A SELECTION OF CONSTITUTIONAL ASPECTS THAT IMPACT ON THE MENTALLY DISORDERED PATIENT IN SOUTH AFRICA

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SUMMARY

This article examines a selection of constitutional aspects that impact on the mentally disordered patient in South Africa. 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. Further rights include the right to dignified and humane treatment, freedom from discrimination in terms of access to all forms of treatment, the right to privacy and confidentiality, the right to protection from physical or psychological abuse and the right to adequate information about their clinical status. These rights should ideally include efforts to promote the greatest degree of self-determination and personal responsibility of patients. Since 1994 many far-reaching improvements have been made to the South African health system. The legal and policy framework described in this article 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 mentally disordered patient becomes a reality for people regardless of factors like mental disorder. Because this is an article of limited scope, focus is placed on a discussion of sections 10, 12(2)(b) and 14 of the Constitution.

1 INTRODUCTION

The impact of the Constitution[1] 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.[2] 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

[1] The Constitution of the Republic of South Africa, 1996 (hereinafter “the Constitution”).

[2] 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.”

the interpretation of legislation and the development of the common law.[3] 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.[4] 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 limitation of the right in question.[5] Further rights include the right to dignified and humane treatment,[6] freedom from discrimination in terms of access to all forms of treatment,[7] the right to privacy and confidentiality,[8] the right to protection from physical or psychological abuse and the right to adequate information about their clinical status.[9] According to Zabow[10] these rights should ideally include efforts to promote the greatest degree of self-determination and personal responsibility of patients. Because this is an article of limited scope, focus is placed on a discussion of sections 10, 12(2)(b) and 14 of the Constitution.

The overall aim of the Mental Health Care Act[11] is the regulation of the mental health environment so as to provide mental health services in the

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[3] 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."

[4] Gobodo-Madikizela "Psychology and Human Rights" in Tredoux (ed) *Psychology and Law* (2005) 347.

[5] 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 and De Waal *The Bill of Rights Handbook* (2005) 26.

[6] S 10.

[7] S 9.

[8] S 14.

[9] S 12.

[10] Zabow "Psychiatry and the Law" in Robertson, Allwood and Gagiano (eds) *Textbook of Psychiatry for Southern Africa* (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.

[11] The Mental Health Care Act 17 of 2002 (hereinafter "the Mental Health Care Act").

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 health care 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' stigmatization 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.[12] Mentally disordered people have the right to be treated under the same professional and ethical standards as any other ill person. Zabow[13] 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 Health Act[14] 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.

2 THE ORIGIN AND CONCEPT OF HUMAN RIGHTS

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 article 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[15] 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"[16] and laid down its essential features. According to Socrates,[17] man possesses "insight" and this "insight" reveals to him the goodness and badness of things and makes him know the absolute and eternal moral

[12] Zabow "The Mental Health Care Act" in Baumann (ed) *Primary Health Care Psychiatry: A Practical Guide for South Africa* (2007) 570-571.

[13] Zabow "The Mental Health Care Act (Act 17 of 2002)" in Kaliski (ed) *Psycholegal Assessment in South Africa* (2006) 61.

[14] The National Health Act 61 of 2003 (hereinafter "the National Health Act").

[15] Without necessarily referring to human rights, the Bible, for example, urges people to treat others in the same way they 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 *The Protection of Human Rights in South Africa* (2005) 4.

[16] 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 Doebbler *International Human Rights Law: Cases and Materials Vol 1* (2004) 53ff.

[17] (469-399 BC.)

rules. This human "insight" is the basis to judge the law.[18] The idea of natural law was reaffirmed by the philosopher Aquinas[19] in the Middle Ages and later supported by Blackstone[20] in the seventeenth century.

More fundamental human rights principles originated in the 1948 Universal Declaration of Human Rights.[21] 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 recognized as a legal standard. The Universal Declaration of Human Rights is a keystone document. It has been translated into over 3000 languages and dialects.[22]

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.[23] 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

[18] 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 and Jaswal *Human Rights and the Law* (1996) 4. See also Daes *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.

[19] (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 *The Problem of Natural Law* (2008) 72ff.

[20] (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 *Law, Crime and English Society 1660-1830* (2002) 142ff; and Tucker *Blackstone's Commentaries: With Notes of Reference to the Constitution and Laws, of the Federal Government of the United States, and of the Commonwealth of Virginia* (2008) iiiff. Other well-known philosophers and thinkers, particularly in the 17th and 18th 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 (contributor) *The French Idea of Freedom: The Old Regime and the Declaration of Rights of 1789* (1994) 212ff.

[21] 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.

[22] Morsink *The Universal Declaration of Human Rights: Origins, Drafting & Intent* (1999) ixff.

[23] Gobodo-Madikizela 344.

virtue of being human.[24] 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".[25]

3 SECTION 10 OF THE CONSTITUTION: HUMAN DIGNITY[26]

In *Carmichele v Minister of Safety and Security* it was said that human dignity is a central value of the objective, normative value system.[27] Chaskalson[28] 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."

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*[29] that recognizing 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.

3 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[30] and unwanted medication with very serious risks and side effects. In addition, their liberty and dignity are taken away –

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24 Mubangizi 3.

25 United Nations *Human Rights: Questions and Answers* 4 (1987) as quoted in Mubangizi 3.

26 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.

27 *Carmichele v Minister of Safety and Security* 2001 4 SA 938 (CC).

28 Chaskalson "Human Dignity as a Foundational Value of Our Constitutional Order" 2000 *SAJHR* 193 196.

29 *S v Makwanyane* 1995 3 SA 391 (CC).

30 See the discussion of electroconvulsive therapy below.

sometimes for many years.[31] 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?[32]

According to Levenson[33] physical restraints and seclusion may be required for confused, mentally unstable patients, especially when chemical restraint is ineffective or contraindicative. Confused mentally 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 mentally disordered patients, and for respecting their dignity, should be considered, keeping in mind that there are clinical and legal risks both in inappropriately using the foregoing restraints.

With regard to seclusion of mentally disordered patients, there are, according to Saks,[34] 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.[35] According to section 8 of the Mental Health Care Act, the person, human dignity and privacy[36] of

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[31] Saks *Refusing Care: Forced Treatment and the Rights of the Mentally ill* (2002) 1-3.

[32] See also the discussion of involuntary confinement below.

[33] "Legal Issues in the Interface of Medicine and Psychiatry" 2007 *Primary Psychiatry* http://www.primarypsychiatry.com/aspx/articledetail.aspx?articleid=117 accessed 2009-05-22.

[34] Saks 125-126.

[35] 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.

[36] See the discussion of the right to privacy below.

every mental health-care user[37] must be respected.[38] 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.[39] A mental health-care user must receive care, treatment and rehabilitation services to the degree appropriate to his or her mental health status.[40]

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."[41]

4 SECTION 12(2)(b) OF THE CONSTITUTION: FREEDOM AND SECURITY OF THE PERSON[42]

Section 12(2)(b) reads:

> "Everyone has the right to bodily and psychological integrity, which includes the right –
> (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."[43] Chaskalson P held in *Ferreira v Levin*[44] that the primary purpose of section 11(1) was to ensure the 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.

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[37] "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.

[38] S 8(1).

[39] S 8(2).

[40] S 8(3).

[41] "Professional Board for Psychology: Rules of conduct pertaining specifically to the profession of psychology" published in GN R717 in *GG* 29079 2006-08-04 s 10(1).

[42] For the purposes of this discussion focus is placed on s 12(2)(b).

[43] Currie and De Waal 292.

[44] In *Ferreira v Levin NO* 1996 1 SA 984 (CC), 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 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.

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."[45]

4 1 Section 12(2)(b): Security in and control over one's body

4 1 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.[46] Section 12(2)(b) has two components: "security in" and "control over" one's body. These components are 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[47] 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.[48]

Mill[49] 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 disordered patients is permeated by the need to strike the appropriate balance between two

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[45] *Ferreira v Levin supra.*

[46] Currie and De Waal 308.

[47] In *Phillips v De Klerk* 1983 TPD (Unreported), 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 recognized. 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* (1991) 30 and 31.

[48] Currie and De Waal 308.

[49] Mill *On Liberty* (1859) 22-23. See also Strauss 31-32.

dimensions of the obligation to show respect for persons, and respect for the wishes of the person. As Harris[50] 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."

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 emphasizing the entitlement of patients to be free from discrimination, and to have adequate treatment and support services.[51]

Over time, a mentally disordered individual's right of choice to make personal health-care decisions has been recognized, 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.[52]

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 proved 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

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[50] Harris "Profession Responsibility and Consent to Treatment" in Hirsch and Harris (eds) *Consent and the Incompetent Patient: Ethics, Law and Medicine* (1988) 37-47 and 39-42 as published in Fennell "Inscribing Paternalism in the Law: Consent to Treatment and Mental Disorder" 1990 *Journal of Law & Society* 29.

[51] Fennell 1990 *Journal of Law & Society* 29-30.

[52] Jorgensen "Is Today the Day We Free Electroconvulsive Therapy?" 2008 *ExpressO* http://works.bepress.com/mike_jorgensen/1 accessed 2010-05-09.

patient must be examined to 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).[53]

4 1 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."[54]

When electroconvulsive therapy is mentioned in conversation it invokes strong reactions from scientists and lay people 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.[55] 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 minimize 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 legislated treatment modality in South Africa. According to Segal and Thom,[56] 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 utilizing 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

[53] Appelbaum and Grisso "Capacities of Hospitalised Medically ill Patients to Consent to Treatment" 1997 *Psychosomatics* 119-125.

[54] Kesey *One Flew Over the Cuckoo's Nest* (2002) 249.

[55] Newell "Competency, Consent, and Electroconvulsive Therapy: A Mentally ill Prisoner's Right to Refuse Invasive Medical Treatment in Oregon's Criminal Justice System" 2005 *Lewis & Clark LR* 1019 1022.

[56] Segal and Thom "Consent Procedures and Electroconvulsive Therapy in South Africa: Impact of the Mental Health Care Act" 2006 *South African Psychiatry Review* 206 207.

in the aforementioned phenomenon both as cause and effect. On the contrary, Jorgensen[57] argues that the stigma that electroconvulsive therapy suffered due to prior barbaric-type applications in the past is largely historical, and most medical professionals should agree that electroconvulsive therapy is safe today, has very minimal side effects, is not inherently abusive, and presents 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*,[58] Neser 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."

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. 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.[59]

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[57] Jorgensen http://works.bepress.com/mike_jorgensen/1.

[58] *Rompel v Botha* 1953 (T) (Unreported). It is important to note that this case is rather old and shock therapy is now much safer than in 1953.

[59] Jorgensen http://works.bepress.com/mike_jorgensen/1.

4 1 3 Institutionalization 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 institutionalized on a long-term basis in psychiatric hospitals and other institutions. While institutionalized, 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 electroconvulsive therapy, grossly inadequate sanitation, and inadequate nutrition. Women are particularly vulnerable to sexual abuse and forced sterilizations. 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.[60]

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;[61]
> (b) it was authorised by a court order or a review board;[62]
> (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".[63]

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;[64] 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[65] is made within the 24-hour period.[66]

Chapter V of the Mental Health Care Act regulates voluntary, assisted and involuntary mental health care. Subject to section 9(1)(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

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[60] Hunt and Mesquita "Mental Disabilities and the Human Right to the Highest Attainable Standard of Health" 2006 *Human Rights Quarterly* 332 333.
[61] S 9(1)(a).
[62] S 9(1)(b)
[63] S 9(1)(c)(i)-(iii).
[64] S 9(2)(a).
[65] Chapter V consists of ss 25-40 of the Mental Health Care Act.
[66] S 9(2)(b).

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;[67] 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;[68] and the mental health-care user is incapable of making an informed decision on the need for the care, treatment and rehabilitation services.[69]

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,[70] 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.[71] 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.[72] 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;[73] if the applicant is a health-care provider, state the reasons why he is making the application;[74] and what steps were taken to locate the relatives of the user in order to determine their capability or availability to make the application;[75] set out grounds on which the applicant believes that care, treatment and rehabilitation services are required;[76] and state the date, time and place where the user was last seen by the applicant within seven days before the application is made.[77]

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.[78] 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.[79] 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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67 S 26(1)(a).

68 S 26(1)(b)(i).

69 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."

70 S 27(1)(a).

71 S 27(1)(a)(i).

72 S 27(1)(a)(ii).

73 S 27(2)(a).

74 S 27(2)(b)(i).

75 S 27(2)(b)(ii).

76 S 27(2)(c).

77 S 27(2)(d).

78 S 27(4)(a).

79 S 27(4)(b).

circumstances referred to in section 26(b) are applicable;[80] and the mental health-care user should receive assisted care, treatment and rehabilitation services as an outpatient or inpatient.[81]

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;[82]
>
> (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;[83] 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."[84]

4 1 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 v Xaba*,[85] in the Durban and Coast Local Division, Southwood AJ held that the Criminal Procedure Act did not authorize 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 authorizing 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 the bullet would connect him to the crime. The respondent refused. The applicants relied on section 27 and 37 of the Criminal Procedure Act.[86]

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80 S 27(5)(a).

81 S 27(5)(b). See also ss 27(6)-27(10).

82 S 32(1)(a).

83 S 32(1)(b)(i) and (ii).

84 S 32(1)(c).

85 2004 1 SACR 149 (D).

86 S 27 of the Criminal Procedure Act authorizes 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 authorizes 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

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 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.[87]

In a similar case, *Minister of Safety and Security v Gaqa*,[88] 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.[89] The court held that section 27 of the Criminal 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

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.

87 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 authorized 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.

88 2002 1 SACR 654 (C).

89 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 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.

bodily integrity, and the power of a person to refuse a surgical invasion of his or her person is essential for both.[90]

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."[91]

5 SECTION 14 OF THE CONSTITUTION: THE RIGHT TO PRIVACY[92]

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 recognized 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 integrity, freedom, reputation, dignity and privacy. The right to privacy has been recognized 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.[93]

Another reason for protecting privacy is related to the reasons for protecting human dignity.[94] It guarantees the right of a person to have

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90 For a comprehensive discussion on these constitutional principles, see Pearmain *A Critical Analysis of the Law of Health Service Delivery in South Africa* (2004) LLD dissertation, University of Pretoria.

91 S 10(3).

92 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.

93 For a discussion of the *boni mores* see Neethling and Potgieter *Deliktereg* (2002) 23.

94 *Mistry v Interim National Medicinal and Dental Council of South Africa* 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 (hereinafter "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.

control over the use of private information.[95] 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.[96] Freedom of information is closely connected to and overlaps with the right to privacy.[97]

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[95] 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).

[96] 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 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).

[97] See, *eg*, 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

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.[98]

In *NM v Charlene Smith, Patricia De Lille and New Africa Books (Pty) Ltd*,[99] three women had originally instituted legal action against the defendants after they had published their full names and HIV status 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

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).

98 Siegler "Sounding Boards: Confidentiality in Medicine – A Decrepit Concept" 1982 *The New England Journal of Medicine* 1518-1521.

99 *NM v Charlene Smith, Patricia De Lille and New Africa Books (Pty) Ltd* [2005] 3 All SA 457 (W).

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.[100]

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 for the violation of privacy rights.[101] 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 disordered 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

[100] For a detailed discussion of this case, see Carstens and Pearmain *Foundational Principles of South African Medical Law* (2007) 101ff.

[101] 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 "Legal Issues Concerning Electronic Health Information: Privacy, Quality and Liability" 1999 *The Journal of the American Medical Association* 1466ff.

history of mental health difficulties will be an easy target for incompetent or fraudulent internet counselling service providers.[102]

- 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 not to 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 consent to treatment, patients need to understand fully 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 implemented constitutionally, legally and ethically 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 socialize with others, a small percentage will be suffering some kind of emotional disturbance and they are likely to seek assistance from this new medium.[103]

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[102] Huang and Alessi "The Internet and the Future of Psychiatry" 1996 *The American Journal of Psychiatry* 861-869.

[103] King and Poulos "Ethical Guidelines for On-line Therapy" in Fink (ed) *How to Use Computers and Cyberspace in the Clinical Practice of Psychotherapy* (1999) 121 121-122.

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 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,[104] including information relating to his or her health status, treatment or stay in a health establishment is confidential.[105] 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.[106]

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."[107]

6 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 geo-political affairs. The language of human rights is understood and utilized by many people in very diverse circumstances. Human rights have become indispensable to the contemporary understanding of how

[104] "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 authorized 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 authorized by law to act on the first mentioned person's behalf". See s 1.

[105] S 14(1).

[106] See also s 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 s 1 of the Promotion of Access to Information Act. See also s 16 of the National Health Act, dealing with access to health records by health-care providers, and s 17 of this Act, which deals with the protection of health records.

[107] S 26.

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 realized represents a gross failure by the contemporary world to institute a morally compelling order based upon human rights.[108]

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 article 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 mentally disordered patient becomes a reality for people regardless of factors like mental disorder.[109] The Constitution and the Mental Health Care Act introduced changes relating to the administration of mental health care in South Africa. The Review Boards[110] 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.[111]

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[108] The Internet Encyclopedia of Philosophy "Human rights" http://www.iep.utm.edu/h/hum-rts.htm accessed 2009-05-22. See also Freeman *Human Rights: An Interdisciplinary Approach* (2002) 1ff.

[109] Hassim *Health & Democracy: A Guide to Human Rights, Health Law and Policy in Post-apartheid South Africa* (2007) 25.

[110] See Chapter 4 of the Mental Health Care Act.

[111] Zabow (2006) 61.