691 – 692; Van Oosten, FFW Castell v De Greef and the Doctrine of Informed Consent: Medical Paternalism ousted in favour of Patient Autonomy *De Jure* (1995) 164 – 179, 167 – 169; Bradfield, Owen At the heart of Chappel v Hart: a warning about warning! Australian Law Students' Association: Academic Journal http://www.alsa.asn.au.files/acj/2000/chappel_hart.html ; Meisel, Alan The "Exceptions" to the Informed Consent Doctrine: Striking a balance between competing values in medical decision-making *Wisconsin Law Review* 2 (1979) 413 – 488, 415 – 416.
[558] Schuck, Peter H Rethinking Informed Consent *The Yale Law Journal* (1993) Vol 103, 899 – 959, 933.
[559] Schuck, Peter H Rethinking Informed Consent *The Yale Law Journal* (1993) Vol 103, 899 – 959, 925.
[560] *Canterbury v Spence* 464 F. 2d 772 (D.C. Cir. 1972), 790; Dworkin, Roger B Getting what we should from doctors: Rethinking patient autonomy and the doctor-patient relationship *Health Matrix: Journal of Law-Medicine* 13 (2003) 235 – 296.
[561] Schuck, Peter H Rethinking Informed Consent *The Yale Law Journal* (1993) Vol 103:899 – 959, 935.

wrongfulness and causation.[562] According to Carstens and Van Oosten it is inherently incorrect that the risk or injury must first materialise and causation be proven since in these cases the violation is against the patient's physical integrity, dignity and privacy, rather than against his/her health.[563] This is also in line with the general spirit of the South African Constitution and should be seen as an infringement of a person's right to bodily integrity, entrenched in section 12(2)(b). While the court in *Castell* accepted this reasoning and granted compensation (in the form of a *solatium*) by way of the *actio iniuriarum* for the infringement of bodily integrity (irrespective of whether the plaintiff suffered physical injury), the supreme court of appeal in the case of *Broude v McIntosh* found this way of pleading "conceptually odd" and held that it be re-examined when an appropriate case arose.[564] This is unfortunate since the doctrine would be much more effective if compensation were measured by the interests that are really affected, the patient's autonomy and the right to self-determination. Waddam also believes that if moderate sums for such actions were awarded this would be welcomed by the medical profession since the approach would be predictable, it would facilitate settlements and it would distinguish between negligence in the consulting room and in the operating room.[565]

3.5.4. The efficiency of the doctrine of informed consent

The most important shortcoming of the current doctrine of informed consent is that it does not succeed in its aim to protect patient autonomy and self-determination in medical decision-making.[566] It consequently does not provide efficient relief to address the extensive power and authority medical practitioners have in the doctor-patient relationship and does

[562] Carstens, Pieter and Pearmain, Debbie *Foundational Principles of South African Medical Law* LexisNexis: Durban 2007, 878.

[563] Carstens, Pieter and Pearmain, Debbie *Foundational Principles of South African Medical Law* LexisNexis: Durban 2007, 687, 891; Van Oosten The Doctrine of Informed Consent in Medical Law (unpublished LLD thesis) UNISA 1989, Supervisor: Prof SA Strauss, 452; Thomas, Rhiannon Where to from Castell v De Greef? Lessons from recent developments in South Africa and abroad regarding consent to treatment and the standard of disclosure *South African Law Journal* (2007) 188- 215, 193.

[564] Thomas, Rhiannon Where to from Castell v De Greef? Lessons from recent developments in South Africa and abroad regarding consent to treatment and the standard of disclosure *South African Law Journal* (2007) 188- 215, 193; This reasoning was also rejected in Chester v Afshar; Broude v McIntosh and others 1998 (3) SA 60 (SCA), 68.

[565] Thomas, Rhiannon Where to from Castell v De Greef? Lessons from recent developments in South Africa and abroad regarding consent to treatment and the standard of disclosure *South African Law Journal* (2007) 188- 215, 202.

[566] Some writers suggest that the purpose of the doctrine was to expand the liability of the medical profession, the author of this dissertation respectfully disagrees with such a viewpoint; Robertson, Gerald Informed Consent in Medical Treatment *Law Quaterly Review* 97 (1981) 102 – 126, 100.

not allow for rational and participatory medical decision-making. As Judge Brown in the case of *Pratt v Davis* stated, the right to the inviolability of one's person is the most important right of all.[567] This right is the subject of universal acquiescence and although both the physician and patient share the same interest — the patient's health — such shared interest does not allow for an implied acquiescence in anything the medical practitioner may decide on to reach this common goal. Although the doctrine of informed consent promises to protect patient autonomy and self-determination in medical decision-making, it certainly does not deliver adequately on this promise within the wider context of an emerging appreciation of basic human rights and human dignity.[568]

However, some argue that the failed practical consequences of this doctrine are not that important and that irrespective of how poorly it achieves its goals, the value of autonomy and self-determination which it aims to promote is paramount, while the costs involved in achieving this are *de minimis*.[569] In other words if the consequence of the doctrine of informed consent, irrespective of whether it is successful in its aim or not, is to raise the medical profession's consciousness about the need to fully inform patients, then the law has been successful in this instance and the inherent inequality in power between the professional provider and vulnerable patient has been redressed.[570] In the *Rosenberg* case for example Justice Kirby stated that the obligation of the physician to disclose all relevant and material information and risks may even out the power imbalances inherent in the doctor-patient relationship. He also expressed the view that rigorous legal standards, like the doctrine of informed consent, may bring about change in medical practice. According to this reasoning informed consent is an ideal to which daily practice can only aspire but will never fully reach.[571] This argument is inherently flawed and in essence paternalistic. Autonomy and self-determination cannot remain idealistic values, but have to be realised in accordance with the fundamental rights in the Bill of Rights, especially as set out in sections

[567] *Pratt v Davis* 118 Ill. App 161 (1905), 163.
[568] Teff, Harvey *Reasonable Care: Legal Perspectives on the Doctor-patient Relationship* Clarendon Press Oxford (1994) 204; *Rosenberg v Pervical* [2001] HCA 18, par 145.
[569] Schuck, Peter H Rethinking informed consent *The Yale Law Journal* (1993) Vol 103, 899 – 959, 939.
[570] Jones, Michael A Informed Consent and other Fairy Stories *Medical Law Review* Vol 7 (1999) 103-134, 108; *Rosenberg v Pervical* [2001] HCA 18, par 145.
[571] Kirby, MD Informed consent: what does it mean? *Journal of Medical Ethics* (1983) 9, 69 – 75, 73.

10 and 12. Autonomy and self-determination should be the primary point of reference in medical decision-making.

3.5.5. Recommendations

Brenner suggests that the following three principles should govern medical decision-making: first, the paternalistic approach to medical decision-making should be rejected; second, the altruistic ethic of medical professionals should be endorsed and, third, patient autonomy should be actualised through reassurance and mutual participation in the decision-making process.[572] Based on the analysis and suggestions in this chapter so far, as well as Brenner's suggestions, further recommendations can be made to:

- address the power imbalance identified in this chapter;
- address the identified weaknesses of the doctrine of informed consent; and
- propose a new approach to disclosure and consent which will ensure that patient autonomy is protected and self-determination is realised in medical decision-making.

Clearly, a new doctrine of informed consent with a different standard of disclosure or an altogether different point of view is not suggested. The recommendations are based on the underlying values of patient autonomy, dignity and self-determination, with due cognisance of the principle of beneficence, and in line with the constitutional principles and values.

In the first instance the protection of patient autonomy and self-determination, and the assurance that patients will still receive the maximum benefit from professional expertise and guidance can only be achieved with a more honest relationship between doctor and patient. In other words, a moral[573] relationship built on trust, equality and respect.[574] The doctor-patient relationship is a moral relationship for four reasons:

- the patient's reliance on the doctor's competence, morality and compassion;

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[572] Brennan, Troyen *Just Doctoring: Medical Ethics in the Liberal State* Berkeley: University of California Press (1991) 93.

[573] A moral relationship in this context refers to the concept of morality and denotes a social institution, composed of a set of standards pervasively acknowledged by the members of the particular culture; Faden, Ruth R & Beauchamp, Tom L *A History and Theory of Informed Consent* Oxford University Press: NY 1986; Pellegrino, Edmund D & Thomasma, David C *The virtues in Medical Practice* Oxford University Press: NY 1993, chapter 3.

[574] Bradfield, Owen At the heart of Chappel v Hart: a warning about warning! Australian Law Students' Association: Academic Journal http://www.alsa.asn.au.files/acj/2000/chappel_hart.html ; Also see Talcott Parsons view on trust in the doctor-patient relationship as discussed on page 24 of this dissertation – "*The clarifications on the physician role and the sick role illustrate that the relationship is build on mutual trust*."

- the holistic, caretaker-like character of the medical decisions made by doctors;
- society's investment of faith in medicine; and
- the personal commitment and advocacy that patients expect from their doctors.[575]

Trust in this context can be defined as individual's expectations that certain other individuals or institutions will meet their responsibilities.[576] In this sense trust and respect are synonymous with autonomy, although the focus is changed. Trust in the doctor-patient relationship cannot refer to blind faith in, and unquestioned submission to, the physician's authority. Patients should be considered as thinking, willing, active beings, taking responsibility for their own choices and able to explain them by reference to their own ideas and purposes. The doctor-patient relationship can furthermore be regarded as a moral phenomenon that imposes collective responsibilities on physicians based on the following three attributes of medical practice: first, the nature of illness; second, the non-proprietary nature of medical knowledge; and third, the nature and circumstances of medical ethics.[577] Physicians should respect and trust their patients, and as a result do what is best for patients within the limits of their expertise, valuing their patients' interest and acknowledging their patients' autonomy and right to self-determination.[578] Although autonomy is still placed first, beneficent components may be added to, and constrained by, respect for this patient autonomy. Put in another way, the physician's duties are not founded in the principle of beneficence but rather in the correlative rights of patients.[579] According to this perspective, physicians' altruism is based on patients' autonomy and when physicians therefore act in a beneficent manner, patients' autonomy will not necessarily be diminished.[580]

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[575] Hiepler, Mark O & Dunn, Brian C Irreconcilable Differences: Why the Doctor-Patient Relationship is disintegrating at the hands of Health Maintenance Organisations and Wall Street *Pepperdine Law Review* Vol 25 (1998) 597 – 616, 600.

[576] Ommen, Oliver et al Trust, social support and patient type – Associations between patients perceived trust, supportive communication and patients' preferences in regard to paternalism, clarification and participation of severely injured patients *Patient Education and Counseling* (2008) doi: 19.1016/j.pec2008.03.016.

[577] Pellegrino, Edmund D & Thomasma, David C *The virtues in Medical Practice* Oxford University Press: NY 1993, 35, 44; The distinguishing characteristics of the medical profession (see Chapter Two, section 2.2.1) also constitute an internal morality of medicine – something which is built into the nature of medical practice.

[578] Dworkin, Roger B Getting what we should from doctors: Rethinking patient autonomy and the doctor-patient relationship *Health Matrix: Journal of Law-Medicine* 13 (2003) 235 – 296, 275.

[579] *Sidaway v Board of Governors of Bethlem Royal Hospital and the Maudsley Hospital* [1985] A.C. 871 HL, 888.

[580] Brennan, Troyen *Just Doctoring: Medical Ethics in the Liberal State* Berkeley: University of California Press (1991) 91.

Such a humanised relationship between doctor and patient will reinforce patients' confidence in physicians and will also reinforce the authority of the medical profession, while improving the quality of both patients' and physicians' treatment decisions.[581] This new relationship can, however, only exist if physicians learn how to communicate effectively with their patients and how to assess whether their patients' informational needs have been satisfied.[582] It is clear from the case law discussed in this chapter that disclosure of particular warnings and risks by one party in the relationship, as the current doctrine of informed consent requires, does not allow for active participation but actually cosigns patient participation in decision-making to an unacceptable passive role, which does not assist in establishing meaningful communication and consent.[583] Reform is therefore necessary since autonomous decisions require a two-way conversation. Information in this context can therefore only be meaningful if patients are active participants in the decision-making process.[584] Such a social ethic of participation in the decision-making process will go beyond the liberal ethic of autonomy and will also validate patients' views, obviate a paternalistic stance towards patients, and improve treatment decisions.[585]

However, many still believe in the supremacy of professional knowledge inherent in the principle of beneficent paternalism and may regard shared decision-making as de-professionalising the medical profession.[586] Traditional professional notions of trust and respect are also based on a paternalistic model which calls for patients' absolute and unquestioning trust in their physicians and medical professionals in general. A new

[581] Katz, Jay *The Silent World of Doctor and Patient* Johns Hopkins University Press: Baltimore (2002) 26; Wilson-Barnett, Jenifer Limited autonomy and partnership: professional relationships in health care *Journal of medical ethics* 15 (1989) 12 – 16.; Schuck, Peter H Rethinking informed consent *The Yale Law Journal* (1993) Vol 103, 899 – 959, 948; Rosenberg v Pervical [2001] HCA 18, par 143.
[582] Katz, Jay *The Silent World of Doctor and Patient* Johns Hopkins University Press: Baltimore (2002) 78.
[583] *Rosenberg v Pervical* [2001] HCA 18, par 143; *Richter and another v Estate Hammann* 1967 (3) SA 226 (C); *Collins v Meeker* 424 P.2d 488 (Kan.) 1967; *Bly v Rhoads* 222 S.E. 2d 783 (Virg.) 1967; Louwrens v Oldwage 2006 (2) SA 161 (SCA); Katz, Jay *The Silent World of Doctor and Patient* Johns Hopkins University Press: Baltimore (2002) 83.
[584] Katz, Jay *The Silent World of Doctor and Patient* Johns Hopkins University Press: Baltimore (2002) 79.
[585] Wilson-Barnett Jenifer Limited autonomy and partnership: professional relationships in health care *Journal of Medical Ethics* 15 (1989) 12 – 16; Schuck, Peter H Rethinking Informed Consent *The Yale Law Journal* (1993) Vol 103:899 – 959, 932; Shaw, Josephine Informed Consent: A German Lesson (1986) Vol 35, No 4 *International and Comparative Law Quaterly* 864 – 890, 866.
[586] Wilson-Barnett Jenifer Limited autonomy and partnership: professional relationships in health care *Journal of Medical Ethics* 15 (1989) 12 – 16.

understanding of trust and respect in the doctor-patient relationship is therefore necessary and should be based on the following assumptions:

- there is no single right decision for dealing with health and illness;
- both physicians and patients bring their own vulnerabilities to the decision-making process;
- both physicians and patients should relate to one another as equals and unequals (physicians have expert medical knowledge and patients know what their specific needs and personal beliefs are); and
- all human conduct is influenced by rational and irrational expectations.[587]

By being aware of these assumptions in the medical decision-making process patients will receive the maximum professional benefit from medical practitioners, while the main focus remains on patient autonomy. It will rid the law of fiction, reduce opportunities for abuse of patients, promote people's actual desires, foster good medical care and give society the benefits it deserves in exchange for the support it provides to professionals.[588] It will also ensure that a higher quality of therapeutic success is achieved and the quality of medical decisions will improve.[589] It has been suggested that shared decision-making will enable patients to survive, heal or otherwise improve their health.[590] However, it must be remembered that the therapeutic gains to be achieved from the practice of informed consent cannot be the aim for or justification of this doctrine. These consequences are secondary to the purpose of giving the necessary significance to autonomy and self-determination in medical decision-making. To argue that a patient's welfare will be maximised by shared decision-making will allow for justification based on the principles of beneficence and will not give the necessary and required consideration to patient autonomy

[587] Annas, George J et al *American Health Law* Little Brown and Company, Boston 1990, 610; Katz, Jay *The Silent World of Doctor and Patient* Johns Hopkins University Press: Baltimore (2002) 102.
[588] Dworkin, Roger B Getting what we should from doctors: Rethinking patient autonomy and the doctor-patient relationship *Health Matrix: Journal of Law-Medicine* 13 (2003) 235 – 296, 276, 281.
[589] Dworkin, Roger B Getting what we should from doctors: Rethinking patient autonomy and the doctor-patient relationship *Health Matrix: Journal of Law-Medicine* 13 (2003) 235 – 296, 276, 281; Olufowote, James Olumide A Structural Analysis of Informed Consent to Treatment: Societal Evolution, Contradiction and Reproductions in Medical Practice *Health Communication* 23 (2008) 292 – 303, 293.
[590] Beauchamp, Tom L The promise of the Beneficence model for Medical Ethics *Journal of Contemporary Health Law and Policy* 6 (1990) 145 – 155, 150.

and self-determination.[591] Thus, the core value of informed consent must constantly be reviewed and defended, even at the risk of triteness.[592]

Secondly, it is evident that the courts place too great an emphasis on consent while paying relatively little attention to the quality of choice and the extent to which patients' decisions made exhibit understanding.[593] In essence, informed consent suggests more than a notification. It suggests a process of deliberation and understanding. The aim of this doctrine must be served and in the absence of patient comprehension individual choice cannot be preserved.[594] It has even been suggested that the doctrine of informed consent should rather be referred to as informed choice or informed decision-making, since the suggested expressions better reflect the underlying notion of autonomy based on knowledge and appreciation.[595] An emphasis on informed choice will not only focus on what information is disclosed but also how, when and by whom the information is disclosed.

In this sense the rebuilding of patient autonomy and self-determination in medical decision-making is actually the responsibility of the medical profession as well as that of the judiciary.[596] However, physicians' apprehension of and resistance to breaking with the 2500 year old tradition and practices of the medical paternalistic approach will be the major

[591] Compare the arguments of Beauchamp, Tom L The promise of the Beneficence model for Medical Ethics *Journal of Contemporary Health Law and Policy* 6 (1990) 145 – 155, 150, Teff, Harvey *Reasonable Care: Legal Perspectives on the Doctor-patient Relationship* Clarendon Press Oxford (1994) 227 and Shaw, Josephine Informed Consent: A German Lesson (1986) Vol 35, No 4 *International and Comparative Law Quaterly* 864 – 890, 867.

[592] Kottow, M The battering of informed consent *Journal of Medical Ethics* 30 (2004) 565 – 569.

[593] Teff, Harvey *Reasonable Care: Legal Perspectives on the Doctor-patient Relationship* Clarendon Press Oxford (1994) 197; Carstens, Pieter and Pearmain, Debbie *Foundational Principles of South African Medical Law* LexisNexis: Durban 2007, 875; Thomas, Rhiannon Where to from Castell v De Greef? Lessons from recent developments in South Africa and abroad regarding consent to treatment and the standard of disclosure *South African Law Journal* (2007) 188- 215, 206; *Rogers v Whitaker* 175 CLR 479 [1992], 490.

[594] Teff, Harvey *Reasonable Care: Legal Perspectives on the Doctor-patient Relationship* Clarendon Press Oxford (1994) 196, 206; Van Oosten, FFW The Doctrine of Informed Consent in Medical Law (unpublished LLD thesis) UNISA 1989, Supervisor: Prof SA Strauss, 448; Also see chapter 9 of Faden, Ruth R & Beauchamp, Tom L *A History and Theory of Informed Consent* Oxford University Press: NY 1986.

[595] Thomas, Rhiannon Where to from Castell v De Greef? Lessons from recent developments in South Africa and abroad regarding consent to treatment and the standard of disclosure *South African Law Journal* (2007) 188- 215, 206; Carstens, Pieter and Pearmain, Debbie *Foundational Principles of South African Medical Law* LexisNexis: Durban 2007, 690; Skegg, P.D.G. English medical law and 'Informed Consent': An Antipodean Assessment and Alternative *Medical Law Review* Vol 7 (1999) 135 – 165, 149; Teff, Harvey *Reasonable Care: Legal Perspectives on the Doctor-patient Relationship* Clarendon Press Oxford (1994) 196 - 197.

[596] Brennan, Troyen *Just Doctoring: Medical Ethics in the Liberal State* Berkeley: University of California Press (1991) 112.

obstacle in the change of medical decision-making.[597] Katz suggests that this resistance is due partly to a reluctance to depart from their familiar practices but also their concern that shared decision-making will reveal vexing problems about the state of the art and science of medicine.[598] Although a degree of empathy with the medical profession is not out of place, action is now necessary, action that goes beyond symbolic gestures and provides guidance on how to translate rhetoric into practice.[599] The current doctrine of informed consent can be described as "*a charade, a symbolic but contentless formality*" and it does not give true meaning to patient autonomy and self-determination in medical decision-making.[600]

3.6. Conclusion

The paternalistic approach in medical decision-making has been accurately described as a sad tale of high hopes, good intentions, dashed expectations, much anguish and ensuing recriminations.[601] Clearly, there is no place for medical paternalism in either the medical profession and doctor-patient relationship or medical- and health law, not even if it is thought to be in the name of the patient's best interests.[602] "*Paternalism was more appropriate to a by-gone age when the population were presumed to be uneducated and therefore incapable of playing an equal role in the doctor-patient relationship. Such a view has no foundations in our present society and consequently does not have any right to be reflected in our legal system*".[603] Patient autonomy and self-determination are values fundamental to the Constitution and the general rights-based approach in South Africa. The medical paternalistic practices and justifications for the limitation of this basic human right are therefore intolerable. In the case of *Ex parte Minister of Safety and Security: In re S v Walters* Judge Kriegler observed that "*…the rights to life, to human dignity and to bodily integrity are individually essential and collectively foundational to the value system prescribed by the Constitution. Compromise them and the society to which we aspire*

[597] Katz, Jay *The Silent World of Doctor and Patient* Johns Hopkins University Press: Baltimore (2002) 85.
[598] Katz, Jay *The Silent World of Doctor and Patient* Johns Hopkins University Press: Baltimore (2002) 85.
[599] Katz, Jay *The Silent World of Doctor and Patient* Johns Hopkins University Press: Baltimore (2002) 71.
[600] Morris, Grant H Dissing Disclosure: Just What the Doctor Ordered *Arizona Law Review* 44 (2002) 313 – 371, 316; Wilson-Barnett, Jenifer Limited autonomy and partnership: professional relationships in health care *Journal of medical ethics* 15 (1989) 12 – 16.
[601] *Broude v McIntosh and others* 1998 (3) SA 60 (SCA), 62.
[602] Brennan, Troyen *Just Doctoring: Medical Ethics in the Liberal State* Berkeley: University of California Press (1991) 112.
[603] Giesen, Dieter From Paternalism to Self-determination to shard Decision making *Acta Juridica* (1988) 107 – 127, 115 - 116.

becomes illusory. It therefore follows that any significant limitation of any of these rights would for its justification demand a very compelling countervailing public interest".[604]

The current doctrine of informed consent, as applied by our courts, is monolithic and needs to be refined in order to be more sensitive to the intricacies of the distinctive doctor-patient relationship and to be more context specific with due regard to the unique attributes and needs of the health care setting.[605] It also needs to be remembered that informed consent is a normative variable; a doctrine that treats all physicians and patients the same although they are not, exacts a price.[606] In section 3.3. of this chapter it was shown that the power imbalances in the doctor-patient relationship ultimately result from the conflict between patient autonomy and medical paternalism. It is quite clear from the discussion above that both the value of patient autonomy and self-determination as well as practices based on a medical paternalistic approach (which require of physicians to make moral judgements instead of medical judgements) cannot co-exist in a doctor-patient relationship. However, the functional specificity of medical practitioners, the basic tenets of the medical profession and the realities of medical practice can also not be ignored. An exaggerated focus on one of these concepts will have dire consequences for both the quality of care patients can expect as well as the functional specificity of the medical profession. Balance is therefore key.

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[604] *Ex parte Minister of Safety and Security: In re S v Walters* 2002 (4) SA 613 (CC) 631 para 28; Carstens, Pieter and Pearmain, Debbie *Foundational Principles of South African Medical Law* LexisNexis: Durban 2007, 29.

[605] Schuck, Peter H Rethinking Informed Consent *The Yale Law Journal* (1993) Vol 103:899 – 959, 906.

[606] Schuck, Peter H Rethinking Informed Consent *The Yale Law Journal* (1993) Vol 103:899 – 959, 956 – 957; Teff, Harvey *Reasonable Care: Legal Perspectives on the Doctor-patient Relationship* Clarendon Press Oxford (1994) 190.

PART B

In this part, two alternative perspectives on health service delivery will be introduced. The discussion of these two alternative approaches in this particular part also serves as an illustration of the development of medical practice from its historical roots described in Part A.

__Chapter 4:__ **The doctor-patient relationship in the medical marketplace**

__Chapter 5:__ **The fiduciary nature of the doctor-patient relationship**

CHAPTER FOUR: The doctor-patient relationship in the medical marketplace

4.1. Defining the business model in medical practice

4.2. The relevance of the business model to medical practice and the doctor-patient relationship

4.3. The business model and the power imbalances in the doctor-patient relationship

4.3.1. Informed consent

4.3.2. Patients' rights, patient autonomy and the defiance of beneficence

4.3.3. The erosion of trust in the doctor-patient relationship

4.4. Conclusion

The discussion in Chapter Three revealed a real conflict between autonomy and beneficence in the doctor-patient relationship, and the ethically and legally unacceptable power imbalances resulting from this conflict. The doctrine of informed consent as a legal mechanism to address these power imbalances, specifically with regard to medical decision-making, was found to be an inadequate attempt to ensure a more equal distribution of power in this relationship. Clearly, a new approach to, or understanding of, health care delivery — as opposed to the traditional paternalistic ethic discussed in Chapter Three — is required.

In Chapter Four the first of two dominant alternative approaches to health care delivery will be considered. This approach emphasises the contractual nature of the doctor-patient relationship in the medical marketplace and is known as the business model to health service delivery. According to the business model, health service delivery is viewed as an ordinary commodity and the doctor-patient relationship as a contractual relationship regulating the distribution of this commodity. The question whether an alternative perspective on the doctor-patient relationship can assist (if at all) in ensuring a more equal distribution of power between doctor and patient will also be considered.

The second alternative approach, focusing on the fiduciary nature of the doctor-patient relationship will be discussed in Chapter Five. As indicated in Chapter One, these two approaches to health service delivery serve as a framework within which the power imbalances in the doctor-patient relationship will be considered.

In section 4.1. of this chapter the characteristics and effects of the business model in medical practice will be described to provide a general overview of this development in health service delivery. In section 4.2. this alternative approach will be analysed in more detail order to determine its relevance and suitability to health service delivery. Some of the power imbalances in the doctor-patient relationship will be considered in section 4.3.; medical decision-making, informed consent, patients' rights, patient autonomy and beneficence will again be discussed. The importance of trust in the doctor-patient relationship will be considered with regard to the identified power imbalances and in preparation for the discussion and analysis of the fiduciary nature of the doctor-patient relationship in Chapter Five. The present chapter will conclude with a summary of how the proletarianisation of medical practice influences health service delivery in general, as well as the power imbalances in the doctor-patient relationship in particular.

4.1. Defining the business model in medical practice

Until the second half of the nineteenth century there was no open trade in medical care as was the case with other commodities such as food, machines and other materials. Yet as far back as the end of the eighteenth century, the stage was set for a radical change in the nature and economic status of medicine; primarily due to increased medical possibilities, a decline in mortality and morbidity, an enthusiastic embrace of medical research and the emergence of a market for medical care.[607] Today, health care delivery is increasingly regarded as a business; an ordinary commodity[608] produced directly for its exchange value, to be bought and sold in the marketplace and bound by the rules and principles of the law of contract. Patients are referred to as *clients*, *customers* or *consumers*, while medical practitioners are described as *service providers*. This inevitable revolution in medical practice is a result of

- the increased incorporation of competitive market values in health care;
- escalating medical malpractice costs;

[607] Callahan, Daniel & Wasunna, Angela A *Medicine and the Market: Equity v Choice* The Johns Hopkins University Press: Baltimore 2006, 20 - 21.

[608] In general, commodities can be defined as goods with a price and that are interchangeable with other goods of like type and quality. The value of commodities are furthermore regarded as instrumental rather than intrinsic; Kaveny, Cathleen Commodifying the Polyvalent Good of Health Care *Journal of Medicine and Philosophy* Vol 24, No 3 (1999) 207 – 223, 208 – 212.

- scientific and technological advances in medicine;[609]
- the growth of specialisation areas in medicine at the expense of general medical practice;[610]
- the bureaucratisation of medical practice;[611]
- the de-professionalisation and proletarianisation of the medical profession;[612] and
- the commercialisation of health service delivery in general.

In summary, the increased complexity of modern medicine in an industrial and commercialised context, as well as the growing functional significance of health as a social factor, have led to the increase in the cost of medical services and the rise of this organisational mode of health care delivery referred to as the business model in medical practice.[613] This model is replacing the lone physician with his/her "familiar black bag"[614] and the paternalistic medical ethic[615] (discussed in Chapter Three) with a new depersonalised medical industrial complex and ideal.[616] In the medical industrial complex, the role of the physician has shifted from that of a direct provider of health care to a co-ordinator of the production of complex services, including the use of the resources provided

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[609] Including the changing nature of medical training which now requires the training of physicians to be technologically dependent; Callahan, Daniel & Wasunna, Angela A *Medicine and the Market: Equity v Choice* The Johns Hopkins University Press: Baltimore 2006, 6.

[610] McKinlay John B and Arches, Joan Towards the proletarianisation of physicians *International Journal of Health Services* Vol 15, No 2 (1985) 161 – 195, 168.

[611] McKinlay John B and Arches, Joan Towards the proletarianisation of physicians *International Journal of Health Services* Vol 15, No 2 (1985) 161 – 195, 163.

[612] See Chapter Two pages 28 and 29 for a discussion on the de-professionalisation and proletarianisation of the medical profession; Proletarianisation in this context refers to the process by which an occupation is divested of control and subordinated to the broader requirements of production.

[613] Compare this medical industrial complex with the historical development of the doctor-patient relationship discussed in Chapter Two of this dissertation, especially section 2.1.2.; Field, Mark G The doctor-patient relationship in the Perspective of "Fee-for-Service" and "Third-party" Medicine *Journal of Health and Human Behaviour* Vol 2, No 4 (1961) 252 – 262, 253; Carstens, Pieter and Pearmain, Debbie *Foundational Principles of South African Medical Law* LexisNexis: Durban 2007, 381.

[614] An image captured perfectly for example by the famous nineteenth-century William Fields painting of a doctor kneeling at the home bedside of a sick child (*The Doctor*); Callahan, Daniel & Wasunna, Angela A *Medicine and the Market: Equity v Choice* The Johns Hopkins University Press: Baltimore 2006, 28.

[615] *"The ethic of a group is the normative system that governs the conduct of people in the group When a group has a unique situation, there will be a normative system with a set of moral obligations and prohibitions to cover that situation The ethic of a group is the application of our fundamental ethical principles to the particular situation that the group is in"*. Rainbolt, George W Competition and the Patient-centered Ethic *Journal of Medicine and Philosophy* Vol 12 (1987) 85 – 99, 86.

[616] Traditional medical practice have also been described as a 'cottage industry', where solo practitioners provided health care out of their homes and in patient's homes for fees. Esser, Jan Hendrik *Who cares? Moral reflections on business in healthcare* Thesis presented in partial fulfillment of the requirements for the degree M Phil (Applied Ethics) Stellenbosch University, March 2001 (Supervisor: Prof AA van Niekerk), 6; McKinlay John B and Arches, Joan Towards the proletarianisation of physicians *International Journal of Health Services* Vol 15, No 2 (1985) 161 – 195, 163.

by hospitals.[617] In this dissertation the way in which intrusions of capitalist initiatives have led to the bureaucratisation and proletarianisation of medical practice and the extent to which the medical profession has as a consequence been de-professionalised, will not be discussed. In the present chapter only the business model to health service delivery will be considered as a framework for the discussion and continued analyses of the power imbalances in the doctor-patient relationship.

The business model regards the doctor-patient relationship as an economic relation and also suggests that the cost, price, availability and distribution of health care services should be left to the free market. The nature of the doctor-patient relationship as an economic relation can be described as a legal bond or juridical relation consisting of a system of rights and duties, in other words, a contract. A contract, in terms of the South African law of contract still seems to be primarily premised on business concepts, perceptions of the manner in which markets operate and the kinds of goods and services relevant to such an exchange market.[618] The business model consequently regards medical practice as a commodity transaction, similar to buying a motor vehicle or taking it to a mechanic – the letting or hiring of work (*locatio conductio operis)* or the letting and hiring of services (*locatio conductio operarum)*.[619] In stark contrast to Parsons's physician's and sick role discussed in Chapter Two, section 2.2.2., the physician and patient are, in terms of the business model, not only regarded as contracting equals, but they also have minimal ethical obligations to each other.[620] No special attributes are attached to either role and the physician is only required to provide a "good product" while the patient is expected to pay for the service provided. Patients are furthermore free to choose among providers of medical services. It has been suggested that these characteristics of the business model of

[617] Esser, Jan Hendrik *Who cares? Moral reflections on business in healthcare* Thesis presented in partial fulfillment of the requirements for the degree M Phil (Applied Ethics) Stellenbosch University, March 2001 (Supervisor: Prof AA van Niekerk), 7.

[618] Carstens, Pieter and Pearmain, Debbie *Foundational Principles of South African Medical Law* LexisNexis: Durban 2007, 413.

[619] The principal difference between *locatio conductio operis* and *locatio conductio operarum* is that in the former the lessee (doctor) does not stand under the supervision and control of the lessor (patient), whereas in the latter the lessee (employee) stands under the supervision and control of the lessor (employer); Strauss, SA The Doctor/Hospital – Patient Relationship, Chapter 1 Part II of the *International Encyclopedia of Laws Volume 3 : Medical Law* Suppl 49 (January 2007) 59 – 65, 60; Strauss, SA *Doctor, Patient and the Law: A selection of practical issues* Van Schaick: Pta 1991, 3ed 69; *Tulloch v Marsh* 1910 TPD 453.

[620] See Chapter Two, section 2.2.2., page 19.

medical practice will result in a decline in the cost of health care services, while the quality and accessibility of such services will be maintained or will improve.

Supporters of the business model in health care contend that the contractual nature of this approach will also close the traditional power gap between doctor and patient, since it will empower the patient to play a more active role in the doctor-patient relationship and foster a culture of competitive service provision between the suppliers of medical services.[621] The approach is therefore a direct response to paternalism and represents a move towards more patient autonomy. It is based on the patient's right to make decisions — a right's ethic — equal to consumer rights. This right's ethic outweighs the "right" of benevolent others to manipulate a person for his/her own good, also known as the professional public service ideal (or principle of beneficence), which traditionally formed the cornerstone of health service delivery and was discussed in Chapter Three, section 3.3.[622] The present chapter will only consider the business model of health care delivery and the movement towards a right's ethic in so far as this approach attempts to provide for a more equal distribution of power in the doctor-patient relationship. (Consumerism and patient choice as a product of this approach will form the basis of the discussion in Chapter Seven, while managed care will be discussed in Chapter Six.)

The practical effects of the business model of medical practice are evident from the case law. In *E v Australian Red Cross Society*[623] a public hospital in New South Wales was described by a court as engaged in *trading activities* comprising patients' fees and other *business activities,* and was deemed to be a *trading corporation*.[624] The judge held that if patients are to be regarded as consumers, the *trade* of the hospital is the *provision of services* to the patients and a contract between any patient and the hospital is entered into

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[621] Also see Chapter Seven; Carstens, Pieter and Pearmain, Debbie *Foundational Principles of South African Medical Law* LexisNexis: Durban 2007, 382.

[622] See Chapter Three, section 3.3. for a discussion of the principle of beneficence; Pellegrino, Edmund D & Thomasma, David C *For the Patient's Good: The Restoration of Beneficence in Health Care* Oxford University Press: NY 1988, 51; Teff, Harvey *Reasonable Care: Legal Perspectives on the Doctor-patient Relationship* Clarendon Press Oxford (1994) 94, 103.

[623] *E v Australian Red Cross Society and Others* [8 February 1991] Australian Law Reports 1991;99:601-72.

[624] Teff, Harvey *Reasonable Care: Legal Perspectives on the Doctor-patient Relationship* Clarendon Press Oxford (1994) 162; *E v Australian Red Cross Society* [1991] 2 Med LR 303; Compare with *Smith v Auckland Hospital Board* [1965] NZLR 191 where it was held that the legal relationship between a Hospital Board, its medical officers and the patients was not a contractual/business relationship.

in the course of business.[625] Although the court's stance on how health care should be provided cannot directly determine the nature of the doctor-patient relationship, the view that medical relationships should be regarded as ordinary contractual and business relationships does have a bearing on how patients and physicians perceive medical care.[626] Sulmasy submits that the linguistic symbols and metaphors used to describe any human endeavour, including medical practice, also shape our thoughts about that particular endeavour.[627] In South African case law the "language" of the business model of health service delivery is also evident. In *Shiels v Minister of Health*[628] the process whereby orthopaedic technicians make and fit artificial limbs for patients was compared to that of a tailor making suits for a client. In *Afrox Healthcare v Strydom,*[629] which will be discussed in greater detail in section 4.3.3., the effects and rationale of the business model of health service delivery also influenced the judgement as well as the arguments submitted in this case for the exemption of the hospital nursing staff from any liability based on negligence.

Some countries seem to be more willing than others to entertain and pursue market related ideas and principles in their health care system and medical practice in general, but hardly anywhere in the world have these initiatives not been applied to health service delivery in some way or another.[630] While the USA is described by Callahan and Wasunna as the heartland of market and health care experiments, Europe in general is said to use market practices in health service delivery in a much more pragmatic and less ideological manner than the USA.[631] Since ex-president Clinton's administration, however, there has been a move away from a pure market economy in the USA health care system. In Germany, there is a move towards *Ökonomisierung* – a more market-oriented approach to health care.[632] Other European countries with a history of rejecting large-scale market practices in health

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[625] Teff, Harvey *Reasonable Care: Legal Perspectives on the Doctor-patient Relationship* Clarendon Press Oxford (1994) 162; *E v Australian Red Cross Society* [1991] 2 Med LR 303, 327.

[626] Teff, Harvey *Reasonable Care: Legal Perspectives on the Doctor-patient Relationship* Clarendon Press Oxford (1994) 100.

[627] Sulmasy, D What is so special about Medicine? *Theoretical Medicine* 14 (1993) 27 - 41, 27.

[628] 1974 (3) SA 276 (RA), at page 279.

[629] *Afrox Healthcare BPK v Strydom* 2002 (6) SA 21 (SCA).

[630] Callahan, Daniel & Wasunna, Angela A *Medicine and the Market: Equity v Choice* The Johns Hopkins University Press: Baltimore 2006, 1.

[631] Callahan, Daniel & Wasunna, Angela A *Medicine and the Market: Equity v Choice* The Johns Hopkins University Press: Baltimore 2006, 2.

[632] Heubel, Friedrich Patients or Customers: Ethical Limits of Market Economy in Health Care *Journal of Medicine and Philosophy* Vol 25 No 2 (2000) 240 – 253, 241.

service delivery and who continue doing so are Denmark, Ireland, Italy, Sweden and France.[633] Canada, with the help of its 1984 National Health Act, has also largely managed to hold on to its traditional health care values and organisation, fending off market proponents.[634] Tanzania can be singled out as an African country that also rejects market practices in health service delivery even in the face of economic pressure, while Ghana, Kenya, Malawi and Zambia represent African countries that have put various market practices in place under pressure from the World Bank.[635] Countries that show a willingness to introduce market ideas and mechanisms in their health care systems include Argentina, Brazil and Chile, while India and China can be described as *laissez-faire* countries where the health care market is allowed to flourish in an unimpeded and unregulated way with few safety-net features.[636] Belgium, the Netherlands, Switzerland and Australia can be described as market accommodators, that is, countries that have found a role for some market practices in their health care systems, and New Zealand and the Czech Republic are two examples of countries that first pursued market related principles in their health care systems but became disillusioned with the results and moved back to a strong solidarity model.[637]

This revolution in health service delivery is also evident from the manner in which health care institutions and providers are being managed and viewed in South Africa and is recognised in South African case law. However, the preamble to and objectives of the National Health Act 61 of 2003 as well as the preamble to the National Patients' Rights Charter reaffirm that health care delivery in South Africa is a special service, regarded as the primary responsibility of the state and sustained by the dedication, promise and commitment of the medical profession in South Africa. Other examples confirming the special nature of health service delivery in South Africa are the relatively recent amendments to the Medical and Related Substances Act 101 of 1965, which make express

[633] Callahan, Daniel & Wasunna, Angela A *Medicine and the Market: Equity v Choice* The Johns Hopkins University Press: Baltimore 2006, 91.
[634] Callahan, Daniel & Wasunna, Angela A *Medicine and the Market: Equity v Choice* The Johns Hopkins University Press: Baltimore 2006, 66 - 74.
[635] Callahan, Daniel & Wasunna, Angela A *Medicine and the Market: Equity v Choice* The Johns Hopkins University Press: Baltimore 2006, 91.
[636] Callahan, Daniel & Wasunna, Angela A *Medicine and the Market: Equity v Choice* The Johns Hopkins University Press: Baltimore 2006, 92.
[637] Callahan, Daniel & Wasunna, Angela A *Medicine and the Market: Equity v Choice* The Johns Hopkins University Press: Baltimore 2006, 92.

provision for a transparent system for the pricing of medicines, a single exit price and professional fee for the suppliers of medicines. Sections 18A, 18B and 22G of this act prohibit a mark-up on the cost price of medicine and outlaw systems for bonusing, rebates, sampling and volume or bulk discounts. Although such practices are common in other trades and sectors they have been outlawed by the act, thereby emphasising the fact that health services are different from other services, the global proletarianisation of medical practice notwithstanding.[638]

The notion of market principles in health service delivery can invoke stereotypes of crass commercialism, the commodification of important health needs and aspirations as well as the falling away of an ideal such as the affordability of health care for all. Market principles may, on the other hand, hold some appeal since they promise greater patient choice and stricter external control and regulation according to trade related principles. Clearly, the effects of the depersonalised medical industrial complex cannot be ignored. But has this business ethic in health care delivery transformed the underlying reality of the traditional doctor-patient relationship or is it simply commercial rhetoric? In other words, what is the place of market theory and practice in medicine and health care? In the following section the relevance of the business model and business ethics to health service delivery, as well as the ethical implications of this development, will be evaluated in order to determine the suitability of this alternative approach to health care delivery, and to the doctor-patient relationship.

4.2. The relevance of the business model to medical practice and the doctor-patient relationship

When evaluating the influence of the business model and its perspectives on health service delivery, it is essential to revisit the historical development of the medical profession as well as the unique qualities and characteristics of both the medical practitioner and the patient in the doctor-patient relationship.[639] When comparing the business model of health service

[638] Carstens, Pieter and Pearmain, Debbie *Foundational Principles of South African Medical Law* LexisNexis: Durban 2007, 417

[639] See Chapter Two, section 2.2. and section 2.2.1. where it was submitted that: "*The word "trade" is etymologically derived from Germanic and Anglo-Saxon noun roots, "footstep" or "track" , derivatively*

delivery with the altruistic and service orientated approach of the early medical practitioners discussed in Chapter Two section 2.1., as well as the unique characteristics of medicine as a profession and the social dynamics of the doctor-patient relationship discussed in section 2.2., the vast disparity between the traditional medical ethic and business ethics becomes evident. The business model does not make provision for the unique culture of medical care.[640] For example, one of the characteristics of medical professionalism is the profession's orientation towards service. However, from a *business-is-business* point of view the maximisation of one's own profits takes priority over altruism. Another characteristic of the medical profession is its independence from lay influence and control based on the advanced and prolonged education of its members and their expert knowledge. In business though, more emphasis is placed on appropriate training than extensive education. Professions also have extensive self-regulatory powers and their own ethical codes, disciplinary guidelines and procedures. Businesses on the other hand lack such political and commercial independence and their comments on public policy usually verbalise vested interests.

According to the business model, health care delivery should not be regarded as a "special" good qualitatively distinct from other commodities. Health care delivery in the business model of medical practice is an ordinary commodity, which refers to a product valued for its usefulness to the consumer or its satisfaction of the consumer's preferences.[641] The business model consequently suggests that health care is not of a moral and economic order different to any other good or service. On a practical level this means that the patient retains authority over all personal matters while the physician possesses authority over the goals and values regarding all technical matters.[642] However, limiting the physician's

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meaning the course, manner or way of life, a regular habitual course of action. The word "profession " can be traced to an act of self-conscious or public – even confessional – speech".

[640] It is important to take note that business ethics is not depreciated or criticised in this dissertation, the question here is rather whether business ethics and the business model in health care delivery are an appropriate model for medical practice; Carstens, Pieter and Pearmain, Debbie *Foundational Principles of South African Medical Law* LexisNexis: Durban 2007, 286.

[641] Or the general name given to goods and services considered as the basic objects of production and exchange; Sulmasy, D What is so special about Medicine? *Theoretical Medicine* 14 (1993) 27 - 41, 29; Pellegrino, Edmund D The Commodification of Medical and Health Care: The Moral Consequences of a Paradigm shift from a Professional to a Market Ethic *Journal of Medicine and Philosophy* Vol 24, No 3 (1999) 243 – 266, 245 - 247.

[642] Pellegrino, Edmund D & Thomasma, David C *For the Patient's Good: The Restoration of Beneficence in Health Care* Oxford University Press: NY 1988, 51

interests to technical matters is not very realistic, since this disregards the physician's humanity and interest in the patient's well-being and also ignores the fact that physicians do not deal only with technical matters.[643] Health care services cannot be regarded as an ordinary commodity and the relationship between doctor and patient is certainly not stripped of personal interests. This is so for the following reasons:

- The nature of health care is non-proprietary. One cannot sell that which is not owned, and physicians cannot claim ownership of the health care that they provide.[644] It is therefore obvious, given the special nature of illness and healing as well as the non-proprietary nature of medical practice, that although commodities may be used in the process of providing health care, health care as a whole is not an ordinary commodity and health services rendered demand obligations not associated with general commerce.[645]
- The vulnerability of patients and the large measure of trust placed in a physician is unique to the doctor-patient relationship.[646] Health care delivery is a special good, the product of the historical development of medical practice, influenced by the characteristics of professionalism — which is necessary due to the functional specificity of medical practitioners and the vulnerability of patients — as well as the particular social dynamics of the doctor-patient relationship.[647]

[643] See Chapter Two for an exposition on the nature of medical care and the unique qualities of the doctor-patient relationship.

[644] Esser, Jan Hendrik *Who cares? Moral reflections on business in healthcare* Thesis presented in partial fulfillment of the requirements for the degree M Phil (Applied Ethics) Stellenbosch University, March 2001 (Supervisor: Prof AA van Niekerk), 65.

[645] The non-proprietary nature of medical practice refers to the notion that one cannot sell what one don't own and medical practitioners and health care organisations cannot claim ownership of the health care that they provide. Esser, Jan Hendrik *Who cares? Moral reflections on business in healthcare* Thesis presented in partial fulfillment of the requirements for the degree M Phil (Applied Ethics) Stellenbosch University, March 2001 (Supervisor: Prof AA van Niekerk), 65; Pellegrino, Edmund D The Commodification of Medical and Health Care: The Moral Consequences of a Paradigm shift from a Professional to a Market Ethic *Journal of Medicine and Philosophy* Vol 24, No 3 (1999) 243 – 266, 247; Sulmasy, D What is so special about Medicine? *Theoretical Medicine* 14 (1993) 27 - 41, 30.

[646] Esser, Jan Hendrik *Who cares? Moral reflections on business in healthcare* Thesis presented in partial fulfillment of the requirements for the degree M Phil (Applied Ethics) Stellenbosch University, March 2001 (Supervisor: Prof AA van Niekerk), 65.

[647] Health care delivery can also be described as a primary good; primary goods are those that every rational individual is presumed to want and that are always regarded as valuable; Rainbolt, George W Competition and the Patient-centered Ethic *Journal of Medicine and Philosophy* Vol 12 (1987) 85 – 99, 89.

- Medical care is built on a moral relationship of trust, confidence and honesty, and it is not a business transaction.[648]
- It is said that there are only two types of commodities – necessary and adventitious. Health care delivery does not conform to either of these types, as there is a qualitative difference between health care and other commodities.[649] In Sulmasy's analyses on necessary commodities, based on Aristotle's *Metaphysics*, it becomes evident that a good can only be considered a necessary commodity if, when absent over some period of time varying according to the item, illness results.[650] Adventitious commodities, on the other hand, are described as goods and services which do not directly address basic human needs and it has already been established that health is a very important and basic human need.[651]

The business model furthermore overestimates patient autonomy and the rationality of patient decisions. Since the model views the doctor-patient dynamic as a simple, straightforward purchase of services, it overlooks the complex nature of health service delivery and the historical development of the medical profession, which have contributed significantly to the understanding and practical dynamic of the doctor-patient relationship today.[652] Supporters of the business model of health care delivery submit that this contractual approach overcomes the paternalistic interpretation of the Hippocratic ethic and aims to provide a more balanced view of the dynamics in the doctor-patient relationship, but this is an oversimplification of the nature of the Hippocratic ethic, - which was discussed in Chapters Two and Three – and it fails to address clinical realities and the impact of illness and disease on vulnerable patients. A measured, dispassionate appraisal in medical decision-making, which is normally associated with the abstract distinguishing on

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[648] Esser, Jan Hendrik *Who cares? Moral reflections on business in healthcare* Thesis presented in partial fulfillment of the requirements for the degree M Phil (Applied Ethics) Stellenbosch University, March 2001 (Supervisor: Prof AA van Niekerk), 65.

[649] Esser, Jan Hendrik *Who cares? Moral reflections on business in healthcare* Thesis presented in partial fulfillment of the requirements for the degree M Phil (Applied Ethics) Stellenbosch University, March 2001 (Supervisor: Prof AA van Niekerk), 65.

[650] Sulmasy, Daniel P What's so Special about Medicine *Theoretical Medicine* Vol 14 (1993) 27 – 42, 35.

[651] Sulmasy, Daniel P What's so Special about Medicine *Theoretical Medicine* Vol 14 (1993) 27 – 42, 35.

[652] Teff, Harvey *Reasonable Care: Legal Perspectives on the Doctor-patient Relationship* Clarendon Press Oxford (1994) 113.

rights, is implied by the business model.[653] However, it is clear that this suggested rational and detached style in medical decision-making is unrealistic and does not take into account the specific attributes and vulnerabilities attached to both the physician's role and the sick role in the doctor-patient relationship.[654] A rational and detached style in medical decision-making makes no allowance for the particular qualities and traditional ethical obligations of medical professionals — like their altruistic commitments and actions based on beneficence — to be utilised for the benefit of and in the best interests of the patient in the doctor-patient relationship.

The market model of health service delivery can also be criticised because it does not account for the fact that physicians and patients do not explicitly discuss the particulars of their relationship like they would in any other ordinary contractual setting, or understand their relationship as a contract. In Chapter Five it will be shown that courts sometimes view and describe physicians as fiduciaries, and most medical practitioners do regard themselves as such. A fiduciary is held to something stricter than the morals of the marketplace and the goal of fiduciary law is to raise the morality of the marketplace.[655] Finally and probably most importantly, there is a disparity between the business model and traditional health ethics as to the application of the price mechanism of the market economy on health service delivery.[656] The price mechanism of the business model is "*…that kind of economic coordination that uses freely formed prices as the central means for allocating resources on the one hand and for the production and distribution of goods and services on the other*".[657] This means that

- price rations – if a patient is unable to pay for a service he/she does not have access to that particular health service;
- price indicates scarcity – the greater the demand and the less supply of the particular service the higher the price; and

[653] Teff, Harvey *Reasonable Care: Legal Perspectives on the Doctor-patient Relationship* Clarendon Press Oxford (1994) 114.
[654] See Chapter Two, section 2.2.2.
[655] Johnston, Kim Patient Advocates or Patient Adversaries? Using Fiduciary Law to Compel Disclosure of Managed Care Financial Incentives *San Diego Law Review* Vol 35 (1998) 951 – 992, 960 - 961.
[656] Heubel, Friedrich Patients or Customers: Ethical Limits of Market Economy in Health Care *Journal of Medicine and Philosophy* Vol 25 No 2 (2000) 240 – 253, 243.
[657] Heubel, Friedrich Patients or Customers: Ethical Limits of Market Economy in Health Care *Journal of Medicine and Philosophy* Vol 25 No 2 (2000) 240 – 253, 243.

- price directs resources in the direction of demand – the higher the price of the service, the more profitable it will be to provide this service.[658]

In sum then the business model in health service delivery does not make provision for the clinical realities and gives rise to a moral conflict with the social and constitutional obligations of providing access to health care.[659] The rationale of the business model offers an idealistic and oversimplified perspective of the intricate doctor-patient relationship, which does not acknowledge the unique and complex dynamics inherent in this relationship. Consequently, it is not an appropriate approach to health care delivery.[660] As Sulmasy indicated: "*Health care…is fundamentally a relationship of caring and is not fundamentally an object of production and exchange*."[661]

However, there do seem to be potential improvements and advantages involved in allowing the perspectives of the business model in health service delivery to set the stage for medical practice in general. If patients are encouraged to view themselves as consumers, the quality and extent of patient choice should increase. The quality and provision of services should also improve since the medical profession will not have the exclusive and extensive self-regulatory and decision-making powers usually associated with the profession. Also, the cost of health care might decrease and medical services could become more affordable due to consumer choice and competitive market values. Unfortunately none of these potential advantages for patients as consumers of health care services have so far realised, despite increased reliance on the business model in medical practice.[662]

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[658] Heubel, Friedrich Patients or Customers: Ethical Limits of Market Economy in Health Care *Journal of Medicine and Philosophy* Vol 25 No 2 (2000) 240 – 253, 243.

[659] Section 27(1) Constitution of the Republic of South Africa 108 of 1996; Esser, Jan Hendrik *Who cares? Moral reflections on business in healthcare* Thesis presented in partial fulfillment of the requirements for the degree M Phil (Applied Ethics) Stellenbosch University, March 2001 (Supervisor: Prof AA van Niekerk), 62.

[660] The unique and complex nature of health care delivery and the doctor-patient relationship was evident from the exposition in Chapter Two, which included the historical development of the medical profession and doctor-patient relationship as well as references to Parsons's sick role and physician role, that health service delivery in general and the doctor-patient relationship in particular is a multi-dimensional and complex construct influenced not only by its historical roots but also by the current social context.

[661] Teff, Harvey *Reasonable Care: Legal Perspectives on the Doctor-patient Relationship* Clarendon Press Oxford (1994) 113; Sulmasy, D What is so special about Medicine? *Theoretical Medicine* 14 (1993) 27, 30.

[662] Callahan, Daniel & Wasunna, Angela A *Medicine and the Market: Equity v Choice* The Johns Hopkins University Press: Baltimore 2006, 209 - 246; For a discussion on why health care goes beyond these economic and business considerations see Clement, Douglas Beyond supply and demand: The reasons for increased health care costs go beyond simple supply and demand, and solutions are tougher than they seem *Fedgazette*

It may be concluded then that the business model results in an overwhelming concern for "rights" and overestimates patient autonomy. It is overly individualistic and moreover unrealistic in discounting the social dimension of medical care.[663] The business model views the doctor-patient relationship in economic rather than moral terms and is therefore incompatible with the clinical realities of medical practice, reducing the doctor-patient relationship and medical practice to "objective" quantitative phenomena.[664] However, as indicated in section 4.1., the inevitable bureaucratisation and proletarianisation of medical practice and the consequent realities of market related principles in health service delivery can not be ignored. Pass et al described this complexity and the variety of market mechanisms in health care as follows:

> *"There is no single, simple concept of market that can be adopted for use in a health system. Rather, market-style mechanisms include a number of specific instruments such as consumer sovereignty (patient choice), negotiated contracts and open bidding. They can be adopted in markets organized on different principles: on price, on quality or on market share. Markets can, in turn, be introduced into different sectors of the health system: in health care funding, in one or more subsets of the production of health services...Competitive incentives can be brought to bear on the behaviour of physicians, nurses, support personnel or home care personnel. In practice, then, there is not one decision but a series of decisions to be made. Rather than a monolithic commitment to one of two abstractions – state or market – both Western and Eastern European health care systems confront a range of smaller decisions...it typically involves a multitude of approximations, if not compromises".*[665]

The business model is therefore not a suitable approach to the complex and unique culture of medical practice and the discussion in section 4.3., will show that it is also not an effective compromise to ensure a more equal distribution of power in the doctor-patient relationship.

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of the Federal Reserve Bank of Minneapolis May 2002 http://www.minneapolisfed.org/pubs/fedgaz/02-05/supply.cfm [Accessed on 27/06/2007].

[663] Teff, Harvey *Reasonable Care: Legal Perspectives on the Doctor-patient Relationship* Clarendon Press Oxford (1994) 116.

[664] Agich, George J Medicine as Business and Profession *Theoretical Medicine* Vol 11 (1990) 311 – 324, 312.

[665] Callahan, Daniel & Wasunna, Angela A *Medicine and the Market: Equity v Choice* The Johns Hopkins University Press: Baltimore 2006, 4.

4.3. The business model and the power imbalances in the doctor-patient relationship

Some of the power imbalances in the doctor-patient relationship will now be considered against the background provided in sections 4.1. and 4.2. In the context of medical decision-making, informed consent, patients' rights, patient autonomy and beneficence will again be discussed. The importance of trust in the doctor-patient relationship will also be considered with regard to the identified power imbalances in the relationship and in preparation for the discussion and analysis of the fiduciary nature of the doctor-patient relationship in Chapter Five.

4.3.1. Informed consent

In essence, the discussion in Chapter Three centred on the concepts of autonomy, self-determination and beneficence in the doctor-patient relationship and the need to find a balance between these conflicting qualities. The business model of health service delivery brings with it further potential conflicting qualities with regard to medical decision-making. While the traditional way of practicing medicine was not necessarily free of moral conflicts or dilemmas, the physician's obligations to each patient are now also embedded in a network of competing obligations and conflicting interests.[666] These competing obligations and conflicting interests have, to a certain extent, always been present in medical practice, but until now were not powerful enough to make a significant impact on the medical decision-making process.[667] In this section, the economic and price considerations of the business model as well as the influence of other role players in the medical decision-making process will be considered.

The following two statements illustrate the presence of economic and price considerations in medical decision-making: "*For a patient who is unlikely to be able to afford the treatment on his own, disclosure may be not only pointless, but also cruel*"[668] and "*It is the patient's prerogative, not the physician's, to decide which medical options are worthwhile, at what*

[666] Esser, Jan Hendrik *Who cares? Moral reflections on business in healthcare* Thesis presented in partial fulfillment of the requirements for the degree M Phil (Applied Ethics) Stellenbosch University, March 2001 (Supervisor: Prof AA van Niekerk), 3.

[667] Esser, Jan Hendrik *Who cares? Moral reflections on business in healthcare* Thesis presented in partial fulfillment of the requirements for the degree M Phil (Applied Ethics) Stellenbosch University, March 2001 (Supervisor: Prof AA van Niekerk), 3.

[668] Hall, Mark A A Theory of Economic Informed Consent *GA Law Review* 31 (1997) 511, 528.

price."[669] Krause suggests that while the doctrine of informed consent requires the patient be informed of alternatives to the proposed treatment, considerations about the cost of such alternative treatments and which treatments will or will not be covered by the patient's health insurance policy may influence the extent of the information the physician is willing to disclose.[670] Krause also submits that the traditional doctrine of informed consent (discussed in Chapter Three) is ill equipped to address non-disclosure due to financial, rather than medical paternalistic, considerations.[671] Since the analysis in section 3.5. of this dissertation already concluded that the doctrine of informed consent is not a truly effective legal mechanism to allow for the full realisation of patient autonomy and self-determination in medical decision-making, the utilisation of the medical profession's own regulation system to enforce the physician's obligation to disclose will be considered in this section.

To allow cost considerations to dictate the types of information that should be disclosed to patients is a consequence of the business model of health service delivery. The fact that this consideration may take priority over patient autonomy and self-determination in a particular situation causes another power imbalance in the doctor-patient relationship, limiting the patient's ability to participate in medical decision-making. The failure to disclose alternative treatments which the patient in all probability may not be able to afford or which will not be covered by the patient's health insurance policy prevents the patient from making an informed decision and prevents the patient from exercising his/her right to self-determination since the patient is not even aware, in situations like these, that an alternative has been denied.[672] Medical practitioners have historically been trusted to make decisions on what is best for their patients and such trust was based on their medical

[669] Morreim, Haavi E Economic Disclosure and Economic Advocacy: New Duties in the Medical Standard of Care *Journal of Legal Medicine* 12 (1991) 275, 291.

[670] Krause, Joan H Reconceptualising Informed Consent in an Era of Health Care Cost containment *Iowa Law Review* 85 (1999 -2000) 260 – 386, 265.

[671] Krause, Joan H Reconceptualising Informed Consent in an Era of Health Care Cost containment *Iowa Law Review* 85 (1999 -2000) 260 – 386, 265.

[672] Krause, Joan H Reconceptualising Informed Consent in an Era of Health Care Cost containment *Iowa Law Review* 85 (1999 -2000) 260 – 386, 303; Miller, Frances H Denial of Health Care and Informed Consent in English and American Law *American Journal of Law and Medicine* 18 (1992) 37 – 71, 40; Wolf, Susan Toward a Systemic Theory of Informed Consent in Managed Care *Houston Law Review* Vol 35 (1999) 1631 – 1681, 1660.

expertise and certainly not on their financial opinions.[673] An example of a situation where financial incentives influenced the extent of disclosure can be found in the case of *Shea v Esensten.*[674] The patient died of cardiac symptoms after his physician told him that it was not necessary for him to see a cardiologist. The deceased's wife argued that the deceased would have disregarded the physician's opinion and would have consulted a cardiologist at his own expense had the physician disclosed that the particular health maintenance organisation (HMO) gave the physician financial incentives to reduce referrals.[675]

The business model also gives other role players like the pharmaceutical industry, hospital governing bodies and health insurance companies a more prominent place in the medical decision-making process. Such role players, who often have competing interests, certainly influence the doctor-patient relationship in general, as well as the power imbalances in this relationship with regard to informed consent. Medical practitioners' co-operation with, and in some instances, dependency on these role players may affect the nature and degree of their disclosure to patients. The USA case of *Wickline v State*[676] serves as a point in case. The plaintiff, who had undergone vascular surgery, was discharged from hospital on a certain date determined by her insurer's theoretical length-of-stay guidelines. These guidelines incorporated quality of care as well as cost-containment considerations. However, the plaintiff developed post-surgical complications and her doctor requested an eight-day extension of her stay in the hospital. Based on the said guidelines, the insurer only approved a four day extension and the surgeon consequently signed her discharge order after only four days. Further complications developed after the plaintiff left the hospital and these necessitated that her right leg be amputated. The plaintiff's action against the insurer was based on the negligent implementation of the cost-containment programme which corrupted her doctor's professional judgement. In this case all the medical expert witnesses agreed that the physician acted within the standards of the medical profession by discharging the plaintiff early, according to the insurer's edict. It was also clear from the evidence provided by these medical expert witnesses that the physician's obedience of third

[673] Krause, Joan H Reconceptualising Informed Consent in an Era of Health Care Cost containment *Iowa Law Review* 85 (1999 -2000) 260 – 386, 370.
[674] 107 F.3d 625 (8th Cir 1997); Also See *Nead v Portes* 710 N.E.2d 418 (Illnois 1999).
[675] Also see the discussion in Chapter Six, section 6.2.3.
[676] 192 Cal. App. 3d 1630, 239 Cal Rptr 810 (2d Dist. 1986); Also see *Aetna Health Inc v Davila* 124 S.Ct 2488 (Texas 2004)

party directives in the personal doctor-patient relationship and crucial situations of medical decision-making did not fall outside customary practice. Since the particular doctor was found not to be negligent, based on this customary practice as confirmed by the expert witnesses, the court did not have to decide on the question whether the insurer's directive improperly undermined medical judgement. However, the court did note that "…*the physician who complies without protest with the limitations imposed by a third party payor, when his medical judgement dictates otherwise cannot avoid his ultimate responsibility for his patient's care. He cannot point to the health care payor as the liability scapegoat when the consequences of his own determinative medical decisions go sour*."[677]

In another USA case, *Truman v Thomas,*[678] a patient refused to undergo a pap smear test which her physician recommended several times over the course of six years. She continuously cited financial pressures and difficulties as reasons for not undergoing the test. After the patient subsequently died of cervical cancer, her estate brought an action against the physician alleging that he had negligently failed to provide the deceased with sufficient information about the importance of undergoing such a test. It was affirmed in this case that a doctor also has a professional duty to disclose the hazards of declining treatment, even though the reason for the refusal may be financial constraints.[679] In the case of *Moore v Regents of the University of California*[680] it was held that professional conflicts of interest that might compromise physician recommendations should also be disclosed. The majority in this case concluded that a physician must disclose personal interests unrelated to the patient's health that may affect his/her judgement, irrespective of whether such interests are based on research or economic considerations. Thus, the only way in which to ensure that a patient's interest and autonomy remain paramount is by obtaining the patient's consent based on disclosure of *all* relevant and related information. This is also the case in South African law where section 6(1)(d) of the National Health Act 61 of 2003 requires that

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[677] Miller, Frances H Denial of Health Care and Informed Consent in English and American Law *American Journal of Law and Medicine* 18 (1992) 37 – 71, 49 – 50; 192 Cal. App. 3d 1630, 239 Cal Rptr 810 (2d Dist. 1986) at IV.

[678] 611 P.2d 902 (Cal. 1980).

[679] Miller, Frances H Denial of Health Care and Informed Consent in English and American Law *American Journal of Law and Medicine* 18 (1992) 37 – 71, 63; 611 P.2d 902 (Cal. 1980) at 910.

[680] Cal. 249 Cal. Rptr. 494 (1988); 793 P.2d 479 (Cal. 1990).

a patient be informed of the right to refuse health services, as well as the implications, risks and obligations of such a refusal.

In English law, however, such truly informed consent is not possible due to the fact that medical alternatives may theoretically be available and necessary but may not be practically accessible, due the English health care system's economic limitations. (The UK system is a centrally planned system funded almost entirely by the public sector.)[681] According to Proff Schwartz and Grubb, medical practitioners in such situations elect not to inform their patients of the true circumstances.[682] "…[I]*nstead of openly advising patients that economic and societal considerations are the constraint, they are led to believe that a medical decision has been made, assumed (incorrectly) to be in the patient's best interests*."[683] Thus, economic decisions in such cases are disguised as medical judgements and Abrams argues that these physicians fail to be patient advocates, acting in the best interests of their patients, but rather become agents of the state, regulating and controlling the UK health care system.[684] This practice is unacceptable since self-determination and patient autonomy cannot realise if the patient is not even aware that all information about alternatives and risks has not been disclosed.

Patients should therefore be informed of all the alternatives, with their risks and benefits, *as well as* the costs involved. This is also confirmed in section 6(1)(c) of the National Health Act 61 of 2003. According to the American Medical Association Council on Ethical and Judicial Affairs the non-disclosure of information on alternative treatments due to financial incentives interfering with such disclosure constitutes an unethical intrusion on the doctor-patient relationship.[685] Physicians who withhold information on alternative treatments based on financial considerations not only usurp patient autonomy and self-determination

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[681] Banks, Dwayne A The Economic Attributes of Medical Care: Implications for Rationing Choices in the United States and United Kingdom *Cambridge Quaterly of Healthcare Ethics* (1996) 5, 546 – 558, 546.

[682] Schwartz and Grubb as referred to and discussed in Abrams, FR Patient advocate or secret agent? *JAMA* Vol 256 (1986) 1784 – 1785; For example, in Great Britian persons over the age of 55 with end-stage renal disease are steered away from long-term dialysis. Abrams, FR Patient advocate or secret agent? *JAMA* Vol 256 (1986) 1784 – 1785; Levinsky, Norman G The doctor's master *New England Journal of Medicine* Vol 311 (1984) 1573 – 1575, 1574.

[683] Abrams, FR Patient advocate or secret agent? *JAMA* Vol 256 (1986) 1784 – 1785.

[684] Abrams, FR Patient advocate or secret agent? *JAMA* Vol 256 (1986) 1784 – 1785.

[685] Krause, Joan H Reconceptualising Informed Consent in an Era of Health Care Cost containment *Iowa Law Review* 85 (1999 -2000) 260 – 386, 306.

but also assume the moral burden by compromising the *raison d'etre* of the informed consent doctrine.[686] At the very least physicians who cannot, due to economic reasons, make use of the necessary medical resources that they believe their patient needs should have an affirmative professional obligation to provide this information.[687] However, Katz and others warn that such disclosure of financial interests or incentives which might have a bearing on medical decision-making may also have a downside: it can undermine physician-patient trust, which is a cornerstone of the doctor-patient relationship as well as the aim informed consent is designed to foster.[688] (Trust and the power imbalances in the doctor-patient relationship will form the foundation of the discussion in Chapter Five below.)

It is clear from this discussion, especially the case-law references cited, that medical practitioners have a duty to disclose and assist patients with regard to their economic responsibilities in health care. Medical practitioners also have to reveal conflicts of interest which may compromise their loyalty to their patients.[689] These specific duties and obligations of medical practitioners can be based on the doctrine of informed consent; or patient autonomy and the right to self-determination; or even contract-based obligations. It is trite, though, that these duties and obligations are necessary to protect an already vulnerable patient in the medical marketplace.

To what extent then should medical practitioners assist patients in making wise economic as well as medical decisions? While the traditional doctor-patient relationship required medical practitioners to act only as healers, helping the patient to attain and maintain health, the business model of health service delivery now also requires that medical practitioners act as

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[686] Krause, Joan H Reconceptualising Informed Consent in an Era of Health Care Cost containment *Iowa Law Review* 85 (1999 -2000) 260 – 386, 306; Miller, Frances H Denial of Health Care and Informed Consent in English and American Law *American Journal of Law and Medicine* 37 (1992) 37 – 71, 70; Wolf, Susan Toward a Systemic Theory of Informed Consent in Managed Care *Houston Law Review* Vol 35 (1999) 1631 – 1681, 1662.

[687] Miller, Frances H Denial of Health Care and Informed Consent in English and American Law *American Journal of Law and Medicine* 18 (1992) 37 – 71, 41; Wolf, Susan Toward a Systemic Theory of Informed Consent in Managed Care *Houston Law Review* Vol 35 (1999) 1631 – 1681, 1661.

[688] Hall, Mark A A Theory of Economic Informed Consent *Georgia Law Review* 31 (1996 - 1997) 511 – 586, 547; This erosion of trust in the doctor-patient relationship in the context of the business model of health care delivery will be discussed in sections 4.3.2. and 4.3.3. of this chapter. Also see chapter 5.

[689] Morreim, Haavi E Economic Disclosure and Economic Advocacy: New Duties in the Medical Standard of Care *Journal of Legal Medicine* 12, 275 – 329, 280.

business agents.[690] Morreim suggests that the principle of self-determination and patient autonomy – discussed in Chapter Three – encompasses duties of economic disclosure as well as economic advocacy.[691] Medical practitioners should not only disclose all information relevant to economic and price considerations, but they should also provide patients with the necessary assistance and information to make sound economic decisions about health service delivery. Without this assistance from medical practitioners, patients will not be able to give full effect to self-determination in medical decision-making.[692] The law of contract also provides a foundation for such economic disclosure and advocacy; patients hire medical practitioners to promote particular interests and goals implicitly as well as explicitly, expecting that medical practitioners will be dedicated to their patients' welfare in preference to competing interests.[693]

The ongoing economic reorganisation of health care delivery is reshaping medical practice and contributing to the existing power imbalances in the doctor-patient relationship. To ensure some protection for the vulnerable patient in the medical marketplace, society will have to broaden its understanding of the type of service and assistance medical practitioners should provide to patients.[694] A prominent legal textbook stated: "*…expert physicians who care for their patients will also care about their patients' economic welfare and the financial impact of their medical care. It is not proper to abrogate responsibility for medical costs by assuming that some third-party payer will provide coverage. It is the physician's responsibility not only to hold down costs for society overall but also to know what the costs of tests and treatments are for individual patients and how much of the cost the patient will have to bear*".[695] Since patients cannot escape the effects and consequences of the business model in health service delivery, their right to receive pertinent information

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[690] Morreim, Haavi E Economic Disclosure and Economic Advocacy: New Duties in the Medical Standard of Care *Journal of Legal Medicine* 12, 275 – 329, 306.
[691] Morreim, Haavi E Economic Disclosure and Economic Advocacy: New Duties in the Medical Standard of Care *Journal of Legal Medicine* 12, 275 – 329, 280.
[692] Morreim, Haavi E Economic Disclosure and Economic Advocacy: New Duties in the Medical Standard of Care *Journal of Legal Medicine* 12, 275 – 329, 293.
[693] Morreim, Haavi E Economic Disclosure and Economic Advocacy: New Duties in the Medical Standard of Care *Journal of Legal Medicine* 12, 275 – 329, 295.
[694] Morreim, Haavi E Economic Disclosure and Economic Advocacy: New Duties in the Medical Standard of Care *Journal of Legal Medicine* 12, 275 – 329, 328.
[695] Morreim, Haavi E Economic Disclosure and Economic Advocacy: New Duties in the Medical Standard of Care *Journal of Legal Medicine* 12, 275 – 329, 306.

and assistance with regard to the economics of care is crucial for ensuring that patient autonomy and self-determination are realised.[696]

4.3.2. Patients' rights, patient autonomy and the defiance of beneficence

Although at first glance it may seem that the right's ethic and the increased focus on patients' self-determination associated with the business model of health care delivery may truly help realise patient autonomy, it actually does not provide the necessary security for the patient in the medical decision-making process. Doctors nearly always have a better understanding and knowledge of the medical indications, nature and quality of the proposed treatment as well as the available alternatives.[697] In addition, patients have a diminished objectivity and autonomy together with the physical incapacities brought on by illness and are therefore exceptionally vulnerable. Thus, the greater the emphasis on patient autonomy and the equality of the contracting parties, the more vulnerable the patient actually becomes.[698]

In this respect Teff argues that the primary concern for patients is usually the pursuit of mutual harmony in medical decision-making and not the excessive assertion of rights, since patients are aware that they might risk transforming what may have been a caring and amicable relationship into an adversarial one, should they stake out a position based on rights.[699] Such an impersonal relationship will not encourage dialogue, trust and honesty and will certainly not ensure that patients obtain the maximum benefit from their professional relationship with the medical practitioner. The contractual approach may consequently lead to the erosion of trust in the doctor-patient relationship since it discourages the patient's involvement in medical decision-making as well as dialogue between the doctor and patient.[700]

[696] Morreim, Haavi E Economic Disclosure and Economic Advocacy: New Duties in the Medical Standard of Care *Journal of Legal Medicine* 12, 275 – 329, 328.
[697] Teff, Harvey *Reasonable Care: Legal Perspectives on the Doctor-patient Relationship* Clarendon Press Oxford (1994) 169.
[698] Teff, Harvey *Reasonable Care: Legal Perspectives on the Doctor-patient Relationship* Clarendon Press Oxford (1994) 170.
[699] Teff, Harvey *Reasonable Care: Legal Perspectives on the Doctor-patient Relationship* Clarendon Press Oxford (1994) 114 - 115.
[700] Teff, Harvey *Reasonable Care: Legal Perspectives on the Doctor-patient Relationship* Clarendon Press Oxford (1994) 113.

With regard to beneficence and the right's-ethic of the business model, it should also be noted that physicians traditionally played a special role in the doctor-patient relationship; acting as patient advocates and, based on the Hippocratic principle of beneficence, putting patients interests before their own.[701] In other words, "[p]*hysicians' dedication to patients' best interests expressed a special professional ethos and thus created the rational foundation for patient trust*".[702] However, the rationale of the business model seeks to empower patients by emphasising patients' rights and patient autonomy, by protecting patients from benevolent others in medical decision-making and providing security within the boundaries and principles of the law of contract, for example, by exclusively relying on contractual principles like bona fides, boni mores, reasonableness and fairness; principles which presuppose the equality of the contracting parties. It furthermore overestimates patient autonomy as well as the medical profession's commitment to full disclosure of all relevant facts and considerations and ignores the fact that the physician's beneficent aim is precisely to restore the patient's previous degree of autonomy.[703]

The case of *Afrox Healthcare BPK v Strydom*[704] is an example of how the business model of health service delivery places new responsibilities on newly empowered patients, diminishing the role of beneficence in health care, while assuming that patients have all the facts and truly comprehend all the information disclosed.[705] In this case, where the Supreme Court of Appeal overturned a judgement by the Pretoria High Court,[706] the respondent had been admitted to a private hospital, owned by the appellant, for an operation and post-operative medical treatment. Upon admission, the respondent signed an agreement which also contained an indemnity clause exempting the hospital and its staff/agents from any liability due to any loss or injury (of any nature) caused directly or indirectly by any factor or element connected to the respondent's stay and treatment in the facility. After the operation, the negligent conduct of a nurse led to complications, which caused the respondent to suffer damages. The respondent argued that the negligent conduct of the

[701] Dougherty, Charles J The costs of commercial medicine *Theoretical Medicine* 11 (1990) 275 – 286, 282.
[702] Dougherty, Charles J The costs of commercial medicine *Theoretical Medicine* 11 (1990) 275 – 286, 282.
[703] Sulmasy, D What is so special about Medicine? *Theoretical Medicine* 14 (1993) 27 - 41, 32.
[704] *Afrox Healthcare BPK v Strydom* 2002 (6) SA 21 (SCA); Also see *St Augustine's Hospital (Pty) Ltd v Le Breton* 1975 (2) SA 530 (D).
[705] Only the facts and sections of the judgement relevant to this discussion will be referred to here. Also see the discussion in Chapter Six, section 6.3.1.
[706] Now the North Gauteng High Court according to the Renaming of High Courts Act No 30 of 2008.

nurse constituted a breach of a tacit term in the agreement that the appellant's nursing staff would treat him in a professional manner and with reasonable care. The appellant, however, denied liability and relied on the indemnity clause contained in the agreement. The respondent advanced several reasons why the provisions of the indemnity clause could not operate against him, including that the particular clause was contrary to public interest due to the unequal bargaining positions of the parties as well as the nature and ambit of the conduct of hospital personnel, and that the clause was in conflict with the principles of good faith.[707]

The crucial error in the judgement of Brand JA is his reliance on the business model of health care delivery, assuming that providers of health care services are no different from any other commercial supplier.[708] The judgement is based exclusively on the principles of the law of contract and does not take into account the special nature of medical practice and the unique doctor-patient relationship.[709] The court, for example, held that it was not obvious that an unequal bargaining power between contracting parties justifies a conclusion that a contractual provision, which is to the advantage of the stronger party, will be in conflict with public interest. The court also found that there was absolutely no evidence that the respondent was in a weaker bargaining position than that of the appellant during the conclusion of the agreement. In actual fact, the respondent had no bargaining power regarding the clause since all private and public hospitals in South Africa make use of indemnity clauses in their admission agreements. If he objected to it he would have nowhere else to go and would not have gained access to the required health care

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[707] The court a quo ruled in favour of the respondent - that a contract contrary to public policy is unenforceable in terms of section 39(2) of the Constitution and that the respondent's right of access to health care services (section 27(1)(a) of the Constitution) entitled him to health care administered with reasonable care. Since the indemnity clause limited the respondent's right of access to such health care the provision was held to be contrary to public policy and unenforceable; Strydom v Afrox Healthcare Ltd [2001] 4 All SA 618 (T).

[708] Compare with *Barkhuizen v Napier* 2007 (7) BCLR 691 (CC) where the Constitutional Court recently also affirmed the dominance of contractual autonomy in defiance of the inequality in bargaining power between insurance companies and their clients; Pieterse, Marius The Interdependence of Rights to Health and Autonomy in South Africa *South African Law Journal* 2008(3) 553 – 572, 567; Carstens, Pieter and Pearmain, Debbie *Foundational Principles of South African Medical Law* LexisNexis: Durban 2007, 462.

[709] For a complete discussion on the inadequacy of the law of contract with regard to health service delivery see from page 1386 to 1392 in Pearmain, Deborah L *A Critical analysis of the Law on Health Service Delivery in South Africa* Doctoral dissertation presented in fulfillment of the requirements of the degree LLD at the University of Pretoria, November 2004 (Supervisor: Prof PA Carstens)

services.[710] Strauss furthermore argues that such an exemption clause, whether in a contract with a medical practitioner or with a hospital, ought to be regarded as null and void and contrary to public policy, since it does not protect the patient's fundamental interest in his/her bodily inviolability due to the patient's inherent vulnerability in the doctor-patient relationship, and it erodes the patient's trust in the motives of the service provider, who is apparently more concerned about its commercial interests than about providing care and complying with professional standards.[711]

It was also hinted in the *Afrox* judgement that since the appellant had a reputation and competitive edge to maintain, that this would be adequate protection for patients against risks of professional negligence of the appellant's employees.[712] These observations suggest that health care delivery is a marketable commodity in the same category as other services advertised by means of word of mouth recommendations and also suggesting that people regularly "shop" at hospitals.[713] Brand JA furthermore confused the true purpose and character of professionalism and the characteristics of the medical profession in particular, by creating the impression that the disciplinary powers of the relevant professional bodies for physicians as well as nurses somehow reduce the weight of the public policy considerations in favour of holding the employer vicariously liable, and that the threat of disciplinary action by professional bodies and the general concern for the hospital's reputation will ensure that hospitals avoid negligent conduct.[714] The emphasis should rather have been on the professional standards and obligations associated with the medical profession and medical service providers in general.

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[710] 2002 (6) SA 21 (SCA) para 12 at 35C – D; Carstens, Pieter and Pearmain, Debbie *Foundational Principles of South African Medical Law* LexisNexis: Durban 2007, 453; Brand, D Disclaimers in hospital admission contracts and constitutional health rights: *Afrox Healthcare v Strydom ESR Review* Published by the Socio-Economic Rights Project UWC (Sep 2002) Vol 3, No 2.

[711] Naude, T & Lubbe GF Exemption clauses – a Rethink occasioned by *Afrox Healthcare BK v Strydom SALJ* Vol 122, Issue 2 (2005) 441 – 463, 456; S A Strauss & M J Strydom *Die Suid-Afrikaanse Geneeskundige Reg* (1967) Van Schaik (Pta) 104 and 105.

[712] 2002 (6) SA 21 (SCA) para 20-21 at 37G – 38A; Carstens, Pieter and Pearmain, Debbie *Foundational Principles of South African Medical Law* LexisNexis: Durban 2007, 465.

[713] Carstens, Pieter and Pearmain, Debbie *Foundational Principles of South African Medical Law* LexisNexis: Durban 2007, 465.

[714] Carstens, Pieter and Pearmain, Debbie *Foundational Principles of South African Medical Law* LexisNexis: Durban 2007, 464; 2002 (6) SA 21 (SCA) para 20-21 at 37G – 38A; Brand, D Disclaimers in hospital admission contracts and constitutional health rights: *Afrox Healthcare v Strydom ESR Review* Published by the Socio-Economic Rights Project UWC (Sep 2002) Vol 3, No 2.

The Supreme Court of Appeal in the *Afrox* case did not distinguish between the providers of health services and other service providers and consequently did not take into account the particular culture of medical practice, the nature of the medical profession and the vulnerable position of patients in the medical marketplace. In the *Afrox* case, too much emphasis was placed on patient autonomy and the equal bargaining position of the contracting parties as well as the business interests of the hospital, rather than on the non-commercial interests of the patient and the vulnerable position of the patient in the doctor-patient relationship or the relationship between a medical service provider and patient. The contrasting viewpoint of Justice Tobriner in *Tunkl v Regents of the University of California*[715] and Yekiso J in the case of *Oldwage v Louwrens*[716] with regard to medical services is preferable. According to this view, the medical profession deals with protecting the life, personality, physical integrity, health and dignity of human beings and for this reason the profession is the focus of a constant searchlight and appears to be one of the most over-regulated professions in the world.[717]

4.3.3. The erosion of trust in the doctor-patient relationship

As stated earlier,[718] the business model of health service delivery suggests that the transaction between physician and patient is a commercial relationship, regulated by the rules of commerce and the law of contract. The business model also presumes that health care delivery is not of a different moral and economic order than any other good or service.[719] The precepts of professional ethics, which include altruism and the traditional moral obligations a physician is expected to have towards his/her patients (based on the Hippocratic ethic and also described in Parsons's physician's role) have no place in this relationship.[720] However, professionalism and the medical profession in particular are

[715] *Tunkl v Regents of the University of California* 383 P.2d 441 (CA 1963); This case dealt with similar facts as found in the *Afrox Healthcare* case. However, in this case it was accepted that there is an unequal bargaining position between the health service provider and the patient and that the exemption clause was contrary to public policy.
[716] [2004] 1 All SA 532 (C) at page 551 par [73].
[717] Carstens, Pieter and Pearmain, Debbie *Foundational Principles of South African Medical Law* LexisNexis: Durban 2007, 483.
[718] Chapter Four, section 4.1., especially par 2, page 128.
[719] Pellegrino, Edmund D & Thomasma, David C *For the Patient's Good: The Restoration of Beneficence in Health Care* Oxford University Press: NY 1988, 51
[720] Pellegrino, Edmund D The Commodification of Medical and Health Care: The Moral Consequences of a Paradigm shift from a Professional to a Market Ethic *Journal of Medicine and Philosophy* Vol 24, No 3 (1999) 243 – 266, 252.

rooted in the medical practitioner's moral nature – to profess is an ethical act and it makes the professional a moral being who prospectively affirms the moral nature of his/her activity.[721] Esser contends that the business enterprise and the capitalist free market system of the business model of health service delivery has a "questionable moral history" which does not correspond with the history of medical practice and the nature of medical care described in Chapter Two.[722] The business model is devoid of specific moral principles and virtues important to medical practice and is driven by desires of self-interest, greed and competitive strategies. Profit and efficiency are the essential components on which this model is based.[723] Many medical practitioners and patients are already socialised into this corporate way of thinking which depreciates the true value of the doctor-patient relationship:[724] "*If health care comes to be viewed primarily as a commodity whose value is purely instrumental to the improvement of one's health status, such persons could slowly be trained to label as 'silly' or 'sentimental' their own desires to attach intrinsic value to the manner and context in which care is provided to them*."[725] The business model of health service delivery may thus create an atmosphere in which medical practitioners believe that contractual provisions define the outer limits of their professional obligations.[726]

Brennan described the net effect of this new approach to health service delivery, and the doctor-patient relationship in particular, as an approach in which rights rather than duties are the appropriate form of moral discourse.[727] However, moral certainty in health service

[721] See Chapter Two, section 2.2.3. for a discussion of the physician's moral authority; Kass, Leon R Medicine: Profession or Trade? *Medicine on the Midway* Spring 1989 8 – 11, 9; Also see chapter 2, section 2.2.1. on professionalism.
[722] Esser, Jan Hendrik *Who cares? Moral reflections on business in healthcare* Thesis presented in partial fulfillment of the requirements for the degree M Phil (Applied Ethics) Stellenbosch University, March 2001 (Supervisor: Prof AA van Niekerk), 26.
[723] Esser, Jan Hendrik *Who cares? Moral reflections on business in healthcare* Thesis presented in partial fulfillment of the requirements for the degree M Phil (Applied Ethics) Stellenbosch University, March 2001 (Supervisor: Prof AA van Niekerk), 26 - 27.
[724] Pellegrino, Edmund D The Commodification of Medical and Health Care: The Moral Consequences of a Paradigm shift from a Professional to a Market Ethic *Journal of Medicine and Philosophy* Vol 24, No 3 (1999) 243 – 266, 253.
[725] Kaveny, Cathleen Commodifying the Polyvalent Good of Health Care *Journal of Medicine and Philosophy* Vol 24, No 3 (1999) 207 – 223, 214.
[726] Teff, Harvey *Reasonable Care: Legal Perspectives on the Doctor-patient Relationship* Clarendon Press Oxford (1994) 168.
[727] Also see page 34, Chapter Two of this dissertation on Foucault and his theory of right; Teff, Harvey *Reasonable Care: Legal Perspectives on the Doctor-patient Relationship* Clarendon Press Oxford (1994) 103; The moral discourse or moral makeup of the doctor-patient relationship in this context refers to the dynamics between the parties of this relationship, their obligations, corresponding duties and expectations.

delivery is not found in the rights contained in statutes, guidelines and the principles of the law of contract but rather in the context of the particularities of the doctor-patient relationship.[728] The moral centre of the doctor-patient relationship is more than merely a contractual understanding; caring and trust are the crux of the relationship.[729] In Chapter Three it was suggested that the protection of patient autonomy and self-determination, and the assurance that patients still receive the maximum benefit from professional expertise and guidance, can only be achieved through an honest relationship between doctor and patient. And although society's understanding of medical practice may change from a paternalistic ethic to a business model, the unchanging event in medicine remains the clinical encounter between patient and physician.[730] The doctor-patient relationship is a moral[731] relationship built on trust, equality and respect. It is not merely a commercial transaction, as the relationship in itself is therapeutic.[732] The success of medical care therefore depends on patients' trust in their physicians – the expectations that

- their physicians will perform their responsibilities in a technically proficient manner (competence);
- they will assume responsibility and not inappropriately defer to others (control); and

[728] Pellegrino, Edmund D & Thomasma, David C *For the Patient's Good: The Restoration of Beneficence in Health Care* Oxford University Press: NY 1988, 53; Siegler, Mark Searching for Moral Certainty in Medicine: A proposal for a new model of the Doctor-Patient Encounter *Bull. N.Y. Acad. Med* Vol 57, No 1 (1981) 56 – 69, 56; Esser, Jan Hendrik *Who cares? Moral reflections on business in healthcare* Thesis presented in partial fulfillment of the requirements for the degree M Phil (Applied Ethics) Stellenbosch University, March 2001 (Supervisor: Prof AA van Niekerk), 1.
[729] Pellegrino, Edmund D & Thomasma, David C *For the Patient's Good: The Restoration of Beneficence in Health Care* Oxford University Press: NY 1988, 54; Sulmasy, D What is so special about Medicine? *Theoretical Medicine* 14 (1993) 27 - 41, 32.
[730] Siegler, Mark Searching for Moral Certainty in Medicine: A proposal for a new model of the Doctor-Patient Encounter *Bull. N.Y. Acad. Med* Vol 57, No 1 (1981) 56 – 69, 57.
[731] A moral relationship in this context refers to the concept of morality and denotes a social institution, composed of a set of standards pervasively acknowledged by the members of the particular culture; Faden, Ruth R & Beauchamp, Tom L *A History and Theory of Informed Consent* Oxford University Press: NY 1986; Pellegrino, Edmund D & Thomasma, David C *The virtues in Medical Practice* Oxford University Press: NY 1993; See Chapter Three, section 3.5.5. page 94.
[732] Chapter Three, page 94; Bradfield, Owen At the heart of *Chappel v Hart*: a warning about warning! *Australian Law Students' Association: Academic Journal* http://www.alsa.asn.au.files/acj/2000/chappel_hart.html ; Also see Talcott Parsons' view on trust in the doctor-patient relationship as discussed on page 24 of this dissertation – "*The clarifications on the physician role and the sick role illustrate that the relationship is build on mutual trust*."; Esser, Jan Hendrik *Who cares? Moral reflections on business in healthcare* Thesis presented in partial fulfillment of the requirements for the degree M Phil (Applied Ethics) Stellenbosch University, March 2001 (Supervisor: Prof AA van Niekerk), 65.

- their commitment towards patients' welfare will be their highest priority (agency).[733]

The rational foundation for patient trust is significant in three ways:

- trust promotes the confidence required for full disclosure and consent in medical decision-making;
- the public's perception of the trustworthiness of medicine affects the willingness of citizens to seek medical care when necessary; and
- the perceived trustworthiness of medicine is a key factor in the prestige associated with the profession.[734]

Other expectations of patients also based on trust in the doctor-patient relationship include mutual respect and abidance by the rules of privacy and confidentiality. Throughout the history of the medical profession, efforts have been made to build this trust and confidence in the medical profession's ability and competence mainly through the implementation of rigorous ethical standards, the high standard set for education and accreditation, as well as through active public relations and consultation.[735] The business model of health care delivery potentially challenges this trust in the doctor-patient relationship by regarding health care delivery as an ordinary commodity, by influencing medical judgement and control, and by restricting open communication between medical practitioners and their patients, so creating multiple conflicts of interest between doctor and patient.[736]

It has been argued that it is imperative that medical practitioners and the medical profession in general develop the skills and motivation to advocate actively and effectively for their patients' best interest and welfare in the medical marketplace.[737] This obligation of medical practitioners is based on the principle of beneficence, as a cornerstone of medical practice, and patients' trust in the doctor-patient relationship. Although it is not the sole

[733] Mechanic, David & Schlesinger, Mark The Impact of Managed Care on Patients' Trust in Medical Care and Their Physicians *JAMA* Vol, 275, No 21 (1996) 1693 – 1697, 1693; Relman, AS Practicing medicine in the new business climate *New England Journal of Medicine* Vol 316 (1987) 1150 – 1151, 1151.

[734] Dougherty, Charles J The costs of commercial medicine *Theoretical Medicine* 11 (1990) 275 – 286, 282.

[735] Mechanic, David & Schlesinger, Mark The Impact of Managed Care on Patients' Trust in Medical Care and Their Physicians *JAMA* Vol, 275, No 21 (1996) 1693 – 1697, 1693.

[736] See sections 4.2., 4.3.1. and 4.3.2.; Mechanic, David & Schlesinger, Mark The Impact of Managed Care on Patients' Trust in Medical Care and Their Physicians *JAMA* Vol, 275, No 21 (1996) 1693 – 1697, 1693; Dougherty, Charles J The costs of commercial medicine *Theoretical Medicine* 11 (1990) 275 – 286, 283.

[737] See sections 4.3.1. and 4.3.2.

responsibility of the medical profession to protect the vulnerable patient and address the power imbalances resulting from the business model of health care delivery, the profession should use its status and the power of professional ethics to eliminate restraints on physician behaviour that may undermine trust in the doctor-patient relationship.[738] Put another way, traditional medical and professional ethics should stop focusing just on individual cases as they arise. Instead medical and professional ethics should address larger ethical concerns such as the effects and consequences of the business model on health care delivery in general, and the ensuing vulnerability of the patient in the medical marketplace.[739]

At the heart of medical practice is the doctor-patient relationship, and since no study has ever proved the actual impact of this relationship on health outcomes, it can safely be assumed that more than health is at stake.[740] The doctor-patient relationship should therefore be protected from conflicts of interest and those aspects of trust that are most important to the public and vital to ensuring the quality of future health care should be preserved.[741] The business model of health service delivery will not ensure a more equal balance of power in the doctor-patient relationship nor contribute to the social dynamics of the relationship.

4.4. Conclusion

The question whether medicine is a business is actually a very old one.[742] In the Republic, Plato has Socrates asking Thryasymachus: "*Now tell me, is the doctor in the precise sense, of whom you recently spoke, a money-maker or one who cares for the sick? Speak about the man who is really a doctor*." Thrasymachus answers and Plato agrees: "*One who cares for the sick*."[743] Plato also writes that "*The business of the physician, in the strict sense, is not to*

[738] Mechanic, David & Schlesinger, Mark The Impact of Managed Care on Patients' Trust in Medical Care and Their Physicians *JAMA* Vol, 275, No 21 (1996) 1693 – 1697, 1696.
[739] Emanuel, Ezekiel J Medical Ethics in the Era of Managed Care: The Need for Institutional Structures instead of Principles for Individual Cases *The Journal of Clinical Ethics* Vol 6, No 4 (1995) 335 – 338, 335.
[740] Callahan, Daniel & Wasunna, Angela A *Medicine and the Market: Equity v Choice* The Johns Hopkins University Press: Baltimore 2006, 263.
[741] Mechanic, David & Schlesinger, Mark The Impact of Managed Care on Patients' Trust in Medical Care and Their Physicians *JAMA* Vol, 275, No 21 (1996) 1693 – 1697, 1697.
[742] Also see Chapter Two section 2.1.3.
[743] Sulmasy, D What is so special about Medicine? *Theoretical Medicine* 14 (1993) 27 - 41, 28.

make money for himself, but to exercise his power over the patient's body...".[744] The moral premise behind Plato's description of the ethically responsible physician in the Republic is that, even though the physician is some kind of merchant who sells his skills, his highest aim must be to remain true to the altruistic medical profession.[745] The Greek poet Pindar celebrated the victory of the athlete Hieron in the Pythian Games of the year 474 BC in an ode that relates the story of the demigod Asclepius.[746] According to this fable, which is deemed to be the first case of medical ethics, a competent physician tutored by the centaur Chiron in the arts of healing is induced by money to perform a forbidden medical service.[747]

The commercialisation of medical practice is a pervasive and an inevitable development of this new millennium in health service delivery dominated by specialisation, technology and bureaucracy.[748] As discussed in section 4.2.2., there may be some positive features associated with the business model of health service delivery, but these features are not necessarily linked to the continued commercialisation of health care and can be secured without it.[749] Also, from the patient's point of view, the law of contract is not the ideal approach to relationships in health service delivery, since the bargaining power of the vulnerable patient does not really compare to the expert and economic power of medical practitioners.[750] To reduce the doctor-patient relationship to ordinary commercial exchanges is demeaning and dangerous for medical practitioners and unacceptable to patients.[751] And to regard health care delivery as an ordinary commodity ignores the special nature of medical practice and health care delivery which has a very direct connotation with

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[744] Callahan, Daniel & Wasunna, Angela A *Medicine and the Market: Equity v Choice* The Johns Hopkins University Press: Baltimore 2006, 16.
[745] Callahan, Daniel & Wasunna, Angela A *Medicine and the Market: Equity v Choice* The Johns Hopkins University Press: Baltimore 2006, 18.
[746] Jonson, A The fall of Asklepios *Plastic and Reconstructive Surgery* (July 1988) Vol 82, 147 – 150, 147.
[747] For other examples in literature see Henri de Mondeville "*The chief object of the patient is to get cured…The object of the surgeon, on the other hand, is to obtain his fee*."; Molière's Physician In Spite of Himself: Medicine is the best of all trades, for whether you perform well or badly, you are always paid just the same."; Jonson, A The fall of Asklepios *Plastic and Reconstructive Surgery* (July 1988) Vol 82, 147 – 150, 148.
[748] Dougherty, Charles J The costs of commercial medicine *Theoretical Medicine* 11 (1990) 275 – 286, 275.
[749] Dougherty, Charles J The costs of commercial medicine *Theoretical Medicine* 11 (1990) 275 – 286, 284.
[750] Carstens, Pieter and Pearmain, Debbie *Foundational Principles of South African Medical Law* LexisNexis: Durban 2007, 377.
[751] Teff, Harvey *Reasonable Care: Legal Perspectives on the Doctor-patient Relationship* Clarendon Press Oxford (1994) 171.

the range of effective life opportunities available to an individual.[752] Fuchs suggests that the business model of medical practice will eventually lead to the loss of public confidence in the medical profession's commitment to the welfare of patients and the weakening of the traditional values of the medical profession.[753]

The business model of health service delivery results in an insensitivity to the symbolic nature of the physician's role and also to the social dynamics of the doctor-patient relationship.[754] It ignores the public's interest in the manner in which health care services are delivered, the nature of the services as well as the accessibility of such services.[755] Although one cannot eliminate money and commerce from health service delivery, since health service delivery is in some way entangled with market practices and ideology, they remain two distinct cultural traditions of service provision, the commercial and the professional.[756] Some suggest that the answer may be to recognise the plural understanding of the doctor-patient relationship and to regard health care delivery as incompletely commodified, a category of goods identified by Margaret Radin as goods that human beings value and as having both market and non-market characteristics.[757] In the South African context however the solution is that the *Grundnorm* in health service delivery should be respect for and the protection, promotion and fulfilment of the rights enshrined in the Bill of Rights as well as the objectives of the National Health Act 61 of 2003 which include the protecting, respecting, promoting and fulfilling of the rights of the people of South Africa to the progressive realisation of the constitutional right of access to health care services.[758]

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[752] Fleck, Leonard M Just Health Care (I): Is Beneficence enough? *Theoretical Medicine* 10 (1989) 167 – 182, 169.

[753] Relman, AS Practicing medicine in the new business climate *New England Journal of Medicine* Vol 316, No 18 (1987) 1150 – 1151, 1150.; Fuchs, VR & Emanuel, EJ Health Care Reform: Why? What? When?" *Health Affairs*, Vol. 24, No. 6, November/December 2005.

[754] Teff, Harvey *Reasonable Care: Legal Perspectives on the Doctor-patient Relationship* Clarendon Press Oxford (1994) 172.

[755] Carstens, Pieter and Pearmain, Debbie *Foundational Principles of South African Medical Law* LexisNexis: Durban 2007, 415.

[756] Kaveny, Cathleen Commodifying the Polyvalent Good of Health Care *Journal of Medicine and Philosophy* Vol 24, No 3 (1999) 207 – 223, 220.

[757] Kaveny, Cathleen Commodifying the Polyvalent Good of Health Care *Journal of Medicine and Philosophy* Vol 24, No 3 (1999) 207 – 223, 220; See Radin, Margaret Reconsidering Personhood Oregon Law Review (1995) Vol 74, 423 for more information on her pershoon-theory.

[758] National Health Act 61 of 2003, Chapter One, section 2(c).

The metaphor of medicine-is-a-business does not contribute to the rationale and objectives of the National Health Act 61 of 2003 and also does not assist in establishing a more equal distribution of power in the doctor patient relationship.[759] Instead, the Oslerian conception that medicine is a calling has been reaffirmed in this chapter. Medicine has indeed no analogy with business and the medical profession ought to be supported for a benign, not a selfish, and for a protective, not an exploitative purpose.[760] How to ensure that the medical-industrial complex serves the interests of patients first is the responsibility of everyone involved in health care services, especially medical professionals, as well as the informed public making use of these services.[761]

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[759] Sulmasy, D What is so special about Medicine? *Theoretical Medicine* 14 (1993) 27 - 41, 27; Callahan, Daniel & Wasunna, Angela A *Medicine and the Market: Equity v Choice* The Johns Hopkins University Press: Baltimore 2006, 262.

[760] Sulmasy, D What is so special about Medicine? *Theoretical Medicine* 14 (1993) 27 - 41, 38.

[761] Relman, AS The new medical-industrial complex *New England Journal of Medicine* Vol 303, No 17 (1980) 963 – 970, 969.

CHAPTER FIVE: The fiduciary nature of the doctor-patient relationship

5.1. The doctor-patient relationship as a fiduciary relationship

5.2. The legal content of the fiduciary relationship between doctor and patient

5.3. The doctor as a fiduciary in the doctor-patient relationship

5.3.1. The duty of loyalty

5.3.2. The duty to act in the patient's best interest

5.4. The patient as a beneficiary in the doctor-patient relationship

5.4.1. Right or entitlement to a benefit enforceable against the fiduciary

5.5. An evaluation of the doctor-patient relationship as a fiduciary relationship

5.6. Conclusion

The discussion so far has emphasised the characteristic dynamics of the doctor-patient relationship and the unique culture of medical care. The unique qualities associated with the medical profession and the doctor-patient relationship in particular, as well as with health service delivery in general, have remained a continued feature of the analysis and discussion. It is evident from the discussion of the historical development of the medical profession, the paternalistic approach to health service delivery and the business model of health service delivery, that the true nature of medical practice and the unique dynamics of the doctor-patient relationship continue to influence the interaction between doctor and patient and consequently the success of the medical intervention. Clearly, these unique qualities remain essential for establishing a more equal distribution of power in the doctor-patient relationship, despite economic and technological advances, and cultural and social transformations.

Some of the unique qualities and characteristic dynamics of the doctor-patient relationship include the following: the ideal medical practitioner is an obligatory altruist – acting selflessly, although not without remuneration, and showing a sincere dedication towards his/her patients. Patients, in turn, have a reasonable expectation of such dedication and rely on it implicitly. The importance and necessity of particular qualities in the doctor-patient relationship, especially respect, honesty and trust, have become apparent in the discussion. It is also clear that these qualities are necessary to establish a more equal distribution of

power in the doctor-patient relationship, while still allowing for the nature of medical practice and the unique dynamics between doctor and patient. Other important aspects highlighted in Chapter Two, section 2.2. and especially vital to this discussion are the extensive self-regulatory powers and general authority of members of the medical profession, which are a result of the functional specificity of medical practitioners, and the contrasting vulnerability of patients.

Given the unique qualities and the characteristic dynamics of the doctor-patient relationship one would expect the fiduciary nature of this relationship and the corresponding fiduciary duties of physicians to be well established in law and that they would also sufficiently address the power imbalances in the doctor-patient relationship. However, the underlying legal content of the fiduciary nature of this relationship is not that obvious and will therefore form the basis of the discussion in this chapter.[762] The aim of the discussion is to determine what exactly the legal content of the fiduciary nature of the doctor-patient relationship is and most importantly, whether it can assist in establishing a more equal distribution of power between doctor and patient.

In section 5.1. the doctor-patient relationship will be analysed in terms of fiduciary principles and values. Specific cases in which the fiduciary nature of the said relationship have been discussed or referred to will also be considered. Section 5.2. of this chapter will look at the legal content of the fiduciary relationship between doctor and patient and in section 5.3. the specific duties of the physician as a fiduciary and the patient as a beneficiary will be considered with reference to relevant case law. The chapter will conclude with an analysis and evaluation of the doctor-patient relationship as a fiduciary relationship.

5.1. The doctor-patient relationship as a fiduciary relationship

The term "fiduciary" comes from the Latin word *fidere*, which means "to trust".[763] A fiduciary relationship is a very special legal relationship and has its origins in the law of

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[762] Litman, Moe Self-referral and kickbacks: Fiduciary law and the regulation of "trafficking in patients" *CMAJ* March 30, 2004 170(7) 1119 – 1120.

[763] Johnston, Kim Patient Advocates or Patient Adversaries? Using Fiduciary Law to Compel Disclosure of Managed Care Financial Incentives *San Diego Law Review* Vol 35 (1998) 951 – 992, 958.

trusts and agency.[764] It comes into being when a beneficiary entrusts another, the fiduciary, with a power which may affect the beneficiary's interests and which may only be exercised for the beneficiary's benefit.[765] The foundation of the fiduciary relationship is the beneficiary's well-placed trust and confidence in the fiduciary's integrity and fidelity.[766] The following four principles are the core values sustaining a fiduciary relationship:

- fiduciaries must avoid conflicts of interest, as well as potential conflicts of interest with the beneficiary;
- fiduciaries must not profit from their position without prior disclosure to and authorisation from the beneficiary;
- fiduciaries owe a duty of undivided loyalty to the beneficiary; and
- fiduciaries owe a duty of confidentiality to the beneficiary.[767]

Fiduciary law plays a significant role in protecting vulnerable people. While fiduciary law has frequently been utilised and developed to remedy perceived injustices in medical- and health law cases, no precise definition of when a fiduciary relationship between a doctor and patient exists and what exactly it entails has been offered.[768] Instead, the fiduciary nature of the doctor-patient relationship has been described by various indicia or qualities associated with the relationship, for example trust, vulnerability, reliance, selflessness, confidentiality and loyalty.[769]

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[764] Rodwin, Marc A Strains in the Fiduciary Metaphor: Divided Physician Loyalties and Obligations in a Changing Health Care System *American Journal of Law and Medicine* Vol 21 (1995) 241 – 257, 243; Johnston, Kim Patient Advocates or Patient Adversaries? Using Fiduciary Law to Compel Disclosure of Managed Care Financial Incentives *San Diego Law Review* Vol 35 (1998) 951 – 992, 958.

[765] *"The law defines a fiduciary as a person entrusted with power or property to be used for the benefit of another and legally held to the highest standard of conduct."*; Rodwin, Marc A Strains in the Fiduciary Metaphor: Divided Physician Loyalties and Obligations in a Changing Health Care System *American Journal of Law and Medicine* Vol 21 (1995) 241 – 257, 243; Grubb, Andrew *Principles of Medical Law* (2nd ed) Oxford University Press 2004, 45.

[766] Johnston, Kim Patient Advocates or Patient Adversaries? Using Fiduciary Law to Compel Disclosure of Managed Care Financial Incentives *San Diego Law Review* Vol 35 (1998) 951 – 992, 960.

[767] Bartlett, Peter Doctors as Fiduciaries: Equitable Regulations of the Doctor-Patient Relationship *Medical Law Review* Vol 5 (1997) 193 – 224, 198; *Hospital Products Ltd v United States Surgical Corporation* (1984) 156 CLR 41 (HC Aust) at 96-7.

[768] Grubb, Andrew *Principles of Medical Law* (2nd ed) Oxford University Press 2004, 45; *Hospital Products Ltd v United States Surgical Corporation* (1984) 156 CLR 41 (HC Aust) at 96-7; Healey, M & Dowling, Kara L Controlling conflicts of interest in the Doctor-Patient Relationship: Lessons from Moore v Regents of the University of California *Mercer Law Review* Vol 42 (Spring 1991) 989 – 1005, 1001.

[769] Widespread adoption of fiduciary terminology in health service delivery began in the 1980s. Leslie Miller described informed consent, for example, as an outgrowth of the Anglo-American concept of the fiduciary relationship; Oberman, Michelle Mothers and Doctors' orders: Unmasking the Doctor's Fiduciary role in Meternal-Fetal Conflicts *Northwestern University Law Review* Vol 94 (Winter 2000) 451 – 501, 455; Grubb, Andrew *Principles of Medical Law* (2nd ed) Oxford University Press 2004, 45; *Hospital Products Ltd v United*

The idea that physicians are, or should be fiduciaries for their patients has been a dominant metaphor in medical ethics and law for some time and is presumed by much of the legal and ethical analysis of physicians' conflicts of interest.[770] According to McCullough, its roots can be traced to two eighteenth century physicians, Dr John Gregory (Scottish) and Dr Thomas Percival (English), who were early proponents of establishing ethical standards for medical practitioners largely as a response to the entrepreneurial nature of medicine at the time.[771] Gregory then already feared that medicine had become commercial in its nature, a trade or means to the end of the physician's self-interest. He wished to re-establish the physician as a moral fiduciary. Both Gregory and Percival laid the groundwork for distinguishing medicine as a profession from medicine as a business by establishing physicians' fiduciary obligations towards their patients as a basic tenet of the ethical practice of medicine.[772] Today, the ethical tenets of medical societies inform the doctor-patient relationship with a fiduciary quality, even if the term is not used expressly.[773]

The doctor-patient relationship thus shows many of the hallmarks of a fiduciary relationship, but is it also regarded as a fiduciary relationship in law? Or, put another way, how far does the law play out this metaphor in the way it treats doctors?[774] Courts have developed fiduciary law by analogy and have consequently expanded the range of fiduciary relationships to include various professionals who stand in a confidential relationship with their clients, like bankers, legal practitioners and priests.[775] These relationships usually

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States Surgical Corporation (1984) 156 CLR 41 (HC Aust); *Yates v El-Deiry* 513 N.E. 2d 519 (Illnois 1987), 522; *Canterbury v Spence* (1972) 464 F.2d 772 (D.C. Cir. 1972), 782; Johnston, Kim Patient Advocates or Patient Adversaries? Using Fiduciary Law to Compel Disclosure of Managed Care Financial Incentives *San Diego Law Review* Vol 35 (1998) 951 – 992, 964.

[770] Scott, Charity Doctors as Advocates, Lawyers and Healers *Hamline Journal of Public Law and Policy* Vol 29 (Spring 2008) 331 – 397, 335; Rodwin, Marc A Strains in the Fiduciary Metaphor: Divided Physician Loyalties and Obligations in a Changing Health Care System *American Journal of Law and Medicine* Vol 21 (1995) 241 – 257, 242.

[771] Scott, Charity Doctors as Advocates, Lawyers and Healers *Hamline Journal of Public Law and Policy* Vol 29 (Spring 2008) 331 – 397, 335.

[772] Scott, Charity Doctors as Advocates, Lawyers and Healers *Hamline Journal of Public Law and Policy* Vol 29 (Spring 2008) 331 – 397, 335.

[773] Scott, Charity Doctors as Advocates, Lawyers and Healers *Hamline Journal of Public Law and Policy* Vol 29 (Spring 2008) 331 – 397, 336.

[774] Rodwin, Marc A Strains in the Fiduciary Metaphor: Divided Physician Loyalties and Obligations in a Changing Health Care System *American Journal of Law and Medicine* Vol 21 (1995) 241 – 257, 242.

[775] Grubb, Andrew *Principles of Medical Law* (2nd ed) Oxford University Press 2004, 48; Rodwin, Marc A Strains in the Fiduciary Metaphor: Divided Physician Loyalties and Obligations in a Changing Health Care System *American Journal of Law and Medicine* Vol 21 (1995) 241 – 257, 243; Johnston, Kim Patient Advocates or Patient Adversaries? Using Fiduciary Law to Compel Disclosure of Managed Care Financial Incentives *San Diego*

involve the property or financial interests of the beneficiary.[776] For instance, when a doctor deals with a patient's property, English law has recognised that the doctor will be in a fiduciary position *vis-à-vis* the patient.[777] In such cases, a presumption of undue influence arises against the doctor because of the particular nature of the relationship — a relationship which is based on trust and confidence.[778] This presumption can be rebutted if it is proved that the property was given freely as a result of the patient's full and informed consent.[779] In Canada it is also generally accepted that where a doctor deals with a patient's property the doctor will be in a fiduciary position *vis à vis* that patient.[780] But does the fiduciary nature of the doctor-patient relationship extend beyond the property or financial interests of the beneficiary?

Grubb submits that the fiduciary nature of the doctor-patient relationship indeed extends beyond such interests, since the said duty does not arise from the subject matter, but rather from the very nature of the relationship between the parties. Where confidential information is entrusted to another who uses it to his/her own advantage, fiduciary principles apply.[781] Thus, the legal duty to respect the confidential nature of the doctor-patient relationship, which is based on a relationship of trust between the confider (patient) and the confidant (doctor), may be regarded as an aspect of the fiduciary duty of loyalty the doctor owes to his/her patient.[782] In English law however, the judiciary have so far been reluctant to ascribe such a fiduciary duty to a doctor, except for the traditional property-

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Law Review Vol 35 (1998) 951 – 992, 958; Morreim, Haavi E Economic Disclosure and Economic Advocacy: New Duties in the Medical Standard of Care *Journal of Legal Medicine* 12, 275 – 329, 296.

[776] Grubb, Andrew *Principles of Medical Law* (2nd ed) Oxford University Press 2004, 48.

[777] Grubb, Andrew *Principles of Medical Law* (2nd ed) Oxford University Press 2004, 48; *Mitchell & another v Homfray* (1881) 8 QBD 587; *Gibson v Russell* (1843) 63 ER 46; *Barclays Bank v O'Brien* [1994] 1 A.C. 180, 189; *Williams v Johnson* [1937] 4 All ER 34.

[778] Grubb, Andrew *Principles of Medical Law* (2nd ed) Oxford University Press 2004, 49; *Williams v Johnson* [1937] 4 All ER 34.

[779] Grubb, Andrew *Principles of Medical Law* (2nd ed) Oxford University Press 2004, 49; *Williams v Johnson* [1937] 4 All ER 34.

[780] But in Canada, this fiduciary position was explicitly not extended to the relationship between a dentist and a patient, in the case of *Brooks v Alker Brooks v Alker* 22 R.F.L. 260, 9 O.R. (2d) 409 "*It is evident that a medical doctor, by reason of his intimate knowledge of the physical and mental condition of his patient obtained in confidence and his power and authority to advise and direct the conduct of his patients' lives in the most intimate details falls into the category of a general confidential adviser whose influence over the patient must be presumed. The same cannot, in my opinion, be said of a dentist*."

[781] Grubb, Andrew *Principles of Medical Law* (2nd ed) Oxford University Press 2004, 49.

[782] Grubb, Andrew *Principles of Medical Law* (2nd ed) Oxford University Press 2004, 50.

type cases.[783] The English informed consent case law discussed in Chapter Three has focussed on the doctor's duty to inform patients in terms of the standards of "the reasonable doctor" and the law of delict, rather than the doctor's fiduciary duty to inform patients of all material facts. In *Sidaway v Bethlem Royal Hospital Governors,* for instance, Lord Scarman admitted that the doctor-patient relationship is a very special one; "*...the patient putting is health and his life in the doctor's hands...*", but held that there was no comparison to be made between the relationship of a doctor and a patient and that of a solicitor and client.[784] Also, in the case of *Barclays Bank v O'Brien* the House of Lords confirmed that the doctor-patient relationship could be characterised as a fiduciary relationship, but unfortunately did not elaborate on this statement.[785]

In the Australian case of *Hospital Products Ltd v United States Surgical Corporation*[786] it was suggested that a fiduciary relationship exists if a person is obliged or undertakes to act in relation to a particular matter in the interests of another, and is entrusted with the power to affect those interests in a legal or practical sense. The reason for this principle was said to be found in the special vulnerability of those whose interests are entrusted to the power of another and the potential for abuse of that power. However, Mason J held that it is not possible to make a general statement about the circumstances in which a fiduciary relationship will exist, since fiduciary relationships are of different types, carrying different obligations. A test which may therefore be appropriate to determine whether a fiduciary relationship exists for one purpose may be inappropriate for another. He used the relationship between a physician and patient as an example of a relationship which may be described as fiduciary if there is a presumption of undue influence. However, according to Mason J the doctor-patient relationship cannot be described as fiduciary in cases of alleged conflict between duty and interest. He also held that inequality of bargaining power alone is not enough to create a fiduciary relationship in every case and for all purposes.

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[783] Grubb, Andrew *Principles of Medical Law* (2nd ed) Oxford University Press 2004, 50; Stauch, Marc; Wheat, Kay; Tringle John *Text, Cases and Materials on Medical Law* 3rd ed Routledge: Cavendish (2006) 39 – 40; Teff, Harvey *Reasonable Care: Legal Perspectives on the Doctor-patient Relationship* Clarendon Press Oxford (1994) 218 – 219; Bartlett, Peter Doctors as Fiduciaries: Equitable regulation of the Doctor-Patient Relationship *Medical Law Review* Vol 5 (1997) 193 – 224, 193.

[784] *Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital* [1985] A.C. 871 HL.

[785] *Barclays Bank v O'Brien* [1994] 1 A.C. 180, 189.

[786] *Hospital Products Ltd v United States Surgical Corporation* (1984) 156 CLR 41 (HC Aust) at 96-7.

However, in the USA case of *Yates v El-Deiry*[787] Justice Heiple decided that public policy, which favours and upholds the sanctity of the doctor-patient relationship, is reflected in the fiduciary relationship existing between a doctor and a patient. The nature of this relationship does not stem from the physician's ethical duties, but rather from his/her unique role in society. Justice Heiple also emphasised the importance of the qualities of trust, confidence and good faith in this relationship. The doctor-patient relationship was thus *in casu* regarded as a fiduciary relationship with all the duties and expectations associated with it. In *Natanson v Kline*[788] the jury was also instructed that the relationship between a physician and a patient is a fiduciary relationship and in the case of *Wohlgemuth v Meyer*[789] the doctor-patient relationship, as well as the hospital-patient relationship, were described as fiduciary.

In the Canadian case of *Norberg v Wynrib*[790] the patient was addicted to painkillers. She obtained a prescription for painkillers from the defendant, a medical practitioner, after she had told him that her ankle, which she had broken the previous year, was hurting. After this particular incident the defendant continued to prescribe painkillers for this and various other illnesses the defendant claimed she was suffering from, even though he realised that she was an addict. After some time the defendant suggested to the patient that he would provide the required drugs on condition that she allow him to engage in sexual activity with her. The patient first declined this proposition but later gave in to the defendant's demands and they had sex on a number of occasions. After some time the patient decided to institute legal action against the defendant, alleging that his conduct amounted to assault and seeking compensation for damages based on the law of delict as well as the doctor's breach of his fiduciary duty towards her as his patient. The patient's action was dismissed by the court a quo, who held that her conduct fell within the defence of *ex turpi causa non oritur actio*. The court did however accept the basis of her claim for breach of fiduciary duty.[791] The action was also dismissed in a majority judgement of the British Columbia Court of Appeal, who rejected her claim for breach of fiduciary duty and also rejected her claim of

[787] *Yates v El-Deiry* 513 N.E. 2d 519 (Illnois 1987), 522.
[788] *Natanson v Kline* 186 Kan. 393, 350 P.2d 1093, 1099.
[789] *Wohlgemuth v Meyer* 293 P.2d 816 (CA 1956), 819..
[790] *Norberg v Wynrib* (1992) 92 DLR (4th) 449.
[791] *Norberg v Wynrib* (1989) 50 DLR (4th) 167; Grubb, Andrew *Principles of Medical Law* (2nd ed) Oxford University Press 2004, 53.

assault based on the grounds that she had consented and that the defence *ex turpi causa non oritur actio* applied.[792] On appeal however the Canadian Supreme Court reversed the lower court's decision and the patient's claim for damages was upheld. Three of the appeal judges in this judgement held that the patient's vulnerability as a drug addict created a relationship of unequal power between her and the doctor and that the latter had exploited his patient. The court applied the contractual principles of unconscionability and inequality of bargaining power and held that the patient's consent was consequently cancelled out. Another appeal judge focussed on the principles of the law of delict and held that the doctor had breached his duty of care to the patient by not treating her addiction and that this had caused her damage in that her addiction was prolonged.

For the purposes of this dissertation, the dissenting judgement (in the Supreme Court) of Justice McLachlin (with Justice L'Heureux Dubé concurring) is of particular importance and will be discussed in more detail. Justice McLachlin rejected the approaches of all the other judges on appeal, as she was of the opinion that the principles of the law of contract and the law of delict did not adequately "*capture the essential nature of the wrong done to the plaintiff*".[793] Instead, Justice McLachlin based her judgement on the principles of fiduciary law and held that there was no reason why a doctor's fiduciary duty should be confined to property and financial cases, since fiduciary law is *"...capable of protecting not only narrow legal and economic interests but also serves to defend fundamental human and personal interests..."*.[794] She held that the most fundamental characteristic of the doctor-patient relationship is its fiduciary nature and described the essence of the said relationship as *"...trust of a person with inferior power that another person who has assumed superior power and responsibility will exercise that power for his or her own good and only for his or her own good and in his or her best interests*".[795] Justice McLachlan also identified three characteristics of the doctor-patient relationship which made the relationship a fiduciary

[792] *Norberg v Wynrib* (1990) 66 DLR (4th) 553; Grubb, Andrew *Principles of Medical Law* (2nd ed) Oxford University Press 2004, 53.
[793] *Norberg v Wynrib* (1992) 92 DLR (4th) 449, 484 par 61; Grubb, Andrew *Principles of Medical Law* (2nd ed) Oxford University Press 2004, 54.
[794] *Norberg v Wynrib* (1992) 92 DLR (4th) 449, 480 – 481 & 499; Grubb, Andrew *Principles of Medical Law* (2nd ed) Oxford University Press 2004, 54.
[795] *Norberg v Wynrib* (1992) 92 DLR (4th) 449, 486 par 65; Grubb, Andrew *Principles of Medical Law* (2nd ed) Oxford University Press 2004, 54.

relationship: the power of the doctor, the affect of the doctor's power on the patient's interests and the vulnerability of the patient.[796]

Justice McLachlin did, however, accept that the doctor-patient relationship is not a fiduciary relationship for all purposes, since fiduciary duty claims would not include all the duties imposed by law on a medical practitioner in a doctor-patient relationship. The law of delict and/or the principles of the law of contract would, for instance, still apply in cases where the doctor failed to exercise the degree of care and skill required of a reasonable medical practitioner, while the criminal law of assault would still be relevant in situations where a doctor treated a patient without obtaining the proper consent first.[797] Justice Sopinka in *Norberg* also agreed that not all obligations existing between doctor and patient are fiduciary in nature and that fiduciary obligations must be reserved only for situations where special protection is truly needed. She therefore described the doctor-patient relationship as a relationship of a hybrid genre with certain obligations fiduciary in nature and others either based on the law of delict or the principles of the law of contract.[798]

While most of the states in the USA[799] regard the doctor-patient relationship as a fiduciary relationship in all contexts and with regard to most disputes, Canadian,[800] English, Australian and South African law seem to prefer a more cautious approach.[801] These jurisdictions recognise the fiduciary nature of the doctor-patient relationship in cases involving the patient's property and/or finances, but do not wish to extend this to recognising the doctor-patient relationship as a fiduciary relationship in all contexts.[802] It can be concluded from

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[796] *Norberg v Wynrib* (1992) 92 DLR (4th) 449, 489; Grubb, Andrew *Principles of Medical Law* (2nd ed) Oxford University Press 2004, 55.

[797] *Norberg v Wynrib* (1992) 92 DLR (4th) 449, 480 par 67; Grubb, Andrew *Principles of Medical Law* (2nd ed) Oxford University Press 2004, 57.

[798] *Norberg v Wynrib* (1992) 92 DLR (4th) 449, 453 par 129.

[799] Generally it can be said that both professional and legal standards in the USA indicate that the doctor-patient relationship is accepted to be fiduciary in nature; Sharpe, Jessica Russak Legal Services Corp. V. Velazquez: Tightening the Noose on Patients' Rights *North Carolina Law Review* Vol 81 (March 2003) 1312 – 1332, 1317.

[800] Two decisions from the Supreme Court of Canada broadened the doctor-patient relationship from a relationship based solely on contract to one giving rise to fiduciary obligations on the part of the doctor – *McInerney v MacDonald* (1992) 93 DLR (4th) 415 (SCC) and *Norberg v Wynrib* (1992) 92 DLR (4th) 449. Both these cases are discussed in this chapter but in different sections of the chapter.

[801] See footnote 797.

[802] Although some case law from these jurisdictions (English, Australia and South Africa) were identified in which the doctor-patient relationship was described in terms of fiduciary metaphors, no example exists where

the analysis that although the doctor-patient relationship has been described and regarded as a fiduciary relationship in a number of cases, and although doctors perform fiduciary-like roles and like to be seen as fiduciaries in their ethical codes, the law generally only holds doctors accountable as fiduciaries in restricted situations.[803]

5.2. The legal content of the fiduciary relationship between doctor and patient

What then is the legal content of the fiduciary aspects of the relationship between doctor and patient? Generally, a fiduciary relationship entails the following:

- the fiduciary must act *intra vires*;
- the fiduciary should promote and preserve the interests of the beneficiary; and
- the fiduciary should not pursue any interest of his/her own which might be in conflict with the particular duties owed to the beneficiary.[804]

According to Birks, fiduciary law is a vehicle for exporting incidents of express trust by analogy, and it is characterised by the high degree of altruism required of the fiduciary.[805] Birks describes this altruism as "*…the third and highest degree of legally obligatory altruism*".[806] Johnston describes the fiduciary duty as the highest standard of duty implied by law and due to its origin in equitable and ecclesiastical courts, believes that fiduciary law has always been heavily imbued with notions of morality and justice.[807] In this dissertation the importance of trust in the doctor-patient relationship has been (and will continue to be) highlighted throughout, and the characteristic qualities of beneficence and altruism in the medical profession have also been discussed in Chapter Three, section 3.3. In Chapter Four the absence of these qualities in the domain of health service delivery was considered and

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the doctor-patient relationship is regarded as a fiduciary relationship based on the unique basis of this relationship and in all contexts.

[803] Rodwin, Marc A Strains in the Fiduciary Metaphor: Divided Physician Loyalties and Obligations in a Changing Health Care System *American Journal of Law and Medicine* Vol 21 (1995) 241 – 257, 242.

[804] Birks, Peter The Content of Fiduciary Obligation *Israel Law Review* Vol 3 No 34 (2000) 3 – 38, 28.

[805] Birks, Peter The Content of Fiduciary Obligation *Israel Law Review* Vol 3 No 34 (2000) 3 – 38, 3.

[806] "*The first degree of obligatory altruism merely requires, negatively, that we abstain from causing injury and damage to another; the second, more rare, requires us to take positive action in the interests of another; the third, very rare, requires both positive action in the interests of another and disinterestedness*."; Birks, Peter The Content of Fiduciary Obligation *Israel Law Review* Vol 3 No 34 (2000) 3 – 38, 3 & 37; Carstens, Pieter and Pearmain, Debbie *Foundational Principles of South African Medical Law* LexisNexis: Durban 2007, 318.

[807] Johnston, Kim Patient Advocates or Patient Adversaries? Using Fiduciary Law to Compel Disclosure of Managed Care Financial Incentives *San Diego Law Review* Vol 35 (1998) 951 – 992, 960; Morreim, Haavi E Economic Disclosure and Economic Advocacy: New Duties in the Medical Standard of Care *Journal of Legal Medicine* 12, 275 – 329, 296.

found to be morally objectionable: To reduce the doctor-patient relationship to ordinary commercial exchanges is demeaning and dangerous for medical practitioners and unacceptable to patients.[808] It is therefore evident that these unique qualities which Birks, Johnston and others usually associate with fiduciary relationships are also central to health service delivery and the dynamics of the doctor-patient relationship.

Rainbolt offers another argument in support of the above. He dismisses both the traditional patient ethic with its emphasis on the qualities traditionally associated with health service delivery and the unique dynamic of the doctor-patient relationship, as well as the business model of health service delivery with its commercialised doctor-patient relationship. Instead he argues that a normal fiduciary ethic is morally preferable.[809] According to Rainbolt, such an ethic encompasses the contractual ethic (discussed in Chapter Four) and the traditional ethic of health service delivery (discussed in Chapters Two and Three).[810] He shows and reminds us that not all relationships in the competitive marketplace are governed by a contractual ethic; the competitive marketplace also involves the fiduciary ethic.[811] Such an ethic can, for example, exist in a competitive, commercialised environment, while still retaining the qualities of the traditional patient ethic, including that the physician should act in the best interest of the patient. In addition, it should be noted that health service delivery is not the only primary or special good in the competitive marketplace. Food, shelter, a certain level of income and education are generally also included in the class of primary goods.[812] There are also many fields in the marketplace where consumers are unable to bargain effectively, due to the particular vulnerable state in which they may find themselves.[813] Rainbolt furthermore submits that the asymmetry of knowledge between doctor and patient in health service delivery is not unique to the field of medical practice.

[808] Teff, Harvey *Reasonable Care: Legal Perspectives on the Doctor-patient Relationship* Clarendon Press Oxford (1994) 171; Rainbolt, George W Competition and the Patient-centered Ethic *Journal of Medicine and Philosophy* Vol 12 (1987) 85 – 99, 85.
[809] Rainbolt, George W Competition and the Patient-centered Ethic *Journal of Medicine and Philosophy* Vol 12 (1987) 85 – 99, 85.
[810] Rainbolt, George W Competition and the Patient-centered Ethic *Journal of Medicine and Philosophy* Vol 12 (1987) 85 – 99, 87.
[811] Carstens, Pieter and Pearmain, Debbie *Foundational Principles of South African Medical Law* LexisNexis: Durban 2007, 285.
[812] Rainbolt, George W Competition and the Patient-centered Ethic *Journal of Medicine and Philosophy* Vol 12 (1987) 85 – 99, 89.
[813] Rainbolt, George W Competition and the Patient-centered Ethic *Journal of Medicine and Philosophy* Vol 12 (1987) 85 – 99, 89.

Tax preparation and architecture are two other examples where such an asymmetry of knowledge in the competitive marketplace exists. And since asymmetry of knowledge is the standard justification for a fiduciary ethic and, according to Rainbolt's argument, not unique to the field of health service delivery, the normal fiduciary ethic is morally preferable and appropriate in the context of the doctor-patient relationship.[814]

Rainbolt supports his argument for an ordinary fiduciary ethic in health service delivery by pointing out that the promulgation in society of the incorrect view that physicians are held to a higher moral standard than other professionals encourages paternalistic actions by medical practitioners, which in turn (see Chapter Three) results in a power imbalance in the doctor-patient relationship.[815] In addition to this individual paternalism, the traditional patient ethic also encourages social paternalism, which promotes the view that physicians as a group have special authority when it comes to public policy and moral issues.[816] A change to a normal fiduciary ethic in medical practice will reduce these individual and social notions of paternalism and increase the autonomy and self-determination of patients.[817] Moreover, since a fiduciary is a moral person, acting within the constraints of the fiduciary ethic, trust, honesty and respect will also remain hallmarks in the doctor-patient relationship. The fact that societies attach such importance to health will ensure that the said relationship will not become similar to other contractual relationships in the commercial marketplace.[818] Finally, a fiduciary relationship is more one-sided than the usual relationship between parties contracting at arm's length due to the special nature of fiduciary obligations and the corresponding expectations of the beneficiary. Public policy and justice to the doctor-patient relationship dictate that the relationship cannot be governed solely by the morals of the marketplace.[819]

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[814] Rainbolt, George W Competition and the Patient-centered Ethic *Journal of Medicine and Philosophy* Vol 12 (1987) 85 – 99, 90.
[815] Rainbolt, George W Competition and the Patient-centered Ethic *Journal of Medicine and Philosophy* Vol 12 (1987) 85 – 99, 93.
[816] Rainbolt, George W Competition and the Patient-centered Ethic *Journal of Medicine and Philosophy* Vol 12 (1987) 85 – 99, 94.
[817] Rainbolt, George W Competition and the Patient-centered Ethic *Journal of Medicine and Philosophy* Vol 12 (1987) 85 – 99, 94.
[818] Rainbolt, George W Competition and the Patient-centered Ethic *Journal of Medicine and Philosophy* Vol 12 (1987) 85 – 99, 96.
[819] Johnston, Kim Patient Advocates or Patient Adversaries? Using Fiduciary Law to Compel Disclosure of Managed Care Financial Incentives *San Diego Law Review* Vol 35 (1998) 951 – 992, 960.

However, in medicine there is a gap between the fiduciary ideal, as described by Rainbolt and practice.[820] This is evident from the discussion in section 5.1., where it was submitted that fiduciary law principles have been applied to physicians only in particular circumstances and for limited purposes.[821] In addition, the idea that physicians are fiduciaries for their patients is further challenged by the following developments in medical practice:

- a shift in influence over doctors from patients to other groups;
- a shift in authority from doctors to managed care organisations (this concept of managed care will be discussed in Chapter Six);
- a growing concern with groups rather than individuals.

According to Rodwin, these trends, as well as the inevitable commercialisation of medical practice in general discussed in Chapter Four, reinforce the idea that physicians should serve interests beyond those of their individual patients.[822] And when doctors serve the interests of several parties and not their individual patients, the fiduciary metaphor is strained.[823]

Yet the competing demands on physicians can be resolved within a fiduciary framework.[824] Dworkin suggests that the fiduciary nature of the doctor-patient relationship requires not only that the fiduciary provide adequate attention to the needs of the beneficiary, but also to the needs of others. The doctor's obligation to act with respect should be extended to all significantly affected individuals.[825] He also refutes the concern that doctors will be overburdened by this extended fiduciary obligation, stating that fiduciary duties are obligations to make reasonable efforts to achieve certain ends, not obligations to actually achieve them.[826] It is furthermore important that the fiduciary metaphor for the doctor-patient relationship should not be abandoned too quickly, since the core of the fiduciary

[820] Rodwin, Marc A Strains in the Fiduciary Metaphor: Divided Physician Loyalties and Obligations in a Changing Health Care System *American Journal of Law and Medicine* Vol 21 (1995) 241 – 257, 247.
[821] Rodwin, Marc A Strains in the Fiduciary Metaphor: Divided Physician Loyalties and Obligations in a Changing Health Care System *American Journal of Law and Medicine* Vol 21 (1995) 241 – 257, 247.
[822] Rodwin, Marc A Strains in the Fiduciary Metaphor: Divided Physician Loyalties and Obligations in a Changing Health Care System *American Journal of Law and Medicine* Vol 21 (1995) 241 – 257, 253.
[823] Rodwin, Marc A Strains in the Fiduciary Metaphor: Divided Physician Loyalties and Obligations in a Changing Health Care System *American Journal of Law and Medicine* Vol 21 (1995) 241 – 257, 255.
[824] Rodwin, Marc A Strains in the Fiduciary Metaphor: Divided Physician Loyalties and Obligations in a Changing Health Care System *American Journal of Law and Medicine* Vol 21 (1995) 241 – 257, 255.
[825] Dworkin, Roger B Getting what we should from doctors: Rethinking patient autonomy and the doctor-patient relationship *Health Matrix: Journal of Law-Medicine* 13 (2003) 235 – 296, 276.
[826] Dworkin, Roger B Getting what we should from doctors: Rethinking patient autonomy and the doctor-patient relationship *Health Matrix: Journal of Law-Medicine* 13 (2003) 235 – 296, 277.

ideal is accountability and greater physician accountability and a more equal distribution of power in the doctor-patient relationship is imperative.[827]

The advantage of the fiduciary metaphor in the doctor-patient relationship is that it provides courts with an increased flexibility to extend obligations beyond the traditional fiduciary situations. This enables them to offer specific, equitable remedies in a range of situations that may arise in health service delivery.[828] The fiduciary metaphor in health service delivery can ultimately guide courts and legislatures in how they treat doctors and view the doctor-patient relationship.[829] In the following section, the scope of the doctor's fiduciary obligations will be considered.

5.3. The doctor as a fiduciary in the doctor-patient relationship

In ordinary fiduciary relationships, the fiduciary duties are usually divided into two classes: the duty of loyalty and the duty of care, the latter also known as the duty to act in the patient's best interest.[830] Justice McLachlin held in the case of *Norberg v Wynrib* (supra) that "[t]*he scope of a physician's fiduciary obligations can only be determined on a case-by-case basis, having reference to the degree of power imbalance and patient vulnerability present in the relationship under examination*."[831] Thus, while the fiduciary duties of the medical practitioner arise from the inherent nature of the doctor-patient relationship, the particular circumstances will indicate whether or not a medical practitioner has abused his fiduciary duty/duties.[832] And this conservative, case-by-case application of the principles of fiduciary law to the doctor-patient relationship will not lead to an increase in unfounded claims based

[827] Rodwin, Marc A Strains in the Fiduciary Metaphor: Divided Physician Loyalties and Obligations in a Changing Health Care System *American Journal of Law and Medicine* Vol 21 (1995) 241 – 257, 255.

[828] Stauch, Marc; Wheat, Kay; Tringle John *Text, Cases and Materials on Medical Law* 3rd ed Routledge: Cavendish (2006) 40.

[829] Rodwin, Marc A Strains in the Fiduciary Metaphor: Divided Physician Loyalties and Obligations in a Changing Health Care System *American Journal of Law and Medicine* Vol 21 (1995) 241 – 257, 256; Litman, Moe & Sheremeta, Lori The Report of the Committee of Inquiry on the Case Involving Dr Nancy Olivieri: A Fiduciary Law Perspective *Health Law Review* Vol 10, No 2 (2002) 3 – 13, 3.

[830] Johnston, Kim Patient Advocates or Patient Adversaries? Using Fiduciary Law to Compel Disclosure of Managed Care Financial Incentives *San Diego Law Review* Vol 35 (1998) 951 – 992, 960 – 961 Some authors identify three classes: the duty of loyalty, the duty of care and also the duty of confidentiality. Healey, M & Dowling, Kara L Controlling Conflicts of Interest in the Doctor-Patient Relationship: Lessons from Moore v Regents of the University of California *Mercer Law Review* Vol 42 (Spring 1991) 989 – 1005, 1002.

[831] *Norberg v Wynrib* (1992) 92 DLR (4th) 449, 497; Grubb, Andrew *Principles of Medical Law* (2nd ed) Oxford University Press 2004, 58.

[832] Grubb, Andrew *Principles of Medical Law* (2nd ed) Oxford University Press 2004, 58.

on the real or perceived inequality of power. Before such a claim can arise, Justice McLachlin's test requires that a court must first establish that there is an imbalance of power, that the potential for interference with a legal interest or a non-legal interest of vital and substantial practical interest be identified. In addition, the fiduciary must have undertaken to look after the beneficiary's interest.[833] In this section the two specific fiduciary obligations referred to above will be considered, namely the duty of loyalty and the duty to act in a patient's best interest.

5.3.1. The duty of loyalty

Probably the most important quality of the fiduciary nature of the doctor-patient relationship is the doctor's fiduciary duty of loyalty towards the patient or beneficiary. Birks describes this duty as the distinguishing obligation of a fiduciary.[834] The obligation entails that the doctor must always endeavour to act in good faith and in the best interests of the beneficiary, since fiduciary law aims to proscribe selfish conduct by the fiduciary and to prevent the abuse of trust vested in him/her.[835] The duty of loyalty also underlies a wide range of ethical obligations, including that physicians must maintain the confidentiality of their patients' disclosures, care for patients who are too poor to pay for such care; and care for the sick even when doing so exposes them to personal health risks.[836] While the business model of health service delivery discussed in Chapter Four assumes that patients and health service providers are at arm's length, primarily concerned with their own self-interests and therefore exist as equal contracting parties in the doctor-patient relationship, the essential qualities of the fiduciary's obligations are focused on the interests of the beneficiary.[837] The claim that the doctor as a fiduciary has exploited the beneficiary and abused the fiduciary duty of loyalty is usually a claim in property cases.

An example of this can be found in the Californian case of *Moore v Regents of the University of California.*[838] The defendant treated the plaintiff for a form of leukaemia while also being

[833] *Norberg v Wynrib* (1992) 92 DLR (4th) 449, 452 par 71 - 75.
[834] Birks, Peter The Content of Fiduciary Obligation *Israel Law Review* Vol 3 No 34 (2000) 3 – 38, 32.
[835] Grubb, Andrew *Principles of Medical Law* (2nd ed) Oxford University Press 2004, 46.
[836] Orentlicher, David Health Care Reform and the Patient-Physician Relationship *Health Matrix* Vol 5 (1995) 141 – 180, 148,
[837] Grubb, Andrew *Principles of Medical Law* (2nd ed) Oxford University Press 2004, 47.
[838] *Moore v Regents of the University of California* Cal 249 Cal Rptr 494 (1988); 793 P.2d 479 (Cal 1990).

involved in a research project to develop a therapeutic cell-line. During the period of treatment, which lasted almost seven years, the defendant collected samples of the plaintiff's bodily tissue and fluids for the purposes of this project and without the plaintiff's knowledge or consent. Some of these samples were taken solely for the purpose of this project and the patient was never informed of the defendant's involvement in the project, its commercial value or that the samples were used for these research purposes. Based on the findings of the research project, a therapeutic cell-line was eventually successfully developed and it was estimated to be worth over $3 billion. On learning of this and his own involvement in the research, the plaintiff instituted legal action against both the defendant and the bio-tech company for a share of the expected profits to be made from the cell-line. The plaintiff alleged that the defendant stood in a fiduciary relationship with him and had to act in his (the patient's) best interests. The defendant also had a fiduciary duty to disclose to him both the research activities and his (the patient's) involvement in them and to obtain neither an interest adverse to his, nor unfairly profit from him. The plaintiff submitted that the bodily tissue and fluid samples obtained from him during the treatment period were his tangible personal property and that the activity of the defendant constituted a substantial interference with the plaintiff's possession or right thereto.

The majority of the California Supreme Court held that the defendant had a duty to inform the plaintiff of his involvement in the research project, the purpose for which the samples were taken, and the financial and commercial interest the doctor (defendant) had in the patient's (plaintiff's) treatment and body materials.[839] They viewed the case as "...*fundamentally raising questions concerning a patient's right to the control of his or her own body, and whether the commercial exploitation of a patient's cells by medical care providers, without the patient's consent, gives rise to an action for damages*...".[840] They also held that the cause of action could be characterised as either a breach of the physician's

[839] *Moore v Regents of the University of California* Cal 249 Cal Rptr 494 (1988); 793 P.2d 479 (Cal 1990), 485; Compare with *Arato v Avendon* 858 P.2d 598 (Cal 1993) where it was held that a physician has no duty to disclose information relevant to a patient's nonmedical interests, for example, his business and investment affairs; Grubb, Andrew *Principles of Medical Law* (2nd ed) Oxford University Press 2004, 60.
[840] *Moore v Regents of the University of California* Cal 249 Cal Rptr 494 (1988); 793 P.2d 479 (Cal 1990), 498.

fiduciary duty or as the failure to obtain informed consent to medical treatment.[841] Although the *Moore* court hereby recognised a new cause of action, they also made the following cautionary statement: "*In some respects the term 'fiduciary' is too broad. In this context the term 'fiduciary' signifies only that a physician must disclose all facts material to the patient's decision.*"[842] However, the *Moore* case is actually better understood as one where the doctor as fiduciary abused his position, using it to further his own personal interests.[843] Grubb correctly suggests that the *Moore* case is similar to classic fiduciary cases where the fiduciary obtains financial gain at the expense of the beneficiary. Based on this analysis the defendant as well as the bio-tech company would be liable for at least a share of the profits.[844] By contrast, the dissenting justices held that while the tissue taken from the patient was his property, and that without the patient's explicit consent the use of these tissues and fluids amounted to conversion of the plaintiff's property, the bulk of the profits was made by the bio-tech company and not the defendant (doctor). Therefore, this was not an action which allowed the patient to reach the profits of the bio-tech company, since only the doctor owed the patient a duty to inform him of the use to which his bodily tissue was to be put.[845]

Another interesting case with regard to the fiduciary duty of loyalty is *D.A.B v Brown*[846] from the Minnesota Court of Appeals. Dr Brown prescribed a particular drug to over 200 patients over a period of eight years for the treatment of growth deficiencies in children. Dr Brown received kickbacks from the distributor of this drug every time he referred patients for drug related services and supplies, but never disclosed this to any of his patients. The court in this case also recognised the fiduciary nature of the doctor-patient relationship, but refused to find that a patient could bring a claim against a physician for breach of fiduciary duty for

[841] *Moore v Regents of the University of California* Cal 249 Cal Rptr 494 (1988); 793 P.2d 479 (Cal 1990), 485; Johnston, Kim Patient Advocates or Patient Adversaries? Using Fiduciary Law to Compel Disclosure of Managed Care Financial Incentives *San Diego Law Review* Vol 35 (1998) 951 – 992, 973.
[842] *Moore v Regents of the University of California* Cal 249 Cal Rptr 494 (1988); 793 P.2d 479 (Cal 1990), 485; Johnston, Kim Patient Advocates or Patient Adversaries? Using Fiduciary Law to Compel Disclosure of Managed Care Financial Incentives *San Diego Law Review* Vol 35 (1998) 951 – 992, 973.
[843] Grubb, Andrew *Principles of Medical Law* (2nd ed) Oxford University Press 2004, 61.
[844] Grubb, Andrew *Principles of Medical Law* (2nd ed) Oxford University Press 2004, 61.
[845] Compare this judgement with the inquiry in the case of Dr Olivieri at Litman, Moe & Sheremeta, Lori The Report of the Committee of Inquiry on the Case Involving Dr Nancy Olivieri: A Fiduciary Law Perspective *Health Law Review* Vol 10, No 2 (2002) 3 – 13, 3; In the case involving Dr Olivieri it was submitted that third parties are guilty if they knowingly participate in a breach of a fiduciary duty.
[846] *D.A.B. v Brown* 570 N.W.2d 168 (Minn. Ct. App. 1997).

conduct that related to examination, diagnosis, treatment and care.[847] Instead the court held that all conduct related to the examination, diagnosis, treatment or care of a patient should be governed solely by the law of delict.[848]

The discussion in this section has shown that the fiduciary approach to the doctor-patient relationship can provide a workable and fair solution to cases of financial conflict or property interests in the doctor-patient relationship, based on the doctor's fiduciary duty of loyalty. According to Grubb the application of fiduciary law to the doctor-patient relationship will give legal effect to many of the existing ethical duties of doctors.[849]

5.3.2. The duty to act in the patient's best interest

From the case law discussed in this dissertation it is evident that a number of jurisdictions accept that doctors have a legal duty to act in a patient's best interest.[850] But where does this duty come from and what does it entail? According to Grubb it has actually been borrowed from case law involving the medical treatment of young children.[851] These cases were about the fiduciary duties of the parent towards a child and the analogous duty of the court as the child's judicial parent. "[T]*here is therefore an unbroken line between these cases and the decisions concerning adult patients. Without appreciating the significance of what they [the courts] were doing, the courts have utilised language reflective of fiduciary law*".[852]

The New Zealand case of *Smith v Auckland Hospital Board*[853] offered another point of view with regard to medical practitioners' duty to act in the best interests of their patients. Justice Turner held that the relationship between a doctor and a patient is not a contractual relationship. Where there is a special relationship of this type, it is unnecessary to do more

[847] *D.A.B. v Brown* 570 N.W.2d 168 (Minn. Ct. App. 1997), 172.
[848] *D.A.B. v Brown* 570 N.W.2d 168 (Minn. Ct. App. 1997), 171; Johnston, Kim Patient Advocates or Patient Adversaries? Using Fiduciary Law to Compel Disclosure of Managed Care Financial Incentives *San Diego Law Review* Vol 35 (1998) 951 – 992, 975.
[849] Grubb, Andrew *Principles of Medical Law* (2nd ed) Oxford University Press 2004, 61.
[850] Grubb, Andrew *Principles of Medical Law* (2nd ed) Oxford University Press 2004, 72; *Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital and Others* [1985] 1 All ER 643, at 665; *Smith v Auckland Hospital Board* [1965] NZLR 191.
[851] Grubb, Andrew *Principles of Medical Law* (2nd ed) Oxford University Press 2004, 73.
[852] Grubb, Andrew *Principles of Medical Law* (2nd ed) Oxford University Press 2004, 73 - 74.
[853] *Smith v Auckland Hospital Board* [1965] NZLR 191, 205.

than to prove its existence; the duty to act in the best interest of the patient will follow. Thus, it was held that wherever there is a relationship equivalent to a contract (like a doctor-patient relationship), there is a duty of care and a corresponding duty to act in the patient's best interests. In contrast to this, it was decided in the USA case of *Regina v Mid Glamorgan Family Health Services Authority and another ex parte Martin*[854] that the relationship between a doctor and a patient *is* contractual in origin and that the doctor implicitly contracts at the same time to act in the patient's best interests.

In Canada, in the case of *Hopp v Lepp,*[855] it was asserted that

> "*…the duty [to act in the best interest of the patient] is assumed to arise in those cases where there was a breach of a duty to which equity had attached its sanction arising from the circumstances and relation of the parties…it includes a moral, as distinguished from a legal duty to be careful, and as an obligation it arises out of the duty independently of contract or of special obligation. For if a man intervenes in the affairs of another, he must do so honestly, whatever be the character of that intervention*."[856]

In the USA case of *Nixdorf v Hicken*[857] a similar line of reasoning was followed. In this case it was also held that the special relationship which exists between a doctor and a patient creates a duty for the physician to act in the patient's best interests, and that this duty stems from the fiduciary nature of the relationship. Unfortunately the court did not elaborate on this duty, nor did it elaborate on the presumed fiduciary nature of the doctor-patient relationship.

In the English case of *Heldley Byrne v Heller & Partners*[858] it was submitted in the court a quo that the duty to act in the best interest of another can only arise in a special relationship and it is doubtful whether the sphere of such a special relationship can be extended beyond that of a contract or a fiduciary relationship. On appeal, however, it was held by the majority that the duty of care and the duty to act in the best interest of another may arise

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[854] *Regina v Mid Glamorgan Family Health Services Authority and another ex parte Martin* [1995] 1 W.L.R. 110 (CA Civ Div), 117.

[855] *Hopp v Lepp* [1980] 2 S.C.R. 192, 203 – 204.

[856] *Hopp v Lepp* [1980] 2 S.C.R. 192, 203 – 204; *Kenny v Lockwood* [1932] O.R. 141, 156.

[857] *Nixdorf v Hicken* 612 P.2d 348, (Utah 1980) 355.

[858] *Hedley Byrne v Heller & Partners* 1964 A.C. 465; [1961] 3 All E.R. 891.

from implied as well as express contracts, including fiduciary relationships and any other special relationships which the courts may find to exist, based on the particular circumstances and the relationships between the parties. The constant factor in all these types of relationships was said to be the *trust* of one party that the other person will act in his/her best interests. In another case it was held that such a duty will arise where a *confidential* relationship exists.[859]

It can therefore be concluded that the doctor's fiduciary duty to act in the best interest of a patient springs from the trust and confidence placed by one party in another, who by reason of a specific skill, knowledge, training, judgement or expertise is in a superior position to advise or to act on behalf of the party bestowing the trust and confidence on him/her.[860] However, the notion that the doctor-patient relationship is a fiduciary relationship with the ensuing fiduciary duty of the doctor to act in the interest of the patient may also create an anomaly with regard to the patient's autonomy and self-determination. When the doctor-patient relationship is described as fiduciary in nature it may potentially create tension when the fiduciary yields control over the beneficiary's well-being in order to foster the beneficiary's autonomy — thereby creating a "power-dependency" nature on the patient in relation to the doctor.[861] This is a realistic danger of the fiduciary metaphor in medical practice, as the primary reason why persons are assigned fiduciary obligations is because their beneficiaries are thought to need special protection and that the fiduciary is well situated to satisfy these needs.[862] The fiduciary metaphor in medical practice can therefore potentially fail to deliver on true patient autonomy and self-determination in the doctor-patient relationship.

Dworkin suggests that this potential anomaly can be addressed by focussing on the qualities of respect, honesty, trust and confidence in the doctor-patient relationship, and by re-

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[859] *Shadrick v Coker* 963 S.W. 2d 726 (Nashville 1998), 736.
[860] *Shadrick v Coker* 963 S.W. 2d 726 (Nashville 1998), 736.
[861] Gilmour, Joan M Overview of Medical Malpractice Law in Canada *Annals of Health Law* Vol 3 (1994) 179 – 204, 197; Healey, M & Dowling, Kara L Controlling conflicts of interest in the Doctor-Patient Relationship: Lessons from Moore v Regents of the University of California *Mercer Law Review* Vol 42 (Spring 1991) 989 – 1005, 1001.
[862] Dworkin, Roger B Getting what we should from doctors: Rethinking patient autonomy and the doctor-patient relationship *Health Matrix: Journal of Law-Medicine* 13 (2003) 235 – 296, 237; Teff, Harvey *Reasonable Care: Legal Perspectives on the Doctor-patient Relationship* Clarendon Press Oxford (1994) 221.

establishing this relationship as a moral[863] relationship built on trust, equality and respect.[864] Under this approach, a doctor's obligation will be not only to act in the best interest of the patient, but also to act with respect. In this particular context, respect can be seen as synonymous with a commitment to autonomy, as the doctor will give the patient's autonomy and self-determination due consideration and value when acting in the patient's best interests.[865]

5.4. The patient as a beneficiary in the doctor-patient relationship

In this section the scope of the rights and entitlements of the patient as a beneficiary in the doctor-patient relationship will be considered.

5.4.1. Right or entitlement to a benefit enforceable against the fiduciary

A patient/beneficiary has a right or entitlement to a benefit enforceable against the fiduciary, based upon the fiduciary's duty to act in the beneficiary's best interest. While such a claim would be unusual in property cases, it may be significant if the doctor were to be seen as a fiduciary and it would also be relevant in cases where the patient asserted a right to information held or known by the doctor.[866] An example of this can be found in the Canadian case of *McInerney v MacDonald.*[867]

In this case the plaintiff was treated by a number of physicians over a period of years. When one of her doctors advised her to cease a particular treatment which she had received from a previous physician, she asked to view a copy of her medical records. The defendant

[863] A moral relationship in this context refers to the concept of morality and denotes a social institution, composed of a set of standards pervasively acknowledged by the members of the particular culture; Faden, Ruth R & Beauchamp, Tom L *A History and Theory of Informed Consent* Oxford University Press: NY 1986; Pellegrino, Edmund D & Thomasma, David C *The virtues in Medical Practice* Oxford University Press: NY 1993, chapter 3.

[864] See Chapter Three section 3.5.5. and Chapter Four section 4.3.3.; Dworkin, Roger B Getting what we should from doctors: Rethinking patient autonomy and the doctor-patient relationship *Health Matrix: Journal of Law-Medicine* 13 (2003) 235 – 296, 275; Bradfield, Owen At the heart of Chappel v Hart: a warning about warning! Australian Law Students' Association: Academic Journal http://www.alsa.asn.au.files/acj/2000/chappel_hart.html ; Also see Talcott Parsons view on trust in the doctor-patient relationship as discussed on page 24 of this dissertation – "*The clarifications on the physician role and the sick role illustrate that the relationship is build on mutual trust*."

[865] See Chapter Three, section 3.3. for a discussion on patient autonomy and self-determination; Dworkin, Roger B Getting what we should from doctors: Rethinking patient autonomy and the doctor-patient relationship *Health Matrix: Journal of Law-Medicine* 13 (2003) 235 – 296, 275.

[866] Grubb, Andrew *Principles of Medical Law* (2nd ed) Oxford University Press 2004, 52.

[867] *McInerney v MacDonald* (1992) 93 DLR (4th) 415 (SCC).

(doctor) agreed with regard to the medical records which she had prepared herself, but refused, out of a sense of ethical propriety, to provide the medical records prepared by previous treating physicians from the patient's file. The patient consequently brought an action against the defendant, requesting that her complete medical file be made available to her. A majority of the New Brunswick Court of Appeal held that there was an implied term in the contract between a doctor and a patient providing the patient with a right of access to material in medical records relating to the patient's treatment or medical advice provided to the patient.[868] The Canadian Supreme Court, however, described the doctor-patient relationship as fiduciary in nature and with particular duties arising from this special relationship built on trust and confidence. These duties include the duty of the doctor to act with utmost good faith and loyalty, to hold information received from or about a patient in confidence, and to make proper disclosure of information to every patient. The doctor also has an obligation to grant access to information used in administering a patient's treatment.[869]

Justice La Forest held that this fiduciary duty is based on the nature of the particular patient's interest in the medical records and the principle that while the doctor is the owner of the actual record, the information is actually held in a fashion akin to a trust and is to be used by the physician for the benefit of the particular patient. This trust-like beneficial interest of a patient in the said information means that the patient's interest in the information continues when the information is conveyed to another doctor, who then becomes subject to the duty to afford the patient access to that information. It was furthermore held that since the doctor has a duty to act with utmost good faith and loyalty, it is imperative that the patient have access to the records to ensure the proper functioning of the doctor-patient relationship and to protect the well-being of the patient. Such a disclosure, it was held, will reinforce the patient's faith in the treatment and will enhance the trust inherent in the doctor-patient relationship.[870] And since the right of access to information, according to this judgement, grows out of the doctor's fiduciary duty of loyalty

[868] Grubb, Andrew *Principles of Medical Law* (2nd ed) Oxford University Press 2004, 64.
[869] *McInerney v MacDonald* (1992) 93 DLR (4th) 415 (SCC), 423.
[870] *McInerney v MacDonald* (1992) 93 DLR (4th) 415 (SCC), 423 - 424.

as a fiduciary, the patient should be permitted to bring a claim against the fiduciary even though she was not exploiting the patient.[871]

But the Canadian Supreme Court was also at pains to limit its ruling, holding that the fiduciary duty of the doctor was conceived in and limited to the realm of information.[872] The confidential nature of the information as well as the patient's interest in that information triggered the doctor's fiduciary duty, limited to allowing the patient access to information or preventing misuse of the information in breach of the patient's trust and confidence.[873] The court furthermore accepted that the right to access to information was not absolute and that the fiduciary duty of the doctor as described here did not mean that the doctor should grant the patient access to medical records at all times and under all circumstances.[874] Since the fiduciary duty was to act in the best interest of the patient, the refusal of access to medical records may be justified in certain circumstances.

Justice La Forest's ruling was severely criticised in the Australian case of *Breen v Williams*.[875] The appellant, who had been a patient of the respondent, claimed to have a legal right of reasonable access to her medical records kept by the respondent as well as a right to inspect and/or copy these records. The appellant submitted that this legal right is based on, respectively, the law of contract, property law and the medical practitioner's fiduciary duty towards the appellant as his patient. (The discussion that follows is limited to the appellant's submission that the legal right is based on the medical practitioner's fiduciary duty towards her.) In their judgement Justices Brennan and Gummow accepted that the unique doctor-patient relationship gives rise to some fiduciary obligations, but stated that there is no fiduciary relationship which gives rise to a duty to give access to or to permit the copying of

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[871] Compare this point of view with *Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital and Others* [1985] 1 AC 871, HL (1984 Q.B. 493) at par D – G page 515 where it was expressed by Justice Brown-Wilkinson that only a claim for abuse of fiduciary duty may be accepted; Also see the English case of *R v Mid Glamorgan FHSA ex p Martin* (1993) 16 BMLR 81 (QBD) where the *Sidaway* decision was confirmed; Grubb, Andrew *Principles of Medical Law* (2nd ed) Oxford University Press 2004, 65 - 67.

[872] Grubb, Andrew *Principles of Medical Law* (2nd ed) Oxford University Press 2004, 65; Compare with Justice Sopinka's judgement in the case of *Norberg v Wynrib* (1992) 92 DLR (4th) 449, 453 par 129, and discussed in section 5.1. of this chapter.

[873] Grubb, Andrew *Principles of Medical Law* (2nd ed) Oxford University Press 2004, 65.

[874] *McInerney v MacDonald* (1992) 93 DLR (4th) 415 (SCC), 430.

[875] *Breen v Williams* [1996] HCA 57; (1996) CLR 71.

the medical practitioner's records.[876] Justices Dawson and Toohey held that duties of a fiduciary nature may be imposed upon a doctor, but that these duties are not confined to, nor cover the entire doctor-patient relationship. Dawson and Toohey could therefore not find any basis for finding that a fiduciary relationship between a doctor and patient carry with it a right of access on the part of a patient to medical records compiled by the doctor in relation to that patient.[877] Justices Gaudron and McHugh stated that there was no basis upon which the court could hold that such a fiduciary duty exists, as the appellant tried to impose fiduciary obligations on a class of relationship which has not traditionally been recognised as fiduciary in nature and which would significantly alter the already existing complex of legal doctrines governing the doctor-patient relationship, particularly in the areas of the law of contract and delict.[878] Justice La Forest's liberal point of view with regard to the fiduciary nature of the doctor-patient relationship and the extended scope of the beneficiary's rights and entitlements was not applied in this case.

The English case of *R v Mid-Glamorgan F.H.S.A., ex parte Martin*[879] involved the claim of a former psychiatric patient to examine records relating to his confinement in a mental hospital. The relevant health authority did not want to provide the patient with unlimited access to the records and agreed to disclose the records to a medical adviser nominated by the patient. This medical adviser would then determine what information could be released without endangering the patient or third parties involved. This judgement is in accordance with the judgement in the *McInerney*[880] case. In the *Mid-Glamorgan* case the fiduciary nature of the doctor-patient relationship was recognised and the duties of the fiduciary as well as the rights and entitlements of the patient were acknowledged. It was also stated that the right to access to information is not absolute and since the fiduciary duty is to act in the best interest of the patient, the refusal of such access to medical records may be justified under particular circumstances.[881]

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876 *Breen v Williams* [1996] HCA 57; (1996) CLR 71, para 16 and 17.
877 *Breen v Williams* [1996] HCA 57; (1996) CLR 71, para 14.
878 *Breen v Williams* [1996] HCA 57; (1996) CLR 71, para 14 and 15.
879 *Regina v Mid Glamorgan Family Health Services Authority and another ex parte Martin* [1995] 1 W.L.R. 110 (CA Civ Div).
880 *McInerney v MacDonald* (1992) 93 DLR (4th) 415 (SCC).
881 Bartlett, Peter Doctors as Fiduciaries: Equitable Regulations of the Doctor-Patient Relationship *Medical Law Review* Vol 5 (1997) 193 – 224, 205.

5.5. An evaluation of the doctor-patient relationship as a fiduciary relationship

> "*The foundation of the patient-physician relationship is the trust that physicians are dedicated first and foremost to serving the needs of their patients*."[882]

Many courts have recognised that the unique characteristics of the doctor-patient relationship show the hallmarks of fiduciary law and have consequently characterised the doctor-patient relationship as a fiduciary relationship. This relationship is a moral relationship built on trust, equality and respect, which also transcends the arms-length transactions of the general marketplace. In the case of *Lockett v Goodill*,[883] for example, the doctor-patient relationship was described as a fiduciary relationship of the highest degree, and involving every element of trust, confidence and good faith. The overall effect of such use of fiduciary principles in health service delivery, especially the doctor-patient relationship, is therefore to allow patients to trust their physicians, to entrust their welfare to physicians and to minimise the need to monitor physicians' behaviour in order to ensure that the patients' best interests are served.[884]

It is submitted that the doctor-patient relationship should be regarded as a fiduciary relationship, a special relationship attracting specific fiduciary principles and values. The main reason for this submission is that fiduciary duty analysis begins with a structure of inequality within which specific obligations are assessed, and this is especially necessary when dealing with unequal relationships like the doctor-patient relationship.[885] Traditionally, three classifications of fiduciaries exist: the fiduciary as advisor, the fiduciary as property holder and the fiduciary as representative.[886] Based on the analysis in this dissertation so far, it is evident that all three classifications are applicable to the doctor-patient relationship. Physicians advise patients on their health and appropriate treatment.

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[882] Council on Ethical and Judicial Affairs – American Medical Association; Johnston, Kim Patient Advocates or Patient Adversaries? Using Fiduciary Law to Compel Disclosure of Managed Care Financial Incentives *San Diego Law Review* Vol 35 (1998) 951 – 992, 963.

[883] *Lockett v Goodill* 430 P.2d 589 (Wash. 1967), 591.

[884] Mehlman, Maxwell J The patient-physician relationship in an era of scarce resources: Is there a duty to treat? *Connecticut Law Review* Vol 25 (1992 – 1993) 349 – 391, 369.

[885] Peppin, Patricia Power and Disadvantage in Medical Relationships *Texas Journal of Women and the Law* Vol 3 (Spring 1994) 221 – 263, 260; In *Magware v Minister of Health* 1981 (4) SA 472 (Z) 475A-B; 476G-H; 477A-B the court held that the contractual obligation flowing from taking on a patient is a 'special relationship' triggering a duty of care.

[886] Morreim, Haavi E Economic Disclosure and Economic Advocacy: New Duties in the Medical Standard of Care *Journal of Legal Medicine* 12, 275 – 329, 296.

In addition to this advisory capacity, physicians can also influence patients' money and property.[887] Physicians have power over the medical costs their patients incur, since they recommend diagnostic and therapeutic interventions and also control patients' access to medical institutions and interventions.[888] Finally, physicians may also, in particular circumstances, act on their patients' behalf and therefore act as a representative.[889]

However, not all scholars agree that the doctor-patient relationship is strictly a fiduciary relationship.[890] Some suggest that it should rather be viewed as a confidential relationship.[891] In a confidential relationship the person who claims that a trust, duty or loyalty has been breached or abused must show that he/she has in fact placed confidence in the other person and that this confidence has in fact been breached or abused.[892] This is contrary to the position in the fiduciary relationship where the fiduciary, and not the beneficiary, carries the burden of proof to show that he/she did not abuse or breach the beneficiary's confidence or trust. Considering the case law discussed in this and the previous chapters, it would seem that the courts prefer to view the doctor-patient relationship as a confidential rather than a fiduciary relationship, since the burden of proof always rests with the patient to prove that, for example, the physician did not provide all the material and relevant information pertaining to a particular treatment.

Justice McLachlin in the case of *Norberg v Wynrib* indicated that "*the foundation of the fiduciary relationship is conceptually distinct from the foundation of contract and delict, although the doctrines may overlap in their application*."[893] Utilising fiduciary law in medical case law will capture all the various facets of the doctor-patient relationship under one conceptual umbrella and may redress the imbalance of power between doctor and patient

[887] Morreim, Haavi E Economic Disclosure and Economic Advocacy: New Duties in the Medical Standard of Care *Journal of Legal Medicine* 12, 275 – 329, 297.
[888] Morreim, Haavi E Economic Disclosure and Economic Advocacy: New Duties in the Medical Standard of Care *Journal of Legal Medicine* 12, 275 – 329, 297.
[889] Morreim, Haavi E Economic Disclosure and Economic Advocacy: New Duties in the Medical Standard of Care *Journal of Legal Medicine* 12, 275 – 329, 298.
[890] Morreim, Haavi E Economic Disclosure and Economic Advocacy: New Duties in the Medical Standard of Care *Journal of Legal Medicine* 12, 275 – 329, 298.
[891] Morreim, Haavi E Economic Disclosure and Economic Advocacy: New Duties in the Medical Standard of Care *Journal of Legal Medicine* 12, 275 – 329, 298.
[892] Morreim, Haavi E Economic Disclosure and Economic Advocacy: New Duties in the Medical Standard of Care *Journal of Legal Medicine* 12, 275 – 329, 298.
[893] *Norberg v Wynrib* (1992) 92 DLR (4th) 449, 451.

where the law of delict or the law of contract fail to provide a fair solution. Fiduciary rules redress this imbalance of power in a number of ways:

- They limit the fiduciary's freedom of action by prohibiting the fiduciary from using superior power to take advantage from the beneficiary.
- They require the fiduciary to act in the beneficiary's best interest.
- While a physician may avoid liability under the law of delict by merely acting reasonably, the physician may still be liable for breach of his/her fiduciary duty if he/she did not act loyally.
- Where the beneficiary challenges the contractual agreement or other transactions with the fiduciary, the burden of justification is shifted from the challenging party to the fiduciary.
- The fiduciary may be required to do more than merely compensate the patient for the loss suffered as a result of a breach of a fiduciary duty, and may face punitive damages.[894]

These fiduciary rules stem from the information disparity between the parties, which generally also lowers the probability that a breach of duty will be detected. This is also true in the sphere of health service delivery where it is extremely difficult for a patient to identify and prove that a physician is acting disloyally.[895] Fiduciary rules like these respond by increasing the severity of the sanction to deter or undo breach of a fiduciary duty.[896] While fiduciary law will not replace the current legal framework of South African medical law (which is based on the law of delict and the law of contract) it will supplement it and impose acceptable standards of conduct on doctors in their dealings with patients.[897] Grubb submits that utilising fiduciary law in medical case law will also enable courts to give content to many of the entitlements which society intuitively feels patients should have but for which a legal basis is (still) missing.[898]

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[894] Mehlman, Maxwell J The patient-physician relationship in an era of scarce resources: Is there a duty to treat? *Connecticut Law Review* Vol 25 (1992 – 1993) 349 – 391, 368 – 369.

[895] The difficulties experienced with proving causation in medical negligence cases does not fall within the ambit of this dissertation.

[896] Mehlman, Maxwell J The patient-physician relationship in an era of scarce resources: Is there a duty to treat? *Connecticut Law Review* Vol 25 (1992 – 1993) 349 – 391, 369.

[897] Grubb, Andrew *Principles of Medical Law* (2nd ed) Oxford University Press 2004, 74; Bartlett, Peter Doctors as Fiduciaries: Equitable Regulations of the Doctor-Patient Relationship *Medical Law Review* Vol 5 (1997) 193 – 224, 212.

[898] Grubb, Andrew *Principles of Medical Law* (2nd ed) Oxford University Press 2004, 74; Harrington, John Law's Faith in Medicine *Medical Law International* Vol 9 (2008) 357 – 374.

Rodwin predicts that the law will continue to address strained physician loyalty within a fiduciary framework and will impose limits on or stretch the fiduciary metaphor to reconcile doctors' obligations towards patients with service to groups and society.[899] Bartlett agrees with this and suggests that rather than continuing a debate on whether or not the doctor-patient relationship is a fiduciary relationship, it would be more appropriate to consider what equitable obligations within the fiduciary framework already attach, or ought to attach, to the doctor-patient relationship in a medical context.[900] This line of thinking has been confirmed by various scholars who argue that it is inappropriate to think of the application of fiduciary relationships as a class, and that it should rather be viewed as special relationships attracting a specific group of fiduciary duties: "*One can question whether the doctor-patient relationship is fiduciary in itself, thus creating status-based fiduciary duties, or whether it is merely a relationship to which a variety of fact-based fiduciary duties attaches, but the practical question of the scope of doctors' equitable duties remains the same*."[901]

Compared to the situation in Canada and the USA, fiduciary law with regard to health service delivery in South Africa is largely underdeveloped.[902] However, it should be noted that in jurisdictions where the fiduciary nature of the doctor-patient relationship is recognised, contradicting judgements and the flagrant disregard of these legally imposed fiduciary duties persist.[903] Carstens and Pearmain contend that, given the approach of the South African courts to regard health service delivery strictly in terms of the law of contract, the latter is likely to remain this underdeveloped unless the legislature steps in.[904] But in the constitutional context in South Africa it is not too difficult to recognise, apply and develop fiduciary law principles in health care in both the public and private sector. The beneficiary in the public health sector holds the right of access to health care services including

[899] Rodwin, Marc A Strains in the Fiduciary Metaphor: Divided Physician Loyalties and Obligations in a Changing Health Care System *American Journal of Law and Medicine* Vol 21 (1995) 241 – 257, 242.
[900] Bartlett, Peter Doctors as Fiduciaries: Equitable Regulation of the Doctor-Patient Relationship *Medical Law Review* Vol 5 (1997) 193 – 224, 194.
[901] Bartlett, Peter Doctors as Fiduciaries: Equitable Regulation of the Doctor-Patient Relationship *Medical Law Review* Vol 5 (1997) 193 – 224, 195 - 197.
[902] Carstens, Pieter and Pearmain, Debbie *Foundational Principles of South African Medical Law* LexisNexis: Durban 2007, 320.
[903] Carstens, Pieter and Pearmain, Debbie *Foundational Principles of South African Medical Law* LexisNexis: Durban 2007, 320.
[904] Carstens, Pieter and Pearmain, Debbie *Foundational Principles of South African Medical Law* LexisNexis: Durban 2007, 320.

reproductive health care in terms of section 27(1) of the Constitution. The state's corresponding duty with regard to this entitlement, and according to the Constitution, is to protect, promote and fulfil this right. In health service delivery in the public sector, an analogy can thus be drawn between the position of a trustee and that of the state.[905] In the private health care sector in South Africa, where health care delivery is primarily viewed in terms of the law of contract, patients depend on the trust, knowledge, professionalism and skill of their physician, thus creating a fiduciary responsibility on the part of the latter.[906] Such added dimensions to contractual relationships are widely recognised and patients consequently have certain rights as a result of this special contractual relationship.[907] Carstens and Pearmain furthermore contend that in some instances, it is even possible for a fiduciary relationship to exist between providers of health related services and health practitioners due to the nature of the contractual relationship in terms of which the practitioner is provided with support services.[908]

Unfortunately, health professionals in South Africa seem to have lost sight of their historical roots with the Hippocratic ethic and the associated qualities and duties inherent in the dynamics of the doctor-patient relationship. "*The fierce resistance of dispensing doctors in South Africa to the legislative introduction of a system of licensing for dispensing doctors and other health professionals who wish to dispense medicine in a series of litigation against the government is a case in point.*"[909] The licensing scheme, introduced in sections 18 and 22C(1)(a) of the Medicines and Related Substances Act 101 of 1965, requires that health care providers, including medical practitioners such as dentists, not be permitted to dispense medicines unless they have been issued with a licence by the Director-General of

[905] Carstens, Pieter and Pearmain, Debbie *Foundational Principles of South African Medical Law* LexisNexis: Durban 2007, 320 - 321.
[906] Carstens, Pieter and Pearmain, Debbie *Foundational Principles of South African Medical Law* LexisNexis: Durban 2007, 321.
[907] Carstens, Pieter and Pearmain, Debbie *Foundational Principles of South African Medical Law* LexisNexis: Durban 2007, 321.
[908] Carstens, Pieter and Pearmain, Debbie *Foundational Principles of South African Medical Law* LexisNexis: Durban 2007, 321.
[909] Carstens, Pieter and Pearmain, Debbie *Foundational Principles of South African Medical Law* LexisNexis: Durban 2007, 337; *Affordable Medicines Trust and Others v Minister of Health of RSA and Another* 2005 (6) BCLR 529 (CC); *Affordable Medicines Trust and Others v Minister of Health of RSA and Another* [2004] 4 All SA 622 (T); *Pharmaceutical Manufacturers Assoc of SA (Assoc Inc in terms of Section 21) & another re ex Parte application of President of RSA the Honourable Dr NR Mandela NO & others* [1999] JOL 5291 (T); *Pharmaceutical Manufacturers Assoc of SA & another; In Re: Ex parte President of the RSA & others* 2000(3) BCLR 241 (CC).

the Department of Health.[910] The licensing scheme also regulates the premises from which medicines may be dispensed and ensures that dispensing health professionals are properly qualified. The objective of the scheme is to increase access to medicines that are safe for consumption. At its inception this scheme had obvious financial and practical implications for all dispensing practitioners. Health care providers also contended, *inter alia*, that the licensing scheme limited the choice of a profession, a right protected in section 22 of the Constitution.[911]

It is very unfortunate that the courts in the cases dealing with the licensing system for dispensing medical practitioners in South Africa did not mention or consider the unique culture of medical care and the special nature of health service delivery in general and the doctor-patient relationship in particular. They did not remind the medical profession of its altruistic and fiduciary obligations towards patients in general, nor did they elaborate sufficiently on how the licensing scheme will assist in promoting, protecting and fulfilling the rights in sections 27(1)(a)[912] and 27(3)[913] of the Constitution. In addition, if the courts had viewed these cases in terms of the fiduciary nature of the doctor-patient relationship, they would probably have recognised that there is a conflict of interest when medical practitioners dispense medicines. In no other "market environment" is it possible for a vendor to instruct a customer to purchase an item with such persuasive force and from such a position of power relative to the customer than in the environment of medical care and health service delivery.[914]

It is even more unfortunate that this example pertaining to the licensing system for dispensing medical practitioners in South Africa is not the only instance where the courts ignored the opportunity to develop fiduciary law principles in the context of health service delivery to promote, protect and fulfil the relevant rights of the Constitution. Development

[910] Also see section 52 of the Health Professions Act 56 of 1974.

[911] Section 22 of the Constitution provides: "*Every citizen has the right to choose their trade, occupation or profession freely. The practice of a trade, occupation or profession may be regulated by law*."

[912] Section 27(1)(a) stipulates that: "Everyone has the right to have access to (a) health care services, including reproductive health care;".

[913] Section 27(3) provides that "*no one may be refused emergency medical treatment*".

[914] Carstens and Pearmain state that the chances of a patient refusing to purchase medicine prescribed for him/her by a medical practitioner are very low; Carstens, Pieter and Pearmain, Debbie *Foundational Principles of South African Medical Law* LexisNexis: Durban 2007, 337.

of such principles is crucial to ensure that medical practitioners do not continue to use their patients as a human shield against the state to assist them in their attempts to circumvent legislation and to serve their self-interests.[915]

5.6. Conclusion

Fiduciary relationships and the doctor-patient relationship are extraordinary legal relationships because both involve the maintenance of high standards as well as special qualities like trust, vulnerability, confidence and loyalty. The fiduciary's duties are quite distinct from ordinary contractual obligations and delictual duties of care. They are also more extensive and complex since they focus on the benefit of a beneficiary while the fiduciary remains an altruistic party in the relationship. The conclusion arrived at in Chapter Four was that the doctor-patient relationship can not be regarded as an ordinary commercial relationship and that the ordinary principles of contractual and delictual liability cannot always be applied to the rather complex relationship between doctor and patient. Based on this conclusion, a possible expansion and development of existing fiduciary principles applicable to the doctor-patient relationship is both desirable and necessary to establish a more equal distribution of power in the doctor-patient relationship.

> *"A new model for the allocation of authority between doctors and patients is needed. Existing legal protection for medical patients' autonomy is more limited than has been recognised and more deficient than should be tolerated. Protection of patient autonomy remains derivative rather than direct, episodic rather than systematic. The subtlety of power-sharing in an ideal relationship between doctor and patient must be acknowledged. The law is not the only relevant tool for achieving such a relationship between doctor and patient. But ultimately the law is about line-drawing, and some basic division of authority is essential both for purposes of norm-setting and of dispute resolution."*[916]

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[915] Judge Ngoepe in the case of *Pharmaceutical Manufacturers Assoc of SA (Assoc Inc in terms of Section 21) & another re ex Parte application of President of RSA the Honourable Dr NR Mandela NO & others* [1999] JOL 5291 (T); Carstens, Pieter and Pearmain, Debbie *Foundational Principles of South African Medical Law* LexisNexis: Durban 2007, 337.

[916] Shultz, Marjorie Maguire From Informed Consent to Patient Choice: A New Protected Interest *Yale Law Journal* Vol 95, No 2 (December 1985) 219 – 299, 298 - 299.

While fiduciary law in theory provides a basis for consolidating the divergent aspects of the doctor-patient relationship and also ensures a more equal distribution of power in the relationship, its promise remains unfulfilled.[917] This is so because the courts have applied fiduciary principles to the doctor-patient relationship only in particular circumstances and for limited purposes. The legal treatment of the doctor-patient relationship therefore remains governed by different and sometimes conflicting legal doctrines.[918] In addition, the courts have not paid enough attention to the advantages of the power analysis that fiduciary law offers in the context of medical- and health law and the doctor-patient relationship. Such analysis has the ability to capture the dynamics of the doctor-patient relationship.[919] However, care needs to be taken to prevent this fiduciary model from becoming the archetypical paternalistic model discussed in Chapter Three. The fiduciary model as it stands does not capture the potential for autonomy in the doctor-patient relationship; it ignores the element of decision-making control with which the law empowers the patient, and it cedes too much power to the physician.[920] In the end, it seems as though the power imbalances in the doctor-patient relationship may be a problem of putting the question correctly, but still finding that the answer eludes us.[921]

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[917] Krause, Joan H Reconceptualising Informed Consent in an Era of Health Care Cost containment *Iowa Law Review* 85 (1999 -2000) 260 – 386, 275.

[918] Krause, Joan H Reconceptualising Informed Consent in an Era of Health Care Cost containment *Iowa Law Review* 85 (1999 -2000) 260 – 386, 275.

[919] Peppin, Patricia Power and Disadvantage in Medical Relationships *Texas Journal of Women and the Law* Vol 3 (Spring 1994) 221 – 263, 261.

[920] Peppin, Patricia Power and Disadvantage in Medical Relationships *Texas Journal of Women and the Law* Vol 3 (Spring 1994) 221 – 263, 262.

[921] "*Putting the question correctly is one thing, finding the answer to it is something different*" Attributed to Anton Chekhov.

PART C

Present important developments in the arena of health service delivery and medical practice will form the foundation of the discussion in this final part. It is important to take note of these general developments and how it influences the doctor-patient relationship and the power imbalances inherent in the relationship in particular.

Chapter 6: The doctor-patient relationship in an era of managed care

Chapter 7: Consumerism and the doctor-patient relationship

CHAPTER SIX: The doctor-patient relationship in an era of managed care

6.1. The history and development of managed care in health service delivery

6.2. The influence of managed care practices on the doctor-patient relationship

6.2.1. Access to health care

6.2.2. The new role of the physician in the doctor-patient relationship

6.2.3. Trust in the doctor-patient relationship and trust in managed care institutions

6.2.4. Informed consent in an era of managed care

6.2.5. Patient advocacy in an era of managed care

6.3. Conclusion

In Chapter Four it was shown that the health care sector is progressively being organised and controlled in a manner similar to that found in the corporate environment, with competitiveness, major technological advances, impersonal relations and industrialisation as prime forces. The health care sector is at present also defined by notions of managed care and consumerism.[922] Health service delivery as a multi-complex, multi-party operation, can therefore not be regarded solely within the paradigm of the individual doctor-patient relationship. It is also necessary to consider the power imbalances in the doctor-patient relationship in the context of the current multi-organisational mode of health service delivery particularly since the institution-patient relationship (as opposed to the doctor-patient relationship) and its ethical foundations have not been analysed sufficiently in research on managed care practices.[923] A better understanding of the institution-patient relationship is needed, as patients now spend more time talking to institutional representatives about their health and treatment options than ever before. In addition, young medical practitioners are also being socialised and professionalised into the managed care ideology and, not having experienced any other form of medicine, they are unaware of

[922] Stoeckle, John D Reflections on Modern Doctoring: Introduction *The Milbank Quaterly* Volume 66 Supplement 2: The changing character of the medical profession (1988) 76 – 91 ; Light, Donald & Levine, Sol The changing character of the Medical Profession: A Theoretical Overview *The Milbank Quaterly* Volume 66, Supplement 2: The changing character of the medical profession (1988) 10 -32 ; Jacobi, John V After Managed Care: Gray Boxes, Tiers and Consumerism *Saint Louis University Law Journal* Volume 47 (2003) 397 – 410; Carstens, P & Pearmain, D *Foundational Principles of Medical Law* LexisNexis 2007, 245.

[923] Peppin, John F Business Ethics and Health Care: The Re-Emerging Institution-Physician Relationship *Journal of Medicine and Philosophy* Vol 24, No 5 (1999) 535 – 550, 536.

many of the general ethical concepts and principles historically attached to the medical profession and described in Chapter Two.

"*Put most simply, managed care is a form of health insurance that combines, in some form or another, the financing aspects of health insurance with clinical decision-making*."[924] In South Africa, the Medical Schemes Act[925] defines managed health care as "*clinical and financial risk assessment and management of health care, with a view to facilitating appropriateness and cost-effectiveness of relevant health services within the constraints of what is affordable, through the use of rules-based and clinical management-based programmes*."[926] Managed health care is best described as a management process instituted once contractual arrangements between health care consumers and health care providers take effect.[927] Its most important characteristic is that funders have more influence over the provision of health care services through intensive auditing and management systems.[928] Under managed health care, enrolled members or their employers pay a set monthly premium to a plan or fund. The plan or fund then contracts with selected providers and facilities who agree to provide a comprehensive package of health care services to members for a predetermined price.[929]

In 1995 Cardinal Joseph Bernardin, the Archbishop of Chicago, correctly stated that managed care attacks the moral centre of the doctor-patient relationship. Health maintenance organisations interfere and constrain the doctor-patient relationship, making

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[924] Parmet, Wendy E Unprepared: why Health Law Fails to Prepare us for a Pandemic *Journal of Health and Biomedical Law* Vol 2 (2006) 157 – 193, 179. "*A managed health care plan is a health insurance programme in which an administrative entity attempts to control patient access to health care providers and provider services in order to contain costs*." Mehlman, Maxwell J The Patient-Physician Relationship in an era of Scarce Resources: Is there a duty to treat? *Connecticut Law Review* Vol 25, 349 – 391, 349; "Managed Care can be defined as an organised system of care that seeks to influence the selection and utilisation of health services (including preventive care) of an enrolled population and ensures that care is provided in a high quality, cost-effective manner." Goldsmith, Seth B *Managed Care* Aspen Publication 1995, 3.

[925] Medical Schemes Act 131 of 1998.

[926] See Medical Schemes Act 131 of 1998, Regulations Chapter Five.

[927] Kinghorn, Anthony The Centre for Health Policy The development of Managed Health Care in South Africa What are the Implications? Centre for Health Policy, Department of Community Health, University of the Witwatersrand, Paper No 39, (November 1994), 10.

[928] Kinghorn, Anthony The Centre for Health Policy The development of Managed Health Care in South Africa What are the Implications? Centre for Health Policy, Department of Community Health, University of the Witwatersrand, Paper No 39, (November 1994), 10 – 11.

[929] Kinghorn, Anthony The Centre for Health Policy The development of Managed Health Care in South Africa What are the Implications? Centre for Health Policy, Department of Community Health, University of the Witwatersrand, Paper No 39, (November 1994), 11.

the two parties in this relationship no longer accountable to each other, "*...all the while standing back and claiming that they [health maintenance organisations] have nothing to do with medical decisions*."[930] While the reality of economics as a constraint on medicine is not denied in this chapter, the discussion will aim rather to examine how economics should relate to medical ethics in an era of managed care with due regard to the unique dynamics of the doctor-patient relationship. The legal issues involved in managed care are countless and complex. Only the specific themes in managed care that are relevant to the dissertation will therefore be dealt with in this chapter. It is also problematic to do a legal comparative analysis in respect of managed care, since legislation pertaining to medical schemes and managed care organisations is based on the unique health care system in each country or state and differs greatly from jurisdiction to jurisdiction.[931] In this chapter, as before, the focus will be on the universal qualities pertaining to the doctor-patient relationship; qualities independent of a particular setting, and relevant to all doctor-patient relationships in modern, western medicine.

Section 6.1. will provide a brief exposition of the history and development of managed care in health service delivery and will clarify the most important terms and practices of managed care. In section 6.2. the influence of managed health care practices on the doctor-patient relationship will be considered. The section will commence with a general discussion on the different relationships in managed health care. In the sub-sections the particular arguments pertaining to the power imbalances and the doctor-patient relationship will be assessed against the background of managed care. The chapter will conclude with some recommendations and general comments on the power imbalances in the doctor-patient relationship identified in the context of managed health care.

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[930] Hiepler, Mark O & Dunn, Brian C Irreconcilable Differences: Why the doctor-patient relationship is disintegrating at the hands of Health Maintenance Organisations and Wall Street *Pepperdine Law Review* Vol 25 (1998) 597 – 616, 597.

[931] For a comprehensive discussion on the law of medical schemes in South Africa see Pearmain, DL *The Law of Medical Schemes in South Africa* JUTA 2008.

6.1. The history and development of managed care in health service delivery

With the rise of the modern hospital in the early 1900s, as well as the advances made in medical science and technology, the medical profession continued to protect the profession's autonomy and economic independence, opposing the notion that medical practitioners are ordinary employees in a medical marketplace.[932] However, the perception about hospitals and their role as capital support and technical provider of health care services also changed: hospitals were increasingly regarded as institutions where medical practitioners could use the management, infrastructure and technology, capitalised by hospitals, to provide a better standard of care.[933] Consequently, the role of medical practitioners in health service delivery shifted from direct providers to co-ordinators of the production of complex services, using the resources provided by hospitals.[934] Concomitant to these developments in the early 1900s, pre-payment schemes for the provision of health care services were also introduced. "*The pooling of funds made it possible for people to create a form of financial and healthcare security, and to spread their financial burden over a period, thus making it an attractive and viable arrangement*."[935]

In the USA, the passing of the Health Maintenance Act in 1973 marked the official recognition of managed care as a new system of affordable quality health care in that country.[936] From 1973 to 1987 the number of health maintenance organisations increased from seventy-two to more than 700.[937] In South Africa, the first medical scheme was established in 1889 by the De Beers Mining Company.[938] The number of schemes had increased to seven by 1910 and by the beginning of the Second World War there were forty-

[932] See Chapter Four for a discussion of the business model of health service delivery.

[933] Esser, Jan Hendrik *Who cares? Moral reflections on business in healthcare* Thesis presented in partial fulfillment of the requirements for the degree M Phil (Applied Ethics) Stellenbosch University, March 2001 (Supervisor: Prof AA van Niekerk), 7.

[934] Esser, Jan Hendrik *Who cares? Moral reflections on business in healthcare* Thesis presented in partial fulfillment of the requirements for the degree M Phil (Applied Ethics) Stellenbosch University, March 2001 (Supervisor: Prof AA van Niekerk), 7.

[935] Esser, Jan Hendrik *Who cares? Moral reflections on business in healthcare* Thesis presented in partial fulfillment of the requirements for the degree M Phil (Applied Ethics) Stellenbosch University, March 2001 (Supervisor: Prof AA van Niekerk), 8.

[936] Jendusa, Jennifer M The denial of benefits quandary and managed care: McGraw v Prudential Insurance Company *DePaul Journal of Health Care Law* (1999) Vol 3 115 – 142, 121.

[937] Armitage, Jamie Lynn Case Note: Pegram v Herdrich: HMO Physicians as Fiduciaries *DePaul Journal of Health Care Law* (2002) Vol 5, 341 – 205, 343.

[938] Jost, Timothy Stoltzfus Consumer-driven Health Care in South Africa: Lessons from Comparative Health Policy Studies *Journal of Health and Biomedical Law* (2005) 83 – 109, 96.

eight.[939] These schemes were created by mutual societies and membership was employment based and exclusively for white employees.[940] By the late 1960s about 80% of whites in South Africa belonged to a medical scheme.[941] Legislation in the form of the Medical Schemes Act, regulating the relationship between health care providers and medical schemes, was introduced, as well as extensive government regulation with the Council of Medical Schemes and the Registrar of Medical Schemes.[942]

The European definition of managed care is "*...a process to maximise health gain of a community within limited resources by ensuring an appropriate range and level of services are provided and by monitoring on a case by case basis to ensure continuous improvements to meet national targets for health and individual needs*".[943] This definition and rationale differs from the South African and American points of view as it promotes a community perspective and is seen as a joint task of policy makers, purchasers, providers and receivers of medical care.[944] European health care systems also differ in the way that they set health care priorities, which affects the extent and choice of managed care practices being implemented in their systems.[945] The NHS of the United Kingdom also shows important features of managed care and actively pursues managed care initiatives like clinical protocols and standardised guidelines.[946] In Europe, Germany was the first to introduce *Krankenkassen* ("sick funds") and it is said that the above average health service delivery available in Germany directly after they lost the Second World War and had to battle with

[939] Esser, Jan Hendrik *Who cares? Moral reflections on business in healthcare* Thesis presented in partial fulfillment of the requirements for the degree M Phil (Applied Ethics) Stellenbosch University, March 2001 (Supervisor: Prof AA van Niekerk), 8.
[940] Esser, Jan Hendrik *Who cares? Moral reflections on business in healthcare* Thesis presented in partial fulfillment of the requirements for the degree M Phil (Applied Ethics) Stellenbosch University, March 2001 (Supervisor: Prof AA van Niekerk), 8.
[941] Esser, Jan Hendrik *Who cares? Moral reflections on business in healthcare* Thesis presented in partial fulfillment of the requirements for the degree M Phil (Applied Ethics) Stellenbosch University, March 2001 (Supervisor: Prof AA van Niekerk), 9.
[942] Medical Schemes Act 72 of 1967; Esser, Jan Hendrik *Who cares? Moral reflections on business in healthcare* Thesis presented in partial fulfillment of the requirements for the degree M Phil (Applied Ethics) Stellenbosch University, March 2001 (Supervisor: Prof AA van Niekerk), 9.
[943] Fairfield, Gillian Managed Care: Origins, Principles and evolution *British Medical Journal* (1997) 314, 1823.
[944] Fairfield, Gillian Managed Care: Origins, Principles and evolution *British Medical Journal* (1997) 314, 1823.
[945] Fairfield, Gillian Managed Care: Origins, Principles and evolution *British Medical Journal* (1997) 314, 1823.
[946] Fairfield, Gillian Managed Care: Origins, Principles and evolution *British Medical Journal* (1997) 314, 1823.

famine and a revolution, was to a large extent, responsible for the relatively good health conditions that existed.[947]

Insurance coverage was and is still provided by either fee-for-service plans or health maintenance organisations (HMO). Fee-for-service plans function as a financial intermediary between individual members, who pay a periodic premium, and the health care providers. Patients covered by a fee-for-service plan normally pay medical practitioners themselves and then claim reimbursement from the insurance company.[948] Health maintenance organisations, on the other hand, finance and deliver a broad range of health care services to their members through money acquired by means of premiums paid by their members.[949] Health maintenance organisations have an obligation to ensure that all their members have access to the services covered by the HMO and that the standard and quality of care is at an acceptable level.[950]

The development of these medical schemes and health insurance plans severed the link between medical treatment and its cost in the minds of patients and providers. In the medical decision-making process, doctors and patients were mostly unaware of the total cost to the medical scheme or insurance plan of providing the medical services patients needed and those they received. And if there was an awareness of cost, it was mostly perceived as irrelevant.[951] This state of affairs encouraged medical practitioners to render any service that was potentially beneficial to the patient and this form of health care

[947] Sigerist, Henry E The Physician's Profession through the ages *Bulletin of the New York Academy of Medicine* Vol IX, No 12 (1933) 661 – 676, 674.
[948] Esser, Jan Hendrik *Who cares? Moral reflections on business in healthcare* Thesis presented in partial fulfillment of the requirements for the degree M Phil (Applied Ethics) Stellenbosch University, March 2001 (Supervisor: Prof AA van Niekerk), 9.
[949] Esser, Jan Hendrik *Who cares? Moral reflections on business in healthcare* Thesis presented in partial fulfillment of the requirements for the degree M Phil (Applied Ethics) Stellenbosch University, March 2001 (Supervisor: Prof AA van Niekerk), 10.
[950] Esser, Jan Hendrik *Who cares? Moral reflections on business in healthcare* Thesis presented in partial fulfillment of the requirements for the degree M Phil (Applied Ethics) Stellenbosch University, March 2001 (Supervisor: Prof AA van Niekerk), 10.
[951] Esser, Jan Hendrik *Who cares? Moral reflections on business in healthcare* Thesis presented in partial fulfillment of the requirements for the degree M Phil (Applied Ethics) Stellenbosch University, March 2001 (Supervisor: Prof AA van Niekerk), 10.

provision became the norm.[952] As it became increasingly possible to have access to health care services through such insurance based funding, more funding became available for medical research and development. Funding through government expenditure and private investments for superior technology and advanced health care facilities were regarded as good investments in this fast growing medical marketplace.[953] This, together with a growing elderly population and increasing public expectations with regard to health service possibilities, resulted in the cost of health care services escalating rapidly.[954] What followed was the implementation of cost-containment practices in response to the escalating cost of health care services. These cost-containment practices have influenced the whole health care system, as well as some of the most fundamental principles on which the system had relied.[955]

Examples of cost-containment practices to restrain the escalating cost of health care services include:

- fund organisations specifically aimed to serve only a particular group of people, like the poor or elderly;
- practices that place restrictions on certain forms of medical treatment and interventions;
- higher co-payments;
- reduced benefits;
- prospective payment plans with contracted, preferred providers; and
- strict scrutiny of medical bills, payable to providers or members, for possible unwarranted claims.[956]

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[952] Esser, Jan Hendrik *Who cares? Moral reflections on business in healthcare* Thesis presented in partial fulfillment of the requirements for the degree M Phil (Applied Ethics) Stellenbosch University, March 2001 (Supervisor: Prof AA van Niekerk), 10.

[953] Esser, Jan Hendrik *Who cares? Moral reflections on business in healthcare* Thesis presented in partial fulfillment of the requirements for the degree M Phil (Applied Ethics) Stellenbosch University, March 2001 (Supervisor: Prof AA van Niekerk), 11.

[954] Sorresso, Eleanor Bhat A Philosophy of Privatisation: Rationing Health Care Through the Medicare Modernisation Act of 2003 *Journal of Law and Health* Vol 21, No 1 (2007-8) 29 – 44, 32.

[955] Esser, Jan Hendrik *Who cares? Moral reflections on business in healthcare* Thesis presented in partial fulfillment of the requirements for the degree M Phil (Applied Ethics) Stellenbosch University, March 2001 (Supervisor: Prof AA van Niekerk), 13 - 14.

[956] Esser, Jan Hendrik *Who cares? Moral reflections on business in healthcare* Thesis presented in partial fulfillment of the requirements for the degree M Phil (Applied Ethics) Stellenbosch University, March 2001 (Supervisor: Prof AA van Niekerk), 14.

Prospective reimbursement programmes were also implemented by government organisations as a cost-containment initiative and allowed health care providers to be paid a calculated, average sum for prospective services and capital expenditures in advance.[957] Health care providers receiving such advance payments consequently needed to exercise greater control over the utilisation of their assets and services in order to ensure that their operations were more cost effective.[958] In an attempt to contain the escalating cost of health service delivery, prospective reimbursement programmes also placed medical practitioners at financial risk for the care they delivered to patients.[959] The effect of these programmes was twofold: The economic incentive of the providers of health care services shifted from the idea that doing more for the patient meant more revenue and profits to the idea that doing less for the patient meant more profit. In addition, medical practitioners still remained in a position to decide what medical care and treatment their patients needed, and they therefore still had a high degree of control over the costs incurred by hospitals for the care of patients.[960]

In 1969, President Richard Nixon referred to the effect of the escalating cost of health care as the "health crisis". This "health crisis", together with the implementation of the cost-containment strategies described above, and the new organisational mode of health service delivery (where practitioners act as co-ordinators of the production of complex services, using the resources provided by hospitals) resulted in a new relationship between health service providers and the health insurance companies, called managed care.[961] Managed

[957] Esser, Jan Hendrik *Who cares? Moral reflections on business in healthcare* Thesis presented in partial fulfillment of the requirements for the degree M Phil (Applied Ethics) Stellenbosch University, March 2001 (Supervisor: Prof AA van Niekerk), 15.
[958] Esser, Jan Hendrik *Who cares? Moral reflections on business in healthcare* Thesis presented in partial fulfillment of the requirements for the degree M Phil (Applied Ethics) Stellenbosch University, March 2001 (Supervisor: Prof AA van Niekerk), 15.
[959] Emanuel, Ezekiel J Medical Ethics in the Era of Managed Care: The Need for Institutional Structures Instead of Principles for Individual Cases *The Journal of Clinical Ethics* Vol 6, No 4, (1995) 335 – 338, 336.
[960] Esser, Jan Hendrik *Who cares? Moral reflections on business in healthcare* Thesis presented in partial fulfillment of the requirements for the degree M Phil (Applied Ethics) Stellenbosch University, March 2001 (Supervisor: Prof AA van Niekerk), 15.
[961] Wolf, Susan Toward a Systemic Theory of Informed Consent in Managed Care Houstan Law Review Vol 35 (1999) 1631 – 1681, 1642; Esser, Jan Hendrik *Who cares? Moral reflections on business in healthcare* Thesis presented in partial fulfillment of the requirements for the degree M Phil (Applied Ethics) Stellenbosch University, March 2001 (Supervisor: Prof AA van Niekerk), 14 & 16; Emanuel, Ezekiel J Medical Ethics in the Era of Managed Care: The Need for Institutional Structures Instead of Principles for Individual Cases *The Journal of Clinical Ethics* Vol 6, No 4, (1995) 335 – 338; Field, Mark G The Doctor-Patient Relationship in the Perspective

care refers not only to medical aid schemes and other health insurance plans but also to organisations that combine the functions of health provider and insurer. The underlying concept of managed care is a system of health care that aims to constrain the medical practitioner's management of care in order to achieve some stated purpose. This purpose may take many forms, for example, the containment of costs, the welfare of society or making profit.[962] Managed care, therefore, represents attempts to control costs by modifying the behaviour of medical practitioners, although it may do so in different ways.[963]

In South Africa, managed care did not feature until the late 1990s, as legislation in the 1980s and early 1990s prohibited any differentiation between risk-related differences of members. Moreover, schemes were required to cover a minimum level of reimbursements for all its members.[964] By the late 1990s, however, the escalating cost of health care together with the implementation of cost-containment strategies also led to some deregulation of the medical schemes industry in South Africa, namely the removal of risk-rating for premiums and minimum benefit stipulations. The first real possibility for managed health care in South Africa came in 1994 when further deregulation allowed for contracting and vertical integration between health care providers and medical schemes.[965]

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of "Fee-for-Service" and "Third-Party" Medicine Journal of Health and Human Behaviour Vol 2, No 4 (1961) 252 – 262.

[962] "*Managed care refers to a variety of methods of financing and organising the delivery of comprehensive health care in which an attempt is made to control costs by controlling the provision of services*."; Iglehart, John K Physicians and the growth of Managed Care *New England Journal of Medicine* Vol 331, Issue 17 (1994) 1167 – 1171; Pellegrino, Edmund D Managed Care at the Bedside: How do we look in the Moral Mirror? *Kennedy Institute of Ethics Journal* Vol 7, No 4 (1997) 321 – 330, 332.

[963] Iglehart, John K Physicians and the growth of Managed Care *New England Journal of Medicine* Vol 331, Issue 17 (1994) 1167 – 1171; Cerminara, Kathy L The Class Action suit as a method of Patient Empowerment in the Managed Care setting *Americal Journal of Law and Medicine* Vol 24 (1998) 7 – 58, 13.

[964] Esser, Jan Hendrik *Who cares? Moral reflections on business in healthcare* Thesis presented in partial fulfillment of the requirements for the degree M Phil (Applied Ethics) Stellenbosch University, March 2001 (Supervisor: Prof AA van Niekerk), 17.

[965] For a complete discussion on the development of managed health care in South Africa see Kinghorn, Anthony The Centre for Health Policy The development of Managed Health Care in South Africa What are the Implications? Centre for Health Policy, Department of Community Health, University of the Witwatersrand, Paper No 39, (November 1994); Esser, Jan Hendrik *Who cares? Moral reflections on business in healthcare* Thesis presented in partial fulfillment of the requirements for the degree M Phil (Applied Ethics) Stellenbosch University, March 2001 (Supervisor: Prof AA van Niekerk), 17.

This development in health service delivery heralded a profound shift in thinking about health care delivery.[966] Instead of the individual patient, the unit of analysis became the patient population of the managed care organisation.[967] The medical practitioner was no longer regarded as the health care provider. Instead it was the managed care organisation that provided the health care service. Success was measured by aggregate health indices and not individual encounters with patients, and medical practitioners increasingly left their solo practices to contract with a managed care organisation as employees of such organisations.[968] The basic values underlying the success and survival of business organisations also became relevant in health service delivery, including the pursuit of profit or commercial interest, as well as the associated ideals of efficiency and competitive behaviour.[969] These changes obviously also influenced bio-ethics, which is based on individual rights, as well as the dyadic obligations in the doctor-patient relationship.[970]

The original allure and objectives of managed care can be summarised as follows: Managed care

- has as its aim to guarantee patients access to a wide range of health care services at a standardised price and with nominal co-payment;
- emphasises "wellness" and preventative services;
- gives health care providers incentives as the means of
- providing health care in the most cost effective manner.[971]

[966] Wolf, Susan Toward a Systemic Theory of Informed Consent in Managed Care *Houston Law Review* Vol 35 (1999) 1631 – 1681, 1643.

[967] According to the Medical Schemes Act 131 of 1998, Regulations Chapter 5, a managed health care organisation refers to a person who has contracted with a medical scheme in terms of regulation 15A to provide a managed health care service. From 1 January 2004 only persons who have been accredited by the Council of Medical Schemes as managed health organisations may contract with medical schemes to provide a managed health care service.

[968] Wolf, Susan Toward a Systemic Theory of Informed Consent in Managed Care *Houstan Law Review* Vol 35 (1999) 1631 – 1681, 1643; Emanuel, Ezekiel J Medical Ethics in the Era of Managed Care: The Need for Institutional Structures Instead of Principles for Individual Cases *The Journal of Clinical Ethics* Vol 6, No 4, (1995) 335 – 338; Pellegrino, Edmund D Managed Care at the Bedside: How do we look in the Moral Mirror? *Kennedy Institute of Ethics Journal* Vol 7, No 4 (1997) 321 – 330, 324.

[969] Esser, Jan Hendrik *Who cares? Moral reflections on business in healthcare* Thesis presented in partial fulfillment of the requirements for the degree M Phil (Applied Ethics) Stellenbosch University, March 2001 (Supervisor: Prof AA van Niekerk), 61.

[970] Wolf, Susan Toward a Systemic Theory of Informed Consent in Managed Care *Houston Law Review* Vol 35 (1999) 1631 – 1681, 1644.

[971] Katz, Jay *The Silent World of Doctor and Patient* John Hopkins University Press: Baltimore 2002 (Originally published in 1984) xvi.

This is a brief and simplified exposition of the history and development of managed health care.[972] This dissertation will not consider managed care as a development in health service delivery in its totality, its advantages, negative consequences, whether it will deprofessionalise the medical profession. Since the main focus of this dissertation is the power imbalances in the doctor-patient relationship, only those aspects of managed care relevant to the legal analysis of these power imbalances have been discussed.

6.2. The influence of managed care practices on the doctor-patient relationship

Presently there is an array of organisations and corporations that implement variations of managed care policies.[973] These institutions all use basic cost-containment and managed health care strategies that influence the way in which different parties relate to one another.[974] The health maintenance organisation (HMO) is the most common managed care organisation.[975] Five basic HMO models are relevant to this discussion:[976]

- The HMO staff model: Medical practitioners are employed by the HMO on a salaried basis with bonus and incentive schemes. The staff model provides a full service for its members and does not usually make use of medical practitioners who are not employees. Where employee practitioners are unable to provide a specific service, the HMO has a contract with other service providers to perform the task for their members. Employee practitioners practise in contracted

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[972] For a detailed discussion on the origin and history of managed care see: Friedman, E Capitation, Integration and Managed Care: Lessons from early experiments *Journal of the American Medical Association* (1996) Vol 275, No 12, 957 – 962.

[973] Esser, Jan Hendrik *Who cares? Moral reflections on business in healthcare* Thesis presented in partial fulfillment of the requirements for the degree M Phil (Applied Ethics) Stellenbosch University, March 2001 (Supervisor: Prof AA van Niekerk), 18.

[974] Esser, Jan Hendrik *Who cares? Moral reflections on business in healthcare* Thesis presented in partial fulfillment of the requirements for the degree M Phil (Applied Ethics) Stellenbosch University, March 2001 (Supervisor: Prof AA van Niekerk), 18.

[975] Other managed care organisations include the preferred provider organisation (PPO), exclusive provider organisations (EPO), point-of-service plans, indemnity insurance organisations and managed care overlapping with indemnity insurance schemes.; Esser, Jan Hendrik *Who cares? Moral reflections on business in healthcare* Thesis presented in partial fulfillment of the requirements for the degree M Phil (Applied Ethics) Stellenbosch University, March 2001 (Supervisor: Prof AA van Niekerk), 18 & 23 - 24.

[976] *"...by the late 1940's the first large scale HMO was developed by Dr Sidney Garfield in collaboration with Heny Kaiser*."; Brennan, Troyen *Just Doctoring: Medical Ethics in the Liberal State* Berkeley: University of California Press (1991) 212.

hospitals and/or other contracted facilities. If HMO members make use of non-contracted practitioners or facilities, the HMO will not pay.[977]

- The HMO group model: This HMO does not employ medical practitioners as employees, but contracts with a group practice. Medical practitioners are employed by a group practice and may only provide services to that particular HMO (captive group) or provide services to various organisations and corporations (independent group). Reimbursement for services is made on a capitation[978] or cost basis.[979]
- The network model: This HMO contracts with a range of group practices and/or primary care physicians, each providing different services to the members of the HMO. The HMO may contract with a limited number of group practices (closed panel plan) or with any physician or group practice that meets the HMO's criteria (open panel plan).[980]
- The individual practice association (IPA) is an open plan model with medical practitioners practising independently, but also as members of an association. The IPA is a separate entity that negotiates on behalf of its members and may contract with HMOs. The IPA is reimbursed for the collective services rendered by all the

[977] The staff model and the group model are the earliest forms of managed care organisations.; Dudley, Adams R & Luft, Harold S Managed Care in Transition *New England Journal of Medicine* Vol 344, Issue 14 (2001) 1087 – 1092; Esser, Jan Hendrik *Who cares? Moral reflections on business in healthcare* Thesis presented in partial fulfillment of the requirements for the degree M Phil (Applied Ethics) Stellenbosch University, March 2001 (Supervisor: Prof AA van Niekerk), 18 – 19; Pellegrino, Edmund D Managed Care at the Bedside: How do we look in the Moral Mirror? *Kennedy Institute of Ethics Journal* Vol 7, No 4 (1997) 321 – 330, 324; Relman, Arnold S Controlling Costs by Managed Competition – Would it work? *New England Journal of Medicine* Vol 328, Issue 2 (1993) 133 – 135.

[978] "*Capitation is a reimbursement system where a fixed amount is paid for contracted services to members of an HMO or members of other managed care organisations.* Three aspects of capitation are of importance. *Firstly, specific services rendered are for a specific period for a predetermined fee. Second, reimbursements are for a determinable patient, and lastly, the provider bears the risk that the cost of care can exceed the prepaid amount.*"; Also see the definition of capitation agreements in the Medical Schemes Act 131 of 1998, Regulations Chapter 5: "*A capitation agreement means an arrangement entered into between a medical scheme and a person whereby the medical scheme pays to such person a pre-negotiated fixed fee in return for the delivery or arrangement for the delivery of specified benefits to some or all of the members of the medical scheme.*"; Esser, Jan Hendrik *Who cares? Moral reflections on business in healthcare* Thesis presented in partial fulfillment of the requirements for the degree M Phil (Applied Ethics) Stellenbosch University, March 2001 (Supervisor: Prof AA van Niekerk), 19.

[979] Esser, Jan Hendrik *Who cares? Moral reflections on business in healthcare* Thesis presented in partial fulfillment of the requirements for the degree M Phil (Applied Ethics) Stellenbosch University, March 2001 (Supervisor: Prof AA van Niekerk), 19.

[980] Esser, Jan Hendrik *Who cares? Moral reflections on business in healthcare* Thesis presented in partial fulfillment of the requirements for the degree M Phil (Applied Ethics) Stellenbosch University, March 2001 (Supervisor: Prof AA van Niekerk), 19.

medical practitioners, normally on a capitation basis. Because the IPA has a broad physician membership, a broad choice of health care services is available to its members, but the HMO also has less control over the direct health care providers than in the previous three models.[981]

- The direct contract model: This HMO contracts directly with individual physicians to provide health care services to its members. This model has a broad physician base and the HMO members therefore have a broad choice of service providers and health care services. While this plan may be more attractive to prospective members, the HMO carries the highest financial risk in this model compared to the others, since the HMO can not transfer any of the potential risks to the contracted medical practitioners. In this model, the HMO has the advantage that they are in a much stronger bargaining position than the medical practitioners, but the practitioners, on the other hand, enjoy a higher degree of independence.[982]

New cost-containment strategies in these HMO health care plans also include incentives for members who contain their own health care expenses. Examples are: savings account systems, leisure and lifestyle benefits, financial benefits obtained in the form of rewards, health and fitness programmes to improve health, preventative healthcare, medical advice hotlines, special disease programmes and proactive management programmes for specific diseases like HIV/AIDS.[983]

Another type of managed care organisation important for this discussion is a medical joint ventures which is a business agreement between investors, medical practitioners and a health care facility, with a direct or indirect working relationship between the latter two parties.[984] All the parties in this relationship share the collective financial risks and profits of

[981] Esser, Jan Hendrik *Who cares? Moral reflections on business in healthcare* Thesis presented in partial fulfillment of the requirements for the degree M Phil (Applied Ethics) Stellenbosch University, March 2001 (Supervisor: Prof AA van Niekerk), 20.

[982] Esser, Jan Hendrik *Who cares? Moral reflections on business in healthcare* Thesis presented in partial fulfillment of the requirements for the degree M Phil (Applied Ethics) Stellenbosch University, March 2001 (Supervisor: Prof AA van Niekerk), 20.

[983] Esser, Jan Hendrik *Who cares? Moral reflections on business in healthcare* Thesis presented in partial fulfillment of the requirements for the degree M Phil (Applied Ethics) Stellenbosch University, March 2001 (Supervisor: Prof AA van Niekerk), 23.

[984] Esser, Jan Hendrik *Who cares? Moral reflections on business in healthcare* Thesis presented in partial fulfillment of the requirements for the degree M Phil (Applied Ethics) Stellenbosch University, March 2001 (Supervisor: Prof AA van Niekerk), 24.

the health care services provided. As a result, the medical practitioners within this partnership have a responsibility to refer patients to other practitioners within the partnership, excluding practitioners from competing facilities.[985] Medical practitioners are also stakeholders in this partnership, and become part of the managed care plan, that is, the corporate identity.[986] Patients consequently lose medical practitioners' advocacy in this system, since practitioners are unlikely to advocate a patient's case against their own interests.[987]

Cost-containment and managed health care strategies in health service delivery, as well as managed care organisations like HMOs and medical joint ventures have come a long way since the historical concept of health service delivery, the traditional doctor-patient relationship, and the lone physician with his black bag making house calls described in Chapter Two. The discussion will now turn to an analysis of how these developments in health service delivery have influenced the doctor-patient relationship, specifically with regard to the distribution of power.

6.2.1. Access to health care

For-profit organisations like managed health care organisations may create a moral conflict with the social and constitutional obligations underpinning the general right of access to health care, as well as the concomitant principle of justice in health care.[988] Access to health care is obstructed by managed care practices in the following ways:

- Managed care organisations target only the most lucrative market segments in health care, for example the young and healthy population groups.
- Managed care organisations employ more primary care physicians than specialists, and this, together with the restriction plans to discourage their members from

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[985] Esser, Jan Hendrik *Who cares? Moral reflections on business in healthcare* Thesis presented in partial fulfillment of the requirements for the degree M Phil (Applied Ethics) Stellenbosch University, March 2001 (Supervisor: Prof AA van Niekerk), 24.

[986] Pellegrino, Edmund D Managed Care at the Bedside: How do we look in the Moral Mirror? *Kennedy Institute of Ethics Journal* Vol 7, No 4 (1997) 321 – 330, 325.

[987] Pellegrino, Edmund D Managed Care at the Bedside: How do we look in the Moral Mirror? *Kennedy Institute of Ethics Journal* Vol 7, No 4 (1997) 321 – 330, 325.

[988] Section 27(1) of the Constitution of the Republic of South Africa 108 of 1996; Esser, Jan Hendrik *Who cares? Moral reflections on business in healthcare* Thesis presented in partial fulfillment of the requirements for the degree M Phil (Applied Ethics) Stellenbosch University, March 2001 (Supervisor: Prof AA van Niekerk), 62.

seeking care from non-participating physicians and specialists, places specialists at a particular risk.[989]

- Managed care organisations consequently only locate in areas considered to have the highest potential return on investment, for example in cities rather than rural areas.
- There is a tendency to concentrate on the provision of those health care services that provide the best return, relative to the cost of supplying the particular services.[990]

These characteristic undertakings of managed care organisations restrict access to health care for those who cannot afford the premiums required of its members, and even if patients can afford the organisation's services, the facilities are usually situated in areas not accessible to them, such as cities, and not in rural areas.[991] Managed care organisations also restrict patients' access to health services in another way: medical schemes and other health insurance plans have the authority to decide which treatments will or will not be covered by the scheme. They may also apply conditions, exclusions and/or other administrative requirements for particular treatments or medical interventions. Due to the considerable cost of health care services, which generally does not fall within the average person's financial abilities, such a decision by a medical scheme or health insurance plan inevitably restricts patients' access to health care services.

The case of *MH v Discovery Health Medical Scheme*[992] illustrates this. Discovery Health imposed a twelve month waiting period[993] upon the appellant, who had applied for membership to the plan, in respect of medical treatment related to a brain tumour. The imposition arose from the appellant's disclosure of his medical history during the

[989] Iglehart, John K Physicians and the growth of Managed Care *New England Journal of Medicine* Vol 331, Issue 17 (1994) 1167 – 1171.

[990] Esser, Jan Hendrik *Who cares? Moral reflections on business in healthcare* Thesis presented in partial fulfillment of the requirements for the degree M Phil (Applied Ethics) Stellenbosch University, March 2001 (Supervisor: Prof AA van Niekerk), 62 - 63.

[991] Esser, Jan Hendrik *Who cares? Moral reflections on business in healthcare* Thesis presented in partial fulfillment of the requirements for the degree M Phil (Applied Ethics) Stellenbosch University, March 2001 (Supervisor: Prof AA van Niekerk), 63.

[992] Decision of the Council for Medical Schemes Appeal Committee, March 2006 Pearmain, DL *The Law of Medical Schemes in South Africa* JUTA 2008, 3 – 31.

[993] The imposition of waiting periods by medical schemes in South Africa is dealt with in section 29A of the Medical Schemes Act 131 of 1998. A discussion of these provisions, however, does not fall within the ambit of this research.

application process, which included previous surgery for a brain tumour as well current physical symptoms which were probably also related to the brain tumour. The appellant was informed of this condition-specific waiting period when the respondent accepted his application for membership. According to the appellant, the true grievance and reason for this appeal case was not that a waiting period had been imposed in the specific circumstances, but that medical schemes in general have the power to impose such waiting periods at all. The Council for Medical Schemes Appeal Committee found that there was no basis for a complaint against the respondent, since it is trite that the law of contract governs the relationship between medical schemes and its members, the imposition of condition specific periods has long been accepted in the South African system of medical insurance and Discovery Health's practices in this regard were no different from those of other medical schemes.

In a similar case, *JP v Discovery Health Medical Scheme,*[994] the appellant complained that the three-month waiting period imposed on him when he joined Discovery Health was not revealed to him prior to his application for membership. The appellant also stated that he did not expect any concrete relief, but merely wished to expose the allegedly inefficient and corrupt practices perpetuated by the respondent. The Council for Medical Schemes Appeal Committee held that if the appellant had been unhappy with the imposition of the three-month waiting period, he could have chosen to abandon his application for membership to Discovery Health. The Appeal Committee could furthermore not find any evidence to make a ruling censuring the respondent for its conduct.

The two cases above illustrate the frustration and powerlessness of medical scheme members when it comes to the impossibility of negotiating the terms of the contract between themselves and the medical scheme involved. The two cases also show how the conditions and requirements imposed by medical schemes on their members can restrict their access to health care. While it is trite that the law of contract regulates the relationship between medical schemes or health insurance plans and their members, and that members are therefore free not to take up membership with a particular scheme/plan if they are not

[994] *JP v Discovery Health Medical Scheme*, Decision of the Council for Medical Schemes Appeal Committee, March 2006.

content with the conditions and requirements, it should also be noted that members do not contract with schemes from a position of equal strength. To state that patients can always switch to another health insurance plan if their current plan does not deliver the quality of care they need assumes that there is competition and free choice in health service delivery. This is rarely the case as employers usually provide a very limited choice of plans to their employees.[995]

The following two examples illustrate this. In the case of *Cannon v Group Health Service of Oklahoma*[996] the appellant, a leukaemia patient, was denied a bone marrow transplant by her health insurance who argued that the treatment was experimental after the first remission of leukaemia. The appellant chose the particular health insurance plan from the three options which her employer provided to employees. And in *Corcoran v United Healthcare Inc*[997] the unborn child of the appellants died after their employee disability plan determined that hospitalisation of the mother was not necessary. To submit that patients have a free choice between health insurance plans and can move freely between these plans is not only untrue, but also insufficient to ensure the realisation of the rights of patients in managed care plans, as well as the improvement of the quality of care.[998]

In the case of *McGraw v Prudential Insurance Company of America*[999] the appellant was diagnosed with multiple sclerosis. Due to the seriousness of the appellant's disease as well as the complications posed by her symptoms, her physician ordered additional outpatient therapy to improve her strength, endurance and mobility. Various episodes of intensive inpatient physical therapy were also required. On receiving the claims for the inpatient care, the respondent denied each claim under the policy's general exclusion of services deemed

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[995] Also see the following two articles on the constitutionality of time limitations in short term insurance contracts: Sutherland PJ Ensuring Contractual Fairness in Consumer Contracts after Barkhuizen v Napier 2007 5 SA 323 (CC) Part 1 *Stellenbosch Law Review* (2008) Vol 3, 390 – 414 and Sutherland, PJ Ensuring Contractual Fairness in Consumer Contracts after Barkhuizen v Napier 2007 5 SA 323 (CC) Part 2 *Stellenbosch Law Review* (2009) 1 50 – 73; Jendusa, Jennifer M The denial of benefits quandary and managed care: McGraw v Prudential Insurance Company *DePaul Journal of Health Care Law* (1999) Vol 3, 115 – 142, 142.

[996] *Cannon v Group Health Service of Oklahoma* 77 F.3d 1270 (U.S. App 1996).

[997] *Corcoran v United Healthcare Inc* 965 F.2d 1321 (U.S.App. 1992).

[998] Annas, George J Patients' Rights in Managed care – Exit, Voice, and Choice *New England Journal of Medicine* (1997) Vol 337, No 3, 210 – 215, 214; For more examples of these cases see *Loyola University of Chicago v Humana Insurance* Co996 F.2d 895 (7th Cir. 1993), *Fuja v Benefit Trust Life Insurance* Co 18 F.3d 1405 (7th Cir 1994), *McGee v Equitor-Equitable HCA Corp* 953 F.2d 1192 (10th Cir. 1992).

[999] 137 F.3d 1253 (10th Cir 1998).

not to be medically necessary.The health plan, administered by Prudential, expressly gave the insurer the discretion to determine what constitutes medically necessary treatment and Prudential viewed the physical therapy in this particular case as medically beneficial but not medically necessary.[1000] The court considered expert evidence from various physicians indicating that while MS is not curable, treatment in the context of MS concentrates on whatever symptoms are currently present and therefore, in the case of MS, "not getting worse" was correctly described as a form of medical improvement. The court ultimately held that Prudential made "*the discretionary decision to 'give up on' the appellant*".[1001] The decision was not based on a review of medical records or a close case analysis, but rather on what was regarded as profitable to the company. The court consequently held that the denial of benefits was arbitrary and capricious.

The *McGraw* decision is of particular significance, since it demonstrates that courts are willing to take on managed care authorisation decisions that place economic gain and cost-containment ahead of patient well-being.[1002] In the cases of *Wickline v State*[1003] (discussed in Chapter Four, section 4.3.1.) and *Wilson v Blue Cross of Southern California*[1004] it was recognised that treating physicians have the ultimate responsibility for their patients' care in a managed care setting and that they should not simply accept the HMO's administrative resolutions. However, it is said that most courts accommodate and protect managed care practices as an important stage of "industrial development" in health care, much the same as they shielded railroads from litigation in the nineteenth century.[1005] According to Jacobson courts presently treat the health care field as they would any other industry and

[1000] Prudential health plan had very specific definitions and requirements to determine which treatments are medically necessary, based on the potential improvement the treatment will have on the patient's illness or condition.
[1001] 137 F.3d 1253 (10th Cir 1998), 1262.
[1002] Jendusa, Jennifer M The denial of benefits quandary and managed care: McGraw v Prudential Insurance Company *DePaul Journal of Health Care Law* (1999) Vol 3, 115 – 142, 140.
[1003] 192 Cal. App. 3d 1630, 239 Cal Rptr 810 (2d Dist. 1986).
[1004] *Wilson v Blue Cross of Southern California* 222 Cal. App.3d 660 (CA 1990).
[1005] Sage, William M Managed Care's Crimea: Medical Necessity, Therapeutic Benefit, and the Goals for Administrative Process in Health Insurance *Duke Law Journal* Vol 53, No 2 597 – 651, 613; Jacobson, Peter D *Strangers in the Night: Law and Medicine in the Managed Care Era* Oxford University Press 2002

show no inclination to overturn market decisions. This amounts to deference to prevailing market principles in health care delivery.[1006]

Based on dicta of the Constitutional Court in the recent decision of *Barkhuizen v Napier*[1007] it is submitted that courts should develop the common law and relevant legislation with regard to medical scheme membership agreements and patients' access to health care in terms of section 8(2)[1008] and 8(3)(a)[1009] and based on section 27(1)(a) of the Constitution.[1010] Justice Cameron in the *Barkhuizen* case found that contractual terms are subject to constitutional rights and that the Constitution will impact on contract law through public policy.[1011] Public policy derives from the founding constitutional values, which include dignity, equality and the advancements of human rights and freedoms.[1012] And while freedom of contract should be respected, since "*constitutional values allow individuals the dignity and freedom to regulate their affairs*", agreements "*even if freely struck, could not be inimical to equity and fairness as sourced from the Constitution*".[1013] The fairness of agreements is therefore paramount.

But "d*ecisions must be made in terms of the best interests of the patient* and the group, (own emphasis) *and not just the entity as a financial enterprise*."[1014] Thus, in order to decide on the fairness of a particular agreement in managed health care, a distinction should be made between the following moral concepts of justice:

[1006] Jacobson, Peter D *Strangers in the Night: Law and Medicine in the Managed Care Era* Oxford University Press 2002; Jacobson, Peter D & Pomfret, Scott D Establishing new Legal Doctrine in Managed Care: A Model of Judicial Response to Industrial Change *Michigan Journal of Law Reform* Vol 32 (1998 – 1999) 813 – 862.

[1007] *Barkhuizen v Napier* 2007 5 SA 323 (CC); In this case the constitutionality of a time limitation in a short insurance contract was considered.

[1008] Section 8(2): "*A provision of the Bill of Rights binds a natural or a juristic person if, and to the extent that, it is applicable, taking into account the nature of the right and the nature of any duty imposed by the right*".

[1009] Section 8(3)(a): "*When applying a provision of the Bill of Rights to a natural or a juristic person in terms of subsection (2), a court – in order to give effect to a right in the Bill must apply, or if necessary develop, the common law to the extent that legislation does not give effect to that right*".

[1010] Section 27(1)(a): "*Everyone has the right to have access to health care services, including reproductive care*".

[1011] *Barkhuizen v Napier* 2007 5 SA 323 (CC), para 6 - 8.

[1012] *Napier v Barkhuizen* 2006 4 SA 1 (SCA) para 11; Sutherland, PJ Ensuring Contractual Fairness in Consumer Contracts after Barkhuizen v Napier 2007 5 SA 323 (CC) Part 2 *Stellenbosch Law Review* 2009 1 50 – 73, 51.

[1013] *Barkhuizen v Napier* 2007 5 SA 323 (CC), para 104; Sutherland, PJ Ensuring Contractual Fairness in Consumer Contracts after Barkhuizen v Napier 2007 5 SA 323 (CC) Part 2 *Stellenbosch Law Review* 2009 1 50 – 73, 52.

[1014] Jendusa, Jennifer M The denial of benefits quandary and managed care: McGraw v Prudential Insurance Company *DePaul Journal of Health Care Law* (1999) Vol 3, 115 – 142, 140.

- Distributive justice in health care and within this particular context of access to health care emphasises the needs of vulnerable patients, focussing on those who lack basic access to care and attending to particular individuals who are denied access to some specific medical intervention.
- Formal justice emphasises that what is done for one person is owed to all others in similar circumstances.
- Contractual justice advocates enforcement of fair agreements.
- Contributive justice observes the legitimate expectations of the many whose contributions create the common resource pool.[1015]

A distinction between these moral concepts of justice is necessary, since managed health care organisations run on a fixed budget each year, so that money spent on one patient is directly unavailable for other members of that particular health plan.[1016] Justice that therefore only focusses on the health care needs of one individual may have adverse, though often hidden, implications for the other members of the health plan.[1017]

Morreim is of the opinion that each of these four notions of justice in health care is equally important and that no “tidy formula” exists to resolve conflicts with regard to managed care practices and access to health care.[1018] One reason, though, to emphasise distributive justice in the context of managed health care is that patients typically have very few choices available in health service delivery dominated by managed care practices. The other forms of justice identified above can only be honoured once patients have real choices with regard to their choice of health insurance plans and available treatments.

6.2.2. The new role of the physician in the doctor-patient relationship

Managed care organisations directly challenge the traditional role of the physician in the doctor-patient relationship. The role and behaviour of medical practitioners in the doctor-patient relationship in an era of managed care requires that practitioners act as economic

[1015] Morreim, Haavi E Moral Justice and Legal Justice in Managed Care: The Ascent of Contributive Justice *Journal of Law, Medicine and Ethics* Vol 23 (1995) 247 – 265, 247.
[1016] Morreim, Haavi E Moral Justice and Legal Justice in Managed Care: The Ascent of Contributive Justice *Journal of Law, Medicine and Ethics* Vol 23 (1995) 247 – 265, 248.
[1017] Morreim, Haavi E Moral Justice and Legal Justice in Managed Care: The Ascent of Contributive Justice *Journal of Law, Medicine and Ethics* Vol 23 (1995) 247 – 265, 247.
[1018] Morreim, Haavi E Moral Justice and Legal Justice in Managed Care: The Ascent of Contributive Justice *Journal of Law, Medicine and Ethics* Vol 23 (1995) 247 – 265, 256.

agents in addition to rendering their traditional professional services.[1019] This was confirmed in the discussion in Chapter Four, section 4.3.1., and is also evident from section 6(1)(c) of the National Health Act 61 of 2003 — medical practitioners have a duty to disclose and assist patients with regard to their economic responsibilities in health care. In the present era of managed care the fiduciary obligations of medical practitioners (discussed in Chapter Five) will also come under pressure as the financial success of practitioners now not only depends on their clinical skills, but also on their ability to manage the financial interests of the managed health care organisation.[1020]

Yet the application of managed care interventions also holds advantages for the patient in the doctor-patient relationship. Managed care principles, including prescribed requirements of pre-authorisation, case-management, provider profiling and peer reviews all promote cost-consciousness with all the parties involved.[1021] This translates into the elimination of unnecessary practices, the effectiveness of medical practice and a corresponding concern for the quality and quantity of care. [1022] Patients, for example, now stay in hospital for fewer days, many surgical procedures previously requiring hospitalisation are now safely performed in day surgery, more attention is given to preventative care, many medical practices have been standardised to produce better outcomes, and satisfied patients have become an explicit goal.[1023]

[1019] Also see Chapter Four, section 4.3.1. as well as sections 6.2.3. and 6.2.4. of this chapter; Esser, Jan Hendrik *Who cares? Moral reflections on business in healthcare* Thesis presented in partial fulfillment of the requirements for the degree M Phil (Applied Ethics) Stellenbosch University, March 2001 (Supervisor: Prof AA van Niekerk), 63; Rodwin, Marc A Consumer Protection and Managed Care: Issues, Reform Proposals, and Trade-Offs *Houston Law Review* Vol 32, (1995-1996) 1319 – 1381.

[1020] Esser, Jan Hendrik *Who cares? Moral reflections on business in healthcare* Thesis presented in partial fulfillment of the requirements for the degree M Phil (Applied Ethics) Stellenbosch University, March 2001 (Supervisor: Prof AA van Niekerk), 64.

[1021] Wolf, Susan Toward a Systemic Theory of Informed Consent in Managed Care *Houston Law Review* Vol 35 (1999) 1631 – 1681, 1644; Esser, Jan Hendrik *Who cares? Moral reflections on business in healthcare* Thesis presented in partial fulfillment of the requirements for the degree M Phil (Applied Ethics) Stellenbosch University, March 2001 (Supervisor: Prof AA van Niekerk), 66.

[1022] Esser, Jan Hendrik *Who cares? Moral reflections on business in healthcare* Thesis presented in partial fulfillment of the requirements for the degree M Phil (Applied Ethics) Stellenbosch University, March 2001 (Supervisor: Prof AA van Niekerk), 66; Relman, Arnold S Controlling Costs by Managed Competition – Would it work? *New England Journal of Medicine* Vol 328, Issue 2 (1993) 133 – 135.

[1023] Kassirer, Jerome P Managed Care and the Morality of the Marketplace *New England Journal of Medicine* Vol 333, No 1 (1995) 50 – 52, 50.

However, the realisation of more efficient medical practices should not be achieved at the expense of quality of care. And to ensure that quality of care is not compromised, desirable goals should be identified and matched with appropriate medical interventions to achieve them.[1024] This involves a consideration of the medical utility of the intervention, the medical contradictions of the intervention, and non-clinical factors such as inconvenience and cost.[1025] The patients' interest is consequently weighed up against the obligation of justice and that of the larger society — a value consideration which also challenges the physician's fiduciary obligations towards the particular patient.[1026] There are a number of regulations and standards pertaining to decision-making by managed health care organisations affecting funding for their members in South Africa.[1027] The regulations stipulate that qualified health care professionals must administer the managed health care programmes and oversee all funding decisions, and that the appropriateness of such decisions must be evaluated periodically by clinical peers.[1028]

However, like most complex organisations, managed care organisations are vulnerable to organisational pathologies.[1029] While complex organisations can perform complex tasks efficiently and institutionalise memory despite changes in staff, such large organisations can also become unresponsive and limit the appropriate use of discretion by professionals.[1030] The law has taken for granted that medical practitioners' clinical judgements are based on sound scientific evidence and are always made in the best interest of the patient. Managed care organisations have changed this perception, revealing the variability in clinical

[1024] Esser, Jan Hendrik *Who cares? Moral reflections on business in healthcare* Thesis presented in partial fulfillment of the requirements for the degree M Phil (Applied Ethics) Stellenbosch University, March 2001 (Supervisor: Prof AA van Niekerk), 66.
[1025] Esser, Jan Hendrik *Who cares? Moral reflections on business in healthcare* Thesis presented in partial fulfillment of the requirements for the degree M Phil (Applied Ethics) Stellenbosch University, March 2001 (Supervisor: Prof AA van Niekerk), 66.
[1026] Esser, Jan Hendrik *Who cares? Moral reflections on business in healthcare* Thesis presented in partial fulfillment of the requirements for the degree M Phil (Applied Ethics) Stellenbosch University, March 2001 (Supervisor: Prof AA van Niekerk), 66 - 67.
[1027] Pearmain, DL *The Law of Medical Schemes in South Africa* JUTA 2008, 2-32.
[1028] Pearmain, DL *The Law of Medical Schemes in South Africa* JUTA 2008, 2-32.
[1029] Rodwin, Marc A Consumer Protection and Managed Care: The need for Organised Consumers *Health Affairs* Vol 15, No 3 (1996) 110 – 123, 111.
[1030] Rodwin, Marc A Consumer Protection and Managed Care: The need for Organised Consumers *Health Affairs* Vol 15, No 3 (1996) 110 – 123, 111.

practice.[1031] Individual physician behaviour and organisational behaviour should therefore interrelate in a broader system of health care delivery. The roles of medical practitioners as patient advocates and as managers of corporate and community resources have to be reconciled.[1032]

6.2.3. Trust in the doctor-patient relationship and trust in managed care institutions

Much has so far been said about the role of trust in the doctor-patient relationship. In Chapter Three, the ideal doctor-patient relationship was described as a moral relationship built on trust, equality and respect.[1033] In this context, trust is synonymous with autonomy and reinforces patients' confidence in physicians, the authority of the medical profession in general and also improves the quality of both patients' and physicians' treatment decisions. In Chapter Four, the erosion of trust in the doctor-patient relationship due to the adoption of a business ethic in health service delivery was considered.[1034] It was submitted that the success of medical care ultimately depends on patients' trust in their physicians. And in Chapter Five, the fiduciary nature of the doctor-patient relationship was analysed and the special place of trust in this fiduciary relationship highlighted.[1035] Trust in managed care organisations is also relevant because it can influence trust in the doctor-patient relationship, and also be influenced by the level of trust in the doctor-patient relationship.[1036]

[1031] Sage, William M 'Health Law 2000': The Legal System and the Changing Health Care Market *Health Affairs* Vol 15, No 3 (1996) 9 – 27, 17.

[1032] Wolf, Susan Toward a Systemic Theory of Informed Consent in Managed Care *Houston Law Review* Vol 35 (1999) 1631 – 1681, 1666 – 1667; Sage, William M 'Health Law 2000': The Legal System and the Changing Health Care Market *Health Affairs* Vol 15, No 3 (1996) 9 – 27, 17.

[1033] See Chapter Three, section 3.5.5; Katz, Jay *The Silent World of Doctor and Patient* Johns Hopkins University Press: Baltimore (2002) 26; Wilson-Barnett, Jenifer Limited autonomy and partnership: professional relationships in health care *Journal of medical ethics* 15 (1989) 12 – 16.; Schuck, Peter H Rethinking informed consent *The Yale Law Journal* (1993) Vol 103, 899 – 959, 948; Rosenberg v Pervical [2001] HCA 18, par 143.

[1034] See Chapter Four, section 4.3.3.

[1035] See Chapter Five, sections 5.2. and section 5.5.

[1036] Goold, Susan Dorr Commentary Money and Trust: Relationships between Patients, Physicians, and Health Plans *Journal of Health Politics, Policy and Law* Vol 23 (1998) 687 – 694, 687.

Managed care practices create a conflict of interest for medical practitioners in the doctor-patient relationship, which may lead to the erosion of trust.[1037] In the realm of managed care, two types of conflicts of interest in the doctor-patient relationship may arise:

- conflicts of commission refer to the practice according to which physicians receive financial incentives to provide more services; and
- conflicts of omission refer to situations where physicians receive financial incentives to provide fewer services.[1038]

Most managed care plans make use of these financial incentive practices and studies have indicated that the majority of these plans regard financial incentives as the single most effective technique to control costs.[1039] Yet an ethical evaluation of both of these conflicts in the doctor-patient relationship show that managed care practices like these are wrong, because they elevate the personal interest of the medical practitioner above that which ought to be the primary interest in health care, namely the health and well-being of the patient.[1040] Pellegrino submits that the managed care system creates ethical conflicts of interests of such magnitude that many medical practitioners feel forced to compromise their own personal integrity in order to survive.[1041]

[1037] For an empirical study on this topic see Kao, Audiey C, Green, Diane C & Zaslavsky, Alan M The Relationship between Method of Physician Payment and Patient Trust *JAMA* (1998) Vol 280, No 19, 1708 – 1714 and Balkrishnan, Rajesh, Dugan, Elizabeth, Camacho, Fabian T & Hall, Mark A Trust and Satisfaction with Physicians, Insurers and the Medical Profession *Medical Care* Vol 41, No 9 (2003) 1058 – 1064; Hall Timothy, S Bargaining with Hippocrates: Managed Care and the Doctor-Patient Relationship *South Carolina Law Review* 689 (2002 – 2003) 689 – 740, 731; Mechanic, David & Schlesinger, Mark The Impact of Managed Care on Patients' Trust in Medical Care and Their Physicians JAMA Vol 275, No 21 (1996) 1693 – 1697.

[1038] Emanuel, Ezekiel J Medical Ethics in the Era of Managed Care: The Need for Institutional Structures Instead of Principles for Individual Cases *The Journal of Clinical Ethics* Vol 6, No 4, (1995) 335 – 338, 336; Rodwin, Marc A Conflicts in Managed Care *New England Journal of Medicine* Vol 332, Issue (1995) 604 – 607.

[1039] Emanuel, Ezekiel J Medical Ethics in the Era of Managed Care: The Need for Institutional Structures Instead of Principles for Individual Cases *The Journal of Clinical Ethics* Vol 6, No 4, (1995) 335 – 338, 336; Hiepler, Mark O & Dunn, Brian C Irreconcilable Differences: Why the doctor-patient relationship is disintegrating at the hands of Health Maintenance Organisations and Wall Street *Pepperdine Law Review* Vol 25 (1998) 497 – 616, 608.

[1040] Emanuel, Ezekiel J Medical Ethics in the Era of Managed Care: The Need for Institutional Structures Instead of Principles for Individual Cases *The Journal of Clinical Ethics* Vol 6, No 4, (1995) 335 – 338, 336.

[1041] Other conflicts of interests that managed care organisations may create in the doctor-patient relationship are restrictions on what physicians may disclose to their patients, as well as imposing a rationing or gatekeeping function on physicians, thereby requiring that physicians minimise referrals or additional tests. The provision of practice guidelines to physicians which serve as systematic, scientifically derived statements of appropriate measures to be taken in the diagnosis and treatment of disease can also create a conflict of interest in the doctor-patient relationship. These conflicts of interests have been dealt with to some extent in other chapters of this dissertation and will not be discussed again here.; Hiepler, Mark O & Dunn, Brian C Irreconcilable Differences: Why the doctor-patient relationship is disintegrating at the hands of Health Maintenance Organisations and Wall Street *Pepperdine Law Review* Vol 25 (1998) 497 – 616, 598; Pellegrino, Edmund D Managed Care at the Bedside: How do we look in the Moral Mirror? *Kennedy Institute of Ethics*

In the cases of *Shea v Esensten*[1042] and *Nead v Portes*[1043] it was alleged that the financial incentive fund controlled by the respective patients' health plans and allegedly giving the respective treating physicians a financial incentive to limit treatment ultimately led to the death of both patients.[1044] Both courts held that there is a fiduciary duty to disclose material information to patients about such incentive programmes. Unfortunately the courts did not indicate with whom this fiduciary duty lies solely with the physician or also with the particular health insurance plan. In the case of *Pegram v Herdrich*[1045] the court also had to decide whether treatment decisions made by a health maintenance organisation, acting through its physician employees, were fiduciary acts. In this case the patient, Herdrich, was experiencing pain in the midline area of her groin. On examination the physician found a six by eight centimetre inflamed mass in the patient's abdomen. The physician, however, did not order an ultrasound diagnostic procedure at the local hospital — which would have been the standard procedure — but, based on the health maintenance organisation's guidelines and incentive scheme, decided that the patient had to wait eight days for an ultrasound to be performed at a facility staffed by the health maintenance organisation about fifty miles away. Before the eight days had passed, however, Herdrich's appendix ruptured and caused peritonitis. It was clear in this case that the physician's interest in limiting the particular health maintenance organisation's expenses had blinded her to the need for immediate diagnosis and treatment.

In this dissertation, the conflicts of interest that medical practitioners may be confronted with in the doctor-patient relationship have been discussed and analysed from various perspectives.[1046] It is evident from the discussion that various structures exist to counter the conflicts of interest that may arise in managed care practices:

Journal Vol 7, No 4 (1997) 321 – 330, 325; Teff, Harvey (ed) *Medical Practice and Malpractice* Aldershot, Hants, England: Ashgate c2000 227 – 257.

[1042] *Shea v Esensten* 107 F.3d 625 (8th Cir 1997); Also see the discussion in Chapter Four, section 4.3.1.

[1043] *Nead v Portes* 710 N.E.2d 418 (Illnois 1999).

[1044] Also see *Lancaster v Kaiser Foundation Health Plan of Mid-Atlantic States Inc* 958 F.Supp. 1137 (Virginia 1997).

[1045] *Pegram v Hedrich* 120 S.Ct. 2143 (Supreme Court 2000); Also see *Cicio v Does* 321 F.2d 83 (U.S. App. 2003) and *Pappas v Asbel* 564 Pa. 407 (Penn 2001).

[1046] See Chapter Two, section 2.2.3, Chapter Three with regard to the unquestionable authority of the medical profession and the underlying assumption that medical practitioners always act in the best interest of their patients, and section 4.3.3. of Chapter Four.

- professionalism, with its ideal that the medical practitioner's primary goal is the welfare of patients; [1047]
- disclosure and the doctrine of informed consent to reveal these conflicts of interest;[1048] and
- the central role of trust and the medical practitioner's fiduciary obligations towards the patient.[1049]

However, one ordering principle is the *sine qua non* with regard to conflicts of interest and managed care: the moral obligation of medical practitioners to act in the best interest of their patients and the patients' corresponding trust in their physicians.[1050]

But should managed care organisations, like health maintenance organisations, be treated as fiduciaries to the extent that they make mixed eligibility[1051] decisions when acting through their physicians? The court in Pegram rejected the notion that health maintenance organisations should be treated as fiduciaries. This posed a fundamental challenge to the health delivery systems that have come to dominate American health care. Instead, the court relied heavily on economic analysis and held that a health maintenance organisation cannot be treated as a fiduciary to the extent that it makes mixed eligibility decisions acting through its physicians.[1052] One of the main reasons cited for this decision was that incentive programmes are an integral part of the health maintenance organisation's functions. These incentive programmes are necessary to ensure cost-containment which is a primary goal of health maintenance organisations. The second reason was that physicians continue to play

[1047] See Chapter Two, section 2.2.3.
[1048] See Chapter Three.
[1049] See Chapter Four and especially Chapter Five, dealing with the medical practitioner's fiduciary duty of loyalty; Emanuel, Ezekiel J Medical Ethics in the Era of Managed Care: The Need for Institutional Structures Instead of Principles for Individual Cases *The Journal of Clinical Ethics* Vol 6, No 4, (1995) 335 – 338.
[1050] Pellegrino, Edmund D Managed Care at the Bedside: How do we look in the Moral Mirror? *Kennedy Institute of Ethics Journal* Vol 7, No 4 (1997) 321 – 330, 322.
[1051] The court in the Pegram case divided the health maintenance organisation's responsibilities with regard to patient care into eligibility decisions, treatment decisions and mixed eligibility decisions. Pure eligibility decisions are decisions which concern the particular condition of medical procedure for a treatment covered by a health plan. Treatment decisions are choices relating to diagnosis and treatment: given a patient's constellation of symptoms, what is the appropriate medical response. And mixed eligibility decisions are a hybrid of the eligibility and treatment decisions. "In the business of health care delivery such decisions are termed 'denial of care' decisions."; McLean, Thomas R & Richards, Edward P Managed Care Liability for breach of fiduciary duty after Pegram v Hedrich: The end of ERISA pre-emption for State Law liability for medical care *Florida Law Review* Vol 53 (2001) 1 – 47, 27 – 28.
[1052] *Pegram v Hedrich* 120 S.Ct. 2143 (Supreme Court 2000), 2155; Ippolito, Richard A Freedom to Contract in Medical Care: HMO's ERISA and Pegram v Herdrich *Supreme Court Economic Review* Vol 9 (2001) 1 – 68, 2.

the dominant role in determining the care that patients receive: it is physicians' orders and not the actions of health maintenance organisations that effect admission or discharge of patients from hospital, while diagnostic and therapeutic procedures are also performed pursuant to a doctor's instructions and not as a result of a directive of a health maintenance organisation.

Yet managed care organisations do have a fiduciary duty towards patients/members to disclose all material information, including incentive schemes or other rationing practices. Health care delivery is a moral endeavour, whether undertaken by an individual medical practitioner or by an institution.[1053] And while managed care organisations — as integrated delivery systems contracting to provide and pay for health care services to a population with limited and prepaid resources — clearly have responsibilities beyond the facilitation of moral relationships between physicians and their patients, their moral responsibilities in health service delivery do not fall away.[1054] The conflicts of loyalty described above are built into managed care to achieve its end, namely cost-containment.[1055] As providers, managed care organisations should, however, have a trust-based relationship with all its members since they have moral obligations towards these members. These moral obligations stem from the same high moral and ethical standards that apply to medical practitioners, since managed care organisations also have extensive power and authority in health service delivery.[1056] Honesty is a vital part of this relationship and enables an informed and justifiable choice to trust.[1057] Trust is therefore a very important quality in the institution-patient relationship just as it is important in the doctor-patient relationship, especially since

[1053] Reasons include the vulnerability of patients and the importance of health; Goold, Susan Dorr Commentary Money and Trust: Relationships between Patients, Physicians, and Health Plans *Journal of Health Politics, Policy and Law* Vol 23 (1998) 687 – 694, 687.

[1054] Goold, Susan Dorr Commentary Money and Trust: Relationships between Patients, Physicians, and Health Plans *Journal of Health Politics, Policy and Law* Vol 23 (1998) 687 – 694, 687; Esser, Jan Hendrik *Who cares? Moral reflections on business in healthcare* Thesis presented in partial fulfillment of the requirements for the degree M Phil (Applied Ethics) Stellenbosch University, March 2001 (Supervisor: Prof AA van Niekerk), 69.

[1055] Pellegrino, Edmund D Managed Care at the Bedside: How do we look in the Moral Mirror? *Kennedy Institute of Ethics Journal* Vol 7, No 4 (1997) 321 – 330, 326.

[1056] Hiepler, Mark O & Dunn, Brian C Irreconcilable Differences: Why the doctor-patient relationship is disintegrating at the hands of Health Maintenance Organisations and Wall Street *Pepperdine Law Review* Vol 25 (1998) 497 – 616, 598.

[1057] Goold, Susan Dorr Commentary Money and Trust: Relationships between Patients, Physicians, and Health Plans *Journal of Health Politics, Policy and Law* Vol 23 (1998) 687 – 694, 691.

nowadays it may be more likely for patients to develop an ongoing relationship with their health insurance provider than with an individual medical practitioner.

6.2.4. Informed consent in an era of managed care

"*Is the doctor-patient dialogue, required by the doctrine of informed consent at the point of treatment, diminished by prior or presumed consent to certain treatment limitations or allocation rules at the point of subscribing to the health plan*?"[1058]

To put it differently: When patients sign their health plan contracts, they agree to certain limitations, exclusions, conditional inclusions and other requirements which may exclude all sorts of coverage. Some argue that such a patient's subscription to a health plan profoundly modifies the informed consent requirements at the point of treatment.[1059] Hall, for example, submits that patients in such situations have waived their right to information about excluded treatment or have given prior consent to a certain cost-containment system and should consequently be held to the deal.[1060] This line of reasoning, however, presents a truncated version of a more complex and systematic problem unfolding over time.[1061]

In managed care, various role players are involved and a patient's treatment options and ultimate treatment decision depend on past actions, information and decisions.[1062] For example, most employees can only choose from a limited menu of health plan options— or are sometimes only presented with one option. Most employees do not select employment based solely on the health plans available at the workplace and the implicit health care choices which they will be making when accepting the position although this may ultimately be to their detriment.[1063] Similarly, other patients signing up with a particular health care plan also cannot foresee how particular limitations, conditions, exclusions and conditional

[1058] Wolf, Susan Toward a Systemic Theory of Informed Consent in Managed Care *Houston Law Review* Vol 35 (1999) 1631 – 1681, 1651.
[1059] Wolf, Susan Toward a Systemic Theory of Informed Consent in Managed Care *Houston Law Review* Vol 35 (1999) 1631 – 1681, 1652.
[1060] Wolf, Susan Toward a Systemic Theory of Informed Consent in Managed Care *Houston Law Review* Vol 35 (1999) 1631 – 1681, 1652.
[1061] Wolf, Susan Toward a Systemic Theory of Informed Consent in Managed Care *Houston Law Review* Vol 35 (1999) 1631 – 1681, 1653.
[1062] Wolf, Susan Toward a Systemic Theory of Informed Consent in Managed Care *Houston Law Review* Vol 35 (1999) 1631 – 1681, 1653.
[1063] Wolf, Susan Toward a Systemic Theory of Informed Consent in Managed Care *Houston Law Review* Vol 35 (1999) 1631 – 1681, 1653.

inclusions will affect their health treatment decisions in future, and in some cases they are not even aware of these particulars until ill health and the necessity of particular treatment plans cause these obstacles. Thus, while the familiar doctrine of informed consent (discussed in Chapter Three) is normally only applied at the point where a patient presents a health problem to a physician and requests a treatment decision, information relevant to treatment decisions is actually being given or withheld at every stage of the managed care process.[1064] Few patients therefore know the full range of facts material to medical decision-making.[1065]

But should patients be informed of these particulars at the various decision points in the managed care process? And, if so, would be the justification for such an expanded duty of informed consent?[1066] The employer's fiduciary obligations towards the employee as an organisational health care provider include the duty to provide enough information in this regard, and to be effectively held accountable.[1067] (The employer's fiduciary duty towards the employee in this context does not fall within the ambit of this research.) The doctor's fiduciary duty to provide all information to the patient has already been dealt with extensively in Chapters Three to Five. Regarding the disclosure of information pertaining to the patient's health plan and economic considerationsitwas argued in Chapter Four section 4.3.1. that patients should be informed of all the alternative treatments, with their risks and benefits, *as well as* the costs involved. This is also confirmed in section 6(1)(c) of the National Health Act 61 of 2003. And, at the very least, physicians who due to economic reasons cannot make use of the necessary medical resources that they believe their patients need, should have an affirmative professional obligation to inform their patients of the fact that potentially beneficial treatment cannot be utilised for economic reasons.[1068]

[1064] Wolf, Susan Toward a Systemic Theory of Informed Consent in Managed Care *Houston Law Review* Vol 35 (1999) 1631 – 1681, 1654.
[1065] Cerminara, Kathy L The Class Action Suit as a method of Patient Empowerment in the Managed Care Setting *American Journal of Law and Medicine* Vol 24 (1998) 7 – 58, 22.
[1066] Wolf, Susan Toward a Systemic Theory of Informed Consent in Managed Care *Houston Law Review* Vol 35 (1999) 1631 – 1681, 1656.
[1067] Wolf, Susan Toward a Systemic Theory of Informed Consent in Managed Care *Houston Law Review* Vol 35 (1999) 1631 – 1681, 1657.
[1068] Miller, Frances H Denial of Health Care and Informed Consent in English and American Law *American Journal of Law and Medicine* 18 (1992) 37 – 71, 41.

A patient and the health insurance provider enter into a contract for health coverage and care on certain conditions and the health insurance provider consequently has an obligation to provide the necessary information to support an informed and enforceable contract with the patient.[1069] But how much information and what type of information should be conveyed by the health maintenance organisation or health insurance providers? Health insurance providers do not usually make a full, detailed contract to a patient who subscribes. The health plan information is summarised in brochures and/or other documents instead and may omit information critical to an individual's specific health needs.[1070]

In addition, no information about rationing and financial incentives is included in these summaries made available by health insurance providers. In the USA some states now have legislation requiring that health plans reveal those financial incentives which they offer physicians to practise cost-conserving care.[1071] The American Medical Association's (AMA) Council on Ethical and Judicial Affairs has also argued that health plans have a duty to reveal information about financial incentives and rationing.[1072] By requiring health insurance providers to furnish this type of information, the fiduciary duty of the doctor-patient relationship is extended to the organisational realm and a fiduciary obligation consequently binds health insurance providers. The fiduciary duty of health insurance providers is based on the patient's dependence on the plan and the comparative lack of insight into the particulars of the plan.[1073]

Many believe that the disclosure of these limitations, conditions and economic considerations of health insurance plans remains the sole responsibility of the health

[1069] Wolf, Susan Toward a Systemic Theory of Informed Consent in Managed Care *Houston Law Review* Vol 35 (1999) 1631 – 1681, 1658.
[1070] Wolf, Susan Toward a Systemic Theory of Informed Consent in Managed Care *Houston Law Review* Vol 35 (1999) 1631 – 1681, 1658.
[1071] E.g. Minn Stat. Ann. §62J.72 (1998), N.J. Stat. Ann. §26:2S-5 (1998), Vt. Stat. Ann. tit. 18.§9414 (1998); Wolf, Susan Toward a Systemic Theory of Informed Consent in Managed Care *Houston Law Review* Vol 35 (1999) 1631 – 1681, 1658.
[1072] Wolf, Susan Toward a Systemic Theory of Informed Consent in Managed Care *Houston Law Review* Vol 35 (1999) 1631 – 1681, 1658.
[1073] For a discussion on the fiduciary nature of the managed care organisations see: Jacobson, Peter D & Cahill, Michael T Applying Fiduciary Responsibilities in the Managed Care Context *American Journal of Law and Medicine* Vol 26 (2000) 155 – 173; Wolf, Susan Toward a Systemic Theory of Informed Consent in Managed Care *Houston Law Review* Vol 35 (1999) 1631 – 1681, 1659.

insurance providers and should not be extended to physicians involved, since such disclosure by physicians would undermine patient trust. [1074] It has been pointed out by Katz and others that such disclosure of financial interests or incentives, which might have a bearing on medical decision-making, may also have a down-side: They can undermine physician-patient trust, which is the cornerstone of the doctor-patient relationship and also the aim informed consent has been designed to foster.[1075] However, not all health insurance plans engage in full and comprehensive disclosure of rationing schemes at the time of subscription, and many individuals do not have a meaningful choice between health insurance plans offered by their employer. Nor do they have any negotiating power to craft an individual deal with insurers. It is therefore difficult to argue that the prior consent or waiver was freely given and that physicians, as fiduciaries in the doctor-patient encounter, should respect that and need not provide full and detailed information on relevant aspects pertaining to the health insurance plan, economic considerations and available treatments.[1076]

In the present era of managed care, it is consequently important to take special cognisance of the true complexity of a managed care system with regard to informed consent, of how the system extends over time and features multiple influences on the medical decision-making process.[1077] The usual analysis of the doctor-patient relationship and the doctrine of informed consent underestimate the number of actors and interests involved.[1078] Moreover, when a patient subscribes to a health insurance plan with limitations, exclusions and conditions, it does not mean that the patient has given up the right to information about the full range of relevant treatments and all the economic considerations involved. "*It also does not mean the individual has given up the kind of doctor-patient relationship in which the*

[1074] Wolf, Susan Toward a Systemic Theory of Informed Consent in Managed Care *Houston Law Review* Vol 35 (1999) 1631 – 1681, 1666.

[1075] See Chapter Four, section 4.3.1.; Hall, Mark A A Theory of Economic Informed Consent *Georgia Law Review* 31 (1996 - 1997) 511 – 586, 547; This erosion of trust in the doctor-patient relationship in the context of the business model of health care delivery will be discussed in sections 4.3.2. and 4.3.3. of this chapter. Also see Chapter Five.

[1076] Wolf, Susan Toward a Systemic Theory of Informed Consent in Managed Care *Houston Law Review* Vol 35 (1999) 1631 – 1681, 1659; Rodwin, Marc A Conflicts in Managed Care *New England Journal of Medicine* Vol 332, Issue (1995) 604 – 607.

[1077] Wolf, Susan Toward a Systemic Theory of Informed Consent in Managed Care *Houston Law Review* Vol 35 (1999) 1631 – 1681, 1671.

[1078] Wolf, Susan Toward a Systemic Theory of Informed Consent in Managed Care *Houston Law Review* Vol 35 (1999) 1631 – 1681, 1671.

physician reveals the truth about the diagnosis and options, serving the familiar role of fiduciary, expert educator, and counselor."[1079] And even if an individual were willing to follow that route, there would be numerous obstacles in enforcing such an agreement, since

- it is contra bones mores to agree to give up unknown information of potentially great significance in a contractual agreement;
- it is impossible to predict what information will be relevant and significant as the health problem and concomitant treatment issue may not yet be apparent; and
- by giving up a doctor-patient relationship where the doctor has a fiduciary duty to provide the patient with all relevant and material information, the patient would be completely dependent on a physician whose rationing decisions cannot be monitored or challenged and whose advice the patient cannot trust to be complete.[1080]

Thus, in the context of a complex managed health care system, patients need full disclosure even more. But they do not only need disclosure, they also need advocacy and they cannot rely on their physicians to advocate for them due to the close allegiance that exists between managed care organisations and the health care providers.[1081] Patients consequently lose not only their ability to participate in medical decision-making, but also their confidence that someone else will have their best interest at heart when making decisions regarding their medical care.[1082]

6.2.5. Patient advocacy in an era of managed care

> "*Providing patients, who depend on their physicians for expert advice, with an effective voice is a long-standing problem that has been highlighted, but not caused, by managed care*."[1083]

[1079] Wolf, Susan Toward a Systemic Theory of Informed Consent in Managed Care *Houston Law Review* Vol 35 (1999) 1631 – 1681, 1674.
[1080] Wolf, Susan Toward a Systemic Theory of Informed Consent in Managed Care *Houston Law Review* Vol 35 (1999) 1631 – 1681, 1674.
[1081] Wolf, Susan Toward a Systemic Theory of Informed Consent in Managed Care *Houston Law Review* Vol 35 (1999) 1631 – 1681, 1666 – 1668; Cerminara, Kathy L The Class Action Suit as a method of Patient Empowerment in the Managed Care Setting *American Journal of Law and Medicine* Vol 24 (1998) 7 – 58, 24.
[1082] Cerminara, Kathy L The Class Action Suit as a method of Patient Empowerment in the Managed Care Setting *American Journal of Law and Medicine* Vol 24 (1998) 7 – 58, 24.
[1083] Annas, George J Patients' Rights in Managed care – Exit, Voice, and Choice *New England Journal of Medicine* (1997) Vol 337, No 3, 210 – 215, 210.

The concern for the vulnerability of patients in managed care, and the endeavour to empower patients and provide them with an effective voice, provides an opportunity to develop meaningful options for them.[1084] More attention should consequently be paid to dispute resolution, grievance mechanisms and appeal procedures in managed care and health maintenance organisations. Such fair procedures for the resolution of disputes are critical in the context of managed care, since it is difficult to make an impartial decision when there are financial incentives not to provide treatment.[1085]

In addition, some scholars suggest that physicians can no longer be advocates for their patients, since the traditional doctor-patient relationship is no longer financially feasible in the era of managed health care.[1086] This leaves patients without help and vulnerable to advocate for themselves if they believe that they require a particular medical treatment not covered by their health insurance plan or not mentioned by their treating physician.[1087] Moreover, for patients to be their own advocates, user-friendly appeal mechanisms are necessary as well as complete information on all available and alternative treatment plans linked to the patient's specific illness. Mehlman and Annas, on the other hand, believe that a new, independent profession of medical advocates is needed to ensure that adequate representation and assistance are available to patients.[1088] In light of the changing nature of medical practice and the pervasive pressure on the traditional doctor-patient relationship, their idea seems appealing.[1089] However, introducing a third party to the doctor-patient relationship will imply accepting that the unique nature of this historical relationship and its

[1084] Annas, George J Patients' Rights in Managed care – Exit, Voice, and Choice *New England Journal of Medicine* (1997) Vol 337, No 3, 210 – 215, 210.

[1085] Annas, George J Patients' Rights in Managed care – Exit, Voice, and Choice *New England Journal of Medicine* (1997) Vol 337, No 3, 210 – 215, 212; E.g. in the case of *Delta Dental Plan of California v Barnasky* 27 Cal. App. 4th 1598 (1994) it was decided that judicial review of procedural fairness should be available to physicians and dentists who contract with managed care plans.

[1086] Annas, George J Patients' Rights in Managed care – Exit, Voice, and Choice *New England Journal of Medicine* (1997) Vol 337, No 3, 210 – 215, 213.

[1087] Annas, George J Patients' Rights in Managed care – Exit, Voice, and Choice *New England Journal of Medicine* (1997) Vol 337, No 3, 210 – 215, 213.

[1088] Goldberg, Susan L The Doctor and the Patient in the New Health Care Economy: Critical Legal Issue v Medical Advocates: A Call for A New Profession *Widener Law Symposium Journal* (1996) Vol 1, 325 – 363, 332; Annas, George J Patients' Rights in Managed care – Exit, Voice, and Choice *New England Journal of Medicine* (1997) Vol 337, No 3, 210 – 215, 213.

[1089] Goldberg, Susan L The Doctor and the Patient in the New Health Care Economy: Critical Legal Issue v Medical Advocates: A Call for A New Profession *Widener Law Symposium Journal* (1996) Vol 1, 325 – 363, 334 Also see Annas, George J Healey, Joseph M The Patient Rights Advocate: Redefining the Doctor-Patient Relationship in the Hospital Context *Vanderbilt Law Review* Vol 27 (1974) 243 – 270, 257 for a complete exposition of a patient rights advocate.

distinctive dynamics no longer exist, and that physicians no longer owe any fiduciary duties to their patients. It is evident from the discussion thus far that such disregard for the historical attributes of the doctor-patient relationship and the nature of medical care is not an option, especially since it will undermine trust in the relationship.

It is recommended that independent administrative review procedures, including dispute resolution, grievance mechanisms and appeals procedures in managed care organisations and health maintenance organisations be developed as a system for screening and controlling litigation. Such procedures will also empower patients and provide them with an effective voice in health service delivery. Sage is also a proponent of this idea and submits that such independent administrative review procedures will function as an extension of health care regulation mechanisms and will offer a standard process for resolving socially contentious entitlement issues that build public values.[1090] And since public trust in the health care system has collective importance, a fair and deliberative procedure such as an independent administrative review will reassure patients that health plans always aspire to find a reasonable balance between access and quality of health care and its cost.[1091]

6.3. Conclusion

The rapidly changing health care marketplace — once a fragmented, professionalised and charitable endeavour and now an industry-dominated, profit-oriented corporate entity — continually generates new issues for lawyers, judges and legislatures.[1092] But due to the regulatory history of medical practice as well as the tradition of deference to professional judgment, the law has difficulty in responding to concerns in the managed care revolution.[1093] The complexities of managed care litigation include matters relating to the interpretation of health plan language and the dichotomy between benefit determination

[1090] Sage, William M Managed Care's Crimea: Medical Necessity, Therapeutic Benefit, and the Goals of Administrative Process in Health Insurance *Duke Law Journal* Vol 53, No 2 (2003) 597 – 651, 621.

[1091] See *Rush Prudential HMO Inc v Moran* 536 U.S. 355 (2002); Sage, William M Managed Care's Crimea: Medical Necessity, Therapeutic Benefit, and the Goals of Administrative Process in Health Insurance *Duke Law Journal* Vol 53, No 2 (2003) 597 – 651, 621 - 622.

[1092] Sage, William M 'Health Law 2000': The Legal System and the Changing Health Care Market *Health Affairs* Vol 15, No 3 (1996) 9 – 27, 9 & 15.

[1093] Sage, William M 'Health Law 2000': The Legal System and the Changing Health Care Market *Health Affairs* Vol 15, No 3 (1996) 9 – 27, 9.

decisions and medical necessity.[1094] To safeguard patients' interest in a managed care environment in South Africa, policy makers should also consider the following issues: freedom of choice with regard to health insurance plans;

- disclosure of all material information, including incentive schemes, exclusions and limitations;
- quality of care, since the inappropriate utilisation of services in a managed care administration may result in poor quality care;
- confidentiality of medical information; and
- financial security – once a member (or employee) has contributed financially to a medical scheme, payment for the services received within that system should be guaranteed.[1095]

In this chapter, it was argued that managed health care organisations have a duty to introduce managed care intervention strategies to address the current economic challenges in health service delivery.[1096] Just as the traditional ideals of the doctor-patient relationship were based on the best interest of the patient, so can managed care practices also work to the patient's advantage. However, the manner in which managed care organisations currently perform their functions is morally questionable. Current managed care practices alter the doctor-patient relationship and the ethos upon which it is founded and present serious concerns with regard to the distribution of power in health service delivery.[1097]

Although managed care organisations are businesses, they are businesses involved in health service delivery and both the unique nature of medical practice, as well as the needs of patients as consumers, require that the ethical responsibility for patient care not only be

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[1094] McKoy, June M, Karsjens, Kari L & MacDonald-Glenn, Linda Is Ethics for Sale?...Juggling Law and Ethics in Managed Care *DePaul Journal of Health Care Law* (2005) Vol 8 559 – 613, 581.

[1095] Veliotes, G & Kgomo *Patient Protection in Managed Health Care: A discussion document* Theme Committee on Patient Protection: Department of Health (1997); Kinghorn, Anthony The Centre for Health Policy The development of Managed Health Care in South Africa What are the Implications? Centre for Health Policy, Department of Community Health, University of the Witwatersrand, Paper No 39, (November 1994).

[1096] Esser, Jan Hendrik *Who cares? Moral reflections on business in healthcare* Thesis presented in partial fulfillment of the requirements for the degree M Phil (Applied Ethics) Stellenbosch University, March 2001 (Supervisor: Prof AA van Niekerk), 71.

[1097] Peppin, John F Business Ethics and Health Care: The Re-Emerging Institution-Patient Relationship *Journal of Medicine and Philosophy* Vol 24, No 5 (1999) 535 – 550, 536.

placed on physicians, but also on managed care organisations.[1098] It is clear from the case law discussed in sections 6.2.1. and 6.2.3. that the law still regards physicians and medical practitioners in general as the primary responsible entity in medical decision-making. While this may be true, the contributory force of managed care organisations in health service delivery and managed care practices in medical decision-making cannot be ignored. Trust is therefore an important quality in the institution-patient relationship and not only relevant to the dynamics in the doctor-patient relationship. Managed care can only be a morally creditable enterprise in health service delivery if it is designed to serve the needs of all those who are or will be ill.[1099]

While some may argue that such reasoning threatens the essence of the medical care industry at present, it must be remembered that patients do not relinquish all rights when becoming members of a health insurance plan. Patients' rights should rather be protected without fear of decreasing the efficiency of managed health care interventions. Protecting patients' rights, however, requires returning medical decision-making power to the patient and a legal redefinition of the doctor-patient relationship.[1100] As one commentator remarked: "*managed care has reduced the once-hallowed physician-patient relationship...to mere sound bites exchanged during hurried office visits, while therapeutic words of empathy have been replaced with Prozac scripts*".[1101]

[1098] Regan, Alycia C Regulating the Business of Medicine: Models for integrating ethics and managed care *Columbia Journal of Law and Social Problems* Vol 30 (1996 – 1997) 635 – 684, 684.
[1099] Pellegrino, Edmund D Managed Care at the Bedside: How do we look in the Moral Mirror? *Kennedy Institute of Ethics Journal* Vol 7, No 4 (1997) 321 – 330, 329.
[1100] Annas, George J Healey, Joseph M The Patient Rights Advocate: Redefining the Doctor-Patient Relationship in the Hospital Context *Vanderbilt Law Review* Vol 27 (1974) 243 – 270, 245.
[1101] Katz, Jay *The Silent World of Doctor and Patient* John Hopkins University Press: Baltimore 2002 (Originally published in 1984) xvii – xviii.

CHAPTER SEVEN: Consumerism and the doctor-patient relationship

7.1. Consumer choice, patient autonomy and the ethical limits of consumer responsibility

7.2. Consumer protection in the doctor-patient relationship

7.3. Consumer empowerment and the doctor-patient relationship

7.4. Conclusion

> "*The evidence about what patients seek in medical relationships has been quite consistent over many years, despite massive changes in the medical information available: patient sophistication in accessing it, and a growing trend toward consumerism and patient activism. Their [the patients'] relationships with health care plans have taken on increasing importance, but most patients still view their medical care in terms of their relationships with a limited number of physicians*."[1102]

As noted in Chapters Four and Six, the market paradigm in health service delivery developed in response to a general commercialisation, de-professionalisation and proletarianisation of the medical profession, as well as the escalation of costs in health service delivery. It was also evident from the discussion in these chapters that the influence of the market paradigm in health service delivery has been pervasive. While the main objective of managed care initiatives have been to contain and lower the rapidly escalating cost of health care, this cost has *again* begun to rise rapidly in recent years.[1103] In this post-managed care era, market advocates are now endorsing consumer-driven health care, "*which seeks to increase consumer sensitivity to cost and effectiveness by making people spend their own money for health care*".[1104] Consumer-directed health care, however, not only aims to control costs in the health care market, but also endeavours to enhance

[1102] Mechanic, David The Managed Care Backlash: Perceptions and Rhetoric in Health Care Policy and the Potential for Health Care Reform *The Milbank Quaterly* Vol 79, No 1 (2001) 35 – 54, 38.

[1103] Rosoff, Arnold J Consumer-Driven Health Care *Journal of Legal Medicine* Vol 28 (2007) 11 – 36, 18; Parmet, Wendy E Unprepared: Why Health Law Fails to Prepare us for a Pandemic *Journal of Health and Biomedical Law* (2006) 157 – 193, 180; Jacobi, John V After Managed Care: Gray Boxes, Tiers and Consumerism *Saint Louis University Law Journal* Vol 47 (2003) 397 – 410; Havighurst, Clark C How the Health Care Revolution fell short *Law and Contemporary Problems* Vol 65, No 4 (2002) 55 – 101; Herzlinger, Regina E (ed) *Consumer-Driven Health Care: Implications for Providers, Payers and Policymakers* John Wiley & Sons 2004.

[1104] Parmet, Wendy E Unprepared: Why Health Law Fails to Prepare us for a Pandemic *Journal of Health and Biomedical Law* (2006) 157 – 193, 180.

consumer control and choice "...*by combining financial incentives with information to help consumers make more informed health care decisions and to appreciate the economic trade-offs of those decisions*".[1105]

A consumer is willing to make independent decisions and to seek out alternative sources of information.[1106] The increased emphasis on cost containment policies also prompts consumers to view cost as a relevant factor in the medical decision-making process.[1107] Haug and Lavin define consumerism in health care in terms of the power relationship between doctor and patient: "*In simple terms, consumerism in medicine means challenging the physician's authority to make unilateral decisions, demanding a share in reaching closure on diagnosis and working out treatment plans. A consumer stance constitutes authority challenge*..."[1108]

Although there are significant differences between managed care and consumer-driven health care, there are important similarities. Both managed care and consumer-driven health care:

- seek to reduce the cost of health care by reducing the use of health care services aim to make parties more aware of the cost of health care services rendered;
- emphasise the sanctity of freedom of contract for patients, as well as private agreements between parties as an essential tool for enabling competition;
- deny individual patients health benefits in order to lower the cost of health care. (Managed care practices deny some patients benefits in order to maximise the economic good of a particular health plan, while consumer-driven health care

[1105] Axtell-Thompson Linda M Consumer Directed Health Care: Ethical Limits to Choice and Responsibility *Journal of Medicine and Philosophy* Vol 30 (2005) 207 – 226, 207; "Consumer-driven plans combine high-deductible insurance coverage – often in the form of a preferred provider organisation – with a personal spending account controlled by the consumer." Jacobi, John V After Managed Care: Gray Boxes, Tiers and Consumerism *Saint Louis University Law Journal* Vol 47 (2003) 397 – 410, 405; Rosoff, Arnold J Consumer-Driven Health Care *Journal of Legal Medicine* Vol 28 (2007) 11 – 36; For a complete study on the subject see Herzlinger, Regina E (ed) *Consumer-Driven Health Care: Implications for Providers, Payers and Policymakers* John Wiley & Sons 2004.

[1106] Hibbard, Judith H & Weeks, Edward, C Consumerism in Health Care: Prevalence and Predictors *Medical Care* Vol 25, No 11 (1987) 1019 – 1032, 1020.

[1107] Hibbard, Judith H & Weeks, Edward, C Consumerism in Health Care: Prevalence and Predictors *Medical Care* Vol 25, No 11 (1987) 1019 – 1032, 1020.

[1108] Hibbard, Judith H & Weeks, Edward, C Consumerism in Health Care: Prevalence and Predictors *Medical Care* Vol 25, No 11 (1987) 1019 – 1032, 1021.

sensitises individuals to the cost of health care services so that they only use the care they actually need, thereby reducing the cost of health care to society as a whole.)[1109]

It is important to note that there is presently no parallel to consumer-directed health care initiatives in the United Kingdom or in most European countries. The primary international model that consumer-driven health care advocates usually refer to that of Singapore.[1110] The use of consumer-directed health care initiatives in South Africa are also often cited in support of the general expansion of consumer-driven health care.[1111] China is also rapidly adopting health care policy and financing vehicles that resemble the consumer-directed health care initiatives of the USA, and Switzerland has also been held up by some as a consumer-driven health care model.[1112] Unfortunately, most of the information available on managed care and consumer-directed health care initiatives in South Africa comes from one source, Shaun Mattisonn, the executive vice president of Discovery Health, one of the largest insurance administrators in South Africa.[1113] This is regrettable for the obvious reason that a truly objective viewpoint, which would also include research and statistics on the influence of these initiatives on the public health care sector in South Africa, is not reflected in Mattisonn's writings. Since about 85% of South Africans were dependent on the country's public health care system in 2005, a more objective view is crucial.[1114]

Currently there is a growing recognition of the potentially potent force that patients, as consumers, can be in bringing about change in the health care sector.[1115] As consumers,

[1109] Parmet, Wendy E Unprepared: Why Health Law Fails to Prepare us for a Pandemic *Journal of Health and Biomedical Law* (2006) 157 – 193, 181.
[1110] Jost, Timothy Stoltzfus Consumer-driven Health Care in South Africa: Lessons from Comparative Health Policy Studies *Journal of Health and Biomedical Law* (2005) 83 – 109, 88.
[1111] Callahan, Daniel Consumer-Directed Health Care: Promise of Puffery? *Health, Economics, Policy and Law* (2008) Vol 3, 301 – 311, 303; Jost, Timothy Stoltzfus Consumer-driven Health Care in South Africa: Lessons from Comparative Health Policy Studies *Journal of Health and Biomedical Law* (2005) 83 – 109.
[1112] Jost, Timothy Stoltzfus Consumer-driven Health Care in South Africa: Lessons from Comparative Health Policy Studies *Journal of Health and Biomedical Law* (2005) 83 – 109, 88.
[1113] Jost, Timothy Stoltzfus Consumer-driven Health Care in South Africa: Lessons from Comparative Health Policy Studies *Journal of Health and Biomedical Law* (2005) 83 – 109, 91; Herzlinger, Regina E (ed) *Consumer-Driven Health Care: Implications for Providers, Payers and Policymakers* John Wiley & Sons 2004, 330 - 337.
[1114] Jost, Timothy Stoltzfus Consumer-driven Health Care in South Africa: Lessons from Comparative Health Policy Studies *Journal of Health and Biomedical Law* (2005) 83 – 109, 92.
[1115] Hibbard, Judith H Engaging Health Care Consumers to Improve the Quality of Care *Medical Care* Vol 41, No 1 (2003) I-61 – I-70, I-61.

patients have, for example, an important and active role to play in improving the quality of their own care, as well as the quality of care delivered in the health care system as a whole.[1116] This chapter will consider the critical role patients, as consumers of health care services in a post-managed care era, have in ensuring a more equal balance of power in the unique doctor-patient relationship. As the doctor-patient relationship becomes more impersonal and distant, patients can rely less on medical practitioners to look after their health interests and need to become more involved in their personal and family health care.[1117] In addition, more attention should be focussed on patients' perspective to make the doctor-patient relationship and interaction more costumer orientated, thereby facilitating behaviour and compliance that positively affect the therapeutic outcome.[1118]

Another fundamental enquiry into the practice of consumer-directed health care is whether thinking of a patient as a knowledgeable consumer could ever make complete sense in the face of complicated, emotionally charged illnesses and complex decision-making situations.[1119] Consumer-directed health care initiatives are yet another example of the commodification of health care first discussed in Chapter Four. Consumer-directed health care rests on the premise that health care can successfully be treated the same as any other commodity.[1120] It was established in Chapter Four section 4.2. that health care can not be regarded as an ordinary commodity. This matter will not be debated any further, except to mention the features Callahan identified in his paper on consumer-directed health care in support of his argument that health care is different from other areas of economic activity. Callahan submits that health care is not an ordinary commodity since

- the nature and demand for health care is irregular and unpredictable;
- lacking knowledge and experience, the patient is forced to trust his/her physician;

[1116] Hibbard, Judith H Engaging Health Care Consumers to Improve the Quality of Care *Medical Care* Vol 41, No 1 (2003) I-61 – I-70, I-61.

[1117] Roth, Martin S Enhancing Consumer Involvement in Health Care: The Dynamics of Control, Empowerment and Trust *Journal of Public Policy and Marketing* Vol 13 (1) (1994) 115 – 132, 115; Gould, Stephen J Consumer Attitudes Toward Health and Health Care: A Differential Perspective *The Journal of Consumer Affairs* Vol 22, No 1 (1988) 96 – 118, 115.

[1118] Roth, Martin S Enhancing Consumer Involvement in Health Care: The Dynamics of Control, Empowerment and Trust *Journal of Public Policy and Marketing* Vol 13 (1) (1994) 115 – 132, 118.

[1119] Callahan, Daniel Consumer-Directed Health Care: Promise of Puffery? *Health, Economics, Policy and Law* (2008) Vol 3, 301 – 311, 301.

[1120] Callahan, Daniel Consumer-Directed Health Care: Promise of Puffery? *Health, Economics, Policy and Law* (2008) Vol 3, 301 – 311, 302.

- recovery from disease is as unpredictable as its incidence; and
- entry into the field of health care is limited by professional and licensing restrictions.[1121]

However, supporters of consumer-driven health care initiatives submit that to judge health care as "different" would block many management techniques that could be effectively used in health care organisations.[1122]

In section 7.1. consumer choice, as one of the main objectives of consumer-directed health care initiatives, will be discussed. How consumer choice contributes to the realisation of patient autonomy in the medical decision-making process, and the ethical limits of such extended consumer responsibility, will be highlighted. Consumer protection in the doctor-patient relationship will be considered in sections 7.2. and in section 7.3. Recommendations will be made on how to enhance and develop consumer empowerment in health service delivery.

7.1. Consumer choice, patient autonomy and the ethical limits of consumer responsibility

As indicated, consumer-directed health care has as aim to inform patients (consumers) properly about health care spending in order to contain the escalating cost of health care services. It also provides consumers with more control and responsibility in medical decision-making by giving them incentives to consider both the cost and quality of considerations when making a health care decision.[1123] Thus, while managed care initiatives control the cost of health care services by placing health providers at financial risk for their decisions, the managed care backlash focuses incentives on patients.[1124] However, while consumer-driven health care is gaining in popularity in the health care market, various concerns with regard to its effectiveness and suitability to contain cost and enhance

[1121] Callahan, Daniel Consumer-Directed Health Care: Promise of Puffery? *Health, Economics, Policy and Law* (2008) Vol 3, 301 – 311, 302; Also see Arrow, Kenneth J Uncertainty and the Welfare Economics of Medical Care *The American Economic Review* Vol 4, No 5 (1963) 941 – 973.

[1122] Callahan, Daniel Consumer-Directed Health Care: Promise of Puffery? *Health, Economics, Policy and Law* (2008) Vol 3, 301 – 311, 303.

[1123] Axtell-Thompson Linda M Consumer Directed Health Care: Ethical Limits to Choice and Responsibility *Journal of Medicine and Philosophy* Vol 30 (2005) 207 – 226, 208; Herzlinger, Regina E (ed) *Consumer-Driven Health Care: Implications for Providers, Payers and Policymakers* John Wiley & Sons 2004.

[1124] Axtell-Thompson Linda M Consumer Directed Health Care: Ethical Limits to Choice and Responsibility *Journal of Medicine and Philosophy* Vol 30 (2005) 207 – 226, 208.

consumer choice have come to the fore.[1125] In this section, the emphasis on consumer choice in health service delivery and how it influences the power imbalances in the doctor-patient relationship will be considered.

> "*The era of the consumer has been declared, with patients seen as the new locus of decision making in the health care system*."[1126]

Consumer-directed health care imposes on consumers the responsibility to choose when and from whom they obtain treatment.[1127] This emphasis on consumer choice implies that patient autonomy and self-determination are now being served in the medical decision-making process. However, this emphasis and reliance on consumer choice also presupposes that

- patients are rational;
- patients have sufficient information to make important decisions about their health care;
- patients are capable of utilising the information provided;
- patients are certain of the outcome of their decisions; and
- a person is the best judge of his/her own welfare.[1128]

The relationship between the availability of material and relevant information and patient autonomy in the medical decision-making process have already been considered. In Chapter Three section 3.5.4. it was argued that the doctrine of informed consent as a legal instrument in the medical decision-making process does not always guarantee patient autonomy and self-determination. In Chapter Four section 4.3.2. a more rights-based approach (in contrast to a more paternalistic approach) in health service delivery was

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[1125] Jacobi, John V After Managed Care: Gray Boxes, Tiers and Consumerism *Saint Louis University Law Journal* Vol 47 (2003) 397 – 410, 405; Axtell-Thompson Linda M Consumer Directed Health Care: Ethical Limits to Choice and Responsibility *Journal of Medicine and Philosophy* Vol 30 (2005) 207 – 226, 210.

[1126] Flynn K, Smith M & Davis M From Physician to Consumer: The effectiveness of strategies to manage health care utilisation *Medical Care Research and Review* Vol 59, No 4, 455 – 481, 456.

[1127] Jacobi, John V After Managed Care: Gray Boxes, Tiers and Consumerism *Saint Louis University Law Journal* Vol 47 (2003) 397 – 410, 408.

[1128] Axtell-Thompson Linda M Consumer Directed Health Care: Ethical Limits to Choice and Responsibility *Journal of Medicine and Philosophy* Vol 30 (2005) 207 – 226, 214 – 215; Bownds, Lynne Consumer-Driven Health Plans: More Choice is not always Better *Journal of Economic Issues* Vol XXXVII, No 2 (2003) 425 – 432, 426; Bernstein, Amy B & Gauthier, Anne K Choices in Health Care: What are they and What are they worth? *Medical Care Research and Review* Vol 56, Supplement 1 (1999) 5 – 23, 11.

considered and found not always to provide the necessary security for the patient in the medical decision-making process. (In fact, the analysis in this chapter showed that the greater the emphasis on patient autonomy, the more vulnerable the patient actually becomes.) And, in Chapter Six sections 6.2.1. and 6.2.4., it became evident that different types of information are required at various points in the medical decision-making process to enable the patient to make an informed decision which will directly affect his/her health care options. With regard to all these limitations placed on consumer choice and patient participation in the medical decision-making process, Henry Ford's remark that customers could have his model T in any colour they preferred as long as it was black, seems particularly apt.[1129]

Access to sufficient information (propagated by the emphasis placed on consumer choice in consumer-directed health care) therefore does not guarantee that autonomy will be the ruling ethical principle in medical decision-making and that the process will be in the particular patient's best interest and to his/her advantage. In fact, too much information can be just as unenlightening as too little information.[1130] Consumers do not always understand or utilise information, and too much information, or the wrong information, can hamper real knowledge and understanding.[1131] In addition, the intent to enhance consumer choice can not be dealt with in such a simple and straightforward manner as suggested by current consumer-directed health care initiatives, especially in a diverse multi-cultural country like South Africa. Not all consumers are alike, different consumers will have different needs and varying capacities for handling information and for taking responsibility to attend to these available health care choices.[1132] Furthermore, the reality of consumer

[1129] Callahan, Daniel Consumer-Directed Health Care: Promise of Puffery? *Health, Economics, Policy and Law* (2008) Vol 3, 301 – 311, 311.

[1130] Rodwin, Marc A Consumer Protection and Managed Care: Issues, Reform Proposals, and Trade-Offs *Houston Law Review* Vol 32, (1995-1996) 1319 – 1381, 1351.

[1131] Kapp, Marshall B Patient Autonomy in the Age of Consumer-Driven Health Care: Informed Consent and Informed Choice *Journal of Legal Medicine* Vol 28 (2007) 91 – 117, 112; Axtell-Thompson Linda M Consumer Directed Health Care: Ethical Limits to Choice and Responsibility *Journal of Medicine and Philosophy* Vol 30 (2005) 207 – 226, 215; Herzlinger, Regina E (ed) *Consumer-Driven Health Care: Implications for Providers, Payers and Policymakers* John Wiley & Sons 2004, 97; Bernstein, Amy B & Gauthier, Anne K Choices in Health Care: What are they and What are they worth? *Medical Care Research and Review* Vol 56, Supplement 1 (1999) 5 – 23, 13.

[1132] Gould, Stephen J Consumer Attitudes Toward Health and Health Care: A Differential Perspective *The Journal of Consumer Affairs* Vol 22, No 1 (1988) 96 – 118, 115; Axtell-Thompson Linda M Consumer Directed

choice and responsibility for health care can exacerbate current disparities in health care, an issue which is already critical in South Africa.[1133] The underprivileged and cost-conscious consumer, for example, is notoriously poor at differentiating between dispensable treatments and those necessary to preserve life and death. The underprivileged and needy would also rather avoid financing expanded choice in health service delivery. Increased consumer cost-sharing will consequently lead to reduced levels of health insurance for the working poor.[1134] There is considerable evidence that an informed and questioning consumer procures better quality services.[1135]

To address the ethical limitations to consumer responsibility in medical decision-making Axtell-Thompson suggests that the principle of beneficence must receive greater status in order to temper autonomy and protect consumers from the unintended consequences of uninformed decisions.[1136] This notion corresponds with the Pellegrino-Thomasma beneficence model,[1137] which suggests that beneficence supersedes both autonomy and paternalism in medical decision-making, but that the beneficence model can be reconstructed to accommodate concerns from the autonomy model. A similar argument is offered by Sunstein and Thaler who note that "libertarian paternalism" should follow naturally as legitimate public policy in order to ensure that consumers make truly informed and advantageous decisions. They submit that "libertarian" in this context means that consumers should be able to opt out of certain arrangements and that "paternalism" refers to institutions, both public and private, capable of designing such arrangements to influence individuals' choices to the institutions' benefit.[1138] On the other hand, the theory of Beauchamp on autonomy and beneficence in medical practice, on the other hand, suggests

Health Care: Ethical Limits to Choice and Responsibility *Journal of Medicine and Philosophy* Vol 30 (2005) 207 – 226, 213 - 214.

[1133] Axtell-Thompson Linda M Consumer Directed Health Care: Ethical Limits to Choice and Responsibility *Journal of Medicine and Philosophy* Vol 30 (2005) 207 – 226, 219; Jacobi, John V After Managed Care: Gray Boxes, Tiers and Consumerism *Saint Louis University Law Journal* Vol 47 (2003) 397 – 410, 408; Bloche, Gregg M Consumer-Directed Health Care and The Disadvantaged *Health Affairs* Vol 26, No 5 (2007) 1315 – 1327.

[1134] Jacobi, John V After Managed Care: Gray Boxes, Tiers and Consumerism *Saint Louis University Law Journal* Vol 47 (2003) 397 – 410, 409.

[1135] Hibbard, Judith H & Weeks, Edward, C Consumerism in Health Care: Prevalence and Predictors *Medical Care* Vol 25, No 11 (1987) 1019 – 1032, 1020.

[1136] Axtell-Thompson Linda M Consumer Directed Health Care: Ethical Limits to Choice and Responsibility *Journal of Medicine and Philosophy* Vol 30 (2005) 207 – 226, 207.

[1137] Which was also discussed in section 3.3., Chapter Three, together with the theory of Beauchamp?

[1138] Axtell-Thompson Linda M Consumer Directed Health Care: Ethical Limits to Choice and Responsibility *Journal of Medicine and Philosophy* Vol 30 (2005) 207 – 226, 217 - 218.

that autonomy should always be the starting point in medical decision-making, but that principles from both the autonomy and beneficence models should be adopted to ensure that the patient's best interests are served, and that such a combined model will not necessarily result in inconsistency.[1139]

The principlism approach to bioethics requires that the ethical principles of beneficence and autonomy be carefully weighed and balanced in consumer-directed medical decision-making.[1140] From the discussion in the previous chapters it is evident that dominance among these principles has shifted over time and that different stakeholders have different views; whether it be the point of view of the medical practitioner, the patient, or a third party involved in health service delivery. It is submitted in this dissertation that autonomy should always be the point of departure in medical decision-making, but that principles of beneficence can and should also be adopted to ensure that a patient's best interests are served. Axtell-Thompson rightly states that the interest in allowing people to make their own choices — which is reiterated in the Constitution in section 12(2) and in the values underlying the Constitution, including dignity,[1141] integrity,[1142] individuality,[1143] independence,[1144] responsibility and self-knowledge[1145] — should be balanced against the interest in protecting people from the potentially bad consequences of their choices due to the impossible expectations and burdens imposed on the decision-making capabilities of consumers of health care. In other words, the traditional ethical obligations of medical professionals with regard to beneficence (discussed in Chapter Two) should not be discarded, but should rather be encouraged for the benefit and in the best interests of the patient. In consumer-directed health care, beneficence should be utilised to temper autonomy in order to protect consumers from the unintended consequences of their own uninformed decisions.

> "*While greater consumer choice is desirable, consumer-driven health care plans should be designed so that consumers are not simply abandoned to all potential*

[1139] Also see Chapter Three, section 3.3.
[1140] Axtell-Thompson Linda M Consumer Directed Health Care: Ethical Limits to Choice and Responsibility *Journal of Medicine and Philosophy* Vol 30 (2005) 207 – 226, 217 - 221.
[1141] Constitution of the RSA, 1996 section 10.
[1142] Constitution of the RSA, 1996 Chapter Two and especially section 12.
[1143] Constitution of the RSA, 1996 section 12, 14, 15, 16, 18 and 21.
[1144] Constitution of the RSA, 1996 section 12, 14, 15, 16, 18 and 21.
[1145] Constitution of the RSA, 1996 Chapter Two.

consequences if their autonomous choices are tainted by missing or inadequate information, comprehension, or decision capability."[1146]

However, consumers of health care services should generally be held accountable for their choices to prevent an increasingly unsustainable health care system. The protection of individual autonomy advocated in this dissertation naturally demands that the greater responsibility placed on each individual, especially in the context of consumer-directed health care, be recognised.[1147]

7.2. Consumer protection in the doctor-patient relationship

Consumers' concerns with regard to the quality of and access to adequate health care services have attracted much attention since the incorporation of managed health care initiatives discussed in Chapter Six. In the USA, ex-president Bill Clinton made consumer protection a cornerstone of his health policy agenda in the late 1990s, introducing measures for the disclosure of benefits and coverage, the utilisation review of health plan decisions and extensive requirements for grievance and appeal procedures, particularly in emergency situations.[1148] It is said that managed health care initiatives have generated this exuberant concern about consumer protection largely because of the way in which managed care organisations employ and pay physicians, which also encourages physicians to limit care.[1149] In this section, it will be argued that the current legal instruments for identifying and resolving consumer concerns in health care are incomprehensible and inaccessible to most consumers, particularly those without any health insurance.[1150] In addition, the limitations

[1146] Axtell-Thompson Linda M Consumer Directed Health Care: Ethical Limits to Choice and Responsibility *Journal of Medicine and Philosophy* Vol 30 (2005) 207 – 226, 217 - 223.
[1147] Axtell-Thompson Linda M Consumer Directed Health Care: Ethical Limits to Choice and Responsibility *Journal of Medicine and Philosophy* Vol 30 (2005) 207 – 226, 217 - 224.
[1148] Kinney, Eleanor D Tapping and Resolving Consumer Concerns about Health Care *American Journal of Law and Medicine* Vol 26 (2000) 335 – 398, 336.
[1149] Kinney, Eleanor D Tapping and Resolving Consumer Concerns about Health Care *American Journal of Law and Medicine* Vol 26 (2000) 335 – 398, 337; Also see Rodwin, Marc A Consumer Protection and Managed Care: Issues, Reform Proposals, and Trade-Offs *Houston Law Review* Vol 32, (1995-1996) 1319 – 1381.
[1150] Rodwin, Marc A Consumer Protection and Managed Care: Issues, Reform Proposals, and Trade-Offs *Houston Law Review* Vol 32, (1995-1996) 1319 – 1381; Kinney, Eleanor D Tapping and Resolving Consumer Concerns about Health Care *American Journal of Law and Medicine* Vol 26 (2000) 335 – 398, 339.

to the empowerment of patients that the biological exigencies of illness and injury impose require special protection for consumers of health care.[1151]

According to Du Preez, the Consumer Protection Act 68 of 2008 lays the foundation for an era of consumers in South Africa by introducing a single, comprehensive legal framework for consumer protection.[1152] The act focuses exclusively on consumer protection by aiming to "...*promote a fair, accessible and sustainable marketplace for consumer products and services, and for that purpose, to establish national norms and standards relating to consumer protection*...".[1153] The purpose of the act, according to section 3(1) is mainly to promote and advance the social and economic welfare of consumers in South Africa.[1154] The act also contains far-reaching provisions which will fundamentally affect the way business is conducted in South Africa. Some of the provisions applicable to the health care market include section 22, which makes provision for the right to information in plain and understandable language: section 35 which relates to customer loyalty programmes; section 48, in which the right to fair, reasonable and just terms and conditions is confirmed and section 13, which relates to the consumer's right of choice.[1155] The provisions of this Act apply to service providers in the health care sector as well as providers of professional services like medical practitioners.[1156]

Consumer concerns with regard to health service delivery vary greatly but pertain primarily to three issues: quality, cost and adequate access.[1157] These three issues and how they relate to the power imbalances in the doctor-patient relationship have been dealt with extensively in this dissertation. The insight that multiple factors, including socio-economic

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[1151] Williamson, Charlotte *Whose Standards? Consumer and Professional Standards in Health Care* Open University Press: Buckingham 1992, 15.

[1152] Du Preez, Monique L The Consumer Protection Bill: A few Preliminary Comments *Tydskrif vir die Suid-Afrikaanse Reg* Vol 1 (2009) 58 – 83, 58.

[1153] Long title of the Consumer Protection Act 68 of 2008; Du Preez, Monique L The Consumer Protection Bill: A few Preliminary Comments *Tydskrif vir die Suid-Afrikaanse Reg* Vol 1 (2009) 58 – 83, 59.

[1154] Consumer Protection Act 68 of 2008; Du Preez, Monique L The Consumer Protection Bill: A few Preliminary Comments *Tydskrif vir die Suid-Afrikaanse Reg* Vol 1 (2009) 58 – 83, 65.

[1155] Consumer Protection Act 68 of 2008; Du Preez, Monique L The Consumer Protection Bill: A few Preliminary Comments *Tydskrif vir die Suid-Afrikaanse Reg* Vol 1 (2009) 58 – 83, 61.

[1156] Du Preez, Monique L The Consumer Protection Bill: A few Preliminary Comments *Tydskrif vir die Suid-Afrikaanse Reg* Vol 1 (2009) 58 – 83, 61.

[1157] Kinney, Eleanor D Tapping and Resolving Consumer Concerns about Health Care *American Journal of Law and Medicine* Vol 26 (2000) 335 – 398, 339.

considerations, cultural influences, the social dynamics of the particular doctor-patient relationship and the general approach to health service delivery determine whether consumers will present claims to legal institutions for resolution is crucial, especially in a non-litigious society like South Africa.[1158] Other factors include the complexity of the health care system and the debilitating effects of illness.[1159] In Chapter Six section 6.2.5. it was submitted that more attention should be paid to developing meaningful options for patients, including alternative dispute resolution mechanisms, grievance mechanisms and appeal procedures in managed health care plans and organisations. In consumer-directed health care, where patients are accorded more responsibility in the health care process, and are required to advocate for themselves, user-friendly appeal mechanisms are crucial.

Extra-legal methods for the resolution of consumer concerns include quality assurance and improvement programmes, risk management programmes, provider ethics committees and customer relations, and ombudsman programmes.[1160] Non-judicial legal regimes for the resolution of consumer concerns include internal review within health care plans and external review by an administrative agency or other entity.[1161] Judicial review of decisions made by health care plans and traditional methods of legal recourse are also available to consumers of health care services. However, not all consumer concerns in health care fit neatly into the available courses of action.[1162] Kinney submits that all these available systems for the resolution of consumer concerns in health care are uncoordinated, inaccessible, inequitable and non-inclusive. "*Even when consumers recognise that they have legitimate concerns about their health care, obtaining remedies is difficult and relief is not always available*."[1163]

[1158] Kinney, Eleanor D Tapping and Resolving Consumer Concerns about Health Care *American Journal of Law and Medicine* Vol 26 (2000) 335 – 398, 340; Schlesinger Mark, Mitchell Shannon, Elbel Brian Voices Unheard: Barriers to Expressing Dissatisfaction to Health Plans *The Milbank Quaterly* Vol 80, No 4 (2002) 709 – 755.

[1159] Schlesinger Mark, Mitchell Shannon, Elbel Brian Voices Unheard: Barriers to Expressing Dissatisfaction to Health Plans *The Milbank Quaterly* Vol 80, No 4 (2002) 709 – 755, 710.

[1160] Kinney, Eleanor D Tapping and Resolving Consumer Concerns about Health Care *American Journal of Law and Medicine* Vol 26 (2000) 335 – 398, 348 – 355.

[1161] Kinney, Eleanor D Tapping and Resolving Consumer Concerns about Health Care *American Journal of Law and Medicine* Vol 26 (2000) 335 – 398, 355 – 368.

[1162] Kinney, Eleanor D Tapping and Resolving Consumer Concerns about Health Care *American Journal of Law and Medicine* Vol 26 (2000) 335 – 398, 368.

[1163] Kinney, Eleanor D Tapping and Resolving Consumer Concerns about Health Care *American Journal of Law and Medicine* Vol 26 (2000) 335 – 398, 380.

The following are major obstacles to the resolution of consumer concerns in health care:

- Providers of health care services and health care plans rarely have a systematic mechanism in place for the identification of consumer concerns, or an informal forum where consumers can voice their concern and get relief.
- Consumers of health care services are greatly disempowered vis-à-vis health care providers and health care plans, which have comparatively more power in terms of medical knowledge, control of the process and general resources.[1164]
- Existing legal doctrines are inadequate to assure accountability of public and private health plans for their treatment of consumers and their concerns.
- Mechanisms for the resolution of consumer concerns are fragmented and incomprehensible from the perspective of consumers.
- These mechanisms usually also exclude uninsured consumers.
- Existing procedures do not always ensure that consumers are able to discover, develop and present all relevant facts and arguments in adjudicative proceedings and obtain unbiased and fair consideration.[1165]

As a result, the focus should rather be on how consumers can be empowered in order to ensure that they are adequately protected in health care disputes. Some suggestions for consumer empowerment include

- greater consumer involvement in the governance and policy making of health plans;
- addressing the power disparities between consumers and plans and/or providers;
- simplifying and consolidating dispute resolution processes to enhance accessibility;
- empowering physicians as advocates on behalf of patients;
- enhancing legal advocacy;

[1164] It is difficult, for example, for consumers of health care services to recognise problems with the health care which they receive, and if they do sense that something is wrong, they may hesitate to complain about services which they poorly understand. It is furthermore often difficult for patients to determine whether their health problems have anything to do with the treatment they received. In the final instance, the costs of voicing grievances in medical settings often seem to exceed the potential benefits. Schlesinger Mark, Mitchell Shannon, Elbel Brian Voices Unheard: Barriers to Expressing Dissatisfaction to Health Plans *The Milbank Quaterly* Vol 80, No 4 (2002) 709 – 755, 716.

[1165] Kinney, Eleanor D Tapping and Resolving Consumer Concerns about Health Care *American Journal of Law and Medicine* Vol 26 (2000) 335 – 398, 380; Also see Rodwin, Marc A Consumer Protection and Managed Care: Issues, Reform Proposals, and Trade-Offs *Houston Law Review* Vol 32, (1995-1996) 1319 – 1381.

- ensuring sufficiency of legal accountability of public and private health plans; and
- pursuing other strategies that provide consumers with a greater "voice" in expressing their concerns about health care.[1166]

A discussion of *all* of these suggestions to enhance and develop consumer empowerment does not fall within in the ambit of this dissertation. The following section will therefore only focus on selected topics relating to consumer empowerment and the doctor-patient relationship, with special emphasis on the power imbalances inherent in this relationship.

7.3. Consumer empowerment and the doctor-patient relationship

Consumer-directed health care is essentially based on the empowerment of patients to enable them to collaborate fully with their health care team in managing their health.[1167] Such health care has real potential to empower patients in the medical marketplace with the availability of information about their health. Patients' newly found empowerment is part of the backlash against managed care practices (discussed in Chapter Six) and the overall negative reaction to being controlled by the managed care system.[1168] The traditional HMO model described in section 6.2. of Chapter Six, for example, is said to be based on patient ignorance; making health care free at the point of consumption and controlling costs by having physicians make rationing decisions.[1169] However, the troubling question remains what effect this shift in the market of health care will have on those who are not able to play the demanding role of knowledgeable, empowered consumers.[1170] It is submitted that the unique social dynamics of the doctor-patient relationship and the special role of the physician in this relationship may assist with patient empowerment in this new age of consumer-directed health care.

[1166] Kinney, Eleanor D Tapping and Resolving Consumer Concerns about Health Care *American Journal of Law and Medicine* Vol 26 (2000) 335 – 398, 381.

[1167] Jost, Timothy Stoltzfus Consumer-Driven Health Care in South Africa: Lessons from Comparative Health Policy Studies *Journal of Health and Biomedical Law* 2005, 83 – 109, 83; Herzlinger, Regina E (ed) *Consumer-Driven Health Care: Implications for Providers, Payers and Policymakers* John Wiley & Sons 2004, 203; Bernstein, Amy B & Gauthier, Anne K Choices in Health Care: What are they and What are they worth? *Medical Care Research and Review* Vol 56, Supplement 1 (1999) 5 – 23, 15.

[1168] Herzlinger, Regina E (ed) *Consumer-Driven Health Care: Implications for Providers, Payers and Policymakers* John Wiley & Sons 2004, 204.

[1169] Herzlinger, Regina E (ed) *Consumer-Driven Health Care: Implications for Providers, Payers and Policymakers* John Wiley & Sons 2004, 225.

[1170] Rosoff, Arnold J Consumer-Driven Health Care *Journal of Legal Medicine* Vol 28 (2007) 11 – 36, 20.

Roth suggests a value-based analysis of consumer involvement in health care in general, and the doctor-patient relationship in particular.[1171] In a qualitative study he conducted, the dynamics of control, empowerment and trust in the doctor-patient relationship were identified as imperative for healthy doctor-patient interactions and a more equal distribution of power in the doctor-consumer relationship. "[P]*hysician understanding and a communicative atmosphere created by physician availability, personality and respect were perceived to facilitate better treatment, leading to peace of mind, acceptance and compliance, as well as a sense of patient empowerment*".[1172] Patients derive control and power from the medical knowledge and information provided to them.[1173] Empowerment, on the other hand, is facilitated when consumers have not only a comprehensive understanding of a health issue, but also believe that they can engage in meaningful dialogue with their physicians and suggest a relevant course of action alone or in conjunction with their physician.[1174] A balance of information content and communication environment is also required to ensure that the patient-physician exchange induces consumer trust.[1175]

Kapp suggests that health professionals should take on an educational role that assists their patients to partake fully of the rights and responsibilities associated with consumer-driven health care.[1176] This is also the recommended mode of patient empowerment supported in this dissertation. Since not all patients are the same, no single empowerment approach is likely to work for everyone.[1177] However, one constant remains in this revolution of medical practice: the doctor-patient relationship. And the physician remains the most important role player in health service delivery to provide consumers with exactly the kind and amount of

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[1171] Roth, Martin S Enhancing Consumer Involvement in Health Care: The Dynamics of Control, Empowerment and Trust *Journal of Public Policy and Marketing* Vol 13 (1) (1994) 115 – 132, 115.
[1172] Roth, Martin S Enhancing Consumer Involvement in Health Care: The Dynamics of Control, Empowerment and Trust *Journal of Public Policy and Marketing* Vol 13 (1) (1994) 115 – 132, 123 – 124.
[1173] Roth, Martin S Enhancing Consumer Involvement in Health Care: The Dynamics of Control, Empowerment and Trust *Journal of Public Policy and Marketing* Vol 13 (1) (1994) 115 – 132, 123 - 125.
[1174] Roth, Martin S Enhancing Consumer Involvement in Health Care: The Dynamics of Control, Empowerment and Trust *Journal of Public Policy and Marketing* Vol 13 (1) (1994) 115 – 132, 123 - 125.
[1175] Roth, Martin S Enhancing Consumer Involvement in Health Care: The Dynamics of Control, Empowerment and Trust *Journal of Public Policy and Marketing* Vol 13 (1) (1994) 115 – 132, 123 - 126.
[1176] Kapp, Marshall B Patient Autonomy in the Age of Consumer-Driven Health Care: Informed Consent and Informed Choice *Journal of Legal Medicine* Vol 28 (2007) 91 – 117, 113.
[1177] Gould, Stephen J Consumer Attitudes Toward Health and Health Care: A Differential Perspective *The Journal of Consumer Affairs* Vol 22, No 1 (1988) 96 – 118, 116.

information that they want and need, as well as the means to become further informed and empowered to take full responsibility for their own health care.[1178]

In addition to the pivotal role that medical practitioners can play in the doctor-patient relationship to empower the consumer-patient, consumer interests also need to be organised, as consumer empowerment can also only be effective in its outcomes when there is organised advocacy.[1179]

7.4. Conclusion

In this dissertation the historical development of the doctor-patient relationship has been traced from its early origins with physicians as the primary decision-makers to the new medical marketplace with patients now the new locus of decision-making in health care.[1180] This change, although not widespread, has become socially desirable.[1181] While much of this dissertation has advocated more patient autonomy and self-determination in order to ensure a more equal distribution of power in the doctor-patient relationship, the discussion in this chapter argued for a more cautious approach in consumer-directed health care.

> "*Consumer-directed health care appears to be a good fair-weather friend, up to dealing with a small squall, but not really bad weather*."[1182]

While consumer-directed health care has the potential to ensure that patients have greater autonomy and control in medical decision-making, it may also exacerbate current disparities. Research indicates that consumer-directed health care initiatives cause patients to avail themselves of fewer health care services, even when that care is essential, and that lower-income individuals and those with serious health concerns are particularly at risk.[1183]

[1178] Rodwin, Marc A Consumer Protection and Managed Care: Issues, Reform Proposals, and Trade-Offs *Houston Law Review* Vol 32, (1995-1996) 1319 – 1381, 1351.
[1179] Rodwin, Marc A Consumer Protection and Managed Care: The Need for Organised Consumers *Health Affairs* Vol 15, No 3 (1996) 110 – 123, 116.
[1180] Flynn Kathryn E, Smith Maureen A, Davis Margaret K From Physician to Consumer: The Effectiveness of Strategies to Manage Health Care Utilization *Medical Care Res Review* Vol 59, No 4 (2002) 455 – 481, 455.
[1181] Gould, Stephen J Consumer Attitudes toward Health and Health Care: A Differential Perspective *The Journal of Consumer Affairs* Vol 22, No 1 (1988) 96 – 118, 114.
[1182] Callahan, Daniel Consumer-Directed Health Care: Promise of Puffery? *Health, Economics, Policy and Law* (2008) Vol 3, 301 – 311, 303.
[1183] Davis, Karen Will Consumer-Directed Health Care Improve System Performance? Issue Brief for the Commonwealth Fund August 2004 *Health Services Research* Special Supplement, Part II, 38(4) 1219 – 1231.

Consumerism in health care is furthermore inconsistent with the traditional relationship of authority between the medical practitioner and patient (described in Chapter Two and Chapter Three) as it challenges traditional physician authority.[1184] It is said that these traditional conceptions of professional authority are being challenged by a more educated and egalitarian society.[1185] And while conventional practices suggested that patients are ill equipped to judge the merits of medical practice and that physicians should act as patients' agents in this regard, business leaders and public officials now overturn these conventional practices by motivating patients to take charge of their own care.[1186]

The overly individualistic approach of consumer-directed health care furthermore discounts the social dimension of medical care, ignoring the clinical realities and impact of illness and disease on vulnerable patients as well as the complex nature of health service delivery. The health care consumer of today is faced with a bewildering set of choices and an equally bewildering barrage of information.[1187] In addition, the ability to engage in a rational medical decision-making process may also wax and wane from time to time for most individuals, depending on the type of choice they are confronted with at a particular time.[1188]

Probably the most worrisome consequence of consumer-directed health care in the South African context is that those least able to navigate through the health care system – typically the least educated and least prosperous – will probably fare the worst in this environment.[1189] And Bloche suggests that those most marginalised by language and

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[1184] Haug, Marie R & Lavin, Bebe Public Challenge of Physician Authority *Medical Care* Vol XVII, No 8 (1979) 844 – 858, 844.

[1185] Haug, Marie R & Lavin, Bebe Public Challenge of Physician Authority *Medical Care* Vol XVII, No 8 (1979) 844 – 858, 845.

[1186] Bloche, Gregg M Consumer-Directed Health Care *New England Journal of Medicine* Vol 355, No 17 (2006) 1756 – 1759, 1756.

[1187] Gould, Stephen J Consumer Attitudes toward Health and Health Care: A Differential Perspective *The Journal of Consumer Affairs* Vol 22, No 1 (1988) 96 – 118, 97; Bownds, Lynne Consumer-Driven Health Plans: More Choice is not always Better *Journal of Economic Issues* Vol XXXVII, No 2 (2003) 425 – 432, 428.

[1188] Kapp, MB From Medical Patients to Health Care Consumers: Decisional Capacity and Choices to purchase Coverage and Services *Aging and Mental Health* Vol 3, No 4 (1999) 294 – 300, 295.

[1189] Bloche, Gregg M Consumer-Directed Health Care and the Disadvantaged *Health Affairs* Vol 26, No 5 (2007) 1315 – 1327, 1325; For an unconvincing but opposite point of view see Herzlinger, Regina E (ed) *Consumer-Driven Health Care: Implications for Providers, Payers and Policymakers* John Wiley & Sons 2004, 161.

cultural barriers, geographic separation, and persisting racial and ethnic bias will have greater difficulties than others with similar incomes.[1190]

> "*Medical coverage is more than a business proposition; it is an expression of our commitment to each other. Cost sharing that renders high-value care unaffordable breaches this commitment. It gives some of us less of a stake in our common civic life. Health policy that disregards people in this fashion is not merely indecent; it puts social peace, and opportunity for all, at risk*."[1191]

[1190] Bloche, Gregg M Consumer-Directed Health Care and the Disadvantaged *Health Affairs* Vol 26, No 5 (2007) 1315 – 1327, 1325.

[1191] Bloche, Gregg M Consumer-Directed Health Care and the Disadvantaged *Health Affairs* Vol 26, No 5 (2007) 1315 – 1327, 1325.

CHAPTER EIGHT: A proposed re-conceptualisation of the doctor-patient relationship to redress power imbalances

8.1. Are there power imbalances in the doctor-patient relationship?

8.2. Can the doctor-patient relationship be re-conceptualised, from a legal perspective, to redress the power imbalances inherent in the relationship?

8.2.1. The role of autonomy, dignity, self-determination and beneficence in the doctor-patient relationship

8.2.2. The doctrine of informed consent and the power imbalances in the doctor-patient relationship

8.2.3. The fiduciary nature of the doctor-patient relationship and the power imbalances inherent to the relationship

8.2.4. The role of trust in the doctor-patient relationship

8.3. Concluding remarks

This study has provided a comprehensive — including a historical (Chapter Two) — perspective on the doctor-patient relationship duly accounting for various approaches to health service delivery, namely: a paternalistic approach (Chapter Three), a market-oriented model of health service delivery (Chapter Four) present notions and developments in health service delivery pertaining to managed care initiatives (Chapter Six) and consumer-directed health care (Chapter Seven). In Chapter Five, an alternative to or a re-conceptualisation of the doctor-patient relationship was also considered in terms of fiduciary law principles. In this concluding chapter some of the arguments and conclusions presented in the previous chapters will be revisited, specifically with regard to the following research question which initiated and guides this research:

> *Are there power imbalances in the doctor-patient relationship and if so, can this relationship be re-conceptualised, from a legal perspective, to address those imbalances?*

8.1. Are there power imbalances in the doctor-patient relationship?

Every system of health service delivery is embedded in a culture.[1192] It is evident from the discussion in Chapter Two that the culture of medical care refers to a set of ideas about what medicine is; how it ought to be practised and distributed; different notions about the causes of illness; the nature of healing; the responsibility of illness and health; the role of private and public institutions in providing medical care; and most importantly, the understanding of the role of healers and the relationship between healers and those who are ill.[1193] The importance of this culture of medical care and the social context of medical practice therefore need to be considered in a study on the power imbalances in the doctor-patient relationship.

The exposition of the historical development of the doctor-patient relationship provides some insight into the continuously changing role of physicians and the relationship between physicians and the ill.[1194] It is evident that, since good health is a universally valued condition, the physician in any particular community has always played an important role and has, since ±600 – 100 BC, has been accorded a special status in society.[1195] This dependency of people, vulnerable due to illness, on physicians with their expert knowledge and skill, has created a power imbalance in the doctor-patient relationship. From medieval times, the practice of medicine started to evolve and attain its present status as a profession.[1196] The unique characteristics associated with a profession create a complex interplay of power, regulation and control of the doctor-patient relationship. It is due to the status of medical practice as a profession that further power imbalances inherent in the doctor-patient relationship can be identified. These power imbalances include the following:

- The medical profession has a monopoly over an esoteric and difficult body of knowledge not accessible to laypersons who, in their turn, depend on this knowledge for good health.

[1192] Stone, Deborah A The Doctor as Businessman: The Changing Politics of a Cultural Icon *Journal of Health Politics, Policy and Law* Vol 22 No 2 (April 1977) 533 – 556, 533.
[1193] Stone, Deborah A The Doctor as Businessman: The Changing Politics of a Cultural Icon *Journal of Health Politics, Policy and Law* Vol 22 No 2 (April 1977) 533 – 556, 533 - 534.
[1194] Chapter Two, section 2.1.
[1195] Chapter Two, section 2.1.2.
[1196] Chapter Two, section 2.2.1.

- Members of the medical profession form an exclusive social group based on their professional activity.
- The medical profession disciplines its own members, thereby securing their independence.
- The medical profession determines its own standards of education, ethical codes, licensing, admission, norms of practice and other matters of control and regulation, thereby asserting its independence.
- The profession is therefore relatively free from lay evaluation and control.
- Every physician is not only trained in the skills and knowledge of the medical profession, but also in its values and attributes, thereby reinforcing a particular culture of medical care.

In addition to the power and authority that the status of professionalism confers on the members of the medical profession, the manner in which both the medical profession and the ill view their respective roles in the doctor-patient relationship also contributes to the inherent power imbalances in the doctor-patient relationship.[1197] These expectations and qualities attributed to the physician role and the sick role are internalised and influence the actions and attitudes of both patients and physicians. The physician role is also associated with status and is a source of power in the doctor-patient relationship as it presupposes a set of rights and duties associated with this status.

The general approaches to health service delivery discussed in this dissertation to facilitate and structure the analyses of the doctor-patient relationship also assist in identifying particular power imbalances in this relationship. It is evident from the discussion in Chapter Three that the doctor-patient relationship in a paternalistic setting is especially problematic with regard to the medical decision-making process, as the power imbalances inherent in this relationship can influence this critical moment in the doctor-patient interaction significantly and most often adversely. In a medical decision-making process in a paternalistic setting, a patient's rights to autonomy, dignity and self-determination are disregarded while the physician's altruistic and beneficent actions and intentions triumph.

[1197] Chapter Two, section 2.2.2.

While it is said that medical practice is no longer conducted in such a paternalistic way and that the use of particular legal instruments, like the doctrine of informed consent, addresses the problems associated with paternalism sufficiently, it is submitted that the paternalistic approach in medical practice is still very much alive in health service delivery today and that historically this approach roots so deeply in a general culture of medical care that it will always influence medical practice to some extent.

In addition to this continuing influence of historical and traditional perspectives on medical practice and the doctor-patient relationship, the present influence of market-orientated principles on health service delivery and the doctor-patient relationship also results in the formation (and prevalence) of additional power imbalances in this relationship. In Chapter Four the doctor-patient relationship was analysed in the context of the medical marketplace, where the relationship is regarded as an economic and juridical relationship made up of rights and duties. In terms of the business model of health care, the doctor and the patient are regarded as contracting equals and health service delivery itself is regarded as an ordinary commodity in the marketplace. But this alternative conceptualisation of the doctor-patient relationship does not address the power imbalances inherent in the relationship and, instead, gives rise to further power imbalances as was indicated.

The business model of health service delivery results in an overwhelming concern for rights and overestimates patient autonomy. Although the initial reaction might be that such a right's ethic and an increased focus on patient autonomy and self-determination may serve as a mechanism to realise patient self-rule and address the power imbalances in health care, it actually does not provide the necessary security for the patient in the medical realm.[1198] In addition, the business model also reconfigures the place of money and the role of the physician in medical practice.[1199] While financial considerations traditionally had no bearing on doctors' clinical judgement, economic and price considerations are now central to medical decision-making. Medical decisions are no longer purely clinical, but are based, at

[1198] Chapter Four, section 4.3.2.
[1199] Stone, Deborah A The Doctor as Businessman: The Changing Politics of a Cultural Icon *Journal of Health Politics, Policy and Law* Vol 22 No 2 (April 1977) 533 – 556, 534.

least in part, on economic principles and potential economic consequences.[1200] This development adds another power dynamic to the doctor-patient relationship. Moreover, the physician has evolved as a businessman and entrepreneur in this medical marketplace, leaving little place for traditional values and moral obligations patients usually associate with the medical profession. These developments have resulted in patients now being more vulnerable than ever before.

The commercialisation of medical practice is a pervasive and inevitable development and the discussion in Chapters Six and Seven has shown that the ongoing economic re-organisation of health service delivery is not only reshaping medical practice, but is also contributing to the existing power imbalances in the doctor-patient relationship. Medical decisions are now not only based, at least in part, on economic considerations, but economic consequences also influence medical decisions by translating them into financial incentives for both physicians and patients.[1201] Hand in hand with this cultural reassessment of the role of commerce in medical practice is a change in the way in which health service delivery is perceived as a social system.[1202] The patient is now the consumer and the doctor the provider of services and the intricacies of this pure market relationship are decided on by managed care organisations and health care insurers. In this era of managed care and consumer-directed health care neither the patient nor the physician, as parties to the doctor-patient relationship has exclusive power and control.

Clearly, then, power imbalances have continued to exist in the doctor-patient relationship. Moreover, these power imbalances are both critical and objectionable from an ethical and legal point of view.

[1200] Stone, Deborah A The Doctor as Businessman: The Changing Politics of a Cultural Icon *Journal of Health Politics, Policy and Law* Vol 22 No 2 (April 1977) 533 – 556, 542.
[1201] Stone, Deborah A The Doctor as Businessman: The Changing Politics of a Cultural Icon *Journal of Health Politics, Policy and Law* Vol 22 No 2 (April 1977) 533 – 556, 542.
[1202] Stone, Deborah A The Doctor as Businessman: The Changing Politics of a Cultural Icon *Journal of Health Politics, Policy and Law* Vol 22 No 2 (April 1977) 533 – 556, 543.

8.2. Can the doctor-patient relationship be re-conceptualised, from a legal perspective, to address the power imbalances inherent in the relationship?

In Chapters Three to Seven a different approach to health service delivery was discussed in order to facilitate the discussion on the power imbalances in the doctor-patient relationship and to provide a framework for the overall analyses. For each of these approaches the relevant legal instruments used and the efforts made to address the power imbalances were also considered and fully assessed. The aim here is therefore not to comment on the arguments presented in previous chapters, but rather to provide a broad and feasible re-conceptualisation of the doctor-patient relationship based on the discussion in these chapters.

8.2.1. The role of autonomy, dignity, self-determination and beneficence in the doctor-patient relationship

Any attempt to address the power imbalances inherent in the doctor-patient relationship should pay special attention to the role of autonomy, dignity, self-determination and beneficence. In this dissertation the importance of these values in health service delivery have been highlighted throughout.[1203] In sum it can again be emphasised that individuals have sovereignty over their life and also the right to make decisions without interference by others.

Both autonomy and self-determination are recognised in the Constitution in the provisions regarding the right to bodily and psychological integrity,[1204] the right to privacy,[1205] the right to life,[1206] the right to freedom of movement,[1207] and the right to freedom of religion and belief.[1208] In addition, the values of dignity, integrity, individuality, independence, responsibility and self-knowledge constitute the foundation of a person's right to autonomy. Among these values, dignity is singled out as being particularly closely connected with a person's health. Health is seen to be essential for life. Human dignity is also a founding value of the Constitution and is furthermore protected as a fundamental right in the Bill of

[1203] See Chapter Three, section 3.3. in particular.
[1204] Section 12(2) of the Constitution of the Republic of South Africa, 1996.
[1205] Section 14 of the Constitution of the Republic of South Africa, 1996.
[1206] Section 11 of the Constitution of the Republic of South Africa, 1996.
[1207] Section 21(1) of the Constitution of the Republic of South Africa, 1996.
[1208] Section 15(1) of the Constitution of the Republic of South Africa, 1996.

Rights.[1209] Moreover, autonomy and self-determination are also recognised in the National Health Act 61 of 2003.[1210] It is thus evident that autonomy, dignity and self-determination are values central to health service delivery in general and the doctor-patient relationship in particular.

The importance of beneficence in health service delivery has also been highlighted in this dissertation. Beneficence is regarded as the *raison d'être* of the medical profession, and is recognised in the provisions of the Constitution, which state that everyone has the right to life,[1211] access to health care within available resources[1212] including reproductive health care,[1213] that children have a right to basic health care services,[1214] and that everyone has the right to information necessary to exercise or protect their rights.[1215] It is evident from the analyses in the previous chapters that the altruistic and beneficent commitment of medical professionals should not simply be disregarded in preference to a more rights' ethic approach, as the moral obligations of health care professionals can serve the best interest of patients— especially in the current commercialised medical marketplace.[1216]

Principles of both the autonomy and beneficence models of health service delivery should therefore be given their rightful place in a re-conceptualisation of the doctor-patient relationship. It will, however, not be easy to find a balance between these sometimes conflicting principles and values. It is therefore also necessary to recognise the limits of both beneficence and autonomy in medical practice: Excessive claims by patients dictating treatment cannot be justified in the name of patient autonomy, but at the same time physicians cannot be allowed to decide exclusively and unilaterally. Physicians, on the other

[1209] Thomas, Rhiannon Where to from *Castell v De Greef*? Lessons from recent developments in South Africa and abroad regarding consent to treatment and the standard of disclosure *South African Law Journal* (2007) 188- 215, 204; *S v Makwanyane and another* 1995 (3) SA 391 (CC) para 328; Carstens, Pieter and Pearmain, Debbie *Foundational Principles of South African Medical Law* LexisNexis: Durban 2007, 29; Section 1(a) and section 10 of the Constitution of the Republic of South Africa.

[1210] Sections 6 – 8 and 12 of the National Health Act 61 of 2003.

[1211] Section 11 of the Constitution of the Republic of South Africa, 1996.

[1212] Section 27(1)(a) of the Constitution of the Republic of South Africa, 1996.

[1213] Section 27(1)(a) of the Constitution of the Republic of South Africa, 1996.

[1214] Section 28(1)(c) of the Constitution of the Republic of South Africa, 1996.

[1215] Section 32(1) of the Constitution of the Republic of South Africa, 1996; Also see Chapter Three, section 3.3. for a discussion on non-maleficence which is a concept closely linked to beneficence.

[1216] Patients, for example, seek medical assistance not merely to exercise their right to self-determination, but also to ask medical practitioners to act for their benefit, based on their expert skill and knowledge; In Chapter Seven this was described in terms of the ethical limits to patient autonomy and responsibility.

hand, can also not withhold their guidance, lest patients forfeit the benefit of professional expertise in medical decision-making.

The principles of the autonomy model should thus always serve as the foundation of any enquiry concerning the power imbalances in the doctor-patient relationship, with the principles of the beneficence model adopted and adapted where necessary to serve the best interest of the patient.

8.2.2. The doctrine of informed consent and the power imbalances in the doctor-patient relationship

At present, the doctrine of informed consent as a legal mechanism to address the power imbalances in the doctor-patient relationship — specifically with regard to medical decision-making — is ineffective. While the dominant rhetoric of this doctrine is patient autonomy and self-determination, it is definitely not the dominant real value being served. Possible reasons for this failure of the doctrine of informed consent to ensure patient-centred decision-making and patients' freedom of choice include

- the diverse perceptions of the doctrine;[1217]
- the different (and sometimes conflicting) standards of disclosure applied by courts;[1218]
- the historical attributes associated with the sick role and the physician's role that still influence physician and patient behaviour;[1219]
- the great disparity between the theory of informed consent and the practical application of these theoretical principles;[1220] and
- the general inefficiency of the doctrine in practice.[1221]

The traditional doctrine of informed consent is also ill equipped to address non-disclosure due to financial and other considerations with regard to medical decision-making that may arise in the era of commercialised health service delivery. For example, the business model

[1217] Chapter Three, section 3.5.
[1218] Chapter Three, section 3.5.1.
[1219] Chapter Three, section 3.5.2.
[1220] Chapter Three, section 3.5.3.
[1221] Chapter Three, section 3.5.4.

of health service delivery assigns a more prominent place in the medical decision-making process to other role players with sometimes competing interests. Such new role players certainly influence the doctor-patient relationship in general, as well as the power imbalances inherent in that relationship. In addition, there are various stages at which decisions are made and at each of these stages a different level of information is required. For this reason, there can not be a single moment of informed consent and decision-making in medical practice.

It is submitted that the protection of patient autonomy and self-determination, and the assurance that patients will still receive the maximum benefit from professional expertise and guidance, can only be achieved though a more honest relationship between doctor and patient, a moral relationship built on trust, equality and respect. Such a humanised relationship will reinforce patients' confidence in physicians and the authority of the medical profession, while improving the quality of both patients' and physicians' treatment decisions. Such a relationship can, however, only exist if physicians learn to communicate with their patients effectively and to assess whether patients have been informed to their satisfaction. It is also suggested that courts should place more emphasis on the quality of choice and the extent to which decisions made by patients exhibit understanding, rather than focussing solely on whether there was consent in a particular case.

In this sense, the rebuilding of patient autonomy and self-determination in medical decision-making in order to ensure a more equal distribution of power in the doctor-patient relationship is actually the responsibility of the medical profession as well as the judiciary.

8.2.3. The fiduciary nature of the doctor-patient relationship and the power imbalances inherent in the relationship

Fiduciary law plays a significant role in protecting vulnerable people. The fiduciary nature of the doctor-patient relationship and the suitability of fiduciary principles to doctor-patient interactions were discussed in Chapter Five. It is evident that the doctor-patient relationship displays many hallmarks of a fiduciary relationship. Moreover, the idea that physicians are or should be fiduciaries for their patients has been a dominant metaphor in medical- and

health law and ethics for some time and is presumed by much of the legal and ethical analysis on physicians' conflict of interest.

According to Birks, fiduciary law is a vehicle for exporting incidents of express trust by analogy, and it is characterised by the high degree of altruism required of a fiduciary.[1222] In support of Birks's argument, Rainbolt suggests that a normal fiduciary ethic for the doctor-patient relationship is morally preferable as such an ethic also encompasses the contractual ethic (discussed in Chapters Four, Six and Seven). To this he adds another requirement, the acts and the advice of the fiduciary, which can be equated with the traditional ethic of health service delivery (discussed in Chapters Two and Three).[1223]

A fiduciary framework for the doctor-patient relationship can resolve the competing demands on physicians, specifically with regard to medical decision-making. A further advantage of the fiduciary metaphor is that it provides courts with an increased flexibility to extend obligations beyond the traditional fiduciary situations to offer specific equitable remedies in a range of situations that may arise in health service delivery.

The fiduciary duty to act in the best interest of a patient springs from the trust and confidence reposed by one party in another, who by reason of a specific skill, knowledge, training, judgement or expertise is in a superior position to advise or act on behalf of the party bestowing the trust and confidence on him/her. However, a doctor's obligation is not only to act in the best interest of a patient, but also to act with respect, as the doctor-patient relationship is a moral one built on trust, equality and respect.

It is submitted that the doctor-patient relationship should be regarded as a fiduciary relationship, as the fiduciary duty analysis always commences with a structure of inequality within which certain obligations are assessed. This is crucial when dealing with an unequal relationship like the doctor-patient relationship. Fiduciary principles furthermore redress the imbalance of power in the doctor-patient relationship in a number of ways:

[1222] Chapter Five, section 5.2.
[1223] Chapter Five, section 5.2.

- They limit the fiduciary's freedom of action by prohibiting the fiduciary from using superior power to take advantage of the beneficiary.
- They require the fiduciary to act in the beneficiary's best interest.
- While a physician may avoid liability under the law of delict by merely acting reasonably, the physician may still be liable for breach of his/her fiduciary duty if the physician did not act loyally.
- Where the beneficiary challenges the contractual agreement or other transactions with the fiduciary, the burden of justification is moved from the challenging party to the fiduciary.
- The fiduciary may be required to do more than merely compensate the patient for the loss suffered as a result of a breach of a fiduciary duty as punitive damages may also be imposed.[1224]

8.2.4. The role of trust in the doctor-patient relationship

The importance of trust in the doctor-patient relationship has been emphasised throughout this dissertation.[1225] This present section will consider how trust can address the power imbalances inherent in the relationship. For the purposes of this discussion trust refers to

> "...*the expectations of the public that those who serve them will perform their responsibilities in a technically proficient way (competence), that they will assume responsibility and not inappropriately defer to others (control) and that they will make patients' welfare their highest priority (agency). Implicit in these criteria are the further expectations that responses will be sensitive and caring, that they will encourage honest and open communication, and that rules of privacy and confidentiality will be respected*."[1226]

[1224] Chapter Five, section 5.5.

[1225] In Chapter Four, the erosion of trust in the doctor-patient relationship as a consequence of the business model of health service delivery was considered. In Chapter Five the special place of trust in the fiduciary relationship was highlighted and in Chapter Six and Seven it was also submitted that trust in managed care organisations and health insurance plans are important because it can influence trust in the doctor-patient relationship, and also be influenced by the level of trust in the doctor-patient relationship; For a comprehensive discussion of trust in the doctor-patient relationship see Hall, Mark A Law, Medicine and Trust *Stanford Law Review* Vol 55, No 2 (2002) 463 – 527.

[1226] Mechanic, David & Schlesinger, Mark The Impact of Managed Care on Patients' Trust in Medical Care and Their Physicians JAMA Vol 275, No 21 (1996) 1693 – 1697, 1693; Mechanic, David Changing Medical Organisation and the Erosion of Trust *The Milbank Quaterly* Vol 74, No 2 (1996) 171 – 189, 173.

It is suggested that professionalism underpins the public's trust in health care practitioners and the practice of medicine:[1227] While the purpose of health service delivery is to care for the ailing and sick, promote health interests and well-being, and to strive towards healing environments, the delivery of health care goes beyond just clinical and technical expertise. Health service delivery is also concerned with experiences, feelings and interpretations of human beings in often extraordinary moments of fear, anxiety and doubt.[1228] And it is professionalism and professional integrity that are central to health service delivery and the moral contract between doctor and patient, as the particular qualities associated with professionalism enhance this moral contract between them. Such a contract is essentially based on trust.[1229]

However, an excessive focus on patient autonomy and patient-centred bio-ethics, coupled with a total disregard of the traditional moral obligations of physicians towards their patients, can lead to the erosion of trust in the doctor-patient relationship.

> "*The language of rights and the language of trust move in opposite directions from one another. The scrupulous insistence on observance of one's rights is an admission that one does not trust those at hand to care properly for one's welfare*."[1230]

Such a right's ethic discounts the psychological realities of trust, vulnerability and illness and views trust in normative terms, questioning whether physicians deserve trust.[1231] It is for this reason that the doctor-patient relationship should rather be described as a moral relationship built on trust, equality and respect. Trust in this context is synonymous with autonomy and reinforces patients' confidence in physicians, as well as the authority of the medical profession in general. Such trust is the glue that holds the doctor-patient relationship together and makes its functional specificity possible, thereby improving the quality of both patients' and physicians' treatment decisions and the success of medical

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[1227] Dhai, Ames & McQuoid-Mason, David J What does professionalism in health care mean in the 21st century? *South African Journal of Bioethics and Law* Vol 1, No 1 (June 2008) 2 – 3.
[1228] Dhai, Ames & McQuoid-Mason, David J What does professionalism in health care mean in the 21st century? *South African Journal of Bioethics and Law* Vol 1, No 1 (June 2008) 2 – 3.
[1229] Dhai, Ames & McQuoid-Mason, David J What does professionalism in health care mean in the 21st century? *South African Journal of Bioethics and Law* Vol 1, No 1 (June 2008) 2 – 3.
[1230] Hall, Mark A Law, Medicine and Trust *Stanford Law Review* Vol 55, No 2 (2002) 463 – 527, 469.
[1231] Hall, Mark A Law, Medicine and Trust *Stanford Law Review* Vol 55, No 2 (2002) 463 – 527, 469.

interventions.[1232] Moreover, such trust will empower the consumer-patient in the doctor-patient relationship.

A new understanding of trust and respect in the doctor-patient relationship is therefore necessary built on the following foundations:

- There is no single correct decision for how health and illness should be dealt with.
- Both physicians and patients bring their own vulnerabilities to the decision-making process.
- Both physicians and patients should relate to one another as equals and unequals (physicians have expert medical knowledge and patients know what their specific needs and personal beliefs are).
- All human conduct is influenced by rational and irrational expectations.[1233]

Emanuel and Dubler support this argument for trust and respect in their theory of the ideal physician-patient relationship.[1234] According to them trust is the culmination or the realisation of these fundamental elements:

- patient choice;
- the competence of medical practitioners;
- effective communication;
- true compassion;
- continuity of the doctor-patient relationship; and
- no conflict of interest.[1235]

But how to incorporate this concept of trust into medical- and health law? While trust has pervasive importance in all kinds of human interactions, medical trust differs in critical aspects from other types of trust. Medical trust, for instance, is the sole example of trust arising from an intimate arena where the primary value of trust is not intrinsic to the

[1232] Dhai, Ames & McQuoid-Mason, David J What does professionalism in health care mean in the 21st century? *South African Journal of Bioethics and Law* Vol 1, No 1 (June 2008) 2 – 3; Hall, Mark A Law, Medicine and Trust *Stanford Law Review* Vol 55, No 2 (2002) 463 – 527, 470.

[1233] Chapter Three, section 3.5.5.

[1234] Emanuel, Ezekiel J & Dubler, Nancy Neveloff Preserving the Physician-Patient Relationship in the Era of Managed Care *JAMA* Vol 273, No 4 (1995) 323 – 329, 323.

[1235] Emanuel, Ezekiel J & Dubler, Nancy Neveloff Preserving the Physician-Patient Relationship in the Era of Managed Care *JAMA* Vol 273, No 4 (1995) 323 – 329, 324; Mechanic, David & Schlesinger, Mark The Impact of Managed Care on Patients' Trust in Medical Care and Their Physicians JAMA Vol 275, No 21 (1996) 1693 – 1697.

relationship; medical trust facilitates a relationship or transaction that achieves other purposes.[1236] However, trust in the doctor-patient relationship does not merely facilitate treatment, it also alters and enhances the benefit derived from treatment.[1237] Hall therefore contends that trust is more essential in medical and health law than elsewhere in meeting instrumental goals.[1238]

It has been shown in this dissertation that the law can effectively incorporate these psychological realities of trust in the doctor-patient relationship. By regarding the doctor-patient relationship as a fiduciary relationship, and by the law's intrinsic and predicated stance towards trust, various rights, responsibilities, and rules are, for example, premised on the strength and pervasiveness of trust in medical relationships.[1239] In other words, the law fashions rules, rights and regulations consistent with the presence of trust. An example of this can be found in the doctrine of informed consent. In other instances, the law views trust in the doctor-patient relationship as a virtue and actively seeks to promote it with legal rules intended to maintain or increase trust where it already exists or to restore trust where it is threatened or has been breached. An example of such a supportive legal stance on trust in the doctor-patient relationship can be found in the recognition of confidentiality of doctor-patient communications.[1240]

8.3. Concluding remarks

Despite the revolutionary changes in health service delivery, and the evolution of medical practice from a cottage vocation to the present multi-complex industry, the unique doctor-patient relationship in medical practice has remained a constant in health service delivery.[1241] The primary purposes of medical practice, as described in this dissertation, and the function of the doctor-patient relationship in fulfilling its objectives, have also remained

[1236] Hall, Mark A Law, Medicine and Trust *Stanford Law Review* Vol 55, No 2 (2002) 463 – 527, 483.
[1237] Hall, Mark A Law, Medicine and Trust *Stanford Law Review* Vol 55, No 2 (2002) 463 – 527, 483.
[1238] Hall, Mark A Law, Medicine and Trust *Stanford Law Review* Vol 55, No 2 (2002) 463 – 527, 483 - 484.
[1239] See Chapter Five; Hall, Mark A Law, Medicine and Trust *Stanford Law Review* Vol 55, No 2 (2002) 463 – 527, 472 & 487.
[1240] Hall, Mark A Law, Medicine and Trust *Stanford Law Review* Vol 55, No 2 (2002) 463 – 527, 498.
[1241] Salmon Warren J, White William, Feinglass Joe The Futures of Physicians: Agency and Autonomy Reconsidered *Theoretical Medicine* Vol 11 (1990) 261 – 274.

unchanged. The doctor-patient relationship can consequently be described as the cornerstone for achieving, maintaining and improving health.[1242]

The inherent power imbalances in the doctor-patient relationship are, however, critical and objectionable from an ethical and legal point of view. A re-conceptualisation of the doctor-patient relationship to address the power imbalances inherent in the relationship is therefore necessary. Such a re-conceptualisation should not focus exclusively on principles of autonomy and beneficence as two opposite extremes to the solution. The clinical realities and the social context of medical practice, and the numerous influences on and historical attributes associated with the doctor-patient relationship should rather be considered in context. While patients' autonomy and self-determination should always form the foundation of a medical intervention, a physician's role can not, for example, be reduced to that of a mere technologist.[1243]

The medical profession has been identified as one of society's most trusted social institutions. Trust is regarded as a vital value in the moral relationship between doctor and patient, dependent on the quality of the said relationship. Protection of this relationship will ultimately best preserve those aspects of trust that are most important to the public and vital to ensuring quality of care.[1244]

[1242] Emanuel, Ezekiel J & Dubler, Nancy Neveloff Preserving the Physician-Patient Relationship in the Era of Managed Care *JAMA* Vol 273, No 4 (1995) 323 – 329, 328.

[1243] Emanuel, Ezekiel J & Dubler, Nancy Neveloff Preserving the Physician-Patient Relationship in the Era of Managed Care *JAMA* Vol 273, No 4 (1995) 323 – 329, 328.

[1244] Mechanic, David & Schlesinger, Mark The Impact of Managed Care on Patients' Trust in Medical Care and Their Physicians JAMA Vol 275, No 21 (1996) 1693 – 1697, 1697.

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Chappel v Hart (1998) 72 ALJR 1344, [1999] Lloyd's Rep Med 223, Aust HC *107*

E v Australian Red Cross Society and others [8 February 1991] Australian Law Reports 1991; 99: 601 - 672 .... *129, 130*

Hospital Products Ltd v United States Surgical Corporation (1984) 156 CLR 41 (HC Aust)........ *160, 163*

Rogers v Whitaker 175 CLR 479 [1992] *87,107, 121*

Rosenberg v Percival [2001] HCA 18 .... *107, 116, 119, 213*

Canada

Arndt v Smith [1997] 2 S.C.R. 539 .... *106, 108, 110*

Brooks v Alker 22 R.F.L. 260, 9 O.R. (2d) 409 .... *162*

Ciarlariello v Schacter [1993] 2 S.C.R. 119 .... *107*

Hopp v Lepp [1980] 2 S.C.R. 192 .... *176*

McInerney v MacDonald (1992) 93 DLR (4th) 415 (SCC)........ *166, 178 - 181*

Norberg v Wynrib (1992) 92 DLR (4th) 449 .... *164 - 166, 171, 172, 180, 183*

Parslow v Masters [1993] 6.W.W.R. 273, 15 C.C.L.I. (2d) 13, 110 Sask. R 253 .... *12*

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Japan

Makino v The Red Cross Hospital May 29, 1989 Chisai [Nagoya District Court] *95*

New Zealand

Smith v Auckland Hospital Board [1965] NZLR 191 .... *129, 175*

South Africa

Affordable Medicines Trust & others v Minister of Health of RSA & another 2005 (6) BCLR 529 (CC) *186*

Affordable Medicines Trust & others v Minister of Health of RSA & another 2004 (4) ALL SA 622 (T) *186*

Afrox Healthcare BPK v Strydom 2002 (6) SA 21 (SCA)........ *130, 147 - 150*

Barkhuizen v Napier 2007 5 SA 323 (CC)........ *148, 207, 209*

Broude v McIntosh & others 1998 (3) SA 60 (SCA) *40, 94, 100, 108, 115, 122*

Castell v De Greef 1994 (4) SA 408 (C) .... *40, 60, 91 – 95, 108, 115*

Dawood, Shalabi, Thomas & others v Minister of Home Affairs 2000 (3) SA 936 (CC) *73*

Esterhuizen v Administrator, Transvaal 1957 (3) SA 710 (T) *46, 67, 87*

Ex Parte Dixie 1950 (4) 748 (W) *69*

JP v Discovery Health Medical Scheme, Decision of the Council for Medical Schemes Appeal Committee, March 2006 ....*206*

Louwrens v Oldwage 2006 (2) SA 161 (SCA)...*99, 105*

Magware v Minister of Health 1981 (4) 472 (Z)..*10, 182*

McDonald v Wroe [2006] 3 All SA 565 (C)...*94, 99*

MH v Discovery Health Medical Scheme, Decision of the Council for Medical Schemes Appeal Committee, March 2006 ....*205*

Napier v Barkhuizen 2006 (4) SA 1 (SCA) *209*

Oldwage v Louwrens [2004] 1 All SA 532 (C)...*150*

Pharmaceutical Manufacturers Assoc of SA (Assoc Inc In terms of Section 21) & another re ex Parte application of the President of the RSA, the Honourable Dr NR Mandela NO & others [1999] JOL 5291 (T).. *186, 188*

Pharmaceutical Manufacturers Assoc of SA & another: In Re: Ex Parte President of RSA & others 2000 (3) BCLR 241 (CC).. *186, 188*

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Shiels v Minister of Health 1974 (3) SA 276 (RA) *130*

St Augustine's Hospital (Pty) Ltd v Le Breton 1975 (2) SA 530 (D) *147*

Strydom v Afrox Healthcare Ltd [2001] 4 All SA 618 (T) *148*

Stoffberg v Elliot 1923 CPD 148 ....*74*

Tulloch v Marsh 1910 TPD 453...*128*

United Kingdom

Barclays Bank v O'Brien [1994] 1 A.C. 180 .... *162, 163*

Bolam v Friern Hospital Management committee [1957] 1 W.L.R. 582 QBD... ....*40, 67, 86 – 89, 91, 101, 102, 106, 107*

Chatterton v Gerson & another [1981] Q.B. 432 ....*86*

Chester v Afshar [2002] 3 All ER 552 ....*101,102, 108, 115*

Gibson v Russell (1843) 63 ER 46 ....*162*

Gold v Haringey Health Authority [1988] Q.B. 481 CA *40, 89*

Hedley Byrne v Heller & Partners 1964 A.C. 465 ....*176*

Maynard v West Midlands Regional Health Authority [1984] 1 W.L.R. 634 HL *87*

Mitchell & another v Homfray (1881) 8 QBD 587 ....*162*

Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital [1985] A.C. 871 HL *40, 60, 90, 91, 118, 163, 175, 180*

Whitehouse v Jordan & another [1981] 1 W.L.R. 246 HL *87*

Williams v Johnson [1937] All ER 34 .... *162*

United States of America

Arato v Avedon 858 P.2d 598 (Cal. 1993)........ *100, 101, 108, 173*

Bennan v Parsonnet 83 A. 948 (N.J. 1912) *69*

Bienz v Central Suffolk Hospital 163 AD 2d 269 N.Y.S. 2d 139 (1990)........ *10*

Bly v Rhoads 222 S.E. 2d 783 (Wirg. 1976) *89*

Cannon v Group Health Service of Oklahoma 77 F.3d 1270 (U.S. App 1996) *207*

Canterbury v Spence 464 F.2d 772 (D.C. Cir. 1972)........ *40, 84 – 86, 88, 90, 106, 105, 114, 161*

Clanton et al v Von Hamm 70991 (177 Ga App 694) (340 SE.2d 627) 1986........ *10*

Cobbs v Grant 502 P. 2d 1 (1972)........ *85, 108*

Collins v Meeker 424 P.2d 388 (Kan. 1967) *89, 119*

Corcoran v United Healthcare Inc 965 F.2d 1321 (U.S. App 1992) *207*

Culbertson v Mernitz 602 N.E. 2d 98 (Ind. 1992) .... *81, 85, 96, 108 – 110, 112*

D.A.B. v Brown 570 N.W.2d 168 (Minn. Ct. App. 1997) *174, 175*

Delta Dental Plan of California v Barnasky 27 Cal. App. 4th 1598 (1994) *223*

Dougherty v Gifford 826 SW. 2d 668 (Tex. App. – Texarkana 1992)........ *11*

Fuja v Benefit Trust Life Insurance Co 18 F. 3d 1405 (7th Cir 1994)........ *207*

Haskins v Howard 16 S.W.2d 20 (Tenn. 1929) *69*

Hunt v Bradshaw 88 S.E. 2d 762 (N.C. 1955) *70*

Lancaster v Kaiser Foundation Health Plan of Mid-Atlantic States Inc 958 F. Supp 1137 (Virginia 1997) *215*

Laskowitz v CIBA Vision Corporation 215 A.D. 2d 25 (N.Y. 1995) *96*

Lockett v Goodoll 430 P.2d 589 (Wash. 1967)........ *182*

Lopez v Aziz 852 SW.2d 303 (Tex. App. – San Antonio) 1993........ *13*

Lotspeich v Chance Vought Aircraft 269 SW.2d 705 (1963)........ *12*

Loyola University of Chicago v Humana Insurance Co 996 F.2d 895 (7th Cir. 1993)........ *207*

Malloy v Shanahan 421 A.2d 803 (Penn 1980) *89*

Matthies v Mastromonaco 709 A.2d 238 (N.J. Super. Ct. App. Div. 1998)........ *85, 109, 110, 112*

McGee v Equitor-Equitable HCA Corp 953 F.2d 1192 (10th Cir. 1992)........ *207*

McGraw v Prudential Insurance Company of America 137 F.3d 1253 (U.S. App. 1998) .... *194, 207 - 209*

McPherson v Ellis 287 S.E. 2d 892 (North Carolina 1982) *100, 106, 108*

Mohr v Williams 104 N.W. 12 (Minn 1905) *68, 69*

Moore v Regents of the University of California Cal. 249 Cal. Rptr. 494 (1988); 793 P.2d 479 (Cal. 1990) .... *142, 172 - 174*

Natanson v Kline 186 Kan. 393, 350 P.2d 1093 .... *70, 71, 83, 84, 88, 106, 164*

Nead v Portes 710 N.E. 2d 418 (Illnois 1999) *141, 215*

Pappas v Asbel 564 Pa. 407 (Penn. 2001) *215*

Perez v Wyeth Laboratories Inc 734 A.2d 1245 (N.J. 1999) *112*

Pratt v Davis 118 Ill. App. 161 .... *67, 68, 116*

Regina v Mid Glamorgan Family Health Services Authority & another ex parte Martin [1995] 1 W.L.R. 110 (CA Civ Div) *176, 181*

Rush Prudential HMO Inc v Moran 536 U.S. 355 (2002) *224*

Salgo v Leland Stanford Jr. University Board of Trustees 317 P.2d 170 (Cal. Dist. Ct. App. 1957) .... *81 – 83, 86, 88, 103, 106*

Scaria v St Paul Fire & Marine Ins Co 227 N.W. 2d 647 (Wis. 1975) *101*

Schloendorff v Society of New York Hospital 105 N.E. 92 (N.Y. 1914) 69, *74, 84*

Schreiber & Krueger v Physicians Insurance Company of Wisconsin 579 N.W. 2d 730 (Wis. 1998) *96*

Scott v Bradford 606 P.2d 554 (Okla. 1980) *90, 91, 108, 109*

Shadrick v Coker 963 S.W. 2d 726 (Nashville 1998) *177*

Shea v Esenstein 107 F.3d 625 (8th Cir 1997) *141, 215*

Truman v Thomas 611 P.2d 902 (Cal. 1980) *142*

Tunkl v Regents of the University of California 383 P.2d 441 (CA 1963) *150*

Wickline v State of California 192 Cal. App. 3d 1630, 239 Cal. Rpt 810 (2d Dist. 1986) *141, 208*

Wilson v Blue Cross of Southern California 222 Cal. App. 3d 660 (CA 1990) *208*

Wohlgemuth v Meyer 293 P.2d 816 (CA 1956) *164*

Woolley v Henderson 418 A.2d 1123 (Maine 1980) *70, 89*

Yates v El-Deiry 513 N.E. 2d 519 (Illnois 1987) *161, 164*

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Constitution of the Republic of South Africa, 1996 . *2,4,5, 15, 16,- 18, 72 – 73, 76, 185 – 187, 209, 235, 250*

Consumer Protection Act 68 of 2008 (South Africa) ... *237 - 240*

Dental Technicians Act 19 of 1979 (South Africa) ... *5, 7, 9*

Health Professions Act 56 of 1974 (South Africa) ... *5, 7 - 9*

Florida Statute Ann. §768.132(3)(a) (USA) ... *96*

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Medical Schemes Act 131 of 1998 (South Africa) ... *192, 195, 200, 202, 205*

Medicines and Related Substances Act 101 of 1965 (South Africa) ... *7, 186*

Mental Health Care Act 17 of 2002 (South Africa) ... *80*

Minn. Stat. Ann §62J.72 (1998) (USA) ... *96*

National Health Act 61 of 2003 (South Africa) ... *2, 18, 73, 96, 131, 142, 143, 156, 211, 219, 251*

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N.J. Stat. Ann. §26:2S-5 (1998) (USA) ... *220*

Nursing Act 50 of 1978 (South Africa) ... 7

Patients' Rights Act 2 of 63 (1999) (Norway) ... *96*

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Renaming of High Courts Act 30 of 2008 (South Africa) ... *147*

Sterilisation Act 44 of 1998 (South Africa) ... *80*

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INDEX

A

altruism, 19, 38, 43, 119, 134, 151, 168, 255
  altruistic commitment, 76, 77, 137
  altruistic motivation, 18, 77
Asclepius, 28, 29, 156
  Asclepian authority, 47
autonomy, iv, viii, ix, 15, 18, 35, 40, 48, 49, 50, 52, 58, 60, 61, 63, 65, 66, 69, 71, 72, 73, 75, 76, 77, 78, 79, 80, 81, 82, 84, 87, 88, 89, 91, 93, 94, 96, 99, 103, 104, 105, 106, 107, 109, 110, 113, 114, 115, 117, 118, 119, 120, 121, 122, 123, 124, 126, 127, 130, 136, 139, 140, 141, 143, 144, 145, 146, 147, 148, 149, 151, 153, 170, 171, 178, 179, 189, 190, 195, 214, 232, 233, 234, 235, 236, 237, 243, 248, 249, 251, 252, 253, 254, 257, 260, 268, 271, 276
  patient autonomy, viii, ix, 61, 63, 66, 71, 72, 73, 75, 79, 80, 81, 82, 84, 88, 89, 91, 93, 94, 103, 104, 105, 106, 107, 109, 110, 113, 114, 115, 116, 118, 119, 121, 122, 124, 127, 130, 136, 139, 140, 141, 144, 145, 146, 147, 148, 151, 153, 171, 178, 179, 189, 232, 233, 243, 249, 252, 253, 254, 257, 268

B

bargaining power, 149, 156, 164, 166
Beauchamp, 18, 32, 66, 67, 72, 76, 78, 79, 80, 106, 118, 121, 122, 153, 179, 235, 266, 277
beneficence, iv, viii, ix, 18, 29, 32, 38, 59, 60, 66, 72, 76, 77, 78, 79, 80, 81, 83, 96, 104, 106, 118, 119, 121, 126, 127, 130, 137, 140, 147, 148, 154, 168, 235, 236, 251, 252, 253, 260, 266
benevolence, 76
business model of health care, 130, 136, 145, 147, 149, 154, 155, 222, 249
business model of health service delivery, iv, 15, 36, 57, 131, 134, 140, 141, 145, 148, 151, 155, 156, 157, 159, 169, 173, 195, 249, 254, 256

C

commodity, 18, 53, 126, 127, 129, 134, 135, 136, 150, 152, 154, 156, 231, 249, 270
consumer choice, 138, 232, 233, 234, 236
consumer empowerment, 232, 240, 241, 243
consumer protection, 20, 237, 238
consumer responsibility, ix, 232, 235
consumer-directed health care, iv, 15, 20, 230, 231, 232, 234, 236, 237, 239, 241, 243, 244, 246, 250
consumer-driven health care, 46, 228, 229, 230, 232, 236, 242
consumerism, 33, 51, 62, 192, 228, 229, 270
contractual nature of the doctor-patient relationship, 126
cost-containment, 142, 198, 199, 200, 202, 204, 209, 217, 218, 219
culture of medical care, vii, 17, 23, 24, 34, 35, 134, 159, 188, 247, 248, 249

D

David Thomasma, 79
decision-making, iv, viii, 1, 2, 3, 18, 20, 57, 58, 59, 60, 61, 62, 65, 67, 68, 70, 72, 73, 79, 80, 81, 82, 84, 88, 89, 91, 92, 96, 98, 101, 104, 106, 109, 111, 112, 113, 114, 115, 117, 118, 120, 121, 122, 123, 126, 127, 137, 138, 140, 141, 143, 145, 146, 147, 148, 154, 190, 193, 213, 220, 222, 223, 227, 229, 231, 232, 233, 234, 235, 236, 243, 244, 248, 249, 253, 254, 255, 258, 267, 272
  medical decision-making, iv, viii, 3, 18, 20, 57, 58, 60, 65, 66, 69, 70, 71, 72, 79, 80, 82, 83, 88, 89, 91, 96, 101, 104, 106, 109, 111, 113, 115, 116, 118, 121, 122, 123, 126, 127, 136, 140, 141, 142, 145, 146, 147, 148, 154, 197, 220, 222, 223, 227, 229, 232, 233, 234, 235, 236, 243, 244, 248, 249, 253, 254, 255, 272
  medical decision-making process, iv, 18, 66, 72, 96, 121, 140, 142, 147, 197, 222, 229, 232, 233, 244, 248, 254
  participatory decision-making, 65, 81, 98
  patient centred decision-making, 104
de-professionalisation, 50, 52, 105, 128, 228
dignity, iv, viii, ix, 2, 29, 66, 72, 74, 99, 103, 111, 116, 117, 118, 123, 151, 210, 236, 248, 251
duty of care, 92, 102, 108, 166, 172, 177, 183
duty of loyalty, viii, 163, 172, 173, 175, 176, 180, 217

E

Edmund Pellegrino, 79
Eliot Freidson, 48, 49, 50, 63
ethics
  business ethic, 19, 133, 134, 214
  business ethics, 133, 134
  contractual ethic, 169, 255
  medical ethic, 4, 65, 66, 67, 72, 75, 78, 79, 80, 81, 119, 120, 123, 128, 134, 156, 162, 194, 214, 266, 276
  medical ethics, 4, 65, 66, 67, 72, 75, 78, 79, 80, 81, 119, 120, 123, 156, 162, 194, 214, 266, 276
exemption clause, 150, 151

F

fiduciaries, 137, 161, 162, 168, 171, 183, 217, 222, 254
fiduciary duty, 163, 165, 166, 167, 168, 172, 173, 174, 175, 176, 178, 180, 181, 182, 183, 185, 216, 217, 218, 220, 221, 223, 255, 256
fiduciary ethic, 169, 170, 255
fiduciary law, 137, 161, 162, 166, 168, 171, 172, 173, 176, 183, 184, 185, 186, 188, 190, 246, 255
fiduciary metaphor, 167, 171, 172, 178, 186, 255
fiduciary nature of the doctor-patient relationship, iv, viii, ix, 15, 19, 126, 127, 140, 159, 160, 161, 163, 167, 171, 173, 175, 177, 182, 186, 188, 214, 254
fiduciary principles, 19, 160, 163, 183, 189, 190, 254
fiduciary rules, 185

financial incentives, 142, 144, 215, 221, 224, 229, 250
functional specificity, 38, 39, 44, 48, 49, 80, 124, 135, 160, 257
functional specificy, 38, 39, 48, 49, 80, 124, 135

G

Galen of Perganum, 30

H

health insurance plans, 19, 197, 200, 206, 207, 208, 211, 221, 226, 256
health maintenance organisation
HMO, 142, 195, 197, 202, 203, 204, 209, 217, 225, 241, 264, 266, 270
health maintenance organisations, 194, 195, 197, 217, 224, 225
Hippocratic ethic, 136, 151, 187
dignity, 2, 74, 99, 117, 123

I

Immanuel Kant, 73
informed consent, iv, viii, ix, 18, 74, 75, 77, 78, 81, 82, 83, 84, 85, 87, 88, 89, 90, 91, 92, 93, 95, 96, 97, 98, 99, 100, 101, 103, 104, 105, 106, 107, 109, 110, 112, 113, 114, 115, 116, 117, 118, 120, 121, 122, 123, 124, 126, 127, 140, 141, 142, 144, 145, 161, 163, 164, 175, 214, 217, 219, 220, 222, 233, 249, 253, 254, 259, 271, 272, 276, 280
doctrine of informed consent, iv, viii, ix, 81, 82, 83, 85, 87, 88, 89, 91, 92, 93, 95, 97, 99, 101, 102, 104, 105, 106, 110, 112, 113, 115, 116, 117, 118, 120, 122, 123, 124, 126, 141, 145, 217, 219, 220, 222, 233, 249, 253, 259, 280
institution-patient relationship, 15, 19, 192, 218, 227

J

John Stuart Mill, 73

L

lack of consent, 71

M

managed care, iv, ix, 15, 19, 20, 34, 130, 171, 192, 193, 194, 195, 196, 199, 200, 201, 202, 203, 204, 205, 206, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 237, 241, 246, 250, 256, 267, 270
managed care organisations, 171, 194, 202, 203, 205, 206, 213, 214, 215, 217, 218, 221, 223, 225, 226, 237, 250, 256
managed health care, 19, 29, 97, 193, 194, 200, 201, 202, 205, 210, 211, 212, 213, 223, 224, 226, 227, 237, 239
Marie Haug, 50, 229
market paradigm in health service delivery, 228
market-oriented approach, 131
medical marketplace, viii, 18, 20, 33, 37, 44, 126, 145, 146, 151, 154, 195, 198, 241, 243, 249, 250, 252
medical profession, vii, 1, 7, 8, 17, 18, 23, 24, 27, 28, 29, 30, 32, 33, 34, 35, 38, 39, 40, 41, 43, 47, 48, 49, 50, 51, 52, 53, 56, 57, 61, 64, 65, 66, 67, 68, 71, 76, 77, 80, 86, 88, 89, 90, 96, 103, 105, 106, 111, 112, 114, 116, 117, 118, 119, 120, 122, 123, 124, 128, 129, 132, 133, 136, 138, 141, 142, 148, 150, 151, 154, 156, 157, 158, 159, 160, 168, 188, 192, 193, 195, 202, 214, 216, 228, 236, 247, 248, 250, 252, 254, 257, 260, 271, 273, 276
medical scheme, 19, 194, 195, 197, 200, 201, 203, 206, 207, 210, 226
medical schemes, 19, 194, 196, 197, 200, 201, 206, 207
moral concepts of justice, 210, 211
moral relationship, 118, 136, 153, 179, 183, 214, 218, 254, 257, 260

N

non-disclosure, 62, 71, 86, 114, 115, 141, 144, 253
non-proprietary nature of medical practice, 135

P

paternalism, viii, 15, 17, 59, 60, 61, 62, 63, 64, 65, 72, 73, 76, 79, 80, 82, 88, 89, 92, 93, 95, 106, 107, 110, 113, 114, 119, 120, 123, 124, 130, 170, 235, 249, 271, 273, 279
beneficent paternalism, 120
medical paternalism, viii, 15, 17, 60, 61, 62, 63, 64, 65, 72, 73, 76, 79, 82, 88, 89, 93, 95, 107, 123, 124, 271
paternalistic approach, 16, 18, 33, 59, 63, 64, 69, 72, 80, 81, 107, 113, 114, 118, 122, 123, 124, 159, 233, 246, 249
paternalistic attitudes, 112
paternalistic medical setting, viii, 65
paternalistic practices, 61, 64, 123
patient empowerment, 241, 242, 267
principle of beneficence, 29, 38, 76, 77, 78, 79, 80, 81, 84, 106, 118, 119, 130, 148, 154, 235
profession, vii, 1, 5, 6, 7, 8, 9, 17, 18, 24, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 39, 40, 41, 42, 43, 44, 46, 47, 48, 49, 50, 51, 52, 53, 55, 56, 57, 58, 62, 63, 65, 66, 67, 71, 77, 80, 86, 88, 89, 90, 92, 96, 102, 103, 104, 105, 106, 111, 114, 116, 117, 119, 120, 123, 124, 128, 129, 132, 134, 136, 138, 141, 142, 148, 150, 151, 154, 155, 156, 157, 158, 159, 160, 162, 168, 188, 192, 193, 195, 202, 214, 216, 224, 228, 247, 248, 250, 252, 254, 257, 271, 273, 276
professional autonomy, 48
professional duty, 143
professionalism, 17, 35, 36, 38, 39, 40, 41, 47, 48, 55, 57, 59, 63, 71, 112, 134, 135, 150, 151, 152, 187, 217, 248, 257, 258, 267
proletarianisation, 50, 51, 52, 127, 128, 129, 133, 139, 228

R

right to bodily and psychological integrity, 73, 74, 98, 251

right to freedom of association, 2
right to freedom of movement, 73, 251
right to life, 73, 77, 251, 252
right to privacy, 2, 73, 251

S

self-determination, iv, viii, ix, 18, 66, 69, 71, 72, 73, 74, 75, 78, 80, 81, 82, 83, 84, 85, 86, 88, 89, 91, 92, 93, 94, 95, 96, 98, 101, 103, 104, 105, 106, 107, 108, 110, 112, 113, 115, 116, 117, 118, 119, 121, 122, 123, 124, 140, 141, 144, 145, 146, 147, 153, 170, 178, 179, 233, 243, 248, 249, 251, 252, 253, 254, 260
sick role, vii, 27, 35, 42, 45, 46, 55, 57, 63, 65, 71, 112, 118, 129, 137, 138, 153, 179, 248, 253
standards of disclosure, 103, 106, 115, 253
  professional practice standard, 88, 89, 101, 106
  reasonable patient standard, 108, 109
  subjective personal standard, 109

T

Talcott Parsons, 42, 43, 55, 63, 65, 71, 76, 112, 118, 153, 179
Thomas Percival, 67, 162
trust, iv, viii, ix, 19, 20, 28, 44, 46, 47, 65, 84, 113, 115, 118, 119, 120, 127, 135, 136, 140, 141, 145, 147, 148, 150, 151, 153, 154, 155, 159, 160, 161, 163, 165, 166, 168, 170, 173, 178, 179, 180, 181, 183, 184, 187, 189, 214, 215, 217, 218, 222, 223, 225, 231, 242, 254, 255, 256, 257, 258, 259, 260, 273

V

Vincente Navarro, 50, 52