

# Legal reflections on the doctor-patient relationship in preparation for South Africa's National Health Insurance

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The doctor-patient relationship is the foundation of any medical intervention. Over time, the relationship has changed, from the era of paternalism to the era of self-determination or patient autonomy, following changes resulting from consumerism and lately, in South Africa, socialised medicine as a result of the proposed National Health Insurance (NHI). The premise of this article is that patient autonomy is invariably limited by a determination of who will carry the cost of a medical intervention. In recent years, legislative developments have affected the understanding of a patient and doctor through the introduction of new references, such as 'user', 'data subject' and 'consumer' for a patient, and 'service provider' and 'responsible party' for a doctor, each giving different meanings to the doctor-patient relationship. Recent statutory additions also include new remedies available to aggrieved patients as parties in the doctor-patient relationship. The article concludes with brief observations on how the NHI will alter the essence and nature of the doctor-patient relationship in future.

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Recent legislative developments in South Africa (SA) have led to a different understanding of the traditional doctor-patient relationship. These changes include the introduction of new remedies for patients over and above those conventionally sought for compensation in response to professional medical negligence, rooted in the law of delict and contract law. The National Health Insurance (NHI) Bill,<sup>[1]</sup> a recent addition to the regulation of health in SA, aims to give effect to section 27 of the Constitution of the Republic of South Africa, 1996 (the Constitution), which provides that 'everyone has the right to have access to healthcare services.' The objective of achieving universal access to healthcare services for all South Africans was launched in 2012, and is estimated to be completed by 2026.<sup>[2]</sup> The implementation of the NHI will bring about significant changes to the current healthcare context in SA that consists of the two-tiered system of a public and a private healthcare system.

The objective of this article is to briefly consider how the doctor-patient relationship has evolved over time, and how the implementation of the NHI may ultimately affect this relationship. The article first discusses when the doctor-patient relationship commences and ends, followed by an overview of recent legislative developments that have changed the conventional roles of the doctor and patient, including a few observations regarding new statutory remedies that were introduced for the benefit of the patient. The article concludes with a projection of the nature of the doctor-patient relationship under the NHI, once implemented. Due to the limited scope of the article, the issues will not be canvassed in depth.

## When does the doctor-patient relationship start and end?

A patient who consults a doctor enters into a contractual relationship with the doctor. The agreement is usually a consensual one where

the patient agrees to be treated and the doctor undertakes to treat the patient. It is usually a tacit agreement, but for more invasive procedures, written consent should be required. Once treatment has begun, it must be completed.<sup>[3]</sup> Although there is no obligation on doctors in private practice to take on a patient or a case, once they do, they must carry it through, unless: (i) the doctor can leave the treatment in the hands of another competent doctor; (ii) the doctor issues sufficient instructions for treatment to the patient; (iii) the patient is cured or does not require further treatment; or (iv) the patient refuses further treatment.<sup>[4]</sup> Doctors in the public sector, however, as employees of the state and not independent contractors, as is the position in private practice, have less of a choice whether to treat a patient or not, but they too have to complete a patient's treatment once they have started it.

## Evolution of the doctor-patient relationship

The significance of a good doctor-patient relationship in order to achieve the goals of medicine was recognised by Plato<sup>[5]</sup> almost 2 500 years ago, when he labelled poor doctor-patient relationships 'slave medicine'. As for good doctor-patient relationships, reserved for free men, Plato stated that a doctor should never treat a patient unless he has won the patient's trust, and when he has done so, he must aim to complete restoration by persuading the patient to co-operate with the treatment.<sup>[5]</sup>

For Plato, the best clinical medicine is practised when a relationship between the doctor and the patient exists, and where the scientific aspects of the patient's care are grounded in a personal relationship – a relationship characterised by shared decision-making. This view is commendable, but in current times, where the practice of medicine is influenced by the advent of fundamental rights,<sup>[6]</sup> respect for

patient autonomy has become a key element in a good doctor-patient relationship. Doctors, in addition, have increasingly become healthcare service providers to their patients (as consumers of healthcare),<sup>[7]</sup> and under the NHI, those who sign up as healthcare service providers will become contractors of the state. As will be discussed below, the shift from a traditional paternalistic model to a consumerist model has pertinent ethical and legal consequences for the healthcare context. Healthcare has become a 'product' supplied by the healthcare 'provider', increasing the risk that doctors will replace professional ethics with those of the marketplace.<sup>[7]</sup> Plato's ideal has thus slowly diminished, with the emphasis in current times on numbers and services, rather than relationships.

Over time, the doctor-patient relationship has been shaped by certain social and political influences and developments, discussed next.

### Paternalism

The early doctor-patient relationship was characterised by an era of paternalism, also described as the age of the doctor.<sup>[8]</sup> This period lasted for thousands of years, from around 500 BC to the 1960s, and represents the authoritarian stream in the history of medical practice. The model was premised on trust in the physician's skills and moral stature, and was characterised by patient dependency and physician authority.<sup>[4]</sup> Medical prognosis was a mystery understood only by the trained physician.<sup>[5,7]</sup> Today, medical information is easily accessible through the click of a button. Moreover, patients have become joint decision-makers concerning their health and medical treatment. Dhai and McQuoid-Mason<sup>[4]</sup> argue that paternalism and the notion that the doctor should protect or advance the interests of the patient, even if contrary to the patient's own immediate desires or freedom of choice,<sup>[9]</sup> no longer has a place in the healthcare context.

### Self-determination

The erosion of the era of paternalism was followed by the recognition of the autonomy of the patient. Patients no longer passively follow the authority of a doctor, but have become self-determining free agents.<sup>[7]</sup> The doctrine of informed consent, which gives expression to patient autonomy and self-determination, follows from the Latin phrase *volenti non fit iniuria*, loosely translated as 'to him who consents, no harm can be done.'<sup>[10]</sup> Patients, instead of doctors, are now the ultimate decision-makers with regard to their own bodies and health.<sup>[11]</sup>

The right to self-determination has furthermore been codified in section 12(2) of the Constitution, which entrenches everyone's right to freedom and security of the person, as well as the right to bodily and psychological integrity, which includes the right to security in and control over their body, among other aspects. The National Health Act (NHA),<sup>[12]</sup> in sections 6, 7, and 8, requires that a user (patient) should have full knowledge of his or her health status, and that (s)he must provide informed consent for any treatment, as well as participate in all decisions concerning his or her health.

We find ourselves presently in the era of self-determination and respect for the autonomy of the patient. Despite the patient being fully informed about the proposed treatment as well as the best options, his or her decision will ultimately depend on whether or not payment for the procedure or treatment will be possible. This, in turn, requires clarity on who will be footing the bill. In the private

healthcare sector, where a patient is a member of and has access to a medical scheme, a proposed procedure or treatment may be covered by the scheme. In the public sector, on the other hand, services rendered to patients will depend on the availability of allocated resources to the relevant health department.<sup>[13]</sup> The era of self-determination overlaps with the era of the 'payer', leading to the question of in whom the ultimate decisional authority vests to decide whether and which medical procedure should be conducted – is it the doctor, the patient, both, or the 'payer' (medical aid scheme/state)? Although a doctor may recommend a specific treatment plan and a patient may agree, their decisions will ultimately be approved or rejected by the payer of the bill.

Consider this example: a young woman who has excessively large breasts and who, as a result of the weight of the breasts, develops complications with her back, may be advised by her doctor to have a breast reduction. After her doctor discusses the procedure and the risks with her, she may, based on the information, decide that the breast reduction is the best option for her. If her medical scheme views her procedure as cosmetic surgery and refuses authorisation, she may have to pay for the procedure out of her own pocket. So, despite a patient's freedom to make decisions about his or her healthcare based on the information provided by the doctor, the final decision will ultimately be dependent on the patient's health insurance coverage.

In the public sector, organ transplants present an especially clear example. Organ transplants are expensive procedures, and therefore the state may limit the number of transplants performed in the public sector. Hence a patient may be informed that an organ transplant is the indicated route, but because of lack of funds in the public sector, or long waiting lists, the exercising of the choice to have an organ transplant remains a choice on paper only. The right to self-determination is thus limited on a cost scale.<sup>[13]</sup>

The doctor-patient relationship in the public health sector, in contrast to those with private health cover, is affected by the employment contract between the state and the doctors employed by the state, in the sense that doctors are vicariously liable for harm or injury suffered by their patients. This situation introduces an inevitable distance between doctor and patient with regard to trust and responsibility generally.

### Socialism

When the NHI is fully implemented, the healthcare service model in SA will become a predominantly socialist one. Blaylock<sup>[14]</sup> observes that the term 'socialised medicine' is often avoided, with preference given to descriptions of national healthcare, universal health insurance and/or a single-payer system. In the case of SA, the single payer is none other than the taxpayer, with the government as the administrator of the system. Under this system, a patient's good will be balanced against other goods, such as the needs of society, supported by the notion of distributive justice, with an emphasis on the collective rather than individuals.

The objective of SA's NHI Bill is to provide universal access to quality healthcare for all South Africans by providing a framework for the strategic purchasing of healthcare services by the NHI Fund on behalf of users (patients). The beneficiaries of the NHI include all SA citizens, permanent residents, refugees, correctional services inmates and certain categories of individual foreigners. Asylum seekers and

illegal foreigners are only entitled to emergency medical services and services for notifiable conditions of public health concern. All children, including those of asylum seekers and illegal immigrants, are entitled to basic healthcare services, which is aligned with section 28(1)(c) of the Constitution.<sup>[15]</sup>

Membership of the NHI will be compulsory for all SA citizens and permanent residents. Medical schemes will only be allowed to cover procedures or treatment not provided by the state. These changes prompt the question regarding how the NHI will affect the doctor-patient relationship. Briefly, a patient under the NHI will no longer be able to insist on receiving services from his or her own doctor. This is furthermore complicated by the willingness or not of the doctor to register with the NHI. Even if the doctor registers with the NHI, this does not mean that the patient will see the doctor on demand, as this doctor will have to serve all patients (mostly public/NHI patients) in need of treatment on that day. The convenience of booking a specific time with one's own general practitioner, as has been the practice for many years, will disappear.

The NHI is premised on primary care and will require patients to access healthcare services first at the primary healthcare level, which refers to a relevant clinic, after which they will be referred further, if necessary. If patients do not follow the suggested pathway, they will have to pay for the medical service from their own pockets. The conventional doctor-patient relationship that has persisted throughout time, and beyond paternalism to self-determination, will cease to exist. The patient will only be one of many, and the treating doctor will have to serve a new patient cohort and whomever needs treatment more urgently.

## Statutory references relevant to the doctor and patient and alternative remedies for patients

### National Health Act No. 61 of 2003

The NHA, with the exclusion of chapters 6 and 8, came into operation on 2 May 2005. The Act in section 1 refers to a 'healthcare provider' (a doctor) as 'a person providing health services in terms of any law, including in terms of the [...] Health Professions Act 56 of 1974'. A patient is referred to as a 'user' in the Act and is defined in section 1 as 'the person receiving treatment in a health establishment, including receiving blood or blood products, or using a health service'. The terms of provider and user have a distinct consumerist and depersonalised tone. As a precursor to the formulation of the NHI, the NHA has already set the tone for a complete overhaul of the doctor-patient relationship for the future.

The NHA has also expanded the remedies available to patients (users). In terms of section 18, any person may lay a complaint about the way (s)he is treated at a health establishment. Provinces and municipalities must establish the procedure for the laying of complaints in their respective areas. Section 77 establishes an Office of Health Standards Compliance, whose objectives are to protect and promote the health and safety of users of health services, as well as to investigate complaints relating to non-compliance of healthcare providers. The office functions under the guidance of a board and a chief executive officer (CEO) as the head of the office.<sup>[16]</sup>

Section 81 authorises the appointment of an ombud. The ombud may receive written or verbal complaints that he or she must investigate. After every investigation, a report, together with

recommendations on appropriate action, must be submitted by the ombud to the CEO. Where the CEO fails to act in accordance with the findings and recommendations of the ombud, the ombud may request the intervention of the Minister of Health. After the conclusion of an investigation, the ombud must inform the complainant and the respondent of his or her findings and recommendations. Any person aggrieved by any decision of the office or the ombud in relation to matters regulated by the Act may within 30 days of him or her gaining knowledge of the decision, lodge a written appeal with the Minister of Health. The minister must then appoint an independent *ad hoc* tribunal for adjudication of the dispute. Such a tribunal may confirm, set aside or vary the decision of the office or ombud, and must notify the parties of the decision. Section 90 authorises the minister to make regulations concerning national health. As the NHA refers in chapters 10 and 11 to 'national health', it is assumed that the process outlined in this section will be similar under the NHI, discussed below.

### Consumer Protection Act No. 68 of 2008

The Consumer Protection Act (CPA)<sup>[17]</sup> provides a legislative framework for the protection of consumers' rights. The CPA defines in section 1 a 'consumer' in respect of any particular goods or services as 'a recipient or beneficiary of [...] particular services'. Service means 'any work or undertaking performed by one person for the direct or indirect benefit of another' as well as 'the provision of any [...] advice or consultation'. A 'service provider' is defined as 'a person who promotes, supplies or offers to supply any service'. A patient is thus the receiver or beneficiary of advice or services supplied by a service provider (the doctor). The CPA applies to every transaction concerning the supply of goods and services in exchange for consideration, unless the transaction is exempted from the application of the Act. Because healthcare services have not been exempted from the definition of 'consumer services', a patient is clearly considered a 'consumer' for the purpose of the legislation. The definition of 'service' refers to, among other things, work performed by a person or institution for the direct or indirect benefit of another, including the provision of information, advice or consultation. 'Service' thus applies to the actual treatment of the patient (diagnostic treatment or all other services rendered by the doctor, including performing an operation) as well as the actual consultation and goods (medicines or devices) recommended, prescribed or used by the doctor when serving the patient.

The CPA creates in chapter 2 of the Act eight basic consumer rights that also apply to patients as consumers, which include, among others, the right to equality in the consumer market, privacy, choice, disclosure and information, fair and honest dealing, fair, just and reasonable terms and conditions, fair value, good quality and safety, and the right to hold the supplier accountable to consumers. Some of these rights overlap with the common law and Constitutional rights of a patient, notably those relating to privacy, choice, disclosure and information and the right to hold the supplier (doctor) accountable, discussed extensively by Carstens and Pearmain.<sup>[18]</sup>

The CPA creates specific remedies for consumers (patients). One such novel feature of the CPA is that it provides in section 61 for strict or no-fault liability for damage caused by goods or equipment supplied. What this entails is that the consumer (patient) has the right to expect that goods and equipment are reasonably suitable for the purposes for which they are intended, in good working order, free from defects and usable and durable for a reasonable period.

The producer or importer, distributor or retailer of goods will now be liable for harm caused as a result of the supply of unsafe goods or a product failure, irrespective of whether the harm is the fault or result of negligence of any of these parties. Even when there is no contractual relationship between the user and an entity such as the manufacturer, the latter will still incur liability. All that needs to be shown by the patient is that the relevant goods or equipment that were defective caused harm. Because the claimant can sue anyone in the supply chain in terms of section 61(3) of the CPA, or may not be able to identify one or more from the others in the supply chain, the claimant may target the doctor who most recently supplied the goods, equipment or service.<sup>[19,20]</sup> Thus, before buying, recommending or selling goods or equipment to a patient, such as defective prostheses and implants, a doctor should make sure that the goods are safe and of good quality.

The CPA provides in sections 69, 70 and 71 that a consumer or patient may enforce his or her rights by referring a complaint to the National Consumer Tribunal, the National Consumer Commission, an alternative dispute resolution agent or a court with jurisdiction.

### Protection of Personal Information Act No. 4 of 2013

The objectives of the Protection of Personal Information Act (POPIA)<sup>[21]</sup> are, among others, to promote the protection of personal information processed by public and private bodies, and to introduce certain conditions so as to establish minimum requirements for the processing of personal information. The reference in POPIA to a 'data subject', defined in section 1 of the Act as 'the person to whom personal information relates', refers to a patient as well. The doctor who processes a patient's information is regarded as the 'responsible party', which refers to 'a public or private body or any other person which, alone or in conjunction with others, determines the purpose of and means for processing personal information'. A patient's health information belongs to 'personal information', which refers *inter alia* to 'information relating to an identifiable, living, natural person [...] including information relating to the (a) [...] physical or mental health [...] of a person [...] (b) information relating to the [...] medical [...] history of the person [...] and (d) the biometric information of the person'. Section 32 is concerned with the authorisation of a data subject's health information. The prohibition on processing of personal information concerning a data subject (patient)'s health does not apply to the processing by medical professionals if such processing is necessary for the proper treatment and care of the data subject (patient). It may only be processed by a responsible party (doctor) subject to an obligation of (medical) confidentiality.

A patient who may feel aggrieved as a result of the manner in which his or her personal information has been processed has recourse to section 74 of POPIA, which provides that any person may submit a complaint (in writing) to the Information Regulator alleging interference with the protection of his or her personal information. The regulator must, as soon as is reasonably practicable, advise the complainant (patient) and the responsible party (doctor) to whom the complaint relates of the course of action that (s)he proposes. The regulator will try to settle the dispute, but if it is not possible, investigation proceedings may be followed. The Act also provides for civil remedies. According to section 99(1) of POPIA, 'a data subject [patient] or, at the request of the data subject, the regulator, may

institute a civil action for damages in a court of law [...] against a responsible party [doctor] for breach of any provision of the Act [...] whether or not there is intent or negligence on the part of the responsible party' [the doctor].

### National Health Insurance Bill

As alluded to earlier, the NHI Bill in section 1 defines a doctor as a 'healthcare service provider', which means 'a natural or juristic person in the public or private sector providing healthcare services in term of any law'. A patient is labelled a 'user' in terms of section 5 of the Bill, which corresponds with the term for a patient as found in the NHA. Section 5 states that a user is 'a person eligible to receive healthcare services [...] [who] must register as a user of the Fund at an accredited healthcare service provider or health establishment [a hospital]'. The NHI Bill requires in section 5(8) that such user must present proof of registration to the healthcare service provider when seeking healthcare services.

The dispensation under the NHI relating to the doctor-patient relationship points to an undetermined and unresolved relationship. As the focus of the NHI is on primary healthcare, a patient's first point of call when (s)he experiences an ailment will be a clinic. The clinic will then refer the patient to a doctor, should it be necessary. The doctor will treat the patient and refer him or her to a specialist, should such need for more specialised treatment arise. When a user (patient) contacts the clinic for an appointment and (s)he is referred to a registered NHI health service provider (doctor), (s)he may end up with another health service provider (doctor) who may never have interacted with the patient, except to have knowledge relating to the patient that is contained in the patient's electronic health record (EHR).<sup>[22]</sup>

The successful implementation of the NHI will require an effective EHR system and the ability to register and track patients as they move from one healthcare provider to another. The traditional relationship between a doctor and a patient as previously understood, where patients and their families are treated by the same doctor (or family physician), often for many years, will be significantly compromised.

In terms of the objectives of the NHI Bill, the NHI will establish a national health *insurance* instrument and not, as is the case in the UK, a national health *service* instrument. An appropriate procedure to follow when an alleged breakdown in the doctor-patient relationship, or alleged medical negligence, has occurred is not addressed in the Bill. It is assumed that the process outlined in the NHA, and discussed above, may be one possible route. The aggrieved patient will of course also have the choice to institute a civil action, a criminal action, as well as an action based on breaches in terms of the CPA or in terms of POPIA, depending on the nature of the claim and the relevant facts at hand.

### Conclusion

The care of a patient has always been a doctor's first concern. However, as time has passed, this noble view has been challenged by various developments. Doctors do not just treat patients any more. They also treat 'consumers', 'users' and 'data subjects'. With the practice of medicine having become more rights-centred and litigious,<sup>[23]</sup> not only have doctors become more informed, but so have patients, who have numerous remedies at their disposal under

different acts of parliament that cut across the practice of medicine. This article has set out to point to some changes that have affected the conventional doctor-patient relationship, which has developed from a paternalistic model to one of patient autonomy, and recently to a consumerist model, which will finally evolve into a socialist model with the implementation of the NHI. The article has not discussed the effect of these changes on health delivery itself. Only time will testify to the wisdom of this proposed change.

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