

**LAW, PSYCHIATRY AND PSYCHOLOGY: A SELECTION OF CONSTITUTIONAL,  
MEDICO-LEGAL AND LIABILITY ISSUES**

by

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submitted in accordance with the  
requirements for the degree of

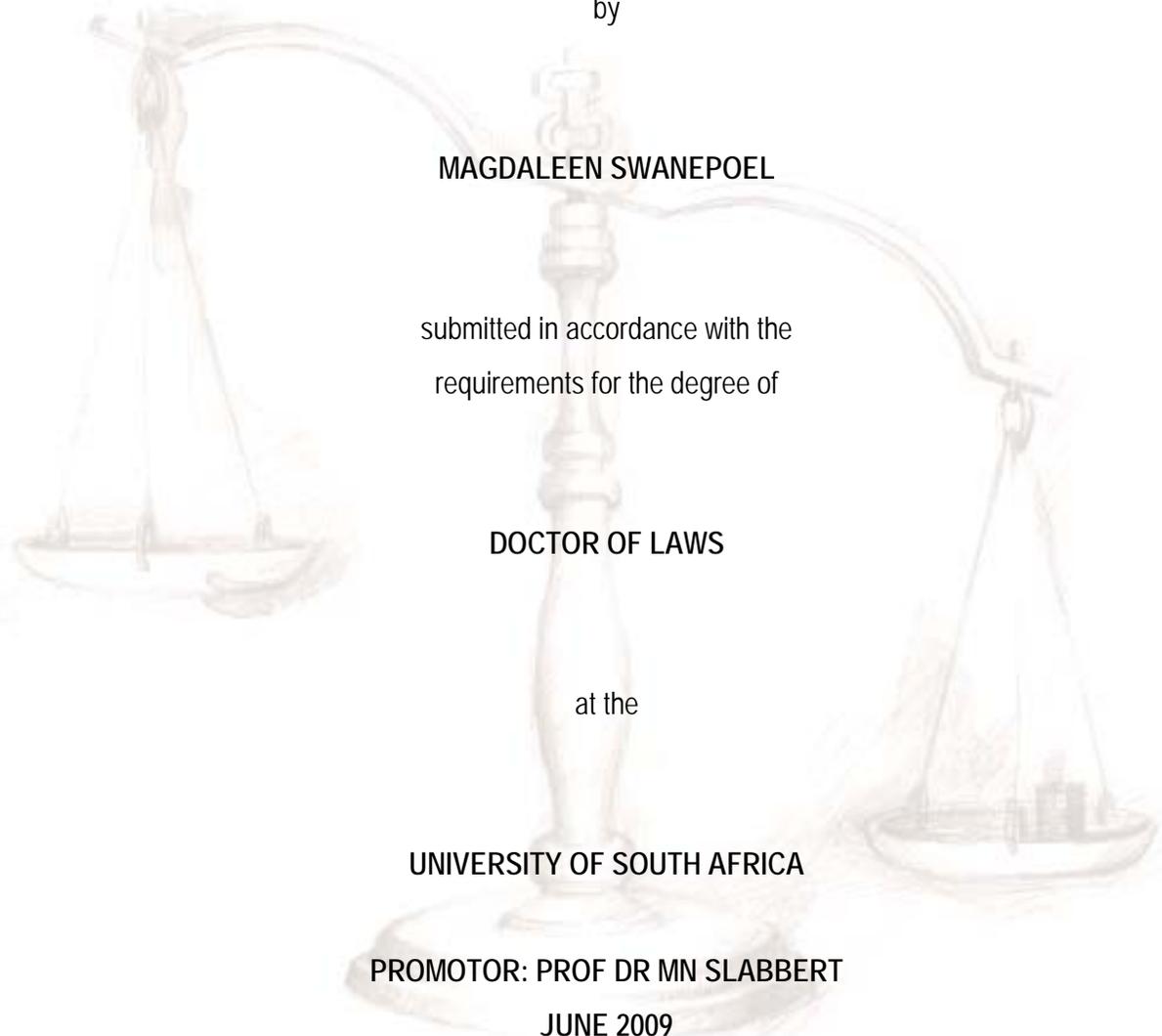
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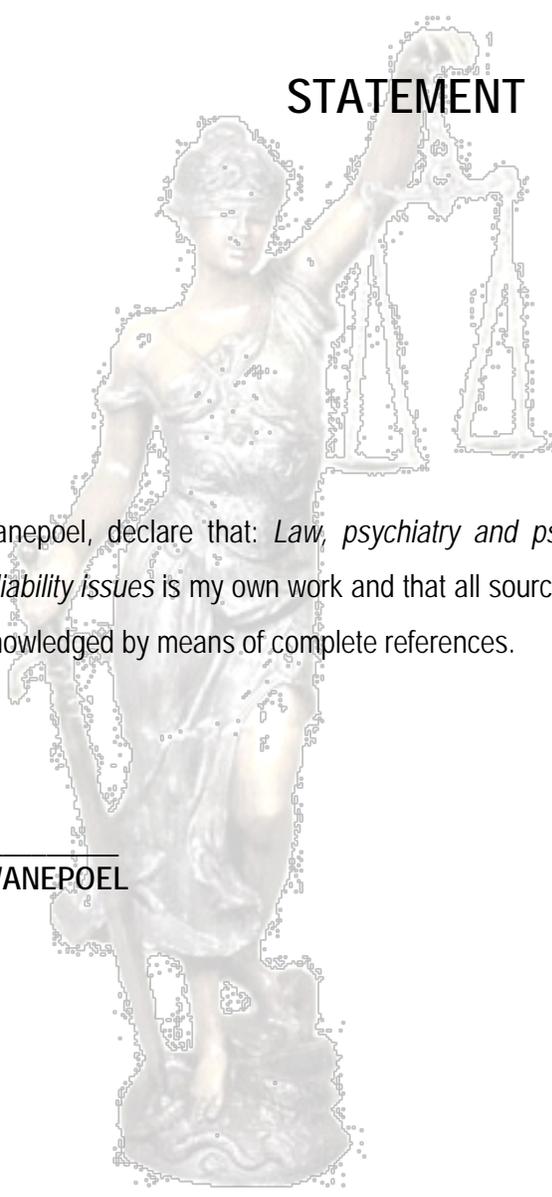
at the

**UNIVERSITY OF SOUTH AFRICA**

**PROMOTOR: PROF DR MN SLABBERT**

**JUNE 2009**





## STATEMENT

Student number: 3150-876-6

I, Magdaleen Swanepoel, declare that: *Law, psychiatry and psychology: A selection of constitutional, medico-legal and liability issues* is my own work and that all sources that I have used or quoted have been indicated and acknowledged by means of complete references.

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MAGDALEEN SWANEPOEL

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## MEANING IN MADNESS

Inside, all at once  
without warning or notice  
one cell broke loose

Mitotic madness

Anaplastic anarchy

In schizophrenic splits  
without order structure or  
any attention to limits.

Caught off guard what's a soul to do?  
What's the soul to do?

Meaning and purpose  
in the face of such cellular psychoses?

It is a choice  
is it not?  
That is, to find order  
and connection.

Perhaps the somatic insanity  
is but our last  
wake-up call:

To embrace the senses  
of this, our only owned existence.  
And to love, to always, always love.

(Robert B Granet<sup>1</sup>)

*This thesis is dedicated to all individuals who struggle with and suffer from mental illness; to those who had the resilience to overcome it; to those who could not; and to the people who accept responsibility for their care.*

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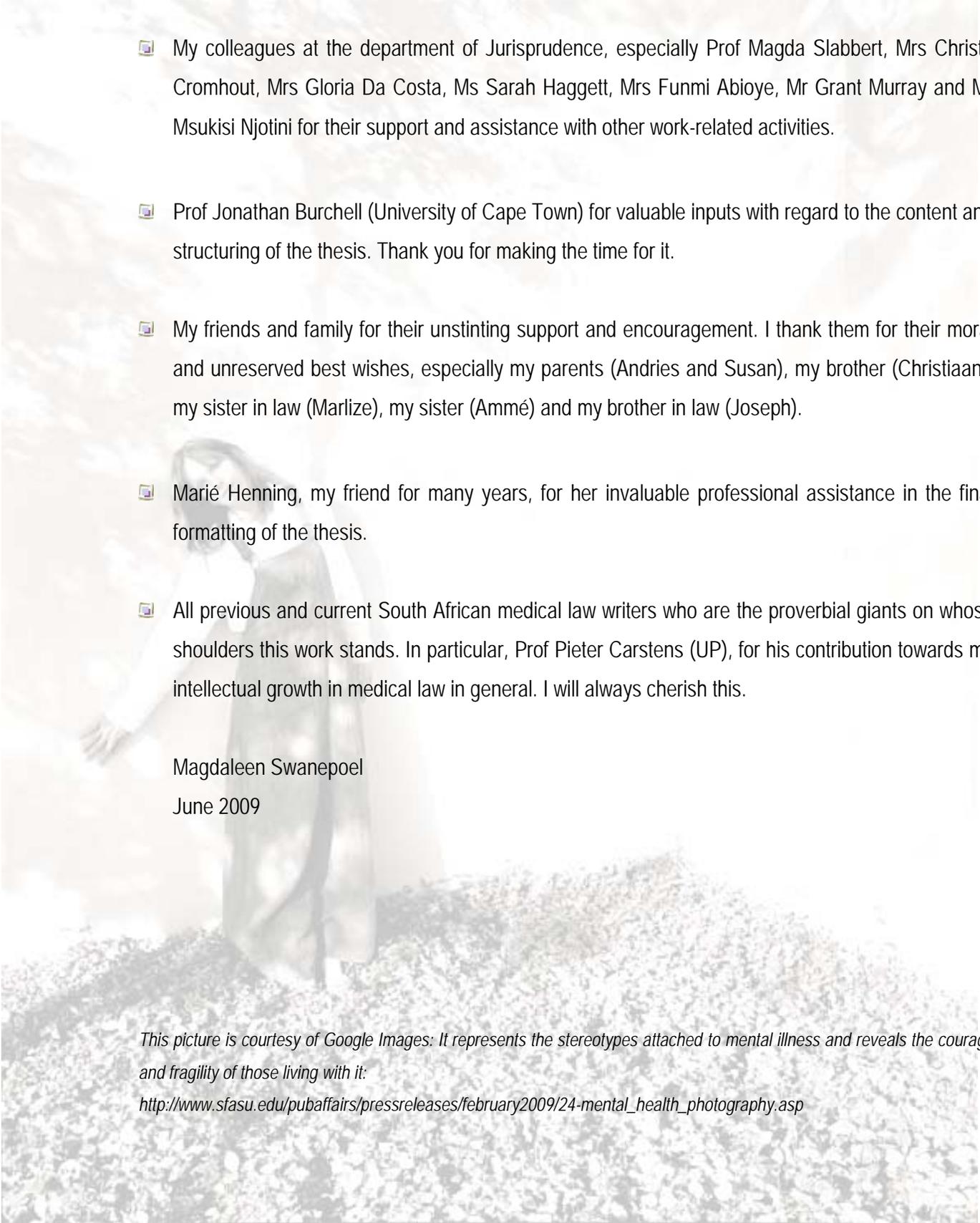
<sup>1</sup> "Meaning in madness" 2005 3 *Palliative & Supportive Care* 2: 147.

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## ACKNOWLEDGEMENTS

No one reaches a goal without the help and support of others. I wish to acknowledge this help and support, and extend my gratitude and appreciation towards the following persons:

- ❏ My promotor, Prof Melodie Slabbert (Unisa), whom I had as a mentor, teacher and friend – a person of immense and patient wisdom and a gentle but unyielding fortitude. I think that if I were not destroyed at times by a sense of hopelessness that these gigantic labours awakened in me, it was largely due to her courage and patience. I did not give up because she would not let me give up. I look up to her with appreciation as a brilliant teacher, but with gratitude for touching my human feelings. A dream begins with a teacher who believes in you, who tugs and shoves and leads you to the next plateau. Thank you for believing in me and for constantly reminding me that I could do it. Her academic and personal support leaves me thankful and inspired. What a privilege to have been one of her students.
- ❏ Dr Louise Olivier (forensic, clinical and counselling psychologist in private practice), for her insights into forensic psychology and psychiatry, which enriched this research immensely. The creativity, determination and sense of joy with which she responds to life's challenges have led me to seek this in myself. The time under her guidance has been a privilege and her example has left an indelible impression. Life blessed me with the opportunity to meet Dr Olivier, an exceptional woman, whom I am still anxious to learn from.
- ❏ Prof Irma Kroeze (Chair of Department, Jurisprudence, Unisa) for granting me leave from work. Without this the writing of the thesis would not have been possible. Her continuous encouragement and support is highly appreciated.
- ❏ My colleague and friend, Maureen Mswela, for embarking on and completing this journey with me, because we believed in it ...

- 
- A woman in a graduation gown is walking on a path of flowers. The background is a soft, out-of-focus landscape with trees and a bright sky. The woman is in the lower-left quadrant of the image, walking towards the right. The path is made of small, light-colored flowers or gravel.
- My colleagues at the department of Jurisprudence, especially Prof Magda Slabbert, Mrs Christa Cromhout, Mrs Gloria Da Costa, Ms Sarah Haggett, Mrs Funmi Abioye, Mr Grant Murray and Mr Msukisi Njotini for their support and assistance with other work-related activities.
  - Prof Jonathan Burchell (University of Cape Town) for valuable inputs with regard to the content and structuring of the thesis. Thank you for making the time for it.
  - My friends and family for their unstinting support and encouragement. I thank them for their moral and unreserved best wishes, especially my parents (Andries and Susan), my brother (Christiaan), my sister in law (Marlize), my sister (Ammé) and my brother in law (Joseph).
  - Marié Henning, my friend for many years, for her invaluable professional assistance in the final formatting of the thesis.
  - All previous and current South African medical law writers who are the proverbial giants on whose shoulders this work stands. In particular, Prof Pieter Carstens (UP), for his contribution towards my intellectual growth in medical law in general. I will always cherish this.

Magdaleen Swanepoel

June 2009

*This picture is courtesy of Google Images: It represents the stereotypes attached to mental illness and reveals the courage and fragility of those living with it:*

*[http://www.sfasu.edu/pubaffairs/pressreleases/february2009/24-mental\\_health\\_photography.asp](http://www.sfasu.edu/pubaffairs/pressreleases/february2009/24-mental_health_photography.asp)*

## SUMMARY

The purpose of this thesis is to develop a comprehensive process for identifying and addressing primarily constitutional, medico-legal and liability issues, and in addition ethical, social and scientific issues related to the psychiatric and psychology professions in South Africa. In fulfilling this purpose, a comprehensive search is conducted of relevant historical, ethical, philosophical and clinical aspects pertaining to psychiatry and psychology, as well as an evaluation of the current juridical framework regarding the legal liability of the psychiatrist and psychologist balanced against the constitutional rights of the mentally disordered patient in South Africa. Recommendations are made for the establishment of any new controls needed to mitigate and prevent the exposure of mentally disordered patients, further attempting to provide specific remedies to adapt the current juridical framework in South Africa. The examination is conducted within the framework of the South African and United Kingdom's legal systems. Focus is placed on aspects of medical law, human rights law (as envisaged in the Bill of Rights in the Constitution of the Republic of South Africa, 1996), criminal law and the law of delict and, to a lesser extent, administrative law and the law of evidence.

**Key terms:** Psychiatry; psychology; forensic psychiatry and forensic psychology; forensic medicine; mental health; mentally disordered patients; human rights law; medical law; psychiatric malpractice and psychological malpractice; capacity; causation; culpability; intent; discrimination; duty of care; expert testimony; informed consent; necessity; negligence; therapeutic privilege; unlawfulness; wrongfulness; unprofessional conduct.

## OPSOMMING

Die doel van hierdie proefskrif is om 'n omvattende proses te ontwikkel waardeur hoofsaaklik grondwetlike, regs-mediese en aanspreeklikheidskwessies, en daarbenewens etiese, maatskaplike en wetenskaplike kwessies wat verband hou met die psigiatriese en sielkunde beroepe in Suid-Afrika geïdentifiseer en aangespreek kan word. Om hierdie doel te bereik word die toepaslike historiese, etiese, filosofiese en kliniese aspekte met verwysing na psigiatrie en sielkunde volledig ondersoek, en word die juridiese raamwerk met betrekking tot die regs-aanspreeklikheid van die psigiater en sielkundige teenoor die grondwetlike regte van die geestesongestelde pasiënt in Suid-Afrika geëvalueer. Voorstelle word ook gemaak vir die instel van enige nuwe maatreëls wat nodig geag te wees om die blootstelling van die geestesongestelde pasiënt te verminder of te voorkom. Verder word gepoog om die huidige juridiese raamwerk in Suid-Afrika sodoende te wysig. Die studie word binne die raamwerk van die Suid-Afrikaanse en Verenigde Koningrykse regstelsels gedoen. Dit fokus op aspekte van die geneeskundige reg, menseregte (soos verskans in die Menseregtehandves in die Grondwet van die Republiek van Suid-Afrika, 1996), strafreg en deliktereg en, tot 'n mindere mate, administratiefreg en bewysreg.

**Sleutelterme:** Psigiatrie; sielkunde; forensiese psigiatrie en forensiese sielkunde; geregtelike geneeskunde; geestesgesondheid; geestesongestelde pasiënte; menseregte; geneeskundige reg; psigiatriese wanpraktyke en sielkundige wanpraktyke; handelingsbevoegdheid; kousaliteit; toerekeningsvatbaarheid; opset; diskriminasie; plig tot sorgsaamheid; deskundige getuie; ingeligte toestemming; noodtoestand; nalatigheid; terapeutiese privilegie; wederregtelikheid; onregmatigheid; onprofessionele gedrag.

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# CHAPTER 1

## INTRODUCTION

"I am not an advocate for frequent changes in laws and constitutions, but laws and institutions must go hand in hand with the progress of the human mind."<sup>1</sup>

### 1.1 BACKGROUND

#### 1.1.1 Introductory remarks

Much of the literature on law, psychiatry and psychology is premised upon the notions that these disciplines co-exist in mutual antagonism. This is applicable, regardless of which of the dominant concerns of the literature is considered. The first concern is the moral-philosophical debate concerning the responsibility of individuals for their wrongful acts. The second and more diverse body of literature is directed at analysing the emergence, content and operation of the legal frameworks that constitute, regulate and legitimise the psychiatric and psychology professions. Often the terms law, psychiatry and psychology are used when what is really meant is legal practitioners, psychiatrists or psychologists, or more accurately, some legal practitioners and some psychiatrists or psychologists. Nowhere is this more evident than in debates around free will and determinism. As Moore<sup>2</sup> points out, the caricatured portrayal of the "psychiatric [and psychological] world view" represents it as highly deterministic, leaving little scope for the exercise of free will, while the "legal world view" is often seen as being based exclusively on the foundation of individual free will. This leads to a culture conflict between law, psychiatry and psychology. Legal practitioners who act for patients want to protect their fundamental rights. That can include a right to obtain treatment and rights within treatment, but sometimes what legal practitioners seek to vindicate is a right to the least intrusive alternative treatment or even a right to refuse treatment altogether. Psychiatrists and psychologists again work for the patient's interests as they understand them, not for their rights – an instance of a well-known distinction between interests and rights. Therefore, psychiatrists and psychologists sometimes regard legal practitioners as practitioners preventing them from doing what is best for their patients.<sup>3</sup>

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<sup>1</sup> Jefferson T as quoted in *Constitutionalism: The philosophical dimension* (Rosenbaum AS) (1988) 127.

<sup>2</sup> Moore MS *Law and psychiatry: Rethinking the relationship* (1984) 3.

<sup>3</sup> Levine ML (ed) *The International Library of Medicine, Ethics and Law: Mental illness, medicine and law* (2009) xvii.

Law, psychiatry and psychology, in spite of their differences, seek through conceptualisation procedures and techniques to codify, understand and correct human misbehaviour through punishment, rehabilitation and psychotherapy<sup>4</sup> respectively. Viewed broadly, the law codifies misbehaviour (for example crime) through the concept of intent, specific or general; while psychiatry and psychology aim to assess the genesis of criminal action through the study of the criminal's mental conflicts and personality trends.<sup>5</sup>

The starting point of any examination on law, psychiatry and psychology must be an acknowledgement of the fact that psychiatry and psychology have a greater problem of legitimacy than virtually any other branch of medicine because of the very nature of "mental disorder".<sup>6</sup> The key source of legitimising general medicine is the consent of the patient to be treated by the doctor. If the doctor is negligent, the patient has a remedy in private law. Mentally disordered patients,<sup>7</sup> on the other hand, even if they recognise that they are ill, may be incapable of giving a valid consent or may (rationally or irrationally) withhold consent to therapeutic interventions that are indicated as necessary in the interests of their wellbeing or for the protection of others. Another source of psychiatry's and psychology's problem with legitimisation lies in the fact that the main way of ensuring that involuntary patients receive the treatment deemed necessary up to now has been through their detention in a hospital. Therefore, while general medicine is legitimised by consent and regulated almost wholly by medical, private and contract law, psychiatry and psychology – because it may involve the intrusion of public authority into private life through the detention of patients – requires legitimisation through public law procedures. With these observations as a background to the

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<sup>4</sup> See the definition and discussion of psychotherapy in chapters 2 and 3.

<sup>5</sup> Fennell P "Law and psychiatry: The legal constitution of the psychiatric system" 1986 13 *J L & Soc* 1:35-36.

<sup>6</sup> The concept of mental disorder in a clinical as well as legal context is discussed in chapters 3 and 4.

<sup>7</sup> When discussing mental health and mental disorders, a complicating factor is the absence of agreement on the most appropriate terminology. *Mental illness, mental disorder, mental incapacity, psychiatric disability, psychiatric illness, mental disability, psychosocial disability, intellectual disability* and several other terms are all used with different connotations and shades of meaning. Some of the terms reflect very important and sensitive debates, such as the discussion about a "medical model" or "social model" of functioning. Moreover, terminology has also evolved significantly in recent years and continues to do so. For example, intellectual disability, once commonly referred to as mental retardation or handicap, is now sometimes referred to as developmental disability. Manic depression is now referred to as bipolar mood disorder. In this thesis the term mental disorder is most frequently used, although it is sometimes used interchangeably with some of the terms mentioned above. These terms include disorders arising from major mental illness and psychiatric disorders, for example, schizophrenia and bipolar disorder and more minor mental ill health and disorders, often called psychosocial problems, for example, mild anxiety disorders and intellectual disabilities. The term disorder is used to refer to a range of impairments, activity limitations, and participation restrictions, whether permanent or transitory. See Hunt P & Mesquita J "Mental disabilities and the human right to the highest attainable standard of health" 2006 28 *Human Rts Quarterly* 2: 332 at 335. See also the discussion of the concept of "mental illness" below.

study, an examination and analysis on the issues<sup>8</sup> pertaining to law, psychiatry and psychology are conducted in the chapters that follow.

### 1.1.2 Law, psychiatry and psychology in South Africa

People suffering from mental disorders are among the most stigmatised, discriminated against, marginalised, disadvantaged and vulnerable members of society. Although much has been done in recent years to improve the status quo, Johnstone<sup>9</sup> states that it is evident that a great deal more needs to be done to improve the moral standing of and to achieve social justice for the mentally disordered patient. It is only a decade ago that South Africans were living and working in an oppressive and discriminatory system. As part of the national policy, health services were fragmented along racial lines. Of all the medical specialities, psychiatry and psychology (the most influenced by the prevailing social and political climate) were the most criticised by the international community. Psychiatric services were inspected by overseas groups and condemned. Concern was also expressed regarding the Royal College of Psychiatrists' continued silence on the political abuses of psychiatry in South Africa. In 1984 a call went out to the World Psychiatric Association to expel the "racist Society of Psychiatrists of South Africa" because of its collusion with apartheid. In 1987 a resolution was approved by the Royal College of Psychiatrists condemning racism and urging College members to support the Commonwealth Nassau Accord of October 1985, which recommended discouragement of participation in cultural and scientific events except where these contributed towards the ending of apartheid or had no possible role in promoting it.<sup>10</sup>

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<sup>8</sup> Where reference is made to "issues" (throughout this thesis) it includes primarily constitutional, medico-legal and liability issues, and additionally ethical, social and scientific issues.

<sup>9</sup> Johnstone MJ "Stigma, social justice and the rights of the mentally ill: Challenging the status quo" 2001 10 *Aust & NZ J Mental Health Nursing* 200.

<sup>10</sup> In response to the hideous violations of human rights in the past, the post-apartheid government established a Truth and Reconciliation Commission to promote national unity and reconciliation. The intention was to establish as far as possible the nature, causes and extent of gross human rights violations by granting amnesty to perpetrators who made full disclosures and by affording victims the opportunity to give accounts of their sufferings. For the nation as a whole, the Truth and Reconciliation Commission has had a positive and perhaps even therapeutic effect. There are a number of issues regarding the Truth and Reconciliation Commission that are of relevance to psychiatry. Both perpetrators and victims recounted almost unbelievable incidents of extreme emotional trauma. Mental health professionals provided advice regarding the manner in which testimony should be taken, and provided psychological support when necessary to those who testified. Truth and Reconciliation Commission staff members were trained in issues relevant to psychological support, and some of the Truth and Reconciliation Commission commissioners were mental health professionals. See Emsley R "Focus on psychiatry in South Africa" 2001 178 *Br J Psychiatry* 382 at 384. See also Jones TF "Prospects of a progressive mental health system in 1940's South Africa: Hereditarianism, behaviourism and radical therapies" 1 *Workshop on South Africa in the 1940's: South African Research Centre* (2003) 1; Strous RD "Hitler's psychiatrists: Healers and researchers turned executioners and its relevance today" 2006 14 *Harv Rev Psychiatry* 1:30-37.

The situation faced by people with mental illnesses in South Africa was and sometimes is characterised by levels of inequality and discrimination. Social, economic and political barriers interact to create conditions of underdevelopment, marginalisation and unequal access to resources. One of the central factors that contributed to these conditions is the failure of our society to recognise the rights of mentally disordered individuals as equal to those of able-bodied persons. Moreover, policies and practices adopted by the apartheid government served not only to ignore these rights, but also to set up and maintain mechanisms which contributed to further abuse and discrimination. However, with the advent of democracy in South Africa, the authority of the Constitution<sup>11</sup> and Constitutional Court, the introduction of the Bill of Rights, the establishment of the Human Rights Commission and the enactment of the Mental Health Care Act<sup>12</sup> an infrastructure is created in South Africa. This infrastructure addresses the past inequalities and attempts to ensure that the rights of all people, including mentally ill patients are protected.<sup>13</sup>

Against the background of the above developments in mental health care, three aspects of South African law need to be considered: A number of private law rules dealing with, for example, consent, contracts and delictual liability, may find application. Criminal law in context of the relationship between mental illness and crime as well as in context of the criminal liability of the psychiatrist and psychologist further find application. A second area is constitutional law and more specifically the Bill of Rights. The right to human dignity, the right to equality (non-discrimination), and the right to privacy, among other rights, feature prominently as basic concepts in the ongoing development of protective measures. These concepts are dealt with under the provisions of the South African Constitution. The rights envisaged in the Constitution are, however, not absolute and may be limited in terms of section 36.

A third aspect concerns legislation in the field of health. The first is the Mental Health Care Act, which makes provision to provide for the appropriate care, treatment and rehabilitation of persons who are

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<sup>11</sup> The Constitution of the Republic of South Africa, 1996 (hereafter referred to as the Constitution). According to section 1 and 2 of the Citation of Constitutional Laws Act 5 of 2005, no Act number is to be associated with the Constitution of the Republic of South Africa. Any reference to the Constitution of the Republic of South Africa, contained in any law in force immediately prior to the commencement of this Act, must be construed as a reference to the Constitution of the Republic of South Africa, 1996.

<sup>12</sup> The Mental Health Care Act 17 of 2002 (hereafter referred to as the Mental Health Care Act).

<sup>13</sup> Independent Living Institute: "Disability" 1997 *Policy Paper for the South African Human Rights Commission*.

mentally ill and to address exploitation and abuse so as to safeguard the rights of the mentally ill patient. The second is the National Health Act,<sup>14</sup> which establishes a health system based on decentralised management, principles of equity, efficiency, sound governance, internationally recognised standards of research and a spirit of enquiry and advocacy which encourages participation; and promotes a spirit of co-operation and shared responsibility among public and private health professionals and providers. More legislation finds application in the field of mental health and is discussed in chapter 5 of the thesis.<sup>15</sup>

The Medical Research Council of South Africa has years' experience and background in the ethics of health sciences research. The entrenchment of the culture of human rights as core value in health research and as one of the four strategic goals of the Medical Research Council has elevated the critical role ethics play in the conduct of research and in society, particularly in a developing country undergoing major changes. The first (1977) and second (1987) editions of the Medical Research Council's guidelines on ethics outlined general philosophical approaches to research ethics based on the Declaration of Helsinki<sup>16</sup> and the Nuremberg Code.<sup>17</sup> The third edition (of 1993) differs considerably from the first two by presenting

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<sup>14</sup> The National Health Act 61 of 2003 (hereafter referred to as the National Health Act).

<sup>15</sup> The following legislation impacts on the medical profession in general: The South African Medical Research Council Act 58 of 1991; Pharmacy Act 53 of 1974 as amended by Act 88 of 1997 and Act 1 of 2000; Medical, Dental and Supplementary Health Service Professions Act 56 of 1974 as amended by Act 89 of 1997 (now known as the Health Professions Act), Nursing Act 50 of 1978; Chiropractors, Homeopaths and Allied Health Service Professions Act 63 of 1982 as amended; Dental Technicians Act 19 of 1979 as amended; Academic Health Centres Act 86 of 1993 as amended; Choice of Termination of Pregnancy Act 92 of 1996 as amended; Medical Schemes Act 131 of 1998; Inquests Act 58 of 1959 as amended; South African Institute of Drug-Free Sport Act 14 of 1997; Prevention and Treatment of Drug Dependency Act 20 of 1992 as amended by Act 14 of 1999; National Road Traffic Act 93 of 1996; Medicines and Related Substances Control Amendment Act 90 of 1997; Health Act 63 of 1977; Births and Deaths Registration Act 51 of 1992; Child Care Act 74 of 1983 as amended; Boxing and Wrestling Control Act 39 of 1954 as amended; Compensation for Occupational Injuries and Diseases Act 130 of 1993; Correctional Services Act 111 of 1998 as amended; Criminal Procedure Act 51 of 1977 and Amendment 1998; Human Tissue Act 65 of 1983 (to be replaced by Chapter 8 of Act 61 of 2003); Sterilisation Act 44 of 1998; Aged Persons Amendment Act 100 of 1998; Domestic Violence Act 116 of 1998; Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000; Promotion of Access to Information Act 2 of 2000; Promotion of Administrative Justice Act 3 of 2000; National Health Laboratory Act 37 of 2000; Council for Medical Schemes Levies Act 58 of 2000. See Carstens PA & Pearmain DL *Foundational principles of South African medical law* (2007) 249.

<sup>16</sup> The World Medical Association has developed the Declaration of Helsinki as a statement of ethical principles to provide guidance to physicians and other participants in medical research involving human subjects. It is widely regarded as the cornerstone document of human research ethics although it is not a legally binding instrument in international law. The Declaration of Helsinki was adopted in 1964 and has been amended six times since, most recently at the General Assembly in October 2008. See The World Medical Association Declaration of Helsinki: Ethical Principles for Medical Research Involving Human Subjects (2008).

<sup>17</sup> With the Nuremberg Code, the United States and its allies responded to the horrors of the Nazi war crimes by restating the principle ensuring that human dignity would not again be trampled on in the pursuit of medical knowledge. The Nuremberg Code has not been officially adopted in its entirety as law by any nation or as ethics by any major medical

information in a codified form with more detailed, specific recommendations. It is more of a handbook than the first two editions and could be used as a ready reference. Although these guidelines do not constitute law, they are still legally relevant. These guidelines subscribe to the values enshrined in the Constitution, namely human dignity, the achievement of equality, and the advancement of human rights and freedoms. All research sponsored by the Council must be of the highest ethical standard. These guidelines are discussed in context of research and clinical trials conducted on mentally ill patients.

## 1.2 THE INTERFACE BETWEEN LAW, MEDICINE, PSYCHIATRY AND PSYCHOLOGY

### 1.2.1 Background

Medicine and law have been related from ancient times. The bonds that first united these professions were religion, superstition and magic.<sup>18</sup> The priest, the jurist and the physician were at once united in one person.<sup>19</sup> Physicians and legal practitioners in advanced societies are usually struck by the following synthesis: "Medicine is the law, and the law is medicine, and the amalgam is perfused and strengthened by the authority of tradition, religion, and the arts, such as music, the dance, and painting."<sup>20</sup> They are surprised to find that their respective professions arise from a common source in prehistoric societies, because today these streams are so sharply differentiated that physicians, psychiatrists, psychologists and legal practitioners scarcely move in the same circles or talk the same language. In early civilisations, primitive legal codes, religious doctrines and social precepts were often ill distinguished, and laws with a medical content were often found within their context.<sup>21</sup> In primitive societies medicine was concerned with magical power over natural objects, exercised through rites, spells and charms. In modern medicine physicians believe they are emancipated from these rites, spells and charms. Cawte<sup>22</sup> however argues that they admit some responsibility - through the branch of psychiatry (and psychology) - for the control of emotional and behavioural disturbances. Some may find it tantalising that primitive men achieved a

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association. Nonetheless, its influence on global human rights law and medical ethics has been profound. The Nuremberg Code was formulated in 1947. See Shuster E "Fifty years later: The significance of the Nuremberg Code" 1997 337 *N Eng J Med* 20: 1436 at 1439.

<sup>18</sup> Wecht CH "The history of legal medicine" 2005 33 *J Am Acad Psychiatry Law* 2: 245.

<sup>19</sup> Smith EJ "Medicine, the law and juvenile delinquency" 1936 27 *J Criminal L & Criminology* 4: 503 at 505.

<sup>20</sup> The native doctor's philosophy as quoted in *Medicine is the law: Studies in psychiatric anthropology of Australian tribal societies* (Cawte J) (1974) xxii.

<sup>21</sup> Wecht 2005 *J Am Acad Psychiatry Law* 245.

<sup>22</sup> Cawte xvii, xviii, xxi.

synthesis of medicine and justice that escapes the technocrats of today where others may accept this dissociation as the price of specialisation and progress.<sup>23</sup>

The "law of madness" provided a way in which societies conceived madness, was (and still is) contiguous to that of medical and legal professions. At the centre of traditional medical discourse were the concepts of disease and diagnosis. This is as true of the history of psychiatry as of any other branch of medicine. The medical causes of mental disorders have long been a matter of medical debate, and the relationship between patient and doctor has been characterised as one of cure or, at least, care. Pivotal to the legal discourse, instead, were the protection of society and whether individuals were responsible for themselves and their actions. In this relatively broad understanding of the history of "madness", the relevance of legal sources is clear. At the most fundamental level, law determines the rights of the mentally disordered person and the legal liability of the health care practitioner. Therefore since ancient times medicine and law were conceived as spanning a large part of man's relationships: with the care (medicine) and control (law) of their members.<sup>24</sup> It becomes evident from the discussion in this thesis that often legal and medical approaches interact in co-operative ways in such a manner that it raises the question of whether they should be considered two histories or one.

### 1.2.2 Defining the concepts of "medical law" and "health law"

According to Strauss<sup>25</sup> the term "medical law" is not readily definable. He states that one reason for this is that the principles and practice of medicine<sup>26</sup> embrace an extremely wide range of topics and activities.

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<sup>23</sup> The formation of Medico-Legal Societies testifies to the need felt by members of these professions to ingrate more closely. The purpose of these societies is to promote medico-legal knowledge in all aspects. In 1867, a Medico-Legal Society was organised in New York. It was the first society in the world to be organised for the purpose of promoting the principles that an attorney could not be fully equipped for the prosecution or the defense of an individual indicted for homicide without some knowledge of anatomy and pathology and that no physician or surgeon could be a satisfactory expert witness without some knowledge of the law. Harvard University established a separate professorship in legal medicine in 1877. See Cawte xxii; Wecht 2005 *J Am Acad Psychiatry Law* 245 at 248.

<sup>24</sup> Bartlett P "Legal madness in the Nineteenth century" 2001 14 *Soc Hist Med* 1:107 at 108.

<sup>25</sup> Strauss SA "Medical law - South Africa" in *International encyclopaedia of laws* ((eds) Blanpain R & Nys H) (2006) par [42].

<sup>26</sup> Medicine (in a broad sense) refers to the art concerned with the alleviation, cure and prevention of suffering, with the preservation of health and with the correction of environmental conditions conducive to sickness. See Cawte xvii, xviii, xxi. The word "medicine" is derived from the Latin term *medicina*, which means "the art of healing". The term "medical" is derived from the Latin word *medicus*, which broadly means "healer". This is evidenced by its relation to the verbs *medeor*, which means "heal, cure, remedy", and *medicare*, which means "to heal, cure...". Steyn submits that in this sense, the terms "medicine" and "medical" should include all professionals involved in bringing out healing. See Steyn

Another is that the principles and practice of medicine are relevant to most if not all branches of law. It is further evident to him, that the term "health law", which is also often used in this context and which overlaps with the term "medical law", has a wider meaning than the term "medical law": Since health law is not necessarily related to the principles and practice of medicine, the former includes the latter, but the opposite is not necessarily true. Therefore, he is of the opinion that without attempting to undertake the daunting task of formulating a precise definition of the term "medical law" and delineating in exact terms "medical law" from "health law", medical law, may be taken to refer to the body of rules of law relating to:

- the medical profession;
- the relationship between doctor or hospital on the one hand and patient on the other;
- the relationship between the medical profession and other health-care workers; and
- the doctor and health care legislation.

As Carstens<sup>27</sup> explains it, the distinction between the concepts of "medical law" and "health law" is not easily drawn. In the first part of the twentieth century, the legal literature started to use the term "medical law". At the outset, medical law was primarily engaged in the issues of malpractice and medical negligence. In the course of time, its scope was enlarged and additional matter, for example, abortion, euthanasia and organ transplantations have gradually entered the realm of medical law. At the end of the twentieth century and in the first decade of the twenty first century, medico-legal experts started to use the term "health law" instead of "medical law". Health law, however, is the concern of a complex group of professions and is practised by a wide range of professionals. It extends beyond the established medical and nursing practices and communities. Health law further deals with not only patients and diseases but with healthy people and public health as well.

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CR *A critical assessment of the principles underlying the interactions of law, medicine and psychology: A holistic multidisciplinary management approach* (unpublished LLD thesis, Unisa, 2005) 47-48. Cf the term "medical psychology", which is a branch of applied psychology devoted to problems arising in the practice of medicine, including psychological aspects of pain, terminal illness, bereavement, disability and reactions to medical advice. It overlaps to some extent with health psychology (a field of applied psychology concerned with psychological aspects of physical health, including health promotion and the prevention and treatment of illness and the identification of psychological causes and correlates of health and illness). See Colman AM *Oxford dictionary of psychology* (2006) "medical psychology" 447; "health psychology" 335.

<sup>27</sup> Carstens & Pearmain 3. See also Carmi A "From medical law to biolexology" in *Medical law 1980-2005: Looking back with a view to the future* ((eds) Carmi A & Nachshon D) (2006) 3ff.

Nys<sup>28</sup> explains medical law and health law as follows:

Medical law is an area of law, medical law does not respect traditional compartments with which lawyers have become familiar, such as torts, contracts, criminal law, family law and public law. Instead, medical law cuts across these subjects and today must be regarded as a subject in its own right. We maintain that it is a discrete area concerned with the law governing the interactions between doctors and patients and the organisation of health care ... [H]ealth law is that branch of law which covers studies on both the individual and social aspects of the right to health care. It can be defined as the body of rules that relates directly to the care for health as well as the application of general, civil, criminal and administrative law designed to provide healthy conditions. Medical law ('the study of the juridical relations to which the doctor is a party'...) is part of health law. In health care there is a large range of juridical relations in which the doctor is not involved.

Steyn<sup>29</sup> submits that "medical law" is the preferable term to use, since it is semantically more precise. "Health law" can have additional connotations of "law designed to protect human health," such as environmental legislation and commercial hygiene standards, which could more correctly fall under other appropriate areas of law. "Medical law" is further the most frequent term used in South African law.

### 1.2.3 Defining the concept of mental health law

In the field of "mental health law" decisions with consequences of the utmost gravity - decisions about compulsory medical treatment and the loss of liberty - are entrusted to mental health care practitioners.<sup>30</sup> Yet, how do these non-legal practitioners make decisions where the legitimacy of those decisions derives from law?<sup>31</sup> Mental health law examines the practical, ethical and legal terrain of duo-disciplinary decision-making by, for example, addressing issues such as the dilemmas that psychiatrists and psychologists encounter. Do they reach the same or similar decisions regarding mentally disordered patients, and how are these decisions justified in law? Mental health law, like psychiatry and psychology, is a language of reason about mental disorders. Both languages sometimes speak symbiotically, and sometimes in uneasy juxtaposition in the pages that follow in this thesis. These languages are both paradigms of rationality in

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<sup>28</sup> Nys H as quoted in Van Oosten FFW "Medical Law – South Africa" in *International encyclopaedia of laws* ((ed) Blanpain R) (1996) 26-27. See also Carstens & Pearmain 3-4; Leenen HJJ "Health law and legislation" *Health services in Europe Vol 1* (1981) Regional Analysis, World Health Organization, Copenhagen 60; Pearmain DL *A critical analysis of the law of health service delivery in South Africa* (unpublished LLD thesis, UP, 2004).

<sup>29</sup> Steyn *LLD thesis* 53.

<sup>30</sup> Section 1 of the Mental Health Care Act defines a "mental health care practitioner" as "a psychiatrist or registered medical practitioner or a nurse, occupational therapist, psychologist or social worker who has been trained to provide prescribed mental health care, treatment and rehabilitation services".

<sup>31</sup> Peay J *Decisions and dilemmas: Working with mental health law* (2003) xv. See also Appelbaum PS *Almost a revolution: Mental health law and the limits of change* (1994) 1ff; Glover-Thomas M *Reconstructing mental health law and policy* (2002) 27ff.

their way and thus each is faced with the same problem: how to impose order onto "mental disorders" – a realm that would seem *ex hypothesi* to be lacking order – to be irrational.<sup>32</sup> There is no pretence that all mental health law issues can be solved in this thesis, but some issues are articulated for investigation and further research.

#### 1.2.4 Defining forensic medicine<sup>33</sup>

Forensic medicine<sup>34</sup> (also known as legal medicine or medical jurisprudence) is principally concerned with the provision of medical advice in the investigation of crimes and other offences where medical knowledge and experience is essential to assist the legal process.<sup>35</sup> Without accurate documentation and expert interpretation of injuries by forensic clinicians, who can also properly evaluate medical history and circumstances, conclusions about how the injuries occurred might be flawed. Such conclusions will affect investigations of both criminal and civil trials.<sup>36</sup> The relationship between law and medicine is twofold: First, medical science often assists the administration of justice, both in civil and criminal matters, whilst secondly, most branches of medicine themselves become the objects of legal scrutiny when issues of malpractice arise.<sup>37</sup>

#### 1.2.5 Defining malpractice liability and professional negligence

The term "medical malpractice" incorporates the term "professional negligence", and further embraces all forms of professional medical misconduct, committed either intentionally or negligently, including confidentiality and fiduciary doctor-patient relationships, thereby reflecting a broader conception of the field.<sup>38</sup> The term "malpractice" literally refers to "poor practice". Steyn<sup>39</sup> explains that in context of liability,

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<sup>32</sup> Bartlett P & Sandland R *Mental health law: Policy and practice* (2007) 1-2.

<sup>33</sup> Forensic medicine can broadly be divided into the following components: (1) Postmortem forensic pathology, which involves the postmortem investigation of unnatural human deaths by manner of a medico-legal necropsy. (2) Clinical forensic pathology, which involves the investigation of conditions in living persons, for example, examining the level of acute alcohol intoxication of a driver of a vehicle. (3) Forensic psychiatry, which involves the performing of psychiatric assessments relevant in the legal system, which facilitates comparison with the scope of forensic psychology. See Steyn *LLD-thesis* 54-56. For a discussion of what forensic psychiatry and psychology entail, see chapter 3 of this study.

<sup>34</sup> The name forensic medicine is derived from the word "forum" (of the courts of law). This was the Roman market place where lawyers worked in ancient times. See Knight B *Simpson's forensic medicine* (1997) 1.

<sup>35</sup> Wells D "Forensic medicine: Issues in causation" 309-330 in *Causation in law and medicine* ((eds) Freckelton I & Mendelson D) (2002) 309.

<sup>36</sup> Wells D *et al Ethical practice in laboratory & medicine & forensic pathology* (1999) 41.

<sup>37</sup> Knight 1.

<sup>38</sup> Carstens & Pearmain 599.

however, the poor practice in question would have to be of such a degree that it warrants raising the issue of professional liability. He submits that malpractice should be defined as: "Professional conduct which falls outside the limits of acceptable practice in that profession."<sup>40</sup> These concepts are further dealt with in chapter 6.

### 1.3 PURPOSE, PROBLEM STATEMENT AND MOTIVATION

The constitutional, medico-legal and liability issues related to the psychiatric and psychology professions and the influence thereof on the mentally disordered patient in South Africa set the framework for this thesis. The discussion focuses on an examination of the current juridical framework in South Africa. A further aim of this thesis is to propose recommendations to facilitate the regulation of the psychiatric and psychology professions, psychiatric institutions and the mentally disordered patient.

The challenge faced with this thesis, therefore, is to ensure a comprehensive and detailed study of the law, psychiatry and psychology (which could not aim to be complete in a thesis of limited scope), whilst proposing recommendations for the regulation of the psychiatric and psychology professions balanced against the rights of the mentally disordered patient in South Africa. Although this topic has been written about extensively in the international context, the area is still in its infancy in South Africa, although there has been some substantive research conducted in the country.<sup>41</sup> However, more research needs to be

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<sup>39</sup> Steyn CR *The law of malpractice liability in clinical psychiatry: Methodology, foundations and applications* (unpublished LLM dissertation, Unisa, 2002) 62.

<sup>40</sup> The application of the concepts of "profession" and "professionalism" in medical practice are discussed in chapter 4.

<sup>41</sup> See, for example, Allan A *The law for psychotherapists and counsellors* (1997); Allan A "Psychiatric diagnosis in legal settings" 2005 11 *S Afr J of Psychiatry* 2: 52-55; Blackbeard M "Epilepsy and criminal liability" 1996 9 *S Afr J Criminal Justice* 2: 191-210; Blackbeard M *Epilepsy – Legal problems* (unpublished LLD thesis, Unisa, 1994); Burchell J "Non-pathological incapacity: Evaluation of psychiatric testimony" 1995 8 *S Afr J Criminal Justice* 1: 37-42; Calitz FJW "Evaluering van die geestestoestand van 'n beskuldigde wat van 'n misdryf aangekla is: 'n Multiprofessionele benadering" 1993 18 *TRW* 1: 31-40; Carstens PA "The defense of non-pathological incapacity with reference to the battered wife who kills her abusive husband" 2000 13 *S Afr J Criminal Justice* 2: 180-189; Carstens PA "Paraphilia in South African criminal case law" 2002 119 *SALJ* 3: 603-622; Carstens PA *Die strafregtelike en deliktuele aanspreeklikheid van die geneesheer op grond van nalatigheid* (unpublished LLD thesis, UP, 1996) 522ff; Carstens & Pearmain 745ff; Cassim F "The accused person's competency to stand trial: a comparative perspective" 2004 45 *Codicillus* 17-27; De Villiers WP "Onbevoegdheid van 'n getuie vanweë geestesongesteldheid of verstandsverbystering" 2005 68 *THRHR* 2: 349-353; Fraser IS "Psychiatry and the law: Forensic psychiatry" 1992 15 *SALUS* 2: 18-19; Freeman M "New mental health legislation in South Africa – principles and practicalities: A view from the Department of Health" 2002 5 *S Afr Psychiatry Rev* 3: 4-8; Gagiano CA "Unnecessary committals for forensic observation" 1991 108 *SALJ* 4: 714-718; Haysom N *et al* "The mad Mr Rochester revisited: The involuntary confinement of the mentally ill in South Africa" 1990 6 *SAJHR* 341-362; Hoctor S "Amnesia and criminal responsibility" 2000 13 *S Afr J Criminal Justice* 3: 273-287; Joubert AF & Verschoor TJ "Epilepsy in forensic psychiatry" 1995 17 *Specialist Med* 8: 38-46; Joubert AF & Calitz FJW "How can a successful

conducted as no in-depth framework combining or integrating all three these topics exists. It is therefore imperative to undertake a broad-ranging analysis of the legal issues involved, while an in-depth study of the medical, clinical and scientific aspects of psychiatry and psychology is also required to ensure clarification and exposition of the issues surrounding the complex nature of this topic.

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comprehensive primary health care service bring relief to overcrowded forensic wards in psychiatric hospitals?" 1995 17 *Specialist Med* 8: 58-62; Kaliski S (ed) *Psycholegal assessment in South Africa* (2007) Oxford University Press: Southern Africa; Kaliski S *Sensation seeking, impulsivity and violence in schizophrenics found unfit to stand trial* (1993); Labuschagne JMT "Die audi alteram partem-reël by 'n psigiatriese ondersoek deur 'n hof beveel" 1994 9 *SAPL* 1: 204-206; Labuschagne JMT "Strafregtelike aanspreeklikheid van 'n psigiater weens seksuele misbruik van 'n pasiënt" 1995 28 *De Jure* 2: 450-453; Labuschagne JMT "Aktiewe eutanase en professionele hulpverlening by selfdoding van 'n psigiatriese pasiënt" 1995 112 *SALJ* 2 227-230; Le Roux J & Mureriwa I "Paedophilia and the South African criminal justice system: A psychological perspective" 2004 17 *S Afr J of Criminal Justice* 1: 41-56; McCurdie J "The interface between the legal and mental health professions with particular reference to the office of the family advocate" 1994 6 *S Afr J Child Adolescent Psychiatry* 1: 12-16; Ryan C & Ewart-Smith M "When insanity is convenient; ... and a psychiatrist responds" 2005 5 *Without Prejudice* 4: 7-9; Segal J & Thorn R "Consent procedures and electroconvulsive therapy in South Africa: Impact of the Mental Health Care Act" 2006 9 *S Afr Psychiatry Rev* 4 206-215; Snyman JL "Die deliktuele aanspreeklikheid van die psigiater of inrigting vanweë gewelddade gepleeg deur gehospitaliseerde geestesongestelde pasiënt" 1982 *De Jure* 227; Snyman JL *Die siviele opneming van geestesongesteldes: Regte en regsbeskerming van die betrokke* (unpublished LLD thesis, Unisa, 1990); Snyman JL "Die Deliktuele aanspreeklikheid van die psigiater vanweë nalatige behandeling van die geestesongestelde pasiënt" 1982 7 *TRW* 1: 1-19; Steyn LLM dissertation; Steyn CR "Liability for undue familiarity, abandonment and suicide in the context of psychotherapy" 2005 38 *De Jure* 1: 51-58; Steyn CR "Liability for misdiagnosis and negligent therapy in psychiatry" 2005 30 *TRW* 2: 95-106; Steyn CR "Breach of confidentiality and the duty to warn in medical law: Examples from clinical psychiatry" 2006 31 *TRW* 1: 134-142; Steyn LLM thesis; Strauss SA "Nie-patologiese ontoerekenbaarheid as verweer in die strafreg" 1995 16 *S Afr Practice Management* 4: 14-34; Strauss SA *Doctor, patient and the law: A selection of practical issues* (1991) 131ff; Swanepoel M *Professionele mediese nalatigheid met spesifieke verwysing na die psigiater* (unpublished LLB dissertation, UP, 2003); Szabo CP "The Mental Health Care Act: Challenges and opportunities" 2006 9 *S Afr Psychiatry Rev* 1: 1-5; Van der Merwe RP "Sielkundige perspektiewe op tydelike nie-patologiese ontoerekeningsvatbaarheid" 1997 18 *Obiter* 1: 138-144; Van Oosten FFW *The doctrine of informed consent in medical law* (unpublished LLD thesis, Unisa, 1989); Van Oosten FFW "The insanity defence: Its place and role in criminal law" 1990 3 *S Afr J of Criminal Justice* 1: 1-9; Van Oosten FFW "Non-pathological criminal incapacity versus pathological criminal incapacity" 1993 6 *S Afr J of Criminal Justice* 2: 127-147; Van Staden CW "Can involuntary admitted patients give informed consent to participation in research?" 2007 13 *S Afr J of Psychiatry* 1: 10-12; Verschoor TJ *Die posisie van psigopate en ander analoë figure in die reg* (unpublished LLD thesis, UP, 1981); Verster I "Mental disorders in patients referred for psychiatric observation after committing homicide" 1999 24 *TRW* 1: 58-66; Vorster M "Psychiatry in the medico-legal setting" 2005 11 *S Afr J of Psychiatry* 2: 42; Westmore IB & Oosthuizen H "The role of schizophrenia in forensic psychiatry: A literature review" 1995 17 *Specialist Med* 8: 48-56; Zabow T & Flisher AJ "Do changes in mental health law improve the quality of patient management? Professional activities of psychiatrists in South Africa: Implications for the year 2000: A study of a general hospital psychiatric unit" 1996 86 *S Afr J of Psychiatry* 12: 1606-1607; Zabow T "New health-related legislation and the psychiatrist:" 2005 5 *Specialist Forum* 11: 61-62.

Because of the multifaceted focus of this work, it is necessary to consult numerous legislative texts. For example, a detailed analysis of interrelated constitutional provisions such as the right to equality (non-discrimination), the right to life, the right to dignity, the right to bodily and psychological integrity, the right to privacy, and the right to freedom of scientific research and experimentation is needed to be undertaken together with a study of the common law, various acts, regulations, guidelines and policy documents. A scrutiny of conflicting scholarly viewpoints of renowned authors embodying constitutional, medico-legal, and liability issues are also carried out. It is trusted that this research will assist in addressing these issues and challenges in South Africa.

Taking the above into consideration the wide scope and nature of this thesis is necessitated by the fact that law, psychiatry and psychology cover a wide range of disciplines that need to be researched to ensure that the study is current, inclusive and comprehensive. It is proposed that this thesis is the first comprehensive LLD-thesis written on this topic in South Africa and, in this regard, is an original contribution to the field of study.

#### **1.4 HYPOTHESIS**

Rapid progress has undoubtedly been made regarding South Africa's dedication to the improvement of mental health care and the regulation of the medical profession in the country. For example, government has included clauses in the Constitution protecting the rights of the mentally disordered patient, for example, the right not to be discriminated against (the right to equality), the right to bodily and psychological integrity, the right to dignity, the right to privacy as well as access to health care services, and has also promulgated extensive domestic legislation for example the Mental Health Care Act and the National Health Act. However, regardless of these developments, it is put forward that legislation regulating the medical, psychiatric and psychology professions and the rights of the mentally disordered patient remains fragmented and ineffective. It is proposed that the current legal framework is still responsible for some improper, fragmented and inadequate management and provision of health care services at present, including mental health care services in South Africa. The proposition advanced by this research is that the absence of a centrally co-coordinated health care structure has attributed to confusion and overlaps. In essence, this research investigates where accountability should lie, and will attempt to establish the reasons for this unfocussed approach, while proposing recommendations for the regulation of

constitutional, medico-legal and liability issues concerning psychiatry and psychology and the mentally disordered patient in South Africa.

## 1.5 CHOICE OF LEGAL SYSTEMS

### 1.5.1 South Africa

The focus point of this thesis is an examination of the South African juridical framework with regard to law, psychiatry and psychology. Constitutional, medico-legal and liability issues are addressed to analyse, point out shortcomings within, and improve the South African juridical framework. In addition, a number of considerations have led to an examination of aspects with regard to the current juridical framework of the United Kingdom and other foreign case law. The motivation for this is that, according to section 39(1) of the Constitution, international law must be considered, and foreign law may be considered, in the interpretation of the Bill of Rights.<sup>42</sup> Although there are some existing directly relevant South African sources on this topic, the specific matter of integrating law, psychiatry and psychology has not as of yet been extensively explored in South African legal literature. This necessitates a heavy reliance on foreign sources throughout the thesis. Focus is mostly placed on the position in the United Kingdom, although, if necessary, reference is made to other foreign legal systems as well.

### 1.5.2 The United Kingdom

Although English law continued to trail scientific growth during the eighteenth and nineteenth centuries, advances in psychiatric and psychological knowledge began to infiltrate. The United Kingdom produced two great minds, one legal and the other psychiatric. Thomas Erskine<sup>43</sup> was considered England's leading trial lawyer. Alexander Crichton<sup>44</sup> authored *An inquiry into the nature and origins of mental derangement* in 1798. His work focused on the influence of emotions on thinking processes and he had an influence on the

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<sup>42</sup> Section 39 of the Constitution reads as follows: "39(1) When interpreting the Bill of Rights, a court, tribunal or forum – (a) must promote the values that underlie an open and democratic society based on human dignity, equality, and freedom; (b) must consider international law; and may consider foreign law. (2) When interpreting any legislation, and when developing the common law or customary law, every court, tribunal, or forum must promote the spirit, purport, and objects of the Bill of Rights. (3) The Bill of Rights does not deny the existence of any other rights or freedoms that are recognised or conferred by common law, customary law, or legislation, to the extent that they are consistent with the Bill."

<sup>43</sup> (1750-1823.) See Barak G *et al Battleground: Criminal Justice* (2007) 259ff.

<sup>44</sup> (1763-1856.) See Robinson DN *Wild beasts and idle humours: The insanity defense from antiquity to the present* (1996) 142ff.

development of modern psychiatry. When James Hadfield<sup>45</sup> attempted to assassinate George III in 1800, Erskine was called to defend him, and he challenged Cricghton as his expert witness. Hadfield was acquitted of attempted murder by reason of insanity. Law and psychiatry were joined. Law was used to address the complexities of mental disorders, focusing on the relevance of delusions in legal insanity.<sup>46</sup>

Forensic psychiatry was germinating, nurtured by a spectrum of developments in the psychological- and -neurosciences. William Cullen,<sup>47</sup> a pathologist, published his study of insanity, and his influence was extended by his students to America. But the English courts were still grappling with the issues of mental illness, reluctant to give up old notions of global cognitive dysfunction as the legal definition of mental illness in criminal cases.<sup>48</sup> In 1813, Samuel Tuke made the York Retreat into one of the most renowned "moral treatment" asylums in the world by publishing a widely-read book.<sup>49</sup> In 1839, the physician John Conolly<sup>50</sup> started a movement to abolish mechanical restraints and later chemical restraints such as bromide and chloral hydrate for overactive asylum patients. Non-restraint was first accepted in 1841 at a meeting of the Association of Medical Officers of Hospitals for the Insane, today the Royal College of Psychiatrists, which in 1853 founded the *Asylum Journal* - today the *British Journal of Psychiatry*.<sup>51</sup>

## 1.6 STRUCTURE AND OVERVIEW OF THE THESIS

### 1.6.1 Part one: Historical, clinical and ethical aspects concerning the psychiatric and psychology professions and the mentally disordered patient

Over the course of the past 30 years, interest in the history of psychiatry and psychology has boomed. Much of this proliferation of interest has taken place under the broad influence of postmodernism and has resulted in multiple and diverse histories that no longer seek to provide a linear narrative of constant

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<sup>45</sup> (1771/1772 – 1841.) Also spelled Hatfield.

<sup>46</sup> Barrel J *Imagining the king's death: Figurative treason, fantasies and regicide 1793-1796* (2000) 370ff.

<sup>47</sup> (1710-1790.) Tuke DH *A Dictionary of psychological medicine: Giving the definition, etymology and synonyms of the terms used in medical psychology with the symptoms, treatment, and pathology of insanity and the law of lunacy in Great Britain and Ireland* (1892) 641ff.

<sup>48</sup> Bordenn WA "A history of justice: Origins of law and psychiatry" 1999 24 *AAPL Newsletter* 2:12-14.

<sup>49</sup> (1784–1857.) See Tuke S *Description of the retreat: An institution near York, for insane persons of the Society of Friends* (1813) 1ff.

<sup>50</sup> (1794–1866.) See Conolly J *et al Treatment of the insane without mechanical restraints* (1973) 1ff.

<sup>51</sup> Sadock BJ & Sadock VA (eds) *Kaplan & Sadock's comprehensive textbook of psychiatry* (2000) 3304; Katona C & Robertson M *Psychiatry at a glance* (2005) 62.

evolutionary progress. Rather, these new histories explore and disrupt taken for granted assumptions about the past and provide a starting point for discussion and debate about the some of the very foundations of mental health care.<sup>52</sup> Therefore, the research conducted for chapter two focuses on the history and development of psychiatry and psychology. This chapter serves as a background to the study.

In order to understand the issues associated with psychiatry and psychology as well as the mentally disordered patient, an understanding of what psychiatry and psychology entail is of utmost importance. Therefore, chapter three provides a clinical overview of psychiatry and psychology and of these professions. An explanation of what mental disorder / illness is, the process of diagnosing mental disorders, the different forms of mental disorders and different treatment methods for these disorders canvass the issues associated with such work, and outlines the regulatory framework in which it operates. Medical and psychological interventions, for example electroconvulsive treatment therapy and psychotherapy are explained. Medical concepts and terminology are defined in this chapter, therefore a glossary is not provided at the end of the thesis. In addition to the information provided in chapter two this research serves as a further background to the study.

The research conducted for chapter four explains the ethical aspects and issues related to the psychiatric and psychology professions. Focus is placed on guidelines and different ethical rules. Although ethical rules do not constitute law, they are still legally relevant.

### **1.6.2 Part two: Medico-legal aspects concerning the psychiatric and psychology professions and the mentally disordered patient: The position in South Africa**

Because the Constitution is considered to be the supreme law in South Africa, chapter five focuses on constitutional issues in psychiatry and psychology. Focus is also placed on the rights of the mentally disordered patient. There are specific fundamental human rights protected in the Bill of Rights that are applicable to these professions and the mentally disordered patient. The first is section 36 of the Constitution – the general limitation clause. If a court determines that a law or the conduct of a respondent impairs a fundamental right, it must be considered whether the infringement is nevertheless a justifiable

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<sup>52</sup> Ion RM & Beer MD "Valuing the past: The importance of an understanding of the history of psychiatry for healthcare professionals, service users and carers" 2003 12 *Int J Mental Health Nursing* 4: 237.

limitation of the right in question.<sup>53</sup> Further rights include the right to dignity, the right to bodily and psychological integrity, the right to privacy, the right not to be subjected to medical experimentation without giving informed consent and the right to access to health care services. Secondly, common law aspects are discussed and examined and thirdly, domestic legislation in the field of health are incorporated, discussed and examined, for example, the Mental Health Care Act and the National Health Act.

Chapter six outlines aspects pertaining to the criminal and delictual liability of the psychiatrist and psychologist. An explanation of the establishment of medical malpractice is also provided. Issues involving for example the "the proof of medical negligence", the *res ipsa loquitur*, the establishment of causation, expert testimony and relevant case law are also dealt with in this chapter.

Chapter seven concludes the research with a summary and submission of recommendations in light of the research conducted for this study.

## **1.7 RESEARCH APPROACH AND METHODOLOGY**

### **1.7.1 Research methodology**

The following research methodologies are employed: A literature study of the Constitution, statutes, and case law as primary sources of law is followed. In addition, textbooks and writings of authors as secondary sources of law are utilised. Other sources include the internet and electronic databases.

### **1.7.2 Explanatory note on source referencing and bibliography**

- In the main body of the thesis, the initials of the authors are given only in the first occurrence of the reference within each chapter. Thereafter, only their surnames are used when indicating the reference. Their initials are also reflected in the bibliography at the end of the thesis.
- The date of publication of textbooks is either referred to with reference the actual year of publication or to the number of the edition of the book.
- Where a passage from a judgment or textbook is quoted and the quote itself contains references to other materials, the format of these references will not be altered to follow the format in the text of the thesis (on the basis that it is a quote and as such must remain unaltered).

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<sup>53</sup> Currie I & De Waal J *The Bill of Rights Handbook* (2005) 26.

- With regard to journal references, abbreviated names are used in the main body of the text and also in the bibliography, since the full names can be found by referring to the table of abbreviations.
- References to case names appears in the main body of the text in italics, except when they are intended as references to the people themselves, in which case they will appear as regular text, for example *Soobramoney* means the case of *Soobramoney v the Minister of Health, KwaZulu-Natal* while Soobramoney means the applicant in that case.
- The bibliography is compiled by listing all sources cited in the footnotes in full and not only by listing principal sources, cases and statutes. This is to ensure a comprehensive and complete list of sources, covering primarily medical law sources as well as important sources on other various branches of law.
- In general, the house-style of the Journal for Contemporary Roman Dutch Law (*THRHR –Tydskrif vir Hedendaagse Romeins-Hollandse Reg*) will be used.
- With reference to sources, the citations are given as follows:
- Journal article citation for the first time: Allan A "Psychiatric diagnosis in legal settings" 2005 11 *S African J of Psychiatry* 2: 52-55. (Reference is made to volumes and issues or to either the volume or the issue, depending on the availability of the volume and issue number.) Second citation: Allan 2005 *S African J of Psychiatry* 52.
- Textbook citation for the first time: Claassen NJB & Verschoor TJ *Medical negligence in South Africa* (1992) 40. Second citation: Claassen & Verschoor 40. In the case of multiple sources used of a specific author an abbreviated title of the source is also given.
- Edited books – for the first time: Dickens BM (ed) *Medicine and Law* (1993) 20. Citation for the second time: Dickens (ed) 20.
- Academic theses and dissertations - citation for the first time: Blackbeard M *Epilepsy - Legal Problems* (unpublished LLD thesis, Unisa, 1994) 20. Citation for the second time: Blackbeard *LLD thesis* 20.
- Publications / contributions in an edited book - citation for the first time: Harris J "Profession responsibility and consent to treatment" 37-47 in *Consent and the incompetent patient: Ethics, law and medicine* ((eds) Hirsch SR & Harris J) (1988) 39-42. (A distinction is made between a contribution and a publication within a book.) Citation for the second time: Harris in *Consent and the incompetent patient: Ethics, law and medicine* 39-42.

- South African court cases - citation for the first time: *Van Wyk v Lewis* 1924 AD 438. Citation for the second time: *Van Wyk v Lewis supra*.
- Foreign court cases – citation for the first time: Cases are cited in their foreign form, for example *Winch v Jones* [1985] 3 ALL ER 97 (CA). Citation for the second time: *Winch v Jones supra*.
- South African statutes - citation for the first time: The National Health Act 61 of 2003. Citation for the second time: The National Health Act.
- Foreign statutes are cited in their original form throughout the thesis to avoid confusion with South African statutes, for example, the Mental Health Act of 1983.
- Websites - citation for the first time: American Academy of Psychiatry and the law: "Ask a question on forensic psychiatry" 2003 <http://images.google.co.za/images?hl=en&q> (Date of access: 10 May 2009). Citation for the second time: American Academy of Psychiatry and the Law <http://images.google.co.za/images?hl=en&q>.
- The style further does not cite pages with reference to the letter "p" but simply refers to the page number, for example 35.
- Paragraphs in footnotes are cited as follows: par [26].
- Quotations (in the text as well as in the footnotes) are placed between double inverted commas; and not single inverted commas. Long quotations are indented and no inverted commas are used.

## 1.8 CONCLUSION

We live in an increasingly complicated world and it becomes more and more difficult to know where to seek the answers to problems which affect so many of us. As mentioned above, one area of particular importance is mental health care in South Africa. Whether they are psychiatrists, psychologists or patients, nowadays there appears to be less willingness to accept decisions and far greater opportunities for disputes to arise and quicker recourse to litigation. This thesis covers a number of important subjects ranging from the development of psychiatry and psychology, clinical aspects in psychiatry and psychology to ethical, constitutional and liability issues. The starting point, before the crucial issues are discussed, is a historical survey of the development of psychiatry and psychology in the following chapter.

PART 1:  
HISTORICAL, CLINICAL AND ETHICAL ASPECTS CONCERNING THE PSYCHIATRIC  
AND PSYCHOLOGY PROFESSIONS AND THE MENTALLY DISORDERED  
PATIENT



*Philippe Pinel is releasing "lunatics" from their chains at the La Salpêtrière Asylum in Paris.*

(This picture is courtesy of Google Images:  
<http://imagecache.allposters.com/images/pic/BRGPOD/164471%7EPhilippe-Pinel-Releasing-lunatics-from-Their-Chains-at-The-Salpetriere-Asylum-in-Paris-in-1795-Posters.jpg>.)

## CHAPTER 2

### MEDICINE, PSYCHIATRY AND PSYCHOLOGY: A HISTORICAL SURVEY

"History, despite its wrenching pain, cannot be unlived, but if faced with courage, need not be lived again."<sup>1</sup>

#### 2.1 INTRODUCTION

Before the end of the eighteenth century neither psychiatry nor psychology existed as defined fields of medicine or mental health. Although individual doctors had occupied themselves with the care of the insane and had written manuals about it since the time of the ancient Greeks, psychiatry did not then exist as a discipline to which a group of physicians devoted themselves with a common sense of identity. Yet, except for surgery, few other specialities had come to life either. The advent of medical specialism<sup>2</sup> was a phenomenon of the nineteenth century, but mental illness as such had always been familiar and society always had ways of coping with it.<sup>3</sup> The history of psychology also reaches back to ancient times when philosophers and religious leaders were asking questions about human nature and trying to explain human behaviour.<sup>4</sup>

The origin of psychiatry and psychology actually begins with the Greeks. The Greco-Roman outlook survived unchanged until the eighteenth century and even a large part of the Greek nomenclature is still used today. While the great cultures of old, such as those of Egypt and Mesopotamia, vacillated between naturalistic and supernatural explanations of diseases, the Greeks declared themselves outspokenly in

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<sup>1</sup> Angelou MAJ "Inaugural poem" as quoted in *The psychology of terrorism: A public understanding* ((ed) Stout CE) (2002) 39.

<sup>2</sup> The origin and development of medicine and medical specialism can be divided into three periods: The Mythological period from infancy of the human race to about the year 400 BC; the Dogmatic period or Empirical age from the Hippocratic period from 400 BC to the close of the eighteenth century and the Rational age in medicine beginning at the close of the eighteenth century and the beginning of the nineteenth century. See Carstens PA & Pearmain DL *Foundational principles of South African medical law* (2007) 608; Massengill SE *A sketch of medicine and pharmacy* (1943) 10.

<sup>3</sup> Shorter E *A history of psychiatry: From the era of the asylum to the age of Prozac* (1997) 1.

<sup>4</sup> Papalia DE & Olds SW *Psychology* (1987) 6.

favour of naturalistic explanations of mental illness and therefore became the founders of scientific medicine, psychiatry and psychology.<sup>5</sup>

It is, however, safe to say that the history of psychiatry and psychology - as independent disciplines - is divided into three periods: The asylum period of the years 1770-1870 in which biological concepts held sway; the psychotherapy<sup>6</sup> period of the years 1870 to more or less 1970 during which Freud's<sup>7</sup> doctrine of psychoanalysis came increasingly to the fore; and the second biological psychiatry from the 1970's to the present. As mentioned above it goes without saying that since ancient times medicine has always been interested in psychiatric illness, yet psychiatry as a medical speciality arose with the birth of the therapeutic asylum in the late eighteenth century. This is due to the fact that only then a corps of trained physicians was established to run these new institutions and persons became knowledgeable about administering a mental hospital in a way that could prove beneficial to patients as opposed to merely safeguarding society from them. This implied some knowledge of psychiatric illness, an understanding of mental therapeutics (healing) and some sense of the beneficent use of the environment.<sup>8</sup> Psychology as a science is an even younger discipline, which is only a little more than 100 years old.<sup>9</sup>

In compiling a history of psychiatry and psychology one has to bear in mind that the difference between modern concepts of these professions and ancient views on abnormal behaviour and the subsequent healing practices of mentally ill persons (although very interesting) may raise certain difficulties. It is possible to set well defined boundaries for present day psychiatry and psychology with its relatively clear nosology, but when the boundaries of psychiatry overlap those of law, general medicine, socio-politics,<sup>10</sup>

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<sup>5</sup> Ackerknecht EH *Short history of psychiatry* (1968) 10.

<sup>6</sup> Psychotherapy is defined as the treatment of mental disorders and allied problems by psychological methods. It also includes body therapies, client-centred therapy, co-counselling, cognitive-analytic therapy, cognitive behaviour modification, conjoint therapy, crisis intervention, dance therapy, family therapy, narcotherapy, play therapy etc. See Colman AM *Oxford dictionary of psychology* (2006) "psychotherapy" 621. Cf the terms "psychotherapeutic" and "psychotherapist", which means "one who practises psychotherapy". These terms are derived from the Greek words *psyche* (mind) and *therapeia* (service or treatment), from *therapeuein* (to take care or to heal). See Colman "psychotherapeutic"; "psychotherapist" 621. For a more detailed discussion of what psychotherapy entails, see chapter 3 of this study.

<sup>7</sup> Rice E *Freud and Moses: The long journey home* (1990) 1, 18. See the discussion of Freud's work below.

<sup>8</sup> Shorter E *A historical dictionary of psychiatry* (2005) 3-4.

<sup>9</sup> Papalia & Olds 6.

<sup>10</sup> An examination of the treatment of the mentally ill reveals a history marked by both state and personal abuse and neglect. In the Soviet Union, psychiatry has been used as an instrument of repression and in the West proponents of the anti-psychiatry movement and other social advocates have ubiquitously reported institutional abuses. These occurrences

philosophy,<sup>11</sup> anthropology,<sup>12</sup> sociology<sup>13</sup> and folk practices,<sup>14</sup> the task becomes more complicated and extremely difficult.

This history may be viewed from many directions: the train of scientific advancements that have brought it to its present level of technology; the flow of underlying philosophical assumptions and tenets (especially the relation of mental and physical phenomenon) across time; the influence of social and religious institutions on mental illness; the development of the different modern schools of psychiatric and psychological practice and the actual place and treatment of the mentally ill in society. Simon,<sup>15</sup> in a 1996

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are not merely isolated to other countries and have also been reported in South Africa. Although this points to a lack of fundamental human rights for the mentally ill, a comprehensive understanding of rights in this area has not been clearly documented. Rather many polemic conceptualisations have been postulated, each with their own strengths and limitations. See Hamber B & Rock B "Mental health and human rights: In search of context, consequence and effective care" 1993 1 *Rethinking Rts* 72.

<sup>11</sup> To practice or to do research in the field of psychiatry requires the assumption of certain positions on several philosophical issues - two of which are particularly central. The first issue is the nature of the interrelationship of the brain and the mind. The second is to understand how the various explanatory approaches that can be taken toward psychiatric disorders can best be interrelated. Jaspers concluded: "Many a psychiatrist has said that he did not want to burden himself with a philosophy...but the exclusion of philosophy would...be disastrous for psychiatry." See Jaspers K *General psychopathology* (1963) 769 as quoted in Kendler KS "Toward a philosophical structure for psychiatry" 2005 162 *Am J Psychiatry* 3: 433.

<sup>12</sup> Perhaps the greatest medical interest in social anthropology over the last few years has come from psychiatry and its allied disciplines of psychology and social work. Medical anthropology seems to be developing along two broad specialisations of study: First, ethnographic medical anthropology, which describes and analyses mental illness, roles of for example the shaman in primitive societies, subjects (nutrition), concepts (the evil eye), knowledge, practices (acupuncture), and systems, in given cultures, or cross-culturally, and frequently across time and space. Secondly, clinical medical anthropology, or applied medical anthropology, which operates in conjunction with, or parallel to, schools of medicine, nursing, and public health; federal agencies; international agencies such as the World Health Organization; as well as many other public and private agencies; and engages in teaching and research, planning and administration, consulting and advising, in an effort to deliberately and actively help improve the Western system of medicine and make it more available to those who may be unaware of their need for it, or who are unable, or unwilling, to so avail themselves. See Shiloh A "Therapeutic Anthropology" 1980 12 *Anthropology NL* 1: 14-15.

<sup>13</sup> Sociology in psychiatry has its roots very firmly in the writings of Emile Durkheim, a French sociologist (1858-1917). Whereas sociology in psychiatry accepts the legitimacy and validity of what psychiatry is trying to do, the sociology of psychiatry wishes to examine and challenge precisely those assumptions. Sociology is inherently more critical, and has been accordingly less acceptable to many psychiatrists. Yet while certain elements of sociology of psychiatry fit into an "anti-psychiatry" framework, it is not necessarily part of that broad alliance. See Dunham WH "Social psychiatry" 1948 13 *Am Sociological Rev* 2: 183.

<sup>14</sup> Research about folk medicine (alternative medicine) incorporates various fields of knowledge, including folklore, anthropology, magic, religion and medicine, and different disciplinary perspectives emphasise different aspects of the topic. A common basis, however, can be found in the tacit idea that folk medicine is a variant of scientific medicine; problems and questions are defined with scientific medicine as a background. Research about folk medicine therefore has tended to centre on the effectiveness of folk healing and has focused on behaviour and ritual. In effect, the study of folk medicine has been reduced to a study of folk treatment, and the concept of medicine has become more important than the concept of folk. See Selberg T "Faith healing and miracles: Narratives about folk medicine" 1995 32 *J Folklore Research* 1: 35.

<sup>15</sup> Bennett Simon (1933-).

review of several recent histories of psychiatry and psychology contends that: "There is no good one-volume history of psychiatry [and psychology] because the field is in a state of 'great creative flux' with so many varied and different histories that no one history can please all." But he believes that history might help us see the new kinds of heroism required in the confusing and difficult state of psychiatry and psychology today, the ability to have vision and purpose and steadfastness but not be blind to the legitimate tensions and disagreements that are part and parcel of the enterprise.<sup>16</sup>

It is evident from the above that this historical background results in a vast area of consideration and the scope of the research (which could not aim to be complete) is therefore immense. Each of the above themes is discussed in the paragraphs below, some only briefly, by following (where possible) a chronological approach. It is important to note that terminology employed in this chapter is the same as those used by medical historians, philosophers, medical practitioners and academic writers of the specific period in time to ensure that the desire for historical accuracy is reflected.<sup>17</sup>

## 2.2 THE SIGNIFICANCE OF A HISTORICAL SURVEY

### 2.2.1 A survey of the past

According to Krumbhaar<sup>18</sup> the advantages of a respectable acquaintance with the history of one's profession should be obvious to all and have been recognised by many. Without its background a science

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<sup>16</sup> Sadock BJ & Sadock VA (eds) *Kaplan & Sadock's Comprehensive textbook of psychiatry* (2000) 3313. For an overview of the development of psychiatry see also Cavenar JO & Brodie H (eds) *Critical problems in psychiatry* (1982) 1ff; Swartz L "Images of culture and mental illness: South African psychiatric approaches" 1984 10 *Soc Dynamics* 1:17-25; Stone MH *Healing the mind: A history of psychiatry from antiquity to the present* (1997) 1ff; Stevens A & Price J *Evolutionary psychiatry: A new beginning* (2000) 1ff; Spaulding WD & Sullivan ME *et al Treatment and rehabilitation of severe mental illness* (2003) 1ff.

<sup>17</sup> For a discussion and explanation of certain legal and medical terms and concepts, see chapter 1 of this study.

<sup>18</sup> Krumbhaar EB "The lure of medical history" 1927 66 *Sci New Series* 1696: 1. Historical aspects relating to medicine and psychiatry have been discussed (to name only a few, in chronological order) by Renouard PV *History of medicine: From its origin to the nineteenth century* (1856) 25-707; Dunglison R *History of medicine from the earliest ages to the commencement of the nineteenth century* (1872) 17ff; Withington ET *Medical history from the earliest times: A popular history of the healing art* (1894); Park R *Epitome of the history of medicine* (1901); Osler W *The evolution of modern medicine: A series of lectures delivered at Yale University on the Silliman Foundation* (1913) 5-120; Garrison FH *An introduction to the history of medicine* (1921) 15; 24ff; Massengill SE *A sketch of medicine and pharmacy* (1943) 1ff; Hunter R & Macalpine I *Three hundred years of psychiatry, 1533-1860: A history presented in selected English texts* (1963) 1ff; Foucault M *Madness and civilization: A history of insanity in the age of reason* (1973) 1-274; Treacher A & Baruch G "Towards a critical history of the psychiatric profession" in *Critical psychiatry: The politics of mental health* (ed Ingleby D) (1981) 120-149; Ackerknecht EH *A short history of medicine* (1982) xi-244; Szasz TS "The origin of psychiatry: The alienist as nanny for troublesome adults" 1995 6 *Hist Psychiatry* 1-19; Porter R *A social history of madness: Stories of the insane* (1996); Loudon I (ed) *Western medicine: An illustrated history* (1997) Beveridge A

is reduced to the category of a mere trade and it is maintained that the history of a science is the science itself. A study of the history of ideas in any subject is important not only as an abstract field of enquiry, but also as a method of retaining an appropriate perspective on the current status of the subject and proposed developments.<sup>19</sup> If each age steps on the shoulders of the ages that have gone before, then certainly those who hope to be in the forefront of medicine, psychiatry and psychology must be acquainted with the body of the preceding age on whose shoulders they are to step.<sup>20</sup> As a matter of practical importance knowledge of how knowledge accrues and knowledge of the mistakes of the past is of prime importance in preventing similar mistakes in present and future work.<sup>21</sup>

An important reason for specifically understanding historical psychiatry and psychology is the fact that many of the uncertainties experienced in the present are a direct result of decisions made in the past.<sup>22</sup> For example, in many parts of the United Kingdom and elsewhere, the old asylums are still a part of the mental healthcare systems. Many of these relics from the past were built to contain and segregate the mentally ill at a time when mental illness was thought to be both hereditary and progressive.<sup>23</sup> Ion and Beer<sup>24</sup> explain

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"Relevance to the history of psychiatry to practicing clinicians" 1999 5 *Adv Psychiatric Treatment* 46-52; Micale MS & Lerner P (eds) *Traumatic pasts: History, psychiatry, and trauma in the Modern Age, 1870-1930* (2001) 1-306; Porter R *Madness: A brief history* (2002); Tosh J *The pursuit of history: Aims, Methods and New Directions in the Study of History* (2002); Melechi A *Fugitive minds: On madness, sleep and other twilight afflictions* (2003).

<sup>19</sup> Thompson C (ed) *The origins of modern psychiatry* (1987) 1.

<sup>20</sup> Garrison 15.

<sup>21</sup> Krumbhaar 1927 *Sci New Series* 1.

<sup>22</sup> Ion RM & Beer MD "Valuing the past: The importance of an understanding of the history of psychiatry for healthcare professionals, service users and carers" 2003 12 *Int J Mental Health Nursing* 4: 237.

<sup>23</sup> The ideas of sequestration and segregation have fallen into disrepute long ago but, while on the decline, the old asylums still remain a feature of the mental health landscape. Their continued use has little to do with their therapeutic value and much to do with the fact that they are there and provide a ready solution to the problem of what to do with the mentally ill. In the past, ignorance, superstition, religious fanaticism, and prejudice had blocked the path of progress in the understanding of various mental disorders. The mentally ill have been subject to just about every strange, cruel, or heartless treatment conceivable in some of these asylums. For a discussion of the history and background of various asylums (some of which are discussed below) see Conolly J *An inquiry concerning the indications of insanity with suggestions for the better protection and care of the insane* (1830) 1-33; Earle P *History, description and statistics of the Bloomingdale asylum for the insane* (1848) 1-145; Parigot J "Asylums and psychiatric administration in France and England" 1863 20 *Am J of Insanity* 2: 186ff; Lindsay WL "Mechanical restraint in English asylums" 1879 35 *Am J of Insanity* 4: 543ff; Wright D "Getting out of the asylum: Understanding the confinement of the insane in the nineteenth century" 1997 10 *Soc Hist Med* 1: 137ff; Adair R & Forsythe B *et al* "A danger to the public? Disposing of pauper lunatics in late-Victorian and Edwardian England: Plympton St Mary Union and the Devon County Asylum, 1867-1914" 1998 42 *Medical Hist* 1: 1ff; Bartlett P "The asylum, the workhouse and the voice of the insane poor in 19<sup>th</sup> century England" 1998 21 *Int J L & Psychiatry* 421ff; Wright D *Mental disability in Victorian England: The Earlswood asylum 1847-1901* (2001) 1ff.

<sup>24</sup> Ion & Beer 2003 *Int J Mental Health Nursing* 237 at 238. For a comprehensive resource on Victorian psychiatry of detailed social historical scholarship - with the emphasis on history rather than sociological analysis - see Scull AT (ed)

that as a result these asylums were often sited on outskirts of towns in order to reduce the likelihood of the mentally ill passing on what was considered to be their defective stock. According to them it is important to note that we live with the legacy of decisions made by our forbearers and considerable numbers of patients still receive treatment in buildings designed by Victorian moralists who could have had no understanding of the needs of people with mental health problems in the twenty first century. They mention another example of the way in which the past remains active in the present, which can be seen in the manner how current, unhelpful, stereotypes of the mentally ill and those who work with them can be traced back through time. Walter<sup>25</sup> has argued that negative stereotypes of those who work with the mentally ill have become embedded in popular culture and consciousness over the course of hundreds of years. Deadman<sup>26</sup> has traced the way in which negative views of the mentally ill have developed over the years. Clearly, the unhelpful stereotypes that we encounter in the present have their roots in the past. An understanding of this might help to appreciate the fact that current efforts to address issues such as stigma must be well planned, sustained and systematic if they are to make an impression on the layers of prejudice that have built up over time.<sup>27</sup>

### 2.2.2 The influence of history on the present

Historical research has demonstrated that social factors as well as clinical research programmes have played a part in the creation and acceptance of some cherished modern concepts. A good example of this can be found in the case of dementia praecox, which was the direct precursor of the diagnosis of schizophrenia.<sup>28</sup> The former concept was initially rejected in the United Kingdom by the psychiatric establishment.<sup>29</sup> Its eventual acceptance was a result of a combination of clinical and social factors such as

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*Madhouses, mad-doctors, and madmen: The social history of psychiatry in the Victorian Era* (1981); Scull AT "A brilliant career? John Conolly and Victorian psychiatry" 1984 27 *Victorian Studies* 2: 203ff.

<sup>25</sup> Walter G "The stereotype of the mad psychiatrist" 1989 23 *Aust & NZ J Psychiatry* 547-554 as quoted in Ion & Beer 2003 *Int J Mental Health Nursing* 237 at 238.

<sup>26</sup> Deadman JC "Social attitudes towards the mentally ill: A historical perspective" 1997 2 *Mentalities* 61-69 as quoted in Ion & Beer 2003 *Int J Mental Health Nursing* 237 at 238.

<sup>27</sup> Ion & Beer 2003 *Int J Mental Health Nursing* 237 at 238.

<sup>28</sup> Mahoney RF & Kell FJ "Case study: Dementia Praecox" 1936 36 *Am J of Nurs* 10: 1051-1054. For a clinical/medical explanation of dementia praecox and schizophrenia, see chapter 3 of this study. For further reading of the historical development of these concepts see Kirby GH & Davis TK *et al* (eds) *Schizophrenia [dementia praecox]: An investigation of the most recent advances: The proceedings of the Association, New York, December 27th and 28th, 1929* (1931) 16ff; Patterson RM "The pre-psychotic personality" 1940 10 *Rev Edu Research* 5: 460 at 461-463; Messinger E "Pharmacologic shock treatment for mental disease" 1941 53 *Scientific Monthly* 2: 155 at 157ff.

<sup>29</sup> The *Rosenhan experiment* was a famous experiment into the validity of psychiatric diagnosis of schizophrenia conducted by David Rosenhan, an American psychologist, in 1972. He concluded from his work that psychiatric diagnosis is

changing demographics and power relations in the British Medico-Psychological Association which made it more receptive to new ideas.<sup>30</sup> This example is useful in terms of illustrating the fact that scientific advances do not occur in a vacuum but that they are often driven by changes in the social world. One of the other key benefits that can arise as a result of the study of the past is an understanding of the precariousness and fragility of the current state of knowledge concerning mental health care and mental health law problems.<sup>31</sup> In the present hi-tech, modernist world of evidenced based care<sup>32</sup> it is tempting to believe that the world is on the verge of great discoveries and that mental health care practitioners are about to uncover the "facts" that will revolutionise mental health care. However, if the past is examined, it is clear that our predecessors were often equally convinced that they were in possession of the information that would enable them to respond most effectively to the care of the mentally ill.<sup>33</sup> Therefore an understanding of the past can alert the dangers of presumptuousness. If we can appreciate the fact that much of what we now see as "cruel and unnecessary" was instigated out of a genuine belief in its efficacy, then we can also get a sense of our own place in history and how those who follow may look back with similar astonishment at current practices and therapies.<sup>34</sup> Foucault<sup>35</sup> draws on the "genealogical method",<sup>36</sup> which revolves around the ideas of

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subjective and does not reflect inherent patient characteristics. He supports the view that psychiatric diagnosis betrays little about the patient but much about the environment in which an observer finds him. See Rosenhan DC "On being sane in insane places" 1973 179 *Sci* 250-258 for a detailed discussion of the methods use and startling (or even nightmarish) outcomes of the experiment.

<sup>30</sup> Ion RM & Beer MD "The British reaction to dementia praecox 1893-1913: Part 1" 2002 13 *Hist Psychiatry* 51: 285ff; Ion RM & Beer MD "The British reaction to dementia praecox 1893-1913: Part 2" 2002 13 *Hist Psychiatry* 52: 419ff.

<sup>31</sup> Cf the text of Ibbetson on studies of legal history where the following is stated: "Legal history is too important to remain within the domain of specialist legal historians. The structure of modern law is too heavily dependant on the legacy of the past for it to be marginalized as something of purely antiquarian interest. If we are to make sense of today's law we have to understand its history, and it is only when we can make sense of it that we can confidently begin to reform it." See Ibbetson DJ *A historical introduction to the law of obligations* (1999) v-vi.

<sup>32</sup> Evidence-based medicine is a medical movement based upon the application of the scientific method to medical practice, including long-established existing medical traditions not yet subjected to adequate scientific scrutiny. See Strauss SE & Richardson WS *et al Evidence-based medicine: How to practice and teach EBM* (2005) 1ff.

<sup>33</sup> For example, Ion and Beer refer to Scull who pointed out that when those who attended King George III beat and humiliated him, they did so out of the firm conviction that they were doing the right thing. How else is it possible to explain why the King of England was exposed to beatings, blistering and intimidation during the period in which he was deemed to be mentally unstable? It has to be accepted that those who pioneered insulin coma therapy and psychosurgery did so in the belief that these treatments were effective and appropriate. To think otherwise is to run the risk of seeing the people of the past as monsters and caricatures and, while it is naïve and anachronistic to attribute modern sensibilities to individuals from the past, it is also foolhardy to imagine that we are immune to the types of folly and error that our predecessors made when constructing their responses to the mentally ill. See Scull AT "Moral treatment reconsidered: Some socio-logical comments on an episode in the history of British psychiatry" 1979 9 *Psychological Medicine* 421-428 as referred to in Ion & Beer 2003 *Int J Mental Health Nursing* 237 at 239.

<sup>34</sup> Ion & Beer 2003 *Int J Mental Health Nursing* 237 at 239.

<sup>35</sup> Michel Foucault (1926-1984) was a French philosopher, historian, intellectual, critic and sociologist. He held a chair at the *Collège de France* with the title "History of Systems of Thought," and also taught at the University of California,

"descent" and "emergence," where descent "disturbs what was previously considered immobile; it fragments what was thought unified; it shows the heterogeneity of what was imagined consistent within itself". Ducey and Bennett<sup>37</sup> state that to the degree that we wish to understand notions of sickness and healing we have to get a clearer understanding of those assumptions about man and his psyche that derive from antiquity, but still underlie and inform our contemporary theories and practices.

### 2.2.3 A framework for the future

Psychiatry and psychology are subjects that are still developing and in order to understand future controversies and assess the adequacy of proposed changes, a historical perspective is essential. For example, knowledge of the treatment before the advent of the Victorian asylum of those who were poor and mad is both a warning to those planning future community services without adequate medical and legal provisions and a lesson in the historical inadequacy of the view that asylums were simply machines for social control.<sup>38</sup> The key issue is that while it is tempting to experience current psychiatric, psychological and legal approaches towards the mentally ill as natural and permanent, an understanding of the past helps mental health and legal practitioners to see things in a different perspective. Psychiatric, psychological and legal approaches towards the mentally ill have changed over time and can undoubtedly also be changed in future.<sup>39</sup>

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Berkeley. He is best known for his critical studies of social institutions, most notably psychiatry, medicine, the human sciences and the prison system, as well as for his work on the history of human sexuality. His work on power and the relationships between power, knowledge and discourse, has been widely discussed. See Adams B *Contemporary sociological theory* (2002) 237; Bouchard DR (ed) *Michel Foucault, language, counter-memory and practice: Selected essays and interviews* (1997) 147. See also Smart B *Michel Foucault* (1994) 19ff; Macey D *The lives of Michel Foucault: A biography* (1995) 1ff.

<sup>36</sup> The value of the genealogical method lies in the fact that it deconstructs truth and refuses the uniformity and regularity of history, focusing instead on showing the plural and often contradictory history that reveals traces of the influence of power on the so-called truth. In contrast to a traditional historical analysis that take the present as self-evident, focusing on the continuities that inevitably led to the present, genealogy turns to the discontinuities in history and asks instead why the present came to appear natural to us. See Slabbert MN "Human bodies in law: Arbitrary discursive constructions?" 2008 19 *Stellenbosch L Rev* 1: 71 at 74 fn 19; Butchart A *The anatomy of power: European construction of the African body* (1998) 10.

<sup>37</sup> Ducey C & Bennett S "Ancient Greece and Rome" in *World history of psychiatry* ((ed) Howells JG) (1975) 1-2.

<sup>38</sup> Thompson (ed) 2.

<sup>39</sup> According to Griffiths the psychiatric profession must continue to move forward by entering into dialogue with other health service managers, other professions and other organisations to ensure that previous failings are never repeated and that psychiatry plays its full and rightful part in improving services for those who use them and those who work in them. See Ion & Beer 2003 *Int J Mental Health Nursing* 237 at 239; Kandel ER "A new intellectual framework for psychiatry" 1998 155 *Am J Psychiatry* 4: 457ff; Griffiths H "Medical managers in psychiatry – vital to the future" 2006 30 *Psychiatric Bull* 6: 201-203.

#### 2.2.4 History cannot be surveyed in a vacuum

By viewing the origin and development of psychiatry and psychology as well as psychiatric and psychological practices as a universal phenomenon, it provides the possibility to perceive a series of eras – each dominated by a specific theme. It also illustrates a world wide movement through these eras in a predictable direction. According to Howells<sup>40</sup> this movement has direction, but cannot necessarily be claimed to be uniformly progressive if one define progress to be increasing knowledge and improving practice. There can be regression and recession. It may be useful to bring this pattern to relief as it may offer an appreciation of the psychiatric and psychological history of a particular region or of the whole. In such a way many viewpoints are strengthened, some appear in a new light and a few prove contradictory.

Further, according to Bartlett<sup>41</sup> the history of madness cannot only be equated to the histories of doctoring and medical science. It also includes the study of historical experiences of the mad, the broader public understanding of insanity, and the array of social systems and power structures through which society controlled and comprehended the individuals, and in which the mad individual negotiated day-to-day life. As such, it is essential that mental health care and legal practitioners show awareness of the socio-political context in which care for the "mad" took place. The focus of this thesis is an analysis of the South African, United Kingdom's and Canadian legal systems, but it is of the utmost importance (in a socio-political context) to make mention of the fact that there were hideous circumstances in for example Nazi Germany, Sweden, and the Soviet Union.<sup>42</sup> This illustrates that society should be aware of potential political abuse of psychiatry even in twenty first century democracies.<sup>43</sup> By providing a general survey of a global history of psychiatry perspectives are deepened, conspicuous advances are emphasised (which are often repeated in history) and lessons emerge from the cross comparison of regions.

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<sup>40</sup> Howells JG (ed) *World history of psychiatry* (1975) ix, xvii.

<sup>41</sup> Bartlett P "Legal madness in the nineteenth century" 2001 14 *Soc Hist Med* 1: 107-108.

<sup>42</sup> For a history of psychiatric abuse, see for example Kennedy F "The problem of social control of the congenitally defective: Education, sterilisation, euthanasia" 1942 99 *Am J Psychiatry* 1: 13-16; Bloch S & Reddaway P *Soviet psychiatric abuse: The shadow over world psychiatry* (1985) 13ff; Calloway P *Soviet and Western psychiatry. A comparative study* (1992) 1ff; Weine SM *When history is a nightmare: Lives and memories of ethnic cleansing in Bosnia-Herzegovina* (1999) 87-222; Pickett B *On the use and abuse of Foucault for politics* (2005) 9-124; Strous RD "Hitler's psychiatrists: Healers and researchers turned executioners and its relevance today" 2006 14 *Harv Rev Psychiatry* 1: 30-37.

<sup>43</sup> Ion & Beer 2003 *Int J Mental Health Nursing* 237 at 241.

## 2.3 THE ORIGIN AND DEVELOPMENT OF MEDICINE AND MADNESS

### 2.3.1 Paleopathology<sup>44</sup>

Medical science has its origin and its foundation in the science of paleopathology.<sup>45</sup> The study of the ancient evidences of disease is a phase of medical history which must depend upon paleontological data for its extension. The fact that pathological lesions, especially those on the bones, retain all of their characteristics after many hundreds of thousands and millions of years has been clearly shown and distinct evidences of disease are known as far back in geological time as the Carboniferous.<sup>46</sup> According to Moodie<sup>47</sup> the relation of paleontological data to medical history is based on the assumption that the manifestations of disease are the same whether seen on man or in animals. The importance of paleopathology is that it gives an opportunity of studying evidences of disease over a great period of time, and especially is this true in regard to the data offered by paleontology.

Paleopathology is thus the study of prehistoric disease and, as such, deals predominantly with skeletal remains and prehistoric populations. In its broadest sense, paleopathology deals with diseases in animal as well as human tissues, and consequently it is a field of interest to many scientific disciplines. When infection, malfunction, or traumas affect bones and teeth, the lesions or other abnormalities can be observed and studied, and in many cases the cause can be identified. The psychiatric profession finds great interest in the mutilations, scarifications, and decorations of prehistoric peoples and in burial customs and other cultural practices that have left their marks upon the skeleton or are depicted in stone or paint.<sup>48</sup> This form of primitive surgery is discussed below.

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<sup>44</sup> The term paleopathology was proposed by Mark Armund Ruffer (1859-1917) in 1914 during his studies on the pathology of ancient Egyptian mummies. He defined paleopathology as the science of the diseases that can be demonstrated in human and animal remains of ancient times. The Paleolithic era (Old Stone Age), coincides with the geological epoch known as the Pleistocene (Great Ice Age) which ended about 10 000 years ago with the last retreat of the glaciers. See Magner LN *A history of medicine* (1992) 1.

<sup>45</sup> Carstens & Pearmain 608.

<sup>46</sup> The Carboniferous Period (360-290 million years ago) is divided into two parts. The Lower Carboniferous, also called the Mississippian, began approximately 360 million years ago and ended 310 million years ago. The Upper Carboniferous, or Pennsylvanian, extended from about 310 to 290 million years ago with the beginning of the Permian Period. See Harland WB *A geological timescale 1989* (1990) vi, viii, xiv, 19, 40-48ff.

<sup>47</sup> Moodie RL "Synthesis of palaeontology and medical history" 1918 48 *Sci New Series* 1251: 619.

<sup>48</sup> Kerley ER & Bass WM "Paleopathology: Meeting ground for many disciplines" 1967 157 *Sci New Series* 3789: 638, 642.

## 2.3.2 Pre-historic medicine and beliefs<sup>49</sup>

### 2.3.2.1 Primitive Stone Age societies

The concept of medicine and in particular mental illness during the Stone Age was a very mythical one. Mental illness was assumed to stem from magical beings that interfered with the mind. It was universally believed that mental illness was caused by supernatural phenomena. It represented a breakdown of the magical-religious system and was mainly attributed to a violation or neglect of ritual obligations and further by demonic possessions. Treatments for mental illness were mostly provided by individual groups of shamans.<sup>50</sup> Although not specialised in the sense that they earned their livelihood from their vocation, their role in society was nevertheless to represent medical and legal belief and authority. These treatments often took the form of exorcisms in which the shaman would attempt to coax the evil spirit causing the illness.<sup>51</sup>

Psychosurgery<sup>52</sup> might be one of the oldest of all medical procedures performed by primitive societies.<sup>53</sup> This observation is supported by physical evidence dating back to many years ago to Neolithic times.<sup>54</sup>

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<sup>49</sup> "Prehistory" is a term often used to describe the period before the existence of actual and original "recorded history". Because, by definition, there are no "recorded history" from these times, the information known about this time period is informed by the fields of paleontology, biology, palynology geology, archaeoastronomy, anthropology, archaeology and other natural and social sciences. Even though the date marking the end of prehistory (which is the date when written historical records became a useful academic resource) varies from region to region it is generally accepted that prehistory ended around 3500 BC in Egypt. See Kerley & Bass 1967 *Sci New Series* 638ff. For further reading of prehistoric times, see Wells HG *The outline of history: Being a plain history of life and mankind* (1920) xiii, 50ff; Robinson CA *Ancient history from prehistoric times to the death of Justinian* (1951) 7, 13ff; Quennell M & Quennell CHB *Everyday life in prehistoric times* (1973) 1ff. Stearns PN & Langer WL *The encyclopaedia of world history: Ancient, Medieval, and Modern, chronologically arranged* (2001) 1-20.

<sup>50</sup> Shamans have been credited with the ability to control the weather, divination, the interpretation of dreams, astral projection, and travelling to upper and lower worlds. Shamanism refers to a range of traditional beliefs and practices concerned with communication with the spirit world. There are many variations in shamanism throughout the world, though there are some beliefs that are shared by all forms of shamanism. For an in depth discussion of Shamanism, see Campbell J *The masks of God: Primitive mythology* (1976) 211-272; 311ff; Demetrio FR "The Shaman as psychologist" 1978 37 *Asian Folklore Studies* 1: 57ff; Winkelman MJ "Shamans and other 'magico-religious' healers: A cross-cultural study of their origins, nature and social transformations" 1990 18 *Ethos* 3: 308ff.

<sup>51</sup> For a full discussion of the topic, see Brand M "Is mental illness a myth?" 1970 3 *J Contemp Psychotherapy* 1: 13ff; Mora G "History of psychiatry" in *Comprehensive text book of psychiatry* ((eds) Kaplan HI & Sadock BJ) (1985) 2034-2054.

<sup>52</sup> Psychosurgery is defined as surgical operations performed on physical normal brain tissue to treat mental disorders rather than brain pathologies. Brain tissue is destroyed during the performance of the procedure. See Colman (2006) "psychosurgery" 621; cf the term neurosurgery, which is defined as a branch of surgery devoted to treating disorders of the brain, spinal cord, and other parts of the nervous system. See Colman "neurosurgery" 503.

<sup>53</sup> According to Ackerknecht "primitive surgery" is one of those arbitrary procedures, which are to a certain extent unavoidable if we try to analyse primitive phenomena for a better understanding of our own cultural processes, and which are justifiable as long as we remain aware of its arbitrary character. See Ackerknecht EH "Primitive surgery" 1947 49 *Am Anthropologist* 1: 25.

<sup>54</sup> (5500-2500 BC.) This very short Neolithic time period represents the last part of the Stone Age. The era follows the terminal Holocene Epipalaeolithic periods, beginning with the rise of farming, which produced the "Neolithic Revolution"

Some anthropologists speculate that Stone Age societies performed trepanning<sup>55</sup> on people with mental illnesses to release the evil spirits or demons from their heads. Ackerknecht states that the trepanation procedure is of the highest importance (in certain contexts) as it is the "sole existing tangible evidence" of prehistoric medicine and surgery.<sup>56</sup> Archaeologists have found numerous human skulls showing signs of trepanation.<sup>57</sup> According to Oakley and Winifred trepanation was frequently practiced by the "battle-axe people" who constructed chambered tombs in the Seine-Oise-Marne area of France.<sup>58</sup> So many skulls in their tombs have been trepanned that it seems probable that the operation had some ritual significance. Roundels of human skull bone have been found in early prehistoric graves suggesting that such objects were treated as fetishes by the shamans and prehistoric men.<sup>59</sup>

In the absence of original written records, however, it is impossible to know exactly why the operation was performed. Buckland refers to Broca<sup>60</sup> who believed that this dangerous and painful operation was

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and ending when metal tools became widespread in the Copper Age (Chalcolithic) or Bronze Age or developing directly into the Iron Age, depending on geographical region. For a discussion of this period, see Weinberg SS "Neolithic figurines and Aegean interrelations" 1951 55 *Am J of Archaeology* 2: 121ff; Perrin T "Mesolithic and Neolithic cultures co-existing in the upper Rhône valley" 2003 77 *Antiquity* 298: 732ff.

<sup>55</sup> Trepanning (also spelled trephining) is known as a surgical procedure of cutting a hole in the skull in order to access the brain. A key feature of the wounds found in ancient skulls is the smoothness and shininess around the edges of the holes. This is a clear sign of new bone growth and evidence that the person whose skull was opened not only survived the operation but lived months or even years afterwards while the bone regrew and the skull structure healed. See Oakley KP & Winifred MA *et al* "Contributions on trepanning or trephination in ancient and modern times" 1959 59 *Man* 93; Feldman R & Goodrich J "Psychosurgery: A historical overview" 2001 48 *Neurosurgery* 3: 647, 648, 649ff.

<sup>56</sup> (Trepanation is also spelled "trephination".) See Ackerknecht 1947 *Am Anthropologist* 33-34.

<sup>57</sup> The crudest method of performing this procedure was to simply scrape a hole in the skull-cap with a polished mussel-shell. A second method was to make a circular cut in the bone with a flint or obsidian knife and to deepen it until the hard brain-membrane was reached. Third, the operation was performed by using a rusty nail, stone, or a hammer to remove the bone from the skull and finally, a wreath of tiny holes was made with a drill-bore, called *trypanon* in Greek. These could be united easily with a chisel or knife. Such an operation took little time even with primitive tools. The term "trepanning" originated from the latter procedure. See Oakley & Winifred *et al* 1959 *Man* 93-96.

<sup>58</sup> (3100-2000 BC.) The Seine-Oise-Marne culture is the last culture of the Neolithic and first culture of the Chalcolithic in Northern France. The "battle axe people" represent late Neolithic times (early Mesolithic). The name comes from the perforated cast copper battle-axes of a particular double-bladed form that were found at archaeological sites associated with them. Their successors, the Beaker culture, if they were in fact separate people, copied the new axe head types in stone, but everywhere the arrival of the "battle-axe" or "corded-ware" cultures mark the phasing out of the Neolithic time period. Trepanation was also occasionally practiced by early Danubians (3000 BC). For a discussion of this culture, see Tilley CA *An ethnography of the Neolithic: Early prehistoric societies in Southern Scandinavia* (1996) 9-69, 325-335.

<sup>59</sup> Another singular circumstance with reference to prehistoric trepanning is that some of the skulls have been left entire, while others have been largely mutilated to provide cranial amulets. Researchers have wondered whether the demand for skull-bone contributed to the prescription of trepanations. There are actual records of amulets measuring about 8-9 cm. It is argued that no medical reason can exist for making such enormous holes, and it is very unlikely that the patients survived the serious risk of infection with meningitis. See Oakley & Winifred *et al* 1959 *Man* 93-96.

<sup>60</sup> (1824-1880.) Paul Broca is best known for his contribution to neurology (specifically the concept of functional localisation by cerebral convolution) and was also intrigued by trepanned skulls. He integrated his anthropological and medical

performed for the cure of epilepsy and convulsions. Broca argued justly from the superstitious practices found in connection with it, that at that period, as well as long subsequently, these diseases were regarded as peculiarly the work of spirits. He shows that even as late as the seventeenth century, all convulsive diseases were regarded as epilepsy, especially in infancy, although true epilepsy seldom shows itself before the age of ten. He also believed that this explains why the operation was so constantly practised upon young children, since the apparent cures effected by the process would be more numerous at that age experience, having proved that sufferers at a later age, that is true epileptics, were not cured thereby. However, those who in early infancy were submitted to the operation might grow up as living witnesses of its efficacy.<sup>61</sup>

The question still remains on how this procedure was introduced into the practice of medicine. No one really knows. Prunières<sup>62</sup> supposed that this practice of trepanning was only extended to idiots, the insane and to convulsive patients. Broca considered this possible, although he still maintained that its primary use was for infants suffering from convulsions, who were consequently supposed to be possessed by spirits.<sup>63</sup>

It is evident from the above that evil spirits and demons were identified to be the cause of mental illness during prehistoric times. This ancient time period is the only known period in history which lacks evidence to suggest a materialistic cause<sup>64</sup> of mental illness which coexisted with a mentalistic explanation<sup>65</sup> in all

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knowledge and helped to create an environment in which scientists pondered what Neolithic and primitive people really knew regarding the brain and surgery. See Osler W *The evolution of modern medicine: A series of lectures delivered at Yale University on the Silliman Foundation* (1913) 10; Sagan C *Broca's brain: Reflections on the romance of science* (1979) 3, 7, 8, 9, 11-15; Clower W & Finger S "Discovering trepanation: The contribution of Paul Broca" 2001 49 *Neurosurgery* 6: 1417ff.

<sup>61</sup> Buckland AW "Surgery and superstition in Neolithic times" 1882 11 *J Anthropological Inst Great Britain & Ireland* 7 at 9, 10.

<sup>62</sup> Dr Prunières, a colleague of Broca, discovered his first Neolithic trepanned skull in the Lozère, France, in 1865. It was clear to him that the hole in this skull had been deliberately made, as its edges were smooth and appeared to be polished. See Walker AE *Genesis of neuroscience* (1998) 3-8; Arnott R & Finger S *et al* (eds) *Trepanation: History – discovery – theory* (2003) x, xi, 15-41, 348, 355, 363-404.

<sup>63</sup> Broca argues that the exemption from mutilation was due to the opposition of the survivors, but Buckland suggests that it might rather be that the unutilated had not been cured, and that therefore their skulls were not regarded with the same veneration, or perhaps the posthumous mutilations may have taken place at a later date, in consequence of a new superstition and the unutilated may have remained undiscovered. See Buckland 1882 *J Anthropological Inst Great Britain & Ireland* 7 at 11, 19. See also Loughborough JL "Notes on the trepanation of prehistoric crania" 1946 48 *Am Anthropologist* 3: 416ff; Oakley & Winifred *et al* 1959 *Man* 93ff; MacCurdy GG "Prehistoric surgery – A Neolithic survival" 1905 7 *Am Anthropologist* 1: 17ff.

<sup>64</sup> A materialist monism cause of mental illness refers to the conception that mental events are nothing but neural events. This is a monist viewpoint because it implies the existence of only one dimension namely the neural dimension. For a

the other eras. It is suggested that lack of scientific thoughts made them believe in non-scientific cause of mental illnesses. It was impossible for these prehistoric cultures to blame the cause of mental illness on something non-scientific, because they did not have developed scientific techniques to diagnose materialistic causes for mental illness.<sup>66</sup> DeWitt explains it as follows:

[During] [t]he Stone Age man was no less intelligent than his posterity and whether by the spoken word or the dexterous hand he was capable of producing art, but the logic of his thought was confined within the limits marked by myth and magic, oracle and miracle.<sup>67</sup>

The difficulties in making any formulation of the development of medicine, psychiatry and psychology of prehistoric civilisations are very great. Data on early periods are incomplete, not only because research has been limited but also because it has been directed toward special and restricted problems.<sup>68</sup>

### 2.3.3 Western and Eastern medicine

Western medicine, with its objective, pragmatic, fact-orientated philosophies and methodologies, and traditional Eastern medicine, with its intuitive holistic philosophies, are the products of two great civilisations in the medical history of mankind and they contribute to the health of a huge proportion of the world population. Studying the medical history of both these traditions provides the possibility of looking at things from two different points of view – as part of a whole – not understandable without understanding the whole

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more detailed discussion of these viewpoints, see Circadian Rhythm Laboratory: Refinetti R *Philosophy of physiological psychology* (1992) Electronic publishing <http://www.circadian.org/PPP/chap6.html> (Date of access: 30 July 2007).

<sup>65</sup> Mentalism refers to the conception that mental events can be fully explained by psychodynamic concepts without any reference to the nervous system. This is a dualistic viewpoint, as it implies that mind and brain are distinct and independent from each other. Refinetti identifies five groups in which to classify the contenders in the mind-brain controversy, namely mentalism, materialist monism, organicism, psychophysical parallelism, and psychophysical complementarism. Organicism goes one step past materialist monism, in the sense that it claims not only that mental events are neural events but also that each part of the brain is responsible for a particular class of mental events. Psychophysical parallelism refers to the conception that mind and brain are distinct but related to each other. This form of dualism may imply that mind and brain are only different sides of the same coin or even that neural activity induces mental activity. Finally, psychophysical complementarism refers to the conception that mental and neural events complement each other as causes of behaviour. According to Refinetti, cognisance should be taken of the fact that these five conceptions could all be described as particular ways of dealing with the much broader materialism-idealism controversy. Indeed, materialist monism and organicism are clearly materialistic, where, in contrast, mentalism is idealistic, and the other two conceptions are paradoxically both idealist and materialist. See Refinetti <http://www.circadian.org/PPP/chap6.html>.

<sup>66</sup> Swinton J *Spirituality and mental health care: Rediscovering a "forgotten" dimension* (2001) 7, 40-92.

<sup>67</sup> DeWitt NW "Epicurus: Philosophy for the millions" 1947 42 *Classical J* 4: 195.

<sup>68</sup> Steward JH "Cultural causality and law: A trial formulation of the development of early civilizations" 1949 51 *Am Anthropologist* 1: 1 at 16.

or as separate entities through which larger systems can be understood by analysis. Western medicine is seen widely as the orthodox modern medicine, while Eastern medicine is often regarded as an alternate and parallel system of medicine.

South Africa is a country with a highly heterogeneous population and with its cultural and ethnic diversity offers unique opportunities for investigating these different medical, cultural and religious aspects of mental illness. In addition different provisions of the South African Constitution<sup>69</sup> are concerned with culture, language and religion. It is therefore obvious that cultural, linguistic and religious matters are elevated to notable levels of constitutional significance, which justifies and necessitates a discussion of both Western and Eastern medical cultures. It is interesting to note that there are clear concordant advances in Western and Eastern landmarks of medical and psychiatric and psychological history, which will become clear in the discussion below.<sup>70</sup>

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<sup>69</sup> The Constitution of the Republic of South Africa, 1996 (hereafter referred to as the Constitution). See sections 15, 30 and 31. Constitutional aspects pertaining to psychiatry and psychology are discussed in chapter 5.

<sup>70</sup> Merkel explains these concordant advances as follows: "Most non-western and probably early western cultures distinguished between natural and supernatural causes of illness and hardship referring to what would be presently considered as mental illness. Egyptian and ancient Middle Eastern influences can be seen as incorporated into Greek culture, for example the importance of dreams and dream interpretation. The Judaic tradition, as evidenced in Judaic scripture, saw insanity as the result of heredity, physiology, improper sexual behaviour, failure to uphold ritual prescriptions, idleness, but most importantly as a punishment from God directly or through the agency of evil spirits or demons. Those with mental illness appeared to have been treated with benevolence, similar to children, but they were often feared and avoided if violent. Laws were instituted for their care and limiting their responsibilities and obligations. These beliefs and practices play an important role in later Christian beliefs. Much of western beliefs about mental functioning can be traced to Greek and Roman sources. During the Hellenistic period, with the spread of Greek culture through the Middle East and the eastern Mediterranean region, there was a growth of both rationalistic religion and mystery cults. Both focused on individual salvation. Eastern ideas entered the western tradition from India and the Middle East. Important centres for learning and experimentation developed, especially at Alexandria. Here a school of anatomy developed that argued for different functional areas in the brain. With the ascendancy of Christianity to predominance in the Roman Empire and the later collapse of the Roman Empire, Christian dogma became the basis of philosophical inquiry in the west. Platonic ideas were combined with Christian teachings, creating a worldview that dominated in the west for several centuries. St. Augustine (354-430 AD) championed Platonic conceptions of the mind, including the essential dichotomy between body and mind/soul. In the Islamic world of the 7<sup>th</sup> century and beyond, classical Greek and other Hellenistic ideas were elaborated. The teachings of Hippocrates, Galen, and the philosophy of Aristotle were combined to create an advanced level of science and medicine. Through the Holy Qur'an's teachings that the mentally ill are precious to God, asylums were established in Baghdad in the 8<sup>th</sup> century, Damascus in the 9<sup>th</sup> century, and several in Egypt, that were renowned for their humane treatment of the mentally ill. There was a focus on providing a calm and relaxed environment, with fountains, gardens, and the use of soothing baths, perfumes, music and special diets. Under this influence, Constantinus Africanus (1020–1087) founded a medical school in Salerno." For further reading, see Brown Medical School: Department of Psychiatry and Human Behaviour: Merkel L "The history of Psychiatry" 2003 <http://www.healthsystem.virginia.edu/internet/psych-training/seminars/history-of-psychiatry-8-04.pdf> (Date of access: 27 August 2007); Beaubrun MH & Bannister P "The West Indies" in *World history of psychiatry* 507-527; Miller L "Israel and the Jews" in *World history of psychiatry* 528-546; Rao V "India" in *World history of psychiatry* 624-649; Havens LL *Approaches to the mind* (1973) 1ff; Conrad LI *The western medical tradition* (1995) 1ff.

### 2.3.3.1 *The Far East*

The ancient medical history of China<sup>71</sup> is shrouded by legends and myths describing the ceremonies, customs, industries, taboos, and other related folkways of the different merging cultures. These folkways were orally passed among the migrating tribes from person to person and from generation to generation over the millennia. They were also transmitted in other forms, some of which included folk arts, folktales, folk dances and songs.<sup>72</sup> The professional values of ancient Chinese medicine arose with the development of medical professionalism itself. In ancient China, "profession" meant one's duties.<sup>73</sup>

The first monograph of medical theory of Chinese medicine, the *Internal Classic of the Yellow Emperor*, laid the foundations for the traditional Chinese medical theory. Making use of the archaic philosophical thinking of ancient China, the nucleus of this medical theory is made up of the *yin-yang* and "five phases" principles,

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<sup>71</sup> The history of China is told in traditional historical records that refer as far back as the Three Sovereigns and Five Emperors about 5000 years ago, supplemented by archaeological records dating to 1500 BC. China is one of the world's oldest continuous civilisations. Chinese medicine has been practiced for well over two thousand years and its effectiveness has been experienced by millions of people. Throughout time it has evolved and changed, but its fundamental roots have always remained the same. As Western influences threatened the validity of Chinese medicine, a movement began to develop to selectively thin out any aspect of the medicine that might not be acceptable to the Western scientific tradition. Traditional Chinese medicine is an outgrowth of this movement and as a result, many of the classical traditions were put aside. For a discussion of the history of China, see Schwartz BI *The world of thought in ancient China* (1985) 16-406; Loewe L & Shaughnessy EL *The Cambridge history of ancient China: From the origins of civilization to 221 BC* (1999) 1ff.

<sup>72</sup> The origin of Chinese folk medicine is found in the plant lore, religio-magical beliefs, and rudimentary medical techniques and faith healings of the Neolithic pastoralists and hunter-gatherers, who, in their daily encounter with nature, were instinctively aware of survival measures, many of which may still be observed in many cultures throughout China. Early in the New Stone Age, they learned how to treat disease with stone tools and this eventually led to the invention of acupuncture therapy. They discovered, through the production process, that movement of the body and extremities are capable of conquering fatigue and exhaustion, and even curing some diseases. Furthermore, this greatly promoted the condition of the body. Such activity, on the other hand, led to the invention of the art of *Dao Yin*, or what are known today as *Qigong* (breathing exercises) and *Tai Ji Quan* (shadow boxing). See Schiffeler JW "The origin of Chinese folk medicine" 1976 35 *Asian Folklore Studies* 1: 17; Lorenz KY & Sung J *et al Principles and practice of contemporary acupuncture* (1994) 3, 9-16, 99-101, 137, 144, 411-445.

<sup>73</sup> During the Zhou Dynasty (1065-771 BC), an independent medical profession and medical system took shape, built around four aspects: dietetic, internal, surgery, and veterinary. Standards for evaluating, and paying, doctors were established. The *Rites of the Zhou Dynasty* recorded that at the end of each year, doctors were paid according to their medical performance, the highest payment to those who achieved 100 percent cure rate, the payment for 90 percent cure rate ranks second, 80 percent cure rate ranks third and so forth. See Zhang D & Cheng Z "Medicine is a humane art: The basic principles of professional ethics in Chinese medicine" 2000 30 *Hastings Center Report* 4: S8.

which explains quite uniquely physiology, pathology and etiology, guides the diagnosis, treatment and prevention of disease, and provides the criteria for the application of drugs.<sup>74</sup>

As is generally known, Confucianism,<sup>75</sup> (the ruling and guiding philosophical ideology of Chinese feudal society for over 2000 years), established by the great educationalist, thinker and philosopher, Confucius,<sup>76</sup> was also the guiding principle of medical ethics in ancient China. The core of Confucian thinking is "benevolence" or "love and kind heartedness", "humanity", maintaining that "those who are kind hearted or benevolent love the people". In other words, all people should love one another, not alone doctors their patients. As a motto for physicians, Confucianists advocate that "medicine is a benevolent art" or, as a technical art for saving life and curing disease, physicians should have a kind heart. Confucius also pointed out that he who does not have perseverance is not qualified to become a doctor.<sup>77</sup>

The history of psychiatry and psychology has never been systematically pursued, which is in all probability a reflection of the fact that psychiatry and psychology itself has not been systematically practiced in the Far East. Religious considerations guided the behavioural attitude of Far Eastern cultures toward health and

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<sup>74</sup> This monograph instructed ancient physicians to focus their attention, in addition to their skill, primarily on the prevention of disease, instead of focussing on treatment after the onset of disease. He who is conversant with the prevention of disease is a "superior worker" in the medical province. It also stated as a prerequisite that a physician should have been erudite, with extensive knowledge regarding "astronomy, geography and worldly affairs". Only those with such great originality could serve their patients well and combat and conquer disease. See Zhang & Cheng 2000 *Hastings Center Report* S8-S12; Veith I *The Yellow Emperor's Classic of internal medicine* (2002) 15, 42-58, 65, 125ff.

<sup>75</sup> Confucianists have been mostly concerned with conducting a person's social life. Another philosophical tradition, Taoism, existed where Taoists have persistently devoted attention to searching for the optimal way for an individual to live a harmonious personal life in relation to cosmological and natural spheres. Both these concentrated interests in the well-being of the individual as an integrated organism within the context of his cosmological, natural and social environments has shaped and permeated Chinese thoughts all through the centuries. For a discussion of these philosophical traditions, see Tsung-yi BL & Kleinman A *Normal and abnormal behaviour in Chinese culture* (1981) 95ff; Liu J & Shao D "Early Buddhism and Taoism in China (AD 65-420)" 1992 12 *Buddhist-Christian Studies* 35ff; Taylor R & Arbuckle G "Confucianism" 1995 54 *J Asian Studies* 2: 347ff.

<sup>76</sup> Confucius (551–479 BC) was a Chinese philosopher and teacher of poetry, history, philosophy and founder of the Confucian school of thought, which greatly influenced political and social life in China. His teaching was compiled by his disciples in the *Analects*. Hundreds of millions of people still rely on Confucius's writings as a guide to living because they are able to relate to his teachings. Confucianism was the state orthodoxy in China until the revolution of 1911. For a comprehensive discussion of his teachings and life, see Dubs HH "'Nature' in the teaching of Confucius" 1930 50 *J Am Oriental Society* 233ff; Homer HD "The political career of Confucius" 1946 66 *J Am Oriental Society* 4: 273ff; Homer HD "Confucius: His life and teaching" 1951 26 *Phil* 96: 30ff; Taam CW "On studies of Confucius" 1953 3 *Phil East & West* 2: 147ff; Blackburn S *Oxford dictionary of philosophy* (2005) "Confucius" 73.

<sup>77</sup> Although this precept of medicine as an art has been well accepted as the basic principle of professional ethics as a general principle that emphasises doctors' self-accomplishment and self-restraint, there has never been a universally accepted professional code and binding principles in Chinese medicine comparable to the Hippocratic Oath in Western medicine. See Zhang & Cheng 2000 *Hastings Center Report* S8.

disease, even more than the religious tenets of Judeo-Christian beliefs influenced the emotional climate of the West.<sup>78</sup> The study of Chinese medical literature reveals an early awareness of the mind-body relationship and a profound understanding of what is currently known as psychosomatic medicine.<sup>79</sup> Any disease, but particularly mental disease, was caused by an imbalance of the two primary forces in man: the *yin* and the *yang*. The two forces, which mean the negative and the positive, the dark and the light, the moon and the sun, the noxious and the beneficial, also denote the female and male elements, both of which are ever-present in man and woman alike. It was believed that disease arose when the proportions of the two elements began to vary from the normal. It was further believed that this imbalance was caused by the patient himself, who had committed a transgression by deviating from the prescribed way of nature and society. It was this concept of the "way" (*Tao*), which provided the guiding principle of all human conduct in the China.<sup>80</sup>

Body and mind were seen as separate entities – it conceived of a duality of mind and matter, all of which was corroborated by Buddhism and the latent ideas of the transmigration of souls with the belief in reincarnation. Sleep and especially dreams were another corroborating factor in the body and soul dichotomy. With the first indication of illness, especially when it strangely affected the mind, or rather the patient's behaviour, specific rituals came into play that gradually developed for these occasions. These patients were carried out by certain priests whose pre-eminent function was to counteract and defeat the noxious powers that caused the illness.<sup>81</sup>

Another cause of mental illness was the ability attributed to the dead to steal the souls of the living. This was believed to happen while sleeping when the soul was occupied with dreams and could easily be lured away. With this strong implication of the spirit of the dead in all forms of mental alienation, it was

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<sup>78</sup> Veith I "The Far East: Reflections on the psychological foundations" in *World history of psychiatry* 662-663.

<sup>79</sup> For a medical/clinical discussion of psychosomatic medicine, see chapter 3 of this study.

<sup>80</sup> Chen concludes that in the *Tao Te Ching*, the concept of *te* agrees closely with the idea of nature in Western philosophy. More specifically, *te* stands for the initial state of nature, when nature, having emerged from *Tao*, returns to and abides by *Tao*, and when man, as a child of nature, keeps close to and abides by nature. As such *te* represents the unity and continuity between *Tao*, nature, and man. The *Tao Te Ching* (literally, the "Canon of *tao* and *te*") is a treatise on *Tao*, the hidden foundation of all, and *te*, its manifestation as nature. See Chen EM "The meaning of Ge in the Tao te Ching: An examination of the concept of nature in Chinese Taoism" 1973 23 *Phil East & West* 4: 457ff.

<sup>81</sup> In their role as priests, even though they used magical influence, they belonged to the realm of *yang* – to the light of life and the positive element. They were therefore endowed with an ascendancy over disease which was in the realm of *yin* – the darkness, death and all negative attributes. See Veith in *World history of psychiatry* 674-675.

reasonable to attempt restoration to sanity by immediate efforts to propitiate the departed. Ceremonies and gifts at the graves and ancestral altars and elaborate rituals were devised to recapture the souls of the demented for their rightful owners. It is important to note that since the supernatural was involved, failure to produce the desired results was not considered the fault of the medical priests, but ascribed to the implacable hostility of the dead.<sup>82</sup> One further aspect of the make-up of the Far Eastern psyche, which was of great importance, existed in the determination of behaviour in sickness and in health. This dealt with the belief surrounding longevity, fertility and sexual potency. Prominent among these sexual delusions suffered by those who thought of themselves to be bewitched was the firm belief in the loss or shrinkage of their primary sex organs. It is important to note that interesting parallels can be drawn to European psychiatric literature on hysteria and sexual delusions, including the writings of Freud, Charcot, Kraepelin and von Krafft-Ebing on hysteria and sexual deviance (discussed below).<sup>83</sup> The pattern that emerges from Chinese literature is build around a world of wizardry, nature, spirits, animal demons and malignant ancestral spirits, each of which can bring madness as well as cure it.<sup>84</sup>

### 2.3.3.2 *The Arabic countries*

Arab countries reflect a region of great religions and civilisations. These people have been among the torchbearers of science, philosophy, poetry, medicine and art. The history of psychiatry as part of this cultural heritage has passed through many stages and developments as will become clear from the discussion below.

#### 2.3.3.2.1 *The Nile Valley*

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<sup>82</sup> It is interesting to note that the idea of suicide as a moral imperative appeared early in Chinese recorded history. Confucius remarked that men might have had to give up their lives in the name of goodness. For a discussion of suicide, the family and specifically the role of women and suicide in light of Confucius's role as the spokesman for a fading slave society, see Hsieh ACK & Spence JD "Suicide and the family in pre-modern Chinese society" in *Normal and abnormal behaviour in Chinese culture* 29-48.

<sup>83</sup> The fox-belief of the Far East almost invariably ascribed preternatural causes to all forms of aberrant behaviour, including sexual disturbances such as impotence and frigidity, nymphomania and satyriasis. The association, equally prevalent in China and Japan of sex and psychological aberrations was frequent in fox-lore and existed also in most other forms of animal and spirit possession. The fox represented an animal of darkness to the highest degree. The external evil (in the shape of a fox) entered people whose "light spirit" had diminished. The external evil referred to bad demons. See Veith in *World history of psychiatry* 688-689. For further reading on the topic see Handwerker L "Conceptions of female infertility in Modern China" in *Deviant bodies* (ed) Terry J & Urla J (1995) 358-386. (See also the discussions below of hysteria and sexual deviations and delusions in ancient Egypt, Greece and Rome.)

<sup>84</sup> Veith in *World history of psychiatry* 673.

The main sources for studying medical knowledge in ancient Egypt during the Pharaonic era<sup>85</sup> are the surviving papyri,<sup>86</sup> which first required transliteration into modern languages. Ancient Egyptians thought that diseases were either due to evil spirits or the wrath of the gods. Organic causes for illnesses were also described.<sup>87</sup> Their philosophy of life and death centred upon the idea that these were part of a continuous cycle - the belief that life after death demanded elaborate funeral ceremonies and complex rituals in preparation for it. This belief emphasised the psychology of the dead and the nature of the personality thereafter. The individual was considered to be composed of three integral parts: First, the "khat", which represented the body. Second, the "ka" that represented the soul of the individual's double and was symbolised by uplifted arms, whose main function was to protect the body of the deceased and finally the "ba", which symbolised a flying bird carrying the key of eternity. The "ka" was believed to leave the body after death and reside in heaven, periodically visiting the burial place of the mummified body.<sup>88</sup>

Mental disorders have been recognised in Egypt for millennia from approximately 5000 years ago. In the fourteenth century – approximately 600 years before similar institutions were founded in Europe – the first medical and mental institute was established, in Kalaaon Hospital in Cairo.<sup>89</sup> Ancient Egyptians did not

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<sup>85</sup> The Pharaonic Era dates back to 3100 BC. During this time period Egypt witnessed many aspects of progress and renaissance in all fields. Historians divide the Pharaonic Era into three successive divisions: Old Kingdom, Middle Kingdom and Modern Kingdom. For a discussion of this time period see Midant-Reynes B *The prehistory of Egypt: From the first Egyptians to the first Pharaohs* (2000) vi, xi-xiii, 1-15, 37, 65, 160-330; Peden AJ *The graffiti of Pharaonic Egypt: Scope and roles of informal writings (c.3100- 332 BC)* (2001) 2, 9 16, 18, 19, 25, 293-294; Vernus P & Yoyotte J *The book of the Pharaohs* (2003) 6-12, 52-58, 114ff.

<sup>86</sup> The oldest yet discovered papyrus is the "Kahun Gynaecology Papyrus", dating back to 1825 BC, during the reign of Amnemat III. It describes methods of diagnosing pregnancy and the sex of the fetus, toothache during pregnancy, diseases of women, as well as feminine drugs, pastes and vaginal applications. It mainly deals with gynaecological matters and refers to the subject of "hysteria", attributing it to displacement of the uterus. The most famous "Edwin Smith papyrus", and to a lesser extent the "Ebers papyrus", provide a very favourable idea of the medicine, anatomy, and physiology of the Egyptians, and of the scientific outlook that they obtained at least 2000 years before Hippocrates. See Todd TW "Egyptian medicine: A critical study of recent claims" 1921 23 *Am Anthropologist* 4: 460 at 462, 463; Ritner RK "Innovations and adaptations in ancient Egyptian medicine" 2000 59 *J Near East Studies* 2: 107 at 108, 109.

<sup>87</sup> Organic disorders refer to disorders involving a physical lesion in an organ or body part (from Greek *organikos* meaning of or pertaining to an organ, from *organon* meaning an implement, from *ergein*, meaning to work). See Mohit A "Mental health and psychiatry in the Middle East: Historical development" 2001 7 *Eastern Mediterranean HJ* 3: 336; Colman "organic disorders" 533. For in depth discussions of the history of Egypt and Mesopotamia see Diringier D *The book before printing: Ancient, medieval and oriental* (1982) 106ff; Verbrugge GP & Wickersham JM *Berosos and Manetho, introduced and translated: Native traditions in ancient Mesopotamia and Egypt* (1996) 1ff.

<sup>88</sup> Okasha A "Egyptian contribution to the concept of mental health" 2001 7 *Eastern Mediterranean HJ* 3: 377, 378.

<sup>89</sup> This institute was established by the Sultan al-Mansour Kalaaon in 1284 AD. It contained sections for surgery, ophthalmology, medical and mental illnesses. Two features were striking: The care of mental patients in a general hospital and the involvement of the community in the welfare of these patients. According to Okasha these features foreshadowed modern trends by many centuries. See Okasha A & Arboleda-Flórez J *et al* (eds) *Ethics, culture, and*

differentiate between mental and physical illnesses. They believed that despite their manifestations, all diseases had physical causes. Mental illnesses were considered to be physical ailments of the heart or uterus, as described in the "Ebers" and "Kahun Gynaecology" papyri. These disorders carried no stigma, as there was no demarcation then between psyche<sup>90</sup> and soma.<sup>91</sup> Of major significance is the fact that the "Kahun Gynaecology" papyrus included more than 30 prescriptions for a variety of diseases attributed to changes in the womb. Consequently it is concluded that the ancient Egyptians anticipated by ten centuries the Hippocratic teachings on the pathogenesis of hysteria.<sup>92</sup> The similarity between some of the ethical precepts of ancient Egyptian physicians and the Hippocratic Oath shows the close connection of the origin between pre-Hippocratic medicine in Greece and Egyptian medicine. It is interesting to note that suicide was not condemned during this time.<sup>93</sup> One of the recommended treatments for mental illness was to turn to religion and faith. Suggestion played an important role in all forms of medical treatment, including treatment of the mentally ill, which was associated with Imhotep,<sup>94</sup> the earliest known physician in history.

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*psychiatry: International perspectives* (2000) 23ff; Okasha A "Focus on psychiatry in Egypt" 2004 185 *Br J Psychiatry* 3: 266.

- <sup>90</sup> Psyche refers to the human mind or soul. In Greek mythology, the soul was personified by Psyche, a young woman who was loved by Eros, the god of love who married her but visited her only at night and insisted that she should never see his face. She symbolises the human soul, suffering, hardship and struggle in life, but re-emerging after death in a new and better existence (from Greek *psyche*, which means breath, from *psychein*, which means to breathe, alluding to the ancient belief that breathing was evidence that the soul had not left the body yet). See Colman "psyche" 614.
- <sup>91</sup> Soma (a cell body) refers to: (1) The central part of a neuron or other cell containing the nucleus and other structures that keep the cell alive. (2) The body of an organism as distinct from its mind, or (in physiology and genetics) as distinct from its germ cells (from Greek *soma*, which means a body). See Colman "soma" 710.
- <sup>92</sup> See the discussion of hysteria in ancient Greece and Rome below. See also the discussion of hysteria in ancient China above.
- <sup>93</sup> Suicide as a form of human behaviour is probably as ancient as mankind itself. Views on suicide varied over the centuries and were affected by culture, economy, politics, religion and the intellectual thinking at the time. In primitive cultures suicide was an expression of anger, grief, loss of a loved one, preserving honour or claiming innocence. The argument for and against suicide began in the early stages of human existence and has not come to a conclusion yet. The oldest known written document about suicide was *A dispute over suicide* also known as *Dialogue between a man tired of life and his "ba"* which was written by an unnamed Egyptian writer. It is possibly the oldest description of suicidal thoughts and its associated depressive cognition. It was written as a poem between 2000-1740 BC on papyrus in hieroglyphics. The writer is known as the *Eloquent Peasant* and was commissioned by King Meri-Ka-Re to write a poem in order to dissuade people from committing suicide. The writer ended the argument without any specific conclusion. Tadros and Pahor submit that by doing so, he may have predicted that the argument for and against suicide would always remain unsettled. See Pahor AL & Tadros G "Did the ancient Egyptians know about the psychopathology of suicide?" (Paper presented at the 40<sup>th</sup> International Congress on the History of Medicine, Hungarian Academy of Sciences, Budapest/Hungary, 27 August 2006) <http://www.ishm2006.hu/scientific/abstract.php?ID=247> (Date of access: 11 August 2007). For further reading on this issue, see O'Mathuna DP & Amundsen DW "Historical and Biblical references in physician-assisted suicide court opinions" 1999 *Notre Dame J Law, Eth & Pub Policy* 12 2: 473-496.
- <sup>94</sup> Imhotep (he who comes in peace), was the physician vizier of the Pharaoh Zoser, founder of the Third Dynasty, in the 13<sup>th</sup> century. He was a learned man - astronomer, physician and architect. In later times he was worshiped as a hero, as a blameless physician, and later still as the god of medicine, the prototype of Asclepius. Little is known about Imhotep's medical knowledge but his apotheosis is significant and we may well take him at the Egyptian valuation as the first great

One of the psychotherapeutic methods used in ancient Egypt was "incubation" or "temple sleep".<sup>95</sup> The course of treatment depended greatly on the manifestations and contents of dreams, which were highly affected by the psycho-religious climate of the temple, or the confidence in the supernatural powers of the deity and on the suggestive procedures carried out by the divine healers. The principal aims of the treatment were knowledge of the sufferer's future, of the dangers that threatened him and of the evil spells that were following him. But he was also seeking a cure for his ailments. The principle of the healing dreams was attributed to Isis,<sup>96</sup> although many other deities in Egypt also possessed the same powers.<sup>97</sup>

The reputation of Egyptian physicians<sup>98</sup> was consistently high throughout Egypt and the rest of the Mediterranean world. Among these were *Iry*, called "Keeper of the King's Rectum", a court physician who, about 2500 BC attended to diseases of the eye and belly as well as the anus. *Hawi* was an Old Kingdom healer of the teeth and anus. The standards of training and of practice seem to have been set by the pharaoh's physician (*Great of the palace doctors*), who stood at the apex of the hierarchy. Beneath him were the palace physicians (the Egyptian term is *saw*, meaning "guardian"), among whom one may have been the supervisor of physicians. The others were inspectors of physicians, a group of lesser chief physicians, and a lower order of physicians comprising the great bulk of practitioners. There were also physicians who took care of workmen and a special cadre of doctors for miners (the Egyptian term is *wabw*, meaning "pure of the goddess Sekhmet"). Temple physicians (the Egyptian term is *swnw* meaning "doctor

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man in medicine. See Turnure 1952 *Record of the Art Museum, PU* 25 at 26, 27; Linzey MPT "The duplicity of Imhotep stone" 1984 48 *J Architectural Edu* 4: 260.

<sup>95</sup> A suppliant, on presenting himself to one of the priests, would be assigned a place in the temple to spend the night. While the sufferer was sleeping, Imhotep would supposedly appear to him in a dream and recommend a cure. Should Imhotep fail to appear, or should the patient be unable to sleep, a priest would substitute for the deity, evidently without complaint from the patient. Incubation is characterised by creative thinking while the problem is turned over in the mind, often unconsciously. See Turnure JH "A statuette of Imhotep" 1952 11 *Record of the Art Museum, PU* 2: 25 at 27, 28; Colman "incubation" 371. See also the paragraphs below where mention is made of how "incubation" or "temple sleep" find application in Greek culture.

<sup>96</sup> Isis was worshipped by the Egyptians, who affirm that she discovered many drugs, and was versed in healing, giving aid during sleep while standing above the sick. They say that many who had lost the use of their eyes, or other part of their body, were restored to their previous condition whenever they turned for help to Isis. See Magie D "Egyptian deities in Asia minor in inscriptions and on coins" 1953 57 *Am J of Archaeology* 3: 163 at 167ff.

<sup>97</sup> Okasha 2001 *Eastern Mediterranean HJ* 377 at 378.

<sup>98</sup> Egyptian physicians were also priests. It was common for different priests to act as physicians for different parts of the body, in much the same way that doctors specialise now, as they believed that different gods governed different sectors of the human body. The great number of persons who practiced medicine in Egypt was mentioned by Herodotus, a Greek historian who is regarded as the father of history (484 BC-425 BC). He also noticed the remarkable fact that besides general practitioners, there were many who devoted themselves to special branches of medical science, some being oculists, some dentists, some skilled in treating diseases of the brain, and other for treating diseases of the intestines etc. See Laurie SS "The history of early education II: The ancient Egyptians" 1893 1 *School Rev* 6: 353 at 358.

of people"), possibly of lower social standing, were available to all people and visited patients' homes as well. Army physicians accompanied military expeditions and gave service to soldiers in the barracks.<sup>99</sup>

Before these physicians could prescribe any treatment, they had to make a diagnosis<sup>100</sup> by employing their powers of observation and experience in determining the nature of the illness. He would then refer to the medical papyri to determine the most appropriate course of treatment. Normally this would take the form of an unguent comprised from natural ingredients. In treatment of illnesses drugs were administered and mechanical procedures included incantations to drive out demons. Amulets could ward off illnesses of most kinds, but serious mental illnesses required the exorcism of demons. Trepanation is not mentioned in any of the medical papyri, but seems to have been performed occasionally using a mallet and chisel. Only fourteen skulls, some healed or partially healed, have been found.<sup>101</sup>

#### 2.3.3.2.2 *Ancient Mesopotamia*<sup>102</sup>

The oldest medical text extant found is a cuneiform tablet<sup>103</sup> from Mesopotamia (a land of Assyrian-Babylonian culture) and the cradle of civilisation. The most ancient known Egyptian medical writings date

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<sup>99</sup> This strange combination actually makes embryological sense because the mouth (stomadeum) and the anus (proctodeum) are derived from the same types of tissue systems. For a detailed discussion of this topic see Health Guidance: Lyons AS "Ancient Egypt" 2007 <http://www.healthguidance.org/entry/6310/1/Ancient-Egypt.html> (Date of access: 09 August 2007). See also Estes JW *The medical skills of ancient Egypt* (1989) 1ff.

<sup>100</sup> Egyptian methods of diagnosis relied on information from the patient, but the actual taking of a detailed patient history had not yet developed. The examination was however complex and included probing of wounds with the fingers and a study of the sputum, urine, feces and other bodily parts. The pulse was recognised as transmitted by the heart and was carefully checked in different parts of the body. Although these physicians did not state a prognosis, they did make decisions on whether to contend with or avoid treatment. Conditions thought to be hopeless were denied treatment. This attitude of withholding treatment to the incurable was a recurring theme throughout history. Lyons discusses this theme in detail and states this might be due to pragmatism or insensitivity, or maybe just pure honesty and sincerity. See Health Guidance <http://www.healthguidance.org/entry/6310/1/Ancient-Egypt.html>.

<sup>101</sup> Egyptology Online: Discovering ancient Egypt: High T "Medicine and healthcare" 2001-2007 <http://www.egyptologyonline.com/treatments.htm> (Date of access: 11 August 2007).

<sup>102</sup> Mesopotamian history extends from the emergence of urban societies in Southern Iraq in the 4th millennium BC to the arrival of Alexander the Great in the 4th century BC (which is seen as the hallmark of the Hellenisation of the Near East, therefore supposedly marking the "end" of Mesopotamia). For further reading on the topic, see Speiser EA "Ancient Mesopotamia and the beginning of science" 1942 55 *Scientific Monthly* 2: 159 at 160, 161; Pollock S *Ancient Mesopotamia: The Eden that never was* (1999) vii, 3, 9, 10-40, 45-70, 107, 114, 149, 186-220.

<sup>103</sup> The cuneiform script is one of the earliest known forms of written expression. Cuneiforms were written on clay tablets, on which symbols were drawn with a blunt reed called a stylus. The impressions left by the stylus were wedge shaped - giving rise to the name cuneiform. See Postgate JN *Early Mesopotamia: Society and economy at the dawn of history* (1994) 56-60.

from a later period, but they refer back to texts far older.<sup>104</sup> In ancient Mesopotamia, illnesses, including mental illnesses were blamed on pre-existing spirits and ghosts. Each disease was attributed to one certain spirit. As such, medicine was a part of magic. Among their primitive forebears, illness was a curse, a punishment by the gods which could be visited on the family and descendants as well as on the sinner who had knowingly or inadvertently violated a moral code. However, according to Lyons there was probably some realisation of non-spiritual causes for illness since physicians were admonished - for ethical reasons - to avoid continuing treatment for incurable diseases.<sup>105</sup>

A medical practitioner, *Ashipu* (who was identified as a sorcerer in older accounts) was the diagnostician who determined which spirit and/or sin had caused the illness. He then could refer the patient to a healer, *Ashu*, who was a specialist in herbal medicine.<sup>106</sup> *Baru*, as a diviner, dealt with diagnosis and prognosis, but not only of illness. He also had to discover the causes and probable outcome of many other kinds of problems. In clay tablets discovered from different Assyrian and Babylonian eras, references were made to prescriptions for diseases of the head. Dream interpretation was also a way to understand and affect the human mind. In addition, certain numbers, for example the number seven, were believed to have therapeutic effects and particular rituals were practised to elicit these effects.<sup>107</sup>

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<sup>104</sup> Most important among the more ancient treatises were: *The Physician's Secret: Knowledge of the Movement of the Heart and Knowledge of the Heart and Collection on the Expelling of the Wehedu* (a toxic principle in the body). See Health Guidance <http://www.healthguidance.org/entry/6310/1/Ancient-Egypt.html>.

<sup>105</sup> Mesopotamian physicians depended on divination to uncover the sin committed by a sick person and to learn the expiation demanded by the gods, but they also observed a patient's symptoms to estimate the seriousness of the illness. Recitations, ceremonies, prayers, and sacrifices were common religious means of beseeching the gods for a cure; however, along with these a veritable pharmacopoeia of drugs was used in the treatment of disease. In addition to clay tablets which report illnesses with their symptoms and diagnosis, prognosis, and treatment, others were found that list drugs and their appropriate uses. Furthermore, references to bronze lancets in the Code of Hammurabi and elsewhere indicate the use of instruments in surgical operations, and there have been a few isolated archaeological recoveries of knives. No examples of trepanned skulls have yet been found in Mesopotamia. However, they have been uncovered in nearby Judea, which received its medical knowledge and skills from Mesopotamia. See Health Guidance: Lyons AS "Ancient civilizations – Mesopotamia" 2007 <http://www.healthguidance.org/entry/6308/1/Ancient-Civilizations--Mesopotamia.html> (Date of access: 09 August 2007).

<sup>106</sup> Herbal medications have been used for the treatment of illness for thousands of years. Herbal medication has been identified at Neanderthal archaeological sites as well as homo sapien sites in Egypt, Mesopotamia, Mesoamerica, and China. The first "Physicians Desk Reference" was compiled by a Chinese emperor more than 5000 years ago, and contained instructions on how to select, prepare, and administer thousands of herbal remedies, for a number of ailments including mental illness. In addition to the treatment of mental illness, two of these herbs (rauwolfia and ololiuqui) also played a significant part in the development of the dopamine and serotonin theories of schizophrenia. Many cultures continue to rely upon these medications for their health needs. See Wong A & Smith MW *et al* "Herbal remedies in psychiatric practice" 1998 55 *Arch Gen Psychiatry* 11: 1033 -1044.

<sup>107</sup> Mohit 2001 *Eastern Mediterranean HJ* 336 at 338.

### 2.3.3.2.3 *The Middle East*

The inception of Islam brought about radical changes in the behaviour and customs of the Arab people. The pre-Islamic<sup>108</sup> era is commonly known as the period of ignorance (the Islamic term used is *Jahilliyyah* also spelled *Jahiliyya*). Political and economic forces partially caused the fall of ancient Arab kingdoms. In addition, the old Arab civilisation which had existed for more than two millenniums and had extended into Assyrian-Babylonian times was lost and forgotten. Ancient poetry, legends and folklore provide the only source for information on socio-medical matters of this period. Beliefs in supernatural forces influenced the attitude of the people towards diseases, and consequently the art of healing. Arab physicians were influenced by other cultures, notably Indians and Persians with whom they came in contact. Though physical causes for illness were recognised it was mostly attributed to supernatural forces.<sup>109</sup>

In ancient Iran, medicine was being practised and even different medical specialties existed. Physicians functioned as masters of health. There were healers of the body and healers for the psyche, who were the equivalent of today's psychiatrist. There was a system of registration, and non-registered practitioners were considered quacks or charlatans. Medicine was a separate profession from priesthood, but medical students were selected from the highest class of Iranians and they studied both theology and medicine. After finishing their studies they would become either a priest or a doctor. Psychiatric diseases were taught to the students in Jundi-Shapur University during the Sasanide dynasty.<sup>110</sup> Treatment methods included psychotherapy. Belief in talismans and amulets in relation to causes and treatments of diseases also existed. In some rural parts of the Islamic Republic of Iran, people still wear amulets to counteract evil.

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<sup>108</sup> This period ended in AD 610. The history of Arabia before the rise of Islam is not known in great detail. Archaeological exploration in the Arabian Peninsula has been sparse; indigenous written sources are limited to a few inscriptions and coins from southern Arabia. Existing material consists primarily of written sources from other traditions (such as Egyptians, Greeks, Persians and Romans) and oral traditions later recorded by Islamic scholars. For a discussion of the periods of Islamic history, see Endress G *Islam* (2002) 110-130; Hitti PK *The Near East in history: A 5000 year story* (1961) vii, ix, 17ff.

<sup>109</sup> Baasher T "The Arab countries" in *World history of psychiatry* 550-551.

<sup>110</sup> "Higher Education" which has an ancient past in the dynamic culture and civilisation of Iran and Islam reached the peaks of prosperity at the time of the Sassanids with the establishment of centralised higher education institutions in the cities of "Riv Ardeshir" and "Jondi Shapour" from 241 AD onwards. Because of the importance given to medicine and medical education in those days and the ample use of the experiences and scientific achievements of the Greeks, Indians, and Iranians, these cities turned into two real centres of ancient higher education. For further reading on medical education during this time period, see Nakosteen M *History of Islamic origins of Western education* (1964) 1ff.

Belief in the effects of the evil eye is still quite strong among some sections of the population. In southern parts of the country, the "practice of *zar*" existed.<sup>111</sup>

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<sup>111</sup> The *zar* cult is a spirit possession cult found in Ethiopia, Eritrea, Djibouti, Somalia, Arabia, south and south-west Iran, Egypt, and the Sudan. Messing explains the "practice of *zar*" as follows: Symptoms of possession by the *zar* spirits include proneness to accidents, sterility, convulsive seizures, and extreme apathy. The healer is himself *zar*-possessed, but has "come to terms" with the spirit. His first task is to diagnose what specific spirit or "syndrome of spirits" ail the patient. Everyone in the culture knows the procedure that follows: The patient will be "interrogated" in the house of the doctor. There the doctor will lure his own *zar* into possessing him in a trance, and through his intercession try to lure the unknown *zar* of the patient ("his horse") into public possession. Then the spirit will be led to reveal his identity by means of adroit cajolery, promises, and threats. The demands of the *zar* will be negotiated through a lengthy process of financial bartering. Finally, the patient will be enrolled, for the rest of his life, in the "*zar* society" of fellow-sufferers, renting, as it were, his temporary freedom from relapse through regular donations and by means of participation in the worship of the spirit. See Messing SD "Group therapy and social status in the *zar* cult of Ethiopia" 1958 60 *Am Anthropologist* 6: 1120; Mohit 2001 *Eastern Mediterranean HJ* 336 at 337-338; Natvig R "Oromos, slaves and the *zar* spirits: A contribution to the history of the *zar* cult" 1987 20 *Int J Afr Hist'l Studies* 4: 669-689.

#### 2.3.3.2.4 *The beginning of Islam*

Islam is the youngest of the major monotheistic religions of the Middle East. It began in the seventh century in the Arabian Peninsula.<sup>112</sup> Mental illness in particular was thought to be due to evil spirits and *jinn*s.<sup>113</sup> A *jinn* is a supernatural spirit, lower than the angels. This supernatural spirit can either be good or bad. Although a person might have been perceived as being possessed, the possession could have been by a good or a bad spirit. Consequently one could not generalise punishment or condemn the mentally ill unconditionally. Apart from the concept of the mentally ill person being possessed, Islam had another positive concept where such an individual was seen as the one who dared to be innovative, original or creative or attempted to find alternatives to a static and stagnant mode of living.<sup>114</sup> Treatment was based on magico-religious practices. Prophylactic devices in the form of amulets and charms were also used as methods of treatment. Arab physicians<sup>115</sup> of that period prescribed a variety of herbal drugs and used minor surgical incisions for example cauterization, blood letting and cupping<sup>116</sup> in the general management of diseases.

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<sup>112</sup> Arabia was the first home of Islam. Mecca was the place of the shrine and the spiritual focus of this religion while Medina was the city of the Prophet and of the first Islamic community. Islamic medicine can be considered the convergence and the melting point between the Hippocratic Galenic medicine on one hand and the Persian Indian practical medicine on the other. Islamic medicine refers to a "body of medicine" that was inherited by the Muslims in the early phase of Islamic history (661-861 AD) from mostly Greek sources, but medical knowledge was added from Persia, Syria, India and Byzantine. See Endress 97ff; Nagamia HF "Islamic medicine history and current practice" 2003 2 *Hist Islamic Med* 4: 19 at 20; Sarton G *Introduction to the history of science* (1927) 463-475.

<sup>113</sup> Nasaboury (who died in 1014), author of *The sane insane* divided the mentally ill into five categories classified on an etiological basis namely those who are born mentally ill; those disturbed by burnt bile; those touched by the *jinn* and Satan; those overcome by passionate love to the degree of madness; and a group of "sane insane" people with defective judgment, incompetence in management, and disturbances of temperament. See Baasher in *World history of psychiatry* 561.

<sup>114</sup> This is to be found in various attitudes towards certain mystic philosophies such as *Sufism*, where the expansion of self and consciousness has been taken as a rationale to label some *Sufis* as psychotic. The writings of various *Sufis* do indeed reveal the occurrence of psychotic symptoms and much mental suffering in their quest for self-salvation. The most profound metaphysics in Islam is to be found in the writings of the *Sufi* masters, especially those who have chosen to deal with the theoretical aspects of the spiritual way, or with *scientia sacra* called gnosis. In general one can distinguish two tendencies in *Sufi* spirituality, one which takes the human intellect to be a ladder to the luminous world of the spirit and the other which emphasises more the discontinuity between the human reason and the "Divine Intellect" and seeks to reach the world of the spirit by breaking completely the power of ratiocination within the mind. The final result, which is union with God, is the same in both cases, but the role played by reason is somewhat different in the two instances. The relevance of *Sufism* to mental health lies in the concept of "freedom from the self". See Nasr SH "The meaning and role of philosophy in Islam" 1973 37 *Studia Islamica* 57 at 63, 70ff; Okasha *Eastern Mediterranean HJ* 377-378; Ghaemi SN *The concepts of psychiatry: A pluralistic approach to the mind and mental illness* (2003) 124, 125.

<sup>115</sup> It is interesting to note that the great physician El Tabari divided the physicians of his time into physician-philosophers and non-philosophers, and advocated a philosophical approach in the art of medicines. Similar philosophical and psychological approaches are detected in the handling of medical problems in the works of distinguished physicians like Rhazes and Avicenna. See Baasher in *World history of psychiatry* 557.

<sup>116</sup> Cauterization is a medical term describing the burning of the body to remove or close a part of it. Cautery can also mean the branding of a human, either recreational or with force. Bloodletting involved the withdrawal of often considerable quantities of blood from a patient in the hopeful belief that this would cure or prevent a great many illnesses and

It is not clear whether these physicians applied similar remedies for mental illnesses. However, cautery was used at later periods by traditional healers in the treatment of epilepsy and psychotic disturbances.<sup>117</sup>

The Islamic approach to mental illness can be traced most importantly to the Holy Qur'an. The Qur'an was given to believers as "a guide and a medicine"<sup>118</sup> and the restorer of both physical and mental health. The most common word used to refer to the mentally ill in the Qur'an is *majnoon* (also spelled *majnun*). The word is originally derived from the word *jinn*. In the Qur'an the *jinn* and the human being are almost always mentioned together. This has altered the concept and management of the mentally ill.<sup>119</sup>

From a psychiatric and psychological point of view the passage of the Qur'an which includes Joseph's interpretations of the Pharaoh's dreams of the seven fat and seven lean cows is of great significance.<sup>120</sup> This probably stimulated some of the Arab thinkers to develop an elaborate system of dream interpretation. The Qur'an is firm about mental illness and states clearly: "Do not kill yourself, for God was merciful to you".<sup>121</sup> There is also a low incidence of alcoholism in Arab countries. The Qur'an contains various passages dealing with wine prohibition that have been subject of analysis.<sup>122</sup> It was also believed that for

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diseases. Cupping referred to the removal of bad blood beneath the skin. See Ackerknecht 1947 *Am Anthropologist* 25 at 29, 30; Aufderheide AC & Rodríguez-Martin C *The Cambridge encyclopedia of human paleopathology* (1998) 36, 37; Elgood C "Tibb-ul-Nabbi or Medicine of the Prophet" 1962 14 *Osiris* 33 at 102, 126, 146; Magner 149. For further reading on this topic see Dols MW "The treatment of the insane" 2006 1 *J Muslim Mental Health* 2: 185-203.

<sup>117</sup> Baasher in *World history of psychiatry* 551-552.

<sup>118</sup> Chapter 17 of the Qur'an reads: "Bani Isra'eel [meaning the children of Israel]" and further "We sent down (stage by stage) in the Qur'an that which is a healing and mercy to those who believe." See the Holy Qur'an Chapter 17, verse 82. The Arabic word for healing is *shifa*. Ibn Sina wrote a book entitled *Kitab al-Shifa* (Book of Healing) in 1228. The book covers nine volumes on Avicennian logic; eight on the natural sciences (including Earth science, Islamic geography and Islamic physics); four on the quadrivium of arithmetic, geometry, astronomy and music; and the remaining volumes on Avicennian philosophy, metaphysics and psychology. See Goodman LE *Avicenna* (1992) 31.

<sup>119</sup> The Qur'an contains the holy scriptures of the Muslims and describes the revelations made to the Prophet Muhammad by God. The Qur'an, as a religious code, led the Muslims into a new way of life, which radically replaced the cultural style of the previous period. Islam identified the unity of the body and the psyche. The psyche (*elnaf*s) is mentioned 185 times in the Qur'an as a broad reference to human existence, meaning at different times body, behaviour, affect, and/or conduct for example a total psycho-somatic unity. See Okasha *Eastern Mediterranean HJ* 377 at 378; Baasher in *World history of psychiatry* 552.

<sup>120</sup> The story of Joseph (*Yusu*f) can be found in the Holy Qur'an Chapter 12 verses 1-111.

<sup>121</sup> The Holy Qur'an Chapter 4 verse 29.

<sup>122</sup> One of the passages states: "Come not to pray when you are drunk." See the Holy Qur'an Chapter 4 verse 43. This was followed by the proclamation that wine drinking is a detestable act of Satan. The general rule in Islamic principles is that beverage or drugs that cloud the mind should be prohibited. The Qur'an also reminds Muslim communities to beware of the gloomy fate of sexual disorders and is a deterrent to deviant behaviour. The teachings expressed in the revelations and compiled in the Qur'an were supplemented by traditions and sayings of the Prophet. The sayings with regard to medical problems were collected separately and came to be known as "the Medicine of the Prophet". Generally

every disease there is a cure. The teachings expressed in the revelations and compiled in the Qur'an were supplemented by traditions and sayings of the Prophet (the Islamic term for Prophet's words is *hadith*). The sayings with regard to medical problems were collected separately and came to be known as "the Medicine of the Prophet".<sup>123</sup> Generally speaking, these sayings point out early Islamic concepts and outline the basis of religious therapy, which has influenced traditional healing to the present day.

Of importance was the emphasis that on the relationship between psychological factors and somatic diseases. This was demonstrated clearly in the Prophet's saying: "He, who is overcome by worries, will have a sick body".<sup>124</sup> Epileptic patients also received treatment by the Prophet. It is not known how psychosis was treated during the Prophet's time, but it was probably treated in the same manner as epileptic manifestations and similar disorders.<sup>125</sup>

### 2.3.4 Ancient Greece and Rome

The history of psychiatry in ancient Greece and Rome extend over a period of twelve centuries, from the time of Homer<sup>126</sup> to the age of the later Graeco-Roman physicians and encyclopaedists.<sup>127</sup> A study of this

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speaking, these sayings point out early Islamic concepts and outline the basis of religious therapy, which has influenced traditional healing to the present day. See Baasher in *World history of psychiatry* 554-555.

<sup>123</sup> Since the content of the Qur'an did not take care of all the possible religious and ethical circumstances, devout Muslims patterned their lives after the Prophet Muhammad. See Levey M "Medical ethics of Medieval Islam with special reference to Al-Ruhāwī's 'Practical ethics of the physician'" 1967 57 *Transactions of the Am Phil Soc* 3: 1 at 6. See also Mula S "Muhammad and the saints: The history of the Prophet in the 'Golden Legend'" 2003 101 *Modern Philology* 2: 175-188.

<sup>124</sup> Muslim theologians believed that the Prophet advocated combining medicine with divine healing and physical treatment with psychological treatment. See Boehnlein JK (ed) *Psychiatry and religion: The convergence of mind and spirit* (2000) 17.

<sup>125</sup> The Qur'an, honey and cautery were the main remedies generally advocated by the Prophet. Muslim theologians believe that the Prophet combined medicine with divine healing, physical treatment with psychological medicine and secular treatment with heavenly remedy. See Baasher in *World history of psychiatry* 555. See Baasher in *World history of psychiatry* 555; Ahmed AS "Defining Islamic anthropology" 1984 65 *Royal Anthropological Inst News* 2-4; Dols 2006 *J Muslim Mental Health* 135ff.

<sup>126</sup> (700 BC.) Homer was the major figure of ancient Greek literature and the author of the earliest and finest epic poems, the *Iliad* and the *Odyssey*. Homer believed that mental illness was caused by God's taking of the mind. He further believed that mental life was externally caused, interactional and accessible to public view and further that thought and affect were not differentiated from one another, nor were body and mind. He also stated that disturbance and conflict were caused by external events and that the model of the therapist was the bard with his poetry. He offered no treatment. For a discussion of related topics see Grote G *A history of Greece* (1846) 196ff; Müller KO *History of the literature of ancient Greece: To the period of Isocrates* (1847) 15ff; Blackwood W *Blackwood's Edinburgh Magazine* (1856) 199ff; Rostovtzeff M *A history of the ancient world: The Orient and Greece* (1926) 232ff; Robinson CE *Hellas: A short history of ancient Greece* (1955) 19-22; Adkins AWH *Merit and responsibility* (1960) 1ff; Harlan W *The horizon book of ancient Greece* (1965) 1ff; Hooper F *Greek realities: Life and thought in ancient Greece* (1967) 1ff; Adkins AWH *Moral values and political behaviour in Ancient Greece: From Homer to the end of the fifth century* (1972) 1ff; McGlew JF *Tyranny and*

history is extremely difficult since the field of psychiatry scarcely existed as a defined area of medicine or as a category of knowledge on mental illnesses. There was a lack of specialists in the field, no textbooks were written on the topic and no technical term for psychiatry or psychology existed. However, there are two main reasons for examining the history of psychiatry during this time period: First, the final legacy of antiquity in this area namely the writings of Galen<sup>128</sup> and of summarisers such as Caelius Aurelianus<sup>129</sup> and Alexander of Tralles<sup>130</sup> provided the basic framework of medical psychiatric thought and practice that

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*political culture in ancient Greece* (1996) 166, 167; Trundle M *Greek mercenaries: From the late archaic period to Alexander* (2004) 40ff; Deger-Jalkotzy S & Lemos IS (eds) *Ancient Greece: From the Mycenaean palaces to the age of Homer* (2006) 101ff.

<sup>127</sup> (AD 500-600.) For discussions of this period, see Mahaffy JP *The silver age of the Greek world* (1906) 1ff; Angus S *The religious quests of the Graeco-Roman world: A study in the historical background of early Christianity* (1967) 239ff; Starr CG *The ancient Greeks* (1971) 1ff; Starr CG *The ancient Romans* (1971) 1ff; Marcovich M *Studies in Graeco-Roman religions and gnosticism* (1988) 1ff; Arthur MFW & Verhoogt S (eds) *The two faces of Graeco-Roman Egypt: Greece and demotic and Greek-demotic texts and studies* (1998) 1-15, 93-155.

<sup>128</sup> (AD 100.) Galen was educated as a philosopher. His hometown, Pergamum, was the site of a magnificent shrine of the healing god, Asclepius that was visited by many distinguished figures of the Roman Empire for cures. When he was 16, he chose a career of medicine, which he studied at Pergamum, at Smyrna and finally at Alexandria in Egypt, which was the greatest medical centre of the ancient world. After more than a decade of study, he returned in AD 157 to Pergamum, where he served as chief physician to the troop of gladiators maintained by the high priest of Asia. Psychic functions of the brain were considered by Galen to be the foremost cause of mental illness. Treatment consisted of confrontation, humour and exercise. Devotion to Galen's medical teachings led to the adoption of four major categories of mental illness namely frenzy, mania, melancholy, and fatuity. Each of these was purportedly caused by an imbalance in the humours. To restore the balance was a goal of the physicians of that time. See Johnson HJ *The medico-surgical review* (1847) 311 -313; Dunglison R *History of medicine from the earliest ages to the commencement of the nineteenth century* (1872) ix, 23, 26; Smith W *Dictionary of Greek and Roman biography and mythology* (1880) 44, 95, 182ff; Handerson HE & Baas JH *Outlines of the history of medicine and the medical profession* (1889) 101ff; Sayce AH & Maspero G *et al History of Egypt, Chaldea Syria, Babylonia, and Assyria* (1904) 88; Van Hook L *Greek life and thought: A portrayal of Greek civilisation* (1923) 148, 277, 279ff; Gomperz T *Greek thinkers: A history of ancient philosophy* (1905) 574-575, 581ff; Duke University *Greek, Roman and Byzantine studies* (1959) 335, 356 – 359; Persehouse W & Wightman D *Science and the Renaissance* (1962) 85, 162, 204; Clarke E & O'Malley CD *The human brain and spinal cord: A historical study illustrated by the writings from antiquity to the twentieth century* (1996) 22-25; Nancy G *The clock and the mirror: Girolamo Cardano and Renaissance medicine* (1997) 141ff; Furdell EL *Essays on Medieval and early Modern medicine* (2005) 69 – 77; Blackburn "Galen of Pergamum" 146.

<sup>129</sup> (AD 400.) Caelius Aurelianus was the last of the medical writers of the Western Roman Empire and is usually considered the greatest Greco-Roman physician after Galen. His most famous work, *De morbis acutis et chronicis* ("Concerning acute and chronic diseases"), is a thorough exposition of classical medical knowledge. Caelius Aurelianus described gout, motor and sensory paralyses, encephalitis, stammering and speech defects. He distinguished between epileptic seizures and hysterical attacks, and recommended humane treatment of the insane. He left two valuable texts on chronic and acute diseases. See Kaufman MR "The Greeks had some words for it: Early Greek concepts on mind and 'insanity'" 1966 40 *Psychiatric Q* 1: 1-33; Temkin O *The falling sickness: A history of epilepsy from the Greeks to the beginnings of modern neurology* (1994) 5-7, 22-37, 40-41; Hankinson RJ *Galen: On antecedent causes: Cambridge classical texts and commentaries* (1998) 217, 224-228, 267ff; Van der Eijk PJ *Medicine and philosophy in classical antiquity: Doctors and philosophers on nature, soul, health and disease* (2005) 107-110, 122-135, 264.

<sup>130</sup> (AD 500.) Alexander was the youngest of five famous brothers and he too was a famous physician and once practiced in Rome where he was introduced as one of the greatest scholars from the time of Galen to the Renaissance. He recommended baths, wines, diets, and sedatives for the mentally deranged. See Sarton G *Introduction to the history of science* (1927) ix, 427-334. Nutton V "From Galen to Alexander, aspects of medicine and medical practice in late

endured through the Middle Ages of Europe and into the Renaissance and persisted as the "paradigm" for psychiatry well into the nineteenth century. Second, classical antiquity has largely defined our sense of the nature of man, of what is accurate, realistic and vivid in the portrayal of human life.<sup>131</sup>

With regard to the problems surrounding diagnosis,<sup>132</sup> etiology<sup>133</sup> and the treatment of mental illness "the major models of mind and madness in Greek and Roman thought" and the "social-psychological stresses and strains in Greek and Roman civilisation" are still part of the major issues and controversies in contemporary psychiatry today. Of specific relevance is the notion of the various "models of madness" (for example medical, social, causal and psychodynamic) as well as the closely related problems of the social and psychological context of mental illness.<sup>134</sup>

Plato,<sup>135</sup> in particular, appropriated the idea that philosophy is a quasi-medicine and he sometimes combined this idea with the claim that the Socratic type of dialogue was the most effective method of cure for psychological illness. Of importance is the start of the *Charmides*, an early Platonic dialogue. Here, Socrates<sup>136</sup> presented himself as a special kind of doctor, who would not cure the body without the

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antiquity" 1984 38 *Dumbarton Oaks Papers* (Symposium on Byzantine Medicine) 3ff; O'Dowd MJ *The history of medications for women: Materia medica woman* (2001) 99; Pioreschi P *A history of medicine* (2001) 57ff.

<sup>131</sup> Ducey C & Bennett S "Ancient Greece and Rome" in *World history of psychiatry* ((ed) Howells JG) (1975) 1-2.

<sup>132</sup> Diagnosis refers to the process of identifying a disorder by examining its signs and symptoms (from the Greek word *dia* (between) and *gnosis* (knowing)). See Colman "diagnosis" 207.

<sup>133</sup> Etiology (also spelled aetiology) is the cause of a particular disorder or study of the causes of disorders in general (from the Greek words *aitia* (cause) and *logos* (discourse or reason)). Etiological discovery in medicine is well known in medical history with reference to Robert Koch, a German bacteriologist (1843-1910). He demonstrated that the tubercle bacillus (*Mycobacterium tuberculosis* complex) causes the disease tuberculosis that *Bacillus anthracis* causes anthrax, and that cholera is caused by *Vibrio cholerae*. This line of thinking and evidence is summarised in *Koch's postulates*. In general it is a study of the problem of causation in medical disorders, which is still a mystery when it comes to the understanding of the causes of mental illness. For further reading of the background of causation, causality, diagnosis and treatment procedures in natural sciences see Evans AS *Causation and disease: A chronological journey* (1993) 1-226; Colman "aetiology" 16; Millon T *et al Masters of the mind: Exploring the story of mental illness from ancient times to the new millennium* (2004) 1ff.

<sup>134</sup> Ducey & Bennett in *World history of psychiatry* 3.

<sup>135</sup> (428 BC – 348 BC.) Plato was a member of a well established aristocratic family. His real name is said to have been Aristocles. He became a student of Socrates, who remained a friend and teacher until his execution. Plato's writings remain among the richest and most fascinating in all philosophy. See King PJ *One hundred philosophers: A guide to the world's greatest thinkers* (2004) 24-25.

<sup>136</sup> Socrates (469-399 BC) was born into the golden age of Athens. Socrates' method was the method of cross-examination. It consisted in asking questions and of bringing out the hidden confusions and absurdities of people's positions. He described himself as helping people to give birth to the truth by their own efforts. He was later charged with helping to corrupt the youth of Athens by neglecting the gods and was found guilty and sentenced to the traditional death penalty,

psyche,<sup>137</sup> and who would not attempt to cure until he has made a diagnostic examination of the psyche of the patient to see if he possessed self-control or not. The diagnostic test and the proposed "cure" were conducted in Socrates' distinctive method of questioning dialogue.<sup>138</sup>

Hippocrates<sup>139</sup> was one of the first writers to challenge the belief in supernatural causes of mental illness. He coined the term *hysteria* and thought that the cause of this illness was due to the uterus wandering around the body in search of children.<sup>140</sup> He held the belief that the body must be treated as a whole and not just a series of parts. He believed in the natural healing process of rest, a good diet, fresh air and cleanliness. He noted that there were individual differences in the severity of disease symptoms and that

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namely poison. He died a painful and prolonged death. See King 23; Potter JP *Characteristics of the Greek philosophers: Socrates and Plato* (1845) 1-122.

<sup>137</sup> Psyche, became gradually equated with the *rational* in man, especially the abstracting and generalising functions of the mind. A division existed between the rational functions and the irrational, appetitive, or somatic ones. This division was usually presented as between portions of the psyche but might also have been conceptualised as the split between psyche and soma. See Ducey & Bennett in *World history of psychiatry* 12.

<sup>138</sup> According to Gill, Socratic therapeutic methods may seem superficial - like a psychotherapeutic dialogue in the modern sense - for example, both types of dialogue required the "patient" to examine himself closely. But the actual content of the dialogue was a very different one. Instead of exploring the particularities of personal life (especially its emotional aspects), Socratic dialogue examined a person's capacity for defining abstract ideas. Given the Socratic tendency to identify moral excellence with knowledge, this procedure makes sense, but it means that Socratic dialogue was a quite different kind of technique from modern psychotherapy. See Gill C "Ancient psychotherapy" 1985 46 *J Hist Ideas* 3: 307 at 321.

<sup>139</sup> (460 BC- 370 BC.) Hippocrates was a Greek physician born on the island of Cos (also spelled Kos), Greece. He became known as the founder of medicine and was regarded as the greatest physician of his time. He based his medical practice on observations and on the study of the human body. He travelled throughout Greece practicing his medicine. He founded a medical school on the island of Kos and began teaching his ideas. He soon developed an Oath of Medical Ethics for physicians to follow. This Oath is still taken by physicians as they begin their medical careers. Hippocrates is well known as the "Father of Medicine". See Hippocrates *The genuine works of Hippocrates* ((trans) Adams F) (1849) 131ff; Jones MC "The Hippocratic Oath" 1909 9 *Am J of Nurs* 4: 256-260; Hippocrates *Hippocrates* ((trans) Withington JET) (1948) 1ff; Bulger RJ & Barbato AL "On the Hippocratic sources of Western medical practice" 2000 30 *Hastings Center Report* 4: S4-S7; Goldberg HS *Hippocrates: Father of medicine* (2006) 1ff.

<sup>140</sup> As mentioned above, the Egyptian "Kahun Gynaecology Papyrus" described disturbances resulting from the movement of the uterus but had not yet been given a specific appellation. This step was taken in the Hippocratic writings where the connection of the uterus with the disease resulting from its disturbance was first expressed by the term "hysteria", which occurred most commonly in virgins and widows. The same general definition (also known as female hysteria), came into widespread use in the middle and late 19<sup>th</sup> century to describe sexual dissatisfaction. Typical "treatment" was sexual intercourse (the woman was advised to get married), child-bearing, massage of the patient's genitalia by the physician and later the use of vibrators or water sprays to cause orgasm. For a discussion of hysteria in antiquity, female sexuality as a hysterical pathology, hysteria as a disease paradigm, orgasm treatment in the practice of Western medicine, masturbation as treatment therapy as well as physicians and the female orgasm, see Tilt EJ *A hand-book of uterine therapeutics, and of diseases of women* (1869) 12ff; King H *Hippocrates's woman: Reading the female body in ancient Greece* (1998) 21-53, 205-246; Maines RP *The technology of orgasm: Hysteria, the vibrator and women's sexual satisfaction* (2001) 22-25, 50-58, 11-113. (See also the discussion below on Sigmund Freud, Jean-Martin Charcot, Richard von Krafft-Ebing and Emile Kraepelin with regard to their writings on hysteria and sexual dissatisfaction. See also the discussion of hysteria and sexual deviance in ancient China above.)

some individuals were better able to cope with their disease and illness than others. He claimed that mental disease had a physiological and natural basis. He described a number of mental conditions in clinical detail (currently known as phobias, mania, depression and paranoia) and was the first physician to accurately describe the symptoms of pneumonia, as well as epilepsy in children.<sup>141</sup> He was also the first physician who believed that thoughts, ideas, and feelings came from the brain and not the heart as others of his time. According to Hippocrates:<sup>142</sup>

Men ought to know that from the brain and from the brain only arise our pleasure, joys, laughter and jests, as well as our sorrows, pains, griefs and tears ... It is the same thing [the brain] which makes us mad or delirious, inspires us with dread and fear, whether by night or by day, brings sleeplessness, inopportune mistakes, aimless anxieties, absentmindedness, acts that are contrary to habit ... Madness comes from moistness ... The corruption of the brain is caused not only by phlegm but by bile. You may distinguish them thus. Those who are mad through phlegm are quiet, and neither shout nor make a disturbance; those maddened through bile are noisy, evildoers, and restless, always doing something inopportune. These are the causes of continued madness. But if terrors and fears attack they are due to a change in the brain.

Undoubtedly these Hippocratic notions are based on *bona fide* scientific and clinical observations about madness with obvious concurrent physical disease. It is understandable then why the physician should have been prone to ascribe all madness to physical and physiological causes. It is evident that the history of madness in ancient Greece presents the first attempts at a classification of mental illnesses. Treatment was essentially physical, sometimes psychological and always empirical. Although its successes did not measure up to those in other branches of Greek medicine it is still of considerable importance, particularly when one considers subsequent achievements in psychiatry.<sup>143</sup>

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<sup>141</sup> For a clinical/medical explanation of these diseases, see chapter 3 of this study. See Goodman JT "Treatment of mental illness" in *The Canadian encyclopedia historica* (ed) Marsh JH) (1985) <http://www.thecanadianencyclopedia.com/index.cfm?PgNm=TCE&Params=A1ARTA0005235> (Date of access: 11 January 2009).

<sup>142</sup> Hippocrates *Sacred disease* (400 BC) 25 XV11 as quoted in Ducey & Bennett in *World history of psychiatry* 15. The theme of *Sacred disease* is epilepsy or fits. Hippocrates stated that this disease was in his opinion no more divine or sacred than other diseases, but that it had a natural cause and that its supposed divine was due to man's inexperience and to their wonder about its peculiar character. He rejected the notion that epilepsy was caused due to possession by the devil. He further stated that it was no less curable than other diseases, unless by long lapses of time it could be so ingrained as to be more powerful than the remedies that were applied. See Jones WHS *Philosophy and medicine in ancient Greece: With an edition of Perry Archaiēs Ietrikes* (1979) 24.

<sup>143</sup> Other physicians, for example Soranus, Celsus and Aretaeus recognised three mental diseases namely phrenitis, mania and melancholia. According to Drabkin these descriptions would correspond to various modern manic-depressive and schizophrenic forms and also to some severe neuroses, whereas certain milder neuroses might not be recognised as mental diseases at all by ancient medical writers. Ackerknecht opines that neither mania nor melancholia can be recognised as present-day syndromes. Mania simply meant an agitated form of insanity and melancholia a quiet one. For a comprehensive discussion of these physicians and diseases, see Ackerknecht *History of psychiatry* 15, 16; Singer CJ

As in early Greek thought, the most sensitive, complex and psychologically oriented explanation of madness in Roman thought was found in the philosophical literature, especially in the work of Lucretius.<sup>144</sup> He stated that mental disorder was fully recognised as an illness. He demarcated a sharp dichotomy between external causation of behaviour and individual motivation. He offered, more explicitly than ever, an internal, psychologically based model of mental disorder. He stated that man acted in the neurotic fashion depicted because he was trying to avoid the full force of depression that arose from the unconscious fear of death. Lucretius saw these feelings as the symptoms of a "sickness" whose primary cause was an unrecognised fear of death. He undertook to cure this sickness by his teaching and his poem constituted a kind of therapeutic dialogue, designed for this purpose. He anticipated the theories and outlook of Freud (discussed below) and modern psychoanalysis.<sup>145</sup>

Cicero<sup>146</sup> expanded and enriched the vocabulary of the emotions. He made a distinction between *insania* and *furor*, both usually translated as "madness". He stated that *furor* was more serious and could even befall the wise man. It also involved delusions. He distinguished between exterior, object, presentation and judgment. He recognised the productive imagination where falsely judged presentations (for example hallucinations), accepted by the mind, would build up an internal structure not corresponding, but believed to be corresponding to an exterior reality – and that would be madness. Therefore by Cicero's time the

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*Greek biology and Greek medicine* (1922) 119ff; Drabkin IE "Remarks on ancient psychopathology" 1955 46 *Isis* 3: 223 at 226-227.

<sup>144</sup> Titus Lucretius Carus (99/94-55/51BC) was a Roman Epicurean poet who wrote *De Rerum Natura* (On the nature of things). *De Rerum* is an epic, written in six books, which explains life and the world in terms of Epicurean principles and Atomism. Epicurus of Samos (341 BC-270 BC) was one of the most prolific ancient philosophers. Epicureans divided philosophy into three parts namely ethics, logic and physics. Of importance was happiness rather than living a life of shallow pleasure. This included freedom from pain in the body and from disturbance in the mind. See Blackburn "Epicurus" 117; "Lucretius" 217; King 31; Jope J "Lucretius's psychoanalytic insight: His notion of unconscious motivation" 1983 37 *Phoenix* 3: 224ff.

<sup>145</sup> Gill 1985 *J Hist Ideas* 3: 307 at 322. For a detailed discussion of Lucretius's writings see Snyder JMI *Puns and poetry in Lucretius De Rerum Natura* (1980) 11-146; Sedley DN *Lucretius and the transformation of Greek wisdom* (2003) 1ff.

<sup>146</sup> Marcus Tullius Cicero (106-43 BC) was a Roman orator and statesman in philosophy. He transmitted Greek ideas in Latin and promoted the unity of philosophy and rhetoric. Rhetoric refers to the art of using language so as to persuade or influence others. If one thinks of philosophy as a "matter of argument" rather than a "doctrine" as most academics do, then rhetoric is a good practice to follow. See Blackburn "Cicero, Marcus Tullius" 62; "rhetoric" 318; Treggiari S "The freedmen of Cicero" 1969 16 *Greece & Rome* 2: 195ff; Rowland RJ "Cicero and the Greek world" 1972 103 *Transactions & Proc of the Am Philological Soc* 451ff.

explicit recognition of the possibility of internal ideas not corresponding to external reality had firmly been achieved.<sup>147</sup>

It is interesting to note that a variety of responses to suicide existed at this time. The importance of shame and honour to these ancient people meant that a distinction between honourable and cowardly suicide was widely recognised. The former was acceptable and even praiseworthy, but the latter was to be condemned. Suicide was often a response to such social pressures as the desire for honour, fear of shame, or simply society's demand for one's self-sacrifice for the good of the whole.<sup>148</sup>

### 2.3.5 Middle Ages<sup>149</sup> and Renaissance<sup>150</sup>

There is not much to write about the development of psychiatry and psychology during the Middle Ages, since little is known about mediaeval medicine in general and because there were few positive developments in medicine during this time period. On the contrary, much occurred that was harmful such as the fragmentation of medicine. Surgery fell into the hands of barbers and their assistants, obstetrics into those of ignorant midwives, and psychiatry and psychology were practiced by exorcising priests and witch-hunting clerics.<sup>151</sup> There were many health problems and treatment and distinctions became overwhelming. Outbreaks of bubonic plague, smallpox and leprosy would come in waves and decimate populations. Mental illness was another concern.<sup>152</sup>

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<sup>147</sup> Ducey & Bennett *World history of psychiatry* 27; Mackendrick P "Cicero's ideal orator: Truth and propaganda" 1948 *Classical J* 43 6: 339ff.

<sup>148</sup> For a comprehensive discussion of suicide in ancient times see Dublin LI *Suicide: A sociological and statistical study* (1882) 110ff; Dublin LI *To be, or not to be: A study of suicide* (1993) 1ff; Garrison EP "Attitudes towards suicide in ancient Greece" 1991 121 *Transactions of the Am Philological Soc* 1-34.

<sup>149</sup> (AD 400-1400.) There is actually no definite agreement among historians on the beginning of the Middle Ages. What is certain is that new political, social and cultural configurations slowly emerged from the ruins of the Roman Empire. Only the Western part of the empire, which is of interest here, collapsed and was taken over around the end of the 5<sup>th</sup> century by younger civilisations coming from the North, resulting in the medieval culture, expression of the reciprocal interplay of the old Roman and the new "barbarian" forces. See Berkhouwer & Vorstman 18ff.

<sup>150</sup> The Middle Ages and especially the thirteenth century were not a time when the world stood entirely still. Among the younger generation, there was life, there was enthusiasm and there was a restless, if somewhat bashful, asking of questions. Out of this turmoil grew the Renaissance. See Van Loon HW *The story of mankind* (2008) 183. For further reading of the Renaissance period, see Haskins CH *The Renaissance of the twelve century* (1971) 1ff; Ferguson WK *The Renaissance in historical thought: Five centuries of interpretation* (1948) 1ff.

<sup>151</sup> Ackerknecht *History of psychiatry* 17. See also Jelliffe SE "Some random notes on the history of psychiatry of the Middle Ages" 1930 87 *Am J Psychiatry* 2: 275-286.

<sup>152</sup> "Madness", "insanity" and "lunacy" were terms used to describe a variety of mental illnesses or disorders, mental retardations and mental handicaps. See Kelly EB "Mental illness during the Middle Ages" 2005 <http://www.bookrags.com/research/mental-illness-during-the-middle-ag-scit-0212/> (Date of access: January 9 2009).

Many Europeans believed that people who acted strangely – some of whom were probably mentally ill – were witches. Suspected witches were subjected to horrendous tortures to rid them of evil spirits.<sup>153</sup> The main supernatural causes of illness were thought to be evil astrological influences and demons entering the body and possessing the soul. Some often-observed psychiatric reactions were symptoms of possession by the devil, who was supposed to choke and throw its victims about; dance mania characterised by an irresistible urge to dance and make noises; and *acedia*, a form of depression occurring in anchorites when they experienced distressful doubts about being able to live a religiously meaningful life.<sup>154</sup> Misfortune and suffering were often perceived as consequences of sinful behaviour: just punishments meted out through divine intervention. One who fell into the despondency of depression or who experienced delusion of sin and guilt was considered to be spiritually rather than physically ill. Such individuals were often "treated" by the Church, sometimes tortured, or even burned at the stake. The Christian Church published texts, such as the *Malleus Maleficarum*,<sup>155</sup> which explained how such "possessed" individuals could be identified and put to death. The last hanging of a witch in England took place in 1684, but witch trials in the United States continued into the eighteenth century.<sup>156</sup> Physicians or lay persons who claimed to have had special powers also provided treatment in the form of exorcism of demons by magical techniques; medicinal treatments recommended by Hippocrates and Galen; and time-honoured folk remedies, including the use of plants, animal parts and such esoteric medicines as bark from a tree from Paradise.<sup>157</sup>

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<sup>153</sup> Sternberg RJ *Psychology: In search of the human mind* (2001) 513. Sternberg refers to a famous example of assigning demonic causes for abnormal behaviour which happened in the 1690's, near Salem, Massachusetts. Eight girls started acting strangely – hallucinating and convulsing – but doctors could not find anything wrong with them. The girls claimed to have been bewitched and the related witchcraft hysteria spread rapidly, resulting in the execution of 20 townsfolk. For a further discussion of this witchcraft hysteria, see Davidson JW & Lytle MH *After the fact: The art of historical detection* (1986) 38ff.

<sup>154</sup> Sadock & Sadock (eds) (2000) 3302.

<sup>155</sup> (*The Witches' Hammer*) was first published in Germany in 1486. It quickly proliferated into many editions spreading throughout Europe and England. The impact of the work was felt in witch trials on the Continent for almost 200 years. The work's authors were two inquisitors of the Dominican order, Heinrich Kramer and James Sprenger. They were both empowered by Pope Innocent VIII in his Bull of 9 December 1484 to prosecute witches throughout northern Germany. The purpose of the papal edict (a pastoral letter that was meant to inform the whole church on a particular matter of importance) was to squash the Protestant opposition to the inquisition and to solidify the case made in 1258 by Pope Alexander IV for the prosecution of witches as heretics. The complete biographies of Kramer and Sprenger are unknown. What is known is that they distinguished themselves in the ecclesiastical field. Both became priors of Dominican houses of studies. See Institoris H & Sprenger J *et al The Malleus Maleficarum of Heinrich Kramer and James Sprenger* ((trans) Summers M) (1971) vii, viii ff.

<sup>156</sup> Gangat A "The history of psychiatry" 1-6 in *Textbook of psychiatry for Southern Africa* ((eds) Robertson B, Allwood C & Gagliano C) (2007) 1.

<sup>157</sup> Sadock & Sadock (eds) (2000) 3302.

Folk beliefs and traditions largely guided the perception of mental illness among the common people. The belief that the moon caused lunacy persisted into the nineteenth century. The mentally ill person was thought to have slept where the moon beams hit his head, which caused the erratic behaviour.<sup>158</sup>

Saint Mary of Bethlem<sup>159</sup> was established in London, in 1247, to house people "deprived of reason". By 1403 six people were housed in this hospital.<sup>160</sup> The hospital gained more and more patients and eventually developed into the infamous Bedlam.<sup>161</sup> The first full-length history was the work of a Bethlem chaplain, Edward O'Donoghue, whose book *The Story of Bethlehem Hospital from its Foundation in 1247* came out in 1914. This book was never reprinted and is rather rare to find.<sup>162</sup> One point worth stressing about this hospital is that it was an open building. "Raving lunatics" were chained up and in some cases they were "shut up" too. Other inmates seem to have been free to wander about the hospital. Bedlam was characterised by the crying, screeching, roaring, brawling, shaking of chains, swearing and fretting, which made it a place liable to send a sane man mad.<sup>163</sup>

By the time of the Renaissance, a few brave voices began to suggest that mental illnesses were diseases rather than forms of possession and bewitchment. This period, therefore, is an age of profound contradictions. Side by side with the ruthless persecution of the insane as witches, a deep sympathy for the

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<sup>158</sup> Kelly 2005 <http://www.bookrags.com/research/mental-illness-during-the-middle-ag-scit-0212/>.

<sup>159</sup> Also spelled Bethlehem.

<sup>160</sup> The Medieval term "hospital" (*hospitale* in Latin) embraced four main types of institutions: leper houses, alms houses, hospices for poor wayfarers and pilgrims and institutions that cared for the sick poor. There is up to date still no satisfactory general study of medieval English hospitals. The most useful work is probably Knowles D & Hadcock N *Medieval religious houses, England and Wales* (1971), which contains a gazetteer of 1103 hospitals with a brief history of each. See Granshaw L & Porter R *The hospital in history* (1989) 21.

<sup>161</sup> The word bedlam (an old English word meaning: "a person who was discharged and licensed to beg"), which is derived from the hospital's name, has long been applied to any place or scene of wild turmoil and confusion. "Bedlamers," "Bedlamites," or "Bedlam Beggars" had to wear a tin plate on their arms to be identified as "official" beggars. It is particularly intriguing that little serious historical investigation has been conducted into Bethlem, given that histories of Bethlem started very early – over 200 years ago – which is long before most asylums were established let alone acquired a history that could be written up. See Andrews J & Briggs A *The history of Bethlem* (1997) 3. See also Alexander FG & Sheldon S *The history of psychiatry: An evaluation of psychiatric thought and practice from prehistoric times to the present* (1967) 1ff; McMillan I "Insight into Bedlam: One hospital's history" 1997 35 *J Psychosoc Nurs Ment Health Serv* 6:28-34; Forchuk C & Tweedell D "Celebrating our past: The history of Hamilton psychiatric hospital" 2001 39 *J Psychosoc Nurs Ment Health Serv* 10: 16-24.

<sup>162</sup> Andrews & Briggs (1997) 3.

<sup>163</sup> *Idem* 51, 52. For an in-depth discussion of the circumstances in this hospital, see Battie W & Monro J *et al A Treatise on Madness* (1962) 1ff; Turner T "The history of Bethlem" 1999 29 *Psychological Med* 3: 747ff.

unfortunate "sick patient" is also found.<sup>164</sup> Scot<sup>165</sup> and Bright<sup>166</sup> were among those who first advocated this view in the late sixteenth century. In spite of the fact that these revolutionary ideas did not gain wide acceptance at first, the foundations of modern psychiatry and psychology were laid.<sup>167</sup> Mentally ill Europeans were hospitalised rather than executed, but their treatment was still far from humane or therapeutic and many people continued to consider the mentally ill to be witches.<sup>168</sup> But the significance of the Renaissance for psychiatry and psychology goes further than the rebirth of a humane attitude towards the insane. Doubts as to the supernatural causation of mental illness led to a search for natural forces and natural causes of mental illness.<sup>169</sup>

## 2.3.6 South Africa<sup>170</sup>

### 2.3.6.1 *The origin of Western medical practice*

Institutional medical practice originated in South Africa over 300 years ago. The Cape of Good Hope settlement was established in the seventeenth century to provide a refreshment station for the crews of the vessels of the Dutch East India Company. Jan van Riebeeck arrived at the Cape in 1652 with instructions to build this "defensive fort" (hospital), to lay out a garden, to obtain sheep and cattle by bartering with the

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<sup>164</sup> Ackerknecht *History of psychiatry* 21.

<sup>165</sup> (1538-1599.) Reginald Scot was the English author of *Discoverie of Witchcraft*, which was published in 1584. It was written to show that witches did not exist, by exposing how feats of magic were done. The book is often deemed the first textbook about magic and supernatural themes. He believed that the prosecution of those accused of witchcraft was irrational and non-Christian and he held the Roman Church responsible for it. All obtainable copies of this publication were burned on the accession of James I in 1603 and those remaining are rare and not accessible. See Haight AL & Grannis CB *et al Banned Books 387 BC to 1978 AD* (1978) 105, 123.

<sup>166</sup> (1551-1615.) Timothy Bright was the English author of *A treatise of melancholie* published in 1586 wherein he regarded "madness" primarily as a disease and expressed a compassionate concern for alleviating the suffering the mad endured. Although he attributed the first to a guilty conscience, enduring the wrath of God and the pain of remorse, the remedy he prescribed namely the acceptance of sincere counsel indicates that he rejected the harsh punishment recommended by those of his contemporaries who equated madness with sin. He believed instead in the efficacy of compassion for the relief of spiritual torment and viewed "madness" as essentially a disorder of the brain. See Feder L *Madness in literature* (1983) 116-118. See also Silbert D "Melancholy and music in the Renaissance" 1947 4 *Notes SS* 4: 413-424.

<sup>167</sup> Gangat in *Textbook of psychiatry for Southern Africa* 2.

<sup>168</sup> Sternberg 513.

<sup>169</sup> Ackerknecht *History of psychiatry* 21.

<sup>170</sup> According to Emsley, South Africa is a country of great fascination to those interested in the origins, development and behaviour of humankind. For example, recent fossil discoveries appear to confirm Darwin's hunch that Africa - and perhaps southern Africa - was the cradle of humankind. Caves in the Sterkfontein Valley near Johannesburg have produced abundant scientific information on the evolution of modern man over the past 3.5 million years. This is of interest not only from a historical point of view but also in terms of modern science. With the significant advances in medical genetics in general, and psychiatric genetics in particular, there has been a growing interest in homogeneous populations with novel gene pools. South Africa is a rich source of homogeneous populations with an apparently common ancestry. See Emsley R "Focus on psychiatry in South Africa" 2001 178 *Br J Psychiatry* 382; Afolayan FS *Culture and customs of South Africa* (2004) 1ff.

natives and to establish a settlement so that the company's crew could refresh themselves with vegetables, meat, water and other necessities by which means the sick on board could be restored to health. The aim of this hospital was mainly rehabilitative. According to Hurst this hospital could perhaps be regarded as an early and fairly successful example of occupational medicine.<sup>171</sup>

Psychiatry did not yet exist as a science during the seventeenth century in the Cape. The Dutch East India Company recruited its surgeons from the surgeons' guilds.<sup>172</sup> The incidence of mental illness in the Cape must have been high. Mentzel explains how the Dutch East India Company recruited its men. They came from the dregs of society, were poorly paid and always in debt to the company.<sup>173</sup> People with military experience were preferred and many of these recruits suffered from diseases.<sup>174</sup> Drunkenness was also common and became even more widespread when wine-growing was introduced at the Cape. Burrows summarised the situation in Cape Town as follows:

The pattern of disease in the Cape settlement – hypovitaminosis, alcoholism,<sup>[175]</sup> infection, exhaustion, and venereal disease – was one which might predispose to mental illness and the records make sporadic mention of the incidence of such cases.<sup>176</sup>

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<sup>171</sup> Occupational medicine is the branch of clinical medicine most active in the field of occupational health. Its principal role is the provision of health advice to organisations and individuals to ensure that the highest standards of health and safety at the workplace can be achieved and maintained. See Hurst LA & Lucas MB "South Africa" in *World history of psychiatry* 600ff; Zens C *Developments in occupational medicine* (1980) 7ff; Thom HB & Van Riebeeck Society (eds) *Journal of Jan van Riebeeck* (1952) xviiiif; Marais D *South Africa: Constitutional development, a multi-disciplinary approach* (1989) 17.

<sup>172</sup> Physicians were university graduates or doctors and were not usually appointed to ships as their salaries were too high. In the Dutch Republic external medicine could be learned within the surgeon-guild system in the larger cities. A pupil was inscribed at the guild and placed in the home and shop of a master surgeon. There he lived and worked for a couple of years until he passed the first examination and received the *Leerbrief*. With this certificate he could finalise his training with another master surgeon (journeymanship) which training ended by the successful passing of the master's examination (*huisproef*). The examinations took place at the guild. Bandaging lessons in the local hospitals were obligatory, as well as the sessions on the compounding of ointments and identifying herbs in the botanical gardens, the lectures given by the *praelectores*, and the witnessing of the dissecting of corpses. Surgeons were licensed to practice external medicine while physicians were licensed to practice internal medicine. Surgeons (also known as barber-surgeons, because traditionally they shaved people in their shops) were not allowed to meddle with diseases, but only with wounds and fractures. See Verdoorn PHF *Science and scientists in the Netherlands Indies* (1945) 309; Deacon HJ "Midwives and medical men in the Cape Colony before 1860" 1998 39 *J Afr Hist* 2: 271ff.

<sup>173</sup> Mentzel OF *The Cape in the Mid-Eighteenth century: Being the biography of Rudolf Siegfried Alleman, captain of the military forces and commander of the castle in the service of the Dutch East India Company at the Cape of Good Hope* ((trans) Greenless M) (1920) as quoted in *World history of psychiatry* 601.

<sup>174</sup> Theal MC *History of South Africa under the administration of the Dutch East India Company (1652-1795)* (1897) 214ff.

<sup>175</sup> The first known case of alcoholism that was recorded in South African history was the one of Krotoa (whom the Dutch called Eva), the first "Hottentot" to be converted to Christianity. She was brought up in van Riebeeck's house and worked as an interpreter. She married Pieter van Meerhof, a surgeon, who became the superintendent of Robben Island in 1665. After he was massacred, Eva disgraced herself by drinking too much. Her drunken and adulterous behaviour led to her

The mention of venereal disease is of specific interest in the predisposition of mental illness.<sup>177</sup> Lichtenstein<sup>178</sup> stated that it was not very frequent among the white people, but that "when they are afflicted with it, from their total ignorance of the manner in which it ought to be treated, it commonly gets to a formidable height". Burrows<sup>179</sup> and Lichtenstein<sup>180</sup> remarked that the Dutch women were both hysterical and fecund. Burrows attributes both to the fact that they had nothing better to do. Lichtenstein's explanation was more ingenious and was in keeping with the scientific beliefs of the day. According to Hurst and Lucas<sup>181</sup> we are reminded that the term "hysteria" is derived from the Greek word *husterikos*, which means "of the womb" and that by definition only women could be hysterical. According to Lichtenstein:<sup>182</sup>

A very remarkable effect of the climate of Africa and of the modes of living among the women there, is the facility with which they bear their children. A woman dying in childbed is a thing almost unheard of; on the contrary by the fourth day they generally begin to return to their household affairs and by the seventh or eighth leave the house and are perfectly recovered; and this not only among the hard working women in the country but among the ladies in the town, though in many respects they are delicate enough. *Perhaps, however, this facility may be a principle cause of their propensity towards growing so extremely corpulent and of that disposition to hysterical affections which has been mentioned and therefore may be balanced by its concomitant evils.* [Own emphasis]

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imprisonment at Robben Island. Only two centuries later a hospital for the insane was established on Robben Island (see the discussion below). See Heale J *They made this land* (1981) 367, 368, 376, 377.

<sup>176</sup> Burrows EH *A history of medicine in South Africa up to the end of the nineteenth century* (1958) as quoted in *World history of psychiatry* 602.

<sup>177</sup> Venereal disease refers to any infection that can be sexually transmitted, such as chlamydia, gonorrhoea, ureaplasma, and syphilis. Many of these diseases interfere with fertility and some causes severe illness. It is very interesting to note that earlier during the years 1530-1546 Girolamo Fracastoro (1484-1553), an Italian physician and humanist, published accounts of a new epidemic illness with loathsome and disfiguring symptoms and significant mortality. He named it syphilis and correctly stated that it was caused by sexual contact between two persons. The concept of sexual contagion was new and syphilis caused a unique and unprecedented mass fear about the danger of sexual activity – a fear that was later sustained when chronic syphilis was recognised as a major cause of dementia. That fear was equalled only by recent fears of acquired immune deficiency syndrome (AIDS). See Sadock BJ & Sadock VA (eds) *Comprehensive textbook of psychiatry: Volume II* (1999) 3303; Balfour A *War against tropical disease, being seven sanitary sermons addressed to all interested in tropical hygiene and administration* (1920) 44. For further reading on syphilis as a cause of mental illness see Fracastoro G *Syphilis* (1857) 1ff.

<sup>178</sup> Lichtenstein H *Travels in Southern Africa in the years 1803, 1804, 1805 and 1806* (1928) as quoted in *World history of psychiatry* 605.

<sup>179</sup> Burrows (1958) as quoted in *World history of psychiatry* 602.

<sup>180</sup> Lichtenstein H *Travels in Southern Africa in the years 1803, 1804, 1805 and 1806* (1928) as quoted in *World history of psychiatry* 605.

<sup>181</sup> Hurst & Lucas in *World history of psychiatry* 600ff.

<sup>182</sup> Lichtenstein as quoted in *World history of psychiatry* 605.

Many other conditions which would be regarded as psychiatric concerns at present were given little priority. Suicide, for example, was lightly passed over.<sup>183</sup> The sick from the Interior could not be treated in the company's hospital in Cape Town. That was for the company's employees only. During the seventeenth and eighteenth centuries ordinary people were not treated in hospitals. They were cared for at home. If they were not dangerous, including the insane, they were cared for by their own families – an outside room usually specially built for them. This was in keeping with Roman-Dutch law which stated that the insane were the responsibility of their families.<sup>184</sup>

Quite often dangerously insane people became deranged because of the prevalence of pellagra<sup>185</sup> and were then given free accommodation in the Cape Town hospital, where they were allowed to wander at will and even go into the town. Violent deranged people were locked in a small windowless room and the barber-surgeons treated them.<sup>186</sup> Blood-letting, opiates and restraint were the methods used for treatment. However, chains were never used for treatment but leather belts, wrist straps and canvas restraints were employed.<sup>187</sup>

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<sup>183</sup> Van Riebeeck recorded in his diary that when the ship *Hoff van Zeelandt* arrived at the Cape, it was reported that there had been 37 deaths on the outward voyage. "Two others had jumped overboard in desperation but the rest of the men are mostly healthy." On 24 December 1705 Adam Tas (1668-1722) reported a "singular affair" in his diary and never paid attention to the matter again: "They tell me this day that the Governor's wife had, in a fit of despondency, tried to drown herself by jumping into the fountain behind the house at the Cape; however Mrs Berg was on the spot, and ran to help her, pulling her out of the water, to whom the Governor's wife lamented bitterly that her life had become one of terror for her on account of the many scandalous acts she must daily hear and witness." The Governor was Willem Adriaan van der Stel at whose hands Tas himself suffered severely. Tas was an early Dutch free burgher, farming in the Stellenbosch district. He is best known for the part he played in the free burgher conflicts with van der Stel, concerning the corruption of Company officials and their misuse of trading monopolies. See Van Riebeeck *J Journal* (1952-1958) 42; Thom & Van Riebeeck Society (eds) 42; Valentijn F & Böeseken AJ (eds) *Descriptions of the Cape of Good Hope with the matters concerning it: Amsterdam 1726* ((trans) Smuts J) (1971-1973) 131.

<sup>184</sup> The church looked after the indigent chronic sick and those mentally ill patients who could not be cared for by their own families were often boarded out by the Charity Board of the Dutch Reformed Church. See Hurst & Lucas in *World history of psychiatry* 606. See also Searle C *The history of the development of nursing in South Africa 1652-1960* (1965) 1ff.

<sup>185</sup> Pellagra is a vitamin deficiency disease caused by dietary lack of niacin (vitamin B3) and protein, especially proteins containing the essential amino acid tryptophan. Because tryptophan can be converted into niacin, foods with tryptophan but without niacin, such as milk, prevent pellagra. However, if dietary tryptophan is diverted into protein production, niacin deficiency may still result. Tryptophan is an essential amino acid found in meat, poultry, fish, and eggs. See Roberts RS *Pellagra: History, distribution, diagnosis, prognosis, treatment, etiology* (1912) 17ff; Roe DA *A plague of corn: The social history of pellagra* (1973) 1ff.

<sup>186</sup> For a discussion of the history of barber-surgeons, see Landau PS "Explaining surgical evangelism in Colonial Southern Africa: Teeth, pain and faith" 1996 37 *J Afr Hist* 2: 261-281.

<sup>187</sup> Hurst & Lucas in *World history of psychiatry* 606; Imperato PJ *African Folk Medicine: Practices and beliefs of the Bambara and other peoples* (1977) 76, 171-178; Deacon HJ & Phillips H *The Cape doctor in the nineteenth century: A social history* (2004) 46, 134ff.

In 1795 the British occupied the Cape for the first time. The Dutch East India Company had gone bankrupt and in 1795 most medical services came under control of the military. Since then lunatic asylums were administered by the State. The Cape Colony, which comprised most of the western, northern, and eastern Cape Provinces of South Africa, was under British rule from 1795 to 1803 and again from 1806 to 1910, when it became part of the Union of South Africa.<sup>188</sup> The inhabitants of the Cape at this time consisted mainly of indigenous Africans, including Nguni speakers in the northern and eastern areas, Khoekhoen ("Hottentots") and San or Bushmen; slaves (mainly from the East Indies) and their descendants; Dutch-Afrikaners (who descended from Dutch and German settlers) and British settlers. Deacon suggests professional and institutional factors acted as key influences on the emergence of a highly differentiated, although broadly racist, field of colonial medicine in the Cape Colony. She further suggests that in understanding racism in colonial medicine, a distinction between "racist medicine" and "medical racism" should be drawn.<sup>189</sup>

In 1818 Samuel Bailey established the first civilian hospital at the Cape, later to be known as the Old Somerset Hospital. This hospital was the first to offer care for the insane from its inception in 1818. In 1821 Bailey, being bankrupt, was forced to sell the hospital to the Burgher Senate. In later years the mismanagement of this hospital became the subject of a great deal of criticism from James Barry, the military doctor, who after death, was discovered to be a woman.<sup>190</sup> Barry found in 1824 that five out of the fifteen lunatics in the hospital were quite sane and that the wards were as dirty as the patients themselves.

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<sup>188</sup> For a discussion of the British ruling during this time, see Bourne HRF *The stories of our colonies: With sketches of their present conditions* (1869) 1ff; Sanderson E *The British Empire in the nineteenth century: Its progress and expansion at home and abroad: Comprising a description and history of the British colonies and dependencies* (1898) vff.

<sup>189</sup> She explains it as follows: "It is not, of course, an easy matter to decide whether racism in science is best identified by examining explicit theoretical content, or the way in which theories were used or applied. It is hard to separate racist theory from practice because both emerged out of broader, often unarticulated, racist discourses, only some of which were arbitrarily elevated by contemporary science to the status of theories. In understanding the trajectory of racism within science it is, however, useful to differentiate (if only in degree) between "scientific racism," which created scientific justifications for racist practice, and "racist science," which incorporated elements of popular racism in the theory and practice of an otherwise universalist science. (In the same way, medical racism can be differentiated from racist medicine.) This distinction can help us to understand the degree to which notions of race became an essential part of the way in which the scientific enterprise was defined ... It also suggests that, in understanding racism in colonial medicine, we should differentiate between racist medicine (the institution of discriminatory practices in medicine based on broader social discrimination) and medical racism (the application of racially discriminatory practices in medicine justified on medical grounds)." See Deacon HJ "Racism and medical science in South Africa's Cape Colony in the mid-to late nineteenth century" 2000 15 *Osiris* 190 at 193; Dubow S *Scientific racism in modern South Africa* (1992) 20-291; Moore S *Race, nature and the politics of difference* (2003) 105ff.

<sup>190</sup> Hurst & Lucas in *World history of psychiatry* 607.

The case of the seaman Abel Smith whom Barry considered sane because "the absence of vinous and spirituous liquors was sufficient to restore him to his senses, such as they are" caused a flutter in governmental circles because Barry's forthrightness was not in accord with protocol. She did her utmost best to alleviate the suffering of all unfortunate people. In 1826 it was reported to the Supreme Medical Committee that John Honey and an attendant named Gaches had ill-treated two lunatics at the hospital. Gaches flogged a patient called Hartwick, who was a mason by trade, with a horse chase because he had scraped off some plaster from his cell wall. A female Hottentot was also flogged while she was held down by two men because she had been noisy. Honey mentioned that he had seen other eminent physicians apply the same treatment with beneficial results. The Committee considered that flogging mental patients was reprehensible for "it was highly discreditable to the respectability of character and the propriety and decorum of conduct to be expected from the different members of the medical profession".<sup>191</sup>

The British were reluctant to spend money on welfare in the "new" colonies of the nineteenth century and because labour was scarce at the Cape it was felt that people should maintain themselves by working. There were no Poor Laws in the colony and state relief was administered mainly through the churches or on an ad hoc basis to worthy applicants. Ex-slaves and British immigrants who placed increased pressure on charitable resources in Cape Town were considered to be especially "worthy". This prompted the provision of state-administered indoor relief on Robben Island for those long-term cases that would otherwise monopolise resources for the sick poor in Cape Town.<sup>192</sup> There was still only this one state-funded Somerset Hospital. District gaols housed many of the destitute and the sick.<sup>193</sup>

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<sup>191</sup> Deacon HJ "Insanity, institutions and society: The case of the Robben Island Lunatic Asylum, 1846-1910" in *The confinement of the insane: International perspectives, 1800-1965* ((ed) Porter R & Wright D) (2003) 22-46, Theal M (comp) *Records of the Cape Colony from February 1793: By Cape of Good Hope (South Africa), Great Britain Public Record Office* (1905) 171, 175, 175; Hurst & Lucas in *World history of psychiatry* 608.

<sup>192</sup> A series of public scandals about the management of the Robben Island Infirmary in the early 1850s challenged the use of physical restraint and punishment in the treatment of lunatics. The Asylum Reforms at the Cape borrowed their form and content from Humanitarian Reforms in European asylums from the beginning of the nineteenth century. This brought a new understanding about the insane as patients amenable to reform through psychological treatment to restore their rationality which had slowly replaced the older view of lunatics as animal-like creatures requiring physical punishment and isolation from society. The emphasis on humanitarian reform of patient treatment at the Robben Island asylum was, as in Europe, accompanied by concern with asylum position and design. There was a new interest in building asylums in the style of a country retreat within a carefully-ordered garden environment, away from the socially and physically polluting atmosphere of the town. While Robben Island kept patients away from the polluting atmosphere of Cape Town, it lacked the countrified surroundings now considered essential to a modern asylum. Teetering at the edge of the social wilderness, the Island had to be brought back into the colonial landscape as a garden. See Deacon HJ & Hall L "The place and space of illness: climate and garden as metaphors in the Robben Island medical institutions" 2000 *Hist in*

In 1846 the prison colony on Robben Island was converted into a hospital for lepers, lunatics and other chronically ill patients. To ensure that mentally ill patients were largely isolated from the community several other "lunatic asylums" were also built.<sup>194</sup> In Grahamstown lunatics were housed in jails until they could be transferred to Robben Island. Matthews, one of the first doctors to practiced in Kimberley, stated:

It is a painful thought, that among the poorer patients, who from the ills of life suffer mental alienation ... that these, all suffering from diseases that might have been stayed, should be thrust into jails without attendants, simply put in irons if violent, and almost compelled through sheer inhumanity and neglect to suffer the misery of incurable lunacy ... What tales the walls of its jail could tell! One poor black, to my certain knowledge, has been locked within its gates for twelve long years, and there you can see him – tomorrow if you like – bemoaning his fate, and cursing the government in the same breath! A poor white girl, the daughter of a man whom old residents remember well in the palmy days of the Diamond News, has day after day, and every day since 1876, paced like a caged tigress up and down a small court yard, panting for freedom, and growling in despair! One poor girl, black her skin may be, is handcuffed, so I learnt, for days together, to prevent her from stripping herself of all she wears. Two women I saw there myself, not three days ago, clad simply in nature's garb, as naked as when born.<sup>195</sup>

Valkenberg Asylum, established on the outskirts of a Cape Town suburb, in the Cape Colony, was opened in 1891 and was until 1916 a "Europeans only" asylum, created to cater for the "better class" patients, "hopeful cases" for whom there was some kind of cure. Prior to its opening, lunatics were poorly provided for.<sup>196</sup> Valkenberg's reputation was certainly enhanced by the fact that it accommodated European patients only. According to Swartz<sup>197</sup> it appears to have been seen as a haven for white women because they would not be forced into the company of doubly-stigmatised black lunatics. In view of these factors, Valkenberg earned in the first decade extravagant praise from official visitors. After decades of debate and controversy,

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*Focus: Medical Hist* 3 <http://www.history.ac.uk/ihr/Focus/Medical/articles2.html> (Date of access: 9 September 2007); Porter & Wright (ed) 20-53.

<sup>193</sup> Deacon HJ "Madness, race and moral treatment: Robben Island Lunatic Asylum, Cape Colony, 1846-1890" 1996 *7 Hist Psychiatry* 287 at 288.

<sup>194</sup> These included the Town Hill Asylum in Pietermaritzburg, Fort England Mental Hospital in Grahamstown, Valkenberg Lunatic Asylum in Cape Town, and the Pretoria Lunatic Asylum. See Emsley 2001 *Br J Psychiatry* 382.

<sup>195</sup> Matthews JW *Incwadi yami; or, twenty years personal experience in South Africa* (1887) as quoted in Hurst & Lucas in *World history of psychiatry* 609-610.

<sup>196</sup> By this time there were four asylums in the colony: Robben Island Asylum, the Old Somerset Hospital, Grahamstown Asylum, and Port Alfred Asylum. Of the asylums serving the Cape Town area, Robben Island housed 225 "lunatics" in 1890 and the Old Somerset Hospital 110. These asylums were not designed to care for lunatics and the Old Somerset Hospital in particular was considered to be "absolutely unsuitable for their treatment". The number of "lunatics" housed there dropped to 15 by 1906. Robben Island had prison-like buildings, and was stigmatised as a "dumping-ground". Its inaccessibility reinforced its reputation as a place of banishment. See Swartz S "Changing diagnoses in Valkenberg Asylum, Cape Colony, 1891-1920: A longitudinal view" 1995 *6 Hist Psychiatry* 431 at 432.

<sup>197</sup> Swartz 1995 *Hist Psychiatry* 431 at 432.

the first black male patients were admitted in 1916. They were housed in buildings strictly segregated from the European patients' facilities. In 1919 and 1920 the first black female patients were admitted, also to segregated accommodation. With the opening of Valkenberg to black patients, Robben Island gradually stopped admitting lunatics and by 1921 no lunatics remained on the Island.<sup>198</sup>

Deacon<sup>199</sup> further explains how doctors even found differences between the bodies of black and white people. She explains how racial attitudes influenced diagnostic practices in these asylums. For example Greenlees remarked: "The native brain has its analogue in the European child's cerebrum; in many respects his mental attributes are similar to those of a child, and in the breakdown of this infantile brain we can investigate the (cerebral) condition from an aspect not obtainable in any other way."<sup>200</sup> Seeing Natives in the colony as childish, irresponsible and carefree led to the view that they were more likely to suffer from "simpler forms of mania" than any other mental disorder. According to Swartz,<sup>201</sup> the statistics collected in the colony's asylums "proved" this view to be "correct" over the entire period of 1891-1920.<sup>202</sup>

Sparman visited the Caledon warm baths where he helped to treat a Madagascan slave from Cape Town who was suffering from an ulcerated leg. His comments on the case indicated that he expected to find that racial differences were more than skin deep, but he could not support that assumption through his observations of the black man's wound:

Being curious to examine a negro's flesh, I had for some time undertaken to look after the sore myself . . . The raw flesh appeared exactly of the same colour with that of an European . . . [As] the ulcer began to heal, [it threw out] fresh fibres in the same manner as ours do, with something whitish on the side of the skin, which otherwise was of a dark colour.<sup>203</sup>

Undaunted by finding similarity where he sought difference Sparman treated several farm workers (slaves and Khoisan) and a settler girl for "bilious fever." He treated them all with a strong mixture of tobacco, water and alcohol. He gave racial explanations for the differences he observed in the patients' symptoms, disease

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<sup>198</sup> *Ibid.*

<sup>199</sup> Deacon 1996 *Hist Psychiatry* 287 at 288.

<sup>200</sup> Greenlees TD "Insanity among the natives of South Africa" 1895 xli *J Mental Science* 71 at 75.

<sup>201</sup> Swartz 1995 *Hist Psychiatry* 431 at 432.

<sup>202</sup> Swartz 1995 *Hist Psychiatry* 442; cf Schnittker J & Freese J *et al* "Nature, nurture, neither, nor: Black - white differences in beliefs about the causes and appropriate treatment of mental illness" 2000 78 *Soc Forces* 3: 1101ff.

<sup>203</sup> Sparman A *A voyage to the Cape of Good Hope towards the Antarctic Polar Circle and around the world* (1786) 48 as quoted in Deacon 2000 *Osiris* 190 at 195.

progress and reactions to his treatment. He explained these differences in cultural rather than biological terms, suggesting that those indigenous Khoekhoen ("Hottentots") who had recently "made too sudden a transition from their strange manner of living" responded less quickly to the medication than settler patients and Khoekhoen servants brought up with the family. At this time in Europe the idea of race was still linked to culture as well as to biology. It is clear that by the 1880s Cape doctors had begun to develop cultural explanations for racial difference in the field of psychiatry and according to Deacon this is a shift in perspective that would soon characterise other fields of medicine too.<sup>204</sup>

It is evident from the above that race had become an increasingly important marker of both social and psychiatric difference at the Cape during the last decades of the nineteenth century. Racist practice was openly advocated on social and psychiatric grounds by the 1890s, for example, sleeping, ablution and eating facilities were racially segregated at the Old Somerset Hospital, Grahamstown and Port Alfred asylums and racially exclusive institutions were the norm.<sup>205</sup> This pattern was continued in other British colonies in Africa. In colonial Kenya after 1910, racial segregation was considered an essential prerequisite of medical provision. On the one hand, the recuperative potential of non-Africans was seen to be dependent on the elimination of "Africa" from the treatment environment as this was seen as largely responsible for their disorder. On the other hand, the superiority of the colonists could only be maintained if their insane were kept apart from the African insane.<sup>206</sup>

In addition, eugenics<sup>207</sup> and Christian-nationalism provided important arguments for the justification of a certain racial order. Eugenics provided arguments for social inequality in terms of biology, while Christian-

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<sup>204</sup> Deacon 2000 *Osiris* 190 at 195; cf Swartz S "The Black insane in the Cape, 1891-1920" 1995 21 *J South'n Afr Studies* 3: 399-415.

<sup>205</sup> The Commissioner of Mental Hygiene, DT Dunston, noted in 1929: "Now, the ("white") South-African-born rightly regards himself as separated from the coloured and natives by an unbridgeable gulf created in the history of our country and our people. When we therefore find some of our poor mixing intimately with these inferior ethnic types, we may justifiably conclude that they by doing so sacrifice the heritage of race, through a certain community of interests with them. It will thus be seen that Mental Hygiene concerns itself with much more than mere intelligence and mental deviation, it deals with economic inadequacy, social mindedness and adaptation to approved standards of living." See Union of South Africa *Report of the Commissioner for Mental Hygiene 1926-28* (1929) 25-29.

<sup>206</sup> Deacon 1996 *Hist Psychiatry* 287 at 295.

<sup>207</sup> Eugenics refers to a scientific movement devoted to the enrichment of the human race by regulating heredity. See Fantham HB "Heredity in man: Its importance both biologically and educationally" 1924 XXI *S Afr J Sci* 498-527; Fantham HB "Some factors in eugenics, together with notes on some South African cases" 1925 XXII *S Afr J Sci* 400-412; Fantham HB "Some thoughts on the social aspects of eugenics, with notes on some further cases of human inheritance observed in South Africa" 1926 *S Afr J Sci* XXIII 624-643; Fantham HB "Some thoughts on biology and race"

nationalism provided similar arguments based on theology. However, Christian-nationalism also enabled Afrikaner politicians and social scientists to mobilise impoverished Afrikaans speakers and had therefore a greater policy impact than eugenics.<sup>208</sup> Dubow's extensive study on the views of eugenicists in South Africa shows how many medical professionals adopted eugenic views to deal with the prevalence of mental disorder among "poor whites", particularly Afrikaans poor whites. Fears of mental and intellectual degeneration of the white race led eugenicists to promote compulsory segregation and/or sterilisation of the mentally defective.<sup>209</sup> Eugenicists relied on controlling and detaining those deemed genetically weak and reinforced the custodial role of psychiatry. However, by the 1940's eugenic solutions in the medical profession began to lose popularity, and beliefs that patients could actually be cured became more popular.<sup>210</sup>

An important nineteenth century contribution was the development of legislation for the protection of the insane.<sup>211</sup> The Ordinances of 1833, 1837, 1879 and 1891 culminated in the Mental Disorders Act<sup>212</sup> of the Union of South Africa. Section 6 of this Act prescribed the standard certification procedure for commitment to a mental hospital or institution for the mentally defective. Section 44 provided for the admission of voluntary boarders who were not certifiable and who applied for admission on their own free will for periods varying from one day to a year. The Amendment Act provided for two new categories of patients – the temporary patient and the inebriate. Apart from the civil admission procedures the Mental Disorders Act provided the procedures to be followed in medico-legal cases. Sections 27 and 28 provided for periods of observation of criminals in mental hospitals. The medical superintendent or his deputy issued a certificate

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1927 *S Afr J Sci* XXIV 1-20; Vale PCJ *Security and politics in South Africa: The regional dimension* (2003) 61ff; Dubow 61ff.

<sup>208</sup> Louw J "Social context and psychological testing in South Africa, 1918-1939" 1997 *7 Theory Psychology* 235ff.

<sup>209</sup> For a comprehensive discussion of perceptions of mental health care providers of the role of psychiatric symptoms in sexual behaviour, the kinds of sexual behaviour engaged in and the quality of sexual relationships for women with severe mental illness, see Collins PY "Dual taboos: Sexuality and women with severe mental illness in South Africa: Perceptions of mental health care providers" 2001 *5 AIDS and Behaviour* 2: 151-161.

<sup>210</sup> Dubow 61ff; Jones TF "Prospects of a progressive mental health system in 1940s South Africa: Hereditarianism, behaviourism and radical therapies" (Workshop on South Africa in the 1940's Southern African Research Centre, Kingston, September 2003) <http://www.queensu.ca/sarc/Conferences/1940s/Jones.htm> (Date of access: 1 September 2007).

<sup>211</sup> It is important to note that when the Union of South Africa came into being on 31 May 1910, all laws affecting the insane and all the institutions established for their treatment in the four Provinces were placed under the administration of the Minister of the Interior. Thomas Dunston was appointed commissioner for mentally disordered people. In 1922 his title changed to Commissioner for Mental Hygiene. See Hurst & Lucas in *World history of psychiatry* 615.

<sup>212</sup> The Mental Disorders Act 38 of 1916 as amended by the Mental Disorders Amendment Act 7 of 1944 and regulations (hereafter referred to as the Mental Disorders Act).

for consideration of the court and where necessary appeared in court to defend or elaborate it. The question of criminal responsibility in relation to mental disorder at the time of the crime and the patient's fitness to plead are still central issues in modern day legal and psychiatric practices.<sup>213</sup> The Mental Disorders Act was later repealed by the Mental Health Act<sup>214</sup> and the Mental Health Act was recently repealed by the Mental Health Care Act.<sup>215</sup>

In 1946 an innovative and therapeutic neuropsychiatric hospital was opened on the outskirts of Johannesburg. Tara Hospital was the first of its kind in South Africa. It was an open, therapeutic hospital that combined contrasting notions of hereditarianism and behaviourism, and integrated new biomedical and behavioural approaches in the treatment of its patients. For the first time, a mental hospital in South Africa offered promises of cures for previously neglected mental patients within a relatively hospitable environment. Tara was the embodiment of an emerging innovative approach towards mental health care that challenged a previous custodial system.<sup>216</sup>

It is only a decade ago that South Africans were living and working in an oppressive and discriminatory system. As part of the national policy, health services were fragmented along racial lines. Of all the medical specialities, psychiatry (the one most influenced by the prevailing social and political climate) was the one most criticised by the international community. Psychiatric services were inspected by overseas groups and condemned. Concern was also expressed about the Royal College of Psychiatrists' continued silence on the political abuses of psychiatry in South Africa. In 1984 a call went out to the World Psychiatric Association to expel the "racist Society of Psychiatrists of South Africa" because of its collusion with apartheid. In 1987 a resolution was approved by the Royal College of Psychiatrists condemning racism and urging College members to support the Commonwealth Nassau Accord of October 1985, which recommended discouragement of participation in cultural and scientific events except where these contributed towards the ending of apartheid or had no possible role in promoting it.<sup>217</sup>

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<sup>213</sup> See the discussion of the role of criminal law in psychiatry and psychology in chapter 5 of this study.

<sup>214</sup> The Mental Health Act 18 of 1973 (hereafter referred to as the Mental Health Act).

<sup>215</sup> The Mental Health Care Act 17 of 2002 (hereafter referred to as the Mental Health Care Act). For a discussion of South African legislation, see chapter 5 of this study.

<sup>216</sup> For further reading of Tara hospital, see Wilkinson G *Talking about psychiatry* (1993) 262ff.

<sup>217</sup> In response to the hideous violations of human rights in the past, the post-apartheid government established a Truth and Reconciliation Commission to promote national unity and reconciliation. The intention was to establish as far as possible

However, with the advent of democracy in South Africa, the authority of the Constitution and Constitutional Court, the introduction of the Bill of Rights, the establishment of the Human Rights Commission and the enactment of the Mental Health Care Act an infrastructure had been created in South Africa. This infrastructure addresses the past inequalities and ensures that the rights of all people, including mentally disordered people are protected. These rights are thoroughly discussed in chapter 5.

### 2.3.6.2 *The traditional healer in South Africa*

Anthropologists recognise that folk medicine (traditional and faith healing) in a society like South Africa is a health-seeking practice for many people.<sup>218</sup> However, following on from the "dark ages" of African psychiatry that predate independence for many African countries, a time described as the renaissance of psychiatry, was embodied in the life and times of African giants who during the 1950's and 1960's ensured there were regular meetings across the continent during very difficulties times. The decline of many African economies, violent changes into dictatorships and the plunder of national resources led to widespread poverty in Africa, and an atmosphere in which psychiatry went into major decline.<sup>219</sup>

The nature and practice of traditional healers and other magico-religious healing practitioners are issues of long-standing anthropological concern. A clear understanding of the shaman's characteristics and practices has been hampered by their association with magic and religion and by a lack of systematic cross-cultural study methods. There are no widely accepted definitions or characterisations based on systematic cross-cultural examination of those practitioners called "shaman." As a result, terms such as *shaman*, *medicine*

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the nature, causes and extent of gross human rights violations by granting amnesty to perpetrators who made full disclosures and by affording victims the opportunity to give accounts of their sufferings. For the nation as a whole, the Truth and Reconciliation Commission has had a positive and perhaps even therapeutic effect. There are a number of issues regarding the Truth and Reconciliation Commission that are of relevance to psychiatry. Both perpetrators and victims recounted almost unbelievable incidents of extreme emotional trauma. Mental health professionals provided advice regarding the manner in which testimony should be taken, and provided psychological support when necessary to those who testified. Truth and Reconciliation Commission staff members were trained in issues relevant to psychological support, and some of the Truth and Reconciliation Commission commissioners were mental health professionals. See Emsley 2001 *Br J Psychiatry* 382 at 384.

<sup>218</sup> Abrahams N & Jewkes R "Indigenous healing practices and self-medication amongst pregnant women in Cape Town, South Africa" 2002 6 *Afr J Rep Health* 2: 79 at 80.

<sup>219</sup> Njenga FG "African psychiatry has come of age" 2007 10 *S Afr Psychiatry Rev* 1: 1-3. For a discussion of this time and the renaissance of psychiatry, see Masserman JH *The practice of dynamic psychiatry* (1955) 1ff; Lasagne LS *The doctor's dilemma* (1970) 242ff; Cochrane AL *Effectiveness and efficiency: Random reflections on health services* (1972) 8ff.

man, diviner, witch doctor, medium, traditional healer, sangoma and others are often used interchangeably and without specification of the assumed common characteristics or consideration of the possible differences among such practitioners.<sup>220</sup>

Winkelman<sup>221</sup> suggests that shamanism is a religious complex that originated in hunting and gathering societies and that there were types of religions corresponding to ecological conditions of the societies in which they were found. Traditional healers were generally thought to acquire the position through an illness or calling of the spirits, perhaps accompanied by a vision quest (in which they seek a trance state vision). The shaman may undergo a death and rebirth experience as well. Although the shaman is generally contrasted with the social and political position of the priest, the shaman may be characterised as having political power. The characteristics of traditional healers include for example selection by spirits and the capacity to fly, to transform oneself into an animal, to become one with a helping spirit, to become that which is labelled a witch or wizard, to use auxiliary spirits, and to communicate with the spirit world on behalf of the shaman's group members.<sup>222</sup> The important role that these religious beliefs of traditional healers may have on perceptions of mental illness cannot be ignored. Many religions advocate witchcraft and spirit possession. These are thought to influence the behaviour of a person so as to resemble that of a mentally ill individual.<sup>223</sup>

Traditional healers already existed in South Africa before its colonisation by the Dutch in the seventeenth century.<sup>224</sup> These indigenous healing practices are increasingly of scientific interest. Much of the interest to date in medical writing has been the potential for harm caused by traditional practices.<sup>225</sup> Abrahams<sup>226</sup>

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<sup>220</sup> Kale R "South Africa's health: Traditional healers in South Africa: A parallel healthcare system" 1995 310 *Br Medical J* 6988: 1182.

<sup>221</sup> Winkelman 1990 *Ethos* 308 at 309.

<sup>222</sup> *Idem* 308 at 318.

<sup>223</sup> For a discussion of religious beliefs, mental illness and traditional healers see Gaw A *Culture, ethnicity, and mental illness* (1993) 288ff; Adekson MO *The Yoruba traditional healers of Nigeria* (2003) 19ff; Koenig HG *Faith and mental health: Religious recourses for healing* (2005) 43-276.

<sup>224</sup> Kale 1995 *Br Medical J* 1182.

<sup>225</sup> The witches (umthakathi: Xhosa ) and sorcerers (baloyi: Sotho) are people who are believed to have the mystical ability to harm others and can become possessed by evil spirits, change shape, use medicines to harm and send agents, for example, animals to do evil deeds. Witchcraft is a force to be reckoned with. Many Southern African Bantu-speakers protect themselves against it. The trans-human state, for example spirits and magic, is not perceived as an intangible abstract concept, but is considered to be a powerful force that can be used to manipulate outcomes for the good or bad. There is commonplace selling of protective plant charms (intelezis) that are believed to thwart the malicious intents of others who are sometimes believed to be witches. Often such witches are people who are jealous of the success of

argues that there is a need for a shift in emphasis towards developing an understanding and recognition for the value of indigenous knowledge. According to Mkize,<sup>227</sup> psychiatry has its roots not only in biological medicine but also in behavioural science. Gureje<sup>228</sup> asserts it cannot be divorced from the history of the society in which it is practised, and historically, African medicine differs widely from Western medicine. The short but impressive path that psychiatry has traversed in Africa is littered with the splinters of broken myths. Such myths commonly result from the fact that research activity is still relatively small on the continent and opportunities to examine, accept or refute research findings on the basis of new data are not many.<sup>229</sup>

The African view of mental illness encompasses (historically and presently) a wide spectrum which ranges from ancestors, folk belief in witchcraft, to modern medical science. All the systems function simultaneously with the African culture and within the individual and easily fit and complement one another. The problem has been for a long time the inability to bring the Western and traditional healing systems together. In traditional African cultures mental illness has always been integrated into social order and cosmic order. Each member of the culture has precise conceptual and operational models for the causes of the mental illness. In African medicine the sick are treated or cared for in a particular way in terms of traditional African thinking, which is claimed to be different from Western thinking. A very important reason for this is that the African view of what a human being is differs from other views,<sup>230</sup> especially from the so-called Western view.<sup>231</sup>

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others. One example of a plant that is used to protect people from witchcraft attacks is umathithibala or *Haworthia fasciata* and Haw that is grown around the homestead. See Ngoma Traditional Healing: Sobiecki JF "Indigenous healing in South Africa: An overview" 2007 <http://www.wits.ac.za/lizangoma/index.htm> (Date of access: 11 September 2007). For a discussion of witchcraft in South Africa, see Minnaar A "Witchpurging and *muti* murder in South Africa" 2001 2 *Afr Legal Studies: Special issue: Witchcraft violence and the law* 1-21; Niehaus I "Witchcraft in the new South Africa" 2001 2 *Afr Legal Studies: Special issue: Witchcraft violence and the law* 116-148; Faure V "Notes on the occult in the new South Africa" 2001 2 *Afr Legal Studies: Special issue: Witchcraft violence and the law* 170-176.

<sup>226</sup> Abrahams & Jewkes 2002 *Afr J Rep Health* 79 at 80.

<sup>227</sup> Mkize DL "Towards an Afrocentric approach to psychiatry" 2003 9 *S Afr J Psychiatry* 3, 4.

<sup>228</sup> Gureje O "Psychiatry in Africa: The myths, the exotic, and the realities" 2007 10 *S Afr Psychiatry Rev* 1: 11.

<sup>229</sup> *Ibid.*

<sup>230</sup> The reason for this difference is the fact that African-philosophy forms part of the natural law philosophy, which differs strongly from the Western (liberal) philosophical model. For a detailed discussion of these models, see Van Blerk AE *Jurisprudence: An introduction* (1998) 1-25, 80 – 81; Roederer C & Moellendorf D *Jurisprudence* (2006) 25-57, 438-460.

<sup>231</sup> Mkize 2003 *S Afr J Psychiatry* 3-4.

Care of the mentally ill in Africa has for centuries been in the hands of traditional and religious healers. Most illnesses could be dealt with fairly satisfactorily, irrespectively of the culture of patient and doctor. But according to Mkize, this is not true of mental illness. Psychiatry is crucially informed by culture and other social, biological and psychological factors and processes. Cultures differ regarding their definition of health, ill health and healing. Western psychiatry now has much to offer to the African patient, but there are serious obstacles in the way. The chief obstacle is a fundamental difference in social and cultural background between doctor and patient. All traditional types of psychotherapy must obviously reflect local beliefs regarding human nature, and in many cultures this means that the close links between individuals, their ancestors, and the spirit world play a prominent role in treatment.<sup>232</sup> Healing is based on the establishment and maintenance of satisfactory relationships between these different elements of the present, the past, and the spirit world. Mkize further explains that the patient, therefore, does not consider the "illness" as something to be cured or controlled but as something to be understood and acknowledged.<sup>233</sup>

Currently the practice of traditional healers are not fully understood or accepted by the medical profession. Traditional healers are further not allowed to register with the Health Professions Council of South Africa and according to Robertson<sup>234</sup> much more knowledge need to be gained, widely shared and debated about how traditional healers' practice before they can join the medical profession. The role of the traditional healer in medicine is further discussed in chapters 3 and 4.

## 2.4 THE HISTORY OF PSYCHIATRY AND PSYCHOLOGY

### 2.4.1 Seventeenth century psychiatry and psychology

At the beginning of the seventeenth century there were still no mental hospitals as we are currently familiar with it. Although some special facilities for housing lunatics existed before the seventeenth century, for example in ancient Greece and in medieval England, these were isolated arrangements for looking after a

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<sup>232</sup> For a discussion of folk beliefs, ancestors and the spiritual world and mental illness in Africans, see Carothers JC "A study of mental derangement in Africans, and an attempt to explain its peculiarities, more especially in relation to the African attitude to life" 1948 93 *J Medical Science* 548-596; Rwegellera GGC "Cultural aspects of depressive illness" 1981 17 *Psychopat Africaine* 41-63; Green EC *Indigenous theories of contagious disease* (1999) 221ff; Moreau S & Netland HA *et al Evangelical dictionary of world missions* (2000) 365ff.

<sup>233</sup> Mkize 2003 *S Afr J Psychiatry* 4-6.

<sup>234</sup> Robertson BA "Does the evidence support collaboration between psychiatry and traditional healers? Findings from three South African studies" 2006 9 *S Afr Psychiatry Rev* 2: 87 at 90.

few "unwanted persons". They were not instances of an institutional arrangement serving the explicit purpose of incarcerating persons categorised as insane.<sup>235</sup> There were no facilities such as Bethlem hospital.<sup>236</sup> By the end of the century there was, however, a flourishing new industry, called the "trade in lunacy".<sup>237</sup> When this trade began, the individuals incarcerated as "insane" were members of the propertied classes who posed a problem to their families. Originally called "mad-doctoring", psychiatry began later in this century with the establishing of madhouses and the legal empowering of doctors to incarcerate persons denominated as insane. Until the end of the nineteenth century, every relationship between psychiatrist ("mad-doctor") and patient was based on domination and coercion - almost equal to a relationship between master and slave. Psychiatry - its emblem the state "madhouse" - was a part of the public sphere - the sphere of coercion.<sup>238</sup> Except for some historians of psychiatry and psychology, few people realised that the early madhouses were not hospitals, but were simply the keepers' homes (usually lay persons) into which they took a few mad people as involuntary boarders or house-guests.<sup>239</sup>

In 1676, a much enlarged Bethlem hospital was opened "for the relief and cure of persons distracted". Despite its specialised function, none of its seventeenth-century physicians published anything of consequence in psychiatry, although Tyson<sup>240</sup> was a distinguished comparative anatomist.<sup>241</sup> Further thoughts on mental illness were influenced by the work of two eminent English physicians: Firstly, Willis,<sup>242</sup>

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<sup>235</sup> Szasz TS "The origin of psychiatry: The alienist as nanny for troublesome adults" 1995 6 *Hist Psychiatry* 1 at 2, 4-5.

<sup>236</sup> For a discussion on the confinement of a small number of "insane people" in Bethlem (also spelled Bethlehem) hospital (better known as Bedlam), see the discussion above.

<sup>237</sup> Szasz 1995 *Hist Psychiatry* 1 at 2. See also Jones K *Lunacy, law and conscience, 1744-1845: The social history of the care of the insane* (1955) 1-26; Parry-Jones WLL *The Trade in Lunacy: A Study of Private Madhouses in England in the Eighteenth and Nineteenth Centuries* (1972) 1ff. Parry-Jones traces the development of the madhouse system in the eighteenth and nineteenth centuries and also supplies valuable references on the development of psychiatry; Scull AT "A new trade in lunacy: The recommodification of the mental patient" 1981 24 *Am Behavioural Scientist* 6: 1ff; Andrews J & Scull AT *Customers and patrons of the mad-trade: The management of lunacy in Eighteenth-century London* (2003) 1-209.

<sup>238</sup> Szasz TS *Liberation by oppression: A comparative study of slavery and psychiatry* (2002) xii, 5, 8, 27ff.

<sup>239</sup> Szasz 1995 *Hist Psychiatry* 1 at 7.

<sup>240</sup> (1650/51-1706/08.) Edward Tyson was a British scientist and physician, commonly regarded as the founder of comparative anatomy, which compared the anatomy between species. His work suggested a continuity of traits between humans and other primates nearly a century before evolution was first theorised. See Shepherd M & Zangwill OL (eds) *Handbook of psychiatry 1: General psychopathology* (1982) 24. For further reading on this topic, see Tyson E *The anatomy of a pygmy compared with that of a monkey, an ape, and a man. With an essay concerning the pygmies of the ancients* (1751) 1ff; Russell KF (rev) "Edward Tyson's *Orang-Outang*" 1967 11 *Medical Hist* 4: 417-423.

<sup>241</sup> Shepherd & Zangwill (eds) (1982) 24.

<sup>242</sup> (1621-1675.) Thomas Willis extended the concepts proposed by the Roman physician Galen, that the brain was the organ responsible for the excretion of animal spirits (which was thought to originate from the cribiform plate, a bone in the base of the skull, overlying the nasal cavity). Willis proposed that the choroid plexus was responsible for the absorption of

who performed autopsies on some of his patients. He recognised the difference between mental symptoms of gross brain disease and diseases in which the brain seemed normal, which he attributed to disturbed animal spirits. Secondly, Sydenham,<sup>243</sup> who gave a comprehensive account of the many symptoms of hysteria. An Italian papal physician, Zacchia<sup>244</sup> insisted that a physician rather than a lawyer evaluates the mental status of a patient. An Oxford dean of divinity, Burton<sup>245</sup> provided authoritative summaries of writings on melancholy from ancient times through the Renaissance.<sup>246</sup>

It must further be mentioned that blood transfusion was introduced in the seventeenth century as a psychiatric treatment method. Denis<sup>247</sup> transferred appreciable amounts of arterial blood from lambs to the veins of mental patients, with some success, at first (due to the effect of shock), but subsequent fatalities led to the prohibition of this procedure.<sup>248</sup>

Szasz<sup>249</sup> states clearly that no medical historian can doubt the fact that, for the patient, this type of treatment and the circumstances in madhouses, did more harm than good. These houses were places of

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cerebrospinal fluid. Later, in *De Anima Brutorum*, he proposed that the corpus striatum received all sensory information, while the corpus callosum was associated with imagination and the cerebral cortex with memory. Willis is recognised as the father of neurology. See Molnár Z "Thomas Willis (1621–1675), the founder of clinical neuroscience" 2004 5 *Nat Rev's Neurosci* 329ff.

<sup>243</sup> (1624-1689.) Thomas Sydenham observed that hysteria occurred in both males and females, and ascribed it to abnormal animal spirits. His work resembled the modern psychiatric endeavour of constructing theoretical classifications of mental disease. This classification was one of the first attempts to incorporate contemporary physiological and psychological knowledge into a systematic analysis of insanity. See Pearce JM "Thomas Sydenham 'the British Hippocrates'" 1995 58 *J Neurol Neurosurg Psychiatry* 3: 292; Dewhurst K *Dr Thomas Sydenham (1624-1689): his life and original writings* (1966) 1ff.

<sup>244</sup> (1584-1659.) Paola Zacchia's views in *Questiones medico-legales* (1621-1635) were the beginning of forensic psychiatry. See Cyril H & Wecht MD "The history of legal medicine" 2005 33 *J Am Acad Psychiatry Law* 2: 245ff.

<sup>245</sup> (1577-1640.) Robert Burton's *The Anatomy of Melancholy* (1621) was widely read and caused some forms of melancholy to become fashionable in England. See Junior D *The anatomy of melancholy, what it is, all the kinds, causes, symptoms, prognosis, and several cures of it: In three partitions* (1850) 1ff.

<sup>246</sup> Colp R "Psychiatry: Past and future" in ((eds) Kaplan & Sadock) (1985) 3301-3344 at 3303.

<sup>247</sup> (-1706.) Although it has long been known that blood was conveyed into human veins in Paris in 1667 by Jean Denis, historians of medicine and anatomy have never described these experiments in detail, nor evaluated their outcome, nor even suggested their importance in the medical and intellectual world of their day. The lack of positive success of these trials led to their being buried under a mass of unfavourable comments by both contemporaries and later writers on medical history; and as a result, an episode which attracted much attention in its time, and which therefore offers a vivid insight into the changing atmosphere of the 17th century in France, has been almost completely forgotten. See Brown H "Jean Denis and transfusion of blood, Paris, 1667-1668" 1948 39 *Isis* 1/2: 15ff; O'Dowd (2001) 319.

<sup>248</sup> Ackerknecht *History of psychiatry* 33.

<sup>249</sup> Szasz *Liberation by oppression* 171.

horror.<sup>250</sup> Fortunately the harm they could do was limited by the fact that most of the sick people who went there were hopelessly ill and would have died soon in any case. Therefore the real "beneficiaries" under these circumstances and in this century were not the patients, but rather the patient's families.

#### 2.4.2 Eighteenth and early nineteenth century psychiatry and psychology

With the influence of the eighteenth century enlightenment, belief in the power of rational thinking replaced belief in Hippocratic, Galenic and demonic ideas and led to new theories of mental illness. For most of the eighteenth century, the insane inmates in public mental asylums<sup>251</sup> were often regarded as having incurable diseases and were subjected to physical restraints, beatings and constant fear.<sup>252</sup> Scull<sup>253</sup> explains it as follows:

It was in the eighteenth century that Bethlem as "Bedlam" truly assumed its archetypal place as a by-word for all things mad and chaotic. At the hands of a Swift, a Pope, a Hogarth, to say nothing of a whole host of more anonymous Grub Street scribblers, cartoonists and pamphleteers, it became a vehicle for satirizing the follies of the nation, even as it began to generate its own internal history of scandal and vilification. Cast open to the prying eyes of the public through a policy that (at least until 1770) allowed outsiders virtually indiscriminate access and licence as visitors to come and gaze at the insane, it became one of the sights of London, an ever more popular source of public entertainment. Its wards had become emblematic of Unreason, its very name synonymous with lunacy, and its crazed inmates reduced to a spectacle to which the masses responded with mirth, mockery and callous teasing. Yet even as insanity came to occupy so unenviable an ontological space, the tide began to turn. If more and more hoi polloi gathered to gawk and to laugh, to view inmates as animals in a peculiarly human sort of zoo, those who thought themselves their social superiors and moral betters began to parade their own sense of sorrow, mortification and disgust, maximizing the distance between polite and popular culture, and in so doing, making manifest their own more refined sensibilities.<sup>254</sup>

These treatments ensured that madness was controlled during this period. This realisation of power, which was latent in the ability to manipulate the environment and of the possibility of radically transforming the

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<sup>250</sup> The main problem with private madhouses was the absence of licensing and inspection. Anyone could open a madhouse and advertise for patients. This led to inevitable abuses. See Torrey EF & Miller J *The invisible plague: The rise of mental illness from 1750 to the present* (2001) 29.

<sup>251</sup> The eighteenth century saw the creation of numerous asylums, which continued into the nineteenth century and which provided the material structure for the future development of psychiatry and psychology. To name only a few: Bologna (1710); Warsaw (1726); Berlin (1728); Dublin (1745); Ludwigsburg (1746); London (1759); Deventer (1760); Manchester and Copenhagen (1766); Williamsburg (1773); Vienna (1784) and Frankfurt on Main (1785). See Ackerknecht *History of psychiatry* 35.

<sup>252</sup> Colp in Kaplan & Sadock (eds) 3304.

<sup>253</sup> Scull AT "The insanity of place" 2004 15 *Hist Psychiatry* 4: 417 at 420-421.

<sup>254</sup> For further reading of the horrifying circumstances in "lunatic asylums" see Conolly J *On the construction and government of lunatic asylums* (1849) 1ff; Crammer J *Asylum history: Buckinghamshire County Pauper Lunatic Asylum – St. John's* (1990) 1ff; Goffman E *Asylums: Essays on the social situation of mental patients and other inmates* (1961) 1ff; Winslow LF *Recollections of forty years* (1910) 1ff.

individual's "nature", was translated in context of "madness" into a wholly new stress on the importance of cure. The insane were to be restored to reason by a system of rewards and punishments not essentially different from those used to teach a young child to obey the dictates of "civilised" morality.<sup>255</sup>

Rush<sup>256</sup> was the most famous American physician of his time and became known as the father of American psychiatry. The practice of restraint reached its apogee in Rush's "tranquilliser" of 1811. Here the patient vanished into the apparatus. He was faceless, his every movement blocked. But the madman in the restraining chair was only one of the representations of treatment in this century.<sup>257</sup> Rush's belief in somatic causation (what he believed to be the morbid actions of cerebral blood vessels) and his non-acceptance of moral treatment caused his influence to wane after his death, when prominent superintendents of American asylums were practicing moral treatment.<sup>258</sup>

However, a resurgence of scientific questioning in Europe led to the development of more humanitarian approaches to understanding and treating abnormal behaviour. Tuke<sup>259</sup> housed the mentally ill in his newly established *York Retreat* in a humane way. At the same time Pinel<sup>260</sup> established humane and moral conditions for caring for the mentally ill at the hospitals *La Bicêtre* and *La Salpêtrière* in Paris.

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<sup>255</sup> Wallace ER & Gach J (eds) *History of psychiatry and medical psychology* (2008) 43.

<sup>256</sup> (1745-1813.) Benjamin Rush's book *Medical inquiries and observations upon the diseases of the mind* (1812) was the first comprehensive book on mental illness by an American physician. See Colp in Kaplan & Sadock (eds) 3304.

<sup>257</sup> Cf the methods of shock treatment for insanity; treatment by steam and shower baths; William Saunders Hallaran's "circulating swing" from his *Practical observations on insanity* (1818); standing restraint first depicted by Horn in 1818, as reproduced in Schneider's work of 1824; military drill in asylum courtyards; and the use of straightjackets. See Gilman SL *Seeing the insane* (1982) 156. For further reading on this topic see Granville JM *The care and cure of the insane* (1877) 1ff; Grange K "The ship symbol as a key to former theories of the emotions" 1962 36 *Bull Hist of Med* 512-523; Hill RG *Total abolition of personal restraint in the treatment of the insane* (1839) 1ff; Maudsley H *Responsibility in mental disease* (1874) 1ff; Prichard JC *A treatise on insanity* (1833) 1ff. See also the discussion of shock therapy below.

<sup>258</sup> Colp in Kaplan & Sadock (eds) 3304.

<sup>259</sup> (1732-1822.) Because William Tuke an English Quaker, businessman and philanthropist believed in the more humane treatment of the mentally ill, his approach toward them came to be known as "moral treatment". See Nicholas L (ed) *Introduction to psychology* (2008) 184.

<sup>260</sup> (1745-1826.) Philippe Pinel made notable contributions to the classification of mental disorders (for example, mania, melancholia, idiocy and dementia) and has been described by some as "the father of modern psychiatry". While working at *Bicêtre*, Pinel did away with bleeding, purging, and blistering in favour of a therapy that involved close contact with and careful observation of patients. He visited each patient, often several times a day, and took careful clinical notes over a time period of two years. His objective was to assemble a detailed case history of the patient's illness. In 1795, Pinel became chief physician of the *Hospice de la Salpêtrière* (with 7000 elderly indigent and ailing women). He created an inoculation clinic in his service at the *Salpêtrière* in 1799 and the first vaccination in Paris was given there in April 1800. A statue in his honour stands outside the *Salpêtrière*. Pinel called his regiment the "moral treatment of insanity". See Colp in Kaplan & Sadock (eds) 3304; Riese W "Philippe Pinel (1745-1826): His views on human nature and disease – his medical thought" 1951 114 *J Nervous & Mental disease* 1: 313; Nicholas 184.

Despite all the cruel treatments mentioned above, the eighteenth century was also the century of the development of psychotherapy.<sup>261</sup> Freud's<sup>262</sup> interest in neuroanatomy led to his discovery that many "nervous diseases" had a psychological rather than organic origin. He showed that mental illness may result from psychoneuroses and develop this special therapeutic approach called psychoanalysis.<sup>263</sup> Many writers<sup>264</sup> also recommended psychotherapy not only as a treatment for mental illnesses but also as a treatment for ordinary physical complaints.<sup>265</sup> It was discovered that psychotherapy was more effective than the usual methods of purgation and blood-letting.<sup>266</sup> Freud's work with Breuer<sup>267</sup> alerted them to the possible link between childhood experiences and neurotic symptoms. Freud and Breuer jointly published *Studies in Hysteria* in 1895, which is considered the birth year of psychoanalysis. In addition, Freud's theories, together with the theories of Jung,<sup>268</sup> influenced different schools of psychiatry, but, more important, they influenced each other during intellectually formative years of their lives.<sup>269</sup>

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<sup>261</sup> See the definition of psychotherapy *supra*.

<sup>262</sup> Sigmund Freud (born Sigismund Shlomo Freud, 1856-1939) was an Austrian psychiatrist, although born in Freiberg, Czechoslovakia, who founded the psychoanalytic school of psychology. See Rice (1990) 1, 18. See also Lewis HB *Freud and modern psychology: Volume 1: The emotional basis of mental illness* (1981) 201-228.

<sup>263</sup> Nicholas 2.

<sup>264</sup> See, for example, (to name only a few), Scheidemantel FCG *Die Leidenschaften als Heilmittel betrachtet* (1787); Falconer W *A dissertation on the influence of the passions upon disorders of the body: Being the essay to which the Fothergillian Medal was adjudged* (1788); Pinel P *A treatise on insanity in which are contained the principles of a new and more practical nosology of manical disorders* ((trans) Davis DD) (1806).

<sup>265</sup> Ackerknecht *History of psychiatry* 38.

<sup>266</sup> *Ibid.*

<sup>267</sup> (1842-1925.) Josef Breuer was born in Vienna, where his father was a well-known teacher and author of Jewish thought. Breuer adopted the views of modern or liberal Judaism and decided to follow a career in medicine where he engaged in a series of experimental biological studies. He devoted his primary efforts to his clinical practice. He helped Freud financially in his early years and, most importantly, whetted his curiosity about hysteria and hypnosis (a trance-like altered state of consciousness) in discussing a young patient (later to become famous under the pseudonym of *Anna O*). As described to Freud, the case of *Anna O* was a classical example of hysteria that followed a period when the young woman had nursed her father through a major illness. See Millon *et al* 255. For further reading see Hirschmüller A *The life and work of Josef Breuer: Physiology and psychoanalysis* (1990) 1ff; Ludy TB *A brief history of modern psychology* (2007) 116-122; Strachey J & Strachey A (eds & trans's) *Studies on hysteria: Josef Breuer and Sigmund Freud* (1991) 7ff.

<sup>268</sup> (1875-1961.) Carl Gustav Jung was a Swiss psychiatrist who gained recognition for his work on using the word-association technique in the psychological diagnosis of guilt. He was also the founder of analytical psychology. He worked as a doctor under the psychiatrist Eugen Bleuler in the *Burghölzli* and became familiar with Freud's idea of the unconscious through Freud's publication *The Interpretation of Dreams* (1900) and was a proponent of the "new psychoanalysis". At the time, Freud needed collaborators and pupils to validate and spread his ideas. The *Burghölzli* was a renowned psychiatric clinic in Zürich at which Jung was an up-and-coming young doctor whose research had already given him a worldwide reputation. See King DB & Wertheimer M *Max Wertheimer and gestalt theory* (2007) 66ff; Cambray J & Carter L (eds) *Analytical psychology: Contemporary perspectives in Jungian analysis* (2004) 1-5, 56-115.

<sup>269</sup> Papadopoulos RK (ed) *Carl Gustav Jung: Critical assessments* (1992) 172ff. See also Roazen P *The trauma of Freud: Controversies in psychoanalysis* (2002) 15ff.

By the end of the eighteenth century and into the nineteenth century, clinicians were attempting to treat the psychological basis of abnormal behaviour. For example, Charcot<sup>270</sup> used hypnosis<sup>271</sup> as a treatment method to cure hysteria and other mental illnesses. Breuer also treated hysterical patients with the use of hypnotherapy.<sup>272</sup> His method of treatment became known as "the cathartic method", in which the patient was encouraged to reveal and discuss the painful origins of a psychological problem as a means of purging the problem from the patient's mental life.<sup>273</sup> An unrecognised form of hypnosis was practised by Mesmer<sup>274</sup> who successfully treated hysteria and many other illnesses by putting patients in a trance and invoking the healing powers of an invisible and impalpable fluid that he called "animal magnetism".

Of further importance was the work of Von Krafft-Ebing,<sup>275</sup> who developed an increasingly complex system for the categorisation of what he considered to be psychosexual disorders. His landmark study

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<sup>270</sup> (1825-1893.) Jean-Martin Charcot was a French neurologist and professor of anatomical pathology. He is known as "the founder of modern neurology" and is "associated with at least 15 medical eponyms", including Charcot-Marie-Tooth disease and amyotrophic lateral sclerosis. His work greatly influenced the developing fields of neurology and psychology. He was the "foremost neurologist of late nineteenth-century France" and has been called "the Napoleon of the neuroses". Among Charcot's students were Binet, Janet and Freud. They were impressed with Charcot and went on to use hypnosis in their own way, but disagreed with their teacher that it was a neurological phenomenon. They considered the hypnotic state a psychological one. See Finger S *Origins of neuroscience* (1994) 225, 262ff. For a further discussion of Charcot's work, see Hartz A (trans) *Invention of hysteria: Charcot and the photographic iconography of the Salpêtrière* (2004) 3ff; Sahakian WS *History of psychology: A source book in systematic psychology* (1968) 313ff.

<sup>271</sup> Hypnosis refers to alterations in sensations, perceptions, thoughts, feelings or behaviour brought about by suggestion, often interpreted as a trance-like altered state of consciousness. It is characterised by heightened suggestibility, associated with such phenomena as suggested. Cf the terms "hypnotism", "mesmerism", "susceptibility", "neodissociation theory" and "hidden observer". See Colman "hypnosis" 356.

<sup>272</sup> Hypnotherapy is a form of psychotherapy in which hypnosis is used – sometimes with the aim of recovering repressed memories. See Colman "hypnotherapy" 356.

<sup>273</sup> Sternberg (2001) 546.

<sup>274</sup> (1734-1815.) Franz Anton Mesmer was an Austrian physician who discovered that he could relieve medical and psychological symptoms in his patients by passing magnets over their bodies. He believed that the fluids in the body were magnetised and that many mental illnesses were caused by a misalignment of these fluids. See Ludy 9. See also Silverberg A *Scientists and scoundrels: A book of hoaxes* (2007) 16-33.

<sup>275</sup> (1840-1902.) Richard von Krafft-Ebing, an Austrian-German psychiatrist and sexologist, worked as a professor of psychiatry in Vienna. He was one of the first scientific investigators to take a special professional interest in the sexual impulses of individuals. He believed that the purpose of sexual desire was procreation, and that any form of desire that didn't go towards that ultimate goal was a perversion. Rape, for instance, was an aberrant act, but not a perversion, because pregnancy could result. He saw women as basically sexually passive, and recorded no female sadists or fetishists in his case studies. Behaviour that would be classified as masochism in men was categorised in women as "sexual bondage", which, because it did not interfere with procreation, was not a perversion. See Stryker S & Whittle S *The transgender studies reader* (2006) 21. For further reading on this topic, see Von Krafft-Ebing R ((trans) Klaf FS) *Psychopathia Sexualis: With especial reference to the antipathic sexual instinct; a medico-forensic study* (1998) 1ff; Libbrecht K *Hysterical psychosis: A historical survey* (1995) 35ff; Oosterhuis H *Stepchildren of nature: Krafft-Ebing, psychiatry, and the making of sexual identity* (2000) 97ff.

*Psychopathia Sexualis* has been in print in various revised editions ever since its first publication in 1877. The text undertakes a vast project, attempting to distinguish and classify specific features of the various case studies he offers for consideration. Underlying this entire project is his assumption that any departure from proactive heterosexual intercourse represents a form of emotional or physical disease.<sup>276</sup>

The beginning of a "modern" classification of psychiatry begins with the contributions of Bleuler<sup>277</sup> and Kraepelin.<sup>278</sup> In 1896, Kraepelin, made his important differentiation between the manic-depressive psychoses and dementia praecox. The latter term was used, more or less, for some time thereafter. In 1911, Bleuler, introduced the term schizophrenia to designate all cases of functional, mental disturbance with the exception of the typical manic-depressive psychoses. He suggested that all other psychoses could be classed as a splitting of the personality. "Schizo" means "to split" and "phrenia" refers to mind. Therefore, schizophrenia literally means "splitting of the mind." Kraepelin described three distinct types of dementia praecox which he termed hebephrenic, catatonic, and paranoid. He later added a fourth type which he called simplex, or simple.<sup>279</sup>

### 2.4.3 The development of shock therapy

#### 2.4.3.1 Background

The attempt to shock persons out of derangement is also an ancient concept and therapists utilised whatever materials were available and reasonable for treatment methods. Consequently, the mental patient

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<sup>276</sup> Stryker & Whittle 21.

<sup>277</sup> (1857-1939.) Paul Eugen Bleuler was a Swiss psychiatrist most notable for his contributions to the understanding of mental illness and for coining the terms "schizophrenia" (24 April 1908), "ambivalence" and "autism". In the 1890s Bleuler became interested in Freud's work, favourably reviewing Breuer and Freud's *Studies on Hysteria*. Like Freud, Bleuler believed that complex mental processes could be unconscious. He encouraged his staff at the *Burghölzli* to study unconscious and psychotic mental phenomena. Firman J & Gila A *Psychosynthesis: A psychology of the spirit* (2002) 9-10. See also Kuhn R ((trans) Cahn CH) "Eugen Bleuler's concepts of psychopathology" 2004 15 *Hist Psychiatry* 3: 361-366; Falzeder E "The story of an ambivalent relationship: Sigmund Freud and Eugen Bleuler" 2007 52 *J Anal Psychology* 3: 343-368.

<sup>278</sup> (1856-1926.) In 1883, Emil Kraepelin, a noted German psychiatrist, published a list of mental disorders that was adopted worldwide. His system of classification was based on causation, the degree of involvement of the brain and nervous system, as well as symptoms and their treatment. He studied the symptoms and clinical life histories of thousands of psychotic patients. He was identified as the founder of contemporary scientific psychiatry, as well as of psychopharmacology and psychiatric genetics. Kraepelin believed that the chief origin of psychiatric disease was biological and genetic malfunction. See Nicholas 184; Colp in Kaplan & Sadock (eds) 3305. See also Jaspers K ((trans's) Hoenig J & Hamilton MW) *General psychopathology: Volume 11* (1997) 852ff; Kraepelin E *Manic-depressive insanity and paranoia* (1921) 1ff; Smith S *Ideas of great psychologists* (1983) 1ff. For a clinical/medical explanation of dementia praecox and schizophrenia, see chapter 3 of this study.

<sup>279</sup> Mahoney RF & Kell FJ "Case study: Dementia Praecox" 1936 36 *Am J of Nurs* 10: 1051-1054.

has been lowered into icy pools, tossed into snake pits and injected with convulsion-producing chemicals, to mention but a few of the remedies based on the premise that an individual might be frightened back into his wits and - as history records - some were.<sup>280</sup> The old treatment by "ducking" was supplemented by the so-called "Darwin chair" in which the insane were rotated until blood oozed from their mouths, ears and noses. For years most successful cures were reported as a result of its use. Castration and starvation cures were also employed. Old drugs such as datura and camphor were introduced once more and the newly discovered drug, digitalis, was used in large quantities to treat cases of insanity as well as all other types of disease.<sup>281</sup>

#### 2.4.3.2 *The development of electro-shock therapy<sup>282</sup> by Cerletti and Bini<sup>283</sup>*

The first electroconvulsive therapy<sup>284</sup> machine was constructed by Bini, together with electrical engineers at the Rome clinic. It had two circuits – a direct one for measuring the resistance of the patient's head in ohms and an altering current circuit to elicit the convulsion. The latter circuit included a timer which measured one-tenth of a second interval up to one minute. It was possible to vary the voltage from 50-150 volts.<sup>285</sup>

The story of the first electro-shock treatment<sup>286</sup> is well known, but worth repeating here. The first patient was found wandering in a railway goods yard in Rome and was taken straight to the Rome clinic. Because he could not speak or give an account of himself, he was chosen as the first subject for electro-shock therapy. Two electrodes, well wetted in a salt solution, were applied by elastic and to the patient's temples.

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<sup>280</sup> Maloney EM "The fears and feelings of the patient on electroconvulsive therapy" 1958 58 *Am J of Nurs* 4: 560.

<sup>281</sup> Ackerknecht *History of psychiatry* 38.

<sup>282</sup> In 1938 Cerletti became interested in pigs that were prepared for slaughter by being electrically shocked through their temples. This rendered them unconscious but did not kill them – indeed, they could survive the shock if allowed to recover. He found, by experimenting on his mentally ill patients, that such electric shocks caused that they (the obsessive and difficult mental patients) became more manageable. Large quantities of insulin can also chemically shock patients into a coma that lasts up to almost an hour and was also starting to be used on them. Other physicians quickly adopted these new therapies. See Thompson C (ed) *The origins of modern psychiatry* (1987) 265. See also Impastato DJ "The story of the first electro shock treatment" 1960 116 *Am J Psychiatry* 1113-1114.

<sup>283</sup> (1877-1963.) Ugo Cerletti (an Italian neuropathologist and psychiatrist) and Lucino Bini (an excellent Italian clinician and Cerletti's assistant (born 1908)) invented electro-shock therapy and treated schizophrenic patients with applications of electricity. See Kneeland TW & Warren CAB *Pushbutton psychiatry: A history of electroshock in America* (2002) 48ff.

<sup>284</sup> Electroconvulsive therapy is defined as a treatment for some forms of depression and other mental disorders by administering an anaesthetic and a muscle relaxant drug and then passing an electric current through the brain to induce either convulsions or coma. Its mode of action is controversial and poorly understood. It is also called electric shock therapy; electroconvulsive shock; or shock therapy. See Colman "electroconvulsive therapy" 244.

<sup>285</sup> Thompson (ed) 265.

<sup>286</sup> Cf the first electro shock treatments by the Hungarian psychiatrist Ladislav Meduna (1896-1964) and by the Viennese physician Manfred Sakel (1900-1957). See Colp in Kaplan & Sadock (eds) 3305.

The first stimulus was of 70 volts for 0.2 seconds of a second. This produced a sudden jump of the patient on the bed and a short period of tensing of his muscles, before the patient immediately collapsed on the bed, but remained conscious. Cerletti reported that the patient went on to have eleven complete treatments and three incomplete ones over a period of about two months and was discharged from his clinic in complete remission.<sup>287</sup> Electro shock therapy was found to be most effective in treating mood disorders and today modified forms of electro shock therapy are still used to treat mood disorders.<sup>288</sup>

## 2.5 CONCLUSION

It is clear from the discussion above that history strongly links medicine, psychiatry and psychology. This history has had a long evolution, as had other branches of medicine. Psychiatry and psychology are disciplines concerned with the healing of the psyche, but ignorance of pathology and psychopathology had led to unclear differentiation of psychic and somatic syndromes – particularly when the latter have given rise to states not always easy to differentiate from psychic states, for example, the excitement of delirium and the agitation of acute anxiety. Hippocrates<sup>289</sup> made this essential mistake in seeing insanity and emotional illness as both arising from the brain and affected by the equilibrium of the humours. This confusion is as well marked today in medicine as it was in antiquity. During the Middle Ages it was still believed that mentally ill patients were possessed by the devil or demons. They were considered to be spiritually rather than physically ill. It was suggested only during the Renaissance period that mental illnesses were diseases rather than forms of possession and bewitchment. Throughout history the legal care of the insane has also been influenced by the legal enactments of the past.

In South Africa, institutions for mentally ill people served more to remove these patients from society and to contain them in a secure environment rather than providing them with medical care. This strictly custodial

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<sup>287</sup> Thompson (ed) 266.

<sup>288</sup> Weiner D *The practice of electroconvulsive therapy: Recommendations for treatment, training, and privileging* (2001) 1, 5ff; Dukakis LT *Shock: The healing power of electroconvulsive therapy* (2006) 1ff. Cf the treatment of mentally ill patients by the use of lobotomies under the influence of two neurologists: Egas Moniz (1874-1955) and Walter Freeman (1895-1972). Lobotomies are defined as the surgical severing of one or more nerve fibres in the frontal lobe of the brain as a method of treating intractable mental disorders. It is more correctly called a frontal lobotomy or frontal leucotomy. (The term derives from the Greek words *lobos* (a lobe) + *tome* (a cut)). Some patients improved, but others suffered severe and irreversible personality deterioration. With the advent of psychotropic drugs, the use of lobotomies declined markedly. See Colman "lobotomy" 426; Scott T *America fooled: The truth about antidepressants, antipsychotics, and how we've been deceived* (2006) 264ff; El-Hai J *The lobotomist: A maverick medical genius and his tragic quest to rid the world of mental illness* (2005) 1ff.

<sup>349</sup> See the discussion of Hippocrates's methods above.

function was possibly employed as there was no effective treatment for serious mental illnesses at the time when Jan van Riebeeck arrived at the Cape.<sup>290</sup> However, over the past 30 years there has been a move away from institutionally based psychiatry towards community care in the developed world. Psychiatric services have also become more integrated with other health services. Unfortunately, progress in South Africa has been slow. While the major urban areas are relatively well developed, vast areas are still underdeveloped and poorly resourced. A primary healthcare system will be the appropriate way to provide a service of high standard for individuals with mental health problems. There are, therefore still important challenges facing psychiatry and psychology in South Africa. According to Baumann,<sup>291</sup> these challenges create the opportunity to develop models of care and service delivery that are more just, effective and appropriate to the Southern African context.

A fundamental question that arises from this chapter is: Does the history of psychiatry and psychology suggest any means by which we can make progress in future? This research emphasises the message as would the history of any subject. Advance depends on knowledge, knowledge depends on careful observation, observation leads to worthwhile theories and theories need to be proved by systematic enquiry. But the fact remains that when making cross comparisons between regions of the world, the reader must be struck by the fact that so many views and practices are held in common.<sup>292</sup> The most common explanation for these similarities are that conquering people carry their traditions with them and even impose them on the conquered, particularly if they improve on the native practice, and therefore the happiest thought for the present generation of psychiatrists and psychologists is the extent of the undiscovered – their age is yet to come.<sup>293</sup>

A legal study of the psychiatric and psychology professions requires an understanding of the legal and ethical issues and challenges associated with it. Before discussing these legal and ethical issues and challenges facing psychiatry and psychology, the next chapter provides a clinical overview of what psychiatry and psychology entail, which serves as a background to the discussion of these issues in the following chapters.

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<sup>290</sup> Baumann (ed) *Primary Health Care Psychiatry: A Practical Guide for Southern Africa* (2007) 41.

<sup>291</sup> *Idem* 45.

<sup>292</sup> Howells JG (ed) *World history of psychiatry* (1975) xvii-xviii.

<sup>293</sup> As Shakespeare said: "Things won are done: joy's soul lies in the doing." See *Troilus and Cressida*, I, ii, 313.

## CHAPTER 3

### MEDICO-LEGAL AND CLINICAL ASPECTS OF PSYCHIATRY AND PSYCHOLOGY

"It is with disease of the mind, as with those of the body; we are half dead before we understand our disorder, and half cured when we do."<sup>1</sup>

#### 3.1 INTRODUCTION

Mental or psychiatric illness is a vast subject, however, one which is of great importance in legal matters, particularly those with regard to medical law, criminal law and the law of delict.<sup>2</sup> The various conditions range from a mild anxiety state<sup>3</sup> to which we are all prone - the full blown-picture of insanity. Compartmentalising of mental illness is difficult but can be explained under the headings of anxiety disorders; psychoneurosis<sup>4</sup> and psychosis,<sup>5</sup> which is divided into functional psychosis (including bipolar disorder and schizophrenia<sup>6</sup>) and the organic types of psychosis. In addition to frank psychiatric illness, one must also consider personality disorders, for example antisocial personality disorder.<sup>7</sup> These disorders are disorders of the mind that interfere substantially with a person's ability to cope with life on a daily basis, which becomes clear in the discussion below. As previously mentioned, mental illness has a history as long

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<sup>1</sup> Colton CC as quoted in *Ethics in psychology and mental health professions: Standards and cases* ((eds) Koocher G & Keith-Spiegel P) (2008) 115.

<sup>2</sup> For a discussion of mental illness in the criminal law context, see chapter 5.

<sup>3</sup> Anxiety is a state of uneasiness, accompanied by dysphoria (a feeling of uneasiness, discomfort, anxiety or anguish) and somatic signs and symptoms of tension, focused on apprehension of possible failure, misfortune, or danger. Cf also "anxiety disorders", which are a class of mental disorders in which anxiety features prominently. See Colman AM *Oxford dictionary of psychology* (2006) "anxiety"; "anxiety disorders" 46; "dysphoria" 233.

<sup>4</sup> Psychoneurosis is a mild or moderately severe emotional disorder. It is sometimes simply called neurosis. The patient is able to lead a fairly normal life, but often suffers from feelings of depression, anxiety or inadequacy. Everyone experiences some symptoms of neurosis, particularly when under a strain. A neurotic person experiences these uncontrollable feelings frequently when there is no apparent cause. Neurosis is defined as an emotional or mental disorder accompanied by obsessional behaviour. Obsessions include excessive anger, anxiety or jealousy, or a phobia (an unreasoned fear of hatred such as agoraphobia), or an excessive fear of open spaces. See Reader's Digest Home Doctor Library *Illustrated family medical encyclopaedia* (1977) "psychoneurosis" 279; "neurosis" 238.

<sup>5</sup> Psychosis is defined as a severe mental disorder of organic or functional origin characterised by gross impairment in reality testing. The individual incorrectly evaluates the accuracy of his perceptions and thoughts and makes incorrect inferences about external reality, even in the face of contrary evidence. Specific symptoms indicative of psychosis are delusions, hallucinations, markedly incoherent speech, disorientation and confusion. Psychotic individuals have little or no insight into their symptoms and are so impaired that they cannot meet the usual demands of life. See Goldenson RM *Longman dictionary of psychology and psychiatry* (1984) "psychosis" 607.

<sup>6</sup> See the discussion of bipolar disorder (also known as manic-depressive disorder) and schizophrenia below.

<sup>7</sup> Mason JK & McCall-Smith RA *Butterworths Medico-legal encyclopaedia* (1987) 447. See the discussion of personality disorders below.

as history exists. It also has a history of misunderstanding, stigma and discrimination, all of which are still significantly present even in well educated societies and all of which can be reduced by research, information and education.<sup>8</sup>

Fortunately the twentieth century brought with it the development of amazing advances and achievements in research, technology, medicine, neurosciences, psychiatry and psychology. By the mid-century, psychiatry and psychology was in full swing and literally hundreds of psychotherapeutic methods evolved. The 1950's saw the introduction of the first reference manual to assist physicians in diagnosing mental illness. It was also the beginning of the clinical application of psychotropic drugs for the treatment of mental illness.<sup>9</sup> Scientific research still continues its search for causes and cures for mental illness, legal acts are proposed by supporters to deal with the many issues surrounding it as well as the issues surrounding moral and ethical debates pertaining to treatment and mistreatment of those diagnosed with mental illness worldwide.<sup>10</sup>

The aim of this chapter is to provide a basic, condensed, general overview of the psychiatric and psychology professions; the concepts of psychotherapy and psychoanalysis and an explanation of the concepts of mental or psychiatric illness, mental disorder and disease of mind. Furthermore it provides a discussion of the diagnosis and classification of diseases in a clinical and forensic context as well as the biological approaches to therapy. In addition, aspects pertaining to forensic psychiatry and psychology are discussed. Aspects regarding the mentally ill offender are also included. A background study of these clinical aspects of psychiatry and psychology is required to ensure clarification and exposition of the constitutional, medico-legal, liability and ethical issues surrounding the complex nature of this topic, which are dealt with in the following chapters.

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<sup>8</sup> Thompson ML *Mental illness* (2007) ix, xi.

<sup>9</sup> Although much excitement was felt with the advent of psychotropic medication, it is by no means the final answer for all mental health problems. Drugs cannot repair all behavioural, physical and social symptoms of mental illness. However, appropriate medication in addition to other therapy will often allow the patient who suffers from mental illness to live a productive and meaningful life. See the definition and discussion of psychotropic drugs below. See also Barry PD & Farmer S *Mental health and mental illness* (2002) 419; Keltner NL & Folks DG *Psychotropic drugs* (2005) 6.

<sup>10</sup> Thompson xiv.

## 3.2 THE FOUR "PSYCHS": PSYCHIATRY, PSYCHOLOGY, PSYCHOTHERAPY AND PSYCHOANALYSIS

### 3.2.1 Introductory remarks

All four of the above terms describe different approaches to understand and help individuals with psychological and emotional (mental) problems. There is a lot of overlap between these terms and sometimes the work done by the same highly qualified therapist can be described by several of these terms. It is therefore not surprising that people confuse them. Each of these terms are described in the paragraphs below in order to find a clear understanding and clarification of what psychology, psychiatry and its subsequent healing practices entail.<sup>11</sup>

### 3.2.2 Psychiatry

#### 3.2.2.1 *Psychiatry in general*

Psychiatry is defined as: "The branch of medicine [medical specialty] devoted to the diagnosis, classification, treatment, and prevention of mental disorders."<sup>12</sup> After completing the medical undergraduate degree (usually a MB Ch.B/MB B. Ch.) the aspiring psychiatrist has to complete a one-year internship in a general hospital. After at least two years of further general practice the doctor enters into a four-year registrar training programme under the auspices of an academic department of psychiatry, while working full time in a state psychiatric hospital. The registrar works during the course of the four years in six-month rotations in various specialised areas of psychiatry, such as acute and emerge psychiatry, child and adolescent psychiatry, old age psychiatry, neuropsychiatry, psychotherapy units as well as liaison and consultation for the medically ill.<sup>13</sup> Psychiatrists are further required to register with the Health Professions Council of South Africa. According to section 17 of the Health Professions Act:

**Registration a prerequisite for practicing:**

- 17 (1) No person shall be entitled to practice within the Republic -  
(a) the profession of a medical practitioner, dentist, psychologist or as an intern or an intern psychologist or any profession registrable in terms of this Act;<sup>14</sup> or

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<sup>11</sup> Burns T *Psychiatry: A very short introduction* (2006) 2.

<sup>12</sup> Colman "psychiatry" 614.

<sup>13</sup> The training psychiatrist further has to write examinations that are administered in two parts: One for basis neurosciences and psychology and two for neurology and clinical psychiatry. The universities offer a degree (M.Med.), and the College of Psychiatry a fellowship (FCPsych(SA)) to successful candidates. See Kaliski S "Appendix: Mental health care practitioners: The psychiatrist" in *Psycholegal assessment in South Africa* ((ed) Kaliski S) (2006) 377.

<sup>14</sup> [Par (a) substituted by s 2 of Act 33 of 1976 and by s 15 (a) of Act 89 of 1997.]

- (b) except in so far as it is authorized by the provisions of the Nursing Act, 1978 (Act 50 of 1978), the Chiropractors, Homeopaths and Allied Health Service Professions Act, 1982 (Act 63 of 1982), the Pharmacy Act, 1974 (Act 53 of 1974), and sections 33, 34 and 39 of this Act, for gain any other profession the practice of which mainly consists of -
- (i) the physical or mental examination of persons;
  - (ii) the diagnosis, treatment or prevention of physical or mental defects, illnesses or deficiencies in man;
  - (iii) the giving of advice in regard to such defects, illnesses or deficiencies; or
  - (iv) the prescribing or providing of medicine in connection with such defects, illnesses or deficiencies,<sup>[15]</sup> unless he is registered in terms of this Act.
- (2) Every person desiring to be registered in terms of this Act shall apply to the registrar and shall submit the qualification which, in his or her submission, entitles him or her to registration, together with such proof of identity and good character and of the authenticity and validity of the qualifications submitted as may be required by the professional board concerned.<sup>[16]</sup>
- (3) If the registrar is satisfied that the qualification and the other documents submitted in support of the application satisfy the requirements of this Act, he shall, upon payment by the applicant of the prescribed registration fee, issue a registration certificate authorizing the applicant, subject to the provisions of this Act or of any other law, to practice the profession in respect whereof he has applied for registration, within the Republic.<sup>[17]</sup>
- (4) If the registrar is not satisfied that the qualification or other documents submitted in support of the application satisfy the requirements of this Act, he or she shall refuse to issue a registration certificate to the applicant, but shall, if so required by the applicant, submit the application to the professional board concerned for decision.<sup>[18]</sup>

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<sup>15</sup> [Par (b) amended by s 8 of Act 58 of 1992 and by s 15 (b) of Act 89 of 1997.]

<sup>16</sup> [Ss (2) substituted by s 15 (c) of Act 89 of 1997.]

<sup>17</sup> [Ss (3) substituted by s 47 (1) of Act 57 of 1975.]

<sup>18</sup> [Ss (4) substituted by s 15 (d) of Act 89 of 1997.] Either the university degree or the fellowship from the College of Psychiatry mentioned above is sufficient for registration with the Health Professions Council as a specialist psychiatrist. Further, according to s 36 of the Health Professions Act (Penalties for practising as a medical practitioner or as an intern, or for performing certain other acts, while unregistered): 36(1) Subject to the provisions of subsections (2) and (3) and section 37 any person, not registered as a medical practitioner or as an intern, who - (a) for gain practises as a medical practitioner (whether or not purporting to be registered); (b) for gain - (i) physically examines any person; (ii) performs any act of diagnosing, treating or preventing any physical defect, illness or deficiency in respect of any person; (iii) advises any person on his physical state; (iv) on the ground of information provided by any person or obtained from him in any manner whatsoever: (aa) Diagnoses such person's physical state; (bb) advises such person on his physical state; (cc) supplies or sells to or prescribes for such person any medicine or treatment; (v) prescribes or provides any medicine, substance or thing; or (vi) performs any other act specially pertaining to the profession of a medical practitioner; (c) except in accordance with the provisions of the Medicines and Related Substances Act, 1965 (Act 101 of 1965), the Pharmacy Act, 1974 (Act 53 of 1974), the Health Act, 1977 (Act 63 of 1977), the Nursing Act, 1978 (Act 50 of 1978), the Chiropractors, Homeopaths and Allied Health Service Professions Act, 1982 (Act 63 of 1982), and sections 33, 34 and 39 of this Act, performs any act whatsoever having as its object - (i) the diagnosing, treating or preventing of any physical defect, illness or deficiency in any person; and (ii) by virtue of the performance of such act, the obtaining, either for himself or for any other person, of any benefit by way of any profit from the sale or disposal of any medicine, foodstuff or substance or by way of any

### 3.2.2.2 *The psychiatrist*

The Mental Health Care Act<sup>19</sup> defines a psychiatrist as a "mental health care practitioner"<sup>20</sup> who has been trained to provide prescribed mental health care, treatment and rehabilitation services and registered as such in terms of the Health Professions Act.<sup>21</sup> Carstens<sup>22</sup> regards this definition as very vague and generic and states that it does not offer a full perspective of the role and function of psychiatrists. In this regard he refers to Kaliski<sup>23</sup> who states that:

Psychiatrists are primarily orientated to assess and treat mental disorders (as described in the DSM-IV), and in the first instance should be consulted to exclude the presence of these disorders, or comment on treatment strategies. Often the psychiatrist will be able to comment on so-called normal behaviour in various contexts, especially as it pertains to the disorders under discussion. Generally psychiatrists use the same methods of examination as other medical specialists (including blood tests, brain scans, cerebro-spinal fluid tests EEGs etc and prefer to use biological treatments (together with psychotherapy). Many psychiatrists have additional expertise in the various psychotherapies (such as psychoanalysis, cognitive

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donation or gift or by way of the provision of accommodation, or the obtaining of, either for himself or for any other person, any other gain whatsoever; [Par (c) amended by s 12 (a) of Act 58 of 1992 and by s 33 (a) (i) of Act 89 of 1997.] (d) pretends, or by any means whatsoever holds himself out, to be a medical practitioner or intern (whether or not purporting to be registered) or a healer, of whatever description, of physical defects, illnesses or deficiencies in man; (e) uses the name of medical practitioner, intern, healer or doctor or any name, title, description or symbol indicating, or calculated to lead persons to infer, that he is the holder of any qualification as a medical practitioner, physician or surgeon, or as an obstetrician or intern or of any other qualification enabling him to diagnose, treat or prevent physical defects, illnesses or deficiencies in man in any manner whatsoever, or that he is registered under this Act as a medical practitioner or an intern; (f) except in accordance with the provisions of the Medicines and Related Substances Act, 1965, the Pharmacy Act, 1974, the Health Act, 1977, the Nursing Act, 1978, the Chiropractors, Homeopaths and Allied Health Service Professions Act, 1982, and sections 33, 34 and 39 of this Act, by words, conduct or demeanour holds himself or herself out to be able, qualified or competent to diagnose, treat or prevent physical defects, illnesses or deficiencies in man or to prescribe or supply any medicine, substance or thing in respect of such defects, illnesses or deficiencies; or [Par (f) substituted by s 12 (b) of Act 58 of 1992 and by s 33 (a) (ii) of Act 89 of 1997.] (g) (i) diagnoses, treats or offers to treat, or prescribes treatment or any cure for, cancer; (ii) holds himself out to be able to treat or cure cancer or to prescribe treatment therefore; or (iii) holds out that any article, compound, medicine or apparatus is or may be of value for the alleviation, curing or treatment of cancer, shall be guilty of an offence and on conviction liable to a fine or to imprisonment for a period not exceeding twelve months or to both such fine and such imprisonment. [ss (1) amended by s 33 (a) (iii) of Act 89 of 1997.] See also s 36(2) – 36(4). "Cancer" includes all neoplasms irrespective of their origin, including lymphoma and leukaemia. See s 36(4) of the Act.

<sup>19</sup> S 1 of the Mental Health Care Act 17 of 2003 (hereafter referred to as the Mental Health Care Act). See also the "General Regulations" in terms of this Act published in GN 27117 in GG R1467, 15 December 2004. See further the "Correction Notice to the General Regulations" published in GN 27236 in GG R8147, 11 February 2005.

<sup>20</sup> See the definition of a mental health care practitioner in chapter 1.

<sup>21</sup> The Health Professions Act 56 of 1974, as amended by Act 29 of 2007 (hereafter referred to as the Health Professions Act). In this Act a psychiatrist falls within the scope of a medical practitioner, which is defined as "a person registered as such under this Act". See s 1.

<sup>22</sup> Carstens PA & Pearmain DL *Foundational principles of South African medical law* (2007) 745.

<sup>23</sup> Kaliski "Appendix: Mental health care practitioners: The psychiatrist" in *Psycholegal assessment in South Africa* 377.

behavioural therapy etc), or in sub-specialities such as child psychiatry. It is always crucial to ascertain each psychiatrist's actual area of expertise.<sup>24</sup>

### 3.2.2.3 Forensic psychiatry

Forensic psychiatry operates at the interface of two disparate disciplines, namely law and psychiatry. Although most cases in forensic psychiatric practice produce little conflict, functioning at the interface of these two disciplines can lead to confusion and ethical dilemmas.<sup>25</sup> Forensic psychiatry can be defined as follows:<sup>26</sup>

Forensic psychiatry is a subspecialty of psychiatry in which scientific and clinical expertise is applied to legal issues in legal contexts embracing civil, criminal, correctional or legislative matters; forensic psychiatry should be practiced in accordance with guidelines and ethical principles enunciated by the profession of psychiatry.<sup>27</sup>

Most forensic psychiatrists do not see themselves as functioning outside of their medical and psychiatric roles. They see themselves (and probably generally are perceived) as utilising their medical and psychiatric skills and techniques.<sup>28</sup> Controversy exists regarding to whom the forensic psychiatrist owes a duty. This problem is part due to the fact that a standard doctor-patient relationship does not apply.<sup>29</sup> Stone<sup>30</sup> believes that psychiatry enters an ethical morass when it leaves the clinical situation as in the case of forensic psychiatry.<sup>31</sup>

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<sup>24</sup> Cf the definitions of psychiatrist: "A medical specialist who treats mental and psychological disorders or illnesses;" see Tredoux *et al* "Glossary of key terms" 411-428 in *Psychology and law* ((eds) Tredoux *et al*) (2005) 424; "a physician who specialises in the diagnosis; treatment, prevention, and study of mental and emotional disorders;" see Goldenson "psychiatrist" 598.

<sup>25</sup> Weinstock R *et al* "Defining forensic psychiatry: Roles and responsibilities" 7-12 in *Principles and practice of forensic psychiatry* ((ed) Rosner R) (1994) 7.

<sup>26</sup> This definition of forensic psychiatry was adopted by the American Board of Forensic Psychiatry (ABFP) and the American Academy of Psychiatry and the Law (AAPL). See Weinstock in *Principles and practice of forensic psychiatry* 7.

<sup>27</sup> Cf Prins, who prefers to use the term "forensic mental health", because it reflects shifts in emphasis in a number of dimensions in the field of psychiatry. According to him there is the increasing recognition that work with mentally ill offenders needs to encompass a very wide range of disciplines if the many and varied needs of this group of individuals are to be met. This trend does not diminish the importance of psychiatry, but serves to recognise the many-faceted elements in the challenges that offenders and offender-patients represent. The term "forensic mental health" would therefore then include, for example, law, management, psychiatry, psychology, social work and probation, as well as pharmacy. See Prins H "Foreword" in *Multidisciplinary working in forensic mental health* (Wix S *et al*) (2005) ix.

<sup>28</sup> Weinstock in *Principles and practice of forensic psychiatry* 9.

<sup>29</sup> For a discussion of the duty of the psychiatrist and the doctor-patient relationship as well as what it entails, see chapters 4 and 6.

<sup>30</sup> Stone AA "The right to treatment - comments on the law and its impact" 1975 132 *Am J Psychiatry* 1125.

<sup>31</sup> For a comprehensive discussion of ethical issues in psychiatry and psychology, see chapter 4.

### 3.2.3 Psychology

#### 3.2.3.1 Psychology in general

Psychology is defined as: "The scientific study of the nature, functions, and phenomena of behaviour<sup>32</sup> and mental experience. The etymology of the word [psychology] implies that it is simply the study of the mind, but much of modern psychology focuses on behaviour rather than the mind, and some aspects of psychology have little to do with the mind."<sup>33</sup> In order to qualify as a psychologist, an individual is required to complete a university undergraduate degree in social sciences with a three-year major in Psychology. Thereafter they have to do a one-year Honours degree, followed by a Masters Degree in Psychology. At the Honours level, students begin to specialise in particular areas, for example, counselling,<sup>34</sup> clinical<sup>35</sup> and educational and industrial psychology.<sup>36</sup> A recent requirement is a one-year community placement before the person can practise as a fully qualified psychologist.<sup>37</sup> Psychologists are (as in the case of psychiatrists) required to register with the Health Professions Council of South Africa.<sup>38</sup>

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<sup>32</sup> The term "behaviour" has a much wider meaning for the psychologist than for the layman. Both use the term to refer to those actions which are overt and directly observable by other people, such as social interaction, speech and motor skills. In addition, most psychologists extend "behaviour" to include also "private" experiences and processes, such as thoughts and emotions. The importance of the term "behaviour" in psychology is that it emphasises *how* the phenomena under consideration should be studied. The main technical problem in psychology is therefore to devise behavioural indices of private experience such as thoughts and feelings. See McPherson FM "Psychology in relation to psychiatry" 30-49 in *Companion to psychiatric studies* (eds) Kendell RE & Zealley AK) (1988) 30.

<sup>33</sup> Many textbooks define psychology simply as the study of behaviour, or the science of behaviour, but that too is to exclude much of psychology: The study of cognition, for example, is concerned with behaviour only indirectly, as evidence of mental processes. See Colman "psychology" 617.

<sup>34</sup> Counselling psychologists assist relatively healthy people in dealing with normal problems of life, concerning all stages and aspects of a person's existence, in order to facilitate desirable psychological adjustment, growth and maturity. See Nicholas LJ "An introduction to psychology" 1-8 in *Introduction to psychology* ((ed) Nicholas LJ) (2008) 8.

<sup>35</sup> Clinical psychology is the branch of psychology, which is the closest to psychiatry. A clinical psychologist often works with a psychiatrist in a mental health clinic, mental hospital or private practice. With the aid of such methods as intelligence tests and personality tests, the clinical psychologist evaluates a person's mental and emotional problems and then helps him or her through counselling. Clinical psychologists further assess, diagnose and intervene in order to alleviate or contain relatively serious forms of psychological distress and dysfunction, particularly psychopathology or "abnormal" behaviour. See Reader's Digest Home Doctor Library "clinical psychology" 279.

<sup>36</sup> The primary role of educational psychologists is to facilitate the healthy development of the child towards adulthood, within the educational contexts of the family, the school and social groups. Industrial psychologists apply the principles of psychology to issues related to the work situation of relatively well-adjusted adults in order to optimise individual, group and organisational well-being and effectiveness. Research psychologists may address any of the mentioned four fields, although not to render services to the public, but to apply research methods and techniques purely in order to contribute to the knowledge base of a particular field. See Nicholas in *Introduction to psychology* 8-9.

<sup>37</sup> Lay S "Appendix: Mental health care practitioners: The clinical psychologist" in *Psycholegal assessment in South Africa* 378.

<sup>38</sup> See s 17 of the Health Professions Act *supra*. Further, according to s 37 of the Health Professions Act (Penalties for practising as a psychologist or as an intern-psychologist, or for performing certain other acts, while unregistered): 37(1) Subject to the provisions of subsections (4) and (6) of this section and section 36, any person, not registered as a psychologist or as an intern-psychologist, who - (a) for gain, practises as a psychologist (whether or not purporting to be

To study psychology (the mind, behaviour and the relationship between them) is to seek to understand how humans and other organisms think, learn, perceive, feel, act, interact with others and even understand themselves. Although people are the predominant focus of psychological theory and research, many psychologists study a broad array of other organisms (from single-celled creatures to mammals). Sometimes, these studies are ends in themselves, and sometimes they are ways to investigate structures and phenomena, which would be impossible, impractical, or unethical to study in humans.<sup>39</sup> Because psychology encompasses both human and social issues as well as biological and physiological ones, psychology is categorised as both a natural and a social science.<sup>40</sup> As a natural science, psychology

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registered); (b) for gain - (i) mentally examines any person; (ii) performs any act of diagnosing, treating or preventing any mental defect, illness or deficiency in respect of any person; (iii) advises any person on his mental state; (iv) on the ground of information provided by any person or obtained from him in any manner whatsoever: (aa) diagnoses such person's mental state; (bb) advises such person on his mental state; (cc) supplies or sells to or prescribes for such person any medicine or treatment; (v) prescribes or provides any medicine, substance or thing; or (vi) performs any other act specially pertaining to the profession of a psychologist; (c) except in accordance with the provisions of the Nursing Act, 1978 (Act 50 of 1978), and sections 33, 34 and 39 of this Act, performs any act whatsoever having as its object - (i) the diagnosing, treating or preventing of any mental defect, illness or deficiency in any person; and (ii) by virtue of the performance of such act, the obtaining, either for himself or for any other person, of any benefit by way of any profit from the sale or disposal of any medicine, foodstuff or substance or by way of any donation or gift or by way of the provision of accommodation, or the obtaining, either for himself or for any other person, of any other gain whatsoever; [Par (c) amended by s 13 (a) of Act 58 of 1992 and by s 34 (a) (i) of Act 89 of 1997.] (d) pretends, or by any means whatsoever holds himself out, to be a psychologist or intern-psychologist (whether or not purporting to be registered) or a healer, of whatever description, of mental defects, illnesses or deficiencies in man; (e) uses the name of psychologist, intern-psychologist or doctor or any name, title, description or symbol indicating, or calculated to lead persons to infer, that he is the holder of any qualification as a psychologist or as an intern-psychologist or of any other qualification enabling him to diagnose, treat or prevent mental defects, illnesses or deficiencies in man in any manner whatsoever, or that he is registered under this Act as a psychologist or as an intern-psychologist; (f) except in accordance with the provisions of the Nursing Act, 1978, and sections 33, 34 and 39 of this Act, by words, conduct or demeanour holds himself out to be able, qualified or competent to diagnose, treat or prevent mental defects, illnesses or deficiencies in man or to prescribe or supply any medicine, substance or thing in respect of such defects, illnesses or deficiencies, [Par (f) substituted by s 13 (b) of Act 58 of 1992 and amended by s 34 (a) (ii) of Act 89 of 1997.] shall be guilty of an offence and on conviction be liable to a fine or to imprisonment for a period not exceeding twelve months, or to both such fine and such imprisonment [ss (1) amended by s 34 (a) (iii) of Act 89 of 1997.] See also s 37(2)-37(6).

<sup>39</sup> For example, the study of animal physiology (such as responses to various kinds of rewards) offers insights into possible analogies in human physiology and behaviour. See Sternberg RJ *Psychology: In search of the human mind* (2001) 3.

<sup>40</sup> Hung-Yul S "The philosophical foundation of natural science and social science" 1981 5 *Soc Science J* 1: 48. For comprehensive discussions of the categorisation of psychology as a natural and social science, see Walker EL *Psychology as a natural and social science* (1970) 1ff; Gray PO *Psychology* (2007) 1ff; Jovchelovitch S *Knowledge in context: Representations, community and culture* (2007) 9-57; Bornstein MH (ed) *Psychology and its allied disciplines: Volume 3: Psychology and its natural sciences* (1984) vii-xiv. Cf also the definition of psychologism: "An exaggeration of the importance or significance of psychology; a belief that psychology is the basis of philosophy or of all natural and social sciences; any unjustified or fanciful psychological explanation for a non-psychological phenomenon, such as drapetomania [a form of mania supposedly affecting slaves in the nineteenth century, manifested by an uncontrollable impulse to wander or run away from their white masters, preventable by regular whipping] or dysaesthesia [a loss of

involves the study of the laws of nature.<sup>41</sup> As a social science, psychology involves the study of the laws of thoughts, feelings and behaviour of humans and other organisms.<sup>42</sup> Some psychologists deal more with the natural-scientific aspects of psychology, studying, for example, the brain and its relations to behaviour. Other psychologists deal more with the social-scientific aspects of psychology, studying, for example, how people interact in groups.<sup>43</sup>

### 3.2.3.2 *The psychologist*

The Mental Health Care Act<sup>44</sup> defines a psychologist as a "mental health care practitioner"<sup>45</sup> who has been trained to provide prescribed mental health care, treatment and rehabilitation services and registered as such in terms of the Health Professions Act.<sup>46</sup> It can also be argued that this definition is very vague and generic and neither does it offer a full perspective of the role and function of psychologists. In this regard Lay<sup>47</sup> states that:

Psychologists are more concerned with the emotional and psychological factors that contribute to mental states. Therefore their treatment modality usually follows one of the forms of psychotherapy/counselling. Psychological assessments generally proceed with interviews that are similar to those used by psychiatrists, with corresponding types of conclusions. Psychologists have additional expertise in being able to administer and interpret psychometric

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feeling, usually experienced as numbness ... often resulting from spinal injury and experienced below the level of the lesion]." See Colman "psychologism" 617; "drapetomania" 226; "dysaesthesia" 231.

<sup>41</sup> Gifford defines natural psychology as: Natural psychology is that branch of environmental psychology in which the scientific study of person-nature transactions is pursued." See Gifford R "Natural psychology: An introduction" 1995 15 *J Environmental Psychology* 3:167. A naturalist will be opposed, for example, to mind-body dualism, since it leaves the mental side of things outside the explanatory grasp of biology or physics; opposed to acceptance of numbers or concepts as real but non-physical denizens of the world; and opposed to accepting real moral duties and rights as absolute and self-standing facets of the natural order. See Blackburn S *Oxford dictionary of philosophy* (2005) "naturalism" 246.

<sup>42</sup> Social psychology is defined as: "The branch of psychology devoted to social behaviour in all its forms, including attitudes, social compliance, conformity, obedience to authority, interpersonal attraction, attribution processes, helping behaviour, and non-verbal communication." See Colman "social psychology" 708.

<sup>43</sup> Sternberg 3-4.

<sup>44</sup> S 1 of the Mental Health Care Act.

<sup>45</sup> See the definition of a "mental health care practitioner" *supra*.

<sup>46</sup> The Health Professions Act defines a psychologist, as well as an "intern-psychologist as "a person registered as such under this act". See s 1. Cf the definition of a psychologist as stipulated in the psychologist's Ethical Code of Professional Conduct: "For the purposes of these regulations [psychologist] means a person registered under the [Health Professions] Act as a psychologist, registered counsellor, psychometrist, psycho-technician, intern in psychology or student in professional psychology." See "Professional Board for Psychology: Rules of conduct pertaining specifically to the profession of psychology" published in GN R717 in GG No 29079, 4 August 2006. See further "Ethical rules of conduct for practitioners registered under the Health professions Act, 1974: Amendment" published in GN 30952 in GG 8873, 8 April 2008.

<sup>47</sup> Lay in *Psycholegal assessment in South Africa* 378.

tests. These consist of predetermined items that are administered in an objective and standardised fashion.<sup>48</sup>

### 3.2.3.3 Forensic psychology

Forensic psychology is the study of the integration of psychology and the law.<sup>49</sup> Adler<sup>50</sup> explains that forensic psychology is a discipline concerned with providing psychological information to people, agencies and systems, involved directly and sometimes indirectly, in the implementation of justice. It can be defined more narrowly as work provided for use by the courts. There are no particular skill requirements that definitely separate a forensic psychologist from any other type of psychologist.<sup>51</sup> Rather, it is the context within which they practice and apply their knowledge that makes it forensic.<sup>52</sup>

### 3.2.4 Psychotherapy and psychoanalysis<sup>53</sup>

According to Bateman<sup>54</sup> psychotherapy is essentially a conversation which involves listening to and talking with those people in trouble with the aim of helping them to understand and resolve their predicament. It is an intervention that uses the principles of psychology to try to treat mental disorders and to improve the life of a person who is unhappy or disturbed. Psychotherapy takes many forms, but common to many of the therapeutic approaches and techniques is the idea that by working on a problem with a trained therapist, one can improve one's life. Psychotherapy can be performed by either psychiatrists or psychologists.<sup>55</sup>

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<sup>48</sup> Cf the definition of psychologist in Tredoux *et al* "Glossary of key terms" in *Psychology and law*: 424 "A professional who deals with diagnosing and treating mental, emotional and behavioural problems."

<sup>49</sup> Lenore E *Introduction to forensic psychology: Clinical and social psychological perspectives* (2004) 3.

<sup>50</sup> Adler JR (ed) *Forensic psychology: Concepts, debates and practice* (2004) 3.

<sup>51</sup> Kaliski "Introduction" 1-7 in *Psycholegal assessment in South Africa* 3.

<sup>52</sup> For a comprehensive discussion of what forensic psychology entails, see Bartol CR *et al* *Introduction to forensic psychology: Research and application* (2008) 1ff; Weiner IB *Handbook of psychology: Forensic psychology* (2003) 1ff; Lenore 1ff.

<sup>53</sup> See also the discussion of psychotherapy and psychoanalysis in chapter 2.

<sup>54</sup> Bateman A *et al* *Introduction to psychotherapy: An outline of psychodynamic principles and practice* (2000) xiii. For further reading on psychotherapy, see Farber BA *et al* "The benefits and risks of patient self-disclosure in the psychotherapy of women with a history of childhood sexual abuse" 2009 46 *Psychotherapy: Theory, Research, Practice, Training* 1: 52-67; Martin D *et al* "The clinical exchange: The girl who cried everyday for three years" 2009 19 *J Psychotherapy Integration* 1: 1-33; Adrienne LB "Affect-focused body psychotherapy in patients with generalized anxiety disorder: Evaluation of an integrative method" 2009 *J Psychotherapy Integration* 19 1: 67-85; Phelan JE "Exploring the use of touch in the psychotherapeutic setting: A phenomenological review" 2009 46 *Psychotherapy: Theory, Research, Practice, Training* 1: 97-111; Dugbartey AT *et al* "Review of boundaries in psychotherapy: Ethical and clinical explorations" 2009 50 *Canadian Psychology* 1: 42-43.

<sup>55</sup> Sternberg 549.

There are several main broad systems of psychotherapy, which includes, but is not limited to:

- Psychoanalysis, which has been highly influential in psychology and many other disciplines. Tredoux<sup>56</sup> states that the most famous and central idea in psychoanalysis is that our behaviour and conscious mental activity is influenced by unconscious processes. Psychoanalysis is a practical discipline and its practitioners use a variety of means, for example free association,<sup>57</sup> dream analysis,<sup>58</sup> transference<sup>59</sup> and defence and resistance analysis<sup>60</sup> to analyse patients. The rationale is to find the source of current problems in a patient's particular developmental history and in the

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<sup>56</sup> Tredoux *et al* "What is psychology?" 1-37 in *Psychology and law* 4. For an interesting discussion of psychoanalysis, see Mollon P *Psychoanalytic energy psychotherapy* (2008) 1ff; Person ES *et al The American psychiatric publishing textbook of psychoanalysis* (2005) 3ff; Frosh S *For and against psychoanalysis* (1997) 3ff.

<sup>57</sup> Free association is defined as a technique of psychoanalysis in which the patient is encouraged to relate to the analyst all thoughts, feelings, wishes, sensations, memories and images that come to mind how even embarrassing or trivial they might seem. It is designed to incapacitate the *second censorship* between the preconscious and consciousness, thereby exposing the unconscious defences operating through the *first censorship* between the unconscious and the preconscious. Freud revealed that he was influenced by the German political writer and satirist Ludwig Börne (originally called Löb Baruch (1786-1838)) who recommended a form of generative writing that begins by putting on paper everything that comes to mind, in order to avoid self-censorship and to increase originality. Some credit for developing the technique should, however be given to Frau Emmy von N, one of Freud's earliest patients who asked him "not to keep on asking her where this or that came from, but to let her tell me what she had to say and when she followed this procedure, her verbal accounts turned out to contain a fairly complete reproduction of the memories and new impression which often leads on, in a quite unexpected way, to pathogenic reminiscences of which she unburdens herself without being asked to." See Freud S *A note on the prehistory of the technique of analysis* (1920) 63; 263-265. At about the same time (independently from Freud), Jung introduced his world-association test and this also influenced the development of the technique of free association. See Colman "free association" 296.

<sup>58</sup> Whether or not a psychotherapist has been trained and supervised in dream analysis, it is likely that some patients will bring up the question of dreams and their place in the psychotherapeutic process. Dreams generally involve strong emotional responses. Whether dreams are analysed by free association, amplification, existential analysis or content analysis, they supply a rich source of information about the structure, dynamics, development and abnormalities of human personality. The visualise that which is invisible and are the kaleidoscope of the mind. See Blau TH *Psychotherapy tradecraft: The technique and style of doing therapy* (1988) 154.

<sup>59</sup> Transference occurs when a patient start relating to the therapist in ways that resemble or mimic critical relationships from his or her past and present. The patient would be unconsciously transferring his or her conflicted feelings and perceptions of a specific person onto the therapist. The therapist's task is to encourage this transference, identify it, explain it to the patient and thereby facilitate the patient's working through of the unconscious conflict. See Nicholas LJ & Bawa U *et al* "Psychotherapy" 204-213 in *Introduction to psychology* 206.

<sup>60</sup> According to Freud's structural theory (that the ego is the organising process itself), an individual's libidinal and aggressive impulses are continuously in conflict with his or her own conscience as well as with the limits imposed by reality. In certain circumstances, these conflicts may lead to neurotic symptoms. The goal of psychoanalytic therapy is to establish a balance between bodily needs, psychological wants, one's own conscience, and social constraints. Ego psychologists argue that the conflict is best addressed by the psychological agency that has the closest relationship to consciousness, unconsciousness, and reality: the ego. The clinical technique most commonly associated with ego psychology is defence analysis (psychological strategies brought into play by various entities to cope with reality and to maintain self-image). Through clarifying, confronting, and interpreting the typical defence mechanisms a patient uses, ego psychologists hope to help the patient gain control over these mechanisms. See Blanck R *Ego psychology II: Psychoanalytic developmental psychology* (1979) 3ff. See also Mitchell A *Freud and beyond: A history of modern psychoanalytic thought* (1995) 1ff.

rupturing of the unconscious into conscious mental life and behaviour. In doing this they attempt to eliminate or reduce the detrimental effects of unconscious processes.<sup>61</sup>

- Psychodynamic counselling<sup>62</sup> works on the premise that in understanding something of the past and its influence upon the present, the path towards change become clearer, if often not much easier to negotiate. Yet the relationship between past and present is rather more complex. Not only may a person be influenced in the present by memories of the past, but memories of the past may be influenced by present experience. Although it has its roots in psychoanalysis, psychodynamic therapy tends to be briefer and less intensive than traditional psychoanalysis.<sup>63</sup>
- Cognitive therapy rests on the assumption that faulty learning of emotional responses or automatic thoughts persists without effective challenge by a person, but responds rapidly to challenge by the therapist.<sup>64</sup> This would seem to suggest that the relationship with the therapist is itself of importance to the treatment, but the theory does not contain an account of this. According to Tantam<sup>65</sup> this is obviously a weakness. The great strength of the theory is that it generates clear explanations, which are consistent with common-sense psychology. Typical interventions are to identify negative automatic thoughts or anxiety-sustaining habitual behaviours, determine counter-evidence or alternative behaviours and practice the latter during exposure to triggers which would normally evoke the former. The goal of cognitive therapy is to alter the patient's cognitive style. Patients are first taught to identify their cognitive errors. Second, the therapist helps clients to develop realistic cognitive evaluations of themselves and their circumstances. Third, the therapist explores the cognitive errors to identify the error assumptions that underlie the patient's negative thinking and cognitive style. To this end, cognitive therapists play an active role in directing the

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<sup>61</sup> Tredoux *et al* "What is psychology?" in *Psychology and law* 4. Cf the definition of psychoanalysis in Colman: "A theory of mental structure and function, consisting of a loosely connected set of principles and propositions, a theory of mental disorders, and an associated method of psychotherapy (the 'talking cure') based on the writings of Sigmund Freud (1856-1939), its distinctive character residing in the emphasis that Freud placed on unconscious mental processes and the various mechanisms people use to repress them. As a therapeutic method, its major techniques are free association, dream analysis, the interpretation of parapraxes (in psychoanalysis, a minor error in speech or action, such as a slip of the tongue or a slip of memory), and the analysis of the transference." See Colman "psychoanalysis" 615. See also the term "psychoanalyst," which is one who practises psychoanalysis. See Colman "psychoanalyst" 615; "parapraxes" 549.

<sup>62</sup> For an in-depth discussion of psychodynamic counselling, see Jacobs M *Psychodynamic counselling in action* (2004) 2ff; Howard S *Psychodynamic counselling in a nutshell* (2006) 8ff; McLoughlin B *Developing psychodynamic counselling* (1995) 3ff.

<sup>63</sup> Jacobs M *The presenting past: The core of psychodynamic counselling and therapy* (2006) 1.

<sup>64</sup> Sternberg 555.

<sup>65</sup> Tantam D "Psychotherapy and traditional healing" 57-72 in *Psychiatry for the developing world* ((eds) Tantam D *et al*) (1996) 60.

therapeutic process. They challenge the patient's thinking and assumptions and actively suggest alternative modes of thinking.<sup>66</sup> Cognitive therapy started as a treatment for depression, but is currently used to treat, for example, obsessive-compulsive personality disorder,<sup>67</sup> other personality disorders<sup>68</sup> and somatoform disorders.<sup>69</sup> Therapy is usually conducted on an individual basis although group methods are sometimes helpful.<sup>70</sup> One of its greatest advantages is that it is focused on symptoms and is time-limited.<sup>71</sup>

- Hypno-psychotherapy is the branch of psychotherapy where hypnosis is used for treatment. Hypnosis is a state of relaxation, which people enter voluntarily during which there occurs an altered state of conscious awareness. The therapist can intervene to draw the patient's attention to new possibilities, to alternate patterns of thought, emotions and behaviour.<sup>72</sup> Nicholas<sup>73</sup> explains that there are three main views of the hypnotherapeutic relationship: The authoritarian approach, the standardised approach and the utilisation approach developed by Erickson.<sup>74</sup> The authoritarian

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<sup>66</sup> Nicholas in *Introduction to psychology* 207-208.

<sup>67</sup> Sufferers from obsessive-compulsive personality disorder tend to be preoccupied with order, perfectionism and mental and interpersonal control at the expense of flexibility and efficiency. This may interfere with task completion. They may be excessively conscientious, find it hard to delegate and they may be overly moral, rigid and stubborn. Such individuals are predisposed to depressive disorders and other anxiety disorders. See Fainman D "Problems associated with personality disorders" 509-523 in *Primary healthcare psychiatry: A practical guide for Southern Africa* (ed) Baumann SE) (2007) 514-515.

<sup>68</sup> Examples of specific personality disorder types are: Paranoid personality disorder; schizoid personality disorder; schizotypal personality disorders; antisocial personality disorder; borderline personality disorder; histrionic personality disorder; narcissistic personality disorder; avoidant personality disorder; dependent personality disorder; and obsessive-compulsive personality disorder. See also the discussion below. See Fainman in *Primary healthcare psychiatry: A practical guide for Southern Africa* 509; Maj M *et al* (eds) *Personality disorders* (2005) 1ff.

<sup>69</sup> Somatoform disorders are those disorders in which bodily sensations or functions, as the patient's predominant focus, are influenced by a disorder of the mind. This clustering was not based on theoretical construct or laboratory findings. In fact, physical and laboratory examinations persistently fail to show significant substantiating data about the patient's complaints, which, nevertheless, are vigorous and sincere. Patients with somatoform disorders are convinced that their suffering comes from some type of presumably undetected and untreated bodily derangement. These complaints are not imaginary and should be attended to. See Sadock BJ & Sadock VA (eds) *Kaplan & Sadock's synopsis of psychiatry: Behavioural sciences/clinical psychiatry* (2007) 634.

<sup>70</sup> The therapy's cognitive approach includes four processes: Eliciting automatic thoughts; testing automatic thoughts; identifying maladaptive underlying assumptions; and testing the validity of maladaptive assumptions. See Sadock & Sadock (eds) 958.

<sup>71</sup> Nicholas in *Introduction to psychology* 208.

<sup>72</sup> United Kingdom Council for Psychotherapy *National register of psychotherapists* (2004) xii.

<sup>73</sup> Nicholas in *Introduction to psychology* 4.

<sup>74</sup> Milton Hyland Erickson (1902-1980) was an American psychiatrist specialising in medical hypnosis and family therapy. He was the founding president of the American Society for Clinical Hypnosis and a fellow of the American Psychiatric Association, the American Psychological Association as well as the American Psychopathological Association. He is well known for his approach to the unconscious mind as creative and solution-generating. He believed that treatment should be specifically construed for each patient, because each patient is unique. He is also known for influencing brief therapy,

approach characterised most of the early use of hypnosis and because it is much favoured by stage hypnotists, it is often the conceptualisation held by the uninformed layperson. Many trained clinicians also adhere to this view, which usually involves some powerful and charismatic operator exercising some strange power over some suggestible subject. It was considered that the operator, through what he or she said and did to the subject, was more important than the inner behavioural processes of the subject. Nicholas states that<sup>75</sup> the authoritarian approach has limited value because direct suggestion does not generally facilitate trance<sup>76</sup> very well. The standardised approach, adhered to by many experimentalists, is partly a reaction to the misplaced emphasis of the authoritarian approach on the power of the hypnotist. This approach assumes that hypnotic responsiveness is determined by some inherent ability of the subject. The hypnotist is not really important because the subject is either hypnotisable or not. The fact that trance is a subjective internal experience, whose behavioural manifestations vary across individuals, is ignored. The utilisation approach, proposed by Erickson, stresses the interactional nature of the hypnotic relationship. This approach assumes that unconscious processes can operate in an intelligent, autonomous and creative manner and those resources stored in the unconscious are all the resources necessary to transform experience. This theory emphasises that every person's particular range of abilities must be surveyed in order to determine which preferred modes of functioning can be evoked and utilised for therapeutic purposes. The hypnotherapist provides fresh ideas and situations to break through the limiting preconceptions that have blocked the client's own problem-solving abilities and to evoke unconscious processes of search and solution that lead clients to resolve the problems in their own way.<sup>77</sup>

- Narcoanalysis is a technique of psychotherapy, induced by narcotic drugs, in which an attempt is made to bring out repressed emotions in a semi-sleep state. It refers to the practice of administering barbiturates (drugs that act as central nervous system depressants and produce a

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strategic family therapy, family systems therapy, solution focused brief therapy, and neurolinguistic programming. See Gorton GE "Milton Hyland Erickson, 1901-1980" 2005 162 *Am J Psychiatry* 7: 1255.

<sup>75</sup> Nicholas in *Introduction to psychology* 4.

<sup>76</sup> "Trance" is defined as an altered state of consciousness shown by a narrowing of awareness of events in the immediate surroundings. It is a suspension of the sense of personal identity and diminution in the range of motor activity and speech. It is characteristic of certain forms of intoxication, some mental disorders and hypnosis. See Colman "trance" 772.

<sup>77</sup> Nicholas in *Introduction to psychology* 4. See also Yapko MD *Trancework: An introduction to the practice of clinical hypnosis* (2003) 6, 61ff; Fromm E & Shor RE (eds) *Hypnosis: Research developments and perspectives* (2007) 43ff; Spiegel D et al *Trance and treatment: Clinical uses of hypnosis* (2004) 3ff.

wide spectrum of effects - from mild sedation to anesthesia)<sup>78</sup> or certain other chemical substances, most often to lower a patient's inhibitions, in the hope that he or she will share information and feelings more freely. While the patient is in this state the therapist can make some suggestions (narcosuggestions) of how to solve the patient's problems. The information obtained during this session can be used for later interpretation (narcosynthesis).<sup>79</sup>

In addition, in South Africa, ritualistic healing in African societies is carried out by a number of different health workers commonly known as traditional healers. This group includes workers such as sangomas, herbalists, and Zionist Christian healers. They use a range of alternative treatments, many of which straddle both the psychosocial and physical realms, for example, a sick person might be encouraged to eat specific herbs, administer an enema, visit the graves of ancestors and organise a feast. Western psychosocial interventions as conducted by doctors, psychiatrists, psychologists, social workers and counsellors involve similarly powerful processes of bringing change, for example developing a new coping strategy in a known stressful situation.<sup>80</sup>

Traditional healing, like psychotherapy, covers many different schools and no single treatment is typical of all of them. Often this treatment includes the use of herbs and religious exercises. Severe problems may be treated by exorcism. The lack of emphasis on diagnosis or patient history, the rather perfunctory and stereotyped nature of the spirit explanation and the complete lack of attention to the actions of the patient leading up to possession are all contrary to other psychotherapeutic methods. According to Tantam<sup>81</sup> it

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<sup>78</sup> Clayton L *Barbiturates and other depressants* (2001) 6ff.

<sup>79</sup> Louw G & Plug M *Psigologie-woordeboek* (1979) "narkoanalise" 195-196. See also

<sup>80</sup> Malcolm C & Berard R "Psychosocial interventions" 429-444 in *Textbook of psychiatry for Southern Africa* ((eds) Robertson B, Allwood C & Gagiano C) (2007) 429. See also the discussion in chapter 2

<sup>81</sup> Tantam D in *Psychiatry for the developing world* 61. See also Meissner O *Traditional medicine and its accommodation in the South African national health care system with special attention to possible statutory regulation* (unpublished LL.D thesis, Unisa, 2003); Robertson BA "Does the evidence support collaboration between psychiatry and traditional healers? Findings from three South African studies" 2006 9 *S Afr Psychiatry Rev* 2: 87-90, where the author proposes that there is a significant lack of information about the contribution of traditional healers in South Africa to mental health, and over recent years conducted three studies designed to fill some of the gaps. The combined data of the studies suggests that, while traditional healers provide a valued mental health service to certain types of clients, they resemble faith based practitioners and counsellors more than medical practitioners. The author concludes that collaboration should be promoted, but further knowledge and debate is needed about the best way for mental health practitioners to collaborate with traditional healers, and on what basis it should be founded. See further Bereda JE *Traditional healing as a health care delivery system in a transcultural society* (unpublished MA dissertation, Unisa, 2002).

seems likely that explanation plays a rather smaller role in traditional healing than it does in other forms of therapy.

The types of psychotherapy described above are but a few of the many forms of treatment developed in the past few decades. Many great other forms of psychotherapy exist, for example, modalities such as gestalt therapy,<sup>82</sup> transactional analysis<sup>83</sup> and rational behaviour emotive therapy.<sup>84</sup> There are also many different schools of thought besides Freudian psychology within psychodynamic psychotherapy.<sup>85</sup> A general survey of all these types of therapy is beyond the scope of a thesis of this nature. Rather, this discussion is meant to indicate some therapies in the range of psychosocial treatments currently in use.

### 3.3 THE CONCEPT OF MENTAL DISORDER / ILLNESS

#### 3.3.1 Mental disorder / mental illness (psychiatric illness)

Mental illness is a disorder (or a disease) of the mind that is judged by experts to interfere substantially with a person's ability to cope with the demands of life on a daily basis. It can profoundly disrupt a person's thinking, feeling, moods and ability to relate to others. Mental illness is manifested in behaviour that deviates notably from normal conduct.<sup>86</sup> The landmark analysis of mental illness by the United States

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<sup>82</sup> "Gestalt" is derived from the German verb *gestalten*, which means "to give form or structure to". Max Wertheimer (1880-1943) founded the School of Gestalt Psychology. It began as the study of the visual perception of motion and developed as a system based on a holistic view of mental and behavioural processes. The strength of the theory derives from experimental investigations verifying the dynamic whole, which could neither be reduced to the sensory elements nor explained as a sum or succession of sensations. Gestalt therapy is an existential and experiential psychotherapy that focuses on the individual's experience in the present moment; the therapist-client relationship; the environmental and social contexts in which these things take place; and the self-regulating adjustments people make as a result of the overall situation. It emphasises personal responsibility and is particularly involved with "contact". See Masquelier G *et al Gestalt therapy: Living creatively today* (2006) 9ff; Nicholas in *Introduction to psychology* 5

<sup>83</sup> Transactional analysis is a theory and a form of psychotherapy, originated by the Canadian-born psychoanalyst Eric Berne (1910-1970). It is primarily aimed at improving interpersonal relations by adjusting the balance between the child, adult and parent ego states that are assumed to coexist within the same personality. See Colman "transactional analysis" 772.

<sup>84</sup> Rational behaviour emotive therapy is a comprehensive, active-directive, philosophically and empirically based psychotherapy, which focuses on resolving emotional and behavioural problems and disturbances advocating unconditional self-acceptance. It also focuses explicitly on reducing secondary problems, such as depression about depression. It enables people to live more fulfilling lives. Rational behaviour emotive therapy was created and developed by the American psychotherapist and psychologist Albert Ellis (1913-2007). See David D & Szentagotai A "Rational emotive behaviour therapy, cognitive therapy and medication in the treatment of major depressive disorder: A randomised clinical trial, post-treatment outcomes and six-month follow-up" 2008 *64 J Clinical Psychology* 6: 730.

<sup>85</sup> See, for example, Jungian, Adlerian and Sullivanian theories and techniques. See Waldinger RJ *Fundamentals of psychiatry* (1986) 392.

<sup>86</sup> Bartol CR *et al Criminal behaviour: A psychosocial approach* (2008) 228-229.

surgeon general states that it is "the term that refers collectively to all diagnosable mental disorders".<sup>87</sup> However, according to Bartol<sup>88</sup> the word "illness" encourages us to look for etiology, symptoms and cures and to rely heavily on the medical profession both to diagnose and to treat. It further encourages us to excuse the behaviour of persons plagued with the "illness". The term mental disorder need not imply that a person is sick, to be pitied, or even necessarily less responsible for his or her actions. Therefore, although the term mental illness (psychiatric illness) is more frequently used in the legal literature, and despite the difference between the technical interpretations of these terms, both are used interchangeably throughout the thesis.<sup>89</sup>

According to the American Psychiatric Association<sup>90</sup> no definition adequately specifies precise boundaries for the concept of "mental disorder". This concept, like many other concepts in medicine and science, lacks a consistent operational definition that covers all situations. Mental disorders have been defined by a variety of concepts, for example, distress, disadvantage, disability, inflexibility, irrationality, and statistical deviation. Each is a useful indicator for a mental disorder, but none is equivalent to the concept and different situations call for different definitions.

Despite the different concepts mentioned above, mental disorder in a clinical context is defined as:<sup>91</sup>

... a clinically significant behavioural or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (for example a painful symptom) or disability (for example impairment in one or more important areas of functioning) or with a

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<sup>87</sup> "Mental Health: Report of the surgeon general" 1999 in *Mental illness* 4.

<sup>88</sup> Bartol *Criminal behaviour: A psychosocial approach* 228-229.

<sup>89</sup> Another term that must be distinguished from mental illness and mental disorder is "mental retardation", professionally known as developmental disability. This is a cognitive deficiency - measured by IQ tests (specifically, IQ below 70), which cannot be cured. It is a syndrome of delayed or disordered brain development evident before age 18 years. It results in difficulty learning information and skills needed to adapt quickly and adequately to environmental changes. See Ainsworth P *et al Understanding mental retardation* (2004) 3.

<sup>90</sup> American Psychiatric Association *Diagnostic and Statistical Manual of Mental Disorders* (1994) xxi.

<sup>91</sup> According to the American Psychiatric Association the term "mental disorder" unfortunately implies a distinction between "mental disorders" and "physical disorders", which is a reductionistic anachronism of mind / body dualism. A compelling literature documents that there is much "physical" in "mental disorders" and much "mental" in "physical disorders". However, the problem raised by the term mental disorder has been much clearer than its solution, and the term will have to persist until an appropriate substitute is found. See American Psychiatric Association *DSM-IV* xxi. Cf the definition of mental disorder according to ICD-10: "a mental disorder is a clinically recognisable collection of symptoms or behaviour associated in most cases with distress or interference with personal functions. A deviant pattern of behaviour, whether political, religious, or sexual, or a conflict between an individual and society, is not a mental disorder unless it is symptomatic of a dysfunction in the individual".

significantly increased risk of suffering death, pain disability, or an important loss of freedom. In addition, this syndrome or pattern must not be merely an expectable and culturally sanctioned response to a particular event, for example, the death of a loved one. Whatever its original cause, it must currently be considered a manifestation of a behavioural, psychological, or biological dysfunction in the individual. Neither deviant behaviour (for example, political, religious, or sexual) nor conflicts that are primarily between the individual and society are mental disorders unless the deviance or conflict is a symptom of a dysfunction in the individual...

Mental illness in a legal context is defined as:<sup>92</sup>

... a positive diagnosis of a mental health related illness in terms of accepted diagnostic criteria made by a mental health practitioner authorised to make such diagnosis.<sup>93</sup>

From a philosophical perspective, it is reasonably clear that there can be chronic mental malfunction when a person's capacities to respond to the world, to absorb and remember information, respond with appropriate emotions and form coherent plans are impaired. What is not so clear is whether the mind can be the self-contained locus of an illness, or whether mental malfunction should always be thought of as the by-product of physical or bodily illness or impairment. If the mind can be the self-contained locus of an illness, then the mind might be cured by mental means, such as conversation with a therapist. If not, the only effective responses would be medical or pharmacological. Therefore the issue of what mental illness is has practical as well as purely philosophical importance.<sup>94</sup>

In addition, the term "disease of mind" is rarely encountered in psychiatric and psychological writing, but is, however, crucial for legal practitioners and has been the subject of considerable judicial analysis, which has been considered largely with determining what particular conditions of impaired consciousness come within the scope of the term as used in the M'Naghten Rules.<sup>95</sup> As a corollary the issue has become important in

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<sup>92</sup> S 1 of the Mental Health Care Act.

<sup>93</sup> See also the definition of "severe or profound intellectual disability": "means a range of intellectual functioning extending from partial self-maintenance under close supervision, together with limited self-protection skills in a controlled environment through limited self care and requiring constant aid and supervision, to severely restricted sensory and motor functioning and requiring nursing care". See s 1 of the Mental Health Care Act.

<sup>94</sup> Blackburn "mental illness" 230. For interesting views of the philosophy of mental illness or health, see Gibson J *et al* (eds) *The literary Wittgenstein* (2004) 267ff; Craig E (ed) *Routledge encyclopedia of philosophy* (1998) 314-316.

<sup>95</sup> The M'Naghten Rules (also spelled McNaughton) were the first serious attempt to codify and rationalise the attitude of criminal law toward a mentally disordered accused. These rules arose from the attempted assassination of the British Prime Minister, Robert Peel, in 1843 by Daniel M'Naghten. M'Naghten shot Minister Peel's secretary, Edward Drummond, who died five days later. The medical evidence was in substance this: That persons of otherwise sound mind, might be affected by morbid delusions: that the prisoner was in that condition: that a person so labouring under a

context of automatism in criminal cases.<sup>96</sup> Two decisions have served to clarify the distinction between a "disease of the mind" and other abnormal mental conditions. In *Rabey v R*,<sup>97</sup> the Canadian Supreme Court adopted the following statement:

[T]he distinction to be drawn is between a malfunctioning of the mind arising from some cause that is primarily internal to the accused, having its source in his psychological or emotional makeup, or in some organic pathology, as opposed to a malfunctioning of the mind which is the transient effect produced by some specific external factor such as, for example, concussion.

In *R v Sullivan*<sup>98</sup> Diplock LJ (House of Lords) ruled that a "disease of the mind" was any disease, which had the effect of so severely impairing the mental faculties as to prevent the accused from knowing that it was wrong. It is unimportant whether the impairment is the result of organic factors (as in epilepsy) or whether it is functional. It is further irrelevant whether it is transient or permanent. Mason and McCall-Smith<sup>99</sup> state that the decision in *Sullivan* confirms that, in English law, epilepsy constitutes a disease of the mind.<sup>100</sup>

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morbid delusion, might have a moral perception of right and wrong, but that in the case of the prisoner it was a delusion which carried him away beyond the power of his own control, and left him no such perception; and that he was not capable of exercising any control over acts which had a connection with his delusion: that it was of the nature of the disease with which the prisoner was affected, to go on gradually until it had reached a climax, when it burst forth with irresistible intensity: that a man might go on for years quietly, though at the same time under its influence, but would all at once break out into the most extravagant and violent paroxysms. Hereafter, the House of Lords instructed a panel of judges, presided over by Sir Nicolas Conyngham Tindal, Chief Justice of the Common Pleas, to set down guidance for juries in considering cases where an accused pleads insanity. The rules formulated as *M'Naghten's Case* 1843 10 C & F 200 have been a standard test for criminal liability in relation to mentally disordered defendants in common law jurisdictions ever since, with some minor adjustments. When the tests set out by the Rules are satisfied, the accused may be adjudged "not guilty by reason of insanity" and the sentence may be a mandatory or discretionary (but usually indeterminate) period of treatment in a secure hospital facility, or otherwise at the discretion of the court (depending on the country and the offence charged) instead of a punitive disposal. The M'Naghten rules are sometimes referred to as the "right and wrong test". See *M'Naghten's Case* 1843 10 C & F 200; Elliott C *The rules of insanity: Moral responsibility and the mentally ill offender* (1996) 10-13; Hall J *General principles of criminal law* (2008) 472ff.

<sup>96</sup> Mason & McCall-Smith 164.

<sup>97</sup> *Rabey v R* (1981) 114 DLR (3d) 193.

<sup>98</sup> *R v Sullivan* [1983] 2 All ER 673 HL.

<sup>99</sup> Mason & McCall-Smith 164-165.

<sup>100</sup> See also *R v Foy* [1960] Qd R 225; *R v O'Brien* (1966) 56 DLR (2d) 65; *R v Kemp* [1956] 3 All ER 249. In *Kemp*, the accused suffered from arteriosclerosis, which interfered with the supply of blood to the brain. It was ruled, as a matter of law, that arteriosclerosis, being capable of affecting the mind, was therefore a disease of the mind in context of the M'Naghten Rules. Cf *R v Quick* where it was held that automatism due to hypoglycaemia in a diabetic was not the result of the underlying disease, but rather, was due to the external factor of injected insulin. The somewhat perverse implication to be derived from *Quick* is that diabetes *per se* is a disease of the mind. See *R v Quick* [1973] 3 All ER 347; [1973] QB 910.

Dissociative states<sup>101</sup> have met with a varied fate in the criminal courts. In *R v Isitt*,<sup>102</sup> the Court of Criminal Appeal did not accept that a state of dissociation might lead to non-insane automatism but did not go so far as to say that hysterical dissociation was a disease of the mind. The Canadian courts have, however, ruled in *R v MacLead*<sup>103</sup> that a dissociative state is a disease of the mind for purposes of the insanity defence. Hysterical dissociation has been accepted as a disease of the mind in Australia in *R v Joyce*<sup>104</sup> and in *R v Williams*.<sup>105</sup> The Royal Commission on Capital Punishment concluded that the definition of the term "disease of the mind" should, in future, exclude *inter alia*, the neurosis<sup>106</sup> and should only be used to describe psychotic disorders.<sup>107</sup>

Contrary to the concepts of mental (psychiatric) illness or disorder or disease of mind, "mental health" again is defined as the successful performance of mental function, resulting in productive activities, fulfilling relationships with other people and the ability to adapt to change and to cope with adversity.<sup>108</sup>

### 3.3.2 Genetic aspects of mental disorders

The proposition that abnormal genes may cause abnormal behaviour still provokes controversy.<sup>109</sup> Some of the antipathy towards psychiatric genetics has stemmed from the mistaken belief that the term "genetic" is equivalent to "untreatable".<sup>110</sup> A more apposite criticism is that much of the familial clustering of behavioural traits could simply be due to the effects of cultural transmissions and shared environments. A further

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<sup>101</sup> Dissociation is an absence of the normal integration of thoughts, emotions, and experiences into the stream of consciousness and memory. It is a frequent symptom of a range of severe psychopathologies, from reactive attachment disorder of infants to dissociative identity disorders, psychotic experiences, borderline personality disorders and post-traumatic stress disorders of adults. A central tenet of a developmental psychoneurobiological perspective is that continuity exists between early traumatic attachment and later severe disorders of personality development. The incidence of abuse in the childhood histories of adults with dissociative disorder is extremely high. When dissociation first occurs, it is usually the result of "psychological shock". See Panzer A & Viljoen M "Dissociation: A developmental psychoneurobiological perspective" 2004 7 *S Afr Psychiatry Rev* 11.

<sup>102</sup> *R v Isitt* (1978) 67 Crim App R 44.

<sup>103</sup> *R v MacLead* (1980) 52 CCC 193.

<sup>104</sup> *R v Joyce* [1970] SASR 184.

<sup>105</sup> *R v Williams* [1973] 1 ACTR 1.

<sup>106</sup> See the definition of neurosis *supra*.

<sup>107</sup> Mason & McCall-Smith 165; Gowers EA (chairman) *Report of the Royal Commission on Capital Punishment* (Cmd 8932) (1953) 131 HMSO, London.

<sup>108</sup> Thompson 4. Cf also the definition of "mental health status": "[M]eans the level of mental well-being of an individual as affected by physical, social and psychological factors and which may result in a psychiatric diagnosis". See s 1 of the Mental Health Care Act.

<sup>109</sup> Murray RM & McGuffin P "Genetic aspects of mental disorders" 161-190 in *Companion to psychiatric studies* 161.

<sup>110</sup> Kuper A & Kuper J (eds) *The social science encyclopedia* (1985) 331.

difficulty for the subject is that genetic analysis is most straightforwardly performed on those observable characteristics which are constant and clear-cut, whereas most mental disorders tend to fluctuate in severity and present difficulties in the definition of their boundaries.<sup>111</sup>

Despite these problems, the recent history of psychiatric and psychological genetics has been one of considerable progress, and there is nearly incontrovertible evidence of a genetic contribution to schizophrenia and bipolar disorder,<sup>112</sup> with strong suggestions of a genetic component in many other common illnesses.<sup>113</sup>

### 3.4 DIAGNOSIS AND CLASSIFICATION OF MENTAL DISORDERS

#### 3.4.1 Background

Diagnosis and classifications in psychiatry have undergone tremendous changes in the last 40 years. Before the 1950's, diagnosis were not only unreliable, but even had meanings that varied considerably across the world. By the end of that decade, "anti-psychiatrists", including Laing,<sup>114</sup> and Szasz<sup>115</sup> had started to suggest that diagnosis and classification in psychiatry should be abandoned, together with the

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<sup>111</sup> Murray & McGuffin in *Companion to psychiatric studies* 161.

<sup>112</sup> See Torrey EF *Schizophrenia and manic-depressive disorder: The biological roots of mental illness as revealed by the landmark study of identical twins* (1994) 3ff. See the definitions of these concepts below.

<sup>113</sup> However, the task of psychiatric and psychological genetics goes beyond simply asking whether genetic contributors are important. Having demonstrated that genes do play a part in the aetiology of a condition, research must explore the ways in which genes become expressed, attempt to trace the tortuous path from aberrant genes to observable clinical manifestation, and examine the ways in which genes and environment co-act and interact to produce their joint effect. (These clinical aspects are worth mentioning, but falls outside the scope of a thesis of this nature and will not be discussed any further). For a comprehensive discussion on genetics aspects of mental disorders, see Murray & McGuffin in *Companion to psychiatric studies* 161-190.

<sup>114</sup> (1927-1989.) Ronald David Laing was a Scottish psychiatrist who wrote extensively on mental illness – in particular, the experience of psychosis. Laing's views on the causes and treatment of serious mental dysfunction (greatly influenced by existential philosophy) ran counter to the psychiatric orthodoxy of the day by taking the expressed feelings of the individual patient or client as valid descriptions of lived experience rather than simply as symptoms of some separate or underlying disorder. Often associated with the anti-psychiatry movement, he himself rejected the label as such, as did certain others critical of conventional psychiatry at the time. See Miller G *RD Laing* (2005) 7, 19ff.

<sup>115</sup> (1920-.) Thomas Stephen Szasz is a Professor Emeritus of Psychiatry at the State University of New York Health Science Center in Syracuse, New York. He is a prominent figure in the anti-psychiatry movement, a well-known social critic of the moral and scientific foundations of psychiatry, and of the social control aims of medicine in modern society, as well as of scientism. He is well known for his books: *The myth of mental illness* (1960); and *The manufacture of madness: A comparative study of the inquisition and the mental health movement*, which set out some of the arguments with which he is most associated. See Slade AL *A bibliography of works by and about Thomas Stephen Szasz MD, 1947-1975* (1976) 1ff.

concept of mental disorder.<sup>116</sup> In the 1960's, the World Health Organization instigated a world-wide programme aimed at improving diagnosis and classification of mental disorders, fostering research into the reliability of diagnosis and classification. The mental health section of the *International Classification of Diseases* is currently in its 10<sup>th</sup> edition (ICD-10). The American Psychiatric Association developed its own classificatory system, the *Diagnostic and Statistical Manual of Mental Disorders* (DSM); the current classification, DSM-IV-TR,<sup>117</sup> was published in 2000.<sup>118</sup>

### 3.4.2 System of classification

An examination of a person with psychiatric or psychological problems begins with the attempt to recognise the individual pattern of symptoms and experiences that leads to the establishment of a specific psychiatric diagnosis. This diagnosis should be expressed in a particular nomenclature according to a recognised classification system. The fundamental purpose of diagnosis and classification in medicine is to define a group of discrete disease entities, each of which is characterised by a distinct pathophysiology and / or aetiology. However, for most psychiatric diseases the approach is based more on phenomenology than pathophysiology or aetiology.<sup>119</sup>

The two main current systems of classification in South Africa are the ICD-10 and the DSM-IV.<sup>120</sup> It is important to note that there are textual differences between ICD-10 and DSM-IV, but according to treaties between the United States and the World Health Organization, the diagnostic code numbers must be identical to ensure uniform reporting of national and international psychiatric statistics.<sup>121</sup> ICD-10 is a uniaxial system, which attempts to standardise by using descriptive definitions of the syndromes and operational criteria, as well as producing directives on differential diagnosis. DSM-IV is a multiaxial system, which relies

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<sup>116</sup> The term anti-psychiatry usually refers to a movement that emerged in the 1960's, which is hostile to most of the fundamental assumptions and common practices of psychiatry. The term anti-psychiatry was first used by the South African psychiatrist David Cooper in 1967. Two central contentions of the anti-psychiatry movement are that: (1) The specific definitions of, or criteria for, hundreds of current psychiatric diagnoses or disorders are vague and arbitrary, leaving too much room for opinions and interpretations to meet basic scientific standards; and (2) prevailing psychiatric treatments are ultimately far more damaging than helpful to patients. See Baker RA *Mind games: Are we obsessed with therapy?* (1996) 1ff. See also Laing RD "Violence and psychiatry" 14-33 in *Psychiatry and anti-psychiatry* ((ed) Cooper D) (1967) 14ff.

<sup>117</sup> TR stands for "text revision".

<sup>118</sup> Katona C & Robertson M *Psychiatry at a glance* (2005) 10.

<sup>119</sup> Pretorius H "Classification" 7-13 in *Textbook of psychiatry for Southern Africa* 7.

<sup>120</sup> Allan A "Psychiatric diagnosis in legal settings" 2005 11 *S Afr J of Psychiatry* 2: 55.

<sup>121</sup> Sadock & Sadock (eds) viii.

on operational criteria, rather than descriptive definitions. It states which symptoms need to be present (often quantifying their number and requiring a specific length of time for symptoms to be present) as well as exclusion criteria.<sup>122</sup>

A multiaxial system involves an assessment on several axes, each of which refers to a different domain of information that may help the clinician plan treatment and predict outcome.<sup>123</sup> The use of the multiaxial system facilitates comprehensive and systematic evaluation with attention to the various mental disorders and general medical conditions, psycho-social and environmental problems as well as the level of functioning that might be overlooked if the focus were on assessing a single presenting problem.<sup>124</sup>

### 3.4.3 Types of classification of mental disorders

Traditionally, mental disorder is differentiated into *mental retardation*<sup>125</sup> (learning disability, in which features of the disorder have been present from birth or an early age), *personality disorder* (usually present from childhood or adolescence onwards), *mental illness* (where there is an identifiable onset of illness preceded by normal functioning), adjustment disorder (less severe than mental illness, occurring in relation to stressful events or changed circumstances), *disorders of childhood and other disorders* (those which do not fit into any other group, including behavioural disorders and substance misuse). Mental illness has traditionally been differentiated into organic and functional (psychotic<sup>126</sup> and neurotic<sup>127</sup>) types.<sup>128</sup>

ICD-10 assumes an explicitly descriptive approach and organises psychiatric disorders in ten categories on the basis of shared aetiologies as follows:<sup>129</sup>

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<sup>122</sup> Katona & Robertson 11.

<sup>123</sup> See American Psychiatric Association *DSM-IV* 25.

<sup>124</sup> A multiaxial system further provides a convenient format for organising and communicating clinical information, for capturing the complexity of clinical situations, and for describing the heterogeneity of individuals presenting with the same diagnosis. In addition, this system promotes the application of the bio-psychosocial model in clinical, educational and research settings. See American Psychiatric Association *DSM-IV* 25.

<sup>125</sup> Cf the definition of "mental retardation" *supra*.

<sup>126</sup> See the definition of psychosis *supra*.

<sup>127</sup> See the definition of psychoneurosis and neurosis *supra*.

<sup>128</sup> Katona & Robertson 11.

<sup>129</sup> This table was taken from Tyrer P & Steinberg D *Models for mental disorder: Conceptual models in psychiatry* (1998) 106-107 and Smith P "Diagnosis and classification" 90-101 in *Primary healthcare psychiatry: A practical guide for Southern Africa* 94-95.

Axis	Description
I	Clinical diagnosis
II	Disablements
III	Contextual factors

The ICD-10 (chapter 5) categories of mental disorder are:<sup>130</sup>

Category	Description
F0	<p><b>Main category:</b> Organic, including symptomatic, mental disorders</p> <p><b>Subcategories:</b></p> <ul style="list-style-type: none"> <li>- Dementias;<sup>[131]</sup></li> <li>- delirium;<sup>[132]</sup></li> <li>- mental disorders due to physical disease; and</li> <li>- behaviour disorder due to brain disease or injury;</li> <li>- personality disorder<sup>[133]</sup> due to brain disease or injury</li> </ul> <p><b>Main features:</b> Conditions in which brain functions are present and manifested by disturbances of cognition, mood, perception or behaviour.</p>
F1	<p><b>Main category:</b> Mental and behavioural disorders due to psychoactive (psychotropic) substance / drug abuse</p> <p><b>Subcategories:</b></p> <ul style="list-style-type: none"> <li>- States of intoxication;</li> <li>- harmful use;</li> <li>- dependence and withdrawal states;</li> <li>- psychosis resulting from the use of alcohol and</li> </ul>

<sup>130</sup> This system is compulsory and it is illegal not to code a diagnosis. See Tzitzivakos D "International classification of diseases 10<sup>th</sup> edition (ICD-10)" 2007 25 *S Afr J Con Med Edu* 1: 8-10.

<sup>131</sup> Dementia is an impairment or loss of memory, especially evident in the learning of new information and of thinking, language, judgment and other cognitive faculties without clouding of consciousness (a state of consciousness affecting thinking, attention, and perception, in which one is confused about, or not fully aware of, one's immediate surroundings). It falls in the category of any of a family of mental disorders characterised by memory impairment, especially of newly acquired information, and one or more cognitive disturbances. The most important types are: Alzheimer's disease; Parkinson's disease; Huntington's disease; Creutzfeldt-Jakob disease and substance-induced persisting dementia resulting from alcohol, inhalants, sedatives, hypnotics or anxiolytics. See Colman "dementia" 199; "clouding of consciousness" 140.

<sup>132</sup> Delirium is an acute mental disturbance marked by excitement, restlessness, confusion, disordered speech and frequently hallucinations. The causes of delirium include fever, physical or mental shock, insulin shock, toxins produced by bacteria in certain disease, alcoholism and excessive use of sedatives. Delirium sometimes occurs in the course of emotional and mental disorders. The condition is serious and requires prompt medical attention. Reader's Digest Home Doctor Library "delirium" 90-91.

<sup>133</sup> See the discussion of personality disorders below.

	<p>Opioids;<sup>[134]</sup></p> <ul style="list-style-type: none"> <li>- the use of cannabis and sedatives;</li> <li>- the use of cocaine, tobacco, hallucinogens;<sup>[135]</sup></li> <li>- other drugs.</li> </ul> <p><b>Main features:</b></p> <p>Includes all mental disorders, which are considered to be a direct consequence of drug use, and which would not have occurred without using the drug or drugs.</p>
F2	<p><b>Main category:</b></p> <p>Schizophrenia,<sup>[136]</sup> schizotypal and delusional disorders</p> <p><b>Subcategories:</b></p> <ul style="list-style-type: none"> <li>- Persistent delusional disorders;</li> <li>- acute and transient psychotic disorders; and</li> <li>- schizoaffective disorders.</li> </ul> <p><b>Main features:</b></p> <p>Conditions in which there are distortions of thinking, perception and mood, not due to an organic condition, and which are most prominent in schizophrenia.</p>
F3	<p><b>Main category:</b></p> <p>Mood (affective) disorders<sup>[137]</sup></p> <p><b>Subcategories:</b></p> <ul style="list-style-type: none"> <li>- Manic episodes;</li> <li>- depressive episodes;</li> <li>- bipolar affective disorder;</li> <li>- recurrent depressive disorder; and</li> <li>- persistent affective disorders.</li> </ul> <p><b>Main features:</b></p> <p>A range of disorders in which disorders of mood (affect) is the main feature, together with other symptoms, which are easily understood in context of change of mood and activity.</p>
F4	<p><b>Main category:</b></p> <p>Neurotic, stress-related and somatoform disorders</p>

<sup>134</sup> Opioids (opiate) refer to any of a group of drugs that contain opium or an alkaloid of opium and that tend to have narcotic effects and are sometimes used as analgesics. See Colman "opiate" 528; "opioids" 529.

<sup>135</sup> Two types of hallucinogens (a special kind of chemical substance, which happens to be illegal) exist: Natural and synthetic hallucinogens. Natural hallucinogens come from raw plants, which include some types of mushrooms and peyote (a cactus plant). Synthetic varieties are made by humans. The "state of ecstasy", experienced by using hallucinogens, attract thousands of people. See Harmon DE *Hallucinogens: The dangers of distorted reality* (2009) 4, 8-9. See also Laing R (ed) *Hallucinogens: A forensic drug handbook* (2003) 1ff.

<sup>136</sup> See the discussion of schizophrenia below.

<sup>137</sup> See the discussion of mood affective disorders below.

	<p><b>Subcategories:</b></p> <ul style="list-style-type: none"> <li>- Phobic disorder;<sup>[138]</sup></li> <li>- other anxiety disorders;</li> <li>- obsessive-compulsive disorder;<sup>[139]</sup></li> <li>- stress and adjustment disorders;</li> <li>- dissociative and conversion disorders;<sup>[140]</sup> and</li> <li>- somatoform disorders.</li> </ul> <p><b>Main features:</b></p> <p>A group of disorders in which certain symptoms, (historically recognised as part of "neurosis"), are most marked, and which may have a psychological causation.</p>
F5	<p><b>Main category:</b></p> <p>Mental disorders associated with physiological dysfunction and physical factors</p> <p><b>Subcategories:</b></p> <ul style="list-style-type: none"> <li>- Eating disorders;</li> <li>- psychogenic sleep disorders;</li> <li>- sexual dysfunctions; and</li> <li>- mental disorders associated with the puerperium.</li> </ul> <p><b>Main features:</b></p> <p>Disorders in which physiological and hormonal factors may be involved in causation or be prominent in association with the disorder.</p>
F6	<p><b>Main category:</b></p> <p>Abnormalities of adult personality and behaviour</p> <p><b>Subcategories:</b></p> <ul style="list-style-type: none"> <li>- Personality disorder;</li> <li>- enduring personality change;</li> <li>- habit and impulse disorders;</li> <li>- gender identity disorders; and</li> <li>- sexual preference disorders.</li> </ul> <p><b>Main features:</b></p> <p>Conditions of clinical significance in which behaviour patterns tend to be persistent and which are "the expression of the individual's characteristic lifestyle and mode of relating to self and others".</p>
F7	<p><b>Main category:</b></p>

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<sup>138</sup> Phobic disorders may be related to repressed aggressive impulses, or may symbolise fear of something else in the patient's unconscious life. It refers to an extreme fear, particularly one so overwhelming that the victim cannot function in a normal way. A phobia is abnormal and may be a symptom of neurosis or psychosis. See Reader's Digest Home Doctor Library "phobia" 264.

<sup>139</sup> See the discussion of obsessive-compulsive disorder *supra*.

<sup>140</sup> See the explanation of dissociation *supra*.

	<p>Mental retardation</p> <p><b>Subcategories:</b></p> <ul style="list-style-type: none"> <li>- Mild mental retardation;</li> <li>- moderate mental retardation;</li> <li>- severe mental retardation;</li> <li>- profound mental retardation; and</li> <li>- other types of mental retardation.</li> </ul> <p><b>Main features:</b></p> <p>A condition of "arrested or incomplete development of the mind" manifest by impairment of skills commonly associated with intelligence.</p>
F8	<p><b>Main category:</b></p> <p>Developmental disorders</p> <p><b>Subcategories:</b></p> <ul style="list-style-type: none"> <li>- Speech and language;</li> <li>- specific developmental disorder of scholastic skills</li> <li>- specific developmental disorder of motor function; and</li> <li>- pervasive developmental disorder, for example autism.</li> </ul> <p><b>Main features:</b></p> <p>Conditions that begin in infancy or childhood; delay in the development of functions related to maturation of the nervous system, and which generally have a steady rather than remitting course.</p>
F9	<p><b>Main category:</b></p> <p>Behavioural and emotional disorders with onset usually occurring in childhood or adolescence</p> <p><b>Subcategories:</b></p> <ul style="list-style-type: none"> <li>- Hyperkinetic disorder;<sup>[141]</sup></li> <li>- conduct disorder;<sup>[142]</sup></li> </ul>

<sup>141</sup> The essential characteristics of hyperkinetic disorders are: Persistent traits of severe and pervasive inattentiveness, over-activity, and impulsiveness, beginning in the first five years of life. British doctors are likely to diagnose and treat hyperactivity in children. There are three reasons for this: Firstly, the ICD-10 includes a definition of "hyperkinetic disorder" that is more explicit than previous versions. The disorder is much more than naughtiness or high energy that overtaxes weary or depressed parents. Centres that have changed from using ICD-9 to using ICD-10 have already noted that the diagnosis is being made more often. See Taylor E & Hemsley R "Treating hyperkinetic disorders in childhood" 1995 310 *Br Medical J* 6995: 1617-1618.

<sup>142</sup> The essential feature of conduct disorder is a repetitive and persistent pattern of behaviour in which the basic rights of others or major age-appropriate societal norms or rules are violated. These behaviours fall into four main groupings: Aggressive conduct that causes or threatens physical harm to other people or animals; non-aggressive conduct that causes property loss or damage; deceitfulness or theft; and serious violations of rules. See American Psychiatric Association *DSM-IV* 85.

	<ul style="list-style-type: none"> <li>- mixed disorder of conduct and emotions;</li> <li>- emotional disorder of childhood; and</li> <li>- disorders of social function.</li> </ul> <p><b>Main features:</b> A mixture of disorders in which the only common features are an onset early in life and a fluctuating or unpredictable course.</p>
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As mentioned previously, the DSM-IV adopts a multi-axial model to allow clinicians to capture a comprehensive range of information about the individual's medical history, psychological circumstances and current functioning. Axis I encompasses the mental disorders, substance abuse disorders and mental disorders related to medical conditions. Axis II codes mental retardation and the personality disorders, while Axis III is used for coding the relevant co-morbid medical conditions. Axis IV is used for recording the nature and severity of psychosocial stressors. Axis V is for an estimation of the individual's current level of functioning as well as the highest level of functioning in the past year. This is measured on the Global Assessment of Relation Functioning scale (GAF).<sup>143</sup>

#### The DSM-IV multi-axial system<sup>144</sup>

Axis	Description
I	Mental disorders, developmental disorders
II	Personality disorders and mental retardation
III	Medical conditions of possible relevance to Axis I
IV	Psychosocial stressors
V	Global Assessment of Functioning

The overall structure and diagnostic groupings in the DSM-IV are:<sup>145</sup>

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<sup>143</sup> The GAF Scale considers psychological, social and occupational functioning on a hypothetical continuum of mental health-illness. It does not include impairment in functioning due to physical or environmental limitations. Cf the Global Assessment of Relational Functioning Scale (GARF), which can be used to indicate an overall judgment of the functioning of a family or other ongoing relationship on a hypothetical continuum ranging from competent, optimal relational functioning to a disrupted, dysfunctional relationship. It is analogous to Axis V (GAF Scale) provided for individuals in DSM-IV. The GARF Scale permits the clinician to rate the degree to which a family or other ongoing relational unit meets the affective and / or instrumental needs of its members in the following areas: Problem solving; organisation and emotional climate. Other rating scales used in the DSM-IV include: the Social and Occupational Functioning Assessment Scale (SOFAS); Defensive Functioning Scale (DFS); Brief Psychiatric Rating Scale (BPRS); Hamilton Rating Scales for Depression and Anxiety (HAM-D and HAM-A); Positive and Negative Syndrome Scale (PANSS) and the Scales for the Assessment of Positive Symptoms (SAPS) and the Assessment of Negative Symptoms (SANS). See Sadock & Sadock 310-311; American Psychiatric Association *DSM-IV* 32.

<sup>144</sup> This table was taken from Smith in *Primary healthcare psychiatry: A practical guide for Southern Africa* 95.

<sup>145</sup> American Psychiatric Association *DSM-IV* 13-24.

- Disorders usually evident in infancy, childhood and adolescence;
- delirium, dementia and cognitive disorders;
- disorders due to a general medical condition not elsewhere classified;
- substance-related disorders;
- schizophrenia and other psychotic disorders;
- mood disorders;
- anxiety disorders;
- somatoform disorders;
- factitious disorders;
- dissociative disorders;
- sexual, gender identity disorders;
- eating disorders;
- sleep disorders;
- impulse-control disorders not elsewhere classified;
- adjustment disorders;
- personality disorders (coded on Axis II); and
- other conditions that may be a focus of clinical attention (V-codes on Axis I).

The text of the DSM-IV includes extensive information about each disorder, including their essential and associated features; age; gender and cultural features; prevalence, course and familial pattern; differential diagnoses; and associated medical features and laboratory findings where relevant. There are also a number of appendices, including ones devoted to decision trees for differential diagnoses, a glossary of terms, a proposed structure for a cultural formulation and a glossary of culture-bound syndromes.<sup>146</sup>

#### 3.4.4 The use of DSM-IV in forensic settings<sup>147</sup>

Misuse or misunderstanding of medical diagnosis should concern all physicians, no matter what the setting. The accuracy and reliability of psychiatric and psychological diagnosis in legal settings are particularly important, because diagnosis often influences court findings, financial judgments, the liberty interests of

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<sup>146</sup> Smith in *Primary healthcare psychiatry: A practical guide for Southern Africa* 96.

<sup>147</sup> This discussion is limited to diagnosis in forensic settings. The role of the psychiatrist and psychologist in court as well as the approach to expert evidence followed by the Supreme Court of Appeal in South Africa are discussed in chapter 4.

defendants and even social policy. We therefore need the highest possible confidence level for diagnoses and other contributions in legal settings.<sup>148</sup> The law does not set the threshold for determining clinical illness, but it does determine "what particular forms and degree of psychopathology it will recognise as exculpatory" or otherwise relevant to the court's needs. Individual behaviour and functioning are more important than diagnostic label, although the psychiatrist or psychologist may have to convince the judge or jury of that fact.<sup>149</sup>

DSM-IV is a classification of mental disorders that was developed for use primarily in clinical, educational and research settings. According to the American Psychiatric Association<sup>150</sup> there are significant risks that diagnostic information will be misused or misunderstood when the DSM-IV categories, criteria and textual descriptions are employed for forensic purposes. These dangers arise because of the imperfect fit between the questions of ultimate concern to the law and the information contained in a clinical diagnosis. In most situations, the clinical diagnosis of a DSM-IV mental disorder is not sufficient to establish the existence for legal purposes of a mental disorder, mental disability, mental disease or mental defect. In determining whether an individual meets a specified legal standard, (for example, competence, criminal responsibility or disability), additional information is usually required beyond that contained in the DSM-IV diagnosis. This might include information about the individual's functional impairments and how these impairments affect the particular abilities in question. It is precisely because impairments, abilities and disabilities vary widely within each diagnostic category that assignment of a particular diagnosis does not imply a specific level of impairment or disability. However, by providing a compendium based on a review of the pertinent clinical and research literature, DSM-IV may facilitate the legal decision maker's understanding of the relevant characteristics of mental disorders.

According to Allan<sup>151</sup> when asked to give a diagnosis in legal settings, practitioners should be mindful of the tentative nature of psychiatric diagnoses and that courts require that such a diagnosis must have scientific

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<sup>148</sup> Reid WH & Wise MG *et al* "The use and reliability of psychiatric diagnosis in forensic settings" 1992 15 *Psychiatric Clinics North Am* 3: 529.

<sup>149</sup> Diamond BL "Reasonable medical certainty, diagnostic thresholds, and definitions of mental illness in the legal context" 1985 13 *Bull Am Acad Psychiatry Law* 121 at 126.

<sup>150</sup> American Psychiatric Association *DSM-IV* xxiii-xxiv.

<sup>151</sup> Allan A "Psychiatric diagnosis in legal settings" 2005 11 *S Afr J of Psychiatry* 2: 52. See also Meintjies-Van der Walt L *Expert evidence in the criminal justice process: A comparative perspective* (2001) 1ff.

credibility. While South African courts have not been explicit on how they determine the credibility of scientific evidence, they generally appear to apply the test that was formulated in *Frye v United States*.<sup>152</sup> This judgment regards evidence on a scientific construct admissible if it has gained general acceptance in the particular field in which it belongs. More recently in *Daubert v Merrell Dow Pharmaceuticals*<sup>153</sup> the United States Supreme Court stipulated that a court should also take three other factors into account. First, whether the construct can be, and has been, tested; second, whether it has been subjected to peer review and publication; and finally, the known or potential rate of error. The *Daubert* test has not been discussed in a reported case in South Africa, yet it provides practitioners with a useful framework to evaluate the scientific credibility of a diagnostic label.<sup>154</sup>

Vorster,<sup>155</sup> however, argues that Allan appears to overstate the tentative status of psychiatric diagnostic categories by giving little weight to the large body of systematic research on which these diagnostic categories are based. Allan makes the point that the diagnosis must be generally accepted by other experts in the field. His comments, although valuable, are less pertinent to the South African context where the situation is quite different. In South African courts there are usually no experts available other than the one giving the evidence. Allan concedes in his article that the *DSM-IV* contains disorders that are controversial. According to Vorster, the converse can also be stated, for example, that psychiatric disorders that may be pertinent are not included. Peer review and publication should be included. In South African courts these are frequently accepted with the use of a single source of reference discouraged. Fortunately case law is vital and the system of precedence is always followed. Allan fails to mention the importance of this procedure. However, he makes the important point that making a psychiatric diagnosis is only the

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<sup>152</sup> *Frye v United States* 293 F 1013 (DC Cir, 1923).

<sup>153</sup> *Daubert v Merrell Dow Pharmaceuticals* 951 F2d 1129 (9th Cir, 1993).

<sup>154</sup> Allan explains that the descriptive validity of a diagnosis is considered good when its characteristics are so unique and well defined that it can be distinguished from other disorders. It is clear that the distinguishing criteria of a disorder could become very important where witnesses disagree on the correct diagnosis. According to him, good descriptive validity requires five things. First, that the features of the disorder are well delineated, unambiguously and accurately described, and operationally defined. Second, there must be a clear indication regarding how the information on each of these features should be weighted and integrated. Third, diagnostic criteria should provide explicit rules about what to do when information is insufficient or if other uncertainties exist. Fourth, the diagnosis should as far as possible rely on observable signs, or the results from reliable laboratory or psychological tests, rather than be inferred from symptoms and other subjective reports provided by the patient. Finally, there should ideally be enough signs and symptoms unique to the specific disorder to make it distinct from other disorders or diseases. See Allan 2005 *S Afr J of Psychiatry* 52 at 53. See also Campbell TW "Challenging the evidentiary reliability of DSM-IV" 1999 17 *Am J Forensic Psychology* 47ff.

<sup>155</sup> Vorster M "Psychiatry in the medico-legal setting" 2005 11 *S Afr J of Psychiatry* 2: 42.

beginning of the task of a forensic psychiatrist. Vorster further states that if forensic diagnoses and assessment are to be reliable and credible, it is essential that forensic psychiatrists and not interfering relatives or legal representatives, be in control of the psychiatric examination.<sup>156</sup>

### 3.4.5 Ethnic and cultural considerations

According to the American Psychiatric Association<sup>157</sup> efforts have been made in the preparation of DSM-IV to incorporate an awareness that the manual is used in culturally diverse populations in the United States and internationally. Clinicians are often called upon to evaluate individuals from numerous different ethnic groups and cultural backgrounds. A clinician who is unfamiliar with the nuances of an individual's cultural frame of reference may incorrectly judge as psychopathology those normal variations in behaviour, belief or experience that are particular to the individual's culture. DSM-IV includes three types of information specifically related to cultural considerations:

- A discussion in the text of cultural variations in the clinical presentations of those disorders that have been included in the DSM-IV Classification;
- a description of culture-bound syndromes that have not been included in the DSM-IV Classification; and
- an outline for cultural formulation designed to assist the clinician in systematically evaluating and reporting the impact of the individual's cultural context.

The provision of a culture-specific section in the DSM-IV text, the inclusion of a glossary of culture-bound syndromes, and the provision of an outline for cultural formulation are designed to enhance the cross-cultural applicability of DSM-IV.<sup>158</sup>

### 3.4.6 Categories of mental disorders

For the discussion to follow in this thesis, the four categories of mental disorders most relevant are schizophrenic disorders; paranoid disorders; mood disorders; and some personality disorders. Schizophrenic and paranoid disorders fall within the scope of the "psychotic category" as previously known.

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<sup>156</sup> See also the ethical discussion of this topic in chapter 4.

<sup>157</sup> American Psychiatric Association *DSM-IV* xxiv. See also Reid WH & Wise MG *DSM-IV training guide* (1995) 3ff.

<sup>158</sup> American Psychiatric Association *DSM-IV* xxv.

Mood disorders were considered in that category only if it were serious enough, such as bipolar disorder. These four types of disorders are relevant because they are most likely to be associated with violent, serious criminal or antisocial behaviour and are often cited to support an insanity defence to criminal charges.<sup>159</sup>

### 3.4.6.1 *Schizophrenic disorders*

Schizophrenia is a syndrome composed of abnormal clinical signs and symptoms in the areas of behaviour, volition, attention, cognition and motor activities. While a number of these features are suggestive of the illness, none is pathognomonic of it. While many patients manifest some of these abnormalities, or a combination of it, few patients manifest all.<sup>160</sup> The DSM-IV outlines five characteristic symptoms of schizophrenia, at least two of which must be manifested before diagnosis can be entertained: (1) delusions; (2) hallucinations; (3) disorganised speech; (4) grossly disorganised behaviour and; (5) inappropriate affect.<sup>161</sup> According to ICD-10, nine groups of symptoms are important for diagnosing schizophrenia: (1) thought echo, insertion, withdrawal and broadcasting; (2) delusions of control, influence or passivity; (3) hallucinatory voices; (4) other persistent delusions that are culturally inappropriate and impossible; (5) persistent hallucinations; (6) breaks or interpolation in thinking; (7) catatonic behaviour; (8) negative symptoms resulting in social withdrawal and poor social performance but not caused by depression or medication and; (9) consistent, overall change in behaviour.<sup>162</sup>

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<sup>159</sup> Bartol *Criminal behaviour: A psychosocial approach* 230.

<sup>160</sup> Gureje O "Schizophrenia" 111-131 in *Psychiatry for the developing world* 112.

<sup>161</sup> Cf also schizoaffective disorder, which is a disturbance in which a mood episode and the active-phase symptoms of schizophrenia occur together and were preceded or are followed by at least two weeks of delusions or hallucinations without prominent mood symptoms; delusional disorder, which is characterised by at least one month of non-bizarre delusions without other active-phase symptoms of schizophrenia; brief psychotic disorder, which is a psychotic disturbance that lasts more than one day and remits by one month; shared psychotic disorder, which is a disturbance that develops in an individual who is influenced by someone else who has an established delusion with similar content; psychotic disorder due to a general medical condition where the psychotic symptoms are judged to be a direct physiological consequence of a general medical condition; substance-induced psychotic disorder where the psychotic symptoms are judged to be a direct physiological consequence of a drug of abuse, a medication, or toxin exposure and; psychotic disorder not otherwise specified, which is included for classifying psychotic presentations that do not meet the criteria for any of the specific psychotic disorders defined under this category or symptomatology about which there is inadequate or contradictory information. See American Psychiatric Association *DSM-IV* 285.

<sup>162</sup> World Health Organization *The ICD-10 Classification of Mental and Behavioural Disorders: Diagnostic Criteria for Research* (1993) 87-88.

ICD-10 requires one clear symptom or two or less clear symptoms from any one of groups one through four or symptoms from at least two of groups five through eight to be present for most of the time during one month or more. Similar conditions lasting less than a month should be diagnosed as schizophrenia-like disorders.<sup>163</sup> DSM-IV defines schizophrenia as a disturbance of at least six months' duration, with two or more symptoms active for at least one month. A disorder diagnosed as schizophrenia under ICD-10 standards may be diagnosed as schizophreniform disorder under DSM-IV standards.<sup>164</sup> Schizophreniform is according to DSM-IV equivalent to schizophrenia, except for its duration, which is one to six months and the absence of functional decline.<sup>165</sup>

Since Kraepelin and Bleuler,<sup>166</sup> schizophrenia has commonly been sub-typed into:

- Paranoid schizophrenia, where the clinical picture is dominated by the patient's delusions.<sup>167</sup>
- Hebephrenic or disorganised schizophrenia, which is a disorder of affect, such as incongruity, together with grossly disorganised thought and severe loss of social judgment, which may be predominant. Associated features include grimaces, strange mannerisms, complaints of non-existent physical ailments, extreme social withdrawal and other oddities of behaviour.<sup>168</sup>
- Catatonic schizophrenia where the clinical presentation is characterised by motor abnormalities such as excitement or retardation, posturing, negativism and waxy flexibility.<sup>169</sup>
- Mixed or undifferentiated schizophrenia where the patient cannot be fitted into any of the above sub-types. People with this type of disorder display active psychotic features, such as hallucinations, delusions, incoherent speech, or confused and disorganised behaviour, but do not meet the specifications of the other types.<sup>170</sup>

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<sup>163</sup> World Health Organization *ICD-10* 87ff.

<sup>164</sup> American Psychiatric Association *DSM-IV* 290-291.

<sup>165</sup> Sadock & Sadock 497.

<sup>166</sup> See the discussion of Kraepelin and Bleuler in chapter 2.

<sup>167</sup> Gureje in *Psychiatry for the developing world* 116.

<sup>168</sup> Bartol *Criminal behaviour: A psychosocial approach* 231.

<sup>169</sup> Costello CG *Symptoms of schizophrenia* (1993) 265ff.

<sup>170</sup> Sadock & Sadock 496.

- Residual schizophrenia, where the individual had at least one episode of schizophrenia, and there is evidence that some of the symptoms are continuing, for example, the person may still display blunted emotions or illogical thinking, but no other symptoms.<sup>171</sup>

A large number of anti-psychotic medications are available for the treatment of schizophrenia, but Greeff<sup>172</sup> states that the monthly injectable ones are often the preferred treatment due to improved compliance because patients tend to stop their medication when their symptoms improve - having no insight in their own condition.

### 3.4.6.2 *Paranoid disorders*

Paranoid disorders are characterised by the presence of one or more *non-bizarre* delusions that persist for at least one month. The judgment of whether the delusion's systems are bizarre or non-bizarre is especially important in deciding between a delusional disorder and schizophrenia. In paranoid personality disorder the delusions are reasonably believable and not completely far-fetched.<sup>173</sup> Patients with paranoid personality disorder also have a long-standing suspiciousness of others and their motives, and a mistrust of people in general. Because of this they have an excessive need to be self-sufficient and a strong sense of autonomy.<sup>174</sup> Brief psychotic episodes may occur during times of stress. Persons suffering from this disorder rarely seek treatment but are usually brought in by family members or employers.<sup>175</sup>

Psychotherapy is the treatment of choice for paranoid personality disorder and pharmacotherapy is useful in dealing with agitation and anxiety.<sup>176</sup>

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<sup>171</sup> Bartol *Criminal behaviour: A psychosocial approach* 232.

<sup>172</sup> Greeff D "Schizophrenia: Medical terms explained" 2003 3 *S Afr Pharmacist's Assistant* 4: 9

<sup>173</sup> An example of a non-bizarre delusion is the belief that a neighbour is spying and attempting to poison one's dog when there is no evidence to that effect. Even so, neighbours sometimes do spy and sometimes do poison dogs. A bizarre delusion (more characterised of schizophrenia) is the belief that the neighbour has disguised herself as a mosquito and is hovering outside one's window. See Bartol *Criminal behaviour: A psychosocial approach* 232-233.

<sup>174</sup> American Psychiatric Association *DSM-IV* 635.

<sup>175</sup> Nair M & Lay S "Personality disorders" 249-264 in *Textbook of psychiatry for Southern Africa* 252.

<sup>176</sup> Sadock & Sadock 795.

### 3.4.6.3 *Mood disorders*

Mood disorders are a class of mental disorders with disturbance of mood as the predominant feature.<sup>177</sup> These disorders are divided into depressive and bipolar disorders. The depressive disorders feature persistent feelings of sadness and despair and loss of interest in previous sources of pleasure. It further includes feelings of worthlessness or excessive inappropriate guilt, (which may be delusional), that are experienced nearly everyday and is not merely self-reproach or guilt about being sick.<sup>178</sup> In bipolar disorders, people experience both depressed and manic episodes. When a person who suffers from bipolar disorder swings to the manic phase, the most prominent symptom of mania is a mood in which a person feels highly energetic and extremely joyful. Manic persons may believe there is no limit to their possible accomplishments and may act accordingly. Occasionally, the manic person suffers from other delusions, for example, false beliefs that contradict known facts. They also have a greatly reduced need for sleep and tend to be immune from the fatigue that would hit most people after very strenuous periods of activity.<sup>179</sup>

Treatment for mood disorders is usually a combination of medication and formal psychotherapy. Several trials of a combination of pharmacotherapy and psychotherapy for chronically depressed outpatients have shown a higher response and higher remission rates for the combination than for either treatment used alone.<sup>180</sup>

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<sup>177</sup> Mood is defined as a temporary but relative sustained and pervasive affective state, often contrasted in psychology and psychiatry with a more specific and short-term emotion. In linguistics mood is defined as a category or verb expressing a mode or manner of action or being, typical grammatical moods being indicative, subjunctive and imperative. In logic, mood is defined as the form of a syllogism, depending on the nature of its three constituent propositions: (1) Sense (Sense 1 from the old English word *mod*, mind or feeling; senses 2 and 3 from the Latin word *modus*, manner). See Colman "mood disorders" 476; "mood" 475.

<sup>178</sup> Some of the symptoms for a depressive disorder further include: The depressed mood is experienced most of the day, nearly every day, as indicated by either subjective reports, for example, feels sad or empty, or observations made by others, for example, the person appears tearful. Markedly diminished interest or pleasure is experienced in all or almost all activities, most of the day, nearly everyday. Insomnia (inability to sleep) or hypersomnia (excessive sleeping) is experienced nearly everyday. Fatigue or loss of energy is experienced nearly everyday; diminished ability to think or concentrate is experienced nearly everyday and also recurrent thoughts of death or recurrent suicide attempt or a specific plan for committing suicide. Significant weight loss when the person is not dieting or weight gain, for example, a change of more than five percent of body weight in a month, or the experience of a decrease or increase in appetite nearly every day. See Nicholas LJ & Malcolm C *et al* "Psychopathology" 183-202 in *Introduction to psychology* 193.

<sup>179</sup> Sternberg 526-527.

<sup>180</sup> It is important to note that bipolar disorder is categorised into bipolar I disorder and bipolar II disorder. Bipolar II disorders are characterised by major depressive episodes together with hypomanic episodes, rather than manic episodes as in bipolar I disorder. Hypomania is also a mood abnormality with the qualitative characteristics of mania, but somewhat less intense. See Sadock & Sadock 278; 536-537, 560.

#### 3.4.6.4 Personality disorders

Personality disorders represent persistent long-standing, maladaptive patterns of behaviour that cause significant distress and impairment of functioning. These disorders are more appropriately conceptualised in dimensional rather than categorical terms: The distress and impaired functioning are the defining criteria and separate this group of disorders from the wide range of emotional and behavioural problems encountered in the general population. Treatment is often complex, lengthy and difficult.<sup>181</sup>

According to the DSM-IV<sup>182</sup> the general and specific criteria for the diagnosis of personality disorders are:

- A. An enduring pattern of inner experience and behaviour that deviates markedly from the experience of the individual's culture. This pattern is manifested in two (or more) of the following areas:
  1. *cognition* (perception and interpretation of self, others and events)
  2. *affectivity* (range, intensity, lability and appropriateness of emotional response)
  3. *interpersonal* functioning
  4. *impulse control*
- B. The enduring pattern is inflexible and pervasive across a broad range of personal and social situations.
- C. The enduring behavioural pattern causes clinically significant distress or impairment in social, occupational other important areas of functioning.
- D. The pattern is stable and of long duration and its onset can be traced back at least to adolescence or early adulthood.
- E. The enduring pattern is not better accounted for as a manifestation of another mental disorder.
- F. The enduring pattern is not due to the direct physiological effects of a substance (eg a drug of abuse, a medication) or general medical condition (eg head trauma).

#### Specific personality disorder criteria:<sup>183</sup>

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<sup>181</sup> Fainman in *Primary healthcare psychiatry: A practical guide for Southern Africa* 509. For further reading on this topic, see Castillo H *Personality disorder: Temperament or trauma?* (2003) 69ff; Loranger AW & Sartorius JN *Assessment and diagnosis of personality disorders* (1997) 3ff.

<sup>182</sup> American Psychiatric Association 633.

<sup>183</sup> According to DSM-IV paranoid personality disorder is a pattern of distrust and suspiciousness such that other's motives are interpreted as malevolent. Schizoid personality disorder is a pattern of detachment from social relationships and a restricted range of emotional expression. Antisocial personality disorder is a pattern of disregard for, and violation of, the rights of others. Histrionic personality disorder is a pattern of excessive emotionality and attention seeking. Avoidant personality disorder is a pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation. Dependent personality disorder is a pattern of submissive and clinging behaviour related to an excessive need to be taken care of. Personality disorder not otherwise specified is a category provided for two situations: Firstly where the individual's personality pattern meets the general criteria for a personality disorder and traits of several different personality disorders are present, but the criteria for any specific personality disorder are not met and; secondly where the individual's personality pattern meets the general criteria for a personality disorder, but the individual is considered to have a personality disorder that is not included in the Classification. See the definition of obsessive-compulsive disorder *supra*. See American Psychiatric Association *DSM-IV* 629; Fainman in *Primary healthcare psychiatry: A practical guide for Southern Africa* 509.

Cluster A (odd-eccentric) includes paranoid, schizoid and schizotypal.  
Cluster B (dramatic-emotional) comprises antisocial, borderline,<sup>[184]</sup> histrionic and narcissistic.  
Cluster C (anxious-fearful) comprises avoidant, dependent and obsessive-compulsive.

**Other specific personality disorders include:**

- A. Mixed personality disorder, where some traits of different specific personality disorders are met without sufficient criteria to be regarded as a case for one;
- B. Passive-aggressive personality disorder;
- C. Personality disorder secondary to catastrophic experiences (eg torture, prolonged incarceration) or chronic psychiatric illness (schizophrenia, depression) or following bereavement or chronic pain, and
- D. Personality disorder not otherwise specified, for example depressive personality disorder.

Medication for each specific personality disorder is available and long term treatment is required. During treatment specific problem areas should be targeted by means of techniques such as problem-solving, anger management, assertiveness training and social skills training.<sup>185</sup>

### 3.5 BIOLOGICAL APPROACHES TO THERAPY

#### 3.5.1 Drugs in psychiatry

##### 3.5.1.1 Psychotropic drugs

Psychotropic drugs are chemical agents that have an effect on the mind.<sup>186</sup> It affects normal and abnormal psychological processes through their action on the brain. During the second half of the twentieth century, following the introduction of chlorpromazine,<sup>187</sup> drug treatment became a major area of practice and research in mental illness.<sup>188</sup> The World Health Organization suggests the following classification of drugs which affect mainly mental symptoms:

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<sup>184</sup> Borderline personality disorder is a pattern of instability in interpersonal relationships, self-image, affects, and marked impulsivity. See also Gunderson JG *Borderline personality disorder: A clinical Guide* (2001) 3ff; Wirth-Cauchon J *Women and borderline personality disorder: Symptoms and stories* (2001) 1ff.

<sup>185</sup> Nair & Lay in *Textbook of psychiatry for Southern Africa* 252.

<sup>186</sup> Waldinger *Fundamentals of psychiatry* 396.

<sup>187</sup> Chlorpromazine is a phenothiazine antipsychotic and the oldest in the antipsychotic category of medication. It was mainly used in the treatment of schizophrenia, although it has also been used to treat severe manic episodes in people with bipolar disorder. Chlorpromazine was the first drug developed with a specific antipsychotic action in December 1950. Its use has been described as the single biggest advance in psychiatric treatment, heralding the era of biological psychiatry. Its use today has been largely supplanted by the newer atypical antipsychotics such as olanzapine, quetiapine, and risperidone. See Frank RG *Better but not well: Mental health policy in the United States since 1950* (2006) 28ff; Hogarty GE *Personal therapy for schizophrenia and related disorders* (2002) 108ff.

<sup>188</sup> Duncan A "Physical treatment in psychiatry" 73-110 in *Psychiatry for the developing world* 80.

### 3.5.1.2 *Antipsychotics*

Antipsychotic medications are useful primarily in the treatment of thought disorders and, more acutely, to relieve severe agitation. Most acutely psychotic patients will respond to antipsychotic medication.<sup>189</sup> Antipsychotic drugs exhibit possibly the most complex pharmacological mechanisms of any drug class in the field of clinical psychopharmacology.<sup>190</sup> Several illnesses usually call for the use of antipsychotic medication namely: Schizophrenia; bipolar disorder; amphetamine psychosis; drug-induced psychosis; agitated or psychotic depression; chronic brain syndromes; and anxiety.<sup>191</sup>

### 3.5.1.3 *Antidepressants*

Antidepressants fall into two major classes namely the tricyclic antidepressants and tricyclic-like medications and the monoamine oxidase inhibitors. These medications, along with electroconvulsive therapy are the most effective somatic therapies now available for the treatment of certain types of depression.<sup>192</sup> The depressive symptoms most likely to be alleviated by antidepressant medication are the vegetative signs, for example, appetite disturbance and weight loss; sleep disturbance (especially early morning awakening); decreased energy; decreased sexual drive; psychomotor agitation or retardation and diurnal mood variation (depression worse in the morning).<sup>193</sup> The symptoms less likely to respond to antidepressants are those that are the more subjective and psychological signs, for example, demoralisation; low self-esteem; hopelessness and helplessness. Such feelings are more responsive to psychotherapeutic interventions.<sup>194</sup>

### 3.5.1.4 *Anti-anxiety (anxiolytic) / hypnotic drugs*

The distinction between the anti-anxiety and sedative-hypnotic drugs is largely a matter of terminology. The same families of drugs have been used for both purposes. These drugs are among the most frequently prescribed drugs worldwide. Although the term sedative implies a depressant effect on arousal, causing

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<sup>189</sup> Andreasen NC & Black DW *Introductory textbook of psychiatry* (2006) 125.

<sup>190</sup> Stahl SM *Antipsychotics and mood stabilizers* (2008) 82ff.

<sup>191</sup> Csernansky JG & Lauriello J *Atypical antipsychotics: From bench to bedside* (2004) 207ff.

<sup>192</sup> Waldinger *Fundamentals of psychiatry* 422; Nicholi AM *The Harvard guide to psychiatry* (1999) 296.

<sup>193</sup> Rodin G *et al Depression in the medically ill: An integrated approach* (1991) 301ff; Waldinger RJ *Psychiatry for medical students* (1990) 542.

<sup>194</sup> Waldinger *Fundamentals of psychiatry* 423.

drowsiness, newer drugs are more specifically anxiolytic.<sup>195</sup> The older drugs were highly sedative and have now largely been abandoned except for particular indications. These drugs are mostly used for the treatment of debilitating anxiety and do not interfere with the REM (rapid eye movement)<sup>196</sup> sleep cycle. They are also used in some instances to treat psychosis and other behaviour disorders.<sup>197</sup>

### 3.5.1.5 Psychostimulants

Psychostimulants are controlled, amphetamine-like drugs<sup>198</sup> that are currently approved for the treatment of attention-deficit / hyperactivity disorder (ADHD) and for narcolepsy.<sup>199</sup> Some of these agents are also employed in the treatment of apathetic withdrawal in both medically ill and older (including dementia) patients.<sup>200</sup> A major drawback to the use of psychostimulants is their potential for abuse, dependence and addiction. Although there are no physical withdrawal symptoms, patients who have used high doses of psychostimulants for prolonged periods may experience a marked central syndrome, including fatigue, hypersomnia, hyperphagia (overeating) and severe depression in the short term and drug craving in the long term.<sup>201</sup>

Two other groups of drugs not mentioned in the World Health Organization Classification are *mood stabilisers* and *anti-Parkinson drugs*. Anti-Parkinson drugs<sup>202</sup> are types of drugs, which are intended to treat

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<sup>195</sup> Murray R & Hill P (eds) *et al The essentials of postgraduate psychiatry* (1997) 621ff. See also Bandelow B *et al* "Meta-analysis of randomized controlled comparisons of psychopharmacological and psychological treatments for anxiety disorders" 2007 8 *World J Biological Psychiatry* 175-187.

<sup>196</sup> REM sleep is a stage of sleep occurring in progressively lengthening episodes roughly every 90 minutes throughout the night in human adults and occupying about twenty percent of sleeping time and is strongly associated with vivid dreams. It is characterised by rapid eye movements, theta waves, absence of delta waves, and REM atonia (absence of normal muscle tonus) of the skeletal muscles preventing dreams being acted out. See Colman "REM sleep" 648.

<sup>197</sup> Torres LS *et al Basic medical techniques and patient care in imaging technology* (2003) 274.

<sup>198</sup> Amphetamines and amphetamine-like drugs are the most widely used illicit substances second to cannabis in the United States, Asia, Great Britain, Australia and several other Western European countries. These drugs are known to increase motivation, mood, energy and wakefulness. See Sadock & Sadock 1098.

<sup>199</sup> Narcolepsy is a rare neurological disorder, which is characterised by the following four symptoms: Sleep attacks; cataplexy (sudden and transient episode of loss of muscle tone, often triggered by emotions); sleep paralysis and; sleep-related hallucinations. A person with narcolepsy may experience any or all of these classic phenomena. See Balch PA *Prescription for nutritional healing* (2006) 590.

<sup>200</sup> Spiegel R & Fatemi SH *Psychopharmacology: An introduction* (2003) 24ff.

<sup>201</sup> Rosenbaum JF *et al Handbook of psychiatric drug therapy* (2005) 289ff.

<sup>202</sup> For a discussion of these drugs, see Duvoisin RC & Sage J *Parkinson's disease: A guide for patient and family* (2001) 55ff; McGoan DC *Parkinson's handbook* (1994) 1ff.

or relieve the symptoms of Parkinson's disease.<sup>203</sup> Most mood stabilisers are purely anti-manic agents, meaning that they are effective at treating mania and mood cycling and shifting, but are not effective at treating depression.<sup>204</sup> Even with the addition of these two drugs to the World Health Organization Classification, not all the drugs currently used in psychiatry fit into this scheme.<sup>205</sup>

### 3.5.2 Electroconvulsive therapy<sup>206</sup>

Electroconvulsive therapy is either administered unilaterally or bilaterally. Unilateral electroconvulsive therapy is the delivery of an electrical current through an electrode on one side of the head, usually the non-dominant cerebral hemisphere. Bilateral electroconvulsive therapy is the delivery of the electric current through electrodes placed on opposite sides of the head. The anatomical location is the mid point of each electrode placed approximately 4 cm above the midpoint of a line extending from the tragus of the ear to the external canthus of the eye.<sup>207</sup> The primary indication for electroconvulsive therapy is in the treatment of patients with major depression.<sup>208</sup> Such patients typically exhibit depressed mood, anorexia and weight loss, constipation, loss of sexual drive, early morning waking, agitation or retardation and ruminations of guilt, worthlessness, hopelessness and suicide. In severe cases, psychotic symptoms can be present in the form of mood-congruent delusions. Electroconvulsive therapy is also indicated for the treatment of patients who meet the criteria for schizophrenia.<sup>209</sup> There are drawbacks to electroconvulsive therapy, including the risks that occur with the use of any anesthetic and significant side effects include amnesia.<sup>210</sup>

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<sup>203</sup> Parkinson's disease is a slowly progressing degenerative disease affecting a small area of cells in the middle part of the brain. The degeneration of these cells can lead to one or more of the typical signs of Parkinson's disease, including tremors, slow movement, stiff limbs, balance problems and depression. See Christensen JH & Tuite P *Parkinson's disease: An essential guide for the newly diagnosed* (2005) 1.

<sup>204</sup> Fatemi HS *et al* *The medical basis of psychiatry* (2008) 604ff.

<sup>205</sup> Duncan in *Psychiatry for the developing world* 82.

<sup>206</sup> See also the discussion of electroconvulsive therapy in chapter 2.

<sup>207</sup> Duncan in *Psychiatry for the developing world* 77. For a comprehensive discussion of electroconvulsive therapy, see Abrams R *Electroconvulsive therapy* (1992) 3-7, 10-21, 22-46.

<sup>208</sup> Croake MMJ *Treatment of depression in managed care* (1997) 108ff.

<sup>209</sup> Abrams R & Swartz CM *ECT instruction manual* (1989) 20-21.

<sup>210</sup> Seligman L & Reichenberg LW *Selecting effective treatments: A comprehensive, systematic guide to treating mental disorders* (2007) 201ff.

### 3.6 THE MENTALLY DISORDERED OFFENDER<sup>211</sup>

The relationship between disorder and crime varies from case to case and a failure to consider the alternatives sometimes leads to erroneous conclusions. Although not uniform, the relationship between mental disorder and crime is not so variable as to be unique to each case. According to Dietz,<sup>212</sup> certain patterns occur with sufficient frequency that should be considered in every case. He describes the five patterns frequently observed among mentally disordered offenders (according to the relationship between the mental disorder and the criminality) as:

- Pattern 1: *Crime in response to psychotic symptoms*: Crimes committed in obedience to command hallucinations or in accordance with other psychotic perceptions sometimes meet cognitive tests of insanity, but it is less clear whether they ever meet volitional tests of insanity, which prove for exculpation of offenders who acted under an irresistible impulse or whose capacity to conform their conduct to the requirements of law was impaired substantially by mental disease at the time of the offence.<sup>213</sup>
- Pattern 2: *Crime to gratify compulsive desire*: In these cases mental disorder provides the motive for the crime, but does not impair the offender's knowledge of what he or she is doing or that it is wrong. Examples are crimes motivated by sexual sadism; crimes committed by kleptomaniacs and; illegal gambling by compulsive gamblers.
- Pattern 3: *Crime reflecting personality disorder*: Many mentally disordered offenders are pattern three offenders, most often antisocial adults or conduct-disordered youngsters. Some of these defendants have other conditions as well that provide an arguable, though sometimes unsuccessful basis for presenting an insanity defence or for mitigation at sentencing, for example, post-traumatic stress disorder.
- Pattern 4: *Coincidental crime and mental disorder*: In this pattern there occurs to be a crime committed, which is unrelated to and not a result of the person's mental disorder. It illustrates the coincidental occurrence of mental disorder and criminality in a single individual.<sup>214</sup>

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<sup>211</sup> See chapter 5 for a more detailed discussion on this topic and the insanity defense.

<sup>212</sup> Dietz PE "Mentally disordered offenders: Patterns in the relationship between mental disorder and crime" 1992 15 *Psychiatric Clinics of North Am* 3: 539 at 540, 544, 546, 547, 549.

<sup>213</sup> See also Hollin CR *Criminal behaviour: A psychological approach to explanation and prevention* (1992) 105ff.

<sup>214</sup> See also Eysenck HJ & Gudjonsson GH *The causes and cures of criminality* (1989) 217.

- Pattern 5: *True or feigned mental disorder in response to crime*: This pattern refers to the offender developing symptoms of mental disorder that were not present before or during committing the crime. Such cases often pose a difficult diagnostic challenge, particularly because there are usually no pre-offence psychiatric records. Perhaps the most diagnostically challenging of all cases are talented and well-trained malingerers,<sup>215</sup> such as those who have succeeded in malingering mental illness for so long that they have learned all the symptomatic nuances from fellow patients or those who have been trained to enact the role of multiple personality disorder by therapists and examiners who specialise in the condition.<sup>216</sup>

Dietz<sup>217</sup> explains that pattern 1 offenders do meet legal criteria for insanity, depending on the facts of each case and the applicable legal standards. It is arguable whether or not pattern 2 offenders ever meet legal criteria of insanity. Offenders evidencing only patterns 3, 4, or 5 are not candidates for an insanity defence.

### 3.7 CONCLUSION

This chapter sought to provide an overview of the clinical aspects of psychiatry and psychology as well as an explanation of the nature and scope of both professions. It further included discussions with regard to the classification and diagnosis of diseases in clinical and forensic settings and provided an explanation of the concept of mental disorder, together with an explanation of the concept of disease of the mind. It further explained some clinical and biological approaches to therapy and to the treatment of patients who suffer from mental disorder. It also began to focus on the relationship between mentally disordered individuals and crime and reviewed diagnostic categories that are most often associated with criminal behaviour namely schizophrenic disorders; paranoid disorders; mood disorders and personality disorders. Persons accused of crime may introduce these diagnoses to support an insanity defence.

It is clear from the discussion above that psychiatrists and psychologists work to develop a valid and reliable body of scientific knowledge based on research. They apply that knowledge to human behaviour in

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<sup>215</sup> Malingering is the intentional feigning or exaggeration of physical or psychological symptoms, motivated by external incentives such as avoidance of work or military service, receipt of financial compensation, evasion of criminal prosecution or procurement of prescription drugs. See Colman "malingering" 438.

<sup>216</sup> See also Prins HA *Offenders, deviants, or patients: An introduction to the study of socio-forensic problems* (1980) 41ff.

<sup>217</sup> Dietz 1992 *Psychiatric Clinics of North Am* 540-541.

a variety of contexts. In doing so, they perform many roles, such as researcher, educator, diagnostician, therapist, supervisor, social interventionist and expert witness. Their goal is to broaden knowledge of behaviour and, where appropriate, to apply it pragmatically to improve the condition of both the individual and society. They further strive to help mentally disordered patients in developing informed judgments and choices about their treatment and behaviour.<sup>218</sup>

Psychiatrists and psychologists are further important role players in the legal environment. As explained by Allan<sup>219</sup> in view of the tentative nature of psychiatric and psychological disorders, it is imperative that practitioners remind themselves and legal practitioners that diagnostic constructs should be used with caution in legal settings, preferably only if the diagnosis satisfies the legal perception of scientific credibility. This means that at the very least the witness must be able to demonstrate that the disorder is generally accepted as evidenced by its inclusion in a diagnostic manual and / or published peer reviews. Even then a diagnosis should only be given if the required diagnostic criteria are present. A competent witness should also have data on the other indicators of scientific credibility that may also be relevant depending on the specific issues contested in the case.

It remains however a fact that psychiatrists and psychologists encounter legal and ethical conflicts whenever they enter the courtroom. Their approach must not be simply diagnostic, simply ethical or simply legal. They must be able to translate their findings for the court, but these findings must come from clinical experience, not some solely legal or ethical perspective. The legal system needs psychiatric and psychological knowledge about the interfaces of mental disorders, function and behaviour. However, after they provided their opinions, the legal issues must be left to the legal practitioners and the final determinations left to the judge.<sup>220</sup> With the research conducted in this chapter as background information, the next chapter explains the relevant ethical issues that the psychiatric and psychological professions encounter.

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<sup>218</sup> American Psychological Association "Ethical principles of psychologists and Code of Conduct" 6-24 in *Ethical conflicts in psychology* (ed) Bersoff DN (1996) 7.

<sup>219</sup> Allan 2005 *S Afr J of Psychiatry* 52 at 55.

<sup>220</sup> Reid & Wise *et al* 1992 *Psychiatric Clinics North Am* 529

## CHAPTER 4:

### THE REGULATION OF THE PSYCHIATRIC AND PSYCHOLOGY PROFESSIONS

"Always do right. This will gratify some people, and astonish the rest."<sup>1</sup>

#### 4.1 INTRODUCTION

In the strict sense, apart from certain supreme provisions in the Constitution of the Republic of South Africa<sup>2</sup> and the applicable national common law principles, which may generally impact on the medical profession in South Africa, the practice of the psychiatric and psychology professions is primarily regulated by statute. This chapter, therefore contains various and long discussions (and sometimes direct quotes) from the relevant statutes and ethical codes. Pivotal to all the statutory enactments governing the professions is The Health Professions Act.<sup>3</sup> This Act is of particular importance as it establishes the Health Professions Council of South Africa (HPCSA), a statutory body that is the main regulator together with twelve Professional Boards that operates under its jurisdiction to, *inter alia*, promote the health of the South African population, determine standards of professional education and training and set and maintain fair standards for professional practice.<sup>4</sup> The Medical and Dental Professions Board, which includes psychiatry

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<sup>1</sup> Twain M as quoted in *Ethics in psychology and mental health professions: Standards and cases* ((eds) Koocher G & Keith-Spiegel P) (2008) 3.

<sup>2</sup> The Constitution of the Republic of South Africa, 1996.

<sup>3</sup> The Health Professions Act 56 of 1974 as amended by Act 89 of 1997 (hereafter referred to as the Health Professions Act). The long title of Act 56 of 1974 as amended by s 13 of Act 18 of 1995 and s 66 of Act 89 of 1997 reads: "To establish the Health Professions Council of South Africa; to provide for control over training, registration and practices of practitioners of health professions; and to provide for matter incidental thereto". See Carstens PA & Pearmain DL *Foundational principles of South African medical law* (2007) 249-250.

<sup>4</sup> In *Veriava v President, South African Medical and Dental Council* the court ruled that the South African Medical and Dental Council is the *custos morum* of the medical profession and as such indeed the guardian of the prestige, status and dignity of the profession and public interests. See *Veriava v President, South African Medical and Dental Council* 1985 (2) SA 293 (T) 316D-E. For further reading on the topic of the HPCSA, see, for example, Carstens & Pearmain 249-281; Strauss SA and Strydom MJ *Die Suid-Afrikaanse geneeskundige reg* (1967) 10ff; Bateman C "Landmark HPCSA inquiry picks up steam" 2002 92 *S Afr Med J* 7: 492-494; Dhai A & Mkhize B "The Health Professions Council of South Africa and the medical practitioner: Changes in the Health Professions Council of South Africa over the past decade" 2006 16 *S Afr J of Cont Med Edu* 1: 8-11; McQuoid-Mason DJ and Strauss SA "Medicine, dentistry, pharmacy, veterinary practice and other health professions" in *The law of South Africa first reissue Vol 17* ((eds) Joubert WA and Scott TJ) (1999) par 204; Strauss SA "Reëls van die Mediese Raad" 1988 9 *S Afr Practice Management* 3: 5; Strauss SA "Penalties for unprofessional conduct: Practitioner may now be fired by SAMDC" 1991 12 *S Afr Practice Management* 1: 16-17; Strauss SA "Hoe SAGTR se tugkomitee die ondersoek moet hanteer" 1992 13 *S Afr Practice Management* 1: 14-18; Taitz JR "The disciplinary powers of the South African Medical and Dental Council" 1988 *Acta Juridica* 40-64; Verschoor TJ *Verdicts of the Medical Council* (1990); Verschoor TJ and Oosthuizen H (eds) *Handbook of the rules and regulations for medical practitioners and dentists* (1990); Strauss *Doctor, patient and the law: A selection of*

and the Professional Board for Psychology both operate under the jurisdiction of the HPCSA.<sup>5</sup> In addition to the statutory framework regulating the medical profession is the Traditional Health Practitioners Act,<sup>6</sup> which was introduced to establish the Interim Traditional Practitioners Council of South Africa and to give recognition to the role of traditional healers practising in conjunction with medical practitioners<sup>7</sup> trained in western medicine in South Africa. This Act is however not yet fully in operation.

The legal and ethical regulation of the medical profession is intimately interrelated, but the two are not identical. Ethical regulation deals with right versus wrong; with value systems and their relationships and with how they may govern individual conduct. Laws are ruling on right or wrong when legal intervention is demanded.<sup>8</sup> Although psychiatrists and psychologists would like to believe that ethical issues encountered in their practices can be viewed in black and white - they mostly come in shades of gray. That is why the practice of psychiatry and psychology require an ongoing examination and discussion of both long-standing and evolving practical issues as well as the ethical, legal and professional resources on which they rely to guide their professional conduct. There are many factors that can contribute to ethically questionable conduct or clear misconduct on the part of the psychiatrist and psychologist, some of which is intentional

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*practical issues* 369; Van Oosten FFW "Medical law: South Africa" in *International Encyclopaedia of laws* (1996) ((ed) Blanpain R); Strauss SA "Medical law – South Africa" in *International Encyclopedia of laws* (eds Blanpain R and Nys H) (2006); Van den Heever P *The application of the doctrine of res ipsa loquitur to medical negligence cases: A comparative survey* (unpublished LLD thesis, UP, 2002) 341ff.

<sup>5</sup> Section 15 of the Health Professions Act provides for the establishment of Professional Boards with regard to any profession in respect of which a register is kept in terms of the Act, or with regard to two or more such professions. These professional boards operate in conjunction with, and under the jurisdiction of, the HPCSA to broadly promote the health of the South African population, to determine standards of professional education and training, and to set and maintain fair standards of professional practice. The following professional boards operate under the jurisdiction of the HPCSA: Professional Board for Dental Therapy and Oral Hygiene; Professional Board for Dietetics; Professional Board for Emergency Care Practitioners; Professional Board for Environmental Health Practitioners; Medical and Dental Professions Board; Professional Board for Medical Technology; Professional Board for Occupational Therapy and Medical Orthotics/Prosthetics; Professional Board for Optometry and Dispensing Opticians; Professional Board for Physiotherapy, Podiatry and Biokinetics; Professional Board for Psychology; Professional Board for Radiography and Clinical Technology; and the Professional Board for Speech, Language and Hearing Professions. In context of this thesis, the Professional Board for Psychology and the Medical and Dental Professions Board is of particular importance. The Medical and Dental Professional Board is exclusively responsible for dealing with all registered medical and dental practitioners as well as the training of medical and dental students in South Africa. See s 15 of the Health Professions Act; Carstens & Pearmain 253.

<sup>6</sup> The Traditional Health Practitioners Act 35 of 2004 (hereafter referred to as the Traditional Health Practitioners Act). Under section 52 of the Traditional Health Practitioners Act, 13 January 2006 was determined as the date on which sections 7, 10, 11(3), 12-15, 47, 48 and 50 of the said Act came into operation.

<sup>7</sup> "Medical practitioner" means a person registered as such under the Health Professions Act. See s 1.

<sup>8</sup> Greenblatt M "Law and ethics in psychiatric administration" 68-75 in *Principles and practice of forensic psychiatry* ((ed) Rosner R) (1994) 68.

and some of which is unintentional. In an attempt to prevent such claims from succeeding and to alert psychiatrists and psychologists to the concurrent ethical problems that may lead to malpractice suits, this chapter offers material on some important issues such as: Ethical decision-making and principles; professional ethics; the regulation of psychiatry and psychology as professions; the Code of Ethical Rules and Rulings of the HPCSA in the context of unprofessional conduct;<sup>9</sup> the Ethical Code of Professional Conduct to which a Psychologist should adhere; ethical aspects and issues pertaining to forensic psychiatry and psychology in general; some ethical issues pertaining to child forensic psychiatry and psychology; summary guidelines for ethical decision-making; and some steps to follow to ensure sound ethical decision-making. The scope of this thesis does not allow for the provision of a detailed, in-depth ethical framework. It merely attempts to highlight some of the relevant issues in the field of ethics in psychiatry and psychology.

## 4.2 THE CONCEPTS OF "PROFESSION" AND "PROFESSIONALISM" IN MEDICINE: AN OVERVIEW

### 4.2.1 Introductory remarks

This overview serves as a background for the formulation and explanation of the concepts of "professionalism" and "profession" with regard to medical, psychiatric and psychological practices. According to Carstens<sup>10</sup> the application of these concepts in medical practice serves as a normative yardstick and is indicative of a professional code of conduct, which sets the acceptable requirements and boundaries to which medical practice should conform. The importance thereof is further pivotal in the assessment of "professional medical negligence" and "unprofessional conduct with regard to the profession" of medical practitioners. An understanding of "professionalism" is therefore the key to an appreciation for the ideals and actualisation of the medical, psychiatric and psychology professions.

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<sup>9</sup> Disciplinary proceedings against medical practitioners, psychiatrists and psychologists and the concept of "unprofessional conduct" are discussed in chapter 6, where the legal liability of medical practitioners is discussed in detail. Some mention is also made of disciplinary proceedings against traditional health practitioners (to be regulated by the Traditional Health Practitioners Act).

<sup>10</sup> Carstens & Pearmain 606-607; Carstens PA *Die strafregtelike en deliktuele aanspreeklikheid van die geneesheer op grond van nalatigheid* (unpublished LLD thesis, UP, 1996) 103. See also Ficarra BJ "Prophylaxis against medical negligence" 1978 *Legal Med Annual* 287 at 319.

#### 4.2.2 The medical profession

Burnham<sup>11</sup> submits that medical historians simply cannot escape the notion of "profession". He states that there is something special about medicine namely the "spirit of professionalism", which already existed in Western cultures.<sup>12</sup> In defending the exceptionalism of medical history and medical historians, Burnham provides a curiously idealistic history of ideas.<sup>13</sup> According to him most medical historians working with primary sources found references to the profession of medicine. The word "profession" is found, with varying frequency, in the literature of medicine from medieval times to the present. From ancient times, medical writers occasionally referred to the expertise of physicians as a profession. In addition to this idea of profession as special knowledge, however, a second meaning developed: a collectivity of those who defined themselves, and were defined by society, as practitioners who followed the vocation of medicine. Moreover, the identity of "professional" took on historical and social meanings. It is those meanings, so important in very modern discussions, and the accompanying spirit of professionalism, that Burnham researched in the writings of medical historians.<sup>14</sup>

Historical writers have depicted the work of Le Clerc,<sup>15</sup> first published in 1696, as the model that established the traditional format of the history of medicine. He noted that some ancients made physic "their sole

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<sup>11</sup> Burnham JC "How the idea of profession changed the writing of medical history" 1998 18 *Medical Hist Suppl* 1 at 160.

<sup>12</sup> Throughout Western European history there were two major trends: the professionalism of physicians who belonged to the upper classes and the folk healers who lived among the peasant population. The professionals developed in order to enhance their status in life, while the folk healers developed out of the necessity to survive. In Europe, the Catholic church played a central role. At first, the Church suppressed all development. Later on, the Church supported the development of professional physicians. For further reading on this topic see Worsley P "Non-Western medical systems" 1982 11 *Annual Rev Anthropology* 315 at 320, 321, 322, 324, 327, 328; Frevert U "Professional medicine and the working classes in imperial Germany" 1985 20 *J Contemp History* 4: 637-658.

<sup>13</sup> Burnham 1998 *Medical Hist Suppl* 1 at 160. See also Lloyd PJ "A history of medical professionalisation in NSW: 1788-1950" 1994 17 *Aust Health Rev* 2: 14ff; Novak SJ "Professionalism and bureaucracy: English doctors and the Victorian public health administration" 1973 6 *J Soc Hist* 4: 440ff.

<sup>14</sup> Burnham JC "How the concept of profession evolved in the work of historians of medicine" 1996 70 *Bull Hist of Med* 1: 1-2. The topic of medicine as a profession and medical professionalism have also been discussed by Gelfand T "The history of the medical profession" in *Companion encyclopaedia of the history of medicine* (eds Bynum WF & Porter R) (1993) 1119-1150; Bostock J *Sketch of the history of medicine* (1835) 13, 22, 26, 40, 41 44, 56, 58, 59, 73-81, 104, 115, 121, 139-150, 167-192, 210-240; Farr W "History of the medical profession and its influence on public health in England" 1839 *Med Annual* 113-178; Singer C *A short history of medicine: Introducing medical principles to students and non-medical readers* (1928) viiiiff; Bullough VL *The development of medicine as a profession: The contribution of the Medieval University to modern medicine* (1966) 1-125. This book examines the development of medicine as a profession from ancient times to the end of the Medieval Period and argues that the major contribution of medieval medicine to modern medicine was the professionalisation of the physician.

<sup>15</sup> Daniel Le Clerc was a learned physician-historian (1652-1728). It may be worth mentioning that little attention was paid to the history of the medical profession before the seventeenth and even eighteenth centuries. The few works published

profession," and he observed that Hippocrates was able to "support the reputation of his profession by his works as well as by his words." In general, then, Le Clerc used "profession" as an equivalent to occupation or vocation - that is, calling, as understood in the 1690s.<sup>16</sup> In 1725-1726 Friend,<sup>17</sup> a member of the English medical elite published another landmark medical history, bringing the story of medicine down through the sixteenth century. Freind used "profession" more frequently than Le Clerc, but without adding to it any new meaning.<sup>18</sup> In 1839 Farr, in the midst of well-known professional struggles in England, wrote explicitly about the history of the medical profession. In a lecture presented in London he gave a valuable study of Hippocrates and of critical days in disease. Answering the question: "Why study hygiene when by promoting the general health it would diminish the number of patients?" he replied: "I know that our profession will not for a moment harbour sentiments so base ... We exist as a body to promote the public health".<sup>19</sup> It was with this sentiment as his pole-star that Farr was able to prepare the way for and to facilitate greater sanitary reforms than have occurred in any other period of human history.<sup>20</sup> Learned

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prior to Le Clerc's *Histoire de la médecine* (1696) were largely concerned with the lives of the physicians and the medical sects. See Shorr P "Sir John Friend (1675-1728) M.D. pioneer historian of medicine" 1937 27 *Isis* 3:453.

<sup>16</sup> Burnham 1996 *Bull Hist of Med* 1 at 3-4, cf Clark G "The history of the medical profession: Aims and methods" 1966 10 *Medical Hist* 3: 213ff.

<sup>17</sup> John Freind was a well known physician-historian (1675-1728). Before the appearance of Freind's *History of Physick: From the time of Galen to the beginning of the sixteenth century* - chiefly with regard to practice, in a discourse written to doctor Mead (published in two volumes 1725 & 1726) - only two books were published on the topic of medicine, namely Barchusen JC *Historia medicinae* (1710), which dealt with the history of medical sects and the other by Goelicke AO entitled *Historia medicinae universalis* (1721), which dealt with the antediluvian epoch, the Egyptian period and further to the period of the Alexandrian school. See Shorr 1937 *Isis* 453 at 454.

<sup>18</sup> Freind noted, for example, that in 1310 Robert, King of Naples, "had in his service two Physicians, who made a considerable figure in their Profession at that time." Freind spoke of "professing medicine," and he also used the term in the classic sense as the knowledge base of medicine: "[I]n other branches of the profession there were some advances made: for instance, the Physicians began to make more curious inquiries into the qualities of mineral waters." See Burnham 1996 *Bull Hist of Med* 1 at 3, 6.

<sup>19</sup> Burnham 1996 *Bull Hist of Med* 1 at 3. See also London School of Economics and Political Science, Suntory-Toyota International Centre for Economics and Related Disciplines, IngentaConnect (Online service), JSTOR (Organization), OCLC FirstSearch Electronic Collections Online, Synergy (Online service) *Economica* (1923) 189.

<sup>20</sup> William Farr (1807-1883) entered the field of vital statistics after a period of medical study which included two years in Paris during the late twenties. This was the period when the noted French statistician Louis René Villermé was beginning his investigations in Paris into the relationship between public health and social conditions, and Villermé's work must have come to the notice of Farr. It was also the period during which he noted physician Pierre Louis establishing the "numerical method" in clinical *medicience*, which also may have had its effect upon Farr. He was greatly skilled in medical statistics and in the history of medicine. See Hilts VL "William Farr (1807-1883) and the 'human unit'" 1970 14 *Victorian Studies* 2: 143 at 144; Newsholme A "The measurement of progress in public health with special reference to the life and work of William Farr" 1923 9 *Economica* 186 at 189.

physicians even before the eighteenth century had long searched in history for much of the authority that later physicians would derive from science.<sup>21</sup>

Theories and concepts about the medical profession tend to reflect the norms and outlook of their time. Parsons<sup>22</sup> recast the medical profession's norms about how doctors and patients should behave into normative sociological theory purporting to describe how they do behave. Most of medical sociology, working comfortably within the profession's construction of reality, followed his lead, but Freidson<sup>23</sup> challenged the tenets of normative theory. His ultimate concern is with the practitioner-client relationship as it is moulded by structural considerations which flow into it from both sides of the relationship. At the larger level, his theory of professional dominance challenged the normative concepts of Parsons about the nature of the profession. For example, normative theory held that professional training differed from others in being prolonged, specialised, and theoretical. Freidson provocatively asked how prolonged, how specialised, and how theoretical must it be to qualify as "professional"? Professions were said to be special in their service orientation, but how would one measure the difference between this orientation and that of a waiter or myriad other service "professionals"?<sup>24</sup> He concluded that the professions dominance over its sphere of work is what distinguishes it, or at least in the profession of medicine.<sup>25</sup> Professionalism, as

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<sup>21</sup> Huisman F & Warner JH (eds) *Locating medical history: The stories and their meanings* (2004) 5, 24. Eighteenth century medicine is discussed in this part of the book and reference is also made to the medical profession "... to create responsible physicians; as a tool in researching the etiology of epidemic disease; as platform for legitimizing the medical profession; as a source of metaphors to analyze society; ... ." Burnham refers to Kurt Sprengel who at the end of the eighteenth century in his work, *Versuch einer pragmatischen Geschichte der Arzneikunde* (published in five volumes 1792-1803) also characterised medicine as a profession. See Burnham 1996 *Bull Hist of Med* 1 at 3.

<sup>22</sup> Talcott Parsons (1902-1979) was for many years the best known sociologist in the United States as well as one of the best known in the world. See Parsons T *The social system* (1951) 120, 238, 428-479; Parsons T *Essays in sociological theory* (1954) 34-68; cf Light D & Levine S "The changing character of the medical profession: A theoretical overview" 1988 *66 Milbank Q* 2: 10 at 12.

<sup>23</sup> Eliot Freidson (1923-2005) was a distinguished student of the sociology of professions. He had been particularly interested in the sociology of medicine, where his contributions have long been appreciated by physicians concerned with the ethical and social aspects of their profession. See Freidson E "The impurity of professional authority" in *Institutions and the person* (Becker HS & Geer B *et al* eds) (1968) 25-34; Freidson E "The changing nature of professional control" 1984 *10 Annual Rev Soc* 1ff. For a discussion of the concept of professionalism, see also Freidson E *Professionalism reborn: Theory, prophecy, and policy* (1994) 47-92, 147-216.

<sup>24</sup> Freidson E "The reorganization of the medical profession" 1985 *42 Medical Care Rev* 11ff.

<sup>25</sup> *Ibid.* In this context dominance refers to autonomy over one's work. According to Light & Levine, this seems necessary but not sufficient for dominance. Many occupations have autonomy over their work without having much power. A second example is control over the work of others in one's domain. Such control provides power well beyond autonomy, but it implies bureaucratic structures (like hospitals), and bureaucracies have a way of generating their own sources of power through regulations and hierarchy. Another source of professional dominance lies in the cultural beliefs and deference that people exhibit toward doctors as healers. This credibility is reproduced in the class hierarchy, institutions, and culture of medicine. They further argue that culture is the most fundamental source of professional power; but it is subtle,

rewritten by Foucault, became a "new 'micro-physics' of power," indeed the quintessentially modern mode of wielding power. According to Goldstein it is hardly surprising that the "disciplines"/"professions" grew up, as Foucault repeatedly pointed out, in close collaboration with the state, making use of those bureaucratic and "police" networks which had been spun out by the early modern state to check, observe, and preserve the population systematically.<sup>26</sup>

By the early twentieth century, the "history-of-ideas" and "great-doctors" approach had become a fixed convention. Within that convention, earlier authors like Haeser<sup>27</sup> concentrated on the body of learning, which in later formulations appeared as the necessary identifying basis of the profession of medicine.<sup>28</sup>

#### 4.2.3 The South African medical profession

There was significant differentiation within the South African medical profession during the first half of the nineteenth century in the Cape Colony that contributed to a slow and uneven process of professionalisation. Differences in permitted practice, settlement patterns, economic and organisational opportunities gave doctors in Cape Town, the colony's biggest and most important city, greater incentives and more scope to develop professional regulation and organisation than those in the rest of the colony. A

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intangible, and may shift the ground from under the feet of the profession as deference is replaced by wariness. A final source of dominance would be institutional power. For a comprehensive discussion of the concepts of "profession", "professionalism", and the three alternate and distinct concepts that challenge these concepts (deprofessionalisation, proletarianisation and corporatisation), see Light & Levine 1988 *Milbank Q* 10 at 12ff; Alexander JA & Morrissey MA *et al* "Effects of competition, regulation, and corporatization on hospital-physician relationships" 1986 27 *J Health & Soc Behaviour* 3: 220 at 221-225.

<sup>26</sup> Foucauldian "discipline" carries a threefold connotation: a branch of knowledge; the particular modes of "training" to which the clientele of the professional is subjected; and finally the rigorous "disciplined" training to which the professional has himself submitted (for everyone in the Foucauldian system, the supposed elite as well as the supposed underlings, is equally in the thrall of "discipline) and through which he has gained mastery over a body of knowledge and has come to view his possession of this knowledge as entailing a serious commitment or higher calling. See Goldstein J "Foucault among the sociologists: The 'disciplines' and the history of professions" 1984 23 *Hist & Theory* 2: 170 at 176-179.

<sup>27</sup> According to Haeser (1811-1885), a widely famous medical historian (particularly eminent for his history of epidemic diseases), an account of physicians and discoveries was a very relevant history of one aspect of a modern profession: the knowledge base with an emphasis on a scientific knowledge base. See Ebenezer H & Baas JH *Outlines of the history of medicine and the medical profession* (1889) 947, 1123.

<sup>28</sup> One explicit and widely imitated example of this genre was the deft synthesis of the history of medicine written by Fielding Hudson Garrison (1870-1935), first published in 1913. Garrison was a student of the history of medicine and was recognised as the pre-eminent American authority in this field. In 1911, he published in *JAMA* a list of classic medical publications, the by product of research he had done for an exhibit of significant books, pamphlets and articles in the library's collection. This checklist of milestones in the development of medicine from ancient times to the 20th century was revised and greatly expanded by Garrison in 1933 and later by others. See Burnham 1996 *Bull Hist of Med* 1 at 3, 7, 8, 9; Colman EG "A portrait of Fielding H Garrison (1870-1935): America's pioneering medical historian" 2004 12 *J Medical Biography* 4: 222-230.

government Ordinance passed in 1807 gave regularly trained medical practitioners a legal monopoly over medical practice, but did not initially prevent those practising outside Cape Town from selling both medicines and medical advice. Cape Town doctors enjoyed greater social differentiation from tradesmen and better legal control over competition from druggists and "irregulars" than country practitioners by representing themselves as "professional gentlemen" within the professional model of the time.<sup>29</sup> It was in 1880 during the period of industrialisation that many doctors immigrated to the Cape and were able to organise themselves into a powerful profession. These doctors were regulated and licensed by state appointed Medical Committees until 1891. No medical education was available in Cape Town Universities until the early twentieth century.<sup>30</sup>

#### 4.2.4 The psychiatric profession

The rise of the psychiatric profession is seen by traditionalists as a consolidation of the reformer's gains. Revisionists like Scull<sup>31</sup> have exposed the realities of contradiction and conflict in the relationship between the medical profession and the reformers regarding the care and treatment of the mentally ill.<sup>32</sup> Nevertheless, psychiatry developed as a clinical and academic profession (a medical specialty) in the early nineteenth century, particularly in Germany. It became a subject of clinical demonstration and a discipline in its own right.<sup>33</sup> The field sought to systematically apply concepts and tools from general medicine and neurology to the study and treatment of abnormal mental distress and disorder. The term psychiatry was coined in 1808 by Reil, from the Greek words *psyche* (soul) and *iatros* (doctor).<sup>34</sup> Official teaching of

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<sup>29</sup> Deacon HJ "Cape Town and 'country doctors' in the Cape Colony during the first half of the nineteenth century" 1997 *Soc Hist Med* 25.

<sup>30</sup> For a comprehensive discussion of professionalisation of Cape Town doctors, see Deacon & Phillips 17-104.

<sup>31</sup> Scull argued that the medical profession was barely interested in mental health until during the middle of the eighteenth century when a number of doctors realised the profits to be made in private "mad-trade". This suggests that their motivations and intentions went beyond a straightforward desire to improve the treatment of the mentally disordered. See Coppock V & Hopton J *Critical perspectives on mental health* (2000) 20.

<sup>32</sup> The psychiatric profession has constantly faced challenges to its legitimacy in terms of the legal codification of its activities. Focus was primarily on the processes surrounding the detention of individuals diagnosed as mentally ill and the supervision and management of psychiatric institutions. Of crucial significance was the creation of a fluid boundary between legal and medical control. See Coppock & Hopton 117, 155.

<sup>33</sup> Marx OM "What is the history of psychiatry?" 1992 3 *Hist Psychiatry* 11: 279 at 281.

<sup>34</sup> Johann Christian Reil (1759-1813) was one of the most highly regarded German medical scientists of the late eighteenth century. He divided medicine into three fields namely physiology, anatomy, and psychiatry and he made important contributions to each of these with his early work on a non-vitalistic physiology, his anatomical studies of the nervous system, and his pioneering work in psychiatry and the reform of mental asylums. Prior to 1808, the term "psychic medicine" had been used. The word psychiatry also refers to "healer of the spirit". See Richards RJ "Rhapsodies on a cat-piano, or Johann Christian Reil and the foundations of romantic psychiatry" 1998 24 *Critical Inq* 3: 700 at 702ff;

psychiatry first began in Leipzig in 1811, with the first psychiatric department established in Berlin in 1865. Rush<sup>35</sup> pioneered the same approach in the United States.

It has been said that psychiatry, born out of jails and asylums, had a more ignoble birth than other branches of medicine. Although psychiatry is perhaps the first specialty to develop out of medicine, the field soon became lost to scientific medicine in the morass of the concerns of its custodial institutions. Only recently in its development did it rejoin the movement of scientific and therapeutic medicine but the psychiatrist may still remain somewhat isolated in his special concerns.<sup>36</sup>

#### 4.2.5 The psychology profession

In Europe, Melancthon<sup>37</sup> is credited with coining the term psychology, which was popularised by von Wolff,<sup>38</sup> but gained little usage until the early eighteenth century.<sup>39</sup> The establishment of psychology as an independent discipline, separate from the disciplines of philosophy and biology from which it emerged, is attributable to the German psychologist, Wundt.<sup>40</sup> He stated in the opening sentence of his book *Principles of physiological psychology* in 1873: "The book that I herewith offer to the public attempts to mark out a new domain of science." This was the first major textbook of experimental psychology published in 1904. Wundt also founded the first psychological laboratory in Leipzig in 1879.<sup>41</sup>

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Broman T "University reform in medical thought at the end of the eighteenth century" 1989 5 *Osiris* 2: 36ff; Broman T "Rethinking professionalization: Theory, practice and professional ideology in eighteenth-century German medicine" 1995 67 *J Mod History* 4: 835 at 865-867.

<sup>35</sup> (1746-1813.) Benjamin Rush is known as the "father of American psychiatry". He published the first textbook on mental disorders in the United States in 1812: *Medical inquiries and observations upon the diseases of the mind*. He undertook to classify different forms of mental disorders and to theorise as to their causes and possible cures. See Deutsch A *The mentally ill in America - A history of their care and treatment from Colonial times* (2007) 72ff.

<sup>36</sup> Smith HL "Psychiatry in medicine: Intra-or-inter-professional relationships?" 1957 63 *Am J Sociology* 3: 285 at 286.

<sup>37</sup> (1497-1560.) Philip Melancthon was a German professor, philosopher and theologian, and a friend and associate of Martin Luther. See Kusakawa S *The transformation of natural philosophy: The case of Philip Melancthon* (1995) 1ff.

<sup>38</sup> (1679-1754.) Christian von Wolff was an advocate of the complete secularisation of education. He was the most eminent German philosopher between Leibniz and Kant. See Arrington RL & Beversluis J (eds) *A companion to the philosophers* (1999) 4ff.

<sup>39</sup> See Nicholas L "Introduction" 1-8 in *Introduction to psychology* (ed) Nicholas L (2008) 1-2.

<sup>40</sup> (1832-1920.) Wilhelm (Max) Wundt, a professor of physiology and philosophy, has been generally acknowledged as the founder of modern experimental psychology. He also trained those who became leaders in psychology around the world, including Emil Kraepelin and Stanley Hall. Wundt's emphasis on experimental methodology gave psychology a strong scientific basis, and his system of structuralism tested the method of introspection. See Sternberg RJ *Psychology: In search of the human mind* (2001) 11.

<sup>41</sup> Colman AM *Oxford dictionary of psychology* (2006) "psychology" 617.

To summarise the concepts of "profession and professionalism", Burnham<sup>42</sup> asks the question of why empirical historians have repeatedly returned to the concept of profession. Evidence from centuries of medical historical writings shows that the term, however much ignored, continued to obtrude into the records the historians studied. Repeatedly, evidence suggested to investigators that versions of the "spirit of the profession" had detectable historical impacts on physicians, on patients, and on society. Burnham then suggests that the persisting interest of historians in the professional aspects of health care means that the sources they studied, regardless of different scholars' interpretations or constructions at different times, showed that physicians as professionals acted distinctively - indeed, that the peculiar history of physicians in Eurocentric societies provided a focus for understanding the role of the healer who was found in all cultures of which we have knowledge.

#### 4.3 THE STATUTORY REGULATION OF THE PSYCHIATRIC AND PSYCHOLOGY PROFESSIONS:<sup>43</sup>

##### 4.3.1 Introductory remarks

The Health Professions Council of South Africa was established by the Health Professions Act, replacing the old South African Medical and Dental Council (SAMDC) and Interim South African Medical and Dental Council, as the supreme statutory body regulating the medical profession by virtue of subsequent amendments to the Health Professions Act. Some provisions of the Health Professions Act are discussed below.

##### 4.3.2 Section 3: The objects of the Council<sup>44</sup>

The objects of the HPCSA are:

- To co-ordinate the activities of professional boards established in terms of the Act;

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<sup>42</sup> According to Burnham it may well be that the history of the medical profession, as profession, will remain ancillary to other historical inquiries, whether the intellectual history of medical science or one of a variety of social histories. He further suggests that what helps distinguish much of the work of medical historians is scholars' even marginal awareness of the changing place of the *special spirit* of being a medical professional. That insight of difference may help explain, in part, why historians of medicine themselves still sense that they profess a different and special calling. Burnham 1996 *Bull Hist of Med* 1 at 23-24.

<sup>43</sup> This topic is also thoroughly discussed in Carstens & Pearmain 249-281.

<sup>44</sup> "Council" means the Council (Health Professions Council of South Africa) referred to in section 2 of the Act. See s 1.

- to promote and to regulate inter-professional liaison between registered professions in the interest of the public;
- to determine strategic policy with regard to the professional boards and the registered professions, for matters such as finance, education, registration, ethics and professional conduct, disciplinary procedure, scope of the professions, inter-professional matters and maintenance of professional competence;
- to consult and liaise with relevant authorities on matters affecting the professional boards in general;
- to assist in the promotion of the health of the population of the Republic of South Africa;
- subject to the provisions of section 15A of the Act, the Nursing Act 50 of 1978, the Chiropractors, Homeopaths and Allied Health Service Act 63 of 1982 and the Pharmacy Act 53 of 1974, to control and to exercise authority in respect of all matters affecting the training of persons in, and the manner of the exercise of the practices pursued in connection with, in diagnosis, treatment or prevention of physical or mental defects, illnesses or deficiencies in human kind;
- to promote liaison in the field of training referred to both in the Republic of South Africa and elsewhere, and to promote the standards of training in the Republic of South Africa;
- to advise the Minister of Health on any matter falling within the scope of this Act in order to support the universal norms and values of the health professions, with greater emphasis on professional practice, democracy, transparency, equity, accessibility and community involvement; and
- to communicate to the Minister of Health information of public importance acquired by the Council in the course of the performance of its functions under this Act.<sup>45</sup>

The HPCSA is clearly a regulatory body, which is ultimately responsible to ensure quality health standards for all South African citizens, to protect the public and to guide the medical profession. It also assists in the promotion of the health of the population of South Africa.

#### 4.3.3 Section 4: The general powers of the Council

The Health Professions Council may:

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<sup>45</sup> S 3(a-i).

- Acquire, hire or dispose of property, borrow money on the security of the assets of the council and accept and administer any trust or donation;
- render financial assistance to professional boards in order to enable such boards to perform their functions;
- after consultation with the relevant professional board, consider any matter affecting the health professions registrable under this Act and, consistent with national health policy determined by the Minister,<sup>46</sup> make representations or take such action in connection therewith as the council deems necessary;
- consistent with national health policy determined by the Minister, make rules on all matters which the council considers necessary or expedient in order that the objects of this Act may be achieved;
- delegate to any professional board or committee or any person such of its powers as it may determine, but shall not be divested of any power so delegated; and
- perform such other functions as may be prescribed, and do all such things as the council deems necessary or expedient to achieve the objects of this Act within the framework of national health policy determined by the Minister.<sup>47</sup>

According to section 10 of the Act, the Council has the power to establish committees, including disciplinary committees, as it may deem necessary, each consisting of so many persons as the Council may determine, but including at least one member of the Council, who must be the chairperson of such committee, except in the case of a disciplinary committee referred to in subsection (2). The Council may, subject to the provisions of subsection (3), delegate to any committee so established or to any person some of its powers as it may from time to time determine, but must not be divested of any power so delegated.<sup>48</sup> The Council must from time to time, as the need arises, establish *ad hoc* disciplinary appeal committees, each consisting of, as chairperson, a retired judge or retired senior magistrate, or an attorney or advocate with at least ten years' experience, not more than two registered persons drawn from the profession of the registered person in respect of whose conduct a disciplinary committee of a professional board had held an

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<sup>46</sup> "Minister" means the Minister of Health. See s 1.

<sup>47</sup> S 4(a-f).

<sup>48</sup> S 10(1)(a-b).

inquiry, and a member of the Council appointed to represent the community, which member shall not be a registered person.<sup>49</sup>

A disciplinary appeal committee referred to in subsection (2) must have the power to vary, confirm or set aside a finding of a disciplinary committee established in terms of subsection (1) or to refer the matter back to the disciplinary committee with such instructions as it may deem fit.<sup>50</sup>

Further, according to subsection (4), a decision of a disciplinary committee, unless appealed against, shall be of force and effect from the date determined by the disciplinary committee. Where a matter has been considered by a disciplinary appeal committee, the decision of the disciplinary appeal committee, unless appealed against, shall be of force and effect from the date determined by the disciplinary appeal committee.<sup>51</sup> The Council may, after consultation with one or more professional boards, establish a joint standing committee of the Council and the board or boards.<sup>52</sup>

#### 4.3.4 Section 5: The constitution of the Council

The Constitution of the HPCSA is provides for a broad representation in terms of its membership. In particular, it determines that:

- (1) The council shall be representative and shall consist of the following members, namely:

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<sup>49</sup> S 10(2).

<sup>50</sup> S 10(3).

<sup>51</sup> S 10(5).

<sup>52</sup> S 10(6). See also s 12: **Appointment of registrar and staff:** 12(1) The Council shall appoint a registrar and may appoint such other persons as it may deem necessary for carrying out its functions under this Act, and may dismiss any of such other persons. (2) The registrar shall be the secretary of the council and of each professional board and he or she shall perform the functions and carry out the duties assigned to or imposed upon him or her in terms of this Act as well as such functions and duties as may from time to time be assigned to or imposed upon him or her by the council. (2A) The registrar may in writing authorise any member of his or her staff to exercise or perform any power, duty or function conferred or imposed on him or her by or in terms of this Act. (3) The appointment or dismissal of the registrar shall be subject to the approval of the Minister. S 13: **Financing of council:** 13(1) All registration and examination fees and any other fees payable under this Act shall, unless otherwise provided, be paid to the council and shall constitute its funds and the council shall utilize its funds for defraying expenses incurred in connection with the performance of its functions. (2) The Council may invest any unexpended portion of its moneys and may establish such reserve funds and pay therein such amounts as it may deem necessary or expedient. Further according to section 14, the Minister may rectify defects. If anything required to be done under the Act in connection with the appointment of any member is omitted or not done within the time or in the manner required by the Act, the Minister may order all such steps to be taken as may be necessary to rectify the omission or error or may validate anything done in an irregular manner or form, in order to give effect to the objects of the Act.

- (a) not more than 16 persons designated by the professional boards, on a basis proportional to the number of persons registered to practise the professions falling under each professional board: Provided that each professional board shall be entitled to designate at least one person registered in terms of this Act;
  - (b) one person in the employment of the Department of Health, appointed by the Minister;
  - (c) one person in the employment of the Department of Education, appointed by the Minister of Education;
  - (d) nine community representatives not registered in terms of this Act, appointed by the Minister;
  - (e) one person from the South African Military Health Service, appointed by the Minister of Defence;
  - (f) three persons appointed by the South African University Vice-Chancellors' Association; and
  - (g) ...  
[Para. (g) deleted by s. 5 of Act 29/2007]
  - (h) ...  
[Para. (h) deleted by s. 5 of Act 29/2007]
  - (i) one person versed in law, appointed by the Minister.
- (2) Subject to the provisions of section 6, the members of the council shall hold office for a period of five years, but shall be eligible for redesignation or reappointment for one more term.
- (3) Not less than three months prior to the date of expiry of the term of office of the members of the council, the persons and bodies referred to in subsection (1), except the Minister, shall inform the registrar in writing of the names of the persons to be designated or appointed by them in terms of that subsection.
- (4) As soon as possible after the process referred to in subsection (3), the Minister shall inform the registrar of the names of the persons to be appointed by the Minister in terms of subsection (1).
- (5) If any of the persons or bodies referred to in subsection (1), except the Minister, fails to make a designation or an appointment or to inform the registrar in terms of subsection (3) of the names of the persons to be designated or appointed by them, the Minister shall make the necessary designation or appointment, and any designation or appointment so made by the Minister shall be deemed to have been properly made in terms of the appropriate paragraph of subsection (1).
- (6) The names of the members of the council and the date of commencement of their term of office shall be published by the registrar in the *Gazette* as soon as possible after the constitution of the council.
- (7) A person may not be appointed as a member of the Council if he or she is, at the time of his or her appointment, or was, during the preceding 12 months:
- (a) a member of a municipal council, a provincial legislature or Parliament; or
  - (b) a provincial or national office bearer or employee of any party, organisation or body of a political nature.

#### 4.3.5 Section 15A: The objects of a professional board<sup>53</sup>

The objects of a professional board are:

- To consult and liaise with other professional boards and relevant authorities on matters affecting the professional board;
- to assist in the promotion of the health of the population of the Republic on a national basis;
- subject to the provisions of section 3 of the Act, the Nursing Act 50 of 1978, the Chiropractors, Homeopaths and Allied Health Services Act 63 of 1982 and the Pharmacy Act 53 of 1974, are to control and exercise authority in respect of all matters affecting the training of persons in, and the manner of the exercise of the practices pursued in connection with, any profession falling within the ambit of the professional board;
- to promote liaison in the field of the training contemplated both in the Republic and elsewhere, and to promote the standards of such training in the Republic;
- to advise the Minister of Health on any matter falling within the scope of this Act as it relates to any profession falling within the ambit of the professional board in order to support the universal norms and values of the profession, with greater emphasis on professional practice, democracy, transparency, equity, accessibility and community involvement;
- to communicate to the Minister information on matters of public importance acquired by the professional board in the course of the performance of its functions under this Act;
- to maintain and enhance the dignity of the profession and the integrity of the persons practising the profession;
- to guide the profession and to protect the public.<sup>54</sup>

Carstens<sup>55</sup> noted that if a comparison is drawn between the objects of the HPCSA and those of the professional boards, a significant overlap and similarity can be noted. This overlap and similarity are indicative of the fact that the various Professional Boards are in reality an extension of the HPCSA operating as it were as the bureaucratic arm that regulates the respective professions registered with the HPCSA on a day-to-day basis, while the HPCSA can be seen as the executive, over-arching regulatory

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<sup>53</sup> See the discussion of the establishment of professional boards *supra*.

<sup>54</sup> S 15A(a-h).

<sup>55</sup> Carstens & Pearmain 253-254.

body. The role and function of the various professional boards must thus always be assessed in conjunction with the HPCSA.

Van Niekerk<sup>56</sup> states that there are currently many concerns with the current HPCSA, namely:

- First, there has been a Department of Health takeover of a body that is solely funded by the registered practitioners.<sup>57</sup>
- Second, the values of democracy have been eroded as there will not be a single member directly elected by the practitioners themselves. Instead the Department of Health appoints the members from a list of nominees. While there will undoubtedly be excellent candidates doing outstanding and selfless work, Van Niekerk argues that this opens up the possibility of application of the favoured policy of the ruling party of "deployment" of its ideological look-alikes into areas that it wishes to control.
- Thirdly, the well-intentioned proposed changes to the composition and functioning of the "professional conduct inquiry" structures are cause for grave concern. Senior legal advisors who have served on such hearings have generally been very favourably impressed, but are concerned about the new proposals. People with considerable experience in these matters are concerned that chairpersons and lay committee members without medical knowledge will lack the ability to assess whether adverse outcomes in patients are due to doctors seriously erring or the result of a variation of the disease process. Legal minds believe that proposed penalties will result in many court cases.<sup>58</sup>

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<sup>56</sup> Van Niekerk JP de V "HPCSA: A mess in the Health Department's pocket" 2009 99 *S Afr Med J* 4: 203.

<sup>57</sup> See "Health Professions Act (56/1974): Regulations relating to the nominations and appointments of members of a professional board" published in *GN R1257* in *GG* No 31633, 28 November 2008 s 4(2-3): "(2) The Minister must appoint a panel/s comprising of at least four people, of whom at least two shall be persons registered in the relevant profession in terms of the Act, who have experience in the operations and functioning of the boards and who shall not have already been nominated, to consider and advise the Minister on the nominations received. (3) The Minister shall have the power to call for further nominations if the names of persons validly nominated are less than the required number or if the nominated persons do not meet the requirements contemplated in sub-regulation 5." Minister refers to the Minister of Health.

<sup>58</sup> See also "Health Professions Council of South Africa: Notice of nominations: Nominations of members of the Professional Board for Psychology" published in *GN R123* in *GG* No 31625, 28 November 2008; "Health Professions Council of South Africa: Nominations of members of professional boards: List of names of persons validly nominated for appointment to the professional boards" published in *GN R28* in *GG* No 31957, 06 March 2009.

#### 4.3.6 Section 15B: The general powers of a professional board

A professional board may:

- In such circumstances as may be prescribed, or where otherwise authorised by the Act, remove any name from a register or, upon payment of the prescribed fee, restore thereto, or suspend a registered person from practising his or her profession pending the institution of a formal inquiry in terms of section 41 of the Act;
- appoint examiners and moderators, conduct examinations and grant certificates, and charge such fees in respect of such examinations or certificates as may be prescribed;
- subject to prescribed conditions, approve training schools;
- consider any matter affecting any profession falling within the ambit of the professional board and make representations or take such action in connection therewith as the professional board deems advisable;
- upon application by any person, recognise any qualification held by him or her (whether such qualification has been obtained in the Republic or elsewhere) as being equal, either wholly or in part, to any prescribed qualification, whereupon such person shall, to the extent to which the qualification has so been recognised, be deemed to hold such prescribed qualification;
- after consultation with another professional board or boards, establish a joint standing committee or committees of the boards concerned;
- perform such other functions as may be prescribed, and generally, do all such things as the professional board deems necessary or expedient to achieve the objects of this Act in relation to the profession falling within the ambit of the professional board.<sup>59</sup>

In terms of section 15B(2), it is important to note that any decision of a professional board relating to a matter falling entirely within its ambit shall not be subject to ratification by the Council, and the Council shall, for this purpose, determine whether a matter falls entirely within the ambit of the professional board.

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<sup>59</sup> S 15B(1)(a-g).

#### 4.3.7 Section 52: Medical practitioners and dentist may dispense medicine<sup>60</sup>

Every medical practitioner or dentist whose name has been entered in the register is, on such conditions as the Council may determine in general or in a particular case,<sup>61</sup> entitled to personally compound or dispense medicines prescribed by himself or by any other medical practitioner or dentist with whom he is in partnership or with whom he is associated as principal or assistant or *locum tenens* for use by a patient under treatment of such medical practitioner or dentist or of such other medical practitioner, provided that he shall not be entitled to keep an open shop or pharmacy.<sup>62</sup> The Council may (on such conditions as it may determine) exempt any medical practitioner or dentist from the requirement of registration contemplated in paragraph (a), and may, after an investigation, withdraw such exemption.<sup>63</sup>

#### 4.3.8 Section 53: Charging of professional fees by practitioners

Every person registered under the Act must (unless the circumstances render it impossible for him or her to do so) before rendering any professional services,<sup>64</sup> inform the person to whom the services are to be rendered or any person responsible for the maintenance of such person, of the fee which he or she intends to charge for such services. This is applicable either when a fee structure is requested by the person

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<sup>60</sup> This limited right to compound or dispense medicine may only be effected in terms of a licence obtained from the Director-General of Health in terms of the Medicines and Related Substances Control Act 101 of 1965 as amended by the Medicines and Related Substances Control Amendment Act 90 of 1997 (hereafter referred to as the Medicines and Related Substances Control Act). With regard to the requirement that medical practitioners have to obtain a dispensing licence, there has been a constitutional challenge to certain aspects of the licensing scheme introduced by government. For a discussion of this constitutional challenge, see Carstens & Pearmain 259ff; *Affordable Medicines Trust v Minister of Health* 2006 (3) SA 247 (CC).

<sup>61</sup> These conditions are set out in s 52(2), which reads as follows: "The registrar shall keep a register in which he or she shall enter, at the direction of the Council, the name and such other particulars as the Council may determine of a medical practitioner or dentist: (a) Who within three months after the commencement of the Medical, Dental and Supplementary Health Service Professions Amendment Act, 1984, submits proof to the satisfaction of the registrar that at such commencement he or she compounded or dispensed medicine as contemplated in subsection (1)(a) in the practice of his or her profession; or (b) who informs the registrar in the prescribed manner of his or her intention to compound or dispense medicine in the practice of his or her profession as contemplated in subsection (1)(a)." The Council may, after an investigation, direct that the name of any person be removed from the register contemplated in subsection (2), or prohibit him for a specified period from making use of the right contemplated in subsection (1). See s 52(3). The Council may further determine fees to be paid for the entering of a name in the register contemplated in subsection (2). See s 52(4).

<sup>62</sup> S 52(1)(a).

<sup>63</sup> S 52(1)(b).

<sup>64</sup> According to s 53(6) "professional services" includes the supply of any artificial part for the human body and the fitting of such part of the human body.

concerned; or when such fee exceeds the amount usually charged for such services. In a case to which the latter relates the person concerned must also be informed of the usual fee charged.<sup>65</sup>

The medical practitioner must furthermore furnish the patient with a detailed account within a reasonable period.<sup>66</sup> A patient may within three months after receiving the account apply in writing to the relevant professional board to determine what a reasonable fee would be for the services rendered. The professional board shall as soon as possible after receipt of the application determine the said amount and notify the practitioner and the patient in writing of the amount so determined, provided that before the professional board determines the said amount, it shall afford the practitioner concerned an opportunity to submit to it in writing his or her case in support of the amount claimed.<sup>67</sup> A claim referred to the professional board is not recoverable until the determination has been made by the professional board. If the patient has paid to the practitioner an amount in settlement or part settlement of such claim and such amount exceeds the amount so determined, the practitioner has to pay the amount by which that payment exceeds the amount determined back to the patient.<sup>68</sup> In addition to such action, the professional board may still take disciplinary action against the practitioner involved.<sup>69</sup>

#### 4.4 THE ETHICAL FRAMEWORK FOR THE REGULATION OF THE PSYCHIATRIC AND PSYCHOLOGY PROFESSIONS

##### 4.4.1 The Code of Ethical Rules and Rulings

In order to promote ethical conduct within the medical profession, the HPCSA, in consultation with the professional boards, has in terms of the Health Professions Act, drawn up a code of conduct for medical

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<sup>65</sup> S 53(1).

<sup>66</sup> S 53(2).

<sup>67</sup> S 53(3)(a). See also s 53(3)(d) which makes provision that a professional board may from time to time determine and publish the fees used by the professional board as norm for the determination of amounts contemplated in s 53(3)(a).

<sup>68</sup> S 53(4).

<sup>69</sup> The Ethical Code of Professional Conduct to which a Psychologist shall adhere regulates fees and financial arrangements in ss 35-43. According to s 35: "As early as is feasible in a professional or scientific relationship, a psychologist and a client or other appropriate user of psychological services shall reach an agreement specifying the compensation and the billing arrangements." S 36 states that: "(1) A psychologist shall not exploit a user of psychological services or payers with regard to fees. (2) Any fee charged by a psychologist for a psychological service rendered shall be based on the national tariffs recommended by the Psychological Society of South Africa." Of importance is s 40, which regulates the withholding of information, reports or records for non-payments and reads as follows: "A psychologist shall not, due to non-payment of fees, withhold information or reports or records under his or her control which are required and imminently needed for a client's treatment or court action." S 43 further states that: "A psychologist shall not withhold emergency psychological services because the user is unable to guarantee remuneration for the said service."

practitioners, dentists, psychologists and practitioners of supplementary health services.<sup>70</sup> In August 2006, the Minister of Health approved new regulations<sup>71</sup> containing the latest version of the applicable Ethical Rules. As to the legal status of the Ethical Rules, Carstens<sup>72</sup> states that although courts of law are evidently not bound by medico-legal codes of conduct, the Ethical Rules and prevailing practices of the medical and psychology professions will undoubtedly be an important consideration in ascertaining what constitutes psychiatric and psychological malpractice. According to van Oosten<sup>73</sup> medical practice is frequently influential in shaping medical law; that medical law sometimes necessitates changes in medical ethics; that the dictates of medical law and medical ethics often coincide, and that medical law and medical ethics are occasionally in conflict with one another. In this regard the Ethical Rules of Conduct are pivotal to determine whether "unprofessional conduct" (in the generic sense of the word) on the part of a psychiatrist

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<sup>70</sup> These rules are made in terms of s 49 of the Act, which reads as follows: "Council to make rules relating to offences under this Chapter: (1) The Council shall, in consultation with a professional board, from time to time make rules specifying the acts or omissions in respect of which the professional board may take disciplinary steps under this Chapter: Provided that the powers of a professional board to inquire into and deal with any complaint, charge or allegation relating to a health profession under this Chapter, shall not be limited to the acts or omissions so specified." See also the Ethical Guidelines for good Practice in the Health Care Professions: The following Booklets are separately available: *Booklet 1: General ethical guidelines for health care professions*; *Booklet 2: Ethical and professional rules of the health professions council of South Africa as promulgated in Government Gazette R717/2006*; *Booklet 3: National Patients' Rights Charter*; *Booklet 4: Professional self-development*; *Booklet 5: Guidelines for making professional services known*; *Booklet 6: Guidelines on over servicing, perverse incentives and related matters*; *Booklet 7: General ethical guidelines for health researchers*; *Booklet 8: Ethical guidelines for biotechnology research in South Africa*; *Booklet 9: Research, development and the use of the chemical, biological and nuclear capabilities of the State*; *Booklet 10: Seeking patients' informed consent: The ethical considerations*; *Booklet 11: Confidentiality: Protecting and providing information*; *Booklet 12: Guidelines for the management of patients with HIV infection or AIDS*; *Booklet 13: Guidelines withholding and withdrawing treatment*; *Booklet 14: Guidelines on reproductive health management*; *Booklet 15: Guidelines on patient records*; *Booklet 16: Canvassing of patients abroad*; and *Booklet 17: Guidelines for the management of health care waste*.

<sup>71</sup> As per Government Notice 7 of 4 August 2006 (GG No 29079) whereby the Rules specifying the acts or omissions in respect of which disciplinary steps may be taken by a Professional Board and the Council, published under Government Notice 2278 of 3 December 1976 and Government Notice R1379 of 12 August 1994, as amended by Government Notice R 1405 of 22 December 2000, are repealed. The various sections with concomitant ethical rules are listed as follows: Section 2: Interpretation and application; section 3: Advertising and canvassing or touting; section 4: Information on professional stationery; section 5 contains the rules pertaining to the naming of a practice; section 6: Itinerant practice; section 7: Fees and commission; section 8: Partnerships and juristic persons; section 9: Covering; section 10: Supersession; section 11: Impeding a patient; section 12: The professional reputation of colleagues; section 13: Professional confidentiality; section 14: Retention of human organs; section 15: The signing of official documents; section 16: The management of certificates and reports; section 17: Issuing of prescriptions; section 18: Professional appointments; section 19: Secret remedies; section 20: Defeating or obstructing the council or board in the performance of its duties; section 21: The performance of professional acts; section 22: The prohibition against exploitation; section 23 contains the ethical considerations with regard to medicine; section 24: Financial interests held by medical practitioners in hospitals; section 25: The reporting of impairment or of unprofessional, illegal or unethical conduct; section 26: Research, development and use of chemical, biological and nuclear capabilities; and section 27: Dual registration.

<sup>72</sup> Carstens & Pearmain 264; see 265 for the order in which the previous Ethical Rules were listed. These previous Ethical Rules may serve as a sounding board for the interpretation and application of the new Code of Ethical Rules.

<sup>73</sup> Van Oosten FFW in *International Encyclopaedia of Laws* par [57].

and psychologist warrants the institution of disciplinary proceedings. These ethical rules are discussed throughout the chapter.

#### 4.4.2 Professional ethics: Psychiatrists and psychologists as "professionals"

The term "professional" is hard to define and no generally accepted definition of the term exists, yet a working concept is needed for a study of professional ethics.<sup>74</sup> Definitions can be framed around criteria such as the number of years of preparation required, whether or not the professional engages in private or institutional practice, whether or not the profession is represented by formal groups or associations and other similarly superficial considerations. But according to Biggs<sup>75</sup> professions arise out of public trust. This trust defines the profession and permits the members of the professional group to function in professional ways. The public trust that creates and sustains any profession stems from three sets of beliefs that are widely held about the profession and its members namely competence, maintenance of standards and altruistic values. As Biggs<sup>76</sup> further explains, public trust begins with a perception of competence. Professionals are seen to have special expertise and competence not readily found in the general public. In some situations professionals may even have to demonstrate continuing competence through periodic re-examination, continuing professional education or other means. The Ethical Code of Professional Conduct describes this as follows: "Psychologists shall develop, maintain and encourage high standards of professional competence to ensure that the public is protected from professional practices that falls short of

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<sup>74</sup> According to Bayles, three necessary features have been singled out to characterise professions and professionals. First, a rather extensive training is required to practice as a professional. Second, the training involves a significant intellectual component. Physical skill may be involved in, for example, electroconvulsive therapy, but the intellectual skill aspect is still predominant. Third, the trained ability provides an important service in society where the professionals have autonomy in their work. For example, psychiatrists are free to use their own judgment about treatment procedures, provided that they remain within the bounds of professional practice. See Bayles MD "The professions" 27-30 in *Ethical issues in professional life* ((ed) Callahan JC) (1988) 27-28. Cf the explanation of Hughes: "Professionals profess to know better than others the nature of certain matters, and to know better than their clients what ails them or their affairs. This is the essence of the professional idea and the professional claim." See Hughes EC "Professions" 1-14 in *The professions in America* ((ed) Lynn KS) (1967) 2. Cf the spirit of professional guidelines as stated by the HPCSA: "Practice as a health care professional is based upon a relationship of mutual trust between patients and health care practitioners. The term 'profession' means 'a dedication, promise or commitment publicly made'. To be a good health care practitioner, requires a life-long commitment to sound professional and ethical practices and an overriding dedication to the interests of one's fellow human beings and society. In essence, practice as a health care professional is a moral enterprise." Pellegrino ED "Medical professionalism: Can it, should it survive?" 2000 13 *J Am Board Fam Practice* 2: 147 at 148; also quoted in the Health Professions Council of South Africa: *Guidelines for good practice in the health care professions: Confidentiality: Protecting and providing information* (2007) i.

<sup>75</sup> Biggs D & Blocher D *Foundations of ethical counseling* (1987) 3-4.

<sup>76</sup> *Idem* 4.

international and national best practice standards."<sup>77</sup> Further, in terms of the Health Professions Act, it has become compulsory for all medical practitioners registered in South Africa to undergo continuing education and training. The HPCSA is mandated to make rules from time to time, which prescribe:<sup>78</sup>

- Conditions relating to continuing education<sup>79</sup> and training to be undergone by persons registered in terms of the Act in order to retain such registration;<sup>80</sup>
- the nature and extent of continuing education and training to be undergone by persons registered in terms of the Act; and

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<sup>77</sup> "Professional Board for Psychology: Rules of conduct pertaining specifically to the profession of psychology" published in GN R717 in GG No 29079, 4 August 2006, s 2(1). See also s 2(2): "A psychologist shall accept that he or she is accountable for professional actions in all domains of his or her professional life." See further s 3 *Competency limits*: "(1) A psychologist shall limit his or her practice to areas within the boundaries of his or her competence based on formal education, training, supervised experience, and/or appropriate professional experience. (2) A psychologist shall ensure that his or her work is based on established scientific and professional knowledge of the discipline of psychology." S 4 *Maintaining competency*: "A psychologist shall maintain up to date competency in his or her areas of practice through continuing professional development, consultation, and/or other procedures in conformance with current standards of scientific or professional knowledge." S 5 *Adding new competencies*: "(1) When a psychologist is developing competency in a psychological service or technique that is either new to him or her or new to the profession, he or she shall engage in ongoing consultation with other psychologists or relevant professions and shall seek and obtain appropriate education and training in the new area. (2) A psychologist shall inform a client of the innovative nature and the known risks associated with the psychological services or techniques, so that such client can exercise freedom of choice concerning receipt of such services or the application of such techniques."

<sup>78</sup> S 26 (a-c) of the Health Professions Act. The Minister of Health may, on recommendation of the Council, prescribe the qualifications obtained by virtue of examinations conducted by a university, a technikon or any other examining authority in the Republic of South Africa, which, when held singly or conjointly with any other qualification, shall entitle any holder thereof to register in terms of the Act, provided that he or she complied with such conditions or requirements as prescribed. The Minister may also, in consultation with the Council, by regulation provide for the registration of persons qualified outside the Republic of South Africa as a medical practitioner, dentist or psychologist, subject to the requirement that such a person, if the Council does not accept that such qualification indicates a satisfactory standard of professional education, may be required to pass to the satisfaction of the Council, an evaluation determining whether such a person possesses adequate professional knowledge and skill and whether he or she is proficient in any of the official languages of the Republic. A person not permanently resident in the Republic of South Africa may be registered as a medical practitioner, dentist or psychologist in South Africa for the purposes of promoting medical, dental or psychological education, or to undergo training for the practising of a supplementary health service profession or to enable such a person to engage in postgraduate studies. A non-resident who is registered may give demonstrations in approved institutions. The Act also provides for the registration of specialities. Universities, technikons and other training institutions have to furnish the Council with particulars as to the minimum age and standard of general education required of students, the course of study, training and examinations required of a student before such qualification is granted and the results of any examination conducted by it, or any other particulars relating to the mentioned matters as the Council may from time to time require. See ss 24, 25, 29 30, 31, 35.

<sup>79</sup> The requirement for continuing education and training (CPD) in practical terms translates into obtaining so-called CPD points over a five-year period through the attendance of and/or participation in accredited or approved CPD programmes which normally consist of workshops, seminars, professional lectures and training sessions in medical practice, medico-legal practice and medical ethics. See Carstens & Pearmain 256.

<sup>80</sup> Registration certificates remain valid for one year only, thereafter annual practising certificates will be issued on payment of the required annual fee and the submission of such information as may be required by the Council to enable it to keep accurate statistics on human resources in the health field. See s 22(2) of the Health Professions Act.

- the criteria for recognition by the Council of continuing education and training courses and of education institutions offering such courses.<sup>81</sup>

In addition, the Ethical Code of Conduct regulates the performance of professional acts by medical practitioners or medical specialists as follows: A medical practitioner or medical specialist:

- Shall perform professional acts only in the field of medicine in which he or she was educated and trained and in which he or she has gained experience, regard being had to both the extent and the limits of his or her professional expertise;
- shall not fail to communicate and cooperate with medical practitioners, medical specialists and other health practitioners in the diagnosis and treatment of a patient; and
- shall not sign official documents such as reports, certificates or prescriptions unless his or her name is printed next to his or her signature.<sup>82</sup>

The second perception that sustains public trust in a professional group is the belief that such groups both regulate themselves and that these groups are further regulated by society in the public interest. An important part of this perception is a faith in the codification of professional behaviour. Another aspect of this perception is the belief that members of the profession will organise and work to uphold prescribed standards of professional conduct by applying their Code of Ethics and maintaining its standard of practice. The final perception is that members of a profession are motivated to serve the people with whom they work. Ethical questions are rooted in the public trust that defines any profession. Whenever the perceptions of the public are changed by the unethical, irresponsible or unprofessional conduct<sup>83</sup> of a member of the

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<sup>81</sup> It is important to note that in terms of s 24A(1) and s 24A(2) any person registering for the first time for a profession listed in the regulations in terms of the Act (after the commencement of the Medical, Dental and Supplementary Health Service Professions Amendment Act of 1997) shall perform remunerated medical community service for a period of one year in terms of the regulations, and such a person shall, on the completion of such service, be entitled to practise the profession in question. The Minister of Health may, after consultation with the Council, make regulations concerning the performance of the community service with reference to the place(s) at which it is to be performed and the conditions of employment.

<sup>82</sup> "Medical and Dental Professions Board: Rules of conduct pertaining specifically to the medical and dental professions" published in GN R717 in GG No 29079, 4 August 2006, Annexure 6, Rule 1(a-c).

<sup>83</sup> "Unprofessional conduct" is defined as "*improper or disgraceful* or dishonourable or unworthy conduct which, when regard is had to the profession of a person who is registered in terms of the Act, is improper or disgraceful or dishonourable or unworthy". See s 1 of the Health Professions Act. In terms of s 1 of the Traditional Health Practitioners

profession, all other members are harmed and indeed their ability to function in professional ways is diminished or impaired.<sup>84</sup>

In 2001, a movement to clarify the concept of "professionalism" was begun by the American Board of Internal Medicine. A set of principles called the *Physician Charter of Professionalism* was developed, which describes what it means for physicians to perform at their highest and most ethical level.<sup>85</sup> The fundamental principles of the Charter are:<sup>86</sup>

- *Principle of primacy of patient welfare:* This principle is based on a dedication to serving the interest of the patient. Altruism contributes to the trust that is central to the

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Act, "unprofessional conduct" is defined as any act or omission which is improper or disgraceful or dishonourable or unworthy of the traditional health profession. See the discussion in chapter 6.

<sup>84</sup> Biggs & Blocher 4.

<sup>85</sup> The preamble of this Charter reads as follows: "**Professionalism is the basis of medicine's contract with society:** It demands placing the interests of patients above those of the physician, setting and maintaining standards of competence and integrity, and providing expert advice to society on matters of health. The principles and responsibilities of medical professionalism must be clearly understood by both the profession and society. Essential to this contract is public trust in physicians, which depends on the integrity of both individual physicians and the whole profession. At present, the medical profession is confronted by an explosion of technology, changing market forces, problems in health care delivery, bioterrorism, and globalization. As a result, physicians find it increasingly difficult to meet their responsibilities to patients and society. In these circumstances, reaffirming the fundamental and universal principles and values of medical professionalism, which remain ideals to be pursued by all physicians, becomes all the more important. The medical profession everywhere is embedded in diverse cultures and national traditions, but its members share the role of healer, which has roots extending back to Hippocrates. Indeed, the medical profession must contend with complicated political, legal, and market forces. Moreover, there are wide variations in medical delivery and practice through which any general principles may be expressed in both complex and subtle ways. Despite these differences, common themes emerge and form the basis of this charter in the form of three fundamental principles and as a set of definitive professional responsibilities." See Sadock BJ & Sadock VA (eds) *Kaplan & Sadock's synopsis of psychiatry: Behavioural sciences/clinical psychiatry* (2007) 1389; Project of the ABIM Foundation, ACP-ASIM Foundation, and European Federation of Internal Medicine "Medical professionals in the new millennium: A physician charter" 2002 136 *Annals of Internal Med* 3: 243 at 244.

<sup>86</sup> The *Physician Charter of Professionalism* was written by the members of the Medical Professionalism Project: ABIM Foundation: Troy Brennan, MD, JD (Project Chair), Brigham and Women's Hospital, Boston, Massachusetts; Linda Blank (Project Staff), ABIM Foundation, Philadelphia, Pennsylvania; Jordan Cohen, MD, Association of American Medical Colleges, Washington, DC; Harry Kimball, MD, American Board of Internal Medicine, Philadelphia, Pennsylvania; and Neil Smelser, PhD, University of California, Berkeley, California. ACP-ASIM Foundation: Robert Copeland, MD, Southern Cardiopulmonary Associates, LaGrange, Georgia; Risa Lavizzo-Mourey, MD, MBA, Robert Wood Johnson Foundation, Princeton, New Jersey; and Walter McDonald, MD, American College of Physicians-American Society of Internal Medicine, Philadelphia, Pennsylvania. European Federation of Internal Medicine: Gunilla Brenning, MD, University Hospital, Uppsala, Sweden; Christopher Davidson, MD, FRCP, FESC, Royal Sussex County Hospital, Brighton, United Kingdom; Philippe Jaeger, MB, MD, Centre Hospitalier Universitaire Vaudois, Lausanne, Switzerland; Alberto Malliani, MD, Università di Milano, Milan, Italy; Hein Muller, MD, PhD, Ziekenhuis Gooi-Noord, Rijksweg, the Netherlands; Daniel Sereni, MD, Hôpital Saint-Louis, Paris, France; and Eugene Sutorius, JD, Faculteit der Rechts Geleerdheid, Amsterdam, the Netherlands. Special Consultants: Richard Cruess, MD, and Sylvia Cruess, MD, McGill University, Montreal, Canada; and Jaime Merino, MD, Universidad Miguel Hernández, San Juan de Alicante, Spain.

physician-patient relationship. Market forces, societal pressures, and administrative exigencies must not compromise this principle.

- *Principle of patient autonomy:* Physicians must have respect for patient autonomy. Physicians must be honest with their patients and empower them to make informed decisions about their treatment. Patients' decisions about their care must be paramount, as long as those decisions are in keeping with ethical practice and do not lead to demands for inappropriate care.
- *Principle of social justice:* The medical profession must promote justice in the health care system, including the fair distribution of health care resources. Physicians should work actively to eliminate discrimination in health care, whether based on race, gender, socio-economic status, ethnicity, religion, or any other social category.
- The set of commitments as stipulated in the Charter is:
  - *Commitment to professional competence:* Physicians must be committed to lifelong learning and be responsible for maintaining the medical knowledge and clinical and team skills necessary for the provision of quality care. More broadly, the profession as a whole must strive to see that all of its members are competent and must ensure that appropriate mechanisms are available for physicians to accomplish this goal.
  - *Commitment to honesty with patients:* Physicians must ensure that patients are completely and honestly informed before the patient has consented to treatment and after treatment has occurred. This expectation does not mean that patients should be involved in every minute decision about medical care; rather, they must be empowered to decide on the course of therapy. Physicians should also acknowledge that in health care, medical errors that injure patients do sometimes occur. Whenever patients are injured as a consequence of medical care, patients should be informed promptly because failure to do so seriously compromises patient and societal trust. Reporting and analysing medical mistakes provide the basis for appropriate prevention and improvement strategies and for appropriate compensation to injured parties.
  - *Commitment to patient confidentiality:* Earning the trust and confidence of patients requires that appropriate confidentiality safeguards be applied to disclosure of patient information. This commitment extends to discussions with persons acting on a patient's behalf when obtaining the patient's own consent is not feasible. Fulfilling the commitment to confidentiality is more pressing now than ever before, given the widespread use of electronic information systems for compiling patient data and an increasing availability of genetic information. Physicians recognise, however, that their commitment to patient confidentiality must occasionally yield to overriding considerations in the public interest (for example, when patients endanger others).
  - *Commitment to maintaining appropriate relations with patients:* Given the inherent vulnerability and dependency of patients, certain relationships between physicians and patients must be avoided. In particular, physicians should never exploit patients for any sexual advantage, personal financial gain, or other private purpose.
  - *Commitment to improving quality of care:* Physicians must be dedicated to continuous improvement in the quality of health care. This commitment entails not only maintaining clinical competence but also working collaboratively with other professionals to reduce medical error, increase patient safety, minimize overuse of health care resources, and optimize the outcomes of care. Physicians must actively participate in the development of better measures of quality of care and the

application of quality measures to assess routinely the performance of all individuals, institutions, and systems responsible for health care delivery. Physicians, both individually and through their professional associations, must take responsibility for assisting in the creation and implementation of mechanisms designed to encourage continuous improvement in the quality of care.

- *Commitment to improving access to care:* Medical professionalism demands that the objective of all health care systems be the availability of a uniform and adequate standard of care. Physicians must individually and collectively strive to reduce barriers to equitable health care. Within each system, the physician should work to eliminate barriers to access based on education, laws, finances, geography, and social discrimination. A commitment to equity entails the promotion of public health and preventive medicine, as well as public advocacy on the part of each physician, without concern for the self-interest of the physician or the profession.<sup>87</sup>
- *Commitment to a just distribution of finite resources:* While meeting the needs of individual patients, physicians are required to provide health care that is based on the wise and cost-effective management of limited clinical resources. They should be committed to working with other physicians, hospitals, and payers to develop guidelines for cost-effective care. The physician's professional responsibility for appropriate allocation of resources requires scrupulous avoidance of superfluous tests and procedures. The provision of unnecessary services not only exposes one's patients to avoidable harm and expense but also diminishes the resources available for others.
- *Commitment to scientific knowledge:* Much of medicine's contract with society is based on the integrity and appropriate use of scientific knowledge and technology. Physicians have a duty to uphold scientific standards, to promote research, and to create new knowledge and ensure its appropriate use. The profession is responsible for the integrity of this knowledge, which is based on scientific evidence and physician experience.
- *Commitment to maintaining trust by managing conflicts of interest:* Medical professionals and their organisations have many opportunities to compromise their professional responsibilities by pursuing private gain or personal advantage. Such compromises are especially threatening in the pursuit of personal or organisational interactions with for-profit industries, including medical equipment manufacturers, insurance companies, and pharmaceutical firms. Physicians have an obligation to recognise, disclose to the general public, and deal with conflicts of interest that arise in the course of their professional duties and activities. Relationships between industry and opinion leaders should be disclosed, especially when the latter determine the criteria for conducting and reporting clinical trials, writing editorials or therapeutic guidelines, or serving as editors of scientific journals.
- *Commitment to professional responsibilities:* As members of a profession, physicians are expected to work collaboratively to maximise patient care, be respectful of one another, and participate in the processes of self-regulation, including remediation and discipline of members who have failed to meet professional standards. The profession should also define and organise the educational and standard-setting process for current and future members. Physicians have both individual and collective obligations to participate in these processes. These obligations include

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<sup>87</sup> See also the discussion of "access to healthcare" in chapter 5".

engaging in internal assessment and accepting external scrutiny of all aspects of their professional performance.

#### 4.5 THE THERAPIST-PATIENT RELATIONSHIP AND THE STANDARD OF CARE<sup>88</sup>

##### 4.5.1 The therapist-patient relationship

The quality of the therapist-patient relationship is crucial to the practice of psychiatry and psychology. The capacity to develop an effective relationship requires a solid appreciation of the complexities of human behaviour and a rigorous education in the techniques of talking and listening to people. To diagnose, manage and treat an ill person, therapists must be able to listen.<sup>89</sup>

Because of the absence of a traditional therapist-patient relationship in forensic psychiatry and psychology, Appelbaum<sup>90</sup> states that forensic psychiatrists and psychologists lose the primacy of the duties of beneficence and non-maleficence owed by a treating therapist to his or her patients. He states that although controversy still exists, survey results best support a position of multiple agencies and multiple responsibilities for forensic psychiatrists and psychologists. Such multiple responsibilities would be true for forensic psychiatrists and psychologists and is already required of treating psychiatrists and psychologists. Multiple responsibilities have become a part of psychiatric and psychology practices.

According to Rosner,<sup>91</sup> even though there is an absence of a therapist-patient relationship in forensic psychiatry and psychology, medical ethics are still relevant and important and can be seen as pertinent to the functioning of forensic psychiatrists and psychologists. It is clear that medical- ethical requirements such as providing competent medical service with compassion and respect for human dignity or dealing honestly with patients and colleagues still apply. Therefore, even if judicial immunity applies, or the court finds no therapist-patient relationship for malpractice purposes,<sup>92</sup> an ethics violation with, for example, sanctions for negligent evaluations can still be found. Rosner further explains that ethical violations can exist even if there is no legal liability, with ethical requirements commonly more stringent than legal ones. However, awareness is essential that plaintiff perceptions can be distorted because the psychiatrist and

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<sup>88</sup> The therapist-patient relationship and the standard of care within a legal context are discussed in more detail in chapter 6.

<sup>89</sup> See Sadock & Sadock (eds) 1.

<sup>90</sup> Appelbaum PS "Resurrecting the right to treatment" 1987 38 *Hospital & Community Psychiatry* 7: 703-704, 721.

<sup>91</sup> Rosner R & Weinstock R (eds) *Ethical practice in psychiatry and the law* (1990) 52.

<sup>92</sup> See the discussion of the legal liability of the forensic psychiatrist and psychologist in chapter 6.

psychologist could be correctly seen by the plaintiff as an adversary. The best defence against charges of ethical (as well as legal) violations is diligence and clarification of roles and responsibilities. Equally important is documentation regarding the aspects of the case considered, especially if some risk is involved and knowingly undertaken.

#### 4.5.2 The standard of care

Although Hippocratic physicians saw their duties only to individual patients, the responsibilities of physicians or therapists both ethically and legally have been extended to include society. Ethics itself considers both deontological (duty) and utilitarian or consequentialist values, and philosophy itself provides no clear resolutions to this conflict. Dilemmas occur when no resolution seems entirely satisfactory since some ethical values are sacrificed.<sup>93</sup> Traditionally, physicians or therapists have been expected to deliver a roughly uniform standard of care to all patients whom they accept for care. They must always at least provide ordinary and reasonable care. Morally, it has been customary to expect that the therapist will serve his or her patients' best interests without regard to others.<sup>94</sup> According to Rosner,<sup>95</sup> diligence remains the best policy to maintain a proper standard of care in medical practice.

### 4.6 THE TRADITIONAL HEALTH PRACTITIONERS ACT

Traditional healing is widespread in South Africa. The government passed the Tradition Health Practitioners Act in 2004, which requires all traditional health practitioners<sup>96</sup> to register with a newly established Council.<sup>97</sup> As the new legislation is implemented, it will put in place standards of education, training and practice. However, many of the rules and standards are not yet in place. It is unclear what impact this will have on the integration of traditional medicine practitioners<sup>98</sup> into the public health system, recognition of

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<sup>93</sup> Weinstock R & Leong GB *et al* "Ethical guidelines" 59-67 in *Principles and practice of forensic psychiatry* 59.

<sup>94</sup> Morreim EH *Balancing act: The new medical ethics of medicine's new economics* (1991) 58-59.

<sup>95</sup> Rosner *Ethical practice in psychiatry and the law* 52.

<sup>96</sup> "Traditional health practitioner" means a person registered under this Act in one or more of the categories of traditional health practitioners. See s 1 of the Act.

<sup>97</sup> According to s 4 of this Act: "(1) A juristic person to be known as the Interim Traditional Health Practitioners Council of South Africa is hereby established. (2) The registrar must convene the first meeting of the Council within three months of the commencement of this Act. (3) The term of office for the Council is three years, but the Minister may, in order to facilitate the implementation of, or development of amendments to, this Act, extend the term of office of the Council for a further period of not more than 24 months."

<sup>98</sup> "Traditional medicine" means an object or substance used in traditional health practice for: "(a) The diagnosis, treatment or prevention of a physical or mental illness; or (b) any curative or therapeutic purpose, including the maintenance or

their diagnosis and certification of the sick and on practitioner reimbursement. Some aspects of the Act are discussed below.

The purpose of this Act is to establish the Interim Traditional Health Practitioners Council of South Africa; to provide for a regulatory framework to ensure the efficacy, safety and quality of traditional health care services; to provide for the management and control over the registration, training and conduct of practitioners, students and specified categories in the traditional health practitioners profession; and to provide for matters connected therewith.

The objects of this Council will be to:

- Promote public health awareness;
- ensure the quality of health services within the traditional health practice;<sup>99</sup>
- protect and serve the interests of members of the public who use or are affected by the services of traditional health practitioners;
- promote and maintain appropriate ethical and professional standards required from traditional health practitioners;
- promote and develop interest in traditional health practice by encouraging research, education and training;
- promote contact between the various fields of training within traditional health practice in the Republic and to set standards for such training;
- compile and maintain a professional code of conduct for traditional health practice; and

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restoration of physical or mental health or well-being in human beings, but does not include a dependence-producing or dangerous substance or drug." See s 1(a-b) of the Act.

<sup>99</sup> "Traditional Health Practice" means "the performance of a function, activity, process or service based on a traditional philosophy that includes the utilisation of traditional medicine or traditional practice and which has as its object: (a) The maintenance or restoration of physical or mental health or function; or (b) the diagnosis, treatment or prevention of a physical or mental illness; or (c) the rehabilitation of a person to enable that person to resume normal functioning within the family or community; or (d) the physical or mental preparation of an individual for puberty, adulthood, pregnancy, childbirth and death, but excludes the professional activities of a person practising any of the professions contemplated in the Pharmacy Act, 1974 (Act No. 53 of 1974), the Health Professions Act, 1974 (Act No. 56 of 1974), the Nursing Act, 1974 (Act No. 50 of 1974), the Allied Health Professions Act, 1982 (Act No. 63 of 1982), or the Dental Technicians Act, 1979 (Act No. 19 of 1979), and any other activity not based on traditional philosophy." See s 1 of the Act.

- ensure that traditional health practice complies with universally accepted health care norms and values.<sup>100</sup>

In terms of section 7 (Constitution of Council) of the Act: The composition of the Council, which consists of a maximum of 22 members, appointed by the Minister in the prescribed manner, is as follows:<sup>101</sup>

- One must be a traditional health practitioner appointed as the chairperson of the Council by the Minister;
- one is the vice-chairperson of the Council and is elected by the members of the Council from amongst their number;
- nine must be traditional health practitioners, one from each province, of whom each must have been in practice for not less than five years;
- one must be an employee in the service of the Department of Health;
- one must be appointed on account of his or her knowledge of the law;
- one must be a medical practitioner who is a member of the Health Professions Council of South Africa;
- one must be a pharmacist who is a member of the South African Pharmacy Council;
- three must be community representatives; and
- one must be a representative from each category of traditional health practitioners defined in this Act.

Of importance is section 21(1), which states that no person may practise as a traditional health practitioner within the Republic unless he or she is registered in terms of this Act.<sup>102</sup> In addition, no remuneration is

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<sup>100</sup> S 5(a-h).

<sup>101</sup> S 7(a-i).

<sup>102</sup> See also s 49(1): A person who is not registered as a traditional health practitioner or as a student in terms of this Act is guilty of an offence if he or she: (a) For gain practises as a traditional health practitioner, whether or not purporting to be registered; (b) for gain: (i) Physically examines any person; (ii) performs any act of diagnosing, treating or preventing any physical defect, illness or deficiency in respect of any person; (iii) advises any person on his or her physical or mental state; (iv) by reason of information provided by any person or obtained from such person in any manner whatsoever: (aa) Diagnoses such person's physical or mental state; (bb) advises such person on his or her physical or mental state; (cc) supplies or sells to or prescribes for such person any traditional medicine or treatment; (v) prescribes or provides any traditional medicine, substance or thing; or (vi) performs any other act specially pertaining to the profession. See also s 49(1)(c-g), s 49(2-5). It is important to take note of s 51, which states: No person is subject to legal or disciplinary action

recoverable in respect of any act which relates to the profession of a traditional health practitioner if such an act is performed by a person who is not authorised under this Act to perform such act for gain.<sup>103</sup> No person other than a person registered in terms of this Act, and holding the necessary qualifications, is eligible for or entitled to hold any appointment to any establishment, institution, body, organisation or association, whether public or private, if such appointment involves the performance of any act which an unregistered person, in terms of this Act, may not perform for gain.<sup>104</sup>

## 4.7 ETHICAL DECISION-MAKING IN PSYCHIATRY AND PSYCHOLOGY

### 4.7.1 Introductory remarks

Making ethical or moral decisions, like any other decision in health care, is not a precise art but a learned skill. *What* decision is ultimately made and *how* that decision is made has always been the topic of intense debate. In making ethical decisions three important factors need to be taken into account: First, psychiatrists and psychologists always have choices they can select from as they make decisions. Second, in making these decisions the consequences of these choices have to be taken into account. Lastly, the context or setting of the ethical dilemma will affect the decision to be made and this must be taken into account as well.<sup>105</sup>

In clinical and forensic practice situations often arise where there is no right answer or right course of action. The psychiatrist and psychologist should then be guided by a set of ethical principles, laying different emphases on different components of the problem. For example utilitarian ethics focus on the consequences of actions. Virtue-based ethics consider what a fictional "good man or woman" might do in the same circumstances. Liberal individualism sets store by the right of the individual, in possible contrast to the position of *ubuntu*<sup>106</sup> in this country, focusing more on what is good for the community. The ethics of

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or to any penalty contemplated in this Act for engaging in traditional health practice during the period of one year following the date of commencement of this Act without being registered to do so.

<sup>103</sup> S 44(1).

<sup>104</sup> Provided that nothing in this subsection precludes the training of traditional health practitioners or students under the supervision of a suitably qualified traditional health practitioner, or the employment in any hospital or similar institution of any person undergoing training with a view to registration in terms of this Act, under the supervision of a suitably qualified traditional health practitioner or other health professional. See s 44(2).

<sup>105</sup> Singh JA & Ngwenya C "Bioethics" 33-52 in *Introduction to medico-legal practice* ((eds) Dada MA & McQuoid-Mason DJ) (2001) at 35.

<sup>106</sup> The development of human potential requires traits such as dignity, warmth, empathy, understanding, the ability to communicate, interaction, participation, sharing, reciprocation, harmony, cooperation and a shared world-view, which

care again emphasis on the duty to care in clinical and forensic practice and focus on the principle of making the right choice on the basis of the facts of the case. Principle-based ethics proposes that moral decisions are based on the consideration of four principles, namely: autonomy, beneficence, non-maleficence and justice.<sup>107</sup> Brim<sup>108</sup> states that: "Absolute rules do not offer useful solutions to conflicts in values. What is needed is wisdom and restraint, compromise and tolerance, and as wholesome a respect for the dignity of the individual as the respect accorded the dignity of science."

From a practical point of view, there are several specific ethical issues that most frequently involve psychiatrists and psychologists, which include:

#### 4.7.1.1 Confidentiality

Medicine began addressing the issue of confidentiality in the early nineteenth century. With increasing threats to privacy, for example, legal representatives and third party insurers, psychiatry paid increasing attention to this complex issue beginning in the early 1970's and especially since the mid 1980's.<sup>109</sup>

The Ethical Rules of Conduct for Practitioners Registered under the Health Professions Act regulates professional confidentiality as follows: A practitioner shall divulge information verbally or in writing regarding a patient, which he or she ought to divulge only:

- In terms of a statutory provision;
- at the instruction of a court of law; or

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collectively make up *ubuntu* culture. *Ubuntu* links up with communalism and involves wealth distribution. There is a strong emphasis on duties and virtues in *ubuntu* societies though rights are always implied. Human dignity gains a central place and seems to be related to both morality and rationality. According to *ubuntu* thinkers, there is no dualism in this position because both rationality and morality are acquired from community life and do not follow from the so-called universal categories or fixed ideologies. See Prinsloo ED "Ubuntu culture and participatory management" 41-51 in *The African philosophy reader* ((eds) Coetzee PH & Roux APJ) (1998) 42-43.

<sup>107</sup> Pienaar W "Ethical aspects of psychiatric practice" in *Primary healthcare psychiatry: A practical guide for Southern Africa* ((ed) Baumann SE) (2007) 536-548 at 536. See also Beauchamp TL & Childress JF *Principles of biomedical ethics* (1994) 1ff; *Belmont Report: Principles and guidelines for the protection of human subjects of research* Report of the United States National Commission for the protection of human subjects of biomedical and behavioural research (1976).

<sup>108</sup> Ruebhausen OM & Brim OG "Privacy and behavioural research" 1965 65 *Columbia LR 7*: 1184-1211 as quoted in Papalia DE & Olds SW *Psychology* (1987) 23.

<sup>109</sup> The word confidentiality is derived from the Latin words *con* (intensive) and *fidere* (trust). See Weintrob A "Confidentiality and its dilemmas in child and adolescent psychiatry" 323-330 in *Principles and practice of forensic psychiatry* 323.

- where justified in the public interest.<sup>110</sup>

Any information other than the information referred to in subrule (1) shall be divulged by a practitioner only:

- With the expressed consent of the patient;
- in the case of a minor under the age of 14 years, with the written consent of his or her parent or guardian; or
- in the case of a deceased patient, with the written consent of his or her next-of-kin or the executor of such deceased patient's estate.<sup>111</sup>

With regard to confidentiality in respect of the nature of illness, ailment or injury of patient, the Executive Committee of the Medical and Dental Professions Board resolved that the fundamental principle of confidentiality between doctor or dentist and patient should be maintained. It should not be obligatory for a medical practitioner or dentist to specify the nature of an illness, ailment or injury and only to do so with the consent of a patient. If a patient consulted another medical practitioner or dentist, full information on the condition of the patient should be made known to that medical practitioner or dentist on request. The Executive Committee further resolved that a description of the illness, disorder or malady in layman's language could be provided by a medical practitioner or dentist on a medical certificate, but only with the informed consent of the patient. Where a patient was not prepared to give consent, the medical practitioner or dentist should merely specify that, in his or her opinion, based on an examination, the patient was unfit for work.<sup>112</sup>

The Ethical Code of Professional Conduct to which a Psychologist shall adhere regulates privacy and confidentiality as follows:

#### **24 Rights to confidentiality**

- (1) A psychologist shall safeguard the confidential information obtained in the course of practice, teaching, research or other professional duties, subject only to the exceptions set forth as limits to confidentiality.

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<sup>110</sup> S 13(1)(a-c).

<sup>111</sup> S 13(2)(a-c).

<sup>112</sup> Medical and Dental Professions Board of the Health Professions Council of South Africa *Handbook on ethical rulings* (2002) 36, 40.

- (2) A psychologist shall only disclose confidential information to others with the written informed consent of a client

## 25 Discussing the limits of confidentiality

- (1) A psychologist is obliged to discuss with persons and organisations with whom they establish a scientific or professional relationship (including, to the extent feasible, persons who are legally incapable of giving informed consent and their legal representatives), the limitations on confidentiality, including any limitations on confidentiality that may apply to group, marital and family therapy or to organisational consulting and the foreseeable uses of the information obtained.
- (2) A psychologist shall unless it is contraindicated, discuss confidentiality at the outset of the relationship and thereafter as new circumstances warrant its discussion.
- (3) A psychologist shall obtain permission from a client for electronic recording of interviews or electronic transmission of information prior to such recording or transmission and such psychologist shall inform such client of the risks to privacy and confidentiality intrinsic to electronic recording or transmission of information.
- (4) A psychologist shall, when engaging in electronically transmitted services, ensure that confidentiality and privacy are ensured and shall inform a client of the measures undertaken to guarantee confidentiality.
- (5) A psychologist shall not withhold information from a client who is entitled to such information, where it does not violate the confidentiality of others, and where the information requested is required for the exercise or protection of any rights.<sup>113</sup>

A concern for psychiatrists and psychologists are that psychiatrists and psychologists must release confidential information upon court order or to conform to legal imperatives or upon the written authorisation

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<sup>113</sup> The Code of Professional Conduct further requires: **26 Limits on intrusions on privacy:** A psychologist shall include in a written report, oral report or consultations, only information relevant to the purpose for which the communication is made and shall discuss confidential information obtained in his or her work only for appropriate scientific or professional purposes and only with persons concerned with such matters. **27 Disclosures:** (1) A psychologist may disclose confidential information: (a) only with the permission of a client; (b) as mandated by law; (c) when permitted by law for a valid purpose such as to provide needed professional services to a client; (d) to obtain appropriate professional consultations; (e) to protect a client or others from harm; or (f) to obtain payment for a psychological service, in which instance disclosure is limited to the minimum necessary to achieve that purpose. (2) A psychologist shall not disclose confidential information if unless prohibited by law. **28 Multiple clients** (1) When a psychological service is provided to more than one client during a joint session (for example to a family or couple, or parent and child, labour disputants, or a group), a psychologist shall, at the beginning of the professional relationship, clarify to all parties the manner in which confidentiality will be handled. (2) All parties referred to in sub-rule (1) shall be given an opportunity to discuss with such psychologist and to accept whatever limitations on confidentiality are adhered to in the situation. **29 Legally dependent clients** (1) A psychologist shall be cognisant that a child's best interests are of paramount importance in every professional matter concerning direct or indirect psychological services to children. (2) A psychologist shall take special care when dealing with children 14 years of age and younger. (3) A psychologist shall, at the beginning of a professional relationship, inform a child or a client who has a legal guardian or who is otherwise legally dependent, of the limits the law imposes on the right of confidentiality with respect to his or her communications with such psychologist.

of the client, parent of a minor client, or legal guardian. This issue is discussed below under the heading of "the release of raw data".

Further, according to the Ethical Code of Professional Conduct, when a psychologist renders psychological professional services as part of a team or when he or she interacts with other appropriate professionals concerning the welfare of a client, such psychologist may share confidential information about such client, provided that such psychologist takes reasonable steps to assure that all persons who receive such information are informed about the confidential nature of the information and abide by the rule on professional confidentiality. When consulting with colleagues, a psychologist shall:

- Not disclose confidential information that reasonably could lead to the identification of a client, research participant, or other person or organisation with whom he or she has a confidential relationship, unless he or she has obtained the prior consent of the person or organisation; or the disclosure cannot be avoided; and
- disclose information only to the extent necessary to achieve the purposes of the consultation.<sup>114</sup>

With regard to maintenance, dissemination and the keeping of records: A psychologist shall create, maintain, store, disseminate and retain records and data relating to his or her scientific and professional work in order to:

- enable efficacious provision of services by him or her or by another professional;
- allow for replication of research design and analysis;
- meet institutional requirements;
- ensure accuracy of billing and payments;
- facilitate subsequent professional intervention or inquiry; and

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<sup>114</sup> Ss 32(1), 32(2)(a-b). See also Rule 33: **Disguising confidential information used for didactic or other purposes:** A psychologist shall not disclose in his or her writings, lectures or other public media, confidential and personally identifiable information which he or she obtained during the course of his or her work concerning a client, organisation, research participant, supervisee, student, or other recipient of his or her psychological services, unless: (a) He or she takes reasonable steps to disguise such client, organisation, research participant, supervisee, student, or other recipient; (b) such client, organisation, research participant, supervisee, student, or other recipient has consented in writing; or (c) there is other ethical or legal authorisation for doing so.

- ensure compliance with the law.

A psychologist must maintain confidentiality in creating, storing accessing, transferring, and disposing of records under their control, whether these are written, automated, or in any other medium. In addition, a psychologist must, if confidential information concerning users of psychological services is entered into a database or system of records available to persons whose access has not been consented to by the user, use coding or other techniques to avoid the inclusion of personal identifiers. A psychologist must make plans in advance to facilitate the appropriate transfer and to protect the confidentiality of records and data in the event of his or her unavailability through factors such as death, incapacity or withdrawal from practice.<sup>115</sup>

#### **4.7.1.2 Informed consent<sup>116</sup>**

The concept of informed consent is superficially an uncomplicated one. Competent patients have a right to make informed decisions for their treatment, which must be free from coercion. However, the translation of this seemingly straightforward principle into practice has been fraught with confusion and dissent.<sup>117</sup> Consent is legally and ethically required for both conventional and experimental treatment. Patients must be given sufficient information about their diagnosis, prognosis and treatment options to make a knowledgeable decision. This includes, for example, discussion of potential risks and benefits, available alternative treatments and the results of not receiving treatment. This approach may come at some psychological cost; severe anxiety and occasional psychiatric decompensation (the inability to maintain defence mechanisms in response to stress, resulting in personality disturbance or psychiatric / psychological imbalance) can occur when patients feel overburdened by demands to make decisions.<sup>118</sup> Therefore, psychiatry and psychology stand in a unique and somewhat paradoxical position with regard to informed consent.<sup>119</sup>

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<sup>115</sup> S 34(1)-(4).

<sup>116</sup> See also the legal discussion of the doctrine of informed consent in chapter 5.

<sup>117</sup> Schwartz HI "Informed consent and competency" 103-110 in *Principles and practice of forensic psychiatry* 103.

<sup>118</sup> Sadock & Sadock (eds) 1360.

<sup>119</sup> Schwartz in *Principles and practice of forensic psychiatry* 103.

The Ethical Code of Professional Conduct to which a Psychologist shall adhere regulates informed consent to professional procedures as follows: "When a psychologist conducts research or provides assessment, psychotherapy, counselling, or consulting services in person or via electronic transmission or other forms of communication, he or she shall obtain the written informed consent of a client, using a language that is reasonably understandable to such client."<sup>120</sup>

Taking into account that the content of written informed consent referred to in sub-rule (1) above will vary depending on circumstances, informed consent ordinarily requires that a client:

- Has the capacity to consent;
- has been provided with information concerning participation in the activity that reasonably might affect his or her willingness to participate, including limits of confidentiality and monetary or other costs or reimbursements;
- is aware of the voluntary nature of participation and has freely and without undue influence expressed consent; and
- has had the opportunity to ask questions and receive answers regarding those activities: Provided that, in the case of a client who are legally incapable of giving informed consent, a psychologist shall nevertheless: (i) provide an appropriate explanation; (ii) seek the client's assent; (iii) consider such client's preferences and best interests; and (iv) obtain appropriate permission from a legally authorised person, if such substitute consent is permitted or required by law, but if consent by a legally authorised person is not permitted or required by law, a psychologist shall take reasonable steps to protect the client's rights and welfare.<sup>121</sup>

It is important to note that when psychological services are court ordered or administratively decreed or ordered through mediation or arbitration, a psychologist shall:

- inform the individual of the nature of the anticipated services, including whether the services were ordered and any limits of confidentiality, before proceeding;
- appropriately document written or oral consent, permission or assent.<sup>122</sup>

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<sup>120</sup> S 11(1).

<sup>121</sup> S 11(2)(a-d)(i-iv).

<sup>122</sup> S 11(3)(a-b). See also s 46(1-6) with regard to informed consent in assessments: (1) A psychologist shall obtain written informed consent from a client for assessments, evaluations, or diagnostic services. (2) The written informed consent

When obtaining informed consent to therapy as required in standard informed consent forms, a psychologist must inform a client as early as is feasible in the therapeutic relationship about appropriate information, including the nature and anticipated course of therapy, fees, involvement of third parties, and confidentiality and when:

- Obtaining informed consent from a client for treatment involving emerging areas in which generally recognised techniques and procedures have not been established, such psychologist must inform his or her client of the developmental nature of the treatment, the potential risks involved, alternative treatments that may be available, and the voluntary nature of their participation; and
- the therapist is a trainee and the legal responsibility for the treatment provided resides with the supervisor, such client, as part of the informed consent procedure, shall be informed that the therapist is in training and is being supervised and the client shall be given the name of the supervisor.<sup>123</sup>

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referred to in sub-rule (1) shall indicate at least the following: (a) details of such client; (b) the exact nature of the psychological service(s) to be provided; and (c) any limits inherent in providing psychological services to such client for example: (i) a client's right to refuse participation; (ii) limits to confidentiality; or (iii) any potential harmful effects inherent to providing such psychological services. (3) Written informed consent referred to in sub-rule (1) is not necessary when: (a) testing is a legal requirement; (b) informed consent is implied because testing is conducted as a routine educational, institutional, or organisational activity (as in job interview testing); or (c) the a psychologist's purpose in testing is to evaluate decision-making and mental incapacity. (4) A psychologist shall inform a client with questionable capacity to consent or for whom testing is mandated by law about the nature and purpose of the proposed assessment services, using language that is reasonably understandable to such client being assessed. (5)(a) A psychologist shall, when using the services of an interpreter, obtain informed consent from a client or patient to use the interpreter, and ensure the confidentiality of test results and test security are maintained, and discuss any limitations on the data obtained. (b) A psychologist shall remain cognisant of the limits to data obtained via the use of an interpreter and frame his or her conclusions and recommendations accordingly. (6) A psychologist shall when conducting automated or internet-based testing, obtain informed consent from the client or patient and shall: (a) ensure that confidentiality of test results and test security are maintained; and (b) discuss with the client or patient any limitations on the data obtained.

<sup>123</sup> S 57(a-b). See also ss 90-91: **90 Dispensing with informed consent:** Before determining that planned research (such as research involving only anonymous questionnaires, naturalistic observations, or certain kinds of archival research), does not require the informed consent of a participant, a psychologist shall consider applicable regulations and institutional review board requirements, and shall consult with colleagues as may be appropriate. **91 Informed consent in research filming or recording:** A psychologist shall obtain informed consent from a participant prior to filming or recording him or her in any form, unless the research involves simply naturalistic observations in public places and it is not anticipated that the recording will be used in a manner that could cause personal identification or harm to such participant.

Obtaining informed consent with regard to disclosures in the public interest in cases where health care practitioners have considered all the available means of obtaining consent, but are satisfied that it is not practicable to do so, or that patients are not competent to give consent, or exceptionally, in cases where patients withhold consent, personal information may be disclosed in the public interest where the benefits to an individual or to society of the disclosure outweigh the public and the patient's interest in keeping the information confidential, (for example, endangered third parties such as the spouse or partner of a patient who is HIV positive, who after counselling refuses to disclosure of his or her status to such spouse or partner; or reporting a notifiable disease). In all such cases the health care practitioner must weigh the possible harm (both to the patient, and the overall trust between practitioners and patients) against the benefits that are likely to arise from the release of information.<sup>124</sup>

#### **4.7.1.3 Sexual boundary violations**

For a psychiatrist or psychologist to engage in a sexual relationship with a patient is clearly unethical. The issue of whether sexual relations between an ex-patient and a therapist violate an ethical principle, however, remains controversial. Proponents of the view, "once a patient, always a patient," insist that any involvement with an ex-patient – even one that leads to marriage – should be prohibited. They maintain that a transference reaction that always exists between the patient and the therapist prevents a rational decision about their emotional or sexual union. Others insist that, if a transference reaction still exists, the therapy is incomplete and that as autonomous human beings, ex-patients should not be subjected to paternalistic moralising by physicians. Accordingly, they believe that no sanctions should prohibit emotional or sexual involvements by ex-patients and their psychiatrists or psychologists. Some psychiatrists and psychologists maintain that a reasonable time should elapse before such a liaison. The length of the reasonable period also remains controversial. Some psychiatrist and psychologists have suggested two

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<sup>124</sup> Examples of circumstances to protect the patient or other persons from death or serious harm, include, but are not limited to: Access to prophylactic treatment for a person who has had contact with an infectious disease; or an employee with a health condition which may render him or her unable to work safely posing a danger to co-workers or clients; or a driver of a vehicle who requires medication to control an illness that might impair his or her driving ability. See Health Professions Council of South Africa: *Guidelines for good practice in the health care professions: Confidentiality: Protecting and providing information* (2007) 6.

years. Others maintain that any period of prohibited involvement with an ex-patient is an unnecessary restriction.<sup>125</sup>

According to the Ethical Code of Professional Conduct to which a Psychologist shall adhere, a psychologist shall not engage in sexual intimacies of any nature (whether verbal, physical or both) with current therapy clients.<sup>126</sup> Furthermore, a psychologist shall not engage in sexual intimacies with an individual he or she knows to be a parent, guardian, spouse, significant other, child or sibling of current client<sup>127</sup> and shall not terminate therapy to circumvent this standard referred to in sub-rule (1).<sup>128</sup> In addition, a psychologist may not accept any person with whom he or she has engaged in sexual intimacies as a therapy client.<sup>129</sup>

With regard to sexual intimacies with former therapy patients a psychologist shall not engage in sexual intimacies with a former client for at least 24 months after cessation or termination of therapy and even then, such psychologist who enters into a sexual relationship after such a period with a former client, bears the burden of demonstrating that there has been no exploitation, in light of all relevant factors such as:

- The amount of time that has passed since the therapy terminated;
- the nature, duration, and intensity of the therapy;
- the circumstances of termination;
- the client's personal history;
- the client's current mental status;
- the likelihood of an adverse impact on the client; and
- any statements made or actions taken by the therapist during the course of therapy suggesting or inviting the possibility of a post-termination sexual or romantic relationship with the client.<sup>130</sup>

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<sup>125</sup> An egregious example of a sexual boundary violation was where a psychiatrist had a seven-year affair with a patient who was schizophrenic. He not only had sex with the patient but also had her procure prostitutes with whom he and she would have group sex. He paid for their services by providing them with prescriptions for controlled substances and went so far as to bill Medi-Cal (in California) for these encounters as group therapy. The psychiatrist's license was revoked and he was also criminally charged with and convicted of fraud. See Sadock & Sadock (eds) 1386; *Medical Board of California Action Report* (July 2006).

<sup>126</sup> S 61. See also s 13, which states that a psychologist shall not engage in sexual harassment.

<sup>127</sup> S 62(1).

<sup>128</sup> S 62(2).

<sup>129</sup> S 63.

<sup>130</sup> S 64(a-g).

Furthermore, according to section 85: "A psychologist shall not engage in a sexual relationship with a student, supervisee or trainee who is in his or her department, agency, or training centre or over whom such psychologist has or is likely to have evaluative authority."

#### **4.7.1.4 Impaired physicians**

According to Breen,<sup>131</sup> protecting the public from medical practitioners and therapists who (through illness or drug dependence) are impaired in a manner which makes it dangerous for them to continue to practice should be a major function of professional boards. Impaired practitioners who may be putting the public at risk usually fall into one of three categories – psychiatric illness; drug or alcohol addiction or illness leading to intellectual or physical impairment. Impairment usually involves loss of insight. Confronting a possibly ill and impaired colleague or notifying a medical board of such concern is a serious and difficult responsibility for medical practitioners, which is frequently ignored or deferred to the detriment of both the impaired practitioner and the community.

According to the Ethical Code of Professional Conduct to which a Psychologist shall adhere, a psychologist who may be impaired as defined in the Act:

- Shall refrain from undertaking professional activities when there is the likelihood that his or her personal circumstances (including mental, emotional, physiological, pharmacological or substance abuse conditions), may prevent him or her from performing such professional activities in a competent manner;
- shall be alert to signs of, and obtain appropriate professional assistance for, his or her personal problems at an early stage in order to prevent impaired performance; and
- shall, if he or she becomes aware of personal circumstances that may interfere with his or her performing of professional duties adequately, take appropriate measures such as obtaining

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<sup>131</sup> Breen KJ *et al Ethics, law and medical practice* (1997) 92-93. See also Mengel MB *et al Fundamentals of clinical practice* (2002) 93ff; Martin A *et al Lewis's child and adolescent psychiatry: A comprehensive textbook* (2007) 21ff.

professional consultation or assistance, and determine whether he or she should limit, suspend or terminate his or her professional duties.<sup>132</sup>

With regard to the reporting of colleague impairment: If a psychologist has a reasonable basis for suspecting that a colleague is professionally impaired due to psychological disturbance, physical illness or substance abuse, he or she shall timeously inform the board of his or her concerns.<sup>133</sup> Where a psychologist informs the board as referred to in sub-rule (1), factual proof is not required provided the concerns are *bona fide*.<sup>134</sup> The board will consider the matter and possibly initiate an investigation by the appropriate organ of the board.<sup>135</sup>

#### 4.7.1.5 *Resolving ethical issues*

When a psychologist is uncertain whether a particular situation or course of action would violate the ethical rules, such psychologist must consult with another psychologist knowledgeable about ethical issues, with appropriate national ethics committees in psychology, or with another appropriate authority in order to choose a proper response.<sup>136</sup> When a psychologist believes that there may have been an ethical violation by another psychologist, he or she must attempt to resolve the issue by bringing it to the attention of that individual if an informal resolution appears appropriate and the intervention does not violate any confidentiality rights that may be involved.<sup>137</sup>

If an apparent ethical violation is not appropriate for informal resolution or is not resolved properly in that fashion, a psychologist must take further action appropriate to the situation, unless such action conflicts with confidentiality rights in ways that cannot be resolved.<sup>138</sup> Action referred to in sub-rule (1) may include

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<sup>132</sup> S 7(a-c).

<sup>133</sup> S 107(1).

<sup>134</sup> S 107(2).

<sup>135</sup> S 107(3).

<sup>136</sup> S 102. See also s 104, which regulates conflicts between ethics and organisational demands: If the demands of an organisation with which a psychologist is affiliated, conflict with the ethical rules, such psychologist must clarify the nature of the conflict, make known his or her commitment to these rules, and to the extent feasible, shall seek to resolve the conflict in a way that permits the fullest adherence to these rules.

<sup>137</sup> S 105.

<sup>138</sup> S 106(1).

referral to an appropriate professional ethics committee or colleague for arbitration, conciliation, or advice on further course of action.<sup>139</sup>

A psychologist must co-operate in an ethics investigation, proceeding or related requirements of the board and make a reasonable effort to resolve for purposes of such investigation, proceeding or requirements any issues relating to confidentiality.<sup>140</sup> It is important to note that failure by a psychologist to co-operate in an ethics investigation, proceeding or related requirements of the board referred to in sub-rule (1) is itself an ethics violation.<sup>141</sup>

#### **4.7.1.6 Conflicts between ethics and law**

According to the Ethical Code of Professional Conduct to which a psychologist shall adhere, if a psychologist's ethical responsibilities conflict with law or other legal authority, such psychologist shall make known his or her commitment to these rules and take steps to resolve the conflict.<sup>142</sup> If the conflict referred to in sub-rule (1) is irresolvable via such means, a psychologist may adhere to the requirements of the law or other legal authority.<sup>143</sup>

## **4.8 THE ROLE OF THE PSYCHIATRIST AND PSYCHOLOGIST IN COURT**

### **4.8.1 Introductory remarks**

The professions of psychiatry and psychology have much to offer to the legal system and to those individuals with possible or clearly identified psychiatric and psychological difficulties who are involved in legal matters. As a result these professions have emerged as distinct speciality areas within the broader fields of psychiatry and psychology.<sup>144</sup> Therefore, forensic psychiatrists and psychologists may have

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<sup>139</sup> S 106(2). See also s 109, which deals with improper complaints: A psychologist shall not file or encourage the filing of an ethics complaint that is frivolous and is intended to harm the respondent rather than to protect the public.

<sup>140</sup> S 108(1).

<sup>141</sup> S 108(2). See also Lo B *Resolving ethical dilemmas: A guide for clinicians* (2009) 1ff.

<sup>142</sup> S 103(1).

<sup>143</sup> S 103(2).

<sup>144</sup> See also the *Practice framework adopted by the Professional Board for Psychology*, which was adopted in September 2007. The Practice framework for Psychology was formulated by the Professional Board for Psychology as the Standards Generating Body and revised after consultation with all relevant stakeholders such as the Psychological Society of South Africa, Society for Industrial and Organizational Psychology of South Africa and Heads of Department of Psychology and all registered psychology professionals on various occasions in meetings and other forms of communication. This document was also informed by the Human Resources Plan of the Department of Health for the country formulated by the National Department of Health. The purpose of the document is to define and delineate the

multiple professional identities representing both their primary areas of training and experience and their subsequent application of their knowledge and skills to forensic matters.<sup>145</sup> The role of the psychiatrist and psychologist in court (for purposes of this thesis) differ in four ways: First, in context of criminal law, a finding that the accused lacked criminal capacity can only be made on the basis of expert psychiatric or psychological evidence. The court cannot arrive at a verdict on the basis of its own observations. Strauss<sup>146</sup> states that where the evidence submitted for the prosecution conflicts with that submitted for the defence, the court is of course entitled to consider that the burden of proving non-imputability rests on the accused. Second, as a general rule of evidence, in the context of medical law, a plaintiff in a medical negligence action is required to present expert medical evidence in support of allegations thereof. Expert psychiatric evidence, for example, will therefore be pivotal in support or defence of psychiatric negligence. Where expert witnesses give conflicting evidence, the court must to the best of its ability make a choice between the different points of view. Third, in context of professional conduct inquiries into the alleged unprofessional conduct of a psychiatrist or psychologist, falling within the jurisdiction of the HPCSA, expert psychiatric or psychological evidence must be led in support and defence of the allegations against the practitioner.<sup>147</sup> Lastly, a psychologist may be summonsed to appear as a fact witness in court cases.<sup>148</sup>

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various registration categories within the profession of psychology. In the document each category is described in terms of scope of practice, psychological assessment, psychological intervention, and so forth. New categories were introduced such as Neuropsychology and Mental Health Assistant. The Board took a resolution that the final status of Forensic Psychology be determined at a later stage after further consultation. The document should be read as whole and it is in no way meant to determine the level of importance of each category. It should also be used as a reference source for all practitioners registered with the Board.

<sup>145</sup> In addition to psychiatrists and psychologists who pursue professional involvement in the legal system, some of them may inadvertently find themselves involved in the legal matters of their patients. Involvement may be either requested or required. For example, a neuropsychiatrist- or -psychologist may be subpoenaed to testify about the evaluation findings of a patient who sustained a traumatic brain injury in a motor vehicle accident. See Shane S *et al Ethical practice in forensic psychology: A systematic model for decision making* (2006) 9. A further discussion of this topic falls outside the scope of this thesis.

<sup>146</sup> Strauss *Doctor, patient and the law* 131.

<sup>147</sup> In general terms, a professional conduct committee is bound by the ordinary rules of evidence. In the case of *McLoughlin v South African Medical and Dental Council* Ramsbottom J observed the following in this regard: "The Medical Council and the disciplinary committee are bodies of a very different kind. They are entrusted with the most important duties; they have the power to compel the attendance of witnesses; evidence is given on oath and any person who gives false evidence on oath before the Council or the committee or refuses to answer commits an offence; the parties have the right to appear by counsel and witnesses are examined and cross-examined; a legal assessor may be appointed to advise on matters of law procedure and evidence . . . In my opinion a body of this kind should be held more strictly to the rules of procedure and evidence than a body such as ... (trade unions and the like)." See *McLoughlin v South African Medical and Dental Council* 1947 (2) SA 377 (W). Cf the discussions of this topic in Carstens & Pearmain 275; Taitz 1988 *Acta Juridica* 40ff; Van Oosten FFW in *International Encyclopaedia of Laws* par [85].

<sup>148</sup> According to the Ethical Rules of Professional Conduct to which a Psychologist shall adhere: (1) When a psychologist is required by a court to appear as a fact witness, such psychologist is legally obliged to present evidence. (2) A

#### 4.8.2 Psychiatrists and psychologists as expert witnesses

Psychiatrists and psychologists, being so-called "expert witnesses" carry with it an awesome responsibility. Recommendations made by them may impact severely on many individual's lives.<sup>149</sup> The primary function of an expert witness is to guide the court to a correct decision on questions falling within the expert's specialised field, but not to pass judgment in court.<sup>150</sup> In one of South Africa's leading cases *Van Wyk v Lewis*,<sup>151</sup> Innes CJ ruled explicitly: "The testimony of experienced members of the profession is of the greatest value ... [The court] will pay high regard to the views of the profession, but is not bound to adopt them." Therefore the probative value of expert evidence is dependant upon the qualifications, skill and level of experience (competency rule) of the expert and the ability of the court to assess this testimony.<sup>152</sup>

Unfortunately some professionals in South Africa who conduct psycho-legal assessment<sup>153</sup> and testify in court do not have the requisite qualifications or expertise to do so. Yet many claim that they have vast amount of experience (to claim legitimacy) without conceding that they might be practising incorrectly and continue to do so. Psycho-legal work is commonly performed by either psychiatrists or psychologists (mental health practitioners<sup>154</sup>) in private practice, or professional staff in large psychiatric institutions that do evaluations as part of their general duties because their institutions are obligated to do them. There is no formal training programme or examinations for forensic mental health in South Africa. Therefore,

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psychologist may declare his or her reluctance to appear as a fact witness by appearing as a witness under protest. (3) Irrespective of whether a psychologist appears as a witness under protest or not, such psychologist shall serve as a truthful and fully disclosing witness. See s 74(1-3).

<sup>149</sup> Kennedy R *Psychotherapists as expert witnesses: Families at breaking point* (2005) 1.

<sup>150</sup> Carstens & Pearmain 861; Hoffman LH and Zeffert D *SA Law of Evidence* (1988) 97; Schmidt CWH *Bewysreg* (2000) 463; *S v Gouws* 1967 (4) SA 527 (E).

<sup>151</sup> *Van Wyk v Lewis* 1924 AD 438 447-448.

<sup>152</sup> Carstens & Pearmain 860.

<sup>153</sup> All psycho-legal assessments have the following three components in common: (1) the determination of a diagnosis; (2) an appreciation of the functional demands contained within the relevant legal and juridical briefs; and; (3) the strength of the causal connection between the first and the second requirements. See Kaliski "Introduction" 1-7 in *Psycholegal assessment in South Africa* (ed) Kaliski S (2006) 2-3.

<sup>154</sup> The Mental Health Care Act 17 of 2002 (hereinafter referred to as the Mental Health Care Act) defines a mental health practitioner as "a psychiatrist, registered medical practitioner, nurse, clinical psychologist, occupational therapist, or social worker who has been trained to provide prescribed mental health care, treatment and rehabilitation services". See s 1.

according to Kaliski<sup>155</sup> a mental health practitioner – to be acknowledged a forensic expert – should at least have worked in an academic forensic facility for an appreciable period and be convincingly experienced.<sup>156</sup>

The Ethical Code of Professional Conduct to which a Psychologist shall adhere regulates the maintenance of the expert witness role as follows: "A psychologist shall be aware of the competing demands placed upon him or her by the code and the requirements of the court system, and shall attempt to resolve such conflicts by making known his or her commitment to these rules and by taking steps to resolve such conflict in a responsible manner."<sup>157</sup>

In the case of *Michael v Linksfeld Park Clinic (Pty) Ltd*<sup>158</sup> the Supreme Court of Appeal had the opportunity to authoritatively enunciate the general applicable considerations in assessing expert medical evidence.<sup>159</sup> The approach to expert evidence followed by the Supreme Court of Appeal in this case can be summarised<sup>160</sup> as follows:

- In delictual claims the issue of reasonableness or negligence of a defendant's conduct is one for the court itself to determine on the basis of the various and often conflicting expert opinions presented;
- as a rule that determination will not involve considerations of credibility but rather the examination of the opinions and the analysis of their essential reasoning, preparatory to the court reaching its own conclusion on the issues raised;

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<sup>155</sup> Kaliski "Introduction" in *Psycholegal assessment in South Africa* 3.

<sup>156</sup> It is envisaged that a formal postgraduate course will be introduced in South Africa in future. Haas concedes that the mere possession of generic professional credentials cannot be used as justification of necessary and sufficient skill to perform in a forensic role. See Haas L "Competence and quality in the performance of forensic psychologists" 1993 3 *Ethics & Behaviour* 3/4: 251. The Ethical Code of Professional Conduct to which a Psychologist shall adhere also regulates psycho-legal activities and requires in s 67(1) that a psychologist who performs psycho-legal (including forensic) functions, such as assessments, interviews, consultations, reports or expert testimony, shall comply with all the other provisions of the rules to the extent that they apply to such activities. It further requires in s 67(2) that a psychologist shall base his or her psycho-legal work on appropriate knowledge of and competence in the areas underlying such work, including specialised knowledge concerning specific populations.

<sup>157</sup> S 72.

<sup>158</sup> *Michael v Linksfeld Park Clinic (Pty) Ltd* 2001 (3) SA 1188 (SCA).

<sup>159</sup> For a discussion of *Michael v Linksfeld Park Clinic* in context of the assessment of expert medical testimony in South Africa, see Carstens & Pearmain 860-862; Carstens PA "Setting the boundaries for expert evidence in support or defence of medical negligence: *Michael v Linksfeld Park Clinic (Pty) Ltd* 2001 (3) SA 1188 (SCA)" 2002 65 *THRHR* 3: 430-436.

<sup>160</sup> See *Michael v Linksfeld Park Clinic supra* 1200A-1201F.

- in the case of professional negligence, the governing test is the standard of conduct of the reasonable practitioner in the particular professional field, but that criterion is not always itself a helpful guide to finding the answer;
- what is required in the evaluation of expert evidence bearing on the conduct of such persons is to determine whether and to what extent the opinions advanced are founded on logical reasoning;
- the court is not bound to absolve a defendant from liability for allegedly negligent professional conduct (such as medical treatment or diagnosis) just because evidence of expert opinion, albeit genuinely held, is that the conduct in issue accorded with sound practice;
- the court must be satisfied that such opinion had a logical basis, in other words that the expert has considered comparative risks and benefits and has reached a defensible conclusion. If a body of professional opinion overlooks an obvious risk, which could have been guarded against, it will not be reasonable, even if almost universally held;
- a defendant can be held liable despite the support of a body of professional opinion sanctioning the conduct in issue if that body of opinion is not capable of withstanding logical analysis and is therefore not reasonable. However, it will very seldom be correct to conclude that views genuinely held by a competent expert are unreasonable;
- the assessment of medical risks and benefits is a matter of clinical judgment which the court would not normally be able to make without expert evidence, and it would be wrong to decide a case by simple preference where there are conflicting views on either side, both capable of logical support;
- only where expert opinion cannot be logically supported at all will it fail to provide the benchmark by reference to which the defendant's conduct fails to be assessed;
- finally, it must be borne in mind that expert scientific witnesses tend to assess likelihood in terms of scientific certainty and not in terms of where the balance of probabilities lies on a review of the whole of the evidence.<sup>161</sup>

## 4.9 ETHICAL DECISION-MAKING IN FORENSIC PSYCHIATRY AND PSYCHOLOGY

### 4.9.1 The forensic psychiatrist and psychologist

As previously mentioned, forensic evaluations do not usually occur within context of the normal "therapist-patient" relationship in which there has to be concern that the assessed individual's autonomy is respected,

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<sup>161</sup> This topic is further dealt with in chapter 6.

care taken that no harm befalls him or that his best interests are served. Professional boundaries in psycho-legal practice are intended to maintain a professional distance and respect between the patient and the forensic psychiatrist and psychologist. It is possible that the therapist might feel sympathy for the client and as such recommend a particularly lenient sentence or award custody unfairly. Therefore the boundaries of psycho-legal relationships should be regarded as more strict and formal than in most other clinical relationships.<sup>162</sup> Appelbaum<sup>163</sup> writes as follows: "The forensic psychiatrist, in truth, does not act as a physician... If the essence of the physician's role is to promote healing and/or to relieve suffering, it is apparent that the forensic psychiatrist operates outside the scope of the role... Were we to call such a person a 'forensicist,' or some similar appellation, it might more easily be apparent that a different – non-medical - role with its own ethical values is involved. Psychiatrists [and psychologists] operate outside the medical framework when they enter the forensic realm, and the ethical principles by which their behaviour is justified are simply not the same."

Most forensic psychiatric and psychological evaluations do not present ethical dilemmas, although functioning at the interface of law, psychiatry and psychology may lead to conflicts without clear resolution methods, for example:

- The basic boundary problem of whether psychiatry and psychology have anything to offer the law;
- the potential for psychiatrists and psychologists trying to help a patient by twisting rules of justice and fairness;
- the potential for psychiatrists and psychologists to deceive a patient in order to serve justice and fairness; and
- the power of the adversarial legal system to both seduce and abuse psychiatrists and psychologists in ways that demean the profession.<sup>164</sup>

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<sup>162</sup> Zabow T & Kaliski S "Ethical considerations" in *Psycholegal assessment in South Africa* 359-360.

<sup>163</sup> Appelbaum PS "The parable of the forensic psychiatrist: Ethics and the problem of doing harm" 1990 13 *Int J L & Psychiatry* 4: 249 at 258. See also Candilis PJ *et al Forensic ethics and the expert witness* (2007) 23ff.

<sup>164</sup> Weinstock & Leong in *Principles and practice of forensic psychiatry* 59. See also Appelbaum PS "Forensic psychiatry: The need for self regulation" 1992 20 *Bull Am Acad Psychiatry Law* 2: 153-162.

## 4.9.2 Ethical practice in forensic psychiatry and psychology

### 4.9.2.1 *Psycho-legal activities*

One of the major concerns in criminal forensic psychiatry and psychology is stated by Harris,<sup>165</sup> who wrote: "What amazes me is that in any trial I've ever heard of, the defence psychiatrist [psychologist] always says the accused is insane, and the prosecuting psychiatrist [psychologist] always says he's sane. This happened invariably in 100% of the cases, thus far exceeding the laws of chance. You have to ask yourself, 'What is going on here?' ..." The answer is that some experts have earned the label of hired-guns, because they are prepared to express the opinion requested by the lawyer irrespective of whether that is objectively the correct opinion. As it is the lawyer's ethical duty to present their client's case in the most positive way it is almost inevitable that the information that they give to the expert will be specifically selected and presented in order to strengthen a particular viewpoint, which almost certainly leads to incomplete information.<sup>166</sup> Experts should examine information critically and must make sure that such material does not only support the view of the instructing lawyer. Another factor that leads to the impression of bias is that some experts receive financial incentives and tend to work exclusively for certain legal firms or a specific group, for example defendants in civil cases, which factors may be contributing to the unethical conduct of the forensic psychologist. It is of the utmost importance that experts must be impartial and honest and an awareness of these common ethical challenges in forensic psychology can help psychologists to examine their own practices and the practices of their colleagues.<sup>167</sup>

According to the Ethical Rules of Professional Conduct to which a Psychologist shall adhere, a psychologist must ensure that psycho-legal assessments, recommendations and reports are based on information and techniques sufficient to provide appropriate substantiation for the findings.<sup>168</sup> Furthermore, according to section 69, a psychologist must provide written or oral psycho-legal reports or testimony of the psychological characteristics of a client only after he or she has conducted an examination of the client

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<sup>165</sup> Jeffrey Harris, Executive Director US Attorney General's Task Force on Violent Crime. See Citizens Commission on Human Rights available at [www.cchr.org](http://www.cchr.org) 2007 (Date of access 21 August 2008).

<sup>166</sup> For a general discussion and examination of the dilemmas posed by the involvement of expert witnesses in court cases and the institutional constraints on the ethics of expert testimony; the causes for the incorporation of bad science into legal decisions, potential solutions to this dilemma and the limitations of these solutions, see Sales BD & Simon L "Institutional constraints on the ethics of expert testimony" 1993 3 *Ethics & Behavior* 3/4: 231-249. They concluded that law, science, and experts must respond to the problems posed by expert witnessing.

<sup>167</sup> Allan A & Meintjies-Van der Walt L "Expert evidence" in *Psycholegal assessment in South Africa* 353.

<sup>168</sup> S 68.

which is adequate to support his or her findings: Provided, however, that when, despite reasonable efforts, such an examination is not feasible, such psychologist shall clarify the impact of his or her limited information on the reliability and validity of his or her reports and testimony while appropriately limiting the nature and extent of his or her findings.

It is important to note that in psycho-legal testimony and reports, a psychologist must:

- Testify truthfully, honestly, candidly and consistently with applicable legal procedures; and
- describe fairly the basis for their testimony and conclusions.<sup>169</sup>

The obvious but essential starting point to avoid the impairment of the objectivity of the forensic expert is that a thorough clinical assessment (with accepted diagnosis) should precede any consideration of the legal or juridical issues. It is important that clinicians base their diagnoses on the criteria listed in the DSM-IV or ICD-10 or the diagnosis should at least be well defined in academic literature. According to Kaliski<sup>170</sup> the rationale behind this approach is that modern psycho-legal practice can no longer tolerate assessments in which the expert provides an opinion based solely on "my experience". Opinions have to be objective and based on good evidence.

#### ***4.9.2.2 Professional competence and training in the use of standardised tests***

If a psychiatrist or psychologist is instructed by an attorney to conduct an assessment to determine whether a defendant was insane at the time he or she committed a specific crime the psychiatrist or psychologist must be able to recognise that this is in fact a forensic assessment and not a clinical assessment. The psychiatrist or psychologist must then determine whether his or her specific graduate training program and internship provided an adequate foundation for conducting this type of assessment. Therapists who conduct forensic assessments on a regular basis may be vulnerable to a special occupational hazard: Having assembled a standard battery of tests with which they are comfortable, they may use that battery without evaluating whether the tests are appropriate for the specific assessment task at hand for each new case. Tests conducted should also be appropriate for the individual. Even if the tests have been carefully

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<sup>169</sup> S 70(a-b).

<sup>170</sup> Kaliski "Introduction" in *Psycholegal assessment in South Africa* 4.

selected on the basis of validity in addressing the tasks at hand there are significant factors that can affect whether the tests are appropriate for a specific individual, for example, passage of time, geographic and educational representatives and avoiding ethnic and racial bias. It is further important for standardised tests to be used in a standardised manner. The power and effectiveness, as well as the validity and reliability of standardised instruments are assured only by using standardised procedures for administration, scoring and interpretation. Shortcuts are tempting to many psychologists in light of busy schedules and pressure from lawyers. By departing from the standardised method of administration, scoring and interpretation the vital link between the test and the validating research from which the test draws its strength is cut. In addition, computers should be used in an appropriate manner for forensic assessment. Some crucial considerations include that the psychologist is confident that there are no bugs in the scoring program; there should be adequate evidence that the computer transforms raw scores into interpretive statements; and the degree to which the interpretive statements in the computer generated report actually apply to the individual who is being assessed, needs to be determined. Factors that can influence the test data and their meaning, for example, distractions while a client is taking a test or a client taking a test while heavily medicated should be taken into account and be included in forensic testimony as well as the forensic report.<sup>171</sup>

#### **4.9.2.3 Culture, language and race**

In a country that has eleven official languages and a multitude of cultures and races it is likely that many psycho-legal examiners will derive from very different backgrounds as their examinees. Many forensic psychologists in this country have little knowledge and understanding of the various local African cultures, although training programmes usually include seminars on transcultural psychiatry. At least there is an awareness of and empathy for ethnic, religious and cultural diversity.<sup>172</sup> According to Tseng,<sup>173</sup> cultural competence requires the attainment of several qualities: First, cultural sensitivity that refers to recognition of the diversity of viewpoints, attitudes and lifestyles among human beings. Second, basic cultural knowledge about humankind as whole with which to put the particular client and family into perspective is

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<sup>171</sup> Butcher JN & Pope KS "Seven issues in conducting forensic assessments: Ethical responsibilities in light of new standards and new tests" 1993 3 *Ethics & Behavior* 3/4: 267-288.

<sup>172</sup> Kaliski "Introduction" in *Psycholegal assessment in South Africa* 6. See also Fernando S *et al Forensic psychiatry, race and culture* (1998) 1ff; Tseng WS *Cultural competence in forensic mental health* (2004) 1ff.

<sup>173</sup> Tseng WS & Streltzer J *Cultural competence in clinical psychiatry* (2004) 4ff.

desirable. Third, cultural empathy for the client, which entails an intellectual understanding as well as the ability to feel and understand the client's own cultural perspectives on an emotional level. Lastly, an understanding of the importance of culturally relevant interactions, for example, an appreciation of gender interactions, what causes embarrassment and shame and ultimately how the psycho-legal assessment process itself may be biased according to the examinee's beliefs about authority figures.

#### **4.9.2.4 Conflict of interest and multiple relationships**

A multiple relationship can occur when a psychologist is in a professional role with a person and at the same time is in another role with the same person. A psychologist should refrain from entering into a multiple relationship if the multiple relationship could reasonably be expected to impair the psychologist's objectivity, competence, or effectiveness in performing his or her functions as a psychologist or otherwise risks exploitation or harm to the person with whom the professional relationship exists. Psychologists should minimise harm where it is foreseeable and unavoidable. By mixing valuation and treatment services the psychologist, if not careful to maintain boundaries, is at risk of violating ethical standards of practice by combining clinical and forensic roles. Forensic examiners as well as clinical examiners must maintain objectivity in all aspects of the examination process and critically assess the information and data obtained.<sup>174</sup>

#### **4.9.2.5 Confidentiality, privilege and privacy**

It is imperative that the psychologist understands the nature of the respective relationships with the client and the lawyer. This has a significant influence on confidentiality. The psychologist must inform the client that a forensic relationship does not carry a confidentiality clause and that all clinical and other information can be communicated to the court and to the lawyers in a written report. The client should be aware that

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<sup>174</sup> For example a young man is referred to a neuropsychologist by his neurologist for evaluation and treatment following a motor vehicle accident. The neuropsychologist performs the evaluation and begins treatment, at which point she receives a request from the patient's attorney (third party claim) for copies of her reports and notes. After one year of treatment the neuropsychologist determines that a second neuropsychological evaluation is needed to assess progress since the initial evaluation and to update her treatment plan. She conducts the second evaluation and modifies the treatment plan to address persisting deficits. For a discussion of the possible ethical implications see Bush SS *Ethical decision making in clinical neuropsychology* (2007) 44-46. In addition, the Ethical Rules of Conduct to which a Psychologist shall adhere regulates conflicting roles in psycho-legal activities, and states in s 71 that: "(1) A psychologist shall avoid performing multiple and potentially conflicting roles in psycho-legal matters. (2) When a psychologist may be called on to serve in more than one role in a legal proceeding, for example, as consultants or experts for one party or for the court and as fact witnesses, he or she shall clarify his or her role expectations and the extent of confidentiality in advance to the extent feasible, in order to avoid compromising his or her professional judgement and objectivity."

this report may be presented in the public domain.<sup>175</sup> Nevertheless the psychologist still has a duty not to disclose information or material that is not relevant to the parameters of the evaluation.<sup>176</sup>

#### **4.9.2.6 *The release of "raw" psychological data to non-experts***

Psychologists are often requested to provide "raw" psychological data for example scores, test stimuli, client or patient responses to non-experts, especially in personal injury litigation cases in which there may be a court order or subpoena for such information. Requests from judges and lawyers frequently place the psychologist in a conflict in which legal and ethical considerations point in different directions. The release of raw data creates numerous potential for misuse. For example, laypersons lack an appreciation of the context in which psychological test stimuli are administered and may reach wrong conclusions about the meaning of individual answers. When this occurs, for example, in a courtroom by lawyers and judges, the ramifications of the errors may be great. A viable course of action if a layperson should request raw data from a psychologist would be to advise the person to engage the consultation of another psychologist who is qualified by virtue of licensure, training and experience to receive the data. This psychologist can then interpret the data to the layperson. It is important that the psychologist explains the reasons for not releasing the data, for example, that psychologists cannot afford to have test stimuli circulated in the public domain and that raw data is difficult or impossible for a non-expert to interpret.<sup>177</sup>

#### **4.9.2.7 *Facilitating informed consent***

Respect for autonomy demands that informed consent should always be obtained before a procedure or examination is contemplated. In many forensic settings, such as court ordered evaluations of an accused's competence, an assessment can proceed without the examinee's consent. The psychologist should at least attempt at obtaining informed consent. Further the psychologist may also specifically be required to assess an individual's ability to provide informed consent in the following situations:

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<sup>175</sup> Cohen A & Malcolm C "Psychological assessment for the courts" in Tredoux C *et al Psychology and law* (2005) 63-87 at 73.

<sup>176</sup> Zabow & Kaliski in *Psycholegal assessment in South Africa* 363.

<sup>177</sup> Tranel D "The Release of psychological data to nonexperts: Ethical and legal considerations" 1994 25 *Professional Psychology: Research and Practice* 1: 33-38 at 33, 34.

- A mentally ill person refuses to be admitted to hospital and an involuntary admission is being contemplated;
- there is doubt whether a person is able to provide consent for a medical or legal procedure;
- a retrospective analysis is needed of whether an individual who was subjected to a procedure or intervention actually did provide informed consent; and
- whether a person who has been referred for a psychological assessment, for example, for determination of child custody, provided informed consent.

It is generally accepted that to achieve informed consent the elements of voluntariness, competency, disclosure of information and the dynamic nature of the process have to be fulfilled.<sup>178</sup>

#### **4.9.2.8 The forensic report**

Where it is certain that the opinions of forensic experts will not be seriously challenged it may be sufficient if they simply describe (in general terms) the nature of their investigations and conclusions. Although in most cases forensic experts must testify and give an accurate account of the investigations that they carried out and substantiate their conclusions. Reports should be clear and accurate enough to ensure that decision-makers make appropriate decisions. While nothing prevents a lawyer from settling or finalising the report of an expert, Lord Wilberforce made it clear in *Whitehouse v Jordan*<sup>179</sup> that: "... it is necessary that expert evidence presented to the court should be and should be seen to be, the independent product of the expert, uninfluenced as to form or content by the exigencies (requirements) of litigation." The danger to this procedure was further highlighted in the case where Denning MR<sup>180</sup> stated: "In the first place, their joint report suffers to my mind of the way it was prepared. It was the result of long conference between the two professors [experts] and counsel ... and was actually settled by counsel. In short it wears the colour of special pleading rather than an impartial report. Whenever counsel 'settles' a document, we know how it goes. 'We had better put this in', 'We had better leave this out', and so forth. A striking instance is the way in which ... [the] report was 'doctored'." Where an expert makes an obvious error or was misinformed a

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<sup>178</sup> Zabow & Kaliski in *Psycholegal assessment in South Africa* 370.

<sup>179</sup> *Whitehouse v Jordan and Another* [1981] 1 All ER 267 (HL) at 276 par b.

<sup>180</sup> *Whitehouse v Jordan* [1980] 1 All ER 650 at 655 par f-g.

correction is called for. But even here it would be advisable to leave the original report intact and to write an addendum explaining the reason for the error and correcting it.<sup>181</sup>

### 4.9.3 Ethical issues pertaining to child forensic psychology

#### 4.9.3.1 *Child neuropsychology*

Woody<sup>182</sup> suggested in 1997 that the growing recognition of the speciality of child neuropsychology has increased the potential for legal liability by virtue of the speciality being part of the health care industry. He provides the following four reasons: First, neuropsychologists do not possess a well-defined role. Qualifications for the title "neuropsychologist" have yet to be specified in a universally accepted manner, especially the title "clinical child neuropsychologist". The quality of training in clinical forensic neuropsychology is not assured, at least compared to other clinical specialities. There is considerable dispute over and contradictory results from research that addresses neuropsychological theories and procedures. Second, the increased identity as a psychologist in a medical context increases the risk for legal action. The medical context combined with the brain-based focus of neuropsychology may produce additional risk of legal action against the clinical and forensic neuropsychologist. Third, the principle of vicarious liability can apply to a member of a health care team, including the neuropsychologist, despite any direct claim of fault against the neuropsychologist. Lastly, neuropsychology (by virtue of its brain-related issues) has the potential to increase the basis of legal action claims.

The foundation of ethical practice in forensic child neuropsychology is professional competence. Without the knowledge and skills needed to appropriately address referral questions and serve consumers of neuropsychological services, the remaining ethical requirements are largely irrelevant. Bush<sup>183</sup> states it simpler in just saying that: "If we do not know what we are doing, we should not be engaging in professional activities. For example, in the absence of competence to provide neuropsychological services, issues such as test selection, informed consent, and confidentiality should not come into play because we should not be engaging in neuropsychological activities in the first place. [Again, in contrast,] practising in accordance

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<sup>181</sup> Allan A "The psychologist as expert witness" in Tredoux *et al* (2005) 287-320 at 308-309.

<sup>182</sup> Woody RH "Psycholegal issues for clinical child neuropsychology" in *Handbook of clinical child neuropsychology* ((eds) Reynolds CR & Fletcher-Janzen E) (1997) 719. See also Fennell BE "Ethical issues in pediatric neuropsychology" in *Ethical issues in clinical neuropsychology* ((eds) Bush SS & Drexler ML) (2002) 75-86 at 76.

<sup>183</sup> Bush (2007) 37.

with other ethical standards is essential for competence. For example one must understand and apply appropriate methods of test selection, informed consent, and confidentiality to provide competent services."

Psychologists increasingly find themselves providing evaluation services involving children to lawyers and to the courts, with potentially serious consequences to children, their families and the evaluators themselves. Special competence is required for forensic assessments in child Neuropsychology, for example, training in specialised knowledge of developmental psychology, family dynamics, neuropsychology, child psychology and specialised assessment instruments.<sup>184</sup> This training is important for example where the psychologist has to make a diagnosis. Unfortunately, current diagnostic systems leave neuropsychologists struggling to select a correct diagnosis from among inadequate alternatives and this contributes to the concern of the ability of neuropsychologists to use tests reliably and the relevance of testing for the child's functional adaptation.<sup>185</sup>

Some further factors that the neuropsychologist must consider and should have knowledge of include languages spoken by the relevant family and child, cultural background, educational background and socioeconomic status, each of which has been shown to influence performance on psychometric testing. Given the multi-ethnic, multicultural nature of South Africa, a certain percentage of children referred to neuropsychologists for testing may not properly speak the language of the psychologist – such children present a challenge for the neuropsychologist who must decide how to conduct the assessment to maximise its chances of being meaningful and useful. Cultural background may also influence test results through such variables as attitude toward education, experience with the concepts and skills being tested, response to time pressure on timed tasks and comfort with being the sole focus of a professional adult's attention.<sup>186</sup>

#### **4.9.3.2 Child custody disputes**

The assessment of children during custody disputes between two divorcing parents most frequently evokes the accusation of "hired guns". It is here that the confluence of incompetence, multiple relationships, role

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<sup>184</sup> Steven N *et al* (eds) *Forensic mental health assessment of children and adolescents* (2006) 3ff.

<sup>185</sup> Roman MJ "Child neuropsychological assessment" in *Principles and practice of behavioural neurology and neuropsychology* ((eds) Rizzo M & Eslinger PJ) (2004) 843-862 at 847, 857.

<sup>186</sup> *Ibid.*

conflicts and biased advocacy is most prominent. These evaluations are among the most difficult evaluations involving at minimum the evaluation of two adults and one child, the review of legal documents, contact with family, review of medical records, review of school records and so forth.<sup>187</sup> Unless the disputes are settled on a friendly basis there are always going to be parents who feel aggrieved by the decision of the court. Rightly or wrongly such parents are increasingly filing ethics complaints against assessors.<sup>188</sup> Common criticisms in psychologist's work in child custody cases include: deficiencies and abuses in professional practice; inadequate familiarity with the legal system and applicable legal and ethical standards; inappropriate application of psychological assessment techniques; presentation of opinions based on partial or irrelevant data; overreaching by exceeding the limits of psychological knowledge of expert testimony; offering opinions on matters of law; loss of objectivity through inappropriate engagement in the adversary process; failure to recognise the boundaries and parameters of confidentiality in custody context;<sup>189</sup> and giving written or oral evidence about the psychological characteristics of particular individuals (for example one of the parents) when they have not had an opportunity to conduct an examination of the individual adequate to the scope of the statements, opinions or conclusions to be issued. It does not serve the "best interest of the child" if the psychologist appears to be a "hired gun" and even the most ethical psychologist may feel some pressure to shade the results of a custody evaluation in the direction of the parent who is paying the bill. Even merely the fact of being employed by one side or the other will create a tendency toward bias or somewhat diminished objectivity – sometimes even without awareness on the part of the expert that such a tendency is operating. To avoid tendencies such as these Shapiro<sup>190</sup> states that: "Under no circumstances should a report on child custody be rendered to the court, based on the evaluation of only one party to the conflict."

Furthermore, forensic psychologists must avoid improper and potentially harmful multiple relationships. They must avoid situations where loyalty is owed to more than one person or institution or that may otherwise compromise the quality of the psychologist's judgment by involving a conflict of interest. In a custody case the primary loyalty is owed to the "best interests of the child" but loyalty is also owed to the

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<sup>187</sup> Ackerman MJ & Kane AW (eds) *Psychological experts in divorce actions* (2005) 14.

<sup>188</sup> Golding SL "Mental health professionals and the courts: The ethics of expertise" in *Ethical conflicts in psychology* (ed) Bersoff DN) (1996) 421-422 at 422.

<sup>189</sup> Koocher & Keith-Spiegel 468.

<sup>190</sup> Shapiro DL *Forensic psychological assessment: An integrative approach* (1991) 99.

psychologist's other clients namely the court, each person evaluated and unless the psychologist is court-appointed, to one or more attorneys. The psychologist is therefore required to abide by ethical obligations regarding informed consent for those assessed, confidentiality, clarification of any matters related to fees and so forth. Evaluators have a responsibility to the person who retained them and if not one and the same also have a separate responsibility to the individual or individuals being evaluated. They have responsibilities to their codes of ethics, which may be in conflict with statutes, case law and rulings by judges in the specific case. They also have responsibilities to those who may be harmed by the person being evaluated.<sup>191</sup>

There are also many reasons why a psychologist should not be retained or appointed as an expert to evaluate his or her own patient or client. If the evaluation favours the patient the psychologist could be accused of favouritism. If it does not, the therapeutic relationship could be seriously harmed and the therapy accomplished up to that point may become relatively worthless. In addition, in therapy an individual has a right to expect confidentiality, to expect the psychologist to do only what is in the person's best interest (beneficence) and to avoid doing anything harmful (non- maleficence) except in a "duty to warn or protect"<sup>192</sup> situation. The only significant exception may be in rural areas where the psychologist is the only expert available to provide the necessary forensic services.<sup>193</sup>

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<sup>191</sup> Ackerman & Kane 106; *Tarasoff v Regents of the University of California* 13 Cal 3d (1974) 177, 529, 553. In this case the California Supreme Court indicated that when a doctor or psychotherapist in the exercise of his professional skill and knowledge, determines, or should determine, that a warning is essential to avert danger arising from the medical or psychological condition of his patient, he incurs a legal obligation to give that warning. In a second *Tarasoff* ruling in 1976 the California Supreme Court went further ruling that the therapist must not only warn – he or she must also protect: "When a therapist determines, or pursuant to the standards of his profession should determine, that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such danger. The discharge of this duty may require the therapist to take one or more of various steps, depending on the nature of the case. Thus it may call for him to warn the intended victim or other likely to apprise the victim of the danger, to notify the police, or take whatever other steps are reasonably necessary under the circumstances. [W]hen the avoidance of foreseeable harm requires a defendant to control the conduct of another person, or to warn of such conduct, the common law has traditionally imposed liability only if the defendant bears some special relationship to the dangerous person or to the potential victim ... [T]he relationship between a therapist and his patient satisfied this requirement... We recognise the difficulty that a therapist encounters in attempting to forecast whether a patient presents a serious danger of violence. Obviously, we do not require that the therapist, in making that determination, render a perfect performance; the therapist need only exercise 'that reasonable degree of skill, knowledge, and care ordinarily possessed and exercised by member of [that professional specialty] under similar circumstances ... The protective privilege ends where the public peril begins." *Tarasoff v Regents of the University of California* 17 Cal 3d (1976) 425, 431, 435, 551.

<sup>192</sup> See *Tarasoff supra*.

<sup>193</sup> Appelbaum PS "Ethics in evolution: The incompatibility of clinical and forensic functions" 1997 154 *Am J Psychiatry* 445-446. For a detailed discussion of avoiding dual or multiple relationships see Ackerman & Kane (2005) 106-111.

Taking into consideration the massive amount of information that must be considered, one must have a model that will foster the gathering and interpretation of information and communication regarding its relevance to and impact upon the ultimate decision that must be made by the court. Martindale and Gould<sup>194</sup> provide a proposed model, termed "The Forensic Model", in which they indicate that the evaluator must:

- Be familiar with relevant forensic interviewing techniques and requirements and forensic use of psychological tests and other instruments.
- The psychologist should have sufficient experience with child custody evaluations to clearly understand the process and the requirements of the law and be familiar with the laws relevant to child custody evaluations, including any statutory or case law definitions with regards to "the best interest of the child". Further a psychologist who claim to have special expertise should have achieved it through education, training, supervised experience, consultation, study or professional experience.
- The forensic expert should conceptualise him- or herself as an extension of the court, contributing to a mind-set centred on objectivity and impartiality.
- Use tests and other instruments that validly and reliably assess functional abilities relevant to the question before the court.
- While either structured or unstructured interviews may be utilised, make provision for questions that address information or issues that arise during the evaluation.
- Actively seek corroborating information including documents from collateral sources for example teachers and physicians.
- Include in the forensic reports both information that supports the evaluator's conclusions and information that is not supportive and specify why he or she came to these conclusions in spite of the non-supportive information.
- The psychologist must obtain informed consent from all adult participants and, as appropriate, inform child participants of the purpose, nature and method of evaluation; who has requested the

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<sup>194</sup> Martindale DA & Gould JW "The forensic model: Ethics and scientific methodology applied to custody evaluations" 2004 1 *J Child Custody: Research Issues & Practices* 1-22.

psychologist's services; and who will be paying the fees. Further, regarding the nature of the assessment instruments and techniques, inform those participants about the possible disposition of data collected. The psychologist should also provide this information to children to the extent that they are able to understand and consent.<sup>195</sup>

Regardless of the model proposed, the key element is that the expert should accumulate enough evidence to be able to support his or her conclusions, including a strong empirical database that includes information about each parent and all children as well as the scientific literature to support any conclusions made.<sup>196</sup>

#### **4.9.3.3 Forensic evaluation of child perpetrators**

Psychologists may be called upon to assist child offenders in a number of ways: By assessing the competence to stand trial of a young accused person; by giving expert testimony on the mental capacity of a young witness; or by providing preparation and support for a young victim or witness who is required to give evidence in court. The first applicable principle is that the assessment should be performed by a psychologist who does not have a prior privileged relationship with the child or his or her parents. It will be unethical of the psychologist to use information previously gained under a presumption of confidentiality to the later detriment of a patient. Obtaining information for a forensic assessment has to be carried out with the child's knowledge of the use to which that information may be put. A child's therapist may often be asked for previously acquired clinical information in a report with the consent of the child's guardian and the assent, where appropriate, of the child and may then be called as a witness for the defence. Again, the psychologist making such an assessment should be qualified to do so. No child should proceed to trial without a competent assessment of their general health, their intellectual capacity, their mental health state and their developmental history. A thorough assessment of the child's family and social context is also mandatory and usually carried out by a social worker.<sup>197</sup>

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<sup>195</sup> American Psychological Association "Guidelines for child custody evaluations in divorce proceedings" in Bersoff (1996) 423-427 at 425.

<sup>196</sup> Ackerman & Kane (2005) 15.

<sup>197</sup> Hawkrigde S "Children as perpetrators" in *Psycholegal assessment in South Africa* 253-254.

#### 4.9.4 A proposed model of ethical decision making in forensic psychology

Determining a course of professional behaviour that avoids ethical misconduct according to an ethics code, and also adheres to high standards, requires a commitment to ethical ideals. Bush<sup>198</sup> proposes an eight-step model that was designed to provide forensic psychologists with a means to resolve ethical challenges. The steps of the forensic psychology ethical-decision-making model are as follows:

- Identify the problem: Forensic psychologists must keep in mind that a wide range of potential behaviours may be appropriate when considering courses of action and when reviewing the work of colleagues. A distinction may need to be made between ethical, legal, moral and professional perspectives. These overlapping concepts may need to be parsed out to clarify the ethical problem or dilemma.
- Consider the significance of the context and setting: Psychologists work in widely varying settings and contexts. Professional activities that are appropriate in one forensic setting or context may be inappropriate in others. Consequently, some ethical rules that are relevant in one setting or context may be less relevant in other situations. For example, a forensic psychologist's fee structure may differ, quite appropriately depending on the nature of the services provided. To the extent that the fee structure may compromise objectivity, the distinction made regarding context is of ethical importance.
- Identify and use ethical and legal resources: This step may be the most challenging in the ethical decision making process. This method involves applying a general rule to a specific case. First, assess the foundational values for example general bioethical principles. Examples of South African values would include the right to self-determination and the right to adequate healthcare. These values underlie general bioethical and constitutional principles such as respect for a client's autonomy and the need to "do no harm" to the parties served by the psychologist. Determining the values underlying a given ethical standard or law will help to clarify the spirit behind the letter of the standard or law and by extension will help to clarify the appropriate course of action. However dilemmas emerge or increase in complexity in situations in which one value is pitted against another. For example from an ethical perspective, releasing raw test data to a patient may, depending on the context be consistent with respecting the patient's autonomy but it may also

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<sup>198</sup> Bush SS *et al* (eds) *Ethical practice in forensic psychology: A systematic model for decision making* (2006) 28-34.

result in psychological harm to the patient and harm to society at large depending on the uses to which the data are put. Weighing the relative importance of the principles involved and attempting to strike a balance that satisfies the greater good is the task of the forensic psychologist. Such determinations need not and often should not be made in isolation. Second, psychologists must be familiar with the relevant Code of Ethics for psychologists and also with the laws that regulate the profession.

- Consider personal beliefs and values: To the extent possible psychologists should attempt to understand their biases and the potential impact that their values and biases have on their professional and ethical decision making. Psychologists sometimes rely on their personal values other than those reflected in a model of professional ethics, such as their religion or cultural background. It is critically important that psychologists attempt to understand the potential influences of their personal beliefs on their professional behaviour.
- Develop possible solutions to the problem: Consider for example the release of raw data. When provided with an appropriate client release, there are a variety of options that the forensic psychologist should consider. Some of these options include: immediately releasing the data; refusing to release the data on the basis of published professional guidelines; offering to release the data to a psychologist retained by the opposing attorney, or to the opposing attorney; requesting a court order to release the data; and / or requesting a protective order from the court.
- Consider the potential consequences of various solutions: Forensic psychologists must consider potential positive and negative consequences, weigh their options and pursue the highest ethical option available.
- Choose and implement a course of action: The timing of the chosen course of action may be critical to its success. Consultation with colleagues may be particularly valuable in weighing the best time to respond to situations in which timing must be taken into account.
- Assess the outcome and implement changes as needed: With many difficult ethical decisions the chosen action will likely be unsatisfactory to one or more of the parties involved. The forensic psychologist should be prepared to receive and respond to feedback about the decisions made and actions taken. Also, the psychologist must evaluate the effectiveness of his or her decision or action and implement changes as needed.

#### 4.9.5 Summary guidelines for ethical decision making in forensic psychiatry and psychology

The following guidelines are proposed for the adherence to ethical decision making in forensic psychology:

- Psychologists have to recognise that forensic practice constitutes a specialty area that demands specific clinical skills and knowledge of the ethical rules and the legal system. They should not venture into this arena without specialised training in the laws that regulate the profession; the interface of the forensic psychology practice with the legal system; and risk management. However, knowledge and experience is not enough - forensic psychologists must be committed to applying that knowledge in a manner that is consistent with ethical practice.
- When psychologists find themselves drawn into a legal case inadvertently they should seek consultation from a colleague with specialised forensic knowledge before responding to the legal proceeding.
- Child custody disputes constitute a frequent basis for ethical complaints, particularly when the psychologist makes a recommendation based on incomplete data or interviews with only one party. Psychologists should exercise great caution and follow professional guidelines when undertaking such assignments.
- Where professional competence has been established and is being maintained, the greatest risk to ethical misconduct in forensic psychology seems to be the potential influence of bias. Bennett *et al*<sup>199</sup> states: "Too often, we fail to evaluate our own performance, attitudes, behaviours, and work skills objectively in terms of the ethics and practice guidelines of the profession."
- Psychologists should carefully clarify their roles and stay within the agreed upon or court defined parameters in all forensic cases. To justify their positions and behaviours, clear and detailed documentation of the rationale should be maintained. Documentation that the psychologist understood the values at stake and followed a rational process of ethical decision making will, if necessary inform any outside reviewer that the ethical challenge was addressed in thoughtful and systematic manner. Such documentation of the decision-making process will be the forensic psychologist's best protection against liability.<sup>200</sup>

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<sup>199</sup> Bryant BK, VandenBos GR & Greenwood. See Bennett BE *et al Professional liability and risk management* (1990) 7.  
<sup>200</sup> Bush *et al* (2006) 35.

- Psychologists must distinguish carefully between legal issues and mental health issues and when acting as an expert witness they should remain focused on the legal issues.<sup>201</sup>

#### 4.10 CONCLUSION

The practice of medicine in the modern era is beset with unprecedented challenges in virtually all cultures and societies. These challenges centre on increasing disparities among the legitimate needs of patients, the available resources to meet those needs, the increasing dependence on market forces to transform health care systems, and the temptation for physicians to forsake their traditional commitment to the primacy of patients' interests. To maintain the fidelity of medicine's social contract during this turbulent time, physicians must reaffirm their active dedication to the principles of professionalism, which entails not only their personal commitment to the welfare of their patients but also collective efforts to improve the health care system for the welfare of society.<sup>202</sup>

It is clear that psychiatric and psychological expert testimony in forensic settings form an integral part of the legal system. Despite the context in which they function, practitioners acting as expert witnesses owe duties not only to the court, but also to their respective disciplines or professions.<sup>203</sup> Sound ethical decision making is based on a process that involves multiple steps, some of which are preventive and taken in advance, and some of which are taken at the time the ethical dilemma presents itself. Canter<sup>204</sup> summarises these steps as follows: (1) Knowledge of the Code of Ethics is important. It is also important to be alert to any revisions that may occur in parts of the Code of Ethics over time; (2) psychiatrists and psychologists must be well informed about current legislative provisions and should keep up to date with changes that may occur at times. This is important in matters such as confidentiality, record keeping, testing and assessment, consent to treatment etc; (3) identify when there is a potential ethical problem and address the problem. At times psychiatrists and psychologists engaged in ethical dilemmas or decision-making for a particular set of circumstances may find insufficient guidance from either the Code of Ethics or

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<sup>201</sup> Koocher & Keith-Spiegel 479. For a general discussion of forensic psychology see Archer RP *et al* (eds) *Forensic uses of clinical assessment instruments* (2006) 1ff; Sparta SN *et al* (eds) *Forensic mental health assessment of children and adolescents* (2006) 74ff; Goldstein AM (ed) *Forensic psychology: Emerging topics and expanding roles* (2007) 1ff; Sales BD & Shuman DW *Experts in court: Reconciling law, science, and professional knowledge* (2005) 1ff.

<sup>202</sup> Project of the ABIM Foundation, ACP-ASIM Foundation, and European Federation of Internal Medicine 2002 *Annals of Internal Med* 243 at 246.

<sup>203</sup> Allan & Meintjies-Van der Walt in *Psycholegal assessment in South Africa* 353.

<sup>204</sup> Canter MB *et al* *Ethics for psychologists: A commentary on the APA ethics code* (1996) 3-7.

legislative provisions. In these cases it is best to consult with a senior psychiatrist or psychologist experienced in ethics. As a part of taking these steps psychiatrists and psychologists should bear in mind that sound ethical behaviour is ultimately based on a solid knowledge of ethical codes and regulations, sharpened by a clear understanding of the consequences of one's actions.

The starting point for examining the legal issues and implications surrounding psychiatry and psychology in South Africa is an investigation into the provisions of the South African Constitution. Consideration must also be given to South African common law. Against the background of the constitutional and common law principles it is further necessary to examine domestic legislation in the field of health. These relevant provisions and principles are discussed in the following chapter.

## PART 2:

# MEDICO-LEGAL ASPECTS CONCERNING THE PSYCHIATRIC AND PSYCHOLOGY PROFESSIONS AND THE MENTALLY DISORDERED PATIENT: THE POSITION IN SOUTH-AFRICA



### *Integrating Law and medicine*

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[http://www.parksmedicallegal.com/yahoo\\_site\\_admin/assets/images/caduceus\\_scales\\_trim.73144056.jpg](http://www.parksmedicallegal.com/yahoo_site_admin/assets/images/caduceus_scales_trim.73144056.jpg).)

## CHAPTER 5

### THE CONSTITUTIONAL IMPERATIVE, COMMON LAW POSITION AND DOMESTIC LEGISLATION IN CONTEXT OF MENTAL HEALTH

"A right is not what someone gives you; it's what no one can take from you."<sup>1</sup>

#### 5.1 INTRODUCTION

The impact of the Constitution<sup>2</sup> on psychiatry, psychology and mentally disordered patients is threefold: First, the Constitution is considered to be the supreme law in South Africa, and any legislation that is irreconcilable with it is invalid to the extent of the conflict.<sup>3</sup> Second, according to section 39 of the Constitution, the Bill of Rights applies to all law and binds the executive, legislature, judiciary and all organs of state. Every court, tribunal or forum must promote the spirit and objects contained in the Bill of Rights in the interpretation of legislation and the development of the common law.<sup>4</sup> Third, the Bill of Rights instructs the state to use the power that the Constitution provides for in ways that do not violate fundamental rights. The Bill of Rights declares many of the traditional human rights and has been praised as one of the best human rights instruments in the international context. South Africa has certainly made great strides in terms of its human rights awareness or at least in terms of the Constitution and policies that address human rights.<sup>5</sup> There are specific fundamental human rights protected in the Bill of Rights that are applicable to the psychiatric and psychology professions and the mentally disordered patient. The first is section 36 of the Constitution - the general limitation clause. If a court determines that a law or the conduct of a respondent impairs a fundamental right, it must be considered whether the infringement is nevertheless a justifiable

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<sup>1</sup> Clark R as quoted in *Flag burning: Moral panic and the criminalization of protest* (Welch M) (2000) 187.

<sup>2</sup> The Constitution of the Republic of South Africa, 1996 (hereafter referred to as the Constitution).

<sup>3</sup> S 2 of the Constitution reads as follows: "This Constitution is the supreme law of the Republic; law or conduct inconsistent with it is invalid, and the obligations imposed by it must be fulfilled."

<sup>4</sup> S 39 of the Constitution reads as follows: "39(1) When interpreting the Bill of Rights, a court, tribunal or forum: (a) must promote the values that underlie an open and democratic society based on human dignity, equality, and freedom; (b) must consider international law; and may consider foreign law. (2) When interpreting any legislation, and when developing the common law or customary law, every court, tribunal, or forum must promote the spirit, purport, and objects of the Bill of Rights. (3) The Bill of Rights does not deny the existence of any other rights or freedoms that are recognised or conferred by common law, customary law, or legislation, to the extent that they are consistent with the Bill."

<sup>5</sup> Gobodo-Madikizela P *et al* "Psychology and human rights" in *Psychology and law* ((eds) Tredoux C *et al*) (2005) 347.

limitation of the right in question.<sup>6</sup> Further rights include the right to dignified and humane treatment (section 10), freedom from discrimination in terms of access to all forms of treatment (section 9), the right to privacy and confidentiality (section 14), the right to protection from physical or psychological abuse and the right to adequate information about their clinical status (section 12). According to Zabow<sup>7</sup> these rights should ideally include efforts to promote the greatest degree of self-determination and personal responsibility of patients.

The overall aim of the Mental Health Care Act<sup>8</sup> is the regulation of the mental health environment so as to provide mental health services in the best interest of the patient. The provision of care at all levels becomes the responsibility of the state. The Act promotes treatment in the least restrictive environment with active integration into general healthcare being required. Furthermore, respect for individual autonomy and decreased coercion procedures have been introduced in the management of the acute stages of illness. The Act also addresses the potential and alleged malpractices in institutions and provides for prevention and detection. This is related to reports of human rights abuses of those with mental illnesses, which required attention. Psychiatric hospitals' stigmatisation of patients used to occur. This is an important aspect in terms of the Constitution, which requires that there be no discrimination toward persons with disabilities.<sup>9</sup> Mentally disordered people have the right to be treated under the same professional and ethical standards as any other ill person. Zabow<sup>10</sup> states that this must include efforts to promote the greatest degree of self-determination and personal responsibility on the part of patients. He further states that admission and treatment should always be carried out in the patient's best interest. The National

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<sup>6</sup> S 36 of the Constitution reads as follows: "The rights in the Bill of Rights may be limited only in terms of law of general application to the extent that the limitation is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom, taking into account all relevant factors, including – (a) the nature of the right; (b) the importance of the purpose of the limitation; (c) the nature and extent of the limitation; (d) the relation between the limitation and its purpose; and (e) less restrictive means to achieve the purpose. (2) Except as provided in subsection (1) or in any other provision of the Constitution, no law may limit any right entrenched in the Bill of Rights. See also Currie I & De Waal J *The bill of rights handbook* (2005) 26.

<sup>7</sup> Zabow T *et al* "Psychiatry and the law" in *Textbook of psychiatry for Southern Africa* ((eds) Robertson B, Allwood C & Gagjano C) (2007) 384. The rights of mentally disordered patients have also been addressed in various documents by international bodies for example the United Nations, the World Health Organization and the World Psychiatric Association.

<sup>8</sup> The Mental Health Care Act 17 of 2002 (hereafter referred to as the Mental Health Care Act).

<sup>9</sup> Zabow T "The Mental Health Care Act" in *Primary health care psychiatry: A practical guide for South Africa* ((ed) Baumann SE) (2007) 570-571.

<sup>10</sup> Zabow T "The Mental Health Care Act (Act 17 of 2002) in Kaliski S (ed) *Psycholegal assessment in South Africa* (2006) 61.

Health Act<sup>11</sup> further provides a legal framework, based on consent, for the regulation of mental health with regard to adults and children. These constitutional principles, common law position and domestic legislative provisions are discussed in more detail below.

## 5.2 THE ORIGIN AND CONCEPT OF HUMAN RIGHTS

### 5.2.1 The origin of human rights

To understand the concept of human rights, it is important to understand its origin and history. The depth and purpose of this thesis do not allow for the provision of a detailed account of the history of human rights. It merely seeks to provide a brief overview of the origin and history of the concept. According to Mubangizi<sup>12</sup> it is generally believed that human rights has its origin in religion, humanitarian traditions and the increasing struggle for freedom and equality in all parts of the world. The Greek thinkers developed the idea of "natural law"<sup>13</sup> and laid down its essential features. According to Socrates,<sup>14</sup> man possesses "insight" and this "insight" reveals to him the goodness and badness of things and makes him know the absolute and eternal moral rules. This human "insight" is the basis to judge the law.<sup>15</sup> The idea of natural law was reaffirmed by the philosopher Aquinas<sup>16</sup> in the Middle Ages and later supported by Blackstone<sup>17</sup> in the seventeenth century.

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<sup>11</sup> The National Health Act 61 of 2003 (hereafter referred to as the National Health Act).

<sup>12</sup> Without necessarily referring to human rights, the Bible, for example, urges people to treat others in the same way themselves would like to be treated, thereby espousing the idea of equality. This idea is a reflection of the concept of man and women created in the image of God and endowed with a worth and dignity from which there can logically flow the components of a comprehensive human rights system. See Mubangizi JC *The protection of human rights in South Africa* (2005) 4.

<sup>13</sup> The oldest theory is perhaps that of the natural law of human rights. Natural law theories base human rights on a "natural" moral, religious or even biological order that is independent of transitory human laws or traditions. See Doebller CFJ *International human rights law: Cases and materials Vol 1* (2004) 53ff.

<sup>14</sup> (469-399 BC.) See also the discussion of Socrates in chapter 2.

<sup>15</sup> Citizens of Greek city-states enjoyed certain rights, for example, *isonomia* (equality before the law); *isotimia* (equal respect for all); and *isogoria* (equal freedom of speech). These rights figure prominently in the modern human rights jurisprudence. Jaswal PS & Jaswal N *Human rights and the law* (1996) 4. See also Daes EIA *Freedom of the individual under law: A study on the individual's duties to the community and the limitations on human rights and freedoms under Article 29 of the Universal Declaration of Human Rights* (1990) 137ff.

<sup>16</sup> (1225-1274.) Saint Thomas Aquinas was the foremost classical proponent of natural theology, and the father of the Thomistic school of philosophy and theology. His influence on Western thought is considerable, and much of modern philosophy was conceived as a reaction against, or as an agreement with, his ideas, particularly in the areas of ethics, natural law and political theory. See Kries D *The problem of natural law* (2008) 72ff.

<sup>17</sup> (1723-1780.) Sir William Blackstone was the great Eighteenth Century English legal scholar whose philosophy and writings were infused with Judeo-Christian principles. This eminent English law professor and author of *Commentaries on the Laws of England*, has wielded incalculable effects on law in America for the past 225 years. His *Commentaries* were the law textbook in Great Britain and the United States well after their initial publication. See Landau N (ed) *Law, crime and English society, 1660-1830* (2002) 142ff; Tucker G *et al Blackstone's commentaries: With notes of reference to the*

More fundamental human rights principles originated in the 1948 *Universal Declaration of Human Rights*.<sup>18</sup> The aim of this Declaration was to set basic minimum international standards for the protection of the rights and freedoms of the individual. The fundamental nature of these provisions means that they are now widely regarded as forming a foundation of international law. In particular, the principles of the Universal Declaration of Human Rights are considered to be international customary law and do not require signature or ratification by the state to be recognised as a legal standard. The *Universal Declaration of Human Rights* is a keystone document. It has been translated into over 3000 languages and dialects.<sup>19</sup>

### 5.2.2 The concept of human rights

At the centre of the concept of human rights vests the idea that every person should be accorded a sense of value, worth and dignity and that every person (including the mentally disordered person) should be protected from infringements and abuses of these fundamental rights, whether the infringements emanate from political states, authorities, or fellow human beings.<sup>20</sup> In a general sense, human rights are understood as rights which belong to an individual as a consequence of being a human being and for no other reason. Clearly then, human rights are those rights one possesses by virtue of being human.<sup>21</sup> According to the United Nations the denial of human rights and fundamental freedoms is not only an individual and personal tragedy, but also creates conditions of social and political unrest, sowing the seeds of violence and conflict within and between societies and nations. The first sentence of the Universal Declaration of Human Rights states that respect for human rights and human dignity "is the foundation of freedom, justice and peace in the world".<sup>22</sup>

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*constitution and laws, of the Federal Government of the United States, and of the Commonwealth of Virginia* (2008) iiff. Other well-known philosophers and thinkers, particularly in the 17<sup>th</sup> and 18<sup>th</sup> centuries, were also instrumental in providing the necessary impetus to the movement of freedom and liberty. These included Hugo Grotius of Holland, John Locke of England, Jean-Jacques Rousseau of France and Emmanuel Kant of Germany. See Van Kley D *et al* (contributors) *The French idea of freedom: The old regime and the Declaration of Rights of 1789* (1994) 212ff.

<sup>18</sup> *The Universal Declaration of Human Rights* (1948) was drafted by the United Nations Commission on Human Rights in 1947 and 1948. The Declaration was adopted by the United Nations General Assembly on 10 December 1948.

<sup>19</sup> Morsink J *The Universal Declaration of Human Rights: Origins, drafting & intent* (1999) ixff.

<sup>20</sup> Gobodo-Madikizela in *Psychology and law* 344.

<sup>21</sup> Mubangizi *The protection of human rights* 3.

<sup>22</sup> United Nations *Human rights: Questions and answers* 4 (1987) as quoted in Mubangizi 3.

### 5.3 SECTION 36 OF THE CONSTITUTION: LIMITATION OF RIGHTS

Fundamental rights and freedoms, as protected in the Bill of Rights, may be limited or restricted, and are therefore not absolute. Section 36, the general limitation clause, sets out specific criteria for the restriction of the fundamental rights in the Bill of Rights. However, given the importance of the rights and the total and irremediable negation of it caused by an infringement, the justification for a limitation would have to be exceptionally compelling.<sup>23</sup> Therefore, where an infringement can be justified in an open and democratic society based on human dignity, equality and freedom, it will be constitutionally valid.<sup>24</sup> The limitation of the rights in context of this thesis is discussed below, together with the applicable fundamental rights protected in the Constitution. To understand the general limitation of rights it is necessary to explain exactly what section 36 entails.

Devenish<sup>25</sup> explains the general limitation of rights as follows:

It is widely accepted in the domestic law of most states, in international law and according to international and other human rights documents, that only a very limited number of rights, if any, are absolute. These include freedom from torture, the abuse, and exploitation of children and possibly freedom from servitude, freedom of conscience, belief, thought, and opinion. The overwhelming majority of human rights and liberties are of necessity restricted by the inherent duty, which should be perceived as the inextricable counterpart of a corresponding right, to respect the rights of others. The classical example in this regard is that freedom of speech does not allow one person to defame another nor would it sanction a person shouting 'fire' in a full theatre when there is no fire.

The relationship between the state and the individual is not one of equality, and therefore a Bill of Rights was traditionally designed to protect individuals against the abuse of state power. However, section 8 of the Constitution makes it clear that the Bill of Rights applies vertically (which is in relation to the state) and

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<sup>23</sup> "Limitation" is a synonym for "infringement" or, perhaps, "justifiable infringement". A law that limits a right infringes that right. See Currie & De Waal 163, 164.

<sup>24</sup> One consequence of the inclusion of a general limitation clause in the Bill of Rights is that the process of considering the limitation of fundamental rights must be distinguished from that of the interpretation of the rights. If it is argued that a provision of the law infringes a right in the Bill of Rights, it will first have to be determined whether that right has in fact been infringed. Limitations on rights are established by means of interpretation of the right by a court. Even if a respondent makes no attempt at justification, the court must nevertheless consider the issue of limitation. In *National Coalition for Gay and Lesbian Equality v Minister of Justice*, the court *mero motu* considered whether a limitation argument could be made in favour of the laws, despite the fact that the Minister indicated that he would abide by the decision of the court and did not attempt to defend the laws in question. See *National Coalition for Gay and Lesbian Equality v Minister of Justice* 1999 (1) SA 6 (CC). See also *S v Makwanyane and Another* 1995 (3) SA 391 (CC).

<sup>25</sup> For a comprehensive discussion on the limitation clause and other human rights protected in the constitution see Devenish GE *A commentary on the South African constitution* (1998).

horizontally (which is in relation to private persons).<sup>26</sup> Section 38 of the Constitution provides that anyone listed in the section<sup>27</sup> has a right to approach a competent court, alleging that a right in the Bill of Rights has been infringed or threatened, and the court may grant appropriate relief, including a declaration of rights.

According to section 36, the rights in the Bill of Rights may only be limited in terms of "law of general application", which is the expression of a basic principle of liberal political philosophy and of constitutional law, known as the "rule of law".<sup>28</sup> According to the decision in *Khala v Minister of Safety and Security*,<sup>29</sup> the word "law" includes legislation, common law and customary law. Legislative bodies may only limit rights when they regulate matters within their sphere of competence.<sup>30</sup> The limitation must also be "reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom", which describes the kind of balance that must exist between the limitation and its purpose. In considering the legitimacy of a limitation, reference should be made to the following paragraph as stated in *S v Makwanyane*:<sup>31</sup>

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<sup>26</sup> S 8 of the Constitution reads: "(1) The Bill of Rights applies to all law, and binds the legislature, the executive, the judiciary and all organs of state. (2) A provision of the Bill of Rights binds a natural or a juristic person if, and to the extent that, it is applicable, taking into account the nature of the right and the nature of any duty imposed by the right. (3) When applying a provision of the Bill of Rights to a natural or juristic person in terms of subsection (2), a court: (a) in order to give effect to a right in the Bill, must apply, or if necessary develop, the common law to the extent that legislation does not give effect to that right; and (b) may develop rules of the common law to limit the right, provided that the limitation is in accordance with s 36(1). (4) A juristic person is entitled to the rights in the Bill of Rights to the extent required by the nature of that juristic person.

<sup>27</sup> The persons who may approach a court are: (a) Anyone acting in their own interests. (b) Anyone acting on behalf of another person who cannot act in their own name. (c) Anyone acting as a member of, or in the interest of, a group or class of persons. (d) Anyone acting in the public interest. (e) An association acting in the interest of its members.

<sup>28</sup> Currie & De Waal 168.

<sup>29</sup> *Khala v Minister of Safety and Security* (1994) 2 BCLR 89 (W).

<sup>30</sup> It was argued in *Makwanyane* that s 277 of the Criminal Procedure Act, 1977 (Act 51 of 1977) (hereafter referred to as the Criminal Procedure Act) did not constitute a law of general application, since it did not apply uniformly to the whole of South Africa. The death sentence had already been abolished in Ciskei in 1990, and therefore a person could not be sentenced to death in that part of South Africa. The court rejected the argument and remarked as follows: "Such a construction would defeat the apparent purpose of s 229[IC], which is to allow different legal orders to exist side by side until a process of rationalisation has been carried out, and would inappropriately expose a substantial part if not the entire body of our statutory law to challenges under s 8 of the Constitution. It follows that disparities between the legal orders in different parts of the country, consequent upon the provision of s 229 of the Constitution, cannot for that reason alone be said to constitute a breach of the equal protection provision of s 8, or render the laws such that they are not of general application." See *Makwanyane supra*. In contrast, it was decided in *Hoffmann v South African Airways* that the policy of an organ of state that HIV-positive persons were not qualified to be employed as airline cabin attendants does not constitute a "law of general application". See *Hoffmann v South African Airways* 2001 (1) SA 1 (CC).

<sup>31</sup> *Makwanyane supra*.

The limitation of constitutional rights for a purpose that is reasonable and necessary in a democratic society involves the weighing up of competing values, and ultimately an assessment based on proportionality. This is implicit in the provisions of s 33(1)[IC].<sup>32</sup> The fact that different rights have different implications for democracy, and in the case of our Constitution, 'for an open and democratic society based on freedom and equality,' means that there is no absolute standard which can be laid down for determining reasonableness and necessity. Principles can be established, but the application of those principles to particular circumstances can only be done on a case-by-case basis. This is inherent in the requirement of proportionality, which calls for the balancing of different interests. In the balancing process, the relevant considerations will include the nature of the right that is limited, and its importance to an open and democratic society based on freedom and equality; the purpose for which the right is limited and the importance of that purpose to such a society; the extent of the limitation, its efficacy, and particularly where the limitation has to be necessary, whether the desired ends could reasonably be achieved through other means less damaging to the right in question. In the process regard must be had to the provisions of a s 33(1)[IC], and the underlying values of the Constitution, bearing in mind that as a Canadian Judge has said, 'the role of the court is not to second-guess the wisdom of policy choices made by legislators.'<sup>33</sup>

In addition to "all relevant factors" as stated in section 36, five factors must be considered in determining whether the limitation is "reasonable and justifiable" in an open and democratic society based on human dignity, equality and freedom. These factors are examined in short below:<sup>34</sup>

- The nature of the right: This entails the weighing up of the infringement of a fundamental right against the benefits that the law seeks to achieve.<sup>35</sup>
- The importance of the purpose of the limitation: At a minimum, reasonableness requires the limitation of a right to serve some purpose. The purpose has to be one that is worthwhile and important in a constitutional democracy.<sup>36</sup>

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<sup>32</sup> Constitution of the Republic of South Africa, 1993 (hereafter referred to as the Interim Constitution).

<sup>33</sup> *Makwanyane supra*. See also *S v Bhulwana* 1996 (1) SA 388 (CC), where the court said: "In sum, therefore, the Court places the purpose, effects, and importance of the infringing legislation on one side of the scale and the nature and effect of the infringement caused by the legislation on the other. The more substantial the inroad into fundamental rights, the more persuasive the grounds of justification must be."

<sup>34</sup> See *Currie & De Waal* 163-188.

<sup>35</sup> See *Makwanyane* where O'Regan J said: "The right to life is, in one sense, antecedent to all the other rights in the Constitution. Without life in the sense of existence, it would not be possible to exercise rights or to be the bearer of them. But the right to life was included in the Constitution not simply to enshrine the right to existence. It is not life as mere organic matter that the Constitution cherishes, but the right to human life: the right to live as a human being, to be part of a broader community, to share in the experience of humanity. This concept of human life is at the centre of our constitutional values." Therefore, this must be demonstrated by the state in everything that it does, including the way it punishes criminals. Very compelling reasons would therefore have to be found to justify the limitation of such important rights. See *Makwanyane supra*. See also *Ex parte Minister of Safety and Security: in re S v Walters* 2002 (4) SA 613 (CC); *New National Party v Government of the Republic of South Africa* 1999 3 SA 191 (CC), 1999 (5) BCLR 489 (CC).

- The nature and extent of the limitation: This requires the court to assess the way in which the limitation affects the right concerned.<sup>37</sup>
- The relation between the limitation and its purpose: To serve as a legitimate limitation of a right, a law that infringes the right must be reasonable and justifiable. Therefore, there must be a good reason for the infringement.<sup>38</sup>
- Less restrictive means to achieve the purpose: To be legitimate, a limitation of a fundamental right must achieve benefits that are in proportion to the costs of the limitation. The limitation will not be proportionate if other means could be employed to achieve the same ends that will either not restrict rights at all, or will not restrict them to the same extent.<sup>39</sup>

A selection of individual fundamental human rights as protected in the Bill of Rights and its possible limitation in context of psychiatry, psychology and the mentally disordered patient is discussed below.

#### 5.4 SECTION 10 OF THE CONSTITUTION: HUMAN DIGNITY<sup>40</sup>

In *Carmichele v Minister of Safety and Security* it was said that human dignity is a central value of the objective, normative value system.<sup>41</sup> Chaskalson<sup>42</sup> in this regard wrote:

The affirmation of human dignity as a foundational value of the constitutional order places our legal order firmly in line with the development of constitutionalism in the aftermath of the Second World War.

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<sup>36</sup> For an explanation of this factor see *National Coalition for Gay and Lesbian equality supra*. See also *Ferreira v Levin NO 1996 (1) SA 984 (CC)*; *Harksen v Lane NO 1998 (1) SA 300 (CC)*.

<sup>37</sup> "It is the effect of the limitation on rights and not the effect of the limitation on a particular right-holder that is of concern to this part of the analysis." See *S v Meaker 1998 (8) BCLR 1038 (W)*. See also *S v Mamamela 2000 (3) SA 1 (CC)*.

<sup>38</sup> In *Makwanyane*, Didcott J said: "According to the state the death penalty was designed to serve the purposes of deterrence and prevention of violent crimes ... The protagonists of capital punishment bear the burden of satisfying us that it is permissible under s 33(1) [IC]. To the extent that their case depends upon the uniquely deterrent effect attributed to it, they must therefore convince us that it indeed serves such a purpose. Nothing less is expected from them in any event when human lives are at stake, lives which may not continue to be destroyed on the mere possibility that some good will come of it. In that task they have failed, and as far as one can see, could never have succeeded."

<sup>39</sup> *Makwanyane supra*. See also *Larbi-Odam v MEC for Education 1998 1 SA 745 (CC)*.

<sup>40</sup> S 10 of the Constitution reads: "Everyone has inherent dignity and the right to have their dignity respected and protected." International instruments also refer to the importance of preserving human dignity. Article 1 of the Council of Europe's *Convention on Human Rights and Biomedicine* of 1996 refers to the aim of the Convention, which is to secure the dignity and identity of human beings in the application of biology and medicine. It is suggested that human dignity has to be respected as soon as human life begins.

<sup>41</sup> *Carmichele v Minister of Safety and Security 2001 (4) SA 938 (CC)*.

<sup>42</sup> Chaskalson A "Human dignity as a foundational value of our constitutional order" 2000 16 *SAJHR* 2: 193 at 196.

He continues to say that as an abstract value common to the core values of our Constitution, dignity informs the content of all the concrete rights and plays a role in the balancing process necessary to bring different rights and values into harmony. It too, however, must find place in the constitutional order. O'Regan J remarked in *Makwanyane*<sup>43</sup> that recognising a right to dignity is an acknowledgment of the intrinsic worth of human beings: Human beings are entitled to be treated as worthy of respect and concern. This right is therefore the foundation of many of the other rights that are specifically entrenched in the Bill of Rights.

#### 5.4.1 Human dignity and the use of physical restraints for and seclusion of mentally disordered patients

It has been said that how a society treats its least well-off members says a lot about its humanity. Sometimes mentally disordered people are treated with extreme measures that they do not want, for example, psychosurgery, electroconvulsive therapy<sup>44</sup> and unwanted medication with very serious risks and side effects. In addition, their liberty and dignity are taken away - sometimes for many years.<sup>45</sup> There are many mentally disordered people who are treated, who do not want to be treated. The question then arises: When should we treat those who do not want to be treated and when should we respect their choices?<sup>46</sup>

According to Levenson,<sup>47</sup> physical restraints and seclusion may be required for confused, medically unstable patients, especially when chemical restraint is ineffective or contraindicative. Confused medically disordered patients often climb over bed rails risking falls, which may result in fractures and head trauma. The stringent legal regulation of physical restraints has increased during the past decade, yet courts have generally held that restraints are appropriate when a patient presents a risk of harm to themselves or others and a less restrictive alternative is not available. While it should be acknowledged that physical restraints have been overused in the past, some argue that there are times when these restraints are the safest and most humane option. A full range of alternatives for preventing harm in confused medically disordered

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<sup>43</sup> *Makwanyane supra*.

<sup>44</sup> See the discussion of electroconvulsive therapy below.

<sup>45</sup> Saks ER *Refusing care: Forced treatment and the rights of the mentally ill* (2002) 1-3.

<sup>46</sup> See also the discussion of involuntary confinement below as well as the discussion on the "duty to protect" in chapter 6.

<sup>47</sup> Levenson JL "Legal issues in the interface of medicine and psychiatry" 2007 *Primary Psychiatry* <http://www.primarypsychiatry.com/asp/articleDetail.aspx?articleid=117> (Date of access: 22 May 2009).

patients, and for respecting their dignity, should be considered, keeping in mind that there are clinical and legal risks both in inappropriately using and foregoing restraints.

With regard to seclusion of mentally disordered patients, there are, according to Saks,<sup>48</sup> at least two theories of how seclusion is directly therapeutic: First, the patient is separated from stressful interpersonal relations and is so permitted to reconstitute and to feel more settled. Second, seclusion is therapeutic because of the destimulation it provides. The idea is that patients, especially psychotic ones, have a real problem with overstimulation. They have, as it were, lost their ability to filter out unnecessary detail. Therefore, placing a patient in a bare room with no stimuli to distract, impinge on and overwhelm him or her, can be most therapeutic. It is submitted that should less restrictive means be available to achieve the same putative therapeutic ends, seclusion should not be justified as a means of therapy.

The rights and duties of persons, bodies or institutions are set out in Chapter 3 of the Mental Health Care Act and are in addition to any rights and duties that they may have in terms of any other law.<sup>49</sup> According to section 8 of the Mental Health Care Act, the person, human dignity and privacy<sup>50</sup> of every mental health care user<sup>51</sup> must be respected.<sup>52</sup> Every mental health care user must be provided with care, treatment and rehabilitation services that improve the mental capacity of the user to develop to full potential and to facilitate his or her integration into community life.<sup>53</sup> A mental health care user must receive care, treatment and rehabilitation services to the degree appropriate to his or her mental health status.<sup>54</sup>

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<sup>48</sup> Saks 125-126.

<sup>49</sup> See s 7. "(1) The rights and duties of persons, bodies or institutions set out in this Chapter are in addition to any rights and duties that they may have in terms of any other law. (2) In exercising the rights and in performing the duties set out in this Chapter, regard must be had for what is in the best interests of the mental health care user." Further legislation pertaining to mental health in South Africa include: The Criminal Procedure Act 51 of 1977 and amendment 1998; The Prevention and Treatment of Drug Dependency Act 20 of 1992; The Prevention of Family Violence Act 116 of 1998; The Choice on Termination of Pregnancy Act 92 of 1996; The Promotion of Access to Information Act 2 of 2000 and the Children's Act 38 of 2005.

<sup>50</sup> See the discussion of the right to privacy below.

<sup>51</sup> "Mental health care user" means a person receiving care, treatment and rehabilitation services or using a health service at a health establishment aimed at enhancing the mental health status of a user, state patient and mentally disordered prisoner and where the person concerned is below the age of 18 years or is incapable of taking decisions, and in certain circumstances may include: (i) prospective user; (ii) the person's next of kin; (iii) a person authorised by any other law or court order to act on that persons' behalf; (iv) an administrator appointed in terms of this Act; and (v) an executor of that deceased person's estate and "user" has a corresponding meaning. See s 1 of the Mental Health Care Act.

<sup>52</sup> S 8(1).

<sup>53</sup> S 8(2).

<sup>54</sup> S 8(3).

In addition, the Ethical Code of Professional Conduct to which a Psychologist shall adhere stipulates that: "A psychologist shall respect the dignity and worth of a client and shall strive for the preservation and protection of fundamental human rights in all professional conduct."<sup>55</sup>

## 5.5 SECTION 11 OF THE CONSTITUTION: THE RIGHT TO LIFE

### 5.5.1 Introductory remarks on the right to life

The right to life as protected in section 11 of the Constitution is the most basic human right on which all other rights are premised.<sup>56</sup> With the possible exception of human dignity, life itself is the most basic value protected by the Constitution.<sup>57</sup> In addition, The *Universal Declaration of Human Rights*<sup>58</sup> reads: "Everyone has the right to life, liberty, and security of the person." The *International Convention on Civil and Political Rights*<sup>59</sup> also qualifies the right to life as follows: "Every human being has the inherent right to life. This right shall be protected by law. No one shall be arbitrarily deprived of his life." The right to life is however not absolute.

In *Makwanyane*,<sup>60</sup> the Constitutional Court described the rights to life and dignity as the "most important of all human rights, and the source of all other personal rights in [the Bill of Rights]". By committing ourselves

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<sup>55</sup> "Professional Board for Psychology: Rules of conduct pertaining specifically to the profession of psychology" published in GN R717 in GG No 29079, 4 August 2006 s 10(1).

<sup>56</sup> *Makwanyane supra*. In this case, the two accused were convicted of murder in the Witwatersrand Local Division and were sentenced to death. They appealed to the Appellate Division against the death sentences. After hearing argument and coming to the conclusion that, in the circumstances of the case, the death sentence was the proper sentence, the court postponed the further hearing of the appeals until the Constitutional Court had decided whether the death sentence in terms of s 277(1)(a) of the Criminal Procedure Act was in conflict with the provisions of the Constitution or not. The Constitutional Court issued, in terms of s 98(5) of the interim Constitution, an order declaring that, with effect from the date of the order, the provisions of s 277(1)(a), (c), (d), (e), and (f) of the Criminal Procedure Act and all corresponding provisions of other legislation sanctioning capital punishment (which were in force in any part of the national territory of South Africa in terms of s 229 of the interim Constitution), were inconsistent with the Constitution, and therefore invalid.

<sup>57</sup> Chaskalson M *et al Constitutional law of South Africa* (2005) 37-1.

<sup>58</sup> Article 3 of the *Universal Declaration of Human Rights*.

<sup>59</sup> Article 6(1) of the *International Convention on Civil and Political Rights*. The *International Convention on Civil and Political Rights* was adopted and opened for signature, ratification and accession by the General Assembly resolution 2200A (XXI) on 16 December 1966. It was entered into force on the 23<sup>rd</sup> of March 1976 in accordance with Article 49, which states that: "1. The present Covenant shall enter into force three months after the date of the deposit with the Secretary-General of the United Nations of the thirty-fifth instrument of ratification or instrument of accession. 2. For each State ratifying the present Covenant or acceding to it after the deposit of the thirty-fifth instrument of ratification or instrument of accession, the present Covenant shall enter into force three months after the date of the deposit of its own instrument of ratification or instrument of accession."

<sup>60</sup> *Makwanyane supra*.

to a society founded on the recognition of human rights, we are required to value these two rights above all others.

The right to life is textually unqualified and may only be limited in terms of the limitation clause.<sup>61</sup> The unqualified nature of the right to life was referred to by several judges in *Makwanyane*.<sup>62</sup> In this case, Chaskalson P rejected an argument that those who are convicted of murder have forfeited their right to life. He wrote the leading opinion, signed by all the other judges, and did not invalidate the death sentence on the basis of its conflict with the right to life, but held the death sentence to be a form of cruel, inhuman or degrading punishment.<sup>63</sup> A majority of the members of the Constitutional Court nevertheless found the death penalty to violate the right to life. Although no comprehensive definition of the right to life was put forward by any of these judges, most of them agreed that the right must, at least, incorporate the right not to be deliberately and systematically killed by the state. Since the right to life has remained unqualified in the 1996 Constitution, it appears that the Constitutional Assembly decided not to interfere with the Constitutional Court's decision in *Makwanyane*.<sup>64</sup> This means that unless the Constitution is amended, the death penalty remains an unconstitutional form of punishment.<sup>65</sup>

### 5.5.2 Executing the mentally disordered offender

Although the death penalty is currently an unconstitutional form of punishment in South Africa, the question remains universally whether the death penalty should be an appropriate form of punishment for the mentally disordered offender. Arrigo<sup>66</sup> explains that a substantial number of incarcerated individuals suffer from mental disorders in one form or another. It is therefore not surprising that mental disorder is a significant factor affecting the legal system's response to serious crimes whose punishment can (and sometimes does) amount to a death sentence. The concern of mentally disordered death row prisoners

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<sup>61</sup> S 36 of the Constitution.

<sup>62</sup> *Makwanyane supra*.

<sup>63</sup> S 11(2) in chapter 3 of the interim Constitution refers to cruel and inhuman punishment.

<sup>64</sup> *Makwanyane supra*.

<sup>65</sup> Currie & De Waal 281. See also *S v Ntsang* 1995 (4) BCLR 426. See also *Ex parte Minister of Safety and Security: in re S v Walters supra*: "[The state's] role in our violent society is rather to demonstrate that we are serious about the human rights the Constitution guarantees for everyone, even suspected criminals." In *Makwanyane*, Chaskalson P said: "... (R)ights vest in every person, including criminals convicted of vile crimes. Such criminals do not forfeit their rights under the Constitution and are entitled, as all in our country now are, to assert these rights, including the right to life ... ." See *Makwanyane supra*.

<sup>66</sup> Arrigo BA *Punishing the mentally ill: A critical analysis of law and psychiatry* (2002) 147-148.

draws specific attention to the matter of one's psychological competency and legal right to treatment refusal.<sup>67</sup> The situation for the mentally disordered offender on death row is quite profound. The prevalence of mental disorders that predated sentencing and imprisonment, the exacerbating conditions of incarceration and impending execution and the legal assertion of incompetency to be executed as a "last chance" for circumventing capital punishment, represent a complex clustering of variables significantly impacting the life or death of criminally confined individuals.<sup>68</sup>

In the 1957 case of *R v Roberts*,<sup>69</sup> the appellant was tried on a charge of murder in the Cape Provincial Division by Van Wyk J and a jury. He was convicted and, in spite of a finding by the jury of extenuating circumstances, was sentenced to death. His application for leave to appeal against the conviction was refused by the Trial Court, which however granted him leave to appeal against the sentence of death. His petition to the Chief Justice for leave to appeal against the conviction was refused by this Court. The appeal is therefore against the sentence only.

The appellant was a sailor. He joined the Navy in 1954. The description of his home life and his character which follows was summarised from his own evidence. His father was bad-tempered and cruel towards animals. His mother drank to excess and deserted his father. He was distressed as a child when his father assaulted his mother. When he was twelve years old he had intercourse with a woman of 18 or 19, and thereafter he frequently had intercourse with women. When he was only seven or eight years old he had a homosexual experience. On one occasion he saw his father having intercourse with a native woman. He exposed himself to native women and had intercourse with them. He masturbated and during the act pictured himself as having intercourse with a woman and then strangling her, or driving her over a cliff in a car, or stabbing her to death. He shot his own dog and killed two house cats, one by hanging and the other by throwing a pair of pliers at it. In both cases he cut the corpse of the cat to pieces with his knife. These acts of killing made him feel excited. At the age of fifteen he used to telephone women and ask them to

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<sup>67</sup> Arrigo BA & Tasca JJ "Right to refuse treatment, competency to be executed, and therapeutic jurisprudence: Toward a systematic analysis" 1999 23 *L & Psychology Rev* 1: 1 at 17. See the discussion of treatment refusal below.

<sup>68</sup> Johnson R *Death work: A study of the modern execution process* (1998) 70-71; Heilbrun K *et al* "The debate on treating individuals incompetent for execution" 1992 149 *Am J Psychiatry* 5: 596-597.

<sup>69</sup> *R v Roberts* 1957 (4) SA 265 (A). The facts appear from the judgment of Hoexter JA. Cf *R v von Zell* (2) 1953 (4) SA; *R v Taylor* 1949 (4) SA; *R v Anderson* 1956 (4) SA; *R v Swanepoel* 1945 AD 444; *R v de Vos* 1939 OPD 36; *R v Mkize* 1953 (2) SA.

have intercourse with him. He was caught by the police and appeared before a magistrate who cautioned and discharged him. On a few occasions he aroused feelings of excitement in himself by dressing as a woman. He started drinking wine and beer at the age of fourteen, and the effect of liquor was to arouse a desire for intercourse with women accompanied by an urge to do violence to them. He raped a native woman in the veld near Kloofzicht station. He had sexual intercourse about two or three times a week, quite indiscriminately, and generally whilst intoxicated. In the absence of a woman, he would use a man as a "makeshift".

During his period of training in the Navy, he gave his fellow trainees the impression that he was not normal and they advised him to see a psychiatrist. He went to see Dr Van Wyk, the military medical officer, and told him that he wanted to see a psychiatrist. Apparently Dr Van Wyk, who noticed no signs of abnormality in the appellant, smiled at this request. The appellant felt embarrassed and lost confidence, with the result that he did not tell Dr Van Wyk about his strong sexual urges but merely complained that he was very nervous. Dr Van Wyk prescribed a sedative and the appellant did not consult a psychiatrist. The description of his own character by the appellant, even if it was regarded by the jury as being not entirely truthful, makes it possible to understand in some measure, at least, why he committed the horrible sex murder of which he was convicted. The appellant met the deceased for the first time on the evening of the 29<sup>th</sup> of December 1956 in the Cafe Del Monico in Cape Town.

The appellant described in a statement made to the magistrate what happened on the evening of 7 January 1957:

In the flat I took off my jacket and Clara and myself lay on the divan. We started making love. Then she said she was getting hot and wanted to remove her dress. She then came and lay next to me on the divan. We then carried on making love. I then asked her if she wouldn't have intercourse with me. She then said to me that a man had never had her in her life yet. I tried to persuade her. She wouldn't. I then suddenly grabbed her by the throat and started strangling her. She was stronger than what I thought so I hit her with my fist in her face. I grabbed a pillow lying next to us and I smothered her with the pillow. Afterwards I went to the kitchen. I got a table knife out of one of the drawers. I then threw her on the floor and cut her throat with the knife after which I dragged her into the bathroom. Then I cut her stomach open and I stabbed her in her chest and the knife broke when I stabbed her. I then cut her some more with the knife. I then washed my hands in the wash basin in the bathroom. I dried my hands on a towel hanging up in the bathroom. I then went into the other room and I put my jacket on; as I was leaving I saw her purse lying on the table. I picked it up and opened it. I found a £5 note and about 16s in two bob pieces. I took this money and the keys. I then went out and closed the door. Then I walked down a street towards the Gardens. I then threw the keys in a drain

along the street. After which I went down to the Grand Parade, I then asked a taxi driver to get a woman for the night. He said I must wait and he'd go and fetch me one. Later he came back with a woman and we went for a drive out Three Anchor Bay way. I had intercourse with the woman and paid her £5. We then came back to town.<sup>70</sup>

A great deal of evidence was given by two psychiatrists as to the mental state of the appellant. The defence was one of insanity,<sup>71</sup> but it was rejected by the jury who returned a verdict of guilty of murder, with extenuating circumstances, which they specified as follows:

- The accused is a psychopath and patently an abnormal person.<sup>72</sup>
- His whole life, upbringing and history.
- The amount of alcohol consumed during the day of the crime.
- Encouragement by the deceased and subsequent frustration, having due regard to his abnormal sexual urges.
- Apparent lack of supervision and guidance at camp and work.
- Apparent lack of organisation of the leisure hours leading to uncontrolled drinking and depravity.

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<sup>70</sup> *R v Roberts supra* 268.

<sup>71</sup> See the discussion of the insanity defence below.

<sup>72</sup> A psychopath is an individual who demonstrates a distinct behavioural pattern that differs from the general population in its level of sensitivity, empathy, compassion and guilt. See Bartol CR *et al Criminal behaviour: A psychosocial approach* (2008) 648. Cf the definition of "psychopathy", which is a mental disorder roughly equivalent to antisocial personality disorder, but with emphasis on affective and interpersonal traits such as superficial charm, pathological lying, egocentricity, lack of remorse and callousness that have traditionally been regarded by clinicians as characteristic of psychopaths, rather than social deviance traits such as need for stimulation, parasitic lifestyle, poor behavioural controls, impulsivity and irresponsibility that are prototypical of antisocial personality disorder. People with psychopathy focus on the present and lack normal anxiety or fear responses to future aversive events. Such people also have a primary dysfunction of empathic social responses. See Colman AM *Oxford dictionary of psychology* (2006) "psychopathy" 618. It is important to note that psychopathy is not listed in the DSM-IV as a diagnosis, but has been extensively described in academic literature and is therefore accepted as a valid disorder or personality style. See Kaliski S "Introduction" 1-7 in *Psycholegal assessment in South Africa* ((ed) Kaliski S) (2006) 4. However, in *S v Mnyanda* 1976 (2) SA 751 (A) par [99], Rumpff CJ stated: "[I]n the absence of any exceptional symptom, a full-fledged psychopath does not lack criminal capacity. He is *doli capax* because he knows what is and what is not lawful and has the mental capacity to act accordingly. ...". In *S v Lehnberg* 1975 (4) SA 553 (A), Rumpff CJ stated: "It is ... necessary to point out that the question of psychopathy as an extenuating circumstance ought to be dealt with with great care because it would otherwise be easy thereby to introduce the doctrine of determinism into our criminal law by the back door. ... On the other hand it is possible that a psychopath is not able to mount the same resistance as a perfectly normal person and in such cases his weakness may be considered as an extenuating circumstance. ... It must further be pointed out that the evidence about psychopathy must also be approached with care." In *S v Phillips* 1985 (2) SA 727 (N) at 739F, Milne JP regarded psychopathy in conjunction with other factors as a mitigating factor regarding sentence. See also the *Interim Report of the Commission of Enquiry into the Continued Inclusion of Psychopathy as Certifiable Mental illness and the dealing with Psychopathic and other Violent Offenders*, March 1994, in which the Commission recommended that the "retention of psychopathy as a mental illness in the Mental Health Act [18 of 1973] is not only scientifically untenable, but is also not effective in practice".

In addressing the trial Court in mitigation of sentence, the appellant's counsel also made the following points:

- That the appellant had no previous convictions other than the one in respect of which he was cautioned and discharged in the children's court.
- That he made a voluntary confession.
- That he tried to see a psychiatrist.
- That his warrant officer described him as a good worker and polite and his friends regarded him as generous and as a good friend.

The learned trial Judge gave the following reasons for imposing sentence of death on the appellant:

The accused suffers from strong sexual urges and, under the influence of liquor, experiences a desire to rape and do violence to women. It is this criminal tendency that makes him the dangerous killer that he is. I have given careful consideration to the extenuating circumstances found by the jury, as well as to what Mr. Gordon has said, but I must do my duty as I see it. My duty is to protect the public against the accused and other would-be killers. The accused belongs to a class of person whose conscience is gravely impaired. They are deterred only by fear of detection and punishment. I believe the fear of the death sentence is still the strongest single deterring factor with this type of person. I have a strong feeling that if the accused were ever to be set free again this desire to rape and to do violence to women when under the influence of liquor may well manifest itself again. As I see it, anybody who should give the accused his liberty again will be risking somebody else's life. The accused committed a horrible murder, a typical sex murder, and may strike again if given the opportunity.<sup>73</sup>

It was argued by the appellant's counsel that the learned trial Judge acted upon a wrong principle. The foundation of his argument was that the learned Judge had accepted the finding of the jury that the appellant was a psychopath and patently an abnormal person. It is obvious that this finding did not mean that the appellant had not appreciated the nature and quality of his conduct or that it was wrong. In his summing-up the learned Judge made it clear to the jury that if they found that, by reason of a mental disorder, the appellant was unable to appreciate the nature and quality of his conduct, or that it was wrong, the proper verdict would be one of "guilty but insane". As soon as the jury returned a verdict of guilty of

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<sup>73</sup> *R v Roberts supra* 269.

murder the sentence of death became a competent sentence, and the effect of the finding of extenuating circumstances was to give the trial Judge a discretion whether to impose the death sentence or not.<sup>74</sup>

It followed that the learned trial Judge was not precluded from passing sentence of death merely because he accepted the finding of the jury that the appellant was a psychopath. Counsel for the appellant contended that the terms of the learned Judge's summing-up showed that he regarded the mental condition of the appellant as an extenuating circumstance and that it was therefore illogical of him, in passing sentence, to treat that condition as an aggravating circumstance. The relevant portion of the summing-up reads as follows:<sup>75</sup>

As to what are extenuating circumstances: any factor including any subjective factors which, in your opinion, reduces the moral guilt of the accused, could be extenuating circumstances. You may find one or two or three circumstances in themselves do not amount to extenuating circumstances, but that they nonetheless cumulatively amount to extenuating circumstances. It is impossible to enumerate all the possible circumstances in this case which could, in theory, be regarded as possible extenuating circumstances. I will mention a few, but they are not exhaustive. For instance, the fact that the accused had a large quantity of alcohol; that on his evidence he had been teased and tantalised; that he had a retarded mentality - if that be your finding - that he is an emotional person; his mental condition.

With regard to the death penalty and mental disordered offenders, Steyn CR remarked as follows:

... Die jurie het egter ook bevind dat hy 'n psigopaat en 'n kennelik abnormale persoon is. Volgens die mediese getuienis bestaan sy geestelike afwyking daarin dat sy buitengewoon sterk gestlagsdrif by geleentheid bevrediging vind in pyniging, verminking en doodslag. Vermoedelik het die jurie dit aanvaar. Trouens, die mediese getuienis laat weinig ruimte vir 'n ander gevolgtrekking. Wat die jurie egter klaarblyklik nie aangeneem het nie, is dr. McGregor se getuienis ten effekte dat die appellant, hoewel nie onbewus van wat hy doen nie, waarskynlik nie in staat was om sy handeling te beheer nie. Wat daardie aspek van die saak betref wil dit voorkom dat hul dr. Weinberg se sienswyse verkies het. Wat ons dus hier het, is 'n erkende patologiese reaksie wat, hoewel dit voortgespruit het uit 'n besonder sterke drang, nie onbedwingbaar was nie. Dit plaas die geval in die middel, tussen kranksinnigheid aan die een kant en gesonde geestesvermoëns aan die ander kant. Met betrekking tot hierdie soort

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<sup>74</sup> *R v Roberts supra* 270. The duty of the judge to impose sentence was defined in *R v Von Zell supra* as follows: "The Judge has to weigh a variety of factors, some of them facts, others impressions regarding the accused's character and probable reactions to clemency, others again matters of policy. In so far as there is room at the sentencing stage for doubt as to the existence of any relevant fact the trial Judge ... must reach his own conclusions as he thinks right, and there is no obligation upon him to use the language of *onus* of proof in examining the issues. All that can fairly be said in this connection is that mitigating factors are naturally put forward and supported by the defence and the Judge is accordingly entitled to ask himself whether he is satisfied of their existence and, if not so satisfied, to treat them as if they did not exist for the purpose of deciding on his sentence."

<sup>75</sup> *R v Roberts supra* 271.

van geval is daar persone wat meen dat die galg nie 'n gepaste antwoord is nie op gedrag, hoe wreed en onmenslik ook al, wat ten dele altans sy oorsprong vind in 'n bekende patologiese geestesverskynsel. Hul wil aan die dader 'n verminderde toerekeningsvatbaarheid toeskryf en meen dat hy, na analogie van 'n lewensgevaarlike en nie minder wreedaardige kranksinnige, afsonderlike spesiale behandeling moet ontvang. *Sover my bekend, is daarin ons regstelsel geen spesifieke voorsiening vir dergelike behandeling nie.* Hoewel ek geen vaste oortuiging daarop nahou nie, wil dit my tog voorkom dat genoemde beskouing nie sonder meer van die hand gewys kan word nie, en ook binne die perke van ons tans geldende reg by straffoemeting oorweging verdien. ... Wat by ons die probleem aksentueer, is die aard van die bewyslas. Dit is die beskuldigde wat moet bewys dat hy as kranksinnige ten tyde van die daad beskou moet word, en hy kwyd hom nie van die bewyslas deur slegs 'n redelike moontlikheid aan te toon dat hy kranksinnig was nie. Hy moet dit bewys met 'n oorwig van waarskynlikheid. Dit laat die moontlikheid dat hy, afhangende van die getuienis, skuldig bevind moet word, hoewel daar 'n redelike twyfel omtrent sy toerekeningsvatbaarheid bestaan. As dit eenmaal blyk dat hy waarskynlik nie tydens die daad in 'n regtelike sin kranksinnig was nie, dan sou 'n oorblywende redelike twyfel nie dieselfde uitwerking as in ander rigtings hê nie. Dit kan hom nie van 'n skuldigbevinding red nie. ... Die skuldigbevinding aan moord sou nog regtens juis wees, en ten spyte van die jurie se bevinding insake versagende omstandighede, sou die doodstraf nog aan die goeiddunke van die Verhoorregter oorgelaat wees. ... [D]at die appèl bygevolg van die hand gewys moet word. (Own emphasis.)<sup>76</sup>

The appeal was accordingly dismissed and Roberts was sentenced to death. Mello<sup>77</sup> asks the following questions: If the mentally disordered shouldn't be put to death, what is the correct standard for measuring "execution competency"; what kinds of mental disorders "count"? Who should set that standard? Who, employing what procedural vehicles, should decide whether a particular prisoner is sane enough to die? These questions lead to the ultimate issue of whether it should be permitted to execute individuals who, due to mental disorders, do not understand that they are truly being executed as punishment for their crimes. For example, gross delusions stemming from a severe mental disorder may put an awareness of a link between a crime and its punishment in a context so far removed from reality that the punishment can serve no proper purpose.

It is important to note that someone who suffers from a mental disorder who commits a crime - who didn't know right from wrong or didn't know what he or she was doing - should be found not guilty by reason of insanity. If a mentally disordered individual has been found guilty of a crime and received the death penalty, he or she probably presented the insanity defence and did not succeed. Attorneys acting for a mentally

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<sup>76</sup> *R v Roberts supra* 272-273. Cf *R v Lloyd* 1941 CPD 162. See also Bekker PM "Die doodvonnis: Voor en na 27 Julie 1990" 1993 6 *S Afr J Criminal Justice* 1: 57-71. See further *S v Pieterse* 1982 (3) SA 678 for a discussion of the meaning of psychopathy and its effect on criminal liability. See also Strauss SA "Geestesongesteldheid en die strafreg: Die voorgestelde nuwe reëling in die Straffoerwetsontwerp" 1974 2 *THRHR* 1: 219-244.

<sup>77</sup> Mello M "Executing the mentally ill: When is someone sane enough to die?" 2007 22 *Criminal Justice* 3: 30 at 31.

disordered offender convicted of a crime can still argue during a trial's punishment phase that a client is more deserving of a life sentence than the death penalty because of his or her mental disorder. Many mentally disordered individuals end up in the criminal justice system because mental health services are not available to them.<sup>78</sup> Because the mental health system does not have the resources, a person doesn't have the opportunity to get better and, as a result, he or she winds up following a path that leads to a bad outcome.<sup>79</sup> When the result of a crime committed becomes a matter of life and death, the structural distortions caused by mental disorders become magnified, and the contradictions can rise to constitutional magnitude. Due to a lack of authoritative case law in South Africa on this issue, the following words of Justice Stevens in the American case *Atkins v Virginia*<sup>80</sup> may give some guidance in deciding on whether mentally disordered offenders should be executed or not:<sup>81</sup>

[Mentally [disordered persons] ... have diminished capacities to understand and process information, to communicate, to abstract from mistakes and learn from experience, to engage in logical reasoning, to control impulses, and to understand the reactions of others. There is no evidence that they are more likely to engage in criminal conduct than others, but there is abundant evidence that they often act on impulse rather than pursuant to a premeditated plan...Their deficiencies do not warrant an exemption from criminal sanctions, but they do diminish their personal culpability. ... [Justice Rucker:] *I respectfully dissent because I do not believe a sentence of death is appropriate for a person suffering a severe mental illness. The risk that the death penalty will be imposed in spite of factors which may call for a less severe penalty, is enhanced, not only by the possibility of false confessions, but also by the lesser ability of mentally retarded defendants to make a persuasive showing of mitigation in the face of prosecutorial evidence of one or more aggravating factors. Mentally retarded defendants may be less able to give meaningful assistance to their counsel and are typically poor witnesses, and their demeanor may create an unwarranted impression of lack of remorse for their crimes. (Own emphasis.)*

In context of the above discussion, it is now imperative to discuss sections 12(1) and 35 of the Constitution as well as the insanity defence.

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<sup>78</sup> See the discussion of access to health care below.

<sup>79</sup> Amnesty International USA: Action for human rights. Hope for humanity: Malone D "Cruel and inhumane: Executing the mentally ill" 2009 *Amnesty Magazine* <http://www.amnestyusa.org/amnesty-magazine/amnesty-magazine-aftershocks/page.do?id=1105013> (Date of access: 27 May 2009).

<sup>80</sup> *Atkins v Virginia* 536 US (2002) 306.

<sup>81</sup> Justice Stevens in *Atkins v Virginia supra*. The court held in this case that executions of mentally disordered criminals are cruel and unusual punishments.

## 5.6 SECTION 12(1) OF THE CONSTITUTION: FREEDOM AND SECURITY OF THE PERSON AND SECTION 35: ARRESTED, DETAINED AND ACCUSED PERSONS

### 5.6.1 Introductory remarks

Section 12(1) states:

"Everyone has the right to freedom and security of the person, which includes the right: (a) not to be deprived of freedom arbitrarily or without just cause; (b) not to be detained without trial; (c) to be free from all forms of violence from either public or private sources; (d) not to be tortured in any way; and (e) not to be treated or punished in a cruel, inhuman or degrading way."

When a person is deprived of physical freedom, s 12(1) guarantees both substantive and procedural protection. The substantive component requires the state to have good reasons for depriving someone of their freedom and the procedural component requires the deprivation to take place in accordance with fair procedures.<sup>82</sup> O'Regan J described these components as follows:<sup>83</sup>

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<sup>82</sup> Currie & De Waal 292. See also *Ferreira supra* [par 54] where Ackerman J proposed a "broad and generous" reading of s 12(1). He argued that the right to freedom was a constitutional protection of a sphere of individual liberty: "I would ... define the right to freedom negatively as the right of individuals not to have 'obstacles to possible choices and activities'. Chaskalson P again argued that the primary purpose of this section was to ensure the protection of the physical integrity of the individual.

<sup>83</sup> *S v Coetzee* 1997 (3) SA 527 (CC) [par 159]. See also *De Lange v Smuts NO* 1998 (3) SA 785 (CC) [par 22-25] where Ackermann J confirmed that both components of the freedom right form part of s 12(1): "It can therefore be concluded that s 12(1), in entrenching the right to freedom and security of the person, entrenches the two different aspects of the right to freedom. ... The one that O'Regan J has, in the above-cited passages, called the right not to be deprived of liberty 'for reasons that are not acceptable' or what may also conveniently be described as the substantive aspect of the protection of freedom, is given express entrenchment in section 12(1)(a) which protects individuals against deprivation of freedom 'arbitrarily or without just cause'. The other, which may be described as the procedural aspect of the protection of freedom, is implicit in section 12(1) as it was in section 11(1) of the interim Constitution. The substantive and the procedural aspects of the protection of freedom are different, serve different purposes and have to be satisfied conjunctively. The substantive aspect ensures that a deprivation of liberty cannot take place without satisfactory or adequate reasons for doing so. In the first place it may not occur 'arbitrarily'; there must in other words be a rational connection between the deprivation and some objectively determinable purpose. If such rational connection does not exist the substantive aspect of the protection of freedom has by that fact alone been denied. But even if such rational connection exists, it is by itself insufficient; the purpose, reason or 'cause' for the deprivation must be a 'just' one. ... Although paragraph (b) of section 12(1) only refers to the right 'not to be detained without trial' and no specific reference is made to the other procedural components of such trial it is implicit that the trial must be a 'fair' trial, but not that such trial must necessarily comply with all the requirements of section 35(3). ... In the interests of clarity it is necessary to point out that where the 1996 Constitution has, in relation to a specific subject matter, dealt with the procedural aspect of the right to liberty in a particular provision, it is to such provision that one must turn in order to determine the nature and extent of the procedural liberty right guaranteed in that particular context, and not to the general provision of section 12(1)(b). This would seem to follow from both a structural and purposive approach to the chapter 2 Bill of Rights. Thus, in order to determine, for example, what the procedural freedom rights are of persons arrested for allegedly committing an offence and of accused persons, one would have regard to the provisions of subsections (1) and (3) respectively of section 35 and of persons after their detention one would have regard to section 35(2). ... At the same time, however, sight must not be lost of the fact that, for example, accused persons are entitled to challenge the constitutional validity of

... [T]wo different aspects of freedom: the first is concerned particularly with the reasons for which the state may deprive someone of freedom; and the second is concerned with the manner whereby a person is deprived of freedom. ... [O]ur Constitution recognises that both aspects are important in a democracy: the state may not deprive its citizens of liberty for reasons that are not acceptable, nor when it deprives its citizens of freedom for acceptable reasons, may it do so in a manner which is procedurally unfair.

Section 35 states:

- (1) Everyone who is arrested for allegedly committing an offence has the right-
  - (a) to remain silent;
  - (b) to be informed promptly-
    - (i) of the right to remain silent; and
    - (ii) of the consequences of not remaining silent;
  - (c) not to be compelled to make any confession or admission that could be used in evidence against that person;
  - (d) to be brought before a court as soon as reasonably possible, but not later than-
    - (i) 48 hours after the arrest; or
    - (ii) the end of the first court day after the expiry of the 48 hours, if the 48 hours, expire outside ordinary court hours or on a day which is not an ordinary court day;
  - (e) at the first court appearance after being arrested, to be charged or to be informed of the reason for the detention to continue, or to be released and;
  - (f) to be released from detention if the interests of justice permit, subject to reasonable conditions.
- (2) Everyone who is detained, including every sentenced prisoner, has the right-
  - (a) to be informed promptly of the reason for being detained;
  - (b) to choose, and to consult with, a legal practitioner, and to be informed of this right promptly;
  - (c) to have a legal practitioner assigned to the detained person by the state at state expense, if substantial injustice would otherwise result, and to be informed of this right promptly;
  - (d) to challenge the lawfulness of the detention in person before a court and, if the detention is unlawful, to be released;
  - (e) to conditions of detention that are consistent with human dignity, including at least exercise and the provision, at state expense, of adequate accommodation, nutrition, reading material and medical treatment; and
  - (f) to communicate with, and be visited by, that person's -
    - (i) spouse or partner;
    - (ii) next of kin;
    - (iii) chosen religious counsellor; and
    - (iv) chosen medical practitioner.<sup>84</sup>

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a criminal offence with which they are charged on the substantive freedom right ground that such offence does not, for purposes of section 12(1)(a), constitute 'just cause' for the deprivation of their freedom."

<sup>84</sup> See also s 35(3-5): "(3) Every accused person has a right to a fair trial, which includes the right - (a) to be informed of the charge with sufficient detail to answer it; (b) to have adequate time and facilities to prepare a defence; (c) to a public trial before an ordinary court; (d) to have their trial begin and conclude without unreasonable delay; (e) to be present when

The influence of the Bill of Rights on the criminal justice system has been significant.<sup>85</sup> As mentioned above, it provides grounds for reviewing both the substantive and procedural content of the intricate web of laws shaping criminal justice as well as providing remedies for breaches of the Constitution. In doing so it has impacted on the content of law in addition to influencing the conduct of those who participate in the criminal justice system.<sup>86</sup>

In addition, the Ethical Code of Professional Conduct to which a Psychologist shall adhere stipulates that: "A psychologist shall never coerce a recipient of a psychological service into complying with the provision of such service nor shall he or she compel a client to give self-incriminating evidence via the use of psychological techniques or otherwise."<sup>87</sup> Because the present discussion focuses on mentally disordered offenders, the insanity defence is discussed next.

### 5.6.2 The insanity defence

Burchell<sup>88</sup> explains that mental disorders may deprive persons of the capacity to appreciate the unlawfulness of their conduct. It may also deprive them of the capacity to control their conduct. A person who suffers from a mental disorder that has such an affect is said (in legal terms) to be "insane". The

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being tried; (f) to choose, and be represented by, a legal practitioner, and to be informed of this right promptly; (g) to have a legal practitioner assigned to the accused person by the state and at state expense, if substantial injustice would otherwise result, and to be informed of this right promptly; (h) to be presumed innocent, to remain silent, and not to testify during the proceedings; (i) to adduce and challenge evidence; (j) not to be compelled to give self-incriminating evidence; (k) to be tried in a language that the accused person understands or, if that is not practicable, to have the proceedings interpreted in that language; (l) not to be convicted for an act or omission that was not an offence under either national or international law at the time it was committed or omitted; (m) not to be tried for an offence in respect of an act or omission for which that person has previously been either acquitted or convicted; (n) to the benefit of the least severe of the prescribed punishments if the prescribed punishment for the offence has been changed between the time that the offence was committed and the time of sentencing; and (o) of appeal to, or review by, a higher court. (4) Whenever this section requires information to be given to a person, that information must be given in a language that the person understands. (5) Evidence obtained in a manner that violates any right in the Bill of Rights must be excluded if the admission of that evidence would render the trial unfair or otherwise be detrimental to the administration of justice.

<sup>85</sup> See, for example, *S v Nombewu* 1996 (2) SACR 396 (E); *S v Agnew* 1996 (2) SACR 535 (C); *S v Zuma* 1995 (2) SA 642 (CC); *S v Dlamini* 1999 (4) SA 623 (CC); *S v Mfene* 1998 (9) BCLR 1157 (N); *S v Mhlakaza* 1996 (2) SACR 187 (C); *Msila v Government of South Africa* 1996 (1) SACR 365 (SE); *Makwanyane supra*; *Van Biljon v Minister of Correctional Services* 1997 (4) SA 441; *Strydom v Minister of Correctional Services* 1999 (3) BCLR 342 (W); *S v Ramuongiwa* 1997 (2) BCLR 268 (V); *Shabalala v Attorney-General of Transvaal* 1996 (1) SA 725 (CC) and *S v Madiba* 1998 (1) BCLR 38 (D).

<sup>86</sup> Currie & De Waal 740.

<sup>87</sup> S 10(4).

<sup>88</sup> Burchell *J Principles of Criminal Law* (2006) 370.

underlying premise of the insanity defence is that "insane persons" are the victims of an affliction that causes them to behave in an abnormal manner, which is beyond their control. To be fair they cannot be blamed for their conduct while afflicted by the illness. The test for capacity is entirely subjective,<sup>89</sup> for example, relating to the capacity of the particular accused person who is alleged to be "insane"<sup>90</sup>

### 5.6.2.1 *Fitness to stand trial*

Since 1977 the defence of insanity has been governed by statute.<sup>91</sup> In terms of section 77 of the Criminal Procedure Act, an accused who suffers from mental illness or defect may as a result not be fit to stand trial.<sup>92</sup> The enquiry into the capacity of the accused to understand the nature of the trial process is seen as a preliminary issue that has to be finalised before the issue of criminal responsibility for the conduct is examined. Burchell<sup>93</sup> argues that this approach can severely prejudice an accused who has a defence to the charge or where the State has a weak case against him or her. The Criminal Matters Amendment Act<sup>94</sup> addressed this problem. Section 3(b) of this Act provides that the court may order that such evidence be

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<sup>89</sup> See Burchell J "A provocative response to subjectivity in the criminal law" 2003 *Acta Juridica* 23-47.

<sup>90</sup> Several authors have conducted research on the insanity defence, for example, Badenhorst C *Criminal capacity of children* (unpublished PhD thesis, Unisa, 2006); Blackbeard M "Epilepsy and criminal liability" 1996 9 *S Afr J Criminal Justice* 2: 191-210; Burchell J "Non-pathological incapacity: Evaluation of psychiatric testimony" 1995 8 *S Afr J Criminal Justice* 1: 37-42; Calitz FJW "Evaluering van die geestestoestand van 'n beskuldigde wat van 'n misdryf aangekla is: 'n Multiprofessionele benadering" 1993 18 *TRW* 1: 31-40; Carstens PA "The defense of non-pathological incapacity with reference to the battered wife who kills her abusive husband" 2000 13 *S Afr J Criminal Justice* 2: 180-189; Cassim F "The accused person's competency to stand trial: a comparative perspective" 2004 45 *Codicillus* 17-27; Gagliano CA "Unnecessary committals for forensic observation" 1991 108 *SALJ* 4: 714-718; Jonck JW "Noodsaaklikheid van toestemming deur 'n beskuldigde by 'n ondersoek kragtens artikel 79 van die Strafproseswet" 1997 22 *TRW* 2: 196-203; Jordaan L "General principles of liability: Sane automatism" 1999 40 *Codicillus* 2:83-84; Kaliski S *Sensation seeking, impulsivity and violence in schizophrenics found unfit to stand trial* (1993); Kruger A "J.C. de Wet se bydrae tot die leerstuk van toerekeningsvatbaarheid by geestesongesteldheid" 1991 4 *S Afr J Criminal Justice* 2: 145-147; Kruger A "The insanity defence raised by the state, minister's decision, patients and a Bill of Rights" 1993 6 *S Afr J Criminal Justice* 2: 148-154; Le Roux J "Strafregtelike aanspreeklikheid en die verweer van nie-patologiese oftewel gesonde outomatisme" 2000 33 *De Jure* 1: 190-193; Le Roux J "Strafregtelike aanspreeklikheid en die verweer van tydelike nie-patologiese ontoerekeningsvatbaarheid" 2002 65 *THRHR* 3: 478-481; Oosthuizen H & Verschoor T "Verwysing van onverhoorbare beskuldiges en die daarstelling van 'n verhoorbaarheidvasstellingseenheid" 1993 6 *S Afr J of Criminal Justice* 2: 155-164; Snyman CR "Die verweer van nie-patologiese ontoerekeningsvatbaarheid in die strafreg" 1989 14 *TRW* 1: 1-15; Strauss SA "Nie-patologiese ontoerekenbaarheid as verweer in die strafreg" 1995 16 *S Afr Practice Management* 4: 14-34; Van Oosten FFW "The insanity defence: Its place and role in criminal law" 1990 3 *S Afr J of Criminal Justice* 1: 1-9; Verster I "Mental disorders in patients referred for psychiatric observation after committing homicide" 1999 24 *TRW* 1: 58-66.

<sup>91</sup> Ss 77-79 of the Criminal Procedure Act. See also the *Report of the Commission of Inquiry into the Responsibility of Mentally Deranged Persons and Related Matters* RP 69/1967 (also called the *Rumpff Report*).

<sup>92</sup> S 77(1): "(1) If it appears to the court at any stage of criminal proceedings that the accused is by reason of mental illness or mental defect not capable of understanding the proceedings so as to make a proper defence, the court shall direct that the matter be enquired into and be reported on in accordance with the provisions of section 79."

<sup>93</sup> Burchell 372.

<sup>94</sup> The Criminal Matters Amendment Act 68 of 1998 (hereafter referred to as the Criminal Matters Amendment Act).

placed before the court so as to determine whether the accused committed the act. This enquiry can be initiated by the prosecution, the defence or by the court of its own accord. The court usually relies on medical evidence and must be satisfied that there is a reasonable suspicion that the accused lacks the capacity to appreciate the nature of the trial proceedings or to conduct a proper defence.<sup>95</sup> Such capacity to understand can be challenged at any stage of the proceedings.<sup>96</sup>

### 5.6.2.2 *The test to determine criminal responsibility*

If the defence of insanity is raised, the test to determine the accused's criminal responsibility must be applied. This test is set out in section 78(1) of the Criminal Procedure Act.<sup>97</sup> Section 78(1) reads as follows:

A person who commits an act which constitutes an offence and who at the time of such commission suffers from a mental illness or mental defect which makes him incapable –  
(a) of appreciating the wrongfulness of his act; or  
(b) of acting in accordance with an appreciation of the wrongfulness of his act, shall not be criminally responsible for such act.

It is clear from the content of section 78(1) that the words "an act which constitutes an offence" do not refer to an offence for which the accused is liable, but only to an act which corresponds to the definitional elements of the relevant crime.

It is important to note that since the decision of the court depends on the facts and the medical evidence of each case, Rumpff JA stated in *S v Mahlinza*<sup>98</sup> that it is impossible and dangerous to attempt to lay down any general symptom by which a mental disorder could be recognised as a mental "disease" or "defect". Therefore, for the purposes of the insanity defence in South Africa, there is no formal definition of mental illness. However, the court held in *S v Stellmacher*<sup>99</sup> that in order to constitute a mental illness or defect it

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<sup>95</sup> The question of fitness to stand trial is determined by a psychiatric examination and report. A person who is found not fit to stand trial is detained in a mental hospital or prison until they become fit to be tried. See s 77(6) and s 77(7). See also *S v Leeuw* 1987 (3) SA 97 (A) 17. In this case two psychiatrists, prof WH Wessels and Dr PJ Gouse, reported in par [4] as follows: "Hy is weens verstandelike vertraging nie in staat om hofverrigtinge dermate te begryp dat hy sy verdediging na behore kan voer nie. ... Hy was weens verstandelike vertraging ten tyde van die betrokke handeling nie in staat om die ongeoorlooftheid daarvan te besef of om ooreenkomstig 'n besef van die ongeoorlooftheid van die betrokke handeling op te tree nie. Hy is dus nie strafregtelik toerekenbaar nie."

<sup>96</sup> Burchell 372.

<sup>97</sup> Snyman CR *Strafreg* (2000) 164.

<sup>98</sup> *S v Mahlinza* 1967 (1) SA 408 (A) at 417.

<sup>99</sup> *S v Stellmacher* 1983 (2) SA 181 (SWA) at 187. In this case the accused had been on a strict weight-loss diet for a period of weeks and also performed strenuous physical labour on the day in question. He consumed at least half a bottle

must at least consist in: "[A] pathological disturbance of the accused's mental capacity and not a mere temporary mental confusion which is not attributable to a mental abnormality but rather to external stimuli such as alcohol, drugs or provocation."<sup>100</sup> Furthermore, every person is presumed not to suffer from a mental illness or mental defect so as not to be criminally responsible in terms of section 78(1), until the contrary is proved on a balance of probabilities.<sup>101</sup> Whenever the criminal responsibility of an accused with reference to the commission of an act or an omission which constitutes an offence is in issue, the burden of proof with reference to the criminal responsibility of the accused shall be on the party who raises the issue.<sup>102</sup>

In terms of section 78(2), if it is alleged at criminal proceedings that the accused is by reason of mental illness or mental defect or for any other reason not criminally responsible for the offence charged, or if it appears to the court at criminal proceedings that the accused might for such a reason not be so responsible, the court must in the case of an allegation or appearance of mental illness or mental defect, and may, in any other case, direct that the matter be enquired into and be reported on in accordance with the provisions of section 79.<sup>103</sup>

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of brandy the evening. According to him there was in the bar a strong reflection of the setting of the sun in his eyes which shone through an empty bottle. As a result, he lapsed into an automatic state, during which he began shooting at people in the bar, killing one person. The question was whether the accused had suffered from a mental illness as contemplated in s 78 of the Criminal Procedure Act. The state did not prove beyond reasonable doubt that the conduct of the accused was indicative of a pathological disorder which is not due to a temporary clouding of the mind not attributable to a mental abnormality. A foundation was laid in the evidence for a reliance on lack of criminal responsibility not caused by mental illness. Bearing in mind the reasonable doubt which exists regarding the cause of his lack of criminal responsibility, the accused had to be given the benefit of the doubt. He was found not guilty and discharged. See Burchell *J Cases and materials on criminal law* (2007) 356.

<sup>100</sup> It is important to note that the defence of insanity should not be confused with the defence of non-pathological criminal incapacity. The defence of non-pathological criminal incapacity is not set out in any statutory provision, but forms part of the common law. Criminal incapacity is not the result of a specific cause; it may have any cause, for example, emotional collapse, fear, provocation or intoxication. If this defence succeeds, the accused leaves the court a free person and is not sent to a psychiatric hospital or prison. See Snyman 161ff. See also *S v Chretien* 1981 (1) SA 1097 (A). In this case, the accused, after driving away from a party at which he had been drinking, drove into a crowd of people, killing one and injuring five others. He was acquitted on the basis of his lack of intention due to his level of intoxication. The court, however, accepted that there were degrees of intoxication and depending to what extent an individual was intoxicated, his or her intoxication could impair either his or her intention, criminal capacity or the voluntariness of the conduct. Due to tremendous criticism the legislature enacted a special offence in the Criminal Law Amendment Act 1 of 1988 that made it a criminal offence while intoxicated if the level of the accused's intoxication was such that he or she lacked capacity.

<sup>101</sup> S 78(1)(A).

<sup>102</sup> S 78(1)(B).

<sup>103</sup> See also s 78(3-8): " (3) If the finding contained in the relevant report is the unanimous finding of the persons who under section 79 enquired into the relevant mental condition of the accused, and the finding is not disputed by the prosecutor or the accused, the court may determine the matter on such report without hearing further evidence. (4) If the said finding is

In the case of *S v Kavin*,<sup>104</sup> Kavin was charged on three counts of murder. He took a gun one evening and shot his wife and two children. When his sister asked him what was going on, he replied that it was only a car backfiring. His defence was one of insanity. An inquiry in terms of section 78 of the Criminal Procedure Act was held. Kavin suffered from severe reactive depression super-imposed on a type of personality disorder displaying immature and unreflective behaviour. In the opinion of Dr Shubitz and Dr Garb it produced a state of dissociation. Both these psychiatrists as well as Prof Bodemer agreed that Kavin could not act in accordance with an appreciation of the unlawfulness of his act. They based their opinion on the basis of progressive depression. He was therefore not regarded as being criminally responsible for the acts in question. He was thereafter admitted in a psychiatric clinic in terms of section 78(6) of the Criminal Procedure Act.

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not unanimous or, if unanimous, is disputed by the prosecutor or the accused, the court shall determine the matter after hearing evidence, and the prosecutor and the accused may to that end present evidence to the court, including the evidence of any person who under section 79 enquired into the mental condition of the accused. (5) Where the said finding is disputed, the party disputing the finding may subpoena and cross-examine any person who under section 79 enquired into the mental condition of the accused. (6) If the court finds that the accused committed the act in question and that he or she at the time of such commission was by reason of mental illness or mental defect not criminally responsible for such act - (a) the court shall find the accused not guilty; or (b) if the court so finds after the accused has been convicted of the offence charged but before sentence is passed, the court shall set the conviction aside and find the accused not guilty, by reason of mental illness or mental defect, as the case may be, and direct - (i) in a case where the accused is charged with murder or culpable homicide or rape or another charge involving serious violence, or if the court considers it to be necessary in the public interest that the accused be - (aa) detained in a psychiatric hospital or a prison pending the decision of a judge in chambers in terms of section 29(1)(a) of the Mental Health Act, 1973 (Act No. 18 of 1973); (bb) admitted to, detained and treated in an institution stated in the order in terms of Chapter 3 of the Mental Health Act, 1973 (Act No. 18 of 1973), pending discharge by a hospital board in terms of section 29(4A)(a) of that Act; (cc) treated as an outpatient in terms of section 7 of that Act pending the certification by the superintendent of that institution stating that he or she need no longer be treated as such; (dd) released subject to such conditions as the court considers appropriate; or (ee) released unconditionally; (ii) in any other case than a case contemplated in subparagraph (i), that the accused - (aa) be admitted to, detained and treated in an institution stated in the order in terms of Chapter 3 of the Mental Health Act, 1973 (Act No. 18 of 1973), pending discharge by a hospital board in terms of section 29(4A)(a) of that Act; (bb) be treated as an out-patient in terms of section 7 of that Act pending the certification by the superintendent of that institution stating that he or she need no longer be treated as such; (cc) be released subject to such conditions as the court considers appropriate; or (dd) be released unconditionally. (7) If the court finds that the accused at the time of the commission of the act in question was criminally responsible for the act but that his capacity to appreciate the wrongfulness of the act or to act in accordance with an appreciation of the wrongfulness of the act was diminished by reason of mental illness or mental defect, the court may take the fact of such diminished responsibility into account when sentencing the accused. (8) (a) An accused against whom a finding is made under subsection (6) may appeal against such finding if the finding is not made in consequence of an allegation by the accused under subsection (2). (b) Such an appeal shall be made in the same manner and subject to the same conditions as an appeal against a conviction by the court for an offence. (9) Where an appeal against a finding under subsection (6) is allowed, the court of appeal shall set aside the finding and the direction under that subsection and remit the case to the court which made the finding, hereupon the relevant proceedings shall be continued in the ordinary course."

<sup>104</sup> *S v Kavin* 1978 (2) SA 731 (W).

### 5.6.2.3 Panel for purposes of enquiry and report under sections 77 and 78

In terms of section 79 of the Criminal Procedure Act, the court can refer an accused at any stage of the trial for a psychiatric or psychological assessment of his or her mental state with reference to either section 77 or 78 of the Criminal Procedure Act. The Act distinguishes between offences that involve serious violence and those that are non-violent.<sup>105</sup> The accused is usually admitted to a state psychiatric hospital under a warrant for a period of observation for 30 days. Effectively the court must appoint a panel of two or three psychiatrists if the alleged offence involved serious violence. The court has the discretion to appoint a clinical psychologist as well. The court may, for the purposes of the relevant enquiry, commit the accused to a psychiatric hospital or to any other place designated by the court, for such periods not exceeding thirty days at a time, as the court may from time to time determine, and where an accused is in custody when he is so committed, he shall, while he is so committed, be deemed to be in the lawful custody of the person or the authority in whose custody he was at the time of such committal.<sup>106</sup> When the period of committal is for the first time extended under paragraph (a), such extension may be granted in the absence of the accused unless the accused or his legal representative requests otherwise.<sup>107</sup>

According to Kaliski,<sup>108</sup> it is important to note that the critical first stage in any assessment is to determine whether the accused is suffering from a mental illness or whether there are other psychological or psychiatric factors that are associated with the terms of referral. The Criminal Procedure Act requires that mental illness or defect must be present before the question of whether the accused is fit to stand trial or criminally responsible can be examined. However, the courts will demand a variety of deeper insights into the accused and his or her behaviour. Consequently, it is good practice to conduct complete clinical examinations and to learn how to anticipate the court's requirements.

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<sup>105</sup> See s 79(1)(a)(b): "78 - (1) Where a court issues a direction under section 77 (1) or 78 (2), the relevant enquiry shall be conducted and be reported on - (a) where the accused is charged with an offence other than one referred to in paragraph (b), by the medical superintendent of a psychiatric hospital designated by the court, or by a psychiatrist appointed by such medical superintendent at the request of the court; or (b) where the accused is charged with murder or culpable homicide or rape or another charge involving serious violence, or if the court considers it to be necessary in the public interest, or where the court in any particular case so directs - (i) by the medical superintendent of a psychiatric hospital designated by the court, or by a psychiatrist appointed by such medical superintendent at the request of the court; (ii) by a psychiatrist appointed by the court and who is not in the full-time service of the State; (iii) by a psychiatrist appointed for the accused by the court; and (iv) by a clinical psychologist where the court so directs."

<sup>106</sup> S 79(2)(a).

<sup>107</sup> S 79(2)(b).

<sup>108</sup> Kaliski S "The criminal defendant" 93-111 in *Psycholegal assessment in South Africa* 97, 110-111.

### 5.6.3 The regulation of State patients and mentally ill prisoners in terms of the Mental Health Care Act

Chapter 6 of the Mental Health Care Act regulates the position with regard to State patients. In terms of section 41, the head of the national department must, with the concurrence of the relevant heads of the provincial departments, designate health establishments, which may admit, care for, treat and provide rehabilitation services to State patients. Where a court issues an order in terms of the Criminal Procedure Act for a State patient to be admitted for mental health care, treatment and rehabilitation services, the Registrar or the Clerk of the court must send a copy of that order to the:

- Relevant official *curator ad litem*;<sup>109</sup> and
- officer in charge of the detention centre where the State patient is or will be detained.<sup>110</sup>

In terms of section 46(1) of the Mental Health Care Act, the head of a health establishment where a State patient is admitted or if on leave of absence or conditional discharge must cause the mental health status of the State patient to be reviewed after six months from the date on which care, treatment and rehabilitation services were commenced, and every 12 months thereafter. The review must make recommendations on:

- A plan for further care, treatment and rehabilitation service;<sup>111</sup>
- the merits of granting leave of absence;<sup>112</sup> or
- the discharge of the State patient.<sup>113</sup>

Chapter 6 of the Act further regulates the transfer of State patients between designated health establishments;<sup>114</sup> the position with regard to State patients who abscond;<sup>115</sup> leave of absence from

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<sup>109</sup> S 42(1)(a).

<sup>110</sup> S 42(1)(b).

<sup>111</sup> S 46(2)(a).

<sup>112</sup> S 46(2)(b).

<sup>113</sup> S 46(2)(c).

<sup>114</sup> S 43.

<sup>115</sup> S 44.

designated health establishments;<sup>116</sup> the application for discharge of State patients; and the conditional discharge of State patients, amendments to conditions or the revocation of conditional discharge.<sup>117</sup>

Chapter 7 of the Mental Health Care Act regulates the position with regard to mentally ill prisoners. In terms of section 49, the head of the national department must, with the concurrence of the heads of the provincial departments, designate health establishments which may admit, care for, treat and provide rehabilitation services to mentally ill prisoners. If it appears to the head of a prison through personal observation or from information provided that a prisoner may be mentally ill, the head of the prison must cause the mental health status of the prisoner to be enquired into by a psychiatrist<sup>118</sup> or where a psychiatrist is not readily available, by a medical practitioner<sup>119</sup> and a mental health care practitioner.<sup>120</sup> The person conducting the enquiry must submit a written report to the head of the prison, and must specify in the report the mental health status of the prisoner;<sup>121</sup> and a plan for the care, treatment and rehabilitation of that prisoner.<sup>122</sup>

If the person conducting the enquiry referred to in section 50 finds that the mental illness of the convicted prisoner is of such a nature that the prisoner concerned could appropriately be cared for, treated and rehabilitated in the prison, the head of the prison must take the necessary steps to ensure that the required levels of care, treatment and rehabilitation services are provided to that prisoner.<sup>123</sup>

#### 5.6.4 End of life decisions: Euthanasia and a right to suicide?

According to Strauss,<sup>124</sup> the so-called "right to die", in the context of "passive euthanasia",<sup>125</sup> has raised a number of difficult philosophical, theological, ethical and legal problems. Two factors in particular have in

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<sup>116</sup> S 45.

<sup>117</sup> S 48.

<sup>118</sup> S 50(1)(a).

<sup>119</sup> S 50(1)(b)(i).

<sup>120</sup> S 50(1)(b)(ii).

<sup>121</sup> S 50(2)(a).

<sup>122</sup> S 50(2)(b).

<sup>123</sup> S 51. See also ss 52-58.

<sup>124</sup> Strauss SA "The 'right to die' or 'passive euthanasia'" 1993 6 *S Afr J Criminal Justice* 2: 196. See also Campbell T "Euthanasia as a human right" 447-459 in *First do no harm: Law, ethics and healthcare* ((ed) McLean SAM) (2006); Slabbert M & Van der Westhuizen C "Death with dignity in lieu of euthanasia" 2007 22 *SAPL* 2: 366-384.

<sup>125</sup> The word "euthanasia" originates from the Greeks, where it means "a good death" or "dying well". Passive euthanasia is the intentional allowing of a person to die (for their sake). Active euthanasia is the intentional killing of a person (for their sake). Voluntary euthanasia (whether active or passive) is where the physician performs the death-causing act after determining that the patient indeed wishes to end his or her life. Involuntary euthanasia is contrary to the expressed wish

modern times brought these issues to the fore: First, the apparently limitless capability of modern medicine to sustain life artificially and secondly, the increasing importance that is attached to patient autonomy (selfbeskikkingsreg).<sup>126</sup> These factors have resulted in large-scale use by many individuals of a document known as "the living will".

Carstens<sup>127</sup> explains that the controversial legal and often emotional public debates with regard to the possible legalisation of euthanasia in South Africa, have increasingly gained momentum over the last decade since the advent of the Constitution. The reason is that the right to dignity (section 10), the right to life (section 11), the right to freedom and security of the person (section 12) and the right to privacy (section 14), as foundational cross-currents to the debate, have all been entrenched in the Bill of Rights. Advocates for the legalisation of assisted suicide have sought to permit the practice only under highly limited circumstances, namely, when the requesting patient is terminally ill.<sup>128</sup> Pivotal to the euthanasia debate is the content to be afforded to the right to life, in context of what is to be regarded as the "quality of life" and to what extent patient autonomy and the right to self-determination may be influential to request a physician to end a life which is "not worth living" on account of terminal illness. In this regard, O Regan J, in *Makwanyane*,<sup>129</sup> remarked as follows:

[T]he right to life is, in one sense, antecedent to all other rights in the Constitution. *Without life in the sense of existence, it would not be possible to exercise rights or to be the bearer of them.* But the right to life was included in the Constitution not simply to enshrine the right to existence. It is not life as mere organic matter that the Constitution cherishes, *but the right to*

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of the person who dies, for example, he or she wishes to continue living. Non-voluntary euthanasia occurs without the express request of the person who dies, either because he or she is not asked what his or her wish is, or because he or she is unable to give an answer to this question - perhaps because he or she is comatose, infantile, senile or in some other way incompetent to state a wish, for example a severely mentally disordered patient. Neither of these terms apply to what is sometimes called "indirect euthanasia", when the administration of drugs primarily for pain relief may have the secondary effect of causing death, as the physician is well aware. This practice, too, is ethically and legally sanctioned. The term "physician assisted suicide" applies to cases where a person brings about their own death, but with the assistance provided by a doctor, for example, by using lethal drugs supplied by the doctor. See McLean GR "Euthanasia: A problem for psychiatrists" 2004 200 *S Afr Psychiatry Rev* 7: 10.

<sup>126</sup> See also the discussion on patient autonomy below.

<sup>127</sup> Carstens PA & Pearmain DL *Foundational principles of South African medical law* (2007) 200.

<sup>128</sup> Appel JM "A suicide right for the mentally ill? A Swiss case opens a new debate" 2007 37 *Hastings Center Report* 3: 21.

<sup>129</sup> *S v Makwanyane supra* par [326-327]. Cf De Montaigne's writing: "Death is a remedy against all evils: it is a most assured haven, never to be feared, and often to be sought. All comes to a period, whether man makes an end of himself, or whether he endures it. Whether he runs before his day, or whether he expects it. Whence so ever it come, it is ever his own, where ever the thread is broken, it is all there, it's the end of the web. The voluntariest death is the fairest. Life dependeth on the will of others, death on ours." See De Montaigne M *The Essayes of Michael Lord of Montaigne* (1908) 27.

*human life: the right to share in the experience of humanity.* This concept of human life is at the centre of our constitutional values. The Constitution seeks to establish a society where the individual value of each member of the community is recognised and treasured. The right to life is central to such a society. The right to life, thus understood, incorporates the right to dignity. So the rights to human dignity and life are entwined. The right to life is more than existence, it is a right to be treated as a human being with dignity: without dignity, human life is substantially diminished. Without life, there cannot be dignity. (Own emphasis.)

Since serious mental disorders could make life seem as unbearable to some patients as serious illness do to others, the question remains of whether those mentally disordered patients who repeatedly expressed a wish to end their lives should be permitted to do so. Should euthanasia and assisted suicide be transformed from what is now a crime into a sacred "right to die"? Should euthanasia and assisted suicide be defined as a legitimate form of "medical treatment" that is readily available to all persistently suffering people, including to the mentally disordered person?

Both supporters and opponents of euthanasia and assisted suicide have been highly critical of extending suicide rights to psychiatric patients.<sup>130</sup> One set of objections is directed against the practice of assisted suicide itself - for a host of reasons ranging from a belief in the inherent sanctity of human life to a fear of sliding down a slippery slope toward involuntary euthanasia. Another set of objections are from those who support a basic right to assisted suicide in certain situations, such as those of terminal disease, but do not wish to extend it to cases of severe and incurable mental disorders. This resistance may be inevitable, considering the increased emphasis that contemporary psychiatry places on suicide prevention, but the principles favouring legal assisted suicide lead logically to the extension of these rights to some mentally disordered patients.<sup>131</sup>

In terms of reported case law in South Africa, it is clear that apart from voluntary passive euthanasia, in cases of patients who are in a persistent vegetative state, all other forms of euthanasia, for example,

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<sup>130</sup> The Independent: Russell B & Firth M "Swiss clinic wants to offer assisted suicide to the mentally ill" 2006 <http://www.independent.co.uk/news/uk/politics/swiss-clinic-wants-to-offer-assisted-suicide-to-the-mentally-ill-416897.html> (Date of access: 09 May 2009).

<sup>131</sup> Appel uses the following example: "Obviously, there is a difference in kind between the terminally ill cancer patient and the acutely depressed teenager who transiently desires to end his life after a romantic setback; it seems logical to prevent patients from committing suicide until they have considered all of their options over an extended period of time, and to be certain that they are not acting in haste. But the difference between a patient who desires suicide after enduring the long-term agonies of rheumatoid arthritis or trigeminal neuralgia and the patient who wants to end his life after years of debilitating anxiety or intermittent psychotic episodes is not so clear. See Appel 2007 *Hastings Center Report* 21.

voluntary or involuntary active euthanasia, involuntary passive euthanasia and assistance to suicide, will be unlawful and will render a physician who performed such forms of euthanasia, liable of either murder, attempted murder or culpable homicide, depending on the circumstances. These instances (albeit performed with a noble motive), at most, will lead to mitigation of sentence.<sup>132</sup> The first decision of a division of the South African Supreme Court on the "right to die" was handed down in July 1992 in the case of *Clarke v Hurst*.<sup>133</sup> It is a landmark judgment which has clarified several major legal issues relating to the withdrawal of life-sustaining treatment in a case of terminal illness and, particularly, in cases of patients who are in a persistent vegetative state.<sup>134</sup>

Frederick Cyril Clarke (a well-known medical practitioner and politician), suffered a sudden drop in blood pressure and went into cardiac arrest. His heartbeat and breathing ceased. Resuscitative measures were instituted but by the time that his heartbeat and breathing were restored, he had suffered serious and irreversible brain damage due to prolonged deprivation of oxygen to the brain. Dr Clarke became deeply comatose and remained in that condition. He was fed artificially by means of a naso-gastric tube. Because of his inability to swallow, nasal secretions tended to flow down his trachea into his lungs. In order to maintain respiration unimpeded and to prevent infection, excess secretions were removed by suction several times a day. A plastic tube passed through a tracheotomy opening in the trachea into his lungs. A suction machine was used to expel the excess fluid from the lungs. Dr Clarke was in a persistent vegetative state. There was no prospect of any improvement in his condition and no possibility of recovery. It is important to note that Dr Clarke was a member of the South African Voluntary Euthanasia Society. He signed a living will before his last illness. During his active life he held strong views on the individual's right to die with dignity when living has ceased to be worthwhile and when there is no hope of improvement or recovery. In a public speech delivered in 1983 Dr Clarke said the following:<sup>135</sup>

"I feel sure that the general public gets a certain degree of satisfaction in knowing that if they, by a stroke of misfortune, became cabbages or suffered prolonged and intractable pain where a successful outcome is impossible, no valiant and fruitless endeavours will be instituted by the medical team to prolong intense suffering and anguish and to in fact prolong death."

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<sup>132</sup> Carstens & Pearmain 205-206.

<sup>133</sup> *Clarke v Hurst* NO 1992 (4) SA 636 (D).

<sup>134</sup> Strauss 1993 *S Afr J Criminal Justice* 196 at 201.

<sup>135</sup> See Strauss 1993 *S Afr J Criminal Justice* 196 at 201.

The applicant, the patient's wife, applied to be appointed as *curatrix* to the patient's person with powers in that capacity to:

- Agree to or withhold agreement to any medical or surgical treatment for the patient;
- authorise the discontinuance of any treatment to which the patient was subjected, or to which the patient may in future be subjected, including the discontinuance of any naso-gastric or other non-natural feeding regime or like regime for the hydration of the patient;
- act as set forth in above notwithstanding that the implementation of her decisions may hasten the death of the patient.

The applicant intended to put an end to the artificial feeding regime whereby the patient obtained the necessary sustenance for his bodily functions. She expressed herself as follows:

If the order is granted, I will consult with the medical practitioners with whom my husband will be in custody at the time and give such directions as will ensure that any physical distress which accompanies the removal of the tube is minimised; that being necessary, as I understand it, to preserve the dignity of the relationship between the attending medical staff and my husband and to alleviate the stress on family members. I am of course mindful of the fact that my husband's death will follow the removal of the tube from his stomach. However, I respectfully submit that the removal of the tube will not cause his death. In my respectful submission what will cause my husband's death is the cardiac arrest that occurred on 30 July 1988. Notwithstanding their best efforts and intentions, all that the various medical attendants have been able to do is to suspend the process of death. They did not save my husband's life.

In the judgment of the court, Thirion J commented on Dr Clarke's statement above as follows:

These statements undoubtedly stemmed from a settled, informed and firmly held conviction on [Dr Clarke's] part that should he ever be in the condition in which he has been since the cardiac arrest, no effort should be made to sustain his life by artificial means but that he should be allowed to die.

The Attorney-General of Natal opposed the application on a number of grounds. One of the main grounds of opposition was summed up by the judge as follows:

The discontinuance of the artificial feeding would hasten the patient's death and would thus be a cause<sup>[136]</sup> of it and as the applicant foresees death as a probable result of the discontinuance of the artificial feeding; she would in law be liable for having unlawfully killed the patient.<sup>[137]</sup>

The patient's curator-ad-litem argued as follows:

An adult of full legal competence has, while of sound mind, an absolute right to the security and integrity of his body. In the exercise of that right he is entitled to refuse to undergo medical treatment, irrespective of whether such refusal would lead to his death. ... Where, as in the present case, such a person while he is of sound mind, has directed that should he lapse into a persistent vegetative state with no prospect of recovery, he should be allowed to die and that he should not be kept alive by artificial means, then if he does lapse into such a state, there is no reason why a curator appointed to his person should not have the power to give effect to his direction.

Pearmain<sup>138</sup> argues that medical treatment does not necessarily have the effect of breaking the line of causation between the original injury and the death of a person. Even from the point of view of factual causation,<sup>139</sup> the withdrawal of medical treatment from a person who has suffered mortal injury cannot be

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<sup>136</sup> See the case of *S v Williams* where the court was faced with a situation in which a person was wounded so seriously that the injuries, in the absence of prompt medical intervention, would very soon lead to death. The victim of the crime was kept alive artificially by means of a respirator. She was subsequently taken off the respirator once it had been established that her brainstem was no longer functioning. Her heart and lungs ceased functioning some ten minutes after the ventilator was disconnected. The appellant was sentenced to death for her murder. He appealed on the grounds that the real cause of the victim's death was the disconnection of the respirator. The argument was that a *novus actus interveniens* ("new" intervening act) had occurred to cause her death. The court held that it was not necessary to decide the case on the basis of whether the medical definition of death as being brainstem death must be accepted in law, since it was possible to deal with the matter on the more traditional view of the community that death occurred when there was no longer a heartbeat or respiration. (The trial court found that, according to traditional medical standards, the moment of death is when brainstem death sets in.) It held that the appellant's allegation of a *novus actus interveniens* was unreasonable and unacceptable in that he had given the deceased a wound which, had she not received medical assistance, would have led rapidly to her death. Medical practitioners had done their best to save her. In the process, her life was artificially maintained. When the ventilator was finally disconnected this action was not the cause of her death but rather the termination of a fruitless attempt to save her life. *S v Williams* 1986 (4) SA 1188 (A).

<sup>137</sup> The Attorney-General relied *inter alia* on the two 1975 "mercy-killing" cases of *S v Hartmann* and *S v De Bellocq*, respectively, in which it had been held that an intentional killing is murder even though the killer did not harbour any evil motive. In *S v Hartmann* 1975 (3) SA 532 (C), Dr Hartmann injected his 87 year old father who was suffering from terminal cancer, at his father's request, with an overdose of pentothal, which caused his death. This is clearly a case of voluntary active euthanasia. Dr Hartmann was convicted of murder and sentenced to one year imprisonment, but only detained until the rising of the court. In *S v De Bellocq* 1975 (3) SA 538 (T), De Bellocq killed her own baby. The baby suffered from toxoplasmosis, a condition that severely affected the mental capabilities of the baby and the baby also had a minimal life-expectancy. She was charged with murder. She was found guilty of murder, but the sentence that the court gave was that she could be summoned for sentencing anytime within the following six months. De Bellocq was never summoned to court for sentencing.

<sup>138</sup> Carstens & Pearmain 514.

<sup>139</sup> Where the conduct in question takes the form of a positive act, the question is asked whether, but for the accused's conduct, the consequence in question would not have occurred at all or when it did. If the answer to this question is in the affirmative, then the accused's conduct is a factual cause of the consequence. This question is decided by an application

said to constitute a new intervening cause of the ultimate result. From the point of view of legal causation<sup>140</sup> the argument of a *novus actus interveniens* in, for example, *S v Williams* is clearly wrong, since it would be contrary to the legal convictions of the community and the values of the Constitution to allow a wrongdoer to escape the consequences of such a heinous crime on the basis that medical practitioners tried to save the victim's life but failed. The argument of a *novus actus interveniens* in the context of medical treatment could only succeed if there was convincing evidence that the medical treatment itself precipitated the person's death and that the initial injury would not have had the same result.

Thirion J ruled as follows:

The fallacy of counsel's argument lies in the fact that in our law the curator personae is at all times under a duty to act in the best interests of the patient and not necessarily in accordance with the wishes of the patient; the well-being of the patient being the paramount consideration. In our law the Court would not simply weigh the patient's interest in freedom from non-consensual invasion of his bodily integrity against the interest of the state in preserving life or the belief in the sanctity of human life; nor would it necessarily hold that the individual's right to self-determination and privacy always outweighs society's interest in the preservation of life. Furthermore, in our law a person who assists another to commit suicide<sup>141</sup> may, depending on the circumstances of the particular case, be guilty of murder or culpable homicide.

With regard to wrongfulness, the court seems to have attached most weight to the preservation of life; the best interest of the patient; the patient's autonomy and the wishes expressed by the patient himself when he was still in good health. These were then weighted in a balancing act where no single factor carried absolute weight. The court granted the relief sought by the applicant and ruled that she can refuse nasogastric feeding of Dr Clarke without incurring criminal or delictual liability, even if such action would shorten the life of Dr Clarke.<sup>142</sup>

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of the *conditio sine qua non* test. In *S v Haarmeyer* 1971 (3) SA 43 (A) at 47, Jansen JA said: "... [T]he negligence of the perpetrator must at least be *sine qua non* of the death before there can be any question of liability." For a discussion of factual causation, see Burchell 210-213.

<sup>140</sup> The essence of legal causation lies in policy limits on the extent of liability. In *S v Mokgethi* 1990 (1) SA 32 (A), Van Heerden JA formulated a broad general test of legal causation. Was there a sufficiently close connection between the accused's conduct and the unlawful consequence? See also *S v Daniëls* 1983 (3) SA 275 (A) for a discussion of legal causation.

<sup>141</sup> See the discussion below.

<sup>142</sup> The decision of whether the discontinuance of the artificial nutrition of the patient and his resultant death would be wrongful, depended on whether, judged by the legal convictions of society, (its *boni mores*), it would be reasonable to discontinue the artificial nutrition of the patient. The decision of that issue, the court said, depends on the quality of the life which remains to the patient, for example, the physical and mental status of that life. The evaluation has to be made in relation to the medical procedures which would have to be instituted or maintained to sustain the patient's life. Thirion J

In deciding the case, it is to be noted, that the judge was not prepared to give absolute recognition to an advance directive (for example, in the form of a living will). Strauss<sup>143</sup> explains that the essence of the ruling in *Clarke* is that discontinuance of medical treatment in the circumstances of the case would not be unlawful. The reasoning of the court was as follows: The decision whether the discontinuance of the artificial nutritioning of the patient and his resultant death would be wrongful, depends on whether, judged by the *boni mores* (legal convictions) of our society, it would be reasonable to discontinue such nutritioning. The decision of the issue depends on the quality of life which remains to the patient, for example, the physical and mental status of that life. The evaluation has to be made in relation to the medical procedures which would have to be instituted or maintained to sustain the patient's life. Lupton<sup>144</sup> states that this decision is very influential, especially in the sense that it provided a guideline for medical practitioners and future litigation to the effect that human life amounts to more than mere biological functions but must also be accompanied by both cortical and cerebral functioning.

Taitz<sup>145</sup> states that it is interesting to note the evidence led in *Clarke v Hurst* to the effect that the patient was a life member of the South African Voluntary Euthanasia Society. He had signed a "living will: A document directing that should he in the future contract a terminal illness with no hope of recovery or become permanently unconscious, he must not be kept alive by artificial means but be allowed to die. Taitz points out that Thirion J stated that these statements undoubtedly stemmed from a settled, informed and firmly held conviction on the patient's part that should he ever be in the condition in which he has been

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observed that there were no doubt many whose susceptibilities would be offended at the thought that it could ever be reasonable for those responsible for the care of the disabled patient not to take whatever steps it may be reasonably possible to take to keep the patient alive - regardless of the quality of the life which the patient would have to endure if kept alive. A moment's reflection would however tell one that it happens regularly, especially in the case of the terminally ill, that decisions are taken to allow the patient to die rather than to prolong a life of suffering by taking life-support measures. He said he thought society would have regarded as grotesque the thought that the victim in *S v Williams* should have been kept alive on the ventilator after it had been found that her brain had died. He admitted that this was perhaps the extremist of examples but said it nevertheless showed that the decision whether to undertake or to discontinue life-sustaining procedures involves a balancing exercise. Unlike the deceased in *S v Williams supra*, Dr Clarke was however not brain stem dead. See the discussion in Grové LB *Framework for the implementation of euthanasia in South Africa* (unpublished LLM dissertation, UP, 2007) 67. See also *S v Williams supra*.

<sup>143</sup> Strauss 1993 *S Afr J Criminal Justice* 196 at 203.

<sup>144</sup> Lupton ML "Clarke v Hurst NO, Brain NO & Attorney General Natal (unreported 1992 (N)): A living will, brain death and the best interest of a patient" 1992 5 *S Afr J Criminal Justice* 3: 342. See also Grové *LLM dissertation* 68.

<sup>145</sup> Taitz J "Euthanasia and the legal convictions of society in a South African Context" 1993 110 *SALJ* 3: 440. See also McQuoid-Mason DJ "Pacemakers and living wills: Does turning down a pacemaker to allow death with dignity constitute murder?" 2005 18 *S Afr J Criminal Justice* 1: 24-40.

since the cardiac arrest no effort should be made to sustain his life by artificial means. Nonetheless the judge placed no emphasis on these directions neither did he rule on the validity of the "living will". The reason for this, according to Taitz probably lies in the fact that as yet the "living will" has not been recognised in South African law. An examination of the document shows that it is not a will, nor can it be described as a power of attorney. He states that perhaps at best it may be regarded as a written directive having no force of law.

Strauss<sup>146</sup> states that although the result in Clarke's case is to be applauded, it is respectfully regretted that the court was not prepared to give recognition to the patient's right of autonomy. He submits that there is no legal reason why a person, when still in good health, cannot by way of advance directive refuse medical treatment to be operative at a future stage when, on account of ill-health or injury, he becomes incapable to express his will.

The South African Law Commission, in its *Report on Euthanasia and the Artificial Preservation of Life*<sup>147</sup> recommends the enactment of legislation to give effect to the following principles:

- A medical practitioner may, under specified circumstances, cease or authorise the cessation of all further medical treatment of a patient whose life functions are being maintained artificially while the person has no spontaneous respiratory and circulatory functions or where his brainstem does not register any impulse.
- A competent person may refuse life-sustaining medical treatment with regard to any specific illness from which he or she may be suffering, even though such refusal may cause the death or hasten the death of such person.<sup>148</sup>
- A medical practitioner or, under specified circumstances, a nurse, may relieve the suffering of a terminally ill patient by prescribing sufficient drugs to control the pain of a patient adequately even though the secondary effect of this conduct may be the shortening of the patient's life.
- A medical practitioner may, under specified circumstances, give effect to an advance directive or enduring power of attorney of a patient regarding the refusal of cessation or medical treatment or

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<sup>146</sup> Strauss 1993 *S Afr J Criminal Justice* 196 at 208.

<sup>147</sup> *Report on Euthanasia and the Artificial Preservation of Life* (1998) RP 186/1999 ISBN 062129831X.

<sup>148</sup> See the discussion under s 15 of the Constitution.

the administering of palliative care, provided these instructions have been issued by the patient while mentally competent.

- A medical practitioner may under specified circumstances, cease or authorise the cessation of all further medical treatment with regard to terminally ill patients who are unable to make or communicate decisions concerning their medical treatment, provided that his or her conduct is in accordance with the wishes of the family of the patient or authorised by a court order.

An analysis of the draft Bill (to regulate end-of-life decisions and to provide for matters incidental thereto), proposed by the South African Law Reform Commission, is indicative of the fact that no definite recommendation is made regarding active voluntary euthanasia - instead, three options are proposed in this regard: a) confirming the present legal position which sanctions active voluntary euthanasia; b) regulating the practice of active voluntary euthanasia by legislation, permitting a medical practitioner to give effect to the request of a terminally ill person, but mentally competent person to end unbearable suffering; or c) regulating the practice of active euthanasia by legislation conferring the final decision on a panel or committee to decide on set criteria. In addition, the South African Law Reform Commission recommended that a so-called "Living Will" should be legally recognised insofar as it requests a passive form of cessation of life and is drafted by a competent person who foresees the possibility that he or she may, as a result of physical or mental disability, be unable to make rational decisions as to his or her medical treatment and care.

Burchell and Carstens correctly state that the recommendation of the South African Law Reform Commission that a "Living Will" should be legally recognised, gains even more substance in the light of the emphasis in the Constitution on human dignity and patient autonomy.<sup>149</sup>

While the window of opportunity for discovering effective treatment may be longer in cases of chronic mental disorders, it seems reasonable to afford the patient the same choice in balancing likelihoods against other values. And if the offer is that an effective treatment may eventually be found, but a person will have to suffer for some decades more until that happens, then it might still be rational to prefer suicide. An important concern in cases of mental disorder is that of the competence of the decision-maker. It is clear

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<sup>149</sup> Burchell 328; Carstens & Pearmain 209.

that patients who experience psychosis or are incapable of making general medical decisions should not be able to take their own lives until they can think rationally.<sup>150</sup>

Furthermore, the finality of a life-terminating decision indicates that a higher threshold of competence should be required in suicide cases than in more run-of-the-mill health care choices. When a desire to die is considered, the issue of whether the person making the decision is competent to do so is significant. The principle of autonomy, integral to a free society, requires that a person's decisions regarding their own life should be respected wherever possible. However, only the products of the "sound mind" of an adult are generally considered competent and given the status of autonomous decisions. But one can be both deeply depressed and capable of making rational decisions. If the values championed by assisted suicide advocates are maximisation of autonomy and minimisation of suffering - even when they conflict with the extension of life - then it follows that chronically depressed, competent individuals would be ideal candidates for the procedure.<sup>151</sup>

In *S v Nkwanyana*,<sup>152</sup> the accused who was not a doctor, shot and killed the deceased, a woman suffering from anorexia nervosa and psychiatric illness, at her request. She told the accused that she tried to kill herself on several occasions, but unsuccessfully. She also told him that she had suffered enough. The accused was convicted of murder on the basis that a person cannot consent to his or her own death,<sup>153</sup> but was given a suspended sentence. It is submitted by Pearmain<sup>154</sup> that the fact that the accused in this case was very leniently sentenced despite his conviction to a serious crime, is indicative of the difficulties experienced by the courts with euthanasia. The legality of the criminalisation of euthanasia might very well be questioned with reference to the "non-sentences" imposed. Strauss<sup>155</sup> refers to "criminal non-law" in this context.

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<sup>150</sup> Appel 2007 *Hastings Center Report* 21 at 22.

<sup>151</sup> Burgess S & Hawton K "Suicide, euthanasia and the psychiatrist" 1998 5 *Phil, Psychiatry & Psychology* 2: 113 at 120.

<sup>152</sup> *S v Nkwanyana* 2003 1 SA 303 (W). See also *S v Smorenburg* (1992) 2 SACR 289 (C). The accused (a nurse) attempted on more than one occasion to end the lives of patients who were terminally ill. She was charged with attempted murder. The accused's motive was to end the patients' suffering or to put an end to the patients' useless existence. The accused was found guilty as charged but sentenced to only three months imprisonment, which was suspended in its entirety. Again, this is a very lenient sentence imposed by the court.

<sup>153</sup> See *S v Robinson* 1968 (1) SA 666 (A). In this case, Robinson paid the accused to shoot him in order that his wife can benefit from insurance policies on his life. The accused shot Robinson and was convicted of murder. The fact that Robinson wanted and arranged to be killed does not in law exclude the criminal responsibility of the accused for the murder he committed. It was decided that a man cannot ordinarily consent to the infliction upon himself of death.

<sup>154</sup> Carstens & Pearmain 206 fn 446.

<sup>155</sup> Strauss SA *Doctor, patient and the law: A selection of practical issues* (1991) 342.

In the case of *Grotjohn*<sup>156</sup> the Appellate Division held that, although suicide is not a crime in South African law, knowingly assisting another to commit suicide nevertheless constituted the factual and legal cause of death, despite the fact that the last act is committed by the non-criminal hand of the person committing suicide. In this case Grotjohn's manic depressive wife wished to commit suicide and made her intention known to him. He handed her a loaded gun and she shot herself. Grotjohn was charged with murder, but acquitted. The Minister of Justice referred the following questions to the Appellate Division: Does a person who instigates, assists or puts another person in a position to commit suicide, commit a crime? The answer to this question is yes. If so, what crime? The court stated that these are not easy questions to answer, but murder, attempted murder or culpable homicide are crimes that could potentially be committed in these circumstances.

The most compelling argument against extending assisted suicide rights to the mentally ill relates to the role of the psychiatrist and psychologist. Unfortunately, there is at present little guidance for practicing psychiatrists and psychologists faced with ethical dilemmas regarding a patient's wish to die. Psychiatrists and psychologists are trained to prevent suicide. Suicide is an outcome widely regarded by the profession as a failure on their part. This conflict of interest places the psychiatrist and psychologist in the unpleasant bind of choosing between a patient's wish and the standard of care in the field. Psychiatrists might even attempt to avoid treating such rational but chronically suicidal patients in an effort to avoid this decision.<sup>157</sup>

According to Szabo,<sup>158</sup> the concept of autonomy is one that permeates much of psychiatry and is a core component of the principles-based approach to bioethics that informs much of psychiatric decision making. From a psychiatric perspective, the issue of competency is fundamental to decision making. Even those who argue in favour of public policy supporting doctors practising voluntary euthanasia, accept that rational thinking is a central requirement in competence to make end of life decisions. This being the case, respect for autonomy should guide actions. In addition, unqualified acceptance of a right to die raises the spectre of complicity in suicide which is unthinkable. In this regard these public deaths, which are not more

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<sup>156</sup> *Ex parte Minister van Justisie: In re S v Grotjohn* 1970 (2) SA 355 (A). See also *S v Grotjohn* 1970 (2) SA 355 (A).

<sup>157</sup> Appel 2007 *Hastings Center Report* 21 at 23. See also the discussion on the "duty to protect" in chapter 6.

<sup>158</sup> Szabo CP "Public deaths and the right to die" 2005 8 *S Afr Psychiatry Rev* 2: 41.

remarkable than other deaths under such circumstances, have relevance to psychiatry and merit further reflection.

## 5.7 SECTION 28 OF THE CONSTITUTION: THE PROTECTION OF CHILDREN'S RIGHTS<sup>159</sup>

Section 28 sets out a range of rights that provide protection for children, which are additional to the protection they are given by other sections of the Bill of Rights. However, as important as these rights are, children's rights do not have a special status in the Bill of Rights. In *De Reuck v Director of Public Prosecutions*,<sup>160</sup> Epstein AJ held that "a child's best interests<sup>[161]</sup> ... is the single most important factor to be considered when balancing or weighing competing rights and interests concerning children. All competing rights must defer to the rights of children unless unjustifiable." This decision was overruled by the Constitutional Court in *De Reuck v Director of Public Prosecutions*.<sup>162</sup> To say that section 28(2) of the Constitution "trumps" other provisions of the Bill of Rights is "alien to the approach adopted by this Court that constitutional rights are mutually interrelated and interdependent and form a single constitutional value system".<sup>163</sup>

There are currently serious concerns about the placement, treatment and care of children in need of mental health care in South Africa. It is evident that there is a lack of guidelines, protocol and specialised expertise for the treatment of children in psychiatric institutions, leading to practices which are deeply concerning. Incidents of maltreatment and abuse of children admitted to psychiatric institutions are frequently reported.

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<sup>159</sup> S 28 reads as follows: "Every child has the right – (a) to a name and a nationality from birth; (b) to family care or parental care, or to appropriate alternative care when removed from the family environment; (c) to basic nutrition, shelter, basic health care services and social services; (d) to be protected from maltreatment, neglect, abuse or degradation; (e) to be protected from exploitative labour practices; (f) not to be required or permitted to perform work or provide services that – (i) are inappropriate for a person of that child's age; or (ii) place at risk the child's well-being, education, physical or mental health or spiritual, moral or social development; (g) not to be detained except as a measure of last resort in which case, in addition to the rights a child enjoys under sections 12 and 35, the child may be detained only for the shortest appropriate period of time, and has the right to be – (i) kept separately from detained persons over the age of 18 years; and (ii) treated in a manner, and kept in conditions, that take account of the child's age; (h) to have a legal practitioner assigned to the child by the state expense, in civil proceedings affecting the child, if substantial injustice would otherwise result; and (i) not to be used directly in armed conflict, and to be protected in times of armed conflict. (2) A child's best interests are of paramount importance in every matter concerning the child. (3) In this section 'child means a person under the age of 18 years'."

<sup>160</sup> *De Reuck v Director of Public Prosecutions*, Witwatersrand Local Division 2003 (3) SA 389 (W).

<sup>161</sup> See also the discussion under sections 15 and 16 of the Constitution below.

<sup>162</sup> *De Reuck v Director of Public Prosecutions*, Witwatersrand Local Division 2004 (1) SA 406 (CC). See also Currie & De Waal (2005) 600.

<sup>163</sup> *De Reuck supra*.

It has become clear that there are a wide variety of serious systematic problems at psychiatric institutions that require an urgent, holistic and comprehensive solution.

The above systematic problems relate, *inter alia*, to the following:<sup>164</sup>

- The criteria for admitting children in psychiatric institutions as well as the procedures followed for admission;
- whether children admitted to psychiatric institutions for observation are separated from institutionalised children who are receiving care on a continuing long-term basis;
- The staffing of the psychiatric wards, including:
  - Whether staff members are specifically trained to care for children and young people;
  - whether staff members in psychiatric wards are trained to care for children with special needs (such as autistic children); and
  - whether staff members receive continued training on how to care for children with psychiatric and/or special needs.
- The procedures followed by staff when an incident occurs, including:
  - Internal investigations to determine the cause of the incident and the course of action to remedy the situation;
  - disciplinary measures taken by staff to discipline children when they break the rules in a ward or cause an incident; and
  - notification of parents and family of children involved and/or injured in an incident.
- Safety measures to prevent children from absconding from the psychiatric institution and procedures followed by staff when children have absconded from the institution;
- The procedures followed to re-admit children who have absconded from a psychiatric institution, including:
  - Treatment of children by staff members when they are returned to the psychiatric institution;

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<sup>164</sup> Special gratitude is due to the Centre for Child Law, University of Pretoria, for their assistance in identifying these relevant and current issues.

- appropriate measures to manage the behaviour of the children as well as the circumstances in which it would be necessary and appropriate to implement such measures; and
- disciplinary measures for absconding, taken by staff against the children, with specific reference to placing children in seclusion.
- The practice of placing children in seclusion with special reference to the following:
  - Guidelines for the staff and coherence to constitutional provisions on when and under which circumstances children may be placed in seclusion;
  - whether there is a register recording when children are placed in seclusion and if so, what information is entered in the register and whether such information is sufficient.
- The authority of staff to discipline children and the extent of such authority, including which measures are allowed and under which circumstances.

With reference to the matters listed above, the concern arises in South Africa that there are no clear, written policies in place which are adequate and appropriate; and that, to the extent that certain policies are in place, they are not adhered to consistently in practice, and that no measures or insufficient measures are taken when such policies are breached.

Child psychiatry training programmes have further encountered a number of administrative problems resulting from efforts to recognise, without isolating or submerging, the unique aspects of child psychiatry within existing departments of psychiatry. The intention is to question the validity of the concept of general psychiatry, which may be responsible for many of these administrative dilemmas. The author advances that child psychiatry actually represents a distinct field of practice, where training programs for children suffering from mental disorders should be integrated within departments of psychiatry through divisional administrative lines.<sup>165</sup>

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<sup>165</sup> Westman JC "Administrative issues in child and adult psychiatry training programs" 1978 8 *Child Psychiatry & Human Dev* 4:195.

In terms of section 9 of the Children's Act,<sup>166</sup> the care, protection and well-being of a child in all matters concerning the standard that the child's best interest is of paramount importance, must be applied.

The Ethical Code of Professional Conduct to which a Psychologist shall adhere also safeguards the rights of children and stipulates that: "A psychologist shall be cognisant that a child's best interests are of paramount importance in every professional matter concerning direct or indirect psychological services to children."<sup>167</sup> Further, a psychologist must take special care when dealing with children fourteen years of age and younger,<sup>168</sup> and must at the beginning of a professional relationship, inform a child or a client who has a legal guardian or who is otherwise legally dependent, of the limits the law imposes on the right of confidentiality with respect to his or her communications with such psychologist.<sup>169</sup>

## 5.8 SECTION 12(2) OF THE CONSTITUTION: FREEDOM AND SECURITY OF THE PERSON<sup>170</sup>

Section 12(2)(a) and section 12(2)(b) read:

Everyone has the right to bodily and psychological integrity, which includes the right –  
(a) to make decisions concerning reproduction;  
(b) to security in and control over their body ...

Section 12 combines a right to freedom and security of the person with a right to bodily and psychological integrity, where section 11(1) of the interim Constitution stated that: "Every person shall have the right to freedom and security of the person, which shall include the right not to be detained without trial".<sup>171</sup> Chaskalson P held in *Ferreira v Levin*<sup>172</sup> that the primary purpose of section 11(1) was to ensure the

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<sup>166</sup> The Children's Act 35 of 2008 (hereafter referred to as the Children's Act). It is important to note that the Child Care Act 74 of 1983 (hereafter referred to as the Child Care Act) will soon be repealed by the Children's Act. Only certain provisions of the Children's Act are in operation as yet. Therefore the Child Care Act is still applicable in certain circumstances. The following provisions of the Children's Act came into operation on 1 July 2007: SS 1-11; 13-21; 27; 30-31; 35-40; 130-134; 305; 307-311; 313-315.

<sup>167</sup> S 29(1).

<sup>168</sup> S 29(2).

<sup>169</sup> S 29(3).

<sup>170</sup> For the purposes of this discussion focus is placed on s 12(2). This is the section that deals with reproduction, consent and bodily integrity that is applicable to mentally disordered patients.

<sup>171</sup> Currie & De Waal 292.

<sup>172</sup> In *Ferreira supra*, Ackerman J proposed a "broad and generous" reading of subsection 11(1). He held that the section should be read disjunctively. It protected a "right to freedom" and a separate "right to security of the person". The argument Ackerman J put forward was that the "right to freedom" was a constitutional protection of a sphere of individual liberty. He further said: "I would ... define the right to freedom negatively as the right of individuals not to have obstacles

protection of the physical integrity of the individual. The right therefore protects a right to physical liberty and a right to physical security. He conceded: "This does not mean that we must construe section 11(1) as dealing only with physical integrity. The subsection may protect more than this. The new section 12(1) is more specific in its formulation and the debate is unlikely to be re-opened."<sup>173</sup>

### 5.8.1 Section 12(2)(a): Decisions concerning reproduction

The specific inclusion of the right to make decisions concerning reproduction is the recognition that the power to make decisions about reproduction is a crucial aspect of control over one's body.<sup>174</sup> The converse to the positive aspect of reproductive health care is contraception, sterilisation and ultimately abortion. The right to be sterilised like the right to be artificially inseminated is based rather more upon the right to freedom and security of the person than the section 27(1) right to reproductive care, since if one accepts that a person has a right to security in and control over their own body as stated in section 12(2)(b), then the question of whether or not they have a right to medical procedures for the purpose of sterilisation is in principle resolved and it becomes merely a question of the available resources of the state as to whether or not a person can undergo a sterilisation procedure.<sup>175</sup> The section 10 right to human dignity can also have a bearing on the issue of sterilisation especially in the case of mentally disordered patients.

Pearmain<sup>176</sup> explains that the sterilisation of persons under the age of eighteen years is a loaded topic and the issue of the sterilisation of the mentally disordered person is even more so. When a mentally disordered person under the age of eighteen years presents with a problem that can be resolved through sterilisation, health professionals start to get uncomfortable. The Sterilisation Act<sup>177</sup> is currently being amended so as to make it clear that while the reproductive rights of mentally disordered persons under the age of eighteen years must be respected and protected, their other constitutional rights, such as the right to human dignity and psychological integrity, must also be taken into consideration when the question of their sterilisation arises.

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to possible choices and activities ... placed in their way by ... the State". His interpretation of the right was rejected by the majority of the Constitutional Court.

<sup>173</sup> *Ferreira supra*.

<sup>174</sup> Currie & De Waal 308.

<sup>175</sup> Carstens & Pearmain 185.

<sup>176</sup> *Ibid*.

<sup>177</sup> The Sterilisation Act 44 of 1998 (hereafter referred to as the Sterilisation Act).

The age issue is one that often arises as a threshold in law. It is relevant as such in the health care context *inter alia* in terms of the Sterilisation Act which is currently in the process of amendment.<sup>178</sup> Section 2 of the current Act provides that:

- (1) No person is prohibited from having sterilisation performed on him or her if he or she is-
  - (a) capable of consenting; and
  - (b) 18 years or above.
- (2) A person capable of consenting may not be sterilised without his or her consent.
- (3) (a) Sterilisation may not be performed on a person who is under the age of 18 years except where failure to do so would jeopardize the person's life or seriously impair his or her physical health.

The objectives of the Sterilisation Amendment Bill are as follows:

- To amplify the definition of sterilisation so as to include any act or procedure that renders a person incapable of fertilisation or reproduction. The current definition refers to "surgical procedures" that exclude procedures such as hysterectomy if it is for medical reasons other than where a person's physical health is being jeopardised;
- to qualify "consent" as contained in section 4, with an informed consent, so as to obligate the providers to fully explain the procedure and potential or actual consequences of sterilisation;
- to allow sterilisation of a person under the age of eighteen years in circumstances where his or her health is being threatened; health in this regard includes both physical and mental health, as opposed to only physical health as is the case in the current Act;

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<sup>178</sup> See the Sterilisation Amendment Bill [B 12 - 2004] (hereafter referred to as the Sterilisation Amendment Bill). The Sterilisation Amendment Bill is precipitated by the Constitutional problem regarding the right of a person not to be discriminated against on the basis of age, amongst other things. The current Act does not allow a person to be sterilised where such a person is under the age of 18 years and does not fall within the ambit of s 2 or 3 of the Act. The Act defines sterilisation as a surgical procedure and does not allow any non-surgical procedures. The Western Cape Department of Health was recently ordered by the High Court to approve a sterilisation procedure on a person under the age of 18 years, who is severely mentally disabled and who could not understand or acknowledge her own physical condition. The panel contemplated by s 3(2) of the Act had declined the request for sterilisation on the basis that the Act expressly stated that sterilisation can be allowed where the physical health of a person (who is under the age of 18 years) is jeopardised, and not on the grounds of his or her mental health. This Bill, *inter alia*, aims to address those situations, by affording rights where they are due. The Bill was published for public comment on 4 September 2003 in Notice 2303 in GG 25415. In the case of *Doctors for Life v Speaker National Assembly*, the Bill was placed on hold for 18 months to allow for public participation and consultation. See *Doctors for Life v Speaker National Assembly* 2006 (6) SA 416 (CC).

- to enable a parent, guardian, primary care-giver, medical practitioner or the court, to give consent in circumstances where sterilisation will be in the best interest of the person concerned;
- to ensure that the opinion of an independent medical practitioner, who previously consulted with the person to be sterilised, is taken into consideration by the panel. This will ensure that not only the rights of the care-giver are considered by the panel, but the personal circumstances of the mentally disabled person as determined by the said medical practitioner;
- to ensure that the panel contemplated in section 3 must consider factors such as age, mental and physical wellbeing and whether it is in the best interest of the person concerned when dealing with a request for sterilisation of a person under eighteen years of age and where such person is incapable of consenting; and
- to amplify the purport of informed consent contemplated in subparagraph (2) above to ensure that where a person is capable of consenting, he or she must have fully understood the procedure of sterilisation before signing the consent form.

The Department of Health and the State Law Advisers are of the opinion that the Bill must be dealt with in accordance with the Parliamentary procedures established by section 76 of the Constitution,<sup>179</sup> since it falls within a functional area listed in schedule 4 to the Constitution, namely "health services".

According to Pearmain,<sup>180</sup> subsection (2) of the Sterilisation Act is not entirely in keeping with subsection (1)(b), which although it separates the capacity to consent from age, still imposes the age of eighteen as a threshold. The peculiar phrasing of subsection (1) suggests that where a person is capable of consenting but is under the age of eighteen years, sterilisation of that person is prohibited. However such prohibition must be inferred from section 2(1) of the Act itself since there is no other legal prohibition or provision with regard to sterilisation either in the Act or outside of it. Pearmain submits that this subsection on its own could be in conflict with the constitutional right of a minor to bodily and psychological integrity given the arguments raised by the court in the second *Christian Lawyers*<sup>181</sup> case.

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<sup>179</sup> According to s 76(3): "A Bill must be dealt with in accordance with the procedure established by either ss (1) or ss (2) if it falls within a functional area listed in Schedule 4 or provides for legislation envisaged in any of the following sections: (a) Section 65(2); (b) section 163; (c) section 182; (d) section 195(3) and (4); (e) section 196; and (f) section 197."

<sup>180</sup> Carstens & Pearmain 101.

<sup>181</sup> In this case the plaintiff instituted an action in which it sought an order declaring ss 5(2) and 5(3) read with the definition of "woman" in ss 1 and 5(1) of the Choice On Termination of Pregnancy Act 92 of 1996 (hereafter referred to as the

According to the decision of the court in this case, where a person is capable of informed consent, this should be sufficient grounding for a right to be sterilised irrespective of the age of the person being sterilised. Sterilisation, like termination of pregnancy, is an exercise of a reproductive right and the right to security in and control over one's body in terms of section 12(2) of the Constitution. Subsection (2) of section 2 of the Act could be read as taking the principle in subsection (1) a step further in saying that a person capable of consenting may not be sterilised without his or her consent. Thus where a person is either over the age of eighteen or under the age of eighteen, where he or she is capable of consenting, sterilisation may not take place without his or her consent. In this sense it is partially redemptive of subsection (1) because the latter gives everyone who is over eighteen years of age and capable of consenting a right to be sterilised but does not address the converse which is the right of persons capable of consenting but under the age of eighteen years *not* to be sterilised. It is only partially redemptive because the right to be sterilised in terms of subsection (1) is still age restricted even where a person is capable of consenting. It therefore limits the right to sterilisation for those persons who are under eighteen years of age and capable of consenting. Since the right to make reproductive decisions and to security in and control over one's body are constitutional rights, it remains to be seen whether this provision constitutes a limitation of a constitutional right falling within the ambit of section 36(1) of the Constitution. There is an argument that sterilisation from the point of view of the right holder – especially in the case of women - is generally of a more permanent nature than the termination of a pregnancy. A person who terminates one pregnancy can usually still decide to have another pregnancy, but a person who is sterilised cannot always be sure that the procedure can be reversed should he or she have a change of heart later on. Children and young people have the whole of their reproductive lives ahead of them and the question is whether, as a matter of policy, they should be allowed to be sterilised where they are capable of consenting but younger than eighteen years of age. Whilst the inclination of many is likely to be that this should not be

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Choice on Termination of Pregnancy Act) to be unconstitutional and an order striking down ss 5(2) and 5(3) and the definition of "woman" in s 1 of the Act. The provisions of the Act against which the plaintiff's claim was directed are those that allow women under the age of 18 years to choose to have their pregnancies terminated without: (a) The consent of the parents or guardians; (b) consulting the parents or guardians; (c) first undergoing counselling; and (d) reflecting on their decision or decisions for a prescribed period. The measures in (a) to (d) are collectively referred to as parental consent or control. In principle, the plaintiff's case was that young women or girls below that age are not capable on their own (without parental consent or control) to take an informed decision as to whether or not to have a termination of pregnancy which serves their best interests. In order to succeed, the plaintiffs had to establish that the relevant provisions of the Act were in conflict with those of the Constitution. See *Christian Lawyers Association of South Africa v Minister of Health* case no 7728/2000 (TPD).

permitted, the question is if the person is capable of informed consent, why should he or she be denied this choice simply on the basis of age? What is the difference between a mature seventeen year old child who wants to be sterilised and is fully capable of informed consent and a highly immature eighteen year old who is barely capable of informed consent? Perhaps the distinction is that in terms of section 28(3) of the Constitution, a child is defined as a person under the age of eighteen years and section 28(2) stipulates that a child's best interests are of paramount importance in every matter concerning the child. In such a situation it may possibly be argued that a person under the age of eighteen is not capable of knowing what is in his or her best interests even if he or she is capable of giving informed consent.

Pearmain<sup>182</sup> further submits that it is also not in keeping with the concept of administrative justice that rigid criteria such as age limits should be imposed where a large number of factual permutations can occur and not every one of them can be anticipated by legislation. It is a well-established principle of administrative law that each case must be decided on its merits and there is no reason why this principle should not be incorporated into legislation involving minors and the giving of informed consent by them – especially where the right to bodily and psychological integrity is involved.

Section 3 of the Sterilisation Act, which is important in context of mentally disordered patients, stipulates as follows:

- (1) Sterilisation may be performed on any person who is incapable of consenting or incompetent to consent
- (a) upon a request to the person in charge of a hospital and with the consent of a-
  - (i) parent;
  - (ii) spouse;
  - (iii) guardian; or
  - (iv) curator;
- (b) if a panel contemplated in subsection (2) after considering all relevant information, including the fact that –
  - (i) the person is 18 years of age, unless the physical health of the person is threatened; and
  - (ii) there is no other safe and effective method of contraception except sterilisation, concurs that sterilisation may be performed; and
- (c) if the person is mentally disabled to such an extent that such a person is incapable of-
  - (i) making his or her own decision about contraception or sterilisation;
  - (ii) developing mentally to a sufficient degree to make an informed judgment about contraception or sterilisation; and
  - (iii) fulfilling the parental responsibility associated with giving birth.

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<sup>182</sup> Carstens & Pearmain 103.

- (2) The person in charge of a hospital contemplated in subsection (1) must upon request, as prescribed for sterilisation, convene a panel which will consist of –
  - (a) a psychiatrist, or a medical practitioner if no psychiatrist is available;
  - (b) a psychologist or a social worker; and
  - (c) a nurse.
- (3) Where a person to be sterilised is in custodial care, no member of the panel may be an employee of the custodial institution.
- (4) If sterilisation is to be performed in a private health care facility, the members of the panel may not be employees of, or have a financial interest in, that facility.
- (5) The person performing the sterilisation must ensure that the method of sterilisation used holds the least health risk to the person on whom sterilisation is performed.
- (6) Sterilisation may not be performed in terms of subsection (1) unless the person suffers from a severe mental disability.
- (7) For the purposes of this section, "severe mental disability" means a range of functioning extending from partial self-maintenance under close supervision, together with limited self-protection skills in a controlled environment through limited self care and requiring constant aid and supervision, to severely restrained sensory and motor functioning and requiring nursing care.

It is important to note that section 3 does not take the right to psychological integrity referred to in section 12(2) of the Constitution into account in that it refers only to physical health. This section deals specifically with persons who are incapable of consenting to sterilisation. This incapacity is not linked in the Act to mental disability or lack of consciousness due to physical injury or illness. It can therefore also be applied to children who lack capacity simply because of their age. In the case of mentally disabled persons, it may not be relevant at all since persons who are mentally disabled may never achieve legal capacity irrespective of their age. Mental capacity is often indicated or measured in terms of mental or developmental age. Thus an eighteen year old mentally disabled patient's cognitive functions may be pegged at the level of those of a healthy twelve year old. While the mind may not achieve full maturity the body of a mentally disordered person may well reach puberty and be capable of procreation. Indeed one of the primary concerns of the Sterilisation Act when it was first passed was to ensure that unnecessary sterilisation of mentally disordered persons was prohibited since they also have reproductive rights. People, particularly women with mental disorders, have been subjected to forced sterilisations, rape, and other forms of sexual violence, which is inherently inconsistent with their sexual and reproductive health rights and freedoms. Moreover, rape and other forms of sexual violence are psychologically, as well as physically, traumatic; and they negatively impact the right to proper mental health care.<sup>183</sup> It was much easier in the past for parents

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<sup>183</sup> Hunt P & Mesquita J "Mental disabilities and the human right to the highest attainable standard of health" 2006 28 *Human Rts Quarterly* 2: 332 at 343.

and caregivers of such persons to have them sterilised than to worry about sexual activity leading to the birth of an unwanted child. However, on one possible interpretation of section 3, the Act went perhaps too far in the direction of preventing sterilisation of mentally disordered persons under the age of eighteen years insofar as the provisions of this section can be interpreted to mean that disordered persons younger than eighteen years may not be sterilised at all.<sup>184</sup>

With regard to abortion, the Choice on Termination of Pregnancy Act<sup>185</sup> also deals with situations where a woman is severely mentally disabled to such an extent that she is completely incapable of understanding and appreciating the nature or consequences of a termination of her pregnancy, or in a state of continuous unconsciousness and there is no reasonable prospect that she will regain consciousness in time to request and consent to the termination of her pregnancy in terms of section 2. Her pregnancy may be terminated during the first twelve weeks of the gestation period, or from the thirteenth up to and including the twentieth week of the gestation period on the grounds set out in section 2(1)(b), upon request of and with the consent of her natural guardian, spouse or legal guardian, as the case may be, or if such persons cannot be found, upon the request and with the consent of her *curator personae*. However, such pregnancy may not be terminated unless two medical practitioners or a medical practitioner and a registered midwife who has completed the prescribed training course consent thereto.<sup>186</sup>

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<sup>184</sup> Carstens & Pearmain 104.

<sup>185</sup> This Act was promulgated on 1 February 1997. The preamble of the Act recognises the values of human dignity, the achievement of equality, security of the person, non-racialism and non-sexism, and the advancement of human rights and freedoms that underlie a democratic South Africa. It also recognises that the Constitution protects the right of persons to make decisions concerning reproduction, and to security in and control over their bodies. It further states that both women and men have the right to be informed about and have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice; and that women have the right of access to appropriate health care services to ensure safe pregnancies and childbirth. In addition, the Act recognises that the decision to have children is fundamental to a woman's physical, psychological and social health, and that universal access to reproductive health care services includes family planning and contraception, termination of pregnancy, as well as sexual education and counselling programmes and services. The state has the responsibility to provide reproductive health to all, and also to provide safe conditions under which the right of choice can be exercised without fear or harm. Also, the termination of pregnancy is not regarded as a form of contraception or population control, and the Act promotes reproductive rights and extends freedom of choice by affording every woman the right to choose whether to have an early, safe and legal termination of pregnancy according to her individual beliefs. For a discussion of whether the embryo is a bearer of constitutional rights (which falls outside the scope of this thesis), see *Christian Lawyers Association of South Africa and Others v Minister of Health and Others* 1998 (4) SA 1113 (T); (1998) 11 BCLR 1434 (T). For further reading, see Lupton ML "The legal status of the embryo" 1988 *Acta Juridica* 197-215; Lupton ML "The legal position of cryopreserved human embryos" 1992 *TSAR* 3: 466-474; Lupton ML "Does the destruction of a blastocyst constitute the crime of abortion" 1985 102 *SALJ* 1: 92-102. See also in general, Slabbert MN *The human embryo and foetus: Constitutional and other legal issues* (unpublished LLD thesis, Unisa, 2000) at Part III.

<sup>186</sup> S 5(4).

Two medical practitioners or a medical practitioner and a registered midwife or registered nurse who has completed the prescribed training course may consent to the termination of the pregnancy of such a woman in the following circumstances: During the period up to and including the twentieth week of the gestation period if the continued pregnancy would pose a risk of injury to the woman's physical or mental health; or there exists a substantial risk that the fetus would suffer from a severe physical or mental abnormality; or after the twentieth week of the gestation period if the continued pregnancy would endanger the woman's life; would result in a severe malformation of the fetus; or would pose a risk of injury to the fetus. This may only be done after consulting her natural guardian, spouse, legal guardian or *curator personae*, as the case may be; provided that the termination of the pregnancy shall not be denied if the natural guardian, spouse, legal guardian, or *curator personae*, as the case may be, refuses to consent thereto.<sup>187</sup>

The court in the second *Christian Lawyers*<sup>188</sup> case stated that with regard to the question of the capacity to consent in this context, valid consent can only be given by someone with the intellectual and emotional capacity for the required knowledge, appreciation and consent. Because consent is a manifestation of will, Mojapelo J said that: "Capacity to consent depends on the ability to form an intelligent will on the basis of an appreciation of the nature and consequences of the act consented to." The court further said that: A girl or any woman has the capacity to consent to the termination of her pregnancy and its concomitant invasion of her privacy and personal integrity only if she is "in fact mature enough to form an intelligent will". This might not be possible in the case of a severely mentally disabled woman.

## 5.8.2 Section 12(2)(b): Security in and control over one's body

### 5.8.2.1 Introductory remarks

According to De Waal and Currie, the essence of the right to freedom and security of the person is a right to be left alone. And, at least in relation to one's body, the right creates a sphere of individual inviolability.<sup>189</sup> Section 12(2)(b) has two components: "security in" and "control over" one's body. These components are

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<sup>187</sup> S 5(5). See also Van Oosten FFW "The Choice on Termination of Pregnancy Act: Some comments" 1999 116 *SALJ* 1: 60 at 69-71 for an evaluation and criticism of this particular section of the Choice on Termination of Pregnancy Act.

<sup>188</sup> *Christian Lawyers supra*.

<sup>189</sup> Currie & De Waal 308.

not synonymous. "Security in" denotes the protection of bodily integrity against intrusion by the state and others. "Control over" denotes the protection of what could be called bodily autonomy or self-determination<sup>190</sup> against interference. The former is a component of the right to be left alone in the sense of being left unmolested by others. The latter is a component of the right to be left alone in the sense of being allowed to live the life one chooses.<sup>191</sup>

Mill<sup>192</sup> gave eloquent expression to the idea of personal autonomy:

[T]he only purpose for which power can rightfully be exercised over any member of a civilised community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant. He cannot rightfully be compelled to do or forbear because it will be better for him to do so, because it will make him happier, because in the opinions of others, to do so would be wise or even right. These are good reasons for remonstrating with him, or reasoning with him, or persuading him, or entreating him, but not for compelling him, or visiting him with any evil in case he do otherwise. To justify that, the conduct from which it is desired to deter him, must be calculated to produce evil to some one else. The only part of the conduct of any one, for which he is amenable to society, is that which concerns others ... Over himself, over his own body and mind, the individual is sovereign. It is, perhaps, hardly necessary to say that this doctrine is meant to apply only to human beings in the maturity of their faculties ... Those who are still in a state to require being taken care of by others, must be protected against their own actions as well as against external injury.

Decisions made about the health care of mentally ill patients is permeated by the need to strike the appropriate balance between two dimensions of the obligation to show respect for persons, and respect for the wishes of the person. As Harris<sup>193</sup> states:

The problem for all who care about others is how to reconcile respect for the free choices of others with real concern for their welfare when their choices appear to be self-destructive or self-harming. One sort of comprehensive self-harming preference...is that exhibited by a refusal to consent to treatment which would be beneficial, or by an inability to consent.

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<sup>190</sup> In *Phillips v De Klerk*, the right of an individual to dispose over one's own body, in so far as that right is not in conflict with the overriding social interest, was recognised. In the absence of an overriding social interest, the mentally competent individual's right to control his own destiny in accordance with his own value system, his "selfbeskikkingsreg", must be rated even higher than his health and life. Strauss respectfully submitted that the decision must be welcomed. See *Phillips v De Klerk* 1983 TPD (unreported). See also Strauss *Doctor, patient and the law* 30, 31.

<sup>191</sup> Currie & De Waal 308.

<sup>192</sup> Mill *JS On liberty* (1859) 22-23. See also Strauss *Doctor, patient and the law* 31-32.

<sup>193</sup> Harris J "Profession responsibility and consent to treatment" in *Consent and the incompetent patient: Ethics, law and medicine* ((eds) Hirsch SR & Harris J) (1988) 37-47 at 39-42 as published in Fennell P "Inscribing paternalism in the law: Consent to treatment and mental disorder" 1990 17 *J L & Soc* 1: 29.

Nowhere is the tension between autonomy and paternalism more evident than in relation to the treatment of mentally disordered patients. On the one hand is the need to limit the power of mental health professionals, and on the other hand is the right of patients and respecting their autonomously expressed wishes. Also important is the concept of "medicalism" which stresses the need to ensure that the safeguards for patients' individual rights are not so cumbersome that they impede medical interventions aimed at serving those same patients' best interests. In the last decade, the debates have become more refined, especially on the side of the legalists, who are increasingly emphasising the entitlement of patients to be free from discrimination, and to have adequate treatment and support services.<sup>194</sup>

Over time, a mentally disordered individuals' right of choice to make personal health care decisions has been recognised, enhanced and accepted with much deference. The personal autonomy, however, is not without limits and should a state have an interest, and narrowly defines such interest(s), it may be able to demonstrate a compelling interest that will supercede an individual's right to autonomy. The state may act under its *parens patriae* powers to protect the innocent and vulnerable, including from medically-acknowledged and *bona fide* health risks and treatments, but it can not exclude due process.<sup>195</sup>

Consulting psychiatrists are frequently asked to assess a patient's competency, but the definition of competency varies widely depending on the circumstances. From a legal perspective, adults are presumed competent until proven otherwise, and the determination of incompetency requires a court's decision. Although the term "competency" is widely used in the clinical setting, physicians cannot technically "declare" an individual "incompetent". What a clinician can determine, is lack of decisional capacity. Competency is situation-specific, but its elements include the awareness and understanding of the illness and proposed intervention, appreciation of available alternatives, the ability to communicate a choice regarding intervention, and a rational process for deciding. Cognitive disorders can reduce all these elements, while other psychiatric disorders primarily affect rational decision-making. Mental disability, whether in mentally impaired psychiatric patients or psychiatrically impaired medically ill patients, does not automatically render a person incompetent to all decisions. Instead, the patient must be examined to

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<sup>194</sup> Fennell 1990 *J L & Soc* 29-30.

<sup>195</sup> Selected works of Mike Jorgensen: Jorgensen ME "Is today the day we free electroconvulsive therapy?" 2008 *ExpressO* Electronic publishing [http://works.bepress.com/mike\\_jorgensen/1](http://works.bepress.com/mike_jorgensen/1) (Date of access: 09 May 2009).

determine whether he or she is capable of making a particular decision. However, in many countries, proxy consent in the patient lacking decision-making capacity is prohibited when the patient is actively refusing treatment or for specific types of treatment (for example, psychiatric treatment, electroconvulsive therapy and psychosurgery).<sup>196</sup> The concept of involuntary treatment is further discussed in chapter 6.

### 5.8.2.2 *Electroconvulsive therapy*

There had been times when I'd wandered around in a daze for as long as two weeks after a shock treatment, living in that foggy, jumbled blur which is a whole lot like the ragged edge of sleep, that gray zone between light and dark, or between sleeping and waking or living and dying, where you know you're not unconscious any more but don't know yet what day it is or who you are or what's the use of coming back at all - for two weeks.<sup>197</sup>

When electroconvulsive therapy is mentioned in conversation it invokes strong reactions from scientists and laypeople alike. A swirl of controversy has always surrounded the use of shock treatment. Electroconvulsive therapy has undergone many changes since its creation in the early 1930's in Europe.<sup>198</sup> However, despite scientific innovations and legislative actions, South Africa and many other countries are not sufficiently protecting the mentally disordered patient's constitutional right to refuse such an invasive and controversial treatment.

The use of electroconvulsive therapy is not a highly regulated and legislated treatment in South Africa. Up until the introduction of the Mental Health Care Act, legislation and monitoring of the use of electroconvulsive therapy in South Africa had been conspicuous by its absence. Fortunately, the Mental Health Care Act has a potential impact on the practice of electroconvulsive therapy in a variety of ways. One of the major limitations of electroconvulsive therapy is the neurocognitive side-effects that accompany its administration. However, with recent research on the effects of changes in electrode placement and dosing strategies, it is possible to minimise these side effects in the majority of patients. Despite these recent advances in the practice of electroconvulsive therapy, it should remain a highly regulated and

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<sup>196</sup> Appelbaum PS & Grisso T "Capacities of hospitalised medically ill patients to consent to treatment" 1997 38 *Psychosomatics* 2:119-125.

<sup>197</sup> Kesey K One flew over the cuckoo's nest (2002) 249.

<sup>198</sup> Newell ER "Competency, consent, and electroconvulsive therapy: A mentally ill prisoner's right to refuse invasive medical treatment in Oregon's criminal justice system" 2005 9 *Lewis & Clark L R* 4: 1019 at 1022.

legislated treatment modality in South Africa. According to Segal and Thom,<sup>199</sup> it has been shown that the more legislated the procedure becomes the less frequently it is used. Their argument is that paternalistic psychiatrists are conducting electroconvulsive therapy on patients whose rights they are violating, by utilising inadequate procedures for obtaining informed consent, thus undermining autonomy. This treatment is also potentially harmful thus not adhering to the tenets of non-maleficence. Further, the increasing risk of litigation in the field of medicine played a role in the aforementioned phenomenon both as cause and effect. On the contrary, Jorgensen<sup>200</sup> argues that the stigma that electroconvulsive therapy suffered due to prior barbaric type applications in the past are largely historical, and most medical professionals should agree that electroconvulsive therapy is safe today, has very minimal side effects, is not inherently abusive, and no long-term detriments. Yet, with the increase in popularity and the safe applications, electroconvulsive therapy is still treated archaically under certain laws and legislative restraints will cause an indigent, elderly population to be deprived of this useful and sometimes solely effective treatment.

Individuals requiring electroconvulsive therapy fall within groups or categories. The group that is most non-controversial are those who have mental capacity and may either refuse or request electroconvulsive therapy. Such individuals have statutory, common law and constitutional protections of autonomy and self-determination. The more controversial group are those patients who are mentally incapacitated and either refused electroconvulsive therapy, requested electroconvulsive therapy or who have not expressed a decision either way.

In *Rompel v Botha*,<sup>201</sup> Nesor J made the following statement:

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

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<sup>199</sup> Segal J & Thom R "Consent procedures and electroconvulsive therapy in South Africa: Impact of the Mental Health Care Act" 2006 9 *S Afr Psychiatry Rev* 4: 206 at 207.

<sup>200</sup> Jorgensen " [http://works.bepress.com/mike\\_jorgensen/1](http://works.bepress.com/mike_jorgensen/1)

<sup>201</sup> *Rompel v Botha* 1953 (T) unreported, as quoted in Van Oosten *LLD thesis* 47. It is important to note that this case is rather old and shock therapy is now much safer than in 1953.

It is clear from the above that lawful medical interventions require the informed consent of the patient apart from the specific exceptions mentioned above. Therefore, a medical intervention without the required informed consent amounts to a violation of a person's physical integrity, and may amount to criminal assault, civil or criminal *injuria*, or result in an action for damages based on negligence.<sup>202</sup>

Whether in the capacity or incapacity group, each group's autonomy interests should be afforded differently. A group of concern are those patients who were competent, but are now incapacitated. When these individuals enjoyed capacity, they may have either created medical advance directives that did not provide for mental health care decisions or they failed to provide directives at all. The category includes those who may have consented to electroconvulsive therapy before or who may have refused the treatments prior to losing capacity. Procedures are needed, which will protect the vulnerable individuals from the misuse of electroconvulsive therapy and at the same time continue to protect the incapacitated individual's rights and self-determination.<sup>203</sup>

### **5.8.2.3 Institutionalisation of the mentally disordered**

Far from providing a supportive environment, institutional care settings for the mentally disordered are often where human rights abuses occur. This is particularly true in segregated services including residential psychiatric institutions and psychiatric wings of prisons. Persons with mental disorders are often inappropriately institutionalised on a long-term basis in psychiatric hospitals and other institutions. While institutionalised, they may be vulnerable to being chained to soiled beds for long periods of time, violence and torture, the administration of treatment without informed consent, unmodified use of electro-convulsive therapy, grossly inadequate sanitation, and inadequate nutrition. Women are particularly vulnerable to sexual abuse and forced sterilisations. Persons from ethnic and racial minorities are often victims of discrimination in institutions and care systems. A lack of monitoring of psychiatric institutions and weak or nonexistent accountability structures allow these human rights abuses to flourish away from the public eye.<sup>204</sup>

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<sup>202</sup> See the discussion in chapter 6.

<sup>203</sup> Jorgensen [http://works.bepress.com/mike\\_jorgensen/1](http://works.bepress.com/mike_jorgensen/1).

<sup>204</sup> Hunt & Mesquita 2006 *Human Rts Quarterly* 2: 332 at 333.

In terms of the Mental Health Care Act, a health care provider or a health establishment may provide care, treatment and rehabilitation services to or admit a mental health care user only if:

- (a) the user has consented to the care, treatment and rehabilitation services or to admission;<sup>[205]</sup>
- (b) it was authorised by a court order or a review board;<sup>[206]</sup>
- (c) due to mental illness, any delay in providing care, treatment and rehabilitation services or admission may result in the death or irreversible harm to the health of the user; or
- (d) the user can inflict serious harm to himself or herself or others; or cause serious damage to or loss of property belonging to him or her or others.<sup>207</sup>

Any person or health establishment that provides care, treatment and rehabilitation services to a mental health care user or admits the user in circumstances referred to in subsection (1)(c) of the Mental Health Care Act must report this fact in writing in the prescribed manner to the relevant review board;<sup>208</sup> and may not continue to provide care, treatment and rehabilitation services to the user concerned for longer than 24 hours unless an application in terms of Chapter V<sup>209</sup> is made within the 24-hour period.<sup>210</sup>

Chapter V of the Mental Health Care Act regulates voluntary, assisted and involuntary mental health care. Subject to section 9(l)(c), a mental health care user may not be provided with assisted care, treatment and rehabilitation services at a health establishment as an outpatient or inpatient without his or her consent, unless a written application for care, treatment and rehabilitation services is made to the head of the health establishment concerned and he approves it;<sup>211</sup> and at the time of making the application there is a reasonable belief that the mental health care user is suffering from a mental illness or severe or profound mental disability, and requires care, treatment and rehabilitation services for his or her health or safety, or for the health and safety of other people;<sup>212</sup> and the mental health care user is incapable of making an informed decision on the need for the care, treatment and rehabilitation services.<sup>213</sup>

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<sup>205</sup> S 9(1)(a). See further the discussion in chapter 6.

<sup>206</sup> S 9(1)(b).

<sup>207</sup> S 9(1)(c)(i)-(iii).

<sup>208</sup> S 9(2)(a).

<sup>209</sup> Chapter V consists of ss 25-40 of the Mental Health Care Act.

<sup>210</sup> S 9(2)(b).

<sup>211</sup> S 26(1)(a).

<sup>212</sup> S 26(1)(b)(i).

<sup>213</sup> S 26(1)(b)(ii). See also s 25 of the Act, which states that: "A mental health care user who submits voluntarily to a health establishment for care, treatment and rehabilitation services, is entitled to appropriate care, treatment and rehabilitation services or to be referred to an appropriate health establishment."

An application referred to in section 26 may only be made by the spouse, next of kin, partner, associate, parent or guardian of a mental health care user,<sup>214</sup> but where the user is under the age of 18 years on the date of the application, the application must be made by the parent or guardian of the user.<sup>215</sup> If the spouse, next of kin, partner, associate, parent or guardian of the user is unwilling, incapable or not available to make such an application, the application may be made by a health care provider.<sup>216</sup> The applicants referred to in paragraph (a) must have seen the mental health care user within seven days before making the application.

Such application must be made in the prescribed manner, and must set out the relationship of the applicant to the mental health care user;<sup>217</sup> if the applicant is a health care provider, state the reasons why he is making the application;<sup>218</sup> and what steps were taken to locate the relatives of the user in order to determine their capability or availability to make the application;<sup>219</sup> set out grounds on which the applicant believes that care, treatment and rehabilitation services are required;<sup>220</sup> and state the date, time and place where the user was last seen by the applicant within seven days before the application is made.<sup>221</sup>

On receipt of the application, the head of a health establishment concerned must cause the mental health care user to be examined by two mental health care practitioners.<sup>222</sup> Such mental health care practitioners must not be the persons making the application and at least one of them must be qualified to conduct physical examinations.<sup>223</sup> On completion of the examination, the mental health care practitioners must submit their written findings to the head of the health establishment concerned on whether the

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<sup>214</sup> S 27(1)(a).  
<sup>215</sup> S 27(1)(a)(i).  
<sup>216</sup> S 27(1)(a)(ii).  
<sup>217</sup> S 27(2)(a).  
<sup>218</sup> S 27(2)(b)(i).  
<sup>219</sup> S 27(2)(b)(ii).  
<sup>220</sup> S 27(2)(c).  
<sup>221</sup> S 27(2)(d).  
<sup>222</sup> S 27(4)(a).  
<sup>223</sup> S 27(4)(b).

circumstances referred to in section 26(b) are applicable;<sup>224</sup> and the mental health care user should receive assisted care, treatment and rehabilitation services as an outpatient or inpatient.<sup>225</sup>

A mental health care user must be provided with care, treatment and rehabilitation services without his or her consent at a health establishment on an outpatient or inpatient basis if:

- (a) An application is made in writing to the head of the health establishment concerned to obtain the necessary care, treatment and rehabilitation services and the application is granted;<sup>[226]</sup>
- (b) at the time of making the application, there is reasonable belief that the mental health care user has a mental illness of such a nature that the user is likely to inflict serious harm to himself or herself or others; or
- (c) care, treatment and rehabilitation of the user is necessary for the protection of the financial interests or reputation of the user;<sup>[227]</sup> and at the time of the application the mental health care user is incapable of making an informed decision on the need for the care, treatment and rehabilitation services; and is unwilling to receive the care, treatment and rehabilitation required.<sup>[228]</sup>

#### **5.8.2.4 Prevention of crime**

Intrusions on bodily integrity warranting constitutional attention also occur in the context of the investigation or prevention of crime. In *Minister of Safety and Security and another v Xaba*,<sup>229</sup> in the Durban and Coast Local Division, Southwood AJ held that the Criminal Procedure Act did not authorise a police official to use violence to obtain the surgical removal of a bullet from the leg of a criminal suspect for purposes of evidence. In the absence of a law of general application authorising the constitutional infringements of the rights in section 12(1)(b) and section 12(1)(c), the requirements of the limitation clause could not be met. The applicants applied for the confirmation of a rule *nisi*, which would declare the second applicant, a police officer, to be entitled to "use reasonable force, including necessary surgical procedure performed by a medical doctor to remove a bullet lodged in the respondent's thigh, and directing the respondent to subject himself to the procedure, failing which the Sheriff was to furnish the necessary consent on his behalf". It appeared that the respondent was a suspect in a motor-vehicle hijacking case and that the police believed

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<sup>224</sup> S 27(5)(a).

<sup>225</sup> S 27(5)(b). See also ss 27(6)-27(10).

<sup>226</sup> S 32(1)(a).

<sup>227</sup> S 32(1)(b)(i) and (ii).

<sup>228</sup> S 32(1)(c).

<sup>229</sup> *Minister of Safety and Security and another v Xaba* 2004 (1) SACR 149 (D).

the bullet would connect him to the crime. The respondent refused. The applicants relied on section 27 and 37 of the Criminal Procedure Act.<sup>230</sup>

The applicable section of the Constitution, namely section 12, guarantees the right to freedom and security of the person, and the right to bodily and psychological integrity, which includes the right to security and control over one's body. Section 36<sup>231</sup> of the Constitution provides that fundamental rights such as those in section 12 may be limited by a law or general application in certain circumstances. The court held that section 12 would clearly be infringed if the proposed surgery were to take place without the respondent's consent and not under some law limiting its protection as intended in section 36 of the Constitution. The legislature should deal with the issue of striking a balance between the interests of the individual and those of the community in resolving crimes by surgical intervention in cases such as this.<sup>232</sup>

In a similar case, *Minister of Safety and Security v Gaqa*,<sup>233</sup> the applicants applied for an order compelling the respondent to submit himself to an operation for the removal of a bullet from his leg. The applicants alleged that they had reason to believe that the respondent had been shot and injured in the course of an attempted robbery in which two people were killed.

The respondent's counsel argued that the violence envisaged by the applicants would result in several constitutionally guaranteed rights being infringed, including the right to freedom and security of the person, as well as the right to bodily and psychological integrity.<sup>234</sup> The court held that section 27 of the Criminal

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<sup>230</sup> S 27 of the Criminal Procedure Act authorises a police official to use such force as may be reasonably necessary to overcome any resistance against a lawful search of any person or premises. S 37(1)(c) of the Act authorises a police official to take such steps as he may deem necessary to ascertain whether the body of a person has any mark, characteristic or distinguishing feature, or shows any condition or appearance, provided that no police official shall take any blood sample. S 37(2)(a) allows any medical officer of any prison or any district surgeon or, if requested thereto by any police official, any registered medical practitioner or registered nurse to take such steps including the taking of a blood sample as may be deemed necessary to ascertain whether the body of any person has any mark, characteristic, or distinguishing feature or shows any condition or appearance.

<sup>231</sup> See the discussion of s 36 above.

<sup>232</sup> The court further held that since a police official was not entitled to search a suspect by operating on his leg, he could not use the reasonable force authorised by s 27 to do so. Since he could not delegate his powers to search, he could not ask a doctor to do so instead.

<sup>233</sup> *Minister of Safety and Security v Gaqa* 2002 (1) SACR 654 (C).

<sup>234</sup> Other rights that could be infringed include the right to a fair trial, which includes the right to be presumed innocent. The right to remain silent and not to testify during the proceedings could also be infringed. It also includes the right not to be compelled to give self-incriminating evidence as stated in s 35(3)(h) and 35(3)(j) of the Constitution. Another right

Procedure Act permitted the granting of the order. The court held that the police would be hamstrung in fulfilling their constitutional duty if the order were not granted. Southwood AJ, in his judgment in *Minister of Safety and Security v Xaba*, held that this case was wrongly decided.

Once it has been determined that the bodily integrity right has been implicated, the courts will be required to find criteria for distinguishing justifiable from unjustifiable invasions. It is submitted that the decision in the *Minister of Safety and Security v Xaba* case is more consistent with the concept of both the right to bodily integrity and a right to health, since health in its broader sense is based as much on psychological integrity as it is on bodily integrity, and the power of a person to refuse a surgical invasion of his or her person is essential for both.<sup>235</sup>

In addition, the Ethical Code of Professional Conduct to which a Psychologist shall adhere stipulates that: "A psychologist shall recognise the inalienable human right to bodily and psychological integrity, including security in and control over his or her body and person, and the right not to be subjected to any procedure or experiment without his or her informed consent which shall be in a language that is easily understood by him or her."<sup>236</sup>

## 5.9 SECTION 14 OF THE CONSTITUTION: THE RIGHT TO PRIVACY<sup>237</sup>

The debate around privacy is an emotional one. It impacts on bodily privacy, communications, and personal information. The debate is also complex, as the right to privacy is not absolute and can be limited in terms of section 36 of the Constitution. There are also competing interests that need to be balanced. These interests are discussed below. The same considerations that led to the entrenchment of a right to privacy in the Bill of Rights have long been recognised by the common law as important reasons for protecting privacy. In terms of the common law, every person has personality rights such as the rights to physical

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referred to, which is potentially infringed by the relief sought, includes the right to have one's dignity respected and protected, which is provided for in s 10.

<sup>235</sup> For a comprehensive discussion on these constitutional principles, see Pearmain DL *A critical analysis of the law of health service delivery in South Africa* (unpublished LLD thesis, UP, 2004).

<sup>236</sup> S 10(3).

<sup>237</sup> S 14 of the Constitution read as follows: "Everyone has the right to privacy, which includes the right not to have – (a) their person or home searched; (b) their property searched; (c) their possessions seized; or (d) the privacy of their communications infringed." It is interesting to note that in s 13 of the interim Constitution reference was made to "every person" and not to "everyone". The interim Constitution also referred to "personal privacy" and not only to "privacy" as referred to in the final Constitution.

integrity, freedom, reputation, dignity and privacy. The right to privacy has been recognised as an independent personality right that applies to both natural and juristic persons. The so-called "wrongfulness" of an infringement of privacy is determined by means of the criteria of reasonableness or *boni mores*. A court must have regard for the particular facts of the case and judge them in light of contemporary *boni mores* and the general sense of justice in the community as perceived by the court.<sup>238</sup>

Another reason for protecting privacy is related to the reasons for protecting human dignity.<sup>239</sup> It guarantees the right of a person to have control over the use of private information.<sup>240</sup> The right is closely related to the right to dignity, since the publication of embarrassing information or information that places a person in a false light is most often damaging to the dignity of the person.<sup>241</sup> Freedom of information is closely connected to and overlaps with the right to privacy.<sup>242</sup>

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<sup>238</sup> For a discussion of the *boni mores* see Neethling J & Potgieter JM *et al Deliktereg* (2002) 23.

<sup>239</sup> *Mistry v Interim National Medicinal and Dental Council of South Africa and others* 1997 (7) BCLR 933 (D). The central problem in this case was whether the powers of entry, examination, search, and seizure given to inspectors by s 28(1) of the Medicines and Related Substances Control Act 101 of 1965 (hereafter referred to as the Medicines and Related Substances Control Act), are consistent with the provisions of s 13 of the interim Constitution, which guarantees personal privacy. It was decided that s 28(1) of the Act is inconsistent with s 13 of the interim Constitution, and was declared invalid.

<sup>240</sup> In *Jansen van Vuuren v Kruger*, the plaintiff, Mr McGeary, instituted an action for damages for breach of privacy against his general practitioner, the first defendant. The plaintiff applied for life insurance cover. A report on the patient's HIV status was required. The plaintiff asked the first defendant to prepare the report. The HIV test result was positive and the first defendant was notified. The first defendant arranged a consultation with the plaintiff, who was extremely upset and distressed, and concerned about a possible leak of the information. The first defendant promised to keep the information confidential. However, the following day the first defendant disclosed the information during the course of a golf game to two of his colleagues. The news that the plaintiff was HIV positive spread. The plaintiff became aware of the fact that the defendant breached their confidentiality. The first defendant raised an absence of wrongfulness on three alternative bases: (a) The communication had been made on a privileged occasion. (b) It was the truth and was made in the public interest. (c) It was objectively reasonable in the public interest in the light of the *boni mores*. The plaintiff died during the course of the trial, and the appellants were appointed executors of his estate. In his appeal court decision, Harms J remarked: "In determining whether the first defendant had a social or moral duty to make the disclosure and whether Van Heerden (the general practitioner) and Vos (the dentist) had a reciprocal social or moral right to receive it, the standard of the reasonable man applies ... With that in mind, I am of the view that he had no such duty to transfer, nor did Van Heerden and Vos have the right to receive, the information ... I see the matter in this light: AIDS is a dangerous condition. That on its own does not detract from the right to privacy of the afflicted person, especially if that right is founded in the medical practitioner-patient relationship. A patient has the right to expect due compliance by the practitioner with his professional ethical standards: in this case the expectation was even more pronounced because of the express undertaking by the first defendant. Vos and Van Heerden had not, objectively speaking, been at risk and there was no reason to assume that they had to fear a prospective exposure. The real danger to the practitioner lies with the patient whose HIV condition had not been established or (due to the incubation period) cannot yet be determined." See *Jansen van Vuuren v Kruger* 1993 (4) SA 842 (A).

<sup>241</sup> In the case of *C v Minister of Correctional Services*, the plaintiff instituted an action for damages against the Department of Correctional Services for breach of privacy. The plaintiff was a prisoner in the custody of the defendant at the Johannesburg Prison. His duties involved the preparation of food. One day the prisoners were informed that a blood sample would be taken for purposes of testing for HIV and other sexually transmitted diseases, and that they had the

Once the doctor-patient relationship is initiated, the physician assumes an automatic duty to safeguard confidentiality. However, this duty is not absolute, and in some circumstances breaching confidentiality is appropriate and may even be legally required. Psychiatrists must balance patient confidentiality with the need to provide adequate information to other medical providers. Documentation in the medical record, as well as verbal communication to others providing patient care, requires careful consideration of what to communicate and what to keep confidential. Hospital medical records are widely available to all who provide care to the patient, as well as to a great number of non-clinical personnel inside and outside the hospital. In most circumstances, the physician should obtain the competent patient's verbal permission before speaking to their family or other third parties. Yet, there is less need for consent in seeking information from others than for providing information about the patient to them. Even with the patient's authorisation to share information, psychiatrists should limit disclosure to information that would enable staff to function effectively in caring for the patient. For particularly sensitive information, discretion is advised before it is noted in the medical record.<sup>243</sup>

In *NM v Charlene Smith, Patricia De Lille and New Africa Books (Pty) Ltd*,<sup>244</sup> three women had originally instituted legal action against the defendants after they had published their full names and HIV status

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right to refuse to undergo such tests. This information was repeated, in the presence of a fellow prisoner, who assisted the medical aid with the drawing of blood. The plaintiff was subsequently advised that he had tested positive for HIV. Prior to this incident, the Department had adopted the concept that informed consent was a prerequisite for testing prisoners and had specified what norms were applicable. Kirk-Cohen J rejected the contention advanced on behalf of the defendant that the medical aid's deviation from the accepted norm of informed consent laid down by the department was minimal and not wrongful for the following reasons: The first information about the test, its object, and the right to refuse to submit to the test was communicated to the plaintiff as a member of a group of prisoners standing in a row in a passage, with no privacy and little time to reflect. What was repeated to each prisoner in the consulting room was not said by anyone trained in counselling and was also not said privately but in the presence of a fellow prisoner. No reasonable time for consideration and reflection was afforded to each prisoner in the consulting room before he was asked whether he consented to the test. See *C v Minister of Correctional Services* 1996 (4) SA 292 (T).

<sup>242</sup> See, for example, s 32 of the Constitution that reads: "(1) Everyone has the right of access to: (a) any information held by the state; and (b) any information that is held by another person and that is required for the exercise or protection of any rights. (2) National legislation must be enacted to give effect to this right, and may provide for reasonable measures to alleviate the administrative and financial burden on the state." See also s 9 of the Promotion of Access to Information Act. This Act regulates the mandatory protection of privacy of a third party who is a natural person in s 34. According to s 34(1), the information officer of a public body must refuse a request of access to a record of the body if its disclosure would involve the unreasonable disclosure of personal information about a third party, including a deceased individual. See also s 34(2).

<sup>243</sup> Siegler M "Sounding boards: Confidentiality in medicine - a decrepit concept" 1982 307 *N Eng J Med* 24:1518-1521.

<sup>244</sup> *NM v Charlene Smith, Patricia De Lille and New Africa Books (Pty) Ltd* [2005] 3 All SA 457 (W).

without their consent in the biography of Patricia De Lille, written by Charlene Smith and published by New Africa Books. The women argued that the disclosure of their names and HIV status in the book was an invasion of their rights to privacy, dignity, psychological integrity and mental and intellectual well-being. They asked the court to grant them the following relief:

- An order directing the defendants to issue a private apology to each plaintiff;
- an order directing the defendants to cause the offending passages to be excised or removed from all unsold copies of the book; and
- an order directing the defendants to pay damages of R200 000,00 to each plaintiff.

Schwartzman J referred to previous case law which confirmed that the right to privacy entitles an individual to decide when and under what circumstances private facts may be made public. He further acknowledged that because of the ignorance and prejudices of large sections of our population, an unauthorised disclosure can result in social and economic ostracism and can even lead to mental and physical assault. Schwartzman J, however, held that Patricia De Lille and journalist Charlene Smith could not be held liable for the disclosure of the three women's HIV status. Instead, he ruled that only the publisher, New Africa Books, was liable for damages and that they should pay the plaintiffs R15 000,00 each in damages. He also ordered the publishers to delete any reference to the women's names from all unsold copies of the book, and gave the AIDS Law Project the right - any time after 30 June 2005, on 72 hours notice - to inspect all copies of the book in the publisher's possession.<sup>245</sup>

In addition, the mental health industry has recently joined the countless industries already offering web-based services. Online counselling is a rapidly growing means of communicating with professionals worldwide via the internet (by means of live talk or email). The most frequently reported constitutional, legal and ethical concern pertaining to internet psychiatry is the issue surrounding confidentiality. The fundamental problem in assuring confidentiality in an online professional relationship is that electronic communications are inherently unsecured. In addition, the permanency of record creates a new potential

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<sup>245</sup> For a detailed discussion of this case, see Carstens & Pearmain 1011ff.

for the violation of privacy rights.<sup>246</sup> A file of email communication that was intended to be confidential could be accessed, whether intentionally or not, by someone other than the patient.

There is an array of other issues, including, but not limited to the following:

- This method of communication is characteristically anonymous in nature, at least in the visual sense, and while one professional may be quite capable of determining the educational scope and competency level of a peer, the typical online mentally ill patient is at a distinct disadvantage. There is currently nothing to prevent anyone from presenting themselves as a competent mental health professional online. It is not difficult to perceive the potential harm to the unwary patient of these services. Whether or not the definition and professional limitations of such roles as counsellor, therapist and psycho-educational information provider have been determined by a professional standards board, the typical online consumer may perceive any of these definitions as being one and the same. Currently, online psychiatric professional service providers are not subject to verification of their professional status, nor is there any process for review and quality control. "The ease of communications provided by the internet allows anyone to put out information of any sort." A poorly informed patient in crisis who has a history of mental health difficulties will be an easy target for incompetent or fraudulent internet counselling service providers.<sup>247</sup>
- The absence of physical presence also impacts the ability to verify identity. Without the ability to verify identity, the issue of treating minors without parental consent becomes problematic. Therapists seeking to practise online must evaluate what steps will be taken to verify the age of clients so as to not treat minors without the knowledge and consent of their parents. In addition, the issue of informed consent is closely related to the issue of disclosure. In order to give informed

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<sup>246</sup> According to Hodge, the proliferation of electronic data within the modern health information infrastructure presents significant benefits for medical providers and patients, including enhanced patient autonomy, improved clinical treatment, advances in health research and public health surveillance, as well as modern security techniques. Unfortunately, it also presents new legal challenges in three interconnected areas, namely privacy of identifiable health information; reliability and quality of health data; and delict / tort-based liability. Protecting health information privacy (by giving individuals control over health data without severely restricting warranted communal uses) directly improves the quality and reliability of health data. Encouraging individual uses of health services and communal uses of data diminishes delict / tort-based liabilities by reducing instances of medical malpractice or privacy invasions through improvements in the delivery of health care services resulting, in part, from better quality and reliability of clinical and research data. See Hodge JG *et al* "Legal issues concerning electronic health information: Privacy, quality and liability" 1999 282 *J Am Med Ass* 15: 1466ff. For a discussion of medical malpractice, see chapter 6.

<sup>247</sup> Huang M & Alessi NE "The internet and the future of psychiatry" (1996) 153 *Am J Psychiatry* 7:861-869.

consent to treatment, patients need to fully understand the potential risks and benefits associated with an intervention. Specific risks that clients need to be informed about involve the possibility that inadvertent breaches of confidentiality may occur with online communication, the experimental nature of online psychiatric interventions and the possibility of unknown and unintended consequences, and the potential for miscommunication in text-based communication.

- In some ways, the internet offers advantages in developing an informed consent process. Professional web pages allow for multi-faceted and multi-layered discussion of relevant issues which remain constantly available on the internet for clients to review. Web pages can address issues such as the potential risks involved with online treatment and the theoretical underpinnings of the treatment. The discussion of informed consent through email also allows for a documented record of the informed consent process.

It seems that email exchanges currently offer an alternative to establishing a transformative relationship between a patient and a psychiatrist, but the exact manner in which these relationships can be constitutionally, legally and ethically implemented is not well researched. Once a professional psychiatrist-patient relationship has been established, the psychiatrist has a professional responsibility towards the welfare of the patient, and it is unclear how this can be executed completely by email. However, email therapy is occurring, and it behoves both the legal and psychiatric professions to examine the constraints imposed by this medium, as well as the potential benefits to consumers of mental health services. The development of clear ethical guidelines that state the need for online psychiatrists to be experienced in and knowledgeable about this new medium will benefit all involved. Future research on the outcomes of psychiatric therapy done by email is required to fully understand what the true scope of the constitutional, legal and ethical considerations are. One thing is clear: of the millions of people that regularly log on to the Internet looking for information or to socialise with others, a small percentage will be suffering some kind of emotional disturbance and they are likely to seek assistance from this new medium.<sup>248</sup>

Section 13 of the Mental Health Care Act deals with confidentiality and states that a person or health establishment may not disclose any information which a mental health care user is entitled to keep

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<sup>248</sup> King SA & Poulos ST "Ethical guidelines for on-line therapy" 121-132 in *How to use computers and cyberspace in the clinical practice of psychotherapy* (ed) Fink J) (1999) 121-122.

confidential in terms of any other law. The head of the national department, a head of provincial department or the head of a health establishment concerned may disclose such information if not doing so would seriously adversely affect the health of the mental health care user or of other people.

Section 14 of the National Health Act regulates confidentiality. All information concerning a user,<sup>249</sup> including information relating to his or her health status, treatment or stay in a health establishment is confidential.<sup>250</sup> No person may disclose any information contemplated in subsection (1) unless: (a) the user consents to that disclosure in writing; or (b) a court order or any law requires that disclosure. Non-disclosure of the information represents a serious threat to public health.<sup>251</sup>

In addition, the Ethical Code of Professional Conduct to which a Psychologist shall adhere also makes provision for the protection of privacy and stipulates that: "A psychologist shall include in a written report, oral report or consultations, only information relevant to the purpose for which the communication is made and shall discuss confidential information obtained in his or her work only for appropriate scientific or professional purposes and only with persons concerned with such matters."<sup>252</sup>

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<sup>249</sup> "User" means the person receiving treatment in a health establishment, including "receiving ... or using a health service", and if the person receiving treatment or using a health service is – (a) below the age contemplated in section 39 (4) of the Child Care Act ... user includes the person's parent or guardian or another person authorised by law to act on the first mentioned person's behalf; or (b) incapable of taking decisions, 'user' includes the person's spouse or partner or, in the absence of such spouse or partner, the person's parent, grandparent, adult child or brother or sister, or another person authorised by law to act on the first mentioned person's behalf. See section 1.

<sup>250</sup> Section 14(1).

<sup>251</sup> See also section 15, which reads as follows: "(1) A health worker or any health care provider that has access to the health records of a user may disclose such personal information to any other person, health care provider or health establishment as is necessary for any legitimate purpose within the ordinary course and scope of his or her duties where such access or disclosure is in the interests of the user. (2) For the purpose of this section, "personal information" means personal information as defined in section 1 of the Promotion of Access to Information Act 2 of 2000." "Personal information" means information about an identifiable individual. For the complete definition see section 1 of the Promotion of Access to Information Act. See also section 16 of the National Health Act, dealing with access to health records by health care providers, and section 17 of this Act, which deals with the protection of health records.

<sup>252</sup> S 26.

## 5.10 SECTION 9 OF THE CONSTITUTION: THE EQUALITY CLAUSE<sup>253</sup>

People suffering from mental disorders are among the most disadvantaged groups in society. They suffer severe personal distress and they are stigmatised, discriminated against, marginalised and often left vulnerable.<sup>254</sup> Stigma<sup>255</sup> has become an important concept in health law. It is widely accepted that certain diseases are disfavoured in society, leading to discrimination against people diagnosed with it. Burris<sup>256</sup> explains that this leads to the tendency to drive an epidemic underground, for example, to make it more difficult for voluntary public health programs to reach and succeed among populations bent on concealing their diseases or risk status. The need to reduce stigma and its effects has been used to justify the passage of privacy and anti-discrimination law to protect people with disabilities. Stigma also insinuates itself into policy decisions, access to care, health insurance, employment discrimination, and in research allocations and priorities.<sup>257</sup>

The personalised nature of mental illness obscures from general view the intolerable burden of private and public distress that people with serious mental disorders carry. Invariably the mentally disordered person encounters rejection and humiliation that are in some way tantamount to a "second illness". The combination either disrupts or puts beyond reach the usual personal and social life stages of marriage, family life, raising children, sexual relationships, choice of treatment, affordable housing, transportation, education and gainful employment. By lacking financial and social support, if not rejection from society, the

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<sup>253</sup> S 9 of the Constitution read as follows: "(1) Everyone is equal before the law and has the right to equal protection and benefit of the law. (2) Equality includes the full and equal enjoyment of all rights and freedoms. To promote the achievement of equality, legislative and other measures designed to protect or advance persons or categories of persons, disadvantaged by unfair discrimination may be taken. (3) The state may not unfairly discriminate directly or indirectly against anyone on one or more grounds, including race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth. (4) No person may unfairly discriminate directly or indirectly against anyone on one or more grounds in terms of subsection (3). National legislation must be enacted to prevent or prohibit unfair discrimination. (5) Discrimination on one or more of the grounds listed in subsection (3) is unfair unless it is established that the discrimination is fair."

<sup>254</sup> Orovvuje PR & Taylor AJW "Mental health consumers, social justice and the historical antecedents of oppression" 95-111 in *Justice as a basic human need* ((ed) Taylor AJW) (2006) 95.

<sup>255</sup> Stigmatisation is entirely contingent on access to social, economic and political power that allows the identification of indifference, the construction of stereotypes, the separation of labelled persons into distinct categories and the full execution of disapproval, rejection, exclusion and discrimination. The term stigma is applied when elements of labelling, stereotyping, separation, status loss and discrimination co-occur in a power situation that allows them to unfold. See Link BG & Phelan JC "Stigma and its public health implications" 2006 367 *Lancet* 9509: 528.

<sup>256</sup> Burris S "Disease stigma in US public health law" 2002 30 *J L Med & Ethics* 3: 179.

<sup>257</sup> Jamison KR "The many stigmas of mental illness" 2006 367 *Lancet* 9509: 533.

mentally disordered person tend to neglect themselves and their diet, and frequently they delay seeking treatment.<sup>258</sup>

As Burris explains,<sup>259</sup> there are three broad areas where law affects the operation of stigma in society. Law can be a means of preventing or remedying the enactment of stigma as violence, discrimination, or other harm. It can be a medium through which stigma is created, enforced, or disputed; and it can play a role in structuring individual resistance to stigma. For the individual with a stigmatised health condition, acceptance of society's views and self-stigmatisation may lead to concealment to avoid discrimination. But an anti-stigma activism is also possible. For many stigmatised diseases, for example, epilepsy and schizophrenia, the consequences of concealment may often be more severe than those of resistance. In both cases the individual faces status loss and discrimination, but, depending on the nature and incidence of enacted stigma, people who adopt resistance strategies may actually face less stigma, experience less social harm, and be better able to cope with any discrimination. At the same time they avoid the life-long hidden distress and unhappiness experienced by people who conceal.

According to Jamison,<sup>260</sup> the inability to discuss mental illness in an informed and straightforward way, to deal with it as the major public health concern that it is, is unjustifiable. There is a very large group which he refers to of as "the silent successful". These are people who recover from mental disorders, but who are afraid to speak out. This reluctance is very understandable, very human, but it is unfortunate because it perpetuates the misperception that mental disorders cannot be treated and cured. What remains visible in the public eye are the newspaper accounts of violence, the homeless mentally disordered and the untreated illness in friends, family, and colleagues. What is not seen are all the truck drivers, secretaries, teachers, lawyers, physicians and government officials who have been successfully treated, who work, compete and succeed.

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<sup>258</sup> Orovwuje & Taylor in *Justice as a basic human need* 95-96.

<sup>259</sup> Burris S "Stigma and the law" 2006 367 *Lancet* 9509: 529.

<sup>260</sup> Jamison 2006 *Lancet* 533.

Equality (non-discrimination) has a special place in the Bill of Rights, and sets its face against laws and practices that reinforce the subordination of disadvantaged and disabled groups.<sup>261</sup> Equality is also a dominant theme running through the Constitution. It is mentioned expressly in the following sections:

- Section 9: "Everyone is equal before the law";
- section 36: "In an open and democratic society based on freedom, and equality;
- section 39: "When interpreting the Bill of Rights, a court, tribunal, or forum ... must promote the values that underlie an open and democratic society based on human dignity, equality, and freedom".<sup>262</sup>

In *Harksen v Lane*<sup>263</sup> the criteria in determining whether the equality clause may in fact be invoked, requires an inquiry into the fact whether there is differentiation between people or categories of people. If such differentiation exists, it must be determined if there is a rational connection to a legitimate government purpose. The court went on to say that even if there is such a rational connection it might nevertheless still amount to discrimination.

The second step is to distinguish if the differentiation amounts to unfair discrimination, which requires a three-stage analysis: Firstly, it must be established whether the differentiation amounts to discrimination. The court was of the opinion that, if the allegation of unfair discrimination is not based on a listed ground, it must be resolved objectively whether the ground is based on "attributes and characteristics which have the potential to impair the fundamental human dignity of persons as human beings or to affect them adversely in a comparably adverse manner". Secondly, it must be found that if it amounts to discrimination, such discrimination is unfair. If it is found to be on a listed ground (in this case disability), then the court will presume unfairness.<sup>264</sup> However, if on an unspecified ground the test of unfairness primarily focuses on the impact of the discrimination on the complainant and other people in the same situation.<sup>265</sup> Thirdly, if the

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<sup>261</sup> *Brink v Kitshoff* NO 1996 (4) SA 197 (CC), 1996 (6) BCLR 752 (CC). See also *Makwanyane supra*.

<sup>262</sup> See s 7(1) of the Constitution: "This Bill of Rights is a cornerstone of democracy in South Africa. It enshrines the rights of all people in our country and affirms the democratic values of human dignity, equality, and freedom."

<sup>263</sup> *Harksen v Lane supra*.

<sup>264</sup> S 9(3).

<sup>265</sup> The Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000 (hereafter referred to as the Promotion of Equality and Prevention of Unfair Discrimination Act), also contains a general prohibition provision, and states that

discrimination is found to be unfair, it must be determined whether it can be justified under the limitation clause.<sup>266</sup>

According to Link and Phelan,<sup>267</sup> an insidious form of discrimination occurs when stigmatised individuals realise that a negative label has been applied to them and that other people are likely to view them as less trustworthy and intelligent, and more dangerous and incompetent. According to this modified labelling theory, people who have been hospitalised for mental illnesses may act less confidently and more defensively with others, or may simply avoid a threatening contact altogether. The result may be strained and uncomfortable social interactions, more constricted social networks, a compromised quality of life, low self-esteem, depressive symptoms, unemployment and loss of income.

According to Jamison,<sup>268</sup> we need to better understand why stigma exists and he makes the following recommendations:

- We have to acknowledge upfront that untreated mental disorders can be frightening and that it can be associated with violent acts. It should further be acknowledged that mental illness can have a powerful effect on those people close to it.
- Research is the greatest destigmatiser: We need to get people interested in the brain, and in the fact that these are very interesting disorders. We need to capture the imaginations of the young

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"neither the state nor any person may unfairly discriminate against any person". See s 6. The strong link between human dignity and equality is also conceptualised in the value of *ubuntu*. Although not expressly mentioned in the Constitution, it was nevertheless recognised as a constitutional value in *S v Makwanyane*. See *Makwanyane supra*. This culture emphasises the fact that, in treating human beings with dignity, the state is required to act in a reasonable manner to eradicate poverty and is obliged to take steps to ensure the equal treatment of those who are vulnerable in society and have been historically deprived.

<sup>266</sup> S 36 of the Constitution. (See the discussion of this section *supra*). In *President of the Republic of South Africa v Hugo*, Kriegler J suggested that the factors that would or could justify interference with the right to equality under the limitation clause should be distinguished from those relevant to the enquiry as to whether there has been unfair discrimination under the equality clause. The former are concerned with justification, possibly notwithstanding unfairness, and the latter are concerned with fairness and with nothing else. See *President of the Republic of South Africa v Hugo* 1997 (4) SA 1 (CC). In *Harksen v Lane*, the Constitutional Court stated that the limitation analysis involves "a weighing of the purpose and effect of the provision in question and a determination as to the proportionality thereof in relation to the extent of its infringement of equality". See *Harksen supra*. See also Currie & De Waal 238.

<sup>267</sup> Link & Phelan 2006 *Lancet* 528. See also Link BG "Mental patient status, work and income: An examination of the effects of a psychiatric label" 1982 47 *Am Sociological Rev* 2: 212-215; Link BG "Understanding labelling effects in the area of mental disorders: An assessment of the effects of expectations of rejection" 1987 52 *Am Sociological Rev* 1: 96-112.

<sup>268</sup> Jamison 2006 *Lancet* 533 at 534.

and explain that understanding the brain is the last great frontier. To make a disorder interesting is to some extent to help destigmatise it.

- Third, we need to start within our own clinical communities and have more honest and open discussions about impaired doctors, psychologists, nurses and other professionals. Unless we are willing to talk about how to deal with mental disorders among professionals the problem is going to remain silent, creating more fear and more stigmatisation. We also need to standardise the teaching of the clinical science underlying these illnesses. Some of the stigma associated with mental illness exists because there has been so much bad teaching and inadequate treatment over the years. The stigma that those with psychiatric illness face is only truly understood by those who have been on the receiving end of it.<sup>269</sup>

It is stated in section 10 of the Mental Health Care Act that a mental health care user may not be unfairly discriminated against on the grounds of his or her mental health status. All mental health care users must receive the same standard of care, treatment and rehabilitation services.

The right against exploitation and abuse is protected in section 11 of this Act and states that every person, body, organisation or health establishment providing care, treatment and rehabilitation services to a mental

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<sup>269</sup> Jamison (Department of Psychiatry and Behavioural Sciences, Johns Hopkins University School of Medicine) explains that this stigmatisation became more painfully clear to him when he wrote his book *An unquiet mind* that recounted his own experience with bipolar disorder. He wrote: "I received thousands of letters from people. Most of them were supportive but many were exceedingly hostile. A striking number said that I deserved my illness because I was insufficiently Christian and that the devil had gotten hold of me. More prayer, not medication, was the only answer. Others were irate that I had continued my professional work, even though my illness was well-controlled. The most upsetting letters, however, were from doctors, psychologists, and nurses who wrote about their own mood disorders, suicide attempts, and substance misuse problems. All made the irrefutable point that it was disingenuous for hospitals and medical schools to expect health-care professionals to be straightforward about mental illness when their hospital privileges, referral sources, and licences to practice were on the line. This is undeniably true. The chairmen of my academic departments have been compassionate and supportive of my career. I am fortunate in this regard; most others in my situation are not. *Mental illness is as least as common in our colleagues as it is in the general public, which is to say it is common.* Suicide occurs far too often. We need to reach out to our colleagues. As mentors and educators we need to be proactive, we need to educate medical students, house staff, and graduate students about depression and other mental illnesses. We need to make it easy for them to get treatment. We need as well to educate them more effectively about how best to diagnose and treat mental illness in their patients. We as a profession also need to reach out to society to say that we will not tolerate the kind of pain and discrimination that has gone on for far too long. When I wrote my book I had no idea what the long term consequences of being public about my manic depressive illness would be. I assumed that they were bound to be better than continuing to be silent. I was tired of hiding and tired of the hypocrisy. I was tired of being held hostage to stigma and tired of perpetuating it. Now there is indeed no turning back and I find myself continuing to take solace in Robert Lowell's question, the one which had been at the heart of my decision to be public about my illness: 'Yet why not say what happened?'" (Own emphasis). See Jamison 2006 *Lancet* 533 at 534. See also Jamison KR *An unquiet mind* (1995).

health care user must take steps to ensure that users are protected from exploitation, abuse and any degrading treatment. Users should not be subjected to any forced labour either. Care, treatment and rehabilitation services should not be used as punishment or for the convenience of other people. According to section 12 of the Act any determination concerning the mental health status of any person must be based on factors exclusively relevant to that person's mental health status, or to give effect to the Criminal Procedure Act, and not on socio-political or economic status, cultural or religious background or affinity.

In addition, the Ethical Code of Professional Conduct to which a psychologist shall adhere stipulates that:

"A psychologist shall not impose on a client, employee, research participant, student, supervisee, trainee, or others over whom he or she has or had authority, any stereotypes of behaviour, values or roles related to age, belief, birth, conscience, colour, culture, disability, disease, ethnic and social origin, gender, language, marital status, pregnancy, race, religion, sexual orientation, socio-economic status or on any other basis proscribed by law.<sup>270</sup> A psychologist shall not engage in unfair discrimination based on age, belief, birth, colour, conscience, culture, disability, disease, ethnic and social origin, gender, language, marital status, pregnancy, race, religion, sexual orientation, or socioeconomic status or on any other basis proscribed by law.<sup>271</sup>

Further, a psychologist has to make every effort to ensure that language-appropriate and culture-appropriate services are made available to a client and that acceptable standards of language proficiency are met in the provision of a service to such client whose mother tongue varies from that of such psychologist.<sup>272</sup>

#### 5.11 SECTION 15 OF THE CONSTITUTION: CONSCIENCE, RELIGION, THOUGHT, BELIEF AND OPINION<sup>273</sup>

Chaskalson P used the following definition to describe the essence of the concept of freedom of religion in *S v Lawrence*:<sup>274</sup> "The right to entertain such religious beliefs as a person chooses, the right to declare

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<sup>270</sup> S 12(1).

<sup>271</sup> S 12(2).

<sup>272</sup> S 12(3).

<sup>273</sup> S 15 of the Constitution reads as follows: "(1) Everyone has the right to freedom of conscience, religion, thought, belief and opinion. (2) Religious observations may be conducted at state or state-aided institutions provided that – (a) those observances follow rules made by the appropriate public authorities; (b) they are conducted on an equitable basis; (c) attendance at them is free and voluntary. (3)(a) This section does not prevent legislation recognising – (i) marriages concluded under any tradition, or a system of religious, personal or family law; or (ii) systems of personal and family law under any tradition, or adhered to by persons professing a particular religion. (b) Recognition in terms of paragraph (a) must be consistent with this section and the other provisions of the Constitution."

religious beliefs openly and without fear of hindrance or reprisal, and the right to manifest religious belief by worship and practice or by teaching and dissemination."<sup>275</sup>

In *Christian Education SA v Minister of Education*,<sup>276</sup> Liebenberg J summarised the position as follows:

In cases of this nature a court will in the first place consider whether the belief relied upon in fact forms part of the religious doctrine of the religion practised by the person concerned. Once it is found that the belief does form part of that doctrine, the court will not embark upon an evaluation of the acceptability, logic, consistency, or comprehensibility of the belief. But, the court will then inquire into the sincerity of the person's claim that a conflict exists between the legislation and the belief which is indeed burdensome to the person.

The right to freedom of religion and thought is contained in most human-rights treaties. However, members of religious communities may seek to use the freedom of religion as a shield to fend off attacks on constitutionally offensive group practices.<sup>277</sup>

In *Phillips v de Klerk*,<sup>278</sup> the applicant, a confirmed Jehovah's Witness, was travelling in the Northern Province (as it was known then), when he was seriously injured in a collision near Pietersburg (Polokwane). In this case the right of a *compos mentis* adult Jehovah's Witness to refuse a blood transfusion, came to the fore. He was admitted to the local hospital and it appeared that he had sustained several fractures. He subsequently also contracted an infection of the lungs. Ten days later, while the applicant was still in hospital, Dr de Klerk, the orthopaedic surgeon, approached the Supreme Court in Pretoria with an urgent *ex parte* application for an order authorising him or another doctor to administer a blood transfusion to the applicant. It was submitted that the applicant's wife, who was present in the hospital, had refused on religious grounds to consent to a blood transfusion. The condition of the applicant, who at this stage was in the intensive care unit of the hospital due to serious blood loss, rapidly deteriorated and the doctor stated that if a blood transfusion was not administered within six hours, the applicant would die. The urgent application was accordingly granted by the court.

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<sup>274</sup> *S v Lawrence* 1997 (4) SA 1176 (CC).

<sup>275</sup> *R v Big M Drug Mart* [1985] 1 SCR 295 at 336, as quoted in *Lawrence supra*.

<sup>276</sup> *Christian Education South Africa v Minister of Education* 2000 (4) SA 757 (CC) 958E.

<sup>277</sup> *Ibid.*

<sup>278</sup> *Phillips v De Klerk supra*.

Seven months later, the applicant brought an application to the Supreme Court for the earlier order to be set aside. In his supporting affidavit the applicant stated that he was a member of the Jehovah's Witness Faith, and in accordance with its fundamental tenet of that faith, they do not accept blood transfusion. In addition, the applicant stated that he had been conscious after the collision and at the time of his admission to hospital. He also instructed the hospital staff that under no circumstances was he to be given a blood transfusion. He even offered to furnish the hospital and the doctor treating him with a written absolution from any possible future claim against them resulting from his refusal to permit a blood transfusion. He was adamant that at no stage he or his wife had been informed of Dr de Klerk's intention to apply for a court order. It appeared afterwards, that a blood transfusion was never administered, and in this regard the applicant felt vindicated.

In an affidavit by another doctor who was called in as a consultant to attend to the applicant at the time, it was stated that he (the consultant) had also strongly recommended a blood transfusion, but that he was, however, prepared to respect the applicant's right to refuse blood. The consultant doctor also confirmed that the applicant was fully conscious and capacitated at the time. The application for rescission of the earlier court order was not opposed. Esselen J, who heard the case, said that he was dealing with the case on the basis that it was unopposed. On the papers before him he was satisfied that the applicant was *compos mentis* at the relevant time and that he was entitled to refuse to be given blood. The court ruled that the previous order was made erroneously and accordingly that order was set aside.

In *Hay v B*,<sup>279</sup> the applicant, Dr Hay, a paediatrician at the Garden City Clinic, Johannesburg, applied, as a matter of urgency, for an order authorising her to administer a blood transfusion to an infant, the child of the first and second respondents. The applicant testified that, while no guarantee could be given that the infant would survive if the blood transfusion were administered, the probability was that, if a blood transfusion were not administered, the infant would not survive. The first and second respondents, both Jehovah's Witnesses, were opposed to the administration of the blood transfusion on the grounds that the acceptance of a blood transfusion was contrary to their religious beliefs and that they had concerns relating to the risk of infection associated with blood transfusions. The applicant testified as to the procedures adopted in screening blood and the unlikelihood of the blood transfused being contaminated.

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<sup>279</sup> *Hay v B* 2003 (3) SA 492 (W).

Jajbhay J ruled that in terms of s 28(2) of the Constitution, a child's best interests were of paramount importance in every matter concerning the child and was the single most important factor to be considered when balancing or weighing competing rights and interests concerning children. The duty to afford children protection fell on law enforcement agencies, all right-thinking people and ultimately the court, which was the upper guardian of all children.<sup>280</sup> The court further held that the right to life was a value that was constitutionally protected. If the blood transfusion was not administered, the death of the infant was imminent. The infant's right to life<sup>281</sup> was an inviolable one and was capable of protection, and it was in the best interests of the infant that this right be protected. While the first and second respondents' concerns were understandable, they were neither reasonable nor justifiable. Their private beliefs could not override the infant's right to life.<sup>282</sup> The court, however, stated that the interests of the infant in receiving the blood transfusion outweighed the reasons advanced by the first and second respondents in opposing the administration of the transfusion. The application was accordingly granted.

Carstens<sup>283</sup> submits that the enunciated principles emanating from the foregoing judgments offer significant jurisprudential insights into the way the courts will resolve issues pertaining to Jehovah's Witnesses and their refusal to submit to blood transfusion on religious grounds. Clearly a distinction is to be drawn between the position of the adult *compos mentis* Jehovah's Witness and that of the Jehovah's Witness child whose parents are refusing a blood transfusion on the child's behalf. It is submitted by the author that the same distinction will have to be drawn with regard to the mentally disordered patient, who is not competent to make an informed decision. The outcome might be different where the adult mentally disordered Jehovah's Witness patient had a "living will" or other directive not to receive any blood, even in a life-saving situation.

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<sup>280</sup> *Hay v B supra* 494I-495 par [A].

<sup>281</sup> See the discussion *supra*.

<sup>282</sup> *Hay v B supra* 495 par [E].

<sup>283</sup> Carstens & Pearmain 923.

In addition, the Ethical Code of Professional Conduct to which a Psychologist shall adhere stipulates that: "A psychologist shall respect the right of a client to hold values, attitudes, beliefs and opinions that differ from their own."<sup>284</sup>

## 5.12 THE CONSTITUTIONAL FRAMEWORK PERTAINING TO MEDICAL RESEARCH AND EXPERIMENTATION<sup>285</sup>

### 5.12.1 Introductory remarks

Scientific research<sup>286</sup> and experimentation have produced substantial social benefits and have made an enormous contribution to human progress. However, it still confronts society with difficult ethical problems.<sup>287</sup> As this thesis is concerned with psychiatry, psychology and the mentally disordered, focus is placed on research and experimentation involving mentally disordered patients. Whether it is ethical to experiment on mentally disordered patients is a contentious question worldwide. The South African Constitution provides the framework on how these issues should be addressed and the applicable sections are discussed below.

### 5.12.2 Section 12(2)(c) and section 16(1)(d) of the Constitution

Section 12(2)(c) of the Constitution reads:

Everyone has the right to bodily and psychological integrity, which includes the right -  
(c) not to be subjected to medical or scientific experiments without their informed consent.

An analysis of this right can be broken down into two parts: Firstly, the question of what constitutes medical or scientific experiments should be examined, and secondly, what counts as informed consent should be defined. According to Currie and De Waal, what constitutes a medical or scientific experiment is not as simple as it sounds.<sup>288</sup> Many of the medical or scientific experiments with which we would be concerned manifest as, for example, gauging the reactions of elderly patients injected with cancer cells, calculating the

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<sup>284</sup> S 10(2).

<sup>285</sup> Medical or scientific "experimentation" probably means nothing other than medical or scientific research. See Van Wyk C "Clinical trials, medical research and cloning in South Africa" 2004 67 *THRHR* 1:1 at 8.

<sup>286</sup> S 1 of the National Research Foundation Act 23 of 1998 (hereafter referred to as the National Research Foundation Act) defines "research" as the generation, preservation, augmentation and improvement of knowledge by means of scientific investigations and methods in the field of science and technology.

<sup>287</sup> Van Wyk C "Guidelines on medical research ethics, medical 'experimentation' and the constitution" 2001 64 *THRHR* 1: 3 at 6.

<sup>288</sup> Currie & De Waal (2005) 310.

death-rates of concentration camp internees subjected to an array of pathogens. But, day to day medical care and therapy also amounts to experimentation, even though of a slightly different kind.<sup>289</sup>

Claassen and Verschoor<sup>290</sup> indicate that there is no other profession in greater need of continuous progress than medicine. It is therefore unavoidable that a measure of experimentation will avail during the manufacture of new drugs or the development of new methods of treatment. In an experimental situation two opposing interests must be balanced, namely:

- The interest of the patient not to be subjected to any abuse that may result from an uncontrolled experiment; and
- the interest of the physician and of society in furthering knowledge of diseases and their treatment.

Section 16(1)(d) of the Constitution reads:

"Everyone has the right to freedom of expression, which includes ... academic freedom and freedom of scientific research."<sup>291</sup>

The "academic freedom right" was initially part of the right to freedom of religion, belief, and opinion in the interim Constitution.<sup>292</sup> The final Constitution's formulation of the right is broader than in the interim Constitution. The right no longer applies only to "institutions of higher learning". Therefore, any academic enterprise is now protected.<sup>293</sup>

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<sup>289</sup> Currie & De Waal indicate that when doctors prescribe approved drugs or engage in accepted practices on their patients, they are still experimenting, because no two patients react exactly alike to the same drug or procedure. Often doctors do not know the side-effects and untoward reactions of various courses of treatment until after years of treatment on a willing and large population of patients. Medical knowledge is therefore controversial and partial.

<sup>290</sup> Claassen NJB & Verschoor T *Medical negligence in South Africa* (1992) 54.

<sup>291</sup> S 16 reads: "16(1) Everyone has the right to freedom of expression, which includes: (a) freedom of the press and other media; freedom to receive or impart information or ideas; (c) freedom of artistic creativity; (d) academic freedom and freedom of scientific research. (2) The right in subsection (1) does not extend to: (a) propaganda for war; (b) incitement of imminent violence; (c) advocacy of hatred that is based on race, ethnicity, gender or religion, and that constitutes incitement to cause harm."

<sup>292</sup> S 14 of the interim Constitution read: "Every person shall have the right to freedom of conscience, religion, thought, belief and opinion, which shall include academic freedom in institutions of higher learning."

<sup>293</sup> Currie & De Waal 370.

The core of the right to academic freedom is the right to do research. This right vests in individual academics, not only in universities. Currie and De Waal<sup>294</sup> point out that, if the state could prescribe to universities that no research critical of the government may be funded by the university or that no researchers critical of the government may be appointed, academic freedom would be left stranded. Section 16 implies a positive duty of the state<sup>295</sup> to promote research and teaching by providing functional academic and scientific institutions, or at least the financial and organisational backup needed to exercise the right to academic freedom and scientific research.<sup>296</sup>

### 5.12.3 Consent as a requisite in medical research and experimentation

#### 5.12.3.1 Introductory remarks

Section 12(2)(c) of the Constitution explicitly states that no one may be subjected to medical or scientific experimentation without their informed consent. Van Oosten points out that the word "their" in section 12(2)(c) makes it patently clear that the only person who is capable of giving consent to medical research is the research subject and that proxy consent to medical research is out of the question. In this respect, section 12(2)(c) is, according to him, clearly out of step with current local and international medical research ethics.<sup>297</sup> If this statement of Van Oosten is taken to its logical consequences, it would imply that all medical research would be covered by section 12(2)(c), and it would therefore mean that all medical research would need the informed consent of the research subject himself.<sup>298</sup> This causes problems where mentally disordered patients are not capable of consenting themselves. The question remains the same: When and to what extent can the benefits that accrue to society for medical and scientific research outweigh considerations of individual dignity and autonomy?<sup>299</sup>

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<sup>294</sup> *Idem* 371.

<sup>295</sup> S 16 only refers to "academic freedom" and therefore does not confer a right to state financial support for specific research projects.

<sup>296</sup> Malherbe EFJ "n Handves van menseregte en onderwys" 1993 *TSAR* 4:686 at 699.

<sup>297</sup> Van Oosten FFW "The law and ethics of information and consent in medical research" 2000 63 *THRHR* 1:5 at 9.

<sup>298</sup> However, Van Oosten submits that therapeutic research could in some instances be allowed without the informed consent of the research subject. Without subjecting the Mental Health Care Act to constitutional scrutiny in terms of s 36, it is concluded that therapeutic research seems to be included under the notion of "medical treatment or operation on" mentally disordered patients, for which proxy consent can be given. Strauss is essentially of the same view. See Van Oosten 2000 *THRHR* 5 at 17.

<sup>299</sup> Currie & De Waal 311.

#### 5.12.4 The doctrine of informed consent

Informed consent to medical treatment is a legal concept that forms part of South African medical law.<sup>300</sup> The point about the nature of medical research also carries with it a lesson as to the meaning of informed consent. The discussion below on the doctrine of informed consent is to provide background on exactly what "informed consent", as stated in section 12(2)(c) of the Constitution, means. This background information also serves as the basis for the interpretation of the statutory provisions pertaining to this doctrine.

Pursuant to or apart from statute, the doctrine of informed consent generally requires a physician or other health care provider to furnish an individual with information sufficient to enable him or her to give intelligent, informed consent to a proposed medical treatment or the performance of a particular medical procedure. Such doctrine takes full account of the probability that, unlike a physician, a patient is untrained in medical science, and therefore completely depends on and trusts in the skill of his physician, for the information on which he makes his decision. Due to the fiduciary relationship between a physician and patient, the scope of the disclosure required can be expanded by a patient's instructions to the physician. In addition, if a physician knows or should know of a patient's unique concerns or lack of familiarity with medical procedures, such knowledge may also expand the scope of the required disclosure.<sup>301</sup>

##### 5.12.4.1 Consent to treatment

There is ample authority for the statement that the patient's consent or the consent of a person acting on his or her behalf to medical interventions is essential to establish a proper doctor-patient relationship. Failure by a medical practitioner to obtain a patient's informed consent may, notwithstanding the absence of negligence in administering the treatment in question and irrespective of whether or not such treatment eventually proves to have been beneficial to the patient, result in legal liability. The concept of consent in a

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<sup>300</sup> See for example Van Oosten FWW "Castell v De Greeff and the doctrine of informed consent: Medical paternalism ousted in favour of patient autonomy" 1995 28 *De Jure* 1:164-179; *Castell v De Greeff* 1994(4) SA 408(C); *Esterhuizen v Administrator Transvaal* 1957(3) SA 710(T); *Stoffberg v Elliott* 1923 CPD 148; Beard M & Midgley JR "Therapeutic privilege and informed consent: A justified erosion of patient autonomy?" 2005 68 *THRHR* 1:51-68; Earle M "Informed consent: Is there room for the reasonable patient in South African law?" 1995 112 *SALJ* 4: 629-642; Howarth G "Informed consent – the basic structure" 2002 44 *Geneeskunde* 3:45.

<sup>301</sup> Claassen & Verschoor 57-60.

medical context can be described as the moral, ethical and legal expression of the human right to respect for autonomy and self-determination.<sup>302</sup>

#### 5.12.4.2 Consent as a requisite for medical interventions

For medical interventions, consent means a voluntary decision made by a competent person on the basis of adequate information.<sup>303</sup> The leading case on compliance with the consent requisite is *Stoffberg v Elliott*,<sup>304</sup> where in an action for damages for assault, Watermeyer J instructed the jury as follows:

In the eyes of the law, every person has certain absolute rights which the law protects. They are not dependent upon a statute or upon a contract, but they are rights to be respected, and one of those rights is the right of absolute security of the person. Nobody can interfere in any way with the person of another, except in certain circumstances ... Any bodily interference with or restraint of a man's person which is not justified in law, or excused in law, or consented to, is a wrong, and for that wrong the person whose body has been interfered with has a right to claim such damages as he can prove he has suffered owing to that interference. A man, by entering a hospital, does not submit himself to such surgical treatment as the doctors in attendance upon him may think necessary ... By going into hospital, he does not waive or give up his right of absolute security of the person, he cannot be treated in hospital as a mere specimen, or as an inanimate object which can be used for the purposes of vivisection; he remains a human being, and he retains his rights of control and disposal of his body; he still has the right to say what operation he will submit to, and unless his consent to an operation is expressly obtained, any operation performed upon him without his consent is an unlawful interference with his right of security and control of his own body, and is a wrong entitling him to damages if he suffers any.<sup>305</sup>

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<sup>302</sup> The term "informed consent" has been held in *Sidaway v Bethlem Royal Hospital* in England to be meaningless or at least inapplicable. At the same time, the term is used by courts to uphold the ethical principle of self-determination, which underlies the legal principle of informed consent to medical treatment. Van Oosten FFW *The doctrine of informed consent in medical law* (unpublished LLD thesis, Unisa, 1989) 31. See also *Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital* 1984 QB 493 (CA), 1984 1 ALL ER 1018, 1985 AC 871 (HL), 1985 1 ALL ER 643. For a discussion on informed consent in general, see Earle 1995 SALJ 629-642.

<sup>303</sup> Earle 1995 SALJ 629.

<sup>304</sup> *Stoffberg supra*.

<sup>305</sup> In *Stoffberg v Elliott supra*, the patient had contracted cancer of the penis. He was operated on in hospital. After the operation he discovered that his penis had been amputated. See Van Oosten LLD thesis 31-53 for a discussion of the "doctrine informed consent". Failure to obtain the required consent was also the basis for the decision in another leading case, namely *Esterhuizen v Administrator Transvaal (supra)*. The patient and her father had consulted a doctor about a small nodule, which had caused her some discomfort. The doctor treated the injury and excised the nodule, which he submitted for analysis. It was identified as a manifestation of Kaposi's sarcoma. The doctor advised the patient's mother to take her to hospital for X-ray treatment. Both parents agreed that the patient should be subjected to the recommended treatment. Superficial X-ray treatment was administered and the patient's wound healed completely. Three months later, fresh nodules on both her feet and right hand appeared. She was again subjected to superficial X-ray treatment at the same institution with the same result. Four years later more nodules appeared on the patient's body. This time another doctor took charge of the patient. He concluded that the patient's disease was progressing and estimated her life expectancy at one year. For this reason he decided to administer X-ray treatment of a radical nature, knowing that the patient would suffer severe irradiation of the tissues in the treated areas, and would possibly sustain ulceration of these tissues, become disfigured or deformed in the sense that permanent harm would be done to her growing bone ends in

### 5.12.4.3 Duty of disclosure

Doctors and patients enjoy a fiduciary relationship where mutual trust and confidence are essential. Out of this relationship arises the physician's obligation to obtain the patient's informed consent to medical treatment. However, for a patient's consent to be informed, it must be given after the doctor offers a fair and reasonable explanation of the contemplated treatment or procedure.

This duty of disclosure came up for decision in the case of *Lymbery v Jefferies*.<sup>306</sup> The patient suffered from fibroses of the uterus. The doctor advised X-ray treatment. The treatment caused the patient to sustain severe burns, which resulted in a great deal of pain and discomfort. The patient contended that the doctor had been negligent in:

- Failing to warn her that her ovaries would be destroyed and, as a result of that, she would be sterile; and
- failing to warn her that the treatment was dangerous and might cause pain and suffering.

With reference to the first contention, Wessels JA reasoned that since the doctor had told the patient that she would not see her menstrual periods again, she must have understood this to mean that she would not be capable of bearing children after the X-ray treatment. With reference to the second contention, the learned judge accepted that it may well have been the duty of a surgeon, before operating, to inform the patient that the operation was dangerous and may result in death, or cause great pain, and to have

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the treated areas, causing a shortening of the limbs and cosmetic changes, and that the treated limbs would possibly have to be amputated.. The doctor did not obtain the mother's consent to the treatment, despite there being ample time and opportunity to do so. As a result of the treatment, both the patient's legs and her right hand had to be amputated. She was also faced with the prospect of losing her left hand. In an action for damages for assault, the court held that the degree of urgency did not justify the radical X-ray treatment without consent. Bekker J rejected the contentions advanced on behalf of the doctor: The fact that the patient was brought to hospital, at the request of her mother, constituted proof of lawful consent to the ultimate radical treatment on the basis that the hospital should do what is best for the patient in order to preserve her life, regardless of the consequences; and that the hospital authorities were entitled to assume implied consent in view of the fact that the patient had on previous occasions been treated for the same condition. Bekker J decided that the first contention could not be supported because the last X-ray treatment was different in form and substance and more dangerous than the previous. The first contention could also not be upheld because, in the absence of knowledge and appreciation on the patient's part of the increased risks attached to the ultimate radical treatment, there could be no question of the necessary consent to subject her to them. See *Esterhuizen supra*.

<sup>306</sup> *Lymbery v Jefferies* 1925 AD 236. See also Van Oosten *LLD thesis* 39.

obtained the patient's consent to such operation. However, no danger was foreseen in the treatment ordered by the doctor and burns were rare in procedures like these. Therefore, the court held that a duty to disclose this information could not be imposed on the doctor.<sup>307</sup>

Although the doctor's duty to disclose has been part of South African law for a long time, the pertinent recognition and acceptance recently of the so called "doctrine of informed consent" by the landmark decision in *Castell v De Greef*<sup>308</sup> is a new development that is likely to make a considerable impact on the doctor-patient relationship in general and particularly on doctor-patient communication in South Africa. The facts of the case can be summarised as follows: On 7 August 1989, the plaintiff underwent a surgical operation known as subcutaneous mastectomy. The defendant, a plastic surgeon, performed the operation. The plaintiff had a family history of breast cancer. In 1989 further lumps were diagnosed. In view of her family history, her gynaecologist recommended a mastectomy as a prophylaxis and referred her to the defendant, who saw her in June 1989. It was common cause that on this occasion the plaintiff and her husband discussed the operation with the defendant at some length. What was proposed was a surgical procedure involving the removal of as much breast tissue as possible with the simultaneous reconstruction of the plaintiff's breast using silicone implants. The plaintiff decided to go ahead with the operation.<sup>309</sup>

However, as a result of the operation a discolouration of the plaintiff's areolae, necrosis of the tissues and an offensive-smelling discharge developed. Furthermore, the plaintiff contracted a *Staphylococcus Aureus* infection, suffered considerable pain, embarrassment and psychological trauma, and had to undergo several further surgical procedures to repair the damage.<sup>310</sup>

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<sup>307</sup> In *Dube v Administrator Transvaal*, the patient contracted Volkmann's ischemia after having been treated for a fractured arm that had been set too tightly in plaster. The hospital was held liable for damages based on negligence in not discharging its duty to inform. There was no contributory negligence on the part of the patient, since his failure to return to the hospital was attributable to the hospital's failure to warn the patient clearly and unambiguously to return immediately once any abnormal symptom became manifest. See *Dube v Administrator Transvaal* 1963 (4) SA 260 (W). According to the decision in *Rompel v Botha*, there is at least a duty on medical practitioners to inform their patients of the serious risks they run. See *Rompel v Botha supra*, as quoted in *Esterhuizen v Administrator Transvaal supra*.

<sup>308</sup> *Castell supra*.

<sup>309</sup> For a discussion of *Castell v De Greef* see Dreyer L "Redelike dokter versus redelike pasiënt: Castell v De Greef 1994 4 SA 408 (K)" 1995 58 *THRHR* 3:532-539. See also Earle 1995 *SALJ* 629; Van den Heever P "The patient's right to know informed consent in SA medical law" 1995 *De Rebus* 325: 53; Van Oosten 1995 *De Jure* 164-179.

<sup>310</sup> *Castell supra*.

The plaintiff asserted that the defendant had had a duty to warn her of the material risks and complications attached to the procedure, and to inform her of any specific alternative procedures that might minimise such risks or complications. In breach of such duty, the plaintiff claimed, the defendant had failed to advise her that:

- A transposition of her areolae, which increased the risk of necrosis developing post-operatively, was intended;
- the transposition of the areolae was not essential, that it was done for cosmetic reasons, and that it was the plaintiff's choice whether or not she wanted it done;
- there was an alternative surgical procedure involving less risk of necrosis and/or infection;
- the intended operation had a complication rate as high as 50%; and
- it is virtually impossible to avert or curtail necrosis once it arises post-operatively.<sup>311</sup>

Many of the grounds of negligence were subsequently abandoned or not persisted in on appeal. The issue of the defendant's negligence was limited to the following three grounds:

- The defendant's failure to warn the plaintiff of the material risks and complications of the operation;<sup>312</sup>
- The defendant's failure to prevent the onset of or limit the extent of necrosis in the plaintiff's breast; and

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<sup>311</sup> *Ibid.*

<sup>312</sup> See further *Richter v Estate Hammann* 1976 (3) SA 226 (C). The patient, a woman, had fallen on the sharp edge of a chair, as a result of which her coccyx was injured. The doctor, a neurosurgeon, gave her an injection to affect a phenol block of the lower sacral nerves. Her pain was relieved, but the injection had unfortunate consequences for the patient namely: (a) Loss of control of the bladder and bowel; (b) Loss of sexual feeling; and (c) Loss of power in the right leg and foot. The plaintiff's action for damages was based on negligence on the doctor's part in that he failed to inform the patient of the dangers associated with a phenol block. Watermeyer J adopted a doctor-based, professional standard approach and made the following remarks: "It may well be that in certain circumstances a doctor is negligent if he fails to warn a patient, and if that is so, it seems to me in principle that his conduct should be tested by the standard of the reasonable doctor faced with the particular problem. In reaching a conclusion a court should be guided by medical opinion as to what a reasonable doctor, having regard to all the circumstances of the particular case, should or should not do. The court must, of course, make up its own mind, but it will be assisted in doing so by medical evidence." The court held that even if the patient indicated she would have refused to undergo the treatment had she been warned of the incidence of risk, the possibility of such complications was too remote to establish negligence on the doctor's part for his failure to warn her of such risks.

- The defendant's failure to adequately or timeously treat the post-operative sepsis that had allegedly developed in the plaintiff's breasts.<sup>313</sup>

After a detailed examination of local and foreign case law and legal opinion, Ackermann J, Friedman JP, and Farlam J, concurring, gave a careful judgment on the following terms: Firstly, the learned judges rejected the notion that the reasonable doctor test of disclosure is well-established in our law, as well as the notion that the reasonable doctor does not leave the determination of a legal duty to the judgment of doctors. There is not only a justification, but indeed a necessity for introducing the patient-orientated doctrine of informed consent into South African law: "It is clearly for the patient to decide whether he or she wishes to undergo the operation, in the exercise of the patient's fundamental right to self-determination."<sup>314</sup> Secondly, the learned judges took the view that the issue of the doctor's duty of disclosure is "(i)n South African law ... treated not as one of negligence, arising from the breach of a duty of care, but as one of consent to the injury involved and the assumption of an unintended risk". In the South African context, the doctor's duty to disclose a material risk must be seen in the contractual setting of an unimpeachable consent to the operation and its *sequelae*.<sup>315</sup> Thirdly, the learned judges concluded that for the patient's consent to constitute a justification that excludes the wrongfulness of medical treatment and its consequences, the doctor is obliged to warn the patient of the material risks<sup>316</sup> inherent in the proposed treatment. A risk is material if in the particular circumstances:

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<sup>313</sup> *Castell supra*.

<sup>314</sup> In *Phillips v De Klerk*, the court confirmed the principle of patient self-determination by recognising the patient's right to refuse a blood transfusion. The case is of special significance in relation to the refusal of medical treatment by a patient. According to Strauss, if there is a conflict between the desire of a person to go his own way, to forego medical treatment and to expire in his own manner on the one hand; and the desire of the doctor to cure him of his disease or to secure his health on the other, the former should be accorded preference. He submits that our law allows a person to refuse medical treatment or a particular form of treatment, even if that may result in the patient's health deteriorating or in his death. See *Phillips v De Klerk supra*. As far as married couples are concerned, the general rule is that each spouse is fully entitled to consent independently to any medical treatment. In *Palmer v Palmer* the judge ruled that the personal guardianship of a husband over his wife does not give the husband the right to interfere with the wife's personal freedom to the extent that he can force her to undergo a medical examination against her will. See *Palmer v Palmer* 1955 (3) SA 56(0).

<sup>315</sup> See *Behrmann v Klugman supra*. For a discussion of the case see Strauss (1991) 176-177. See also *Stoffberg v Elliot supra*; *Esterhuizen v Administrator Transvaal supra*; *Oldwage v Louwrens* (2004) 1 ALL SA 532 (C); *Louwrens v Oldwage* (2005) JOL 15618 (SCA); *Richter v Estate Hammann supra*; *Broude v McIntosh* 1998 (3) SA 60 (SCA).

<sup>316</sup> Under certain circumstances physicians are exempted from their duty to warn and disclose, and the concomitant requirement to obtain a patient's informed consent: (1) In the event of an emergency. (2) Where a patient is brought to hospital in a critical, unconscious condition it is not necessary to try and obtain his permission before treating him. The physician will be able to rely on the doctrine of *negotiorum gestio* to justify his conduct. (3) In cases where the patient

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

This accords the fundamental right of individual autonomy and self-determination, and sets its face against medical paternalism. However, the duty to warn is subject to the therapeutic privilege.<sup>317</sup> A practitioner may withhold information regarding the diagnosis or the potential effect of treatment from his patient where, after thorough consideration, he is of the opinion that the disclosure of such information will be detrimental to the patient's recovery.<sup>318</sup> Finally, it is necessary for the use of expert evidence in determining what risks are inherent in or the result of particular treatment.<sup>319</sup> On the facts, the learned judge found that the evidence in respect of the plaintiff's claims was to the effect that:

- The plaintiff had been aware of the intended transposition of her areolae and the risks involved in the procedure;
- the particular type of subcutaneous mastectomy and prosthesis insertion involved a materially higher risk than the two-stage procedure alluded to, and the defendant had explained the two-stage procedure to the plaintiff, who opted for the procedure practised by the defendant; and
- the plaintiff knew that the damage caused by the operation was not reversible without reconstructive surgery, that it was quite unnecessary for the defendant to explain to the plaintiff the intermediate pathological process, and that an explanation would have influenced the plaintiff's decision.<sup>320</sup>

In conclusion, the decision of *Castell v De Greef* is of importance for both the medical and legal professions for the following reasons:

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indicates that he does not wish to be informed of the nature of the proposed treatment, the risks involved or the probable consequences. See Claassen & Verschoor 69.

<sup>317</sup> Van den Heever 1995 *De Rebus* 53 at 56; Van Oosten 1995 *De Jure* 164 at 173-178.

<sup>318</sup> Claassen & Verschoor 78.

<sup>319</sup> *Castell supra*. See also *Michael v Linksfeld Park Clinic (Pty) Ltd* 2001 3 SA 1188 (SCA); Carstens PA "Setting the boundaries for expert evidence in support or defence of medical negligence: *Michael v Linksfeld Park Clinic (Pty) Ltd* 2001 (3) SA 1188 (SCA)" 2002 65 *THRHR* 3:430-436.

<sup>320</sup> *Castell supra*.

- Medical paternalism is ousted in favour of patient autonomy;
- the court rightly proceeds from the assumption that the decision to undergo or refuse a medical intervention is, in the final analysis, that of the patient and not that of the doctor;<sup>321</sup>
- the question now is whether or not the reasonable patient would have regarded the risk or danger as significant, or whether or not the doctor was or could have been aware that the individual patient would regard the risk or danger as significant;<sup>322</sup>
- although the court gave recognition to the so-called therapeutic privilege,<sup>323</sup> its approach to the defence is to some extent ambivalent. (On the one hand, the court appears to accept that the therapeutic privilege sets a limit to the doctor's duty of disclosure, while on the other, it seems to associate the defence with medical paternalism. The appropriate legal defence in this regard would then be necessity as a justification.);
- the court prefers to place the doctor's duty of disclosure and its concomitant – that the patient's informed consent – within the framework of the wrongfulness element rather than the fault element;<sup>324</sup> and
- the court remarks that the doctor is also under a contractual obligation to furnish the patient with information.

*Castell v De Greef* provided a basis from which further developments within the context of informed consent may follow. With reference to the *Castell* case, the doctrine of informed consent was recently applied in the case of *Oldwage v Louwrens*.<sup>325</sup> The plaintiff experienced back pain and was referred to the defendant for an examination. After examining the plaintiff, the defendant concluded that the plaintiff had a vascular condition. The plaintiff underwent an electrocardiogram and an angiogram, which confirmed the vascular problem, and the plaintiff was informed that an operation was necessary to relieve his pain. On discharge,

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<sup>321</sup> See also *Phillips supra*.

<sup>322</sup> Van Oosten 1995 *De Jure* 164 at 176, 177.

<sup>323</sup> For a discussion of the therapeutic privilege see Welz D "The boundaries of medical therapeutic privilege" 1999 116 *SALJ* 2:299-322.

<sup>324</sup> The wrongfulness element, namely *volenti non fit injuria*, or voluntary assumption, is where the risk of harm is used as a justification. The fault element refers to intention or negligence in delict. See Dreyer 1995 *THRHR* 532 at 534.

<sup>325</sup> *Oldwage supra*. For a discussion of this case, see Wilson M "When is a risk of medical treatment material?" 2006 *De Rebus* 451:22-25.

the plaintiff was still in pain. A few days later, the plaintiff went for a walk and experienced cramps and pains in his leg. The plaintiff complained of this to the defendant. He continued to experience pain in his leg for the following week and consulted another specialist, Dr Kieck. Dr Kieck operated on the plaintiff's back and performed a right L4 laminotomy. The plaintiff's pain was immediately gone after the lumbar operation and he was discharged from hospital four days later. The issues in this case, in the final analysis, that will call for determination are whether the defendant acted in breach of his obligation arising from the agreement entered into between the plaintiff and the defendant; whether the defendant misrepresented to the plaintiff that the vascular procedure performed would relieve the plaintiff of the severe pain; and whether, in that event, the defendant's conduct constitutes assault rendering him liable for whatever damages the plaintiff might prove. The court held that a medical practitioner is bound to employ reasonable skill and care and is liable for the consequences if he does not. The defendant had failed to correctly diagnose the source of the plaintiff's pain. Had the defendant not so failed, he would in all probability have referred the plaintiff to a neurosurgeon, and if that had been done, the neurological problem would have been addressed first, alleviating the need for the procedure performed by the defendant. The standard adopted by the defendant had not been the reasonable standard expected from a man of his calling. With reference to *Castell v De Greef*, the plaintiff had not been properly counselled before the operation, other options had not been properly discussed with him, and he had not been advised of the material risks associated with the operation. It was concluded that the plaintiff had not given an informed consent to the operation. The defendant's conduct had amounted to an assault upon the plaintiff.

On 21 September 2005, the Supreme Court of Appeal delivered judgment in the matter of *Louwrens v Oldwage*.<sup>326</sup> Although the court referred to *Castell v de Greef* and approved the medical opinion/reasonable doctor test as set out in *Richter v Estate Hamman*,<sup>327</sup> it appears from the judgment that the court did not apply either of the tests. The court found that a remote risk need not have been disclosed. It found support for the decision in the *Richter* case. However, in its judgment, the court did not consider exactly what was meant by "remote" in the circumstances of the *Richter* case. The court held that the risk of claudication occurring was remote and need not be disclosed. The court further held that the harm the plaintiff had suffered had not in any event been caused by the risk and the harm had not been caused by the defendant. According to Wilson, the

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<sup>326</sup> *Louwrens v Oldwage supra*.

<sup>327</sup> *Richter v Estate Hamman supra*.

judgment was disappointing. While the court did not apply the subjective patient-centred approach, it did not overrule it. There is, therefore, as yet no binding judgment by the Supreme Court of Appeal as to what the correct approach to determining the boundaries of a material risk to medical treatment may be. In the absence of such a judgment, courts are still free to follow the patient-centred approach, which was extensively and cogently argued in *Castell v de Greef*.<sup>328</sup>

#### 5.12.5 Consent provisions as stipulated in the Mental Health Care Act

Section 9 of this Act states that a health care provider<sup>329</sup> or a health establishment<sup>330</sup> may provide care, treatment and rehabilitation services to, or admit, a mental health care user only if the user has consented<sup>331</sup> to the care, treatment and rehabilitation services or to admission; the provision of these services has been authorised by a court order or a Review Board; or if any delay in providing care, treatment and rehabilitation services or admission could result in the death or irreversible harm to the health of the user, where the delay may cause the user to inflict serious harm on himself or herself or others and where the delay may result in the user causing serious damage to or loss of property belonging to him, or her, or others.

#### 5.12.6 Consent provisions as stipulated in the National Health Act

The National Health Act contains general provisions pertaining to consent to medical treatment, as well as consent to research. Section 6 of the National Health Act requires a user, as defined in the Act, to have full knowledge of the proposed treatment. Every health care provider must inform a user of –

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

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<sup>328</sup> Wilson 2006 *De Rebus* 22 at 24, 25.

<sup>329</sup> "Health care provider" means a person providing health care services. See s 1 of the Mental Health Care Act.

<sup>330</sup> "Health establishment" means institutions, facilities, buildings or places where persons receive care, treatment, rehabilitative assistance, diagnostic or therapeutic interventions or other health services and includes facilities such as community health and rehabilitation centres, clinics, hospitals and psychiatric hospitals. See s 1 of the Mental Health Care Act.

<sup>331</sup> "Informed consent" is defined in s 7(3) of the National Health Act as consent for the provision of a specified health service given by a person with legal capacity to do so and who has been informed as contemplated in s 6.

- (d) the user's right to refuse health services and the implications, risks and obligations of such refusal.<sup>332</sup>

The health care provider concerned must, where possible, inform the user, as contemplated in subsection (1), in a language that the user understands and in a manner that takes into account the user's level of literacy.<sup>333</sup>

Section 7 of the National Health Act regulates the consent of the user and provides for the following:

Subject to section 8,<sup>334</sup> a health service<sup>335</sup> may not be provided to a user without the user's informed consent,<sup>336</sup> unless –

- (a) the user is unable to give informed consent and such consent is given by a person mandated by the user, in writing, to grant consent on his or her behalf; or authorised to give such consent in terms of any law or court order;
- (b) the user is unable to give informed consent and no person is mandated or authorised to give such consent, and the consent is given by the spouse or partner of the user or, in the absence of such spouse or partner, a parent, grandparent, an adult child or a brother or a sister of the user, in the specific order as listed;
- (c) the provision of a health service without informed consent is authorised in terms of any law or a court order;
- (d) failure to treat the user, or group of people which includes the user, will result in a serious risk to public health; or
- (e) any delay in the provision of the health service to the user might result in his or her death or irreversible damage to his or her health and the user has not expressly, implied or by conduct, refused that service.<sup>337</sup>

A health care provider must take all reasonable steps to obtain the user's informed consent.<sup>338</sup>

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<sup>332</sup> S 6(1)(a)-(d).

<sup>333</sup> S 6(2).

<sup>334</sup> S 8 reads as follows: "Participation in decisions: (1) A user has the right to participate in any decision affecting his or her personal health and treatment. (2)(a) If the informed consent required by s 7 is given by a person other than the user, such person must, if possible, consult the user before giving the required consent. (b) A user who is capable of understanding must be informed as contemplated in s 6 even if he or she lacks the legal capacity to give the informed consent required by s 7. (3) If a user is unable to participate in a decision affecting his or her personal health and treatment, he or she must be informed as contemplated in s 6 after the provision of the health service in question unless the disclosure of such information would be contrary to the user's best interest."

<sup>335</sup> "Health service" means: (a) Health care services, including reproductive health care and emergency medical treatment, contemplated in s 27 of the Constitution; (b) Basic nutrition and basic health care services contemplated in s 28(1)(c) of the Constitution; (c) Medical treatment contemplated in s 35(2)(e) of the Constitution; and (d) Municipal health services. See s 1.

<sup>336</sup> For the purposes of s 7, "informed consent" means consent for the provision of a specified health service given by a person with legal capacity to do so and who has been informed as contemplated in s 6. See s 7(3).

<sup>337</sup> S 7(1).

<sup>338</sup> S 7(2).

Section 9 of the National Health Act regulates health services without consent. Subject to any applicable law, where a user is admitted to a health establishment without his or her consent, the health establishment must notify the head of the provincial department of the province in which that health establishment is situated within 48 hours after the user was admitted of the admission and submit any other information as may be prescribed.<sup>339</sup> If the 48-hour-period contemplated in subsection (1) expires on a Saturday, Sunday or public holiday, the health establishment must notify the head of the provincial department of the user's admission and must submit the other information contemplated in subsection (1) at any time before noon of the next day that is not a Saturday, Sunday or public holiday.<sup>340</sup> Subsection (1) does not apply if the user consents to the provision of any health service in that health establishment within 24 hours of admission.<sup>341</sup>

### 5.12.7 Consent to medical research

Section 11 of the National Health Act regulates health services for experimental or research purposes. Before a health establishment provides a health service for experimental or research purposes to any user, and subject to subsection (2), the health establishment must inform the user in the prescribed manner that the health service is for experimental or research purposes or part of an experimental or research project.<sup>342</sup> A health establishment may not provide any health service to a user for a purpose contemplated in subsection (1) unless the user, the health care provider primarily responsible for the user's treatment, the head of the health establishment in question and the relevant health research ethics committee<sup>343</sup> or any other person to whom that authority has been delegated, has given prior written authorisation for the provision of the health service in question.<sup>344</sup>

Section 71 of the National Health Act specifically regulates research on or experimentation with human subjects and reads as follows:<sup>345</sup>

(1) Notwithstanding anything to the contrary in any other law, research or experimentation on a living person may only be conducted –

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<sup>339</sup> S 9(1).

<sup>340</sup> S 9(2).

<sup>341</sup> S 9(3).

<sup>342</sup> S 11(1).

<sup>343</sup> S 73.

<sup>344</sup> S 11(2).

<sup>345</sup> See also Nienaber A "The statutory regulation of children's participation in HIV-related clinical research: More questions than answers" 2008 71 *THRHR* 671-677.

- (a) In the prescribed manner; and
  - (b) with the written consent of the person after he or she has been informed of the objects of the research or experimentation and any possible positive or negative consequences on his or her health.
- (2) Where research or experimentation is to be conducted on a minor for a therapeutic purpose, the research or experimentation may only be conducted –
- (i) if it is in the best interests of the minor;
  - (ii) in such manner and on such conditions as may be prescribed;
  - (iii) with the consent of the parent or guardian of the child; and
  - (iv) if the minor is capable of understanding, with the consent of the minor.
- (3) (a) Where research or experimentation is to be conducted on a non-therapeutic purpose, the research or experimentation may only be conducted –
- (i) in such manner and on such conditions as may be prescribed;
  - (ii) with the consent of the Minister;
  - (iii) with the consent of the parent or guardian of the minor; and
  - (iv) if the minor is capable of understanding, the consent of the minor.
- or
- (b) The Minister may not give consent in circumstances where –
- (i) the objects of the research or experimentation can also be achieved if it is conducted on an adult;
  - (ii) the research or experimentation is not likely to significantly improve scientific understanding of the minor's condition, disease or disorder to such an extent that it will result in significant benefit to the minor or other minors;
  - (iii) the reasons for the consent to the research or experimentation by the parent or guardian and, if applicable, the minor are contrary to public policy;
  - (iv) the research or experimentation poses a significant risk<sup>346</sup> to the health of the minor; or
  - (v) there is some risk to the health or wellbeing of the minor and the potential benefit of the research or experimentation does not significantly outweigh that risk.

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<sup>346</sup> The term "risk" is material to consent in the sense that the risk attached to research undertaken with consent may, depending on whether such research is therapeutic or non-therapeutic, or invasive or non-invasive, not exceed the limits prescribed by the guidelines. In terms of the risk/benefit analysis, the risk to which the patient is exposed "must be justifiable in relation to the value of the information sought". Risk refers to both the probability of a harm resulting from an activity and to its magnitude. Risks are divided into "negligible or less than minimal risk", "minimal risk", and "more than minimal risk". In therapeutic research, the benefits likely to accrue to the patient should outweigh the possible risk of harm and the patient should, as a general rule, not be exposed to greater than minimal risk. In non-therapeutic research, the patient should not be subjected to more than minimal risk. See Van Oosten 2000 *THRHR* 5 at 11, 12.

According to the Medical Research Council's Guidelines, research subjects should know that they are taking part in research, and research involving subjects should only be carried out with their consent. Furthermore, for consent to be valid it should be offered voluntarily and be based on adequate understanding with due regard for the patient's language and culture.

#### **5.12.8 Consent with regard to research on minors**

In terms of section 39(4) of the Child Care Act,<sup>347</sup> and in the absence of specific legislation to the contrary, minors who have reached the age of fourteen years are legally capable of consenting to medical treatment of themselves and their children. Minors who have reached the age of eighteen years are legally capable, in addition, of consenting to medical operations on themselves. Such consent is valid only where the minor is sane and sober. The consent of a parent or legal guardian is required for treatment if the minor is under the age of fourteen years, and for an operation if the minor is under the age of eighteen years. In the event of conflicting views between the child's father and mother, the child's best interest settles the matter. "Medical treatment" is not defined in the Act, but would probably exclude non-therapeutic medical research. Therapeutic research, therefore, may be undertaken with the consent of a minor over the age of fourteen years if it takes the form of treatment; and with the consent of a minor over the age of eighteen years if it involves an operation. Such minors' competence to consent accordingly extends to health research which is tantamount to treatment or an operation and, hence, to therapeutic research only.

According to the Children's Act, a child may consent, subject to paragraph (b), to medical treatment or a surgical operation, provided the child is at least twelve years of age; and is of sufficient maturity and has the mental capacity to understand the benefits, risks and social implications of the treatment or operation. A child may not consent to a surgical operation in terms of paragraph (a) without the assistance of the parent of the child; or the primary caregiver of the child. The parent or primary caregiver of a child may, subject to section 31, consent to the medical treatment of or a surgical operation on the child if the child is under the

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<sup>347</sup> The Child Care Act 74 of 1983 (hereafter referred to as the Child Care Act). It is important to note that the Children's Act will soon be repealed by the Children's Act 35 of 2008 (hereafter referred to as the Children's Act). Only certain provisions of the Children's Act are in operation as yet. Therefore the Child Care Act is still applicable in certain circumstances. The following provisions of the Children's Act came into operation on 1 July 2007: SS 1-11; 13-21; 27; 30-31; 35-40; 130-134; 305; 307-311; 313-315.

age of twelve years; or over that age but is of insufficient maturity or does not have the mental capacity to understand the benefits, risks and social implications of the treatment or operation.<sup>348</sup>

Non-therapeutic research on minors is not permissible, except where parental consent, and the assent of the minor concerned, is obtained for:

- (a) Observation research of a non-therapeutic and non-invasive nature, because there is no risk and no interference with the integrity of the minor, provided that the research entails no more than negligible distress or discomfort; or
- (b) observation research of a non-therapeutic and invasive nature, provided that no more than a normal negligible risk is foreseeable or known from routine clinical practice, and that the distress or discomfort is negligible.

Proxy consent to therapeutic research on incompetent minors younger than fourteen years (to treatment) or younger than eighteen years (to an operation) must be obtained. Furthermore, the assent of minors must also be obtained, provided they are mentally able to comprehend the issues involved. The research should pertain, directly or indirectly, to the illness or disease from which the child suffers. Where non-therapeutic research is involved, proxy consent may be obtained for the following:

- Observation research of a non-therapeutic and non-invasive nature, because there is no risk and no interference with the integrity of the minor, provided that the research entails no more than negligible distress or discomfort to the minor; or
- Observation research of a non-therapeutic and invasive nature, provided that normally no more than negligible risk is foreseeable or known from routine clinical practice and that the distress or discomfort is negligible.

In addition to the above, the following requirements must be met in non-therapeutic research:

- The proposed research must pertain, directly or indirectly, to a condition from which the minor suffers.
- The assent of the minor must be sought and his or her objection must be regarded as decisive.

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<sup>348</sup> S 129 (1-3).

- Research involving minors must significantly benefit minors of the same category as the research participant; and the same scientific results cannot be obtained by research on persons who do not belong to this category, or by other methods.

All types of clinical research on minors are presumed to be non-therapeutic. This avoids labelling clinical research of little or no benefit to the minor as "therapeutic". This ensures that such research is subjected to strict scrutiny and conditions, and that minors are not abused or unduly influenced for research purposes.<sup>349</sup>

In addition, the Ethical Rules of Conduct to which a Psychologist shall adhere stipulates that: "A psychologist shall plan and conduct research in a manner consistent with the law, internationally acceptable standards governing the conduct of research, and particularly those national and international standards governing research with human participants and animal subjects."<sup>350</sup>

Furthermore, a psychologist must:

- Obtain written approval prior to conducting research from a host institution or organisation;
- provide accurate information about his or her research proposals; and
- conduct the research in accordance with the research protocol approved by such institution or organisation.<sup>351</sup>

In terms of section 88, prior to conducting research (except research involving only anonymous surveys, naturalistic observations, or similar research), a psychologist must enter with a participant into an agreement that clarifies the nature of the research and the responsibilities of each party.

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<sup>349</sup> Benatar SR et al "Ethics for health research: Book 1: General principles including research on children, vulnerable groups, international collaboration, and epidemiology" 1999 [www.sahealthinfo.org/ethics/book1.htm](http://www.sahealthinfo.org/ethics/book1.htm) (Date of access: 10 March 2009)

<sup>350</sup> S 86.

<sup>351</sup> S 87(a-c).

Section 89 regulates informed consent with regard to research and requires that: "A psychologist shall use language that is reasonably understandable to a research participant in obtaining his or her appropriate informed consent."<sup>352</sup>

Informed consent must also be appropriately documented and must:

- Inform a participant of the nature of the research;
- inform a participant that he or she is free to participate or to decline to participate or to withdraw from the research;
- explain the foreseeable consequences of declining or withdrawing;
- inform a participant of significant factors that may be expected to influence his or her willingness to participate (such as risks, discomfort, adverse effects or limitations on confidentiality);
- explain other aspects about which a participant enquires;
- when conducting research with a research participant such as a student or subordinate, take special care to protect such participant from adverse consequences of declining or withdrawing from participation;
- when research participation is a course requirement or opportunity for extra credit, give a participant the choice of equitable alternative activities; and
- in the case of a person who is legally incapable of giving informed consent, nevertheless provide an appropriate explanation; obtain the participant's assent; and obtain appropriate permission from a legally authorised person.<sup>353</sup>

With regard to the offering of psychological services as inducements for research participants, a psychologist must:

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<sup>352</sup> S 89(1).

<sup>353</sup> S 89(2)(a-h(i-iv)). In addition, s 90 stipulates that: "Before determining that planned research (such as research involving only anonymous questionnaires, naturalistic observations, or certain kinds of archival research), does not require the informed consent of a participant, a psychologist shall consider applicable regulations and institutional review board requirements, and shall consult with colleagues as may be appropriate." S 91 stipulates that: "A psychologist shall obtain informed consent from a participant prior to filming or recording him or her in any form, unless the research involves simply naturalistic observations in public places and it is not anticipated that the recording will be used in a manner that could cause personal identification or harm to such participant."

- Make clear the nature of such services, as well as their risks, obligations, and limitations; and
- not offer excessive or inappropriate financial or other inducements to obtain a participant, particularly when it might tend to coerce participation.<sup>354</sup>

Of further importance is section 94, which regulates the debriefing of research participants:

- A psychologist shall provide a prompt opportunity for a participants to obtain appropriate information about the nature, results, and conclusions of the research, and such psychologist shall attempt to correct any misconceptions that such participant may have and -
- (a) if scientific or humane values justify delaying or withholding this information, such psychologist shall take reasonable measures to reduce the risk of harm; or
  - (b) when such psychologist becomes aware that research procedures have harmed such participant, such psychologist shall take reasonable steps to minimise the harm.

## 5.13 ENFORCING SOCIO-ECONOMIC RIGHTS<sup>355</sup>

### 5.13.1 Introduction

A primary characteristic of the Constitution is that it provides extensive recognition and entrenchment of socio-economic rights. The Bill of Rights itself makes no distinction between first, second and third generational rights. Socio-economic rights are therefore accorded the same status as political and civil rights. According to Van Wyk, the content of third generational rights, in contrast to second generational rights, cannot be concretised and are not really enforceable.<sup>356</sup> However, in *Ex parte Chairperson of the Constitutional Assembly: In Re: Certification of the Constitution of the Republic of South Africa*, it was confirmed that socio-economic rights, although not universally accepted, are "at least to some extent

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<sup>354</sup> S 92(a-b). S 93 (1-3) regulates deception in research and stipulates that: "(1) A psychologist shall not conduct a study involving deception unless he or she has determined that the use of deceptive techniques is justified by the study's prospective scientific, educational or applied value and that equally effective alternative procedures that do not use deception are not feasible. (2) A psychologist shall never deceive a participant about significant aspects that would affect such participant's willingness to participate, such as physical risks, discomfort or unpleasant emotional experiences. (3) Any other deception that is an integral feature of the design and conduct of an experiment shall be explained by a psychologist to a participant as early as is feasible, preferably at the conclusion of such participant's participation, but no later than at the conclusion of the research."

<sup>171</sup> See Newman DG "Institutional monitoring of social and economic rights: A South African case study and a new research agenda" 2003 19 *SAJHR* 2:189-216; Bollyky TJ "R if C > P + B: A paradigm for judicial remedies of socio-economic rights violations" 2002 18 *SAJHR* 2:161-200; Bilchitz D "Towards a reasonable approach to the minimum core: Laying the foundations for future socio-economic rights jurisprudence" 2003 19 *SAJHR* 1:1-26.

<sup>356</sup> Van Wyk J *Planning Law in South Africa* (1999) 34.

justiciable".<sup>357</sup> This case stressed the concept that the rights entrenched in the Bill of Rights are interdependent and indivisible.<sup>358</sup>

The Constitution places both negative and positive duties on the state in relation to socio-economic rights. Section 7(2) of the Constitution requires the state to "respect, promote, and fulfil" the rights contained in the Bill of Rights. This affords the beneficiary a right to require the state to take both negative and positive action. However, the exact nature and scope of this obligation is dependent on the wording of the right and its relationship with other fundamental rights.<sup>359</sup> "Respect" in this context requires negative action on behalf of the state, in that it may not unjustly interfere with an individual's fundamental rights. In the context of reproductive health, this would require the state to desist from impairing the realisation of a woman's right to reproductive health care, which would include the right to terminate her pregnancy. The duty to "promote" in essence means that the state must take positive steps to guarantee that relevant executive and legislative frameworks are in place to ensure protection of its citizens, in particular the vulnerable groups in society.<sup>360</sup> The term "fulfil" implies that the state must provide for the realisation of the right by directly providing in the need, for example by making necessary resources available.

However, in *Soobramoney v The Minister of Health*, the Constitutional Court confirmed that socio-economic rights may nevertheless be qualified by the availability of resources and that there is no unqualified obligation imposed on the state to meet existing needs.<sup>361</sup> The case served to entrench a non-interventionist approach by the courts, provided that the measures adopted by the state are reasonable in both their conception and implementation. The case of *Government of the Republic of South Africa and Others v Grootboom and Others*<sup>362</sup> stressed that a balance must be struck between the objectives set out in

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<sup>357</sup> *Ex parte Chairperson of the Constitutional Assembly: In Re: Certification of the Constitution of the Republic of South Africa* 1996 (4) SA 744 (CC).

<sup>358</sup> The Constitutional Court in *S v Mhlungu* emphasised that constitutional rights must be understood and determined against the background of past human rights abuses and the legacy of inequality and poverty. See *S v Mhlungu* 1995 (3) SA 867 (CC).

<sup>359</sup> Fundamental rights are not absolute: A specific right may contain an internal limitation, confining its scope and application. S 7(3) makes reference to an external limitation of constitutional rights by providing that the Bill of Rights are subject to the limitation clause contained in section 36, in that the limitation must be justifiable in an open and democratic society based on human dignity, equality and freedom.

<sup>360</sup> *Government of the Republic of South Africa and Others v Grootboom and Others* 2001 (1) SA 46 (CC).

<sup>361</sup> *Soobramoney v Minister of Health, KwaZulu-Natal* 1997 12 BCLR 1696 (CC).

<sup>362</sup> *Government of the Republic of South Africa and Others v Grootboom supra*. See also Liebenberg S "The right to social assistance: The implications of Grootboom for policy reform in South Africa" 2001 17 SAJHR 2:232-257.

the Constitution and the means available to achieve these goals. These measures must seek to attain the aims expeditiously and effectively, but the availability of resources may play a significant role in determining what may be construed as reasonable. The court was of the opinion that the yardstick of reasonableness is to be understood within the context of the Bill of Rights. *Grootboom* drew attention to the fact that due regard must be given to both the extent and impact of the historical disadvantage and must ensure that the basic necessities of life are made available, in particular, to those groups that are the most vulnerable in society.

### 5.13.2 Basic core obligations and essential services

The state, in the context of the International Covenant on Economic, Social and Cultural Rights,<sup>363</sup> has "a minimum core obligation to ensure the satisfaction of, at the very least, minimum essential levels" of these rights.<sup>364</sup> The state only discharges a basic core obligation, provided that it is able to attribute its failure to meet the minimum level of delivery to a lack of available resources. The state has to demonstrate that every effort has been made to meet this minimum level.

## 5.14 SECTION 27<sup>365</sup> OF THE CONSTITUTION: ACCESS TO HEALTH CARE SERVICES

The translation of human rights into rights that transcend rhetoric is an enduring challenge for the community of nations. The challenge is to engage policy-makers and domestic courts to see how they might play a more effective role in promoting the realisation of the right to health care. The challenge also lies in developing new thinking about effective and feasible ways of implementing the right at a

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<sup>363</sup> S 41(6)(d) of The International Covenant on Economic, Social and Cultural Rights. The International Covenant on Economic, Social and Cultural Rights was adopted and opened for signature, ratification and accession by the General Assembly resolution 2200A (XXI) on 16 December 1966. It was entered into force on the 03<sup>rd</sup> of January 1976 in accordance with Article 27, which states that: "1. The present Covenant shall enter into force three months after the date of the deposit with the Secretary-General of the United Nations of the thirty-fifth instrument of ratification or instrument of accession. 2. For each State ratifying the present Covenant or acceding to it after the deposit of the thirty-fifth instrument of ratification or instrument of accession, the present Covenant shall enter into force three months after the date of the deposit of its own instrument of ratification or instrument of accession."

<sup>364</sup> Although South Africa is not a party to the *International Covenant on Economic, Social and Cultural Rights*, a court must consider international law in terms of s 39(2) when interpreting the Bill of Rights.

<sup>365</sup> S 27 of the Constitution reads as follows: "Health care, food, water, and social security. (1) Everyone has the right to have access to: (a) health care services, including reproductive health care; (b) sufficient food and water; and (c) social security, including, if they are unable to support themselves and their dependants, appropriate social assistance. (2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights. (3) No one may be refused emergency medical treatment."

programmatic level so that it does not remain an abstract ideal that rarely rises above rhetoric.<sup>366</sup> Mental health care is among the most grossly neglected elements of the right to health care services.<sup>367</sup>

Hunt<sup>368</sup> submits that states should take steps to ensure a full package of community-based physical and mental healthcare and support services conducive to health, dignity and non-discrimination. The ideal package should include medication, psychotherapy, ambulatory services, hospital care for acute admissions, residential facilities, rehabilitation for persons with psychiatric disabilities, programs to maximise the independence and skills of persons with mental disorders, supported housing and employment, income support, inclusive and appropriate education for children with mental disorders, and respite care for families looking after a person with a mental disability twenty-four hours a day. In this way, unnecessary institutionalisation can be avoided.

It was submitted by Fremouw<sup>369</sup> already in 1976 that the fact that a person has a mental disorder is not a crime. Therefore, if anyone is involuntary restrained of his liberty because of a mental disorder, the state owes a duty to provide him or her reasonable medical attention. If medical attention reasonably well adapted to his or her needs is not given, the person is not a patient but virtually a prisoner. The absence of treatment might draw the constitutionality of the mandatory section of access to health care services into question. It is also submitted by the author that failure to supply treatment may violate the equal protection clause. Indefinite confinement without treatment of one who has been found not criminally responsible may be so inhumane as to be cruel punishment.

Health care is generally considered to be a basic need. Section 27(1)(a) of the Constitution provides specifically that everyone has the right to have access to health care, including reproductive health care.

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<sup>366</sup> Cook RJ & Ngweni CG (eds) *The International Library of Medicine, Ethics and Law: Health and human rights* (2007) xiii.

<sup>367</sup> Hunt & Mesquita 2006 *Human Rts Quarterly* 332 at 333.

<sup>368</sup> Hunt further argues that augmenting interventions to ensure equality of opportunity for the enjoyment of the right to health will require training adequate numbers of professionals, including psychiatrists, clinical psychologists, psychiatric nurses, psychiatric social workers, occupational therapists, speech therapists, behavioural therapists and caregivers in order to work toward the care and full integration of individuals with mental disabilities in the community. General practitioners and other primary care providers should be provided with essential mental healthcare and disability sensitisation training to enable them to provide front-line mental and physical healthcare to persons with mental disabilities. See Hunt & Mesquita 2006 *Human Rts Quarterly* 332 at 345.

<sup>369</sup> Fremouw WJ "A new right to treatment" 7-28 in *The right to treatment for mental patients* ((eds) Golann S & Fremouw WJ) (1976) 7, 9.

This right is, however, limited internally by section 27(2), which says that the state must take reasonable and legislative and other measures, within its available resources, to achieve the progressive realisation of these rights.<sup>370</sup> It is important to note that the Constitution does not guarantee a right to health, but only the qualified right of access to health care services. A further question that is of importance in understanding the right of access to health care services is that of the nature and level of care to which people are entitled.<sup>371</sup>

In the case of *Soobramoney v Minister of Health Kwazulu-Natal*, the Constitutional Court had to interpret the scope and content of the right of access to health care services guaranteed under section 27(1)(b) and 27(3). Mr Soobramoney, the appellant, was a 41-year old diabetic suffering from heart disease, vascular disease and irreversible chronic renal failure. His life could be prolonged by means of regular renal dialysis.<sup>372</sup> He sought dialysis treatment from the Addington State Hospital in Durban. He was however not admitted to the dialysis programme of the hospital. Because the hospital did not have enough resources to provide dialysis treatment for all patients suffering from chronic renal failure, its policy was to automatically admit those suffering from acute renal failure that could be treated and remedied by renal dialysis, to the renal dialysis programme. Patients suffering from irreversible chronic renal failure were not admitted automatically to the dialysis programme but according to a set of guidelines, which made the primary requirement for admission a patient's eligibility for a kidney transplant. A patient who was eligible for a transplant would be provided with dialysis treatment until an organ donor was found and a kidney transplant had been completed. According to the guidelines, patients were not eligible for kidney transplants unless free of significant vascular or cardiac disease. The appellant was therefore not eligible for a kidney transplant.

In July 1997 the appellant, relying on sections 27(3) and 11 of the Constitution,<sup>373</sup> made an urgent application to a local division of the High Court for an order directing the Addington Hospital to provide him

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<sup>370</sup> S 27(1)(a) and s 27(2) of the Constitution.

<sup>371</sup> For a detailed and valuable discussion of this right see in general Pearmain *LLD thesis*.

<sup>372</sup> Renal dialysis is a procedure to preserve or extend someone's life when their kidneys have stopped functioning. See *Soobramoney supra*.

<sup>373</sup> See the discussion of s 11 of the Constitution *supra*.

with ongoing dialysis treatment and interdicting the respondent from refusing him admission to the renal unit of the hospital. The application was dismissed. The appellant appealed to the Constitutional Court.<sup>374</sup>

The court held that:

- Obligations imposed on the state under section 27 of the Constitution were dependent upon the resources available for such purposes, and the corresponding rights themselves were limited by reason of the lack of resources.<sup>375</sup>
- The words "emergency medical treatment" in section 27(3) might possibly be open to a broad construction, which would include ongoing treatment of chronic illnesses for the purpose of prolonging life. But this was not their ordinary meaning and, if this had been the purpose that section 27(3) was intended to serve, one would have expected it to be expressed in positive and specific terms.
- As to the argument that section 27(3) should be construed consistently with the right to life entrenched in section 11 of the Constitution and that everyone requiring life-saving treatment who was unable to pay for such treatment himself was entitled to have the treatment provided at a state hospital without charge, such a construction of section 27 would make it substantially more difficult for the state to fulfil its primary obligations under sections 27(1) and (2) to provide health care services to "everyone" within its available resources. It would also have the consequence of prioritising the treatment of terminal illnesses over other forms of medical care and would reduce the resources available to the state for purposes such as preventative health care and medical treatment for persons suffering from illnesses or bodily infirmities that are not life-threatening.
- The purpose of section 27(3) seems to be to ensure that treatment is given in an emergency, and is not frustrated by reason of bureaucratic requirements or other formalities.

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<sup>374</sup> See *Soobramoney supra*. See also Mubangizi JC "The Constitutional right of access to health care services in South Africa: From renal dialysis to Nevirapine" 2003 24 *Obiter* 1: 203 at 208; Scott C & Alston P "Adjudicating constitutional priorities in a transnational context: A comment on Soobramoney's legacy and Grootboom's promise" 2000 16 *SAJHR* 2: 206-268; Van Oosten FFW "Financial resources and the patient's right to health care: Myth and reality" 1999 32 *De Jure* 1: 1 at 11.

<sup>375</sup> "The Appellant's case must be seen in the context of the needs which the health services have to meet, for if the treatment has to be provided to the appellant it would also have to be provided to all other persons similarly placed ... It would also put a great strain on the existing dialysis machines which are already showing signs of wear."

- Given that the appellant suffered from chronic renal failure and that to be kept alive by dialysis he would require such treatment two to three times a week, his condition was not an emergency calling for immediate remedial treatment.
- Section 27(3) did therefore not apply to this situation. In the context of budget constraints and cutbacks in hospital services in KwaZulu-Natal, there were many more patients suffering from chronic renal failure than there were dialysis machines to treat such patients.
- The appellant's case had to be seen in the context of the needs that the health services had to meet. If treatment had to be provided to the appellant, it would also have had to be provided to all other persons similarly placed. If all the people in South Africa who suffer from chronic renal failure were to be provided with dialysis treatment, the cost of doing so would make substantial inroads into the health budget.

A court would be slow to interfere with rational decisions taken in good faith by the political organs and medical authorities whose responsibility it is to deal with matters like these. The state has a constitutional duty to comply with the obligations imposed on it by section 27 of the Constitution. It was not shown in the *Soobramoney* case that the state's failure to provide renal dialysis facilities for all persons suffering from chronic renal failure constituted a breach of those obligations. Chaskalson P followed a holistic approach to the larger needs of society, and did not focus on the specific needs of particular individuals within society.<sup>376</sup>

Against this background it is important to discuss the *Treatment Action Campaign*<sup>377</sup> case. The Treatment Action Campaign, a campaign for greater access to HIV/AIDS treatment, brought an action in the Pretoria High Court in an effort to compel the government to provide Nevirapine to all pregnant women with HIV or

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<sup>376</sup> The Constitutional Court also noted in this case that "(t)he provisions of the Bill of Rights should furthermore not be interpreted in a way which results in courts feeling themselves unduly pressurised by the fear of the gambling with the lives of claimants into ordering hospitals to furnish the most expensive and improbable procedures, thereby diverting scarce medical resources and prejudice the claims of others", as quoted in Mubangizi (2003) *Obiter* 203 at 208. In *Government of the Republic of South Africa v Grootboom supra*, the Constitutional Court was called upon to address the enforcement of a socio-economic right. A group of adults and children had been rendered homeless as a result of an eviction from their informal dwellings situated on private land earmarked for low-cost housing. One of the important outcomes of this case is that the Constitutional Court made it clear "that it would not prescribe to the state any particular policy option for giving effect to socio-economic rights". The duty of the court was to review a wide range of measures that it could adopt in trying to meet its obligations against the standard of reasonableness imposed by the constitutional provisions protecting socio-economic rights. See *Government of the Republic of South Africa v Grootboom supra*. See also Liebenberg 2001 *SAJHR* 232 at 250.

<sup>377</sup> *Treatment Action Campaign v Minister of Health* 2002 (5) SA 721 (CC).

AIDS as to prevent mother-to-child transmission of the disease. In a unanimous judgment, the Constitutional Court<sup>378</sup> ruled in favour of the respondents and their bid to speed up the provision of Nevirapine to pregnant HIV-positive women. The court concluded as follows:

Section 27(1) of the Constitution does not give rise to a self-standing and independent positive right enforceable irrespective of the considerations mentioned in section 27(2). Sections 27(1) and 27(2) must be read together as defining the scope of the positive rights that everyone has and the corresponding obligations on the state to 'respect, protect, promote, and fulfil' such rights. The rights conferred by sections 26(1) and 27(1) are to have 'access' to the services that the state is obliged to provide in terms of section 26(2) and 27(2).

This judgment clearly shows that the Constitutional Court will hold government to its constitutional duties, and that the government is also a servant of the Constitution.<sup>379</sup>

At the national level, many countries have an absence of sustained and independent monitoring of mental healthcare. All too frequently, abuses of the right to access to healthcare services and of other human rights go unnoticed. This is the case not only in large psychiatric hospitals but also in community-based settings.

Persons with mental disabilities, especially those who are institutionalised but also those living in the community, are often unable to access independent and effective accountability mechanisms when their human rights have been violated. This may arise for various reasons, including the severity of a condition; the absence of effective procedural safeguards, such as the provision of a personal representative for those deemed to lack legal capacity; a lack of access to legal aid; and a lack of awareness of their human rights and other entitlements. In some cases, there is no independent accountability mechanism in the first place.<sup>380</sup>

Because South Africa acknowledges access to health care services in the Constitution, it is submitted that these include adequate treatment services for mentally disordered patients, including adequate treatment in

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<sup>378</sup> *Minister of Health v Treatment Action Campaign* 2002 (5) SA 721 (CC).

<sup>379</sup> See Mubangizi 2003 *Obiter* 203 at 214. For a discussion of private and state funding see Van Oosten 1999 *De Jure* 1-18. See also Davis D & Cheadle H *et al Fundamental rights in the constitution: Commentary and cases* (1997) 358.

<sup>380</sup> Hunt & Mesquita 2006 *Human Rts Quarterly* 2: 332 at 349.

psychiatric institutions, or for example, electroconvulsive therapy, especially if these are the only treatments recognised as appropriate for the purpose and treatment. These therapies could benefit the health and well-being of many South Africans. As individuals have the right to refuse treatment, they also have the right to seek orthodox treatments, and if they suffer incapacity, the person's rights are protected by using proxies and substitute judgment.

## 5.15 SECTIONS 30 AND 31 OF THE CONSTITUTION: LANGUAGE, CULTURE AND RELIGION

In terms of section 30 of the Constitution:

Language and culture –

Everyone has the right to use the language and to participate in the cultural life of their choice, but no one exercising these rights may do so in a manner inconsistent with any provision of the Bill of Rights.

In terms of section 31 of the Constitution:

Cultural, religious and linguistic communities –

- (1) Persons belonging to a cultural, religious or linguistic community may not be denied the right, with other members of that community -
  - (a) to enjoy their culture, practise their religion and use their language; and
  - (b) to form, join and maintain cultural, religious and linguistic associations and other organs of civil society.
- (2) The rights in subsection (1) may not be exercised in a manner inconsistent with any provision of the Bill of Rights.

Culture can have a strong influence on how individuals experience psychiatric disabilities and on care and support preferences. Every patient should have the right to treatment suited to his or her cultural background. For example, mental healthcare and support services for indigenous peoples or racial and ethnic minorities must be respectful of their cultures and traditions.<sup>381</sup>

## 5.16 CONCLUSION

Human rights have a long historical heritage. The principal philosophical foundation of human rights is a belief in the existence of a form of justice valid for all persons (including the mentally disordered), everywhere. In this form, the contemporary doctrine of human rights has come to occupy centre stage in

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<sup>381</sup> Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (MI Principles), GA Res 46/119, UN GAOR, UN Doc A/RES/46/119 (1991) Principle 7(3).

geo-political affairs. The language of human rights is understood and utilised by many people in very diverse circumstances. Human rights have become indispensable to the contemporary understanding of how human beings should be treated, by one another and by national and international political bodies. Human rights are best thought of as potential moral guarantees for each human being to lead a minimally good life. The extent to which this aspiration has not been realised represents a gross failure by the contemporary world to institute a morally compelling order based upon human rights.<sup>382</sup>

It is clear from the above discussion that since 1994 many far-reaching improvements have been made to the South African health system. The legal and policy framework described in this chapter is still relatively new and is a major achievement. However, much remains to be done to implement policies and to ensure that the vision of the protection of the patient becomes a reality for people regardless of factors like mental disorder.<sup>383</sup> The Constitution and the Mental Health Care Act introduced changes relating to the administration of mental healthcare in South Africa. The Review Boards<sup>384</sup> have been created to ensure more supervision and accountability of care provision within health establishments and to ensure that those suffering from mental disorders are protected during periods of vulnerability.<sup>385</sup>

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<sup>382</sup> The Internet Encyclopedia of Philosophy: "Human rights" <http://www.iep.utm.edu/h/hum-rts.htm> (Date of access: 22 May 2009). See also Freeman M *Human rights: An interdisciplinary approach* (2002) 1ff.

<sup>383</sup> Hassim A *et al* (eds) *Health & democracy: A guide to human rights, health law and policy in post-apartheid South Africa* (2007) 25.

<sup>384</sup> See chapter 4 of the Mental Health Care Act.

<sup>385</sup> Zabow in *Psycholegal assessment of South Africa* (2006) 61.

## CHAPTER 6

# PROFESSIONAL MEDICAL MALPRACTICE: THE LIABILITY OF THE PSYCHIATRIST AND PSYCHOLOGIST

"The care of human life and happiness, and not their destruction, is the first and only object of good government."<sup>1</sup>

### 6.1 INTRODUCTION

Not very long ago psychiatry was called the "Cinderella of medicine" because it was referred to as the stepchild of the medical family. Although that sobriquet is no longer suitable, it may explain why psychiatrists enjoyed a certain measure of immunity from litigation for many years. Until recently, lawsuits against psychiatrists and psychologists were virtually unheard of.<sup>2</sup> The factors that influenced this reluctance to litigate are as follows: Psychiatrists and psychologists treated comparatively fewer patients than other health professionals; the diagnosis of mental pathology was imprecise and it was not uncommon for reasonable psychiatrists and psychologists to disagree about various disorders and definitions;<sup>3</sup> the variety of accepted therapeutic approaches made it difficult to establish a cognisable standard of care for evaluating the reasonableness of a psychotherapist's level of care; the stigma attached to mental disorders created considerable resistance to disclose intimate details about one's private life in court; and proof of causation was greatly impaired because the course of many disorders was unclear, making it difficult to determine if the harm was part of the natural progression of the disorder or related to the practitioner's mode of treatment.<sup>4</sup>

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<sup>1</sup> Jefferson T as quoted in *Community health nursing: Caring for the public's health* ((eds) Lundy KS & Janes S) (2009) 187.

<sup>2</sup> Robertson JD *Psychiatric malpractice: Liability of mental health professionals* (1988) 3-4.

<sup>3</sup> Fink VN "Medical malpractice: The liability of psychiatrists" 1973 48 *Notre Dame L Rev* 693 at 699-701.

<sup>4</sup> In addition, therapeutic transference prevented patients from perceiving therapists in anything but a benevolent light, thereby shrouding any thought of filing legal charges; therapists were experienced at defusing a patient's anger, disappointment or retaliatory feelings; and experts usually needed to help establish medical negligence, were frequently reluctant to testify against their fellow colleagues. See Hogan DB *Regulation of psychotherapists* (1978) 401.

However, the traditional reluctance to litigate has crumbled, although not to its full potential in South Africa. There has globally been a steady rise in malpractice litigation against psychiatrists and psychologists since the late 1960's. The aim of this chapter is to provide a basic, condensed, general overview of professional medical malpractice. The starting point for this discussion is to provide a historical overview of the origin and development of medical malpractice. Furthermore it provides a discussion of the delictual and criminal liability of psychiatrists and psychologists. In addition, aspects pertaining to the therapist-patient relationship, the duty of care and specific issues with regard to psychiatric and psychological malpractice are discussed. A further aim is provide an overview of disciplinary inquiries held against medical practitioners in terms of the Health Professions Act.<sup>5</sup> Aspects with regard to the liability of the traditional healer are also included.

## **6.2 HISTORICAL PERSPECTIVES OF THE ORIGIN AND DEVELOPMENT OF MEDICAL MALPRACTICE**

### **6.2.1 Historical perspectives of the origin and development of physician liability**

#### **6.2.1.1 *Prehistoric societies***

It seems as if rules in prehistoric human societies were created through discussion. There was no "written law" or "holy book" from which to take guidance in, for instance, the regulation of the practice of shamans. It was the community that had authority - everyone and no one. No one presumed to be above others in authority. No one exhorted the group about laws laid down by any of the spirits whose presence they felt. These difficulties mean primarily that any present formulation on legal and medical developments during this time period is highly tentative.<sup>6</sup>

#### **6.2.1.2 *Ancient China***

Physicians in ancient China ran tremendous risks while practicing medicine. There were severe punishments for their wrongdoings. A physician, Wenzhi, lost his life for failing to cure an Emperor's illness. To preserve their own reputations and distinguish themselves from folk physicians and to protect themselves, values emerged among physicians and between physicians and their disciples, such as

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<sup>5</sup> The Health Professions Act 56 of 1973, as amended by Act 29 of 2007 (hereafter referred to as the Health Professions Act).

<sup>6</sup> Steward JH "Cultural causality and law: A trial formulation of the development of early civilizations" 1949 51 *Am Anthropologist* 1: 1 at 16.

emphasis on prognosis and observation of codes of conduct. These values gradually formed the foundation of early medical ethics. Unschuld identified three protective mechanisms for physicians in medical history: sorcery, prognosis, and medical ethics.<sup>7</sup>

### 6.2.1.3 *The Nile Valley*

Although Egyptian physicians were people of high standing, they were not exempt from malpractice suits. They were warned to use only the methods promulgated in authoritative ancient treatises, for then, even if the results were poor, he would be above reproach. Therefore, if medicine was prepared and administered according to the physicians' teachings, he was exempt from all blame even if the treatment were unsuccessful. However, if he deviated away from the traditional remedies and tried to increase his knowledge through experimentation, he risked taking full responsibility if it failed. Lyons<sup>8</sup> submits that these principles may have hindered the development of medicine in Egypt. In the Ptolemaic era,<sup>9</sup> the Greek historian Diodorus Siculus<sup>10</sup> even recorded legislative penalties for methodological innovation by state-supported physicians in the army:

For the [Egyptian] physicians draw their support from public funds and administer their treatments in accordance with a written law which was composed in ancient times by many famous physicians. If they follow the rules of this law as they read them in the sacred book ... and yet are unable to save their patient, they are absolved and go unpunished; but if they go contrary to the law's prescriptions in any respect, they must submit to a trial with death as the penalty, the lawgiver holding that but few physicians would ever

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<sup>7</sup> Zhang and Cheng agree with Unschuld but also think that these mechanisms were basically stages in the development of medical ethics. However, the evolution of these three stages wasn't simply a substitute of one for another; there were overlaps among them and even coexistence between them. See Unschuld P *Medical ethics in Imperial China* (1979) 5-10 in Zhang & Cheng 2000 *Hastings Center Report* S8ff.

<sup>8</sup> Health Guidance: <http://www.healthguidance.org/entry/6310/1/Ancient-Egypt.html>.

<sup>9</sup> Ptolemaic Egypt starts chronologically with Alexander the Great's conquest in 332 BC and ends with the death of Cleopatra VII and the Roman conquest in 30 BC. Of the aliens who had come to settle in Egypt, the ruling race, the Graeco-Macedonians and other Greeks, were the most important element. The largest foreign element after the Greek was the Jewish. For further reading on this time period see Irby-Massie GL & Keyser PT *Greek science of the Hellenistic era: A source book* (2002) 1-15; Schaps DM & Katzoff R (eds) *Law in the documents of the Judaean desert* (2005) 10-20, 70-92, 149ff.

<sup>10</sup> Diodorus Siculus was a Sicilian Greek historian. He wrote a world history in 40 books, ending it near the time of his death with Caesar's Gallic Wars. See Robathan DM "Diodorus Siculus in the Italian Renaissance" 1932 27 *Classical Philology* 1: 84; Griffiths JG "Diodorus Siculus i. 22. 4 f" 1973 23 *Classical Rev* 1: 9.

show themselves wiser than the mode of treatment which had been closely followed for a long period and had been originally prescribed by the ablest physicians. (1.82.3)<sup>11</sup>

According to Ritner legal protection by reference to "prevailing medical standards" underlies much of modern, as well as ancient medical practice. The Egyptian physician's oral diagnosis ("an illness I shall treat"; "An illness with which I shall contend"; or "an illness not to be treated") may have had similar implications as set out above.<sup>12</sup> As this passage shows, the Egyptians considered their ancient medical texts to be sacred and binding. These texts, in fact, functioned as a kind of law code, complete with the authority to inflict severe penalties for deviants. Clearly, this Egyptian practice attracted the attention of Greek intellectuals because it illustrated, in microcosm, the collision between traditional wisdom and artistic innovation and, even more importantly, the problematic authority of written rules.<sup>13</sup>

A textual source of evidence concerning the skills of Mesopotamian physicians is to be found from the Law Code of Hammurabi.<sup>14</sup> This Code of Laws was considered the first documented Code ever used by human civilisation in Mesopotamia. It was also Hammurabi who made the first declaration of human rights<sup>15</sup> in history:

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<sup>11</sup> Diodorus Siculus 1.82.3 as quoted in Ritner 2000 *J Near East Studies* 107; cf Nightingale AW "Plato's lawcode in context: Rule by written law in Athens and Magnesia" 1999 49 *Classical Q* 1: 100 at 116.

<sup>12</sup> Ritner 2000 *J Near East Studies* 107.

<sup>13</sup> According to Nightingale the practices of Egyptian doctors raised a number of questions that were being debated in 4<sup>th</sup> century Athens. For example, are rules by written law the best way of governing people? Should written laws be sovereign over every citizen (including a true expert in political affairs)? Should the laws be subject to alteration? If so, how and when should these laws be carried out? See Nightingale 1999 *Classical Q* 100 at 116, 117.

<sup>14</sup> Hammurabi's activity as king of Babylonia dates from the middle of the 23<sup>rd</sup> century BC. From a legal point of view, there is much fundamental value to be found in the Code of Hammurabi. According to Price, the legal fraternity will find that Roman law has its roots in Babylonia, Egypt, and Persia, and that the ancient world was so admirably organised as to furnish better protection, in some respects, to its subjects than does our boasted civilisation of this day. The epilogue too is a remarkable document, which describes the benefits accruing to the subjects of Hammurabi from observance of these righteous laws, and calls down the wrath of the gods upon the transgressor. Like the Roman *Ius civile*, the Hammurabi Code is divided into three sections: *Ius actionum*, *Ius rerum* and *Ius personarum* (this is usually found in reversed order in Roman law). See Price IM "The stele of Hammurabi" 1904 24 *Bib'l World* 6: 468 at 469, 472; Pfeiffer RH "An analysis of the Hammurabi Code" 1920 36 *Am J Semitic Languages & Literatures* 4: 310 at 313. For further reading of Hammurabi's Code of Law, see Duncan GS "The Code of Moses and the Code of Hammurabi" 1904 23 *Bib'l World* 3: 188-193; Vincent GE "The laws of Hammurabi" 1904 9 *Am J Sociology* 6: 737-754; Lyon DG "When and where was the Code of Hammurabi promulgated?" 1906 27 *J Am Oriental Society* 123-134; Prince JD "The name Hammurabi" 1910 29 *J Bib'l literature* 1: 21-23.

<sup>15</sup> For a discussion of human rights law in South Africa, see chapter 5.

Anu [king of the Anunaki] and Bel[lord of heaven and earth] called me, Hammurabi ... to cause justice to prevail in the land, to destroy the wicked and evil, to prevent the strong from oppressing the weak, to go forth like the sun over the blackheaded race, to enlighten the land and to further the welfare of the people. Who made justice to prevail, and who ruled the race with right. I established law and justice in the land, and promoted the welfare of the people.<sup>16</sup>

The practice of medicine was regulated by the state. Halwani<sup>17</sup> explains that malpractice was recognised and was punishable by law. Hammurabi's Code of Law contained several texts (legislative provisions as well as medical ethical rules) showing the liability of physicians who performed surgery. Carelessness and neglect were punished since provision was made for severe penalties. Physicians were to be held liable for surgical errors and failures. Since the laws only specified liability in connection with surgery ("the use of a knife") Halwani assumes that physicians were not held liable for any non-surgical mistakes or failed attempts to cure an ailment. The Code for example specified that if a surgeon performed a major operation on a nobleman, with a lancet (barber's knife) and caused the death of that man, or the loss of an eye, they shall cut off his hands. A slave who died because of surgery had to be replaced with another one and if he lost his eye the physician had to pay half the slave's value. Hammurabi also specified fees for lifesaving operations namely ten shekels of silver for a nobleman, five shekels for a poor man and two shekels for a slave.

Amundsen<sup>18</sup> opines that if the medical regulations of the Code were in fact enforced we can assume that little surgery was practiced during this time. He further remarks that it is reasonable to suspect that the lack of competence on the part of the surgeons was in great part responsible for the promulgation of this type of legislation.<sup>19</sup>

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<sup>16</sup> Prologue in the Code of Hammurabi 1795-1750 BC as quoted in Price IM "The relation of certain gods to equity and justice in early Babylonia" 1932 52 *J Am Oriental Society* 2:174 at 177.

<sup>17</sup> Halwani TM & Takroui MSM "Medical laws and ethics of Babylon as read in Hammurabi's code (history)" 2007 4 *In J of L Healthcare & Ethics* 2: 2.

<sup>18</sup> Amundsen DW "The liability of the physician in Roman law" in *International symposium on society, medicine and law, Jerusalem, March 1972* ((ed) Karplus H) (1973) 17.

<sup>19</sup> *Ibid*; cf Carstens PA *Die strafregtelike en deliktuele aanspreeklikheid van die geneesheer op grond van nalatigheid* (unpublished LLD thesis, UP, 1996) 109; Carstens PA "Regshistoriese perspektiewe oor die oorsprong en ontwikkeling van mediese nalatigheid" 2004 10 *Fundamina* 7: 1 at 3; Carstens PA & Pearmain DL *Foundational principles of South African medical law* (2007) 609.

#### 6.2.1.4 Islamic countries

*The law on medicine (Qanun)*, a book written by Avicenna (*Ibn Sina*)<sup>20</sup> is considered one of the original medical references in Europe, to the extent that no medical diploma was awarded in Islam unless the candidate perfectly knew all theories included in this precious book, which was translated into various languages. Physicians had to observe certain qualities, for example mercy, tender-heartedness, gentleness and patience, because they dealt with people inflicted with illness which made them psychologically vulnerable. It was indisputable that such patients were foremost among people who should receive due care, mercy and leniency, especially from doctors to whom they were entrusted. If a doctor lost such qualities, he then lost the most important characteristic of his profession.

A physician should not have divulged a patient's "secrets", unless it was a necessity.<sup>21</sup> Jurists specified certain conditions for those who professed the medical practice. They had defined "doctors' rights and duties", and cited many examples of penalties against those who transgressed against this sublime profession. Among the conditions laid down by jurists for those professing the medical practice were that the doctor should be learned in the profession, specialised in the medical practice and an expert in its details and subtleties. Ignorant practitioners in medicine were declared incompetent and prevented from treating people. Jurists stated that if a doctor made an error in treatment, by prescribing a drug other than that specified by medicine and known to doctors, and it has inflicted harm upon the patient or led to his death, the doctor should, in this case, pay blood money, being imprisoned, receive slashes on his back, or

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<sup>20</sup> Avicenna, whose works span the entire spectrum of arts and sciences, is one of the most famous figures of Persian culture. He died in 428 AH. He was the doctor of all doctors who defined medicine as "the science by which we learn the various states of the human body when in health, and when not in health, and the means by which health is likely to be lost and when not lost, is likely to be restored." See Daintith J *Biographical encyclopedia of scientists* (1994) 36; Aburawi EH "The Great Professor Ibn Sina (Avicenna)" 2007 2 *Libyan J Med* 1. See also Traill HD & Mann JS (eds) *Social England : A record of the progress of the people in religion, laws, learning, arts, industry, commerce, science, literature and manners, from the earliest times to the present day / by various writers* (1901) Vol 1 436.

<sup>21</sup> The sanctity of "profession confidentiality" in medicine is a deeply rooted legacy. Since the very early stages of this profession, the medical practice has cherished and endeavoured to safeguard this value. The physician, Imhotep of ancient Egypt used to have his students take an oath not to divulge any secrets of their patients followed by the Greek physician, Hippocrates, whose oath is still widely taken by graduates of most medical schools. This oath implies that all information, medical or non-medical, obtained by the physician through audible, visual or deductive means should be treated as secrets that must not be divulged being protected by professional confidentiality. This value conformed to the teachings of Islam and Islam added to its strength and deep-rootedness. Consequently "professional confidentiality" gained firm stability in medical practice. Therefore it was (and still is) a basic brick in the edifice of medical practice, without which the practice is threatened by collapse. Confidentiality is discussed thoroughly in the following chapters. See Hathout H "The sanctity of professional secrecy" (Paper presented at the Medical Jurisprudence Third Symposium on Responsibility of doctors as viewed by jurists, Islam: Science, Environment & Technology, Islam 18-21 April 1987) <http://islamsselect.net/en/mat/63704> (Date of access: 11 January 2009).

whatever the judge might deem as indemnity for the error made.<sup>22</sup> Islamic jurisprudence therefore organised the medical profession and has also restricted its practice to persons eligible for this humane delicate profession by those who were experts in medicine.<sup>23</sup>

Even today, in these traditions, most of the existing laws dealing with mental health are old and were written prior to the new beliefs and concepts of community psychiatry and psychology and integration of mental health into the general health system.<sup>24</sup> It is interesting to note that the reliance on shrines and temples for healing still continues in Egypt, Sudan, many other parts of Africa, the Arab world, the Indian sub-continent and the Islamic Republic of Iran. Although modern medicine is the by-product of many influences, it is generally believed that its very first origins are connected to Egyptian medicine, which influenced Greek medicine more than the other traditions.<sup>25</sup>

#### 6.2.1.5 Greek and Roman law

Both the Greeks and Romans recognised that the mentally ill were capable of causing social problems as well as harm to themselves or others. Since there were no lunatic asylums, the mentally ill became a family responsibility and the seriously impaired were restrained at home. Specific laws were passed, in which the earliest mention of madmen in Rome occurs in the *Twelve Tables*: "When no guardian has been appointed for an insane person, or a spendthrift, his nearest agnates, or if there are none, his other relatives, must

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<sup>22</sup> Hathout <http://islamselect.net/en/mat/63704>. For a comprehensive discussion on this topic, see Levey 1967 *Transactions of the Am Phil Soc* 1-100. Levey translated Adab al-Tabib of Al-Ruhawi's "Practical ethics of the physicians". Al-Ruhawi's Adab al-Tabib is found as a unique copy in the Suleymaniye Kitabhane. It comprises 112 folios, seventeen lines per page and is written in a good Nashki hand. The dedication is to the Sultan Bayezid. See Aksoy S "The religious tradition of Ishaq ibn Ali al-Ruhawi: The author of the first medical ethics book in Islamic medicine" 2004 3 *JISHIM* 5: 9, 10.

<sup>23</sup> These were only excerpts and examples of the responsibility of doctors as viewed by jurists. It is clear how they did not fall short of showing the responsibility, or unequivocally state points of dispute, and even more defining what duties were imposed on physicians and what rights they had. See Hathout <http://islamselect.net/en/mat/63704>. For a comprehensive and fascinating discussion of Muslim medical ethics; bodily and spiritual physics; the physician and the patient; dignity and the medical profession; respect for the physician; medical art for moral people; removal of corruption of physicians; the care of the physician himself; the nature of the ethics that influenced the Arabs; earliest works on medical deontology in medical art; loyalty and faith of the physician; care of the physicians body; the warning against quacks and aid to treatment, see Levey 1967 *Transactions of the Am Phil Soc* 1-100.

<sup>24</sup> Okasha A "Egyptian contribution to the concept of mental health" 2001 7 *Eastern Mediterranean HJ* 3: 377 at 378-380.

<sup>25</sup> Mohit A "Mental health and psychiatry in the Middle East: Historical development" 2001 7 *Eastern Mediterranean HJ* 3: 336 at 337, 338.

take charge of his property."<sup>26</sup> This basic law remained virtually the only legal principle applied to madmen throughout the following nine centuries or more. The law of the *Twelve Tables* formed an important part of the foundation of all subsequent Western civil law.<sup>27</sup>

Furthermore, the *Corpus Iuris Civilis* made provision for the insane:

The insane, therefore, was to retain not only the ownership of his property for the duration of his illness, but also his position, rank and even his magistracy, if he were a magistrate at the time the illness struck him. However, the law did recognize the juridical capacity of the insane person. He was likened to a person who was absent, asleep or even dead. Consequently, he was considered unable to make a valid will according to the principle of law. Soundness of mind, not health of body, is required of a testator when he makes his will.<sup>28</sup>

Children, because of the innocence of their intentions, and the insane, because of the nature of their misfortune, were excused from punishment under the *Lex Cornelia*. In the matter of legal responsibility or culpability for wrongdoing, the Roman law followed a principle stated in one of the opinions of Paulus, namely that an insane person, like an infant, was incapable of malicious intent and the will to insult. Accordingly he was considered immune from any action for damages.<sup>29</sup>

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<sup>26</sup> Table V Law V11. See Scott SP *The Civil Law, including the Twelve Tables, the Institutes Of Gaius, the rules Of Ulpian, the opinions Of Paulus, the enactments of Justinian, and the constitutions of Leo* (1932) Vol 1 67. See also Smith W A *dictionary of Greek and Roman Antiquities* (1875) 688-690.

<sup>27</sup> The Twelve Tables were written by the *Decemviri Consulari Imperio Legibus Scribundis* (the 10 Consuls) who were given unprecedented powers to draft the laws of the young Republic. Originally ten laws were drafted. Two later statutes were added prohibiting marriage between the classes and affirming the binding nature of customary law. The new code promoted the organisation of public prosecution of crimes and instituted a system whereby injured parties could seek just compensation in civil disputes. The plebeians were protected from the legal abuses of the ruling patricians, especially in the enforcement of debts. Serious punishments were levied for theft and the law gave male heads of families enormous social power (*patria potestas*). The important basic principle of a written legal code for Roman law was established and justice was no longer based solely on the interpretation of judges (priests). For a discussion of Roman law see Smith W A *dictionary of Greek and Roman Antiquities* (1878) 334ff; Gibbon E *The history of the decline and fall of the Roman Empire* (1881) viif; Cubberley EP *Readings in the history of education: A collection of sources and readings to illustrate the development of educational practice, theory, and organization* (1920) 23ff; Baynes NH "On teaching the history of the Roman Republic" 1932 1 *Greece & Rome* 2: 87ff; Lucilius *Remains of old Latin: Lucilius: The Twelve Tables* ((trans) Warmington EH) (1938) 424-515; Greenidge AHJ "The Authenticity of the Twelve Tables" 1905 20 *English Hist Rev* 77: 1-21; Steinberg M "The Twelve Tables and their origins: An eighteenth century debate" 1982 43 *J Hist Ideas* 3: 379-396; Coleman-Norton PR "Cicero's contribution to the text of the Twelve Tables" 1950 46 *Classical J* 3: 127-134.

<sup>28</sup> Platt A & Diamond BL "The origins of the right and wrong test of criminal responsibility and its subsequent development in the United States: An historical survey" 1966 54 *Cal LR* 3: 1227 at 1230.

<sup>29</sup> Diamond BL & Quen JM *The psychiatrist in the courtroom: Selected papers of Bernard L Diamond* (1994) 39ff.

The ancient Greeks enacted no legal mechanisms whereby the injured patient or relatives of one who had died while under a physician's care could seek legal redress. The treatise entitled *Law in the Hippocratic Corpus* opens with the assertion that:

Medicine is the most distinguished of all the arts, but owing to the ignorance of those who practise it and of those who rashly judge its practitioners, it is by far inferior to all the other arts. The chief cause of this mistake is that for medicine alone, in the city-states, no penalty has been defined except that of ill repute. But ill repute does not damage those who are compounded of it ... Although many are physicians in name, yet very few are so in reality.<sup>30</sup>

Amundsen<sup>31</sup> quotes in support of this treatise a fragment of a comedy written by Pliny the Younger<sup>32</sup> as further evidence: "Only physicians and lawyers can commit murder without being put to death for it." This brings to mind the words of Pliny the Elder, perhaps the most frequently quoted expression of this prejudice: "Additionally, there is no law that would punish capital ignorance, no instance of retribution. Physicians acquire their knowledge from our dangers, making experiments at the cost of our lives. Only a physician can commit homicide with complete impunity."<sup>33</sup> It is interesting to note that in the lack of penalties for malpractice in Greece an important difference is noticed from the professional discipline in the present.

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<sup>30</sup> *Law in the Hippocratic Corpus* as quoted in and translated by Amundsen DW "The liability of the physician in Classical Greek legal theory and practice" 1977 XXXII *J Hist Med & Allied Sci* 2: 172. According to Amundsen both the author and date of this work are unknown. The only ancient author to mention its existence is Erotian (100 AD), a grammarian and physician who lived under the reign of Nero. Jones WHS, the translator of *Hippocrates* for the *Loeb Classical Library*, finds a Stoic influence in the work but often no suggestion as to its date: The piece is too short for this historian to base any argument upon general style or subject matter. See further Barnes J *Early Greek philosophy* (2001) 217ff.

<sup>31</sup> Amundsen 1977 *J Hist Med & Allied Sci* 172 at 173.

<sup>32</sup> Gaius Plinius Caecilius Secundus (Pliny the younger, adopted by his uncle, Pliny the Elder) (AD 61 – c 113) was a Roman author and administrator who left a collection of private letters of great literary charm, intimately illustrating public and private life in the heyday of the Roman Empire. He practiced law from the age of 18. His reputation in the civil-law courts placed him in demand in the political court that tried provincial officials for extortion. Amundsen 1977 *J Hist Med & Allied Sci* 172 at 173. See also Pliny *Select letters of Pliny the younger (with notes): Illustrative of the manners, customs, and laws of the ancient Romans* (1835) 9-88.

<sup>33</sup> Gaius Plinius Secundus (Pliny the Elder), (23 – 79 AD), was an ancient author, natural philosopher and a naval and military commander and also the author of *Naturalis Historia*. He believed that: "True glory consists of doing what deserves to be written, and writing what deserves to be read." Amundsen 1977 *J Hist Med & Allied Sci* 172 at 173. See also Merrill ET "On the eight-book tradition of Pliny's letters in Verona" 1910 5 *Classical Philology* 2: 175ff.

Pliny's writings have been used as evidence for the absence of procedures for redress under the Roman Empire but Roman law did have very specific provisions for seeking redress against the incompetent physician. The Romans had developed the distinctions between *dolus* (evil intent), *culpa* (including both negligence (*neglegentia*) and incompetence (*imperitia*)), and *casus* (accident). *Dolus* fell under intentional action, but *culpa* and *casus* generally under unintentional action. Both negligent malpractice and incompetent malpractice were classified under the concept of *culpa*.<sup>34</sup> A considerable overlap existed between these areas of law and Roman jurists struggled with the intricacies of the application of these principles.<sup>35</sup>

According to the rule *imperitia culpa adnumeratur*, ignorance or incompetence (of for example physicians) was regarded as negligent malpractice. This rule was applied where a physician performed an operation in an unskilled manner, and also where a physician prescribed the wrong medication to a patient.<sup>36</sup>

Carstens<sup>37</sup> explains that the proof of medical negligence in Roman law was problematic as it is not mentioned in the available source literature. He submits that it can, however, be accepted that the onus of proof in cases of medical negligence was on the plaintiff who had to prove that the alleged negligence by the physician caused personal injury.

#### 6.2.1.6 The Canons

The canons, regulating the internal church relationships, were based on scriptural authority, conciliar decisions and papal decretals. The Roman law tradition made itself felt on the emerging canon law from fairly early times.<sup>38</sup> The *Corpus Iuris Canonici*<sup>39</sup> is the collection of significant sources of canon law of the

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<sup>34</sup> Buckland AW *A textbook of Roman law from Augustus to Justinian* (1950) 556ff.

<sup>35</sup> Amundsen 1977 *J Hist Med & Allied Sci* 172 at 174. These principles are discussed in chapter 6.

<sup>36</sup> *Digest: Ad Legem Aquiliam* 50 17 32 "(Gaius 7 ad edictum provinciale): Imperitia culpa adnumeratur"; *Inst Just* 4 3 7: "Imperitia culpa adnumeratur, veluti si medicus ideo servum tuum occiderit, quod eum male secuerit aut perperam ei medicamentum dederit."; D 9 2 7 8 "(Ulpianus 18 ad edictum) Proculus ait, si medicus servum imperite secuerit vel ex locato vel ex lege Aquilia competere actionem."; D 9 2 7 8 "(Gaius 7 ad edictum provinciale): Idem iuris est si medicamento perperam usus fuerit."

<sup>37</sup> Carstens & Pearmain 614.

<sup>38</sup> Edwards AB *The history of South African law – An outline* (1998) 20.

<sup>39</sup> Translated as: *Body of Canon law*. See Bouvier J & Rawle F *Bouvier's law dictionary and concise encyclopedia* (1914) 417.

Catholic Church<sup>40</sup> that was applicable to the universal church or specifically to churches of the Latin Rite or Eastern Rites.<sup>41</sup> It was replaced by the *Codex Iuris Canonici*,<sup>42</sup> which was promulgated in 1917 and went into effect in 1918.

Although literature sources with regard to psychiatry and psychology as well as to the incidences of medical negligence are limited, Canon law proscribed most "insane" thoughts and behaviour long before they came to be regarded by medical science as indicators of possible mental illness. The *Corpus Iuris Canonici* contains a decree prohibiting secular clerics and regulars from attending public lectures at the universities in medicine and law.<sup>43</sup> As to the practice of medicine by clerics, the Fourth Council of the Lateran (1215) forbade its employment when cutting or burning was involved. In the decree<sup>44</sup> it is said: "Let no subdeacon, deacon or priest exercise any art of medicine which involves cutting or burning." This was especially prohibited to regulars,<sup>45</sup> and they were also forbidden to exercise the science of medicine in any form.<sup>46</sup> Canonists, however, generally held that in case of necessity and where danger to life was not involved, clerics could practise medicine through pity and charity towards the poor, in default of ordinary practitioners.

Physicians who prescribed remedies involving infractions of the Decalogue were themselves guilty of grave sin. This was also the case if they experimented on a sick person with unknown medicines, unless all hope has been given up and there was at least a possibility of doing them good. Physicians were to be reminded that they had no dispensing power concerning the fast and abstinence prescribed by the Church. They,

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<sup>40</sup> Such as those in each diocese and in the courts of appeal at the Vatican (such as the *Sacra Rota Romana*). For an indepth discussion of the Canonical doctrine and legislation, see Burke RL "Lack of discretion of judgment: Canonical doctrine and legislation" 1985 45 *The Jurist* 171ff.

<sup>41</sup> Borkowski A & Du Plessis P *Textbook on Roman law* (2005) 364.

<sup>42</sup> Translated as: Code of Canon law. See Coriden JA *An introduction to Canon law* (2004) xi, xii, 4, 24-29.

<sup>43</sup> (*cap. Nam magnopere, 3, Ne clerici aut monachi*.) The reason adduced is, lest through such sciences, spiritual men be again plunged into worldly cares. They were not hereby forbidden to make private studies in medicine or to teach it publicly. The Council of Tours (1163), in issuing a similar prohibition, had especially in view, monks who left their cloisters under pretext of attending university lectures, and in this were imitated by secular priests, who thus violated their obligations of residence. This law was extended by Honorius III to all clerics having ecclesiastical dignities. It is not binding, consequently, on the lower clergy, or on those clerics who pursue the sciences only as private studies. The penalty imposed for violation was excommunication *ipso facto*. Fanning WHW *The Original catholic encyclopedia: Medicine and canon law* Vol X (1913) 142.

<sup>44</sup> (*c. Sententiam 9, Ne cler. vel mon.*) as referred to by Fanning (n 187) 142.

<sup>45</sup> (*cap. tua nos, 19, De Homicid*.) *Idem* 142, 143.

<sup>46</sup> (*c. Ad aures, 7, de aet. et qual*.) *Ibid.*

however, might have given their prudent judgment as to whether a sick person, owing to grave danger or inconvenience to his health, was obliged by the ecclesiastical precept. They were warned that, if they declared unnecessarily that a person was not obliged to fast, they themselves committed grave sin. They also sinned mortally if their attempt - without being forced by necessity - to cure a serious illness, is the cause of grave harm to the patient through their own culpable ignorance or inexperience.<sup>47</sup>

### 6.2.1.7 *The Middle Ages and Renaissance*

Medieval European medicine and the concept of physician liability became more developed during the Renaissance when many Arabic and Hebrew medical texts on both ancient Greek medicine and Islamic medicine were translated.<sup>48</sup> Based on the views expressed in the *Tosefta*<sup>49</sup> and in the *Talmud*, medical malpractice during the medieval period ranged from total exemption to full liability for surgeons depending on the views of the Rabbinic authorities. Friedell<sup>50</sup> explains that at one extreme is Meir,<sup>51</sup> who lived in Provence in the thirteenth and fourteenth centuries, and who would totally exempt a doctor from liability for

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<sup>47</sup> Fanning 142. See also Clark M & Crawford C *Legal medicine in history* (1994) 89-363.

<sup>48</sup> The Renaissance of the 12th century saw a major search by European scholars for new learning, which led them to the Arabic fringes of Europe, especially to Islamic Spain and Sicily. See Burnett C *The coherence of the Arabic-Latin translation programme in the twelve century in Toledo* (1997) 255.

<sup>49</sup> The word "tosefta" means "supplement". The Tosefta is a Halakhic work which corresponds in structure almost exactly to the Mishna, with the same divisions for sedarim (orders) and masekhot (tractates). It is mainly written in Mishnaic Hebrew, with a few Aramaic sentences. The actual writing is called the Tosefot or Tosefos, depending on the Hebrew dialect. Tosefot was produced by a school of French Rabbis of the 12th century. Their thoughts were combined into a commentary on the Babylonian Talmud. See Bridger D & Wolk S (eds) *The new Jewish encyclopedia* (1976) 28, 85, 90, 92, 123, 157, 162-165, 170, 184-185, 187, 199, 201, 233, 252-253, 263, 273, 288, 311, 324, 399, 416, 429, 442, 456, 484, 526. For additional reading on this topic, see Mendelsohn S *The criminal jurisprudence of the ancient Hebrews: compiled from the Talmud and other Rabbinical writings, and compared with Roman and English penal jurisprudence*. (1891) 31-142; Zeitlin S "Some reflections on the text of the Talmud" 1968 59 *Jewish Q Rev, New Series* 1: 1-8.

<sup>50</sup> Friedell SF "Medical malpractice in Jewish law: Some parallels to external norms and practices" 2006 6 *Chicago-Kent J Int'l & Comp L* 1: 1 at 5. For additional reading on medical malpractice during the medieval period see Beck TR *Elements of medical jurisprudence* (1823) Vol 1: 1-450.

<sup>51</sup> Meir and Nehemiah, both pupils of Akiba, endeavored to accomplish the object held in view by their master; but each restricted himself to one of Akiba's methods. Meir chose the method of condensation, and compiled a work in which he included much of the material from Akiba's Tosefta, and which combined many of the more important features in both of Akiba's collections. Nehemiah followed the same plan of combining both of Akiba's collections in one work; but in doing so he chose the casuistic method. In this way originated two collective works—Meir's Mishnah, edited according to the system used by Akiba in his edition of that work, and Nehemiah's Tosefta, edited according to the method followed by Akiba in his Tosefta edition. The relation of Meir's Mishnah to Nehemiah's Tosefta was not, however, the same as that which existed between Akiba's collections of the same names. The former were not two collections mutually dependent on and supplementing each other; they were rather two independent works, both of which aimed at the preservation and proper arrangement of traditional maxims. Bridger D & Wolk S (eds) *The new Jewish encyclopedia* (1976) 147. For additional reading see Edward C *The second part of the Institutes of the laws of England: containing the exposition of many ancient and other statutes* (1817) Vol 1: 125ff; Brüll N *Begriff und Ursprung der Tosefta*, in Zunz L *Jubelschrift zum Neunzigsten Geburtstag des Leopold Zunz* (1884) 92-110; Neusner J *The Talmud: What it is and what it says* (2006) 1-154.

unintentional injury, even if the doctor had cut off a limb, provided that the doctor had acted to treat the victim. A slightly later commentator in Barcelona, the *Ran*, took a similar position but limited the exemption to expert doctors. This commentator elaborated that the exemption was necessary so as not to discourage medical practitioners from exercising their craft since all medical treatments run a risk of death. As long as the doctor is an expert, his errors are considered to be accidental (*o'ness*) rather than inadvertent (*shogeg*). Friedell<sup>52</sup> further explains that the *Ran* argued that a doctor who unintentionally kills a patient is not liable, even according to heavenly law because the doctor had the good intention of trying to cure.

According to the Tashbetz,<sup>53</sup> surgeons must have been exposed to full liability, including liability for pain, medical expenses and humiliation. In between these two extremes was the view of Nahmanides<sup>54</sup> that was ultimately codified in the Tur and the Shulhan Arukh ("the Set Table").<sup>55</sup> Nahmanides, who spent most of his life in Spain during the thirteenth century, gave a qualified exemption to expert physicians - to those he called "expert and knowledgeable in the science and practice" of medicine. Friedell<sup>56</sup> quotes a passage from the Shulhan Arukh:

A person should not practice medicine unless he is an expert and unless there is none present who is greater than him, for otherwise he sheds blood. If he treated without the permission of the court, he is liable to make compensation even if he is an expert. If he treated with permission of the court and erred and caused injury, he is exempt under the laws of man but liable under the laws of Heaven, and if he killed [the patient] and it is known to him that he was inadvertent, he goes into exile on his account.<sup>57</sup>

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<sup>52</sup> Friedell 2006 *Chicago-Kent J Int'l & Comp L* 1 at 5, 6.

<sup>53</sup> Rabbi Samson ben Tzadok (born in Majorca, Spain in 1361), also known by the acronym the Tashbetz, dedicated his life to seeing to it that his teacher's views on matters of ritual were carried out. It is not known when he passed away. See Fine L *Judaism in practice: From the Middle Ages through the Early Modern Period* (2001) 106. See also Berkovits E & Hazony D *Essential Essays on Judaism* (2002) 80ff.

<sup>54</sup> (1194-1270.) Nahmanides studied medicine which he practiced as a means of livelihood; he also studied philosophy. As a teenager he built a reputation as a learned Jewish scholar and at the age of 16 he began his writings on Jewish law. See Caputo N *Nahmanides in Medieval Catalonia: History, Community, and Messianism* (2008) 20ff.

<sup>55</sup> The Tur of Jacob ben Asher and the Shulhan Arukh of Joseph Karo are arranged in the same fashion, though they serve different purposes. The Tur is a compendium of legal opinions and the Shulhan Arukh simply states the halakhah (Jewish Law). See Broyde MJ & Ausubel M (eds) *Marriage, sex, and family in Judaism: The past, present, and future* (2005) 279. See also Davis J "The reception of the *Shulhan Arukh* and the formation of Ashkenazic Jewish identity" 2002 26 *AJS Rev* 2: 251-276.

<sup>56</sup> Friedell 2006 *Chicago-Kent J Int'l & Comp L* 1 at 7.

<sup>57</sup> According to Friedell, these medieval materials raised several questions. One was what it meant for a Jewish doctor to have "permission of the court," a term first used in the Tosefta. A second question raised by Nahmanides's description of an expert as having training in the "science and practice" of medicine, relates to the professional standards that were expected. A third issue was the source of the Tashbetz's distinction between surgery and medicine, and more generally, what the medieval rabbis regarded as proper medical practice. The fourth issue was the significance of the curious

### 6.2.1.8 Roman-Dutch law

Roman-Dutch jurisprudence is mainly concerned with either the emergent Roman-Dutch law, that is a synthesis of Roman law, Germanic customary law, feudal law, canon law and perhaps also certain natural law and humanistic doctrines, or the Roman law of Justinian.<sup>58</sup> The *imperitia culpa adnumeratur* rule of the Roman law also found application in the Roman-Dutch law when the negligent or ignorant conduct of a physician was assessed. De Groot<sup>59</sup> commented as follows:

Dat de dood door iemands schuld toegekomen, waer onder mede begrepen is verzuim ofte onwetenheid van een geneesmeester, vroedwif, verzuim ofte onverstand van een waghanaer ofte schipper, of der zelve zwackheid in't bestieren van schip ofte paerden.

Carstens<sup>60</sup> explains that the Dutch concepts of *onwetenheid*, *onverstand* and *zwackheid*, in context of legal liability, were equated to the concept of fault, which implies a repetition of the position in Roman law. According to Van Leeuwen it is disputed whether a physician would be punishable for giving medicine to a patient, which has done him harm, or caused his death, through the physician's neglect and ignorance.<sup>61</sup> Because many amendments are made in law, a physician would probably have been punished according to the discretion of the court.

With regard to the imposition of severe penalties on physicians in instances where patients died as a result of medical negligence, Voet<sup>62</sup> remarked as follows:

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provision of exile in the codes, long after exile was no longer practiced in Jewish law. The discussion of each of these issues may be informed by observing parallel developments in the surrounding cultures. For a detailed discussion of the phrases "permission of the court" and the community physician; "professional skills and training;" "proper medical practice;" and "exile in case of death" see Friedell 2006 *Chicago-Kent J Int'l & Comp L* 1at 7-13.

<sup>58</sup> Edwards 53. For a further discussion of Roman-Dutch law see Beinart B *Roman law in South African practice* (1952) 56ff. (1583-1645.) Grotius H *Inleidinge tot die hollandsche rechts-geleerdheid* (1767) 3, 5, 33. Carstens also discusses the application of this rule. See Carstens & Pearmain 616. See also Scott TJ "Die reël Imperitia culpa adnumeratur as grondslag vir die nalatigheidstoets vir deskundiges in die deliktereg" in *Petere Fontes LC Steyn Gedenkbundel: 'n Gedenkbundel uitgegee deur die Vereniging Hugo de Groot ter ere van wyle Hoofregter LC Steyn* ((ed) Joubert DJ) (1980) 124-134.

<sup>60</sup> Carstens & Pearmain 616.

<sup>61</sup> Van Leeuwen S & Isaakszoon C *Commentaries on the Roman-Dutch law* (1820) 494.

<sup>62</sup> Johannes Voet (1647-1713). Berkhouwer C & Vorstman LD *De aansprakelijkheid van de medicus voor beroepsfouten door hem en zijn helpers gemaakt* (1950) 23; Carstens & Pearmain 617; Scott in *Petere Fontes LC Steyn Gedenkbundel* 136 fn 91. See further s 134 of the *Constitutio Criminalis Carolina of 1532*.

*Dum affectare nemo debet id, in quo vel intelligit vel intelligere debet, imperitiam suam aut infirmitatem alteri periculosam futuram, consequens est ut hac quoque lege teneatur medici, pharmacopolae, obstetrics, imperite secants, perperam medicamenta venena propinantes, supponentes infundentes, pro medicamentis venena dantes.*

The free translation reads as follows:

While nobody has the right to claim to do something when he understands or ought to understand that his inexperience or infirmity may be dangerous to another person, it follows that the following people will be liable in terms of this rule: physicians, pharmacists, midwives, those who without experience perform surgery, those who erroneously administer poisonous medicine or administer poison instead of medication.<sup>63</sup>

The first reported case in South Africa with reference to medical malpractice is *Lee v Schönberg*,<sup>64</sup> an old Cape decision. In this case the plaintiff lost both his legs in an accident and he consulted the defendant, a physician. It is not known what the nature and extent of the injuries were or what subsequent medical treatment was administered to the patient. The plaintiff alleged that the defendant was negligent in the performance of his professional duties, and claimed damages. In this decision the court confirmed that where a physician did not exercise reasonable skill and care, he is liable in damages. The court relied on the English decision of *Lamphier v Phipos*.<sup>65</sup> The presiding judge, De Villiers CJ, enunciated the following rule with regard to medical negligence:

There can be no doubt that a medical practitioner, like any professional man, is called upon to bring to bear a reasonable amount of skill and care in any case to which he has to attend; and that where it is shown that he has not exercised such skill and care, he will be liable in damages.<sup>66</sup>

In 1877, in the case of *Kovalsky v Krige*,<sup>67</sup> the court had the opportunity to assess professional medical negligence again. A claim based on medical negligence was instituted against the physician. The physician was summoned to treat a baby of nine months, suffering from bleeding caused by a circumcision performed at a religious ceremony. After the treatment the baby contracted gangreen to his penis resulting in

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<sup>63</sup> *Ibid.*

<sup>64</sup> *Lee v Schönberg* (1877) 7 Buch 136.

<sup>65</sup> *Lamphier v Phipos* (1838) 8 C & P 475.

<sup>66</sup> See *Lee v Schönberg supra* at 136.

<sup>67</sup> *Kovalsky v Krige* (1910) 20 CTR 822.

permanent damage. A claim based on medical negligence was instituted against the physician. It was alleged that the physician abandoned the patient before the bleeding was stopped and that he also failed to follow up on his patient. The court ruled as follows:<sup>68</sup>

The principles there laid down have been applied in this court,<sup>69</sup> and with them I entirely agree. As to capacity, Chief Justice Tindall said that every person who enters into a learned profession undertakes to bring to it the exercise of reasonable care and skill. Speaking of a surgeon, he says he does not undertake that he will perform a cure, nor does he undertake to use the highest possible degree of skill ... he undertakes to bring a fair, reasonable and competent degree of skill to his case.

The plaintiff's case, however, failed but the general principle that a physician's negligence should be assessed with reference to the yardstick of the "reasonable expert" was confirmed in this early case law, with exclusive reliance on comparable English case law.

## 6.3 THE LEGAL BASES FOR MALPRACTICE LIABILITY

### 6.3.1 Physician-patient relationship

The creation of the physician-patient relationship is contractual in nature and therefore based on consensus. Generally, both the physician and the patient are free to enter into or decline the relationship. The basis for most interventions is consent.<sup>70</sup> A physician may decline to undertake the care of a patient whose medical condition is not within the physician's current competence. However, physicians who offer

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<sup>68</sup> *Ibid* 823.

<sup>69</sup> Reference was made to the general principle as stated in *Lee v Schönberg supra* and Sir John Buchanan, also relied on the English decision of *Lamphier v Phipos supra*. See also *R v Van Schoor* 1948 (4) SA 349 (C) 350 where Steyn R made the following ruling: "Coming to the case of a man required to do work of an expert as eg a doctor dealing with life or death of his patient, he too must conform to the acts of a reasonable man, but the reasonable man is now viewed in the light of the expert; and even such expert doctor in the treatment of his patients, would be required to exercise in certain circumstances a greater degree of care and caution than in other circumstances." Cf *R v Van der Merwe* 1953 (2) PH H 124 (W) where Roper J stated the following: "Negligence ... has a somewhat special application in the case of a member of a skilled profession such as a doctor, because a man who practises a profession which requires skill holds himself out as possessing the necessary skill and he undertakes to perform the services required from him with reasonable skill and ability. That is what is expected of him and that is what he undertakes, and therefore he is expected to possess a degree of skill which corresponds to the ordinary level of skill in the profession to which he belongs."

<sup>70</sup> Steyn CR *The law of malpractice liability in clinical psychiatry: Methodology, foundations and applications* (unpublished LLM dissertation, Unisa, 2002) 73. See also Van Oosten FFW "Some reflections on emergencies as justification for medical intervention" 673-684 in *Festschrift für Erwin Deutsch zum 70. Geburtstag* ((eds) Ahrens HJ *et al*) (1999) 673. Van Oosten states that it is trite law in societies subscribing to a human-rights culture that every person has the right to self-determination, which includes the freedom to choose to undergo or forego medical treatment, irrespective of its medical necessity. See also the discussion with regard to informed consent in chapter 5 of this study.

their services to the public may not decline to accept patients because of race, colour, religion, national origin or any other basis that would constitute illegal discrimination.<sup>71</sup>

According to Van Oosten,<sup>72</sup> it is trite law that any medical intervention undertaken without the patient's consent or the consent of a person acting on his or her behalf is in principle unlawful or wrongful unless some other ground of justification exists. Consent by a patient to medical treatment in South African law is regarded as falling under the defence of *volenti non fit iniuria*,<sup>73</sup> a ground of justification which excludes the unlawfulness or wrongfulness element of a crime or delict.<sup>74</sup> If a medical intervention is performed without the patient's lawful consent, the doctor or hospital is exposed to liability for civil or criminal assault, civil or criminal *iniuria*, breach of contract or negligence.<sup>75</sup>

On the contrary, the "therapeutic privilege", in terms of which the harm caused by the disclosure of information will be greater than the harm caused by non-disclosure of information, can denote a professional privilege on the side of the doctor to withhold certain information from a patient, or it can signify a legal defence in terms of which the doctor can justifiably withhold certain information from the patient.<sup>76</sup> Hence, disclosure of potentially harmful information is withheld for therapeutic reasons.<sup>77</sup>

According to English legal principles, failure by a medical practitioner to obtain his or her patient's lawful consent to medical interventions may result in the practitioner incurring civil and/or criminal liability. Such

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<sup>71</sup> Simon RI *Clinical psychiatry and the law* (1992) 6. See also the discussion of section 9 of the Constitution of the Republic of South Africa, 1996 (hereafter referred to as the Constitution) in chapter 5 of this study.

<sup>72</sup> Van Oosten FFW "Castell v De Greef and the doctrine of informed consent: Medical paternalism ousted in favour of patient autonomy" 1995 28 *De Jure* 1:164 at 166.

<sup>73</sup> See *Lampert v Hefer* 1955 (2) SA 507 (A) 508 E-F, where it was said that generally speaking, all the numerous authorities without exception, indicate that, to establish the defence of *volenti non fit iniuria*, the plaintiff must be shown not only to have perceived the danger, for this alone would not be sufficient, but also that he fully appreciated it and consented to incur it. Schreiner JA stated: "It is usual to include in the defence *volenti non fit iniuria*, or, as I call it for convenience, consent, cases of voluntary acceptance of risk as well as cases of permission to inflict intentional assaults upon oneself, as in the case of surgical operations." See also the discussion of *Rompel v Botha* 1953 (T) in chapter 5 of this study.

<sup>74</sup> *Castell v De Greef* 1994 (4) SA 408 (K) 420H, 423B-D. See the discussion of *Castell v De Greef* in chapter 5 of this study.

<sup>75</sup> See *Stoffberg v Elliot* 1923 CPD 148; *Lampert v Hefer supra* 508 E-F; *Esterhuizen v Administrator Transvaal* 1957(3) SA 710(T) 718; *Richter v Estate Hammann* 1976 (3) SA 226 (C) 232 F-G; *S v Kiti* 1994 (1) SACR 14 (E) 18.

<sup>76</sup> Coetzee LC *Medical therapeutic privilege* (unpublished LLM dissertation, Unisa, 2001) 5.

<sup>77</sup> Steyn CR *The law of malpractice liability in clinical psychiatry: Methodology, foundations and applications* (unpublished LLM dissertation, Unisa, 2002) 93ff. For an indepth discussion of grounds of justification for medical interventions and other defences in medical law, see Carstens & Pearmain 871ff.

practitioner may be convicted of criminal assault and battery, and the non-consenting and uninformed patient also has two private law remedies at his or her disposal. These remedies include an action for damages based on assault and battery, as well as an action for damages based on negligence.<sup>78</sup>

In *Chatterton v Gerson*,<sup>79</sup> Bristow stated the following: "In my judgment what the court has to do in each case is to look at all the circumstances and say, 'Was there real consent?' Equally, to avoid a claim of negligence, the information disclosed to patients, when obtaining consent, about risks must be 'reasonable' in the eyes of the court. Leaving aside breaches of professional duty so obvious that they 'speak for themselves' has traditionally been determined by the *Bolam* test." The *Bolam* test applies where expert witnesses, nearly always from within the medical profession, are asked to confirm the appropriateness of a particular aspect of medical care. The care is regarded as appropriate if the experts convince the court that a relevant, reasonable body of professional opinion would endorse the course of action that was actually taken.<sup>80</sup> In the case of consent, the issue would be the amount and accuracy of information disclosed by a doctor and contested by a patient. The appropriateness of this will be irrespective of:

- The degree that claimants believe that they were morally entitled to specific information they were not given;
- the degree of harm they suffered as a result; and
- the extent to which the patient's claim for a financial remedy may be supported by the public's opinion.<sup>81</sup>

Therefore, consent assessed as appropriate by the *Bolam* test is judged by a "professional standard", which may be inappropriate outside the profession if it disregards the patient and is based solely on the views of clinicians.<sup>82</sup>

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<sup>78</sup> Van Oosten FFW *The doctrine of informed consent in medical law* (unpublished LLD thesis, Unisa, 1989) 70-71.  
<sup>79</sup> *Chatterton v Gerson* [1981] 1 All ER 257 (QB).

<sup>80</sup> See the discussion on expert testimony in chapter 4 of this study.

<sup>81</sup> *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118 (QB).

<sup>82</sup> For a discussion of the judicial position of the doctrine of informed consent, and the doctor's duty to disclose in the English law see Van Oosten (1989) 70-189 and the cases discussed therein.

## 6.4 PROFESSIONAL MEDICAL NEGLIGENCE

### 6.4.1 Test for medical negligence

Negligence means that the defendant or the accused failed to foresee the possibility of harm in the form of bodily injury, mental injury or death occurring to another in circumstances where the reasonable person (*diligens paterfamilias*) in the defendant's or accused's position would have foreseen the possibility of harm occurring to another and would have taken steps to avoid or prevent it. The generic test for negligence is therefore one of foreseeability and preventability. Although the test for negligence is fundamentally objective, it does contain subjective elements when the negligence of an expert is assessed. Where the defendant or accused is an expert, the standard of negligence is upgraded from the reasonable layperson to the reasonable expert. Where the expert is a medical practitioner, the standard is that of the reasonable medical practitioner in the same circumstances.<sup>83</sup>

The test for medical negligence was formulated in *Van Wyk v Lewis*<sup>84</sup> in 1924:

... A medical practitioner is not to bring to bear upon the case entrusted to him the highest possible degree of professional skill, but he is bound to employ reasonable skill and care. And in deciding what is reasonable the court will have regard to the general level of skill and diligence possessed and exercised at the time by the members of the branch of the profession to which the practitioner belongs.

In the English case *Hunter v Hanley*<sup>85</sup> the court stated: "The true test for establishing negligence in diagnosis or treatment on the part of a doctor is whether he has been proved to be guilty of such failure as no doctor of ordinary skill would be guilty of if acting with ordinary care."

What is required from a medical practitioner, however, is not the highest possible degree of professional care and skill, but reasonable knowledge, ability, experience, care, skill and diligence. Van Oosten<sup>86</sup> states that the standard that is required is not based on what can be expected of the exceptionally able doctor, but on what can be expected of the ordinary or average doctor in view of the general level of knowledge, ability,

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<sup>83</sup> Carstens & Pearmain 621; Strauss SA *Doctor, patient and the law: A selection of practical issues* (1991) 243ff.

<sup>84</sup> *Van Wyk v Lewis* (1924) AD 438. See also *Mitchell v Dixon* 1914 AD 519, where Innes ACJ observed: "A medical practitioner is not expected to bring to bear upon the case entrusted to him the highest possible degree of professional skill and care, he is bound to employ reasonable skill and care; and he is liable for the consequences if he does not."

<sup>85</sup> *Hunter v Hanley* (1955) SC 200,206. This test was confirmed in *Bolam v Friern Hospital Management Committee supra*.

<sup>86</sup> Van Oosten FFW "Medical Law – South Africa" in *International encyclopaedia of laws* ((ed) Blanpain R) (1996) par [155]. See also *R v Van Schoor supra*.

experience, skill and diligence possessed and exercised by the profession, bearing in mind that a doctor is a human being and not a machine and that no human being is infallible.<sup>87</sup>

In *R v Van der Merwe*,<sup>88</sup> the accused was a medical practitioner charged with culpable homicide. The charge arose from his treatment of the deceased with dicumarol. Evidence showed that the deceased had died of dicumarol poisoning as the result of an overdose.

Roper J stated that the definition of negligence applies to all forms of negligence and that this definition has a special application in the case of a member of a skilled profession such as a doctor, because such a person holds himself out as possessing the necessary skill and he undertakes to perform the services required of him with reasonable skill and ability. He is therefore expected to possess a degree of skill which corresponds to the ordinary level of skill in the profession to which he belongs. In deciding whether such a person is negligent or not the question is whether, applying the definition of negligence, he has exercised the degree of care and skill which a reasonable man, who is also skilled in the profession, would employ. He said that in deciding what is reasonable, regard must be had to the general level of skill and diligence possessed and exercised by members of the branch of the profession to which the practitioner belongs. The standard is the reasonable care and skill which is ordinarily exercised in the profession generally. He further said that this means that a practitioner cannot hide behind the defence that he did not know enough or was not sufficiently skilled. He said that before a medical practitioner uses a dangerous drug with which he is unfamiliar he must satisfy himself as to the properties of the drug and he cannot defend himself if he is called to account afterwards, by saying that he did not know because it is his duty to know. The court observed that in South African law the test for negligence is exactly the same in civil as in criminal cases and that it makes no difference whether a medical practitioner is sued in the civil courts for damages or is prosecuted in the criminal courts by the state. He also stated that in South African law a man is liable criminally for negligence whether his negligence is gross or slight. The jury returned a verdict of guilty.

In the English case of *Hatcher v Black*,<sup>89</sup> Lord Justice Denning explained the law on the subject of negligence against doctors and hospitals in the following words:

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<sup>87</sup> *Van Wyk v Lewis supra*; *Mitchell v Dixon supra*.

<sup>88</sup> *R v Van der Merwe supra*.

Before I consider the individual facts, I ought to explain to you the law on this matter of negligence against doctors and hospitals. Mr. Marvan Evertt sought to liken the case against a hospital to a motor car accident or to an accident in a factory. That is the wrong approach. In the case of accident on the road, there ought not to be any accident if everyone used proper care; and the same applies in a factory; but in a hospital when a person who is ill goes in for treatment, there is always some risk, no matter what care is used. Every surgical operation involves risks. It would be wrong, and indeed bad law, to say that simply because a misadventure or mishap occurred, the hospital and the doctors are thereby liable. It would be disastrous to the community if it were so. It would mean that a doctor examining a patient or a surgeon operating at a table instead of getting on with his work, would be for ever looking over shoulder to see if someone was coming up with a dagger; *for an action for negligence against a doctor is for him unto a dagger. His professional reputation is as dear to him as his body, perhaps more so, and an action for negligence can wound his reputation as severely as a dagger can his body. You must not, therefore, find him negligent simply because something happens to go wrong*; if, for instance, one of the risks inherent in an operation actually takes place or some complication ensues which lessens or takes away the benefits that were hoped for, or if in a matter of opinion he makes an error of judgment.<sup>190</sup> You should only find him guilty of negligence when he falls short of the standard of a reasonably skilful medical man. (Own emphasis.)

With reference to psychiatric negligence (specialists), the test for negligence was formulated as follows in the *Bolam* case:<sup>91</sup> "The test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill at the risk of being found negligent. It is a well established law that it is sufficient if he exercises the ordinary skill of an ordinary man exercising that particular art."

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<sup>89</sup> Lord Denning in *Hatcher v Black* [1954] CLY 2289.

<sup>90</sup> Whether error of clinical judgment will constitute negligence depends on the particular circumstances of a particular instance. The facts in *Whitehouse v Jordan and Another*, illustrate this point: The plaintiff was born with serious brain damage allegedly caused by the negligence of the defendant, a senior registrar in control of confinements in the hospital concerned. The pregnancy of the plaintiff's mother had been problematic. She had been in labour for a considerable time before the defendant took over control of the confinement. He decided on a forceps delivery (a delicate procedure executed with the aim to determine whether a delivery *per vaginam* instead of by caesarean section will be possible) and attempted six times to pull out the baby with the forceps. When no movement was obtained during the fifth and sixth pull he decided to abandon the process in favour of a caesarean section. Shortly after birth it was determined that the plaintiff had suffered serious brain damage which the trial judge found to be caused by the attempted forceps delivery. The judge reasoned that the decision to employ the forceps method rather than immediately start a caesarean section, was reasonable under the circumstances. The defendant was, however, negligent in the he pulled for too long and too hard with the forceps which caused the plaintiff's head to get stuck and suffocation to set in. The English Court of Appeal upheld the defendant's appeal on two grounds: First, the trial court's finding that the defendant had pulled too hard and for too long with the forceps was set aside. Second, even if the defendant had acted as was alleged, this only constituted an error of clinical judgment and not negligence. In his finding in favour of the defendant Lord Justice Denning made the following statement: "... we must say, and say firmly, that, in a professional man, an error of judgment is not negligent." It is to be noted that the House of Lords held this to be an inaccurate statement of the law. At 281a Lord Fraser of Tullybelton expressed the view that: "I think Lord Denning MR must have meant to say that an error of judgment 'is not necessarily negligent.'" See *Whitehouse v Jordan and Another* [1980] 1 All ER 650; *Whitehouse v Jordan and Another* [1981] 1 All ER 267; Claassen NJB & Verschoor TJ *Medical negligence in South Africa* (1992) 19, 35.

<sup>91</sup> *Bolam v Friern Hospital Management Committee supra*.

It is important to note that that the general test for medical negligence in terms of the liability of mental health care practitioners and mental health care establishments, resonates in terms of section 6(1) of the Mental Health Care Act, which reads as follows:

Health establishments must -

- (a) provide any person requiring mental health care, treatment and rehabilitation services with the appropriate level of mental health care, treatment and rehabilitation services within its professional scope of practice; or
- (b) refer such person, according to established referral and admission routes, to a health establishment that provides the appropriate level of mental care, treatment and rehabilitation services.

#### 6.4.2 Proof of medical negligence

Of significance in context of the proof of medical negligence, is the case of *Van Wyk v Lewis*.<sup>92</sup> In this case,<sup>93</sup> the respondent, a physician and surgeon practising at Queenstown, received a telegram from Dr Louw of Sterkstroom asking him to meet the appellant, who was arriving by train. The respondent arranged for her admission to the Frontier Hospital where he examined her the same afternoon. Her condition was so critical that an immediate operation was necessary. He performed the operation the same evening. The anaesthetic was administered by Dr Thomas and a qualified nurse on the hospital staff acted as the theatre sister. The matron and another nurse De Wet were also in attendance. The patient's inflamed and adherent appendix was removed. The gall bladder was also in a state of acute inflammation, much distended with necrosis on the surface and he decided to drain it. Having paced the field of the operation with swabs handed to him by the sister he made an incision and inserted a tube. This was attended with difficulty. There was a rush of highly septic matter to be dealt with and owing to the friability of the gall bladder, it was impossible to suture the opening so as to draw it around the tube. He inserted more packing to prevent the spread of sepsis. At that stage, he was warned by the anaesthetist that the patient should be taken off the operating table as soon as possible. He concluded the operation, removed all the swabs he saw or felt and being satisfied that they had all been accounted for to the satisfaction of the sister, he stitched the patient. The appellant, a young woman of 26 made a rapid recovery and was discharged from hospital on 19 February, by which time the wound had healed over. Between that date and January of the following year,

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<sup>92</sup> *Van Wyk v Lewis supra*.

<sup>93</sup> The facts are discussed as it appears from the judgment of Innes CJ.

the respondent saw the patient on several occasions. Some time after the operation the wound opened slightly, there was an oozing of pus and she informed the respondent that several gall stones had come through the opening. She complained of discomfort but not of pain. The last occasion on which the appellant consulted the respondent was in January 1923 when he found on examination, a slight swelling and tenderness in the region of the gall bladder which pointed, he thought, to a recurrence of the old trouble. Subsequently, on 15 February, the appellant claimed that she evacuated a piece of muslin the shape and dimensions of a small, packing swab with tape attachment. Under those circumstances she refused to pay the respondent's account which had just been rendered but commenced an action for damages. Judgment for the defendant was given by the court *a quo* and the plaintiff appealed.

Innes CJ, with regard to the question of onus of proof, stated that the general rule is that he who asserts must prove. Consequently, a plaintiff who relies on negligence must establish it. If, at the conclusion of the case, the evidence is evenly balanced, he cannot claim a verdict for he will not have discharged the onus resting upon him. Innes CJ noted that it was argued that the mere fact that a swab was sewn up inside the appellant's body is *prima facie* evidence of negligence which shifts the onus so as to throw upon the respondent the burden of rebutting the presumption raised. The maxim *res ipsa loquitur* was invoked in support of this argument. The court said that the maxim means simply what it says - that in certain circumstances the occurrence speaks for itself. It noted that the maxim was frequently employed in English cases where there was no direct evidence of negligence and that the question then arises whether the nature of the occurrence is such that the jury or the court would be justified in inferring negligence from the mere fact that the accident happened. The court said that it is really a question of inference. Innes CJ stated that it was no doubt sometimes said that in cases where the maxim applies the happening of the occurrence is in itself *prima facie* evidence of negligence and that if by this is meant that the burden of proof is automatically shifted from the plaintiff to the defendant, then he doubted the accuracy of the statement. He stated that in the present case there was no shifting of onus. In his opinion, said Innes CJ, the onus of establishing negligence rested throughout upon the plaintiff.

In a minority judgment Kotzé JA differed from the views of Innes CJ with regard to the question of *res ipsa loquitur*, saying that the placing of a foreign substance in the patient's body and leaving it there when sewing up the wound, unless satisfactorily explained, establishes a case of negligence.

He quoted from *Hillyer v The Governors of St Bartholomew's Hospital* where Kennedy LJ observed:

It appears to me that, subject always to the reservation that I have stated in respect of the nature of the defendant's legal liability for the negligent acts or omissions of their professional staff, there was apart from the statements which two of the surgeons made subsequently to the plaintiff, and which were admitted in evidence without objection on the part of the defendant's counsel, a *prima facie* case on the issue of negligence on the facts which I have briefly set forth. I think that so far the plaintiff might, in the circumstances invoke the application of the maxim *res ipsa loquitur*.<sup>194</sup>

Van den Heever<sup>95</sup> submits that there are reasonable grounds for advancing a persuasive argument that the judgment in *Van Wyk v Lewis* should be overruled. He states that although support for applying the doctrine to medical negligence actions can also be found with reference to constitutional and other considerations. Van den Heever further argues that in terms of section 9 of the Constitution everyone is equal before the law and has the right to equal protection and benefit of the law. In this regard, he says it could be argued that the victim of a medical accident is at a procedural disadvantage because of the fact that patients are usually anaesthetised or under the influence of an anaesthetic agent when the accident occurs as a result of which they are completely in the dark as to what actually happened. He says that to permit the plaintiff to rely

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<sup>94</sup> The facts in this case were that a patient, whilst lying on the operating table in St Bartholomew's Hospital in an insensible state through the administration of the necessary anaesthetics had his left arm burned by contact with a heating apparatus under the table and his right arm was also bruised during the operation. The action was brought against the governors of the hospital, the plaintiff's case being that they were responsible in law for the negligence of the surgeons employed at the hospital. The Court of Appeal held that under the circumstances no liability attached to the governors of the hospital for negligence or unskillfulness of the surgeons in attendance at the operation. Kotzé JA said that the actual decision in *Hillyer* had no direct application to the present case but that the quoted observations of Kennedy LJ supported the view that where a plaintiff has proved certain facts from which, if not satisfactorily rebutted or explained, the conclusion may reasonably be drawn that there has been an absence of the necessary care or skill on the part of the medical man, a case of negligence against the defendant has been established, rendering him liable in damages. He noted that it is no doubt true that negligence may be manifested in many and various ways and in complicated instances the difficulties are usually in respect of the *onus probandi*. For an indepth discussion of *Van Wyk v Lewis* in context of the legal basis of the doctor-patient relationship, the test of medical negligence, the proof of medical negligence (specifically with reference to the maxim *res ipsa loquitur*), the locality rule in medical practice and the issue of joint liability of surgical staff as a team, see Carstens & Pearmain 796-801.

<sup>95</sup> Van den Heever P *The application of the doctrine of res ipsa loquitur to medical negligence cases: A comparative survey* (unpublished LL.D. thesis, UP, 2002) 320ff. See also Carstens PA "Die toepassing van *res ipsa loquitur* in gevalle van mediese nalatigheid" 1999 32 *De Jure* 1: 19-28; *Madyosi v SA Eagle Insurance Co Ltd* 1990 (3) SA 442 (A) in which the Appellate Division stated that: "In our law the maxim *res ipsa loquitur* has no bearing on the incidence of proof on the pleadings, and it is invoked where the only known facts, relating to negligence, are those of the occurrence itself." See further *Sardi v Standard and General Insurance Co Ltd* 1977 (3) SA 776 (A) 780 D-E G-H, where the court stated that: "At the end of the case the court has to decide whether, on all of the evidence and the probabilities and the inferences, the plaintiff has discharged the onus of proof on the pleadings on a preponderance of probabilities, just as the court would do in any other case concerning negligence. In this final analysis, the court does not adopt the piecemeal approach of (a) first drawing the inference of negligence from the occurrence itself, and regarding this as a *prima facie* case; and then (b) deciding whether this has been rebutted by the defendant's explanation."

on *res ipsa loquitur* in these circumstances would level the playing fields between the plaintiff and the defendant to a certain extent by promoting procedural equality. He also argues that section 34 of the Constitution also recognises the right to fairness in civil litigation which provides further constitutional motivation for the application of the doctrine to medical negligence actions.

#### 6.4.3 *Imperitia culpa adnumeratur*

A physician will be blamed for being negligent where he performs an operation or embarks on the treatment of a patient well knowing that he does not have the necessary knowledge or experience and the patient is prejudiced thereby. This is in accordance with the principle *imperitia culpa adnumeratur*, which means "lack of skill is reckoned as fault".<sup>96</sup>

In *Dale v Hamilton*,<sup>97</sup> the plaintiff claimed damages for an X-ray burn received by him in the course of an X-ray examination by the defendant. He alleged that the burn was caused by the lack of skill and neglect in treatment of the defendant in conducting the X-ray examination. The defendant admitted that the plaintiff was burned in the course of the X-ray examination he conducted but denied negligence. The defendant had only limited training and experience in radiography and the X-ray equipment at the hospital had been old when he first started to work there. Subsequently new X-ray equipment was purchased but some of the parts of the old apparatus were retained in an attempt to save costs. The defendant had some training on the new equipment which was installed at least partly by the representative of the company from which the X-ray equipment was purchased. It was argued for the plaintiff that the fact that the defendant's burn was caused in diagnostic work and that it was severe was sufficient to establish a *prima facie* case of negligence and to shift the onus onto the defendant of proving that there was no negligence. The expert evidence supported this position. Feetham J stated that if a doctor undertakes to do radiographic work, he must exercise in that work which he undertakes as a medical man, reasonable skill and care. But, he said,

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<sup>96</sup> Claassen & Verschoor 16. Claassen and Verschoor state in connection with this case that according to Giesen and Fahrenhorst, a physician cannot defend himself by averring that he tried his best in accordance with his abilities and professional knowledge. If he is incompetent to treat a patient's specific illness he is obliged to refer the patient back to a specialist. A general practitioner will not, however be blamed for his lack of knowledge, training or experience if he undertakes specialist work in an emergency. See also *R v Van der Merwe supra*; *Coppen v Impey supra*. See also *S v Mkwetshana* 1965 (2) SA 493 (N).

<sup>97</sup> *Dale v Hamilton* 1924 WLD 184.

he was not sure that it made any difference whether he was a doctor or not. Anybody who undertakes radiographic work is obliged to exercise a reasonable degree of skill and care in doing that work.

The court found the defendant guilty of negligence in that he either did not exercise the care which he should have exercised being a trained man and having undertaken to use reasonable skill and care or he lacked the training necessary to enable him to use the tube which he was using. The court awarded damages for loss of earnings and also the effect of the injury on the plaintiff's future earning capacity since he could no longer return to his previous job of shaft timberman. The court further awarded damages for pain and suffering and loss of general health.<sup>98</sup>

#### 6.4.4 Is there a professional duty upon a physician to heal or cure a patient?

In *Buls v Tsatsarolakis*,<sup>99</sup> Nicholas J raised the following question:

Generally speaking every man has a right that others shall not injure him in his person and that involves a duty to exercise proper care. Every man has a legal right not to be harmed; but is there apart from a contract, a legal right to be healed? It is no doubt the professional duty of a medical practitioner to treat his patient with due care and skill, but does he, merely by undertaking a case, become subject to a legal duty, a breach of which founds an action for damages, to take due and proper steps to heal the patient? It is an interesting question, but because it was not argued and because it was not necessary for the purposes of the present decision to answer it, I shall not discuss it further.

Strauss<sup>100</sup> is of the opinion that where a patient consults with a medical practitioner, no more is required of the practitioner than to treat the patient with the reasonable care, skill and experience legally required,

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<sup>98</sup> See also *McDonald v Wroe* [2006] 3 All SA (C). This case is thoroughly discussed in Carstens & Pearmain 636.

<sup>99</sup> *Buls v Tsatsarolakis* 1976 (2) SA 891 at 893 (T). See further the following English cases: *Greaves & Co (Contractors) Ltd v Baynham Mickle & Partners* [1975] 3 All ER 99 (CA); *Eyre v Measday* [1986] 1 All ER 488 (CA); *Thake and Another v Maurice* [1986] 1 All ER 497 (CA).

<sup>100</sup> Strauss *Doctor, patient and the law* 40. In the cases of *Kovalsky v Krige supra*, *Coppen v Impey* 1916 CPD 309, and *Van Wyk v Lewis supra*, the court reiterated that the reasonable care, skill and experience, which are legally required of medical practitioners do not imply that a medical practitioner, in any sense, grants a guarantee to any patient that the patient would indeed be healed or cured. See also *Behrmann v Klugman* 1988 WLD unreported. In this case the plaintiffs (Mr and Mrs B) claimed damages in the amount of R299 609 from the defendant, a specialist surgeon, on account of the birth of a healthy but unwanted child born after an unsuccessful vasectomy was performed on B. The plaintiffs' claim was based on breach of contract and negligence. The plaintiffs alleged that the surgeon gave an undertaking to perform the vasectomy with the necessary skill and care and that the procedure would render B to be permanently sterile. The defendant denied any contractual or delictual liability. The court ruled on the evidence that the plaintiffs did not prove on a preponderance of probabilities that there was an explicit or tacit agreement between them and the defendant to the effect that he gave such an undertaking or guarantee. The claim was dismissed. Mr Justice Melamet held that even if the doctor used the phrase "end of the road" or "you will not father a child", it was not intended in the context as "irreversible"

unless the practitioner explicitly guarantees the patient that he or she will be healed or cured - an undertaking that no prudent practitioner will subscribe to. Carstens<sup>101</sup> further submits that the Constitution does not impose any professional duty on physicians to heal or cure their patients, other than to act with reasonable skill, care, experience and diligence. Every medical intervention is fraught with potential risks, including bodily or mental injuries or even death. To interpret any right in the Constitution to impose a duty on medical practitioners to heal or cure their patients, would imply that medical practitioners are now responsible for man's mortality, which stance will never be sustained by any constitutional justification or limitation.<sup>102</sup>

#### 6.4.5 Liability for failure to intervene

According to Strauss,<sup>103</sup> a doctor in private practice is an independent contractor who may, except in emergency situations, accept or refuse clients at his or her discretion. Failing to perform an operation agreed upon, which results in breach of contract, which failure caused financial loss for the client can result in a malpractice claim. Where a psychiatrist has agreed on a certain intervention and fails to honour such agreement, it might constitute malpractice.<sup>104</sup>

In *Edouard v Administrator Natal*,<sup>105</sup> the respondent's wife was admitted to a provincial hospital for a Caesarian section in order to give birth to their third child. The respondent and his wife requested that a tubal ligation be performed on the wife at the same time as they could not afford to have any more children and the wife wished to be sterilised. The tubal ligation was not in fact performed and one year later the wife gave birth to a fourth child. The respondent sued for damages on the basis of breach of contract including the cost of supporting and maintaining the child born as result of the failure to perform the sterilisation operation, and general damages for the discomfort, pain and suffering and loss of amenities of life suffered by his wife.

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other than to describe the nature of the operation. Strauss submits that the refusal of the courts to regard "therapeutic reassurance" as constituting a guarantee that the patient will be cured, is sensible. The author agrees with Strauss in this regard. See Strauss *Doctor, patient and the law* 41, 176ff.

<sup>101</sup> Carstens & Pearmain 643.

<sup>102</sup> See the discussion of section 11, 12(2) and 27 of the Constitution in chapter 5 of this study.

<sup>103</sup> Strauss *Doctor, patient and the law* 189, 243.

<sup>104</sup> Steyn *LLM dissertation* 134. See also *Edouard v Administrator Natal / Administrator of Natal v Edouard* 1989 (2) SA 368 (A); *Minister van Polisie v Ewels* 1975 (3) SA 590 (A).

<sup>105</sup> *Edouard v Administrator Natal supra*.

The two issues submitted to the court for adjudication were whether the administration was in law obliged, because of its breach of contract, to pay: (1) a sum representing the cost to the respondent and his wife of maintaining and supporting Nicole; and (2) general damages for the non-patrimonial loss suffered by the respondent's wife. It was agreed that, should the court find for the respondent on the first issue, an amount of R22 500 was to be awarded, and that an affirmative finding on the second issue would carry an award of R2 500. The court recognised an action in our law based on wrongful conception or pregnancy and found that in respect of the maintenance and support of the born child, the appellant was obliged, in contract, to pay the claimed amount to the respondents. However, the court observed with regard to damages that in South African law intangible loss is in principle awarded only in delict and then, apart from infringements of rights of personality, only in the case of a bodily injury.

In assessing liability in suicide cases, whether it involves inpatient or outpatient psychiatric or psychological treatment, the threshold issues are as follows:

- Did the defendant have or should he or she have had notice of the patient's dangerous propensities? In other words, was the patient's behaviour foreseeable?
- If such notice was known or should have been known, did the defendant act reasonably in light of that information?<sup>106</sup>

Accordingly, the duty of care owed to a patient by a psychiatrist or hospital is directly related to the patient's dangerous propensities that are known or discoverable by the exercise of reasonable skill and diligence. Therefore, when a hospital, psychiatrist or psychologist knows or reasonably should have known of the patient's suicidal tendencies, the hospital, psychiatrist or psychologist must exercise reasonable care to protect the patient from himself or herself.<sup>107</sup>

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<sup>106</sup> Simon RI *Psychiatric malpractice: Cases and comments for clinicians* (1992) 138.

<sup>107</sup> Steyn *LLM dissertation* 135ff.

According to Goldstein,<sup>108</sup> on the issue of "dangerousness", the psychiatrist and psychologist enter where angels fear to tread. The psychiatrist - being a physician in a doctor-patient relationship and an agent of social control at the same time - is expected to remedy the ills of the mentally disordered individual as well as those of the world in which that individual exist, with potentially brutal consequences. Changes in the social climate and scientific progress questioned and curtailed the power of the psychiatrist, and it was redefined by the courts as society demands civil liberties and then seeks protections. A common thread emerges from the shifting trends in civil commitment, deinstitutionalisation, medicalisation, legislation, and liability. Dichotomous thinking, though comforting in its classification of phenomena as mind or body, sick or evil, has failed to provide solutions to the problem of the "dangerous patient".

In *McMorrow v Colonial Government*,<sup>109</sup> the plaintiff, an employee at Valkenburg mental hospital, was assaulted by a patient. His action for damages instituted against the defendant was based on the averment that the defendant had failed to warn him about the levels or potential levels of dangerousness of the patient. The court, however, rejected the claim on account of the absence of any evidence that the particular patient was indeed dangerous. The court did not answer the question as to whether there was a duty on the defendant to warn or to protect the plaintiff, given the particular circumstances. The court ruled that members of the hospital staff were in a better position to judge whether a patient was dangerous or not and that the plaintiff, as an employee, should have known that one would be exposed to sudden attacks of this nature.

Courts have so far been reluctant to hold statutory authorities liable for the consequences of the actions of persons under their care, supervision or control.<sup>110</sup> Imposing liability on a psychiatrist in an outpatient, short-term setting for the actions of a patient that was, at most, based on risk factors and not foreseeability would have adverse effects on psychiatric care. It would encourage psychiatrists and other mental health providers to return to paternalistic practices, such as involuntary commitment, to protect themselves against possible medical malpractice liability. Despite public perceptions to the contrary, psychiatrists submit that the vast majority of the mentally ill are not violent, or no more violent than the general population. If a liability was imposed each time the prediction of future courses of mental illness was wrong, few releases

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<sup>108</sup> Goldstein MS "Psychiatry and the law: A history of our duty to protect" 1996 2 *McGill J Med* 1:51-54.

<sup>109</sup> *McMorrow v Colonial Government* 1906 CPD 626.

<sup>110</sup> See, for example, *Clunis v Camden & Islington Health Authority* (1998) (QB) 978.

would ever be made and the hope of recovery and rehabilitation of a vast number of patients would be impeded and frustrated.<sup>111</sup>

In *Seema v Executive member of Gauteng*,<sup>112</sup> the plaintiff, the father and guardian of L, a minor, sued the defendant for damages suffered by them when L was kidnapped from the family home and raped by B. B was at the time a patient of a nearby mental hospital managed by the defendant. B was admitted in the mental hospital in terms of a detention order issued under the provisions of chapter 3 of the Mental Health Act 18 of 1973.<sup>113</sup> It was alleged that B suffered (according to psychiatric expert evidence), at the time of the incident from a serious mental disorder, namely psychosis. B was transferred on the day of the rape from a security ward to an open ward. There was no proper fencing of any kind around the perimeter of the hospital premises and no real effort was otherwise made to guard the premises. Potentially dangerous patients were able to enter the adjacent residential area (where the plaintiff's home was located). The court was called upon to decide, *inter alia*, whether there was a legal duty on the defendant and his personnel at the hospital to take proper precautions to ensure that patients did not cause harm to the general public and, if so, whether they had breached that duty and whether their omission had been the direct or at least an important cause of the plaintiff's loss.

The court ruled that there was a legal duty on the defendant to protect the general public against the wrongful and unlawful conduct by one or more of the patients that were being held in the hospital, and that the defendant had negligently breached this duty by failing to take proper precautions to ensure that patients were prevented from leaving the hospital premises, with the result that B was able to kidnap and rape L. B thereby caused damages to the plaintiff which the defendant was obliged to recover. In coming to its judgment, the court relied on the expert evidence of psychiatrists who testified during the trial.

Carstens<sup>114</sup> and the author submit that the judgment is correct. It is also in step with current constitutional jurisprudence as found in the decision of *Carmichele v Minister of Safety and Security*<sup>115</sup> where the

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<sup>111</sup> Scott R "Liability of psychiatrists and mental health services for failing to admit or detain patients with mental illness" 2006 14 *Aust Psychiatry* 3:256ff.

<sup>112</sup> *Seema v Executive member of Gauteng* 2002 (1) SA 771 (T).

<sup>113</sup> This Act has been repealed by the Mental Health Care Act 17 of 2002.

<sup>114</sup> Carstens & Pearmain 750.

<sup>115</sup> *Carmichele v Minister of Safety and Security* 2001 (4) SA 938 (CC).

Constitutional Court ruled that there is a positive duty imposed on the state (in context of the protection of life) in terms of a constitutional obligation to protect its citizens from life-threatening attacks, and, in addition that there is a duty upon the courts to develop the common law in harmony with the objects and spirit of the Bill of Rights.

#### 6.4.6 Negligent administration of medication

The use of medication has become essential to the practice of modern psychiatry. But despite the enormous benefits associated with the administration of psychotropic drugs, these drugs also carry the risk of significant adverse reactions.<sup>116</sup>

Examples of a basis for a malpractice claim with regard to the administering of improper psychiatric medication include:

- Administering dosages of psychiatric medication for the wrong reason or time period;
- negligent misdiagnosis resulting in the wrong prescription of psychiatric medication;
- failure to monitor the patient's condition;
- failure to appropriately reduce or discontinue psychiatric medication;
- the administering of dangerous combinations of multiple psychiatric drugs;
- failure to seek expert consultation;
- failure to take notice of a patient's medical history;
- failure to take risk factors into account; and
- failure to obtain informed consent prior to administering psychiatric medication.<sup>117</sup>

Strauss<sup>118</sup> opines that there have been several cases in South Africa in which a doctor was held legally liable for drug damage but these cases invariably involved over-prescribing or over-administration, on account of ignorance or carelessness on the part of the doctor, of drugs that are quite safe when used in accordance with the manufacturer's directions. He states that in a case of a drug which was properly

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<sup>116</sup> Mills MJ "Legal liability with psychotropic drug use: Extrapryramidal syndromes and tardive dyskinesia" 1987 48 *J Clinical Psychiatry* 28. See the discussion of *R v Van der Merwe supra*.

<sup>117</sup> Steyn *LLM dissertation* 147-148.

<sup>118</sup> Strauss *Doctor, patient and the law* 294ff.

designed, developed, tested, registered and distributed and which was prescribed in conformity with the statutory standards, and which is now alleged to be potentially hazardous to patients, proof of negligence on the part of a doctor may be well-nigh impossible. Without a doubt there is a duty upon the doctor to keep himself adequately informed on developments in the pharmaceutical field in so far as his profession is affected. Strauss points out that, for example, if a doctor were to prescribe or administer a drug despite the fact that its newly discovered risks have been fully described in a medical journal circulating in his area of practice, an inference of negligence can clearly be drawn. This will also be the case when a manufacturer has withdrawn a drug, the safety of which has become suspect and has given wide notice of its decision.

#### 6.4.7 The liability of expert witness

An increasing number of general psychiatrists and psychologists are acting as expert witnesses in the legal system. A growing number of clinicians are augmenting their practices by spending some of their time doing forensic work.<sup>119</sup> Traditionally, expert witnesses have been granted legal immunity for their forensic work; for example, they could not be sued and have charges of negligence or defamation brought against them.<sup>120</sup> The argument has been that expert witnesses are an important part of the legal system and, in the interest of justice, they need to be protected from liability. This is changing for all expert witnesses, including psychiatrists and psychologists. Psychiatrist and psychologist expert witnesses are beginning to be held accountable for their testimony – they are subjected to sanctions by both professional associations and state medical boards, and tort liability actions.

One of the factors leading to the desire to increase the accountability of experts is the fact that the use of experts in the legal system has proliferated over the past 30 years.<sup>121</sup> Many commercial services offer experts for hire to assist with litigation, and some of these services have thousands of experts on file. There is also concern that the safeguards cited by courts to ensure honest expert witness testimony, for example potential prosecution for perjury and cross-examination, are not effective. The second primary safeguard,

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<sup>119</sup> Appelbaum PS "Liability for forensic evaluations: A word of caution" 2001 52 *Psychiatric Services* 885-886.

<sup>120</sup> The witness immunity doctrine originated hundreds of years ago in English common law for broad public policy reasons. The intent of witness immunity has been to encourage open and honest testimony without fear of a subsequent lawsuit related to the testimony. In 1585, one of the courts in England opined that without immunity, "those who have just cause for a complaint would not dare to complain for fear of infinite vexation". Also, in 1859, another court in England held that immunity was important to ensure that witnesses would speak freely when giving testimony. See Binder RL "Liability for the psychiatrist expert witness" 2002 159 *Am J Psychiatry* 1819-1825.

<sup>121</sup> *Ibid.*

cross-examination, is also not an effective means of monitoring expert witness testimony. The field of expert witness ethics, unfortunately, is still undeveloped, and many professional societies do not have specific codes related to forensic work besides the general principles of honesty and avoidance of conflicts of interest. The concept of legal immunity for psychiatrists and psychologists who work as expert witnesses is however eroding.<sup>122</sup>

Occasionally mistakes are made in, for example, cases concerning children where abuse is incorrectly diagnosed. This leads to tragic consequences for the child, family and other caregivers. Children may be taken into foster care and parents may suffer psychological trauma and psychiatric illness. Parents or caregivers may even be wrongly accused of such abuse, and consequently tried and convicted on the basis of expert medical evidence. The question arises whether those wrongly accused of such abuse, may institute a claim for damages and other relief. Although this issue has never been reported in South African law, it is particularly in the common law jurisdictions that this question has recently surfaced in context of the question whether a physician or hospital owes a duty of care to the wrongly accused parent.<sup>123</sup>

In the English case of *JD v East Berkshire Community Health NHS Trust*,<sup>124</sup> JD, the first appellant and a registered nurse, was the mother of a child, M, who suffered from multiple allergic reactions. These allergic reactions, amongst other things, led a consultant paediatrician expert in allergic reactions to suggest that the child might be suffering as a result of *Munchausen by Proxy* ( a syndrome whereby an infant or a child

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<sup>122</sup> See *Cutler v Dixon* 76 Eng Rep 886 (QB 1585); *Henderson v Broomhead* 157 Eng Rep 964, 967-968 (Ex 1859); Moore MV *et al* "Liability in litigation support and court testimony: Is it time to rethink the risks?" 1999 9 *J Legal Economics* 53-63.

<sup>123</sup> Carstens & Pearmain 664.

<sup>124</sup> *JD v East Berkshire Community Health NHS Trust* [2005] UKHL 23. See also Carstens & Pearmain 664ff, where Carstens discusses the facts and judgments. The facts in the case are indicative of three separate appeals. MAK, the second appellant, instituted a claim for damages in negligence for psychiatric injury and financial loss resulting from a clinical misdiagnosis against the Dewsbury Healthcare Trust on behalf of himself and his daughter, R. At the relevant time R was nine years old. She suffered from *Schamberg's disease* which produces discoloured patches on the skin. She hurt herself in the genital area while riding her bicycle which resulted in bruising marks on her legs. R was taken to hospital by her father. A Consultant Paediatrician at the hospital thought that the marks on her legs were suggestive of sexual abuse. The Consultant informed the social services. R was admitted to hospital at once and examined further. The attending doctor concluded that R had been sexually abused. Her mother was also informed. At that stage the diagnosis of *Schamberg's disease* was not known. MAK and his son, R's elder brother, were told that they could not sleep at home when R was released from hospital. In the hospital, in front of other patients and visitors to the ward, MAK was told he was not allowed to see R and that he could not visit her. Later the correct diagnosis of *Schamberg's disease* was made. The social services took no further steps, and it was accepted that there was no question of abuse. The trial court dismissed MAK's claim against the defendants, but the court ruled that R had an arguable claim for clinical negligence against the defendants.

is presented to physicians, often repeatedly, with a disability or illness fabricated by an adult, for the benefit of the adult). It was therefore suggested that JD was fabricating M's condition and harming him. At some stage JD had the opportunity to read the medical notes and discovered that *Munchausen by Proxy* was considered to be a possibility. She subsequently arranged to see a psychiatrist who found nothing wrong with her. She later claimed that she has suffered psychiatric injury as a result of the misdiagnosis of her and M's condition. She had not returned to nursing since this negligent misdiagnosis was made. She subsequently issued summons claiming damages for negligence, but her claim was dismissed on the ground that public policy considerations militated strongly against the existence of any duty on the facts of the case.

The third appellants were RK and his wife AK. They are the parents of a young girl, M. When M was two months old and in the care of her grandmother, she started to scream when the grandmother lifted her from a settee. Her parents and grandmother took her to the hospital. On admission to the hospital the medical staff failed to take an accurate history from them and the grandmother. The attending consultant paediatrician diagnosed M as having an "inflicted injury" - a spiral fracture of the femur. The police and social services were informed. The attending physician did not investigate further the possibility of a diagnosis of *osteogenesis imperfecta* ('brittle bones'). The Oldham Borough Council applied for an interim care order to the effect that when M was discharged from hospital, she was placed in the care of her aunt with supervised access for the parents. Later the court decided that her injuries were non-accidental and care was given to the aunt. M, however, sustained further fractures while in the care of her aunt. Further tests were carried out and the revised medical opinion was that the history and injuries were consistent with brittle bone disease and not indicative of any abuse. Nearly nine months after being admitted to hospital, M was returned to the care of her parents. It was now accepted that the initial diagnosis of non-accidental injury was wrong. The fact remained that M's mother was separated from her child for a period of eight months. The parents claimed damages in negligence from the Oldham NHS Trust and from the attending paediatrician for psychiatric injury resulting from their separation from M. The trial court ruled, however, that neither defendant owed a duty of care to the parents and consequently dismissed the action.

#### 6.4.8 The traditional practitioner

In the case of *S v Mahlalela*,<sup>125</sup> a traditional herbalist prepared a poisonous concoction of herbs mixed with traditional beer, and administered it to a child who consequently died. The herbalist was convicted of culpable homicide. In dealing with the question of negligence and the yardstick of the reasonable expert, Van Berk AJ, observed the following:<sup>126</sup>

Wat 'n redelike mens in 'n gegewe geval sou geweet het en watter gevolge hy voortvloeiend uit sy doen en late in so 'n geval sou voorsien het, sal blyk uit die feite van sodanige geval. Die appellant is 'n persoon wat vanweë sy professie as kruiedokter kennis het van die bestanddele van bome en plante waarvan kruie gemaak word. Hy is dus, wat plante betref, as kind van die natuur nog meer op hoogte van die aanwesigheid van plantaardige gifstowwe in plante as die gewone normale mens, wat van kindsbeen af kennis maak met die alombekende verskynsel van sekere plante - hul wortels, blare en vrugte - eetbaar is, terwyl ander giftig en ook lewensgevaarlik kan wees as dit deur die mens ingeneem word. Myns insiens, kan daar nie twyfel wees dat die kruie moontlik lewensgevaarlik kan wees. Des te meer moes die appellant dan as kenner van die plante dit besef het, in watter geval dit as vanselfsprekend volg dat die dood as moontlike gevolg voorsienbaar was.

Carstens<sup>127</sup> submits that the traditional herbalist, in all fairness, cannot be compared to the qualified medical practitioner, but the general remarks of the Supreme Court of Appeal are *mutatis mutandis* applicable and confirm that physicians, like other professionals, are regarded as experts where an assessment has to be made of their alleged negligence.<sup>128</sup>

### 6.5 DISCIPLINARY PROCEEDINGS AGAINST PRACTITIONERS REGISTERED IN TERMS OF THE HEALTH PROFESSIONS ACT

#### 6.5.1 Unprofessional conduct

The concept of "unprofessional conduct" is defined as "improper or disgraceful or dishonourable or unworthy conduct which, when regard is had to the profession of a person who is registered in terms of the Act, is improper or disgraceful or dishonourable or unworthy".<sup>129</sup> In *Groenewald v South African Medical*

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<sup>125</sup> *S v Mahlalela* 1966 (1) SA 226 (A).

<sup>126</sup> *Ibid* 227.

<sup>127</sup> Carstens & Pearmain 621.

<sup>128</sup> See also the discussion in the context of disciplinary proceedings against traditional practitioners below.

<sup>129</sup> S 1 of the Health Professions Act. According to Carstens, it should be noted that that the term "unprofessional conduct" is not explicitly mentioned in section 42(1) of the Health Professions Act; reference is only made to improper or disgraceful conduct. This leads one to draw the inference that although a medical practitioner registered with the HPCSA may be charged with "unprofessional conduct" (in the generic sense of the term), the inquiry held by the professional

*Council*,<sup>130</sup> the Court sought guidance from the English case law to determine what is meant with improper or disgraceful conduct with reference to the case of *Allinson v General Council of Medical Education and Registrations*.<sup>131</sup> The following definition was adopted:

If it is shown that a medical man, in pursuit of his profession has done something with regard to it which would be reasonably regarded as disgraceful or dishonourable by his professional brethren of good repute and competency, then it is open to the General Medical Council to say that he has been guilty if 'infamous' conduct in a professional respect. The question is not merely whether what a medical man has done would be an infamous thing for anyone else to do, but whether it is infamous for a medical man to do. An act done by a medical man may be 'infamous' though the same act done by anyone else would not be infamous; but, on the other hand, an act which is not done 'in a professional respect' does not come within this section. There may be some acts which, although they would be infamous in any other person, yet if they are done by a medical man in relation to his profession, that is, with regard either to his patients or to his professional brethren, may be fairly considered 'infamous' conduct in a professional respect. I adopt that as a good definition. ...

### 6.5.2 Disciplinary powers of professional boards

In terms of section 41(1) of the Health Professions Act, a professional board is empowered in terms of the Health Professions Act to institute an inquiry into any complaint, charge or allegation of unprofessional conduct against registered practitioners and on finding such a person guilty of such conduct to impose *one or other* of the following penalties:

- A caution or a reprimand and a caution; or
- a suspension for a specified period from practising or performing acts specially pertaining to his profession; or
- removal of his name from the registrar; or
- a fine not exceeding R10 000; or
- a compulsory period of professional service as may be determined by the professional board; or
- the payment of the costs of the proceedings or a restitution.<sup>132</sup>

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board is obliged to make an explicit finding of either improper or disgraceful conduct when regard is had to such a person's profession. See Carstens & Pearmain 262.

<sup>130</sup> *Groenewald v South African Medical Council* 1934 TPD 404.

<sup>131</sup> *Allinson v General Council of Medical Education and Registrations* [1894] 1 QB Div 750.

<sup>132</sup> S 42(1)(a-f). See also *Tucker v SA Medical and Dental Council* 1980 (2) SA 207 (T); *Veriava v President, South African Medical and Dental Council* 1985 (2) SA 293 (T).

With regard to sentencing when erasure from the register is considered, Patel J stated in the case of *De Beer v Health Professions Council of South Africa*,<sup>133</sup> that:

It has frequently been observed that, where professional discipline is at stake, the relevant committee is not concerned exclusively, or even primarily, with the punishment of the practitioner concerned. Their Lordships refer, for instance, to the judgment of Sir Thomas Bingham MR in *Bolton v Law Society* [1994] 1 WLR 512, 517-519 where his Lordship set out the general approach that had been adopted. In particular he pointed out, since the professional body is not primarily concerned with matters of punishment, considerations which would normally weigh in mitigation of punishment have less effect on the exercise of this kind of jurisdiction. And he observed that it can never be an objection to an order for suspension that the practitioner may be unable to re-establish his practice when the period has passed. That consequence may be deeply unfortunate for the individual concerned but it does not make the order for suspension wrong if it is otherwise right. ... The reputation of the profession is more important than the fortunes of any individual member. Membership of a profession brings many benefits, but that is part of the price. ... *Mutatis mutandis* the same approach falls to be applied in considering the sanction of erasure imposed by a committee in this case.

Carstens<sup>134</sup> explains that in assessing an appropriate sentence and penalty on appeal or review, a court will not easily interfere with the sentence imposed by the council unless a misdirection has been made or the sentence imposed is startlingly inappropriate.

### 6.5.3 The Ethical Code of Professional Conduct to which a Psychologist shall adhere

The Ethical Code of Professional Conduct to which a Psychologist shall adhere stipulates the following about disciplinary sanctions against psychologists: "Behaviour by a psychologist that is unprofessional, immoral, unethical, negligent, deceptive or which fails to meet the minimal reasonable standards of the acceptable and prevailing practice of psychology, shall include but not be limited to any act or practice which violates these rules, the Act, any regulations made in terms of the Act which are applicable to a psychologist, board notices or board resolutions."<sup>135</sup> The provisions of sub-rule (1) are applicable to a psychologist and to anyone under his or her supervision.<sup>136</sup> The council has the power to impose any sanction that is provided for in the Act.<sup>137</sup>

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<sup>133</sup> *De Beer v Health Professions Council of South Africa* [2004] JOL 12606 (T); 2005 (1) SA 332 (T).

<sup>134</sup> Carstens & Pearmain 279.

<sup>135</sup> S 111(1).

<sup>136</sup> S 111(2).

<sup>137</sup> S 111(3).

With regard to discrimination against a complainant or a respondent, the Ethical Rules stipulate that a psychologist may not deny any person treatment, employment, advancement, promotion or admission to a training programme on the basis of having made or being the subject of an ethics complaint.<sup>138</sup> The prohibition provided for in sub-rule (1) does not preclude a psychologist from taking action based on the outcome of an inquiry held in terms of section 42 of the Act or consideration of other appropriate information.<sup>139</sup>

In addition, a psychologist may not file or encourage the filing of an ethics complaint that is frivolous and improper and is intended to harm the respondent rather than to protect the public.<sup>140</sup>

With regard to the reporting of ethical violations, the Ethical Rules stipulate that if an apparent ethical violation is not appropriate for informal resolution or is not resolved properly in that fashion, a psychologist shall take further action appropriate to the situation, unless such action conflicts with confidentiality rights in ways that cannot be resolved.<sup>141</sup>

If a psychologist has a reasonable basis for suspecting that a colleague is professionally impaired due to psychological disturbance, physical illness or substance abuse, he or she must timeously inform the board of his or her concerns.<sup>142</sup> The board will consider the matter and possibly initiate an investigation by the appropriate organ of the board.<sup>143</sup>

A psychologist shall co-operate in an ethics investigation, proceeding or related requirements of the board and make a reasonable effort to resolve for purposes of such investigation, proceeding or requirements any

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<sup>138</sup> S 110(1).

<sup>139</sup> S 110(2).

<sup>140</sup> S 109.

<sup>141</sup> S 106(1). See also s 106(2): "Action referred to in sub-rule (1) may include referral to an appropriate professional ethics committee or colleague for arbitration, conciliation, or advice on further course of action."

<sup>142</sup> S 107(1). See also s 107(2): "Where a psychologist informs the board as referred to in sub-rule (1), factual proof is not required provided the concerns are *bona fide*."

<sup>143</sup> S 107(3).

issues relating to confidentiality.<sup>144</sup> Failure by a psychologist to co-operate in an ethics investigation, proceeding or related requirements of the board referred to in sub-rule (1) is itself an ethics violation.<sup>145</sup>

#### 6.5.4 The traditional practitioner

Disciplinary inquiries against traditional practitioners and investigations launched into the practices of traditional practitioners are regulated by the Traditional Health Practitioners Act.<sup>146</sup> In terms of this Act, any person may lay a complaint with the Council about the way in which he or she was treated by a registered health practitioner or student.<sup>147</sup>

The Council may institute an inquiry into any complaint, allegation or charge of unprofessional conduct against any person registered in terms of this Act and, on finding such person guilty of such conduct, impose any of the penalties contemplated in section 34:<sup>148</sup> Provided that in the case of a complaint, charge or allegation which forms or is likely to form the subject of a criminal case in a court of law, the Council may postpone the holding of an inquiry until such case has been concluded.<sup>149</sup>

## 6.6 CONCLUSION

It is clear from the above discussion that psychiatrists and psychologists was (and still is in South Africa) relatively immune to lawsuits. A number of reasons have been cited for this perception and what little relevant data exist appears to give it credence. However, cases in psychiatry and psychology have burgeoned over the past two decades and have been a great concern to practicing psychiatrists and

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<sup>144</sup> S 108(1).

<sup>145</sup> S 108(2).

<sup>146</sup> Traditional Health Practitioners Act 35 of 2004 (hereafter referred to as the Traditional Health Practitioners Act). It is to be noted that this Act is not yet in operation. See also the discussion in chapter 4 of this study.

<sup>147</sup> S 29(1).

<sup>148</sup> In terms of s 34: "(1) A person registered under this Act who, after an inquiry held by the Council, is found guilty of improper or disgraceful conduct, or conduct which, when regard is had to such person's profession, is improper or disgraceful, is liable to one or more of the following penalties: (a) A caution or a reprimand or both; (b) suspension for a specified period from practising or performing acts pertaining to his or her profession; (c) removal of his or her name from the register; (d) a prescribed fine; (e) a period of compulsory community service determined by the Council; (f) the payment of the costs of the proceedings; or (g) restitution of any money paid by the complainant to the registered practitioner. A person who has been suspended or whose name has been removed from the register in terms of section 34 is disqualified from carrying on his or her profession and his or her registration certificate is deemed to be cancelled until the period of suspension has expired or until his or her name has been restored to the register by the Council." See s 36.

<sup>149</sup> S 30(1).

psychologists. Patients have become more litigious in all specialties of medicine. Plaintiff's lawyers have become more increasingly creative in finding reasons to blame physicians, psychiatrists and psychologists for unexpected outcomes or unforeseen events that affect patients and other individuals.<sup>150</sup> This chapter sought to explain situations where physicians were held accountable for their negligent actions or omissions. The next chapter concludes the research conducted in this chapter.

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<sup>150</sup> Simon xvii.

## CHAPTER 7

### CONCLUSION

"Never doubt that a small group of thoughtful, committed citizens can change the world; indeed, it's the only thing that ever does."<sup>1</sup>

#### 7.1 SCOPE AND PURPOSE

A selection of constitutional, medico-legal and liability issues related to the psychiatric and psychology professions and the influence thereof on the mentally disordered patient in South Africa set the framework for this thesis. The discussion focused on an examination of the current juridical framework in South Africa. The challenge faced with this thesis, therefore, was to ensure a comprehensive and detailed study of the law, psychiatry and psychology (which could not aim to be complete in a thesis of limited scope), whilst proposing recommendations for the regulation of the psychiatric and psychology professions balanced against the rights of the mentally disordered patient in South Africa. Although this topic has been written about extensively in the international context, the area is still in its infancy in South Africa and more research will need to be conducted.

It was imperative to undertake a broad-ranging analysis of the legal issues involved, while an in-depth study of the medical, ethical, clinical and scientific aspects of psychiatry and psychology was also required to ensure clarification and exposition of the issues surrounding the complex nature of this topic. Because of the multifaceted focus of this work, it was necessary to consult numerous legislative texts. For example, a detailed analysis of interrelated constitutional provisions,<sup>2</sup> various acts,<sup>3</sup> regulations, guidelines and policy documents. A scrutiny of conflicting scholarly viewpoints of renowned authors embodying constitutional, medico-legal, and liability issues were also carried out. It is trusted that this research could assist in addressing some issues and challenges in South Africa. It was proposed that this thesis is the first

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<sup>1</sup> Mead M as quoted in *Community health nursing: Caring for the public's health* ((eds) Lundy KS & Janes S) (2009) 186.

<sup>2</sup> The Constitution of the Republic of South Africa, 1996.

<sup>3</sup> For example, the Mental Health Care Act 17 of 2002; the National Health Act 61 of 2003 and the Criminal Procedure Act 51 of 1977 and Amendment 1998.

comprehensive LLD-thesis written on this topic in South Africa and, in this regard, is an original contribution to the field of study.

## 7.2 SUMMARY: OVERVIEW OF CHAPTERS

Chapter one stated the problem, methodology and purpose of the research undertaken. The starting point for an examination of law, psychiatry and psychology was an acknowledgement of the fact that psychiatry and psychology have a greater problem of legitimacy than virtually any other branch of medicine because of the very nature of "mental disorder". Mentally disordered patients, even if they recognise that they are ill, may be incapable of giving a valid consent or may (rationally or irrationally) withhold consent to therapeutic interventions that are indicated as necessary in the interests of their wellbeing or for the protection of others. Another source of psychiatry's and psychology's problem with legitimisation lies in the fact that the main way of ensuring that involuntary patients receive the treatment deemed necessary up to now has been through their detention in a hospital. Therefore, while general medicine is legitimised by consent and regulated almost wholly by medical, private and contract law, psychiatry and psychology – because it may involve the intrusion of public authority into private life through the detention of patients – requires legitimisation through public law procedures.

It was further stated that people suffering from mental disorders are among the most stigmatised, discriminated against, marginalised, disadvantaged and vulnerable members of society. Although much has been done in recent years to improve the status quo in South Africa, Johnstone<sup>4</sup> states that it is evident that a great deal more needs to be done to improve the moral standing of and to achieve social justice for the mentally disordered patient. It is to be noted that rapid progress has undoubtedly been made regarding South Africa's dedication to the improvement of mental health care and the regulation of the medical profession in the country. For example, government has included clauses in the Constitution protecting the rights of the mentally disordered patient, for example, the right not to be discriminated against (the right to equality),<sup>5</sup> the right to bodily and psychological integrity,<sup>6</sup> the right to dignity,<sup>7</sup> the right to privacy<sup>8</sup> as well as

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<sup>4</sup> Johnstone MJ "Stigma, social justice and the rights of the mentally ill: Challenging the status quo" 2001 10 *Aust & NZ J Mental Health Nursing* 200.

<sup>5</sup> S 9.

<sup>6</sup> S 12.

<sup>7</sup> S 10.

access to health care services,<sup>9</sup> and has also promulgated extensive domestic legislation for example the Mental Health Care Act and the National Health Act.

Chapter two outlined the history and development of psychiatry and psychology. Neither psychiatry nor psychology existed as defined fields of medicine or mental health before the end of the eighteenth century. While the great cultures of old, such as those of Egypt and Mesopotamia, vacillated between naturalistic and supernatural explanations of diseases, the Greeks declared themselves outspokenly in favour of naturalistic explanations of mental illness and therefore became the founders of scientific medicine, psychiatry and psychology.<sup>10</sup> It was explained that the history of psychiatry and psychology - as independent disciplines - was divided into three periods: The asylum period of the years 1770-1870 in which biological concepts held sway; the psychotherapy period of the years 1870 to more or less 1970 during which Freud's<sup>11</sup> doctrine of psychoanalysis came increasingly to the fore; and the second biological psychiatry from the 1970's to the present. Since ancient times medicine has always been interested in psychiatric illness, yet psychiatry as a medical speciality arose with the birth of the therapeutic asylum in the late eighteenth century. Psychology as a science is an even younger discipline, which is only a little more than 100 years old.<sup>12</sup>

Chapter 3 provided an explanation of the clinical aspects with regard to psychiatry and psychology. It was shown that mental disorder is a vast subject, but however, of great importance in legal matters, particularly those with regard to medical law, criminal law and the law of delict. The concept of "mental disorder" was defined in a clinical context as: "[A] clinically significant behavioural or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (for example a painful symptom) or disability (for example impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain disability, or an important loss of freedom."<sup>13</sup> It was also defined in a legal context as: "[A] positive diagnosis of a mental health related illness in terms of accepted diagnostic

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<sup>8</sup> S 14.

<sup>9</sup> S 27.

<sup>10</sup> Ackerknecht EH *Short history of psychiatry* (1968) 10.

<sup>11</sup> Rice E *Freud and Moses: The long journey home* (1990) 1, 18.

<sup>12</sup> Papalia DE & Olds SW *Psychology* (1987) 6.

<sup>13</sup> American Psychiatric Association *Diagnostic and Statistical Manual of Mental Disorders* (1994) xxi.

criteria made by a mental health practitioner authorised to make such diagnosis."<sup>14</sup> Further concepts that were defined and explained were, for example, "disease of mind" and "dissociative states". Aspects with regard to the mentally disordered offender were also discussed.

Chapter 4 of this study purport to explain the regulation of the psychiatric and psychology professions. The practice of the psychiatric and psychology professions is primarily regulated by statute. An overview of the concepts of profession and professionalism was provided. The application of these concepts in medical practice serves as a normative yardstick and is indicative of a professional code of conduct, which sets the acceptable requirements and boundaries to which medical practice should conform.<sup>15</sup> The importance thereof is further pivotal in the assessment of "professional medical negligence" and "unprofessional conduct with regard to the profession" of medical practitioners. An understanding of "professionalism" is therefore the key to an appreciation for the ideals and actualisation of the medical, psychiatric and psychology professions. Various aspects with regard to ethics in psychiatry and psychology were also discussed. Three important aspects in ethical decision-making are: First, psychiatrists and psychologists always have choices they can select from as they make decisions. Second, in making these decisions the consequences of these choices have to be taken into account. Lastly, the context or setting of the ethical dilemma will affect the decision to be made and this must be taken into account as well.<sup>16</sup>

Furthermore, the role of the psychiatrist and psychologist in court was discussed. The court will pay high regard to the views of the profession, but is not bound to adopt them.<sup>17</sup> Therefore the probative value of expert evidence is dependant upon the qualifications, skill and level of experience (competency rule) of the expert and the ability of the court to assess this testimony.<sup>18</sup> The general applicable considerations in assessing expert medical evidence as set out in *Michael v Linksfeld Park Clinic (Pty) Ltd*<sup>19</sup> were also discussed. Aspects with regard to forensic psychiatry and psychology were discussed, and in this context it

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<sup>14</sup> S 1 of the Mental Health Care Act.

<sup>15</sup> Carstens PA & Pearmain DL *Foundational principles of South African medical law* (2007) 606-607. Carstens PA *Die strafregtelike en deliktuele aanspreeklikheid van die geneesheer op grond van nalatigheid* (unpublished LLD thesis, UP, 1996) 103.

<sup>16</sup> Singh JA & Ngwena C "Bioethics" 33-52 in *Introduction to medico-legal practice* ((eds) Dada MA & McQuoid-Mason DJ) (2001) at 35.

<sup>17</sup> *Van Wyk v Lewis* 1924 AD 438 447-448.

<sup>18</sup> Carstens & Pearmain 860.

<sup>19</sup> *Michael v Linksfeld Park Clinic (Pty) Ltd* 2001 (3) SA 1188 (SCA).

is important to note that forensic evaluations do not usually occur within context of the normal "therapist-patient" relationship in which there has to be concern that the assessed individual's autonomy is respected, care taken that no harm befalls him or that his best interests are served. Professional boundaries in psycho-legal practice are intended to maintain a professional distance and respect between the patient and the forensic psychiatrist and psychologist.<sup>20</sup>

As discussed in chapter 5, the Constitution is considered to be the supreme law in South Africa, and any legislation that is irreconcilable with it is invalid to the extent of the conflict. Secondly, according to section 39 of the Constitution, the Bill of Rights applies to all law and binds the executive, legislature, judiciary and all organs of state. It was also established that, in terms of section 36 of the Constitution, rights may be limited in terms of the Bill of Rights under specific circumstances and in a particular manner for the protection of some public interest or the rights of others.

The constitutional values of human life and dignity are objective value norms constituting an objective value order, giving rise to a constitutional duty on the state. The state has a positive duty to take steps to ensure that human life and dignity are respected, promoted and valued. The right to human dignity, which protects the intrinsic worth of human beings, was also examined. Intrinsic worth is based on our inborn human qualities. Therefore, nobody may be treated as something less than human or as a mere object. The normative premise, upon which the new constitutional dispensation as a system of limited government is based, is the protection of human dignity.

With regard to the right to life,<sup>21</sup> one of the ultimate universal issues are whether it should be permitted to execute individuals who, due to mental disorders, do not understand that they are truly being executed as punishment for their crimes. For example, gross delusions stemming from a severe mental disorder may put an awareness of a link between a crime and its punishment in a context so far removed from reality that the punishment can serve no proper purpose. It was noted that someone who suffers from a mental disorder who commits a crime - who didn't know right from wrong or didn't know what he or she was doing - should be found not guilty by reason of insanity. If a mentally disordered individual has been found guilty of

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<sup>20</sup> Zabow T & Kaliski S "Ethical considerations" in *Psycholegal assessment in South Africa* 359-360.

<sup>21</sup> S 11 of the Constitution.

a crime and received the death penalty, he or she probably presented the insanity defence and did not succeed.<sup>22</sup> The provisions with regard to the insanity defence were also discussed.

End of life decisions also raises a number of difficult philosophical, theological, ethical and legal problems.<sup>23</sup> Pivotal to the euthanasia debate is the content to be afforded to the right to life, in context of what is to be regarded as the "quality of life" and to what extent patient autonomy and the right to self-determination may be influential to request a physician to end a life which is "not worth living" on account of terminal illness. Since serious mental disorders could make life seem as unbearable to some patients as serious illness do to others, the question remains of whether those mentally disordered patients who repeatedly expressed a wish to end their lives should be permitted to do so. The question posed was whether euthanasia and assisted suicide should be transformed from what is now a crime into a sacred "right to die". In terms of reported case law in South Africa, it was found that apart from voluntary passive euthanasia, in cases of patients who are in a persistent vegetative state, all other forms of euthanasia, for example, voluntary or involuntary active euthanasia, involuntary passive euthanasia and assistance to suicide, will be unlawful and will render a physician who performed such forms of euthanasia, liable of either murder, attempted murder or culpable homicide, depending on the circumstances. The case of *Clarke v Hurst*<sup>24</sup> was discussed, in which it was found that the decision whether the discontinuance of the artificial nutritioning of the patient and his resultant death would be wrongful, depends on whether, judged by the *boni mores* (legal convictions) of our society, it would be reasonable to discontinue such nutritioning. It was established that the decision of the issue depended on the quality of life which remained to the patient, for example, the physical and mental status of that life. Strauss<sup>25</sup> states that although the result in Clarke's case is to be applauded, it is respectfully regretted that the court was not prepared to give recognition to the patient's right of autonomy. He submits that there is no legal reason why a person, when still in good health, cannot by way of advance directive refuse medical treatment to be operative at a future stage when, on account of ill-health or injury, he becomes incapable to express his will.

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<sup>22</sup> Mello M "Executing the mentally ill: When is someone sane enough to die?" 2007 22 *Criminal Justice* 3: 30 at 31.

<sup>23</sup> Strauss SA "The 'right to die' or 'passive euthanasia'" 1993 6 *S Afr J Criminal Justice* 2: 196. See also Campbell T "Euthanasia as a human right" 447-459 in *First do no harm: Law, ethics and healthcare* ((ed) McLean SAM) (2006); Slabbert M & Van der Westhuizen C "Death with dignity in lieu of euthanasia" 2007 22 *SAPL* 2: 366-384.

<sup>24</sup> *Clarke v Hurst NO* 1992 (4) SA 636 (D).

<sup>25</sup> Strauss 1993 *S Afr J Criminal Justice* 196 at 208.

With reference to children's rights,<sup>26</sup> there are currently serious concerns about the placement, treatment and care of children in need of mental health care in South Africa. It was mentioned that the concern with regard to mentally disordered children arises in South Africa that there are no clear, written policies in place which are adequate and appropriate; and that, to the extent that certain policies are in place, they are not adhered to consistently in practice, and that no measures or insufficient measures are taken when such policies are breached.<sup>27</sup>

Increased knowledge about mental disabilities and new models of community-based services and support systems have allowed many people with mental disabilities, once relegated to living in closed institutions, to demonstrate that they can live full and active lives in the community. People once thought to be incapable of making decisions for themselves have shattered stereotypes by showing that they are capable of living independently when appropriate legal protections and support services are provided. Moreover, many people once thought to be permanently or inherently limited by a diagnosis of major mental disorder have demonstrated that full recovery is possible. Despite these significant advances, however, people with mental disabilities experience marginalisation in all countries. Institutionalisation persists in many countries. Elsewhere, community-based services do not always ensure integration, autonomy, and dignity.<sup>28</sup>

The yearnings of people with mental illness to be recognised as full citizens able to enjoy the same rights as other citizens have yet to be satisfied. Aspects of the historical paradigm of oppression and disenfranchisement still resonate from earlier days, and they dominate institutional behaviour in terms of public relationships, public policies and clinical management. Social exclusion from the public domain often remains the preferred approach for dealing with mental disorders - despite many complaints that are still surfacing about the mismanagement of patients under the previous regime. However, psychiatric and psychological treatments have improved and handbooks are available that attest to the scientific evidence

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<sup>26</sup> S 28 of the Constitution.

<sup>27</sup> Special gratitude is due to the Centre for Child Law, University of Pretoria, for their assistance in identifying these relevant and current issues.

<sup>28</sup> Hunt P & Mesquita J "Mental disabilities and the human right to the highest attainable standard of health" 2006 28 *Human Rts Quarterly* 2: 332 at 334.

of the treatments proposed.<sup>29</sup> These issues were discussed in the context of non-discrimination as envisaged in the Constitution.<sup>30</sup>

The wording of section 14 of the Constitution indicates that the right to privacy is essential for the preservation of an individual's dignity, including his or her physical, psychological and spiritual wellbeing. This right also allows individuals to make personal decisions about their lives, free from interference by the state, and usually refers to control over matters such as marriage, reproductive freedom, contraception and family relationships. Once the doctor-patient relationship is initiated, the physician assumes an automatic duty to safeguard confidentiality. However, this duty is not absolute, and in some circumstances breaching confidentiality is appropriate and may even be legally required. Psychiatrists must balance patient confidentiality with the need to provide adequate information to other medical providers. Documentation in the medical record, as well as verbal communication to others providing patient care, requires careful consideration of what to communicate and what to keep confidential.<sup>31</sup>

It was further argued that the freedom of scientific enquiry must allow and encourage research and scientific advances. However, although the freedom of scientific research and academic freedom are enshrined in section 16(1)(d) of the Constitution, the right itself must be balanced against the other rights in the Constitution. Therefore, constraints on the freedom of scientific enquiry may be imposed to protect the safety of the community and individuals and the rights and interests of the subjects of scientific enquiry.

Health care is generally considered to be a basic need. Section 27(1)(a) of the Constitution specifically provides that everyone has the right to have access to health care, including reproductive health care. This right is however limited internally by section 27(2), which mentions that the state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of these rights.<sup>32</sup> It was established that the Constitution does not guarantee a right to health, but only the qualified right of access to health care services.

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<sup>29</sup> Orovuje PR & Taylor AJW "Mental health consumers, social justice and the historical antecedents of oppression" 95-111 in *Justice as a basic human need* ((ed) Taylor AJW) (2006) 106.

<sup>30</sup> S 9.

<sup>31</sup> Siegler M "Sounding boards: Confidentiality in medicine - a decrepit concept" 1982 307 *N Eng J Med* 24:1518-1521.

<sup>32</sup> See *Soobramoney v Minister of Health, KwaZulu-Natal* 1997 12 BCLR 1696 (CC).

States should adopt appropriate legislative, administrative, budgetary, judicial, promotional, and other measures toward this end. For example, states should ensure that their population's right to the highest attainable standard of mental health and that the right to health of persons with mental disabilities are adequately reflected in their national health strategies, plans of action, and other relevant policies, such as national poverty reduction strategies and national budgets. Mental health laws, policies, programs, and projects should: embody human rights and empower people with mental disabilities to make choices about their lives; give legal protections relating to the establishment of (and access to) quality mental health facilities, as well as care and support services; establish robust procedural mechanisms for the protection of those with mental disabilities; ensure the integration of persons with mental disabilities into the community; and promote mental health throughout society. Patients' rights charters should encompass the human rights of persons with mental disabilities. States should also ensure that information about their human rights is made available to persons with mental disabilities and their guardians, as well as to other individuals who may be institutionalised in psychiatric hospitals.<sup>33</sup>

This research further revealed that informed consent is of utmost importance with regard to medical treatment. Section 12(2)(c) of the Constitution provides that "everyone has the right to bodily and psychological integrity, which include the right not to be subjected to medical or scientific experiments without their informed consent". The doctrine of informed consent in the context of medical law was discussed. In principle, consent should be given by the patients themselves. Only in exceptional cases may consent for medical treatment or operations be given on behalf of such a person. The patient must have knowledge of all the true and essential facts relating to the treatment he or she is consenting to.<sup>34</sup> The Mental Health Care Act, National Health Act, as well as the Choice on Termination of Pregnancy Act, also includes provisions pertaining to consent.

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<sup>33</sup> Hunt & Mesquita 2006 *Human Rts Quarterly* 332 at 349.

<sup>34</sup> Claassen NJB & Verschoor TJ *Medical negligence in South Africa* (1992) 62.

It was further established that the right to freedom of religion and thought is contained in most human rights treaties. However, members of religious communities may seek to use the freedom of religion as a shield to fend off attacks on constitutionally offensive group practices.<sup>35</sup>

The purpose of chapter 6 was to provide a basic, condensed, general overview of professional medical malpractice. The starting point for this discussion was to provide a historical overview of the origin and development of medical malpractice. Furthermore, it provided a discussion of the delictual and criminal liability of psychiatrists and psychologists. In addition, aspects pertaining to the therapist-patient relationship, the duty of care and specific issues with regard to psychiatric and psychological malpractice were discussed. A further aim was provide an overview of disciplinary inquiries held against medical practitioners in terms of the Health Professions Act.<sup>36</sup> Aspects with regard to the liability of the traditional healer were also included.

Actions against mental health professionals are based on the same legal principles that underlie traditional medical malpractice claims. The fundamental concept underlying malpractice actions is negligence. Negligence on the part of a psychiatrist or any physician has been described as either doing something which he or she should not have done or omitting to do something which he or she should have done. Malpractice claims may also arise as a result of breach of contract.<sup>37</sup>

The first reported case in South Africa with reference to medical malpractice is *Lee v Schönberg*, an old Cape decision.<sup>38</sup> In this decision the court confirmed that where a physician did not exercise reasonable skill and care, he is liable in damages. The court relied on the English decision of *Lamphier v Phipos*.<sup>39</sup> The presiding judge, De Villiers CJ, enunciated the following rule with regard to medical negligence:

There can be no doubt that a medical practitioner, like any professional man, is called upon to bring to bear a reasonable amount of skill and care in any case to which he has to attend; and

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<sup>35</sup> *Christian Education South Africa v Minister of Education* 2000 (4) SA 757 (CC).

<sup>36</sup> The Health Professions Act 56 of 1973, as amended by Act 29 of 2007.

<sup>37</sup> Robertson JD *Psychiatric malpractice: Liability of mental health professionals* (1988) 7.

<sup>38</sup> *Lee v Schönberg* (1877) 7 Buch 136.

<sup>39</sup> *Lamphier v Phipos* (1838) 8 C & P 475.

that where it is shown that he has not exercised such skill and care, he will be liable in damages.<sup>40</sup>

Furthermore, the generic test for medical negligence was explained as one of foreseeability and preventability. The test for medical negligence was formulated in *Van Wyk v Lewis*<sup>41</sup> in 1924:

... A medical practitioner is not to bring to bear upon the case entrusted to him the highest possible degree of professional skill, but he is bound to employ reasonable skill and care. And in deciding what is reasonable the court will have regard to the general level of skill and diligence possessed and exercised at the time by the members of the branch of the profession to which the practitioner belongs.

Reference was also made to chapter 6 of the Mental Health Care Act with regard to the general test for medical negligence. With regard to the question of whether there is a professional duty on a physician to heal, Strauss<sup>42</sup> is of the opinion that where a patient consults with a medical practitioner, no more is required of the practitioner than to treat the patient with the reasonable care, skill and experience legally required, unless the practitioner explicitly guarantees the patient that he or she will be healed or cured - an undertaking that no prudent practitioner will subscribe to.

It was clear from the discussion that psychiatrists and psychologists were (and still is in South Africa) relatively immune to lawsuits. A number of reasons have been cited for this perception. However, cases in psychiatry and psychology have burgeoned over the past two decades and have been a great concern to practicing psychiatrists and psychologists. Patients have become more litigious in all specialties of medicine. Plaintiff's lawyers have become more increasingly creative in finding reasons to blame physicians, psychiatrists and psychologists for unexpected outcomes or unforeseen events that affect patients and other individuals.<sup>43</sup>

Issues involving, for example the, the *res ipsa loquitur*, the establishment of causation, expert testimony and relevant case law were also dealt with in this chapter.

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<sup>40</sup> See *Lee v Schönberg supra* at 136.

<sup>41</sup> *Van Wyk v Lewis* (1924) AD 438. See also *Mitchell v Dixon* 1914 AD 519, where Innes ACJ observed: "A medical practitioner is not expected to bring to bear upon the case entrusted to him the highest possible degree of professional skill and care, he is bound to employ reasonable skill and care; and he is liable for the consequences if he does not."

<sup>42</sup> The author agrees with Strauss in this regard. See Strauss *Doctor, patient and the law* 40, 41, 176ff.

<sup>43</sup> Simon RI *Clinical psychiatry and the law* (1992) xvii.

### 7.3 CONCLUSIVE REMARKS

It remains for strategies to be developed that change negative perceptions and inequities for people with mental illness in the economically more-developed parts of the world. Access to education, welfare benefits and other opportunities in society should not depend on ethnicity, disability, race, gender, religion or membership of any group. Paradoxically, problems of inequality can be exacerbated both by treating members of minorities groups the same as members of the majority, as well as by treating them differently. Above all the strategies should be underpinned by the inalienable respect for the mentally disordered. No matter how similar or how different mental patients might otherwise appear to be from other people in their communities, they are all part of mankind, and they should not be denied their equal share of opportunities to thrive as human beings. There is a moral and ethical requirement for society to respond to the suffering of the innocent. It is indeed a matter of recognising the importance of justice as a basic human need for the mentally disordered, as for everyone else.<sup>44</sup>

To conclude, with the words of Berreman:<sup>45</sup> "The greatest challenge, the most difficult truth, to convey - and also the most important one - is that the welfare of the most powerful and privileged of people, and the future of us all, cannot be isolated from that of the poorest, most vulnerable, most wretched of the earth. Contemporary technology has seen to that. We are all in the same frail boat. Human rights and self-interest - social justice and survival - have finally met on common ground."

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<sup>44</sup> Orowujs PR & Taylor AJW "Mental health consumers, social justice and the historical antecedents of oppression" 95-111 in *Justice as a basic human need* (ed) Taylor AJW) (2006) 107.

<sup>45</sup> Berreman G as quoted in Sluka J "On common ground: Justice, human rights and survival" 114-133 in *Justice as a basic human need* (ed) Taylor AJW) (2006) 114.

\* Architect John Howard's "Provincial Lunatic Asylum" as it would have appeared in the 19th Century.

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## TABLE OF ABBREVIATIONS

AAPL Newsletter	American Academy of Psychiatry and the Law Newsletter
Acta Juridica	Acta Juridica
Afr J Rep Health	African Journal of Reproductive Health
Afr Legal Studies	African Legal Studies
Adv Psychiatric Treatment	Advances in Psychiatric treatment
AIDS and Behaviour	AIDS and Behaviour
AJS Rev	The Journal of the Association for Jewish Studies
Am Anthropologist	American Anthropologist
Am Behavioural Scientist	American Behavioural Scientist
Am J Forensic Psychology	American Journal of Forensic Psychology
Am J of Archaeology	American Journal of Archaeology
Am J of Insanity	American Journal of Insanity
Am J of Nurs	The American Journal of Nursing
Am J Psychiatry	The American Journal of Psychiatry
Am J Semitic Languages & Literatures	The American Journal of Semitic Languages and Literatures
Am J Sociology	The American Journal of Sociology
Am Sociological Rev	American Sociological Review
Amnesty Magazine	Amnesty Magazine
Annals of Internal Med	Annals of Internal Medicine
Annual Rev Soc	Annual Review of Sociology
Annual Rev Anthropology	Annual Review of Anthropology
Anthropology NL	Anthropology News Letter
Antiquity	Antiquity
Arch Gen Psychiatry	Archives of General Psychiatry
Asian Folklore Studies	Asian Folklore Studies
Aust & NZ J Mental Health Nursing	Australian and New Zealand Mental Health Journal of Nursing

Aust & NZ J Psychiatry Journal	Australian and New Zealand of Psychiatry
Aust Health Rev	Australian Health Review
Aust Psychiatry	Australian Psychiatry
Bib'l World	The Biblical World
Br Medical J	The British Medical Journal
Br J Psychiatry	The British Journal of Psychiatry
Buddhist-Christian Studies	Buddhist-Christian Studies
Bull Am Acad Psychiatry Law	Bulletin of the American Academy of Psychiatry and law
Bull Hist of Med	Bulletin of the history of Medicine
Bull College Art Ass Am	The Bulletin of the College Art Association of America
Cal LR	California Law Review
Canadian Psychology	Canadian Psychology
Cf	Compare
Child Psychiatry & Human Dev	Child Psychiatry & Human Development
Chicago-Kent J Int'l & Comp L	Chicago-Kent Journal of International & Comparative Law
Classical J	The Classical Journal
Classical Philology	Classical Philology
Classical Q	Classical Quarterly
Classical Rev	The Classical Review
Columbia LR	Columbia Law Review
Codicillus	Codicillus
Criminal Justice	Criminal Justice
Critical Inq	Critical Inquiry
Cur Anthropology	Current Anthropology
De Jure	De Jure
De Rebus	De Rebus
Eastern Mediterranean HJ	Eastern Mediterranean Health Journal
Economica	Economica
English Hist Rev	The English Historical Review

Ethics & Behaviour	Ethics and Behaviour
Ethos	Ethos
ff	And further
Fundamina	Fundamina
Geneeskunde	Geneeskunde
GG	Government Gazette
Greece & Rome	Greece and Rome
Harv Rev Psychiatry	Harvard Review of Psychiatry
Hastings Center Report	The Hastings Center Report
Hist in Focus: Medical Hist	History in Focus: Medical History
Hist Islamic Med	The History of Islamic medicine
Hist Psychiatry	History of Psychiatry
Hospital & Community Psychiatry	Hospital and Community Psychiatry
Human Rts Quarterly	Human Rights Quarterly
Ibid (ibidem)	The same source as cited directly above
In J L Healthcare & Ethics	The Internet Journal of Law, Healthcare and Ethics
Int J Afr Hist'I Studies	The International Journal of African Historical Studies
Int J L & Psychiatry	International Journal of Law and Psychiatry
Int J Mental Health Nursing	International Journal of Mental Health Nursing
Isis	Isis
J Afr Hist	The Journal of African History
J Am Acad Psychiatry Law	Journal of the American Academy of Psychiatry and the law Online
J Am Board Fam Practice	Journal of the American Board of Family Practice (now known as the American Board of Family Medicine)
J Am Med Ass	The Journal of the American Medical Association
J Am Oriental Society	Journal of the American Oriental Society
J Anthropological Inst Great Britain & Ireland	The Journal of the Anthropological Institute of Great Britain and Ireland
J Architectural Edu	Journal of Architectural Education

J Asian Studies	The Journal of Asian Studies
J Bib'l literature	Journal of Biblical literature
J Child Custody: Research Issues & Practices	Journal of Child Custody: Issues and Research Practices
J Clinical Psychiatry	Journal of Clinical Psychiatry
J Clinical Psychology	Journal of Clinical Psychology
J Contemp History	Journal of Contemporary History
J Contemp Psychotherapy	Journal of Contemporary Psychotherapy
J Criminal L & Criminology	Journal of Criminal Law and Criminology
J Environmental Psychology	Journal of Environmental Psychology
J Folklore Research	Journal of Folklore Research
J Health & Soc Behaviour	Journal of Health and Social Behaviour
J Hist Ideas	Journal of the History of Ideas
J Hist Med & Allied Sci	Journal of the history of medicine and Allied Sciences
J L Med & Ethics	Journal of Law, Medicine & Ethics
J L & Soc	Journal of Law and Society
J Legal Economics	Journal of Legal Economics
J Medical Biography	Journal of medical biography
J Medical Science	Journal of Medical Science
J Mental Science	The Journal of Mental Science
J Mod History	The Journal of Modern History
J Muslim Mental Health	Journal of Muslim Mental Health
J Near East Studies	Journal of Near Eastern Studies
J Neurol Neurosurg Psychiatry	Journal of Neurology, Neurosurgery and psychiatry
J Psychotherapy Integration	Journal of Psychotherapy Integration
J Religion & Health	Journal of Religion and Health
J Psychosoc Nurs Ment Health Serv	Journal of Psychosocial Nursing and Mental Health Services
J South'n Afr Studies	The Journal of Southern African Studies
J Soc Hist	Journal of Social History

Jewish Q Rev, New Series	The Jewish Quarterly Review, New Series
JAMA	The Journal of the American Medical Association
JISHIM	Journal of the International Society for the History of Islamic Medicine
Lancet	Lancet
L & Psychology Rev	Law & Psychology Review
Legal Med Annual	Legal Medicine Annual
Lewis & Clark L R	Lewis & Clark Law Review
Libyan J Med	Libyan Journal of Medicine
Man	Man
McGill J Med	McGill Journal of Medicine
Medical Care Rev	Medical Care Review
Medical Hist	Medical History
Medical Hist Suppl	Medical History Supplement
Mentalities	Mentalities
Milbank Q	The Milbank Quarterly
Modern Philology	Modern Philology
N Eng J Med	The New England Journal of Medicine
Nat Rev's Neurosci	Nature Reviews Neuroscience
Neurosurgery	Neurosurgery
Notes SS	Notes Second Series
Notre Dame J Law, Eth & Pub Policy	Notre Dame Journal of Law, Ethics & Public Policy
Notre Dame L Rev	Notre Dame Law Review
Obiter	Obiter
Osiris	Osiris
Palliative & Supportive Care	Palliative and Supportive Care
Phil	Philosophy
Phil East & West	Philosophy East and West
Phil, Psychiatry & Psychology	Philosophy, psychiatry & Psychology
Phoenix	Phoenix

Primary Psychiatry	Primary Psychiatry
Professional Psychology: Research and Practice	Professional Psychology: Research and Practice
Psychiatric Bull	Psychiatric Bulletin
Psychiatric Clinics of North Am	The Psychiatric Clinics of North America
Psychiatric Q	Psychiatric Quarterly
Psychiatric Services	Psychiatric Services
Psychopat Africaine	Psychopathologie Africaine
Psychotherapy: Theory, Research, Practice, Training	Psychotherapy: Theory, Research, Practice, Training: Journal of the Division of Psychotherapy, American Psychological Association
Record of the Art Museum, PU	Record of the Art Museum, Princeton University
Rethinking Rts	Rethinking Rights
Rev Edu Research	Review of Educational Research
Royal Anthropological Inst News	Royal Anthropological Institute News
SAJHR	South African Journal on Human Rights
SALJ	South African Law Journal
SALUS	SALUS
SAPL	South African Public Law
S Afr J Child Adolescent Psychiatry	South African Journal of Child Adolescent Psychiatry
S Afr J Con Med Edu	South African Journal of Continuing Medical Education
S Afr J Criminal Justice	South African Journal of Criminal Justice
S Afr J Psychiatry	South African Journal of Psychiatry
S Afr J Sci	South African Journal of Science
S Afr Med J	South African Medical Journal
S Afr Pharmacist's Assistant	South African Pharmacist's Assistant
S Afr Practice Management	South African Practice Management

S Afr Psychiatry Rev	South African Psychiatry Review
School Rev	The School Review
Science	Science
Sci New Series	Science New Series
Scientific Monthly	The Scientific Monthly
Soc Dynamics	Social Dynamics
Soc Forces	Social Forces
Soc Hist Med	Social History of Medicine
Soc Science J	Social Science Journal
Specialist Forum	Specialist Forum
Specialist Med	Specialist Medicine
Stellenbosch Law Review	Stellenbosch L Rev
Studia Islamica	Studia Islamica
Supra	Above
The Independent	The Independent
Theory Psychology	Theory Psychology
THRHR	Tydskrif vir die Hedendaagse Romeins-Hollandse Reg
Tour Egypt Monthly: An online magazine	Tour Egypt Monthly: An online magazine
Transaction & Proc of the Am Philological Soc	Transactions and Proceedings of the American Philological Society
Transactions of the Am Phil Soc	Transactions of the American Philosophical Society
Transactions of the Am Philological Soc	Transactions of the American Philological Society
TSAR	Tydskrif vir die Suid-Afrikaanse Reg
TRW	Tydskrif vir die Regswetenskap
Victorian Studies	Victorian Studies
Without Prejudice	Without Prejudice
World J Biological Psychiatry	World Journal of Biological Psychiatry