The duty of therapists to third parties

RALPH SLOVENKO*

To Professor SA Strauss I want to express heartfelt thanks for his collegiality and for his scholarship. I met Sas (as he is affectionately known) in the mid-1970s in South Africa and thereafter on a number of trips I had the pleasure of his company. I have fond memory of our encounters.

Sas has given generously of his time. He is remembered for his service on the board of governors of the World Association for Medical Law and for his editorship of the international journal *Medicine and Law*.

Through the years I have valued his scholarship in medical law. His writings are remarkable in their number and quality. His scholarship is admired worldwide.

Sas is renowned for his integrity, dignity, dependability, and courage. He has been an inspiration.

✡ ✡ ✡

When do therapists owe a duty to persons other than their patients? The threshold question in a negligence action is whether the defendant owed the plaintiff a legal duty. As a general principle, the risk that may result from one's behaviour, as reasonably perceived, determines the duty of care as well as to whom the duty is owed.

It is an axiom that good medical care involves consideration not only of the patient but also of others. The duty to others finds expression in legislation imposing various reporting obligations on physicians. However, in determining to whom a duty of care is owed, the courts are mindful of the extent of liability insurance coverage.[1] The courts not only consider the foreseeability of harm but they also assess the competing public policy considerations for or against imposing a duty. As one court expressed it, 'Liability must be controlled by workable and just limits.'[2] In the event that the court deter-

*Invited member of the False Memory Syndrome Foundation Scientific and Professional Advisory Board. Professor of Law and Psychiatry, Wayne State University Law School.

[1]*Ryan v New York Central RR Co* 35 NY 210 91 Am Dec 49 (1866); AE Smith 'The miscegenetic union of liability insurance and the tort process in the personal injury claims system' 1969 *Cornell L Rev* 645; EJ Weinreb 'Causation and wrongdoing' 1987 *Chi-Kent L Rev* 407.

[2]*Stadler v Cross*, 295 NW 2d 552 (Minn 1980); quoted in *Iacona v Schrupp* 521 NW 2d 70 (Minn App 1994).

mines that no duty exists, summary disposition — that is, judgment without the necessity of going to trial — is the appropriate remedy.

The issue of duty was highlighted in the most discussed of all torts cases, *Palsgraf v Long Island RR Co*[3] A passenger, rushing to catch the defendant's train, was pushed by a train porter as he was about to board and a package was dislodged from his grasp. It fell upon the rails. It contained fireworks, it exploded, and the concussion overturned a weight scale, a distance away on the platform, injuring Mrs Palsgraf, the plaintiff. Judge Cardozo, for the majority, held that there was no liability because there was no negligence toward the plaintiff. Negligence, he said, must be founded upon the foreseeability of harm to the person in fact injured. The defendant's conduct was not a wrong toward the plaintiff merely because there was negligence toward someone else. The plaintiff, Judge Cardozo said, must 'sue in her own right for a wrong personal to her, and not as the vicarious beneficiary of a breach of duty to another.' The law on negligence does not include a concept of 'transfer of negligence' from one party to another. The train porter's behaviour was reasonably foreseeable to cause injury to the passenger but not to Mrs Palsgraf standing a distance away on the platform.

As a matter of law, can therapy or care of a patient result in a foreseeable risk of harm to a third person? The answer is a problematical yes. One result of mal-psychotherapy may be a patient's acting out in an unlawful manner. Clearly, to take an extreme example, a therapist who hypnotizes a patient and suggests the commission of a crime is a wrongdoer.[4]

Mental hospitals are obliged to exercise reasonable care in preventing escapes or approving releases; they have a duty to protect third parties. In numerous cases, hospitals or staff members have been held liable for breach of this duty.[5] In the absence of charitable or governmental immunity, the courts have placed on mental hospitals a duty owing to the general public to exercise reasonable care in escape prevention and release decisions. For the most part, the courts in these cases have not distinguished between foreseeable and unforeseeable victims. The cases mostly involved rather obvious diagnostic, administrative or communication errors.[6]

---

[3]248 NY 339, 162 NE 99 (1928).

[4]Under the influence of Jim Jones, members of the People's Temple in Jonestown murdered Congressman Leo J Ryan and then committed suicide en masse. *United States v Layton* 549 F 2d 903 (ND Cal 1982).

[5]Thus, a New York court said that a state mental hospital 'has a duty to protect the community from acts of insane persons under its care.' In this case, the hospital breached its duty of care by failing to provide adequate security in view of the patient's known violent tendencies. *Jones v State of New York* 267 App Div 254, 45 NYS 2d 404 (1943).

[6]To take an illustration, a complaint that a hospital doctor, after an allegedly superficial psychiatric examination, released a patient without warning to a foreseeable victim, despite knowledge of the patient's previous threats against that victim, made out a negligence cause of action. Hospital treatment of mental patients, the court said, induces the public to rely on and to expect an exercise of reasonable care. The

Policy lines, to some extent arbitrary, are drawn to narrow the scope of duty or actionable causation.[7] A number of states do not allow anyone but the patient to sue over negligent treatment even when that malpractice causes physical injury to others, as occurs when an infectious disease is improperly treated and is passed on to family members. In Illinois, in a case of this sort, the defendant physician raised the spectre of a potentially unlimited liability to all those infected by his patient as well as all those whom they infect, and he also asserted that allowing the patient's immediate family to sue would constitute an artificial distinction between family members and all others whom his patient or they might infect. The majority of an intermediate appellate court agreed.[8] Justice Freedman, dissenting, would have extended the duty to the patient's immediate family. He said, 'I cannot agree that limiting the right to sue ... to a patient's immediate family members, ie, to those with whom he has special relationships, is an artificial and arbitrary distinction'.[9]

In this type of situation, other states have not limited a cause of action only to patients. In a case decided by the Pennsylvania Supreme Court,[10] a physician negligently advised a patient exposed to hepatitis that if she remained symptom free for six weeks she had not contracted the disease and was not contagious. The advice should have been six months rather than six weeks. The patient refrained from sexual intercourse for eight weeks after the exposure and then resumed sexual intercourse with the plaintiff. Both patient and plaintiff were diagnosed with hepatitis. The court held that the plaintiff had a cause of action against the physician.[11]

'obligation of due care extends to the public', said the court. *Fair v United States*, 234 F 2d 288, at 294 (5th Cir 1956). See also *Merchants National Bank & Trust Co of Fargo v United States* 272 F Supp 409 (DND 1967); *Homere v State* 79 Misc 2d 972, 361 NYS 2d 820 (1974).

[7]See *Renslow v Mennonite Hosp* 67 Ill 2d 348, 10 Ill Dec 484, 367 NE 2d 1250 (1977).

[8]*Britton v Soltes* 205 Ill App 3d 943, 150 Ill Dec 783, 563 NE 2d 910 (1990).

[9]Justice Charles Freeman dissenting, 563 NE 2d at 916.

[10]*DiMarco v Lynch Homes* 525 Pa 558, 583 A 2d 422 (1990).

[11]The court said (583 A 2d at 424–425): 'Physicians are the first line of defense against the spread of communicable diseases, because physicians know what measures must be taken to prevent the infection of others. The patient must be advised to take certain sanitary measures, or to remain quarantined for a period of time, or to practise sexual abstinence of what is commonly referred to as "safe sex". Such precautions are taken not to protect the health of the patient, whose well being has already been compromised, rather *such precautions are taken to safeguard the health of others*. Thus, the duty of a physician in such circumstances extends to those "within the foreseeable orbit of risk of harm". If a third person is in that class of persons whose health is likely to be threatened by the patient, and if erroneous advice is given to that patient to the ultimate detriment of the third person, the third person has a cause of action against the physician, because the physician should recognize that the services rendered to the patient are necessary for the protection of the third person ... We further hold that the class of persons whose health is likely to be threatened by the patient includes *any* one who is physically intimate with the patient. Those, like the trial court, who insist that we cannot predict, or foresee, that a patient will engage in sexual activity outside of the marital relationship and that thus, we need not protect those who engage in "casual" sex, are exalting an unheeded morality over reality.' (Emphasis by court.)

In various jurisdictions the courts have held a physician liable to members of a patient's family who contracted tuberculosis as a result of negligent failure of the physician to warn of danger of contagion.[12] A physician's liability has also been held to run to unidentifiable third persons in cases where the physician he failed to warn the patient not to drive because of an uncontrollable diabetic condition.[13] In products litigation, liability has been extended at times to foreseeable victims of a defective product.[14]

In a 1980 California case, *Molien v Kaiser Foundation Hospital*,[15] a physician incorrectly and negligently informed a patient that she had an infectious type of syphilis, and she was advised to tell her husband. The misdiagnosis allegedly caused her to become 'upset and suspicious that [her husband] had engaged in extra-marital sexual activities; tension and hostility arose between the two, causing a break-up of their marriage and the initiation of dissolution proceedings.' The husband sued the hospital and the diagnosing physician for the infliction of emotional distress he suffered and for loss of consortium. The California Supreme Court held that the complaint stated a cause of action because the husband was a 'direct victim' of the physician's alleged negligent act.[16]

---

[12]See *eg Hoffman v Blackmon* 241 So 2d 752 (Fla App 1970); *Skillings v Allen* 173 NW 663 (Minn 1919).

[13]See *eg Myers v Quesenberry* 193 Cal Rptr 733 (Cal App 1983).

[14]WH Hardie 'Confronting Foreseeability in Products Litigation', *For the Defense* Oct 1994 4. In *Enright v Eli Lilly* 77 NY 2d 377, 570 NE 2d 198, 568 NYS 2d 550 (1991), the New York Court of Appeals held that a brain-damaged girl had no legal standing to sue the manufacturer of the drug DES (diethylstilbestrol), which her grandmother took during pregnancy. The suit claimed that DES taken by the grandmother caused the plaintiff's mother to be born with a malformed uterus, which in turn caused her premature birth and resulting cerebral palsy. In a 5–1 decision, the court ruled that the third generation had no right to sue because there was no 'contact with the substance' and liability should be limited to 'those who ingested the drug or were exposed to it in utero.' The court said, 'For all we know, the rippling effects of DES exposure may extend for generations. It is our duty to confine liability within manageable limits. Limiting liability to those who ingested the drug or were exposed to it in utero serves this purpose.' The concept of 'proximate' or 'legal cause' is another way that courts limit liability. As a matter of public policy, the court may find there is no 'proximate cause' between the harm claimed by the plaintiff and the defendant's negligence. In such an instance, the damages are called 'remote.' 'It is not easy at all times to determine what are proximate and what are remote damages.' *Ryan v New York Central RR Co* 35 NY 210, 91 Am Dec 49 (1866). Usually, foreseeability is considered an element of negligence, not cause. Unlike the question of duty, the proximate cause issue is more within the province of the jury. *Stewart v Wulf* 271 NW 2d 79 (Wis 1978).

[15]27 Cal 3d 916, 616 P 2d 813, 167 Cal Rptr 831 (1980).

[16]The court said (27 Cal 3d at 923, 167 Cal Rptr at 835): 'The risk of harm to plaintiff was reasonably foreseeable to defendants. It is easily predictable that an erroneous diagnosis of syphilis and its probable source would produce marital discord and resultant emotional distress to a married patient's spouse; [the doctor's] advice to Mrs Molien to have her husband examined for the disease confirms that plaintiff was a foreseeable victim of the negligent diagnosis. Because the disease is normally transmitted only by sexual relations, it is rational to anticipate that both husband and wife would experience anxiety, suspicion, and hostility when confronted with what they had every reason to believe was reliable medical evidence of a particularly

At trial, of course, the alleged facts would have to be established by a preponderance of the evidence. Proving fault may not be as difficult as proving that the alleged harm is the result of the fault. Causation, unlike duty, is usually a jury determination.

Tarasoff/Duty to warn or protect in the outpatient setting

Social changes have increased the likelihood that therapists will care for potentially dangerous patients who are not under custodial control. No decision caused more concern in the psychiatric community than the decision by the California Supreme Court in *Tarasoff v Regents of the University of California*.[17] Among psychiatrists, the name of the case has become a household word. The decision, though it arose in the mid-1970s, continues to be discussed at psychiatric meetings and in countless publications.[18]

In this case, Prosenjit Poddar, a 25-year-old graduate student from India at the University of California, had met weekly for a total of eight sessions with Dr Lawrence Moore, a clinical psychologist at the outpatient department of the university hospital. He revealed thoughts of harming, even killing, a young woman, readily identifiable as Tatiana Tarasoff, who had rejected him. Dr Moore, with the concurrence of a colleague, concluded that Poddar should be committed for observation under a 72-hour emergency psychiatric detention provision of the California commitment law. He notified the campus police that Poddar was dangerous and should be committed. The campus police questioned Poddar and they also talked to other people familiar with him. They warned him to stay away from the girl. They concluded that commitment was not necessary. Poddar never returned to the clinic, perhaps because he felt his trust in Dr Moore had been betrayed. Two months later, when Tatiana returned from vacation he stabbed her to death.

In *Tarasoff*, as is well known, the California Supreme Court imposed a duty on psychiatrists or other psychotherapists to protect readily identifiable third parties from potential harm by their patients. In so doing, the court made the psychiatrist a proper party defendant whenever a patient causes injury.[19] In jurisdictions following *Tarasoff*, it no longer is possible for therapists to get

---

noxious infidelity. We thus agree with plaintiff that the alleged tortious conduct of defendant was directed to him as well as to his wife. Because the risk of harm to him was reasonably foreseeable we hold, in negligence parlance, that under these circumstances defendants owed a plaintiff a duty to exercise due care in diagnosing the physical condition of his wife.'

[17]The case was actually heard twice. *Tarasoff I* 118 Cal Rptr 129, 529 P 2d 553 (1974), *vacated Tarasoff II* 17 Cal 3d 425, 131 Cal Rptr 14, 551 P 2d 334 (1976).

[18]D Truscott 'The psychotherapists's duty to protect: an annotated bibliography' 1993 *J Psychiatry & Law* 221.

[19]In this case the trial court had sustained a demurrer to the complaint. A demurrer declares that even if everything stated in the complaint were true, it does not state facts sufficient to constitute a cause of action. It is, in effect, a legal shrugging of the shoulder: 'So what?' In modern procedure a 'motion to dismiss' or summary judgment replaces the demurrer, and if denied the case simply proceeds to trial on the merits.

out of the case by summary disposition on the ground that they owe no duty in law to the injured party. Under *Tarasoff*, it is now a matter for the jury to decide on the basis of the facts of the particular case whether the third party was readily identifiable and reasonable care was exercised.

The case was settled but had it gone to trial, the court could have found that the therapist in fact discharged the duty imposed by the court, since he had notified the campus police.

The importance of the case, though it was settled, is that it imposed a legal duty on therapists to readily identifiable third persons irrespective of the standard of care in treating the patient.[20]

However, one might ask whether the therapy was below standard of care. The case might have been litigated, purely and simply, as one of mal-psychotherapy, like mal-chemotherapy, resulting in the patient harming others. One colleague at the clinic suggested that Dr Moore was not sufficiently experienced or otherwise able to handle the case. Not long before, events in Dr Moore's life — a suicide attempt by his wife and her attempted murder of their child — had traumatized him. Following the death of Tatiana, he was dismissed from the clinic.

The case could have been litigated and decided on the basis of negligent treatment rather than on the formulation of a special duty or relationship to third persons. A 'special relationship' to a third party need not be found in cases where the treatment of the patient is negligent and results in 'direct injury' to the third person. The negligent-treatment approach apparently was not taken because of the difficulty in establishing standard of care in psychotherapy.

The California Supreme Court during the 1970s was a 'progressive court' that expanded theories of law in this case and others, and was followed in a number of other jurisdictions. The court held that by virtue of the 'special relationship' that a therapist has with a patient, there results a duty of care to third parties who might be injured by the patient. It is immaterial whether or not the treatment of the patient falls below standard of care, or whether or not there is a causal nexus between the treatment and the injury to the third person. The court said:

> Although under the common law, as a general rule, one person owed no duty to control the conduct of another, nor to warn those endangered by such conduct, the courts have carved out an exception to this rule in cases in which the defendant stands in some special relationship to either the person whose conduct needs to be controlled or in a relationship to the foreseeable victim of that conduct.

The court went on to say that the special relationship with the patient also

[20]When a case may go to a jury, given the uncertainty of their verdict, insurers and others tend to settle.

creates a special relationship with a victim of the patient.[21] Under the *Tarasoff* innovation, a special relation between **A** and **B** creates a special relation between **A** and **C**. Thus, **A** is liable for the injury **B** causes to **C** even though **A** is not directly negligent toward **C**. The *Tarasoff* decision and its progeny represents an evolution of the law from no duty, to a duty to those in a special relation, and now to those who might be harmed by one to whom a duty is owed. The court said:

> Although plaintiff's pleadings assert no special relation between Tatiana and defendant therapists, they establish as between Poddar and defendant therapists the special relation that arises between a patient and his doctor or psychotherapist. Such a relationship may support affirmative duties for the benefit of third persons. Thus, for example, a hospital must exercise reasonable care to control the behavior of a patient which may endanger other persons. A doctor must also warn a patient if the patient's condition or medication renders certain conduct, such as driving a car, dangerous to others.
>
> Although the California decisions that recognize this duty have involved cases in which the defendant stood in a special relationship **both** to the victim and to the person whose conduct created the danger, we do not think that the duty should logically be constricted to such situations (emphasis by court). Decisions of other jurisdictions hold that the single relationship of a doctor to his patient is sufficient to support the duty to exercise reasonable care to protect others against dangers emanating from the patient's illness. The courts hold that a doctor is liable to persons infected by his patient if he negligently fails to diagnose a contagious disease or, having diagnosed the illness, fails to warn members of the patient's family.

Under this ruling, a third party victim may bring a claim against a therapist regardless of whether or not the therapist's care and treatment of the patient constituted malpractice. Indeed, it could have been the best of therapy. One might imagine a situation where an individual comes to a therapist and confides a plan to harm a third party but departs immediately thus depriving the therapist of any therapeutic opportunity. The *Tarasoff* ruling would require the therapist to protect the potential third party victim. Under *Tarasoff*, the focus of concern is the foreseeable risk to a third party.[22]

The court in *Tarasoff* rationalized its holding in part by citing earlier decisions holding physicians liable for failing to warn third parties who contracted contagious diseases from their patients.[23] What care to protect potential victims

---

[21]The common law did not impose on obligation to aid or protect another, even if the other is in danger of losing his life. In a classic example, an accomplished swimmer with a boat and rope at hand, who sees another drowning, but did not put him in that peril, is not required to do anything at all about it. The common law imposed a duty on a person to render aid only when that person created the peril or when there is a special relation between the parties. For example, because of a special relation, a carrier is required to take reasonable affirmative steps to aid a passenger in peril, an innkeeper to aid a guest, or a physician to aid a patient. Unless there is a special relation between the parties, a duty arises only by virtue of misfeasance that is foreseeable will cause injury to the plaintiff. *Osterlind v Hill* 263 Mass 73, 160 NE 301 (1928).

[22]PC Cartensen 'The evolving duty of mental health professionals to third parties: a doctrinal and institutional examination' 1994 *Int'l J Law & Psychiatry* 1.

[23]551 P 2d at 354.

is reasonably necessary, the court said, can be determined only on a case-by-case basis.[24]

Ramona/'Revival of memory'

In a growing area of concern, the question that now arises is whether family members who are hurt by 'recovered memory' therapists have a right of redress in the legal setting. Clearly the patient has a basis for a malpractice action against the therapist; a number of patients who have recanted memories of sexual abuse have reunited with their families and then brought suit against the therapist for malpractice.[25] But what about a claim against a therapist by one other than the patient?

Conceivably, parents may proceed on a theory as in *Molien* that the parents are 'direct victims' of the therapist's negligence, or on a theory as in *Tarasoff* that the 'special relationship' with the patient creates a 'special relationship' with a person who is harmed by the patient. The *Molien* approach is less novel, jurisprudentially speaking, than the *Tarasoff* approach.

With increasing frequency individuals in the course of therapy 'recover' repressed memories of childhood sexual abuse. The memory of abuse supposedly is 'repressed' until, usually with the help of a therapist, it is remembered. Treatment programs use a variety of techniques to help patients recover the memory. The book, *The Courage to Heal* has been influential. It contains statements such as: 'If you are unable to remember any specific instances ... but still have a feeling that something abusive happened to you, it probably did.' 'If you think you were abused and your life shows the symptoms, then you were.' Revenge, anger, and deathbed confrontations are encouraged. The book advises, 'You are not responsible for proving that you were abused.[26] Treatment centres advertise, 'Remembering incest and childhood abuse is the first step to healing'.

What may be helpful therapeutically as a narrative is used as historical, fact-based truth. Patients, convinced that they were abused, are furious at their parents and blame them for their troubles. They take such actions as suing the parents, refusing to let them see their grandchildren, or ruining their reputations by informing friends and acquaintances about the newly

---

[24]To safeguard themselves and to make sure of their legal duty, psychiatrists in various states have lobbied for legislation to provide that issuance of a warning alone discharges their duty. R Slovenko 'The Tarasoff progeny' in RI Simon (ed) *Review of Clinical Psychiatry and the Law* (Washington, DC: American Psychiatric Press, 1990), vol 1 ch 8 177.

[25]*Joyce-Couch v DeSilva* 77 Ohio App 3d 278, 602 NE 2d 286 (1991); see B Marvel 'Past memories present tense' *Dallas Morning News* 10 July 1994, F–1; 'Furor rises over lost memories; more suits expected against therapists' *Dallas Morning News* 10 July 1994 A–1.

[26]E Bass & L Davis *Courage to heal* (New York: Harper & Row, 1988).

discovered memories.[27] Some 700 civil and criminal cases have been filed based on retrieved memories of childhood abuse.[28] In these cases of 'revival of memory' there apparently has been no objective or corroborating evidence of abuse.

A few decades ago the *Zeitgeist* was to blame victims. A woman who was raped was 'asking for it' by walking alone at night or for wearing a short skirt. Today the *Zeitgeist* is a claim of victimhood whatever the reality. The 'victims' are angry and they want to wreak vengeance on those whom they believe have abused them. The legal system (both civil and criminal tracks) provides a ready and willing vehicle for gratifying this morbid desire.[29] Russell Baker of the *New York Times* observed recently that 'anger has become the national habit.'[30] In his book *Culture of Complaint*, Robert Hughes writes, 'The ether is now jammed with confessional shows in which a parade of citizens and their role-models, from Latoya Jackson to Roseanne Barr, rise to denounce the sins of their parents, real or imagined.'[31]

In many cases, the false memory and resulting false accusations of incest and sexual abuse hurt the patient's family. Whatever estrangement had existed in the family is exacerbated. The False Memory Syndrome Foundation, founded in 1992 Philadelphia to aid the victims of what is called false memory syndrome, reports over 13 000 requests for help or advice.[32]

The backlash has been widely reported: National news weeklies *Time* and *Newsweek* in November 1993 both had cover stories on hidden memories.[33] *Time* wrote, 'Repressed-memory therapy is harming patients, devastating families, and intensifying a backlash against mental-health professionals.' Earlier that year, in May, *Insight*, another national newsweekly, had a cover story, 'Malignant Memories: Therapists as Coaches.'[34] Also, in May, the *New*

---

[27]R Slovenko 'The "revival of memory" of childhood sexual abuse: is the tolling of the Statute of Limitations justified?' 1933 *J Psychiatry & Law* 7; H Wakefield & R Underwager 'Recovered memories of alleged sexual abuse: lawsuits against parents' *Behavioral Sciences & Law* 10: 483, 1992.

[28]S Begley 'You must remember this' *Newsweek* 26 Sept 1994 68.

[29]RA Gardner 'You're not a paranoid schizophrenic — you only have multiple personality disorder' *Academy Forum* (American Academy of Psychoanalysis) 1994 Fall 11.

[30]Quoted in M Dickerson 'United we gripe' *Detroit News* 6 Nov 1994 B–1.

[31]R Hughes *Culture of complaint/the fraying of America* (New York: Oxford University Press, 1993) 7. The other week I received a call from a woman who said that she wanted a sodium amythal interview to learn whether she was abused as a child. She asked me for the name of a doctor who would do it. Why? She said, 'I'm interested in doing it. I just want to do it. I read about it and I want to find out about repressed memory. I want to do it for the sake of doing it.'

[32]The Foundation disseminates information about the nature of memory and about how to deal with these therapists.

[33]29 Nov 1993.

[34]24 May 1993.

Yorker ran a two-part article called 'Remembering Satan'.[35]

The American Medical Association has twice warned against the use of 'memory enhancement' techniques in eliciting accounts of childhood sexual abuse. The wording of its last resolution, in August 1993, was especially harsh. Dr Paul McHugh, Chairman of the Psychiatry Department at Johns Hopkins University, said, '[Recovery of memory] is the biggest story in psychiatry in a decade. It is disaster for orthodox psychotherapists who are doing good work.'[36]

Not only are patients and family members affected by 'revival of memory' but also the practice of therapy is impugned. Psychiatrists, long called the 'Rodney Dangerfields' of the medical profession, get little respect, and controversies like 'revival of memory' make it even more difficult to include mental health under insurance coverage. Aggrieved parents have urged health insurers to act as regulators of health care providers by not providing reimbursement to therapists who engage in 'revival of memory' of child sexual abuse. In most states anyone can hang out a shingle and use the title 'psychotherapist'.

Safe from the backlash are prosecutors who bring charges of sexual abuse against parents or others on the basis of little more than the flimsy evidence of a 'revived memory.' The prosecutors have governmental immunity. Some feminist prosecutors have used the occasion to voice rage against sexual abuse. Every movement has its fanatics and zealots, and the feminist movement is no exception.

Psychotherapists have long resisted the notion that they prove the value of what they do — and they claim confidentiality. When a patient sues a therapist, the privilege of confidentiality is waived, but when a third party sues, and the patient does not waive the privilege, the third party faces obstacles in obtaining information as to what went on in therapy.[37]

In what is called a landmark case in California, Gary Ramona sued a medical centre and a pair of psycho-therapists who he claims created false memories

---

[35]The two-part article appears in expanded form in L Wright *Remembering satan* (New York: Knopf, 1994); reviewed in M Kakutani 'A family is destroyed by a sexual chimera' *New York Times* 29 April 1994 B–7. For a review of recent books on revival of memory, see F Crews 'The revenge of the repressed' *New York Review of Books* 17 Nov 1994 54.

[36]Quoted in S Salter 'Recalling abuse in the mind's eye' *San Francisco Chronicle* 4 April 1993 9.

[37]The California Board of Behavioral Science stated: 'If a therapist is incompetent or grossly negligent in treating a client, the Board can investigate the particulars of that situation. However, it is virtually impossible for the Board to conduct such an investigation without the consent and cooperation of the actual client. The confidentiality of psychotherapeutic communication is protected by law and therapeutic treatment records cannot be obtained without a written release from the client, if the client is an adult.' Quoted in *Newsletter of False Memory Syndrome Foundation* 3 May 1994 7.

in his daughter of his sexually abusing her as a child.[38] He was humiliated. His lawsuit sought damages for emotional suffering from the breakup of his family, and for harm to his career and reputation. The daughter was satisfied with the therapy, she testified against her father, and she filed a lawsuit against him.[39] Confidentiality, as a result, was waived.

In Ramona's suit against the hospital and therapists, the trial court citing *Molien* rejected the defense's motion for summary judgment. The trial judge said:

> This lawsuit is a compelling one, and it's a compelling one because it not only has the novelty of new and current legal issues, but also because it has a salient emotionalism to it . ... [T]he most interesting and compelling and difficult [issue] in this case ... is the question of whether a father may maintain a lawsuit against the therapists or other health care providers of his daughter alleging that he was damaged by their negligent treatment of her.
>
> ... I have found that a duty did exist to him by reason of the circumstances of the case under [California] Supreme Court law ... What's going on in a lawsuit of this sort is the conflict of policies. On the one hand, the defendants argue if you allow non-patients to sue health care providers, it will have a terrible, chilling effect upon the ability of any health care provider to do what his or her patient needs to provide the kinds of care that his or her patient needs to receive. How, they ask, is a health care provider to know what to do when presented with a patient who recalls or thinks he or she is recalling the sorts of things that are presented by this lawsuit. That's a big concern. That's an argument that has significant social implications attendant to it.
>
> Of equal significance, however, and with equal social implications, is the question of what is somebody who, for the sake of this point we will presume to be factually innocent of having engaged in misconduct with respect to his daughter, to do if confronted with the unfounded and incorrect accusation of having molested her with results in his loss of everything?
>
> It's as unpalatable to some to have health care providers put in the impossible situation of dealing with a patient presenting real problems but knowing that the health care providers might be subjected to liability as it is to others to have a falsely accused parent lose everything and have no recourse in court.
>
> Those are the kinds of policy issues that the courts are called upon to resolve, because in the area of tort law, and this is a tort action, there's very little statutory law. There's very little law created by the legislature that creates norms ... And the purposes of tort law are twofold: to provide redress for people who are injured in some way or another; and to mediate, to control, to direct the conduct of other people ...
>
> [I]n this case the rules are, from my point of view, fairly clear. They were made clear by the [California] Supreme Court in *Molien v Kaiser Foundation Hospital* in which a woman went to Kaiser Hospital, had a cause of action and could sue Kaiser Hospital for the emotional distress he suffered as a result of the negligent treatment of his wife, or the negligent diagnosis — misdiagnosis of syphilis.
>
> The defense lawyers have argued vigorously, and with good reason that in the ten or twelve years since the *Molien* case was decided, the Supreme Court has

---

[38] *Ramona v Isabella, Rose & Western Medical Center* case no C61898 (1994); see K Butler 'Clashing memories, mixed messages' *Los Angeles Times Magazine* 26 June 1994 12.

[39] The statue of limitations does not begin to run until awareness of the cause of action. R Slovenko 'The 'Revival of memory' of child sexual abuse: is the tolling of the Statute of Limitations justified?' 1993 *J Psychiatry & Law* 7.

> been narrowing its application. There's no question but that it has. That case, at the time it was presented to the Supreme Court, had the same kind of conflicts attending to it, the same kind of important policy issues that are present in this case.
>
> The defense lawyers have argued that I should view the *Molien* case as being history; that the Supreme Court has whittled away at it so far that it no longer exists... I think that the *Molien* case is still the law, because the Supreme Court has had numerous opportunities and has been asked on numerous occasions to simply say it is no longer the law ... Even as recently as late last year the Supreme Court was asked to do that, and they stressed that the reason Mr Molien had a cause of action was because of the instruction to his wife to go home and tell him about the diagnosis of her.
>
> Well, think how similar that is to the allegation that the plaintiff is seeking to prove in this case, which is that not only did somebody tell the patient, go home and tell your father, but in fact, the father was summoned to the meeting and the confrontation and presentation of the charge occurred.

Holding that a duty of care is owed is by itself a victory for the aggrieved whatever the outcome of a trial. In cases where the defendant is said to owe a duty to the plaintiff, as we have noted, the defendant cannot avoid a trial by summary judgment.[40] It allows litigation, and the possibility of it may discourage irresponsible therapy. It also has public relations impact.[41]

In *Ramona*, the accusing daughter had sought therapy for an eating disorder. According to reports, the therapists suggested to her that the eating disorder was caused by childhood sexual abuse that she had repressed. The father was granted standing to sue the therapist no matter that the daughter was completely satisfied with the therapy. Dr Harrison G Pope, Jr, on the basis of research he had done on bulimia nervosa, testified for the plaintiff that evidence is wanting of a link between sexual abuse (even if it had occurred) and eating disorders.[42]

The daughter was also told that if she recovered a memory of abuse under sodium amythal, the memory of abuse would be historically accurate.[43] The plaintiff maintained that the daughter had succumbed to suggestion by manipulative therapists. 'The only time she had memories of her father abusing her was when the doctors told her after the amythal,' testified Dr Park Dietz, another expert witness for the plaintiff. 'Before the amythal she couldn't

---

[40]The jury awarded Gary Ramona $500 00. It is reported that he has agreed to take a 'substantially less' amount in exchange for the defendants' agreement not to appeal. MJ Grinfeld, 'Impact of Ramona case uncertain' *Psychiatric Times* Oct 1994 1. One observer at the trial speculated that the jury made the award out of dismay at the outlandish fees charged by the defendant doctors. DS Chaffin (ltr) *Psychiatric Times* Oct 1994 17. The legal importance of the case, however, is that the judge allowed it to go to the jury.

[41]EF Loftus 'Therapeutic recollection of childhood abuse/When a memory may not be a memory?' *Champion* March 1994 5. See also Editorial 'No standards' *Wall Street Journal* 10 May 1994 18.

[42]HG Pope, B Mangweth, AB Negrao, JI Hudson & TA Cordas 'Childhood sexual abuse and bulimia nervosa: a comparison of American, Austrian, and Brazilian women' 1994 *Am J Psychiat* 732.

[43]J Gross 'Suit asks, does "memory therapy" heal or harm?' *New York Times* 8 April 1994 1.

remember for sure who it was in those images she was having.'[44]

Does the decision open the door to litigation by any person aggrieved by an interpretation made by a therapist to a patient? The decision has sent vibrations throughout the mental health profession. In an address at the 1994 annual meeting of the American Psychiatric Association, Dr Judith Herman, author of 'Trauma and Recovery', said about the *Ramona* case, 'The fact that a third party was given standing to speak on malpractice because he was not happy with the treatment of his daughter really opens the door to permit anyone who is dissatisfied with our treatment of any patient to lay claim against us.'

Hyperbole abounds. The court did not say that the public at large, one and all, may bring a claim against the therapist. Dr Herman acknowledged at the time of her address that she did not have access to the transcript or decision in the case.

In written commentary, Dr Thomas Gutheil, who testified on behalf of the defense in *Ramona*, asked: 'Whose therapy was this anyway? Should the father have been called in to approve each interpretation as it occurred to the therapist? Should the father's consent to the therapy have been sought, even though the patient was not a minor? Should the patient herself have been warned, in some caricature of the warning needed in a forensic context, that her therapy might conceivably be harmful to her father's peace of mind?'[45]

Not long ago, in a 'Murphy Brown' television program, a husband is told by his therapist that his wife is the cause of all of his problems and he is urged not to be passive but act aggressively. He takes out his anger on his wife. The wife complains to the therapist, 'Where do you get off telling my husband that I'm the cause of all his problems?'

Dr Gutheil posed a hypothetical scenario: 'Let's say a young man comes to treatment to work on trouble with relationships. A few years into psychotherapy, without any prompting by the therapist, the patient decides that the problem has been his failure to acknowledge that he is gay. Working this issue through, he feels much better — until he tells his parents, who are homophobic and become outraged at this news. They decide to sue the therapist for implanting foreign ideas or brainwashing or whatever.'

The scenario is what law professors call a parade of horribles, or slippery slope. The important fact, however, is that in *Ramona* the therapists operated on the basis of unsupported beliefs and urged the patient to blame someone for her problems. A resolution of the American Medical Association called for 'external validation' before assuming the authenticity of a patient's trauma

[44]Quoted in B Hewitt & L Mullen 'A father fights back' *People* 6 May 1994 52; see also J Gross 'Heated closing arguments in "recovered memory" case' *New York Times* 12 May 1994 12.

[45]TG Gutheil 'True recollections of a false memory case', *Psychiatric Times* July 1994 28.

history. It took to task those whom they accuse of being unscientifically overzealous in believing or promoting a patient's trauma history. Traditionally, in psychotherapy, objective or corroborating evidence is not sought as it is considered unnecessary for therapy. In 'revival of memory' of sexual abuse, however, it may be incumbent given its impact on others. Dr Paul Appelbaum, representing the American Psychiatric Association, opined that it might be salutary if therapists were found liable in negligence to serve as a chastening lesson.[46]

The trial judge in *Ramona* relied on *Molien* where, it will be recalled, the patient was advised to inform her husband that she had syphilis. In a special verdict answering questions put to them, the jury concluded: (1) the defendants were negligent in providing health care to Holly Ramona by implanting or reinforcing false memories that the plaintiff had molested her as a child; (2) the defendants caused the plaintiff to be personally confronted with the accusation that he had molested Holly Ramona; (3) and the plaintiff suffered damages that were caused by the negligence of the defendants.

The same year, 1994, the Texas Supreme Court declined to recognize a legal claim that would allow lawsuits against mental health professionals by non-patients when the claim is based on a misdiagnosis of child sexual abuse.[47] The case arose in the context of a parental custody dispute and raised policy questions concerning the duties therapists owe to non-clients as well as the scope of protection that is available to reporters of child abuse. In this case, a psychologist, Esther Bird, examined the child, a 6-year-old boy, and reported that he had been sexually abused by his father. The therapist was inexperienced and the examination was perfunctory. In defense, the psychologist asserted there is no professional duty running to third parties as a matter of law, and regardless, her report was a part of the court litigation process, and consequently, privileged as a matter of law.[48] In upholding the trial court's grant of summary judgment, the court ruled: 'We hold that as a matter of law there is no professional duty running from a psychologist to a third party not to negligently misdiagnose a condition of a patient. We further reaffirm that a statement in an affidavit filed as a part of a court proceeding is privileged.'[49] It went on to say:[50]

---

[46]See JR High (ltr) 'Abuse histories' *Psychiatric News* 21 Oct 1994 14.

[47]*Esther Bird v WCW* 868 SW 2d 767 (Tex 1994).

[48]A number of recent cases have denied witness immunity to experts receiving compensation from individual litigants. See EG Jensen 'When "hired guns" backfire: the witness immunity doctrine and the negligent expert witness' 1993 *UMKC L Rev* 185.

[49]868 SW 2d at 768. In *Chatman v Millis* 517 SW 2d 504 (Ark 1975), a divorced husband brought an action against a psychologist alleging malpractice and defamation arising out of a report to his wife's attorney that he was a homosexual and should be denied visitation privileges. The court held that there must be a doctor-patient relationship for an action of malpractice but not for defamation.

[50]868 SW 2d at 769.

> A claimant's right to sue a mental health professional must be considered in light of countervailing concerns, including the social utility of eradicating sexual abuse. Evaluating children to determine whether sexual abuse has occurred is essential to that goal ... Young children's difficulty in communicating sexual abuse heightens the need for experienced mental health professionals to evaluate the child. Because they are dealing with such a sensitive situation, mental health professionals should be allowed to exercise their professional judgment in diagnosing sexual abuse of a child without the judicial imposition of a countervailing duty to third parties.

In a widely publicized case in the late 1970s in Boulder, Colorado, a mother whose 25-year-old son had sued her for 'parental malpractice' filed her own suit against the son's psychiatrist, Dr Jeffrey Anker. The doctor had encouraged the son to sue her 'for therapeutic reasons.' (The demise of family immunity barring suits between family members began with the automobile accident cases and in these cases the insurance company is the defendant as a practical matter.) The son was described as a 'hippie' who was suspended from high school for selling marijuana, who chose to live with friends on a beach in Hawaii, and who refused to find work. In her suit, the mother said the 'parental malpractice' action against her caused her 'great grief, sorrow, and even anger' and she claimed that she had been subjected to widespread 'ridicule and embarrassment.' The case was apparently settled.[51]

Interference with family relations

Another approach is the old action in tort for 'interference with family relations' but this field of law has been described as 'rather ragged in form.'[52] It developed initially as an offshoot of the action for enticing away a servant and depriving the master of the quasi-proprietary interest in his services. Also, under the early common law, the status of a wife, as well as that of minor children, was that of more or less valuable servants of the husband and father, and that action was extended to include the deprivation of their services. In comparatively recent years, there has been a gradual shift of emphasis away from 'services' and toward a recognition of more intangible elements in domestic relations, such as companionship and affection. In a Washington case, an action for alienation of affections was allowed when a pastor counselled a woman to leave her husband who, the pastor said, was 'full of the devil.[53]

Most jurisdictions have abolished a cause of action for 'alienation of affections.'[54] At one time the courts recognized a common-law cause of action for alienation of the affections of a husband or wife, though in general

---

[51]AP news-release, 'Sued mom turns law on psychiatrist' 17 May 1979.

[52]WP Keeton (ed) *Prosser and Keeton on the Law of Torts* (St Paul, MN: West 5 ed 1984) 915.

[53]*Carrieri v Bush* 69 Wash 2d 536, 419 P 2d 132 (1966).

[54]See, eg, *Gasper v Lightbouse* 533 A 2d 1358 (Md App 1987) (action by husband alleging malpractice against marriage counsellor after wife's affair with counsellor was alienation of affection and therefore precluded by virtue of the abolition of such actions).

no cause of action for the alienation of the affections of a child was recognized. The American Law Institute's Restatement of Torts sets out a formulation of the contemporary approach: 'One who, without more, alienates from its parents the affections of a child, whether a minor or of full age, is not liable to the child's parents.'[55] In *Schuppin v Unification Church*,[56] parents brought an action against the religious organization alleging that it alienated and estranged their daughter from her family and friends, thereby interfering with and impairing the parent-child relationship. In accordance with the position expressed in the Restatement, the court, like the majority of jurisdictions, declined to recognize a cause of action by a parent for alienation of a child's affections.[57]

What implication is to be drawn from the words 'without more', as used in the Restatement's formulation?[58] Compensation might be awarded if liability existed on another basis, such as abduction (trespass to person) or intentional infliction of mental distress. A number of states that preclude an action for negligent damage to family ties do permit suits for intentional damage.[59]

In another case decided in 1994, *Sullivan v Cheshier*,[60] a federal court permitted a third party (the parents) to sue a psychologist based on revival of memory. The parents sued on a number of theories. They claimed, among other things, that the defendant created a public nuisance through the unlicensed practice of clinical psychology; intentional and reckless infliction of emotional distress; and intentional injury to their family relationship. The psychologist sought summary judgment under the theory that only the patient may sue for damages caused by estrangement. The court ruled that the parents' nuisance and intentional tort claims were valid.[61]

---

[55]Restatement (Second) of Torts § 699 (1977).

[56]435 F Supp 603 (D Ve 1977).

[57]See *Orlando v Alamo* 646 F 2d 1288 (8th Cir 1981); *Hyman v Moldovan* 166 Ga App 891, 305 SE 2d 648 (1983); *Scholz v Scholz* 177 NJ Super 647, 427 A 2d 619 (1980); *Edwards v Edwards* 43 NC App 296, 259 SE 2s 11 (1979); *Bock v Lindquist* 278 NW 2d 326 (Minn 1979); *McGrady v Rosenbaum* 62 Misc 2d 182, 308 NYS 2d 181 (1970), *aff'd* 37 AD 2d 917, 324 NYS 2d 876 (1971); *Ronan v Briggs* 351 Mass 700, 220 NE 2d 909 (1966); *Pyle v Waechter* 202 Iowa 695, 210 NW 926 (1926).

[58]See *Morris v Bruney* 78 NC App 668, 338 SE 2d 561 (1986); *Bartanus v Lis* 332 Pa Super 48, 480 A 2d 1178 (1984); Right of Child or Parent to Recover for Alienation of Other's Affections 60 ALR 3d 931 (1974). In *Strode v Gleason* 9 Wash App 13, 510 P 2d 250 (1973), the court recognised a parental action for 'malicious' alienation of the affections of a minor child. Malice was defined as an unjustifiable interference with the parent-child relationship. This was preserved when the court decided to abolish actions for alienation of the affections of a spouse. *Wyman v Wallace* 15 Wash App 395, 549 P 2d 71 (1976), *rev'd* 91 Wash 2d 317, 588 P 2d 1133 (1979) reinstated, 94 Wash 2d 99, 615 P 2d 452 (1980).

[59]See, eg, *Siciliano v Capitol City Shows* 124 NH 719, 475 A 2d 19 (1984); *Surina v Lucey* 168 Cal App 3d 539, 214 Cal Rptr 509 (1985).

[60]846 F Supp 654 (ND Ill 1994).

[61]At the same time, the court ruled that the tort claims were barred by the statute of limitations, and thus they were dismissed. 846 F Supp at 6670.

Conclusion

Actions against 'revival of memory' therapists can fall under the general principle that all persons are required to use ordinary care to prevent others from being injured as a result of their conduct. The pertinent factors to consider include the foreseeability of harm to the plaintiff, the degree of certainty that the plaintiff suffered injury, the closeness of the connection between the defendant's acts and the harm suffered by the plaintiff, the moral blame attached to the defendant's conduct, and the policy of preventing future harm.[62]

Professor SA Strauss has noted that the law of torts is evolving regarding the responsibility of therapists not only to their patients but also to third parties reasonably foreseeable as victims of harm caused by their patients. In many circumstances, the duty of the therapist runs not only to the patient but also to others.[63]

[62]*Bastian v County of San Luis Obispo* 199 Cal App 3d 520, 245 Cal Rptr 78 (1988).
[63]SA Strauss *Doctor, patient and the law* (Pretoria: JL van Schaik, 3 ed 1991).

Alcoholism: some medico-legal issues

LS SMITH*

Although I was well aware of Professor Strauss's many publications and had on many occasions heard his views quoted with great respect by Professors 'Polly' Turner, 'Okkie' Gordon and Hillel Shapiro, the then doyens of forensic medicine, it was not until 1968 that I had the privilege of meeting this fine gentleman. The meeting was at a Group discussion convened by the Secretary for Health shortly after the first human heart transplantation, by the Cape Town Transplant Team.

I had been involved in some aspects of the preparative endeavours, and in anticipation of the procedure had had consultations with the then Attorney General the late Mr W van den Berg, and had authorised the removal of the donated heart from the body on which I was to undertake a post mortem examination that day, in terms of the provisions of the Inquest Act.

This Group was to consider whether the Post Mortem Examination and Removal of Human Tissue Act (30 of 1952) as amended by Act 49 of 1961, needed further amendment. In the relevant subsequent legislation and in much of the ensuing health and welfare orientated legislation, Sas, with his convincing ways and wisdom, experience and understanding often played a major role tempering the over enthusiasm of his medical colleagues.

His guidance was often sought, not only by the National Health Authority, but equally so by the various provincial and private hospital organisations. Medical practitioners and members of the nursing profession were at all times made to feel at liberty to seek his advice, of which he gave so willingly. These unstinting endeavours have, in a large measure, contributed to a better understanding between doctor, nurse, patient and the legal profession.

In recognition of his services the Medical Association of South

*MB BCh DPH DBact FRCPath. Professor Extraordinarius, University of South Africa; Professor Emeritus, Department of Forensic Medicine and Toxicology, University of Cape Town.

Africa bestowed upon him the richly deserved singular honour of life membership for 'meritorious services rendered to the medical profession'.

Presently, as a member of the Medical Research Council's Ethical Committee, he continues to serve the needs of his fellow man with distinction.

✡ ✡ ✡

Historical

Alcoholic beverages have been part of social custom since earliest recorded time, and it's effects on behaviour and health clearly identified in biblical writings. Risks even more so today as the tempo and demands of life require greater skill and judgement. Noah was probably the first recorded alcoholic. (Genesis 9:21). Lot's daughters plied their father with drink to suit their own nefarious ends: 'Come let us make our father drink wine' (Genesis 19:32).

Samson's mother was counselled to avoid alcohol to ensure a successful pregnancy as it seems that even in those times there was an awareness of the 'foetal alcohol syndrome' (Judges 13:4).

Wine gives false courage ... which leads to brawls' (Proverbs 20:1), indeed so true of present day violence.

'What wonders does not wine! It discloses secrets, ratifies and confirms our hopes — thrusts the coward forth to battle. It eases the anxious mind of it's burden — instructs the Arts, Whom not quite free and easy of pinchbeck poverty.' (Horace 56BC)

In the New Testament the drinking of wine at social gatherings appears to have been acceptable, (John 2:12) although later texts warn against the health hazards related to alcohol abuse (Ephesians 5:18).

Was it not Macduff who asked: 'What three things does drink especially provoke?'

Porter: 'Marry sir, nose painting, sleep, and urine. Lechery sir, it provokes and unprovokes, it provokes the desire but takes away the performance ...: (Macbeth Act 2 Scene 3.)

(See *Table A*, page 249.)

Candy is dandy, but liquor is quicker.' (Ogden Nash)

The alchemist Lully (1235 - 1315 developed a method of making 'pure' alcohol and enthused, 'of marvellous use and commodite and little before joyning battle to styre and encourage the soldiers' minds' .. it's taste exceedeth all other tastes, and the smell of it all other smells'. What he was smelling and tasting was probably the congeners in his distillate, as alcohol (C2H50H) is tasteless and odourless.

How much history must have been determined by these effects of alcohol?

Metabolism of alcohol

Man has fortunately been provided during evolution with a specific enzyme mediated pathway directed to the breakdown of alcohol to it's final innocuous constituent parts C02 and H20, coupled with the ability to eliminate the remaining alcohol, about 10% via largely the breath and urine.

About 90% of the absorbed alcohol is oxidised initially in the liver to acetaldehyde by alcohol dehydrogenase (ADH) assisted to a lesser degree when high blood levels of alcohol are reached by a microsomal ethanol oxidising system (MEOS) Acetaldehyde which accounts for many of the acute and chronic toxic effects associated with the imbibing of alcohol is broken down further by acetaldehyde dehydrogenase (ALDH) to acetate and then by an ensuing pathway to carbon dioxide and water.[1] (See *Figure 1*, page 243.) This process can account for about 10g of ingested alcohol per hour (equivalent to a little more than one tot of spirits per hour), resulting in a rectilinear fall in the blood alcohol level of 0,01 to 0,02g per 100ml blood after the absorption peak has been reached. Retinal ADH also oxidises methyl alcohol to a very toxic formaldehyde which may result in blindness associated with the imbibing of illicit brews especially during 'Prohibition'. In this regard 'methylated spirits' in the RSA contains 95% ethylalcohol (alcohol) and small amounts of butyl alcohol, as well as pyridines, naphthas, and colouring. Ethyl alcohol is used therapeutically to treat methyl alcohol poisoning by competing preferentially for the ADH activity so limiting the availability of this enzyme to break down the methyl alcohol to formaldehyde, whilst the methyl alcohol is being excreted a such in the urine and breath.

Effects of alcohol on the central nervous system

The early manifestations of alcohol intoxication are thought to be due to the preferential involvement of polysynaptic neuronal pathways in the reticular formation of the brain stem, cerebral cortex and cerebellum. One of the most likely sites of ethanol's intoxicating effect is a complex of cell membranes containing a receptor for the neurotransmitter gamma-aminobutyric acid (GABA) and an associated chloride-ion channel. In electrophysiologic studies alcohol potentiates the GABA-activated inhibition of cerebral cortical neurones.

An excitory amino-acid receptor with a preferential affinity of N-methyl'-d-aspartate has been implicated in the process of memory and learning, of which alcohol is a potent inhibiter.[2] (See *Figure 2*, page 244.)

---

[1]RJ Hift 'Interactions of alcohol and drugs' 1991 *CME* 849–856; CS Lieber 'Ethanol metabolism' 1978 *N Eng J Med* 356.

[2]ME Charness, PS Roger & DA Greenberg 'Medical progress: ethanol and the nervous system' 1989 *New England J of Medicine* 442–454; FK Goodwin 'Alcohol effects on action of GABA' 1989 *JAMA* 260 4; JA Temlett 'Neurological effects of alcohol' 1991 *CME* 839–848.

Foetal alcohol syndrome

Modern epidemiological studies have demonstrated that the dangers to both foetus and mother who drink more than about 40ml of alcohol per day could be profound and life long, and that alcohol abuse during pregnancy is the leading cause of drug induced teratogenesis[3], with a prevalence of from 1 in 1000 live births. This danger may manifest as growth and mental retardation, including microcephaly and congenital cardiac defects. Furthermore spontaneous abortion is twice as likely in women who drink during pregnancy. Although three drinks per day during pregnancy triples the risk of mental retardation in the offspring there is uncertainty as to the amount or frequency or at what stage of pregnancy the risk is greatest.[4]

Other studies suggest a linear relationship between the amount of alcohol and the degree of mental and physical abnormality, but are unable to establish a threshold for adverse effects. It is thus prudent to advise all women to avoid all alcoholic beverages during pregnancy. Certainly a duty which befalls all those responsible for the care of the expectant mother.

The question which inevitably arises is, if the risk exists, whether this is of such an order to advise a therapeutic abortion in terms of the Abortion and Sterilization Act, certainly a very subjective decision. It seems illogical that despite medicine control authorities' world-wide going to great lengths to ensure that similar risks are clearly identified to the prescriber in the package insert, and readily available to the patient, yet the same is not required of the marketers of what has been termed as the most potent psychoactive dependence producing drug readily and lawfully available, the sale of which is persuasively advertised (during 1991 R114,2 million was spent on advertising in South Africa) without at least a warning label.[5] The outcome of a civil action arising out of the effect of alcohol on the mother and or the foetus may be revealing, as would an action by the retarded child against the mother who, aware of the inherent dangers to her foetus, continued to abuse alcohol during the child's intrauterine life.

Insurers

'Exclusion clauses' and related matters

In view of the risks associated with the acute and long term abuse of alcohol, both functionally and physically, it is not unexpected that insurers, make specific provision in the policies which they market with regard to such abuse and the consequences thereof.

The phrasing of these 'clauses' (examples of which follow) are matters for debate.[6]

---

[3]The production of physical defects in offspring in utero.

[4]SM Wiseman, PV Tomson, JM Barnett & Jenns M Wilton 'Use of an alcometer to detect problem drinkers' (1991) 285 *BMJ* 1085–1090; JJ Llinas 'Dependence on alcohol' in 1992 *The Merck Manual* (16ed) 1551–1556, 2009.

[5]C van den Burgh comp. SANCA Report 1992.

[6]Life Offices Association, Cape Town 1995.

- 'Exclusions (applicable only in the event of disablement) This benefit does not insure against: bodily injury sustained whilst under the influence of intoxicating liquor or drugs or disablement due wholly or partly to the effects of intoxicating liquor or drugs not taken in accordance with treatment prescribed and directed by a qualified, registered medical practitioner but not for the treatment of drug addiction.'
- 'Limitations and exclusions: ... shall not be liable under this supplementary contract should disability be wholly or partly, directly or indirectly caused by or traceable to abuse of alcohol or drugs, any violation of the criminal law by the life assured.'
- 'We will not be liable under this policy for any benefit payment if the claim is in our opinion wholly or partly, directly or indirectly caused by or traceable to ... abuse of drugs or alcoholic liquor ... or ... any violation by the life assured of the criminal law.'
- '.., the benefits shall not come into operation where disability is caused by injury or sickness which arose directly or indirectly from or is traceable to any of the following: an act by the assured while he is under the influence of alcoholic liquor or drugs or while the alcohol content of his blood is 0,16 grammes or more per 100ml, taking of alcoholic liquor by the assured or of drugs or medicaments not in accordance with medical prescription, ..'
- 'Exclusions: No benefit is payable in terms of this policy if, at the sole discretion of ..., the injury or illness arises directly or indirectly from, or is traceable to any of the following: Wilful exposure to danger, self-inflicted or wilful injury, attempted suicide, abuse of or dependency on alcohol, drugs or medicaments not prescribed by a medical practitioner.
- '... will not consider any claim for benefits if the event causing death or disablement was brought about or accelerated by any of the following: ... intentional intake of alcohol or drugs ...'.
- 'The effects of alcohol or drugs, other than drugs taken in accordance with treatment prescribed and directed by a qualified registered medical practitioner or pharmacist.'
- 'Any act or deed committed by the life assured in violation of any criminal law' and in the case of the Multilateral Motor Vehicle Accidents Fund Act 93 of 1989.
- '... agents recourse against the owner of a motor vehicle shall only be applicable ... in any case where, at the time of such accident ... under the influence of intoxicating liquor or drug to such a degree that his condition . . . the sole cause . . . ' and, in the case of State employees Treasury Instructions — Exchequer Act 66 of 1973.
- '... made excessive use of alcohol or drugs (for which there is sufficient proof) which may have resulted in or contributed to liability.'

The medical issues inherent in these provisos, relate inter alia to medi-

cine/alcohol interaction, what constitutes 'under the influence', alcohol as a cause of disability, alcohol dependence, trauma and accident causation, establishing the amount of alcohol consumed, blood alcohol back calculations from sampling time to event, the validity of a sample as representing the blood level at the time sampling.

Medicine and alcohol interaction

The potential for interaction between alcohol and medicines as well as with drugs of abuse and the possible grave consequences cannot be over emphasised; consequences relating not only to disturbed behaviour and performance patterns but also to the physical health of the victim of such interaction. (See *Table B*, page 250.)

Antabuse (disulfiram), a drug used in the treatment of alcoholism, inhibits ALDH activity thus preventing the conversion of acetaldehyde to acetate with a resultant build up of acetaldehyde in the blood when alcohol is imbibed, even in small amounts, and producing a well recognised syndrome manifesting as nausea, headache, tremulousness, intense facial and conjunctival flushing, tachycardia, giddiness, confusion, and which on rare occasions may be life threatening. A person on Antabuse therapy must be warned to avoid driving a motor vehicle should they consume even as little as a single tot of drink, as these symptoms may then present and be attributed to alcoholism. Whereas Antabuse is prescribed specifically in the treatment of alcohol abuse, to elicit a revulsion effect, a similar reaction may ensue when alcohol is taken whilst on medication for other conditions. These medicines include certain anti-diabetics (Diabenese), antibiotics (Flagyl and cephalosporins).[7]

It is of interest to record that 85% of Japanese have a hyperactive ADH system, which is about five times faster in action than in the case of others. The intake of alcohol results in a rapid build-up of acetaldehyde which the normal level of ALDH is unable to metabolise timeously, with an ensuing Disulfiram reaction. Despite the fact that the ingestion of a given amount of alcohol does not reach the expected level a Disulfiram effect may be accompanied by signs and symptoms suggestive of a far higher blood alcohol concentration (BAC).[8]

Interaction may result in a synergistic reaction, a merely additive effect exemplified in the case of benzodiazapines and antihistaminics, and alcohol. The interaction with benzodiazapines may not infrequently result in disorientation hyperexciteability aggression and rage, resulting in behaviour out of keeping with the individual's behaviour pattern.

Triazolam has been associated with adverse psychiatric reactions sometimes linked with violent acts. During 1991 an American woman was acquitted of murdering her mother whilst under the influence of this drug. She was awarded an out of court settlement, by the manufacturer, which amounted to

---

[7]RJ Hift 'Interactions of alcohol and drugs' 1991 *CME* 849–856.

[8]FJ Goldstein 'Pharmacodynamics: pharmacogenetics' in 1992 *The Merck Manual* (16ed) 2694.

a substantial amount. In the UK a 54 year old man, whom the Court found to be of 'exemplary character' was charged with the murder of his elderly woman neighbour, whom he had befriended, by strangulation. Despite the fact that he was known to have an 'alcohol problem' he had been prescribed Triazolam for his insomnia. He had taken an overdose in a suicide attempt, it is presumed, the night before the killing. He had vomited shortly after having taken the overdose. He overslept the next morning to feel on awaking 'confused and muddled' and drank lager and whisky. That evening the woman was strangled. A consultant psychiatrist explained that 'the combined effect of Triazolam and alcohol could lead to impaired recollection of recent events and to certain inexplicable actions, including attacks on persons, and suggested that at the time he may have been' the victim of automatism. There was much argument at the trial about how much of the drug was still in the accused's body at the relevant time, as it was assumed if all the drug and it's metabolites had been cleared from the body there would be no residual effects, of any significance. However the effects of the drug, as well as that of the alcohol, persist, and withdrawal symptoms occur only when blood concentrations are very low. Pharmokinetic factors coupled with clinical studies suggest that the rapid elimination of large amounts of Triazolam, would produce intense withdrawal-like symptoms.[9]

Alcohol has a hypoglycaemic inducing effect, and thus when taken concurrently with antidiabetic medications, especially so with oral antidiabetics, may cause a dramatic fall in the blood sugar level (hypoglycaemia) resulting in excessive sympathetic nervous system stimulation, coupled with central nervous system dysfunction, as the brain is dependant on an adequate sugar supply as it's major source of fuel. The former gives rise to sweating, tremulousness, and a sense of faintness, the latter to confusion, inappropriate behaviour resembling alcoholic inebriation, visual disturbances (blurring), which may proceed to stupor, coma, seizures, irreversible neuronal damage and death if not diagnosed and promptly treated. It is important to appreciate that alcohol induced hypoglycaemia may occur at blood alcohol levels below 0,08g%.[10] The situation may arise and indeed has been reported, where an arrest and incarceration on a mistaken charge of drunkenness has had disastrous consequences. The hazard is not peculiar to arrest, but also presents itself as a diagnostic challenge in the trauma and emergency units of hospitals.

Benzodiazapines and alcohol may compete for metabolism resulting in a delayed metabolic rate for both and hence a prolonged effect. Alcohol and drug interactions may be protean in nature and associated with a variety of different drugs. Even aspirin may have side effects enhanced by the concur-

---

[9]C Medawar & E Rassaby 'Triozolam overdose, alcohol and manslaughter' 1991 *Lancet* 1515.

[10]D Bradshaw 'A profile of violence and injury mortality in the Cape Town Metropole' 1989 *SA Medical Research Council, Community Health Group Draft Technical Report.*

rent use of alcohol as in the case of gastrointestinal bleeding. 'As the New Year dawns, the light is too bright the mouth feels as if it has been used as a latrine by some small creatures at night, and a dull headache beats in time with the pulse, many will reach for an aspirin if the headache permits them to move at all, not only are they at the risk of inducing a gastric haemorrhage, but since aspirin may also inhibit gastric ADH, should this be washed down with the 'hair of the dog', the bio-availability of the ingested alcohol may be enhanced. The hepato-toxic risk of paracetamol is enhanced in alcoholics, and their tolerance to other drugs enhanced, and the fatal dose of barbiturates significantly reduced with concurrent alcohol ingestion.'[11]

Caffeine containing substances like coffee may accentuate the effects of alcohol, and it is alleged may even increase accident- proneness. Certain experimental benzodiazepine-like substances bind with the site of action of alcohol at neuronal level, blocks the effect of alcohol on neuronal activity, and even at elevated BAC levels usually associated with overt intoxication no evidence of the effects of alcohol taken subsequent to the administration of this agent may be elicited[12].

It is conservatively estimated that there are 1,025,198 alcoholics in South Africa, identified as those who consume a minimum of 10cl on average per day. This represents 5,8% of the total population over the age of 15 years.[13]

An estimated 75% of South Africans consume alcohol and the concurrent use of alcohol and medicine is statistically a great risk, and especially so where the patient is not warned to avoid his customary drink whilst on treatment.[14] (See *Table C*, page 250.)

The topic of drug and alcohol interaction is a complex pharmoco-dynamic exercise and when this becomes an issue medico-legally the opinion of the pharmacologist is essential.

In emphasising the dangers of alcohol/drug, interaction Kielholz refers to his experimental work with 320 members of the Basle city police corps. The volunteers with a BAC of 0,08% were given a therapeutic dose of one of one of the following drugs: chlordiazepoxide (20mg); mepobromate (800mg); phenobarbitol (200mg); and methylprylon (200mg), which increased the number of test driving faults when compared with the effects of the drugs alone by about '200%, 300%, 100%, and 210% respectively'.[15] In another study the complexity of the problem was highlighted by Garriot. Seventy four

---

[11]R Roine, RT Gentry, R Hernandes-Munoz, E Barsona & CS Lieber 'Aspirin increases blood alcohol concentrations in humans after ingestion of ethanol' 1990 *JAMA* 2406–2408.

[12]'Report ärztliche Praxis' quoted in 1987 *SAMJ* (Editorial) xii 'Anti-drunkenness pill?'.

[13]'Sweden lowers blood alcohol limit for drivers' 1990 *BMJ* (Editorial) 1482.

[14]*Ibid.*

[15]P 'Kielholz Drugs and Driving in Switzerland. Alcohol, Drugs and Road Safety'. Sixth International Conference on Alcohol and Drugs and Road Safety. Toronto, 1974. (Addiction Research Foundation, Toronto).

per cent of drivers arrested for apparent 'drink and driving' and who had 'low blood alcohol concentration', 41% tested positive for barbiturates, 15% for diazepam and 22% for methaqualone.[16] The pattern of this drug related interaction will vary from country to country being determined by the availability of the various drugs, as well as the prescribing and abuse customs prevailing locally. Furthermore although it may be assumed that psychoactive drugs add to the sedative and toxic effects of alcohol at clinical examination, in the absence of established blood levels, it is not possible to determine to what extent each is contributing to the impairment observed.

Under the influence

The expert medical witness should be clear in his own mind what he understands by 'under the influence of alcohol'. (See *Table G*, page 253.) Strictly speaking this is applicable when it can be established that the subject's blood contains alcohol which is exerting some measurable effect on neuronal function albeit ever so slight. It has been suggested that the term should be used to describe any abnormal mental or physical condition which is the result of indulging in any amount of alcohol and which deprives the subject of that clearness, intellect and control which he would otherwise exercise up to a state where death from alcohol poisoning may be at hand.[17]

Not infrequently the intensity of smell of the alcoholic beverage on the subjects breath is erroneously used as a measure of the degree of intoxication, but this is due to the congeners of the drink and may persist in the breath after all the alcohol has been eliminated, and furthermore the intensity will also depend on the nature of the beverage.[18] It is also worth noting that for the same reason the blood may contain significant amounts of alcohol without imparting any smell to the expired air depending on the beverage imbibed.

All the signs and symptoms customarily attributed to acute alcoholic intoxication, individually, are not peculiar to the effects of alcohol, but are merely the result of the depressant action on the central nervous system which can be mimicked by any substance with the same neurological target. Taken as a whole the pattern increases the probability that the picture presenting is due to alcohol, pending laboratory, or breath analysis confirmation, but even so the extent to which other factors may be influencing the clinical picture may often be difficult to elucidate. This is especially true where a driver has been extricated from a vehicle involved in an accident. (See *Table D*, page 251.)

Any equally vexing problem diagnostically is the differentiation between certain natural diseases such as hypoglycaemia, post epileptic confusional states, and particularly so when alcohol has been consumed and again resort to laboratory tests may be necessary.

---

[16]WE Cooper, TG Schwar & LS Smith *Alcohol, drugs and road traffic* 1979 362.
[17]*Ibid* 154.
[18]*Ibid* 166.

That the clinical diagnosis is often correct in the case of the uninjured is rather a measure of the widespread use of alcohol than reflecting on the specificity of the clinical examination.

Although there is in most cases in broad terms, a fairly close correlation between the BAC and the degree of clinical intoxication, the intensity of impairment is generally more marked on the rising blood alcohol tide than at the same level on the falling tide (Mellanby effect). (See *Table E*, page 251.)

This is thought to be due to the development of an acute neurotolerance, in contrast to the tolerance, which is not short lived as in some alcoholics, and which may follow on a long pattern of excessive alcohol consumption. This may result in apparent soberness at BAC, as high as 0,20g% where frank intoxication would be expected, and even survival at levels as high as 1,00g%. This it is postulated may be due to the development of permanent adaptive changes in the former sensitive cellular components of the nervous system, such as membrane lipids, neurotransmitter receptors, ion channels, G proteins and intracellular second messengers that counteract the short term effects of alcohol.[19]

In the words of a medical practitioner, of many years standing, who has examined very many persons arrested on a charge of drink and driving, 'each test carried out is independently questionable' as a diagnostic tool, but 'when taken as a whole ... can ... indicate that there is definitely faculty impairment, which is '*likely* to have been caused by alcohol', and stresses the importance of differentiating between the terms 'possible, likely, and probably' in relation to the conclusions to be drawn from the clinical examination. He continues 'the occasion will most certainly arise, when like all of us, with the certainty (in your own mind) that the suspect is under the influence but you could not find any positive reasons to certify him as such. You examination may reveal no conclusive abnormality, yet the analyst may report a blood alcohol content of nearly 0,3g/100ml ... but rest assured that nobody can fault you for admitting you do not know the answer'.[20]

The dose-response relationship is an important parameter to be considered in an evaluation of a blood alcohol test result. Once the blood alcohol has reached equilibrium with the tissues and especially the brain a broad probable clinical picture is predictable at a given BAC provided the response has not been modified by concurrent medication, drugs of abuse or organic functional mental disorder.[21] (See *Table F*, page 252.) In such predictions the importance of bearing in mind the sigmoid character of the graphically depicted dose-response curve, at the extremities of which wide variations

---

[19]ME Charness, PS Roger & DA Greenberg 'Medical progress: ethanol and the nervous system' 1989 *New England J of Medicine* 442–454.

[20]VD Kemp 'Some random thoughts on the examination of "drunken drivers"' 1986 *SAJ Continuing Medical Education* 29–31.

[21]LC le Roux & LC Smith 'Violent death and alcoholic intoxication' 1964 *J For Med* 131–141.

between the clinical picture and the BAC are encountered, whereas at the 50% point a small variation in the dose of alcohol will include the majority of subjects. This phenomenon is exemplified in Jetter's experimental work[22] (see *Figure 3*, page 245) and is not confined to inter-individual differences but may also manifest in the same individual at different times.

In an attempt to summarize existing knowledge of drink and driving in order to achieve a clearer appreciation of the significance of blood alcohol levels, a group of distinguished Australian scientists prepared the following statement for the Law Reform Commission

- For blood alcohol levels of 0,05%, and below, some individuals are impaired by alcohol but most drivers, even if affected, are affected only slightly. While deterioration in performances of tasks related to driving can be demonstrated 0,05% increased liability to accident appears first somewhat above 0,05%. It is therefore, reasonable to say that at blood alcohol levels of 0,05% or less the person concerned is unaffected, in a practical sense, as regards road safety.
- Blood alcohol levels in the range of 0,05 to 0,10%. All individuals are affected at or before 0,10% is reached. In some people this may be largely compensated by slower or more careful driving — but even in these cases the person concerned is less able to cope with the demands made on his driving ability in emergency situations which often precede accidents and to this extent alcohol in this range is a contributing factor towards accidents It is in this range that measurably increased liability to accident appears, taking drivers as a group.
- Drivers with blood alcohol levels above 0,10% are affected to the extent that their driving becomes distinctly impaired. The impairment increases progressively as the blood alcohol level rises until at levels of 0,15% there is substantially increased liability to accident.
- At levels of 0,20% and above most people are obviously intoxicated. The increased risk of accidents is now severe.

Alcohol and disease causation

Every organ in the body is a potential target of alcohol especially where this is abused on a long term basis. The clinical manifestations are often delayed, and may even present after years of abstinence. Severe bleeding may follow on a retching bout causing tears of the oesophageal mucosa after an alcoholic debauch, as may also be the case in acute gastric erosions and acute pancreatitis, serve as examples of the acute effects.[23]

Well documented consequences of chronic alcohol abuse include a wide spectrum of liver disease, including cirrhosis of the liver which may progress

---

[22]WW Jetter 'Studies in alcohol: diagnosis of acute alcoholic intoxication by correllation of clinical and chemical findings' 1938 *Amer J Med Sci* 481.

[23]E Buchel 'Alcoholism and the GIT' (1991) 97 *CME* 815–823; CS Lieber 'Ethanol metabolism' (1978) 298 *N Engl J Med* 356.

further to malignant tumour, years later.[24] Alcohol is the most common cause of pancreatitis, a very disabling condition often associated with intractable pain, sufficient to induce suicidal tendencies.

Ailment is not confined to the gastro-intestinal system. Central and peripheral nervous and cardiovascular disorders are commonly attributable to alcohol abuse. In the case of the latter it has been recognised for over a century that cardiac failure, rhythm disturbances and hypertension may ensue due to the direct effect of alcohol or it's metabolite acetaldehyde on cardiac muscle. Social drinking can precipitate arrhythmias and sudden death in persons with cardiopathy, and especially so should this be accompanied by a stress incident, such as even a trivial assault or dispute. Even in 'normal' subjects ingestion of alcohol over a period of 1 to 2 hours resulting in a BAC of about 0,10g% has resulted in measurable depression of left ventricle function.[25]

Genetic factors may also influence the susceptibility to neurological complications. Abnormal thiamine dependent enzyme may be the reason why only some malnourished alcoholics develop the Wernicke-Korsakoff Syndrome. Of medico-legal significance in that it is characterised by gait disturbances, confusion and memory defect which may be relevant in the clinical assessment of intoxication as are so many other neurological complications of alcohol abuse, and also by as a striking feature -confabulation, the substituting of imaginary or confused 'experiences' for that which cannot be recalled, and often so convincingly as to deceive an astute observer. Emotional changes may develop to a stage where even fear inducing situations may evoke little response, or a totally misdirected one.[26]

Alcohol dependence

Alcohol dependence may best be defined as a state arising out of the chronic abuse of alcohol which on withdrawal results in physical and/or mental manifestations of withdrawal such as tremulousness agitation hallucinations delusions and a craving for alcohol.

The addicted person is identified by frequent bouts of intoxication which interfere with his ability to socialise and work productively, repeated loss of employment and injury, marriage failure, arrest for drunkenness and the presentation of typical withdrawal signs and symptoms as so often happens on admission to hospital following injury.

Research has provided convincing evidence that the vulnerability to dependence is at least partly due to inherited factors manifesting on exposure to alcohol. The importance of genetic determinants is supported by the familial nature of this condition since there is a significantly higher concordance rate in identical twins than in fraternal twins, and a fourfold higher risk for children

[24] AS Mitha 'The cardiologist and the alcoholic' 1991 *CME* 804–810.
[25] *Ibid.*
[26] JA Temlett 'Neurological effects of alcohol' 1991 *CME* 839–848.

of alcoholics even when adopted out of birth. Furthermore sons of alcoholics have a decreased sensitivity to alcohol's psychological effect and often have altered electroencephographic tracings after the intake of alcohol.[27]

Inherent in this condition are a number of potential issues such as divorce, consent, vicarious liability, employment in dangerous occupations, and the implementation of relevant abuse orientated legislation. The severe confusional state which may accompany sudden withdrawal accompanied by agitation may present within about four days of withdrawal, or reduction in the drinking pattern.[28]

Acute and chronic alcoholism may result in blackouts (palimpsests)), with periods of amnesia which cannot be accounted for by the depressant action of alcohol per se. These tend to occur after or even during the short term imbibing of large amounts of alcohol and are characterised by the inability to form new memory but with no impairment of long or intermediate term recall. Attempts to jog the memory are ineffective and indeed run the danger of false recall which the individual may believe to be true. Recognition of this phenomenon is essential before regarding these memory hiatuses as a convenient lapse or deliberate confabulation.[29]

Measurement of serum enzyme GGT and red blood cell mean corpuscular volume will help identify 3 out of 4 heavy drinkers even before clinical liver changes are identifiable, provided sampling takes place within 48 hours after the last drink, but will rise once again on resumption of alcohol intake.[30]

A group of young alcoholics with no apparent signs of neurological impairment had significantly reduced metabolism in the brain as assessed by positron emission tomography (PET). PET is a sensitive indicator of cerebral dysfunction in alcoholics with very minimal brain structure changes on magnetic resonance imaging (MRI). MRI, PET, and neuropsychological tests were used to evaluate brain structure, regional brain metabolism and neuropsychological performance in 10 apparently healthy alcoholics and 10 normal matched males as controls. The neuropsychological assessment included tests for cognition, memory, motor coordination and language usage.

---

[27]ME Charness, PS Roger & DA Greenberg 'Medical progress: ethanol and the nervous system' 1989 *New England J of Medicine* 442–454; J Chick, N Kreitman & M Plant 'Sensitive markers of alcoholism' 1981 *Lancet* 1249–51; 'Finding the gene(s) for alcoholism' (1990) 263/15 *JAMA* (Editorial) 2094; FK Goodwin 'Basis of alcohol tolerance found' 1988 *JAMA* 3563.

[28]ME Charness, PS Roger & DA Greenberg 'Medical progress: ethanol and the nervous system' 1989 *New England J of Medicine* 442–454; WD Lerner & HJ Fallon 'The alcohol withdrawal syndrome' 1985 951–952; JJ LLinas 'Dependence on alcohol' in *The Merck Manual* (16ed) 1551–1556; E Buchel 'Alcoholism and the GIT' (1991) 97 815–823; MA Schuckit 'Genetics and the risk for alcholism' 1985 *JAMA* 1614–2617.

[29]I Gordon, H Shapiro & SD Berson *Forensic medicine: a guide to principles* (3ed) 1988.

[30]E Buchel 'Alcoholism and the GIT' 1991 815–823; MA Schuckit 'Genetics and the risk for alcholism' 1985 *JAMA* 1614–2617.

The 10 alcoholic subjects were in a detoxication unit, had not imbibed alcohol for two to three weeks, and medication had been withdrawn 6 days before scanning. MRI revealed no significant ventricular enlargement, and no or very slight cortical atrophy. However as seen on PET metabolic activity was decreased in the cortex in the frontal region of the brain of the alcoholics, and whole brain glucose metabolism was reduced on average by 25% as compared with the controls, and compared significantly with memory and motor co-ordination tests in particular. PET would appear to be more sensitive diagnostic procedure for the detection of the early and subtle effects of alcohol abuse, because it measures metabolic change before structural changes in the brain are identifiable by MRI. (Dr Gene-Jack Wang — Brookhaven National Laboratory Upton, NY as reported in Family Practice News.)

Trauma and alcoholism

The most frequently recurring factor in trauma causation is alcohol. Increases in BAC are accompanied by an exponential increase in the predisposition to injury. The clinical management of the intoxicated injured is often problematic and fraught with medico-legal hazards.[31] Because of the depressant action on those faculties so important for safe driving (as well as for the pedestrian venturing onto pavements and roads) vision, hearing, orientation, concentration, caution, anticipation, restraint, judgement, reliability, responsibility, to mention but a few, are all affected by alcohol, the risk of being involved in a motor vehicle accident as a victim or cause is significantly increased. (See *Figure 4*, page 246.) The seriousness, and extent of long term disability for all parties concerned is also increased.[32] (See *Figure 5*, page 247.)

In a survey of drivers dying within one hour of a motor vehicle accident in which they had been involved it was found that about 80% where under the influence at the time of their death; 70% of adult pedestrians were likewise affected, the majority with BAC in excess of 0,15g%. Of interest was the finding, and understandably so, that the male front seat passenger was generally equally intoxicated.[33] (See *Table H*, page 253.)

In other forms of accidental death amongst adults the risk pattern was no different. By way of example in adult drownings as many as about 60% of victims tested positive for alcohol. The cause of death was not only the consequence of injudicious actions arising out of the effects of alcohol on thought processes, but also due to the consequences of immersion in cold water whilst intoxicated, alcohol induced hypoglycaemia, and/or hypothermia

[31]WN van Kralingen & others 'Alcohol and the injured driver; the "Podder" project conducted at the Groote Schuur Hospital Trauma Unit'. Report number DPVT/170 CSIR.

[32]LC le Roux & LC Smith 'Violent death and alcoholic intoxication' 1964 *J For Med* 131–141; WE Cooper, TG Schwar & LS Smith *Alcohol, drugs and road traffic* 1979 362.

[33]LS Smith 'Alcohol and drugs as a cause of traffic accidents' 1979 *Robot* 71–80; LC le Roux & LC Smith 'Violent death and alcoholic intoxication' 1964 *J For Med* 131–141.

aggravated by excessive heat loss due to the vasodilatory effect of alcohol on the peripheral vascular system.[34] (See *Table I*, page 254.)

The effects of alcohol may mask the acute consequences of trauma, particularly so in the case of head and abdominal trauma resulting in a failure to identify timeously the underlying pathology, such delays may, and not infrequently materially influence the prognosis with regard not only to survival, but also in so far as the severity of possible later effects of the trauma pathology. In an evaluation of death and permanent disability arising out of delay in referring injured patients to the neurosurgery department, the cause for the delay in 40% of the cases was due to a failure to recognise the extent of the head injury due to the mistaken diagnosis of 'drunkenness'.

How much alcohol was consumed?

Alcohol which is soluble in water in all proportions, diffuses, in terms of Fick's Law of Diffusion, from the stomach (20%) and the duodenum and remaining small bowel (about 80%) into the vascular bed of these structures to be distributed by an active blood circulation to the various body tissues in amounts proportional to their water content. The size (mass) of the available pool into which the alcohol may diffuse will be determined not only by the mass of the subject but also by the nature of it's constituent parts, in respect of their water content, ie brain tissue, muscle, bone, fat and so forth. (See *Table J*, page 254.) This process of diffusion will continue concurrently with the alcohol metabolic process until equilibrium has been reached in the water content of all the tissues, and maintained thereafter until all the alcohol has been eliminated from the body, represented by the rising and falling tide of alcohol in the blood.

It is on this principle that Widnark formulated that:

$A = pxcxr$ where A = the amount of alcohol absorbed into the body tissues at the time of sampling expressed as grammes of alcohol, and therefore the minimum amount consumed

p = the mass of the subject in kilogrammes.

c = the blood alcohol concentration expressed as g/ 1000g of blood.

r = the ratio between the amount of alcohol in the blood and the body as a whole (The value for 'r' falls between 0,5 to 0,9 - the average for women is 0,6 and for men 0,7. The variation in this value for 'r' is due to the sexual differences on an average in fat, bone and muscle proportions in the sexes. In applying this formula to a particular individual a subjective choice of the relevant 'r' factor is to be taken.

With regard to the 'c' value it must be born in mind that the result of the blood test is usually given as grammes alcohol per 100ml blood. This figure must thus be multiplied by 10 as well as taking into account the specific gravity of blood as, about 1,056, to arrive at the true value of 'c'.

In using this calculation to test the veracity of evidence with regard to the

---

[34]S Davis & LS Smith 'The epidemiology of drowning in Cape Town 1980–1983' 1985 *SA Med J* 739–742.

amount of alcohol consumed the greatest circumspection must be exercised in applying statistical generalisations to an individual case, making allowances for the established variables co-existing.[35] 6 Appendix

Should the blood have been sampled during the rising tide of alcohol in the blood then the four types of response should be taken into consideration, as at their peaks the BAC may differ by as much as 60%, whereas in the post peak rectilinear decline the difference between the upper and lower limbs of this decline may amount to as much as 30%. Clearly this variation if reflected in the Equation would very materially influence the value of 'A'.

'... by simple calculation it may be possible to determine within fairly wide limits how much alcohol must have been consumed... This of course only to be attempted after absorption has stopped and equilibrium between blood and the tissues has been attained. . . '

By way of example: At a BAC of 0,16g%, the level with the same intake of alcohol per kilogram body mass could result, in a matched individual, in a BAC of 0,10g% and in 75kg man the value for 'A' thus would be somewhere between 72 and 45g of alcohol respectively, should the sample have been drawn on the rising tide of blood alcohol, whereas if sampled during the falling tide the value for 'A' could fall between 36 and 49g of alcohol.[36] (See *Figure* **6**, page 248.)

The blood alcohol concentration at the time of the event: Back Calculations.[37]

Out of the very nature of things a blood sample for blood alcohol determinations is often drawn some time after the event at issue. This may be so during life or at autopsy and where the presumptive 2 hour clause is not applicable in terms of the Road Traffic Act it may become necessary to attempt to establish on scientific grounds what the probable BAC was at the material time.

These back calculations in this respect have been, and still are the subject of controversy with regard to the validity of such calculations.[38]

In the absence of evidence as to the pattern of drinking and the intake of food preceding the event any attempt to express and opinion must be with the greatest circumspection.

However if the blood sample is drawn 120 minutes after the last drink then on the substantial balance of probabilities the absorption peak has been reached and elimination has reached the stage of steady linear decline which on

[35] WE Cooper *Motor law* 1981.
[36] *Ibid.*
[37] *Ibid.*
[38] I Gordon, H Shapiro & SD Berson *Forensic medicine: a guide to principles* (3ed) 1988 403–404.

average falls between 0,01 to 0,02g% per hour. (R)

Formula for back calculation
BACC = BAC1 + (t x R)

where

Blood alcohol at time of event = BACo
Blood alcohol at time of sample = BAC
BAC expressed as g/lOOml blood.
t = time in hours from event to sampling time.
R = 0,01 - 0.02 9%

In the case of blood drawn at autopsy the same principles apply. However as the sample is usually taken often many hours after death, it must be established that the sample analysed represents the BAC at the time of death, and does not contain alcohol generated by the fermentation of the body sugar either in the body after death or in the sample before analysis. In the case of gas chromatographic analytical methods if alcohol is produced as aforementioned then the other alcohols, propanol, will be identified. Furthermore if on analysis the sample is shown to contain at least 1% sodium fluoride this is sufficient to prevent fermentation in the sample. Even should alcohol be produced by fermentation in the sample, under optimal conditions in the absence of preservative this would not exceed the third decimal point of a gram per 100ml of blood.

Where death ensues within a short period of the event and particularly so if the stomach contains evidence of a recent meal and even more so if the period of survival was accompanied by severe circulatory embarrassment which would hamper absorption, distribution of any absorbed alcohol, metabolism thereof and elimination, it is probable that the BAC at the time of sampling was materially of the same magnitude at the time of the event.

Of equal importance is the choice of the site from which the blood sample is to be drawn. FOI practical purposes this is from the vein in the groin, which is least likely to contain alcohol which may diffuse from alcohol in the stomach to vessels lying in proximity to the stomach. Under no circumstances should free lying blood in the chest or abdominal cavity be used as a sample. If the chest cavity is intact as well as the stomach, blood drawn from the right ventricle of the heart it is acceptable as second best.[39] Many pathologists prefer ocular fluid as a sample for alcohol testing after death on the grounds that the eye fluid lies in a relatively isolated position and the least likely site to be influenced by post mortem diffusion of alcohol and the effects of putrefaction.

The disadvantage of ocular fluid is that provision must be made for the conversion to the equivalent BAC, by multiplying the result by the conversion

[39]VD Plueckhahn & B Ballard 'Diffusion of stomach alcohol and heart blood alcohol concentration at autopsy' 1967 *J for Sci* 463–470.

factor 0,79, which is an arguable value.[40]

Alcohol as a cause of death: directly or indirectly

As death causation needs to be clearly identified in matters both criminal and civil, and particularly so in respect of life, accident and disability claims, it is appropriate to consider in the absence of a statutory provision what should be viewed as death due to other than natural causes.

It has been proposed, as a guideline, that a death caused by the application of force or the effects of any other extrinsic physical or chemical factor, directly or indirectly, with or without complications, or any death which would normally be viewed as a natural death which in the view of a medical practitioner was brought about by an act or omission on the part of any person should be regarded as a death other than due to natural causes, and death occurring whilst under the influence of a local or general anaesthetic or as a consequence thereof, ... (Section 56 Medical Dental and Supplementary Health Professions Act) commonly referred to as 'anaesthetic death', an unfortunate misnomer as such death could equally well be unrelated to the anaesthetic itself. This definition is applicable to the issuing of a Death Certificate by a medical practitioner.

Where death is due to the depression of the vital centres in the brain controlling heart action and respiration by a high BAC this would not be questioned as being death due to other than natural causes, or where vomitus is inhaled during a bout of alcoholism, but many would argue that death due to the chronic effects of alcohol abuse, such as live cirrhosis, cardiac myopathy or haemorrhage fro m oesophageal varices should not be viewed as 'natural causes' for purposes of the Inquest Act. The implications arising out of such an interpretation would be far reaching for all parties concerned.

Relating event causation to alcoholic intoxication

Despite overwhelming experimental and statistical evidence with regard to the dangers of alcohol as a causation of motor vehicle accidents and other forms of accident, the medical witness should exercise considerable circumspection before applying statistical generalisations to an individual case, for this decision must rest with the judiciary on the basis of the summation of evidence. A situation may present itself where irrespective of even an adequate response from a sober person the outcome would have been inevitable. It has been argued that the same personality traits which give rise to excessive drinking predispose also to risk behaviour

It can nevertheless be stated that chronic alcoholism predisposes by virtue of it's long term effect to increased morbidity and mortality following trauma, as by way of example subdural haemorrhage, and ruptured liver superimposed on hepatic cirrhosis, and also in the case of the neurological consequences of chronic alcoholism resulting in an increase to accident proneness.

---

[40]TG Schwar, JD Loubser & JA Olivier *Die ABC van geregtelike geneeskunde* 1984.

Violation of any criminal law

This 'exclusion' is essentially an issue for legal argument, cognizant of certain medico-legal issues which relate to the validity of the result of the analysis of the sample submitted for alcohol determination, be it blood, ocular fluid or urine drawn from a corpse or living person. In the aforementioned regard consideration must be given to the suitability of the sampling site and the material used to cleanse the surface through which the sample will be drawn the adequacy of sample preservation, intralaboratory specimen identity assurance, laboratory quality control, and overall technological interaction.

Apparent discrepancies between the clinical picture, circumstantial evidence and the relevant result should be diligently pursued before ascribing such discrepancies to biological variation in human response to an alcohol challenge, or the inadequacies of the clinical evaluation. It is of interest to note that in Sweden where a two tier statutory 'drink driving' system is applicable, to wit a BAC of 0,02g% and 0,15g%, and where the burden of proof rests with the prosecution, the pattern of 'defence challenge' is not significantly dis-similar to that encountered in South Africa. (See *Table K*, page 254.) Jones (19) has reported in some depth on the validity of these challenges. In view of the importance in both criminal and civil matters as well as at iquest of BAC result it would seem advisable that as a matter of routine the subject be offered the choice of a duplicate sample for analysis should at a later state a second analysis be deemed necessary.

CONCLUSION

Sir William Osler said of tberculosis — 'a social disease with medical aspects'. The same can be said of alcoholism 'with many medico-legal and economic implications', added as a rider.

A conviction for 'drink and driving' is frequently the first warning of pending addiction, as on a probability basis, due to the inadequacies of law implementation in most parts of the world, the more frequently one drives under the influence of alcohol, the greater is the chance of accident involvement, or identification at road blocks.[41]

In many countries with increasing convictions and the disease model in it's hey-day active steps have been taken and directed to rehabilitation of all convicted drivers and 'drunks' in addition to the legal penalties meted out for alcohol related offences. Such programmes are in widespread use in the USA, Australasia, Scandinavia, Germany, Switzerland, and Holland. In South Africa the occasional 'alcohol schools' of the Department of Welfare scratch the surface of the problem locally.[42]

The exclusion clauses in insurance policies relating to alcohol, although

---

[41]DL Viljoen 'The fetal alcohol syndrome' 1991 *CME* 783–790;

[42]'Drinking drivers: the needs for rehabilitation research and research' 1987 *BMJ* (Editorial) 295; 'Sweden lowers blood alcohol limit for drivers' 1990 *BMJ* (Editorial) 1482.

economically justifiable in the interests of the majority of policy holders are not infrequently disastrous for the dependants of the policy holder, on occasions financial consequences of such magnitude to appear to be out of keeping with the default of the deceased. It would be in the interest of all parties, if insurance underwriters insist that these clauses be explained to the intending purchaser and that the latter acknowledge that this has been done by initialling the relevant proviso accordingly.

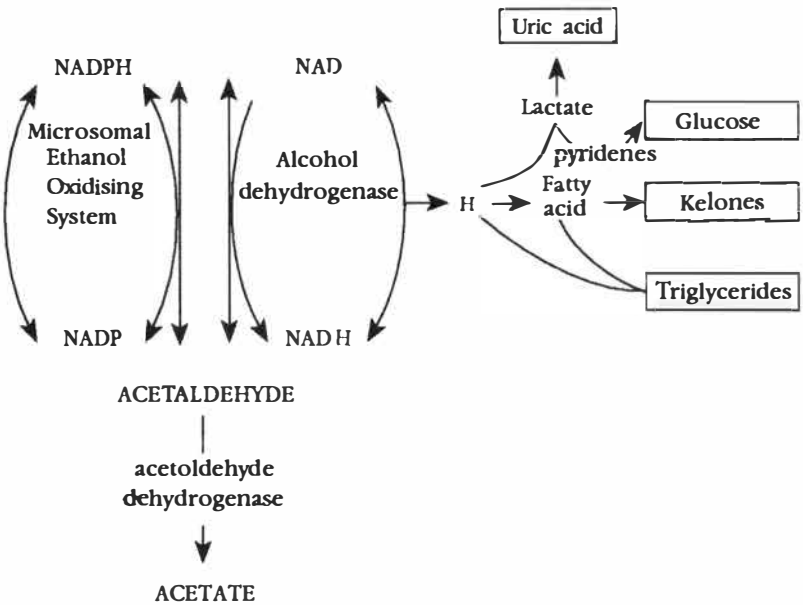

FIGURE 1 METABOLISM OF ALCOHOL

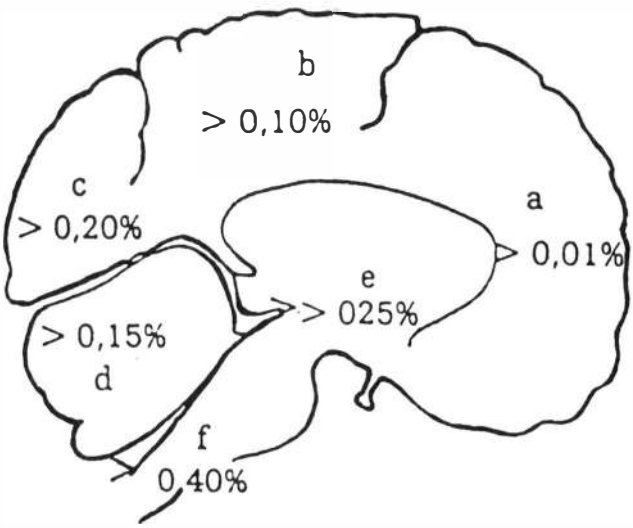

FIGURE 2 Anticipated effects of alcohol on different areas of the brain
The percentages in the diagram refer to the lower blood-alcohol levels at which these areas, annotated a, b, c, d, e and f, may express the effect clinically.

a. Frontal lobe	Diminished inhibitions, self-control, will-power, judgment, attention. Elation. Expansiveness. Increased confidence. Generosity. Talkativeness. (The response is coloured by the individual's personality.)
b. Parietal lobe	*Somaestheto-psychic area* Distorted sensibilities *Psycho-motor area* Apraxia. Agraphia. Ataxia. Tremors. Slurred speech. loss of skills.
c. Occipital lobe	*Visuo-psychic area* Disturbance of colour perception, form, dimension, motion, distance and diplopia.
d. Cerebellum	Disturbance of equilibrium.
e. Diencephalon (*thalamic area*)	Apathy. Inertia. Tremors. Sweating. Stupor. Coma.
f. Medulla	Respiratory depression. Cardio-vascular collapse. Temperature control failure.

(NB The effects of alcohol on driving skills can be measured by sensitive test systems at even lower levels of blood alcohol.

Percentage of persons 'under the influence' when blood alcohol between certain limits

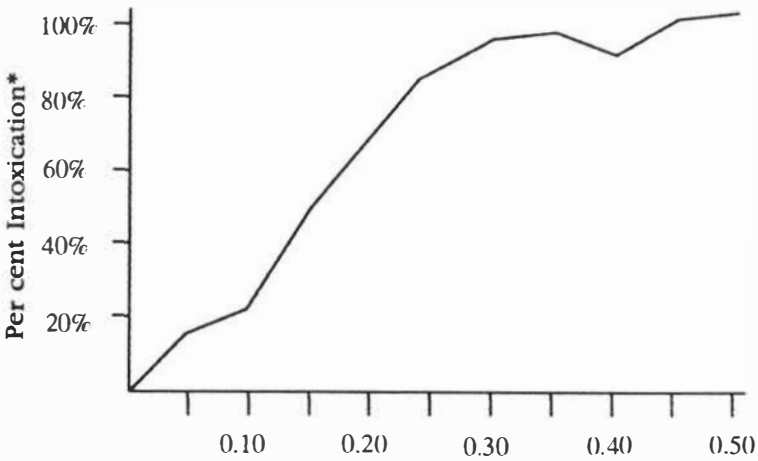

FIGURE 3

Percentage occurrence of clinical intoxication at various blood alcohol concentrations

(1 000 cases)

* Criteria of intoxication

Gross gait abnormality or unable to walk plus two of the following:
- Gross speech abnormality or unable to speak
- Flushed face
- Dilated pupils
- Alcoholic odour in breath

Modified from 'Studies in Alcohol: Diagnosis of Acute Alcoholic Intoxication by Correlation of Clinical and Chemical Findings' by WW Jetter published in *American Journal of Medical Science* (1938) 481.

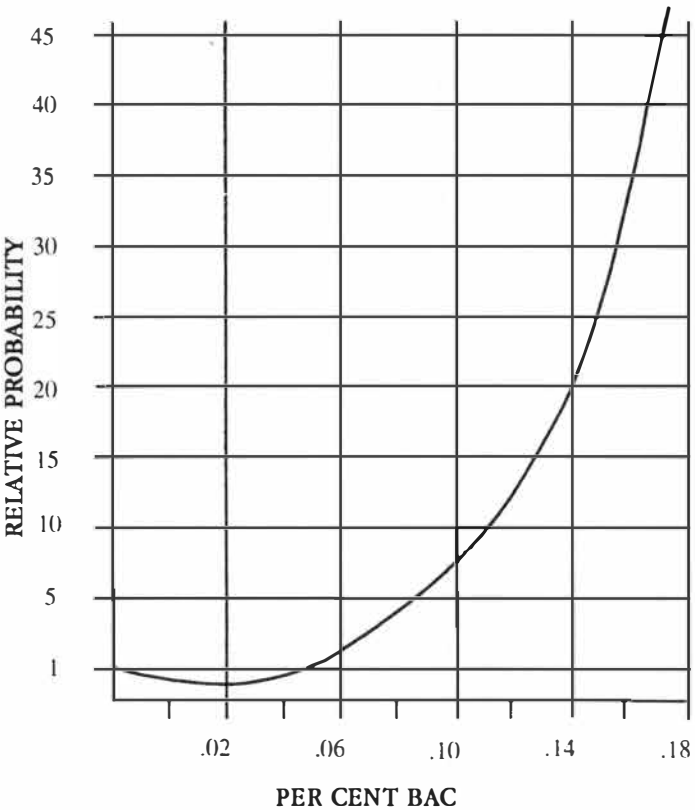

FIGURE 4
Relative probability of causing an accident

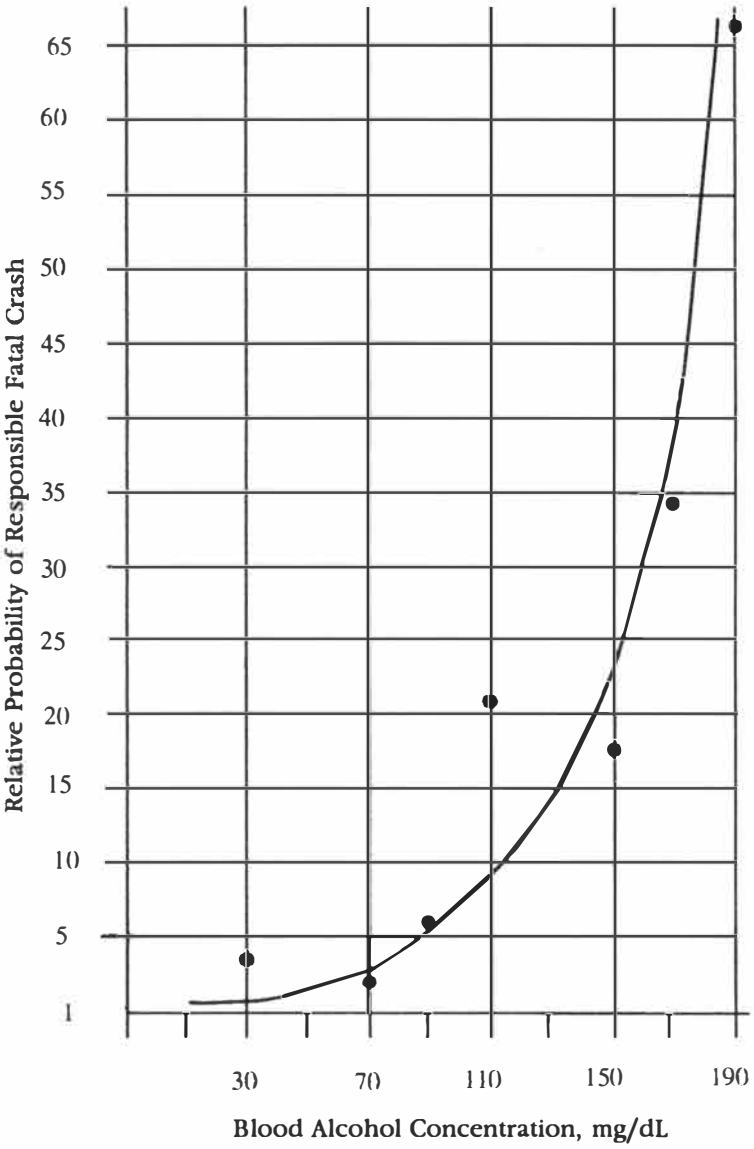

FIGURE 5 Relative probability of being responsible for fatal crash rises with rising blood alcohol concentrations.

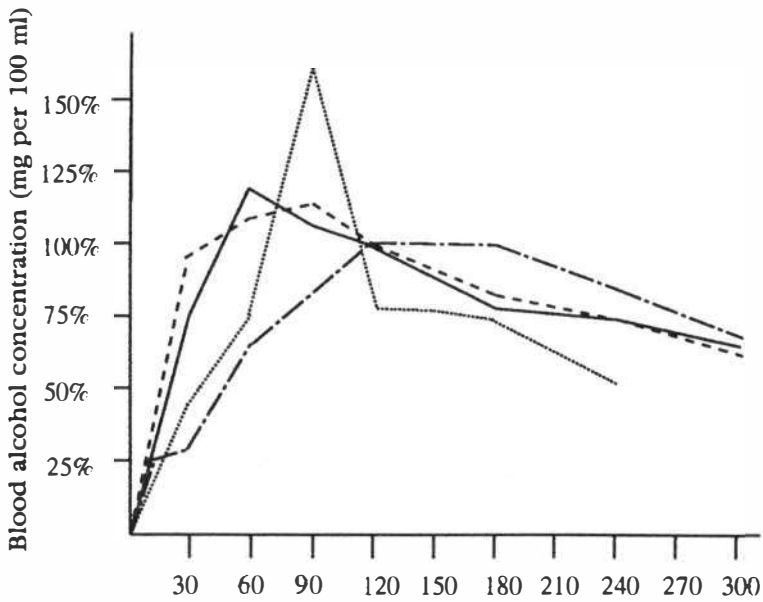

FIGURE 6 Variations in the type of blood alcohol curve (after Alha). *Type 1*. A steep rise with a distinct peak; *Type 2*. A steep rise without a distinct peak; *Type 3*. A slow rise without a distinct peak; *Type 4*. A distinct and high peak with a subsequent depression.
The curves in this figure were obtained after an alcohol dose of 1 g per kg body weight.

TABLE A BLOOD ALCOHOL PROFILE OF NON-NATURAL MORTALITY IN THE CAPE TOWN METROPOLE (1994) BY CAUSE OF DEATH

Cause of Death ✡	Blood alcohol content in g 100 ml				
	0.00	0.01–0.10	0.11–0.20	0.21–0.30	>0.30
Homicide (n* = 1441)	**484**	**155**	**353**	**329**	**120**
Blunt force	55	14	23	20	19
Strangulation	13	1	3	2	1
Firearms	232	56	71	33	8
Sharp force	153	77	246	286	86
Legal intervention	15	1	5	1	2
Suicide (n* = 235)	**148**	**27**	**42**	**16**	**2**
Poisoning	20	2	3	0	0
Gassing	14	2	5	2	0
MV gassing	14	2	7	1	1
Hanging	0	7	8	4	1
Firearms	0	14	17	8	0
Transport (n* = 670)	267	**55**	**110**	**180**	**58**
MVA pedestrian	160	27	63	141	47
MVA passenger	30	8	14	11	2
MVA driver	18	6	15	12	1
Railway accident	49	12	13	13	8
Bicycles/motorcycle	5	1	4	3	0
Other accidents (n* = 328)	**128**	**33**	**69**	67	**31**
Falls	15	9	5	4	2
Fire	58	13	53	50	11
Drowing	29	4	9	6	6
All causes	**1 027**	**268**	**574**	**592**	**211**

n* = the number of fatalities that were tested for blood alcohol level
✡ Total represents all-cause mortality for major categories

TABLE B ALCOHOL / MEDICINE INTERACTION EXAMPLES

amphetamines antihistaminics antipsychotics aspirin barbiturates benzodiazepines bromocriptine	griseofulvine methyldopa monoamine oxidase inhibitors hypoglycaemic agents tricyclic antidepressants	POTENTIATION
cimetidine haloperidol aspirin (?)		ELEVATED BAC

TABLE C ALCOHOL CONSUMPTION (RSA 1990)

Group	**Males**	**Females**
	%	%
Whites	89	77
Blacks	80	60
Coloureds	59	27
Indians	49	8

The estimated % of persons in various groups who consume alcohol. (Adults).

TABLE D ALCOHOL AND THE INJURED DRIVER: THE PODDER PROJECT CONDUCTED AT THE GROOTE SCHUUR TRAUMA UNIT

Driver's Appearance	No. of drivers	BAC (in g/100ml			Prediction errors	
		0	0,01–0,07	0,08–1,00	Number	%
NOT APP. DRUNK						
Conscious	208	165	15	28	28	13,5
Unconscious	7	5	0	2	2	28,6
TOTAL	215	170	15	30	30	14,0
APP. DRUNK						
Conscious	57	4	7	46	11	19,3
Unconscious	3	0	1	2	1	33,3
TOTAL	60	4	8	48	12	20,0
OVERALL						
Conscious	265	169	22	74	39	14,7
Unconscious	10	5	1	4	3	30,0
TOTAL	275	174	23	78	42	15,3

WN van Kralingen, S Whittaker, J van der Spuy, LS Smith, JM Stokol & PM Haddow 'Road and Transport Technology' CSIR Report DPVT/170 1991.

TABLE E PERCENTAGE OF SUBJECTS 'UNDER THE INFLUENCE'
(At various stages of absorption and elimination)

BAC	Rising Tide No %		1–1,5 hrs after BAC peak No %		2–2,5 hrs after BAC peak No %	
0,05	80	50	0	0	4	0
0,08	83	57	18	5	28	0
0,10	49	66	23	4	24	4
0,12	52	77	22	36	19	21
0,14	42	69	21	38	20	15
0,16	33	91	9	73	6	6
0,18	13	85	3	66	4	50
0,20	7	100	5	100	0	0
0,22	4	100	0	0	0	0

(Blood alcohol and inebriation in Finnish men: (1951) 7 *AR ALba* 183).

TABLE F BLOOD ALCOHOL CONCENTRATIONS AND PROBABLE BROAD CLINICAL PICTURE
(Modified from Le Roux & Smith 1964: 131–41)
(These groupings are seldom clear-cut nor are all the elements necessary present.)

Blood Concentration g%	'Inexperienced' Drinkers	'Experienced' Drinkers
0–0,05	'Sober'	'Sober'
0,06–0,09	L1	'Sober'
0,10–0,15	M1	L1
0,16–0,20	H1	M1
0,21–0,25	H1 to VH1	M1 to H1
0,26–0,30	VH1	H1 to VH1
0,31–0,40	Stuporose to comatose	VHI to stuporose
0,41–0,50	Comatose to death	Comatose to death

(a) Lightly Intoxicated (LI):
Flushed faces, dilated pupils, euphoria, some loss of restraint.

(b) Moderately Intoxicated (MI):
(a) + sluggish pupils, incoordination of finer skilled movements, rombergism, thickness of speech, tendency to stagger on turning.

(c) Heavily Intoxicated (HI):
(a), *(b)* + pupils dilated and very sluggish, nystagmus, incoordination of skilled movements, staggering gait, with reeling and lurching when called upon to make sudden turns of to carry out unexpected movements.

(d) Very Heavily Intoxicated (VHI):
(a), *(b)*, *(c)* + faces may be flushed or pale, pupils may be contracted or dilated, mood passing into apathy, mental confusion with disorientation, gross incoordination of movements, rombergism marked. There may be vomiting.

Whereas the averaged graded response reflects on the probable magnitude of the response which will be elicited by a given dose of a drug, the quantal response reflects on the percentage of a population who will respond in a particular way to a given dose or blood level of a particular drug.

TABLE G

g%	Per cent 'Under the Influence'	
	Widmark (± 2 000 cases)	Andresen (± 2 000 cases)
0	–	2,9
0,001–0,02	0	33,3
0,021–0,04	0	18,5
0,041–0,06	0	61,2
0,061–0,08	15	67,8
0,081–0,10	29	76,3
0,101–0,12	38	73,4
0,121–0,14	54	82,9
0,141–0,16	71	90,3
0,161–0,18	84	96,1
0,181–0,20	88	94,8
0,201–0,22	91	98,3
0,221–0,24	95	100,0
0,241–0,26	95	95,8
0,261–0,28	98	100,0
0,281–0,30	96	100,0
0,301–0,32	100	100,0

Modified from (1951) 78 Alha quoting Jungmichel's evaluation of Widmark's Study (Swedish) and Andresen's study (Danish).

TABLE H BLOOD ALCOHOL CONCENTRATION: DRIVER DEATHS WITHIN ONE HOUR OF THE ACCIDENT (GREATER CAPE TOWN) 1980

BAC	No	%
Nil	7 (20)	17,1 (20)
<0,05 " 0,10 " 0,15 " 0,20 " 0,25 >0,25	3 (3) 7 (6) 13 (12) 4 (21) 7 (19) 0 (19)	82,9 (80)
Total	41 (100)	100 (100)

Figures in ( ) 1974–1978

TABLE I BLOOD-ALCOHOL CONCENTRATIONS IN VICTIMS OF DROWNING, CAPE TOWN 1980–1983

Blood-alcohol content (g/dl)	No of victims	%
Nil	93	35,4
<0,05	22	
<0,10	15	
<0,15	14	
<0,20	26	
<0,25	36	64,6
<0,30	38	
<0,35	11	
<0,35	8	
Total	263	100

TABLE J BODY WATER CONTENT
% Total Mass

	Male	**Female**
Body mass	± 60	± 50
Extracellular	15	15
Intracellular	45	40
Muscle	74	
Brain	93	
Fat	50	
Bone	31	
Blood	80	

TABLE K TOP TEN DEFENCE CHALLENGES AMONG INDIVIDUALS APPREHENDED FOR DRIVING WHILE UNDER THE INFLUENCE OF ALCOHOL IN SWEDEN

Rank	Brief description of the defence challenge
1	Drinking after the offence; the hip flask ploy
2	Laced drinks
3	Inhalation of ethanol vapours from the work environment
4	Pathological condition or trauma
5	Use of skin antiseptics containing ethanol
6	Alleged mix-up of blood specimens
7	Post-sampling formation of alcohols
8	Drug-alcohol interactions
9	Consumption of elixirs or health tonics containing alcohol
10	Infusion of blood or other liquids during surgical emergency treatment

Enkele gedagtes oor die kodifikasie van die Suid-Afrikaanse strafreg

CR SNYMAN*

Dit is vir my 'n groot eer om 'n bydrae te skryf vir 'n huldigingsbundel ter ere van professor SA Strauss. My verbintenis met die Universiteit van Suid-Afrika is so nou gekoppel met my verbintenis met professor Strauss dat dit vir my moeilik is om my voor te stel dat ek kan voortgaan met my werk in die Departement Straf- en Prosesreg aan hierdie universiteit sonder dat hy ook in die departement is. My aanstelling as professor by hierdie universiteit het ek aan hom te danke. Die voorbeeld wat hy gestel het, nie net as destydse hoof van hierdie departement nie maar ook in die skryf van studiemateriaal, diens aan die universiteit, die regswese in Suid-Afrika asook ons land se gemeenskap in die algemeen, het 'n onuitwisbare indruk gemaak op almal wat die voorreg gehad het om onder en saam met hom te kon gewerk het. Saam met ander kollegas wens ek hom 'n rustiger tydperk in die toekoms toe; mag die lewe vir hom 'n bietjie gemakliker wees as die sekere koorsagtige dae in die verlede toe hy, in 'n desperate poging om sy werk verrig te kry, letterlik moes vlug, boeke onder die arm, uit sy kantoor en weg van die telefoon, na die verskuilde hoekies in die regsbiblioteek, om die mense wat hom opsoek om hulp en raad — van ongelukkige huisvrouens, regspraktisyns wat in die moeilikheid beland het, koerant- en televisiejoernaliste tot by regters — te ontvlug.

✡ ✡ ✡

Inleiding

Die Suid-Afrikaanse strafreg openbaar 'n unieke eienskap in vergelyking met die strafreg in ander lande deurdat dit nie gekodifiseer is nie. Suid-Afrika is een van die weinige lande wat nog nie oor 'n strafkode beskik nie. Voorbeelde van die weinige lande of jurisdiksies waar die strafreg nog nie gekodifiseer is nie is Engeland en enkele Australiese state. Dit is egter opmerklik dat, ofskoon die strafreg in hierdie jurisdiksies nog nie as 'n samehangende sisteem in 'n wet opgeteken is nie, die grootste deel van die materiële strafreg reeds in afsonderlike wette uiteengesit is, met die gevolg dat 'n mens tog kan praat van

*BA LLB LLD (UOVS). Professor in die Departement Straf- en Prosesreg, Universiteit van Suid-Afrika.

'n gedeeltelike kodifikasie wat al reeds in hierdie jurisdiksies plaasgevind het. So iets het natuurlik nog nie in Suid-Afrika plaasgevind nie.

Alhoewel daar in ons land 'n groot getal misdade bestaan wat in wetgewing uiteengesit is, word byna al die bekende misdade in ons reg, sowel as die meeste reëls met betrekking tot die algemene leerstukke, deur die gemenereg gereël. Die enigste reëls met betrekking tot die algemene beginsels van die strafreg wat reeds in wetgewing vervat is, is die toets om die toerekeningsvatbaarheid van mense wat na bewering geestesongesteld is, vas te stel,[1] die reëls met betrekking tot die strafregtelike aanspreeklikheid van regspersone[2] en laastens die regsbepalings wat sameswering en uitlokking strafbaar stel.[3]

Dit is verder opmerklik dat daar in die lande of jurisdiksies in die vorige paragraaf gemeld sterk pogings aangewend word om die strafreg wel te kodifiseer: die Law Commission in Engeland het reeds met groot moeite 'n gedetailleerde konsepstrafkode opgestel tesame met 'n verklarende kommentaar,[4] terwyl die Criminal Law Officers Committee in Australië besig is om 'n modelstrafkode op te stel en reeds 'n finale konsep van die reëls met betrekking tot die algemene beginsels van die strafreg voltooi het.[5] In Kanada, waar die strafreg lank reeds gekodifiseer is, het die Law Reform Commission van daardie land 'n heeltemal nuwe en vereenvoudigde konsepstrafkode tesame met 'n kommentaar opgetrek.[6] Hierdie drie konsepkodes is van groot belang uit 'n regsvergelykende oogpunt vir iemand wat belangstel om vir Suid-Afrika ook 'n konsepstrafkode op te stel, want hulle weerspieël onteenseglik die jongste opvattinge in verband met strafregtelike aanspreeklikheid — ten minste in die Anglo-Amerikaanse reg.

In die bespreking wat volg sal kortliks gelet word op die belangrikste voor- en nadele van kodifikasie. Die doel van hierdie artikel is egter nie in die eerste plek om al die argumente in verband met hierdie debatspunt — aspekte waarvan al so dikwels in die verlede bespreek is[7] — net eenvoudig te herhaal

---

[1] A 78(1) van die Strafproseswet 51 van 1977.

[2] A 322 van die Strafproseswet 51 van 1977.

[3] A 18(2) van die Wet op Oproerige Byeenkomste 17 van 1956.

[4] The Law Commission A Criminal Code for England and Wales Law Com No 177 (1989). In die voetnotas wat volg sal na die belangrike 'Introduction' tot hierdie kode verwys word as 'Law Com No 177' en na die ontwerpkode self as die 'Engelse ontwerpkode'.

[5] Criminal Law Officers Committee of the Standing Committee of Attorneys-General Model Criminal Code Chapter 2 General Principles of Criminal Responsibility (1992) In die voetnotas wat volg sal na hierdie publikasie verwys word as die 'Australiese model-strafkode'.

[6] Law Reform Commission of Canada Report. Recodifying Criminal Law (1986). In die voetnotas wat volg sal na hierdie publikasie verwys word as die 'nuwe Kanadese konsepstrafkode'.

[7] Sien bv JC de Wet 'Gemene reg of wetgewing?' 1948 *THRHR* 1; HR Hahlo '... And save us from codification' 1960 *SALJ* 432; JC de Wet 'Kodifikasie van die reg in Suid-Afrika?' 1961 *THRHR* 152; WJ Hosten 'Kodifikasie in Suid-Afrika — 'n heroorweging' in SA Strauss (red) *Huldigingsbundel vir WA Joubert* (1988) 59. In hierdie publikasies is die klem hoofsaaklik op die privaatreg, ofskoon baie van die

nie. My persoonlike standpunt, wat ek kortliks sal motiveer, is dat ons strafreg gekodifiseer behoort te word. In die bespreking wat volg sal ek, naas die redes vir kodifikasie, ook kortliks verwys na die inhoud en styl van 'n kodifikasie, en ook twee voorbeelde verskaf van hoe bepalings wat in 'n kodifikasie opgeneem kan word, kan lyk. Die bespreking is egter beperk tot die kodifikasie van ons *strafreg*; die wenslikheid van die kodifikasie van ander gebiede van die reg — veral die privaatreg — sal nie ter sprake kom nie.

Wenslikheid van kodifikasie van die strafreg

Die belangrikste argument ten gunste van kodifikasie van die strafreg is ongetwyfeld die legaliteitsbeginsel, en meer bepaald daardie aspek van die beginsel wat vereis dat die inhoud van die strafreg relatief maklik naspeurbaar behoort te wees vir die gewone burger, sodat hy kan weet watter gedrag misdadig is, en hy gevolglik vooraf kan weet hoe om op te tree sodat hy nie die norme van die strafreg oortree nie.[8] Die reëls van die strafreg is in die eerste instansie gerig tot die gewone burger, die 'man of vrou op die straat', en nie slegs tot regsgeleerdes nie.[9] Die ideaal is dat die breë beginsels en reëls van die strafreg so *toeganklik* moontlik moet wees vir almal in die samelewing. In Amerika word dikwels na hierdie basiese beginsel verwys as 'the principle of due notice or fair warning'. Hierdie beginsel is veral belangrik indien 'n mens in gedagte hou dat die reëls van die strafreg sowel 'n *afskrikkende* as 'n sekere *opvoedkundige* funksie behoort te vervul.[10] Van al die verskillende vertakkings van die reg moet die strafreg sekerlik beskou word as die vertakking wat die belangrikste van almal is om te kodifiseer. Dit is 'n besondere openbare en sigbare deel van die reg, en, soos een bron dit stel, 'the most direct expression of the relationship between a state and its citizens'.[11] Verder moet in gedagte gehou word dat die werk van die strafhowe die afgelope stuk of twee dekades geweldig toegeneem het. Verreweg die meeste verhore in die land is

---

argumente wat geopper word ook op die strafreg betrekking kan hê. Vir 'n pleidooi vir die kodifikasie spesifiek van die strafreg, sien DS Koyana 'Reflections on the criminal law of a new South Africa' 1991 SALJ 730.

[8]Omtrent die legaliteitsbeginsel in die algemeen, sien CR Snyman *Strafreg* (3 uitg 1992) 33-49; J Burchell en J Milton *Principles of criminal law* (1991) 54-63; JMT Labuschagne 'Die sekerheidsbasis van die strafreg' 1988 SAS 52.

[9]'Law, especially criminal law, is made for the citizen, not the lawyer. Too often lawyers ignore this simple fact' — Law Reform Commission of Canada *Towards a codification of Canadian criminal law* (1986) para 1.59; M Goode 'Codification of the Australian criminal law' 1992 *Criminal Law Journal* 5 at 7, 9.

[10]Law Reform Commission of Canada *supra* n 9 para 1.62 65; 3.22; Goode *supra* n 9 11; ATH Smith 'Codification of the criminal law. The case for a code' (1986) *Criminal Law Review* 285 291 beweer dat 'the common law is, in its stewardship of the criminal law, inherently inimical to the principle of legality. It fails, or can fail, to give due notice and fair warning to those who are subject to it'. Die rede hiervoor, volgens die skrywer, is dat '[the common law] is relatively inaccessible, incomprehensible, inconsistent and uncertain ... [I]t is retrospective in its operation, undemocratic in its formulation and systematically uncertain, and ... is permanently subject to manipulation by the courts' (*ibid*).

[11]Law Com No 177 *supra* n 4 para 2.2.5. Vir 'n soortgelyke mening sien ook Herbert Wechsler 'The challenge of a model penal code' 1951–1952 *Harvard Law Review* 1097 1098.

strafverhore. 'n Steeds groeiende getal polisiebeamptes en sekuriteitspersoneel het die taak om van dag tot dag die reëls van die strafreg af te dwing of te administreer. Diegene wat belas is met die afdwinging van hierdie reëls behoort redelik maklik te kan naslaan wat die inhoud van die strafreg is.[12] Kodifikasie kan in 'n sekere sin beskryf word as 'n 'demokratisering' van die strafreg omdat dit die inhoud daarvan maklik toeganklik maak vir almal in die samelewing.[13]

'n Verdere argument ten gunste van kodifikasie is dat dit die wetgewer die geleentheid bied om die strafreg op 'n samehangende manier uiteen te sit, om die reëls daarvan te sistematiseer en om teenstrydighede wat mag bestaan uit die weg te ruim.[14] Kodifikasie skep 'n vaste uitgangspunt by die vasstelling van die inhoud van die strafreg.[15] Dit verteenwoordig 'n amptelike en gesaghebbende uiteensetting van die gedragreëls waaraan 'n burger moet voldoen ten einde die strafsanksies te ontwyk.

'n Belangrike argument teen kodifikasie is dat die howe die bevoegdheid om die reg te verander of aan te pas by veranderde omstandighede mag verloor: kodifikasie mag — so word geredeneer — lei tot 'n inbreukmaking op die soepelheid van die reg en 'n gevolglike 'verstarring' van die reg.[16] Dit is bekend dat die appèlafdeling van die hooggeregshof in die loop van rofweg die afgelope drie of vier dekades in verskeie beslissings die strafreg in ons land in nuwe rigtings gestuur het. 'n Mens hoef maar net te dink aan beslissings soos dié in *Chretien*,[17] wat 'n heeltemal nuwe bedeling in verband met die uitwerking van dronkenskap op aanspreeklikheid ingelei het, *Campher*[18] en *Wiid*,[19] wat 'n heeltemal nuwe verweer genaamd 'nie-patologiese ontoerekeningsvatbaarheid' in ons reg ingevoer het, en *De Blom*,[20] waarin regsdwaling vir die eerste keer in ons reg as 'n verweer wat opset uitsluit, erken is. As ons strafreg gekodifiseer was, is dit meer as twyfelagtig of die appèlafdeling in staat sou gewees het om koersveranderinge soos hierdie aan te bring.

Die antwoord op bogemelde argument is dat 'n kode altyd gewysig kan word

---

[12]Grainne de Burca en Simon Gardner 'The codification of the criminal law' 1990 *Oxford Journal of Legal Studies* 560 562; Goode *supra* n 9 7; FJ Remington 'The future of the substantive criminal law codification movement — theoretical and practical concerns' 1988 *Rutgers Law Journal* 867 868.

[13]Vgl Goode *supra* n 9 8:'The criminal law should be easy to discover, easy to understand, cheap to buy, and democratically made and amended.'

[14]Scarman 'Codification and judge-made law: a problem of coexistence' 1967 *Indiana Law Journal* 355 366–7; Herbert L Packer 'The Model Penal Code and beyond' 1963 63 *Columbia Law Review* 594, wat van mening is dat die 'dominant tone' van die Amerikaanse Model Penal Code 'one of principled pragmatism' is; Francis Bennion 'The technique of codification' 1986 *Columbia Law Review* 295 297.

[15]Smith *supra* n 10 289.

[16]Law Com No 177 *supra* n 4 para 2.16; Smith *supra* n 10 294.

[17]1981 (1) SA 1097 (A).

[18]1987 (1) SA 940 (A).

[19]1990 (1) SASV 561 (A).

[20]1977 (3) SA 513 (A).

ten einde nuwe opvattinge omtrent strafregtelike aanspreeklikheid te weerspieël.[21] Trouens, uit 'n beleidsoogpunt is dit verkieslik dat die parlement, as die verkose versameling van afgevaardigdes van die land se bevolking, na behoorlike ondersoek en bespreking die reg wysig, en dat dit nie aan die howe oorgelaat word om die reg te wysig of om nuwe reg te skep nie.[22] ***Iudicis est ius dicere sed non dare.*** Om die reg by veranderde omstandighede aan te pas is 'n taak wat liewer aan die wetgewer oorgelaat behoort te word. Veral 'n uitbreiding van aanspreeklikheid deur die howe by wyse van analogie behoort so ver as moontlik vermy te word.[23] Wat meer is, howe se bevoegdheid om leemtes in die reg te identifiseer en die leemtes te vul of 'n regstelling te maak, is beperk: hulle moet wag totdat 'n geskikte feitestel voor hulle dien voordat hulle in 'n posisie is om in te gryp.[24] Die wetgewer, daarenteen, is vry om in te gryp wanneer hy wil. 'n Hof het in elk geval geen bevoegdheid om nuwe misdade te skep of om die toepassingsgebied van bestaande misdade uit te brei nie.[25]

Kodifikasie sal nie tot gevolg hê dat die howe blote rubberstempels word in 'n proses waarin hulle slegs meganies die inhoud van 'n strafkode toepas nie. Die howe sal voortgaan om 'n kreatiewe rol te speel deurdat hulle die bepalings van die kode sal moet uitlê.[26] In hierdie verband is dit baie belangrik om in gedagte te hou dat 'n behoorlik opgestelde kode nie 'n gedetailleerde uiteensetting van iedere en elke reël van die strafreg tot in die fynste besonderhede bevat nie. Die detail moet deur die howe uitgepluis word.[27] 'n Kode behoort slegs die leidende beginsels te bevat, en nie daarna te streef om elke moontlike feitestel wat mag opduik, te reël nie.

Suid-Afrika bevind hom in 'n tydperk van sy geskiedenis waarin daar groot

---

[21]Law Com No 177 *supra* n 4 para 2.17; Scarman *supra* n 14 367.

[22]Law Reform Commission of Canada *supra* n 9 para 1.42, 48; Smith *supra* n 10 294.

[23]R v Oberholzer 1941 OPD 48 60; S v Smith 1973 (3) SA 945 (O).

[24]Law Com No 177 *supra* n 4 para 2.11; Scarman *supra* n 14 366, waar die skrywer die volgende stelling van Lord Devlin aanhaal: 'The trouble about judicial law reform was never, as it is with Parliament, lack of time but lack of opportunity ... the delay before a point of principle reaches the House of Lords may be so long as to outdistance by ten times or more the parliamentary process.'; Goode *supra* n 9 15: 'The judicial process places the considerable expense and burden of initiating change on those who lack resources: criminal litigants. A great deal depends on the random accidents of litigation. The judicial process is constrained by criteria of relevance unrelated to the merits of litigation, designed to conserve judicial resources rather than reform the law.'

[25]*R v Roginson* 1911 CPD 319; *R v M* 1915 CPD 334; *S v Solomon* 1973 (4) SA 644 (C); *S v Von Molendorff* 1987 (1) SA 135 (T); Snyman *supra* n 8 40-41.

[26]Scarman *supra* n 14 362-3: 'There is nothing surprising in the continuing importance of the judge in a codified system. However carefully drafted, into whatever detail it goes, a code is likely in places to fall into the error of ambiguity and is bound to contain some omissions. If it be ambiguous, yet the judge's decision must be certain; if it fails to cover the case under consideration, yet the judge must make a decision. The cry "*non possumus*" is simply not open to a judge.' Sien ook Law Com No 177 *supra* n 4 para 2.19; Law Reform Commission of Canada *supra* n 9 para 1.45.

[27]Law Reform Commission of Canada *supra* n 9 para 1.44, 49.

veranderinge op politieke, grondwetlike en maatskaplike terrein plaasvind. Verandering is orals is die lug — ook op die juridiese terrein, waar 'n handves van fundamentele regte in die nuwe oorgangsgrondwet[28] beloof om 'n nuwe, opwindende fase in ons regsontwikkeling in te lui. Met al hierdie veranderinge en ontwikkelinge wat plaasvind in gedagte, is dit miskien juis nou 'n goeie geleentheid om 'n mens af te vra of die tyd nie dalk ryp word vir Suid-Afrika om sy strafreg te kodifiseer nie.

Din inhoud van 'n strafkode

Onder hierdie hoof word die aandag gevestig op enkele vereistes waaraan 'n goeie strafkode behoort te voldoen.

Eerstens behoort daar so ver as moontlik onderskei te word tussen aangeleenthede van 'n prosesregtelike of bewysregtelik belang en aangeleenthede wat deel vorm van die materiële strafreg.[29] Soos bekend is die Suid-Afrikaanse strafprosesreg reeds gekodifiseer in die Strafproseswet 51 van 1977. In die Engelse reg en ander regsisteme wat sterk deur die Engelse reg beïnvloed is, is daar 'n tendens om nie baie skerp tussen die materiële reg en die prosesreg te onderskei nie, terwyl daar in die regsisteme op die Europese vasteland weer redelik skerp tussen hierdie twee gebiede onderskei word. Die skepping van vermoedens vertroebel die onderskeid en behoort liefs vermy te word.[30]

'n Strafkode behoort vervolgens, naas 'n uiteensetting van die reëls van aanspreeklikheid en 'n omskrywing van die afsonderlike misdade, ook die strawwe wat vir elke misdaad opgelê kan word, te spesifiseer. Meer bepaald behoort die maksimumstraf wat vir elke afsonderlike misdaad opgelê kan word, gespesifiseer te word; daar behoort verkieslik nie verpligte minimumstrawwe voorgeskryf te word nie. In die meeste strafkodes verskyn die straf in dieselfde artikel as dié waarin die omskrywing van die betrokke misdaad gegee word. Dit is egter ook moontlik om die voorbeeld van die nuwe Engelse konsepstrafkode te volg en die strawwe in 'n afsonderlike bylae in 'n tabel te plaas.

Daar bestaan 'n baie groot aantal misdade in ons reg wat nie gemeenregtelike misdade is nie maar in wette geformuleer is. Die vraag ontstaan of al hierdie misdade nou oorgeskuif behoort te word na die strafkode. Dit sal 'n onbegonne taak wees om iedere en elke misdaad in ons reg wat deur die wetgewer geskep is, in 'n strafkode te inkorporeer. Daar is eenvoudig te veel sulke misdade. (Die wanaanwending van die strafsanksie in Suid-Afrika deur 'n wetgewer wat van mening skyn te wees dat haas elke verbod wat in 'n wet

---

[28]Grondwet van die Republiek van Suid-Afrika 200 van 1993. Die Fundamentele Regte verskyn in artikels 7–35 van die wet.

[29]Law Com No 177 *supra* n 4 para 3.42; Law Reform Commission of Canada *supra* n 10 para 1.64.

[30]Sien Law Reform Commission of Canada *supra* n 6 3, waar die opstellers van die nuwe Kanadese konsep-strafkode die kode wat hulle opgestel het soos volg beskryf: 'It is drafted in a straightforward manner, with a minimum of technical terms, avoiding complex sentence structure and excess detail ... [I]t avoids deeming provisions, piggybacking and other indirect forms of expression ... .'

geskep word deur die skepping van 'n ooreenstemmende misdaad gerugsteun moet word, en die gevolglike 'inflasie' van statutêre misdade in ons reg, is tereg al gekritiseer.)[31] Indien 'n misdaad in 'n wet geskep in 'n noue verband staan met 'n onderwerp wat nie in hoofsaak 'n strafregtelike aangeleentheid is nie, behoort so 'n misdaad nie in die kode opgeneem te word nie. 'n Mens dink hier byvoorbeeld aan die misdade in verband met insolvensie en maatskappye geskep in die wette wat met hierdie twee aangeleenthede in verband staan. Daar sal natuurlik baie misdade wees wat grensgevalle is en ten opsigte waarvan dit moeilik sal wees om te besluit of hulle in die kode opgeneem moet word of nie.

Wat van verkeersmisdade (soos 'dronk bestuur') en misdade in verband met verdowingsmiddels? Na my mening kwalifiseer nie een van hierdie twee groepe misdade vir opname in 'n strafkode nie. Die omskrywings van verkeersmisdade vorm deel van 'n omvattende reëling in 'n wet (die Padverkeerswet 29 van 1989) wat padverkeer reguleer en 'n groot aantal administratiewe maatreëls (soos lisensiëring) bevat waarmee dit verband hou. Misdade in verband met verdowingsmiddels, soos besit en handeldryf in verdowingsmiddels, vorm eweneens deel van 'n omvattende wet (die Wet op Dwelmmiddels en Dwelmsmokkelary 140 van 1992) waarvan dit liefs nie geskei behoort te word nie. Dit is in elk geval opvallend dat strafkodes in ander lande as 'n reël nie omskrywings bevat van misdade wat in hierdie twee kategorieë val nie.

Aan die ander kant is daar sekere bestaande statutêre misdade wat wel kwalifiseer vir opname in 'n strafkode op grond van oorwegings soos hulle belangrikheid, hulle wye toepassingsgebied of hulle noue verband met bestaande gemeenregtelike misdade. Voorbeelde van sulke misdade is die misdaad geskep in artikel 319(3) van die 'ou' Strafproseswet 56 van 1955 (die aflê van teenstrydige verklarings in twee verskillende eedsverklarings — 'n misdaad wat soms 'statutêre meineed' genoem word); korrupsie (ter oortreding van die Wet op Korrupsie 94 van 1992); bykans al die misdade geskep in die Wet op Seksuele Misdrywe 23 van 1957; en die misdade geskep in artikel 1(1) van die Algemene Regswysigingswet 50 van 1956 (verwydering van goedere vir gebruik — statutêre *furtum usus* en artikels 36 en 37 van die Algemene Regswysigingswet 62 van 1955 (versuim om besit van vermoedelik gesteelde goed te verduidelik en die verkryging van gesteelde goed sonder redelike gronde).

Terwyl die vraag watter misdade by 'n kode ingesluit behoort te word hier bespreek word, kan ook kortliks aandag gegee word aan die vraag watter gemeenregtelike misdade, indien enige, maar uitgesluit kan word van 'n kodifikasie. 'Misdade' wat na my mening maar uitgesluit kan word omdat hulle in werklikheid nie meer in ons reg bestaan nie, is *crimen laesae majestatis* ('n 'variasie' van hoogverraad wat in onbruik geraak het) en *crimen laesae venerationis* (belediging van die staatshoof — 'n ou misdaad wat onversoenbaar is met 'n demokratiese staatsvorm). Onder die hoof 'onnatuurlike

[31] André Rabie 'Error iuris: principle, policy and punishment' 1994 *SAS* 93 98.

geslagsmisdaad' is daar ook 'n aantal vorms van seksuele gedrag wat, ofskoon dit ingevolge die gemenereg strafbaar is, in ons moderne geëmansipeerde samelewing nie meer as misdadig beskou word nie en dus nie kwalifiseer vir opname in 'n strafkode nie.

Daar is 'n sekere aantal gemeenregtelike misdade wat, ofskoon daar algemeen aangeneem word dat hulle nog bestaan, baie selde in die howe ter sprake kom as misdade waarvan beskuldigdes aangekla is of waaraan hulle dalk skuldig bevind kan word. Kodifikasie bied 'n uitstekende geleentheid vir die wetgewer om te besluit of die misdade in hierdie groep nog bestaan. Voorbeelde van sulke misdade is die toediening van gif of ander skadelike stowwe (sodanige gedrag kan altyd as aanranding of poging to moord bestraf word), grafskending, lykskending, die blootstelling van 'n jong kind (*crimen expositionis infantis*) en selfs diefstal deur middel van valse voorwendsels.

Kodifikasie bied ook 'n uitstekende geleentheid aan die wetgewer (hopelik op advies van kundige regsgeleerdes) om ontslae te raak van 'n reeks onbevredigende aspekte in bestaande gemeenregtelike misdade. Sonder om voor te gee dat die lys volledig is, word die aandag hier slegs op sekere aspekte van sommige van hierdie misdade gevestig: die te wye toepassingsgebied van hoogverraad; die vraag of geweld 'n vereiste is vir sedisie; die vraag of 'n objektief valse verklaring 'n vereiste is vir 'n skuldigbevinding aan meineed; die presiese beskrywing van aanranding deur middel van 'n dreigement; die vraag of die handeling by onsedelike aanranding objektief onsedelik moet wees; die vraag of die inbreukmaking op iemand se *dignitas* by *crimen iniuria* en die skending van iemand se reputasie by strafregtelike laster van 'n ernstige aard moet wees; die ongeoorloofde gelykskakeling van menseroof en kinderdiefstal; die onbevredigende omskrywing van 'statutêre *furtum usus*' in artikel 1 (1) van die Algemene Regswysigingswet 50 van 1956; en 'n hele reeks probleme in verband met diefstal en die misdaad huisbraak met die doel om 'n misdaad te pleeg. Die wye misdaad diefstal soos dit in die Romeins-Hollandse reg bekend is, behoort na my mening onderverdeel te word in 'n reeks misdade wat enger omskryf is. Gedrag soos verduistering en 'besitsaanmatiging' (*furtum possessionis*) behoort nie deel te vorm van die diefstalbegrip nie. Die pleeg van diefstal en selfs bedrog deur middel van die onregmatige manipulasie van kredietkaarte of outomatiese tellermasjiene behoort as afsonderlike misdade in die kode gereël te word. Die misdaad huisbraak is so kunsmatig dat selfs die howe al te kenne gegee het dat die Suid-Afrikaanse regskommissie die misdaad se omskrywing behoort te heroorweeg.[32]

Wat die algemene beginsels van aanspreeklikheid betref, moet in gedagte gehou word dat dit nie nodig is om elke denkbare onderwerp — regverdigingsgrond, skulduitsluitingsgrond asook ander verwere — in die kode te inkorporeer nie. Baie teenstaanders van kodifikasie se beswaar daarteen mag gebaseer wees op twyfel aangaande die vraag of dit hoegenaamd moontlik is

[32] *S v Ngobeza* 1992 (1) SASV 610 (T). Sien ook CR Snyman 'Reforming the law relating to housebreaking' 1993 *SAS* 38.

om die breë, abstrakte algemene beginsels van aanspreeklikheid presies in 'n kode te formuleer. Hierdie twyfel is na my mening ongegrond. As 'n mens na veral strafkodes op die Europese vasteland kyk, is dit opmerklik dat slegs enkele algemene verwere in die kodes opgeneem is. As 'n reël swyg die kodes meestal oor onderwerpe soos die vereiste van 'n willekeurige handeling (en hierdie vereiste se spieëlbeeld, naamlik die verweer van 'outomatisme'), kousaliteit, aanspreeklikheid vir 'n late, die verweer van onmoontlikheid, die inhoud van die opset- en nalatigheidsbegrippe, en die toerekeningsvatbaarheidsbegrip — om maar slegs enkeles te noem. Daar behoort 'n bepaling in die begin van die kode te wees wat dit duidelik stel dat die verwere wat 'n beskuldigde kan opper nie beperk is tot die verwere gemeld in die kode nie. Dit sal verseker dat dit 'n hof vrystaan om enige (ongeskrewe) verweer te oorweeg of te erken. Die dogmatiek wat die akademici 'ontwerp' het om die algemene aanspreeklikheidsvoorvereistes wetenskaplik uiteen te sit, verskyn nie in kodes nie. Begrippe soos 'handeling', 'wederregtelikheid' en 'skuld' word as 'n reël nie in die kodes uiteengesit nie. 'n Strafkode behoort immers so ver as moontlik vir iemand wat 'n leek op regsgebied is, verstaanbaar te wees.

Voorbeelde van formulerings

As 'n voorbeeld van die toepassing van die bogemelde riglyne word 'n formulering van 'n bepaling in 'n kode waarin die bekende regverdigingsgrond noodweer omskryf word, hier gegee. So 'n voorskrif kan soos volg lui:

> Iemand wat geweld gebruik om 'n wederregtelike aanval wat reeds begin het of onmiddellik dreigend is op sy of iemand anders se lewe, liggaamlike integriteit, eiendom of 'n ander belang wat na die oordeel van die hof beskerm behoort te word, af te weer, tree nie wederregtelik op nie, mits die afweerhandeling noodsaaklik is om die belang wat bedreig word, te beskerm, dit gerig is teen die aanvaller, en nie skadeliker is as wat nodig is om die aanval af te weer nie.

Daar word aan die hand gedoen dat dit nie nodig is om, wat noodweer betref, enigiets verder by te voeg nie. Dit is eenvoudig die taak van 'n hof om die fynere besonderhede wat in 'n gegewe saak ter sprake mag kom, uit te pluis. Dit is natuurlik eweneens die taak van die hof om die algemene, abstrakte formulering toe te pas op 'n konkrete feitestel.

Die Suid-Afrikaanse reg het (danksy die baanbrekerswerk van professor J C de Wet) die basiese onderskeid wat in die regstelsels op die Europese vasteland tussen wederregtelikheid en skuld getrek word, aanvaar. Om hierdie rede is die bepalings in strafkodes of ontwerpstrafkodes in Anglo-Amerikaanse regstelsels wat handel oor wat ons in ons reg regverdigingsgronde sou noem, nie van veel hulp vir iemand wat na voorbeelde van die formulerings van sodanige regverdigingsgronde soek nie. Dit is veral die geval by noodweer. Hierdie 'verweer', soos ons dit ken, is nie bekend in die Anglo-Amerikaanse strafregsisteme nie. In laasgenoemde sisteme word in plaas daarvan gewoonlik onderskei tussen selfverdediging, verdediging van 'n ander en verdediging van

eiendom.[33] Ten einde voorbeelde te vind van bepalings wat handel oor noodweer soos ons dit in Suid-Afrika ken, kan 'n mens met vrug die bepalings oor hierdie onderwerp in die strafkodes op die Vasteland raadpleeg.[34] Die formulering van noodweer in die Suid-Afrikaanse reg wat hierbo gegee is, is in 'n mate geskoei op die formulerings in die bogemelde Vastelandse kodes.

Nog een ander voorbeeld van 'n formulering in 'n strafkode vir Suid-Afrika kan gegee word. 'n Algemene bepaling omtrent die strafbaarheid van poging om 'n misdaad te pleeg kan soos volg lui:

(1) Iemand is skuldig aan poging om 'n misdaad te pleeg indien hy wederregtelik en met die opset om daardie misdaad te pleeg 'n handeling verrig of versuim om 'n handeling te verrig en sodanige gedrag nie slegs 'n voorbereiding tot die pleeg van die misdaad is nie maar neerkom op minstens die begin van die uitvoering van die misdaad wat hy in gedagte het.

(2) Iemand is skuldig aan poging om 'n misdaad te pleeg al
(a)is die pleeg van die misdaad onmoontlik, indien dit moontlik sou gewees het in die feitlike omstandighede wat volgens sy voorstelling bestaan of op die tersaaklike tyd sal bestaan;
(b) tree hy vrywillig terug van die misdaadpleging nadat sy gedrag reeds die stadium bereik het dat dit neerkom op minstens die begin van die uitvoering van die misdaad wat hy in gedagte gehad het.

Dit is nie nodig om enigiets meer omtrent poging om 'n misdaad te pleeg in die kode te plaas nie. Subartikel (1) sit die algemene reël in verband met poging (en veral sogenaamde geskorste poging) uiteen soos neergelê in beslissings soos *Schoombie*[35] en *Du Plessis*.[36] 'n Mens kan die beginsel in hierdie artikel neergelê dalk selfs nog meer kernagtig stel, deur naamlik die vereiste dat die gedrag nie meer bloot 'n voorbereiding vir die pleeg van die misdaad te wees nie, uit te laat, en net te vereis dat dit moet neerkom op 'n uitvoeringshandeling. Dit kan in baie gevalle natuurlik moeilik wees om te besluit of sekere optrede 'n voorbereidings- dan wel 'n uitvoeringshandeling is, maar dit is die taak van 'n hof om die algemene beginsel op konkrete feitestelle toe te pas.

Subartikel 2(a) beskryf die reël in verband met ondeugdelike poging, soos neergelê in *Davies*,[37] asook die uitsondering op hierdie reël. Subartikel 2(b) beskryf die reël in verband met vrywillige terugtrede, soos neergelê in

---

[33]Sien bv a 44 en 45 van die Engelse ontwerpkode *supra* n 4; a 3.03, 3.04 en 3.05 van die Amerikaanse Model penal code; a 313 van die Australiese model-strafkode *supra* n 5 en a 3(10),(11) en (12) van die nuwe Kanadese konsep-strafkode *supra* n 6.

[34]Nuttige voorbeelde word gevind in artikels 41 van die Nederlandse, 32 van die Duitse, 3 van die Oostenrykse, 33 van die Switserse en 52 van die Italiaanse strafkodes.

[35]1945 AD 541.

[36]1981 (3) SA 382 (A).

[37]1956 (2) SA 52 (A).

Hlatwayo[38] en *Du Plessis*.[39]

Die styl van 'n strafkode

Wanneer besluit word om 'n sekere onderwerp in 'n kode op te neem, hoef 'n mens nie iedere en elke faset van die betrokke onderwerp in die formulering te inkorporeer nie. Slegs die hooftrekke van die onderwerp hoef gemeld te word. Regsgeleerdes debatteer dikwels oor 'n klein besondere onderafdeling van 'n onderwerp; dit is nie nodig om al hierdie detail uit te spel wanneer die betrokke aangeleentheid in 'n kode geformuleer word nie. 'n Kode verskaf derhalwe nie antwoorde tot op die fynste besonderhede van elke onderwerp nie.[40]

In hierdie verband moet daarop gewys word dat die Suid-Afrikaanse wetgewer daarvoor lief is om in die bepalings in wetgewing te streef na uitvoerigheid, dit wil sê om 'n aangeleentheid in soveel detail uiteen te sit dat daar so min as moontlik vir 'n hof oorbly om oor te besluit.[41] Hierdie styl van opstel van wetgewing is die gevolg van die invloed van die Engelse reg asook van die positivistiese regsbeskouing: die 'reg' word hiervolgens beskou as 'n bevel van die owerheid (die parlement) en die howe speel in hoofsaak 'n passiewe rol; hulle is veronderstel om slegs op meganiese wyse die reëls wat die wetgewer geskep het, toe te pas, en om veral nie waarde-oordele uit te spreek nie. Hierdie benadering tot die formulering van wetgewing moet na my mening afgewys word. Die invoering van 'n handves van menseregte in Suid-Afrika[42] bring in elk geval mee dat die howe 'n veel meer skeppende rol sal moet vervul as in die verlede, en geroepe sal wees om veel meer waardeoordele uit te spreek.

Die bogemelde Engelsregtelike benadering verskil aanmerklik van die benadering op die Europese vasteland, waar die regter veel meer aktief is en die wetgewer geneig is om veel kernagtiger te formuleer.[43] Wanneer Suid-Afrika wel eendag sover kom om sy eie strafkode op te stel, kan maar net

---

[38]1933 TPD 441.

[39]*Supra*.

[40]Law Com No 177 *supra* n 4 para 3.39; Scarman *supra* n 14 363-4; Law Reform Commission of Canada *supra* n 9 para 1.44: 'Codification does not mean that the entire body of law must be set down in the finest detail. The task would be impossible by its very nature, since no one can foresee all the particular applications of the law ... In a sense, the notion of a "complete" code is mythical, absurd and utopian ... The purpose [of codification] is achieved if it expresses in clear terms the general rules and the basic, distinctive principles for both judges and lawyers.'

[41]Law Reform Commission of Canada *supra* n 9 para 1.49: 'In the purest British tradition, a statute should spell out everything down to the smallest detail. Its criteria of excellence are meticulousness and precision. Hence, the rule often becomes complex, and one can lose sight of it in the profusion of detail.' Sien ook Hosten *supra* n 7 73: 'Daar was ten alle tye al protes teen die taktiek en styl van ons wetgewers, byvoorbeeld die buitensporige nabootsing van die Engelse modelle en die omslagtige, woordryke en ingewikkelde styl.'

[42]*Supra* n 28.

[43]Hosten *supra* n 7 73.

gehoop word dat die Vastelandse benadering sal seëvier. Dit is opmerlik dat die Law Commission in Engeland in die konsepstrafkode wat vir Engeland opgestel is, bewustelik daarna gestrewe het om lang, ingewikkelde formulerings te vermy en in plaas daarvan 'n bondiger styl te volg. Dieselfde helder, bondige styl word ook gevind in die nuwe Australiese Model Criminal Code asook in die nuwe Kanadese konsepstrafkode.

In navolging van hierdie moderner styl kan by die toekomstige opstel van 'n strafkode vir Suid-Afrika gerus ook maar afgesien word van die irriterende tegniek om artikels of subartikels altyd 'onderworpe aan ...' ander bepalings te maak, of om die konstruksie 'met dien verstande dat ...' te gebruik. Die intelligente leser sal en behoort te besef dat hy nie slegs byvoorbeeld 'n enkele subartikel behoort te lees ten einde agter te kom wat die reg aangaande 'n bepaalde onderwerp is nie, maar dat hy ook die ander subartikels van die betrokke artikel moet raadpleeg. Die substansie van 'n bepaling behoort nie verlore te gaan in 'n moeras van voorbehoudsbepalings of uitsonderings nie.

Distance teaching of law students in the new South Africa, with specific reference to possible changes at (the University of South Africa)

DANA VAN DER MERWE*

Hierdie bydrae word opgedra aan Sas Strauss, my promotor, kollega, vriend en metgesel op die radiogolwe met die program 'Wat sê die Reg?' As 'n persoon wat byna sy hele akademiese loopbaan daaraan gewy het om Unisa te bring tot waar hy is, sal hy miskien belangstel in hierdie poging om te probeer formuleer waarheen Unisa nou op pad is (of behoort te wees), met onderrig vir die 'nuwe Suid-Afrika'. Vir doeleindes van wyer verspreiding word die res van hierdie bydrae in Engels geskryf. Nog 'n rede vir die 'rooitaal' is dat sommige van hierdie 'hoë tegnologie'-uitdrukkings moeilik vertaalbaar is!

✡ ✡ ✡

Background

Unisa is one of the largest universities in the world, with one of the best libraries and a dramatically increasing number of students. Why change a winning game? Why should Unisa attempt to bring about (possibly expensive) changes? If it is was good enough for dad, should it not be good enough for me?

There are two compelling reasons for change. In the first place, South Africa's circumstances have changed dramatically. Owing to the Republic's former isolation from the rest of the world, Unisa had almost had a monopoly as far as distance education in South Africa was concerned. Now we are competing internationally against the likes of the British Open University and Athabasca University in Canada. Our methods and media are being compared with the best in the world. There is also an education crisis in South Africa, with the possibility of Unisa playing a central role in bringing the light of learning to thousands of disadvantaged black students. SAIDE (South African Institute for Distance Education) has brought some overseas consultants to this country and some of them have cast a jaundiced eye over Unisa's activities.

---

* B Iur (UPE); LLB, LLD (Unisa). Professor of Law, Department of Criminal & Procedural Law, University of South Africa.

In the second place, the pace of the computer revolution has never slackened and many new products, such as 'hypertext' and 'multimedia', may change our whole concept of distance education dramatically. In harness with the computer revolution, a 'telecommunications revolution' has also taken place, which has made possible such teaching aids as video-conferencing and the Internet.

Concepts

Before getting into the meat of this essay it would only be fair to the reader to indicate in which sense some frequently used terms will be used.

In their work *Education at a Distance*[1] Garrison and Shale distinguishes between 'learning' and 'education' on the basis that the latter is characterised by interaction between the student and a teacher:

> For our purposes we will use "learning" as a generic term to refer to all of what we come to know, consciously and unconsciously, by whatever means. A part of that will have come to us through education, that process which is characterized by the interaction of a teacher and a student.[2]

This definition raises some interesting points, namely whether interaction between the student and a computer running an educational programme will qualify as 'education' in the above sense. Garrison apparently feels that it does, because in a further essay in the same work[3], he lauds computers for their 'interactive instructional capabilities'. A further question, closer to home, is whether the correspondence 'education' which is still Unisa's mainstay, would qualify as education in the above sense.

In the same essay, Garrison distinguishes between correspondence study as 'the first generation of distance *education*[4] technology'. He further categorises telecommunications in distance education as 'a new generation in designing the educational transaction' (apparently the 'second generation' and finally classifies computer-based technology as the third generation of distance education.[5] Together with Shale, he prefers speaking of 'education at a distance'[6] since this emphasises the educational aspect and not simply the distance. Over-emphasis on the latter aspect tends to make people concentrate on the media, instead of on the end goal, namely that the recipient should be educated.

Garrison does rate some of the media, however. With correspondence study, he criticises 'the infrequent, inefficient and akward' communication between educator and student. Television, which was extensively used by the British

---

1 DR Garrison and D Shale (eds) Robert E Krieger Publishing Co Malabar, Florida (1990).

2 *Op cit* 30.

3 *Op cit* 47.

4 My emphasis.

5 *Op cit* 45.

6 *Op cit* 31.

Open University at first, he describes as 'mass media'. With later technologies, which enable better two-way communication, there has been a 'de-massifying' of the media, which makes them more interactive and individualised. His favourites seem to be interactive video-conferencing, and computers, both in the on-line[7] and off-line[8] modes.

In his doctoral thesis, entitled "n Didaktiese Model vir die Gebruik van Rekenaartegnologie in Afstandonderwys'[9], PHR (Henry) van Zyl warns against the use of computers simply because 'they are there':

> Die gevolg is dat gesonde didaktiese beginsels en modelle nie die onderbou vorm waarop die RGO-program gebou word nie. Dit gaan dus meer om die tegnologie ter wille van die tegnologie, of ter wille van die feit dat dit die onderrig opkikker, of die lewe vir die dosent meer draaglik maak.[10]

Van Zyl argues persuasively that technology be harnessed as part of a didactic model for the whole of Unisa.

As Garrison does, Van Zyl also makes some conceptual distinctions. He distinguishes 'onderrig' (which may be translated as 'teaching') from 'onderwys' (translated as 'education'). 'Onderrig' is the old so-called 'factory model' where the process of teaching is centralised and mass-produced, as Henry Ford did with automobiles during the first part of this century. The model is strongly behavioristic in that success is always measured at the hand of a test performance by the student where his behaviour is measured against a prescribed norm, which determines both the success of the student and his teacher. Van Zyl contrasts this with 'onderwys', which has the aim of independent learning by the student, with the ultimate goal of imparting creative problem-solving abilities to the student. This education has to be individualized, since no two students are alike. In this respect, distance education has a great advantage over conventional education, since the former is much easier to individualise.

Van Zyl, again, as Garrison does, rates the media used, this time specifically in the Unisa context. He is critical of the almost exclusive use of the printed word as medium and points out that the alternative of the spoken word is available in the form of audio- and videocassettes, radio and television. He then specifically distinguishes those media which are interactive, such as the telephone, alone or in conference mode, videoconferencing and computer conferencing, or face to face contact, during personal interviews, group visits and discussion classes.[11] (Personally, I consider personal contact to be a vital

---

[7] This simply means it is connected to a network, by means of which one 'server' can supply the same message to many 'terminals'.

[8] Correspondingly, this means that the computer is not connected to a network, but may have the advantage of a local store of knowledge, for instance that supplied by a CD-ROM (Compact Disc Read Only Memory) drive, built in, or connected, to the computer.

[9] Unisa, October 1992.

[10] *Op cit* 133.

[11] *Op cit* 29.

adjunct to techologically-based education, in accordance with the motto 'high tech, high touch'.)

One of Van Zyl's final recommendations is for a new unit at Unisa for 'elektroniese onderwysvoorsiening' (the supply of electronic education). He also requires two main duties to be carried out by Unisa lecturing staff. In the first place, integrated multimedia course material has to be produced and in the second place, sufficient contact has to be maintained with the students. The latter may also be carried out by making use of electronic media such as video conferencing, electronic bulletin boards, etc.

It is difficult to directly superimpose Van Zyl's model upon that of Garrison, except that both of them uses the phrase 'education' to describe the desired process to be striven for, and that both of them require a degree of interaction and individualisation in this process.

The desired outcome of a legal education at Unisa

Perhaps one should stand the process on its head. If one could identify what the ideal outcome of a 'legal education' should be, one might be able to tailor the curriculum accordingly. This point is also made by JH (Roshnie)Maharaj in a recent article entitled 'The Role of the Law School in Practical Legal Training'[12] She notes, approvingly, the suggestion by instructional designers that educational design should be 'top-down'. In other words, one should do a needs assessment, from that design the curriculum goals, and from that again design the instructional objectives. In carrying out the needs assessment, one should try to find a consensus between 'the broader community affected: the public, and the performers (that is, the lawyers), the educators, and the students.'

Maharaj goes on to point out that there is a 'gap' in legal education between academy and practice and that the public are often treated as guinea pigs by beginner lawyers, learning the practical component of their profession by trial and error. This is because the educational roles are divided at the moment and 'legal education is conducted mostly in distinct stages: academic (university), vocational/practical (profession), and post-admission continuing legal education.' She then proceeds to make some very useful suggestions as to the integration of the academic and the practical components, to which I will refer again later on.

To return to the 'desired outcome' — what does the product look like which should ideally be delivered by a legal education? Maharaj lists several desired attributes of the beginner lawyer, of which my personal favourite is the one that every lawyer needs a basic knowledge base 'which will enable her to define a problem into categories for research purposes and for decisionmaking as to factual and legal issues needing proof and argument.' In addition, the lawyer needs to be able to find (specific) legal information

[12] (1984) 111 *SALJ* 328 *ff*.

'because law teachers cannot cover everything their students will need to know in practice, in terms of subject-matter, and because the field is so vast that it cannot be remembered anyway.'

In other words, our students need a basic knowledge base, some kind of ability to categorise and/or systematise, as well as the ability to find relevant information. The latter ability may seem to be stricly for academics, but I am of the opinion that a practicing lawyer operates in the same way (although his source of information might be a colleague, a golf pal who is highly placed in government or even his deeds typist, and not the library, as it is for most academics.)

Is our present law faculty geared towards delivering the above outcomes?

From hard personal experience, I have found that imparting even the basic knowledge base is very hard if a student does not share the vocabulary or even the language which is used to convey this information. In the first place the student finds it very hard to grasp concepts expressed in strange terminology and, even if he has grasped these, to express himself and prove this grasp to others. Although we could simplify the language of our study guides to some extent, the student still needs to be empowered to handle real life one day (where language is not always simplified), and I should therefore like to add a basic 'legal language literacy' module to the study package.

Although everybody agrees that a lawyer needs to reason in a logical fashion, hard personal experience has also taught me that not all law students are able, for instance, to follow syllogisms,[13] recognize false analogies, or use the *reductio ad absurdum* effectively. The study guide for the Law of Evidence, at Unisa, contains the following phrases, for instance:

> Stated in general terms, one fact is relevant to another when a logical connection exists between them.

(If a student does not fully grasp the meaning of 'logical connection', he therefore also fails to grasp one of the basic principles of evidence, namely relevance.)

and

> ...(W)here a criminal judgment is inadmissible in subsequent civil proceedings. It seems illogical, because the standard of proof is higher in a criminal trial.

(This statement should serve as an excellent test to verify whether a particular student has a grasp of logic, and if he does not yet have it, it should serve equally well as a mechanism to explain it to him.)

I should therefore like to add a module in 'legal logic' to the study package, illustrated, of course, with legal applications.

Close to my heart is the requirement that we should teach students how to

---

[13] Plato is a man. All men are mortal. Therefore Plato is mortal.

find information for themselves. This includes teaching them how to make use of modern retrieval techniques such as computer databases, catalogues, abstracts etc., many of which are today available either on-line of off-line.[14] I am of the opinion that a lawyer who is not able to handle these modern sources of information competently, will soon be at a disadvantage against another lawyer who is able to do so. Yet we do very little to impart these skills during the course of a law degree. A post-graduate course on the researching of CD-ROM databases was mooted at Unisa a couple of years ago, but withered upon a lack of understanding. Interpersonal skills towards the obtaining of relevant information from persons, (interviewing a prospective witness productively, for instance) should also be integrated into the course. Here video and other modern media, could be used to good effect.

How do we learn?

In a recent work, *The way they learn*,[15] Cynthia Ulrich Tobias emphasises the fact that everyone does not have the same learning style, and that learners should therefore not all be approached in the same manner. (This fits in rather well with distance education, which is more amenable to an individualised approach than conventional education.)

Basing her approach on the work done by the American psychologist, Anthony F Gregorc, she explains that there are two different ways in which people take in information and that because of these two styles of perception, namely *concrete* perception, and *abstract* perception, students have different learning *styles*.[16] The group in which concrete perception is dominant, prefer taking in information by means of their five senses, namely sight, smell, touch, taste and hearing. (This group should therefore be happier in a face to face situation with their lecturer, would prefer doing an oral examination to a written one, would prefer group work to studying alone at home, and so forth.) The second group, in which abstract perception is dominant, has a greater ability to visualize in the abstract, to conceive ideas and to believe in concepts which they can never really see, or feel. (This group should therefore be much happier studying in the present Unisa context, where most knowledge is conveyed impersonally by means of printed study guides, to be used by individual students, studying alone at home. In actual fact, however, even part of this group is dependent on visual cues which are only obtained by interacting with other persons, where they can 'read between the lines', note body language, and so on).

According to Gregorc, once the information has been taken in, one may again differentiate between two groups, according to the way in which each group *orders* or *systematises* what they they have been exposed to.[17] The group

[14] See footnotes 7 and 8 above for a brief explanation of these concepts.
[15] Focus on the Family Publishers, Colorado Springs, (1994).
[16] *Op cit* 14–15.
[17] *Op cit* 16.

which prefers to use *sequential* ordering, organises the information in a linear,[18] step-by-step, logical fashion. (This is the method we have inherited from the Greeks and Romans and upon which our Western science has been built. It is difficult for some sequential thinkers to take non-sequential, or random, thinkers at all seriously, because the latter are categorised as being 'unscientific'). The second group prefers to use *random* ordering, which means that their minds organise in larger chunks of meaning, and out of sequence, experimenting with something for fit in one place after the other, without first reducing possible poor fits by clinically logical elimination. (This is a method more popular outside the mainstream of Western thought, and makes one more sympathetic to black claims that most of our South African universities are Euro-centric).

If one now takes all of Gregorc's groupings and systematise the four different combinations, we find that each person has an individual learning *style*, which may be categorised as follows.

The first combination is the 'concrete sequential' (CS)[19], whom Tobias describes with adjectives such as 'hardworking, conventional, accurate, stable, dependable, consistent, factual, organised'. The second is the 'abstract sequential' (AS), described as 'analytic, objective, knowledgeable, thorough, structured, logical, deliberate, systematic.' The third combination, the 'abstract random' (AR), is seen as 'sensitive, compassionate, perceptive, imaginative, idealistic, sentimental, spontaneous, flexible' and the fourth combination, the 'concrete random' (CR), who is 'quick, intuitive, curious, realistic, creative, innovative, instinctive, adventurous.'[20]

When one looks at the learning preferences of these four different styles, one realises that many learning problems may have been the result of teachers and educators not having individualised sufficiently in the past. In fact, the whole trend has been towards centralising and standardising everything (even education) in the name of efficiency.[21] Let us take a brief look at the needs, likes and dislikes of the different styles.

For instance, according to Tobias, a CS prefers working systematically, looking closely at detail, knowing exactly what is expected and establishing routine ways of doing things. He hates working in groups (interesting to bear in mind during discussion classes!), working with abstract ideas, demands to 'use your imagination' and questions with no right or wrong answers (he should

---

[18] Following one line of thought, sequentially, from beginning to end.

[19] Coming to knowledge in a more concrete fashion, as explained above, and then organising that knowledge in a sequential fashion.

[20] Tobias *op cit* 19.

[21] Van Zyl (and others) refer to the 'factory model' of education, but I think the person who has most penetratingly exposed this 'centralize everything' as part of the 'Second Wave' way of thinking has been Alvin Toffler, in his work *The Third Wave* (Pan Books 1980). The 'Third Wave' represents the electronic, 'high tech' revolution, superseding the industrial 'Second Wave', which in turn superseded the rural 'First Wave', where all influence was based on the ownership of land.

therefore do well with most multiple choice questions.)

The AS, on the other hand, is very appreciative of logical reasoning, needs a teacher who is well informed on the subject and likes living in the world of abstract ideas (sounds like the academic ideal!) What they do not enjoy, is not having enough time to deal with a subject thoroughly (again a problem to handle during discussion classes), expressing their emotions, being diplomatic when convincing someone else of their point of view and not monopolizing a conversation about a subject that interests them.

Students of the AR style prefer personalising learning (therefore seemingly not being ideal candidates for distance education), work preferably with very broad, general principles, participate enthusiastically in projects which they believe in, and they often decide with the heart and not with the head. They dislike having to compete[22], giving exact, minute detail, accepting even positive, well-meant criticism (not ideal for the Socratic method, therefore), and focussing exclusively on one thing at a time. (Group discussions and personal contact is therefore a much greater need for this learning style than for the others).

Finally, the CR often uses insight and instinct to solve problems, prefers using real-life experiences to learn and often try out something for themselves, rather than taking your word for it. (The latter two characteristics of this style could be an advantage for practitioners studying at a distance, since some of the academic knowledge gained can immediately be tried out in practice.) CR's hate routine, having to keep or complete formal reports, showing exactly how they came to an answer, and having no options.

How do we remember?

Whereas Gregorc's styles show how our minds work, Tobias explains another model, illustrating how we remember information. According to this, some people memorise better when hearing and repeating the information (the *Auditory modality)*. Others prefers associations with things they see — either concretely in the shape of flash cards, for instance, or abstractly, by visualising (the *Visual Modality).* Finally there is a group who remember best when the act of memorisation is carried out in conjunction with bodily movement (the *Kinesthetic modality).*

This classification is not in contrast to Gregorc's mind styles, but should be used in conjunction with it. When working with real live people it makes the classificatory net finer, and therefore more useful. When working with AR people (who prefer group work, remember?), who are also of an Auditory

[22] A surprising discovery for me at the former Unibo (now University of the North West), was that students hated having their marks put up on the notice board, unless anonimity was guaranteed, by simply using the student number in lieu of the name.

memory modality, it might be useful to use 'rap'[23] to make some concepts stick in the mind.

It might also be useful to target this modality with audio tapes and radio broadcasts, in addition to the printed study guides. Telephone conferencing should also be more successful with this group than with some of the others.

The Visual Modality, on the other hand, seem to be ideally receptive to video-based teaching material (of which there still is a woeful scarcity at Unisa at present)[24] These students would probably also be more interested in video-conferencing, than would some of the other modalities. Outside of Unisa, a few institutes, claiming to improve memory skills, are doing quite well at present by encouraging their student to associate concepts with visualised pictures. This method would obviously be more successful with students who are strong in this particular memorising modality (the visual modality).

It may be hard for some AS academics to take the Kinesthetic Modality seriously, but it has proven to be quite effective in some Bible courses, where hand and body movement help to fix certain concepts in the mind. I have also heard a very convincing argument that theatre and dance performances should be funded and/or subsidised by universities to a greater extent than at present, since this is 'research' in a much more direct sense than by publication, for instance. The speaker used the example of the Yoruba tribe in Nigeria, where the making of mask to be used in the dancing, the pre-dance rituals and then the dance itself, form part of an intricate process of communication and getting to know oneself.

How do we understand?

Tobias explains this by making use of a model of the American psychological researcher, Herman Witkin, who was called in by the US Air Force to determine why some fully trained pilots, flying by instruments, would emerge from a fog bank flying upside down!

After some testing, Witkin distinguished two groups. The first contains people who are more independent of having an external field of vision, which he termed *analytical*, since they were able to break down information into its component parts and to focus on detail. The second group consists of people who are more field dependent, or *global*, in that they needed their external field of vision in order to orientate themselves.

It was also found, even when grasping fields other than instrument flying, that the *analytical* group were more disposed to seeing the constituent parts that make up the big picture, because they felt that one had to understand the parts in order to understand the whole. The *global* group on the other hand,

---

[23] A rythmical recitation, conveying a story or message, especially popular among black youth.

[24] Partially relieved by a Unisa-made video illustrating a typical court case, which is at present quite popular with students of the Department of Criminal Law and Procedure.

felt that the first group could not see the wood for the trees, opining that there was no point in clarifying a detail if one could not see where it fits into the big picture.

This division obviously also has implications for individualising the education of students. What works for the detail person would probably bore the 'global' out of his skull! Conversely, the detail person would probably question the conclusions of the 'global', because of his fuzzier focus on detail. The model again partially overlaps with that of Gregorc, with the analytical group probably approximating the sequential group (CS and AS) more closely, and the globals being closer to the random group (AR and CR).

Implications for Unisa.

In order to see if Gregorc's theories could be utilized at Unisa, I decided to try and delve a bit deeper into his credentials and philosophy. I found valuable information in this regard in his own work *Styles — Beyond the Basics*[25] He explains the concrete/abstract and sequential/random distinctions as follows:

> I found that human beings use two perceptual (spatial) fields for importing and exporting data. These are the concrete (physical) space and abstract (metaphysical) space. I also realised that we order events and facts in a sequential (step-by-step or branchlike) manner and in a random (web-like, multi-tiered, spiral manner. I further came to realize that individuals report more comfort, challenge, and fulfillment when in conditions that provide a particular space and ordering environment).

Surely this is a worthwhile goal that should be striven for. How is it to be carried out at Unisa, specifically? At the present moment, our written, linear study guides and little personal contact with students probably suits the AS learning style best. The logical way in which the guides are structured would reinforce this. Yet, the quotation above provides a clue as to how we may also appeal to the more random style of thinking. When Gregorc speaks of ordering facts in a 'web-like,[26] multi-tiered, spiral' manner, the possibility of using 'hypertext' leaps to mind. (Please do not stop reading at this juncture, since I will endeavour to explain 'hypertext' in the next paragraph.)

'Text' simply means text in the conventional sense, 'hyper' means 'above' in its Greek sense. Basically it comes down to the fact that you can leave the normal linear reading of a text, and at the stroke of a computer 'hot key', jump 'above', to another (related) text, or even to a picture, a map or even a videoclip.[27] The second piece of text provides for further jumps to still other (related) texts, or one may return to the first text and quietly continue reading in a linear fashion, until the next opportunity for a hypertext jump presents

---

[25] Gabriel Systems Inc Massachusetts 1985.

[26] It is significant that the hypertext way of accessing the Internet is by means of the 'World-wide Web' (WWW). This is one of the few cases where the acronym takes longer to pronounce than the full term, therefore computer scientists (who will not be deprived of their acronyms), sometimes speak of W^3!

[27] Since the latter three are not, strictly speaking, forms of text, one should rather speak of 'hypermedia', than 'hypertext'.

itself. The possibility of 'jumping' is usually indicated by one or more words on a page being in a different font, or colour, when compared to the rest of the text. One simply places the computer cursor on one of these special words and presses the appropriate key (with a mouse pointing device it is even easier.) If one gets 'lost in hyperspace' it is usually possible to return to the original starting point by simply using the 'Escape' key (rather aptly named in this instance!) In this way, one may start off with a legal article, jump to the full text of one of the decided cases referred to in the article, leap to a legal dictionary to make sure of the exact meaning of one the phrases used in the case and then 'escape' back to the original article and continue reading, a wiser (and better informed) man.

It is clear that the above procedure is only really feasible on a computer, although efforts have been made in books with 'programmed instruction' to accomplish the same purpose by means of footnotes or instructions/options to 'now go to page 15'. It is also clear, however, that this option should suit the AR and CR learners much better, since they can 'browse' at will, being led by the thread of similarity, rather than the treadmill of contiguity. I fully realise that not all Unisa students have access to computers, but the 'hypertext' and 'hypermedia' considerations should perhaps influence Unisa planners to, at least, strive for greater opportunities of access to computers by students. As I have mentioned above, Henry van Zyl has already mooted the possibility of a 'high tech' electronic education centre. Unisa has got the Sunnyside campus (and sufficient accomodation for temporary visitors on it) to consider the 'winter school' option, which might allow students, whose learning styles crave an alternative approach to learning, to visit such a centre and use the computers to be installed there. In the words of the old adage: 'If the mountain will not come to Mahomet, then Mahomet must go to the mountain.'

The preparation and fitting of such a centre will be expensive, to be sure, but I gain the impression that many computer (and other) firms will welcome the opportunity to invest money in the education of South Africa's youth, provided that it really works. If Gregorc is correct (and I think that he is at least on the right track, by individualising education), it should work. I am also predicating quite a large amount of hard work on the part of Unisa lecturers to make their work available in some alternative formats, for instance, in hypertext. Seeing that there is a major rewrite of study guides taking place at Unisa at the moment, anyway, these new considerations may as well be taken into account too.

Should this whole Sunnyside centre be set up just to give AR and CR students a chance to use hypertext? I think not. When dealing with the AR students above, I mentioned that they liked 'personalising' learning. When dealing with the CR students, I mentioned that they preferred 'finding out for themselves' and learning from real-life situations. On the present Sunnyside campus we already have the training centre of the Association of Law Societies (representing the attorneys' profession). Surely it should not be impossible to integrate some of the 'winter school' Unisa students into the activities of the

training centre? This would also provide a good opportunity for closer liaison with (and perhaps even funding from) the attorneys' profession. On the old Van der Walt street campus of Unisa (presently used by Vista University), we have the Unisa Legal Aid Centre. Surely it should not be impossible to integrate some of the 'winter school' attendees activities with those of the Legal Aid Centre? This might also provide a (partial) answer to the pleas of Roshnie Maharaj (quoted above) for a greater integration between academy and practice during the preparation of lawyers for their profession.

To return to computers. At the moment, most Unisa computers are internally connected by means of a LAN (Local Area Network), which is mainly utilised for administrative purposes. This LAN is linked to a world-wide network which enables access to the Internet. The Internet is itself an international network, mostly frequented by academics, where information is exchanged, accessed, and downloaded[28]. Recently, however, there has been talk of using the Internet for teaching purposes! In the first place, therefore, Unisa students visiting the electronic education centre on the Sunnyside campus will have the opportunity to look up relevant legal information on the network-linked computers there. In the second place, they will have the opportunity to be taught over the network, possibly even by international experts.

This gives us the opportunity to spare a thought for those many students who will not be able to make it to the Sunnyside campus. The beauty of a network is that anything which can be made available on a computer at one point, may also be made available on a computer at another point of the network. If Unisa could 'decentralise', even to the extent of only making a few supervised computers available at other centres, many of the benefits available at the electronic education centre on the Sunnyside campus would also be distributable to the other centres. Here I am thinking of possible co-operation with universities and technikons in the rest of the country, with colleges like the Police Academy in Graaff-Reinet (with which Unisa already has formal links) and so forth.

As might have been gathered above, I am a great believer in the adage 'high tech, high touch'. This means that there should be real human beings available at the computers, to do some 'hand-holding', to help to overcome technophobia and to provide feedback as to successes and weak points in the course material. Also, most importantly, to provide in the needs of the CS and CR (and even AR) learners who prefer learning by means of a human interface. On the Sunnyside campus this should not be a problem, with so many administrative and academic personnel available on the Muckleneuk campus, just across the road. At the 'decentralised' centres, Unisa will have to appoint 'tutors' to help provide the human touch. These tutors should not be scaled-down 'lecturers', but rather 'facilitators', who can help the students use the media effectively, organise discussion groups, answer basic and recurrent questions and route other questions to the proper authority on the main

[28] Saved to one's own computer.

campus. The advantage of using properly structured, modular, course material is that one can get by with a lower degree of specialised knowledge on the part of the 'tutor'.

Conclusion

What are the chances of success for these innovations at Unisa? If this question is interpreted to mean, 'will they be implemented?', I not only hope, but believe, that they will, even if not exactly in the form set out here. Unisa cannot afford to sit still, in these times, on these resources, in this specific country. Alvin Toffler, the futurologist and author of works such as *Future Shock, The Third Wave* and *Powershift,* visited South Africa during 1994 and had this to say on the prospects for the country: 'There has to be some connection between the media, computers and education'

and:

> If South Africa could find a way to crack this education problem, it could become one of the richest countries in the world. And South Africa just might have the right environment and technological background to come up with the solution.

If the question is interpreted to mean 'will they be successful in terms of better and more effective education?', I am, again, cautiously optimistic. I do not believe that computers, by themselves, are the panacaea for education which some 'techno-freaks' believe them to be. In fact, Gregorc himself seems feel that they would only appeal to the sequential type of student and that the machines do not have enough interactivity:

> The teacher who substitutes an instrument's and package's power for his own when dealing with a learner is behaving in a dehumanizing manner. Instruments and packaged prescriptions have no conscience or responsiveness in them.[29]

He is correct, of course. Computers and telecommunication equipment are simply tools, with which no university should ever attempt to eliminate human teachers. These tools can, however, accomplish a more effective use of that scarce resource — a human teacher, lecturer or professor. I disagree with the statement that computer-aided education would only appeal to the sequential type of student. It should be borne in mind that Gregorc's book was published in 1985, ten years ago at the time of writing this article. During this period, the concept of 'multimedia' has made computers much more attractive to the random type of student.

(I promise that 'multimedia' will be the last technical concept that I am going to try and explain in this article.) Originally it literally meant using 'more than one medium' in education. Van Zyl apparently uses it in this original sense, when he agrees with some quoted sources that computers, by themselves, are not sufficient and that they have to be supported by the 'traditional written

[29] *Op cit* 162.

word and other appropriate media'.[30] In the computer world, however, a 'multimedia computer' has come into being. This beast usually boasts a CD-ROM drive (faithful to my recent promise, I am not even going to try and explain that concept), a sound card, sound speakers, and often a videocard, which enables one to see video (and even television) on the computer monitor. It should be clear that this could be quite attractive to a more random type of student.

I have pleaded in this article that education be individualised, since students have different learning styles, some of which I have tried to illustrate. Even according to Gregorc, this does not mean that every student has to be tested first and then put on a certain educational track:

> I then recommend that teachers provide a rich environment for students. That is, they provide many paths to the goal. Let the learner decide for himself how to reach the goal.[31]

This seems to dovetail with a recommendation which Van Zyl also makes:

> Die feit dat RGO alleen nie vir alle leerders geskik is nie, dui dus daarop dat 'n totale multimedia elektroniese pakket aan studente voorsien moet word. Daaruit kan studente dan kies om slegs sekere komponente, of die hele pakket te ontvang.

If this development (or something similar) can start happening at Unisa, I believe that this institution has a future. If not, I would like to leave with the following quotation:

> There is at least one point in the history of any company when you have to change dramatically to rise to the next performance level. Miss that moment and you start to decline. (Andrew Gore).

[30] Van Zyl, *op cit* 150.

[31] Gregorc *op cit* 151.

HIV infection, blood tests and informed consent*

FFW VAN OOSTEN**

This article is dedicated to Sas Strauss as a much appreciated friend, promoter, confidant, adviser, colleague, fellow traveller and sharer of several common interests. The topic of the article befits the occasion in more ways than one: first, Sas's numerous and valuable contributions on the issues of consent and HIV to South African law in general and medical law in particular are a matter of record; secondly, it was my privilege to do a doctoral thesis on informed consent under his promotorship.

✡ ✡ ✡

1 INTRODUCTION

The topic under discussion, HIV infection, blood tests[1] and informed consent, involves at least three pertinent and distinct basic factual situations and corresponding medico-legal questions:

a A, a doctor, takes a blood sample from B, a patient, with B's consent. Must A inform B of a proposed HIV test where A decides upon such test either before, during or after the taking of the blood sample? In more technical terms, is informing the patient of an HIV test a requisite for his or her effective consent to the taking of a blood sample and/or performing an HIV test?

b A, a doctor, receives a laboratory test result which reveals that a patient, B, is HIV positive or HIV negative. Must A inform B accordingly? In other words, is there a duty incumbent upon the doctor to inform a patient who

*The author wishes to express his sincere gratitude to the Deutsche Forschungsgemeinschaft and Prof Dr Erwin Deutsch, Juristisches Seminar, University of Göttingen, Germany, for a research grant and a visiting professorship which enabled him to write this article.

**BA LLB (Potch) LLD (Pret) LLD (Unisa). Professor of Criminal Law and Medical Law, University of Pretoria.

[1]Milk and urine samples can also be used to detect HIV infection: see R Laufs & A Laufs 'AIDS und Arztrecht' 1987 *NJW* 2257 2263; C van Wyk AIDS: Some Medico-Legal Aspects 1991 *Med Law* 139 146. However, since procuring a milk or urine sample does not involve a medical procedure, the principles applicable to HIV milk and urine tests will coincide with those applicable to HIV blood tests only to a limited extent, notably the principles discussed under 3 *infra*; *cf* n 50 and 85 *infra*.

has been tested for an HIV infection of the outcome of the test?

c A, a doctor, administers treatment to or performs an operation upon B, a patient, which exposes B to the risk or danger of HIV infection. Must A inform B of such risk or danger? More particularly, is informing a patient, whose consent to a proposed medical intervention is sought, of the risk or danger of HIV infection during the intervention a requisite for effective consent thereto?

The present article examines these questions in terms of a variety of factual situations and considerations that come into play and with reference to medico-ethical codes of conduct, case law and legal opinion in Germany and South Africa. The topic is expounded and discussed against the backdrop of the fundamental principles of the doctrine of informed consent and the doctor's duty of disclosure.

2 THE DOCTRINE OF INFORMED CONSENT

The relevant and pertinent fundamental tenets of the so-called doctrine of informed consent, for purposes of the present exposition and discussion, may briefly be summarised[2] as follows:

a Since, generally speaking, the patient is, within the context of undergoing or refusing a medical intervention, master of his or her own life and body, the ultimate decision whether or not to subject himself or herself to a medical intervention lies with the patient and not with the doctor. Indeed, to allow doctors to perform medical interventions against their patients' will or without their consent on the basis of the doctor-knows-best and the patient's-best-interest criteria, would be tantamount to practising medical paternalism at the expense of patient autonomy.

b Hence, lawful medical interventions require, in the absence of overriding grounds of justification, such as *negotiorum gestio* or necessity, statutory authority[3] and perhaps even authorisation by the court,[4] the effective consent of the patient.

c Since effective consent is ordinarily out of the question unless the patient knows and appreciates what it is that he or she consents to, the duty will usually be incumbent upon the doctor, as an expert, to furnish the patient, as a person, with appropriate information to establish the requisite knowledge and appreciation and, hence, consent to the proposed

---

[2]For full details and copious references to authorities, see FFW van Oosten *The doctrine of informed consent in medical law* (1991) *passim*.

[3]See within the context of HIV tests VGH München 1988 *NJW* 2318, discussed by O Seewald 'Zu den Voraussetzungen der Seuchenbekämpfung durch Blutuntersuchung und Zwangsinformation' 1988 *NJW* 2921 and HU Gallwas 'Gefahrenerforschung und HIV-Verdacht' 1989 *NJW* 1516; SA Strauss 'Legal issues concerning AIDS an outline' 1988(1) *SAPM* 13; CW van Wyk *Aspekte van die regsproblematiek rakende VIGS* (LLD thesis 1991 UNISA) 259 *ff*.

[4]*Cf* within the context of compulsory HIV tests for prisoners *S v Mabachi* 1993 (2) SACR 36 (Z) 46 *ff*.

intervention.

d The purpose and function commonly attributed to the informed consent requisite are (i) to ensure the patient's right to self-determination and freedom of choice; and (ii) to encourage rational decision-making by enabling the patient to weigh and balance the benefits and disadvantages of the proposed intervention in order to come to a rational and enlightened choice whether to undergo or refuse it.

e This means that the doctor is under a duty to give the patient a general idea, in broad terms and in person's language, of the nature, scope, administration, importance, consequences, risks, dangers, benefits, disadvantages and prognosis of, as well as the alternatives to, the proposed intervention. More particularly, all serious and typical risks and dangers should be disclosed, but not unusual or remote risks and dangers, unless they are serious or the patient makes enquiries about them. At the same time, although the manner of disclosure is essentially a matter of medical discretion, doctors are expected to refrain from causing patients anxiety and distress by unnecessary disclosure of adverse diagnoses, and from scaring or frightening patients from submitting to medically indicated interventions by unnecessary disclosure of their adverse consequences.

f Failure by the doctor to procure the patient's informed consent to a medical intervention may constitute a violation of the patient's bodily integrity, a violation of the patient's autonomy/privacy, damage to the patient's physical or mental health or breach of a term of the contract between the parties, and may accordingly result in the doctor being held liable for criminal and/or civil assault, criminal and/or civil injury to personality, delictual negligence or breach of contract, as the case may be, or in the doctor being unable to recover his or her professional fee. What is more, liability for assault and injury to personality may be incurred even if the medical intervention was administered with due care and skill and eventually proves to have been beneficial to the patient.

g Whether or not disclosure of the diagnosis is obligatory, is a moot point, but it is conceivable that diagnosis disclosure is imperative where (i) it may affect the patient's decision whether or not to submit to the proposed intervention; (ii) it is an express or implied term of the contract between doctor and patient; or (iii) it is essential for therapy.

h An extended duty of disclosure is commonly recognised where (i) the patient asks questions, in which case there is a duty incumbent upon the doctor to respond both fully and truthfully to the patient's enquiries; and (ii) the patient refuses an indicated diagnostic or therapeutic intervention, in which case the doctor is under a duty to prevail upon the patient the necessity or urgency of such intervention.

i No duty of disclosure would appear to exist where (i) the patient is already in possession of the requisite information; (ii) the patient expressly or

impliedly waives his or her right to information;[5] (iii) the defence of a so-called therapeutic necessity[6] or contra-indication, in terms of which the harm caused by disclosure would be greater than the harm caused by non-disclosure,[7] is applicable; or (iv) disclosure is, in the circumstances, physically impossible.

j Without sacrificing the cardinal principles of patient self-determination and the doctor's duty of disclosure, an attempt should be made by the parties to reconcile, insofar as is possible, the doctor's ethical duty to heal and the patient's legal right to information. This can be achieved by employing the so-called shared decision-making and therapeutic alliance models, which strive towards eliminating doctor-patient conflict and distrust and towards promoting trust and confidence between the parties by means of mutual communication and cooperation.

Disclosure in terms of the informed consent requisite is known as self-determination disclosure and must be distinguished[8] from so-called therapeutic disclosure which signifies information that renders the medical intervention possible and provides the necessary preparation and support for it and which, therefore, serves the purposes of therapy.[9]

3 HIV INFECTION AND INFORMED CONSENT

3 1 Preliminary remarks

Before turning to the specifics of each of the three questions under dis-

---

[5]Which is, of course, in principle irreconcilable with the knowledge-and-appreciation requisite of effective consent, but to force unwanted information upon a patient would also constitute a violation of his or her freedom of choice.

[6]On the terminology see FFW van Oosten 'The so-called "therapeutic privilege" or "contra-indication": its nature and role in non-disclosure cases' 1991 *Med Law* 31 34 *ff*.

[7]*Eg* in terminal cancer or emphysema cases, provided there is a real conflict between the doctor's duty to inform and his or her duty to heal.

[8]Although the two may, and in certain circumstances will, overlap; *cf* 3 1 *infra*.

[9]See Van Oosten *Informed consent* 296 *ff* 439–440. The implication of this distinction is that the phrase 'duty of disclosure' has a wider meaning than the phrase 'informed consent'. 'Informed consent' usually includes a duty of disclosure but a 'duty of disclosure' does not necessarily relate to informed consent. This is further borne out by the fact that doctors may, depending upon the circumstances, be under a duty to disclose the fact that the patient is HIV infected to sex partners (*cf* *Gemeinsame Hinweise und Empfeblungen der Bundesärztekammer und der Deutschen Krankenbausgesellschaft zur HIV-Infektion* (hereafter *BäK & DKG*) (1988) 15; Medical Association of South Africa *Guidelines for the Management of HIV/AIDS* (hereafter MASA) (1992) 10; South African Medical and Dental Council *The Management of Patients with HIV Infection or AIDS* (Revised Guidelines) (hereafter SAMDC) (1992) 8; BGH 1991 *NJW* 1948, discussed by E Deutsch 1991 *NJW* 1937) and health care workers (*cf* BäK & DKG VII and 17 ff; College of Medicine of South Africa Management of HIV-positive Patients (Policy Statement) (hereafter CMSA) 1991 *SAMJ* 688 689; MASA 9–10; SAMDC 10; StA Aachen 1989 *DRiZ* 20 21; *Jansen van Vuuren v Kruger* 1993 (4) SA 842 (A)), or in terms of a statutory duty (as opposed to statutory authority), a court order, a disciplinary hearing or an emergency situation. The scope of the present article is restricted to the duties of self-determination disclosure and therapeutic disclosure.

cussion, two aspects concerning the interrelation between the three questions on the one hand and the foregoing remarks on informed consent on the other need to be canvassed:

a Both self-determination disclosure and therapeutic disclosure appear to be relevant to all the questions under discussion:

   i Informing the patient of the proposed HIV test will not only primarily protect his or her autonomy but may also, should the patient turn out to be HIV infected, serve the secondary purpose of therapy.

   ii Informing the patient of an HIV diagnosis will not only primarily serve the purpose of his or her therapy, but may also contribute towards an autonomous decision on subsequent medically indicated interventions and conduct as a secondary consequence.

   iii Informing patients of the danger of HIV infection during medical interventions will enable them to make an enlightened choice either to undergo or forego the proposed intervention on the one hand, and to weigh and balance the risk of HIV infection against the necessity and urgency of, and alternatives to, the proposed intervention on the other, and may thus, at one and the same time, serve the purposes of patient autonomy and patient therapy.

b The risks and dangers inherent in HIV infection seem to be relevant to all the questions under discussion. Although HIV infection, within the context of medical interventions, is hardly likely ever to become the norm, even in health care systems which leave much to be desired, it is common knowledge that HIV infection is never less than potentially lethal. Generally speaking, therefore, HIV infection falls within the ambit of the risks and dangers that patients who consider subjecting themselves to medical interventions should, in terms of the informed consent requisite, be apprised of.[10] Analogous reasoning[11] would seem to justify the conclusion that at least a potentially HIV infected patient[12] and a tested HIV infected patient[13] should likewise, under ordinary circumstances, be informed thereof.

3 2 Informed consent to blood tests and/or HIV tests

As regards the issue of informed consent to blood tests for HIV infection, the factual and legal possibilities may be divided into three broad categories:

---

[10]Case c, referred to *supra*; *cf* W Weissauer 'Bluttransfusion und AIDS — mediko-legale Aspekte' 1987 *MedR* 272 273; CW van Wyk 'VIGS en bloedoortappings: enkele regsaspekte' 1992 *De Jure* 23 29–30 37; the text to n 136 and 137 *infra*.

[11]*Cf* the doctor's contractual and delictual duty of care.

[12]Case a, referred to *supra*; *contra* SA Strauss 'Must a patient be informed that a blood sample will be tested for HIV?' 1989 (1) *SAPM* 6–7: see 3 2 4 a *infra*.

[13]Case b, referred to *supra*.

a The patient grants his or her (informed)[14] consent to an HIV test before or during the taking of the blood sample by the doctor. The viewpoint that this is what is required for a lawful HIV test enjoys substantial *de lege lata*, *de lege ferenda* and medico-ethical support. Probably the most controversial issues here are whether or not the defences of implied consent and therapeutic necessity are applicable, and whether the legal interest violated by a failure to procure the patient's (informed) consent is the patient's physical integrity or his or her autonomy/privacy or both.

b The doctor decides to have the patient's blood tested for HIV infection, and subsequently takes a blood sample with the patient's informed consent to the procedure and its inherent risks and dangers, but without the patient's (informed) consent to the HIV test. The viewpoint that this is sufficient for a lawful HIV test enjoys considerable *de lege ferenda* support. However, whether or not such conduct by the doctor qualifies as a violation of the patient's personality rights, as opposed to a violation of his or her bodily integrity, is somewhat contentious.

c The doctor decides to have the patient's blood tested for HIV infection subsequent to having taken a blood sample from the patient. The legal debate in this case centres on the legal interest violated by such conduct.

Moreover, a differentiation may be made in these three situations between three purposes[15] for which the HIV test are performed:

i Where the HIV test is performed for the benefit of the patient. This will, for example, be the case where AZT treatment may be administered successfully and urgent action is indicated,[16] where AIDS dementia is suspected and a blood sample is diagnostically important,[17] where the patient suffers anxiety and distress for fear of HIV infection and where the patient stands to gain something (employment or insurance) from a negative test result, to mention but a few.

ii Where the HIV test is performed for the benefit of others. This will be the case where the patient poses a potential source of infection for other persons, for example an embryo or fetus, medical practitioners,

---

[14]For an explanation of '(informed)' in this context see 3 2 1 *infra*.

[15]Since HIV tests for purposes of gathering scientific data are neither in the interests of the patient nor for the benefit of others, they fall outside the scope of the present article. Suffice it to say there appears to be unanimity among authorities that lawful HIV tests for purposes of gathering scientific data require the patient's informed consent: G Solbach & T Solbach 'Zur Frage der Strafbarkeit einer Venenpunktion zum Zwecke einer "routinemässigen" Untersuchung auf "AIDS"' 1987 *JA* 298 300; Laufs & Laufs 1987 *NJW* 2263; H Janker 'Heimliche HIV-Antikörpertests — Strafbare Körperverletzung?' 1987 *NJW* 2897 2900; H Herzog 'Die rechtliche Problematik von AIDS in der Praxis des niedergelassenen Arztes' 1988 *MedR* 289 290; FP Michel 'Schmerzensgeldanspruch nach heimlichem AIDS-Test?' 1988 *NJW* 2271 2277; J Langkeit 'Ärztrechtliche Probleme im Zusammenhang mit AIDS-Tests' 1990 *Jura* 452 454; Van Wyk *Aspekte van VIGS* 156 *ff*.

[16]*Cf* Langkeit 1990 *Jura* 458 n 74; Van Wyk 1991 *Med Law* 144.

[17]*Cf* Van Wyk 1991 *Med Law* 144.

other health care workers, sex partners, fellow patients, fellow employees, blood recipients, relatives, colleagues and clients.[18]

iii Where the HIV test is performed for the benefit of both the patient and others. This will be the case where elements of both i and ii are present.

A combination and integration of the aforementioned possibilities and purposes form the framework within which the often divergent and sometimes conflicting medico-ethical, *de lege lata* and *de lege ferenda* solutions to the problems under discussion are expounded and evaluated.

3 2 1 HIV test in patient's interest with (informed) consent

Depending upon the nature of the contract or communication between doctor and patient, the issue of HIV tests and informed consent is, to some extent, either problematic or unproblematic:

a Relatively unproblematic cases[19] of HIV tests and informed consent are the following:

i Where the patient specifically asks the doctor for a comprehensive medical check-up because of a health complaint or as a precautionary measure. Here the patient's tacit consent[20] will, in terms of the contract between the parties, cover all tests, including an HIV test, that are medically indicated.[21]

ii Where the patient specifically asks the doctor to determine the cause of a disease that presents symptoms of an unspecific nature or symptoms which are difficult to diagnose, but which point to the possibility of an HIV infection. Here the patient's tacit consent will, again, in terms of the contract between the parties, cover all medically indicated tests,

---

[18]Van Wyk *Aspekte van VIGS* 161 n 191 also mentions laboratory technicians and undertakers.

[19]See also HIV tests for purposes of gathering scientific data, referred to in n 15 *supra*.

[20]*Ie* tacit consent to serological tests, but express consent to the procedure involved.

[21]BäK & DKG IV(2) and 13, in terms of the implied consent and therapeutic privilege defences and on the basis (a) that the requisite medical report would be incomplete without reference to the patient's HIV status; (b) that '[a]uch in den Ausnahmefällen, in denen von einer stillschweigenden Einwilligung des Patienten in den HIV-Test ausgegangen werden kann, ist ein behutsam und schonend geführtes Aufklärungsgespräch dennoch sinnvoll' (IV(2)); and (c) that the reasons for non-disclosure are properly documented; WH Eberbach 'Heimliche AIDS-Tests' 1987 *NJW* 1470; Laufs & Laufs 1987 *NJW* 2263; G Solbach & T Solbach 1988 *JA* 114 115; *cf* T Brandes 'AIDS: Test und Einwilligung' 1987 *VersR* 747 748; Herzog 1988 *MedR* 290; E Deutsch 'Rechtsprobleme von AIDS: HIV-Test — Infektion — Behandlung — Versicherung 1988 *VersR* 533 535; *cf*, however, E Buchborn 'Ärztliche Erfahrungen und rechtliche Fragen bei AIDS' 1987 *MedR* 260 263, who requires disclosure of an HIV test to a healthy patient who asks the doctor for a comprehensive medical check-up; *contra* Langkeit 1990 *Jura* 454.

including an HIV test.[22]

iii Where the patient specifically asks the doctor for an HIV test. Here the performance of an HIV test is an express term of the diagnosis contract between the parties and, hence, covered by the patient's express consent. Moreover, since the initiative for conducting an HIV test comes from the patient, the patient's consent will not be dependent upon the doctor informing him or her of such test. Indeed, the patient's request to perform an HIV test renders the doctor's duty to inform the patient of such test non-existent.

iv Where the patient specifically asks the doctor whether or not an HIV test is intended. Here the patient must be told the truth.[23]

As regards cases i and ii, however, the proviso has been advocated that if the doctor senses or expects reservations on the patient's part about a possible HIV test or if the doctor entertains doubt about consent on the patient's part to an intended HIV test, he or she is under a duty to consult or question the patient about the matter.[24]

Moreover, cases i, ii and iii highlight the correlation between informing a patient of an HIV test on the one hand and express or tacit consent to such test on the other. In contradistinction to the impression gleaned from the court cases and legal literature, express consent to an HIV test does not necessarily imply informing the patient of such test, nor does tacit consent to an HIV test necessarily imply not informing the patient of such test. Case iii clearly illustrates an instance of express uninformed consent to an HIV test, while cases i and ii clearly illustrate instances of tacit uninformed[25] consent to an HIV test. However, it goes without saying that the patient's oral or written consent may also and will often be preceded by informing the patient of an HIV test (express informed consent). Likewise, informing

[22]BäK & DKG IV(2) and 13, again in terms of the defences of implied consent and therapeutic privilege; M Bruns 'AIDS, Alltag und Recht' 1987 *MDR* 353 355; A Laufs & H Narr 'AIDS — Antworten auf Rechtsfragen aus der Praxis' 1987 *MedR* 282: 'Der Arzt ist als Folge der Übernahme der Behandlung nicht nur dazu berechtigt, sondern auch dazu verpflichtet, alle medizinisch indizierten diagnostischen Massnahmen zu ergreifen'; Eberbach 1987 *NJW* 1470; Laufs & Laufs 1987 *NJW* 2263; Solbach & Solbach 1988 *JA* 115; Herzog 1988 *MedR* 290; Langkeit 1990 *Jura* 454; *cf* Buchborn 1987 *MedR* 263; Brandes 1987 *VersR* 748; Deutsch 1988 *VersR* 535. The notion that so-called high risk groups, such as drug addicts, homosexuals and prostitutes (to which, incidentally, haemophiliacs, bisexuals, the sexually promiscuous and blood recipients may be added) are AIDS suspects and therefore need not be informed of an HIV test is rejected by Langkeit 1990 *Jura* 454; see also FP Michel 'Forum: Aids-Test ohne Einwilligung — Körperverletzung oder Strafbarkeitslücke?' 1988 *JuS* 8 12; *cf*, however, Laufs & Narr 1987 *MedR* 282. In this context it may be observed that in Africa AIDS is predominantly a heterosexual disease.

[23]*Cf* Deutsch 1988 *VersR* 535; Van Wyk 1991 *Med Law* 145.

[24]Laufs & Laufs 1987 *NJW* 2263.

[25]Which does not necessarily mean lack of knowledge and appreciation of the possibility of an HIV test, for the patient may be an expert himself or herself or may have acquired knowledge and appreciation elsewhere.

the patient of an HIV test can be followed by conduct intimating consent[26] thereto (tacit informed consent). Thus although consent will of necessity be express or tacit and informed or uninformed, the distinction between express and tacit consent on the one hand and informed and uninformed consent on the other should not be obscured by creating the impression that express consent and informed consent are synonymous or that tacit consent and uninformed consent are synonymous.

b Largely problematic are cases of HIV tests and informed consent in which a specific request by the patient to perform serological tests or an enquiry by the patient about an HIV test is lacking. Authority for the view that a lawful HIV test in these circumstances requires the patient's informed consent has its origin in medico-ethical codes of conduct, case law and legal opinion. The point of departure is that since the taking of a blood sample from a patient constitutes a medical intervention and, hence, *prima facie* a violation of the patient's physical integrity, the patient's informed consent is usually required to render the taking of the blood sample lawful.[27] Where the blood sample is taken for purposes of an HIV test, this means that the patient must both be informed thereof and consent thereto, and that a failure by the doctor to procure the patient's informed consent to an HIV test may render him or her liable for criminal and/or civil assault.[28]

---

[26]Such as subsequently allowing the taking of a blood sample without explicitly consenting either orally or in writing.

[27]StA beim KG 1987 *NJW* 1495 1496, discussed by Sonnen BR 1987 *JA* 461–462; StA Mainz 1987 *NJW* 2946 2947; Laufs & Laufs 1987 *NJW* 2263; Janker 1987 *NJW* 2899–2900; Brandes 1987 *VersR* 748; Herzog 1988 *MedR* 290; Van Wyk 1991 *Med Law* 143 145.

[28](*Rechtswidrige Körperverletzung*): BäK & DKG IV(1), adding: (a) 'Bei der Aufklärung sollte der Situation des Patienten und der möglichen Tragweite des Testergebnisses Rechnung getragen werden'; and (b) that informed consent to HIV tests must be properly documented but that information and consent forms will not serve as a substitute for a doctor-patient conversation (12–13); MASA 6 7 8; SAMDC 3 7–8, adding (a) that poster displays to inform patients of possible HIV tests must be supplemented by a verbal discussion between doctor and patient; and (b) that the patient must also be informed of the purpose of the HIV test, its advantages and disadvantages, the doctor's reasons for wanting the information, the influence of the test result on the patient's treatment, any alteration of the patient's medical protocol by the information and the psychological impact of an HIV diagnosis; 'AIDS Consortium Charter of Rights on AIDS and HIV' 3.1 1993 *SAJHR* 162, except in the case of unlinked, anonymous epidemiological screening programmes; StA beim KG 1987 *NJW* 1495 1496: 'Jeder ärztliche, zu Heilzwecken vorgenommene Eingriff bedarf einer besonderen Rechtfertigung um die ... sonst vorliegende Rechtswidrigkeit der Integrität des Körpers berührenden Massnahme auszuschliessen. Gerechfertigt wird der Eingriff u.a. durch die Einwilligung des Patienten ... die in der Regel ausdrücklich oder stillschweigend zu erklären ist ... Diese Grundsätze gelten auch für Blutentnahmen ... wobei es keinen Unterschied macht, ob die zum Zwecke einer allgemeinen — routinemässigen — oder einer differentialdiagnostischen Untersuchung vorgenommen werden. Die Einwilligung wird ihrem Umfang nach nicht allein vom Inhalt des Heilbehandlungsvertrages bestimmt. Sie setzt vielmehr grundsätzlich eine ärztliche Aufklärung über Art und Zweck der Untersuchung voraus'; StA Mainz 1987 *NJW* 2946–2947 (criticised by Solbach & Solbach 1988 *JA* 115), which, however, deviates from the principles enunciated in the foregoing quotation in two important respects, namely (a) by requiring *express*

The reasons advanced for this view, which incidentally fails to differentiate between informed consent to the taking of a blood sample and informed consent to an HIV test, are the following:

i Although the taking of a blood sample for purposes of serological tests, inclusive of an HIV test, without informing the patient of the intended HIV test, will constitute no more than a relatively minor violation[29] of the patient's bodily integrity, the very nature and consequences of an HIV test render it a matter of the utmost importance for the patient.[30] Factors such as the public awareness; the social and professional opprobrium, isolation, distrust and prejudice; the impact upon privacy; the anxiety and distress; the personality changes; the possibility of suicide; the incurability of AIDS; and the fatal consequences associated with an HIV diagnosis, negative the contention that HIV tests are routine and covered by the notion of tacit consent.[31] This argument is, how-

---

information about and consent to HIV tests; and (b) by declaring the requisite of informed consent to HIV tests inapplicable to medically indicated *routine* tests which do not entail drastic consequences for the patient's physical integrity and lifestyle; Sonnen 1987 *JA* 462; Bruns 1987 *MDR* 355: 'Die allgemeine Zustimmung eines Patienten in eine Untersuchung und Blutentnahme deckt einen zusätzlichen HIV-Antikörpertest grundsätzlich nicht mit ab'; Buchborn 1987 *MedR* 263; Eberbach WH 'AIDS und Strafrecht' 1987 *MedR* 267 271-272; Brandes 1987 *VersR* 748; Herzog 1988 *MedR* 290; GJ Knobel 'Medicolegal issues in caring for people with HIV infection' 1988 *SAMJ* 150 151; J Burchell 'AIDS and the law — II' 1990 *BML* 255, except where the patient has AIDS dementia; Langkeit 1990 *Jura* 453; E Cameron 'Human rights, racism and AIDS: the new discrimination' 1993 *SAJHR* 22 24; M Figueira 'AIDS, the Namibian Constitution and human rights' 1993 *SAJHR* 30 31–32; *cf* CMSA 1991 *SAMJ* 689; AG Mölln 1989 *NJW* 775 776; Laufs & Narr 1987 *MedR* 282 and Laufs & Laufs 1987 *NJW* 2263, who regard an HIV test without the patient's informed consent as a violation of his or her personality rights, more particularly his or her freedom of choice (*informatielle Selbstbestimmungsrecht*); JL Taitz 'Testing for HIV infection without the surgical patient's consent' 1993 *CME* 79 *ff*.

[29]StA Mainz 1987 *NJW* 2946 2947, in which the court conceded that an HIV test 'unterscheidet sich in nichts von sonstigen Venenpunktionen. Das Blut für den Aids-Test wird durch einen einheitlichen Eingriff zusammen mit dem Blut gewonnen, das für die Durchführung einer routinemässigen bzw auch differentialdiagnostischen Zwecken dienenden Blutuntersuchung erforderlich ist'; StA Aachen 1989 *DRiZ* 20; *contra* Sonnen 1987 *JA* 461. *Cf* further AG Mölln 1989 *NJW* 775 776 and AG Göttingen 1989 *NJW* 776 777, in which it was held that since performing a secret HIV test on a blood sample voluntarily taken from the patient constitutes a minor infringement of his personality rights, the patient could not succeed in an action for sentimental damages (*Schmerzensgeld*) which requires a serious violation of personality rights; see also Michel 1988 *NJW* 2271 *ff*, who points out that this applies irrespective of whether the outcome of the HIV test is positive or negative, but who is critical of the *de lege lata* position (2277); *contra* Langkeit 1990 *Jura* 453 *ff*, who rejects these decisions on the basis that the violation of physical integrity was in the circumstances neither trivial, nor was the violation of personality rights undeserving of sentimental damages.

[30]4 BäK & DKG 12; StA Mainz 1987 *NJW* 2946 2947; Sonnen 1987 *JA* 462; Langkeit 1990 *Jura* 453; *cf* Eberbach 1987 *NJW* 1471; Laufs & Laufs 1987 *NJW* 2263.

[31]StA Mainz 1987 *NJW* 2946 2947, with reference to medical respect for the patient's freedom of choice within the context of his or her personality rights: '[Der Patient] allein muss abwägen und entscheiden können, ob er sich überhaupt einer Blutentnahme zum Zwecke eines Aids-Testes stellen soll'; Bruns 1987 *MDR* 355; Langkeit 1990 *Jura* 453 ff: 'Angesichts alle [die] Auswirkungen, die *zumindest*

ever, not quite convincing:

aa Without losing sight of the causal nexus that may[32] exist between an HIV test and an HIV diagnosis, the majority of the factors enumerated appear to relate to the latter rather than to the former. In terms of the considerations mentioned, therefore, the problem, strictly speaking, seems to be whether or not an HIV *diagnosis* rather than whether or not an HIV *test* should be disclosed to the patient.

bb Barring such factors as the very real social and professional opprobrium, isolation, distrust and prejudice, and the impact upon privacy, these considerations are equally applicable to other incurable and terminal illnesses. It would therefore appear to be society's response to the AIDS disease and the ideological pursuits of afflicted groups rather than the medical implications of AIDS which sets it apart from other incurable and terminal illnesses.

cc Preferential treatment of HIV tests as opposed to other serological tests, defeats the object of normalising and destigmatising AIDS. In fact, it is worth noting that the logical concomitant of informed consent to HIV tests, namely an equally strong plea for informed consent as a requisite for other serological tests, particularly where they also relate to serious, incurable, terminal and contagious diseases, is conspicuously absent in the present context.

dd It is expressly admitted that the taking of a blood sample involves a minor physical intervention and it is tacitly conceded that serological tests other than HIV tests need not be disclosed to the patient for his or her effective consent to the taking of a blood sample. Yet the subsequent performance of an HIV test intended at the time of taking the blood sample is sufficiently serious to justify legal liability for assault. This raises the question whether the assault perpetrated by way of a secret HIV test is serious or trivial and, accordingly, whether a heavy penalty should be imposed and/or substantial damages awarded or a light sentence and/or nominal damages. Regarding the assault as trivial would fly in the face of the supposed serious nature and consequences of an HIV test. Regarding the assault as serious would fly in the face of the supposed trivial nature of the physical intervention. If the assault is

---

potentiell und durchaus *vorhersbebar* mit dem Aids-Test verbunden sind, ist ... zu fordern, dass der Patient über einen beabsichtigten Aids-Test aufgeklärt wird und seine ausdrückliche Einwilligung in die Durchführung des Tests erteilt' (453); *cf* Knobel 1988 *SAMJ* 151; *contra* Solbach & Solbach 1988 *JA* 115. It is interesting to note that in StA beim KG 1987 *NJW* 1495 1496 the court referred to factors such as personality changes, the danger of suicide, the incurability of AIDS and the fatal consequences associated with an HIV diagnosis to substantiate its finding that the defences of therapeutic privilege and implied consent were applicable.

[32]Bearing in mind a negative outcome and false negatives.

considered to be serious *because* it involves a secret *HIV* test this would, again, amount to preferential treatment of HIV tests at the expense of normalising and destigmatising AIDS. If the assault is considered to be trivial because of the minor physical intervention involved, this could diminish the legal sanction for and promote the medical practice of performing secret HIV tests. Whatever the stance taken, coupling secret HIV tests to the notion of legal liability for assault, generally speaking, makes little sense.

ii Since an HIV diagnosis will not enable the doctor to administer life-saving treatment, the patient should have the right to refuse an HIV test.[33] The validity of this argument is also not above suspicion:

aa It is dependent upon all other laboratory tests conducted in ascertaining the presence or absence of all other incurable and terminal diseases also requiring the patient's informed consent. Otherwise it is not an underlying principle but the name and nature of the disease in question that determine whether or not the disclosure of a laboratory test is obligatory.

bb As stated, it ignores the interests of others whose health and lives may depend upon the performance and outcome of a medically indicated HIV test. The patient may sometimes, but will often not, be the only person affected by the performance and outcome of an HIV test.

iii Insisting upon informed consent to HIV tests will promote the patient's trust and confidence and encourage patients to report for HIV tests.[34] The trust-and-confidence part of the argument will, again, only be valid if the same can be said to apply to all other laboratory tests conducted in ascertaining the presence or absence of all other incurable and terminal diseases. Similarly, the encourage-to-report part of the argument will only be valid if the same can be said of all other dangerous and infectious diseases.

Apart from the ethical and legal recognition of the general principle requiring patients' informed consent to HIV tests, an obligation on the doctor to inform the patient of an HIV test has also been advocated in the following specific circumstances:

a Where the patient is depressed and expresses the fear that he or she may have AIDS.[35]

---

[33]*Cf* StA beim KG 1987 *NJW* 1495 1496; StA Mainz 1987 *NJW* 2946 2947; Sonnen 1987 *JA* 461; Bruns 1987 *MDR* 355; Van Wyk 1991 *Med Law* 146; *contra* Solbach & Solbach 1988 *JA* 116.

[34]Eberbach 1987 *MedR* 271; *cf* StA Mainz 1987 *NJW* 2946 2947; Laufs & Laufs 1987 *NJW* 2263; Van Wyk 1991 *Med Law* 146; *contra* G Solbach & T Solbach 'Zur Frage der Aufklärung der Patienten bei Blutentnahmen (AIDS)' 1988 *MedR* 241–242.

[35]Strauss 1989(1) *SAPM* 7.

b Where the patient pertinently refuses a medically indicated HIV test. Although such refusal must be respected,[36] the doctor is expected to prevail upon the patient the necessity of performing such test.[37] If the patient persists in his or her refusal, the doctor should advise the patient to seek a second opinion.[38] Where the patient's continued refusal renders medically indicated diagnosis and treatment impossible or endangers health care workers, the doctor may[39] refuse further to attend to the patient.[40]

It must be pointed out, however, that while the German courts have been fairly consistent[41] in their adherence to the fundamental principle that an HIV test requires the patient's informed consent, their decisions on the defences to the general rule are conflicting in some respects and unanimous in others. On the one hand, some cases have pertinently recognised implied consent[42] and therapeutic privilege[43] as defences to the taking of a blood sample for purposes of an HIV test without the patient's express consent,[44] while others have explicitly rejected these defences.[45] On the other hand, lack of fault on the doctor's part has, in the initial decisions requiring the patient's informed consent to an HIV test, consistently resulted in his acquittal on charges of assault where the doctor, on account of the prevailing legal uncertainty and medical controversy, honestly and mistakenly believed the taking of a blood sample without informing the patient of the intended HIV

[36]StA Aachen 1989 *DRiZ* 20 21; Laufs & Laufs 1987 *NJW* 2263; Brandes 1987 *VersR* 748; Solbach & Solbach 1988 *JA* 116.

[37]Laufs & Laufs 1987 *NJW* 2263; Herzog 1988 *MedR* 290.

[38]Van Wyk 1991 *Med Law* 146.

[39]After having dealt with the case in a spirit of compassion and understanding and after having made every effort to avoid an impasse: Van Wyk 1991 *Med Law* 146; *cf* CMSA 1991 *SAMJ* 689.

[40]BäK & DKG IV(3) and 13–14; CMSA 1991 *SAMJ* 689; Solbach & Solbach 1987 *JA* 300; Laufs & Narr 1987 *MedR* 282; Laufs & Laufs 1987 *NJW* 2263; R Simon-Weidner 'AIDS-Test im Krankenhaus und in der ärztlichen Praxis' 1988 *ArtztR* 151 153; Langkeit 1990 *Jura* 454; *cf* Deutsch 1988 *VersR* 536. In the present context, the following statements by MASA are difficult to reconcile: 'The policy of "no test, no operation" is seen to be coercive, and nullifies freedom of consent' (7) and: 'If the patient is unwilling to consent to a simple investigation necessary for accurate diagnosis, the doctor is free to terminate the relationship' (8).

[41]The exception being StA Aachen 1989 *DRiZ* 20 21.

[42]*Mutmassliche Einwilligung*.

[43]Also referred to as an *ärztliches Fürsorgeprinzip* or *Schonungsgrundsatz*.

[44]StA beim KG 1987 *NJW* 1495 1496, in which the accused was acquitted on a charge of assault on the basis of, *inter alia* these two defences; see also BäK & DKG IV(2) and 13; Brandes 1987 *VersR* 748, who regards implied consent as a defence to an HIV test where the patient consults the doctor about a complaint and consents to the taking of a blood sample for purposes of therapy; Deutsch 1988 *VersR* 535; *contra* Eberbach 1987 *MedR* 272, on the facts of the case.

[45]StA Mainz 1987 *NJW* 2946, in which the court, while rejecting the decision in StA beim KG 1987 *NJW* 1495 in this regard, held that (a) the therapeutic privilege defence was inapplicable because of an absence of the requisite conflict of interests which characterises the defence; and (b) the implied consent defence was inapplicable because the patient was, at the time of the taking of the blood sample, capable of consenting to an HIV test (2946); see also Sonnen 1987 *JA* 462; Solbach & Solbach 1988 *JA* 115; Van Wyk *Aspekte van VIGS* 148 n 38.

test to be lawful.[46] However, the pertinent recognition of informed consent as a requisite for lawful HIV tests by these initial decisions, renders a successful future mistake of law defence on the same basis difficult[47] to imagine.

3 2 2 HIV test for the benefit of others with (informed) consent

There is considerable support for the view that an HIV test carried out for the benefit of others requires[48] the patient's informed consent[49] for the following reasons: (a) Others, and not the patient, will benefit from the proposed HIV test;[50] (b) appropriate precautionary measures[51] against HIV infection may be taken in the health care setting;[52] and (c) HIV tests are not completely reliable.[53]

Moreover, the opinion has been expressed that a fraudulent HIV test performed for the benefit of the doctor or health care workers may result in the doctor being convicted of assault on the basis that a fraudulent failure to inform the patient of the HIV test vitiates his or her consent thereto[54] in the following circumstances: (a) Where the doctor fraudulently takes a blood sample solely for purposes of an HIV test while treating the patient for another

---

[46]StA beim KG 1987 *NJW* 1495 1495–1496, StA Mainz 1987 *NJW* 2946 2947–2948 and StA Aachen 1989 *DRiZ* 20 21-22, in which the accused were acquitted on the basis of (in StA beim KG and StA Aachen, *inter alia*) unavoidable error; see also Sonnen 1987 *JA* 462; Eberbach 1987 *MedR* 272.

[47]*Cf*, however, StA Aachen 1989 *DRiZ* 20 21.

[48]In the absence of situations in which necessity will operate as a defence, such as where hospital personnel are exposed to the risk of HIV infection and an HIV test (eg prior to an operation or subsequent to body fluid contact with the patient) is the only way of averting the danger: Van Wyk *Aspekte van VIGS* 161 *ff*; *cf*, however, Eberbach 1987 *NJW* 1472, Janker 1987 *NJW* 2902–2903 and Herzog 1988 *MedR* 291, who are sceptical about the application of the necessity defence in this context; *contra* Langkeit 1990 *Jura* 454, who denies the application of the necessity defence in this context.

[49]Eberbach 1987 *MedR* 271-272; Laufs & Narr 1987 *MedR* 282; Laufs & Laufs 1987 *NJW* 2263; Janker 1987 *NJW* 2902; Michel 1988 *JuS* 12; Herzog 1988 *MedR* 291; Langkeit 1990 *Jura* 454; *cf* Van Wyk 1991 *Med Law* 147.

[50]Laufs & Narr 1987 *MedR* 282; Eberbach 1987 *NJW* 1471, since the HIV test does not serve the purposes of patient therapy; Laufs & Laufs 1987 *NJW* 2263, since the HIV test is not based upon the patient's wishes and the symptoms presented, adding that the same applies where the patient is a blood donor or a milk donor; Janker 1987 *NJW* 2902, in the absence of a medical indication or ground of justification; Langkeit 1990 *Jura* 454; *cf* Michel 1988 *NJW* 2273; Van Wyk 1991 *Med Law* 147.

[51]For detailed lists of precautionary measures see CMSA 1991 *SAMJ* 689–690; MASA 13 *ff*; SAMDC 6 13 *ff*; *cf* n 48 *supra*.

[52]Eberbach 1987 *NJW* 1472; Janker 1987 *NJW* 2902–2903; Michel 1988 *JuS* 12; Herzog 1988 *MedR* 291; Langkeit 1990 *Jura* 454; *cf* Van Wyk 1991 *Med Law* 147; *cf*, however, Bruns 1987 *MDR* 355.

[53]Especially during the so-called 'window period': *cf* Michel 1988 *NJW* 2273; Van Wyk 1991 *Med Law* 147.

[54]See also Laufs & Laufs 1987 *NJW* 2263; Herzog 1988 *MedR* 291; Deutsch 1988 *VersR* 535.

disease;[55] and (b) where the doctor fraudulently makes use of a blood sample, the taking of which was medically indicated, to perform an additional HIV test.[56]

3 2 3 HIV test for patient's and others' benefit with (informed) consent
Obviously and logically, supporters of the view that an HIV test in the patient's interest requires his or her informed consent, will also require the patient's informed consent for an HIV test for the benefit of others and, hence, also for an HIV test for the benefit of both the patient and others. This will apply irrespective of whether the legal interest violated by an HIV test without the patient's informed consent is considered to be his or her physical integrity or his or her personality rights or both.

3 2 4 HIV test in patient's interest without (informed) consent
There is substantial *de lege ferenda*, as opposed to *de lege lata* and medico-ethical, authority for the view that the patient's informed consent is not a requisite for a lawful HIV test. The reasons[57] advanced for this view are the following:

a Doctors are required to inform their patients of the general nature of the proposed medical procedure and of any substantial risks or dangers attached to it. The medical procedure in question is the taking of a blood sample for medically indicated serological tests[58] which involves no substantial risks or dangers.[59] Hence, only the taking of a blood sample requires the patient's informed consent, which means that the patient need not be informed of a proposed HIV test.[60] Since in the circumstances

---

[55]Eberbach 1987 *NJW* 1471; Michel 1988 *JuS* 11–12, on the basis that a medical indication for the HIV test is lacking.

[56]Eberbach 1987 *NJW* 1471: The doctor's liability for criminal assault rests on the assumption that the patient's consent to the taking of the blood sample and the HIV test is indivisible; however, should the patient's consent be regarded as divisible and, consequently, the taking of the blood sample as lawful (justified by the patient's consent) and the performance of the HIV test as unlawful (because of the doctor's fraud), an action for the violation of the patient's freedom of choice will lie (1471–1472); *cf* Herzog 1988 *MedR* 291.

[57]Which sometimes overlap to some extent.

[58]StA Aachen 1989 *DRiZ* 20 21; Janker 1987 *NJW* 2900; Michel 1988 *JuS* 10; *cf* Solbach & Solbach 1988 *JA* 115 116; Van Wyk 1991 *Med Law* 145; BE Leech 'The right of the HIV-positive patient to medical care' 1993 *SAJHR* 39 66–67.

[59]Since the pain and risks or dangers associated with the taking of a blood sample are currently common knowledge, merely informing the patient of the fact that a blood sample will be taken from him or her will suffice for purposes of effective consent to the procedure: Solbach & Solbach 1987 *JA* 299–300; Van Wyk *Aspekte van VIGS* 146.

[60]StA Aachen 1989 *DRiZ* 20–21: 'Bei Blutentnahmen, die bei einer ärztlichen Behandlung zu diagnostischen oder therapeutischen Zwecken dienen sollen, ist ein Arzt nicht gehalten, über die Einzelheiten der Untersuchung aufzuklären ... [Es bedarf einer besonderen Aufklärung hinsichtlich eines neben zahlreichen anderen Laboruntersuchungen beabsichtigten HIV-Tests nicht, wenn dieser medizinisch indiziert und ein entgegenstehender Wille des Patienten nicht erklärt ist' (21); Solbach & Solbach 1987 *JA* 298 *ff*; Janker 1987 *NJW* 2900; Simon-Weidner 1988

under discussion the procedure of taking a blood sample involves a voluntary physical intervention with the patient's knowledge and appreciation, this argument has considerable substance[61] when answering the question whether or not a violation of the patient's bodily integrity has occurred where a secret and intended HIV test is subsequently carried out. However, since a physical intervention is not essential[62] for a violation of the patient's privacy or freedom of choice, this argument has little substance when answering the question whether or not a secret and intended HIV test constitutes a violation of the patient's personality rights.

b Doctors routinely take blood samples without informing their patients of all or any conditions for which they are to be tested and the same principle should prevail in cases of intended HIV tests.[63] The doctor, in his or her discretion, decides which serological tests are necessary in accordance with the symptoms presented.[64] This argument clearly rests on the assumption that HIV tests are routine, which they are currently not.[65]

c Where the doctor decides upon an HIV test *after* having taken a blood sample from the patient, the patient's consent to the taking of the blood sample is not thereby vitiated. To regard the patient's consent to the taking of the blood sample as being vitiated where the doctor decides upon an HIV test *before* taking a blood sample from the patient is tantamount to a *contradictio in terminis*.[66] Although this argument loses sight of the fact that in the latter situation, as opposed to the former, the doctor had the opportunity to procure the patient's consent to the HIV test before taking

---

ArztR 152; Michel 1988 *JuS* 9 10; Hll Lesch 'Die strafrechtliche Einwilligung beim HIV-Antikörpertest an Minderjährigen' 1989 *NJW* 2309 2311–2312; Strauss 1989(1) *SAPM* 6–7; Van Wyk *Aspekte van VIGS* 147, unless the patient wishes to refuse an HIV test, in which case he or she should inform the doctor accordingly; Leech 1993 *SAJHR* 67, who emphasises the element of mutual trust and honesty between doctor and patient.

[61]Unless, of course, the patient made his consent to the physical intervention conditional upon being informed of the nature of the serological tests intended or upon the non-performance of certain serological tests.

[62]Although, of course, a physical intervention may be part and parcel of a violation of personality rights.

[63]StA Aachen 1989 *DRiZ* 20 21; Solbach & Solbach 1987 *JA* 299; Janker 1987 *NJW* 2900: 'Für [den Patienten] ist ... nicht entscheidend, was später mit dem Blut geschieht, sondern allein massgeblich ob jetzt eine Blutentnahme erforderlich ist oder nicht'; Simon-Weidner 1988 *ArztzR* 152; Michel 1988 *JuS* 10–11, who denies an absence of objectively effective consent to the taking of a blood sample even where the patient subjectively proceeded from the assumption that no HIV test would be performed; Strauss 1989(1) *SAPM* 7; Van Wyk *Aspekte van VIGS* 515–516; Leech 1993 *SAJHR* 66; *contra* Langkeit 1990 *Jura* 453 n 18.

[64]StA Aachen 1989 *DRiZ* 20 21; Solbach & Solbach 1987 *JA* 299; Michel 1988 *JuS* 10; Leech 1993 *SAJHR* 67; *cf* Simon-Weidner 1988 *ArztzR* 152.

[65]See also Eberbach 1987 *MedR* 272, who sees the solution to the problem of secret HIV tests in HIV tests eventually becoming routine; Van Wyk 1991 *Med Law* 144 146.

[66]Michel 1988 *JuS* 9–10, particularly where the doctor fails to perform the intended HIV test: 'mit dem Abschluss der Blutentnahme [ist] der Eingriff in die körperliche Unversehrtheit beendet.'

the blood sample, it does bring to the fore that, if anything, it is the patient's personality rights rather than his or her bodily integrity which are violated by secret HIV tests.

d The indicated and requisite medical procedure to determine the diagnosis of the patient's complaint is, in terms of the contract to treat the patient, not a matter of patient self-determination, but one of medical responsibility. Hence, a blood sample may be taken from the patient without informing him or her of an intended HIV test.[67] The weakness of this argument lies in the fact that it opens the door to diagnostic surgery without the patient's informed consent.

e Reasonable patients need not be informed about the nature and scope of all intended laboratory tests because such information is irrelevant to the procedure and risk or danger of taking a blood sample.[68] Should the individual patient want to know more about the proposed tests, he or she is free to ask questions about them.[69] This argument (i) proceeds from the assumption that the only legal interest concerned in determining the lawfulness or unlawfulness of secret HIV tests is the patient's physical integrity; (ii) fails to substantiate its claim relating to the information needs of reasonable patients in respect of serological tests with supporting empirical data; and (iii) appears to adopt as its standard of disclosure a completely objective reasonable patient (that is the reasonable patient *in abstracto*) rather than the more correct[70] subjectively qualified reasonable patient in the individual patient's position (that is the reasonable patient *in concreto*).

f What ordinary patients want to know, when they consult doctors, is the state of health they are in. Consent to the taking of a blood sample and medically indicated[71] serological tests to determine the patient's state of health will therefore usually imply consent to an HIV test.[72] In fact, a failure by the doctor to perform all the necessary serological tests to arrive at a correct diagnosis and treatment may attract legal liability for negli-

---

[67]Solbach & Solbach 1988 *MedR* 242, who emphasise the doctor's responsibility towards the patient and a relationship of trust and confidence between the parties.

[68]StA Aachen 1989 *DRiZ* 20 21; Solbach & Solbach 1987 *JA* 300; Janker 1987 *NJW* 2900; Lesch 1989 *NJW* 2312: 'Information über Art und Umfang der vorgesehenen Laboratoruntersuchungen gehören weder zur Verlaufserklärung noch im eigentlichen Sinne zur Risikoaufklärung.'

[69]Solbach & Solbach 1987 *JA* 300.

[70]See Van Oosten *Informed consent* 429 *ff*.

[71]*Eg* by symptoms pointing to HIV infection: Van Wyk 1991 *Med Law* 145; *cf* Michel 1988 *NJW* 2271–2272 2277, who concedes, however, that in the absence of a medical indication, the taking of a blood sample for purposes of an HIV test may, as an exception to rule, constitute criminal assault; *contra* Strauss 1989(1) *SAPM* 7: '[I]t makes no difference to the consent issue whether or not the doctor actually suspects AIDS.'

[72]Deutsch 1988 *VersR* 535.

gence.[73] Should the individual patient express the wish to be informed of an HIV test, however, the doctor is under a duty to inform him or her accordingly.[74] Again, there is no effort to substantiate this argument by supporting empirical data on the wishes of ordinary patients and no indication that the ordinary patient refers to the ordinary patient in the individual patient's position.

g Prudent patients would wish to know whether or not they are HIV infected. Being aware of the infection will enable them to take appropriate steps to protect their own interests and to avoid spreading the infection.[75] Besides apparently adopting the completely objective prudent patient standard of disclosure, this argument tends to overlook the fact that the individual patient can be *encouraged* but not *forced* to make a rational and enlightened decision.[76]

h Doctors should refrain from unnecessarily scaring or frightening their patients by disclosing a suspicion of HIV infection, since this may cause harm to sensitive patients.[77] Indeed, it would hardly be commendable beside manners for a doctor who suspects incurable cancer in a patient to inform the patient at the very first consultation that he or she will be examined for cancer and the same can be said to hold true for a suspicion of HIV infection.[78] Except for its wide formulation, which does not cater for circumstances where disclosure of a cancer examination or an HIV test might be required, indicated or appropriate at the very first consultation, this argument has the merit of exposing the demerits of merciless disclosure. It highlights the conflict of interests that may in given circumstances arise between causing harm of one kind (damage to the patient's physical and/or mental health) by disclosure of an HIV test and causing harm of another kind (violation of patient autonomy and/or privacy) by non-disclosure of an HIV test.

i The doctor's duty to inform the patient of an HIV test becomes operative not at the time of taking a blood sample from the patient, but once an HIV

---

[73]StA Aachen 1989 *DRiZ* 20 21; Simon-Weidner 1988 *ArztzR* 152; *cf* Solbach & Solbach 1988 *MedR* 241.

[74]Deutsch 1988 *VersR* 535.

[75]Simon-Weidner 1988 *ArztzR* 153; G Solbach & T Solbach 'Zur Frage der Regelung ärztlicher Verantwortung durch Verwaltungsanordnungen' 1989 *MedR* 225 226, who point out that it is, for therapeutic reasons, also important for the doctor to know whether or not the individual patient is HIV infected; *contra* Langkeit 1990 *Jura* 458.

[76]See Van Oosten *Informed consent* 438–439; *cf* n 116 and 126 *infra*.

[77]Laufs & Narr 1987 *MedR* 282 and Laufs & Laufs 1987 *NJW* 2263, in respect of 'ungesicherte, unsichere, nicht erwiesene oder unbestätigte Verdachtsdiagnosen'; Solbach & Solbach 1988 *MedR* 241; *cf* Simon-Weidner 1988 *ArztzR* 152; Deutsch 1988 *VersR* 535; Leech 1993 *SAJHR* 67.

[78]Strauss 1989(1) *SAPM* 7; *cf* Lesch 1989 *NJW* 2311.

test has rendered a positive result.[79] The problem with this argument is that it confuses and identifies two separate and distinct issues with one another, to wit (i) the doctor's duty to inform the patient of an *intended* HIV test; and (ii) the doctor's duty to inform the patient of the *outcome* of an HIV test.

j It is not the HIV test but an HIV diagnosis which spells grave consequences for the patient.[80] Apart from failing, again, to differentiate between the obligation to disclose an intended HIV test and the obligation to disclose the outcome of an HIV test, this argument tends to ignore (i) the relationship of cause and effect between an HIV test and an HIV diagnosis; (ii) the psychological impact of the inevitable time lapse between the two on the patient; and (iii) the duty of the doctor to disclose the outcome of a secret HIV test.[81]

k AIDS should be destigmatised and normalised in the eyes of the world. It should be dealt with on the same footing as other serious, incurable, terminal and contagious diseases, the fear and diagnosis of which also cause pain and suffering.[82] This is probably the strongest argument in support of HIV tests becoming routine wherever medically indicated.

Some authorities take the matter further and regard consent to the taking of a blood sample as legally effective for purposes of criminal assault even where the doctor fraudulently makes use of a blood sample,[83] the taking of which is medically indicated, to perform an HIV test after having given the patient the assurance that no HIV test will be carried out or after having been pertinently refused permission to carry out an HIV test. The stance taken is that real consent to the HIV test will be vitiated only where the doctor misleads or deceives the patient about a material element of the proposed intervention, such as the nature of the medical intervention (the taking of a blood sample) or the nature of the legal right involved (bodily integrity).[84]

Moreover, it is interesting to note that some of the authorities who are of the opinion that the taking of a blood sample[85] without informing the patient of an intended HIV test does not amount to a violation of the patient's bodily integrity, do concede that such conduct may be tantamount to a violation of

---

[79]Janker 1987 *NJW* 2900 2901; Lesch 1989 *NJW* 2311; Leech 1993 *SAJHR* 66–67; *cf* Michel 1988 *JuS* 10.

[80]Solbach & Solbach 1988 *JA* 115; *cf* Janker 1987 *NJW* 2900.

[81]On which see 3 3 f *infra*.

[82]*Cf* Van Wyk 1991 *Med Law* 145; Solbach & Solbach 1987 *JA* 300.

[83]Lesch 1989 *NJW* 2312: 'Die Enttäuschung erfolgt hier nicht wegen des Eingriffs in die Körperintegrität, sondern wegen des Umgangs mit der Sache Blut.'

[84]Janker 1987 *NJW* 2901–2902; Michel 1988 *JuS* 11–12; *cf* Van Wyk 1991 *Med Law* 145–146.

[85]Or a urine sample: Van Wyk 1991 *Med Law* 146; this will presumably also include a milk sample.

the patient's personality rights,[86] such as his or her freedom of choice or right to privacy.[87] However, this view is sometimes alleged to be somewhat problematic because:

a A violation of personality rights will be dependent upon the existence, at the time the HIV test was carried out, of an HIV infection in the patient.[88]

b The harmful consequences, such as social and professional ostracism which may result from an HIV test, will usually not be attributable to the doctor,[89] but to the disease itself and society's response to it.[90]

c The cause of the patient's troubles is the HIV infection, not the HIV diagnosis which would in any event sooner or later have come to the patient's attention.[91]

These problems appear to be more imaginary than real: The *cause* of the impairment of the patient's privacy or freedom of choice within the present context is the *performance* of a secret HIV test, rather than the *outcome* (and more particularly a positive outcome) of a secret HIV test and society's *response* to it, which are *consequences* of an HIV test. Besides, an impairment of the patient's privacy or freedom of choice by means of a secret HIV test is quite conceivable where the test (as opposed to the taking of a blood sample) is performed against his or her express wishes, and a negative outcome shows the patient not to have been HIV infected at the time the test was carried out.

3 2 5 HIV test for the benefit of others without (informed) consent

There is some support for the view that since there is no risk or danger inherent in the blood test itself, there is no need to inform the patient of an

---

[86] *Cf* the distinction drawn by Deutsch 1988 *VersR* 534 in this context between informed consent to (a) the medical procedure as such; (b) its inherent risks and dangers; and (c) an *Ausforschung* into the *Persönlichkeitssphäre*.

[87] (*Intimsphäre des Patienten*): Janker 1987 *NJW* 2898 2900; Michel 1988 *JuS* 10 12–13, who points out that the erroneous emphasis on the patient's physical integrity as the protected legal interest in cases of secret HIV tests obscures the patient's freedom of choice as the real legal interest deserving of criminal and civil law protection; Lesch 1989 *NJW* 2311 2312; Van Wyk *Aspekte van VIGS* 155 516; *cf* Eberbach 1987 *NJW* 1471; Leech 1993 *SAJHR* 67, where the HIV test was not medically indicated; *cf*, however, StA Aachen 1989 *DRiZ* 20 22, in which the accused was, because of an absence of unlawfulness, (also, apart from assault,) not convicted of *Beleidigung*; Solbach & Solbach 1987 *JA* 299; Langkeit 1990 *Jura* 455 *ff*, who expresses the opinion that an HIV test without the patient's informed consent not only constitutes a violation of the patient's bodily integrity, but also a violation of his or her personality rights (freedom of choice and right to privacy) and a professional error (*ärztlicher Behandlungsfehler*).

[88] Van Wyk 1991 *Med Law* 147.

[89] Provided the doctor does not breach his or her duty of confidentiality towards the patient: Van Wyk 1991 *Med Law* 147.

[90] Van Wyk 1991 *Med Law* 147; *cf* Eberbach 1987 *NJW* 1471.

[91] Van Wyk 1991 *Med Law* 147; *cf* Eberbach 1987 *NJW* 1471.

HIV test even where such test is performed for the benefit of others.[92]

3 2 6 HIV test for patient's and others' benefit without (informed) consent

Obviously and logically, supporters of the view that an HIV test for the benefit of others does not require the patient's informed consent, will also not require the patient's informed consent for an HIV test in his or her own interest and, hence, also not for an HIV test for the benefit of both the patient and others.[93] Of course, this will only apply where an HIV test for the benefit of others without the patient's informed consent is considered to be neither an infringement of bodily integrity nor an infringement of personality rights. Where an HIV test performed in the patient's interest or for the benefit of others without the patient's informed consent is considered to be a violation of his or her personality rights, but not a violation of his or her physical integrity, the position will be the same, *mutatis mutandis*, as in paragraph 3 2 3.

3 2 7 Subsequent decision to perform HIV test in patient's interest

Where the doctor decides to perform a secret HIV test in the patient's interest[94] subsequent to having taken a blood sample with the patient's consent, no legal liability for assault will attach because the requisite consent to the violation of physical integrity (the taking of a blood sample) has been granted prior[95] to the decision to perform the HIV test.[96] Nevertheless such conduct will constitute a violation of the patient's personality rights and may, therefore, result in legal liability on that basis.[97]

3 2 8 Subsequent decision to perform HIV test for the benefit of others

Where the doctor decides upon a secret HIV test for his or her own benefit subsequent to having taken a blood sample with the patient's consent, the view taken is, again, that a conviction for assault is out of the question, but

---

[92]Solbach & Solbach 1988 *JA* 116, who emphasise the anxiety and distress suffered by health care workers who have to attend to patients without knowing whether or not they are HIV infected (115); Strauss 1989(1) *SAPM* 6, by endorsing the view that '[a] positive result may produce *grave social consequences*, but there is no risk of grave physical consequences in the blood test as such' (emphasis supplied); *cf* StA Aachen 1989 *DRiZ* 20 21.

[93]Leech 1993 *SAJHR* 67 takes the view that involuntary HIV tests may be performed in the obstetrical and surgical contexts if in the interests of both the patient and the doctor.

[94]*Eg* for therapeutic purposes: Janker 1987 *NJW* 2899.

[95]*Dolus subsequens* being insufficient for criminal liability: Eberbach 1987 *NJW* 1471; Janker 1987 *NJW* 2899; Michel 1988 *JuS* 9; Van Wyk 1991 *Med Law* 146.

[96]Janker 1987 *NJW* 2899 2901; Michel 1988 *JuS* 9; Herzog 1988 *MedR* 291; Lesch 1989 *NJW* 2312; Langkeit 1990 *Jura* 456; *cf* Van Wyk 1991 *Med Law* 146.

[97]Herzog 1988 *MedR* 291; Langkeit 1990 *Jura* 456, irrespective of whether the outcome of the HIV test is positive or negative.

that an action for an infringement of personality rights will lie.[98]

3 2 9 Subsequent decision to perform HIV test for the patient's and others' benefit

Obviously and logically, where the doctor decides to perform a secret HIV test for the benefit of both the patient and others, the position would be the same, *mutatis mutandis*, as in paragraphs 3 2 7 and 3 2 8.

3 2 10 Mixed cases and the benefit criterion

Thus far the opinions discussed were to the effect either that an HIV test performed for the benefit of the patient and/or others requires the patient's informed consent or that it does not. However, the intricacies and subtleties of the criterion whose interest is served by an HIV test become apparent in the mixed view cases where one considers performing an HIV test in the patient's interest without his or her informed consent as permissible but requires the patient's informed consent for performing an HIV test for the benefit of others.[99] Since one and the same act of taking a blood sample and/or performing an HIV test may be done for the benefit of both the patient and others, the question arises whether such a mixed view would treat such test as lawful or unlawful for purposes of a violation of the patient's bodily integrity and/or personality rights.

If, on the one hand, consent were to be regarded as divisible,[100] one could argue that the patient's tacit consent covers an HIV test in his or her own interest, but not an HIV test for the benefit of others. However, this would lead to the *contradictio in terminis* that one and the same taking of a blood sample and/or performance of an HIV test could at one and the same time, for purposes of a violation of one and the same legal interest, be both lawful and unlawful. If, on the other hand, consent were to be regarded as indivisible, the question arises how one decides whether the doctor's conduct was lawful or unlawful. Here one could argue that the lawfulness or unlawfulness of the doctor's conduct may be determined by looking at the primary and secondary interest served by the HIV test. If the HIV test were to be performed primarily

---

[98]Eberbach 1987 *NJW* 1471, who points out that the courts may, however, refuse to award sentimental damages in these circumstances (*cf* n 29 *supra*) and thus contribute to doctors claiming that they decided on an HIV test only after having taken a blood sample from the patient, and to patients' being 'zwar nicht de jure rechtlos, aber de facto schutzlos'; Michel 1988 *JuS* 9; *cf* Laufs & Laufs 1987 *NJW* 2263, who point out that where a subsequent HIV test is performed without the patient's consent, the doctor would be under a contractual duty of care to inform the patient of an HIV diagnosis: 'dem Patient geschähe, was ihm ohne seinen audrücklich oder schlüssig erklärten Willen gerade nicht widerfahren durfte'; Herzog 1988 *MedR* 291.

[99]The converse mixed view where one considers performing an HIV test for the benefit of others without the patient's consent as permissible but requires the patient's informed consent to performing an HIV test in his or her own interest, is unlikely to muster support, unless the circumstances are out of the ordinary, eg where the patient is deceased and an HIV test would benefit others.

[100]*Cf* n 56 *supra*.

in the patient's interest, it would be lawful, whereas if the HIV test were to be performed primarily for the benefit of others, it would be unlawful. However, this approach leaves unsolved those cases in which no primary and secondary interests can be identified.

In short, while the criterion whose interest is served may sometimes be a useful guideline in dealing with the issue of secret HIV tests, it certainly is not without its problems.

3 3 The duty to disclose the outcome of an HIV test to the patient

A duty on the doctor to inform the patient of the outcome[101] of an HIV test[102] has been recognised[103] in the following instances:

a Where the patient specifically requests the performance of an HIV test[104] or the disclosure of an HIV diagnosis. Here the doctor's obligation to disclose the test result arises from the contract[105] entered into by the parties.[106]

b Where the doctor has undertaken to treat the patient and treatment requires disclosure[107] of an HIV diagnosis. Here the doctor's obligation to disclose the test result arises from the contract to treat[108] the patient.[109]

c Where no mention has been made of an HIV test by either the doctor or the patient. Here the doctor's obligation to disclose the diagnosis is based on a so-called legal duty to rescue, the necessity of counselling[110] the patient

---

[101]It hardly needs any mention that a negligently erroneous diagnosis or a negligent failure to disclose an HIV diagnosis may render the doctor legally liable for consequent damages suffered by the patient and/or others: SA Strauss *Doctor, patient and the law* (1991) 307; Van Wyk *Aspekte van VIGS* 365 *ff* 368–369 521.

[102]Regardless of whether the outcome is positive or negative: Laufs & Laufs 1987 *NJW* 2264; SA Strauss 'Testing for AIDS: consent issues' 1990(4) *SAPM* 13 15; Van Wyk *Aspekte van VIGS* 363–364, particularly to accommodate false positive and false negative tests and the window period.

[103]See also BäK & DKG V(1), which stipulates that (a) such duty must be performed by a medical practitioner and not by other health care workers; (b) a doctor-patient conversation cannot be substituted by information and consent forms; and (c) '[d]ie Aufklärung muss in einer für den Patienten behutsamen and verständlichen Weise erfolgen'; E Deutsch 'Aids und Blutspende' 1985 *NJW* 2746; M Teichner 'Nochmals: AIDS und Blutspende' 1986 *NJW* 761; Buchborn 1987 *MedR* 263; Solbach & Solbach 1988 *JA* 115; R Simon-Weidner 1989 *ArztR* 178 179; *cf* SAMDC 8; Laufs & Laufs 1987 *NJW* 2263 2264; Janker 1987 *NJW* 2900–2901; Burchell 1990 *BMJ* 255 and Leech 1993 *SAJHR* 67, who make mention of a *right* on the patient's part to, as opposed to a *duty* on the doctor's part of, disclosure of the outcome of an HIV test.

[104]*Eg* for purposes of a second opinion: Deutsch E 1988 *NJW* 2306 2307.

[105]*Diagnosevertrag.*

[106]Deutsch 1988 *NJW* 2307; Strauss 1989(1) *SAPM* 7; Van Wyk *Aspekte van VIGS* 361.

[107]'Mit der gebotenen Schonung': Deutsch 1988 *NJW* 2307.

[108]*Behandlungsvertrag.*

[109]Deutsch 1988 *NJW* 2307; Langkeit 1990 *Jura* 458.

[110]*Beratungspflicht.*

and the protection of both the patient's and society's interests.[111]

d Where the patient is likely to refuse essential and important medical treatment if an HIV diagnosis is withheld.[112]

e Where the HIV test was performed with the patient's express or tacit consent. Here the doctor is under a duty to disclose the test result, regardless of whether the outcome is positive or negative.[113]

f Where the HIV test was performed without the patient's consent.[114] However, a difference of opinion exists as to what should be disclosed to the patient. One view is that the doctor is obliged to inform the patient of the HIV diagnosis itself.[115] Another view is that the doctor is merely obliged to inform the patient that an unlawful test was *performed*, and that the doctor's duty to disclose the test *result* is dependent upon the patient's wish to be informed accordingly, regardless of whether the outcome is positive or negative.[116]

g Where a routine HIV test is performed as in the case of compulsory statutory procedures[117] or blood,[118] tissue, gametes or milk donations.[119]

h Where the patient is a pregnant woman.[120] Here the patient should be informed of the risk of HIV infection to the child to be born, of the danger to her health posed by the continuation of the pregnancy and of the alternative option of a therapeutic or eugenic abortion.[121]

Whether or not non-disclosure by the doctor to the patient of an HIV diagnosis may in given circumstances[122] be justified by therapeutic necessity

---

[111]Strauss 1989(1) *SAPM* 7; Van Wyk 1991 *Med Law* 147.

[112]Deutsch 1988 *NJW* 2307.

[113]Langkeit 1990 *Jura* 458.

[114]Laufs & Laufs 1987 *NJW* 2263 (*cf* n 98 *supra*); Langkeit 1990 *Jura* 458–459; Strauss 1990(4) *SAPM* 15; Van Wyk *Aspekte van VIGS* 362 521, who takes the view that the same applies where the HIV test was performed against the patient's wishes.

[115]Van Wyk *Aspekte van VIGS* 362 521.

[116]Langkeit 1990 *Jura* 458–459, on the basis that forcing unwanted information upon the patient would be irreconcilable with his or her right to self-determination and that this option is the lesser of two evils for the doctor; *cf* MASA 9.

[117]Strauss 1990(4) *SAPM* 13.

[118]SA Strauss 'Legal liability for transfusion of AIDS virus by means of blood transfusion' 1991(3) *SAPM* 16 18; Van Wyk *Aspekte van VIGS* 208–209.

[119]Van Wyk *Aspekte van VIGS* 197 208–209.

[120]See also Deutsch 1985 *NJW* 2746.

[121]WH Eberbach 'Juristische Probleme der HTLV-III-Infektion (AIDS)' 1986 *JR* 230 233 234; Laufs & Laufs 1987 *NJW* 2264; Solbach & Solbach 1989 *MedR* 226; Van Wyk 1991 *Med Law* 147–148. Section 3(1)(a), (b) and (c) of the South African Abortion and Sterilisation Act 2 of 1975 and paragraph 218a(1)2 and (2)1 of the German *Strafgesetzbuch* specifically cater for lawful therapeutic abortion to protect the life and physical and mental health of the pregnant woman and the physical and mental health of the child to be born.

[122]'Die umfassende Aufklärung sollte der Regelfall sein': BäK & DKG 15.

or contra-indication, is a matter on which opinions differ.[123] On the one hand there is authority for the view that there is a duty incumbent upon doctors to avoid causing psychological harm to their patients by unnecessary disclosure of HIV diagnoses.[124] Breach of this duty may result in legal liability on the basis of a professional error.[125] On the other hand there is authority for the view that non-disclosure of an HIV diagnosis where disclosure would cause the patient anxiety or distress cannot, on account of the serious threat posed by AIDS to both the patient and others, be justified by the defence of therapeutic necessity or contra-indication.[126] The patient should be informed of an HIV diagnosis for purposes of taking possible prophylactic measures; changing his or her lifestyle; following a healthy diet; leading a responsible life; organising his or her personal affairs timeously; devising ways and means to avoid spreading the disease; and dealing with the deterioration of his or her mental health as the disease progresses.[127] Nevertheless, the doctor should, without making the disease seem better or worse, attempt to alleviate the anxiety and distress the patient experiences when confronted with the prospect of suffering and death, physical and mental deterioration and social and professional ostracism, and should carefully assess the patient's reactions and take precautionary measures, particularly where a possibility of suicide or depression exists.[128]

---

[123] *Cf* BäK & DKG V(2), which stipulates that a medical practitioner who considers withholding an HIV diagnosis from the patient on psychological grounds, must bear in mind that doing so may result in further HIV infections (see also 15).

[124] Irrespective of whether the diagnosis is correct or erroneous: see OLG Köln 1988 *NJW* 2306.

[125] OLG Köln 1988 *NJW* 2306, endorsed by Deutsch 1988 *NJW* 2307 and Simon-Weidner 1989 *ArtztR* 179, but criticised by S Setsevits 'Schadenersatzpflicht des Arztes wegen Mitteilung einer nicht endgültig gesicherten HIV-Infektion an den Patienten' 1989 *MedR* 95–96.

[126] Teichner 1986 *NJW* 761: 'Bei einer Abwägung zwischen den Interessen des betreffenden infizierten Patienten und der von ihm ausgehenden Infektionsgefahr überwiegt das Interesse am Schutz einer Vielzahl Dritter gegenüber dem Interesse des einzelnen Patienten'; Buchborn 1987 *MedR* 263–264, who concedes, however, that, generally, the patient's *Informationsrecht* should not, in cases of waiver, be turned into an *Informationszwang* except, perhaps, where the patient was a blood recipient and the blood donor subsequently turns out to have been HIV infected, because of a lack of opportunity to ask the patient, prior to the HIV test, whether or not he or she wishes to be informed of the test result; Laufs & Laufs 1987 *NJW* 2264; Langkeit 1990 *Jura* 458–459; Van Wyk *Aspekte van VIGS* 361 *ff* 521; *cf* VGH München 1988 *NJW* 2318 2319–2320; Strauss *Doctor, patient and the law* 16–17, who advocates a duty to disclose an HIV diagnosis even where the patient has expressed the wish not to be informed, on the basis that 'the interest of other members of society who might be infected by the patient ... must certainly outweigh the patient's desire not to receive bad news'.

[127] Laufs & Laufs 1987 *NJW* 2264; Langkeit 1990 *Jura* 458 *ff*, emphasising that the individual patient's wishes and not the prudent patient's decisions should prevail when it comes to taking appropriate measures in respect of the HIV infection; Van Wyk *Aspekte van VIGS* 363.

[128] Teichner 1986 *NJW* 761; Laufs & Laufs 1987 *NJW* 2264, who reject written and telephonic communication and insist on 'persönliche und umsichtig schonende Aussprache'; Strauss 1988(1) *SAPM* 13; *cf* VGH München 1988 *NJW* 2318 2320; Langkeit 1990 *Jura* 458–459.

3 4 The duty to inform patients of the risk or danger of HIV infection through medical interventions

A patient may be exposed to the risk or danger of HIV infection through medical intervention in a variety of ways, the most important of which are (a) where the doctor or health care worker in charge of the patient is HIV infected;[129] and (b) where the medical intervention involves the implantation of human organs or tissue or the infusion of body fluids which are HIV infected into the patient, as in the case of organ and tissue transplantation,[130] artificial fertilisation[131] and blood transfusions.[132]

Within the context of blood transfusions, there is authority for the view that where use is made of donor blood, there is a duty incumbent upon doctors to inform patients, prior to the proposed medical intervention, of the risk or danger of HIV infection during a blood transfusion in all those cases where the possibility of a blood transfusion, either before, during or after the operation, merits serious consideration by the doctor. The risk or danger of HIV infection during blood transfusions cannot be regarded as common knowledge which need not be imparted to the patient.[133] In addition, the doctor is under a duty to inform the patient of the alternative of an autologous blood donation, where this is medically possible, instead of a heterologous blood donation,[134] as well as of the benefits and disadvantages of the former as compared to the latter.[135]

Moreover, there is authority for the view that doctors are under a duty to inform patients of the danger of HIV infection in blood transfusion cases on

---

[129] *Cf* SA Strauss 'Gesondheidswerkers wat HIV-positief is' 1989(2) *SAPM* 6, who suggests that although an HIV infected health care worker is probably under a moral duty to inform the patient accordingly even if the risk or danger of transmission is very small, it is unlikely that a corresponding legal duty exists, provided the health care worker takes reasonable steps to prevent transmission from occurring; Van Wyk *Aspekte van VIGS* 280 *ff* 378–379, who submits that HIV infected doctors should either refrain from participating in surgical interventions or from practising gynaecology or inform their patients of their HIV status (378).

[130] Since time is usually of the essence in organ transplantation cases and since it may be difficult if not impossible to perform adequate HIV tests, the patient should be informed of the risk or danger of HIV infection through organ transplantation: CW van Wyk 'VIGS en die reg: 'n verkenning' 1988 *THRHR* 317 332.

[131] Strauss 1988(1) *SAPM* 13 rejects a duty to disclose the danger of HIV transmission in artificial fertilisation cases on account of the risk being statistically highly insignificant where adequate HIV tests have been performed.

[132] A blood transfusion as such, or a blood transfusion associated with an operation (pre-operative, intra-operative or post-operative blood transfusion). *Cf* the recent widely published French and German blood bank scandals in which numerous patients had apparently received HIV infected blood because of insufficient precautionary measures taken to ensure that only HIV free blood is donated to blood recipients.

[133] BGH 1992 *NJW* 743–744, endorsed by Deutsch E 1992 *JZ* 423 and Giesen D 1993 *JR* 21 22.

[134] BGH 1992 *NJW* 743 744; Deutsch 1992 *JZ* 423, who adds that the patient should also be informed of the option of making use of the blood of a nominated donor, eg a relative; *cf* Giesen 1993 *JR* 22.

[135] BGH 1992 *NJW* 743 744.

the basis that, although the risk of HIV infection may be fairly remote,[136] the consequences of HIV infection will be extremely serious.[137] Legal liability based on negligence in blood transfusion cases may be avoided by (a) properly informing the patient of the danger of HIV infection;[138] (b) taking the necessary care in testing the blood used for HIV infection; and (c) obtaining the patient's consent to the blood transfusion.[139] Another way of achieving the same result would be by requiring the patient to sign a waiver of a delictual action for damages arising from a blood transfusion, because this will apprise him or her of the risk of HIV infection and, hence, serve a dual purpose.[140]

4 CONCLUSION

4 1 Informed consent to blood tests and/or HIV tests

It is to some extent surprising and to some extent befitting that the most intensely debated and hotly controversial question of the three under discussion is the first: Surprising because (a) the more 'special' the status granted to potential and actual AIDS victims, the less 'normal' society's response to their predicament is likely to be; and (b) it will ultimately be the HIV diagnosis rather than the HIV test which will expose the patient to individual pain and suffering and to society's by and large adverse reaction. Befitting because (a) it admits of no doubt that the information rendered by an HIV test[141] is, at least in case of a positive result, by nature sensitive and private and a source of potential harm to the patient; and (b) it can, therefore, hardly be denied that appropriate measures for proper protection of the patient against invasions of his or her privacy through secret HIV tests merit at least serious consideration.

---

[136]The marked increase in HIV infections in South Africa will probably have the effect of increasing the risk or danger of HIV infection during blood transfusions: Van Wyk 1992 *De Jure* 29.

[137]M Teichner 'Aufklärung über das Transfusionsrisiko LAV/HTLV-III-Infektion?' 1986 *ArtztR* 201 *ff*, on the basis that the risk or danger of HIV infection is typical (*contra* Simon-Weidner R 1986 *ArtztR* 204–205) albeit improbable, and that informing the patient is imperative even where the proposed operation and/or blood transfusion is necessary to save his or her life; Weissauer 1987 *MedR* 273, unless the blood transfusion is urgently necessary and the patient is incapable of consenting to it, in which case, depending upon the degree of urgency, tacit consent may be assumed (see also Eberbach 1986 *JR* 234); Van Wyk 1992 *De Jure* 29–30; *cf* BGH 1992 *NJW* 743 744; *contra* Strauss 1988(1) *SAPM* 13 (see n 131 *supra* for the reason given).

[138]This may place a heavy burden on the patient who is to undergo an operation with its attendant dangers, plus the dangers inherent in anaesthesia, plus secondary risks, such as a blood transfusion during the operation and an HIV infection (see also Simon-Weidner 1986 *ArtztR* 204; *cf* Teichner 1986 *ArtztR* 202); perhaps the most feasible solution to the problem lies in simply mentioning the possibility of secondary risks, and leaving it to the patient to enquire about the details: Weissauer 1987 *MedR* 273.

[139]Van Wyk 1992 *De Jure* 30.

[140]Strauss 1991(3) *SAPM* 18; Van Wyk 1992 *De Jure* 30.

[141]Incidentally, the same applies to medical procedures such as genome analyses: *cf* D Sternberg-Lieben 'Strafbarkeit eigenmächtiger Genomanalyse' 1990 *GA* 289; E Deutsch 'Medizinische Ethik und Genomanalyse' 1994 *VersR* 1.

Clearly the most important and polemic question under the present heading is whether or not an HIV test may be performed without informing the patient thereof. From the diversity of situations and considerations that come into play when the issue of informed consent to the taking of a blood sample and/or an HIV test arises, it is more or less evident that this question cannot be answered with a simple yes or no. Bearing in mind the critical comments offered above and the variety of situations and considerations identified, the following guidelines[142] are suggested as a solution to the present problem:

a Where the patient expressly consents to an HIV test before, during or after the taking of a blood sample, no problem arises and the performance of the test can be considered lawful. (Incidentally, this means that the distinction between HIV tests intended prior to and subsequent to the taking of a blood sample falls by the wayside, and that, hence, it matters not whether the substance tested is blood, semen, milk, urine or any other substance.)

b Where the patient expressly refuses an HIV test before, during of after the taking of a blood sample, the performance of the test would clearly be against his or her will and, in the absence of a ground of justification, unlawful.[143]

c Where the patient neither expressly consents to nor expressly refuses an HIV test before, during or after the taking of a blood sample, the performance of the test should be regarded as justified by tacit consent provided it is (i) medically indicated; and (ii) in the patient's interest.[144] As with other serological tests which are a matter of medical discretion, the patient need not be informed of an HIV test unless there is a clear indication to the contrary, such as (i) the patient enquiring about the nature of the serological test intended or asking whether or not an HIV test is intended; or (ii) the doctor having reason to believe that the patient would prefer to be informed of the nature of the serological tests intended or of an intended HIV test. This will open the door to medically indicated HIV tests in the patient's interest becoming routine, while at the same time catering for the individual patient's need and wish to be informed of such test and saddling the doctor (as part and parcel of the therapeutic alliance model) with a duty to inform the individual patient if in doubt about his or her consent to such test. It will also pave the way for destigmatising and normalising HIV tests in the eyes of the world. Moreover, routine HIV tests, where medically indicated and in the patient's interest, would effectively dispose of the thorny issue whether or not therapeutic necessity or contra-indication may operate as a defence in cases of non-disclosure of an HIV *test*. The real issue would then be whether or not non-disclosure of an HIV *diagnosis* may be justified by the therapeutic necessity or contra-indication defence.

---

[142]Which, incidentally, are also relevant to genome analyses.

[143]*Cf* MASA 6 8.

[144]*Cf* Leech 1993 *SAJHR* 66–67.

d Where the intended HIV test is performed for the benefit of others, the patient's consent to such test should be considered effective only if he or she was informed thereof before, during or after the taking of a blood sample. In emergency cases, the defence of necessity[145] can be invoked to justify HIV tests for the benefit of others without the patient's consent. Of course, whether or not the necessity defence will avail the doctor, will depend upon the facts of the case (of which a medical indication for an HIV test will be an essential element), as well as upon all the requirements of the defence being satisfied. Moreover, taking HIV tests for the benefit of others without the patient's informed consent out of the arena of tacit consent and placing it in the arena of the necessity defence should not only ensure that such conduct was really necessary in the circumstances but also that the patient's interests are adequately protected. (Incidentally, this means that for purposes of informed consent to HIV tests the distinction between the parties deriving benefit from the HIV test falls by the wayside, and that the prickly pear of the divisibility or indivisibility of consent to an HIV test which is intended for the benefit of both the patient and others is disposed of.)

e Where an HIV test is performed against the patient's will, in the sense that he or she either expressly refused it, or enquired about it but was given the assurance that it was not to be or was led to believe that it was medically indicated and/or in his or her own interest, the doctor may be held criminally and/or civilly liable for fraud and/or a violation of the patient's personality rights.[146]

f Where an HIV test is performed without the patient's express or tacit consent and without a fraudulent misrepresentation, the doctor may be held criminally and/or civilly liable for a violation of the patient's personality rights. Provided the patient gave his or her informed consent to the medical procedure whereby a blood sample is taken and its attendant risks and dangers, no liability for assault should lie. Not only does the assault option as a solution to the problem of secret HIV tests confuse and identify informed consent to an HIV test with informed consent to the taking of a blood sample, but it is also fraught with contradictions and inconsistencies. Since secret HIV tests affect information about the patient of a highly sensitive and private nature rather than information about the nature, risks and dangers of taking a blood sample, the personality rights option is not only more suited to accommodate the problem of unlawful HIV tests, but also fits in well with the notion that no distinction should be drawn (i) between cases where an HIV test was intended prior to and subsequent to

[145]On which see generally FFW van Oosten 'The legal liability of doctors and hospitals for medical malpractice' 1991(7) *SAMJ* 23 25 and within the context of HIV tests Van Wyk *Aspekte van VIGS* 161 *ff*; Taitz 1993 *CME* 80 ff; *cf* CMSA 1991 *SAMJ* 689; MASA 7 *ff*; SAMDC 8–9.

[146]Of which the right to privacy is recognised as a specific legal interest in both Germany and South Africa, and freedom of choice is recognised as a specific legal interest in Germany but not in South Africa.

the taking of a blood sample; and (ii) between whether the substance used for an HIV test is blood, milk, urine or any other substance.

4 2 The duty to disclose the outcome of an HIV test to the patient

Since the disclosure of an HIV diagnosis and its implications and consequences to the patient will usually be of paramount importance to his or her own interest and especially to the interests of others, it is submitted that non-disclosure of an HIV diagnosis should be very much the exception to the rule. Since the doctor will, where medically and legally permissible or obligatory, ordinarily be in no position to warn all potential victims who may come into contact with an innocent HIV infected patient, it is imperative that the patient be informed of an HIV diagnosis and the risks and dangers it presents to others. One such exception that comes to mind is where in terms of the therapeutic necessity or contra-indication defence the harm done by disclosure of an HIV diagnosis would not only be greater than the harm done by non-disclosure, but where the patient in the particular circumstances also presents no risk or danger of HIV infection to others. To mention but one example: Where the reasonable possibility exists that the life or health of a depressive and suicidal patient who practises sexual abstinence and presents no threat of infection to health care workers may be seriously jeopardised by the disclosure of an HIV diagnosis. Here non-disclosure would both serve the patient's own interests and not threaten the interests of others. Whether or not the therapeutic necessity defence will find its application where the patient in these circumstances enquires about the diagnosis or concluded a diagnosis contract with the doctor, involves the moot point whether or not a lie may be justified in circumstances of necessity. A possible solution to this difficult problem[147] would be that, notwithstanding the patient's enquiries or a diagnosis contract, a lie may be justified by circumstances of necessity where the patient does not insist upon disclosure of the HIV diagnosis. Should the patient insist upon full and truthful information in terms of his or her enquiries or a diagnosis contract, however, disclosure of the HIV diagnosis is indicated and any harm suffered by the patient as a consequence may be attributed to a voluntary assumption of the risk of harm by the patient.

More important than the question *whether* an HIV diagnosis should be disclosed, is the question *how* an HIV diagnosis should be disclosed. The answer to this question is furnished by the ordinary principle that the manner of disclosure is essentially a matter of medical discretion, provided the doctor refrains from causing the patient unnecessary anxiety and distress,[148] and bearing in mind the therapeutic alliance model.

---

[147]For a discussion of the problem see Van Oosten 1991 *Med Law* 36–37 38–39.

[148]On legal liability for over-information see FFW van Oosten 'The doctor's duty of disclosure and excessive information liability' 1992 *Med Law* 633 634 *ff.*

4 3 The duty to inform patients of the risk or danger of HIV infection through medical interventions

The obligation of the doctor to inform the patient of the risk or danger of an HIV infection through a medical intervention can simply be dealt with in terms of the ordinary principles of informed consent, particularly in terms of the disclosure dictates relating to the risks and dangers of, as well as the alternatives to, the medical intervention in question.

Discoursing about legality, democracy and the death sentence in South Africa

JAN H VAN ROOYEN*

I made Sas's acquaintance while I was a student at the University of Pretoria and secretary of the Political Science Association. In this capacity I invited Sas in 1963 to address a meeting of Tuks students on the 'Sabotage Act'. I thereupon received a phone call from a certain Tuks lecturer who urged me not to allow 'such a man' onto the Tuks campus. I ignored the lecturer and Sas delivered his lecture. Sas and I became friends and in 1965 he invited me to join his department at Unisa (then the Department of Public Law) as an assistant. I accepted and stayed. With the exception of several bouts overseas and two years at the University of Cape Town, I have spent my entire academic career in the same department as Sas. While I was at UCT (1977–78), I visited Pretoria. Sas took me to tea, in the course of which he persuaded me to return to Pretoria. Between ourselves we still refer to that event as the 'Singing Kettle Conversation'. I owe Sas a great deal of gratitude for the way in which he supported and encouraged me and promoted my career. I admired his viewpoints and was influenced thereby, as will appear from this contribution. Thanks, Sas, and God bless!

☼ ☼ ☼

Introduction

This contribution will examine some of Sas Strauss's early ideas on legality and law — especially the criminal law and the law of criminal procedure — and assess their significance in the context of the present state of discourse about legality, democracy and the death sentence in South Africa. Three of his academic publications will be scrutinised, viz his inaugural professorial lecture,[1] his critique of certain security legislation,[2] and his views on basic

*BA LLB (Pretoria) MCL (Michigan). Head, Department of Criminal and Procedural Law, and Chair, Criminal Justice Research Unit, University of South Africa.

[1]Strauss *Nuwe weë in die Suid-Afrikaanse Strafprosesreg* (Pretoria 1961: Communications of the University of South Africa, No A 15).

[2]Strauss 'Sabotasie — Artikel 21 van die Algemene Regswysigingswet, 1962' 1962 *THRHR* 231.

values of the South African system of criminal procedure.[3] His views on the death sentence will also be examined in this context.

The theme: legality

Right from the beginning of his career in the Department of Criminal and Procedural Law (formerly the Department of Public Law) in the University of South Africa (Unisa), Sas emphasised that the scientific study of law involves more than the positivistic analysis of rules; that the measure of 'good' law involves more than (perceived) efficiency; that in criminal justice the apprehension, trial, conviction and punishment of offenders are not necessarily the highest value; that there are meta-juridical considerations against which the law must be tested (virtually a 'law above the law'); that 'law' and 'justice' are not synonymous. He referred to this approach in general as a concern for 'legality'.[4] This approach was, at the time (the early nineteen sixties), new and bold — especially in Afrikaner circles; after all, Afrikanerdom had at that time embraced Verwoerdian ideology, including the 'kragdadigheid' necessary for the repression that was seen as essential for Afrikaner survival.

Sas would be different. When he became Professor at Unisa, he lost no time, but stated his basic philosophy in his inaugural lecture titled 'New trends in the South African law of criminal procedure'.[5] He suggested that the deeper meaning ('die diepere sin') of criminal procedure and substantive criminal law is not merely effectiveness, but the protection of the fundamental legal values of societal life ('die beskerming van die elementêre regswaardes van die gemeenskapslewe'); this inter alia implies that penal sanctions may only be utilised under certain circumstances ('onder sekere voorwaardes')[6] — a view which refers to aspects of the Rule of Law and the principle of legality as a limit on state power, and, moreover, impliedly as a limit on democracy or, rather, populism.[7] He stressed that it is no wonder that the constitutions of many states contain provisions of a criminal procedural nature,[8] quoting Jerome Hall who contended that the American Bill of Rights is 'largely a

---

[3]Strauss 'Basic values of the South African system of Criminal Procedure' in McQuoid-Mason (ed) *Legal Aid in South Africa* 177.

[4]A comprehensive doctoral dissertation on legality in criminal procedure has recently appeared — see JJ Joubert *Die legaliteitsbeginsel in die strafprosesreg* (LLD dissertation, Unisa 1995) — in which the author analyses and systematises terms and doctrines such as Rule of Law, '*Rechtsstaat*', Due Process of Law, and Human Rights, distinguishing between their formal and substantive contents and examining the meaning of 'justice' in this context. The sophisticated classification and terminology of the dissertation have not necessarily been followed in the present contribution; more time is needed to digest the dissertation!

[5]See above, n 1.

[6]*Id* 5.

[7]See further below. *Cf* the wording in the English summary of the lecture, id 21: 'Criminal Law assists in shaping the social ethics and strengthens the individual's respect for these values. The rules of the Law of Criminal Procedure *can be approved of only if* they too have this effect.' (My emphasis.)

[8]*Id* 6.

document of criminal procedure'.[9]

Insofar as many rules of criminal procedure constitute a limitation on individual rights (for instance in the pre-trial phase, where the rules of arrest operate as a limit on the right to personal liberty), Sas contended that the latter should only be sacrificed where and insofar it is essential ('onontbeerlik') for efficiency[10] — thus anticipating the principle of the 'limitation clause' in the present South African Constitution[11] by some thirty-five years.[12] Sas continued:

> Naïef en gevaarlik sou die beskouing wees dat die Strafprosesreg uit 'n klomp ... reëls bestaan wat uitsluitlik beoog om dit vir die staat makliker te maak om misdadigers voor die gereg te bring en die afhandeling van prosesse op die snelste wyse te bewerkstellig[13]

— a view which will be endorsed by modern constitutionalists but probably rejected by populists; if a question in this regard were put to the popular vote today, a substantial majority would conceivably be willing to scrap 'Bill of Rights' type of guarantees in favour of greater police efficiency in the face of massive fear of crime in the new South Africa.[14] Precisely herein lies the boldness of Sas's insistence that the criminal process must above all ('bowenal') be just ('regverdig'):

> Regverdigheid mag nie opgeoffer word aan gerief vir die staat nie, anders verydel die Strafprosesreg sy eie grondliggende doel.[15]

Sas contended further that the scientific study of criminal procedure should be undertaken in a comparative way; science knows no national boundaries.[16] Here he once again foreshadowed the present constitutional provision which states that in interpreting the provisions of chapter 3 of the Constitution ('Fundamental Rights'), a court of law must inter alia have regard to public international law and may have regard to comparable foreign case law.[17]

A year later, Sas had occasion to criticise the so-called Sabotage Clause[18] in an article in the Journal for Contemporary Roman-Dutch Law.[19] After

---

[9]Id, referring to Hall *Studies in jurisprudence and criminal theory* (1958) 221.

[10]Id.

[11]Section 33 of the Constitution of the Republic of South Africa, Act 200 of 1993 (the latter will hereafter be referred to as 'the Constitution').

[12]See further, below.

[13]Id. See also his discussion of search, seizure and arrest, id 10–12.

[14]See Glanz *Crime in South Africa: Perceptions, fear and victimization* (HSRC 1994).

[15]*Id* 7.

[16]Id, stated in Sas's inimitably succinct style: 'Die wetenskap ken geen landsgrense nie', period.

[17]Section 35(1) of the Constitution.

[18]Section 21 of the General Law Amendment Act 76 of 1962, which created a new offence 'Sabotage', introduced drastic procedural rules, and prescribed tough mandatory sentences.

[19]See above, n 2.

subjecting the draconian legislation to stringent analysis and criticism,[20] Sas lamented the ultimate source of the legislation, viz the sovereignty of a Parliament unbounded by a Bill of Rights:

> Die Parlement as soewereine wetgewende liggaam kan natuurlik sy wette so wyd formuleer as hy wil en kan die beginsel *nullum crimen sine lege* in dié opsig na wense oor die hoof sien. Deur 'n halsmisdaad te skep met wetsbepalinge wat, indien hulle die werk van 'n stadsraad was, deur ons howe op grond van vaagheid ongeldig verklaar sou word, onderstreep die Parlement sy onbegrensde oppergesag, maar beïndruk hy nie met sy wysheid nie.[21]

Even though the (white) voting public would probably have endorsed and applauded the legislation, Sas wanted it 'out' on grounds of justice, legality, Rule of Law, a 'law above the law' as a limit on populistic 'democracy'. His reasoning was highly technical and sophisticated, and would probably have been lost on the voters if a referendum had been held on the issue; however, as Sas saw, right and wrong, or 'justice' in criminal justice, are not determined by the general voting population, but by other considerations.[22]

The final academic contribution of Sas's for present purposes is his 'Basic values of the South African system of Criminal Procedure'.[23] He commenced by immediately making it clear that existing law may, indeed must, be 'assessed', and that the standard for such assessment is constituted by 'basic *regstaatlike* values'.[24] He further stated that the first and great commandment of the *regstaat* is, without a doubt, legality.[25] Legality is, for him, also a basic principle of adjective criminal law.[26] He reiterated that 'Criminal Procedure is largely a subject of constitutional rights'[27] — a bold view at a time when South Africa did not yet even contemplate having a constitution with a justiciable Bill of Rights.[28] He recognised that in criminal justice there must be limits on state power, even at a cost to society in general:

> It must be stressed that the prevention and prosecution of crime is not the highest value in our society. If it were, no legal limits would have been imposed on police powers. Then we would probably have had a situation of maximum authority and control, with a minimum of crime ... But our system would then have been completely authoritarian and altogether incompatible

---

[20] *Id* 232, 235, 240.

[21] *Id* 242.

[22] See below.

[23] *Supra* n 3.

[24] *Id* 177.

[25] Id.

[26] Id.

[27] *Id* 179.

[28] His view of legality, to be sure, was limited; he included only positivistic *wetmatigheid* and Montesquieu's judicial control over executive (not legislative) action. Even Nazi Germany conformed to legality in this sense. More is needed, including *substantive* legality, which involves inter alia assessing the constitutionality of legislative acts against a justiciable Bill of Rights. See Joubert, *supra* n 4. Although Sas did not spell this out in his general statements, his particular comments indicate that he was indeed aware of, and cared for, legality in the sense of 'a law above the law'; see id *passim*.

> with the ideals of Western democracy, with the freedom of the individual and the protection of the interests of privacy and personality. In order to protect these interests we are therefore prepared to tolerate the fact that all criminals cannot be successfully prosecuted.[29]

In other words, there are higher values than the suppression of crime; there is 'a law above the law'. Although Sas squared this idea with 'the ideals of Western democracy', it is evident that it is basically a *limit* upon democracy; the public might want and indeed clamour for an authoritarian system of maximum authority and control, with a minimum of crime,[30] but in the long term, public interest requires that they should not get it. A Bill of Rights should limit populist democracy.[31] Later in the contribution Sas came close to stating this explicitly; while he severely criticised certain provisions of the then Suppression of Communism Act 44 of 1950, he recognised that a 'majority of the electorate undoubtedly supported' the legislation. That, however, did not make it good, right, wise or just. In fact, Sas stated that 'as a jurist'[32] he had to say that 'the type of arguments which have been used in recent times to justify (the Act), are disquieting ... (casting) doubt upon the very foundations' of the South African criminal justice system.[33]

In commenting on Sas's contribution, Professor Anthony Mathews (then Dean of the Faculty of Law, University of Natal) recognised that precisely because at the time of Sas's contribution there was no 'law above the law' and Parliament reigned supreme, Sas's restatement of fundamental values was of utmost importance, because 'we are going to have to reintroduce many of them when political power shifts take place in the country'.[34] The ideas must accordingly be kept alive.[35]

This is precisely what happened. Sas's ideas, joined by those of others, took root; were kept alive; were promoted by younger academics and others; were studied, absorbed and internalised — and eventually, in the 1990s, found place in the new South African Constitution. That all South Africans, including academics, do not now embrace the new Constitution enthusiastically or understand it properly, was to be expected; the old order dies but slowly in the hearts of many. A human rights culture needs to be nurtured in South Africa. The present controversy around the death sentence illustrates this well.

Sas and the death sentence

In the 1970s Sas became a prominent member of the abolitionist movement

---

[29] *Supra* n 3 at 180. See Geldenhuys and Joubert (eds) *Criminal Procedure Handbook* (1994) ch 1 for an extended treatment of this theme.

[30] See Packer *The limits of the criminal sanction* (1968) for the 'crime control model' in criminal justice. For a discussion of the inverse relationship between police powers and individual rights, see Geldenhuys and Joubert *supra* n 29 ch 1.

[31] For a discussion of the true nature of a constitutional democracy, see *infra*.

[32] *Id* 184.

[33] Id.

[34] *Id* 186.

[35] Id.

in South Africa.[36] In 1971 he wrote a strongly-worded attack on the death sentence in a popular magazine[37] in which it was apparent that his primary argument was based on higher values than those recognized in then-current public opinion:

> Dit is vir my 'n logiese stap in die vooruitgang van die beskawing dat hierdie strafvorm moet verdwyn. 'n Kenmerk van die Westerse beskawing, wat ook voortvloei uit die Christelike leer, is eerbied vir die lewe ... Die opsetlike ontneming van 'n lewe deur die staat — al is dit die van 'n misdadiger — druis hierteen in ... Hierdie beskouing berus nie op die gedagte dat boosdoeners op die hande gedra en vertroetel moet word nie, maar op die uitgangspunt dat die reg nie aangewend moet word as 'n instrument vir lewensvernietiging nie.[38]

The 'values' approach is restated in a contribution in the *Rand Daily Mail*:[39]

> The abolitionist cause is fundamentally based on the changing values of a civilisation — and specifically on more civilised notions of what is a decent, fair and acceptable mode of punishment. We are honouring our legal tradition, not violating it, by introducing more enlightened notions.

In those days there was no way in which South African law could be tested against such higher values or higher laws; Parliament reigned supreme, and with it, public opinion — ie the opinion of the enfranchised public, the whites. The constitutional validity of the death sentence could not be challenged in a court of law.

The nature of our democracy

It is evident that at the time of writing the contributions cited above, Sas primarily conceived of legality as a meta-juridical principle, as an *appeal* to the (sovereign) legislature, as an aspect of wisdom and good government, rather than a justiciable juridical precept.[40] For him, the limitation of state power and the protection of human rights should take place through the common-law; his disagreements with Parliament were because the latter was abolishing important common-law principles, limitations and protections, albeit in a piecemeal fashion.

But this is precisely the point of the Fundamental Rights movement and of constitutionalism: Parliaments cannot be trusted (this has surely been proved

---

[36]See eg *Vaderland* 4 April 1971, where he stated: 'Ek is 'n lidmaat van die NG Kerk en beywer my vir die afskaffing van die doodstraf ...'. The missiologist, Dr (later Professor) David Bosch, served with Sas in the Executive of the Society for the Abolition of the Death Penalty in South Africa (which had been founded by Professor Barend van Niekerk); the heart-transplant surgeon, Dr Christiaan Barnard, was also an active member.

[37]*Ster* 28 May 1971 at 69.

[38]Sas here virtually predicts the main reason for the abolition of the death sentence ... 25 years in advance. See *infra*.

[39]29 May, 1971 at 11.

[40]Except, of course, in the case of subordinate legislation, which a reviewing superior court could even in those days declare null and void on certain grounds, inter alia some which would fall under 'legality'. See eg the quotation *supra* text at n 21 (Sabotasie).

by history) and must therefore be limited by a justiciable Bill of Rights.[41] This is true even if a 'true' democracy, in the sense that it is based on universal franchise, is achieved.[42] This is because the modern idea of democracy involves (a) representative, rather than direct, government; and (b) limitations on state power which render the democracy a relative, not an absolute, one.[43] This is in essence the model on which the present South African Constitution is based.[44] Thus, while in the apartheid era we had limited franchise ('whites only') and a Parliament with unlimited powers, we now conversely have universal franchise and a Parliament with limited powers. This is often inadequately grasped by the present-day 'democrats in criminal justice' who want a referendum solely on the death sentence issue.[45] A recent issue of *Time* magazine[46] explains the modern concept of democracy succinctly:

> The [Founding Fathers of America's representative system of democracy] explicitly took lawmaking power out of the people's hands, opting for a representative democracy and not a direct democracy. What concerned them, especially James Madison, was the specter [sic] of popular 'passions' unleashed. Their ideal was cool deliberation by elected representatives, buffered by the often shifting winds of opinion ... Madison insisted in the *Federalist Papers* on the need to 'refine and enlarge the public views by passing them through the medium of a chosen body of citizens, whose wisdom may best discern the true interest of their country and whose patriotism and love of justice will be least likely to sacrifice it to temporary or partial considerations.'[47]

A constitution is, furthermore, not self-executing; it must be interpreted by a judicial authority. This is but part of Montesquieu's separation of powers

---

[41]See Bullock *et al* (eds) *The Fontana Dictionary of Modern Thought* (2 ed 1990) qv 'constitutionalism': 'The doctrine that governments must act within the constraints of a ... constitution ...'.

[42]When Sas did most of his writing, South Africa had no true democracy in this sense; in terms of apartheid legislation, only persons classified as 'white' could vote for the national Parliament.

[43]See n 41 *supra* qv 'democracy'.

[44]Regarding (a), see eg the Preamble of the Constitution of the Republic of South Africa, Act 200 of 1993, which commences 'We, the people ...', but then recognises that '*elected representatives* of all the people ... should be mandated (to adopt a new constitution, etc)'; see also Constitutional Principle VIII in Schedule 4 of the Constitution: 'There shall be *representative government* embracing multi-party democracy ... (etc)'; *cf* chapter 4 of the Constitution ('Parliament'). Regarding (b), see inter alia Constitutional Principles II and IV in Schedule 4 of the Constitution: 'Everyone shall enjoy all universally accepted fundamental rights (etc), which shall be ... protected by *entrenched and justiciable* provisions in the Constitution ... The Constitution shall be the *supreme law* of the land. It shall be *binding on all organs of state* at all levels of government.' *Cf* chapter 3 of the Constitution ('Fundamental Rights'); section 7(1) inter alia confirms that even (or especially?!) Parliament is limited by this chapter: 'This chapter shall bind all legislative ... organs of state ...'.

[45]Usually such 'democrats' are but thinly disguised retentionists. That they have a limited understanding of modern democracy and constitutionalism is not surprising, since most of them have no record of democratic ideals, human rights involvement or opposition to apartheid.

[46]*Time* January 23, 1995, at 39–44.

[47]*Id* 40. 'Intensely felt public opinion leads to the impulsive passage of dubious laws' — *id*. Surely the apartheid era should have taught us this much?

doctrine. In South Africa such interpretation will be done primarily by The Constitutional Court; section 98(2) of the Constitution provides as follows:

> The Constitutional Court shall have jurisdiction ... as the court of final instance over all matters relating to the interpretation, protection and enforcement of the provisions of this Constitution, including —
> (a) any alleged violation or threatened violation of any fundamental right entrenched in Chapter 3;
> (b) any dispute over the constitutionality of any executive or administrative act or conduct ... of any organ of state;
> (c) any enquiry into the constitutionality of any law, including an Act of Parliament ...

The present Constitution is an interim one. A Constitutional Assembly — once again representative government! — is presently in the process of writing a final version.[48] As far as legitimising the final Constitution itself is concerned, chapter 5 of the present Constitution provides for a popular vote on its text by way of a popular referendum, where the text must be approved of by a majority of at least 60 per cent of the votes cast.[49] But even here there are limitations; the new constitutional text inter alia must comply with the Constitutional Principles contained in Schedule 4 to the present Constitution, and the Constitutional Court must certify that this is indeed the case.[50] The electorate may reject the new Constitution, in which case Parliament must be dissolved, an election held, and further procedures followed.[51]

In sum, the new South Africa has opted for a constitutional dispensation with inter alia the following characteristics:

- Representative, not direct, government.
- Constitutionalism instead of Parliamentary sovereignty (this implies limited democracy: the Constitution, not the people or Parliament, is sovereign).
- Justiciability of the Constitution; it has to be interpreted by a Constitutional Court, whose decision is final.

Public opinion and the abolition of the death sentence

The new Constitutional Court heard argument on the constitutionality of the South African death sentence on 15 to 17 February 1995, and delivered judgment on 6 June 1995.[52] The main judgment was delivered by Chaskalson P. Although each of the other ten judges wrote a separate concurring opinion,

---

[48]See chapter 5 of the Constitution ('The adoption of the new Constitution').

[49]See section 73.

[50]See sections 71(1), 71(2), 73(2).

[51]See section 73(9)–(12).

[52]*The State v T Makwanyane and M Mchunu*, unreported at the date of writing this section, hereafter cited as *S v Makwanyane*. For a history of the efforts of one strand of the abolitionist movement in South Africa, see JH van Rooyen: 'Toward a new SA without the death sentence — struggles, strategies, and hopes' 1993 *Florida State University Law Review* 737–786.

they were unanimous in *inter alia* holding, with Chaskalson P, those parts of section 277 of the Criminal Procedure Act 51 of 1977 which authorise and regulate the death sentence to be inconsistent with the Constitution and, accordingly, invalid.

If one assumes[53] that public opinion in South Africa, at the time of the judgment, was broadly in favour of 'the' death sentence,[54] the meaning and significance of the judgment within the context of the fledgling South African democracy becomes apparent. In the aftermath to the judgment,[55] many people clamoured for a referendum on the death sentence issue; perplexed, they asked, 'If we now supposedly have a democracy and if the people want a death sentence, why can't they get it? How can a court block the popular will?'

The short answer is that the new South Africa does *not* have an unbridled 'democracy' or a populist dispensation; it opted for constitutionalism.[56] *Inter alia* chapter 3 of the Constitution ('Fundamental Rights') sets limits on state power, on democracy, on the sovereignty of Parliament. Parliament is no longer sovereign; that dispensation has been discarded totally. Even if the people, even if Parliament, wanted the reintroduction (*à la* the old South Africa, apartheid, Nazism, fascism or in terms of whichever model) of inequality before the law, disregard in law for human dignity ('*Menschenverachtung*'), selective restriction of internal movement (the 'Pass Laws'), incommunicado detention, detention without trial, torture, whipping with the cat-o'-nine-tails, etc etc, the Constitution would say, 'No, you can't get it'.[57]

---

[53]As Chaskalson P did — *S v Makwanyane* par 87; *cf* Didcott J par 188.

[54]Measurements of public opinion in this connection are often open to serious dispute, mainly on the basis that one does not know what was measured; outcomes of polls depend largely on how the question was phrased and on the various options that were or were not available to the voters. The subject of measuring and assessing the meaning of public opinion is a sophisticated one which will not be discussed in this contribution. *Cf* Kentridge AJ par 200–201 and *cf* WJ Reichmann *Use and abuse of statistics* (1976) esp ch 18 'Popping the question'; HM Blalock *An introduction to social research* (1970) (cf 92: 'Are there any reasonably rigorous ways of inferring what is going on inside a person's head by examining the patterning of his responses to paper-and-pencil tests?'); SP Cilliers SP *Maatskaplike navorsing* (1973); Bowers 'Popular support for the death penalty: mistaken beliefs' in *The machinery of death* 69–74. The HSRC survey on which much emphasis was placed by the retentionist lawyers in *Makwanyane* is so flawed that it could not have survived any cross-examination — see De Kock *et al Perceptions of current sociopolitical issues in South Africa* (HSRC Centre for Sociopolitical Analysis, Dec 1994).

[55]And even before.

[56]*Cf* Bullock *supra* n 41 qv 'populism': 'A form of politics which emphasises the virtues of the incorrupt and unsophisticated common people against the double-dealing and selfishness to be expected of professional politicians and their intellectual helpers ... Edward Shils, Seymour Lipset and Daniel Bell have described all varieties of populism as pathological.'

[57]These human rights abuses all existed at some or other time in the old South Africa. *Cf* Mahomed J par 174: 'The South African Constitution ... retains from the past only what is defensible and represents a decisive break from, and a ringing rejection of, that part of the past which is disgracefully racist, authoritarian, insular and

This is constitutionalism as opposed to unbridled democracy or populism.[58]

As has been stated, a constitution is not self-executing; it has to be interpreted. This is the function of the Constitutional Court in the new constitutional dispensation for which South Africa opted.

The foregoing policies have been neatly, succinctly and simply stated by the Constitutional Court per Chaskalson P:

> The question before us ... is not what the majority of South Africans believe a proper sentence for murder should be. It is whether the Constitution allows the sentence.[59]
>
> If public opinion were to be decisive there would be no need for constitutional adjudication ... but this would be a return to parliamentary sovereignty, and a retreat from the new legal order established by the 1993 Constitution.[60]
>
> By the same token the issue of the constitutionality of capital punishment cannot be referred to a referendum ...[61]

Once one understands the foregoing — ie the complete break with the past dispensation where Parliament reigned supreme; the nature of the new democratic dispensation, ie constitutionalism; and the role of the Constitutional Court — one needs but one further insight in order to understand the abolitionist judgment: the existence of a law above the law.[62] One needs to understand that the 'higher values' approach which Sas Strauss used in his protests against injustices in the old South Africa, has in the new South Africa become concretised in law; the Constitution, its values, and its 'Bill of Rights' have become a *Grundnorm* which is enforceable against laws which do not reflect those values. The break with the past is so fundamental that one can or must indeed speak of a 'new order' in South Africa.[63] The Constitution itself states in section 4(1) that 'The Constitution shall be the supreme law of the Republic and any law or act inconsistent with its provisions shall ... be of no force and effect to the extent of the inconsistency'. Ackermann J states:[64] 'In reaction to our past, the concept and values of the constitutional state, of the 'regstaat'... are deeply foundational to the creation of the 'new order' referred to in the preamble [of the Constitution]'. Langa J states:[65]

---

repressive ... The contrast between the past which it repudiates and the future to which it seeks to commit the nation is stark and dramatic.'

[58]*Cf People v Anderson* 493 P 2d 880 at 888 (Cal 1972): A constitution 'operates to restrain legislative and executive action and to protect fundamental individual and minority rights against encroachment by the majority'. See also *West Virginia State Board of Education v Barnette* (1942) 319 US 624 at 638: 'The very purpose of a bill of rights was to withdraw certain subjects from the vicissitudes of political controversy, to place them beyond the reach of majorities ...'

[59]*S v Makwanyane* par 87. *Cf* Kentridge AJ par 192; Kriegler J par 206.

[60]Chaskalson P par 88.

[61]Id.

[62]*Cf* Madala J par 257.

[63]*Cf* Chaskalson P par 7.

[64]*S v Makwanyane* par 156.

[65]*Id* par 220–221.

> When the Constitution was enacted, it signalled a dramatic change in the system of governance from one based on rule by parliament to a constitutional state in which the rights of individuals are guaranteed by the Constitution ... It may well be that for millions in this country, the effect of the change has yet to be felt in a material sense. For all of us though, a framework has been created in which a new culture must take root and develop.

For purposes of this contribution it is not necessary to enter into a full analysis of the judgment in *S v Makwanyane*. Suffice it to summarise the values enshrined in chapter 3 of the Constitution which, when interpreted by the Constitutional Court, served to render the death penalty unconstitutional:

- Section 11(2): 'No person shall be subject to torture of any kind, whether physical, mental or emotional, nor shall any person be subject to cruel, inhuman or degrading treatment or punishment.'
- Section 9: 'Every person shall have the right to life.'
- Section 10: 'Every person shall have the right to respect for and protection of his or her dignity.'
- Section 8: 'Every person shall have the right to equality before the law and to equal protection of the law.'[66]

All punishments in South Africa have to comply with the above values or standards.[67] Even a cursory reading of the four sections cannot fail to impress one with the fundamental nature of the break between the past old order and the new South Africa. It is the stated values, and their justiciability, which inevitably had to lead to the fall of the death sentence — no other result was possible. The death sentence with its roots deep in the old order, cannot by any stretch of the imagination co-exist with the value system, the justiciable law above the law, of the new order.

Conclusion

The idealism reflected in Sas Strauss's early work, including his emphasis on higher values in criminal justice, has found a secure foothold in the new Constitution.[68] Those values, having been concretised into enforceable law above the law, have triumphed over Parliament and populism in the new South Africa. Ultimately and inexorably the impact of 'legality' on the death sentence in the new South Africa has been its extinction.[69]

---

[66]For a brief study of the racial inequalities associated with the death sentence, see Zimring, Van Vuren and Van Rooyen 'Selectivity and racial bias in a mandatory death sentence dispensation: a South African case study' 1995 *CILSA* 107.

[67]See *S v Makwanyane* par 10, including n 11 (Chaskalson P); *cf* O'Regan J par 337.

[68]I am not suggesting any direct causality; that would be the 'post hoc ergo propter hoc' fallacy. See above, text before and after n 35.

[69]*Cf* Madala J par 165: The death sentence is 'clearly offensive to the cardinal principles for which our Constitution stands'. Mahomed J par 262–264 also illustrates why a contrary decision is inconceivable; *cf* Mokgoro J par 313. Sachs J par 358ff examines the sources of the values enshrined in the Constitution.

HIV-infeksie en die grondwetlike reg op gelykheid

CHRISTA VAN WYK*

Wanneer ek aan Sas dink, is dit nie soseer aan die eerste keer wat ek as jong LLB-student sy klas bygewoon het in geneeskundige reg (wat hy destyds nog saam met dr H Shapiro by Unisa se vakansieskool aangebied het), of aan die baie kere wat ek hom daarna met flair sien optree het nie. Nee, ek dink eerder aan die keer wat ek begin skryf het aan my proefskrif en ons die eerste verkennings op die terrein gedoen het. 'In watter taal gaan jy skryf?' het hy my met die intrapslag gevra. 'Onthou net, as jy in Engels skryf, is jou 'mark' veel groter as wanneer jy in Afrikaans skryf.' My reaksie was dadelik dat ek graag in my moedertaal, Afrikaans, sou wou skryf. Sas was met die antwoord tevrede en het my vertel dat hy in 'n puristiese Afrikaanse huis grootgeword het. So puristies trouens, dat sy pa hulle verbied het om van 'Marmite' te praat. Hulle moes na 'die soutigheid' verwys. Ek moes hierdie bedekte waarskuwing ter harte geneem het, want ek het spoedig met Sas se eie puristiese taalstreep te doen gekry. Nooit sal ek vergeet van al die 'effektief's wat ek in my proefskrif moes vervang met 'doeltreffend's nie, en van ander latinismes wat moes plek maak vir meer gepaste germanismes nie. 'Dokter' moes van meet af aan die wyk neem voor 'geneesheer'. Hierdie dissipline het my bewus gemaak van goeie en konsekwente taalgebruik—'n belangrike stuk gereedskap van die regsgeleerde wat ongelukkig hedendaags dikwels toegelaat word om te verroes. Die regskennis van my promotor het ek vanselfsprekend geneem — die taalpurisme was 'n bonus.

Hiermee dan Sas, 'n soutigheidjie vir die aftrede. Vergeef maar die woord 'geïnfekteerd'? Al gaan hierdie woord gebuk onder vreemde invloede ('n mens sou kon sê dit is as't ware daarmee besmet), is dit na my mening (en ek het lank hieroor getob) 'n beter keuse as 'besmet; bederf; verpes;' (sien *Tweetalige Woordeboek* reds Bosman, Van der Merwe, Hiemstra 8 uitg onder 'infected') in die konteks van VIGS.

✡ ✡ ✡

*BA (Stell); HOD (Pret); LLB, LLD (Unisa). Professor in die Departement Regsgeskiedenis, Regsvergelyking & Regsfilosofie, Universiteit van Suid-Afrika.

INLEIDING

VIGS[1] is ongeneeslik, dodelik en seksueel oordraagbaar[2] en ontlok dikwels dieselfde reaksie as ander gevreesde toestande (soos melaatsheid, cholera en sifilis) deurdat mense geïnfekteerde persone blameer, verwerp en stigmatiseer.[3] Ten spyte van die feit dat VIGS al geruime tyd in ons midde is,[4] bestaan daar steeds 'n groot mate van onkunde daaroor onder die publiek, veral oor die maniere waarop HIV,[5] die virus wat VIGS veroorsaak, oorgedra word[6] en oor die verskil tussen mense met HIV en diegene wat reeds aan volskaalse VIGS ly.[7] Hierdie onkunde versterk die ongegronde vrese en vooroordele en gee dikwels aanleiding tot die onbillike behandeling van persone met HIV en VIGS.

Die oortuiging dat onbillike diskriminasie die stryd teen VIGS belemmer, wen toenemend veld. Volgens hierdie siening gee die vrees vir diskriminasie (en in sommige omstandighede vir strafregtelike vervolging)[8] aanleiding tot

---

[1]VIGS is die akroniem vir 'verworwe immuniteitsgebreksindroom'. Die toestand is verworwe in die sin dat dit veroorsaak word deur 'n virus en nie geneties oordraagbaar is nie.

[2]Sien vn 6 hieronder.

[3]Visser 'Foundering in the seas of human unconcern: AIDS, its metaphors and legal axiology' 1991 *SALJ* 619; Kirby 'AIDS and the law' 1993 *SAJHR* 1; Khaïat 'The law and AIDS: Issues and objectives (a comparative approach)' 1993 *Medicine and Law* 3.

[4]VIGS is vir die eerste keer in 1981 in die VSA en in 1982 in Suid-Afrika gediagnoseer.

[5]'Human immunodeficiency virus'. Die Engelse akroniem HIV word internasionaal gebruik om die virus aan te dui. Die Afrikaanse ekwivalent daarvan is MIV (menslike immunogebreksvirus).

[6]Daar is geen wetenskaplike bewys dat HIV op enige ander manier as deur hetero- en homoseksuele geslagsomgang, die ontvangs van of blootstelling aan HIV-geïnfekteerde (bloed)produkte, saad of organe of deur 'n geïnfekteerde moeder aan haar baba voor of tydens geboorte, of deur borsvoeding oorgedra kan word nie. Blootstelling aan geïnfekteerde bloed is vir relatief min gevalle van infeksie verantwoordelik: Alle bloedskenkings in Suid-Afrika word aan streng toetse onderwerp en bloed wat deur Suid-Afrikaanse bloedbanke verskaf word, is waarskynlik (tans nog) van die veiligste ter wêreld. Verder word in die gesondheidsorgopset klem gelê op die nakoming van universele voorsorgmaatreëls (bv die dra van handskoene en maskers en die veilige hantering van skerp instrumente) om blootstelling aan bloed te voorkom. Slegs twee gevalle van VIGS in Suid-Afrika kan toegskryf word aan die deel van naalde tydens dwelmmisbruik. Gedrag wat hoë risiko inhou, kom dus in hoofsaak neer op onbeskermde seksuele omgang met 'n geïnfekteerde seksmaat of met iemand wie se HIV-status onbekend of onseker is. By gewone sosiale omgang is die risiko van infeksie weglaatbaar klein.

[7]Infeksie met HIV beteken nie op sigself dat 'n persoon siek is nie. So 'n persoon kan vir baie jare fiks bly, geen sigbare tekens van infeksie toon nie en 'n vol en produktiewe lewe lei. In hierdie stadium het 'n persoon nie VIGS nie. Daar word gesê dat 'n persoon VIGS het eers wanneer hy of sy sick word agv een of ander opportunistiese siekte. VIGS is die finale kliniese stadium van HIV-infeksie.

[8]Sien par 2.3 hieronder.

ontkenning van riskante gedrag en ontmoedig dit vrywillige toetsing. Sodoende word diegene wat risiko's loop, nie bereik nie en word hulle nie voorgelig omtrent noodsaaklike gedragsveranderings nie.

Daar word verder ook aanvaar dat VIGS en HIV-infeksie gedestigmatiseer en genormaliseer moet word in die oë van die samelewing omdat dit sal bydra om ongegronde diskriminasie uit die weg te ruim. So 'n benadering sou meebring dat VIGS en HIV-infeksie *dieselfde* as ander siektes en toestande behandel moet word. Nacosa[9] het byvoorbeeld reeds in 1993 in die konteks van VIGS en gesondheidsorg die volgende gesê: 'Policies must be implemented which ensure that HIV disease is regarded in the same way as other potentially progressive life threatening diseases.'[10]

Tog word dikwels ook aangedring op *uitsonderlike* behandeling wat juis die andersheid van HIV en VIGS beklemtoon. Voorstanders daarvan dat geïnfekteerdes in die werkplek geakkommodeer moet word en dat geen HIV-toetse voor indiensneming van voornemende werknemers vereis mag word nie,[11] steun op die feit dat mense vir jare gesond genoeg kan wees om 'n produktiewe lewe te lei. Terselfdertyd word egter ook aanspraak daarop gemaak dat geïnfekteerdes beskou moet word as 'gestremdes' wanneer dit bepaalde voordele vir hulle kan inhou.[12]

'n Aandrang op uitsonderlike behandeling blyk ook uit die beswaar wat soms gemaak word[13] teen die feit dat HIV-toetse vereis word voordat lewensversekeringskontrakte vir bepaalde bedrae[14] gesluit word, in weerwil van die feit dat die risiko wat met HIV-infeksie gepaard gaan, vergelykbaar is

---

[9]'The National AIDS Committee of South Africa'. Nacosa het in Oktober 1992 tot stand gekom nadat 'n ooreenkoms tussen die destydse regering en die ANC bereik is om die probleme rondom VIGS die hoof te probeer bied. Persone en instansies van die openbare en privaatsektor het sedertdien 'n gesamentlike nasionale strategie aangepak wat in 'n nasionale VIGS-plan neerslag gevind het (*Nacosa National AIDS Plan* (1994)).

[10]*National AIDS Strategy: Law Reform and Human Rights Sub-committee: Report of the Committee* 8. Hierna Nacosa se 1993-verslag genoem.

[11]Sien Nacosa se 1993-verslag 4 en 5.

[12]Sien die bespreking in par 2.3 hieronder.

[13]Sien bv Visser 'AIDS and insurance law: A preliminary laundry list of issues' 1993 *SAJHR* 130 136 vir redes van beswaar, meestal gegrond op menslikheidsoorwegings.

[14]Die Vereniging van Lewensversekeraars van Suid-Afrika het 'n nuwe VIGS-ooreenkoms en HIV-toetsprotokol op 1993-11-04 aanvaar. Hierdie ooreenkoms het op 1994-01-01 in werking getree met 'n verdere grasietydperk van ses maande waarbinne lede van die vereniging dit in werking moes stel. Hiervolgens word 'n negatiewe HIV-toets vereis alvorens 'n polis vir lewensversekering van R200 000 of meer, of ongeskiktheidsversekering van R2 000 per maand of meer uitgereik word. Indien die persoon wat aansoek om versekering doen nie die toets wil ondergaan nie, kan die versekeraar op versoek van die aansoeker 'n polis uitreik waarin voorsiening gemaak word daarvoor dat dekking uitgesluit sal wees in geval van dood of ongeskiktheid wat na die mening van die versekeraar in enige opsig, direk of indirek te wyte is of geheel of gedeeltelik voortvloei uit VIGS of HIV-infeksie. Toetsing vir HIV is nou (in teenstelling met die situasie voordat die nuwe ooreenkoms in werking getree het) die norm, en uitstluitingsklousules die uitsondering.

met dié wat deur kanker, sklerose of hartsiektes verteenwoordig word. Siektes wat so 'n verhoogde risiko meebring, kan nie deur 'n versekeringsisteem wat op 'n gesonde aktuariële basis berus, verontagsaam word nie.[15] Statistiek toon aan dat 'n persoon wat aan VIGS ly, waarskynlik binne twee jaar sal sterf en dat 'n persoon wat 'n HIV-draer is, se kanse om te sterf oor 'n periode van sewe jaar, ses-en-twintig keer hoër is as dié van iemand wat in 'normale' gesondheid verkeer.[16] Indien hoë-risiko gevalle nie opgespoor word nie, sal dit meebring dat sulke individue gesubsidieer word deur die ander polishouers. Dit kan ook antiseleksie meebring — die neiging van mense met swakker as gemiddelde gesondheidsvooruitsigte om in groter mate versekering te wil bekom as mense met gemiddelde en bo-gemiddelde gesondheidsvooruitsigte. Vanselfsprekend kan dit ernstige gevolge vir versekeraars inhou[17] en kan dit die finansiële posisie van ander polishouers benadeel aangesien laasgenoemde hoër premies sal moet betaal om vir verhoogde eise voorsiening te maak. Indien die versekeringsbedryf nie onderskei tussen mense met gewone gesondheidsvooruitsigte en diegene met HIV-infeksie nie, word laasgenoemde aansoekers in werklikheid bevoordeel bo ander polishouers.

Daar is ook geen eenvormigheid binne die geneeskundige opset wat betref die benadering ten opsigte van toetse vir HIV en vir ander mediese toestande nie. Die Suid-Afrikaanse Geneeskundige en Tandheelkundige Raad (SAGTR)[18] het vir die eerste keer in 1989[19] duidelik as etiese riglyn[20] gestel dat die ingeligte toestemming van die pasiënt noodsaaklik is voordat 'roetine-toetse' vir HIV gedoen word. Hierdie beginsel is die 1993-riglyne van die SAGTR[21] herbevestig en die Mediese Vereniging van Suid-Afrika het in 1992 in hul riglyne 'n soortgelyke voorskrif ingesluit.[22] Die siening is dat weens die *besondere* aard van VIGS en die wye implikasies van 'n positiewe uitslag, nie aanvaar kan word dat 'n HIV-toets gedek word deur 'n algemene toestemming vir bloedtoetse nie. Die pasiënt se uitdruklike toestemming vir hierdie toets moet verkry word en hy moet presies weet waartoe hy instem. Die pasiënt

---

[15]Die Versekeringswet 27 van 1943 vereis bv dat elke lewensversekeraar 'n aktuaris moet hê wie se hoofunksie dit is om te verseker dat die langtermynversekeringsbedryf op 'n gesonde finasiële grondslag berus.

[16]Clifford en Iuculano 'AIDS and insurance: The rationale for AIDS-related testing' 1987 *Harvard LR* 1806.

[17]Sien bv 'AIDS payouts cripple insurers' in *Business Day* 1994-11-01.

[18]Wat waarskynlik binnekort deur 'n Interim Nasionale Mediese Raad van Suid-Afrika vervang gaan word. Sien die Wysigingswetsontwerp op Geneeshere, Tandartse en Aanvullende Gesondheidsdiensberoepe, 1995.

[19]'Ethical considerations in the managment of patients with HIV infection' *SAGTR Bulletin* September 1989.

[20]Hierdie riglyn stel 'n maatstaf daar waaraan die optrede van geneeshere, ook wat betref die hoeveelheid inligting wat gegee moet word, gemeet kan word.

[21]'The management of patients with HIV infection or AIDS' *SAGTR Bulletin* April 1994 5.

[22]'Riglyne vir die hantering van MIV/VIGS' bylae tot *Die Suid-Afrikaanse Mediese Tydskrif* Desember 1992.

moet ingelig word nie net oor die mediese implikasies nie, maar ook oor die sielkundige en sosiale gevolge van die toets en van 'n positiewe uitslag. Dit is in teenstelling met die feit dat talle ander toetse,[23] waarvan die uitslag waarskynlik net so ontstellend kan wees, sonder die uitdruklike toestemming van 'n pasiënt uitgevoer kan word.[24] HIV-toetse en die implikasies van 'n positiewe uitslag word egter uitgesonder as iets waaroor die pasiënt omvattend ingelig en eintlik 'gewaarsku' moet word.[25] Daar kan geargumenteer word dat hierdie benadering juis die stigma wat aan VIGS kleef, laat toeneem.

Moet VIGS en HIV-infeksie *eenders* of *anders* as ander vergelykbare toestande, indien hulle bestaan,[26] benader word? Die gedagte dat mense met VIGS en HIV-infeksie se omstandighede uitsonderlik is — veral weens die sosiale gevolge van infeksie — is bevestig deur waarnemende appèlregter Harms (soos hy toe was) in die saak *Jansen van Vuuren NNO v Kruger*.[27] Hy laat hom soos volg uit:[28]

> There are in the case of HIV and AIDS special circumstances justifying the protection of confidentiality ... Disclosure of the condition has serious personal and social consequences for the patient. He is often isolated or rejected by others, which may lead to increased anxiety, depression and psychological conditions that tend to hasten the onset of so-called full-blown AIDS.

Bostaande uiteenlopende opvattings wat betref VIGS kan verklaar word aan die hand van die verskil tussen sogenaamde formele en substantiewe gelykheid. Vir sover dit die regte van mense betref, aanvaar eersgenoemde abstrakte konsep dat almal dieselfde is en dat hulle gelyk behandel moet word. Volgens voorstanders van substantiewe gelykheid neem formele gelykheid egter nie inherente biologiese verskille,[29] en ook nie verskanste of strukturele

---

[23] Die ontwikkeling van wetenskaplike hulpmiddels by die diagnose van siektes laat die vraag ontstaan of die pasiënt werklik ingelig kan word oor elke toets. Bloed word dikwels getoets vir suiker, cholesterol, serum en ander stowwe sonder dat die pasiënt voor die tyd daaromtrent ingelig word.

[24] Ander siektes soos kanker of sklerose word ook gevrees en die diagnose daarvan bring ook pyn en lyding mee.

[25] Hierdie etiese plig om omvattende inligting te gee, kan 'n swaar las op 'n geneesheer plaas. Die Suid-Afrikaanse samelewing bied eiesoortige probleme mbt ingeligte toestemming: In sommige gemeenskappe is die individu se toestemming nie voldoende nie, maar aanvaar die leier van die groep of stamhoof verantwoordelikheid vir so 'n persoon en moet hy/sy toestemming gee. Verder kan algemene kennis ten opsigte van sekere sake nie so geredelik aanvaar word nie.

[26] Pogings is aangewend om 'n vergelykbare siekte te identifiseer wat as model kan dien op grond waarvan beleid tov VIGS en HIV-infeksie gegrond kan word — sonder sukses. VIGS is al vergelyk met seksueel-oordraagbare siektes soos sifilis en gonorree (waaraan tradisioneel ook 'n sosiale stigma gekleef het, maar wat geneesbaar is), met aansteeklike siektes soos tuberkulose, (wat meestal geneesbaar is) en met terminale kanker (wat nie oordraagbaar is nie). Soms word dit beskou as die moderne ekwivalent van melaatsheid (Cameron en Swanson 'Public health and human rights — the AIDS crisis in South Africa' 1992 *SAJHR* 200 201).

[27] 1993 4 SA 842 (A).

[28] 854H.

[29] Bv tussen mans en vroue.

ongelykhede wat in die samelewing bestaan, in ag nie. Dit stel standaarde daar wat oënskynlik neutraal is, maar wat in wese bevoorregte groepe se posisie in die samelewing bevestig. Substantiewegelykheid daarenteenmaak voorsiening vir die verskillende omstandighede van mense[30] deur hulle verskillend te behandel.[31] By die toepassing van substantiewe gelykheid word die werklike sosiale en ekonomiese omstandighede van benadeelde groepe en individue ondersoek en word sosiale, ekonomiese en politieke belemmerings sover moontlik uitgeskakel.[32] In die konteks van VIGS sou dit meebring dat spesiale behandeling (en selfs beskerming) genoodsaak is juis vanweë die sosiale stigma en verwerping wat dikwels met die toestand gepaard gaan.

Die Suid-Afrikaanse Regskommissie is gedurende Januarie 1992 deur die Direkteur-generaal van Gesondheid[33] versoek om alle aspekte van die reg wat betrekking het op HIV-infeksie en VIGS te ondersoek, juis vanweë die gevoel dat 'n groot mate van diskriminasie op verskeie terreine en ten opsigte van talle aspekte van die reg voorkom en dat wetgewing moontlik die diskriminasie mag verminder en sodoende die VIGS-epidemie[34] kan help beperk.[35] 'n Projekkomitee is aangestel om die ondersoek te onderneem met die oog op moontlike wetgewing. Die (tussentydse) Grondwet van die Republiek van Suid-Afrika[36] het intussen in werking getree en die vraag ontstaan nou in watter mate daar reeds op die Grondwet as sodanig gesteun kan word om onbillike diskriminasie teen mense met HIV uit die weg te ruim.

DIE GRONDWETLIKE BEGINSEL VAN GELYKHEID

Die Grondwet is gebaseer op die beginsel van gelykheid. Die reg op gelykheid is trouens die eerste fundamentele reg wat in Hoofstuk 3 (die menseregteakte) genoem word. Dit word ook in die eerste grondwetlike beginsel in Bylae 4 van

---

[30]Du Plessis en Gouws "n Dialektiese perspektief op die statutêre en grondwetlike verwesenliking van vroueregte in Suid-Afrika' 1993 *Stellenbosch Regstydskrif* 240 242 wys op die fisiologiese verskille tussen mans en vroue. Hulle bespreek nie die kwessie of sosiaal gestruktureerde verskille — wat by HIV-infeksie van belang sal wees — ook erkenning behoort te geniet nie.

[31]Omdat dit 'n vrou se biologiese funksie is om kinders te baar, is sy bv geregtig op kraamverlof.

[32]Albertyn en Kentridge 'Introducing the right to equality in the interim Constitution' 1994 *SAJHR* 149 152. Volgens die siening is dit nie genoeg dat diskriminerende wette herroep word nie, maar moet daar ook positief opgetree word om gelykheid te bewerkstellig.

[33]Toe nog die Departement van Nasionale Gesondheid en Bevolkingsontwikkeling.

[34]Doyle 'Scenarios for the HIV/AIDS epidemic in South Africa' (voorgelê aan Nacosa in September 1993) skat dat indien geen radikale gedragsaanpassings gemaak word en geen geneesmiddel of entstof ontwikkel word nie, 21% van die volwasse Suid-Afrikaanse bevolking teen 2010 met HIV geïnfekteer kan wees en dat die infeksiekoers waarskynlik op daardie vlak sal stabiliseer.

[35]Hierdie opdrag het gespruit uit 'n werkswinkel wat die VIGS-eenheid van die Departement van Gesondheid in November 1991 oor die etiese en regsaspekte van VIGS en HIV aangebied het.

[36]200 van 1993. Hierna die Grondwet genoem.

die Grondwet genoem.[37] Die Grondwet steun verder klaarblyklik ook die beginsel van substantiewe gelykheid en maak uitdruklik voorsiening vir die uitskakeling van ongelykhede in die samelewing. Artikel 8(1) ken formele gelykheid aan almal toe en bepaal dat elke persoon die reg het op gelykheid voor die reg en op gelyke beskerming deur die reg, maar artikel 8(2) sonder groepe uit wat (voorheen) op sosiale, politieke of regsgebied benadeel is of wat kwesbaar op hierdie terreine is, of wat tot nog toe as tweedeklasburgers beskou is.[38] Artikel 8(2) bepaal naamlik dat daar teen niemand onbillik gediskrimineer mag word nie, hetsy direk of indirek, en, sonder om afbreuk te doen aan die algemeenheid van hierdie bepaling, in die *besonder*[39] op een of meer van die volgende gronde: ras, geslagtelikheid, geslag, etniese of sosiale herkoms, kleur, seksuele georiënteerdheid, ouderdom, gestremdheid, godsdiens, gewete, geloof, kultuur of taal. Artikel 8(3) maak vir regstellende optrede voorsiening juis om hierdie mense in staat te stel om op gelyke voet van regte en vryhede gebruik te maak.[40]

Uit bostaande blyk dit dat die Grondwet tegelykertyd voorsiening maak vir *eenderse* en *anderse* behandeling. Die gedagte word dikwels geopper dat die Grondwet primêr gerig sou wees op die opheffing van die slagoffers van onderdrukking en van apartheid.[41] Sou dit nou ook mense met VIGS of HIV op 'n soortgelyke manier beskerm? Sou hulle aanspraak kon maak op die reg op (formele) gelyke behandeling en op die *besondere* grondwetlike beskerming (substantiewe gelykheid) waarvoor artikel 8(2) en artikel 8(3) voorsiening maak, met ander woorde op beskerming teen ongelyke behandeling wat uit diskriminasie spruit?

Artikel 8(1)

Mense met HIV kan hulle eerstens beroep op die breë fundamentele reg op gelykheid voor die reg en op gelyke beskerming deur die reg wat in artikel 8(1) vervat word. Artikel 35(1) van die Grondwet maak vir regsvergelykende ondersoeke voorsiening en bepaal dat by die uitleg van Hoofstuk 3 die hof vergelykbare buitelandse hofbeslissings in ag *kan* neem. Hier lyk dit van pas

---

[37]Volgens a 71(1) moet die nuwe grondwetlike teks voldoen aan die grondwetlike beginsels en a 71(2) bepaal dat die Konstitusionele Hof moet sertifiseer dat al die bepalings van die nuwe grondwet aan die beginsels voldoen alvorens dit van krag sal wees.

[38]Albertyn en Kentridge 1994 *SAJHR* 149 154 en bronne aangehaal.

[39]My beklemtoning.

[40]Die tussentydse Grondwet bly slegs vir twee jaar staan. In die nuwe grondwet behoort regstellende optrede uitdruklik as 'n oorgangsmaatreël gestel te word, anders word geïmpliseer dat die nuwe grondwet ook geen gelykheid of geregtigheid sal kan meebring nie, sodat regstelling *in perpetuum* nodig sou wees. Die slotwoord in die Grondwet is in elk geval gerig op 'n 'toekoms wat gevestig is op die erkenning van menseregte ... ongeag kleur, ras, klas, geloof of geslag'.

[41]Sien bv Albertyn en Kentridge 1994 *SAJHR* 149 172; Botha 'The values and principles underlying the 1993 Constitution' 1994 *SA Publiekreg* 233 237 en *De Klerk v Du Plessis* 1994 (6) BCLR 124 (T) 128J. Dit kan ook uit die slotwoord van die Grondwet afgelei word dat die Grondwet 'n geskiedkundige brug (moet) bou 'tussen die verlede van 'n diep verdeelde gemeenskap ... en 'n toekoms wat gevestig is op die erkenning van menseregte ... ongeag kleur, ras, klas, geloof of geslag'.

om na byvoorbeeld vergelykbare Amerikaanse beslissings oor die reg op gelykheid te verwys.[42] Die Veertiende Amendement van die grondwet van die Verenigde State waarborg die 'equal protection of the laws'.[43] 'n Persoon wat hom op die gelyke beskerming van die reg beroep en wat byvoorbeeld wetgewing aan sogenaamde 'strict scrutiny' deur die howe wil laat onderwerp, sal moet bewys dat inbreuk op 'n fundamentele reg gemaak is en dat hy/sy tot 'n klas ('suspect class') behoort waarteen gediskrimineer word. Onderwerping aan 'strict scrutiny' bring mee dat die wetgewer sal moet bewys dat 'n dwingende staatsbelang by die betrokke wetgewing ter sprake is en dat die wetgewing spesifiek daarop gerig is om hierdie belang te dien.[44] Die Amerikaanse hooggeregshof het egter nie 'n baie wye interpretasie aan gelykheid gegee nie[45] en het uitdruklik geweier om 'suspect class'-status aan fisies of geestelik gestremde persone toe te ken.[46] Twee mindere vlakke van hersiening bestaan wel: sogenaamde 'intermediate review' wat toegepas word op byvoorbeeld wetgewing wat die gelykheid van die geslagte aantas en 'minimal scrutiny' oftewel 'rationality review' wat geld ten opsigte van alle ander wetgewing waar gelykheid ter sprake kom. In laasgenoemde gevalle word slegs vereis dat die staat moet aantoon dat 'n 'rational means to serve a legitimate end' aangewend is. Dit is dus onwaarskynlik dat by diskriminasie op grond van HIV-infeksie 'n beroep op vergelykbare Amerikaanse regspraak oor die Veertiende Amendement veel tot die omvattende beskerming van geïnfekteerdes sal kan bydra.

Artikel 33(1)

Selfs al sou mense met HIV hulle met sukses beroep op hul reg op gelykheid ingevolge die Suid-Afrikaanse Grondwet, geld hierdie reg nie absoluut nie. Die staat kan ingevolge artikel 33(1) van die Grondwet — wat 'n opweging van die staat se belange teenoor dié van die individu moontlik maak — aantoon dat die ongelyke behandeling van mense met HIV wel geoorloof is omdat dit in algemeen geldende reg vervat is, redelik en regverdigbaar is in 'n oop en demokratiese samelewing wat gebaseer is op vryheid en gelykheid, en nie die wesenlike inhoud van die reg ontken nie. Die reg op gelykheid is nie een van

---

[42]Die Kanadese Grondwet is ook vergelykbaar met die Suid-Afrikaanse Grondwet. Om egter op die Kanadese Grondwet, en meer spesifiek a 15(1) daarvan te steun, bring sy eie probleme mee (Albertyn en Kentridge 1994 *SAJHR* 149 158 ev). Sien ook Woolman 'Riding the push-me pull-you: Constructing a test that reconciles the conflicting interests which animate the limitation clause' 1994 *SAJHR* 60 70 mbt probleme wat spruit uit die eiesoortige aard van die geskiedenis en omstandighede in die VSA wat ook die oorname van hul standaarde en oplossings problematies maak.

[43]'No state shall ... deny to any person within its jurisdiction the equal protection of the laws.' Geen melding word verder, soos in ons Grondwet, van regstellende optrede of onbillike diskriminasie gemaak nie.

[44]Woolman 1994 *SAJHR* 60 68 wys daarop dat die verskillende vlakke van hersiening 'n maaksel van die Amerikaanse howe is. Sien ook Du Plessis 'A note on the application, interpretation, limitation and suspension clauses in South Africa's transitional Bill of Rights' 1994 *Stellenbosch Regstydskrif* 86 89.

[45]Albertyn en Kentridge 1994 *SAJHR* 149 158.

[46]Sien bv *City of Cleburne, Tex v Cleburne Living Centre* 105 S Ct 3249 (1985).

die regte wat strenger beskerm word en waarvan die beperking ingevolge artikel 33(1) van die Grondwet aan die bykomende voorwaarde van noodsaaklikheid ook moet voldoen nie.[47] Die staat sal gevolglik nie hoef aan te toon dat daar oorwegings is wat die onderskeid *noodsaak* nie. Die staat kan bloot aanvoer dat die beperking op die reg op gelykheid[48] van mense met HIV in die omstandighede redelik en regverdigbaar is.[49]

Artikel 8(2)

Mense met HIV kan hul verder beroep op die verbod op onbillike diskriminasie op grond van die besondere gronde wat in artikel 8(2) van die Grondwet genoem word. Een so 'n grondslag is 'seksuele georiënteerdheid'. Hierdie grondslag kan van belang wees vir homoseksuele mense met HIV. Sodomie (geslagsverkeer tussen manlike persone)[50] is 'n gemeenregtelike misdaad en 'n man[51] wat 'n onbehoorlike of onsedelike daad met 'n seun onder negentien pleeg, is ingevolge die Wet op Seksuele Misdrywe[52] aan 'n misdryf skuldig[53] waarvoor swaar strawwe opgelê kan word. Daar word in hierdie verband geargumenteer dat die positiewe reg homoseksuele mense se reg op gelykheid aantas in die sin dat hulle nie hul seksuele voorkeure op dieselfde wyse as ander lede van die samelewing kan uitleef nie. Ook word gemeen dat 'n eenvormige ouderdom waarop toestemming vir seksuele omgang verleen kan word, moet geld, of dit nou vir heteroseksuele of homoseksuele omgang is.[54] Andersyds word ook geargumenteer dat kriminalisering van hierdie bedrywighede die stryd teen VIGS in die wiele ry.[55] (Die impak wat 'n verbod op diskriminasie in hierdie verband op die verspreiding van HIV kan maak, is hedendaags egter van veel minder belang as vroeër. Uit onlangse statistiek is dit duidelik dat heteroseksuele geslagsomgang, gevolg deur oordrag van moeder na baba, die vernaamste wyse geword het waarop HIV tans in Suid-

[47]So 'n streng toets sou vergelykbaar wees met die 'strict scrutiny'-toets wat in sekere omstandighede in die VSA toegepas word.

[48]Bv by indiensneming of by die bepaling van byvoordele.

[49]Indien bewys kan word dat dit nie ekonomies regverdigbaar is om bv dieselfde byvoordele te verskaf aan mense met HIV as aan gesonde werknemers nie, sal dit mi nie onbillik of irrasioneel wees om HIV-geïnfekteerdes te identifiseer en om aan hulle minder gunstige byvoordele by indiensneming te bied nie.

[50]'Sodomie' is hoofsaaklik in die betekenis van 'onnatuurlike geslagsmidaad' deur die gemeenregtelike skrywers gebruik. Sien bv Van Leeuwen *Cens For* 1 5 28 8; Matthaeus *De Criminibus* 48 3 6 8.

[51]'n Vrou wat 'n onsedelike of onbehoorlike daad met 'n meisie onder negentien jaar pleeg, is sedert 1988 op soorgelyke wyse strafbaar, waarskynlik om gelykheid tussen die geslagte te bewerkstellig (Cameron en Swanson 1992 *SAJHR* 200 205). Homoseksuele dade tussen vroue dra egter nie dieselfde risiko van HIV-oordrag as wat bestaan in die geval van mans nie.

[52]23 van 1957.

[53]Sien a 14(3)(b).

[54]Sien Nacosa se voorstelle vir regshervorming in die 1993-verslag (op 18).

[55]Sien par 1 hierbo. Om dieselfde rede word ook die dekriminalisering en regulering van sekswerk (prostitusie) gepropageer.

Afrika versprei.[56] Dit is in skerp teenstelling met die periode van 1982 tot 1986 toe HIV-infeksie en VIGS in Suid-Afrika hoofsaaklik tot homoseksuele mans beperk was.[57])

Grondwetlike beskerming teen onbillike diskriminasie op grond van geslag kan moontlik 'n groter impak hê. Weens verskeie fisiologiese faktore[58] is vroue, en veral swart vroue in die mees produktiewe fase van hul lewe (15–40 jaar) baie meer vatbaar vir HIV-infeksie as mans.[59] Die mening bestaan dat die bemagtiging van vroue, veral diegene in tradisionele inheemsregtelike verhoudings, veel kan bydra in die stryd teen HIV-infeksie.[60] Die Grondwet stel dit duidelik dat daar teen niemand op grond van onder meer geslag, etniese of sosiale herkoms of kultuur onbillik gediskrimineer mag word nie[61] en wetgewing of besondere bepalings in wette wat die outonomie en gelykheid van vroue aantas,[62] sal deur die Konstitusionele Hof ongeldig verklaar kan word.[63]

Dit is egter so dat beskerming op grond van seksuele georiënteerdheid of op grond van geslag of kultuur of selfs ras[64] hoogstens maar 'n baie indirekte beskerming aan mense met HIV kan bied. Artikel 8(2) van die Grondwet stel dit duidelik dat die gronde waarop nie onbillik gediskrimineer mag word nie en wat genoem word, nie 'n *numerus clausus* uitmaak nie. Op hierdie gronde, wat waarskynlik maar net die mees bekende en algemene vorms van diskrimi-

---

[56]Teen 3 Maart 1995 is 'n totaal van 3 043 VIGS-gevalle onder volwasse mans aangemeld, terwyl 2 812 gevalle onder volwasse vroue en 715 gevalle van kinders wat deur hul moeders geïnfekteer is, aangemeld is (Departement van Gesondheid *Epidemiological Comments* Februarie 1995 45). Die getal VIGS-gevalle onder vroue is besig om dié onder mans in te haal.

[57]Departement van Gesondheid persverklaring (1993-05-14) 2.

[58]Sien bv *AIDSScan* Maart 1994 6.

[59]Die infeksiekoers onder vroue wat voorgeboorteklinieke besoek, was 4,69% in 1993, vergeleke met 2,69% in 1992, 1,49% in 1991 en 0,76% in 1990 (Küstner *Epidemiological Comments* April 1994 67; Swanevelder *Epidemiological Comments* April 1994 70).

[60]Weens hul ondergeskikte posisie vind vroue dit moeilik om hulself te laat geld in seksuele verhoudings en om bv op die gebruik van kondome aan te dring.

[61]A 8(2).

[62]In hierdie verband kan a 11(3) van die Swart Administrasiewet 38 van 1927 (wat die mindere status van swart vroue wat ingevolge inheemse reg getroud is, bestendig) moontlik onder die loep geneem word. Of hierdie (en ander) bepalings van die inheemse reg sal voldoen aan die vereiste van redelikheid en regverdigbaarheid wat a 33(1) van die Grondwet vir die beperking van fundamentele regte stel, sal nog beslis moet word.

[63]a 98(5) van die Grondwet.

[64]Die getal swartmense met VIGS neem geweldig vinnig toe en sal waarskynlik eersdaags nie meer die bevolkingsamestelling weerspieël nie. Teen 3 Maart 1995 was daar 5 823 swart VIGS-lyers teenoor 496 blanke VIGS-lyers (*Epidemiological Comments* Februarie 1995 287). Cameron 'Human rights, racism and AIDS: The new discrimination' 1993 *SAJHR* 22 27 meen dat HIV-infeksie velkleur en ras vervang het as grondslag vir diskriminasie en uitsluiting uit die gemeenskap.

nasie uiteensit, sou dus nog uitgebrei kon word.[65] Maar soms word nietemin in die konteks van VIGS direk op spesifieke beskerming ingevolge artikel 8(2) aanspraak gemaak, naamlik op grond van 'gestremdheid'.[66] Vir so 'n siening word dikwels gesteun op federale wetgewing in die Verenigde State van Amerika en die interpretasie wat die Amerikaanse howe daaraan gegee het.[67]

'n Geding is onlangs in die Transvaalse Provinsiale Afdeling van die Hooggeregshof[68] aanhangig gemaak teen die Minister van Veiligheid en Sekuriteit en die Kommissaris van Veiligheid en Sekuriteit juis op hierdie grondslag. Die 'Aids Law Project' van die Universiteit van die Witwatersrand, Regslui vir Menseregte, Popcru,[69] SAPU[70] en die Transvaalse tak van die 'Black Lawyers' Association' meen dat die beleid van die polisiediens om mense met HIV nie in diens te neem of permanent aan te stel nie, ongrondwetlik is en teen mense met HIV as gestremdes diskrimineer, en dat die beleid hersien moet word.

Soos hierbo vermeld, bepaal artikel 35(1) van die Grondwet dat die hof vergelykbare buitelandse hofbeslissing by die uitleg van Hoofstuk 3 in ag *kan* neem. Wat as 'vergelykbare hofbeslissing' in dié verband beskou kan word, is egter onseker. Verwys dit na beslissings wat oor die uitleg van ander menseregteaktes gegee is of sou beslissings wat ten opsigte van 'mindere' wetgewing gegee is, ook aanvaarbaar wees?[71]

Indien laasgenoemde opsie aanvaarbaar sou wees, kan algemene antidiskriminasiewetgewing in die Verenigde State en die interpretasie wat die howe daaraan gegee het, in hierdie verband van belang wees. Artikel 504[72] van die federale 'Vocational Rehabilitation Act' van 1973[73] verbied diskriminasie[74]

---

[65]Persone wat hierop wil uitbrei, sal moet bewys dat die diskriminasie onbillik is en dat dit die ondergeskikte posisie van 'n sekere groep of klas persone in die samelewing bevestig (Albertyn en Kentridge 1994 *SAJHR* 149 170).

[66]In Engels 'disability'.

[67]Nacosa verwys soos volg in sy 1993-verslag (op 22) na die begrip 'disability' (gestremdheid): 'This term has been held in judicial decisions overseas to include HIV and AIDS. We strongly endorse this development.'

[68]Saakno 22922/94. A 101(3) van die Grondwet bepaal dat 'n provinsiale of plaaslike afdeling van die Hooggeregshof binne sy regsgebied jurisdiksie het met betrekking tot onder meer enige beweerde skending of dreigende skending van 'n fundamentele reg wat in Hoofstuk 3 verskans is of enige geskil oor die grondwetlike bestaanbaarheid van 'n uitvoerende of administratiewe handeling of optrede ... van enige staatsorgaan.

[69]Die 'Police and Prisons Civil Rights Union'.

[70]Die Suid-Afrikaanse Polisievakbond.

[71]Lourens en Frantzen 'The South African Bill of Rights — public, private or both: A viewpoint on its sphere of application' 1994 *CILSA* 340 349 meen bv dat slegs buitelandse beslissings wat oor buitelandse menseregteaktes gegee is, 'vergelykbaar' is.

[72]Hierdie artikel is gegrond op Titel VI van die 'Civil Rights Act' van 1964 wat diskriminasie teen mense op grond van kleur, geloof of geslag verbied.

[73]Pub L No 93–112 Stat 355 (vervat soos gewysig in 29 USC parr 701–796 (1982)).

teen gestremdes deur 'n instelling wat federale fondse ontvang[75] *mits die persoon andersins bevoeg of geskik is om die werk te doen.*[76] Die Amerikaanse wetgewing is dus nie identies met artikel 8(2) van ons Grondwet wat in die algemeen onbillike diskriminasie teen gestremdes verbied nie. (Die voorwaarde in die Amerikaanse wetgewing dat iemand andersins bevoeg moet wees om die werk te doen, bring mee dat iemand wat fisies of verstandelik onbekwaam is om die werk te doen, nie beskerm word nie.[77] 'n Werker is ook nie geskik nie indien hy 'n beduidende gevaar[78] vir die gesondheid of veiligheid van ander persone (kollegas of die algemene publiek) verteenwoordig en die gevaar nie deur gewone maatreëls of redelike aanpassings ('accommodation') uitgeskakel kan word nie. Redelike aanpassings moet vir werknemers se gestremdhede gemaak word, nie aanpassings wat buitengewone ongerief of ontbering vir die werkgewer meebring nie.[79])

Die Amerikaanse wet[80] omskryf 'n gestremde persoon as iemand wat fisies[81]

---

[74]By indiensneming, diensbeëindiging en die bepaling van diensvoorwaardes. A 504 bepaal: 'No otherwise qualified handicapped individual in the United States .... shall, solely by reason of his handicap, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance or under any program or activity conducted by any Executive agency or by the United States Postal Service.' Hier word geen regstellende optrede geïmpliseer nie, maar bloot 'n verbod op diskriminasie geplaas.

[75]Die bepalings van die wet is ingevolge a 503 ook van toepassing op werkgewers wat kontrakte van meer as $2 500 met die federale owerheid aangaan, of wat federale fondse ontvang. Instansies soos hospitale en skole val hieronder.

[76]My beklemtoning. Iemand wat aanspraak maak op die beskerming van a 504 het die moeilike taak om te bewys dat hy so gestremd is dat 'n belangrike lewensaktiwiteit van hom aangetas is (sien vn 82), maar dat hy nie so erg gestremd is dat hy nie meer in staat is om sy werk te doen nie.

[77]Volgens die 'Department of Health and Human Services' is 'n gestremde persoon 'andersins geskik' indien hy met redelike aanpassings die essensiële funksies van sy werk kan verrig (Shumaker 'AIDS: Does it qualify as a 'handicap' under the Rehabilitation Act of 1973?' 1986 *Notre Dame LR* 572).

[78]Of 'n beduidende gevaar bestaan, moet deur die mediese wetenskap bepaal word. Waarskynlik moet minimale risiko's verduur word. Die risiko dat HIV in die normale werkplek sal versprei, is minimaal. Presies wat 'n beduidende ('significant') risiko sal uitmaak, bly onseker. Die gemeenskap is geneig om risiko's wat sosiale waarde het, te aanvaar. In die konteks van VIGS sou moontlik gesê kan word dat opportunistiese en oordraagbare siektes (soos tuberkulose wat weerstandig teen medisyne is) wat intree wanneer iemand volskaalse VIGS het, ander aan beduidende gevaar blootstel.

[79]Leonard 'AIDS in the workplace' in *AIDS and the Law* (red Dalton en Burris) (1987) 109 115. Wat presies redelike aanpassings is, is onseker en sou waarskynlik afhang van die grootte van die werkerskorps, die aard van die besigheid en koste wat daarmee verband hou. Dit sou moontlik die volgende inhou: dat spesiale toerusting verskaf moet word, dat die werklading verminder moet word, dat 'fleksietyd' ingestel moet word, dat rusperiodes toegestaan moet word, dat geleentheid vir mediese besoeke gegee moet word en dat die werkgewer sy werknemers volledig oor VIGS en die oordrag van HIV moet inlig.

[80]29 USC par 706(7)(B)(1982).

[81]By die toepassing van hierdie wet is fisiese gestremdheid al uitgelê as toestande wat die brein, die asemhalingstelsel, die bloed- en limfvatstelsel en die vel aantas (Leonard *AIDS and the Law* (red Dalton en Burris) 109 111). HIV kan ernstige neurologiese skade veroorsaak, terwyl opportunistiese siektes soos longontsteking,

of verstandelik in 'n belangrike lewensaktiwiteit[82] gestrem is, of 'n geskiedenis van so 'n gestremdheid het of as gestremd *beskou word*.[83]

Na die beslissing van die Verenigde State se hooggeregshof in *School Board of Nassau County v Arline*[84] en van die federale appèlhof in *Chalk v United States District Court, Central District of California*[85] word VIGS-lyers, waarskynlik ook HIV-geïnfekteerdes[86] en moontlik selfs mense ten opsigte van wie die vermoede bestaan dat hulle seropositief is, as gestremd ('handicapped') beskou.[87] Werkgewers in die owerheidsektor mag gevolglik nie teen hierdie persone by indiensneming, die bepaling van diensvoorwaardes of ontslag diskrimineer nie. Die wet maak dus daarvoor voorsiening dat gestremde, maar bekwame mense, nie ten gevolge van stereotipe opvattings, onverskilligheid of onnadenkendheid uit die werkplek gesluit word nie.[88]

---

tuberkulose en kanker die vel en asemhalingstelsel aantas.

[82]'Lewensaktiwiteite' sluit daardie funksies in wat 'n mens in staat stel om homself te versorg, eenvoudige take te verrig, te stap, te sien, te hoor, te praat, te leer en te werk (Leonard *AIDS and the Law* (red Dalton en Burris) 109 111). Leonard 'Employment discrimination against persons with AIDS' 1985 *University of Dayton LR* 681 691 meen dat die vermoë om siektes te beveg ook 'n belangrike lewensfunksie is.

[83]Om iemand wat as gestremd *beskou word*, by gestremdes in te sluit, is belangrik gesien in die lig van die stigma wat aan HIV-infeksie kleef.

[84]107 S Ct 1123 (1987). Die hof beslis dat 'n oordraagbare siekte (in die besondere geval tuberkulose) 'n gestremdheid kan wees 'which substantially limits ... major life activities' ingevolge die 'Vocational Rehabilitation Act'. Die 'Civil Rights Restoration Act' van 1987 (wat die Rehabilitation Act' wysig) het hierdie beslissing bevestig deurdat dit bepaal dat by die toepassing van a 503 en a 504 van die eersgenoemde wet, gestremdes in die werkplek nie ook individue insluit wat 'n 'currently contagious disease or infection' het of wat weens so 'n infeksie of siekte 'n direkte bedreiging vir die gesondheid of veiligheid van ander individue daarstel of wat weens die siekte of infeksie nie in staat is om die werk te doen nie. Hiermee is die onderskeid tussen 'n gestremdheid en 'n oordraagbare siekte of infeksie verwyder en word eerder gekyk na die vraag of die gestremde se toestand ander kan benadeel en of die gestremde die werk kan doen.

[85]46 FEP Cases 279 (9th Cir 1988). In hierdie saak het die hof beslis dat 'n onderwyser wat aan VIGS ly, deur a 504 van die 'Vocational Rehabilitation Act' beskerm word. Die hof bevind dat daar geen beduidende risiko van HIV-infeksie in die klaskamer bestaan nie, maar dat die onderwyser se geneeshere gereeld verslag moet doen oor die gevaar wat ander aansteeklike siektes waaraan hy ly, vir die skoolkinders mag inhou.

[86]Kushen 'Asymptomatic infection with the AIDS virus as a handicap under the Rehabilitation Act of 1973' 1988 *Columbia LR* 563.

[87]In *School Board of Nassau County v Arline* hierbo 1129 is die volgende gesê: 'Society's accumulated myths and fears about disability and disease are as handicapping as are the physical limitations that flow from the actual impairment.'

[88]Federale wetgewing om diskriminasie ook in die private werksopset te verbied, is in Julie 1990 aanvaar. The 'Americans with Disabilities Act' bied gestremdes in die private werkplek ongeveer dieselfde beskerming as dié wat aan werkers onder die 'Vocational Rehabilitation Act' verleen word. Die omskrywing van gestremdheid kom ooreen met dié wat in die 'Vocational Rehabilitation Act' voorkom, en sal VIGS-lyers en waarskynlik ook HIV-draers insluit. Die wet verbied werkgewers om teen 'n gestremde persoon, wat andersins vir die werk geskik is en die essensiële funksies daarvan kan verrig, te diskrimineer. Verder word vereis dat werkgewers redelike voorsiening vir gestremdes in die werkplek moet maak, tensy dit sou neerkom op 'undue hardship' vir die onderneming. Die bepalings van die wet het

Indien die Suid-Afrikaanse howe wat artikel 8(2) van die Grondwet uitlê, bostaande hofuitsprake as 'vergelykbaar' beskou, kan 'gestremdheid' in die Suid-Afrikaanse konteks 'n ooreenstemmende betekenis kryen kan VIGS-lyers, waarskynlik ook HIV-geïnfekteerdes en moontlik selfs mense ten opsigte van wie die vermoede bestaan dat hulle geïnfekteer is, op beskerming teen onbillike diskriminasie deur die owerheid aanspraak maak. Die staat en sy organe sal in geval van so 'n interpretasie ingevolge artikel 8(2) van die Grondwet nie onbillik teenoor hulle mag diskrimineer nie, byvoorbeeld waar die staat as werkgewer,[89] of verskaffer van gesondheids-[90] of onderwysdienste[91] optree. Ingevolge artikel 8(4) van die Grondwet word *prima facie*-bewys van diskriminasie op enige van die gronde in artikel 8(2) vermeld, geag voldoende bewys te wees van onbillike diskriminasie, totdat die teendeel blyk. Die bewyslas sal dan op die staat rus om te bewys dat sodanige diskriminasie in die besondere omstandighede nie onbillik is nie.

Die moontlikheid van billike diskriminasie

Artikel 8(2) bepaal dat daar teen niemand *onbillik* gediskrimineer mag word nie, hetsy direk of indirek, op grond van onder meer ras, geslagtelikheid, geslag, seksuele georiënteerdheid of gestremdheid. Artikel 8(3)(a) maak voorsiening vir optrede om ongelyke behandeling van die verlede reg te stel en lui soos volg: 'Hierdie artikel belet nie maatreëls wat daarvoor ontwerp is om die genoegsame beskerming en vooruitgang van persone of groepe of kategorieë persone wat deur onbillike diskriminasie benadeel is, te bewerkstellig ten einde hul volle en gelyke genieting van alle regte en vryhede moontlik te maak nie.'

---

in Julie 1992 in werking getree ten opsigte van werkgewers wat meer as 25 werknemers in diens het en ten opsigte van werkgewers wat meer as vyftien werknemers in diens het, het dit in Julie 1994 in werking getree. Werkgewers met minder as vyftien werknemers, word nie deur die bepalings van die wet geraak nie.

[89]Bv wat betref die beleid oor indiensneming, bevordering of byvoordele. A 27(1) van die Grondwet waarborg verder spesifiek dat elke persoon die reg op billike arbeidspraktyke het.

[90]Gesondheidsinrigtings wat met staatsfondse bedryf word, sal nie onbillik kan diskrimineer teen mense wat gesondheidsorg benodig nie. Aangesien standaard toerusting en basiese mediese voorsorg meestal as genoegsame beskerming teen HIV-oordrag beskou word en basiese mediese versorging meestal geredelik beskikbaar is, sou HIV-infeksie op sigself nie as voldoende rede vir weiering om 'n geïnfekteerde pasiënt te behandel, beskou kan word nie. A 30(1)(c) van die Grondwet waarborg verder ook elke kind ('n persoon onder 18 jaar) se reg op basiese gesondheidsdienste.

[91]In die lig van die uiters geringe risiko van HIV-oordrag in die skoolopset sal die weiering van volgehoue skoolbywoning bloot op grond van HIV-status van 'n leerling waarskynlik onbillik wees. Die Grondwet waarborg verder die reg op basiese onderwys in a 32. Die konsepregulasies ter vervanging van die Regulasies met betrekking tot Oordraagbare Siektes en die aanmelding van Aanmeldbare Mediese Toestand R 2438 van 1987-10-30, maak uitdruklik daarvoor voorsiening dat 'n prinsipaal nie 'n leerling wat 'n HIV-draer is of vermoedelik so 'n draer is, alleen op grond daarvan bywoning van 'n onderwysinrigting mag weier nie. (Sien reg 7(4) van die Konsepregulasies met betrekking tot Oordraagbare Siektes en die Aanmelding van Aanmeldbare Toestande, Kennisgewing 703 van 1993 (*SK* 15011 van 1993-07-30).) Hierdie konsepregulasies het nog nie in werking getree nie.

Uit bostaande is dit duidelik dat die nie-diskriminasie klousule nie absoluut geld nie. Daarvan getuig die voorsiening wat vir regstellende optrede gemaak word en die feit dat sodanige optrede nie getoets word aan die voorwaardes soos gestel in artikel 33 nie.[92] Verder kan die gebruik van die woord 'onbillik' as tiperend van onaanvaarbare diskriminasie in artikel 8 beteken dat 'billike' diskriminasie bestaanbaar en inderdaad aanvaarbaar is. Verskeie woordeboekdefinisies maak voorsiening vir 'n dubbele betekenis van 'diskrimineer', naamlik om *noukeurig* te onderskei en om *onbillik* te onderskei.[93] Die woord 'diskriminasie' het dus nie noodwendig 'n negatiewe betekenis nie. Tog word dikwels hedendaags aanvaar dat diskriminasie op sigself onregverdig of onbillik sal wees en dat dit geen positiewe konnotasie kan hê nie.[94] Diskriminasie word hiervolgens altyd geïnterpreteer as diskriminasie *teen* en nie *tussen* mense nie. Die Grondwet kan egter so uitgelê word dat die woord 'onbillik' daarin geskryf is om duidelik te maak dat wat verbode is, nie slegs onderskeid/differensiasie is nie, maar onderskeid wat sekere groepe of individue onbillik bevoor- of benadeel.[95] Met inagneming hiervan kom sommige skrywers[96] egter tot die gevolgtrekking dat onderskei moet word tussen diskriminasie teen lede van die (tot dusver) benadeelde groep en diskriminasie teen die (tot dusver) bevoorregte groep. Eersgenoemde word as ontoelaatbaar (onbillik) beskou omdat dit die bestaande agterstande voortsit en vererger, terwyl laasgenoemde nie noodwendig as onregverdig/onbillik beskou word nie. Die rede wat aangevoer word vir sodanige onderskeid tussen onbillike en billike diskriminasie, synde dat die een agterstande voortsit en vererger en die ander nie, gaan egter nie op nie[97] en kan die Grondwet laat verval in 'n blote politieke instrument wat op die lange duur nie aan die verwagtinge van die land se mense sal kan voldoen nie. Jenkins stel dit so:[98]

---

[92]Albertyn en Kentridge 1994 *SAJHR* 149 151 ev meen egter dat a 8(3)(a) en (b) nie uitsonderings op a 8(1) of 8(2) daarstel nie, maar dat die onderskeie subartikels mekaar aanvul en dat almal (substantiewe) gelykheid nastreef.

[93]Die *Woordeboek van die Afrikaanse Taal* (reds Schoonees en Toerien) (1974) gee die definisie as: '(1) verskil tussen persone of sake insien, in ag neem; noukeurig onderskei (2) [onbillike] onderskeid maak in behandeling of guns tussen twee of meer persone, groepe, volke ens.' Die *Concise Oxford Dictionary* (red Allen) (1991) beskryf 'discrimination' as: '(1) make or see distinction; differentiate (2) make a distinction esp. unjustly and on the bases of race, colour or sex (3) select for infavourable treatment (4) make or see or constitute a difference in or between (5) observe distinctions carefully; have good judgment'.

[94]Albertyn en Kentridge 1994 *SAJHR* 149 161.

[95]Cachalia *et al Fundamental Rights in the New Constitution* (1994) 28 gee bv so 'n interpretasie daaraan.

[96]Albertyn en Kentridge 1994 *SAJHR* 149 162.

[97]Sien bv Jenkins *Social Order and the Limits of the Law* (1980) 307 ev. Hy meen dat ook sg 'billike' diskriminasie, sy dit dan in die vorm van 'privileged admission' tot Amerikaanse universiteite, die agterstande van die benadeeldes sal bevestig en vererger:'(I)t is my fear that these programs ... will ... lead to both a general lowering of standars and the proliferation of special standards for various minorities'. Sien ook Farber 'The outmoded debate over affirmative action' 1994 *California LR* 893 ev.

[98]311.

> (T)he single-minded pursuit of a particular goal — no matter how worthwhile this may be — blinds us to the larger context in which this pursuit must take place and to the further consequences it inevitably entails. The more passionate and narrowly focused is this pursuit of a particular goal, the more vital it is to have clearly in mind a view of the full field of legal action... (T)he harm we ultimately cause is almost certain to outweigh the good we temporarily achieve.

Die volgende woorde van regter Van Dijkhorst is ook in hierdie verband van belang:[99]

> A constitution ... is drafted with an eye to the future. Its function is to provide a continuing framework for the legitimate exercise of governmental power, and, when joined by a bill of rights, for the unremitting protection of individual rights and liberties. Once enacted, its provisions cannot easily be repealed and amended. It must, therefore, be capable of growth and development over time to meet new social, political and historical realities often unimagined by its framers.

Dit is denkbaar dat omstandighede teenwoordig kan wees wat dit billik maak om (noukeurig) tussen mense met HIV en diegene wat nie geïnfekteer is nie, te onderskei. So 'n onderskeid sal op rasionele oorwegings moet berus. Om te diskrimineer op grond van HIV-infeksie alleen, sal bes moontlik onbillik wees, maar indien bykomende faktore soos die veiligheid van ander of dwingende ekonomiese oorwegings aanwesig is, kan so 'n onderskeid billik wees: '(B)y using the word 'unfairly' it (die Grondwet) accommodates the view that discrimination may have a different quality in different contexts, and requires that the specific context is taken into account'.[100] Diskriminasie kan geregverdig wees as 'a fair and rational means of achieving the end of full equality'.[101] Om te voorkom dat HIV-geïnfekteerdes onbillik bo ander mense bevoordeel word, sou dit aanvaarbaar wees om hulle in bepaalde omstandighede noukeurig van ander te onderskei en anders te behandel.

Artikel 8(3)

In aansluiting hierby ontstaan die vraag op mense met HIV aanspraak behoort te kan maak op regstellende optrede ingevolge artikel 8(3) van die Grondwet en op maatreëls van owerheidsweë wat hulle bo ander bevoordeel. Regstellende optrede is waarskynlik daarop gemik om die belange van persone wat in die verlede aan sistematiese onbillike diskriminasie, veral op politieke terrein, onderworpe was, te beskerm en te bevorder. Dit sluit waarskynlik nie mense met HIV in nie, tensy hulle kan bewys dat die diskriminasie wat hulle ondervind onbillik is en dat dit hul ondergeskikte posisie in die samelewing bevestig.[102]

Samevatting

Uit bostaande blyk dit dat Amerikaanse beslissings moontlik van groter regsvergelykende waarde by die interpretasie van artikel 8(2) as by die

---

[99]*De Klerk v Du Plessis* hierbo 1283.

[100]Albertyn en Kentridge 1994 *SAJHR* 149 162.

[101]*Ibid.*

[102]Sien vn 41 en vn 65 hierbo.

interpretasie van artikel 8(1) van die Grondwet kan wees. Die hof wat artikel 8 uitlê, is natuurlik nie verplig om die genoemde (of ander) buitelandse beslissings in ag te neem nie. Dit is moontlik dat die hof in elk geval sal beslis dat (formele) gelykheid voor die reg omvattend uitgelê moet word en dat kwesbare persone beskerm moet word en/of dat mense met VIGS, sowel as mense met HIV, as gestremdes beskou moet word wat op substantiewe gelykheid geregtig is.[103]

Indien aanvaar word dat mense met HIV konstitusionele beskerming teen onbillike diskriminasie deur die staat en sy organe geniet, sal die beskerming oor 'n wye terrein geld, byvoorbeeld waar die staat as werkgewer of as verskaffer van dienste optree. Om teen iemand te diskrimineer op grond van sy HIV-infeksie alleen, dit wil sê sonder dat daar ander rasionele en aanvaarbare redes vir die ongelyke behandeling voorhande is, sal stellig neerkom op onbillike diskriminasie en op 'n aantasting van die persoon met HIV se reg op gelykheid.

DIE ENTITEITE WAT DEUR HOOFSTUK 3 GEBIND WORD

Die staat en sy organe

Artikel 4(1) bepaal dat die Grondwet oppergesag het en artikel 4(2) bepaal dat die Grondwet alle wetgewende, uitvoerende en regsprekende staatsorgane op alle regeringsvlakke bind. Artikel 7(1) verklaar dat Hoofstuk 3 alle wetgewende en uitvoerende staatsorgane[104] op alle regeringsvlakke bind. Waarskynlik bind die meer spesifieke bepaling in artikel 7(1) die meer algemene bepaling in artikel 4(2) wat betref fundamentele regte en hul toepassing en is die eerste afleiding wat gemaak kan word dat regsprekende organe nie sonder meer deur Hoofstuk 3 gebind word nie.[105]

Artikel 7(2) verklaar verder dat die menseregteakte van toepassing is op alle reg wat van krag is[106] en op alle administratiewe besluite wat geneem word en handelinge wat verrig word gedurende die tydperk waarin hierdie Grondwet in werking is. Artikel 35(3) bepaal dat by die uitleg van enige wet en die toepassing en ontwikkeling van die gemene reg en gewoontereg, 'n hof die gees, strekking en oogmerke van die menseregteakte behoorlik in ag (moet) neem. Artikel 33(2) bepaal dat 'geen regsreël, hetsy 'n reël van die gemene reg,

---

[103]Die begrip substantiewe geregtigheid sluit ook regstellende optrede in, alhoewel dit soos hierbo aangetoon, waarskynlik nie op mense met HIV toepassing sal vind nie. Sien ook vn 32 hierbo.

[104]Volgens a 233(xii) van die Grondwet beteken 'staatsorgaan' ook 'n statutêre liggaam of funksionaris.

[105]Sien Brassey 'Labour relations under the new Constitution' 1994 *SAJHR* 179 189. Hy kom tot die gevolgtrekking dat die regsprekende gesag net in sommige situasies (waar dit regte en verpligtinge oplê en nie slegs regte en pligte wat reeds tussen privaatpersone bestaan, bevestig nie) aan Hoofstuk 3 gebonde gehou sal word. Sien ook Van der Vyver 'The private sphere in constitutional litigation' 1994 *THRHR* 378 ev.

[106]Van der Vyver 1994 *THRHR* 378 390 meen dat hiermee duidelik gestel word dat die menseregteakte van toepassing is op bestaande reg en nie slegs op wette wat na die inwerkingtreding van die Grondwet tot stand kom nie.

gewoontereg of wetgewing' enige reg wat in Hoofstuk 3 verskans is, mag beperk nie, behalwe soos in artikel 33(1) of enige ander bepaling van die Grondwet, bepaal.

'n Saamlees van al hierdie artikels het sommige skrywers tot die gevolgtrekking laat kom dat die Grondwet nie net vertikaal nie (maw tussen die onderdaan en die staat nie), maar ook horisontaal, dit wil sê op regsverhoudings tussen persone onderling kan geld.[107] Hierdie siening word moontlik versterk deur die gedagte dat die tradisionele, 'libertynse' (en myns insiens korrekte) benadering (waarvolgens 'n grondwet owerheidsoptrede moet beperk en kontroleer[108] eerder as om verpligtinge op private individue te plaas)[109] vervang behoort te word deur 'n meer progressiewe, 'bevrydende' benadering.[110] Volgens laasgenoemde benadering het die sosiale welvaartstaat 'n verpligting om alle burgers se regte op bemagtiging en welvaart omvattend te beskerm. So 'n progressiewe bedoeling, dit wil sê om af te wyk van die tradisionele rol van 'n grondwet, blyk egter nie uit die bepalings van die Grondwet nie.[111] Artikel 33(4) bepaal byvoorbeeld uitdruklik dat Hoofstuk 3 nie maatreëls wat daarvoor ontwerp is om onbillike diskriminasie deur *ander liggame en persone* as dié wat ingevolge artikel 7(1) gebonde is, te verbied nie. Indien die wetgewer dit wenslik ag, kan wetgewing mettertyd

[107]Sien bv Basson *South Africa's Interim Constitution: Text and Notes* (1994) 15; Du Plessis 1994 *Stellenbosch Regstydskrif* 86 88; Albertyn en Kentridge 1994 *SAJHR* 149 160; Kruger 'Die beregting van fundamentele regte gedurende die oorgangsbedeling' 1994 *THRHR* 396 400.

[108]Volgens Mureinik 'A bridge to where? Introducing the interim Bill of Rights' 1994 *SAJHR* 31 32 vorm die menseregteakte 'n brug vanaf 'n kultuur van outoriteit na een van verantwoording: 'A Bill of Rights is a compendium of values empowering citizens affected by laws or decisions to demand justification.'

[109]Sien Brassey 1994 *SAJHR* 179 191; *De Klerk v Du Plessis* hierbo 125.

[110]Du Plessis 'The genesis of the chapter on fundamental rights in South Africa's transitional Constitution' 1994 *SA Publiekreg* 1 2–4 skets die stryd tussen die 'libertarians' en die 'liberationalists' by die opstel van die Grondwet. Eg is gesteld op individuele vryheid en minimale inmenging deur die staat. Lg is ten gunste van gelykheid (veral wat betref die verspreiding van middele), staatsinmenging, sosio-ekonomiese opheffing en tweede- en derdegenerasieregte. Eg het die oorhand gehad by die opstel van die tussentydse Grondwet (daar het bv maar weinig tereg gekom van sosio-ekonomiese regte) maar daar kan verwag word dat die finale Grondwet groter erkenning aan lg se waardes en aan bv sosio-ekonomiese regte sal verleen.

[111]R Van Dijkhorst beslis dat die bedoeling van die Grondwet gesoek moet word 'within the four corners of the Constitution' en dat dit nie korrek is om by die interpretasie van die Grondwet te kyk na geskrifte van persone wat betrokke was by die grondwetlike onderhandelings te Kempton Park nie: 'The drafters are presumed to intend what they expressed to be their intention' (*De Klerk v Du Plessis* hierbo 130C). Ook Marcus 'Interpreting the chapter on fundamental rights' 1994 *SAJHR* 92 98 meen dat dit min betekenis sal hê om na die voorafgaande debatte te kyk. Sien egter Du Plessis 1994 *SA Publiekreg* 1 vir 'n teenoorgestelde standpunt oor die waarde van die *travaux préparatoires*. Verskeie teorieë oor die uitleg van grondwetlike tekste bestaan: die teorie wat soek na die oorspronklike bedoeling van die opstellers of na die gewone betekenis van woorde; die teorie wat poog om die teks in sy geheel uit te lê (die strukturaliste) en die teorie wat klem lê op die politieke proses en die beskerming van minderhede (Woolman 1994 *SAJHR* 60 79).

dus ook op dié terrein aanvaar word. Nóg private persone nóg regspersone word in artikel 7(1) genoem. Aangesien die weglating van sulke belangrike kategorieë[112] kwalik 'n oorsig kan wees, moet die gevolgtrekking wees dat hulle nie deur artikel 7(1) gebonde is nie. Wat betref artikel 7(2) wat die akte toepaslik maak op 'alle reg wat van krag is' en artikel 33(2) wat bepaal dat die gemene reg nie uitgesluit is van die howe se toetsingbevoegdheid nie, kan tot die gevolgtrekking gekom word dat alhoewel hierdie artikels verwys na wetgewing, gemene reg en gewoontereg, dit nie beteken dat hulle geld ten opsigte van *alle* toepassings van hierdie onderskeie regsbronne nie, maar slegs in die mate wat hulle die posisie reël van entiteite wat deur Hoofstuk 3 gebind word, met ander woorde die staat in sy wetgewende en uitvoerende vertakkings.[113] Die wetgewer wat gemene reg in wetgewing bevestig, sal ingevolge so 'n siening deur Hoofstuk 3 gebonde wees. Wetgewing is 'n vorm van owerheidsingreep, dit het openbare status en kan teen die Grondwet getoets word.[114] Artikel 7(2) gee met ander woorde die wetgewer opdrag om by wetgewing die grondwetlike regte te eerbiedig en om nie diskriminerende wetgewing uit te vaardig nie. Die optrede van private persone val egter buite die trefwydte van Hoofstuk 3 in die mate wat hul handelings nie op wetgewing nie, maar op die gemene reg, of selfs op geen regsreëling nie,[115] berus.

Artikel 35(3), wat 'n hof opdrag gee om by die uitleg van gemene reg en gewoontereg die gees, strekking en oogmerke van Hoofstuk 3 in ag te neem, kan verder bloot beskou word as 'n benadering tot die interpretasie, aanwending en ontwikkeling van ons reg wat uitdrukking moet gee aan die gees van die menseregteakte en wat daarna streef om regsreëls eerder met geldigheid as met ongeldigheid te beklee.[116] Indien die moontlikheid van horisontale werking na aanleiding van die begrip *mittelbare Drittwirkung* in die Duitse reg ondersoek word,[117] kan die gevolgtrekking gemaak word dat horisontale werking net toepassing behoort te vind waar gemeenregtelike reëls abstrak en algemeen bewoord is en waar die howe 'n wye diskresie gegee is by die interpretasie daarvan. Horisontale werking sou dienooreenkomstig gelding kon geniet in omstandighede waar die gemene reg geen duidelik toepaslike reël het nie of waar die reëls vaag en weersprekend is.[118]

Die Konstitusionele Hof het nog geen uitstluitsel oor die aangeleentheid gegee

---

[112]Volgens Brassey 1994 *SAJHR* 179 186 ev dui a 14(2), a 23 en a 33(1) ook op die uitsluiting van private persone. Private persone kan bv nie 'algemeen geldende reg' waarna a 33(1) verwys, tot stand bring nie.

[113]Sien Brassey 1994 *SAJHR* 179 184.

[114]Lourens en Frantzen 1994 *CILSA* 340 345.

[115]Sien ook Powell 'African customary law, equality and the guarantee of propery under a bill of rights' (LLB-skripsie 1993 Universiteit van Kaapstad) 39–40 soos aangehaal deur Visser 'The future of the law of delict' in *Die Toekoms van die Suid-Afrikaanse Privaatreg* (red Van Aswegen) (1994) 26 34.

[116]Brassey 1994 *SAJHR* 179 187

[117]Sien bv Bennett 'The equality clause and customary law' 1994 *SAJHR* 122 127.

[118]'(W)henever there is room for interpretation ... and development of the common law' (*De Klerk v Du Plessis* hierbo 133F).

nie en die uitsprake van die Hooggeregshof in dié verband — wat weliswaar almal oor die vryheid van uitdrukking soos vervat in artikel 15(1) van die Grondwet gehandel het — weerspreek mekaar.[119] In die lig van bostaande, myns insiens oortuigende, argumente en met inagneming van die besondere reg wat hier ter sprake is[120] (die reg op gelykheid en die verbod op onbillike diskriminasie) word vir die verdere bespreking aanvaar dat slegs 'die wetgewende en uitvoerende staatsorgane'[121] gebonde is aan artikel 8 van die Grondwet en dat hierdie artikel nie horisontale werking sal hê nie. Indien hierdie artikel horisontale werking gegee word, kan dit in botsing kom met verskeie ander fundamentele regte[122] en 'n groot terrein van die privaatreg in onsekerheid dompel.[123]

In die mate wat die gemene reg, of selfs geen regsreël nie, dus die verhouding tussen individue of regspersone onderling reël, word dit myns insiens nie deur die bepalings van artikel 7(2) gebind nie. Die hof sal wel ingevolge artikel 35(3) by die uitleg van enige wet en die toepassing en ontwikkeling van die gemene reg en gewoontereg, die gees, strekking en oogmerke van Hoofstuk 3 in ag moet neem. Hoofstuk 3 sal met ander woorde dien as riglyn by die interpretasie van onduidelike of dubbelsinnige bepalings.

Private persone en regspersone?

Wat sou nou die posisie wees wat betref verhoudings tussen byvoorbeeld werkgewer en voornemende werknemer of geneesheer en pasiënt? Sou voorindiensnemingstoetse vir HIV en die weiering om mense met HIV in diens te neem in die private werkplek byvoorbeeld aanvaarbaar wees? Alhoewel die huidige Wet op Arbeidsverhoudinge[124] werknemers, insluitend dié met HIV,

---

[119]In *Mandela v Falati* 1994 (4) BCLR 1 (W) het r Van Schalkwyk beslis dat Hoofstuk 3 horisontale werking het. In *De Klerk v Du Plessis* hierbo het r Van Dijkhorst beslis dat Hoofstuk 3 net vertikale werking het. In *Gardener v Whitaker* 1994 (5) BCLR 19 (E) het r Froneman beslis dat alhoewel Hoofstuk 3 primêr gerig is op die beskerming van die individu teen die staat, dit — afhangende van die spesifieke reg en die omstandighede — ook horisontale werking kan hê.

[120]Sien *Gardener v Whitaker* hierbo 31BC.

[121]Waarskynlik word hierby ook liggame inbegryp wat onder beheer van die staat staan of wat 'n tradisionele owerheidsfunksie verrig, maar die posisie is geensins eenvoudig nie en hierdie bepaling sal deur die howe uitgelê moet word. Van der Vyver 1994 *THRHR* 378 391 wys daarop dat daar enersyds geargumenteer kan word dat die bepaling so wyd as moontlik uitgelê moet word, maar dat daar aan die ander kant gewaak moet word teen totalitarisme. In die Kanadese beslissing *McKinney v University of Guelph* (1991) 76 DLR (4th) 545 is drie toetse bv aangewend om te bepaal of die Kanadese handves van toepassing is op 'n universiteit se regulasies: die mate van beheer wat die owerheid oor die universiteit uitoefen, die mate waarin die universiteit owerheidsfunksies verrig en die mate waarin dit 'n bepaalde regeringsdoelstelling moet bevorder.

[122]Bv die reg op vryheid van assosiasie (a 17) en die reg op vryheid van ekonomiese verkeer (a 26).

[123]Dit is ondenkbaar dat die opstellers van die Grondwet so-iets bedoel het. Sien *De Klerk v Du Plessis* hierbo 125CE.

[124]28 van 1956.

teen onbillike arbeidspraktyke beskerm,[125] word aansoekers om werk nie teen sodanige arbeidspraktyke of 'n diskriminerende indiensnemingsbeleid beskerm nie. Die siening was tot nog toe dat die posisie van aansoekers om werk òf deur geen regsreëls beheer is nie, òf dat die bestaande gemeenregtelike beginsel van vryheid van kontraksluiting tussen private individue en/of regspersone geld. Hiervolgens sou voorindiensnemingstoetse vir HIV toelaatbaar wees, natuurlik mits die aansoeker om werk sy ingeligte toestemming daartoe gee.[126] Op dieselfde basis kan 'n geneesheer tans met sekere uitsonderings,[127] regtens[128] weier om mense met HIV te behandel.

Ooreenkomstig bostaande uiteensetting word kontrakte wat ingevolge die gemene reg gesluit word, waar die regsbeginsels duidelik is en waarby die staat geen party is nie, nie deur die werking van Hoofstuk 3 en die verbod op onbillike diskriminasie geraak nie. Die toetsing en uitsluiting van HIV-geïnfekteerdes wat aansoek doen om werk in die private sektor, of die weiering van 'n geneesheer wat vir sy eie rekening praktiseer om pasiënte met HIV te behandel, val gevolglik buite die trefwydte van Hoofstuk 3 omdat dit uitsluitlik te doen het met 'n private aangeleentheid. Ook by die uitleg van die gelykheidsbeginsel in die Grondwet sal aansoekers om werk in die private werkplek waarskynlik geen aanspraak op beskerming teen onbillike arbeidspraktyke hê nie omdat die bestaande wetgewing (die Wet op Arbeidsverhoudinge) geen inbreuk op hul vooraf bestaande regte gemaak het nie. Die hof het slegs die bevoegdheid om positiewe inbreuke op bestaande regte te voorkom.[129] Op dieselfde wyse sou pasiënte met HIV regtens geen aanspraak op behandeling deur private geneeshere hê nie.

Die voorstelle vir 'n nuwe Wet op Arbeidsverhoudinge[130] moet waarskynlik

---

[125]Sien bv Strauss 'Employees with AIDS: Some legal issues' *Huldigingsbundel vir WA Joubert* (red Strauss) (1988) 140; Van Wyk 'Enkele opmerkings oor VIGS in die werkplek' 1988 *De Jure* 326.

[126]Oor die praktiese voordele van sulke toetse bestaan daar min eenstemmigheid. Sien bv Mokhobo 'AIDS: Balancing individual rights with business imperatives' 1993 *SAJHR* 105 en Albertyn en Rosengarten 'HIV and AIDS: Some critical issues in employment law' 1993 *SAJHR* 77.

[127]Bv waar 'n noodgeval ter sprake is.

[128]Ingevolge die SAGTR se 1993-riglyne is sodanige weiering nie eties korrek nie. Sien vn 21 hierbo.

[129]Volgens Brassey 1994 *SAJHR* 179 193 ev bring hierdie interpretasie mee dat die gelykheidsklousule slegs aangewend kan word om die bevoorregte groep in dieselfde posisie as die benadeeldes te plaas en sal dit geen verbetering in die posisie van aansoekers om werk teweegbring nie. Indien 'n wyer, meer indirekte benadering gevolg word (wat nie hier voorgestaan word nie), kan geargumenteer word dat die uitsluiting van aansoekers om werk van die beskerming van die Wet op Arbeidsverhoudinge neerkom op 'n verbreking van die reg op gelykheid en op billike arbeidspraktyke deur 'n staatsorgan (die wetgewer). Ingevolge so 'n benadering sou die hof moontlik bereid wees om 'n bevel te gee wat aansoekers se uitsluiting uit die wet verwyder of wat die wetgewer opdrag gee om dit te doen (mits die 'oorsig' deur die wetgewer nie deur a 33(1) gedek word nie).

[130]Sien die *Draft Negotiating Document in the Form of a Labour Relations Bill*, Kennisgewing 97 van 1995 (*SK* 16259 van 1995-02-10). Die konsepwet is ongelukkig slegs in Engels beskikbaar.

in die lig van bostaande beoordeel word en kan beskou word as 'maatreëls wat daarvoor ontwerp is om onbillike diskriminasie deur ander liggame en persone as dié wat ingevolge artikel 7(1) gebonde is, te verbied'.[131] Die primêre oogmerk van die konsepwetgewing is onder meer om gevolg te gee aan die fundamentele reg op billike arbeidspraktyke soos vervat in artikel 27 van die Grondwet.[132] Die konsepwet sal (met enkele uitsonderings) van toepassing wees op alle werknemers[133] sowel as op 'any person seeking employment'.[134] Ingevolge die voorstelle sal 'n werkgewer in die privaat sektor in die toekoms nie onbillik[135] kan diskrimineer teen (gestremde)[136] aansoekers om werk nie.[137] Om op grond van HIV-infeksie alleen te onderskei, met ander woorde sonder dat daar rasionele redes vir die onderskeid aangevoer kan word, sal waarskynlik op onbillike diskriminasie en op 'n onbillike arbeidspraktyk neerkom.[138] Die konsepwet maak egter voorsiening daarvoor dat die vereistes van die besondere betrekking bepaalde onderskeide mag noodsaak.[139] Die verbod op onbillike diskriminasie beteken dus nie sonder meer dat 'n private werkgewer verplig sal kan word om mense in diens te neem ongeag hul HIV-status nie. Omstandighede kan voorsien word waar dit billik sal wees om iemand aan 'n HIV-toets te onderwerp voor indiensneming. Dit sou die geval wees waar wetenskaplike getuienis byvoorbeeld aantoon dat HIV-infeksie in 'n bepaalde betrekking 'n

---

[131]A 33(4) van die Grondwet.

[132]klousule 2 van die konsepwet.

[133]Klousule 1 bepaal dat die wet van toepassing sal wees op alle werknemers en werkgewers in die Republiek, 'save for members of the National Defence Force ... the agencies or services established by section 3 of the Intelligence Services Act ... and the South African Police Service contemplated in section 214 of the Constitution'.

[134]klousule 5(1).

[135]Gelykluidende bepalings as in die Grondwet word gebruik. In die lig daarvan dat klousule 3 bepaal dat die nuwe wetgewing uitgelê moet word in ooreenstemming met die Grondwet, is dit nie vreemd nie.

[136]Soos hierbo gesien, moet 'gestremdheid' soos vervat in a 8 van die Grondwet, nog vertolk word en moontlik sal dat ook HIV-infeksie insluit.

[137]Volgens Van der Vyver 1994 *THRHR* 378 380 kan inmenging in die privaatsfeer in die werkplek tot 'n mate geregverdig word in die lig daarvan dat daar 'n analogie tussen publiekreg — die ware terrein van 'n menseregteakte — en werkgewer-werknemerverhoudings is:' Both are founded on conditions of authority and subordination, and since human rights protection addresses the abuse of authority by the repositories of such authority in power relations, there can be no serious objections to applying a bill provision in the area of labour.' (Hy verwys hier spesifiek na a 9.3 van die Duitse *Grundgesetz* wat vryheid van assosiasie in die konteks van arbeidsverhoudinge waarborg en uitdruklik voorsiening daarvoor maak dat enige ooreenkoms wat daardie vryheid wil beperk of uitsluit, nietig sal wees.)

[138]Volgens klousule 186(1) sluit 'n onbillike arbeidspraktyk die volgende in: '(a) the unfair discrimination, either directly or indirectly, against an employee on the grounds of race ... sex .... sexual orientation ... disability ...(b) the unfair conduct of the employer concerning the promotion, demotion or training of an employee or the provision of benefits to an employee'.

[139]Klousule 186(1)(a) bepaal dat geen onbillike diskriminasie op genoemde gronde mag plaasvind nie '(p)rovided that any distinction, exclusion or preference based on the inherent requirements of the particular position shall not constitute unfair discrimination'.

gevaar vir die veiligheid of gesondheid van ander inhou.[140]

BOTSENDE GRONDWETLIKE WAARDES

Bostaande bespreking, insluitende dié oor die voorgestelde wetgewing oor arbeidsverhoudinge moet egter gesien word teen die agtergrond van artikel 11 van die Grondwet (wat die vryheid en sekuriteit van die persoon waarborg), artikel 17 (wat die vryheid van assosiasie waarborg) en artikel 26(1) (wat die vryheid van ekonomiese verkeer waarborg). Wetgewing wat inbreuk op hierdie regte maak, kan aangeveg word. (Artikel 26(2) bepaal egter dat subartikel (1) nie maatreëls belet wat daarvoor ontwerp is om 'die beskerming of die verbetering van die lewenskwaliteit, ekonomiese groei, mensontwikkeling, sosiale geregtigheid, ... billike arbeidspraktyke of gelyke geleenthede vir almal te bevorder nie, mits sodanige maatreëls regverdigbaar is in 'n oop en demokratiese samelewing gebaseer op vryheid en gelykheid'.)

Die botsende waardes wat in die Grondwet vervat word, spreek duidelik hieruit. Die Grondwet is enersyds 'n reaksie teen outoritêre staatsoptrede en diskriminasie, en andersyds steun dit swaar op internasionale, Westerse norme waarby 'n vrymarkstelsel en demokrasie volgens Westerse standaarde ingesluit word.[141] Daar bestaan 'n spanning tussen die reg op sosiale gelykheid en die reg op individuele vryheid. In wese kom dit neer op 'n moeilik versoenbare botsing tussen die 'bevryders' en die 'libertyne' en tussen voorstanders van aansienlike owerheidsinmenging en die voorstanders van minimale owerheidsinmenging.[142]

Libertyne sal die Grondwet moontlik soos volg interpreteer: Alhoewel soms ontken word dat daar 'n hiërargie van regte in die Grondwet bestaan,[143] stel die Grondwet self strenger voorwaardes vir die beperking van die reg op vryheid as vir die beperking van die reg op gelykheid[144] en sou 'n mens daaruit kon aflei dat die reg op vryheid voorrang bo die reg op gelykheid

---

[140]Indien mediese getuienis afdoende bewys lewer dat demensie alreeds op 'n vroeë stadium van HIV-infeksie aanwesig kan wees, sou dit geregverdig wees om bv mense wat die lugverkeer by lughawens reël, te toets — voor indiensneming, en ook op 'n deurlopende grondslag daarna. Sien Albertyn en Rosengarten 1993 *SAJHR* 77 88.

[141]Sien Botha 1994 *SA Publiekreg* 233 237 ev en Van der Walt 'The future of private ownership of land' 1994 *Codicillus* 4 6. Onder die beginsels wat "n oop en demokratiese samelewing' ten grondslag lê (soos aangehaal in a 33(1) en a 35(1) van die Grondwet) kan 'n wye verskeidenheid waardes ingesluit word: waardigheid van die individu, sosiale geregtigheid, openbare veiligheid, ekonomiese welvaart ens.

[142]En uiteindelik ook tussen eerstegenerasie- en tweedegenerasieregte aangesien kwalik aan tweedegenerasieregte gevolg gegee kan word sonder om eerstegenerasieregte aan te tas (Jenkins 265 ev). Sien vn 110 hierbo.

[143]Sien bv r Froneman se opmerkings in *Gardener v Whitaker* hierbo 21 EF. Sien ook in die algemeen Marcus 1994 *SAJHR* 92.

[144]A 33(1) bepaal dat die beperking van die reg vervat in a 11 (die reg op vryheid en sekuriteit van die persoon) ook aan die vereiste van noodsaaklikheid moet voldoen. Hierdie vereiste word nie gestel tov die beperking van die reg op gelykheid soos vervat in a 8 nie. Woolman 1994 *SAJHR* 60 82 meen ook dat sekere waardes belangriker as ander is en groter beskerming moet geniet.

behoort te geniet.[145] Mense met HIV, wat na verwagting 'n groot deel van ons bevolking gaan uitmaak,[146] se reg op gelykheid kan nie op horisontale vlak beskerm en afgedwing word sonder om die ekonomiese implikasies daarvan in ag te neem nie. Indien sodanige beskerming wesenlike inbreuk maak op vrye ekonomiese bedrywighede in die private sektor, kan ondernemers besluit om hul besighede in ander lande te bedryf waar sulke maatreëls nie bestaan nie. Vir die verwesenliking van talle fundamentele regte, soos die reg op basiese onderwys[147] en kinders se reg op basiese maatskaplike en gesondheidsdienste[148] is ekonomiese groei, werkskepping en internasionale mededingendheid noodsaaklik. Artikel 8(2)[149], artikel 26(2)[150] en artikel 33(1)[151] kan aangewend word om, waar dit werklik aangedui is, die ongelyke behandeling van mense met HIV vir 'n legitieme sosiale doel (ekonomiese groei en werkskepping), te regverdig. Veral artikel 33(1) maak 'n afweging van belange van die staat teenoor dié van die individu moontlik en weerspieël die filosofiese en politieke spanninge wat in 'n liberale demokrasie teenwoordig is.[152]

Aan die ander kant sal die 'bevryders' waarskynlik argumenteer dat omvattende staatsinmenging op horisontale vlak juis nodig is om sosiale geregtigheid en billike arbeidspraktyke te bevorder en dat 'n grondwet nie ernstig opgeneem kan word indien dit nie mense se mees basiese lewensbehoeftes probeer bevredig nie. Ingevolge hierdie siening is eerstegenerasieregte blote luukshede solank as wat mense ly of swaarkry.[153] In die konteks van VIGS beteken dit dat die staat sy versorgingsplig moet nakom en dat nie alleen die staat (en by implikasie die belastingbetaler) nie, maar ook die privaat sektor die las van VIGS in die samelewing moet dra.

Hoe die twee uiteenlopende doelstellings (vryheid en ekonomiese groei aan die een kant en sosiale geregtigheid en gelykheid aan die ander kant) versoen gaan word, of aan welke een voorrang gegee gaan word, sal deur die howe beslis moet word.

GEVOLGTREKKING

Die Grondwet verleen omvattende beskerming teen onbillike diskriminasie en verbied ongelyke behandeling. Mense met HIV en VIGS sal stellig op formele

---

[145]Sien bv r Van Schalkwyk se bereidheid om in *Mandela v Falati* hierbo 8E voorrang te verleen aan die reg op vryheid van spraak en uitdrukking omdat dit die reg sou wees waarvan alle ander fundamentele regte afhanklik sou wees.

[146]Sien vn 34 hierbo.

[147]Sien a 32(a) van die Grondwet.

[148]Sien a 30(1)(c) van die Grondwet.

[149]Met die klem op die billikheid van die onderskeid.

[150]Met die klem op ekonomiese groei as doelstelling.

[151]Met die klem op die redelikheid en regverdigbaarheid van die onderskeid.

[152]Woolman 1994 *SAJHR* 60 62.

[153]Sien bv Mureinik 'Beyond a charter of luxuries: Economic rights in the Constitution' 1992 *SAJHR* 464 en Davis 'The case against the inclusion of socio-economic demands in a Bill of Rights except as directive principles' 1992 *SAJHR* 475.

gelykheid ingevolge die Grondwet aanspraak kan maak. Of hulle ook op substantiewe gelykheid geregtig is, sal daarvan afhang of ons howe VIGS en HIV-infeksie as gestremdhede gaan beskou en bereid sal wees om die spesifieke beskerming teen onbillike diskriminasie na persone met VIGS en HIV uit te brei. Indien wel, sal die staat en sy organe, insluitende die wetgewer, gebonde wees. Wetgewing wat op geïnfekteerdes se gelyke regte inbreuk maak, sal aangeveg kan word, tensy bewys kan word dat die wetgewing redelik en regverdigbaar is in 'n oop en demokratiese samelewing wat op vryheid en gelykheid gebaseer is.

Waar verhoudings tussen private persone ter sprake is en deur die gemene reg (of deur geen regsreëling nie) gereël word, het die verbod op onbillike diskriminasie en die reg op gelykheid nie betrekking nie. Die regsprekende gesag behoort nie oormatig in te gryp op die private terrein en sonder meer horisontale werking aan artikel 8 van die Grondwet te verleen nie. Konstitusionalisme wil die individu juis teen die misbruik van owerheidsmagte beskerm aangesien die verhouding tussen die staat en individu ongelyk is en die staat oor magte beskik waaroor die individu nie beskik nie. Deur aan die howe die bevoegdheid te verleen om met gevestigde privaat belange in te meng, word die basiese norm van die handves ontken, naamlik die beskerming van die individu teen die owerheidsgesag: '(T)he doctrine of individual rights requires that the state not interfere in the lives of its citizens but leave them free to live how ... they choose.'[154] Indien die wetgewer, as verkose verteenwoordiger van die volk, dit egter sou verlang, kan wetgewing ook op horisontale vlak gemaak word om die regte van individue omvattend te beskerm. Dit het trouens reeds in die privaat werkplek gebeur waar die wetgewer ingrypende maatreëls getref het om die verhouding tussen werkgewer en werknemer op horisontale vlak te reël. Met die nuwe konsepwet op arbeidsverhoudinge word die bestaande maatreëls uitgebrei om ook aansoekers om werk en ander werknemers wat voorheen uitgesluit was, teen onbillike arbeidspraktyke te beskerm. Hierdie konsepwet maak egter steeds voorsiening, in taal soortgelyke aan dié in die Grondwet, vir billike diskriminasie. Waar mense met HIV vir spesiale behandeling uitgesonder word, kan hierdie diskriminasie in bepaalde omstandighede billik wees. Dit sou die geval wees waar die onderskeid en die spesiale behandeling nie op die infeksie as sodanig nie, maar op ander rasionele oorwegings berus.

Ten slotte moet in gedagte gehou word dat die reg maar 'n beperkte bydrae kan lewer tot die oplossing van die sosiale probleme wat mense met HIV ondervind en dikwels nie veel aan verhoudings in die samelewing kan verander nie. Die toekenning van regte kan sake oorvereenvoudig en die indruk skep dat alle probleme daarmee uit die weg geruim is. Opvoeding van die publiek — wat ook 'n belangrike owerheidstaak is — het waarskynlik 'n selfs groter rol as die reg in hierdie verband te speel.

[154]Jenkins 265.