LEGAL ISSUES RELATING TO THE TREATMENT OF PERSONS LIVING WITH CANCER

by

CHARLES MAIMELA

Submitted in accordance with the
requirements for the degree of

DOCTOR OF LAWS

at the

UNIVERSITY OF SOUTH AFRICA

PROMOTOR: PROF MN SLABBERT

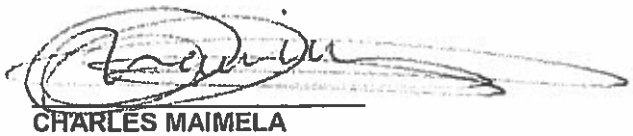
CO-PROMOTOR: DR MM MSWELA

JUNE 2017

Statement

Student number: 42638305

I, Charles Maimela, declare that '*Legal issues relating to the treatment of persons living with cancer*' is my own work and that all sources that I have used or quoted have been indicated and acknowledged by means of complete references.



CHARLES MAIMELA

15 - 06 - 2017
DATE

Summary

Cancer is regarded as a global disease and one of the leading killer diseases in the world. The reason why cancer is so widespread and often misunderstood stems from multiple factors, namely, the lack of knowledge about cancer, unfair discrimination of persons living with cancer, inadequate or inappropriate treatment provided to patients, the stigma attached to cancer, misdiagnosis and late diagnosis of persons living with cancer, as well as the inadequate provision of screening programs to detect cancer at an early stage.

The combination of these issues raises alarming medico-legal problems that merit further attention. The thesis will explore the origin, nature, philosophical and clinical aspects pertaining to cancer, as well as legal issues related to cancer and oncology. The study will conclude with recommendations aimed at mitigating and addressing the shortcomings that exist in the medico-legal framework. The study will also draw on a legal comparison of relevant South African, English and American laws and regulations. Since this thesis entails focussing on medico-legal principles, the study will draw on aspects of medical law, labour law, law of contract, law of delict, constitutional law and criminal law.

Key terms: Cancer, breast cancer, lung cancer, liver cancer, cervical cancer, colorectal cancer, prostate cancer oncologist, oncology, human rights law, medical law, oncologist malpractice, discrimination, unfair labour practices, unfair dismissal, inherent requirements of the job, cancer registry, Cancer Association of South Africa (CANSA), informed consent, negligence, unlawfulness, causation, wrongfulness, unprofessional conduct, expert witness.

Table of contents

Acronyms and Abbreviations

A	Appellate Division
AC	Law Reports, Appeal Cases (Third Series)
AD	Appellate Division Reports
All ER	All England Law Reports
All SA	All South African Law Reports
AORTIC	African Organisation for Research and Training in Cancer
BALR	Butterworths Arbitration Law Reports
BCLR	Butterworths Constitutional Law Reports
BCSC	British Columbia Supreme Court
BLLR	Butterworths Labour Law Reports
BLR	Butterworths Law Reports
Buch.	Buchanan's Reports of the Court of Appeal, Cape of Good Hope
CANSA	Cancer Association of South Africa
CC	Constitutional Court
CCMA	Commission for Conciliation, Mediation and Arbitration
CESCR	United Nations Committee on Economic, Social and Cultural Rights
CTR	Cape Times Reports
D.C Cir	District of Columbia Circuit
F. 3d	Federal 3rd series
GSJ	Gauteng High Court, Johannesburg South
HASA	Hospital Association of South Africa

HL	House of Lords
HOSPERSA	Health and Other Service Personnel Trade Union of South Africa
HPCSA	Health Professions Council of South Africa
IARC	International Agency for Research on Cancer
ICR	Industrial Court Reports
ILJ	Industrial Law Journal and Cases
ILO	International Labour Organisation
IMATU	Independent Municipal and Allied Trade Union
IR	Irish Reports
LAC	Labour Appeal Court
LAWSA	(Joubert) The Law of South Africa
LC	Labour Court
Minn.	Minnesota Reports
N.C	Bingham's New Cases, English Common Pleas
NCR	National Cancer Registry
NEHAWU	National Health Education & Allied Workers Union
NUMSA	National Union of Metalworkers of South Africa
ONCA	Ontario Court of Appeal
OPD	Orange Free State Provincial Division Reports
PH H	Prentice-Hall Reports section H
SA	South African Law Reports
SCA	Supreme Court of Appeal
SCR	Supreme Court Reports (of Canada)

T	Transvaal
TPD	Transvaal Provincial Division
UFS	University of Free State
UKACR	United Kingdom Association of Cancer Registries
UKEAT	United Kingdom Employment Appeal Tribunal
UKHL	United Kingdom House of Lords
Unisa	University of South Africa
UP	University of Pretoria
W	Washington Reports
WHO	World Health Organisation
WL	Westlaw Transcripts
ZACC	Constitutional Court of South Africa
ZALC	Labour Court of South Africa
ZASCA	Supreme Court of Appeal of South Africa
ZAWCHC	Western Cape High Court, Cape Town of South Africa

Table of cases

Pages

Canada

South Africa

United Kingdom

United States of America

Table of statutes

Page

South Africa

United Kingdom

United States of America

Dedicated to

my late sister

Ingrid Edith Baloyi

Chapter 1: Introduction

1.1 Introduction

The topic is aimed at analysing the legal issues relating to the treatment of cancer. This analysis will be done from a number of different vantage points in order to expose the issues and identify common stereotypes affecting health care practitioners and patients alike. This entails outlining the history of cancer in order to develop a comprehensive understanding of the origins of cancer, as well as the impact and effect of cancer in the modern world. It is vital to make reference to the clinical aspects of cancer in order to facilitate a better understanding of the disease. This study will only focus on the most common types of cancers that are major causes of death globally, namely breast cancer, lung cancer, liver cancer, cervical cancer, colorectal cancer and prostate cancer.[1] In addition, problems stemming from employment law that may affect persons living with cancer will be discussed. Other factors such as the stigma attached to cancer which may impact negatively on the realisation of the right of access to health care services by persons living with cancer will also be considered.[2]

The legal environment in which cancer surgery takes place, coupled with the related ethical, philosophical and clinical issues, which include the growing incidence of medical negligence amongst oncologists, provides the context for this study. It is of key importance to also explore how current legislation attempts to balance the rights and obligations of surgeons, or oncologists, and patients respectively. While the study is not restricted to developments in South Africa, a great deal of attention is given to South Africa's juridical framework as it applies to the medical profession, as well as the most significant players in cancer treatment circles such as the Cancer Association of South Africa (CANSA).[3] In addition, the ways in which medical negligence cases are affecting the credibility of the oncology profession will be discussed. To complete the study, reference will be made to the important role of the National Cancer Registry

---

1 World Health Organisation (WHO) "World Cancer Factsheet" 2008 /*ARC* 1.

2 Section 27(1) of the Constitution of the Republic of South Africa, 1996 states that everyone has the right to have access to health care services, which includes reproductive health care.

3 CANSA http://www.givengain.com/cause/1056/ (14 January 2014).

(NCR) of South Africa,[4] as it is responsible for reporting on cancer statistics. An effective and efficient organisation such as the NCR is one of the first steps to moving forward in addressing the problem of cancer, due to the fact that government formulates its plans and budget for addressing cancer based on the information that is being provided by the NCR.[5]

1.2 Legal and social aspects affecting persons living with cancer in South Africa

Persons living with cancer are the most stigmatised, discriminated against, marginalised, disadvantaged and vulnerable members of society.[6] Although much has been done in recent years to improve the *status quo*, a lot more still needs to be done in the form of legislative intervention in order to protect and guard against unfair discrimination and establish an effective health system for all persons living with cancer.[7] It has been two decades since South Africa has transformed from an oppressive and discriminatory system of *apartheid* to a democratic society. As part of the then national policy, the health system was fragmented along racial lines. However, the current health system is built on the foundation of the apartheid system which is evident from the manner in which public and private health systems operate.[8]

The private health system is very efficient in administering health services to patients due to its effective infrastructure and the reasonable number of patients who can afford to pay for health services in that sector.[9] In contrast, the public health system is unable to fulfil its constitutional mandate in terms of section 27 of the Constitution of the

---

4 Stewart BW World Cancer Report 20 (International Agency for Research on Cancer, Lyon 2014).

5 Stewart World Cancer Report 21.

6 Hostad J and Foyle L *Innovations in cancer and palliative care education* 207 (Radcliffe Publishing, London 2007).

7 This includes raising awareness about cancer in society and educating members of the community that cancer is a disease that can affect everyone, irrespective of race, gender, age, and sexuality. See Hostad and Foyle *Innovations in cancer and palliative care education* 208-209.

8 McIntyre D *et al,* "The health and health system of South Africa: historical roots of current public health challenges" 2009 (374) *Lancet* 817-818.

9 Beattie A *Sustainable health care financing in Southern Africa: Papers from the EDI health policy seminar held in Johannesburg, South Africa, June 1996* 64 (Library of Congress Cataloguing in Publication, New York 1998).

Republic of South Africa,[10] because it has to service a large number of patients and in the process finds its efforts being thwarted by the controversial limitation of resources for the provision of health services. During the drafting of this thesis, the national government was trying to resolve the problems which exist in the public health system by proposing the implementation of the national health insurance, with the aim of funding the provision of health services in the public sector. The goal of the government is to bring efficient, equitable and substantial health services to all the people of South Africa, irrespective of their socio-economic status.[11] Whether the national health insurance policy is an appropriate solution to the problems of the entire health system of South Africa remains to be seen at a time when it is finally implemented.[12]

The medico-legal position of persons living with cancer in South Africa was and is still characterised by influences of inequality and discrimination.[13] Social, economic and political barriers interact to create conditions of underdevelopment, marginalisation and unequal access to resources for cancer treatment, such as cancer screening in public hospitals.[14] One of the central factors that contribute to these conditions is the failure to recognise the rights of persons living with cancer as important and equal to those of abled bodied persons without cancer.[15] Moreover, policies and practices

---

10 Section 27(2) of the Constitution of South Africa, 1996 provides that the state must take reasonable legislative and other measures within its available resources to achieve the progressive realisation of each of these rights.

11 Green Paper: National Health Insurance in South Africa Policy Paper 5 2011 available at http://www.hst.org.za/publications/green-paper-national-health-south-africa.

12 The National Health Insurance scheme was proposed in 2009, and has received extensive criticism in the health sector owing to various reasons such as the costs involved, the manner in which it is to be implemented, the poor and ineffective infrastructure in public health care as well as the detrimental effect it will have in the private health system which will result in medical practitioners leaving the country. According to these criticisms it is clear that the national health insurance will not bring co-operation between the two systems of health. See Green Paper: National Health Insurance in South Africa Policy Paper 5 2011 and Slabbert MN *International Encyclopaedia of Laws: Medical Law* 30 (Kluwer Law Publishers, Alphen an den Rijn 2014).

13 Saur L *Encyclopaedia of World Problems and Human Potential* 1 (Publication Union, Michigan University 1986).

14 Green Paper: National Health Insurance in South Africa Policy Paper 5 of 2011. This paper aims to address some of the challenges which are faced by public health care, such as the issue of adequate health care services for persons living with cancer.

15 Sections 9, 10 and 12 of the Constitution of the Republic of South Africa, 1996 guarantee the rights to equality, human dignity and freedom and security of the person respectively, which each and every one must enjoy irrespective of the social status of a person, and whether that person has cancer or not.

adopted by the apartheid government served not only to ignore these rights, but also to set up and maintain mechanisms which contributed to further abuse and discrimination of such rights.[16] However, with the advent of democracy in South Africa, an infrastructure that is designed to address the injustices which are experienced by people in general and persons living with cancer in particular has been put in place. This infrastructure is made up of the authority of the Constitution,[17] and the Constitutional Court, the introduction of the Bill of Rights, and the establishment of chapter nine institutions such as the Public Protector and the Human Rights Commission, to name a few. In addition, the enactment of legislation such as the National Health Act,[18] Labour Relations Act,[19] and the Basic Conditions of Employment Act,[20] also form part of this infrastructure. With this foundation, an attempt is made to address the past inequalities and ensure that the rights of all people in South Africa, including persons living with cancer, are protected.[21]

Four aspects of South African law need to be considered against the background of the abovementioned developments in cancer health care and the protection of basic human rights. Firstly, a number of private law rules and principles dealing with consent, contract and delictual liability, may find application. Secondly, labour law principles will be considered in the context of the employer-employee relationship in which persons living with cancer are employed. Such a consideration is important for the purposes of

---

16 Etowa JB and Mc Gibbson EA *Anti-Racist Health Care Practice* 7 (Canadian Health Scholars Press, Toronto 2009).

17 Section 2 of the Constitution of the Republic of South Africa, 1996 states that the Constitution is the supreme law in the Republic and any law or conduct inconsistent with it is invalid, and the obligations imposed by it must be fulfilled.

18 In terms of the National Health Act 61 of 2003, in its preamble it states that the aim of this Act is to provide a framework for structured uniform health system within the Republic, taking into account the obligations imposed by the Constitution and other laws in the national, provincial and local governments with regard to health services, and to provide for matters connected therewith.

19 Section 1 of the Labour Relations Act 66 of 1995 states that the purpose of the Act is to advance economic development, social justice, labour peace and democratisation of the workplace by fulfilling the primary objects of this Act. More about the purpose and the various provisions of the Labour Relations Act will be explored in chapter three of the thesis.

20 The preamble of the Basic Conditions of Employment Act 75 of 1997 states that the purpose of this Act is to give effect to the right to fair labour practices referred to in section 23(1) of the Constitution by establishing and making provision for the regulation of basic conditions of employment, and thereby to comply with obligations of the Republic as a member state of the International Labour Organisation (ILO) and to provide for matters connected therewith.

21 Section 9(1) of the Constitution of the Republic of South Africa, 1996 states that everyone is equal before the law and has the right to equal protection and benefit of the law.

guarding against unfair discrimination and unfair labour practices pertaining to promotion, among other workplace concerns. Thirdly, constitutional law and more specifically the Bill of Rights will be considered. The right to human dignity, the right to equality, and the right to privacy, feature prominently as a basis for the on-going development of protective measures. However, it should be noted that the rights envisaged in the Constitution are not absolute since they are subject to the limitation clause embodied in section 36 thereof.[22] These concepts are discussed under the analysis dealing with the provisions of the South African Constitution, with specific attention to contractual and delictual principles.

The fourth aspect concerns legislation in the field of health care services. The leading text is the National Health Act,[23] which establishes a health system based on decentralised management, principles of equity, efficiency, sound governance, internationally recognised standards of research, coupled with a spirit of enquiry and advocacy which encourages participation of affected persons and promotes a spirit of co-operation and shared responsibility among public and private health professionals.[24] Other legislation that finds application in the field of cancer will be discussed in the thesis and includes, amongst others, the Health Professions Act,[25] Labour Relations Act,[26] and the Basic Conditions of Employment Act.[27]

1.3 The interface between law, medicine and oncology

Law and medicine have been related since ancient times. The bond that first united these two professions was religion, superstition and magic.[28] The pastor, the lawyer and the surgeon were at once a united front in handling one person as a patient.[29] Surgeons and legal practitioners in advanced societies such as United Kingdom and

---

22 Section 36(1) of the Constitution of the Republic of South Africa, 1996 states that 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.

23 National Health Act 61 of 2003.

24 Section 2 of the National Health Act 61 of 2003.

25 Health Professions Act 56 of 1974.

26 Labour Relations Act 66 of 1995.

27 Basic Conditions of Employment Act 75 of 1997.

28 Wecht CH "The history of legal medicine" 2005 (33) *J Am Acad Psychiatry Law* 245.

29 Wecht 2005 (33) *J Am Acad Psychiatry Law* 246.

America held the view that medicine is law and law is medicine due to the interrelatedness which these fields share.[30] This is no longer the position because currently, oncologists as medical practitioners and legal practitioners are no longer speaking the same language. One may say that this is due to the high incidence of litigation brought against medical practitioners by legal practitioners on the basis of medical malpractice. As a result, medical practitioners and legal practitioners often regard each other as adversaries.[31]

Disease and diagnosis are at the centre of traditional medical discourse. This is true for the history of cancer as any other branch of medicine. The causes of cancer have long been a matter of medical debate, and the relationship between patient and physician has been characterised as one of cure or, at least, care.[32] At the most fundamental level, law determines the rights of persons living with cancer and the legal liability of the oncologist as a medical practitioner. Therefore, since ancient times medicine and law have been conceived as straddling a large part of man's relationships, with medicine as care and the law as control.[33] It will be clearly outlined in the thesis that often legal and medical approaches interact in co-operative ways in such a manner that it raises the question of whether they should be considered two histories or one. Whether the medical and the legal profession will re-unite in future owing to the historical links which they share is a question of fact and time.[34]

1.4 Purpose, problem statement and motivation

The topic of the thesis spans a wide range of legal issues relating to cancer, ranging from private law issues to public and procedural law matters. It would be impossible to concentrate on each of these aspects in detail. Instead, the study will be limited to the interplay between discrimination, health services, medical malpractice, employment of persons living with cancer and the respective functions of the NCR and CANSA regarding the fight against cancer in the present South African context. The

30 Smith EJ "Medicine, the law and juvenile delinquency" 1936 (27) *J Criminal L & Criminology* 505.

31 Swanepoel M *Law, Psychiatry and Psychology: A Selection of Constitutional, Medico-Legal and Liability Issues* 6 (LLD thesis, University of South Africa, 2009).

32 Bartlett P "Legal madness in the Nineteenth century" 2001 (14) *Soc Hist Med* 108.

33 Bartlett 2001 (14) *Soc Hist Med* 109.

34 Wecht 2005 (33) *J Am Acad Psychiatry Law* 245.

objective of this research is to deepen the understanding of the medico-legal position regarding the vulnerability of persons living with cancer with respect to their rights to health care, life, equality, privacy, human dignity, free trade and security. The influence of the constitutional, medico-legal and legal liability issues relating to the oncology profession on the position of persons living with cancer in South Africa will form part of the framework for this thesis. In addition, the discussion will focus on an examination of the current juridical framework in South Africa.

The final aim of this thesis is to propose recommendations to facilitate the regulation of the oncology profession, specifically when it comes to the doctor-patient relationship in order to avoid medical malpractice. The challenge with this thesis is to ensure a comprehensive and detailed study of the law and cancer as to how they relate and how the law can be utilised to best protect the rights of persons living with cancer. Although the topic of the thesis has been written about extensively in the international context, this area of research is still in its early development in South Africa, which serves as motivation to undertake this study in the South African context.[35] It is important to undertake a broad ranging analysis of the legal issues involved, while an in depth study of the medical, clinical and scientific aspects of cancer is also required to ensure clarification and exposition of the issues surrounding the complex nature of this topic.

Taking the above into consideration, the wide scope and nature of this thesis is necessitated by the fact that the relationship between the law and cancer cover a wide range of disciplines. These disciplines include clinical, historical and legal perspectives pertaining to cancer. These fields need to be researched more closely to ensure that the study is current, inclusive and comprehensive.

---

[35] A good example is the case of *Castell v De Greef* 1994 (1) SA 408 (C), which is extensively discussed in chapter six and serves as authority for the protection of persons living with cancer in the hands of negligent medical practitioners who fail to adhere to the relevant standard of care.

1.5 Defining cancer

Before turning to the history and origins of cancer, it is essential to look at the definition of the term "cancer". Although cancer is a word that is recognisable to all people, it is difficult to define. This is due to the fact that cancer means different things to different people at different places and time.[36] Society generally understands cancer to refer to a disease which causes incurable pain to an individual to a point where that person eventually dies. There is also a perception amongst some societies that cancer is a form of retribution by the gods for the past sins of the affected individual.[37]

In the 12th century, Hippocrates, also known as the "Father of Medicine", discovered that tumours which were commonly seen as incurable punishment sent by the gods for the sins of an individual were in actual fact cancer.[38] Cancer is defined as a process where cells in the body grow in an uncontrollable way.[39] The word cancer is derived from the Latin word *"crab"*, which describes the way in which cancer spreads or appears in the human body, and which has a crab-like appearance.[40] These include cancers from covering tissues, skin cancer, mucous membrane cancer and cancer from the glands.[41] Further, the Regulations Relating to Cancer Registration,[42] define cancer as all malignant neoplasms and conditions suspected as such, as contained in the International Classifications of Diseases for Oncology.[43] Another word used to describe cancer is *"sarcoma",* which is the type of cancer that targets supporting body structures such as the bones, tendons, muscles and fibrous tissues.[44]

---

36 Koblenz L *From sin to science: The cancer revolution of the nineteenth century* 15 (PhD Thesis, Columbia University, 2013).

37 Scott RN *Cancer: The Facts* 1 (Oxford University Press, Oxford 1979).

38 Barrow M "Portraits of Hippocrates" 1972 (16) *Medical History* 85-88.

39 Friedberg E *Cancer Answers* 2 (WH Freeman and Company, London 1993).

40 David J *Cancer Care* 2 (Chapman and Hall, London 1995).

41 Scott *Cancer*: *The Facts* 2.

42 Regulations Relating to Cancer Registration GN R380 in GG 34248 issued in terms of the National Health Act 61 of 2003 dated 26 April 2011.

43 Section 1 of the Regulations Relating to Cancer Registration GN R380 in GG 34248 issued in terms of the National Health Act 61 of 2003 dated 26 April 2011.

44 Heney D, Young B and Dixon-Woods M *Rethinking Experiences of Childhood Cancer* 21 (Open University Press, London 2005).

From these definitions it becomes clear that cancer can spread through the human body to an extent where it is uncontrollable and unmanageable. Further, one can affirm that cancer is indeed a very dangerous disease, which affects all of mankind without differentiation. Cancer affects everybody, old and young, men and women, educated and uneducated, in all cultures and all areas across the globe.[45] However, because of its complex nature, new knowledge is discovered daily and there is still a lot to be learned about cancer, both in the medical profession and society in general.[46]

1.6 Defining the terms 'oncology' and 'oncologist'

Before considering the meaning or definition of oncology, is very important to point out that one of the difficult things encountered by anyone who wants to write a historical review or overview is the impracticality to give recognition to everyone who deserves it.[47] This principle is also applicable to the medical field of cancer, which is very complex and broad.[48] For the purpose of this study, reference will be made to oncology, which is the study and treatment of cancer.[49] Oncology is derived from the Greek words "*onkos*", meaning mass or tumour and "*logos*", meaning study, as it is the study of neoplastic diseases.[50] Since oncology is the study and treatment of cancer, an oncologist is defined as a medical specialist who is trained to evaluate and treat cancer.[51] There are three main oncology specialties and several sub-specialties which are characterised by the nature of the treatment which they offer. The three

---

45 Carnevali D and Reiner A *The Cancer Experience* 1 (J.B Lippincott Company, London 1990). Further, it is a true statement and an unfortunate fact that nearly anyone across the globe has had his or her life affected by cancer to a lesser or greater extent, either through them being affected by cancer directly or indirectly, as a result of having a family member or loved one being diagnosed with cancer. Cancer is a disease that preys on all of us, both young and old people are affected. Cancer holds no respect for national boundaries, ethnicity, race and social class because all of us are equal when it comes to the epidemic of cancer. Striking as much from within as without, cancer damages our individual and collective sense of health and well-being, and thus forms an integral part of our whole life. This is due to the fact that its human and economic effects are potent, measured each year in millions of productive years lost and billions of health care money spent. Cancer is a fearsome adversary, leaving tragedy in its wake, as we can see today cancer is the reason why millions of lives are lost annually. See Greenwald P *et al, Cancer Prevention and Control* 9 (Marcel and Dekker Publishing, New York City 2001).

46 Carnevali and Reiner *The Cancer Experience* 2.

47 Wagener DJ *The History of Oncology* 1 (Springer, Uitgeverij 2009).

48 Wegener *The History of Oncology* 1.

49 Ellsworth P *100 Questions & Answers to Prostate Cancer* 81 (Jones and Bartlett Publishers, Canada 2009).

50 Frei E *et al, Cancer Medicine 499* (People's Publishing House, New York 2010).

51 Ellsworth *100 Questions & Answers to Prostate Cancer* 81.

specialist types in oncology are the clinical oncologist, medical oncologist and the surgical oncologist.[52]

Clinical oncologists are specialists trained to use radiotherapy and radioisotopes alongside other treatments to manage cancer, as opposed to medical oncologists who specialise in non-radiological treatment.[53] While medical oncologists are educators, educating medical students, physicians, surgeons and the community at large about the diagnosis and treatment of cancer, the role of the medical oncologist can be summed up to that of a coordinator.[54] Surgical oncologists are specialists who deal with the surgical management of cancer in a patient. These are specialists who provide surgery to a patient, for example, in the case of breast cancer where a lump needs to be removed.[55] More about the role and duties of the various oncologists in the treatment of cancer will be considered in chapter 2, which deals with the historical and clinical overview of cancer.

1.7 Definition of malpractice liability and professional negligence

Malpractice is defined as conduct that constitutes professional negligence. The two concepts are therefore directly linked when it comes to the issue of liability.[56] In the context of cancer, malpractice refers to abuse or improper conduct on the part of the oncologist *vis-à-vis* the patient. Professional negligence refers to the failure by the oncologist to act in conformity with the terms of the contract concluded with the patient – in essence, a breach of the oncologist's fiduciary duty to protect the patient who has

---

52 Elderson M and Turkington N *The Encyclopaedia of Women's Reproductive Cancer* 128 (Library of Congress Cataloging Publication, New York 2005).

53 Sanders S and Eccles S *So You Want to be a Brain Surgeon?* 118 (Oxford University Press, Oxford 2009).

54 Van Custem E *et al, Principles and Practice of Gastrointestinal Oncology* 85 (Lippincott Williams & Wilkins, New York 2008).

55 Ching DC and Feig BW *The M.D Anderson Surgical Oncology Handbook* 288 (Lippincott Williams & Wilkins Publishers, Philadelphia 2012).

56 Scott RW *Legal Aspects of Documenting Patient Care for Rehabilitation Professionals* 4 (Jones & Bartlett Publishers, London 2006).

invested in the oncologist's medical knowledge and practical skills.[57] These concepts are dealt with fully in chapter six.

1.8 Research methodology

The research methodology comprises a literature review covering the South African Constitution, relevant legislation and case law as primary sources of law, and textbooks and the writings of various authors as secondary sources of law. Some internet and electronic databases have also been consulted.

Due to the multifaceted focus of this work, it is important to include numerous legislative texts. For example, it is necessary to embark on a detailed analysis of interrelated constitutional provisions relating to the right to equality, the right to free trade, the right to human dignity, the right to life, the right to bodily and psychological integrity, the right of access to health care, and the right to privacy. A scrutiny of conflicting scholarly viewpoints that have been put forth by some authors will also be carried out in order to draw comparisons, alternatives and recommendations from these views. It is submitted that this research will contribute to addressing the constitutional, medico-legal, and liability issues and challenges concerning cancer in South Africa.

1.9 Structure and overview of the thesis

The study consists of seven chapters. In this first chapter, a general introduction to the study is presented. This chapter provides a contextual background to the research problem, the problem statement and limitations, as well as the overview of relevant constitutional rights. Further, this chapter provides a general overview of the direction which the thesis will take and clearly outline the ultimate purpose of this research endeavour.

Chapter two consists of an overview of the history and origins of cancer, as well as its development and relevance in the modern world. This chapter will focus specifically

---

[57] Swanepoel *Law, Psychiatry and Psychology: A Selection of Constitutional, Medico-Legal and Liability Issues* 10.

on South Africa and the United Kingdom. The reason why reference will be made to English law is due to the fact that South African law is built on the basis of the English legal jurisprudence. Therefore, the English law influence on South African law owing to this history, as well as the similarities between the two legal systems, warrants the proposed comparison. Further, the chapter will focus on the clinical aspects of cancer, which will include reference to some of the different types of cancers, how cancer manifests or develops in the human body, the various ways in which a person may develop cancer and the different types of treatments which are available to persons living with cancer.

Chapter three will focus on employment law issues which affect employees that have been diagnosed with cancer. This investigation will include an examination of the possible unfair discrimination and unfair labour practices that may be encountered by employees living with cancer, amongst others. Possible legal avenues as well as legal remedies available to the employee living with cancer in these circumstances will also be discussed.

Chapter four will continue the discussion following from chapter three, focusing specifically on the protection of employees living with cancer in the workplace. However, the focus will shift to the United Kingdom and the United States with an aim of probing these legal systems and determining their approach when it comes to the protection of employees living with cancer. Again, the historical and the legal influence of English law in South African law warrants a comparison between the two countries. The position of the United States of America is legally relevant on this context as a result of the progress it has made in recognising that employees living with cancer must be protected against unfair discrimination in the workplace.[58] The American position is considered in an attempt to draw a comprehensive comparative analysis. The American jurisprudence relating to persons living with cancer cannot be overlooked because excluding it from this consideration would result in an incomplete comparative study, as the progress which the United States has made in advocating

[58] Americans with Disabilities Amendment Act (ADAA of 2008).

for the specialised legal protection of employees living with cancer is relevant to support this investigation.

In chapter five, the role that CANSA plays in addressing cancer in South Africa will be discussed. This discussion will entail a closer look at the activities of CANSA, which include raising awareness in the form of educating the public about cancer, and advising government accordingly about cancer. Further, the chapter will also explore the importance of having and maintaining an effective cancer registry in the country. This is the first step to managing cancer in the country, because the registry advises and provides government with information that is essential for purposes of planning and budgeting for cancer management.

Chapter consists of a study of relevant medico-legal issues in this context, such as informed consent, medical negligence, the test for negligence, proof of medical negligence as well as the medical negligence case law specifically focusing on cancer related disputes.

Chapter seven is the final chapter in which some recommendations will be presented, based on the analyses of the relevant legal issues in the preceding chapters.

1.10 Conclusion

Cancer can often be cured if detected early and properly treated. Cancer is a problem that needs the intervention of an effective health system that is supported by qualified and committed staff to avoid liability in the form of misdiagnosis. In addition, communities need to be educated about cancer to address the stigma and discrimination surrounding persons living with cancer within their respective communities and workplaces. Finally, it is suggested that cancer can be effectively addressed if there is political will and legal intervention to make the management of cancer a priority in South Africa.

Chapter 2: A historical and a clinical overview of cancer

2.1 Introduction

This chapter focuses on the origins and historical developments of cancer in selected countries. The countries which will be investigated herein include Egypt, where the origins of cancer can be traced, and United Kingdom in which greater advances have been made with regard to the study and treatment of cancer.[1] In addition, reference will be made to the South African legal system, as it is built from the English jurisprudence.[2] The discussion will be aimed at comparing the cancer management approach of South Africa to that of United Kingdom, due to the historical links which the two countries share. The historical analysis is necessary in order to formulate an understanding of cancer as we know it today, as it will point out the origins of many basic concepts associated with cancer.

Further attention will be given to the historical role of oncology when it comes to the history of cancer and the treatment thereof. In addition, a basic understanding of the historical and the clinical aspects relating to cancer will assist in formulating appropriate legal responses regarding the treatment of cancer, with an aim to address socio-economic challenges which persons living with cancer face on a daily basis, such as discrimination in society and in the workplace.[3] The chapter will also focus on the clinical aspects of cancer, including the various treatment options that are offered for persons living with cancer, thereby displaying the scope and extent of this specialised field.

---

1 Mukherjee M *The Emperor of all the Maladies: A Biography of cancer* 24 (Scribner Publishers, New York 2010).

2 Slabbert *South Africa, International Encyclopaedia of Laws: Medical Law* 34.

3 Doyal L and Hoffman M "The growing burden of chronic diseases among South African women" 2009 (27) *CME* 458.

2.2 The history of cancer

2.2.1 The history of cancer in ancient times

The African continent is the birthplace of mankind.[4] As such, the history of cancer can be traced back to the African continent. Although cancer is a disease which has been in existence for many centuries, it is often erroneously regarded as the disease of the modern world due to its prevalence and impact in current times.[5] Cancer manifested first in animals before it was noticed in human beings.[6] In animals, cancer was known to be caused by an infection of viruses,[7] from one animal to another.[8] A virus is a very small particle that cannot be seen with the naked eye, only a microscope can identify a virus.[9] The first case of cancer in animals was found in an armoured fossil fish that had a fractured jaw about 350 million years ago in Cleveland Ohio.[10] Later on cancer was discovered in fossil bones of extinct reptiles in different parts of the world.[11]

The first and oldest reports of cancer can be traced in ancient manuscripts to be found in Egypt.[12] The oldest discovery of cancer was in Egypt around 3000 B.C.[13] Fossilised bone tumours and the records of Egyptian mummies provide material proof of ancient cancers.[14] Cancer was later traced in Egyptian remains of dead bodies, where such

---

4 Ohaegbulam FU *Towards an understanding of the African experience from historical and contemporary perspectives* 50 (University Press of America, Publishers Maryland 1990).

5 Hajdu SI "A Note from History: Landmarks in History of Cancer Part 1" 2010 *Cancer* 1097, See further Coghlan-http://www.newscientist.com/article/dn19591-briefing-cancer-is-not-a-disease-of-the-modern-world.html (Date of use: 10 January 2014).

6 Hajdu 2010 *Cancer* 1098.

7 A virus can be defined as a microorganism which can only multiply inside the cells of a host organism. A virus or viruses, is normally so small that it becomes impossible to see with the naked eye. However, with the use of the microscope one can spot a virus or viruses. See Scott *Cancer: The Facts* 1.

8 Capasso L "Antiquity of Cancer" 2005 (113) *Int. J Cancer* 3.

9 Scott *Cancer The Facts* 5.

10 Capasso 2005 (113) *Int. J Cancer* 4.

11 Capasso 2005 (113) *Int. J Cancer* 4.

12 Zimmerman MR and David R "Cancer: an old disease, a new disease or something in between?" 2010 (10) *Perspective* 728.

13 Nester S *Mammography Review for Technologists* 10 (Rainbow Publishers, New York City 2014).

14 Zimmerman and David" 2010 (10) *Perspective* 729.

cancer included osteogenic sarcoma (bone tumour), and nasopharyngeal carcinomas (cancer of the throat), in the year 2500 B.C.[15]

As far as humans are concerned, cancer was found by examining mummies and corpses. In ancient Egypt, there was a custom of preserving the human body even after death.[16] The dead bodies were buried in hot dry sand in the deserts and they were kept in very good conditions for purposes of preservation. These bodies have served as a tool in the modern day to identify when cancer started to affect human beings in particular.[17]

Ancient Greek scholars have held respect for Egypt's physicians, because of the skill and knowledge which they displayed.[18] Nonetheless these scholars considered Egypt as the "mother country of diseases".[19] This is because the Egyptian skeletons, portraits, writings, and most importantly, the mummies, provided evidence of the disease emerging as a problem in ancient Egyptian times.[20] The purpose of the custom of mummification, in ancient Egypt, was twofold. Firstly, it was believed that the dead body of the deceased had to be treated to render it moral from people and evil spirits.[21] Secondly, the physical appearance of the deceased had to be maintained and preserved as near as possible to what it had originally been in life or after life.[22]

In 1600 B.C. the methods that were used to treat cancer in Egypt included excision with a knife, burning red-hot irons, fumigations with an aim to prevent diseases of the womb, consistent application of pastes, which were a mix of bicarbonate of soda and magnesium oil, and at times, advice to leave the swelling untreated.[23] There are twelve written documents found in Egypt, which are known as "Medical Papyri", which deal

---

15 Oloson J *The History of Cancer* 3 (Greenwood Publishing Group, New York 1964).

16 Guthrie D *A History of Medicine* 27 (Thomas Nelson and Sons Publishers, London 1960).

17 Guthrie *A History of Medicine* 28.

18 Guthrie *A History of Medicine* 29.

19 Magner LN *A History of Medicine* 22 (Marcel Dekker Publishers, New York 1992).

20 Magner *A History of Medicine* 23.

21 Cockburn E *Mummies, Diseases, and Ancient Cultures* 12 (Cambridge University Press, London 1980).

22 Cockburn *Mummies, Diseases, and Ancient Cultures* 12.

23 The excision with the knife was a kind of surgery for purposes of removing the cancer lump on the patient, for example breast cancer. See Ingwerson K, Wilkes G and Barton-Burke M *Cancer Chemotherapy: A Nursing Process Approach* 25 (Jones and Barttler Publishers, Canada 2001).

with its medical history from ancient times.[24] These documents contain the surviving literary evidence of the ancient Egyptians concepts on physiology, and their use of pharmaceutical and cancer surgical treatments which date back from 1538 B.C.[25] Apart from serving as the oldest historical evidence of cancer, Egypt is also known for its best medicines and medical practices.[26] During these times, physicians and dentists were already available in Egypt to treat people.[27] However, despite Egypt's effective health care and special medical practices, religion was dominating their approach, in the sense that medical practices could not be contrary to what was dictated by religion.[28] Religion was viewed to be more important and dominant, particularly in the sphere of diseases and the treatment thereof.[29]

In ancient times, the cause of cancer was considered to be an excess of black bile in human beings.[30] This was because the human body was deemed to consist of four "humours", namely blood, phlegm, yellow bile and black bile. If any of the "humours" were too much in a person's body, that person was considered to be ill.[31]

The Medieval period saw little progress in the field of medicine and science, possibly because religious and political struggles were dominating.[32] During this period,

---

24 Cockburn *Mummies, Diseases, and Ancient Cultures* 13.

25 Zimmerman and David 2010 *Perspective* 729.

26 Zimmerman and David 2010 *Perspective* 730.

27 Rollin C *The ancient history of the Egyptians, Carthaginians, Assyrians and Babylonians* 27 (W. Clowes and Sons Publishers, London 1850).

28 For example, medical practitioners were prohibited by religion from tempering with the physical body of a human being as it was regarded as holy and a temple of God, which is a principle that is still dominating in this day and age. Medical practitioners would not perform surgical procedures such as breast reconstruction as it was viewed to be tempering the body of the individual person and unholy. See Rollin *The ancient history of the Egyptians, Carthaginians, Assyrians and Babylonians* 28.

29 Ackerknecht EH *A Short History of Medicine* 20 (John Hopkins University Press, London 1982).

30 Neligan PC *Plastic Surgery: Craniofacial, Head and Neck Surgery* 398 (Elsevier Publishers, Illinois 2013).

31 The four "humours" in the human body include: Blood - a red fluid that circulates in our blood vessels through the veins and arteries. The main function of blood is to transport the body and further help the body to not get diseases through its defensive mechanism. Phlegm is the type of liquid that is secreted from the respiratory system of human beings through the mucus membranes and is caused by smoking as well as singing excessively. Yellow bile is a discharge which one can experience in the morning and through the mouth due to infection of the respiratory system or dehydration in the case of a person who is not drinking enough water. Black bile is an ancient medical concept which is associated with causing depression. See Ingwerson, Wilkes and Barton-Burke *Cancer Chemotherapy: A Nursing Process Approach* 4.

32 Leff V *Humanist* 72 (Rationalist Press Association Limited, London 1975).

roughly from 500 A.D. to 1500 A.D., cancer was treated by means of charms, good diet and herbal potions.[33]

Today Egypt is the land of civilization and is respected across the globe for its remarkable 7000 years' record of civilization and great knowledge of mankind and medicine, particularly in relation to cancer.[34] Egyptians acquired esteem while they were still occupants in the Nile River and the deserts. Their footsteps and origins can be traced to this very day, and are fundamental for the purposes of understanding modern human evolution across the globe.[35] During the medieval period, the Greeks discovered that surgical treatments could be used as treatment for superficial cancers such as cancer of the bladder, but this method revealed to be inappropriate for deep-seated cancers.[36]

2.2.2 Development of the study of cancer during the 17th century

The 17th century was the period of the golden age of science.[37] This development was brought about by the fact that excess of black bile was no longer believed to be the cause of cancer. Rather, the result of stasis and abnormalities of the lymph system were recognised as the real causes of cancer.[38] As a result, surgery and chemotherapy were introduced as ways of treating cancer.[39] Both methods involve the use of drugs to kill cancer cells in order to treat cancer in the human body. Therefore,

---

33 This is the treatment of cancer through charms which is something that is believed to have magic powers of healing and preventing bad luck. This is a practice that is still dominating in African culture to this very day. Potions are the type of liquid one can drink or apply on the body which is believed to be holy and powerful. See Ingwerson, Wilkes and Barton-Burke *Cancer Chemotherapy: A Nursing Process Approach* 24.

34 Moneer M, Taha FM and Zeeneldin AA "Past and future trends in cancer and biomedical research: a comparison between Egypt and the World using PubMed-indexed publications" 2012 (5) *BMC* 6.

35 Soressi M *et al,* "Middle Egypt in Prehistory: A Search for the Origins of Modern Human Behaviour and Human Dispersal" 1989 (43) *Expedition* 31.

36 Zimmerman and David 2010 *Perspective* 731.

37 Ingwerson, Wilkes and Barton-Burke *Cancer Chemotherapy: A Nursing Process Approach* 5.

38 The medical concept stasis entails the abnormal flowing of bodily fluids which results in reducing the mobility of intestines. While in the case of abnormalities of the lymph system is the disorder of the lymphatic system which involves obstruction, cancer and infection. See Ingwerson, Wilkes and Barton-Burke *Cancer Chemotherapy: A Nursing Process Approach* 6.

39 Shimkin MB *Contrary to Nature: Being an Illustrated Commentary on some Persons and Events of Historical Importance in the Development of Knowledge Concerning* Cancer 3 (Government Printing Office, Washington DC 1977).

the 17th century could be regarded as the period of renaissance for the development and treatment of cancer.[40]

During the renaissance period, scholars began to refine their understanding of the human body.[41] This period saw British scholars such as William Harvey, carry out autopsies for purposes of understanding the circulatory system in order to find better treatment of cancer through drugs, which had been a mystery for centuries.[42] Later during the 17th century, an Italian anatomist by the name of Giovanni Morgagni laid the foundation for the scientific study of cancer as we know it today, by performing autopsies and relating the patient's illness to the pathology found after death.[43] This resulted in the discovery of a Scottish surgeon by the name of John Hunter, who was of the view that cancer could be treated through surgery.[44] He provided guidelines and methods to surgeons to help determine which cancers they could operate on, and he was of the view that if cancer tumours had not invaded the nearby tissues, then there was no impropriety in removing it.[45]

However, despite the developments that took place in medicine and particularly in cancer during the 17th century, this period was characterised by a number of challenges. One such example relates to the reasoning of two eminent scholars of this age, namely Sennert and Zacutus who held the view that cancer was contagious. They equated cancer to diseases such as leprosy, which led to the exclusion of persons living with cancer from hospitals and from access to health care.[46] The view of these

---

40 Shimkin *Contrary to Nature: Being an Illustrated Commentary on some Persons and Events of Historical Importance in the Development of Knowledge Concerning Cancer* 4.

41 Nester *Mammography Review for Technologists* 11-12.

42 Stefanandis C, Karamanou K and Androutsos G "William Harvey (1578-1657): Discoverer of Blood Circulation" 2012 (53) *HJC* 6-7.

43 Pathology is the study of science which is used in the laboratory to study a disease such as cancer or group of diseases as to how they occur, develop and the consequences on the individual. See Shields MB "Morgagni's Cataract" 2013 (17) *SCOPE* 1-5.

44 John Hunter's life was one example that hard work and dedication can really be rewarding to any person living on earth. He roused from the occasion of being a farm worker in the family farm due to the fact that his dad had passed away, and through the assistance of his brother he became a doctor and one of the best medical practitioners of his time. See John Hunter Biography http://www.madehow.com/inventorbios/88/John-Hunter.html (Date of use: 22 February 2014).

45 Neal DM, Thirunavukarasu P and Bartlett DL *Surgical Oncology: Fundamentals, Evidence-based Approaches and New Technology* 1 (Jaypee Brothers Medical Publishers, New Delhi 2011).

46 Jaftha T, Cohen LH and Pervan V *Oncology for Health- Care Professionals* 7 (Creda Press, Cape Town 1995).

scholars had a devastating effect on the treatment of cancer, and persons living with cancer themselves. This view was later rejected, due to its destructive effect and fallacious nature. It was around the middle of the 19th century that persons living with cancer were being readmitted to hospitals for treatment.[47] As a consequence, the research on how to treat persons living with cancer continued.

[47] Chall LP *Sociological Abstracts Volume 45, Issue* 1 5606 (Smith Mark Publishers, New York 1997).

2.2.3 The rise of cancer surgery in the 18th century

The 18th century saw the development of anaesthesia, which allowed surgery to flourish, and made it possible for cancer operations such as radical mastectomy to be performed.[48] It was during this age that surgeons and oncologists started to treat cancer through surgery, despite the view that if cancer had spread throughout the body there would be no cure for that patient, and that surgery could lead to complications such as loss of blood by the persons living with cancer.[49] The manner of treating cancer through surgery was not a new idea, as Galen, a Roman physician, believed that a cure for breast cancer was the early surgical removal of the tumour.[50] Even though the 18th century is generally regarded as the period where cancer surgery began, it was during the 19th and 20th centuries respectively, that advances were made with regard to both general surgery and cancer surgery. This was attributed to the great scientific progress that was made during those centuries, as will be comprehensively explained in paragraphs 2.2.4 and 2.2.5 of this chapter.[51]

Reference should also be made to the findings of Samuel Soemmerring and Conrad Ontyd, two 18th century English scholars of medicine. Soemmerring established the link between pipe smoking and cancer of the lower lip, which has become known as lung cancer.[52] Ontyd developed the term "cancerous diathesis", which refers to a precondition to develop cancer from precancerous lesions.[53] The 18th century was not only the era that introduced surgery as a form of cancer treatment, but also saw other developments, one of which is the "parasite theory".[54] According to this theory, cancer was viewed as an infectious disease that relied on the transmission of an invisible contagion.[55] France was the first country that established an oncology hospital to specifically treat persons living with cancer.[56] However, this hospital was established

---

48 Radical mastectomy involves the removal of the breast tissue and lymph nodes, the oncologist during this medical procedure removes the entire breast. See Acton QA *Breast Cancer: New Insights for Health Care Professional* 1216 (Scholarly Editions, New York 2011).

49 Dunea G, Last JM, and Lock S *The Oxford Illustrated Companion to Medicine* 589-590 (Oxford University Press, Oxford 2001).

50 Norton W and Hudis W *Breast Cancer* 3-4 (BC Decker Publishers, New York 2006).

51 Waxman J and Bower M *Lecture Notes: Oncology* 44 (Black Well Publishers, London 2010).

52 Hajdu SI "A Note from History: Landmarks in History of Cancer, Part 3" 2011 *Cancer* 1156.

53 Hajdu 2011 *Cancer* 1157.

54 Hajdu 2011 *Cancer* 1158.

55 Hajdu 2011 *Cancer* 1159.

56 Plimmer HG "The Parasitic Theory of Cancer" 1903 (2) *BMJ* 1511.

under the belief that the latter mentioned theory was correct in that cancer was an infectious disease, a belief that was later rejected because of its discriminatory nature on persons living with cancer.[57]

2.2.4 The historical role of the oncologist regarding the treatment of cancer in the 19th century

The 19th century evidenced other interesting and significant developments in the field of medicine that had an impact on the study and treatment of cancer. The first is the invention of the modern scientific microscope, which was viewed as another boost to development of medical oncology.[58] The microscope was established for the purposes of studying various forms of diseases, including cancer.[59] The German physician, Rudolf Virchow, combined the pathology techniques established by the 17th century physician Morgagni with those associated with the microscope, to correlate and gather the microscopic pathological evidence of diseases.[60] The microscope is considered to have facilitated the development of positive cancer diagnosis in patients suffering from various forms of cancers.[61] The microscope made it possible to examine the cells (and differentiation of cells) found in tissues that have been removed from a dead or living person.[62] This is a method that still forms part of cancer diagnosis even to this day. The differentiation of cells provides physicians with a better understanding of how cancer operates in the human body and the extent of damage it causes therein.[63]

The 19th century is also characterised by the introduction of pathology as a scientific field.[64] Pathologists were able to advise surgeons as to whether the cancer had been completely removed from the human body or not. Such advice was based on the results of a microscopic examination of the tissues that were removed from a patient

---

57 Plimmer 1903 (2) *BMJ* 1512.

58 Rao DG *Introduction to Biochemical Engineering* 10 (Tata McGraw Hill Publishers, Evanston 2010).

59 Rao *Introduction to Biochemical Engineering* 11.

60 Lotz MM, Moses MA and Pories SE *Cancer* 3-4 (Greenwood Publishers, New York 2009).

61 Xu J and Gerhold M *First International Symposium on Semiconductor and Plasmonics-Active Nanostructures for Photonic Devices and Systems* 70 (Electrochemical Society Publishers, New York 2009).

62 Turksen K *Human Embryonic Stem Cell Protocols* 223-224 (Hamana Press, Boston 2006).

63 Daniel BR *et al, Breast Cancer Recurrence and Advanced Disease Comprehensive Expert Guidance* 13 (Duke University Press, New York 2010).

64 Stoler MH *et al, Stenberg's Diagnostic Surgical Pathology* 2050 (Lippincott Williams and Wilkins, New York 2004).

after having performed surgery on that patient.[65] Nonetheless, a problem that was encountered during this period was the scarcity of qualified pathologists.[66] As a result of the scarcity of pathologists, most surgeons took on the role of pathologists in order to help patients.[67] During the late 19th century, pathologists such as James Paget from United Kingdom, Alfred Velpeau from France and Samuel Gross from the United States of America, collaborated to form a new field of surgical pathology.[68] Furthermore, a theory known as the "Blastema theory" was developed.[69] According to the "Blastema theory", cancer was made up of cells and not lymphatic fluid, and cancer cells came from budding elements which were a form of asexual reproduction, and in which new organisms grew from an outgrowth due to the effects of cell division in one particular area of the body.[70]

2.2.5 The discovery of Deoxyribonucleic Acid (DNA) and its role in the treatment of cancer in the 20th century

Significant developments that marked the 20th century included more accurate theories relating to the origins and pathways of cancer, as well as further discoveries with regard to cancer diagnosis, cancer treatment and cancer research undertaken in the European continent.[71] Most of these discoveries took place in the United States of America.[72] This prompted the American Cancer Society to encourage research and heavy investment therein for the purposes of building world class laboratories with the aim of ultimately finding a cure for cancer.[73] Despite this special focus, high death rates as a result of cancer were experienced.[74] This was attributed to the fact that children with cancer required special care, but such care was not available as a result

---

65 Albores-Saavendra J and Henson DE *Pathology of Incipient Neoplasia* 281 (Oxford University Press, Oxford 2001).

66 Albores-Saavendra and Henson *Pathology of Incipient Neoplasia* 282.

67 Hajdu SI "A Note From History: Landmarks in History of Cancer, Part 4" 2012 *Cancer* 4914.

68 Hajdu 2012 *Cancer* 4915.

69 Jaftha Cohen and Pervan *Oncology for Health-Care Professionals* 8.

70 Jaftha Cohen and Pervan *Oncology for Health-Care Professionals* 8.

71 The State of Oncology in 2013 http://www.i-pri.org/oncology2013/ (Date of use: 24 February 2014).

72 Reid T and Green JE *Genetically Engineered Mice for Cancer Research design, analysis, pathways, validation and pre-clinical testing* 602-605 (Springer, New York 2012).

73 Hajdu SI and Vadmal M "A Note from History: Landmarks in History of Cancer, Part 6" 2013 *Cancer* 4058.

74 Finlay JL and Carroll WL *Cancer in Children and Adolescents* 1 (Jones and Bartlett Publishers, Studbury 2010).

of the perception that paediatric cancer was regarded as a fatal disease.[75]Additionally, medical practitioners also did not know how to treat paediatric cancer.[76] Eventually the publication of the nosology of paediatric diseases during the 20th century, as well as the discovery that early diagnosis and radical surgical treatment can save the lives of paediatric persons living with cancer brought some positive changes in this regard.[77]

The strong financial investment in research during the 20th century yielded further positive results in the field of medicine.[78] One such example is the discovery made by James Watson and Francis Crick regarding the chemical structure of Deoxyribonucleic Acid (DNA), which assisted in solving complex problems that previously remained unresolved for centuries in the field of biology.[79] The chemical structure of DNA was found to be the basis of the genetic code that gives instructions to all cells.[80] After learning and understanding how DNA really worked, scientists were beginning to understand how genes also worked and how they could be damaged through mutations, in other words, mistakes or changes in genes.[81]

By the 20th century, medical practitioners knew that cancer was caused by chemicals, as well as radiation, which refers to the energy that comes from a source and travels either through a material medium, or through viruses.[82] Further discovery showed that in certain cases cancer may be hereditary, as is the case with breast cancer.[83] The increased understanding of DNA and of genetics led to the discovery that it was the damage caused to DNA by chemicals and radiation, or the introduction of new DNA sequences through viruses that may have played a role in the development of

---

75 Finlay and Carroll *Cancer in Children and Adolescents* 2.

76 Finlay and Carroll Cancer *in Children and Adolescents* 2.

77 Nosology of paediatric diseases refers to the type of cancer that targets small children. See Cantor D *Cancer In the Twentieth Century* 332 (Johns Hopkins University Press, New York 2008).

78 Watson JD *The Double Helix: A Personal Account of the Discovery of the Structure of DNA* 1 (Atlantic Monthly Publishers, New York 1968).

79 DNA is defined as a double stranded nucleic acid that comprises of genetic information for purposes of cell division, cell growth and cell functioning. See Watson The *Double Helix: A Personal Account of the Discovery of the Structure of DNA* 2.

80 Watson The *Double Helix: A Personal Account of the Discovery of the Structure of DNA* 2-3.

81 Watson The *Double Helix: A Personal Account of the Discovery of the Structure of DNA* 4.

82 Carson VB, King DE and Koeing HG *Handbook of the Religion and Health* 440 (Oxford University Press, Oxford 2012).

83 Carson, King and Koeing *Handbook of the Religion and Health* 440.

cancer.[84] This discovery made it possible for physicians to identify the exact site of damage on a specific gene. Most things that caused cancer caused genetic damage that looked a lot like mutations which could be inherited. If more genetic damage were to occur, it would cause people in the same family to experience the same types of cancer.[85] The understanding of DNA has further allowed medical practitioners to make a distinction between normal and abnormal tissues.[86] In cancer, the big difference between normal tissues and cancer is that normal cells with damaged DNA die, whereas cancer cells with damaged DNA do not die.[87] The discovery of this critical difference answered a lot of questions that had remained unanswered and which troubled scientists for many years.[88]

The developments of all the scientific methods featuring in medicine from the 17th century to the 20th century have laid a solid foundation for medical research and treatment of various diseases, and specifically cancer. The accumulations of these developments and knowledge have shaped the way in which cancer is treated and dealt with in the 21st century.

2.2.6 The 21st century approach to cancer

An improved understanding of the development and causes of cancer has led to remarkable progress in the methods of diagnosing, treating, and preventing cancer. The 21st century may rightfully be described as a period characterised by technological innovation and creativity in medicine and other fields.[89]

Despite the many improvements that came about in science and technology during the 21st century, challenges that affect people adversely remain, some of which include environmental problems such as air pollution, food scarcity, water and energy security, infectious diseases and of course, cancer.[90] To solve these problems, experts from

---

84 Peet A *Mark's Basic Medical Biochemistry* 313 (Lippincott Williams & Wilkins, Baltimore 2011).

85 Smith NE and Timby BK *Introductory Medical-Surgical Nursing* 236 (Lippincott Williams & Wilkins, Baltimore 2014).

86 Smith and Timby *Introductory Medical-Surgical Nursing* 237.

87 Perry MC *The Chemotherapy Source Book* 7 (Lippincott Williams & Wilkins, Baltimore 2008).

88 Perry *The Chemotherapy Source Book* 8.

89 Chaussee M A Discussion Paper "Creativity, Innovation and Economic Growth in the 21st Century" 2004 *BIAC* 3.

90 McCalla AF "Challenges to World Agriculture in the 21st Century" 2001 (4) *Spring* 1-2.

different fields should work in collaboration with one another.[91] With regard to cancer treatment, oncologists are said to have entered the second decade of targeted therapy.[92] Therefore, this period is regarded as a time for revolutionary, innovative research for cancer therapy.[93]

In the past, oncologists had a limited understanding of all the therapeutic stages of cancer.[94] However, a modern oncologist should be interested in all the stages of therapy in cancer, starting with the first initiated cell, to the mild moderate and severe dysplasia. The main focus should not only rest on therapy for invasive and metastatic cancer, as that is a period where a comprehensive understanding of all cancer stages is required.[95]

Cancer research has developed significantly during the past few decades. Some of the research focuses on the molecular biology of cancer, whereas other studies explore new classes of molecules such as antisense oligodeoxynucleotides, in an attempt to find a cure to treat cancer.[96] Nanotechnology is another innovation of the 21st century. This technology is used for producing materials that form extremely tiny particles, leading to very promising image tests that can accurately show the location of tumours.[97] This technology is also assisting in the development of new ways to deliver drugs that are more specific and effective to treat cancer cells in the body.[98]

The development of robotic surgery also significantly assisted in the treatment of cancer. It deals with the remote manipulation of surgical instruments by robot arms and other devices, which are controlled by the surgeon.[99] Robotic systems have been

---

91 University of Glasgow http://www.gla.ac.uk/about/givingtoglasgow/21st-centurychallenges/ (Date of use: 20 February 2014).

92 Cambrosio A and Keating P "The art of medicine 21st century oncology: a tangled web" 2013 (382) *Perspectives* 45.

93 Cambrosio and Keating 2013 (382) *Perspectives* 46.

94 Alberts DS "A Unifying Vision of Cancer Therapy for the 21st Century" 1999 (17) *JCO* 13.

95 Knol JB *Surviving a competitive health care market: Strategies for the 21st century* 171 (McGraw Hill Publishers, New York 1995).

96 Antisense oligodeoxynucleotides are drugs which have been discovered to play a very important role in the treatment of cancer. See Gambhir SS and Thakor AS "Nanooncology: The Future of Cancer Diagnosis and Therapy" 2013 (63) *CJC* 395-396.

97 Gambhir and Thakor 2013 *CJC* 397.

98 Gambhir and Thakor 2013 *CJC* 398.

99 Tsungawa K and Hashizume M "Robotic Surgery and Cancer: the Present State, Problems and Future Vision" 2004 (34) *JJCO* 228.

utilised by physicians in several types of cancer surgery, with radical prostatectomy as the most commonly used in surgical oncology.[100] As technology improves, with regard to mechanical and computer systems, it is anticipated that new systems will be created to remove tumours more completely and effectively from the human body, and with less surgical trauma being caused to the patient.[101]

2.3 A historical overview of the treatment of cancer in the United Kingdom

In the United Kingdom during the 17th century, cancer was first recognised through a socially and culturally inclined establishment of a hospital that was aimed at specifically treating cancer in Rheims.[102] The hospital was formed by specialist medical practitioners in order to treat cancer, yet it was forced to close down before it was even operational.[103] Such closure was attributed to the stigma that society attached to cancer, since members of the community believed that cancer was contagious and did not form part of their community.[104] Later on, lung cancer was the first type of cancer to be discovered in this part of the world as it began to affect people in large numbers.[105] The major causes of this cancer in the British community have been similar incidences which were discovered in South Africa, such as the exposure to harmful workplace conditions due to industrialisation, and the bad habits adopted by people, such as smoking and alcohol abuse among other things.[106] These events led to the establishment of hospitals in order to deal with the increasing demand of the disease, and consequently, in 1792 the Middlesex hospital opened its first cancer unit.[107] Since lung cancer is one of the leading causes of cancer-related deaths, more will be said about this cancer later on in the discussion dealing with the leading death-

100 Godellas CV, Millikan KW and Saclarides TJ *Surgical Oncology: An Algorithmic Approach* 469 (Springer, New York 2009).

101 Manning J *Health, Humanity and Justice: Emerging Technologies and Health Policy in the 21st* century 6 (Health Publishers, Atlanta 2010).

102 Porter R and Bynum WF *Companion Encyclopaedia of the History of Medicine* 542 (Routledge Publishers, London 2009).

103 Porter and Bynum *Companion Encyclopaedia of the History of Medicine* 543.

104 Porter and Bynum *Companion Encyclopaedia of the History of Medicine* 543.

105 Davis D *The Secret History of the War on Cancer* 246 (Library Cataloguing Congress, New York 2009).

106 Davis *The Secret History of the War on Cancer* 247.

107 Porter and Bynum *Companion Encyclopaedia of the History of Medicine* 544.

causing cancers. The other most common forms of cancers in United Kingdom today are breast cancer, prostate cancer and colorectal cancer.[108]

Surgeons in United Kingdom historically relied strongly on the interventions of the ancient physicians of the 17th century to treat cancer. Treatment took the form of surgery, chemotherapy and radiation.[109] English surgeons had a special preference for surgery as it was considered the most effective cure.[110] The advantage which was found in surgery was that it was associated with the development of antiseptic medication and antibiotics in order to assist the patients to bear with the pain caused by surgery.[111] This introduction of antibiotics resulted in many successful surgeries.[112] However, these days there are screening programs which are also used to detect cancer early, such as the Pap smear test or mammogram test,[113] and thus surgery is regarded as a last resort in the present day context.[114]

Two English physicians made significant contributions to the understanding of cancer through research. Stephen Paget was the first to discover that cancer cells do not only spread through the blood and lymph systems, but could also develop in a few organs.[115] He drew this view from the reasoning that, as the cancer spreads, its seeds are carried in all directions, which can live and grow further if they fall on congenial soil.[116] This theory laid the foundation for the development of cancer surgery in United Kingdom through the development of "regional lymphadenectomy".[117] Regional

---

108 Hume JW and Adlard AW "Cancer knowledge of the general public in the United Kingdom: survey in a primary care setting and review of the literature" 2003 (15) *Clinical Oncology* 175.

109 Shimkin *Contrary to Nature: Being an Illustrated Commentary on some Persons and Events of Historical Importance in the Development of Knowledge Concerning Cancer* 3.

110 Harmer V *Breast Cancer Nursing Care and Management* 101 (Wiley-Blackwell Publishers, London 2011).

111 Randolph F "Surgery in the 1700s" 2009 *Science Scribe* 3.

112 The idea use of antibiotics and antiseptics to reduce pain in patients during surgery was established by an English physician by the name of Joseph Lister in 1867, it was a great achievement not only for cancer surgery in The United Kingdom and remains a great to the rest of the world even to this day. See Randolph 2009 *Science Scribe* 4.

113 Peters T and Hamilton W *Cancer Diagnosis in Primary Care* 26 (Churchill Livingstone Publishers, London 2007).

114 Peters and Hamilton *Cancer Diagnosis in Primary Care* 27.

115 Lawson R *Research and discovery: Landmarks and Pioneering in American Science* 307 (Wiley-Blackwell Publishers, London 2008).

116 Lawson *Research and discovery: Landmarks and Pioneering in American Science* 308.

117 Blach CM *et al,* "Patient Risk Factors and Surgical Morbidity after Regional Lymphadenectomy in 204 Melanoma Patients" 1983 (51) *Cancer* 2152.

lymphadenectomy is a process which entails the removal of lymph nodes that surround an affected area.[118] This method of treatment has resulted in the reduction of the number of tumour reoccurrences for cancers such as breast cancer, stomach cancer and cancer of the bowel,[119] the latter being the major cause of deaths in United Kingdom.[120]

The second English physician who played a significant role with regard to the study of cancer is Dr Harold Warwick, who was the first person to study the treatment of cancer through drugs.[121] He did this by studying the use of nitrogen mustard in a group of elderly patients who were diagnosed with lung cancer.[122] This form of chemotherapy is still very relevant today, and will be explored in-depth later on in the chapter.

2.4 A historical overview of the treatment of cancer in South Africa

The South African perspective on cancer is closely interwoven with the history regarding the mines, notably the diamond mines in Kimberly and the gold mines in Johannesburg. The early 1900s came with the migration of persons from rural areas to the major cities for the purpose of exploiting job opportunities.[123] During the working lives of these people in these cities, cancer was discovered to be very frequent amidst mine workers due to deterioration of health standards of the mine workers in particular.[124] This decline was caused by the harmful and toxic environment which mine workers were exposed to, which in turn contributed to the increase of cancer.[125]

The harmful mining environment caused mine workers to develop various forms of cancers, which included lung cancer, liver cancer, colon cancer, prostate cancer and bladder cancer.[126] Oesophagus cancer was first discovered in the Transkei and Ciskei

118 Blach *et al*, 1983 *Cancer* 2152.

119 Blach *et al,* 1983 *Cancer* 2153.

120 Blach *et al,* 1983 *Cancer* 2154.

121 Cowan DH "O. Harold Warwick: Canada's first medical oncologist" 2011 (18) *PMC* 119.

122 Cowan 2011 *PMC* 119.

123 Reynolds E, Neill K and Krieger L *World History: Perspective on the Past* 550 (Mc Dougal Littell Publishers, New York 1997).

124 Kisting S and Bruan L "Asbestos-Related Diseases in South Africa: The Social Production of an Invisible Epidemic" 2006 (96) *AJPH* 1386.

125 Kisting and Bruan 2006 (96) *AJPH* 1387.

126 Kisting and Bruan 2006 (96) *AJPH* 1388.

mines, as a result of the harmful particles and smoke that persons working in the mines were exposed to.[127]

Before embarking on identifying what oesophagus cancer is, the definition of an oesophagus should first be considered for a better understanding of how oesophagus cancer actually starts. An oesophagus is defined as a hollow, muscular tube or membrane that connects the throat to the stomach, and is found behind the trachea or windpipe and in front of the spine.[128] Cancer of the oesophagus starts to develop in the inner layer of the oesophagus and grows outward through the muscle layer of the oesophagus.[129] The risk factors which are found to be the major causes of oesophagus cancer include, exposure to harmful substances in the workplace, age, obesity, tobacco, alcohol abuse as well as a poor diet.[130] Cancer of the oesophagus can be treated successfully only if it is detected early through screening by an endoscopic test, but success is rarely achieved, as most patients appear once the cancer has fully developed in its late stages.[131] The symptoms of this cancer include the patient experiencing trouble in swallowing, weight loss, vomiting, chest pains and bone pains among other things.[132] However, it is important to note that in the 21st century, cancer of the oesophagus is not the major cause of death amongst the cancers in the world.[133] The most important factor which contributes to preventing oesophagus cancer from being a common health problem in the 21st century is the active participation of patients in fighting the disease through eating a healthy diet, participating in extra-mural activities, avoiding the abuse of alcohol and smoking.[134]

As industrialisation expanded, the demand for the medical treatment of mine workers grew.[135] For example, the first type of cancer that was noted amongst mine workers

---

127 Oloson J *The History of Cancer: An Annotated Bibliography* 127 (Greenwood Publishing Group, Westport 1964).

128 Van Hagen P, Hulshof MC and Van Lanschot JJ "Preoperative chemo radiotherapy for oesophageal or junctional cancer" *2012 (366) N Engl J Med* 2074.

129 Van Hagen, Hulshof and Van Lanschot *2012 (366) N Engl J Med* 2075-2076.

130 Spechler SJ "Barrett oesophagus and risk of oesophageal cancer: A clinical review" 2013 (310) *JAMA* 627.

131 Spechler 2013 (310) *JAMA* 628-629.

132 Spechler 2013 (310) *JAMA* 630.

133 Lagergren J and Lagergren P "Recent developments in oesophageal adenocarcinoma" 2013 (63) *CA Cancer J Clin* 232.

134 Lagergren and Lagergren 2013 (63) *CA Cancer J Clin* 233.

135 Hassan R "Overview of Mesothelioma" 2011 *NCI* 1.

during the period of industrialisation was mesothelioma, which is linked to oesophagus cancer to a greater or lesser degree.[136] This type of cancer attacks the lungs and the abdomen of an individual, and has similar side effects such as oesophagus cancer, such as weight loss and chest pain.[137] Known to be very rare, this cancer has been positively linked to exposure to a harmful environment, and in South Africa the victims of this cancer have been women and children.[138]

Exposure to the harmful environments is one of the major reasons for the increase of cancer in South Africa. In addition, other factors such as heavy alcohol consumption, smoking, poor nutrition and an unhealthy diet also play a role.[139] The various treatment mechanisms for cancer, and more especially the screening tests used for early detection of cancer, have been well-established, although the treatment of cancer is still a challenge due to the inadequate infrastructure in public health institutions.[140] However, the treatment of cancer through surgery, chemotherapy and radiation therapy have always been the mechanisms which are used for purposes of fighting cancer.[141]

At this point it is essential to mention that scientists such as Professor Nyokong have made remarkable progress with regard to cancer research in both South Africa and the rest of the African continent. Professor Nyokong, from Rhodes University, is known for her ground-breaking research in photo-dynamic research, which aims to kill cancer cells with less adverse side effects than chemotherapy.[142] Photo-dynamic therapy entails the process in which dye is used to colour blue denim clothing, and which is inert and harmless by its nature and is activated by exposure to red laser beams.[143] This treatment mechanism introduced by Professor Nyokong, has been approved by many countries across the globe due to its less adverse nature, because patients do

136 Hassan 2011 *NCI* 2.

137 Hassan 2011 *NCI* 2.

138 Hassan 2011 *NCI* 3.

139 Hunter D and Colditz GA *Cancer Prevention: The Causes and Prevention of Cancer* 168-169 (Kluwer Academic Publishers, New York 2002).

140 Vasuthevan S, Dennill K and De Haan M *The health of South Africa* 60 (Juta Publishers, Cape Town 2007).

141 Vasuthevan, *Dennill and De Haan The health of South Africa* 61.

142 Nyokong T and Ogbobu R "The effect of ascorbic acid on photophysical properties and photodynamic therapy activities of zinc phthalocyanine-single walled carbon nanotube conjugate on MCF-7 cancer cells" 2015 (151) *Molecular and Biomolecular Spectroscopy* 177.

143 Nyokong and Ogbobu 2015 (151) *Molecular and Biomolecular Spectroscopy* 178.

not lose hair or experience nausea as a result of this treatment, which is often the case with other cancer treatments.[144] This ground-breaking research puts South Africa and the rest of the African continent in a good position when it comes to cancer research and treatment. Due to the exceptional work of Professor Nyokong, in establishing efficient cancer treatment mechanisms, as well as training students in this area of cancer research, it does not come as a surprise that she has been honoured by President Zuma with an Order of Bronze award, and further honoured by the African Union with an African Union Kwame Nkrumah Scientific Award (AUKNSA), as a continental award due to her excellent work in the field of cancer treatment.[145] This shows and affirms the role of South Africa and the African continent at large, that despite the socio-economic challenges encountered, cancer treatment is becoming a priority through research and innovative programmes. The type of research conducted by Professor Nyokong, and other scientists such as Professor Sartorius from the University of KwaZulu-Natal, who is the head of the Gastrointestinal Cancer Research Centre, is bringing progressive and necessary developments in the fight against cancer,[146] and makes South Africa and the continent of Africa part of the solution in the fight against cancer.

Another point of interest which has been encouraged by both government and medical practitioners are the campaigns endorsed for people to live a healthy lifestyle by eating healthy food and exercising regularly and avoiding bad habits such as smoking and excessive drinking.[147] The active participation of patients in the awareness for leading a healthy lifestyle is the very same approach which has resulted in oesophagus cancer becoming less of a health hazard in the modern world, as outlined above.

144 Nyokong and Ogbobu 2015 (151) *Molecular and Biomolecular Spectroscopy* 179.

145 Richardson D "Distinguished Professor Nyokong honoured with $100 000 science award" http://activateonline.co.za/professor-nyokong-awarded-prestigious-award/ (Date of use: 18 March 2017).

146 Sartorius B "Shocking Cancer facts and statistics" *Herold* (10/01/2017).

147 Vasuthevan, *Dennill and De Haan The health of South Africa* 62-63.

2.5 Clinical aspects with regard to cancer

The clinical aspects of cancer are the main point of focus in this section. Herein, an overview of some of the more common forms of cancers will be laid out. Cancer is a very broad and complex disease, consisting of more than 200 different forms.[148] For purposes of this study, only the most common types of cancers which are the leading causes of death across the world will be considered, and not limited to South Africa and United Kingdom.[149] These include breast cancer, lung cancer, liver cancer, cervical cancer, colorectal cancer and prostate cancer.[150] Each one of these mentioned types of cancers will be briefly discussed in the discussion which follows. In addition, the manner in which cancer manifests or develops in the human body will form part of the discussion. Furthermore, the various treatments that are available to persons living with cancer are also considered in this section. All the listed aspects are necessary to outline for the purpose of forming a comprehensive study of the most common types of cancers which affect all people today.

2.5.1 Breast cancer

Breast cancer begins with the problem where cells run out of control, and the mechanism which regulates cell division ceases to function,[151] specifically in the area of the ducts or lobular tissues of the breast.[152] The cancer cells then multiply in the breast to form a lump or a mass, which is also known as a tumour.[153]

Breast cancer was already noted during ancient times in Egypt.[154] During early times, it was seen as a result of evil people and evil spirits or viewed as punishment from the gods for the sins committed by the individual concerned.[155] Breast cancer is said to be a methodical disease that develops in a contiguous way from the primary site. At this

148 Cancer Research UK http://www.cancerresearchuk.org/cancer-help/about-cancer/cancer-questions/how-many-different-types-of-cancer-are-there (Date of use: 13 January 2014).

149 Cancer is the leading cause of death globally, resulting in the death of 7.6 million people in 2008 alone. See WHO 2008 *IARC* 1.

150 WHO http://www.who.int/mediacentre/factsheets/fs297/en/ (Date of use: 13 January 2014).

151 Carvalho L and Stewart J *The Everything Health Guide to Living with Breast Cancer* 1 (Library of Congress Cataloging in Publication, New York 2009).

152 Carvalho and Stewart *The Everything Health Guide to Living with Breast Cancer* 2.

153 Carvalho and Stewart The *Everything Health Guide to Living with Breast Cancer* 3.

154 Donegan WL "History of Breast Cancer" in Winchester DJ and Winchester DP *Breast Cancer* 1 (BC Decker Publishers, Ontario 2006).

155 Donegan "History of Breast Cancer" in Winchester and Winchester *Breast Cancer* 1.

stage the cancer is still targeting the breast only, by direct extension through the lymphatic, which is the part of the circulatory system that consists of a network of tissues and organs that carry a clear fluid to the lymph nodes and then to the distant metastatic sites.[156] This process requires effective treatment to observe the method of distribution which the cancer takes as it manifests itself in the breast.[157]

It was roughly around 460 B.C. and 475 B.C. when early Greeks started to look for cures to treat diseases such as breast cancer, by sleeping at the ábaton temples of Aesculapius and enjoying the associated baths, recreations and forerunners which are now known as health spas.[158] The early Greeks also made some kind of offerings such as the votive offerings, in the form of breasts which have been found in these areas, which provide evidence that some Greek people came at the temple with the aim of coming up with the cure for breast cancer.[159]

Hippocrates, who is generally accepted as the "father of modern medicine", also had specific views regarding breast cancer.[160] His first case of breast cancer was of a woman in Abdera who had a carcinoma of the breast, with a bloody discharge from her nipple.[161] He saw the bleeding as beneficial and believed that if the discharge would stop, the woman would die.[162] Hippocrates also associated cessation of menstrual bleeding with breast cancer, and based on that view, he aimed to restore the menstrual bleeding of young girls to normal.[163]

The removal of breast cancer through surgery was introduced by Leonides, a physician of the Alexandrian school.[164] He performed surgery by cutting the patient's breast open, and he cauterized the breasts with hot irons in order to control the

156 Hellman S "Natural History of Small Breast Cancers" 1994 (12) *JCO* 2229.

157 Hellman 1994 (12) *JCO* 2230.

158 Donegan "History of Breast Cancer" in Winchester and Winchester *Breast Cancer* 2.

159 Donegan "History of Breast Cancer" in Winchester and Winchester *Breast Cancer* 2.

160 Diamantis A and Grammaticos PC "Useful known and unknown views of the father of modern medicine, Hippocrates and his teacher Democritus" 2008 (11) *HJNM* 2- 4.

161 Klawiter M *The Biopolitics of Breast Cancer: Changing Cultures of Disease and Activism* 53 (University of Minnesota Press, Minnesota 2008).

162 Klawiter *The Biopolitics of Breast Cancer: Changing Cultures of Disease and Activism* 54.

163 Klawiter The *Biopolitics of Breast Cancer: Changing Cultures of Disease and Activism* 54.

164 Demetrious T, Papavramidis T and Papavramidis T "Ancient Greek and Greco-Roman Methods in Modern Surgical Treatment of Cancer" 2010 (17) *ASO* 666.

resultant bleeding.[165] The surgery was concluded with a general cauterizing in order to destroy and clean any residual diseases.[166] Leonides was the first to discover that breast cancer can spread to the axilla, which is the first area that breast cancer spreads to.[167]

Another great physician who had respect for Hippocrates and whose contribution to the treatment of breast cancer deserves mention is Galen.[168] Galen was of the view that breast cancer was caused by an excess of black bile in the blood of a patient.[169] Black bile is formed from blood elements in the liver and is absorbed in the spleen and results in a malfunction of one of these organs, thus causing black bile which then thickens the blood.[170] Where black bile has accumulated, carcinoma develops as hard, non-tender tumours that ulcerate if the bile is particularly acrid.[171] Galen believed that menstruation and the practice of bleeding served the purpose of cleaning the body from an excess of black bile, which was seen as the cause of cancer.[172] Galen recommended bleeding to clean the body, and a good diet for the treatment of breast cancer.[173]

In the modern world breast cancer is no longer understood to be caused by an excess in black bile, which was the position in the primitive years as outlined above.[174] In the modern world breast cancer is known to be caused by a variety of factors such as, age, first menstruation of a girl (early menarche) , late menopause, nulliparity, absence of breast feeding, benign breast disease, high density of breast tissue, obesity, exposure to radiation, alcohol consumption, sedentary lifestyle, oral contraceptives use and hormone replacement therapy.[175] In addition to these environmental factors,

---

165 Demetrious, Papavramidis and Papavramidis 2010 *ASO* 666.

166 Demetrious, Papavramidis and Papavramidis 2010 *ASO* 666.

167 Demetrious, Papavramidis and Papavramidis 2010 *ASO* 667.

168 Donegan "History of Breast Cancer" in Winchester and Winchester *Breast Cancer* 3.

169 Donegan "History of Breast Cancer" in Winchester and Winchester *Breast Cancer* 3.

170 Donegan "History of Breast Cancer" in Winchester and Winchester *Breast Cancer* 4.

171 Donegan "History of Breast Cancer" in Winchester and Winchester *Breast Cancer* 4.

172 Demetrious, Papavramidis and Papavramidis 2010 *ASO* 667.

173 Stringer CA *et al,* "History of the Baylor Charles A. Summons Cancer Centre"2003 (16) *BUMC* 31.

174 Winchester and Winchester *Breast Cancer* 3.

175 Banks E, Verkasalo PK and Key TJ "Epidemiology of Breast Cancer" 2001 (2) *Lancet Oncology* 133.

family history of breast cancer contributes to the rise of this cancer.[176] Patients with a strong family history of breast cancer are likely to inherit the genetic alterations that could make them vulnerable to the risk of breast cancer.[177]

Breast cancer is drastically increasing in the modern world, largely affecting women and widely causing the death of millions of women every year.[178] Breast cancer is one of the leading diseases which women fear to encounter at some stage in their lives. Many women view breast cancer as a death sentence because if contracted, they might have their breast or breasts removed as a necessary consequence, and yet breasts are very important for a woman's body image and self-esteem. Women rather wish to encounter other diseases in their lives but not breast cancer, due to the devastating effect it has on their health and image.[179] It is very important to note that breast cancer not only affects women of all races, different ethnic groups, different beliefs and systems, but also targets men.[180] Breast cancer in men occurs rarely, and usually affects older men.[181]

Male breast cancer represents about 1% of all breast cancers reported worldwide.[182] Male breast cancer is caused by a number of factors which include obesity, high alcohol consumption and a family history of breast cancer as the major factor.[183] Male breast cancer occurs in most patients who have a family history of cancer and frequently occurs in old men ranging between the ages of 60 to 70 years, although it can also affect young men of all ages.[184]

Due to the rare nature of male breast cancer in the world, there is currently a lack of development towards the clinical treatment of the disease. Oncologists make use of

---

176 Stoll BA *Risk Factors in Breast Cancer* 3 (William Heinemann Medical Books Publishers, New York 1976).

177 Stoll *Risk Factors in Breast Cancer* 3.

178 Breast Cancer Statistics Worldwide http://www.worldwidebreastcancer.com/learn/breast-cancer-statistics-worldwide/ (Date of use: 4 March 2014).

179 Grobstein RH *The Breast Cancer Book* 1 (Yale University Press, London 2005).

180 Port DR *Previvors: Facing the Breast Cancer Gene and Making Life-Changing Decisions* 288 (Penguin Group Publishers, New York 2010).

181 Norton W and Hudis W *Breast Cancer* 497 (BC Decker Publishers, Ontario 2006).

182 Sjostorom-Mattson J *et al,* "Male breast cancer: A survey at the Helsinki University Central Hospital during 1981-2006" 2010 (49) *Acta Oncologica* 322.

183 Sjostorom-Mattson *et al*, 2010 (49) *Acta Oncologica* 323.

184 Aleaga ZG *et al*, Hernandez MCR "Synchronous bilateral breast cancer in a male" 2013 (7) *Encancer* 2.

the same method deployed to treat female breast cancer to treat male breast cancer.[185] This means that no research or less research is conducted in the sphere of male breast cancer, while this is not the case on the part of female breast cancer due to its prevalence.[186] However, the fact that breast cancer in men is not the major cause of death, does not mean that it should not be given attention, which is unfortunately the case in South Africa when cancer awareness takes place. A balance must be maintained between men and women, when it comes to raising awareness of breast cancer, because both men and women are affected by breast cancer.

2.5.2 Lung cancer

Lung cancer refers to cancer that forms in the tissues of the lung, usually in the cells that are lining the air passages.[187] Lung cancer may develop into one of two forms, which are the small cell lung cancer and non-small cell lung cancer.[188] Small cell lung cancer is usually caused by smoking on the part of the individual,[189] while non-small lung cancer is caused by being exposed to an unhealthy environment such as gas or smoke in certain mines, especially the coal mines.[190] The history of lung cancer is not as in-depth and primitive as the history of breast cancer outlined in the previous paragraph. Lung cancer is considered the highest cause of cancer mortality after breast cancer.[191] This shows the prevalence and impact of the disease in the modern world, where cancer is viewed to be at its highest peak ever since recorded history.

Lung cancer was a rare type of cancer. It was first discovered in the 18th century as the kind of cancer that was very difficult to diagnose and treat.[192] This was attributed to the fact that it was rare and not much research could be done in order to be able to

185 Sjostorom-Mattson *et al,* 2010 *Acta Oncologica* 322.

186 Breast Cancer Statistics Worldwide http://www.worldwidebreastcancer.com/learn/breast-cancer statistics-worldwide/ (Date of use: 4 March 2014).

187 National Cancer Institute http://www.cancer.gov/cancertopics/types/lung (Date of use: 8 January 2014).

188 National Cancer Institute http://www.cancer.gov/cancertopics/types/lung (Date of use: 8 January 2014).

189 Whittemore S *The Human Body how it works: The Respiratory System* 88 (InfoBase Publishing, Chelsea 2009).

190 Jekel J *et al, Epidemiology, Biostatistics and Preventative Medicine* 65 (Elseiver, New York 2007).

191 Coebergh JW and Jansen-Heijnen MLG "The changing epidemiology of lung cancer in Europe" 2003 (41) *Lung Cancer* 245.

192 Proctor RN "Tobacco and the global lung cancer epidemic" 2001 (1) *Perspective* 83.

diagnose and ultimately treat it.[193] The 17th century Italian anatomist by the name of Giovanni Morgagni laid the foundation for the scientific oncology, which is the study of cancer as we know it today. [194] He laid this solid foundation for oncology by performing autopsies and relating the patient's illness to the pathology found after death.[195] Morgagni is also noted as the first to discover lung cancer.[196] Being the first physician to discover lung cancer in the 18th century, Morgagni was also the first to come up with the treatment of this type of cancer through nitrogen mustard.[197] Although owing to the rarity of the disease and less incident rate in relation to lung cancer, the treatment mechanism of Morgagni remained in force for many years as the ideal form to the treatment of lung cancer, and only 140 cases of the disease were recorded at the time.[198] This shows that less people were in actual fact affected by lung cancer in the world, hence the small numbers of lung cancer incidences. However, lung cancer was at a rise during the 20th century and with the demand of lung cancer, much progress was made in understanding what caused it and which treatment mechanisms could be implemented to deal with the demand of lung cancer incidences.[199]

The discovery of X-ray photographs in the 20th century played a significant role in dealing with the increase in lung cancer incidences. The X-ray photographs where used by physicians for the purposes of making a distinction between lung cancer and other diseases such as tuberculosis and influenza.[200] As the frequency of lung cancer increased, a very serious and robust debate among physicians in the medical fraternity came about as to what exactly caused lung cancer.[201] The view that was held was that lung cancer was caused by air pollution, traffic exhaust from cars, and the exposure to harmful and dangerous gases during the First World War.[202] These factors are still

193 Proctor 2001 (1) *Perspective* 83.
194 Shields 2013 (17) *SCOPE* 1.
195 Shields 2013 (17) *SCOPE* 1.
196 Shields 2013 (17) *SCOPE* 2-3.
197 Shields 2013 *SCOPE* 4-5.
198 Proctor 2001 *Perspective* 83.
199 Proctor 2001 *Perspective* 84.
200 Pulley R and Mantin P *Medicine Through the Ages* 112 (Stanley Thornes Publishers, New York 1997).
201 Proctor RN "The Nazi war on tobacco: ideology, evidence and possible cancer consequences" 1997 (71) *BHM* 435.
202 Proctor 1997 (71) *BHM* 436.

considered to be the major causes of lung cancer even today, where lung cancer has become a leading cause of death cancers in the world.[203]

It is interesting to note that during the 20th century debate on the causes of lung cancer, tobacco was never considered as a cause of lung cancer.[204] However, it was only discovered later by an American physician known as Adler that tobacco was the cause of lung cancer.[205] This view of Adler, that smoking tobacco causes lung cancer, served as a foundation for various physicians across the world, to verify that indeed tobacco smoking was the cause of lung cancer. The first physician, who wanted to verify the view that smoking tobacco was the cause of lung cancer, was a Fritz Lickint from Dresden, who showed that persons living with this cancer were smokers in most instances and proved that indeed Adler's view in this regard was true.[206] Later on a Cologne physician by the name of Franz Hermann Muller was the first to produce a controlled epidemiological study on the link between lung cancer and tobacco smoking.[207] In the study, Muller was of the view that smoking tobacco was indeed the main cause of lung cancer epidemic in the entire world.[208] This study further confirmed Adler's, discovery that tobacco smoking was the cause of lung cancer.

The smoking of tobacco was popular at the turn of the century, however, this practice was extremely popularized by the First World War.[209] This was because soldiers in trenches smoked tobacco to relieve themselves from stress, and so did many people in the world, including women who stayed at home during the war.[210] Smoking of tobacco is still a practice that is dominating and increasing in the modern world, and smoking is considered to be the major cause of lung cancer in the world among men and women.[211] In the past lung cancer was found to be very high in men, but this is no

---

203 Cooley ME "Symptoms in Adults with Lung Cancer: A Systematic Research Review" 2000 (19) *JPSM* 137.

204 Proctor 2001 *Perspective* 84.

205 Proctor 2001 *Perspective* 84.

206 Proctor RN *The Nazi War on Cancer* 67 (Princeton University Press, Princeton 2000).

207 Proctor RN "The history of discovery of the cigarette- lung cancer link: evidentiary traditions corporate denial and global toll" 2012 (21) *Tobacco Control* 87.

208 Proctor 2012 (21) *Tobacco Control* 88.

209 Witschi H "Profiles in Toxiology: A short History of Lung Cancer" 2001 (64) *Toxicological Sciences* 5.

210 Witschi 2001 (64) *Toxicological Sciences* 5.

211 Proctor 2012 *Tobacco Control* 87.

longer the case, as men and women are affected by lung cancer roughly in equal proportions, due to the fact that women are now smoking in large numbers and are exposed to other harmful elements that can cause lung cancer, such as air pollution.[212]

In the modern world, there is no longer the debate as to what the real cause of lung cancer is, and the record has been set straight as to what causes lung cancer. This includes increased air pollution by gases, increased automobile traffic, asphalting roads, and working with benzene or gasoline, working in mines where dust is very much prevalent, smoking of cigarettes as the major causes of lung cancer and alcohol consumption.[213] This means that in the 21st century, the aim is not on discovering the various elements which cause lung cancer. Currently, the focus has shifted to establishing the various treatment mechanisms to deal with the high mortality of lung cancer in order to reduce it. The lung cancer epidemic is in need of a targeted or personalised approach of treatment, as it remains one of the leading killer diseases in the world.[214] As a consequence, the 21st century is considered as an age of coming up with effective treatment mechanisms in order to deal with lung cancer mortality rates.

Lung cancer in the human body manifests itself in two stages namely a localized approach and a systematic approach.[215] The basic view in lung cancer is that the disease starts to develop from a localized process, where it originates from the transformation of lung epithelial cells or through the lung cancer progenitor cells by carcinogens, a substance that is capable of causing cancer in the body.[216] In the case of the systematic approach, it deals with the multistep of carcinogenesis of the cancer. Here, the cancer spreads throughout the lungs and becomes extremely deadly.[217] Squamous cell carcinoma is the predominant cell type which is found in men, while

---

212 DeSantis C, Centre MM and Jemal A "Global Patterns of Cancer Incidences and Mortality Rates and Trends" 2010 (19) *CEBP* 1893.

213 Au J *et al,* "Synergistic effect between alcohol consumption and familial susceptibility on lung cancer risk among chinese men" 2012 (7) *AFSLC* 1.

214 Zakowski MF "Lung Cancer in the Era of Targeted Therapy A Cytologist's Perspective" 2013 (137) *APLM* 1816.

215 Batra SK *et al,* "Recent advances in cancer stem/progenitor cell research: therapeutic implications to overcome resistance to the most aggressive cancers" 2007 (11) *JCMM* 981.

216 Batra *et al,* 2007 (11) *JCMM* 982.

217 Hoogsteden HC *et al,* "Stem cells and the natural history of lung cancer: implications for lung cancer screening" 2009 (7) *Perspective* 2217.

adenocarcinoma cells predominate among women.[218] Smoking of tobacco is said to be the cause of squamous, small and large cell carcinomas, while other risk factors such as air pollution are the cause of adenocarcinoma, which is the type of lung cancer that starts in the glandular cells of the lung and generally affects women.[219] This clearly indicates that men are the most frequent smokers than women, hence there lies a difference in the types of lung tumours which they develop. Small cell lung cancer is largely attributed to smoking and accounts for 20% of all lung cancers.[220] This type of lung cancer increases on a daily basis owing to the high numbers of people who smoke tobacco. [221] The symptoms of small-cell lung cancer include cough, wheeze, dyspnoea, superior vena cava, pain, fatigue and haemoptysis, which is caused by a local intrathoracic spread to the chest wall.[222]

2.5.3 Liver cancer

The definition of liver cancer is simple and clear, as this type of cancer is understood as cancer that begins in the liver.[223] However, it is important to note that liver cancer is structured into two different components. Primary liver cancer refers to cancer that creates or forms tissues in the liver, while secondary liver cancer is cancer that spreads from other parts of the body to the liver, such as pancreatic cancer.[224] Primary liver cancer includes the Hepatocellular carcinoma, which is the type of cancer that affects adults in most instances.[225] Hepatocellular carcinoma starts as a single tumour that grows to a very large size, and when it has grown in the liver at the later stage, it spreads to other parts of the liver.[226] However, this type of cancer can also manifest itself in the liver through many small cancer particles that spread throughout the liver,

---

218 Spencer H *Pathology of the Lung* 4 (Pergamon Press, New York 1977).

219 Osann KE "Lung cancer in women: the importance of smoking, family history of cancer, and medical history of respiratory disease" 1991 (51) *Cancer Research* 4893.

220 Dearnaley D "Small-cell lung cancer" 1995 (345) *The Lancet* 1285.

221 Dearnaley 1995 (345) *The Lancet* 1286.

222 De Ruysscher DKM, Fennell DA and Van Meerbeeck JP "Small-cell lung cancer" 2011 (378) *Seminar* 1741-1742.

223 Billing DM *Lippincott's Content Review for NCLEX-RN* 519 (Wolters Kluwer Health Publishers, Philadelphia 2009).

224 National Cancer Institute http://toxsci.oxfordjournals.org/content/64/1/4.full (Date of use: 10 January 2014).

225 Paul N *Living with Hepatitis C for Dummies* 313 (Wiley Publishers, India 2005).

226 Paul *Living with Hepatitis C for Dummies* 313.

instead of developing as a single tumour at first.[227] This is mostly the case in patients who have a chronic liver damage.[228]

Primary liver cancer is one of the leading and common cancers in the world, and it is more dangerous than most cancers.[229] The prevalence and impact of primary liver cancer is felt in the developing world and is considered as the fourth most common type of cancer in the world.[230] This means that people in the developing world are the ones that are affected by this cancer, because it is very high and dominating in the developing world, specifically in continents like Africa.[231] Evidence to show that liver cancer is prominent in developing countries can be found in South Africa, where alcohol consumption and drug use are very common.[232] This is a problem that does not only contribute towards the growth of liver cancer, but affects other socio-economic factors like crime and abuse, to name a few.

Cancer that originates either from the colon, lungs or stomach and spreads to the liver, is secondary liver cancer which must be treated from the primary site. It means that this type of cancer ought to be treated in the area it first originated from in the body.[233] For example cancer that has started from the breast and metastasized to the liver is called breast cancer with the spread to the liver. It is not liver cancer and will only be treated as breast cancer because it occurred as breast cancer in the first place.[234] Secondary liver cancers are often treated by means of an interruption of the hepatic arterial supply and this has been the standard practice of treatment.[235]

Liver cancer is known to be caused by a variety of factors and this includes: high alcohol consumption, engaging in unprotected sex with multiple partners, obesity, diabetes, smoking and excessive use of drugs administered through the use of

---

227 Paul *Living with Hepatitis C for Dummies* 314.

228 Paul *Living with Hepatitis C for Dummies* 314.

229 Zeng-chen MA *et al,* "Clinical Evaluation of Cryosurgery in the treatment of primary liver cancer: Report of 60 cases" 1988 (61) *Cancer* 1889.

230 Ferlay J, Pisani P and Parkin DM "Estimates of the worldwide incidence of 25 major cancers in 1990" 1999 (80) *IJC* 827.

231 Fraumeni JF *et al,* "International trends and patterns of primary liver cancer" 2001 (94) *IJC* 290.

232 Jameson L and De Groot LJ *Endocrinology* 929 (W.B Saunders Company, Philadelphia 2001).

233 Webster JG *Minimally Invasive Medical Technology* 228 (IOP Publishing, London 2001).

234 Golbey RB *et al,* "Treatment of primary and secondary liver cancer by hepatic artery ligation and infusion chemotherapy" 1973 (178) *Cancer of the Liver* 162.

235 Golbey *et al,* 1973 (178) *Cancer of the Liver* 162.

needles in order to inject oneself.[236] Liver cancer, just like other kinds of cancers, is usually diagnosed late due to the fact that its symptoms and signs do not normally show in the early stages of the cancer but only at a later stage thereof. Only in exceptional cases do these signs and symptoms of liver cancer show up at the earlier stages of the cancer.[237] The symptoms commonly experienced by a person who suffers from liver cancer include weight loss, loss of appetite, feeling full after a small meal, vomiting frequently, experiencing pain in the abdomen, itching, swelling and the change of skin and eyes to an unusual colour such as yellow and red.[238]

Just like any other cancers, early diagnosis of liver cancer is very helpful towards the entire process of treatment. Liver cancer can be traced in its early stages through screening, conducting blood test and examining the patient through an ultrasound machine.[239] The treatment of liver cancer will normally be determined by the stage or the state in which the cancer has manifested itself in the body. Treatment ranges from surgery, in the form of a liver transplant, chemotherapy, radiation therapy, targeted therapy, and tumour ablation.[240]

2.5.4 Cervical cancer

Cervical cancer is defined as a malignant neoplasm arising from the uterine cervix, also referred to as the neck of the womb.[241] About 80% of cervical cancers are of a squamous type that can occur in different organs of the body such as the skin or the lips and the remainder are adenocarcinomas. The type of cancer that originates from the glandular tissue and andenosquamous carcinoma is most common during pregnancy, while other types are rare.[242] Cervical cancer is the kind of cancer that is

---

236 Romaine D and Rothfeld G *The Encyclopaedia of Men's Health* 211 (Amaranth, New York 2005).

237 Strehle M and Popp J *Biophotonics: Visions for Better Health Care* 596 (Wiley Publishers, London 2006).

238 Orr T *Liver Cancer: Current and Emerging Trends in Detection and Treatment* 23 (Rosen Publishing Group, New York 2009).

239 Quah SR, Heggenhougen HK and Van Look RFA *Sexual and Reproductive Health: A Public Perspective* 29 (Elsevier Academic Publishers, New York 2011).

240 Rees AM *Consumer Health USA* 266 (The Oryx Press, Phoenix 1997).

241 Uterine cervix is the lower part of the uterus in the female reproductive system. See Wood J and Martin-Hirsch P "Clinical Evidence Cervical Cancer" 2009 *BMJ* 1.

242 Wood and Martin-Hirsch 2009 *BMJ* 1.

found at the starting point of the cervix. The cervix is the part that connects or links the womb to the vagina, which forms part of the female reproductive system.[243]

Cervical cancer can be caused by a wide variety of factors which include elements such as smoking, sexually transmitted diseases, giving birth at an early age and a weak immune system.[244] Human papillomavirus is the type of virus that affects the human skin and the moist membranes that line the body, such as the throat, cervix and anus. Human papillomavirus is the major cause of cervical cancer as cervical cancer is classified as a multifactorial disease.[245] The different occurrences that result in human papillomavirus infection include the use of oral contraceptives, giving birth to more than one offspring at a time, smoking, host immune response or bacteria that cause a wide variety of diseases such as herpes simplex virus - an infection that causes herpes and appears mostly on the genitals and mouth.[246] In addition to these factors, the major causes of cervical cancer include obesity, minimal physical activity, alcohol abuse and occupational exposures such as the conditions experienced in the coal mines. The factors outlined are classified as risk factors to developing cervical cancer.[247]

Unlike other cancers such as breast cancer, cervical cancer is preventable. The primary prevention of cervical cancer is achieved through the prevention of diseases such as the human papillomavirus, as well as the prevention of other sexually transmitted infections. Screening programs, such as the Pap smear test and human papillomavirus vaccination exist in order to help prevent cervical cancer.[248] However, these screening programs are minimally employed, especially in rural areas, and this is a major cause for concern and thus the reason for high mortality rates relating to cervical cancer. The high mortality rate is also due to the lack of adequate

---

243 Sasieni P *et al,* "Cervical Screening at age 50-64 years of age and the risk of cervical cancer at the age of 65 years and older: population based case control study" 2014 (11) *PLOS Medicine* 13.

244 Fraumeni J and Schottenfeld D *Cancer Epidemiology and Prevention* 1050 (Oxford University, New York 2006).

245 Kim M *et al,* "Mild obesity, physical activity, calorie intake and the risks of cervical intraepithelial neoplasia and cervical cancer" 2013 (8) *Plos One* 1.

246 Kim *et al*, 2013 (8) *Plos One* 2.

247 Fiander A and Rieck G "The effect of lifestyle factors on gynaecological cancer" 2006 (20) *BPRCOG* 227.

248 Kim TH *et al,* "Socioeconomic disparity in cervical cancer screening among Korean women: 1998-2010" 2013 (13) *BMC* 533.

infrastructure in clinics and the lack of awareness about cervical cancer.[249] The Pap smear test contributes significantly to the whole treatment and prevention of cervical cancer and other precancerous lesions as it is an effective mechanism to facilitate the screening of women for such purposes.[250]

Besides prevention, cervical cancer can be also be treated through various forms of treatment mechanisms which include radiotherapy and surgery. However, the treatment administered to persons living with this cancer may have adverse side effects.[251] Patients can experience some form of vaginal abnormalities that can interfere with their sexual ability,[252] because persons living with this cancer undergo the kind of surgery which will usually result in them having a shortened vagina and further, most patients will have reduced lubrication after this form of treatment.[253]

Cervical cancer is the fifth leading cause of death in the world, especially that of women in developing countries, such as South Africa.[254] Cervical cancer claims the lives of about 250 000 people in the world annually due to its prevalence in the developing world.[255] In South Africa, it is believed that 45 out of every 10 000 women have cervical cancer.[256] In the next three to four years, this number is expected grow twice or three times as much.[257] The most common victims of cervical cancer are women in the ages ranging from 45 to 55 years and as a result of the fast growing pace of this cancer a lot of young women who are under the age of 20 years are also victims of this cancer.[258] The abovementioned statistics regarding the impact of

---

249 Elias C, Herdman C and Sherris J "Beyond our borders cervical cancer in the developing world" 2001(175) *WJM* 231.

250 Elias, Herdman and Sherris 2001 (175) *WJM* 232.

251 Steineck G *et al,* "Vaginal changes and sexuality in women with a history of cervical cancer" 2005 (340) *NEJM* 1383.

252 Steineck *et al*, 2005 (340) *NEJM* 1383.

253 Davenport JH and Abitbol MM "Sexual dysfunction after therapy for cervical carcinoma" 1974 (119) *JOG* 181.

254 Lu A *et al,* "Cervical Cancer Screening and Prevention for HIV-Infected Women in the Developing World" 2010 *CECAP* 1.

255 Moodley M "Cervical cancer in Southern Africa: The challenges" 2009 (1) *SAJGO* 11.

256 Moodley 2009 (1) *SAJGO* 12.

257 Moodley 2009 (1) *SAJGO* 13.

258 Mookeng MJ *Factors influencing cervical cancer screening programme implementation within private health care sectors in Soshanguve* 10 (LLM dissertation, University of South Africa, 2005).

cervical cancer in South Africa have been confirmed in the 2015 statistics which show that 5406 people died due to cervical cancer in the relevant year.[259]

Despite the challenges experienced in the developing world in connection to early detection of cervical cancer through screening mechanisms such as the Pap smear test, patients who have been diagnosed with this kind of cancer continue to live for many years as a result of effective treatment.[260] This goes to confirm the fact that cervical cancer can be cured and the patient can live a normal life again, despite being diagnosed with this type of cancer.

2.5.5 Colorectal cancer

Colorectal cancer refers to cancer of the large bowel, rectum and colon and is one of the most frequent cancers in the world.[261] Colorectal cancer develops in the colon and the rectum, and both colon and rectum are body parts that play an active role in the whole digestive system of the individual, which is called the gastrointestinal system.[262] It is unknown when this cancer was first discovered in human beings.[263] However, it is sufficient to state the fact that this type of cancer was found in ancient times in Egypt, and people who suffered from it had a strong family history of the disease.[264] In the past, colorectal cancer was viewed as hereditary, as it moved from one generation to another within the same family. Hereditary development was seen as the only way in which colorectal cancer was contracted by people, and no other means where found to cause this cancer in the past. The position in the modern world still remains the same.[265] However, due to progressive research conducted to discover other factors that cause this cancer, positive results have been revealed and other factors which cause this cancer have been found and will be considered later on in the study.[266]

---

259 Sartorius *Herold* (10/01/2017).

260 Townsend DW and Shreve P *Clinical PET-CT in Radiology: Integrated Imaging in Oncology* 341 (Springer, New York 2011).

261 Welvarrt K, Blumgart J and Kreuning J *Colorectal Cancer* 3 (University Press, Leiden 1980).

262 Walker S *Development of the Gastrointestinal Tract* 324 (BC Decker Publishers, Ontario 1999).

263 Beasley RP *et al,* "Familial Aggression of Colorectal Cancer in Egypt" 1998 (77) *IJC* 812.

264 Beasley *et al*, 1998 (77) *IJC* 812.

265 Beasley *et al*, 1998 (77) *IJC* 812.

266 Beasley *et al*, 1998 (77) *IJC* 813.

Once colorectal cancer has started to grow in the body, normally in the human reproductive system of the individual, this process of growth will take a very long time and can run for a period of about ten to fifteen years before the cancer can fully manifest in the human reproductive system.[267]

The process of screening for colorectal cancer has been found to be the most effective measure of treatment and prevention for this type of cancer.[268] Screening allows for the early detection and diagnosis of colorectal cancer, which in turn allows for treatment to take place as soon as possible.[269] Screening for colorectal cancer is the backbone towards the entire treatment of colorectal cancer, in such a way it reduces the mortality rate of patients through early detection and treatment.[270]

Colorectal cancer is the world's third most deadly disease. The major cause of colorectal cancer is said to be excessive consumption of fat, family history, alcohol abuse, smoking and primary ulcerative colitis which is cancer of the colon, among other factors.[271] Individuals affected by this form of cancer are often discriminated against or isolated by society.[272] To prevent contracting colorectal cancer, one would have to eat healthy, exercise regularly, refrain from smoking and refrain from the excessive intake of alcohol because these are the factors which contribute to the development of colorectal cancer in the human body.[273]

The warning signs which serve to inform a person to go for screening in order to detect colorectal cancer include bleeding from the rectum, black or dark stools, weight loss,

---

267 Alberts DS, Schilsky RL and Kelloff GJ "Colorectal adenomas: a prototype for the use of surrogate end points in the development of cancer prevention drug" 2004 (11) *CCR* 3908.

268 Bayless D *Advanced Therapy in Gastroenterology and Liver Disease* 154 (BC Decker Publishers, New York 2005).

269 Bayless Advanced *Therapy in Gastroenterology and Liver Disease* 155.

270 Bayless Advanced *Therapy in Gastroenterology and Liver Disease* 154.

271 It is important to note that the majority of people who are diagnosed with colorectal cancer have sporadic disease, but up to twenty per cent of survivors of colorectal cancer have inherited it from their family members. See Jemal A and Naishadham SR "Cancer Statistics" 2012 (62) *CA Cancer J* 10-12, Colon Cancer http://www.medicinenet.com/colon_cancer/page2.htm (Date of use: 10 January 2014).

272 Thomson SR and Coetzee EDT "Inherited colorectal cancer: A plea for a national registry" 2013 (51) *SAJS* 41-42.

273 Dominguez-Munoz JE *Clinical Pancreatology for practising Gastroenterologists and Surgeons* 331-332 (Blackwell Publishers, London 2005).

cramping pains of the lower stomach, diarrhoea and constant feelings of discomfort.[274] Colorectal cancer is the type of cancer that affects older people instead of young people, and among old people it affects people from the ages of 50 years and above.[275] Colorectal cancer affects both men and women, but it is found to be very frequent in men.[276]

2.5.6 Prostate cancer

Prostate cancer is the most common cancer in men and is defined as an aggressive growth of malignant cancerous cells in the prostate, which are fatal.[277] A prostate is found just below the bladder and in front of the rectum. The urethra is the tube that carries urine past the prostate. The prostate consists of various cells that make up semen, which function to protect and nourish the sperm.[278] Prostate cancer is also one of the cancers that originated in ancient Egyptian times. Prostate cancer was first discovered in Egypt in a 2, 250 year old mummy and it was found to be visible through the bone forming lesions of that mummy.[279] Just like other cancers, prostate cancer was discovered in ancient times and it was affecting people who were not even resident in Egypt. The second finding of prostate cancer in the world was discovered in the remains of the body of a Russian King about 2 700 years ago.[280]

Prostate cancer is known as the disease of antiquity because of its rich history connected to the ancient times of Egypt, and it is still a disease that is still common and relevant in the modern world.[281] The prostatic carcinoma is the development of cancer in the prostate, a gland in the male reproductive system.[282] There are several cells that are found in the prostate and almost all prostate cancers start from the gland

274 Larson CA *Positive Options for Colorectal Cancer: Self-Help and Treatment* 7 (Hunter House Publishers, California 2005).

275 Sheldon KL *A Nurse's Guide to Caring for Cancer Survivors: Colorectal Cancer* 5 (Jones and Bartlett Publishers, Ontario 2010).

276 Sheldon *A Nurse's Guide to Caring for Cancer Survivors: Colorectal Cancer* 5.

277 Alcoma IE and Cramer SD *Prostate cancer* 13 (InfoBase Publishing, New York 2006).

278 Lange JW *The Nurse's Role in Promoting Optimal Health of Older Adults: Thriving in the Wisdom Years* 208 (Nursing Joane Patzek DaCunha, New York 2012).

279 Ikram S *et al,* "Prostate metastatic bone cancer in an Egyptian Ptolemaic mummy, a proposed radiological diagnosis" 2011 (1) *IJP* 101.

280 Cornwall C *Catching Cancer: The Quest for its Viral and Bacterial Causes* 181 (Rowman and Littlefield Publishing Group, London 2013).

281 Ikram *et al*, 2011 (1) *IJP* 101.

282 Ikram *et al,* 2011 (1) *IJP* 102.

cells.[283] This is the type of cancer that is known as adenocarcinoma prostate cancer.[284] Normally, prostate cancer takes a long time to manifest in the prostate but in other instances it can grow and spread very fast.[285] Studies have shown that old men and young men who were diagnosed with prostate cancer died of other kinds or forms of diseases that were unrelated to prostate cancer. The results of such studies show that prostate cancer develops slowly in the human body and particularly, in the prostate.[286]

A family history of prostate cancer is seen as the major cause thereof, hence prostate tumours are described as the more diverse of the cancers both historically and clinically.[287] Family history of prostate cancer puts a patient at higher risk of the cancer, because this means that the cancer moves from one generation to the other. Family history does not only refer to shared genes among members of the family, but includes things such as shared environment and common behaviours among members of the family.[288] This family history of prostate cancer is called familial prostate cancer which normally moves from one generation to the other.[289] The fact that prostate cancer develops slowly in the prostate, results in the signs and symptoms being difficult to detect. However, screening process such as blood tests and digital rectum exams have helped with the detection of prostate cancer while it is still at its early stages.[290] Difficulty in urinating is a major sign which shows that the cancer has grown and developed in the prostate and other symptoms include signs of blood in urine, difficulty keeping an erection, experiencing pain in the spine, hips, ribs and other bones, loss of blood, loss of bowel and weaknesses in the legs.[291]

---

283 Jones JS *Prostate Cancer Diagnosis: PSA, Biopsy and Beyond* 208 (Springer, New York 2013).

284 Jones *Prostate Cancer Diagnosis: PSA, Biopsy and Beyond* 209.

285 Jones *Prostate Cancer Diagnosis: PSA, Biopsy and Beyond* 210.

286 Cheng L and Bostwick DG *Urologic Surgical Pathology* 1026 (Mosby Elsevier, Philadelphia 2008).

287 Sellers WR and Singh D "Gene expression correlates of clinical prostate cancer behaviour" 2002 (1) *Cancer Cell* 203.

288 Venturino A and Colloca G "The evolving role of familial history for prostate cancer" 2011 (50) *Acta Oncologica 14.*

289 Tubaro A *et al,* "The influence of family history on prostate cancer risk: implications for clinical management" 2010 (107) *BJU* 716.

290 Larson *Positive Options for Colorectal Cancer: Self-Help and Treatment* 7.

291 Hennenfent B *The Prostatitis Syndromes: Approaches to Treating Bacterial Prostatitis* 22 (Springer, New York 1996).

Prostate cancer can be prevented and treated just like any other cancer and this includes eating healthy food, exercising regularly, and going for screening in the form of tests to detect or diagnose whether the cancer is there or not.[292]

2.6 Various treatment mechanisms of cancer

As outlined above, the treatment of cancer takes various standard medical treatments which are prescribed to the patient. Each form of treatment will normally depend on a wide variety of factors such as the time of diagnosis, the time period for which the cancer has been in existence and how the cancer has manifested in the body.

Standard medical treatment to cancer includes surgery, chemotherapy, and radiation therapy. These treatment mechanisms will be discussed for the purposes of seeing how they play a role towards the treatment of cancer. These standard medical treatments of cancer are not the only ones available to treat cancer. Professor Zimmerman argues that cancer is man-made due to the fact that it is prominent in industrial areas.[293] He further argues that in ancient times, cancer was rare due to less industrialisation which is the major cause of cancer and therefore, there is nothing in the natural environment that can cause cancer.[294] Zimmerman further argued that cancer is a man-made disease which can be treated by reducing pollution and changing our lifestyles through eating a healthy diet and keeping fit.[295] In order to curb the spread and growth of cancer in society, the 21st century medical practitioners recommend that people adopt a healthy lifestyle as this is a method which has been tried, tested and proven to help avert being infected with cancer.[296]

2.6.1 Surgery

The practice of surgery in cancer treatment started in ancient times, when cancer was still viewed as incurable by both physicians and people.[297] Both physicians and people have held a stereotype in connection to cancer. This stereotype suggests that once

---

292 Dominguez-Munoz *Clinical Pancreatology for practising Gastroenterologists and Surgeons* 332.

293 Macrae F "Cancer is purely man-made say scientists after finding almost no trace of disease in Egyptian mummies" 15-10-2010 *Daily Mail* 13.

294 Macrae 15-10-2010 *Daily Mail* 13.

295 Macrae 15-10-2010 *Daily Mail* 13.

296 Macrae 15-10-2010 *Daily Mail* 14.

297 Gabriel RA *Man and Wound in the Ancient World: A History of Military Medicine from Summer to the Fall of Constantinople* 43 (Potomark Book Publishers, New York 2012).

cancer had spread throughout the body, there was no way it could be treated.[298] As a result, in most instances people do not seek treatment at all but instead simply wait to die.[299] The first physician who was a proponent of cancer surgery was Hippocrates, as he used surgery to remove the cancer tumours from the bodies of his patients.[300] However, he also recognised that even if the cancer had been surgically removed that particular cancer would normally return in future.[301]

During this age, the practice of cancer surgery was very much primitive and complicated, patients would lose a lot of blood and patients would die as a result of the complications which came with the surgery of cancer.[302] All of this changed during the late stages of the 19th century and the early stages of the 20th century in which great strides were made to improve cancer surgery and general surgery.[303] This is the era in which anaesthesia was discovered and used for surgery to reduce the occurrence of feelings of pain within the patient's body.[304] This era can be considered as the era of renaissance for the surgical treatment of cancer. Great physicians such as Bilroth from Germany, Handley and Halsted from Baltimore contributed significantly to cancer operations as we know them today.[305] They removed the entire tumour along the lymph nodes in the region where the tumour was located in the first place, in order to prevent it from growing and spreading.[306]

It was in the 20th century that William Stewart Halsted, a professor of medicine at Hopkins University in Baltimore, developed the surgery of radical mastectomy.[307] Halsted was of the view that cancer spreads outward by invasion from the original growth and therefore could be effectively treated with radical mastectomy.[308] Radical

---

298 Gabriel *Man and Wound in the Ancient World: A History of Military Medicine from Sumer to the Fall of Constantinople* 44.

299 Gabriel *Man and Wound in the Ancient World: A History of Military Medicine from Sumer to the Fall of Constantinople* 44.

300 Diamantis and Grammaticos 2008 *HJNM* 2-3.

301 Diamantis and Grammaticos 2008 *HJNM* 4.

302 Stringer *et al,* 2003 *BUMC* 33.

303 Redsell S and Hastings A *The Good Consultation Guide for Nurses* 160 (Radcliffe Publishers, London 2006).

304 Redsell and Hastings *The Good Consultation Guide for Nurses* 161.

305 Redsell and Hastings *The Good Consultation Guide for Nurses* 162.

306 Redsell and Hastings *The Good Consultation Guide for Nurses* 162.

307 Mays JA *See One, do One, Teach One* 35 (Xlibris Corporation Publishers, New York 2011).

308 Mays *See One, do One, Teach One* 36.

mastectomy is still relevant and is an important treatment of cancer that is normally used in any type of cancer to remove tumours.[309] As to who qualifies for this surgery normally depends on the advice of the medical practitioner concerned, and who is then guided by how long the cancer started to manifest itself in the patient.[310]

2.6.2 Radiation therapy

Wilhelm Conrand Roentgen, a German physics professor, was the first person to come up with the treatment of cancer through the use of radiation therapy in 1896.[311] He was later honoured and received the first Nobel Prize award in physics in 1901 for his exceptional work to this invention of radiation therapy as a method to be used for cancer treatment.[312] The first use of radiation therapy began with radium and with a relatively low-voltage diagnostic machine in Germany.[313] However, through research, the breakthrough of radiation therapy was accomplished in France where it was discovered that daily doses of radiation therapy over several weeks could greatly improve the patient's chances to be cured of cancer.[314] The methods and machines used to provide radiation therapy to patients have since improved. Today, in the 21st century, radiation is delivered with great precision in order to destroy cancer tumours, while limiting damage to the nearby normal tissues of the patient.[315]

Despite the effectiveness of radiation therapy in detecting and treating cancer, there are dark sides which are associated with this type of treatment. Research has shown that as much as radiation therapy is able to treat cancer, it can conversely cause cancer to the patient. Patients who were exposed to radiation therapy were left with skin cancer and others developed leukaemia due to radiation therapy.[316] Due to the technological advances and the aim of ultimately getting a cure for cancer, the 21st

309 Baum *Breast Cancer The Facts* 2.

310 Baum *Breast Cancer The Facts* 2.

311 Caner A and Lemoigne Y *Radiation Protection in Medical Physics* 25 (Springer, New York 2011).

312 Gorman RF *Great Events from History: The 20th Century, 1901-1940* 3453 (Springer, New York 2007).

313 Lee JH *Meningiomas: Diagnosis, Treatment and Outcome* 163 (Springer, New York 2007).

314 Lee *Meningiomas: Diagnosis, Treatment and Outcome* 164.

315 Wheldon TE "Radiation physics and genetic targeting: new directions for radiotherapy" 2000 (45) *PMB* 78.

316 Chan HSL *Understanding Cancer Therapies* 76 (University Press of Mississippi, Mississippi 2007).

century has seen progress being made in connection with cancer treatment, and in particular radiation therapy.

2.6.3 Chemotherapy

Chemotherapy is the treatment mechanism that was established during the Second World War, which is the era during which nitrogen mustard was considered to be able to treat cancer of the lymph.[317] Chemotherapy has successfully treated a wide variety of cancers, and is also used to treat people with diseases such as Hodgkin's and childhood diseases.[318] Chemotherapy allows for a wide variety of cancers to be controlled for a very long time to a point where they are healed, and in this century, research is focused on making chemotherapy more user-friendly to patients, by reducing the side effects of this medical procedure.[319] The side effects of chemotherapy include hair loss, vomiting, weight loss, constant tiredness, and nausea.[320] Liposomal therapy is a technique used to put chemotherapy drugs inside liposomes, which are the synthetic fat globules.[321] The liposome helps them penetrate the cancer cells more selectively and decreases the side effects of the chemotherapy.[322]

Chemotherapy is usually administered to a patient once he or she has undergone surgery to remove the tumour, and radiation therapy to control the small tumour growths that were not surgically removed by the surgeon. Then chemotherapy would be provided to the patient as a measure of last resort, for the purposes of destroying small tumour growths that had spread beyond the reach of both the surgeon and radiotherapist.[323] Chemotherapy that is administered after surgery in order to destroy any remaining cancer cells in the body is called adjuvant therapy.[324] Adjuvant therapy was first tested in breast cancer and found to be effective, and it was later used in

---

317 Porter R and Bynum WF *Companion Encyclopaedia of the History of Medicine* 1816 (Routledge, London 1997).

318 Porter and Bynum *Companion Encyclopaedia of the History of Medicine* 1817.

319 Rees *Consumer Health USA* 96.

320 Liposomes are vehicles which are used for purposes of transporting or administering nutrients and pharmaceutical drugs in the various parts of the body. See Rees *Consumer Health USA* 96.

321 Bonavida B *Sensitization of Cancer Cells for Chemo/Immuno/Radiotherapy* 19 (Humana Press, New York 2008).

322 Bonavida *Sensitization of Cancer Cells for Chemo/Immuno/Radiotherapy* 19.

323 Ang KK and Cox JD *Radiation Oncology: Rationale, Technique, Results* 591 (Mosby Elsevier, New York 2003).

324 Miller K *Adjuvant Therapy* 64 (IOS Publishers, London 2004).

other cancers such as colon cancer, testicular cancer and many other forms of cancers.[325]

The major discovery of the 21st century in relation to chemotherapy was the combination chemotherapy or multiple-chemotherapy. The discovery of multiple-chemotherapy has yielded positive results in providing effective treatment of cancer and can ultimately provide a cure to some cancers.[326] Chemotherapy is still a relevant and important treatment mechanism, and is changing the lives of persons living with cancer daily.

2.7 Conclusion

Cancer has affected mankind since early times. The emergence of technical advances in medicine has brought about developments that have had a positive effect on the treatment of cancer. Furthermore, cancer is a disease that can manifest in various forms and can be deadly if it is detected very late. The most important clinical aspect in cancer treatment outlined above is the early diagnosis and treatment of cancer, which is indeed what saves the lives of most persons living with cancer. The next chapter will deal with the effect of cancer on employment practices as a result of the unfair discrimination that persons living with cancer experience in the workplace in their capacity as employees.

---

325 Adjuvant therapy refers to care or therapy that is given in addition to the main treatment in order to maximise the effectiveness of the main treatment in fighting cancer. The aim of adjuvant therapy is to modify other therapies or treatments in fighting cancer. See Miller *Adjuvant Therapy* 65.

326 Clark WR *The New Healers: The Promise and Problems of Molecular Medicine in the 21st Century 256* (Oxford University Press, Oxford 1997).

Chapter 3: The employee living with cancer in the employment context: unfair labour practices

3.1 Introduction

One of the most important socio-economic factors which affect persons living with cancer is the issue of employment. Employees living with cancer are often unfairly discriminated against in the workplace, on the basis of their condition.[1] In some instances, this may lead to employees living with cancer losing their jobs, and being economically dependent on family and friends.[2] This type of unfair discrimination may be attributed to the stigma attached to cancer, as well as the ignorance of employers and fellow employees, regarding the disease. The challenges which employees living with cancer face in the workplace include being demoted, being overlooked by the employer for purposes of promotion, as well as receiving unfavourable performance appraisals and general unfair treatment.[3] These challenges tend to arise because an employer may be under the impression that the particular employee's productivity and performance standards will deteriorate below the company's expectations and will cause the employee to no longer be considered as competent and eligible for promotion once they are diagnosed with cancer. Employers commonly have such impressions as a result of the stigma and ignorance surrounding cancer, which is a societal challenge.[4]

This chapter is aimed at bringing to light some of the already mentioned challenges which employees living with cancer experience in the workplace. The various forms of remedies which are available to employees living with cancer, who have been subjected to unfair discrimination and unfair labour practices, will also be discussed in this chapter. This discussion will take the form of an extensive analysis of the South African legal system, with regard to its policy in as far as it relates to the protection of persons living with cancer as employees. Furthermore, part of the discussion will also

---

1 Doyal and Hoffman 2009 (27) *CME* 458.

2 Doyal and Hoffman 2009 (27) *CME* 458.

3 Doyal and Hoffman 2009 (27) *CME* 459.

4 Amir Z, Neary D and Luker A "Cancer Survivors views of work three years post diagnosis: A United Kingdom perspective" 2008 (12) *EJOJ* 192.

touch on the socio-economic factors that affect employees living with cancer, and which serve as pre-emption for employees living with cancer to be fully re-integrated into society after being diagnosed with cancer and treated therefore. For a comprehensive overview of the facts and owing to the historical links that are shared between South Africa and The United Kingdom, it is important to consider the English approach on this subject. However, an in-depth analysis of these two legal systems will be explored in detail in chapter four of this study.

3.2 Effect of cancer on the employee living with cancer's ability to work

On a daily basis, cancer affects millions of people whom are of working age. This has a detrimental effect on the ability of persons living with cancer to partake in employment or continue with employment.[5] The type of cancer which a person is diagnosed with serves as the strongest indication of whether that particular employee will have short or long term impairment. Cancer of the nervous system, leukaemia, and lung cancer, have all been known to negatively affect the employee living with cancer's ability to work, thus being one of the contributory factors to a low employment rate of persons living with cancer in particular.[6] In addition, the treatment mechanisms that are employed to treat persons living with cancer tend to have adverse side effects and have been found to have long term effects which add on to the persons living with cancer's ability to maintain employment.[7] Some of the adverse effects of cancer which have an impact on the employment of persons living with cancer, is that the employee will have to take time off in order to regularly consult with their doctor, and as prescribed by the doctor, the employee may have to work for a limited time, the employee may become temporarily disabled, and additionally, the employee may have to resign from their employment for the purposes of receiving treatment or dealing with the physical and psychological distress of being diagnosed with cancer.[8]

---

5 Haines C *The New Prescription: How to Get the Best Health Care in a Broken System* 115 (Health Communications Publishers, New York 2011).

6 Cooper AF, Low E and Grunfeld EA "Cancer survivors and employers perceptions of working following cancer treatment" 2010 (60) *Occupational Medicine* 612, and See Kraus EK *et al, Chartbook on Disability in the United States* 39-40 (National Department of Education, National Institute on Disability and Rehabilitative Research, Washington DC 1996).

7 Weeks JC *et al,* "Employment among Survivors of Lung Cancer and Colorectal Cancer" 2010 (28) *JCO* 1700.

8 Weeks *et al,* 2010 (28) *JCO* 1701.

These are the common occurrences that persons living with cancer typically experience, especially if their condition becomes worse. However, there are cases in which persons living with cancer are treated successfully. Therefore, it is very important for an employee living with cancer to be able to resume work after having been treated successfully. Job reinstatement forms part of the healing process for surviving persons living with cancer, which then leads to normality and stability.[9]

In 2013 it was estimated that one in every four South Africans has cancer, which is a call for concern.[10] This figure indicates that cancer frequently manifests itself in people who are both young and old. Therefore, it is important to note that cancer is a disease that does not target specific people or individuals, but affects all people either directly or indirectly, irrespective of race, colour, sex, religion or creed.[11]

Since most employees living with cancer are still young and capable of working, it is very important for them to be able to return to work, as this forms part of the healing process for persons living with cancer.[12] Furthermore, job reinstatement is essential for purposes of returning to normal and regaining independence and financial stability in order to claim back one's daily routine of work and family responsibilities.[13] The phase in which an employee living with cancer must return to work is not an easy one, especially after being absent for a long period. In most instances, the employee will isolate himself or herself upon returning from such a lengthy period of leave, owing to the depressing nature of cancer and the stigma attached thereto.[14] However, the relationship which the employee living with cancer initially had with the line manager and fellow employees is very important in the entire process of re-integrating the employee living with cancer in the workplace. If the relationship between the employer and employee was good prior to the cancer, then the employer would be more willing

---

9 Mc Lain RF *Cancer in the Spine Comprehensive Care* 2 (Humana Press, New York 2006).

10 Bradshaw D *et al*, "The burden of non-communicable diseases in South Africa" 2013 (374) *Series* 7.

11 Huber J *Cancer with Joy: How to Transform Fear into Happiness and Find the Bright Side Effects* 13 (Morgan James Publishers, New York 2012).

12 See Cooper, Low and Grunfeld 2010 (60) *Occupational Medicine* 613 and Huber *Cancer with Joy: How to Transform Fear into Happiness and Find the Bright Side Effects* 14.

13 Mazumdar M *et al,* "Employment after a Breast Cancer Diagnosis: A Qualitative Study of Ethnically Diverse Urban Women" 2012 (37) *J Community Health* 763.

14 Loesser JD and Fitzgibbon DR *Cancer Pain* 25 (Morgan James Publishers, New York 2012).

to assist with the re-integration of the employee, without problems.[15] The position is not the same in cases where prior to the circumstances, the relationship between the employer and employee was not good. In such cases the employer is less likely to assist the employee with the re-integration.[16] This form of conduct by the employer will amount to unfair discrimination because the duty of the employer to reasonably accommodate the employee must not be based on personal feelings, as it is a legally binding duty.

The challenges which employees living with cancer experience in returning to work are associated with the long term side effects of the treatment administered to them.[17] Some of these side effects can manifest as the employee experiencing fatigue, depression, pain and an inability to function effectively in the workplace, and all of this consequently negatively influences the confidence and self-esteem of the employee concerned, upon his or her return to work.[18] The three basic factors which cause employees living with cancer to eventually resign and change employment, are:[19] the lack of information and advice from medical doctors and psychologists regarding how the employee should approach their return to work after having gone through treatment, lack of vocational rehabilitation programmes to support employees and to re-integrate them in the workplace, and lastly, the lack of support and the ignorant attitude of most employers when it comes to cancer. The last factor is very important in helping the employee to find it easy to resume work and earn a living, and it is unfortunately the area in which the right to employment is vastly infringed upon.[20]

There are a number of role players involved when employees living with cancer seek to return to work. Various stakeholders have to ensure that the particular employee is fully re-integrated into the workplace. Consequently, the employee living with cancer is not the only person who has to make sure that he or she is re-integrated into the workplace. It is clear that the employer and medical practitioners such as

---

15 Cooper, Low and Grunfeld 2010 (60) *Occupational Medicine* 612.

16 Cooper, Low and Grunfeld 2010 (60) *Occupational Medicine* 612-613.

17 Sprangers MAG *et al,* "Cancer, fatigue, and the return of patients to work - a prospective cohort study" 2003 (39) *European Journal of Cancer* 1562.

18 Sprangers *et al,* 2003 (39) *European Journal of Cancer* 1563.

19 Dahl AA *et al*, "Change in Employment Status of 5-year Cancer Survivors" 2012 (10) *EPHA* 1-2.

20 Dahl *et al,* 2012 (10) *EPHA* 2.

psychologists ought to support and advise the employee before, and during the process of re-integration into the workplace.[21]

The Cancer Association of South Africa (CANSA) has confirmed the reality that one in four South Africans who are of working age, have cancer.[22] This fact plays a part and contributes to the growth of the unemployment rate in South Africa, which stands at 47.5% as reported by the National Union of Metal Workers of South Africa (NUMSA).[23] Similarly, in The United Kingdom it is estimated that employees living with cancer contribute to one out of four unemployed persons, and it has been found that this number is expected to grow in future.[24] These statistics are worrying and require urgent attention through the collaboration of various relevant stakeholders, in order to ensure that employees living with cancer still remain employed despite the status of their health.

In South Africa, the Employment Equity Act serves to protect the interests of employees living with cancer as part of employees generally, and places a duty on the employer to make reasonable accommodation of work, so as to enable the employee to resume with work.[25] The duty of the employer to reasonably accommodate employees living with cancer in terms of the Employment Equity Act will be explored below.

A study relating to the effect of cancer should ideally not only concentrate on cancer treatment and diagnosis, but it should also focus on the impact and effect that cancer diagnosis has on the employee living with cancer's employment status and of returning

---

21 Devane C "Making the Shift, Providing Specialist Work Support to People with Cancer" 2013 (1) *Macmillian Cancer Support* 11.

22 CANSA http://www.cansa.org.za/letter-to-corporates-world-cancer-day-4-feb-2014/ (Date of use: 10 February 2016).

23 NUMSA http://www.numsa.org.za/article/south-africas-youth-unemployment-crisis/ (Date of use: 18 April 2016).

24 Verbeek JH *et al*, "Cancer survivors and unemployment: a meta-analysis and meta-regression" 2009 (301) *JAMA* 753-754.

25 The Employment Equity Act 55 of 1998 is one of the pieces of legislation in South Africa, which strives to protect and promote the rights of employees to fair labour practices and the right not to be unfairly discriminated against on the basis of any disability among other things. See Section 15(2) of the Employment Equity Act which provides an obligation on the part of the employer to reasonably accommodate employees who have any form of disability, this will enable the employee to perform his or her duties in the workplace. More about this provision is outlined later on in the chapter.

to work.[26] Despite the long-term side effects of cancer treatment, patients who overcome cancer are still capable of working and earning a living, as well as keeping social contact with other people.[27] This has been found to form part of the entire process of healing and being fully re-intergraded back into society and work.[28]

3.3 The rights and duties of an employee living with cancer in the workplace

3.3.1 The right of the employee living with cancer to enter into occupation or profession free from discrimination

Section 22 of the Constitution of the Republic of South Africa, 1996 (hereinafter referred to as 'the Constitution'), provides that every citizen has the right to choose their trade, occupation or profession freely. The practice of trade, occupation or profession may be regulated by law.[29] Only the right to freely choose an occupation or profession will form the basis of this discussion, because the study refers to the employer-employee relationship in the workplace, which does not include the concept of trade, where the employee living with cancer runs a business and is often the employer. The reasoning behind incorporating this provision into the Constitution was to enable people to earn their own livelihood and not be dependent on the state for financial and economic maintenance.[30] Further, it can be argued that this right was included in the Constitution to address the injustices of the past, where the majority of black people of this country were excluded from the main stream economic activities through the unjust job location policies that were in place during apartheid.[31]

---

26 Barton MA, Nicholas DR and Veach TA *Cancer and the Family Life Cycle a Practitioners Guide* 157 (Brunner Routledge Publishers, New York 2013).

27 Bradley CJ, Robert N and Barnes AJ "Job attributes, job satisfaction and the return to health after breast cancer diagnosis and treatment" 2013 (23) *Pycho-Oncology* 158.

28 Lindbohm ML *et al*, "Comparative Study of Work Ability between Cancer Survivors and their Referents" 2007 (43) *EJC* 914.

29 Section 22 of the Constitution of the Republic of South Africa, 1996. This right to enter or choose trade, occupation or profession has been defined by the Constitutional Court as the right to earn a living, in the case of *Affordable Medicines Trust v Minister of Health of RSA* 2005 6 BCLR 529 (CC), 2006 3 SA 247 (CC) para 59. The facts of this case will be explored later in the thesis.

30 Section 22 of the Constitution of the Republic of South Africa, 1996.

31 Currie I and Del Waal J *The Bill of Rights Handbook* 6th Edition 459 (Juta Publishers, Cape Town 2013). The past policies and laws which aimed at excluding black people from mainstream economic activities includes the Mines and Works Act of 1926 and the Class Areas Act of 1925 which facilitated the segregation of black people. These are some of the policies or laws of the apartheid era.

A person's freedom to enter into any kind of occupation or profession is a crucial element of individual autonomy and constitutes a basis for the existence of other rights and freedoms,[32] such as the right to human dignity as enshrined in terms of section 10 of the Constitution.[33] Therefore, the right to enter into any form of profession or occupation is a right to provide materially for oneself, and it is aimed at enabling people to live profitable, dignified and fulfilling lives.[34] Seeing that the right to freely partake in a profession or an occupation is guaranteed in terms of the Constitution,[35] the state can regulate the process of seeking a profession or an occupation to be undertaken by people, with the aim of protecting the interests of society.

Du Plessis regards the right to a profession or an occupation as part of a broader society which an individual employee forms part of. He defines this right in broad terms as follows:

> "a measure to promote the protection or improvement of the quality of life, economic growth, human development, social justice, basic conditions of employment, fair labour practices or equal opportunities for all, provided that such measures are justifiable in an open and democratic society based on human dignity, equality and freedom".[36]

According to this interpretation, the right to choose a profession or an occupation cannot be interpreted in isolation from other people's rights and responsibilities because as the individual concerned will become part of a group in that particular profession and occupation. This interpretation also recognises that the right to choose

---

32 Currie and Del Waal *The Bill of Rights Handbook* 289.

33 Section 10 of the Constitution of the Republic of South Africa, 1996 states that everyone has inherent dignity and the right to have their dignity respected and protected. Further, it is important to inquire what human dignity means. It is defined as how an individual or group feels, self-respect and self-worth. Human dignity is concerned with physical and psychological integrity and empowerment, and is harmed or violated by unfair treatment premised upon personal traits or circumstances which do not relate to individual needs, capacities or merits. The right to human dignity is enhanced by laws which are sensitive to their needs, capacities and merits of different individuals, taking into account the context of their differences. The right to human dignity is harmed or violated when people are marginalised, ignored or devalued, and is enhanced when laws recognise the full place of all individuals and groups within society. This definition of human dignity also relates to the position of the persons living with cancer or employee in order to ensure that his or her right to human dignity is not compromised due to his or her medical condition. See *Law v Canada (Minister of Employment and Immigration)* 1 SCR 497 (1999) para 53, this case made an inquiry on the definition or meaning of human dignity.

34 Currie and Del Waal *The Bill of Rights Handbook* 290-291.

35 Section 22 of the Constitution of the Republic of South Africa, 1996.

36 Du Plessis LM "The Ideal Legal Practitioner" 1981 *De Rebus* 424-425.

a profession or occupation is not absolute, and can be limited in terms of the general limitation clause captured in section 36 of the Constitution, which will be discussed at length later on in this chapter.[37]

In the case of *Coetzee v Comitis*,[38] the applicant was a soccer player who was subject to the rules and regulations of the National Soccer League (NSL). The applicant was registered as a member of the club which he was playing for, and the club is subject to the rules of the NSL. In terms of the rules of the NSL, in the case where the contract of the player of the club expires, and if the club he is playing for does not renew his contract, the new team that the player is joining is expected to pay a transfer fee to the old club to enable the player to join the new team. The transfer fee will be determined by the arbitrator.[39] In this case the applicant argued that such a clause was violating his constitutional right in terms of section 22 of the Constitution,[40] which is the freedom to choose his occupation and profession. The applicant claimed this on the basis of the fact that in cases where the player does not get a new team to settle his transfer fees then it means the career of the particular player has come to an end, especially if his former club does not renew his contract.[41] The court found that the provision which instructed that compensation will free the employee as a player, constituted a violation of section 22 of the Constitution.[42] The court held that the rules and policies of the NSL were unreasonable and contrary to public policy. The court declared the relevant rules null and void as they were restricting the right of the player as an employee to choose his profession or occupation, and the freedom of playing for the team of his choice in future.[43]

Furthermore, Judge Traverso stated that section 22 of the Constitution aims to regulate any profession or occupation to a certain extent.[44] These regulations can arise internally from the company or may be imposed by legislation. Whatever the

---

37 Section 36 of the Constitution of the Republic of South Africa, 1996 is the general limitations clause and state the procedure which needs to be followed before a right can be limited lawfully. An in-depth analysis about this provision is considered later in the chapter.

38 *Coetzee v Comitis and Others* 2001 (1) SA 1254 (C).

39 *Coetzee* case 1254.

40 Section 22 of the Constitution of the Republic of South Africa, 1996.

41 *Coetzee* case 1255.

42 *Coetzee* case 1255.

43 *Coetzee* case 1256.

44 *Coetzee* case 1257.

case might be, a profession or occupation can only be regulated in a manner which is reasonable and in a manner which does not violate the constitutional rights of individuals.[45] This was unfortunately the position in this case with regard to the imposition of a payment of a transfer fee, in order for a player to join another team. The decision of the court was correct in dismissing this practice on the basis of section 22 of the Constitution, because it restricts the soccer player in playing soccer as a profession or occupation in future if the is no payment of transfer fee.

Further, the constitutional right to freely enter into a profession or an occupation was also considered and discussed together with the principle of reasonable accommodation in the case of *Imatu & Another v City of Cape Town*.[46] In this case the applicant brought a claim to the Labour Court that he had been unfairly discriminated against on the basis of his diabetic condition, as he was denied employment as a fire-fighter.[47] The respondent reasoned that the applicant was denied employment because he might suffer from hypoglycaemic attack which will cause a threat to him and the public.[48] In this case the court held that in order for a person to be unfairly discriminated against on the basis of disability, he or she must suffer from a long term physical impairment which substantially limits access to, or advancement in employment, and further substantially limits his or her ability to do work.[49]

The court reasoned that although the diabetic condition of the applicant could be described as a long-term impairment, a diabetic patient is not considered to be disabled in terms of the Employment Equity Act, which does not provide the exact meaning or definition of disability.[50] The court found that the effects of diabetes could be controlled by corrective medication.[51] Furthermore, the court held that the applicant's state of being diabetic did not prevent him from performing his duties as a fire-fighter. Despite the fact that the type of discrimination concerned was based on an unlisted ground of discrimination, the court held that such discrimination was based

45 *Coetzee* case para 27.
46 *Imatu & Another v City of Cape Town* [2005] 11 BLLR 1048 (LC).
47 *Imatu* case 1048.
48 *Imatu* case 1048.
49 *Imatu* case 1049.
50 *Imatu* case 1049.
51 *Imatu* case 1049.

on a ground which was analogous to the listed grounds of disability and HIV and AIDS status.[52] The court further held that this ground of differentiation had the potential to impair the applicant's dignity, and that a blanket ban policy prohibiting all applicants with Type 1 diabetes from entering into employment, did in actual fact amount to unfair discrimination on the part of the defendant.[53] The court based its decision on the view that the conduct of the defendant would seriously and adversely affect the right of the plaintiff to enter into any profession or occupation as guaranteed by section 22 of the Constitution.[54]

Section 22 of the Constitution is also applicable to employees living with cancer before and after cancer diagnosis, and goes on to protect them from the point of diagnosis to the point of returning to work after treatment. This broad form of protection is aimed at ensuring that they are in the position to earn an income in order to lead a productive life, instead of being dependant on the state for financial support in the form of social grants. Research has proven that for an employee living with cancer, continuing to work forms part and parcel of the healing process.[55] This is due to the fact that work has both the physical and the psychological benefits that contribute towards the healing process of the employee living with cancer.[56] In fact, when cancer is not manageable or manifests as a disability within the inflicted employee, the relevant employee should not lose his or her right to choose a profession or occupation as guaranteed in section 22 of the Constitution.[57] The employer will have to provide the concerned employee with reasonable accommodation as provided for in terms of section 15(2) of the Labour Relations Act.[58] This is but one of the measures which the employer can use to assist the employee living with cancer in order to prevent discrimination and maintain equality in the workplace. The issue of cancer being unmanageable and resulting in a disability to the concerned employee will be discussed in-depth later in the chapter. However, it is important to take into

52 *Imatu* case 1050.
53 *Imatu* case 1050.
54 *Imatu* case 1050.
55 Amir *et al,* 2008 (12) *EJOJ* 193.
56 Amir *et al,* 2008 (12) *EJOJ* 193.
57 Section 22 of the Constitution of the Republic of South Africa, 1996.
58 Section 15(2) of the Employment Equity Act 55 of 1998.

consideration the fact that section 22 of the Constitution is not a blanket clause,[59] which means that despite having the right to freely enter into profession or occupation, a employee living with cancer still needs to comply with the requirements of that particular profession, such as being in possession of all the formal qualifications that an applicant or an employee ought to possess. The issue of living with cancer is therefore not material when it comes to the right to enter into profession or occupation freely, but the prescribed requirements which are set by the law for that profession are essential.

3.3.2 Duties of an employee living with cancer towards the employer

A contract of employment is a contractual agreement between the employer and the employee, in terms of which the employee agrees to render services under the control and supervision of the employer in exchange for remuneration.[60] The contract between the employer and the employee is reciprocal in nature and both parties must perform their obligations which flow from the contract.[61]

In terms of section 10 of the Basic Conditions of Employment Act 75 of 1997 (hereinafter referred to as 'Basic Conditions of Employment Act'), the duties which an employee living with cancer owes to the employer include: being loyal to the employer, obeying lawful orders of the employer, exercising due care and diligence while executing his or her duties, communicating with the employer and fellow employees on any matter which might render him or her unable to execute his or her duties, and finally the employee living with cancer has a duty to respect the property of the employer, while performing his or her duties in the workplace.[62] Failure by the

---

59 Section 22 of the Constitution of the Republic of South Africa, 1996 is not a blanket clause and can be limited in terms of section 36 of the Constitution of the Republic of South Africa, 1996 which is the general limitation clause.

60 Honeyball S *Great Debates in Employment Law* 123-124 (Palgrave Macmillan Publishers, New York 2011). The cases in which the definition of an employee and what constitutes an employment relationship between the employer and employee include: *Wyeth SA (Pty) Ltd v Manqele & others* (2005) 26 *ILJ* 749 (LAC) where it was held that the definition of employee in section 213 of the Labour Relations Act can be read to include a person or persons who has/have concluded a contract of employment of which the commencement of employment is deferred to a future date/dates. Also in the case of *Phera v Education Labour Relations Council and others* (2012) 33 ILJ 2839 (LAC) it was held that where an employee assumes duties without written permission from the Department, such assumption of duties would not establish an employment relationship *per se*.

61 Grogan J *Workplace Law* 8th Edition 50 (Juta Publishers, Cape Town 2005).

62 Section 10 of the Basic Conditions of Employment Act 75 of 1997 provides the duties which an employee owes to the employer based on a contract of employment.

employee to obey lawful and reasonable instructions amounts to insubordination, and thus a breach of contract.[63]

At this point it is necessary to determine what amounts to a reasonable instruction on the part of the employer. Reasonable instruction simply means the instructions on what job has to be done and how that job must be done.[64] Furthermore, this definition of reasonable instruction is dependent on a number of factors which will serve as a yardstick to determine whether the instruction given by the employer is reasonable or not. These factors include the capacity, the ability, and the capability of an employee to do the work, as well as the experience of the employee.[65] In the case where the employee completely fails to follow the reasonable instruction of the employer, it amounts to insubordination and a breach of contract on the part of the employee. Therefore, the employer is able to terminate the contract of employment of the employee if the breach is serious or severe. Such termination will be justified under common law and will also be justified if a correct and fair procedure has been followed in order to substantiate the termination in terms of section 188A of the Labour Relations Act 66 of 1995.[66]

The duties which the employee owes to the employer were explored in the case of *Council for Scientific & Industrial Research v Fijen*,[67] in which the court held that it is well established that the relationship between the employer and the employee is one

---

63 Section 10 of the Basic Conditions of Employment Act 75 of 1997. See also *Wasteman Group v South African Municipal Workers' Union* [2012] 8 BLLR 778 (LAC) in which the aspect of insubordination was considered. In this case the court considered the difference between insubordination *per se* and insubordination which gives rise to the ultimate sanction of dismissal. It was held that the difference between general insubordination and gross insubordination is a question of degree. It was held that there is a difference between an employee who partially defies an instruction but later completely complies with it and an employee who deliberately refuses to obey an instruction, expressly defying an instruction and challenging the authority of the employer, especially in the presence of other employees.

64 Manamela T "Failure to obey employer's lawful instructions and reasonable instructions: Operational perspective in the case of a dismissal: *Motor Industry Staff Association and Another v Silverton Spraypainters and Panelbeaters* (Pty) Ltd" 2013 (25) *SA Merc LJ* 424.

65 Manamela 2013 (25) *SA Merc LJ* 425-426.

66 Section 188A of the Labour Relations Act 66 of 1995, states that (1) an employer with the consent of the employee, request a council, an accredited agency or the commission to conduct arbitration into allegations about the conduct or capacity of that employee. (2) The request must be made in the prescribed form. (3) The council, accredited agency or the commission must appoint an arbitrator on receipt of: (a) payment from the employer of the prescribed fee, and (b) the employee's written consent to the inquiry.

67 *Council for Scientific & Industrial Research v Fijen* (1996) 17 ILJ 18 (A).

of trust and confidence. The court pointed out that at common law, any conduct between the employer and the employee which is found to be inconsistent with this principle, enabled the innocent party to cancel the agreement.[68] It does seem that, in our law it is not necessary to work with the concept of an implied term, which is a provision in a contract that is not directly stated in written or spoken words. An implied term is normally introduced by the court in a labour dispute in order to establish the obvious intention of the parties.[69]

In the context of an employee living with cancer, cancer can possibly make an individual unable to work productively, thus affecting his or her capacity, ability and aptitude to do work. This does not amount to breach of contract on the part of the employee, and his or her employer cannot dismiss him or her on grounds of insubordination under the circumstances. In this instance a duty will rest on the employer to accommodate the employee in order for the employee living with cancer to do his or her work efficiently, despite having to live with cancer. The role of the employer to accommodate the employee living with cancer in the workplace will be explored later in the chapter in detail, as already outlined earlier in the chapter.

The principle of good faith is one of the implied terms found in all modern day contracts, including the contract of employment between the employer and employee. According to the implied term of good faith, parties to the contract are bound by everything which good faith reasonably and equitably demands.[70] This generally means that the parties to a contract will be acting in good faith, and will not without reasonable or proper cause conduct themselves in a way that will destroy or seriously damage the relationship of trust and confidence between them.[71] In the context of the duties of the employee towards the employer, this simply means that the employee will promote the business of the employer and not act contrary in any manner which will result in bringing the business down.

---

68 *Council for Scientific & Industrial Research Case* 18.

69 *Council for Scientific & Industrial Research Case* 19.

70 Van Jaarsveld M "An Employees Contractual Obligation to Promote Harmonious Relationships in the Workplace- When Are the Stakes too High? Some Pointers from the Judiciary" 2007 (19) *SA Merc LJ* 205.

71 Van Jaarsveld 2007 (19) *SA Merc LJ* 206.

Another case where the duties of employees were highlighted was in *Cyber Scene Ltd and Others v i-Kiosk Internet and Information (Pty) Ltd*,[72] which involved senior employees of the company who left the company to form their own company, thereby acting contrary to their fiduciary duties towards the employer. They were in possession of confidential information of the company with regard to its operation and business.[73] The employer argued that these employees owe him a fiduciary duty because they were in possession of confidential information of the company which led them to form their own company and engage in unlawful competition with him.[74] The employer sought an interdict against these employees to prevent them from engaging in unlawful activities and the employees argued that they were not in breach of fiduciary duties.[75] They denied that they had confidential information about the company because all the information which the employer claimed was confidential was in actual fact available on the company website for all people to see.[76]

In this case, the court held that the common law fiduciary duties of company directors continue to exist even after they no longer work for the company.[77] The employer is entitled to protect itself against any breach of fiduciary duties by any director or any employee through applying for an interdict.[78] In this case the High Court granted the order of interdict against the senior employees on the basis that they still owed the employer the fiduciary duty.[79] This case clearly depicts the broad scope and application of the duty of good faith in an employer-employee relationship. Consequently, it is clear that the relationship between the employee living with cancer and employer is also governed by the principle of good faith. This means that the employer must deal with the employee living with cancer in a fair and reasonable manner, despite the health condition of the employee concerned. Equality must be practiced by the employer when dealing with all employees in the workplace, as prescribed by the principle of good faith.

---

72 *Cyber Scene Ltd and Others v i-Kiosk Internet and Information (Pty) Ltd* 2000 (3) SA 806 (C).
73 *Cyber Scene* case *807*.
74 *Cyber Scene* case 807.
75 *Cyber Scene* case 808.
76 *Cyber Scene* case 808.
77 *Cyber Scene* case 809.
78 *Cyber Scene* case 809.
79 *Cyber Scene* case 810.

3.4 Employees living with cancer and the right to fair labour practices in terms of the Labour Relations Act 66 of 1995

3.4.1 Unfair labour practices and the right to fair labour practices

Unfair labour practice was introduced into South African labour law in 1979 as a mechanism to remedy the absence of fairness in the common law employment regime, which consisted of great inequality and unfairness.[80] The concept of unfair labour practices, at that time, brought more problems rather than solutions, due to the fact that what constituted unfair labour practice was left to the determination of the industrial court. The concept of unfair labour practices depended on a variety of factors based on each case and therefore, the meaning of unfair labour practice varied from case to case.[81]

The adoption of the Constitution, which guarantees the right to fair labour practices, and the Labour Relations Act which expressly provides as to what constitutes unfair labour practices, brought certainty and stability to the meaning of unfair labour practices and conduct or omission that can result in unfair labour practices.[82] In terms of section 23(1) of the Constitution, everyone has a right to fair labour practices.[83] This clearly means that the Constitution promotes fair labour practices in the workplace and unfair conduct or omission on the part of the employer that normally prejudices an employee in the workplace is not permitted. It can be argued that unfair conduct is wider than unfair discrimination, because conduct or omission may be unfair without being discriminatory. This implies that discrimination is a species of unfair conduct, the difference may be academic but it is important to consider the nature of the unfair conduct concerned for purposes of establishing the correct forum to handle the dispute

---

80 Labour Relations Act 28 of 1956. This was due to the fact that during the 17th century, in the Cape colony, the employment relationship between the employer and the employee was generally mandatorily categorised by slavery. This means that the employee as a slave during this time had no rights and was subjected to different forms of unfair labour practices, which the current Labour Relations Act is trying to resolve through advocating for the rights of employees to fair labour practices among other things. See Venter B and Levy A *Labour Relations in South Africa* 38 (Oxford University Press, Cape Town 2009).

81 Grogan J *Employment Rights* 91 (Juta Publishers, Cape Town 2010).

82 Section 23(1) of the Constitution of the Republic of South Africa, 1996 and see the case of *Kylie v CCMA and others (2010) 31 ILJ 1600 (LAC),* the court ruled that every person involved in a relationship of employment, including sex workers, regardless of the fact that sex work is still illegal under the South African law, has a section 23 constitutional right to fair labour practices and that this right involves at the minimum, being treated with dignity by employers.

83 Section 23(1) of the Constitution of the Republic of South Africa, 1996.

in question.[84] Employees who experience unfair discrimination will refer their dispute to the Labour Court or civil courts for adjudication or refer the dispute to arbitration provided that the parties agree to this process,[85] while in the case of employees who have experienced unfair labour practice they can refer the dispute to arbitration in terms of section 186(2) of the Labour Relations Act.[86] The difference between the two lies in the different forums which are available to them, however despite the minimal difference between unfair labour practice and unfair discrimination they share a common goal of ensuring that equity and fairness dominates the workplace despite the disability or state of health of an employee, and in this case the employee living with cancer.

As already stated, in terms of section 23(1) of the Constitution everyone has a right to fair labour practice. However, in terms of section 23(2) of the Constitution, the word everyone is replaced with 'every worker has the right to join or form a trade union, to participate in the activities and programmes of a trade union, and to strike'.[87] This means that the right to fair labour practices is guaranteed not to all people or everyone, but to specific people who are mostly involved in the labour market and thus one can argue that there is a discrepancy between section 23(1) and section 23(2) of the Constitution, in the sense that section 23(1) stands to protect everyone in matters regarding fair labour practices, while section 23(2) limits the scope of section 23(1) by providing specific guidelines or groups of people who are protected thereunder. Despite this discrepancy, the Constitutional Court embraced the view that the right to fair labour practices emanates from an employment context in the case of *South African Defence Force Union v Minister of Defence*.[88] This case arose from the fact that soldiers were prohibited from joining trade unions, in terms of the Labour Relations Act.[89] The South African Defence Union directly relied on section 23(2) of the Constitution to strengthen their argument, stating that every worker has a right to form and join a trade union.[90] The court rejected the blanket clause of section 23(1) of the

84 Grogan *Workplace Law* 263.
85 Section 191(1) of the Labour Relations Act 66 of 1995.
86 Section 186(2) of the Labour Relation Act 66 of 1995.
87 Section 23 (1) and Section 23 (2) of the Constitution of the Republic of South Africa, 1996
88 *South African Defence Force Union v Minister of Defence* 1999 (6) BCLR 615 (CC).
89 *South African Defence Force Union v Minister of Defence* case 615.
90 *South African Defence Force Union v Minister of Defence* case 615.

Constitution which extends to protect everyone, and instead decided the matter on the basis of section 23(2) of the Constitution, and held that the term 'worker' as contained in that provision includes soldiers.[91] The court held that the constitutional right to fair labour practices is considered within an employment relationship that is constituted in a contract of employment as well as a relationship akin to an employment relationship arising from an act such as enrolment in the armed forces.[92]

The right to fair labour practices cannot be measured on the basis of the restrictive interpretation which is generally applied to commercial contracts, but can indeed be measured according to the broad interpretation which is applicable to a contract of employment. The restrictive approach merely focusses on the parties to the contract while the broad approach looks beyond the interests of both the employer and the employee, and takes the inquiry further to consider the interests of society as a whole. This approach can also bring clarity to the wide statement stipulated in section 23(1) of the Constitution, which provides that everyone has a right to fair labour practices. Nonetheless, section 186(2) of the Labour Relations Act provides that unfair labour practices can only occur in the context of an employer-employee relationship and does not extend beyond this relationship. This means a job applicant who happens to have cancer, does not have a right to fair labour practices, which in turns means that unfair labour practices cannot be committed against an applicant, as he or she is not an employee.[93]

However, a job applicant living with cancer is protected from unfair discrimination in terms of the Employment Equity Act.[94] The Employment Equity Act aims to promote economic development, social justice, labour peace and democracy in the workplace.[95] It is apparent that a job applicant living with cancer, who has been refused employment on the basis of his or her condition, has a leg to stand on, and can take the employer to court on the basis of unfair discrimination. This has been the

91 *South African Defence Force Union v Minister of Defence* case 615.
92 *South African Defence Force Union v Minister of Defence* case 616.
93 Section 186(2) of the Labour Relations Act 66 of 1995.
94 Section 2 of the Employment Equity Act 55 of 1998.
95 Section 2 of the Employment Equity Act 55 of 1998.

position in the case of *Hoffmann v South African Airways*,[96] in which an applicant was denied employment on the basis of his HIV and AIDS status. The conduct of the employer was found to be discriminatory towards the applicant and thus unlawful.[97] The employer was ordered to employ the applicant because he was qualified and competent to do the job in question.[98] Based on this assessment, it is clear that a person living with cancer applying for a job can rely on both the Employment Equity Act, and the *Hoffmann* case, in raising an argument about unfair discrimination upon being denied a job position on the basis of their health condition.[99] This is a milestone in our legal system in ensuring that job applicants, in particular those affected by health deformities such as cancer and HIV and AIDS, are protected by the law and their right to human dignity and the right to choose a profession or an occupation is also protected.[100]

The Labour Relations Act needs to adopt a uniform approach of regulation that is in line with the Constitution, because currently these two laws express different views, with the aim of protecting and promoting the same factor, which is fairness in the workplace and in society. If the Labour Relations Act is amended in order to ensure clarity and legal certainty, then one uniform voice can be attained. The Constitution guarantees the right to fair labour practices for everyone, including employees, while the Labour Relations Act embraces the view that only people in the labour market have the right to fair labour practices, and thus leaving everyone else to the vulnerability of being subjected to unfair labour practices.

In the case of *National Education Health & Allied Workers Union v University of Cape Town*, it was stated that the right to fair labour practices is about the continuation of the relationship between the employer and the employee on terms that are fair towards both parties.[101] In this context, fairness will relate to both economic and societal factors

---

96 *Hoffmann v South African Airways* (CCT 19/00) [2000] ZACC 17, 2001 (1) SA 1, 2000 (11) BCLR 1235, [2000] 12 BLLR 1365 (CC) (28 September 2000).

97 *Hoffmann* case 1365.

98 *Hoffmann* case 1365.

99 *Hoffmann* case 1366.

100 Section 10 and Section 22 of the Constitution of the Republic of South Africa, 1996.

101 *National Education Health & Allied Workers Union v University of Cape Town* (2003) 24 ILJ 95 (CC).

such as health, safety, environment and the economy.[102] This will make the right to fair labour practices more inclusive. Fair labour practices are not aimed at restricting the pursuit of gain on the part of employers, but instead are aimed at ensuring that a balance is maintained between the rights of employees and the right of the employer to acquire gain.[103] The Labour Relations Act should facilitate the realisation of both the employer's and employees' rights, as well as those not currently in the labour market.

3.4.2 Labour Relations Act 66 of 1995 and the Basic Conditions of Employment Act 55 of 1997

Section 1 of the Labour Relations Act provides that the purpose of this Act is to advance economic development, social justice and labour peace as well as the democratisation of the workplace by fulfilling the primary objects of this Act, which are:

(a) To give effect to and regulate the fundamental rights conferred in terms of section 27 of the Constitution,
(b) To give effect to obligations incurred by the Republic as a member state of the International Labour Organisation,
(c) To provide a framework within which employees and their trade unions, employers and employers organisation can collectively bargain to determine wages, terms and conditions of employment and other matters of mutual interest and to formulate industrial policy,
(d) To promote orderly collective bargaining, to promote collective bargaining at sectoral level, to promote employee participation in decision-making in the workplace and to promote the effective resolution of labour disputes.

Clearly, the main purpose of the Labour Relations Act is to ensure that the relationship between the employer and the employee is in good standing, and this aim is also targeted by trade union representatives. One can argue that the Labour Relations Act ensures that the relationship between the employer and the employee remains fruitful, through the statute's engaged approach of allowing both parties the opportunity to resolve disputes speedily and to partake in the decision-making process. Whereas

---

102 Vettori S "The role of human dignity in the assessment of fair compensation for unfair dismissals" 2012 (15) *PER/PELJ* 102.

103 Brassey M *et al*, *The New Labour Law* 98 (Juta Cape Town, 1987).

section 2, of the Basic Conditions of Employment Act aims to advance economic development and social justice by fulfilling the primary objects of this Act which are:[104]

(a) To give effect to and to regulate the right to fair labour practices conferred by section 23 of the Constitution, by establishing and enforcing basic conditions of employment and by regulating the variation of basic conditions of employment,
(b) To give effect to obligations incurred by the Republic as a member state of the International Labour Organisation.

This means that the Basic Conditions of Employment Act deals with the contractual obligations of the employer and the employee at the initial stages of employment. The Basic Conditions of Employment Act deals with the regulation of the terms and conditions of employment, in order to ensure that there is fairness and that the employee is not prejudiced. In contrast the Labour Relations Act ensures that the relationship which was concluded by the employer and the employee in terms of the Basic Conditions of Employment Act is maintained and fair, through resolving conflicts speedily and guarding against injustices such as unfair labour practices, among other things.

3.4.3 Unfair labour practice in terms of the Labour Relations Act 66 of 1995

Section 186(2) of the Labour Relations Act outlines what constitute unfair labour practices in the workplace.[105] Unfair labour practice refers to any unfair act or omission that arises between an employer and an employee involving the following matters:[106]

(a) Unfair conduct by the employer relating to the promotion, demotion, probation (excluding disputes about dismissals for a reason relating to probation) or training of an employee or relating to the provision of benefits to an employee,

(b) The unfair suspension of an employee or any other unfair disciplinary action short of dismissal in respect of an employee,

---

104 Section 2(a)-(b) of the Basic Conditions of Employment Act 55 of 1997.

105 Section 186(2) of the Labour Relations Act 66 of 1995 provides a clear definition of what constitutes unfair labour practices on the part of the employer towards the employee. This definition is explored in depth in the text. However, it is important to note that unfair labour practice can only happen if there is a contract of employment between employer and employee. Thus it is clear that unfair labour practice cannot be said to have occurred in the case of a person who is the applicant of the job, because at this stage there is no contract between the parties.

106 Section 186(2)(a) - (d) of the Labour Relations Act 66 of 1995.

(c) A failure or refusal by an employer to reinstate or re-employ a former employee in terms of an agreement,

(d) An occupational detriment, other than dismissal in contravention of the Protected Disclosures Act 26 of 2000, on account of the employee having made a protected disclosure defined in the Act.

In line with the challenges which employees living with cancer experience in the workplace, it is important to define what promotion and demotion actually means as these are the unfair labour practices which employees living with cancer may commonly experience in the workplace.[107]

3.4.4 Common law and statutory law provisions for promotion

Under the common law, employees have no legal entitlement to be promoted to higher positions, unless the employees are in a position to prove that a contractual right thereto exists, or in the case of employees in the public sector, if they are in a position to prove a legitimate expectation exists for them to be promoted.[108] Furthermore, promotion or demotion under common law fell squarely on executive prerogatives or powers of the employer, which is still the case. However, promotion is considered as one of the grounds for unfair labour practices and is regulated by the Labour Relations Act.[109]

Promotion refers to the change of the employee's terms and conditions of employment that result in material increase to the salary, responsibilities and status of the employee.[110]

Nel argues that promotion is based on merit and responsibility, as it is meant to enhance the development of the employee, while at the same time it is directed

---

107 Doyal and Hoffman 2009 (27) *CME* 459.

108 John G *Dismissal, discrimination and unfair labour practices* 52 (Butterworths, Durban 2008).

109 Section 186(2) of the Labour Relations Act 66 of 1995. See *Aries v CCMA & Others* (2006) 27 ILJ 2324 (LC) the court held that there are limited grounds on which an arbitrator, or a court, may interfere with discretion which had been exercised by a party competent to exercise that discretion. The reason for this is clearly that the ambit of the decision-making powers inherent in the exercising of discretion by a party (including the exercise of the discretion, or managerial prerogative, of an employer) ought not to be curtailed. It ought to be interfered with only to the extent that it can be demonstrated that the discretion was not properly exercised. The court held further that an employee can only succeed in having the exercise of discretion of an employer interfered with if it is demonstrated that the discretion was exercised capriciously, or for insubstantial reasons, or based upon any wrong principle or in a biased manner.

110 Martin J *Profiting from Multiple Intelligences in the Workplace* 206 (Gower Publishers, London 2001).

towards the interests of the company.[111] From this reasoning one can argue that, for an employee to be promoted the employee must be qualified and competent enough to carry out the tasks expected of him or her in that particular position. Therefore, it is clear that promotion does not take into account the disability or health status of the employee in question because such concerns may not have a negative impact on the employee's ability to work. This argument is also expanded by O'Brian, who argues that disability or health status of an employee does not take away the competence of the employee although it can have an effect on the ability of the employee to do his or her work to a lesser or greater extent, and therefore this does not take away the right of the employee to be granted a promotion.[112]

Grogan advances the argument that for a employee living with cancer to succeed with a claim of unfair labour practice with specific reference to promotion, he or she must prove certain factors. The employee must show that the employer has exercised his or her discretion capriciously, or for unsubstantiated reasons, or that the decision was taken on the basis of a wrong principle or was even biased.[113] Furthermore, Grogan states that employers can be held liable for unfair labour practice with regard to promotion, if they have provided a reasonable expectation that the employee will be promoted, and then without adequate reasons frustrate the employee by refusing to grant the employee a promotion.[114] From this assessment, it is clear that unfair labour practice disputes relating to promotion are commonly related to the capabilities of the employee or the disability of the employee, which is a problem that arises due to the abuse of power or process on the part of the employer. Based on these arguments, one can come to the conclusion that employers tend to abuse or use the disability of employees, as scapegoats to deny them promotion.

Further, the International Labour Organisation, to which South Africa is a signatory, places an obligation on employers to provide career information to employees who suffer from disabilities or health deformities.[115] The information must be accessible to

---

111 Nel P *et al*, *Human Resources Management* 272 (Oxford University Press, Cape Town 2001).

112 O'Brian R Crippled Justice: The history of modern disability policy in the workplace 152 (University of Chicago Press, Chicago 2001).

113 Grogan J Workplace Law 75 (Juta Publishers, Cape Town 2009).

114 Grogan Workplace Law 76.

115 International Labour Organisation (ILO) "The price of exclusion: the economic consequences of excluding people with disabilities from the world of work: Employment working paper" 2009

these employees to ensure that they are well informed about the various opportunities which are available to them in the workplace. This duty also encompasses the duty to encourage the relevant employees to apply for promotions, particularly in cases where there is evidence that the employee would otherwise be reluctant to do so, on account of their state of health or disability.[116]

If the employee is qualified and competent enough based on the requirements of the position, then there is no way that their health status or disability can be used as a justification to prevent the employee from being promoted. Should this be the case, then it will amount to unfair labour practice in terms of the Labour Relations Act, and the onus of proving the unfair labour practice rests with the employee alleging the unfair labour practice.[117]

Furthermore, in the case where an employee is excluded from promotion due to disability and health deformities, it can be argued that this amounts to systematic discrimination, which is a combination of direct and indirect discrimination.[118] Systematic discrimination in the employment context simply emanates from the established rules or procedures of recruitment, hiring and promotion, and which are not designed to promote discrimination. In this instance, the discrimination is reinforced by the very exclusion of disadvantaged groups, because the exclusion promotes the belief that they are incapable of qualifying for a promotion due to their state of health or disability.[119] To combat or fight systematic discrimination is important for purposes of creating a working environment in which negative attitudes and

(43) *ILO* 2. In terms of the Code of practice on managing disability in the workplace, it states that the objective of this code is to provide practical guidance on the management of disability issues in the workplace with a view of: (a) ensuring that people with disabilities have equal opportunities in the workplace, (b) improving employment prospects for persons with disabilities by facilitating recruitment, return to work, job retention and opportunities for development, (c) promoting a safe, accessible and healthy workplace, (d) assuring the employer that the costs associated with disability are minimized among employees, including health care and insurance payments, in some instances, (e) maximizing the contributions which workers with disabilities can make to the enterprise. (ILO) Geneva 2001.

116 International Labour Organisation (ILO) 2009 (43) *ILO* 2-3. The ILO comprises of three main bodies, this includes the International Labour Conference, the Governing Body and the International Labour Office. This shows that power is not centralized in the ILO and this ensures the effectiveness of this organization in fighting for the rights of employees. See Smit N *et al, Law@Work* 3rd Edition 22 (LexisNexis, Durban 2015).

117 Section 186(2) of the Labour Relations Act 66 of 1995.

118 Hunter R *Indirect Discrimination in the Workplace* 12 (The Federation Press, Sydney 1992).

119 Hunter *Indirect Discrimination in the Workplace* 12-13.

practices are rightfully challenged and discouraged.[120] The process of eliminating systematic discrimination in the workplace goes hand in hand with the obligations set by the International Labour Organisation as discussed earlier, to ensure that those employees with disabilities and those who suffer from health deformities are well informed about the opportunities which are available to them and that they know their rights in the workplace.[121]

The case of *Joint Affirmative Management Forum v Pick n Pay Supermarket*,[122] involved the promotion of staff from being causal workers to becoming permanent employees, and thus the question at hand was whether this kind of change constituted promotion. The employer had a policy in place in which an employee would first be appointed as a causal worker and after a reasonable time, the employee would be appointed as a permanent employee.[123] In this case the Commission for Conciliation Mediation and Arbitration (CCMA) accepted the policy of the employer on the basis that such changes from a causal worker to a permanent employee with benefits amounted to promotion.[124]

The principle of promotion was furthermore considered in the case of *Department of Justice v CCMA & Others*,[125] in this case the Department of Justice advertised vacant senior positions and both internal applicants, which are people who worked in the Department, and external applicants were invited to apply for this opportunity.[126] This meant that the internal employees of the Department would compete with external applicants for the vacant positions. The internal employees of the Department held the view that if they were appointed for the advertised position it would not constitute promotion.[127] However, the Labour Court held that if the internal employees of the Department were appointed for the advertised senior post, this would amount to promotion because they did not occupy the same rank or position as the ones advertised by the Department. The claim of the employees was thus dismissed by the

120 Hunter *Indirect Discrimination in the Workplace* 14.
121 ILO 2009 (43) *ILO* 2.
122 *Joint Affirmative Management Forum v Pick n Pay Supermarket* (1997)18 ILJ 1149 (CCMA).
123 *Joint Affirmative Management Forum* case 1149.
124 *Joint Affirmative Management Forum* case 1150.
125 *Department of Justice v CCMA & Others* [2004] 4 BLLR 297 (LAC).
126 *Department of Justice* case 297.
127 *Department of Justice* case 297.

Labour Court, on the basis that the conduct of the employer did not amount to unfair labour practices on the basis of promotion.[128]

The issue of discrimination in relation to promotion was also considered in the case of *Standard Bank of South Africa v Commission for Conciliation, Mediation and Arbitration and Others*, [129] where the relevant employee had sustained an injury at work, and was subsequently demoted. Due the employee's commitment to the company she did not resign and continued to work, but her working conditions were unbearable as she was not offered reasonable accommodation as a person who was disabled due to her injury.[130] When the employee complained about her working conditions and she was placed back to her old position but was dismissed two months after that.[131] The court found that the conduct of the employer amounted to unfair labour practices, and held that the employee concerned was entitled to a promotion because of her hard work despite the fact that the employer failed to reasonably accommodate her.[132] This case will be covered in-depth later on in the chapter.

3.4.5 Common law and statutory law provisions for demotion

Demotion is the opposite of promotion. A demotion occurs in the case where there is a change in the employee's terms and conditions of employment that causes material reduction of the employee's responsibilities, remuneration and status.[133] It is important to understand that in certain instances, a change in the work of an employee does not amount to demotion. For instance, if the employee experiences being placed in a slightly different work station where the scope of the work falls within the scope of the employees initial duties, or where the employer makes a change to the title of the employee's position.[134] It must be noted that employees cannot be demoted from posts which they were not formally appointed for.[135]

---

128 *Department of Justice* case 298.

129 *Standard Bank of South Africa v Commission for Conciliation, Mediation and Arbitration and Others* (JR 662/06) [2007] ZALC 98, [2008] 4 BLLR 356 (LC) (25 December 2007).

130 *Standard Bank of South* case 356.

131 *Standard Bank of South* case 357.

132 *Standard Bank of South* case 358.

133 Manigault K *Victory in the Workplace: Inspiration for the Working World* 18 (Xulon Press Publishers, New York 2003).

134 Grogan Workplace Law 79.

135 Grogan Workplace Law 79.

At common law, the demotion of employees without their consent amounts to a repudiation of a contract between the employer and the employee concerned.[136] In this regard the demoted employee has the choice to either uphold the contract while instituting a claim for damages, or the employee can seek for an order to compel the employer to restore him or her to the original position.[137] However, it is important to take into account the fact that in terms of section 186(2) of the Labour Relations Act an employer by implication is allowed to demote an employee, provided that this is done in a fair manner.[138] The onus of proving that unfair demotion has occurred rests with the employee who alleges the unfair demotion on part of the employer.[139]

In *Solidarity obo Kern v Mudau & Others*,[140] the concept of demotion was considered. This case involved an employee who was moved from the position of senior personnel officer to the position of committee officer after the restructuring process instituted by the employer, who is the respondent in the proceedings.[141] The employee took the matter to arbitration, and the case was decided against him on the basis that the current position he was occupying was not different from the position he used to occupy initially. It was held that the change which took place in his employment position did not amount to demotion and that no unfair labour practice was committed against him.[142] However, when the matter went to the Labour Court, the judge held that the employee was in fact demoted as he had fewer responsibilities in the present position and consequently received a lower salary, owing to the newly restructured position.[143] The court held that the decision of the employer amounted to a demotion

136 Manigault *Victory in the Workplace: Inspiration for the Working World* 17.

137 Grogan *Workplace Law* 264.

138 Section 186(2) of the Labour Relations Act 66 of 1995 and see the case of *Nxele v Chief Deputy Commissioner, Corporate Services, Department of Correctional Services & others* (2008) 29 ILJ 2708 (LAC) the court considered whether the decision to transfer the employee temporarily to Pollsmoor constituted a demotion. It was held that the status, prestige and responsibilities of the position were relevant to the determination of whether or not a transfer constituted a demotion. In light of the detailed and uncontested evidence of the employee regarding the status, prestige and responsibilities of his position in Cape Town, the court did not hesitate to conclude that that position was of a higher status and prestige and held greater responsibilities than the position he was to occupy at Pollsmoor. The employee's transfer to Pollsmoor therefore constituted demotion. Since the employee did not consent to the demotion, it was unlawful in terms of the common law and unfair in terms of the Labour Relations Act.

139 Grogan *Workplace Law* 265.

140 *Solidarity obo Kern v Mudau & Others* [2007] 6 BLLR 566 (LC).

141 *Solidarity obo Kern* case 566.

142 *Solidarity obo Kern* case 567.

143 *Solidarity obo Kern* case 567.

on part of the employee. The judge went further to state that the arbitrator was lacking knowledge as to what the concept of demotion entails. Accordingly, the company was ordered to compensate the employee for the loss he had endured due to the demotion, as well as the salary he was entitled to.[144]

Another case which deals with demotion is *South African Police Services v Salukazana and Others*.[145] In this case the employee was transferred to another area, and the transfer brought about change to the conditions of service of the employee.[146] The transfer resulted in change of the status of the employee, with regard to the position he occupied, and resulted in him having fewer responsibilities than before he was transferred to the new area.[147] The Labour Court found that indeed the employee was demoted and the conduct of the employer amounts to unfair labour practice.[148]

3.4.6 Workplace promotion and demotion in the context of employees living with cancer

It is common for employers to engage in unfair labour practices by way of side-lining employees living with cancer when it comes to considerations for promotion.[149] Similarly, at some point some employers end up demoting employees living with cancer due to the belief that once an employee is diagnosed with cancer, they are incapable of working in the same capacity as they were, prior to them being diagnosed with cancer.[150] This is the kind of attitude and belief that must be discouraged, through educating the employer and fellow employees about cancer.[151] Apparently in South

144 *Solidarity obo Kern* case 568. See the recent case on the aspect of demotion which is hidden under the aspect of transfer of an employee by an employer. In *SA Police Services v Salukazana & others* (2010) 31 ILJ 2465 (LC) the employee was notified by a letter headed 'lateral transfer' that he had been permanently transferred to a new position. The effect of the transfer was that although he remained on level 13 and his salary and benefits were not changed, his status had been diminished. In the past he reported to the area commissioner, in his new position he was expected to report to a person in a lower position than the area commissioner. The court found that demotion can manifest itself in many ways. It can arise through a reduction of salary, a change to terms and conditions of employment and a transfer. In fact, a demotion and a transfer have common attributes - there is a movement in both a demotion and a transfer. If the movement leads to a reduction in status, it is a demotion. Thus, if a transfer leads to a change in terms and conditions of employment which amounts to demotion, an employee is entitled to bring a claim relating to an unfair labour practice.

145 *SA Police Services v Salukazana and Others* (2010) 31 ILJ 2465 (LC).

146 *SA Police Services v Salukazana and Others* case 2466.

147 *SA Police Services v Salukazana and Others* case 2466.

148 *SA Police Services v Salukazana and Others* case 2466.

149 Mehnert A *et al*, "Employment challenges for cancer survivors" 2013 (1) *Cancer* 2151-2152.

150 Mehnert A *et al*, 2013 (1) *Cancer* 2151-2152.

151 Cooper, Low and Grunfeld 2010 (60) *Occupational Medicine* 612.

Africa, employees who are mostly affected by the possibility of unfair dismissal as a result of cancer are those who are particularly suffering from breast cancer.[152] This occurs as a consequence of the fact that breast cancer is a leading cause of death cancers and affects many employees in South Africa.[153]

In addition to the possibility of unfair dismissal, employees living with cancer find themselves receiving unfavourable performance reviews. [154] The unfavourable performance reviews are commonly caused by a lack of reasonable accommodation in the workplace, as this tends to make employees living with cancer look as if they are floundering in their jobs. Reasonable accommodation is a duty of an employer which needs to be fulfilled in the workplace to enable the employee living with cancer to continue with work. Undoubtedly, the employer's duty is a measure of eliminating arbitrary unfavourable performance reviews, because the working environment will be conducive and productive for the employee living with cancer to do work if this duty is fulfilled.[155] In contrast to the United Kingdom, South Africa is a place where the burden of cancer is very heavy, and which currently has no official statistics that reveal the effects of the disease in the workplace, which is a great concern.[156] In the United Kingdom, it is estimated that thirty five per cent of employees living with cancer who have returned to work have received unfavourable appraisals from their employers as a result of their cancer condition.[157]

It is possible that despite the statutory measures which serve to protect employees against unfair labour practices in South Africa, employees living with cancer may find themselves in a similar position as those affected by cancer in the United Kingdom -

---

152 Galliet 2010-04-13 *Business Day* 7.

153 Galliet 2010-04-13 *Business Day* 7.

154 Macmillan-Cancer-Support http://www.macmillan.org.uk/Cancerinformation/Livingwithandaftercancer/Workandcancer/Supportforemployees/Workcancer/Your%20rights/Protectionfromdiscrimination.aspx (Date of use: 29 March 2014).

155 Cooper, Low and Grunfeld 2010 (60) *Occupational Medicine* 612.

156 See Health 24 http://www.health24.com/Medical/Cancer/News/Enpowering-cancer-patients-in-the-workplace-20130509 (Date of use: 16 July 2014).

157 Seifart CKU *et al*, "Reintegrating Persons living with cancer into the Workplace" 2012 (109) *Medicine* 703.

at the receiving end of demotion and being denied promotion.[158] In this context, it is very clear and important that more education and communication about cancer is required in the workplace.[159]

Brassey argues that the restriction of unfair labour practices is not designed to restrict the gain or profit of the employer, but to ensure fairness is established in the workplace.[160] Employers unfortunately see cancer as deterrence for them in their profit-making ventures. However, through effective communication and support this should not be the position at all. A balance must be maintained between the gains of the company and the rights of employees, which in turn will result in a healthy company that will be profitable for all stakeholders. Furthermore, maintaining a balance between the gains of the company and the rights of employees will also assist the employer in providing all the necessary support and making reasonable accommodation in the workplace to enable the employee to perform his or her duties well, as required by law.[161] A balance between the gains of the company and the rights of employees will also dispel the myth or stigma that is attached to cancer, namely that those diagnosed with cancer are incapable of working effectively.[162]

Witzel argues that the demotion of an employee in the workplace for a reason such as cancer must be taken as a last resort and thought out carefully on how to execute it in line with the operational requirements of the company, in order to avoid legal proceedings being instituted by the employee concerned.[163] Witzel goes further to support her assertions about how demotions must be exercised diligently, because companies demote employees with the aim of avoiding the severity of completely firing

---

158 Section 186(2) of the Labour Relations Act 66 of 1995 as outlined above, clearly state that all employees are entitled to fair labour practices and further states the types of conducts that constitutes unfair labour practices.

159 CANSA http://www.cansa.org.za/letter-to-corporates-world-cancer-day-4-feb-2014/ (Date of use: 22 March 2014).

160 Brassey *et al*, *The New Labour Law* 99.

161 Section 15(2) of the Employment Equity Act 55 of 1998, makes provision for the employer to make means in the workplace through adjusting the working conditions in such a way as to accommodate the cancer survivor who has returned to work and who cannot perform his or her duties than before, due to the adverse effect of cancer treatment. More will be explored about this provision later on in the chapter.

162 CANSA-http://www.cansa.org.za/letter-to-corporates-world-cancer-day-4-feb-2014/ (Date of use: 22 March 2014).

163 Witzel M *Origins of the World's Myths* 21 (Oxford University Press, Oxford 2013).

the employee concerned.[164] Witzel correctly states that the demotion of an employee can be justified on the part of an employer, if the employer demotes a good employee in trying to retain them in circumstances where the particular employee cannot remain in the current position, due to issues such as the inherent requirements of the job.[165]

Willey takes the views of Witzel a step further by putting emphasis on how demotion must be handled in the workplace, and he argues that it must be done with grace as well as with respect. According to Willey, open communication between the employer and the employees about the grounds of demotion as well as encouraging the concerned employee to improve on his or her performance will result in no claim for unfair labour practices on the part of the employee.[166] This approach will leave the employee concerned still feeling attached to the company despite the demotion, and will encourage the employee to improve where he or she has been lacking competence. However, this is unfortunately not the case when employees living with cancer are demoted as they are left emotionally aggrieved, due to lack of communication, as outlined earlier.

Therefore, it is clear that demotion can amount to unfair labour practice, but it can also be justifiable if it is found to be in the interests of the company to do so. The process of handling demotion must be open, taking into account that the employee has the right to human dignity and respect. This clearly affirms that an employee living with cancer who has been demoted on the basis of the inherent requirements of the job, and with the aim of retaining them through an open and transparent process which does not violate any of their human rights, can improve and contribute to the well-being of both the employee living with cancer and the company. Despite the view that the demotion of employees living with cancer can be justified, is important to note that employees living with cancer are still eligible for promotion. Due to the stigma and arrogance of employers, this rarely happens.[167] As mentioned earlier, since employment forms part and parcel of the healing process of cancer, promotion can

---

164 Witzel *Origins of the World's Myths* 21-22.

165 Willey N available at http://www.workforce.com/articles/21366-dealing-with-demotions-from-hrs-perspective (Date of use: 16 May 2016).

166 Willey available at http://www.workforce.com/articles/21366-dealing-with-demotions-from-hrs-perspective (Date of use: 16 May 2016).

167 Willey available at http://www.workforce.com/articles/21366-dealing-with-demotions-from-hrs-perspective (Date of use: 16 May 2016).

indeed serve as a major boost to a competent employee living with cancer. As such, employers must be encouraged to promote employees with disabilities or conditions similar to cancer in order to achieve equality and diversity, among other things, in the workplace.

3.5 Duties of an employer towards the employee

As emphasized earlier, communication and education about cancer is the point of departure towards the successful re-integration of the employee living with cancer in the workplace. It is also a means to alleviate discrimination in the workplace, as outlined above. Nonetheless, the employer also has a role to play in the whole process.[168] Just as the employee has certain duties or obligations towards the employer, the employer also has specific duties towards the employee. This is a bilateral relationship which exists between the two parties and forms part of the contract of employment between them.[169]

In terms of the Basic Conditions of Employment Act, the employer has the duties and responsibilities to remunerate the employee, providing safe working conditions for the employee, treating all employees fairly, without any form of discrimination, and to provide work to the employee.[170]

---

168 CANSA http://www.cansa.org.za/letter-to-corporates-world-cancer-day-4-feb-2014/ (Date of use: 22 March 2014).

169 This bilateral relationship between the employer and employee forms part of the contract between the two parties, and this agreement is regulated by the Basic Condition of Employment Act 75 of 1997.

170 See section 10 of the Basic Conditions of Employment Act 75 of 1997 and the CANSA Guidelines. Furthermore, with regards to cancer, CANSA has also set out social responsibilities for the employer, just like the employee as it has been outlined above. These social responsibilities are not legal duties but may have an impact on the legal position of the employer. CANSA provides four basic steps or social responsibilities on the part of the employer that will help the employer to effectively deal with employees who have cancer, without any form of discrimination. Firstly, the employer is expected to find out what cancer is and raise awareness of cancer in the workplace. This will enable the employer to have an understanding that some of the employees have cancer, or might contract cancer in future, or they have been affected by the disease at some stage in their lives. Furthermore, the employer's understanding of cancer will enable him or her to understand the effect of the disease on the employee diagnosed with cancer as well as the impact thereof on his or her other colleagues. Upon hearing that an employee has been diagnosed with cancer, the employer must sit down with the employee to discuss with the employee things such as how the employer can extend his or her support in relation to affording the employee time off, provide minimal work, and find out about the support structure of the employee, not only at work but also at home. This understanding will pave the way for a fruitful relationship between employer and employee. In addition, the employer upon receiving information about the cancer of the employee must be sensible. The employer needs to be empathetic, in the sense that he or she must know that cancer is not

The duties of the employer towards the employee was considered in thecase of *Murray v Minister of Defence*,[171] where the Supreme Court of Appeal introduced a new general and contractual obligation on employers, namely a duty of fair dealing with employees.[172] In this case the employee affected was a military policeman, who claimed that he had been constructively dismissed by his employer, which resulted in him resigning from his post because his employer made it impossible for him to continue to work.[173] The employee was not protected by the Labour Relations Act, and this meant that he could not claim relief on the basis of this Act, [174] due to the fact that the Labour Relations Act does not cover members of the South African National Defence Force.[175] Therefore, the applicant employee brought this case purely on contractual grounds to the court.[176]

The court held that the employee was entitled to rely directly on his constitutional right to fair labour practices and the associated right to personal dignity, and of course he could also rely on his contractual rights to bring a claim on the basis of unfair labour

---

contagious at all, and encourage the employee living with cancer to continue working if possible. Lastly, upon returning to work, an employer must provide a supportive approach to dispel all the anxiety and restore confidence in the employee living with cancer through the provision of an enabling environment in which work can be done effectively by this employee and fellow colleagues. This will allow for better knowledge and understanding of cancer, and thus eliminate unfair discrimination in the workplace. In 2014 the theme of the world cancer day was on raising awareness for unfair discrimination of employees living with cancer in the workplace. One can argue that the social responsibilities for employers, which have been set by CANSA with regard to understanding cancer, are in fact well in line with the duty of the employer to reasonably accommodate employees who suffer from some form of disability in terms of section 15(2) of the Employment Equity Act. This will ensure that the employer knows and understands the position which the employee living with cancer is experiencing and will assist in offering the necessary support. , it will be appropriate to say that the social responsibilities that are set by CANSA are necessary and important. This is due to the fact that they are derived from the law as it has been shown that they have a legal element in them to a greater or lesser extent and resonate with the employment setting which does not require both the employee and employer to do something new, but to do what is legally required in the employment context while keeping in mind these social responsibilities as a supporting structure.

171 *Murray v Minister of Defence* [2008] 6 BLLR 513 (SCA).

172 *Murray v Minister of Defence* case 513.

173 *Murray v Minister of Defence* case 513.

174 *Murray v Minister of Defence* case 513.

175 *Murray v Minister of Defence* case 513. The Labour Relations Act does not apply to members of the National Defence Force, the National Intelligence Agency, and South African Secret Services. This is in line with the International standards. Military and Secret service personnel are supposed to have a special duty towards the state and therefore do not have the same employment rights like other public servants. However, these personnel have the right to protection against unfair labour practices in terms of the Constitution.

176 *Murray v Minister of Defence* case 514.

practices.[177] The validity of his claim extended to the common law in relation to the contract of employment, as the court held that it imposes a duty on all employers, and the military as an employer to deal fairly with their employees.[178]

Another case that dealt with the duties of the employer towards the employee is *Steward Wrightson (Pty) Ltd v Thorpe*.[179] In this case, an insurance agent who was also a director of the company was informed by the company not to come to work or use his office during the notice period of his termination of employment in the company.[180] The employee director approached the court on the basis that the conduct of the employer was in breach of its duties towards him as the director of the company.[181] The court held that the conduct of the employer constituted a breach of contract and was unreasonable in the sense that the applicant was a director in the company and had special relations with clients and employees of the company.[182] The court further held that denying him access to the company during this period made it impossible for him to continue with his work and also resulted in the degradation of his status.[183] Later, the company did not terminate his employment service but gave him the option to either stay on a contractual basis or to resign as a form of remedial action.[184]

Therefore, it is positive law that if an employer fails to carry out his or her duties in terms of the employment contract, the employee will have recourse to approach either the CCMA or the labour court on the basis of breach of contract.[185] Therefore, in the context of this study, an employee living with cancer can have recourse against the employer in cases were the employer fails to treat all employees equally and fairly, by way of directing unfair treatment towards the employee living with cancer on the basis of his or her condition. In this case the employee living with cancer will have two forms of recourse. On the one hand, the employee can claim breach of contract on the basis

177 *Murray v Minister of Defence* case 514.
178 *Murray v Minister of Defence* case 515.
179 *Steward Wrightson (Pty) Ltd v Thorpe* 1977 (2) SA 943 (A).
180 *Steward Wrightson* case 943.
181 *Steward Wrightson* case 943.
182 *Steward Wrightson* case 944.
183 *Steward Wrightson* case 944.
184 *Steward Wrightson* case 945.
185 Section 191(1) of the Labour Relations Act 66 of 1995.

that the employer has failed to discharge his or her duties by not treating all employees equally in accordance with the provisions of the Basic Conditions of Employment Act,[186] and on the other hand, the employee living with cancer will have recourse on the basis of section 6(1) of the Employment Equity Act,[187] which prohibits employers from engaging in any form of unfair discrimination in the workplace.

3.5.1 The rationale and the foundation of the duty of the employer to reasonably accommodate employees living with cancer

The duty which is placed on employers to provide reasonable accommodation is a non-discriminatory mechanism in its constitutional form, and a juridical tool which is aimed at achieving substantive equality among people,[188] and in this context, specifically employees living with cancer. The principle of reasonable accommodation serves as an integral part of, and is the justification for direct or indirect discrimination which is fair. This is due to the fact that reasonable accommodation gives recognition to equality. This principle recognises that in order to achieve equality among people, it might be necessary to treat people differently.[189] In broad terms, reasonable accommodation entails taking positive steps in order to meet the needs of people who suffer from physical or psychological deformities which other people may not experience. By taking positive steps to provide reasonable accommodation to disabled employees, the employer cannot be viewed as acting discriminatorily, but instead his or her actions should be considered as a positive step towards eliminating any form of discrimination in the workplace.

In as much as employers are required to embrace diversity in the workplace, they are not expected to incur undue hardships in the process of embracing diversity through reasonable accommodation.[190] The type of reasonable accommodation required will depend on the nature and essential functions of the job, the work environment and the nature of the specific impairment experienced by each individual concerned.[191] At this

186 Section 10 of the Basic Conditions of Employment Act 75 of 1997.

187 Section 6(1) of the Employment Equity Act 55 of 1998.

188 Bernard RB "Reasonable accommodation in the workplace: To be or Not to be?" 2014 (17) *PER/PELJ* 2871.

189 Ngwena CG *Disabled people and the search for equality in in the workplace: An appraisal of equality models from a comparative perspective* 460 (LLD thesis, University of Free State, 2010).

190 Bernard 2014 (17) *PER/PELJ* 2880.

191 BC Public Service *A Managers Guide to Reasonable Accommodation* 5 (Columbia Press, Columbia 2008).

stage it is very important to take into consideration that reasonable accommodation on the part of the employer is based on three interrelated criteria which justify its purpose. Firstly, the reasonable accommodation must effectively remove the barriers or obstacles which prevent an individual employee, who is otherwise qualified, from being able to carry out his or her duties.[192] Secondly, the accommodation must allow the individual employee with a disability to enjoy equal access to the benefits and opportunities of employment, such as the right to promotion in the workplace.[193] Lastly, employers can adopt the most cost-effective means which are consistent with the two criteria outlined above.[194]

The principles above outline the basic manner in which the employer can reasonably accommodate an employee who suffers from a disability in the workplace. One can argue that these three aforementioned criteria serve as yardsticks in order to determine if the duty to provide reasonable accommodation has been fulfilled on the part of the employer. When considering whether this duty has been fulfilled, the court will take into account the rational and proportional relationship between the measure employed and the purpose it seeks to achieve.[195] In the context of this study, the purpose of employing reasonable accommodation measures would be to accommodate employees living with cancer to continue working, despite of their medical condition, in order to overcome the effect which their condition may possibly have on their working ability.

In the case of *MEC for Education, Kwazulu Natal v Pillay*,[196] the Constitutional Court stated that "reasonable accommodation requires that the employer must take positive measures such as removing access barriers, even if it means incurring additional hardships or expenses to ensure that all employees enjoy their right to equality".[197] In light of the above, Bernard argues that the duty of reasonable accommodation on the part of employers may be both positive, such as making alterations to the working environment to enable the disabled employee to work, and negative, such as

192 BC Public Service *A Managers Guide to Reasonable Accommodation* 5-6.
193 BC Public Service *A Managers Guide to Reasonable Accommodation* 6.
194 BC Public Service *A Managers Guide to Reasonable Accommodation* 7.
195 BC Public Service *A Managers Guide to Reasonable Accommodation* 7.
196 *MEC for Education, Kwazulu Natal v Pillay* 2008 1 SA 474 (CC).
197 *MEC for Education, Kwazulu Natal v Pillay* case para 73.

dismissing the disabled employee due to incompetence and in the interest of the company in order to achieve the right to equality of all employees in the workplace.[198] However, Bernard cautions that such a duty on the part of employers to reasonably accommodate employees is not absolute, in the sense that no court can expect an employer to excessively incur expenses, if it cannot reasonably accommodate the employee due to his or her state of health.[199]

One can attest to the fact that reasonable accommodation aims to balance the interests of both the employer and the employee concerned, by ensuring that there is equity in employment, in order to avoid the unfortunate situation of one party benefiting at the expense of the other. This is clearly emphasised from the reasoning that in order to justify reasonable accommodation, there must be a relationship between the measure being employed to provide such accommodation, and the purpose which it seeks to achieve.

In the case of *Department of Correctional Services v POPCRU*,[200] the court found that there was no justification for the claim to reasonable accommodation on the basis that there was no relationship between the measure and the purpose which the measure seeks to achieve.[201] This case involved a work policy in the Correctional Services Department which prohibited women from having dreadlocks in the workplace.[202] However, all the employees, both males and females were expected to wear similar clothing because the policy on uniform was the same, except for the one regarding the hairstyle of female employees.[203] The Department argued that such restriction on the part of female employees was justified on the basis that short hair was ideal because long hair such as dreadlocks, will put female employees at risk of being easily harmed by prison inmates.[204] However, it was argued that short hair on the part of female

198 *MEC for Education, Kwazulu Natal v Pillay* case 474.
199 Bernard 2014 (17) *PER/PELJ* 2881.
200 *Department of Correctional Services v POPCRU* 2011 32 ILJ 2629 (LAC).
201 *POPCRU* case 2629.
202 *POPCRU* case 2629.
203 *POPCRU* case para 43.
204 *POPCRU* case para 43.

employees was not an inherent requirement for the job in terms of section 187(2) of the Labour Relations Act.[205]

It was found that the employees were still exemplary officers despite wearing their hair in dreadlocks.[206] No evidence was submitted that the employees were less disciplined and performed poorly in their duties as a result of their hairstyle. Therefore, the discriminatory prohibition on dreadlocks was found to be unfair, disproportionate and overly restrictive.[207] The court held that:

> "[...] refusal to reasonably accommodate diversity and the lack of rationality in its measure aimed at the legitimate purpose of discipline, security and uniformity leads inescapably to the conclusion that the discriminatory prohibition on dreadlocks was unfair, disproportionate and overly restrictive".[208]

The abovementioned case clearly displays the extent of operation of the duty to provide reasonable accommodation,[209] and the decision delivered in this case focusses on ensuring that the duty is not invoked by employers merely to unfairly discriminate against employees. Therefore, the case clearly highlights and reveals how to apply the standard which determines whether the means employed to reasonably accommodate employees are in fact out of proportion with the purpose which they are meant to achieve.

Reasonable accommodation is a non-discriminatory principle in the sense that it ensures that employment equity is upheld in the workplace. Section 15(1) of the Employment Equity Act makes room for the designated employer to implement affirmative action measures in order to ensure that all suitably qualified people from designated groups are represented in all categories of employment in the workplace.[210] However, it is important to take into account that reasonable accommodation is not an affirmative action measure, although it can be used to ensure

---

205 *POPCRU* case para 43.

206 *POPCRU* case para 44.

207 *POPCRU* case 2630.

208 *POPCRU* case para 44-45.

209 See *POPCRU* case at 2630 and the *Standard Bank* case at 358, in which there was a failure on the part of the employer to reasonably accommodate the disabled employee and the conduct of the employer was found to amount to unfair labour practices by the court. This case is discussed extensively later, in this chapter.

210 Section 15(1) of the Employment Equity Act 55 of 1998.

that equity is maintained in the workplace. Reasonable accommodation and affirmative action measures share similar goals such as to ensure that substantive equality is achieved in the workplace, but they are two different concepts which should not be mistakenly construed as one.[211]

Furthermore, section 5 of the Employment Equity Act provides that every employer must take steps to promote equal opportunity in the workplace by eliminating unfair discrimination in any employment policy or practice.[212] Section 15(2)(c) of the Employment Equity Act places a duty on employers to ensure that they provide reasonable accommodation for employees who suffer from disabilities. The aim of such accommodation is to reduce the impact of the impairment on the person's capacity to fulfil the essential functions of their job, and ensure that there is a culture of equity in the workplace.[213] The duty of employers to reasonably accommodate employees emanates from section 9(2) the Constitution, and states that equality entails the full and equal enjoyment of all rights and freedoms by all persons. As such, legislative and other measures designed to protect or advance people or categories of people who are disadvantaged by unfair discrimination, may be implemented with an aim to promote the spirit of equality in the workplace.[214] This is what is referred to as substantive equality, which simply means treating people equally while taking their background into account.

In the Constitutional Court case of *Minister of Finance and Other v Van Heerden*,[215] the court reasoned that substantive equality recognises that besides the uneven race,

---

211 Ngwena *Disabled people and the search for equality in the workplace: An appraisal of equality models from a comparative perspective* 461.

212 Section 5 of the Employment Equity Act 55 of 1998.

213 Section 15(2)(c) of the Employment Equity Act 55 of 1998.

214 Section 9(2) of the Constitution of the Republic of South Africa, 1996. De Vos and Freedman (eds) *South African Constitutional Law in Context* 421 (Oxford University Press, Cape Town 2015), argue that the right to equality can best be described in two ways. Firstly, the right to equality does not entail a guarantee that all people should be treated identically all the time, regardless of their personal attributes or characteristics, social or economic status. The right should therefore be viewed as entailing more than a formal prohibition against discrimination. Secondly, the right to equality must guarantee more than equality before the law and must focus on the effects or impact of legal rules or other differentiating treatment on people. The right to equality cannot therefore focus merely on whether two or more people have been treated in an identical manner by the legal rule or by the company or another individual concerned. One can assert that this two stage inquiry in relation to the meaning of equality is balanced and in line with the principle of substantive equality.

215 *Minister of Finance and Other v Van Heerden*, (CCT 63/03) [2004] ZACC 3, 2004 (6) SA 121 (CC), 2004 (11) BCLR 1125 (CC), [2004] 12 BLLR 1181 (CC) (29 July 2004).

class and gender attributes of our society, there are other levels and forms of social differentiation and systematic privileges which still exist.[216] The role of the Constitution is to enjoin us to dismantle them and to prevent the creation of new patterns of disadvantage. It is therefore important for the courts to scrutinise the complainants' situation in society in each case of equality claims. Furthermore, the courts should make an inquiry into their history and vulnerability, as well as the history, nature and purpose of the discriminatory practice concerned and whether it ameliorates or adds to the disadvantage experienced by a group in real life context, in order to determine its fairness in light of the values of our Constitution.[217] In the assessment of fairness or otherwise, a flexible, but situation-sensitive approach is necessary because of the shifting patterns of harmful discrimination and the stereotypical response in our evolving democratic society. The unfair discrimination enquiry requires several stages, as outlined above.[218]

Therefore, in the context of persons living with cancer as employees, their medical condition must not be isolated in assessing whether or not the employer has discriminated against them because all employees are entitled to equality.[219] Employees living with cancer are also protected by the Employment Equity Act as they may experience long-term or short-term impairment as a consequence of the side effects of the treatment administered to them. At times, cancer treatment, such as chemotherapy may render patients unable to perform their duties effectively, and thus resulting in them being afflicted with a disability in terms of the Employment Equity Act.[220]

The question of whether a disease such as cancer amounts to a disability has not been tested in our courts. However, people who suffer from HIV and AIDS and are thereby rendered unable to work can claim for a disability grant under the Social Assistance Act.[221] One can argue that since cancer has the potential to leave a person

---

216 *Minister of Finance and Other v Van Heerden* case 1181.

217 *Minister of Finance and Other v Van Heerden* case 27.

218 *Minister of Finance and Other v Van Heerden* case 27.

219 Kok A "The promotion of equality and prevention of unfair discrimination act: Why the controversy?" 2001 (2) *TSAR* 294-295.

220 Section 5(1) of the Employment Equity Act 55 of 1998.

221 The Social Assistance Act 13 of 2004, states that people who are living with HIV and AIDS which renders them unable to work are entitled to a disability grant. However, the grant is conditional on the basis that the employee concerned is unable to continue with work and the

with a temporal or permanent disability in the form of a physical and a psychological impairment, then a person living with cancer can end up unable to work and can claim for the grant under the Social Assistance Act as well.[222] Whether cancer or HIV and AIDS amounts to a disability is a question of fact, which will be determined by a court of law, on the basis of the facts of each case as well as on the basis of the effect of the disease on the overall health of the individual. However, only time will tell as to whether health deformities such as cancer will be recognised as disabilities in our law. Nevertheless, it is important to note that in countries like the United Kingdom and America, cancer is recognised as a progressive disease which can render an employee unable to work and thus amount to a disability.[223] In the next chapter concerning the position of both the United Kingdom and America in recognising cancer as a disability, a lot more will be discussed on this issue. For now, it is important to first consider the factors which contribute to the employee living with cancer's inability to perform well in the workplace.

After cancer has emerged, the inability of an employee living with cancer to perform his or her duties is influenced by a number of factors, such as the employee's age, the stage of the cancer at the time of the diagnosis, the financial status and level of education of the patient, the physical demands of the job and the presence of any other health disease in the employee's body.[224] The reason for outlining these factors is that in certain instances, some employees living with cancer can still resume work after treatment and can also seek further employment.[225] However, in the case of physically demanding jobs, the position may be different.[226] Most employees living

---

moment the medical condition of the employee improves through the treatment of ARV's then the disability grant of the employee concerned will terminate.

222 The Social Assistance Act 13 of 2004 states the condition on which a person who suffers from HIV and AIDS can receive a disability grant in circumstances where the HIV renders the person unable to work. The argument raised in this study is that cancer is a chronic disease which can render a person unable to work just like HIV and thus a employee living with cancer whom the cancer has affected adversely can claim for a disability grant.

223 See Section 6(1) of the Equality Act 2010 and section 3 of the American Amended Discrimination Act 2008, an in-depth analysis of these provisions will be extensively discussed later in the chapter.

224 Gabnz PA *Cancer Survivorship Today and Tomorrow* 272 (Springer, New York 2007).

225 Lindbohm ML *et al*, "The impact of education and occupation on the employment status of cancer survivors" 2004 (40) *EJC* 2488.

226 The work activities involved in each case can also be a factor working against the employee if he or she is involved in a job that requires physical labour. See Cancer-Impacts-in-the-Workplace

with cancer who return to work appear to be those who are highly knowledgeable, skilled and well-educated.[227] Some employees living with cancer who don't know their rights regarding fair labour practices usually face very harsh and abusive circumstances, owing to lack of education and experience which is offered in their workplaces.[228] Consequently, a large number of these uneducated employees end up not returning to work, taking early retirement or simply changing jobs.[229]

The issue of reasonable accommodation is relevant to the point of jobs which are physically demanding as well, because reasonable accommodation would obviously be necessary in those kinds of jobs which require extra physical skills and strength. It would be reasonable and justifiable not to put an employee living with cancer in a physically demanding job. When it comes to providing reasonable accommodation on the part of employers, the major problem area is the one consisting of employees living with cancer. [230] Employees living with cancer are usually reluctant to request reasonable accommodation because they are afraid of appearing as different, and also experience feelings of fear about their ability to do work. Additionally, employees living with cancer also fear having to disclose their health status as they anticipate that such disclosure will result in the violation of their right to privacy, as will be discussed below.[231] Some of these difficulties can be attributed to the fact that employees living with cancer tend to avoid being seen as a burden to their employers due to their condition. In this regard, Mary describes these common feelings, which employees living with cancer go through as feelings of guilt. [232] Mary further encourages employees living with cancer to overcome these negative emotions because there is a legal duty that rests on employers to accommodate their needs.[233] This thesis is aimed at emphasizing Mary's view: employees living with cancer do not have to feel

http://www.cancer.org.au/content/pdf/AboutCancer/support/workingwithcancer_sect2.pdf (Date of use: 31 March 2014).

227 Cancer Journey Advisory Group 2012 (4) *CPAC* 45.

228 Doyal and Hoffman 2009 (27) *CME* 459.

229 See Cancer-Net-http://www.cancer.net/coping/relationships-and-cancer/cancer-and-workplace-discrimination (Date of use: 3 February 2014).

230 Sterglou-Kita M *et al*, "The provision of reasonable accommodations following cancer: survivor, provider, and employee perspective" 2015 (26) *J Cancer Surviv* 1-2.

231 Sterglou-Kita *et al*, 2015 (26) *J Cancer Surviv* 2.

232 Sterglou-Kita *et al*, 2015 (26) *J Cancer Surviv* 3.

233 Sterglou-Kita *et al*, 2015 (26) *J Cancer Surviv* 4.

that employers are doing them a favour by providing reasonable accommodation, because in actual fact this is a legal duty which rests on employers.[234]

3.5.1.1 The essentials of the duty of the employer to provide reasonable accommodation in a general context

Having considered the aforementioned realities, the subsequent paragraphs will be dedicated to discussing the main elements of reasonable accommodation in order to grasp an understanding of reasonable accommodation as defined in our law. Furthermore, the focus will slightly shift to highlight the role of knowledge in enforcing the right to have an employer provide reasonable accommodation in the workplace. It is recognised that knowledge is power and is thus essential for all affected parties to understand what is required of them and to what extent they are protected by law. This discussion is aimed at revealing the exact nature and process of reasonable accommodation, especially in its practical, rather than theoretical form.

a) The composition of reasonable accommodation

The question of what precisely constitutes reasonable accommodation on the part of the employer has not been adequately tested in the Labour Courts.[235] However, it is sufficient to say that reasonable accommodation constitutes the act of making existing facilities to be more easily accessible, adapting existing equipment or acquiring new equipment, re-organising workstations, providing specialised supervision, and restructuring work distribution, so that non-essential functions can be redirected to other people.[236] In a nutshell, reasonable accommodation refers to making necessary changes in the workplace, in order to ensure that an employee can perform his or her core employment duties effectively. It ought to be noted that the obligation which rests on the employer to provide reasonable accommodation, is not absolute. This duty need not be fulfilled if it will cause the business of the employer to incur unfavourable effects.[237] This means that the employer will not make reasonable accommodation if

234 Section 15(2)(c) of the Employment Equity Act 55 of 1998.

235 Marumoagae MC "Disability Discrimination and the Right of Disabled Persons to Access the Labour Market" 2012 (15) *PER/PELJ* 350.

236 Marumoagae 2012 (15) *PER/PELJ* 351.

237 Marumoagae 2012 (15) *PER/PELJ* 352.

the provision thereof is found to be contrary to the operational needs or requirements of the company.[238]

In the case of *Kievits Kroon Country Estate v Mmoledi*,[239] the principle of reasonable accommodation was considered. In this case the employee was dismissed from work after taking leave for purposes of training to be a traditional healer.[240] The employee applied for unpaid leave but the employer refused to grant the leave regardless of the employee having submitted all the necessary documents of her initiation, in support of her leave application.[241] Upon returning to work, the employee was subjected to a disciplinary hearing and she was dismissed for misconduct on the basis that she acted unlawfully by absconding from work without the approval of the employer.[242] The employee took the matter to the CCMA, where the commissioner found the conduct of the employer to be unlawful, due to the fact that he did not exercise empathy and understanding to the cultural background of the employee. Therefore, the employer's refusal to grant the employee unpaid leave amounted to failure to provide reasonable accommodation.[243] On review, the Labour Court found that the decision of the commissioner, in favour of the employee was reasonable and dismissed the review application that was initiated by the employer.[244] The matter was taken on appeal to the Labour Appeal Court. The court held that both parties were required to be realistic to each other in order to ensure harmony in the employer–employee relationship, and to achieve a united society.[245] Accommodating one another is nothing other than asserting the spirit of "Ubuntu", which is part of the heritage of our society, and ought to be upheld in all relationships. Accordingly, the appeal was dismissed with costs.[246]

According to the approach adopted by the Labour Appeal Court, employers ought to appreciate the kind of society in which we live. Seeing that there is a rapid increase in

238 In terms of the inherent requirements of the job or the operational needs of the business the employer can dismiss the employee on this ground and will not be viewed as unfair dismissal in terms of the Labour Relations Act 66 of 1995.

239 *Kievits Kroon Country Estate (Pty) Ltd v Mmoledi* 2012 11 BLLR 1099 (LAC).

240 *Kievits Kroon* case 1099.

241 *Kievits Kroon* case para 13.

242 *Kievits Kroon* case para 14.

243 *Kievits Kroon* case 10100.

244 *Kievits Kroon* case 10100.

245 *Kievits Kroon* case 10101.

246 *Kievits Kroon* case 10101.

the number of persons living with cancer, it is vital for employers to pay attention to this reality and for employees to also understand that employers are only obliged to do what they reasonably can to accommodate them. In the case illustration above, it is clear that the court ruled in favour of the employee because the employer failed to reasonably accommodate the cultural beliefs of the particular employee. In the context of an employee living with cancer, the courts are likely to find that an employer would be acting unreasonably if he or she were to fail in recognising that a particular employee living with cancer requires extended leave for purposes of obtaining therapy and treatment.

The aspect of reasonable accommodation was best summed up in the case of *Ontario Public Services Employees Union v Ontario (Ontario Human Rights Commission)*,[247] in which it was held that the most appropriate reasonable accommodation is one that definitely respects the dignity of the individual with a disability, one that meets the individual's needs, one that best promotes the integration and full participation of the individual concerned and ensures that confidentiality is well-maintained throughout.[248] Therefore, by accommodating an employee in this way, the right to equality and human dignity are effectively restored and upheld by the employer.[249] As this study is steered at ensuring that employees living with cancer neither lose their right to enter into any form of occupation nor have their human dignity violated in the process, this mission will require what is termed appropriate accommodation as described in the *Ontario* case above.[250] The principle that is derived from this case dictates that knowledge, understanding of cancer is important in order to ensure that equity, and human dignity is restored in the workplace, as protected by the Constitution.[251] In addition, employees also need to have knowledge and understand the contents of

---

247 *Ontario Public Services Employees Union v Ontario (Ontario Human Rights Commission*) 2015 ONCA 495. In this case, an employee experienced unfair discrimination in the workplace. She was discriminated against on the basis of gender where she was working as a cook in the prison facility concerned. The conduct of the employer was found to be unfair on the basis that it discriminated unjustly on the applicant just because she is a female and was treated differently from other male colleagues in the organisation.

248 *Ontario Public Services Employees Union* case 495.

249 *Ontario Public Services Employees Union* case 496.

250 *Ontario Public Services Employees Union* case 496.

251 The Constitution of the Republic of South Africa,1996 protects the right to human dignity in terms of section 10, and the right to enter into trade or occupation is protected in terms of section 23 thereof. See also *Ontario Public Services Employees Union* case 497.

their right to be reasonably accommodated by the employer, as this forms a constituent part of ensuring that their rights are effectively enforced.

b) The role of knowledge regarding workplace accommodation

First and foremost, knowledge regarding workplace accommodation is crucial to kick-start the whole process. This entails the employee knowing about his or her right to request reasonable accommodation, and the employer understanding his or her corresponding duty to provide for such accommodation.[252] Having both parties being knowledgeable on this issue can ensure that the employee is successfully re-integrated in the workplace, as it would establish understanding and open communication between the parties.[253]

c) The employer's ability to provide reasonable accommodation

Part of the process of enforcing the employee's right to be reasonably accommodated requires that an affected employee has to establish whether the employer has the ability to provide such reasonable accommodation. The employee will first have to request the provision of reasonable accommodation in order to initiate the necessary communication between the parties, and thereafter will be able to establish whether his or her request can be met.[254] In return, this process will allow for an understanding between the parties, and for the employer to assess his or her position with regards to providing reasonable accommodation without incurring any form of undue hardships. The reasonable accommodation to be provided should be beneficial for both the employer and the employee,[255] thus, to facilitate this mutual benefit, the two parties ought to negotiate their approach to the matter and finally agree on the way forward.

d) Negotiation of reasonable accommodation

Therefore, an important factor to be taken into account is the negotiation of reasonable accommodation. This entails that the employer and the employee living with cancer ought to enter into a form of a negotiation regarding their respective needs in order to reach a mutual understanding on how to best address their respective needs, and

252 Fesko SL "Working it out: Workplace Experiences of Individuals with HIV and Cancer" 1999 (5) *ERIC* 4.

253 Fesko 1999 (5) *ERIC* 4-5.

254 Fesko 1999 (5) *ERIC* 6.

255 Shaw WS and Feuerstein M, "Generating workplace accommodations: lessons learned from the integrated case management study" 2004 (3) *J Occup Rehabil* 16.

finally agree on a reasonable accommodation plan which benefits both of them.[256] Smaller companies and those companies that are struggling to stay financially afloat tend to have difficulties providing reasonable accommodation for employees living with cancer, hence the proposed process of negotiation between the parties is important.[257] This may be classified as a give and take process as it is not aimed at unduly benefitting one party at the expense of the other. Ultimately, the process is designed to ensure that equity is maintained by allowing both the employer and the employee living with cancer to receive a benefit out of the facilitation of reasonable accommodation.

3.5.1.2 Reasonable accommodation in the context of employees living with cancer

In the context of cancer, reasonable accommodation entails a four-staged inquiry in order to ensure that the employee living with cancer is fully re-integrated into the workplace. The aforementioned elements which form part of the concept of reasonable accommodation remain relevant in the case of employees living with cancer. However, the following elements are specifically applicable in the process of reasonably accommodating an employee living with cancer.

a) Gradual return to work and flexibility

Firstly, an employee living with cancer returns to work gradually and thus requires that there be flexibility in re-integrating him or her into the workplace for the reason that he or she has been away from work for a while.[258] Progressive re-integration consists of allowing the employee living with cancer to do less hours of work and facilitating flexibility, such as allowing him or her to take work home where possible. This will assist with building both the physical and mental strength of the employee living with cancer and in turn will be beneficial to his or her health.[259] During the process of re-integrating the employee living with cancer in the workplace, his or her right to privacy must also not be compromised, as the employer must allow for the employee living with cancer to take medication in a private area.[260] This will boost the self-confidence

256 Shaw and Feuerstein, 2004 (3) *J Occup Rehabil* 17.

257 Gabnz *Cancer Survivorship: Today and Tomorrow* 21-22.

258 Kennedy F, "Returning to work following cancer: a qualitative explanatory study into the experience of returning to work following cancer" 2007 (16) *Europ J Cancer Care* 17.

259 Kennedy 2007 (16) *Europ J Cancer Care* 18.

260 Kennedy 2007 (16) *Europ J Cancer Care* 18.

of the employee and facilitate a speedy recovery. Furthermore, this may help in avoiding the situation where the employee has to take medication in front of his or her colleagues, who may possibly make the employee living with cancer feel inferior by having to answer multiple questions about his or her health condition.[261]

b) Modifications of work and performance expectations

Secondly, the duty of the employer to modify the work and performance expectations placed on the employee requires the elimination of some duties which the employee living with cancer used to previously carry out.[262] While accordingly modifying the work and duties of the employee, it must be kept in mind that the employee is still recovering and possibly undergoing treatment, and thus the expectation level of the employer must be reasonable enough to accept that work which previously used to be completed in an hour could now probably be done in one hour and thirty minutes instead.[263]

c) Retraining the employee living with cancer

Thirdly, the employer has a duty to train the employee living with cancer again upon his or her return to work. It is important to note that training the employee living with cancer upon his or her return does not constitute demotion as a cause for an unfair labour practice claim.[264] In this context, the purpose of training the employee once again has to do with assisting the employee to do his or her work, with the assistance of a mentor or fellow colleague.[265] The duty to train the employee all over again is normally dependent on the duration of the period in which the employee living with cancer has been away from work. The longer the employee living with cancer has been away from work, the more likely he or she will require training. Employees have greatly embraced this duty of making sure that they are re-integrated to the workplace effectively.[266]

d) Modification to the physical workplace environment

---

261 Kennedy 2007 (16) *Europ J Cancer Care* 18.

262 Kennedy 2007 (16) *Europ J Cancer Care* 18-19.

263 Kennedy 2007 (16) *Europ J Cancer Care* 20.

264 Refer to Mehnert A, "Employment and work-related issues in cancer survivors" 2011 (77) *Crit Rev Oncol Hematol* 109 and Kennedy 2007 (16) *Europ J Cancer Care* 20.

265 Kennedy 2007 (16) *Europ J Cancer Care* 21.

266 Kennedy 2007 (16) *Europ J Cancer Care* 21.

Modifying the physical workplace environment and providing adaptive aids and technologies for employees living with cancer is a duty that entails removing any obstacle which might prevent the employee living with cancer from doing his or her job, as well as providing the relevant employee with a conducive working station in the process.[267] For example, if the work of an employee who suffers from a physical deformity requires moving up and down the stairs, then the employer can recommend that he or she should use a lift or should be stationed where he or she does not need to move up and down when conducting his or her duties. This will amount to reasonable accommodation. In as far as the physical features of the company are concerned in the context of employees living with cancer, reasonable accommodation includes various things, such as the modification of the office temperature, a change of working shifts to accommodate the employee's medical check-up routine, permission to work from home, and the permission to call doctors in the instance where the general policy of the employer prohibits the use of the company's telephone for personal reasons.[268]

3.6 Discrimination in the workplace

Discrimination is often classified as differentiation, because it refers to treating employees differently by unjustifiably including some and unjustifiably excluding others from the activities and processes which take place in the workplace. For example, in the process of promotion, discrimination will take the form of unduly preferring certain employees over other employees who are in the same league of competence and hold the same qualifications.[269] It is important to note that there are different reasons why the employer may apply differentiation between employees, this includes qualifications, experience, seniority and operational requirements of the company. [270] Differentiation does not necessarily amount to discrimination but differentiation will become discrimination in cases were the differentiation is based on

267 Kennedy 2007 (16) *Europ J Cancer Care* 22.

268 Kennedy 2007 (16) *Europ J Cancer Care* 22.

269 Basson AC *et al*, *Essential Labour Law Fifth Edition* 217 (Labour Law Publications, Pretoria 2009).

270 Basson *et al, Essential Labour Law Fifth Edition* 217.

unacceptable standards as outlined in terms of section 6(1) of the Employment Equity Act.[271]

3.6.1 Unfair discrimination on the basis of disability

For purposes of this discussion, it is important to describe what constitutes unfair discrimination in the workplace. Section 6(1) of the Employment Equity Act states that no person may unfairly discriminate either directly or indirectly, against an employee in any employment policy or practice, on one or more grounds including race, gender, sex, pregnancy, marital status, family responsibility, ethnic or social origin, colour, sexual orientation, age, disability, religion, HIV status, conscience, belief, political opinion, culture, language or birth. Cancer is not one of the listed grounds of discrimination in terms of section 6(1) of the Employment Equity Act, however it can be argued that disability as a listed ground includes cancer because the latter has the ability to render an employee temporarily or permanently disabled, owing to its aggressive nature. Disability can be defined as different functional limitations that occur in any group of people and in any country across the globe, and can be in the form of intellectual impairments, physical impairments, sensory impairments, medical conditions and mental illnesses, all of which can be temporary or permanent in nature.[272]

3.6.1.1 The extent and meaning of the concept of disability

Furthermore, when dealing with the concept of disability, it is important to note that there are two schools of thought which deal with bringing a comprehensive understanding to disability. According to these schools of thought, there is a medical model and a social model of disability. The medical model of disability places emphasis on the medical condition or impairment of the person with a disability.[273] For example, in the context of an employee living with cancer, the medical model focusses

---

271 Section 6(1) of the Employment Equity Act 55 of 1998. See *HOSPERSA obo Venter v SA Nursing Council* (2006) 6 BLLR 558 (LC). In applying Article 1 of the International Labour Organisation Convention (No 111), the court held that for purposes of section 6(1) of the Employment Equity Act, discrimination should be interpreted as any distinction, exclusion or preference which has the effect of nullifying or impairing equality of treatment in employment or occupation.

272 Article 17 of the UN Standard Rules on the Equalization of Opportunities for Persons with Disabilities Adopted by UN General Assembly Resolution 48/96 of 20 December 1993.

273 Olivier MP and Smit N "Disability" in Joubert WA (ed) LAWSA 13(2) *Labour Law and Social Security Law* 230 (Durban, Butterworths 2002).

on the employee instead of focussing on the ability of the employee to do work. For this reason, the medical model of disability is criticised because it personalises disability and makes it the problem of the individual concerned, which can be solved through cure or treatment of that disability.[274] The social model of disability is based on the notion that the adverse circumstances which people with disabilities experience and the unfair discrimination which they are subjected to daily, do not emanate from their disability or impairment but emanates from society.[275] In terms of this school of thought, society is characterised as being unable to accommodate people with disabilities, and disability is not seen as an inability which takes away the affected person's ability to do work.[276]

The social model of disability is also known as the human rights model of disability, because it centralises the person with a disability and his or her human dignity as enshrined in the Constitution without any focus on the impairment.[277] The social model of disability is in line with substantive equality and this has been affirmed by Ngwena, who argues that no country follows the social model of disability in its purest form, but both the medical and social model of disability are required when disability is interpreted for a better understanding.[278] This view is correct because cancer can be construed in line with both the medical and social model of disability. The challenges which employees living with cancer experience in the hands of employers who view cancer as only a problem of the employee concerned, takes the form of a medical model of disability, whereas the myths and the stigma maintained by society about cancer which result in the discrimination of employees living with cancer, is in line with the social model of disability.

---

274 Olivier and Smit "Disability" in Joubert WA (ed) *LAWSA* 13(2) *Labour Law and Social Security Law* 230-231.

275 Chapter 1 of the White Paper on Integrated National Disability Strategy: The Social Model of Disability 1-2 1997.

276 Chapter 1 of the White Paper on Integrated National Disability Strategy: The Social Model of Disability 1-2 1997.

277 Section 10 of the Constitution of the Republic of South Africa, 1996. See Wookman S, Roux T and Bishop M *Constitutional Law of South Africa: Student Edition* 35-8 (Juta Publishers, Cape Town 2007).

278 Ngwena C "Interpreting Aspects of the Intersection between Disability, Discrimination and Equality: Lessons for the Employment Equity Act from Comparative Law. Part I (Defining Disability)" 2005 (16)2 *Stellenbosch Law Review* 211.

Persons who suffer from unfair discrimination on grounds other than the ones listed in terms of the Employment Equity Act, must first of all convince the court that the unlisted ground on which they claim to be discriminated against affects them adversely or may potentially affect them in an adverse manner. Once the court is satisfied with this view then the affected employee will have to prove the alleged unfair discrimination on the basis of the unlisted ground.[279] With regard to people who suffer from a progressive or recurring condition such as cancer, we follow the medical model and not the social model of disability. Ngwena argues that the non-recognition of progressive conditions such as cancer, which can leave a person with a temporary or permanent disability, makes a person vulnerable to discrimination in both society and in the workplace.[280]

In South Africa a great deal of focus is only directed towards people with actual disabilities, leaving out a large number of people who suffer from progressive conditions such as cancer. This is contrary to the current position in countries like the United Kingdom, where cancer is recognised as a progressive condition, which constitutes a disability, but more on the English approach to this topic will be discussed in the following chapter. This is in line with the argument raised by Ngwena and Pretorius, that disability must be interpreted in a generous manner, without imposing the substantial limitation requirement on people with disabilities, which tends to exclude those people who suffer from progressive conditions such as cancer.[281] Substantial limitation has caused many people with disabilities to suffer unfair discrimination as imposed by employers and fellow employees. Therefore, their suffering is not experienced as a consequence of their disabilities being substantially limiting in themselves, but they suffer because of the approach which people adopt in their engagements towards people who have disabilities.[282] This is the common trend when it comes to the discrimination of employees living with cancer, because most of

---

279 Section 6(1) of the Employment Equity Act 55 of 1998, prohibits unfair discrimination on the basis of race, sex, disability, religion, HIV status, culture and language in the employment context.

280 Ngwena 2005 (16)2 *Stellenbosch Law Review* 230.

281 Ngwena C and Pretorius L "Conceiving Disability, and Applying the Constitutional Test for Fairness and Disability: A Commentary on *IMATU v City of Cape Town*" 2007 (28) *Industrial Law Journal* 747.

282 Ngwena and Pretorius 2007 (28) *Industrial Law Journal* 747-748.

them are discriminated against unfairly in the workplace, not because they are unable to work but merely because they have cancer.

3.6.1.2 Examples of case law regarding unfair discrimination

In South African law, employees who suffer discrimination on the basis of an unlisted ground such as cancer, carry a heavy burden in succeeding with their claim, because they first have to prove that they will objectively be adversely affected by the unlisted ground before moving on to prove that discrimination took place on the part of the employer.[283] A number of case decisions are relevant in this discussion.

3.6.1.2.1 Harksen v Lane No and Others 1997 (11) BCLR 1489 (CC)

In *Harksen v Lane No*,[284] the court held that the crux of an unspecified ground of discrimination must be comparable to the specified grounds. In other words, the particular ground ought to also relate to personal attributes or characteristics which, if used as a basis for discrimination, could impair the fundamental human dignity of persons or adversely affect them in a comparable serious manner.[285] This case involved the provisions of the Insurance Act, which were found to be discriminating against spouses who were solvent and married out of community of property to the insolvent spouse. This was because the solvent spouses' estate would be taken into account, when the sequestration of the estate of the insolvent spouse was taking place, and this was found to be contrary to the provisions of the Bill of Rights and not in the interest of the administration of justice.[286]

3.6.1.2.2 Hoffmann v South African Airways [2000] 12 BLLR 1365 (CC)

Another case of interest in South African law which deals with unfair discrimination in the workplace is the landmark case of *Hoffmann v South African Airways*.[287] In this case the applicant was living with HIV and applied for the position of a cabin attendant

---

283 Basson *et al, Essential Labour Law Fifth Edition* 217, Section 6(1) of the Employment Equity Act 55 of 1998.

284 *Harksen v Lane NO and Others* (CCT9/97) [1997] ZACC 12, 1997 (11) BCLR 1489, 1998 (1) SA 300 (7 October 1997). See also *NUMSA and Others v Gabriel (Pty) Ltd* (2002) 23 ILJ 2088 (LC) in which it was held that when an employee claims unfair discrimination on an unlisted ground (arbitrary ground), the employee must show that the discrimination impacted on their human dignity.

285 *Harksen* case 1489.

286 *Harksen* case 1490.

287 *Hoffmann v South African Airways* (CCT 19/00) [2000] ZACC 17, 2001 (1) SA 1, 2000 (11) BCLR 1235, [2000] 12 BLLR 1365 (CC) (28 September 2000).

at South African Airways (SAA).[288] The applicant went through all the stages of the interview and was one of the successful applicants for the job in question.[289] The problem only arose when the applicant had to undergo pre-employment medical examination and blood tests, where it was discovered that the applicant had HIV and resulted in the company refusing to employ the applicant.[290]

The company argued that it was not possible to employ a candidate with an HIV status that was positive. This was because the nature of the job required an individual who was healthy, and who would not contract any communicable disease, which would possibly put the lives of other colleagues and airline passengers in danger.[291] Furthermore, the company argued that it was not only in the best interests of the company to reject the applicant, but also in the best interest of its passengers to do so.[292] On several occasions, the applicant approached the High Court to challenge the constitutionality of the decision of the company, which resulted in him being granted leave to appeal to the Constitutional Court. The plaintiff based his claim on the violation of his right to human dignity, equality and freedom, as well as the right not to be unfairly discriminated against on the basis of race, gender, religion, HIV status, family or marital status.[293]

Judge Ngcobo was of the view that persons who live with HIV are often marginalised and unfairly discriminated against in society, due to the stigma that is attached to the disease. These people are vulnerable in our society because when it comes to matters of employment, attention is unduly given to their HIV status, instead of being directed at their abilities and level of education.[294] Ngcobo J further explained that the duty is upon the courts and all the various state organs to ensure that people living with HIV and AIDS are fully protected from any form of discrimination and abuse. South African Airways as an organ of state is compelled and bound by the Constitution and thus it must uphold the values of the Constitution, which includes the prohibition of unfair

288 *Hoffmann* case 1365.
289 *Hoffmann* case 1365.
290 *Hoffmann* case 1366.
291 *Hoffmann* case 1367.
292 *Hoffmann* case 1368.
293 *Hoffmann* case 1369.
294 *Hoffmann* case 1370.

discrimination against any person.[295] It was on the basis of this reasoning that the court came to the decision that South African Airways unfairly discriminated against the applicant on the basis of his HIV status, and ordered South African Airways to employ the applicant as he was appropriately qualified and competent to do the work in question.

3.6.1.2.3 Standard Bank of South Africa v Commission for Conciliation, Mediation and Arbitration and Others [2008] 4 BLLR 356 (LC)

Another example in this regard is the case of *Standard Bank of South Africa v Commission for Conciliation, Mediation and Arbitration and Other*.[296] Ms Ferreira, an employee of Standard Bank, worked as a loan consultant for a period of 17 years.[297] Her job entailed using the company car to travel and to meet with clients.[298] On 2 February 2002 she was involved in a car accident while on duty, and she sustained serious back injuries which later developed into fibromyalgia, a disorder that causes pain and fatigue.[299] As a result of her condition, the employee was moved from being a consultant, to the position of a receptionist, and then later to data capturing and finally ended up shredding papers, which was work that was done by the cleaning personnel of the company.[300] Owing to the demotion she experienced after the accident, she was demotivated and unhappy in her job and thus wanted to resign from the company. Furthermore, she was not provided with all the necessary assistance she required, since her request for the provision of headsets and a computer in order for her to work effectively was not met by management.[301] The company rejected her application for resignation, because the company doctor was of the view that she could fully recover and was still capable of working.[302]

---

295 *Hoffmann* case 1371.

296 *Standard Bank of South Africa v Commission for Conciliation, Mediation and Arbitration and Others* (JR 662/06) [2007] ZALC 98, [2008] 4 BLLR 356 (LC) (25 December 2007).

297 *Standard Bank of South Africa* case 357.

298 *Standard Bank of South Africa* case 357.

299 *Standard Bank of South Africa* case 358.

300 *Standard Bank of South Africa* case 359.

301 *Standard Bank of South Africa* case 360.

302 *Standard Bank of South Africa* case 360.

The employee was later called in by management and directed to resume her old post of a loan consultant. She was happy and appreciated that the company realised her commitment to the company, but her excitement was short-lived as she was dismissed in two months' time after being granted the post.[303] The employer justified this dismissal on the basis that she was not appropriately competent as she wanted most of the time off in order to receive medical treatment.[304] The CCMA ruled in favour of the employee and held that the company discriminated against her on the basis of her disability and failed to reasonably accommodate her so that she can be in a position to carry out her duties effectively.[305] This decision was also affirmed by the Labour Court. [306]

In view of the abovementioned court decisions, one may argue that the courts recognise the broad meaning of the concept of disability on the basis of the facts of each case. For purposes of this study, one may possibly rely on the decision of the judge in the *Hoffmann* case, among others, to support the enforcement of the right of equality in the instances of employees living with cancer.[307] There is nothing preventing a person who is diagnosed with cancer from bringing matters of unfair discrimination based on their condition before the courts. Depending on the facts of the case, their claim may succeed, but the plaintiff will have to prove to the court that an unlisted ground of discrimination such as cancer, objectively has the characteristics to impair his or her fundamental human dignity, and affects him or her adversely by excluding him or her from taking part in employment and exercising their right to freedom of profession and occupation.[308] However, taking into account the fact that litigation is an expensive and time-consuming exercise, it must be emphasized that the law ought to readily and directly serve as protection for the rights of persons living with cancer.

303 *Standard Bank of South Africa* case 361.
304 *Standard Bank of South Africa* case 362.
305 *Standard Bank of South Africa* case 371.
306 *Standard Bank of South Africa* case 372.
307 *Hoffmann* case 1371.
308 Basson *et al*, *Essential Labour Law Fifth Edition* 151.

3.6.1.3 The statutory meaning and scope of unfair discrimination

There lies a duty upon the government to ensure that legislation is developed in such a way that can accommodate employees living with cancer from unfair discrimination. Currently, cancer is not one of the listed grounds of unfair discrimination in terms of the definition provided in the Employment Equity Act.[309] A generic approach ought to be established to recognise chronic diseases which have the ability to render a person incapable of working for either a temporary or long-term period. Such an approach will assist in eliminating the problem of lack of recognition of certain diseases under the listed grounds for discrimination and thus expand the protection measures which are in place for employees living with cancer and others facing similar challenges. It is important to emphasize that there is a need to amend section 6(1) of the Employment Equity Act to include disabilities inflicted by ill health as a listed ground of discrimination, instead of recognising only one disease therein.

It is interesting to note that HIV and AIDS is one of the listed grounds of unfair discrimination which are prohibited in terms of the Employment Equity Act.[310] This is attributed to the fact that HIV and AIDS is a widespread disease.[311] One can argue that the inclusion of HIV and AIDS in the statutory provision of the Employment Equity Act is because of the greater awareness and education invested into teaching people about the disease.[312] There is more knowledge and understanding on the part of employers and the broader society about the disease, though unfortunately, this is not the case when it comes to cancer.[313] Despite the high mortality rate caused by HIV and AIDS, the survivors of this disease or its victims often experience some kind of

---

309 Section 6(1) of the Employment Equity Act 55 of 1998 prohibits unfair discrimination of employees who suffer from any form of disability including cancer in the workplace on the part of the employer.

310 In terms of Section 6(1) of the Employment Equity Act 55 of 1998, it states that no person my unfairly discriminate, directly or indirectly, against any employee in any employment policy or practice, on one or more grounds including race, sex, gender, pregnancy, marital status, family responsibility, ethnic or social origin, colour, sexual orientation, age, disability, religion, HIV status, conscious, belief, political opinion, culture, language and birth.

311 HIV and AIDS is one of the diseases which claim millions of lives of people especially in the developing parts of the world such as Africa. The unfair discrimination of an employee constitutes unfair labour practices in terms of Section 186(2) of the Labour Relations Act.

312 Ambasa-Shisanya CR *Cultural Determinants of Adoption of HIV and AIDS Prevention Measures and Strategies among Girls and Women in Western Kenya* 2-3 (Ethiopian Publishers, Addis Ababa 2009).

313 See Cancer Net http://www.cancer.net/coping/relationships-and-cancer/cancer-and-workplace-discrimination (Date of use: 3 February 2014).

abuse and unfair discrimination and this is attributed to the stigma which society attaches to the disease.[314] The same view can apply to persons living with cancer, who also suffer from socio-economic hardships due to the myth and ignorance surrounding cancer. Some of these myths include that cancer is contagious and that the people who have cancer are unable to work.[315]

Having listed the grounds for unfair discrimination, the Employment Equity Act goes further to define unfair discrimination and to exclude certain specified conduct from the scope of unfair discrimination. In terms of section 6(2) of the Employment Equity Act, it would not amount to unfair discrimination on the part of the employer to take affirmative action measures consistent with the purpose of this Act and, to distinguish, exclude or prefer any person on the basis of an inherent requirement of a job.[316] Unfair discrimination may take two forms, direct and indirect discrimination.[317] The following paragraphs will be dedicated to discussing the contents of direct and indirect discrimination. This discussion will consist of an analysis of these two concepts as illustrated in case law, legislation and the opinions of various authors.

3.6.2 Direct discrimination

3.6.2.1 A theoretical view of direct discrimination

Direct discrimination is relatively easy to recognise and occurs where a differentiation or distinction between employees is clearly and expressly based on one or more of the prohibited grounds of discrimination listed in section 6(1) of the Employment Equity Act.[318] Direct discrimination occurs when people are differentiated because they

---

314 Page J, Louw M and Pakkiri D *Working with HIV and AIDS* 118 (Juta Publishers Cape Town 2006).

315 Farley SP *et al*, "Work disability associated with cancer survivorship and other chronic conditions" 2008 (17) *Psycho-Oncology* 91-92.

316 Section 6(2) of the Employment Equity Act 55 of 1998 champions for affirmative action measures in order to redress disadvantaged people from designated groups in order to ensure that they are represented in the employment context. This includes, black people, women and disabled individuals.

317 Martin LL *et al*, *Lessons from the black working class* 151-152 (Library Congress Publishing, California 2015). See *Harmse v City of Cape Town* (2003) 6 BLLR 557 (LC) 16-18, in which the court held that a distinction between direct and indirect discrimination is not so fundamental that it is not possible for the respondent to reply meaningfully to a claim without knowing whether a claim of direct or indirect discrimination is being relied on. Waglay J found that failure by an applicant to specify whether discrimination is direct or indirect does not render a claim expiable.

318 Martin *et al*, *Lessons from the black working class* 153.

possess particular characteristics which are disvalued by others. For example where an employer clearly treats a woman less favourably than a man in the same position simply because the employee is a woman, or where the employer selects employees with disabilities for purposes of retrenchment.[319] Direct discrimination on the part of the employer can also occur where the employer treats an employee with a disability less favourably than someone without a disability in the same or similar circumstances. For example, denying a person a job or a promotion merely because they have cancer or have a history thereof.[320] This conduct constitutes direct discrimination and can further be challenged as an unfair labour practice as discussed earlier in this chapter.[321] The discussion will now shift to focus on enquiring why employers tend to discriminate against employees living with cancer.

Barofsky argues that employers discriminate against employees living with cancer because they seek to avoid making contact with members of an undesirable group, in this case employees living with cancer, and even do so at the risk of losing money through litigation and legal sanctions.[322] Fobair and Hays attest that discrimination perpetuated by an employer towards employees living with cancer is typically self-imposed discrimination, which is associated with passive coping skills, negative self-esteem, poor body image, decreased energy and depression on the part of the employee living with cancer.[323] Skipper argues that most employers discriminate against employees living with cancer in different ways, including denying them employment benefits such as promotion or providing them with reasonable accommodation. In other circumstances employers even refuse to employ persons living with cancer, because they regard this as a burden to them and the company at large.[324] Skipper points out that such discrimination can be attributed to the myths and false notions which employers have about cancer, as cancer is steeped in myth and

---

319 Basson *et al, Essential Labour Law Fifth Edition* 218, Steenkamp A *et al*, *Labour Relations Law: A Comprehensive Guide* 651 (LexisNexis, Durban 2011).

320 McKeena MA *et al*, "Workplace discrimination and cancer" 2007 (29) *Work* 313.

321 Section 186(2) of the Labour Relations Act 66 of 1995 is very instrumental in outlining as to what constitutes unfair labour practices on the part of the employer as outlined above.

322 Barofsky I, *Work and illness: the persons living with cancer* 22 (Praeger Press, New York 1989).

323 Hays DM, "Adult survivors of childhood cancer" 1993 (10) *Cancer Supplement* 3306.

324 Skipper PL *et al*, "Cancer survivors at work: Job problems and illegal discrimination" 1989 (16) *Oncology Nursing Forum* 41.

is considered a contagious disease.[325] All of this highlights the extreme erroneous misunderstanding of cancer which calls for a better understanding and awareness of cancer.[326] A common thread runs through the different views which the authors express as the reasons why employers discriminate against employees living with cancer, and that is general ignorance towards the disease which emanates from the stigma attached to this disease since ancient times. The issue of discrimination and employers' ignorance has been further evaluated in the cases below, although discrimination in the following cases was on the basis of other factors such as sex and age.

3.6.2.1.1 Association of Professional Teachers & Another v Minister of Education & Others (1995) 16 ILJ 1048 (LC).

In *Association of Professional Teachers & Another v Minister of Education & Others*,[327] a female teacher was denied a housing subsidy by the Department of Education. The decision of the Department was based on the policy that was in place which provided that female teachers were not entitled to a housing subsidy, except in cases where their spouses were permanently and medically unfit to partake in employment.[328] The applicant teacher challenged this policy on the basis that it was directly discriminating against her on the basis of sex.[329] In this case the Industrial Court was of the view that such exclusion of female teachers from the housing subsidy was based on sex and marital status and it was totally irrelevant for the subsistence of the employer-employee relationship.[330] The court found that the exclusion of female teachers in the housing subsidy amounted to direct unfair discrimination.[331]

3.6.2.1.2 Swart v Mr. Video (Pty) Ltd (1998) 19 ILJ 304 (LC)

The issue of direct discrimination was dealt with in the case of *Swart v Mr Video*.[332] In this case, unfair discrimination was based on the age of a person. The employer in

---

325 Skipper *et al*, 1989 (16) *Oncology Nursing Forum* 41.

326 Skipper *et al*, 1989 (16) *Oncology Nursing Forum* 41.

327 *Association of Professional Teachers & Another v Minister of Education & Others* (1995) 16 ILJ 1048 (LC).

328 *Association of Professional Teachers* case 1048.

329 *Association of Professional Teachers* case 1049.

330 *Association of Professional Teachers* case 1049.

331 *Association of Professional Teachers* case 1050.

332 *Swart v Mr Video* (Pty) Ltd (1998) 19 ILJ 304 (LC).

this case was an owner of a chain of video stores who was in the process of opening a new store in Pretoria.[333] The employer advertised that a new assistant who was 25 years old or younger was required. The applicant who was twenty-eight years old called the employer and indicated her interest in the job and filled in some forms in the process. She went for the interview with her friend and the employer took her friend for the job instead, because she was 25 years old.[334] The employer argued that the applicant was not fit for the job as she was older and would not take instructions from younger colleagues.[335]

On conciliation the argument of the employer was rejected and the conduct of the employer was viewed as direct discrimination on the basis of gender and age of the applicant.[336] There was no evidence indicating that the applicant would not comply with lawful instructions from colleagues, and the inherent requirements of the job did not in actual fact call for an age restriction to be placed on potential employees.[337] The employer was ordered to give the advertised position to the applicant due to the unfair discrimination endured by the applicant in the hands of the employer.

3.6.3 Indirect discrimination

3.6.3.1 A theoretical view of indirect discrimination

Indirect discrimination is differentiation resulting from a measure that has discriminatory effects without explicitly differentiating between people, and thus revealing itself in the formulation of operational measures.[338] For example, indirect discrimination occurs where a policy is implemented in such a way that it creates an imbalance of treatment or benefits that are issued within a particular group.[339] Knowles and Prewit provide an ideal definition of this concept. They state that indirect discrimination refers to the behaviour that has become so well institutionalised, in that the individual or employee generally does not have to exercise choices to operate in a discriminatory nature.[340] The rules and procedures of a large organisation or

---

333 *Swart* case 304.

334 *Swart* case 305.

335 *Swart* case 306.

336 *Swart* case 306.

337 *Swart* case 307.

338 Rautenbach IM & Malherbe EFJ *Constitutional Law* 359 (LexisNexis, Durban 2009).

339 Van Reenen TP "Equality, Discrimination and Affirmative Action: An Analysis of section 9 of the Constitution of the Republic of South Africa" 1997 (12) *SA Public Law* 159.

340 Knowles LL and Prewitt KP *Institutional and Ideological Roots of Racism: In A. Aguirre Sources:*

workplace have already restructured the choice.[341] The individual employee only has to conform to the operating norms or rules of the organisation or workplace and the institution will impose the discrimination.[342]

From the above definition it is clear that indirect discrimination or institutionalised discrimination as it is often called, means that the particular organisation or workplace promotes or champions values, structures and processes that deny equal opportunities to a certain group of employees and employees living with cancer in particular.[343] In this instance discrimination will not arise from a single individual but will be seen as a pervasive process across the organisation in excluding people from a certain group. Indirect discrimination simply refers to a process which may seem to be objective or neutral, but which in fact aims to place barriers on a particular group of people so as to exclude them.[344] Examples are to exclude people from employment based on height or weight, and in this case, employees living with cancer on the basis of their illness.[345] Indirect discrimination may be two-fold in the sense that it may refer to intentional or unintentional conduct on the part of the employer as outlined above.[346]

3.6.3.1.1 Leonard Dingler Employee Representative Council v Leonard Dingler (Pty) Ltd (1998) 19 ILJ 285 (LC)

The case which serves as authority when it comes to indirect discrimination is that of *Leonard Dingler Employee Representative Council v Leonard Dingler*.[347] This case involved indirect discrimination on the part of the employer against a particular group of employees.[348] This case centred on the issue of three retirement benefits offered

Notable Selections in Race and Ethnicity 2nd Ed 22 (McGraw Hill Publishers, New York 1998).

341 McCrudden C "Institutional Discrimination" 1982 (2) *OJLS* 303.

342 McCrudden 1982 (2) *OJLS* 303-304.

343 Blyton P and Noon M *The Realities of Work: Experiencing work and employment in contemporary society* 290 (Palgrave Publishers, London 2007).

344 Tobler C *Indirect Discrimination: A Case Study into the Development of the Legal Concept of Indirect Discrimination in the Workplace* 294 (Hart Publishing, London 2005).

345 Tobler *Indirect Discrimination: A Case Study into the Development of the Legal Concept of Indirect Discrimination in the Workplace* 295. See also the landmark case of *Hoffmann v South African Airways* (CCT 19/00) [2000] ZACC 17, 2001 (1) SA 1, 2000 (11) BCLR 1235, [2000] 12 BLLR 1365 (CC) (28 September 2000) as discussed above.

346 Vandenhole W *Non-discrimination and Equality in the View of the UN Human Rights Treaty Bodies* 84 (Hart Publishing, London 2005).

347 *Leonard Dingler Employee Representative Council v Leonard Dingler (Pty) Ltd* (1998) 19 ILJ 285 (LC).

348 *Leonard Dingler Employee Representative Council* case 285.

by the employer, which included a staff benefit fund, pension fund and provident fund.[349] All members of the staff benefit were white personnel who were paid on a monthly basis, except for the four white employees in the company who were not part of the staff benefit. All the members of the pension fund benefits were black and were paid on a weekly basis.[350] Members of the provident fund benefit were black employees who were paid on a monthly basis, as they were permanent members of staff in the company.[351] The conduct of the employer towards contributing more on the staff benefits and less on both the pension and provident fund benefits was found to constitute unfair discrimination on the basis of race.[352]

Furthermore, the court found the conduct of the employer as perpetuating the disadvantaged background which black employees faced in the past, in this context by limiting them to being legible for the pension and provident fund benefits only. The employer was contributing less respectively towards the two schemes to which these black employees belonged.[353] The court came to the decision to reserve its judgment as it saw it fit, since it was in the best interests of justice to allow the two parties to come to a solution. This would allow the employer to rectify the matter in order to ensure that there is no indirect discrimination affecting black employees in the company, especially in relation to employee benefits.[354]

3.6.3.1.2 Dlamini & Others v Green Four Security [2006] 11 BLLR 1074 (LC)

In *Dlamini & Others v Green Four Security,*[355] the employer imposed a rule on all security guards of the company which provided that they were not allowed to have a beard. The employees who were applicants in this case were dismissed by the employer for refusing to shave off their beards on the basis of their religious convictions as they were members of the Nazarene religion which required them not to shave their beards.[356] They further argued that the policy of the employer indirectly

349 *Leonard Dingler Employee Representative Council* case 285.
350 *Leonard Dingler Employee Representative Council* case 286.
351 *Leonard Dingler Employee Representative Council* case 286.
352 *Leonard Dingler Employee Representative Council* case 286.
353 *Leonard Dingler Employee Representative Council* case 287.
354 *Leonard Dingler Employee Representative Council* case 288.
355 *Dlamini & Others v Green Four Security* [2006] 11 BLLR 1074 (LC).
356 *Dlamini & Others* case 1074.

discriminated against them on the basis of religion.[357] The court held that not shaving a beard was not a fundamental rule or principle of the Nazarene church as argued by the applicants, and such application by the applicants was dismissed on the basis that the policy of the employer of no beard was justified, as it was not violating the right of the applicants to religion. However, it is important to note that despite the fact that the court did not rule in favour of the applicants, dress code or appearance policies in the workplace have the ability to indirectly discriminate against a group of employees either culturally or religiously.[358] The reasoning of the court was based on the fact that the applicants had based their claim on false grounds as they could not prove that not shaving their beards was part of their religious practices.[359]

3.6.4 Possible solutions to address unfair discrimination facing employees living with cancer

In South Africa, employees living with cancer often accept a reduction of their salary, as they face the risk of taking unpaid leave due to the fact that employers are not willing to pay them when they are not at work.[360] Employees living with cancer are also at risk of facing unfair labour practices such as demotion and not being considered for promotion even if they are qualified, merely because of their condition.[361] Such discriminatory conduct on the part of employers must be avoided as it is in conflict with section 2 of the Employment Equity Act, which aims to achieve equity in the workplace by promoting equal opportunity and fair treatment in employment through the elimination of unfair discrimination, and implementing affirmative action measures to redress the disadvantages in employment experienced by designated groups, in order to ensure equitable representation in all occupational categories and levels in the workplace.[362] In terms of section 1 of the Employment Equity Act, people from designated groups include black people, women and people with disabilities.[363]

357 *Dlamini & Others* case 1075.

358 *Dlamini & Others* case 1075.

359 *Dlamini & Others* case 1075.

360 Radebe 2013-05-15 *Citizen*-29.

361 Two sources which provide authority for this view are Radebe 2013-05-15 *Citizen* 29 and Health 24 http://www.health24.com/Medical/Cancer/News/Enpowering-cancer-patients-in-the-workplace-20130509 (Date of use: 16 July 2014).

362 Section 2 of the Employment Equity Act 55 of 1998.

363 Section 1 of the Employment Equity Act 55 of 1998.

A solution to addressing either direct or indirect discrimination in the broad society, and particularly in the workplace, involves finding a framework of how to approach differences and how to accommodate them without any pejorative connotations. A starting point is the recognition that differences are rational, due to the diverse nature of our country that consists of different people from different backgrounds. It is logical to acknowledge that due to the diversity of our country, one should establish an understanding that a group is not different by itself, but only different from another group and that the other group is in turn different from the first.[364] The difference is not the problem of the group in which differences are evident, however, it is the product of a comparison which needs to be embraced due to the diverse nature of our society and the historical background which we have.

Based on this reasoning, it is clear that all forms of discrimination can be defeated only if people and organisations learn to tolerate the differences between each other and embrace such differences without making assumptions about the capabilities of other people by judging them because they are different. This will be possible if we adopt the reasoning of Finley, who argued that the very idea of a norm means that whatever is considered normal can take on a quality of objective reality. Such reasoning will make it possible to observe the difference in us as human beings.[365] Disability or disease must be seen as a normal way of life. Furthermore, employees living with cancer face discrimination in the form of unfavourable performance appraisals and unfair hiring practices, this is attributed to the discrimination which is imposed on employees living with cancer by employers who don't view cancer as a way of life and thus normal, as argued by Finley.[366]

---

364 Hunter Indirect Discrimination in the Workplace 4.

365 Finley LM "Transcending Equality Theory: A way out of the maternity and the workplace debate 1986 (86) *CLR* 1118.

366 Fow NR, "Cancer rehabilitation: An investment in survivorship: As more people survive the disease, focus shifts on improving quality of life" 1996 (9) *REHAB Manage* 48. An example of a employee living with cancer who has experienced unfair discrimination from the employer because of his cancer is that of Paul, a 46 year old man who resides in London, who was diagnosed with blood cancer in 2010. He disclosed his medical condition to the employer and the employer immediately fired him on the basis of his cancer, and the employer argued that he was not fully committed 100 per cent to the company. This happened after Paul dedicated his life to the company, which now saw him as incompetent due to the cancer. Paul took the employer to court in order to fight this unfair discrimination, but due to the high legal costs which he could not afford, he settled for an offer of compensation from the employer. The compensation was not that much, but it assisted him in settling some of his expenses and his venture to get a new job

Employers and fellow employees argue that employees living with cancer are discriminated against on the basis of cancer because the employee living with cancer has a lower job satisfaction and is less productive, seeing as the employee would be away in most instances to receive treatment.[367] Furthermore, employers argue that employees living with cancer create a financial burden for the company as integrating them would result in paying higher workers' compensation and disability coverage contributions.[368] McKeena argues that these arguments or allegations on the part of employers and fellow employees persist despite an absence of information or evidence to substantiate the claims that employees living with cancer are unable to work or continue with work.[369] This thesis is written in support of the aforementioned view by McKeena for the reasons outlined earlier regarding how cancer does not prevent an employee from working, and that work actually forms part and parcel of the treatment of cancer due to the psychological and physical benefits which comes with the fulfilment of being employed.[370]

From the above, it is clear that the discrimination of employees living with cancer is merely based on ignorance about cancer and the stigma which is attached to cancer. Such discrimination must be avoided, and provisions such as section 15(2) of the Employment Equity Act,[371] should be implemented. This Act provides for reasonable accommodation and ought to be provided by the employer as one of the measures of eliminating unfair discrimination. For this purpose, employers will have to be extremely conscious and informed about the realities of diversity and disabilities, as this will help them to adhere to their legal obligations, such as the provision of reasonable accommodation.

---

in order to start a new life and reaffirm his role in society, which one could say, was stolen by the company. See also http://www.macmillan.org.uk/Aboutus/News/Latest_News/Riseincancerpatientsfacingdiscriminationatwork.aspx (Date of use: 11 February 2016). In South Africa, many employees living with cancer suffer unfair discrimination in the hands of employers but are afraid to come out due to the stigma that is attached to cancer and not wanting to lose their work in the process, hence a lack of reported incidences in this respect.

367 Adams JE "Judicial and regulatory interpretation of the employment rights of people with disabilities" 1991 (22) *JARC* 28.

368 Adams 1991 (22) *JARC* 28-29.

369 McKeena *et al*, 2007 (29) *Work* 314.

370 McKeena *et al*, 2007 (29) *Work* 316.

371 Section 15(2) of the Employment Equity Act 55 of 1998.

Apart from the duty of employers to provide reasonable accommodation to employees living with cancer as one of the mechanisms to address the problem of unfair discrimination in the workplace, it is also argued that legislative reform on the part of government is essential. As outlined already in this chapter, South Africa follows a medical model to determine disability, which has proven to be less effective on the basis that it excludes a large number of people from benefiting from social security even though their medical condition may make them eligible to benefit. Considering the state of health in our country, the increasing number of HIV and AIDS infections, as well as the high rate of unemployment, which makes many people rely on social security to survive, it has put a great strain on the availability of health care services and social.[372] The question that arises in this context is whether persons or employees living with cancer qualify for a disability grant. In South Africa to this very day, there is no legislation that deals with social security in recognising cancer as a disability, including the Social Assistance Act.

Persons or employees living with cancer need grants in cases where they are deprived employment or are dismissed from work due to their medical condition. The social grant will assist with allowing them to access health care through the regular hospital visits, due to the aggressive nature of cancer which requires continuous treatment. Taking into account the complexity of the medical test and means test requirements, government should consider introducing a chronic disease grant, as was proposed during the briefing on the Social Security Amendment Bill which was held by the Department of Social Development.[373]

The Treatment Action Campaign argues that a chronic disease grant will cover costs specifically related to chronic diseases. Not only would this provide for financial assistance for various additional categories of people, but it would also contribute to reducing the misunderstandings and stigma around cancer. Chronic disease grant

372 Lund F "Social Security and the Changing Labour Market: Access for Non-Standard and Informal Workers in South Africa" 2002 (28) *Social Dynamics* 177.

373 Botha Y "Social Assistance Amendment Bill [B5-2010]: Briefing by the Department of Social Development" at https://pmg.org.za/committee-meeting/11437/ (visited 30 October 2015).

would reinforce the right to health care by making it possible for those with chronic ailments to properly manage their diseases.[374]

It is submitted that the approval of a chronic disease grant by government will benefit persons or employees living with cancer. Government is encouraged to develop a broader definition of disability that covers more moderate physical or mental impairments. Persons or employees living with cancer who are not legally disabled but unable to work, could be included in this definition.

3.6.5 Operational requirements of the company

3.6.5.1 Statutory grounds for discrimination and dismissal

In terms of section 213 of the Labour Relations Act, operational requirements mean requirements of the company based on the economic, technological, structural or similar needs of the employer.[375] Dismissals effected on the basis of operational requirements are classified as no fault dismissals, this means that there is no fault on the part of either the employer or employee upon the occurrence of such a dismissal.[376] Section 189 of the Labour Relations Act states that when an employer considers dismissing employees on the basis of operational requirements, then that employer must consult with trade union or forums, and with all the relevant employees. During this consultation, the employer and the consulting parties must embark on a meaningful joint census-seeking process and endeavour to reach an agreement. The employer must also give notice before the consultation, requesting the consulting party to consult with it, and the employer must also divulge, in writing, all the applicable information for consultation.[377] This is due to the fact that in most cases it has been found that the manner of dismissal which employers conduct, does not comply with the provision of section 189 of the Labour Relations Act, and thus resulting in unfair dismissal.

---

374 "A chronic disease is one that is long-lasting but manageable with the right treatment and lifestyle. HIV is a chronic disease because antiretroviral drugs (ARVs) allow people to live long and healthy lives. Other examples of chronic diseases are diabetes and heart disease." Silber G "A Chronic Disease Grant for South Africans" at http://www.tac.org.za/community/files/file/etmag/ET27English.pdf (visited 15 July 2015).

375 Section 213 of the Labour Relations Act 66 of 1995.

376 Section 189 of the Labour Relations Act 66 of 1995.

377 Section 189 of the Labour Relations Act 66 of 1995.

At this point it is very important to take into account and note that the principle of operational requirements is often abused by employers, where employees are actually unfairly dismissed, and then the employer attempts to justify it by arguing that it is based on the operational requirements of the business, in terms of section 189 of the Labour Relations Act.[378] This is mostly the case in instances where an employee living with cancer is discriminated against on the basis of cancer, and the employer would justify the dismissal on the basis of the operational requirements of the company.[379] The discussion of dismissal based on operational requirements, is aimed at clarifying the process which must be followed by the employer in order to justifiably dismiss employees based on operational requirements. Dismissals based on operational requirements should not be used to the detriment of employees, for instance in this context, to dismiss employees living with cancer due to their condition. Such a dismissal would squarely amount to unfair discrimination. A wide variety of cases have been discussed in our law with regard to dismissal for operational requirements but only a few cases will be sufficient to discuss for the purposes of this study.

3.6.5.1.1 WL Ochse Webb & Pretorius (Pty) Ltd v Vermeulen (1997) 18 ILJ 361 (LAC)

The principle of operational requirements of the company was considered in the case of *WL Ochse Webb & Pretorius v Vermeulen,*[380] where the applicant was an employee of the company as a salesman. He was paid a basic salary and commission.[381] The applicant employee earned more than other employees in the company, because the sale of tomatoes was on the rise and attracted high commission than the sale of other vegetables which were sold by the other employees.[382] This created a lot of problems

---

378 Section 189 of the Labour Relations Act 66 of 1995. See *National Union of Mineworkers v Anglo American Platinum LTD & Others* [2012] 12 BLLR 1252 (LC) the employer was anticipating retrenching 14 000 employees. After interventions and meetings with government and the unions, the number was reduced to 6000 and the employer started consulting in terms of section 189A. The union challenged the procedural fairness on the basis that it alleged the employer had not complied with section 52(1) of the Mineral Petroleum Resources and Development Act 28 of 2002 and as such it did not participate when the question of selection criteria and severance pay was raised. The court held that section 52 does not replace the requirements of section 189A and that if an employer raises selection criteria and severance pay issues but the union refuses to discuss such matters, it does not render the subsequent dismissals unfair.

379 Section 189 of the Labour Relations Act 66 of 1995.

380 *WL Ochse Webb & Pretorius* (Pty) Ltd *v Vermeulen* (1997) 18 ILJ 361 (LAC).

381 *WL Ochse v Webb & Pretorius* case 361.

382 *WL Ochse v Webb & Pretorius* case 362.

among employees which resulted in the employer to come up with means to correct the situation as it stood. The employer tried to solve the problem by proposing a new remuneration system, and provided the applicant employee with three options of either accepting the new system, or that he presents an alternative system of remuneration, or lastly, that he resigns.[383] The applicant employee proposed that the old system be maintained and when this proposal was rejected by the employer he resigned. In this case the Labour Appeal Court held that the conduct of the employer was fair and based on operational requirements of the company, and the application of the applicant employee was dismissed.[384]

3.6.5.1.2 South African Transport and Allied Workers Union v Old Mutual Life Assurance Company South Africa Limited (C 198/2004) [2006] ZALC 51

In *South African Transport and Allied Workers Union v Old Mutual Life Assurance Company South Africa Limited*,[385] the employees challenged the fairness of their dismissals which were effected on the basis of the operational requirements of the company. The retrenchments emanated from a failed management buy-out strategy which was unsuccessful and abandoned.[386] When the proposal was abandoned, the subsequent retrenchment was proposed and the company introduced a system of outsourcing of work. The reasons for the change were as a result of changes or developments in the industry, and that the company was already previously outsourcing its services. The respondent company argued that outsourcing allowed flexibility and was a mechanism which saved costs in the process, and which was better than the in-house operation which was an extremely costly process.[387] The court held that the dismissal of employees must be substantially fair, which was currently not the case, and the application of the applicants was successful.

The employer will not be found to be acting unfairly against the employee in the case where reasonable accommodation would cause excessive hard ships to his or her

383 *WL Ochse v Webb & Pretorius* case 363.

384 *WL Ochse v Webb & Pretorius* case 363.

385 *South African Transport and Allied Workers Union v Old Mutual Life Assurance Company South Africa Limited* (C 198/2004) [2006] ZALC 51 (6 April 2006).

386 *South African Transport and Allied Workers Union* case 51.

387 *South African Transport and Allied Workers Union* case 52.

business.[388] The aim of this provision is not to ensure that the other party benefits at the expense of the other, but to ensure equity between the two parties based on the operational requirements of the company.[389]

Having discussed all the important aspects of unfair discrimination, the focal point of the employer-employee relationship should turn to the consideration of other fundamental human rights which find relevance in the employment context. One of the important rights which deserve mention here is the right to privacy of the employee living with cancer, which the employer must respect and not violate as it is protected under section 14 of the Constitution.[390] The employment environment is a place where the employee living with cancer is going to disclose confidential information to the employer for purposes of affording the employer an opportunity to fulfil his or her legal obligations. Therefore, the employer has an additional duty to uphold the employee's right to privacy in the workplace.

3.7 The right to privacy

Before discussing the right to privacy in South African law, it is important to consider that the Constitution entrenches this right in terms of section 14.[391] Furthermore, it is necessary to take into consideration that the right to privacy is also upheld and protected by various statutes, these includes, the Protection of Personal Information Act and the National Health Act.[392] More about the role of these two statutes will be explored later on in the thesis, when discussing the role of the National Cancer

388 Section 189 of the Labour Relations Act 66 of 1995 outlines that the employee can be dismissed for operation reasons and the employer would not be found to have acted improperly towards the employee.

389 Section 213 of the Labour Relations Act 66 of 1995.

390 Section 14 of the Constitution of the Republic of South Africa, 1996. The right to privacy can rightly be described as a right that aims to protect, and control access to personal information or matters, and control over obtaining, fixation, possession, dissemination and use of information on personal matters. See Rautenbach IM and Malherbe EFJ *Constitutional Law* Sixth Edition 357 (LexisNexis, Durban 2012).

391 Section 14 of the Constitution of the Republic of South Africa, 1996 and section 2(a) of the Protection of Personal Information Act 4 of 2013, which sets out the purpose of this Act by outlining that the aim of this Act is to give effect to the constitutional right to privacy, by safeguarding personal information when processed by a responsible party, subject to justifiable limitations that are aimed at balancing the right to privacy against other rights, particularly the right of access to information, and protecting important interests, including free flow of information within the Republic and across international borders.

392 Section 2 of the Protection of Personal Information Act 4 of 2013 and section 14 of the National Health Act 61 of 2003.

Registry (NCR) in fighting cancer and maintaining the right to privacy of persons living with cancer. Due to this reason and for the purposes of our discussion, the right to privacy will be discussed in light of both the common law and the Constitution. Furthermore, it is important for the reader to take note of the fact that the right to privacy is broad and a lot of cases have come before our courts, but for the purposes of this study, only the landmark cases which form part of the backbone of the right to privacy in terms of both the common law and the Constitution, will be referred to.

3.7.1 Common law definition of privacy

Under common law, every person has personality rights such as the rights to physical integrity, freedom, reputation, dignity and privacy.[393] According to Neethling, privacy is defined as an individual condition of a person's life, which is characterised by seclusion from the public and publicity.[394] Since privacy is considered as personal facts which a person has determined to be excluded from the knowledge of other people, this means that the right to privacy can only be violated when another person learns of the true private facts of another person against his or her will.[395]

The right to privacy has long been entrenched in the common law, in which everyone has personality rights which includes the right to physical integrity, freedom, reputation, dignity and privacy.[396] This right to privacy has been recognised as an independent personal right that applies to both natural persons and juristic persons, such as companies.[397] The violation of the right to privacy is determined by the court, in terms of the reasonableness standard in terms of the interests of the community in order to guard against any form of injustices on an individual or a company.[398] Privacy underpins dignity since a violation of the right to privacy infringes on the right to dignity.[399] This is because these two rights relate to each other, in the sense that the right to privacy ensures that one maintains confidential information that he or she has,

---

393 Neethling J, Potgieter JM and Visser PJ *Neethling's Law of Personality 31* (Butterworths, Durban 2005).

394 Neethling *et al*, *Neethling's Law of Personality 32*.

395 Roos A "Personal Data Protection in New Zealand: Lessons for South Africa" 2008 (4) *PER/PELJ* 191.

396 Roos 2008 (4) *PER/PELJ* 191-192.

397 Neethling *et al*, Neethling's *Law of Personality* 217.

398 Neethling *et al,* Neethling's *Law of Personality* 218.

399 Section 10 of the Constitution of the Republic of South Africa, 1996 states that everyone has the right to dignity and to have they dignity respected and protected.

and if such information is published in a derogatory manner it will damage the dignity of the person.[400]

This rich history which emanates from common law with regard to the right to privacy and other related rights such as dignity and reputation, clearly affirms the view which Burchell argues that "the common law of privacy in South Africa still provide the lion's share when it comes to the right to privacy standard".[401] This is despite the fact that currently in the new Constitutional dispensation, the right to privacy, dignity, reputation and freedom, are recognised individually and independently in order to give them more recognition and further interpretation, which was not the position in common law as these rights were treated collectively rather than individually.[402]

3.7.1.1 Legality of the common law right to privacy in the constitutional era

Section 8(3) of the Constitution provides that when applying a provision of the Bill of Rights to either a natural or juristic person, a court must apply, or if necessary, develop the common law to the extent that legislation does not give effect to the right under consideration, in order to properly give effect thereto.[403] Furthermore, a court may develop the rules of common law to limit a right, provided the limitation is in line with section 36(1) of the Constitution. Section 39(3) of the Constitution, which deals with the interpretation of the Bill of Rights,[404] states that the Bill of Rights does not deny the existence of any other rights or freedoms that are recognised or conferred by the common law, customary law, or legislation to the extent that they are consistent with the Bill of Rights. These constitutional provisions clearly affirm the view that Burchell holds about the common law carrying a lion's share on the right to privacy, as outlined.

However, the common law position with regard to the right to privacy still needs the affirmation of the Constitution before it may be used as a point of departure. The common law right to privacy can be limited as well as declared to be null and void if it

400 See *C v Minister of Correctional Services* 1996 (4) SA 292 (T) as discussed in paragraph 3.7.2.2.2 of this thesis.

401 Burchell JM "Media Freedom of Expression Scores as Strict Liability Receives the Red Card: National Media Ltd v Bogoshi" 1999 *SALJ* 1.

402 Section 14 of the Constitution of the Republic of South Africa, 1996 protects the right to privacy, section 10 thereof protects the right to human dignity and section 12 protects everyone's right to freedom and security.

403 Section 8(3) read with section 8(2) of the Constitution of the Republic of South Africa,1996.

404 Section 39 (3) of the Constitution of the Republic of South Africa, 1996.

is found to be contrary to the provisions of the Constitution.[405] The position is quite clear that although the common law right to privacy in South Africa is fundamental due to its historical scope, it is however subject to the Constitution which is the crucial aspect which Burchell omitted in his assessment of the position of common law right to privacy.

The right to privacy has long been protected in our law dating back from the time it was inherited from the Roman law system in which the *actio iniuriarum* was provided as a remedy in cases where there was an invasion to the sanctity of a person's home.[406] This has been the position before the constitutional dispensation came into existence and provided for the right to privacy in terms of section 14 of the Constitution.[407] Two examples of case decisions dealing with the common law right to privacy can be found in the 1900s. Firstly, an English case will be discussed and then a South African decision thereafter.

3.7.1.1.1 Tolly v Fry and Sons Ltd [1931] AC 333

In *Tolly v Fry and Sons Ltd*,[408] the plaintiff was an amateur golfer and the defendant was a producer of candy. The defendant, in his advertisement of chocolates, showed the plaintiff with a protruding bar of chocolate in his back pocket.[409] This form of advertisement was not done with the consent of the plaintiff and the plaintiff challenged this on the basis that it violated his right to dignity and privacy. Furthermore, the plaintiff argued that such advertisement was done without his consent, and that it had the potential to destroy his golfing career as he was still an amateur, due to the misleading nature of the advertisement.[410] The court found the conduct of the defendant as

---

405 Section 2 of the Constitution of the Republic of South Africa, 1996, states that the Constitution is the highest law in the land and everyone is bound by the Constitution. Any law found to be against the provisions of the Constitution will be changed or set aside as null and void.

Neethling *et al,* Neethling's *Law of Personality 253.* The remedy with regard to the *actio iniuriarum*, which owes its historical development from Roman law, was established and used to recover damages (*Solatium*) based on the intentional infringements of one of the acknowledged personality rights. In order to succeed with this remedy, an infringement of a legally acknowledged interest of personality is required and such infringement has to be intentional in the process. See the case of *Jackson v NICRO* 1976 3 SA 1 (A) 11, in which the history and purpose of this Roman remedy was clearly outlined and applied in the case with the aim of making an informed decision in the process.

407 Section 14 of the Constitution of the Republic of South Africa, 1996.

408 *Tolly v Fry and Sons Ltd* [1931] AC 333**,** [1931] UKHL 1.

409 *Tolly* case 334.

410 *Tolly* case 334.

unlawful and ordered the defendant to compensate the plaintiff for the loss or harm which he had suffered as a result of the advertisement.[411]

3.7.1.1.2 O'Keeffe v Argus Printing and Publishing Company Ltd 1954 (3) SA 244 (C).

In the case of *O'Keeffe v Argus Printing and Publishing Company Ltd*,[412] the plaintiff was a well-known radio personality who consented to the publication of her photograph, taken at the pistol range to be used for a newspaper article by the defendant company.[413] The defendant company however, used the photograph of the plaintiff for advertising purposes which was not what the plaintiff consented to in the first place. Watermeyer AJ held the view that the conduct of the respondent company was unlawful and that the respondent acted contrary to the right to privacy of the plaintiff and was ordered to compensate the plaintiff for the violation of her right to privacy with regard to the derogatory advertisement.[414]

3.7.2 The right to privacy in terms of section 14 of the Constitution of the Republic of South Africa, 1996

Section 14 of the Constitution states that everyone has the right to privacy, which includes the right not to have their person or their home searched, their property searched, their possession seized, or the privacy of their communications infringed.[415] This provision of the Constitution which guarantees the right to privacy is supported by Schoeman who defines privacy as a state or condition of limited access to a person.[416] Furthermore, the right to privacy was explained in the case of *National Media Ltd ao v Jooste.*[417] Harms AJ explained that the right to privacy can best be described as an individual condition of life characterised from the public and publicity. This condition includes all personal facts which the individual has determined to be excluded from the knowledge of other people and in respect of which he or she has

411 *Tolly* case 334-335.

412 *O'Keeffe v Argus Printing and Publishing Company Ltd* 1954 (3) SA 244 (C).

413 *O'Keeffe* case 244.

414 *O'Keeffe* case 245.

415 Section 14 of the Constitution of the Republic of South Africa, 1996.

416 Schoeman F Philosophical *dimensions of privacy: An Anthology* 5 (Cambridge University Press, Cambridge 1984).

417 *National Media Ltd ao v Jooste* 1996 (3) SA 262 (A).

wills that they be kept private.[418] The case of *Kennedy and Arnold v Ireland*,[419] takes the discussion of the right to privacy further by stating that:

> "[...] though not specifically guaranteed by the Constitution, the right to privacy is one of the fundamental personal rights of the citizen which flow from the Christian and democratic nature of the state. The nature of the right to privacy must be such as to ensure the dignity and freedom of an individual in the type of society envisaged by the Constitution, namely a sovereign, independent and democratic society".[420]

This reasoning by the court envisages the position of the South African jurisprudence, in protecting the right to privacy of an individual from other people in a democratic state. Therefore, this illustrates that the employee's right to privacy may place certain duties on the individual in order to facilitate the operation of his or her right in harmony with the rights and duties of other people.

3.7.2.1 The duty of the employee to disclose and its effect on the employer's duties to provide reasonable accommodation

An employee has a responsibility to disclose to the employer that he or she has been diagnosed with cancer, and to further disclose the effect that this may have on his or her employment, such as the need to take leave and to be given fewer responsibilities owing to the treatment of cancer.[421] The employee living with cancer is not legally

---

418 *National Media Ltd ao v Jooste* case 262-263.

419 *Kennedy and Arnold v Ireland* [1987] IR 587.

420 *Kennedy and Arnold* case 587.

421 See Devane 2013 (1) *Macmillian Cancer Support* 11 and CANSA Guidelines which states that, the employee needs to disclose as soon as possible to the employer that he or she has been diagnosed with cancer. The employee must explain to the employer the treatment that he or she will be taking and the effect of this treatment on the ability of the employee to perform his or her duties. This will enable the employer to understand the capabilities of the employee and at some stage make necessary changes to the working conditions of the employee. This social responsibility is in line with section 9 of the Constitution of South Africa 1996, which promotes equality and prohibits unfair discrimination. This is what CANSA strives to achieve through robust awareness of education as to what cancer is, by communication between the employer and the employee living with cancer. if this is the position, then the objective of eliminating discrimination both in society in general and in the work place in particular will be achieved, through knowledge and awareness about cancer, but all of this start with communication as it has been achieved in the fight against HIV and AIDS through greater awareness and education. The employee is expected to come up with solutions, in such a way of explaining how he or she is going to cope during this period. The employee can also ask for assistance on the part of the employer to allow him or her to effectively do his or her duties. From these social responsibilities that are provided by CANSA on the employee living with cancer, these social responsibilities to a lesser or greater extent resemble the duties which are set out by the Basic Conditions of Employment on the part of the employee. This is clear that CANSA took note that the legal implications and practicality of implementing these social responsibilities, will be easy for both the employee and employer because they are in line with the Basic Conditions of Employment and

bound to disclose their cancer status but such a disclosure is meant to assist the employee living with cancer. In turn, this disclosure will ensure that the employer is informed that he or she should make the necessary arrangements to accommodate the employee in the work place, because the employer is now aware about the medical condition of the employee living with cancer.[422] However, this disclosure of the employee is protected in terms of section 14 of the Constitution, which refers to a person's right to privacy.

This means that the disclosure which the employee living with cancer provides to the employer binds the employer not to disclose this communication to people outside the employment setup, as that would amount to unlawful disclosure and would constitute a violation of section 14 of the Constitution.[423] However, any disclosure by the employer to fellow employees so as to assist the employee living with cancer with re-integration in the workplace, will not amount to the violation of section 14 of the Constitution. In this context the case of *Hyundai Motor Distributors*, serves as a basis in which the Constitutional Court stated that:

> "[...] the right to privacy is implicated whenever a person has the ability to decide what he or she wishes to disclose to the public [,] and the expectation that such decision will be respected is reasonable".[424]

---

do not require the employer to do something extraordinary which is contrary to his or her business interests or contrary to the provisions of the law.

422 Section 15(2)(c) of the Employment Equity Act 55 of 1998.

423 The right to privacy is a fundamental Constitutional right which is protected in terms of section 14 of the Constitution of the Republic of South Africa, 1996.

424 *In Investigating Directorate: Serious Economic Offences v Hyundai Motor Distributors (Pty) Ltd: In re Hyundai Motor Distributors (Pty) Ltd v Smit NO* 2001 (1) SA 545 (CC). This case deals with the important issue regarding the circumstances under which judicial officers may grant a warrant of search and seizure for the purposes of investigating criminal activity. The matter arose when the respondents, including Mr Rautenbach and the `Wheel of Africa' group of companies, applied to the Transvaal High Court for relief following a raid on their offices in November 1999 during which a large quantity of documents and computer records were seized. In the High Court, South wood J declared section 29(5) read with sections 28(13) and (14) of the National Prosecuting Authority Act 32 of 1998 ('the Act') unconstitutional to the extent that these provisions permitted the authorisation of a search warrant by a judicial officer in the absence of reasonable grounds to suspect that an offence had been committed. The matter was referred to the Constitutional Court for confirmation of the order declaring these provisions unconstitutional. The appellants lodged an appeal against this order. The Act creates a framework for the establishment of specialised bodies, called Investigating Directorates, to investigate certain specified offences. Three Investigating Directorates have been established since the commencement of the Act. In order to fulfil their mandate of successfully investigating and ultimately prosecuting offenders of these specific crimes, Investigating Directorates may conduct two types of investigatory procedure, an `inquiry' and a `preparatory investigation'. Section 29 grants the Investigating Directorates powers to search and seize property, in order to facilitate its

Currently in the new constitutional dispensation there are variouscases that serve as precedent in protecting the right to privacy in our law and which ought to be discussed in order to give a comprehensive layout of the constitutional right to privacy and the manner in which it is upheld by the courts. Furthermore, one also has to account for cases which specifically dealt with the aspects of how to balance the employee's right to privacy with his or her duty to disclose certain conditions such as cancer.

---

investigations. Limitations are placed by the Act on the exercise of such powers and one of these is a requirement that the search and seizure of property must occur only once a warrant has been issued by a judicial officer. A search warrant may only be granted if the evidence before the judicial officer meets an appropriate standard. This standard in the context of an inquiry clearly requires a reasonable suspicion that a specified offence has been committed. The exact nature of the standard set by section 29(5) in the context of a preparatory investigation and the constitutional validity thereof is the subject of challenge in this case. The Constitutional Court, in a unanimous decision of Langa DP, declined to confirm the order of the High Court. It was held that the right to privacy is clearly violated in a search and seizure operation envisaged by the Act. However, according to a proper interpretation of section 29(5), an adequate justificatory basis has to be provided for the suspicion that an offence has been committed before a judicial officer may authorise a search warrant for purposes of a preparatory investigation. Langa DP held that the section provides sufficient safeguards against an unwarranted invasion of privacy and thus meets the requirements of the limitations clause. In order to reach the conclusion that section 29(5) was consistent with the Constitution, a proper interpretation of this section had to be arrived at. This interpretive exercise had to be performed in light of the principle of constitutional interpretation that judicial officers must prefer interpretations of legislation that fall within constitutional bounds over those that do not, provided that such an interpretation can be reasonably ascribed to the section. Under the new constitutional order, statutes must be interpreted through the prism of the Bill of Rights and, in particular, in light of its 'spirit, purport and objects'. Langa DP went on to undertake a detailed analysis of the relevant provisions. Upon a reading of section 29(5) in the context of a preparatory investigation, it appeared that there was indeed a requirement that a judicial officer should only issue a warrant where there are reasonable grounds to believe that an article connected with a preparatory investigation is on certain specific premises. The Act was, however, not explicit regarding the class of offences in respect of which the reasonable suspicion must exist. The purpose of a preparatory investigation is to determine whether there are reasonable grounds to believe that a specified offence - which falls within the jurisdiction of an Investigating Directorate - has been committed. It is clear that, as a result, a precondition for the issue of a warrant for purposes of a preparatory investigation must be something less than a reasonable suspicion that a specified offence has been committed. There could be instances where an Investigating Directorate wishes to search and seize property for purposes of a preparatory investigation in order to determine whether an offence that has come to its attention is in fact a specified offence that falls within its jurisdiction. In those circumstances, there may well be a reasonable suspicion that an offence, which might be a specified offence, has been committed. Thus, a requirement that there be reasonable grounds to suspect that an offence had been committed is not inconsistent with the purpose of a preparatory investigation. The effect of this decision is that the Act is to be read in future by judicial officers as conferring on them the authority to grant search and seizure warrants for purposes of a preparatory investigation only in circumstances where there are reasonable grounds to believe that an offence, which might be a specified offence, has been committed. In such circumstances, a balance is struck between protecting the right to privacy of individuals and promoting the important interest of the state in the effective investigation of criminal activity so as to curb the high incidence of crime in our society. The appeal accordingly succeeded and the court declined to confirm the order of the High Court.

3.7.2.1.1 Mistry v Interim National and Dental Council and Others 1998 (4) SA 1127 (CC)

In the case of *Mistry v Interim National Medical and Dental Council and Others*,[425] a raid had been carried out in the surgery of Dr Mistry in Pinetown, by an inspector and a health official, without Dr Mistry's consent and knowledge.[426] They seized medicines and other health equipment from his surgery, and as a result of this, Dr Mistry brought the matter to court in order get a ruling on the constitutionality of section 28 of the Medicines and Related Substance Control Act 101 of 1965.[427] He further claimed for the items which were taken from his surgery during this search to be returned to him, and finally he argued that the conduct of the inspector and health official was in actual fact violating his right to privacy.[428]

Sachs J delivered a unanimous judgment in which he held that the provisions which are in place to guide the approach of state officials when entering the private property of civilians are important in a democratic society, rather than a police state.[429] He held further that these provisions secure respect for people's right to privacy, while at the same time ensuring that police officers act within the boundaries of the law and do not act as they please.[430] In passing judgment, Sachs J noted that South Africa has a rich history of police brutality and anarchy which had dire consequences of violating the human rights to privacy and dignity, and he emphasized that such conduct is not acceptable in a new constitutional dispensation.[431] The protection of the right to privacy of all citizens is important and fundamental.

Section 28(1) of the Medicines and Related Substance Control Act grants inspectors a wide scope of powers to enter into the private dwellings of people, and is

---

425 *Mistry v Interim National Medical and Dental Council and Others* (CCT13/97) [1998] ZACC 10, 1998 (4) SA 1127, 1998 (7) BCLR 880 (29 May 1998), the constitutionality of section 28(1) of the Interim National Medical and Dental Council Act 101 of 1965 (Medicines Act) which authorises inspectors of the institution to enter any premises, vessels, car and aircraft to search and seize medical equipment and medicines on reasonable belief that there are illegal activities to be committed. This compromised the right to privacy as provided for in terms of section 14 of the then Interim Constitution.

426 *Mistry* case 882.

427 *Mistry* case 882.

428 *Mistry* case 883.

429 *Mistry* case 884.

430 *Mistry* case 885.

431 *Mistry* case 885.

undoubtedly unconstitutional because it contravenes the Constitution as it undermines and compromises people's right to privacy.[432] The claim instituted by Dr Mistry regarding the violation of his right to privacy and for the return of the goods which were taken during the search, was rejected by the court.[433] The reason for the court to reject the claim was because his right to privacy was not violated as the inspector did not communicate the information about the search to third parties, and further Dr Mistry failed to prove that the law in terms of which these officials acted was in actual fact invalid at the time the goods were taken.[434] In this case it is clear that Dr Mistry failed to discharge his onus of proof on a balance of probabilities that the health inspector acted unlawfully.

3.7.2.2 Balancing the employee's right to privacy with the employee's duty to disclose his or her condition

An employee living with cancer who discloses his or her health condition to the employer, expects a level of respect and tolerance on the part of the employer in order to maintain a good working relationship with his or her employer. However, it is necessary at this point to outline that in practice employees living with cancer are cautious when it comes to disclosing their medical condition to their employers,[435] since they fear being categorised or stereotyped for the reason that they have cancer.[436] Employees living with cancer are typically reluctant to disclose their medical condition to their employers because they believe that their employers and fellow employees will treat them differently once they know about their medical condition. Moreover, disclosure can result in employees living with cancer being less attractive for job opportunities, as employers are likely to find it difficult to provide employees

---

432 *Mistry* case 886 and Section 28(1)(a) of the Medicines and Related Substance Control Act 101 of 1965 states that a health inspector may enter a place or premises from which a person authorised under this Act to compound or dispense medicines or scheduled substances or from which the holder of a licence as contemplated in section 22C(1)(b) conducts business or any premises, vehicle, place, vessel or aircraft if he or she has reason to suspect that an offence in terms of this Act has been or is being committed at or in such premises, place, vessel or aircraft or that an attempt has been made or is being made there to commit such an offence.

433 *Mistry* case 886.

434 *Mistry* case 888.

435 Martinez RL *Childhood Cancer Survivors Workplace Experiences* 19 (Master of Arts, Rice University, Texas 2010).

436 Martinez *Childhood Cancer Survivors Workplace Experiences* 19.

living with cancer with reasonable accommodation in order for them to function well in the workplace.[437]

Despite all these challenges which employees living with cancer experience when it comes to disclosing their medical condition to employers, they are however encouraged to disclose their medical condition because the opposite approach can yield negative results for them. For example, managing a dangerous condition such as cancer can be burdensome on an individual, as it can take away all one's psychological resources which could be effectively used in job-related activities instead, and which could otherwise assist with the overall healing process of the employee living with cancer.[438] This is what Wegner and Lane describe as the "secrecy cycle of cancer", which is very consuming and detrimental to the overall health of the individual and must be avoided at all costs.[439] Following this, one may agree with the sentiments of Collins and Miller, who argue that an employee living with cancer who discloses that he or she has cancer releases the burden of managing a displaced identity.[440] From the above, it is apparent that disclosure can yield positive results for the employee and such positive results include job satisfaction, less job anxiety and higher commitment to working. The aforementioned factors have been proven to lead to the speedy recovery of the employee living with cancer, thus promoting the idea that working forms part and parcel of the elements of cancer treatment.[441]

3.7.2.2.1 Jansen van Vuuren NO v Kruger 1993 (4) SA 842 (A)

The right to privacy in the health context was also discussed in the case of *Jansen van Vuuren NO v Kruger*.[442] In this case the plaintiff was a businessman who resided in Brakpan and who was in a heterosexual relationship.[443] When he sought an insurance policy, it was required that before the approval of his insurance policy a medical report

437 Martinez *Childhood Cancer Survivors Workplace Experiences* 20.

438 Martinez *Childhood Cancer Survivors Workplace Experiences* 20-201.

439 Wegner DM and Lane JD *Emotion, Disclosure and Health* 25 (Pennebaker Publishers, Washington DC 1995).

440 Collins NL and Miller LC "Self-disclosure and liking: A meta-analytic review" 1994 (116) *Psychological Bulletin* 457.

441 Ashforth BE and Humphrey RH "Emotional Labour in Service Roles: The influence of identity" 1993 (18) *Academy of Management Review* 85.

442 *Jansen van Vuuren NO v Kruger* 1993 (4) SA 842 (A).

443 *Jansen van Vuuren NO* case 842

should be provided to show his HIV and AIDS status.[444] The plaintiff requested the first defendant who was his general practitioner of many years to prepare the medical report, and the blood samples were taken from the surgery of the second defendant who was also a medical practitioner and colleague of the first defendant. The second defendant informed the first defendant about the results of the test and the first defendant called the plaintiff to come to his surgery in order to tell him the results of the HIV and AIDS test.[445]

The first defendant informed the plaintiff that he was HIV positive and this left the plaintiff depressed and devastated because of the news. He was also concerned about people knowing his status and the first defendant assured him that he would not disclose such information to anyone.[446] The next day the first defendant attended a golf tournament and disclosed the HIV status of the plaintiff to two of his colleagues whom the plaintiff knew and had relations with.[447] The plaintiff claimed that the first defendant violated his right to privacy by such a disclosure and the first defendant argued that such disclosure was reasonable and in the public interest to do so.[448] However, the plaintiff died from AIDS before the Appeal Court could make a decision but his executors were the ones that still continued with the case.[449]

Harms AJA held that the first defendant was bound by the doctor-patient relationship and was not supposed to have disclosed the status of the plaintiff.[450] The first defendant could have also anticipated the discrimination and marginalisation which the plaintiff could have experienced from people as a result of his disclosure, owing to the stigma that is attached to the disease. However, it could not be determined as to whether the two colleagues which the disclosure was made did in actual fact spread the information about the status of the plaintiff to other people.[451] Despite the fact that the plaintiff died of AIDS and depression, the court found that an amount of R 5 000

444 *Jansen van Vuuren NO* case 842.
445 *Jansen van Vuuren NO* case 843.
446 *Jansen van Vuuren NO* case 843.
447 *Jansen van Vuuren NO* case 843.
448 *Jansen van Vuuren NO* case 844.
449 *Jansen van Vuuren NO* case 844.
450 *Jansen van Vuuren NO* case 845.
451 *Jansen van Vuuren NO* case 845.

instead of R 50 000 would be fair to pay in the current circumstances as a result of the violation of the right to privacy of the plaintiff.[452]

3.7.2.2.2 C v Minister of Correctional Services 1996 (4) SA 292 (T)

In *C v Minister of Correctional Services*, [453] the plaintiff was working as a cook in prison whilst serving his sentence. One day all prisoners were informed about an HIV and AIDS test which everyone needed to do for purposes of screening for HIV and other sexually transmitted diseases. Emphasis was placed on the right of prisoners to refuse to undergo such tests if they so wish and the plaintiff went for testing with the assistance of a fellow prisoner, where the test declared him HIV positive.[454] The plaintiff instituted a claim against the defendant on the basis of the violation of his right to privacy. The plaintiff stated that his right to privacy was violated as he did not provide informed consent to undergo such a test in the first place.[455] The defendant argued that the Department had adopted the concept that informed consent was a prerequisite for testing prisoners and specified the norms which were applicable before this incident took place.[456]

Judge Kirk-Cohen rejected the argument raised by the defendant on the basis that the information about the test, its purpose 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 no time to reflect.[457] 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 fellow prisoners.[458] This clearly shows that the plaintiff did not consent to the test in the first place and thus the conduct of the defendant amounts to the violation of the right to privacy of the plaintiff as protected by the Constitution.[459]

3.7.2.2.3 NM v Smith 2007 (5) SA 250 (CC).

452 *Jansen van Vuuren NO* case 846.
453 *C v Minister of Correctional Services* 1996 (4) SA 292 (T).
454 *C v Minister of Correctional Services* case 293.
455 *C v Minister of Correctional Services* case 293.
456 *C v Minister of Correctional Services* case 294.
457 *C v Minister of Correctional Services* case 294.
458 *C v Minister of Correctional Services* case 295.
459 *C v Minister of Correctional Services* case 295.

Another case in point, that serves as authority in protecting the right to privacy in the health context is *NM v Smith*,[460] where the names and HIV status of the three applicants were published in a biography without their knowledge and consent. The three applicants brought a claim to the court on the basis that such publication violated their right to privacy and human dignity as protected by the Constitution.[461] The court was of the view that the respondents were aware of the fact that the applicants did not give their consent with regard to the publication, but the respondents went ahead with the publication violating the applicants' rights to privacy and human dignity. The use of pseudonyms would not have rendered the book less authentic and nowhere was it shown to be in the public's interest to demand the publication of the real names of the applicants.[462] The court ordered the respondents to compensate the applicant's damages for the violation of their rights to privacy and human dignity as protected in terms of sections 10 and 14 of the Constitution, respectively.[463]

Based on the discussion above, it is clear that the right to privacy of the employee living with cancer is not compromised when he or she discloses his or her current state of health to the employer. This will only serve as an aid in order to allow the employer to understand the medical condition of the employee and provide the necessary support through reasonable accommodation, among other things. Therefore, a link can be identified between the operations of the constitutional right to privacy and the right to fair labour practices in the context of the legal issues which affect employees living with cancer. In order for the employer to execute his obligations, he or she ought

460 *NM v Smith* 2007 (5) SA 250 (CC). *Tshabalala-Msimang v Makhanya* [2008] 1 All SA 509 (W) involved the publication of confidential information of the Minister of Health who was admitted in hospital and the respondents which were the editor and publisher of Sunday Times newspaper. The publication disclosed the medical records of the patient and that she has transgressed hospital rules on several occasions as she was always drinking alcohol while in hospital. The Minister approached the court to order the respondents to return her hospital records which was in their possession and further argued that the article violated her right to privacy in terms of section 14 of the National Health Act and the Constitution. The court held that the conduct of the respondents was unlawful as they acquired the medical records of the applicant illegally and further disclosed such confidential information which is protected in terms of section 14 of the National Health Act and the Constitution. The court ruled in favour of the applicant because the conduct of the respondents violated her right to privacy.

461 *NM v Smith* case 250.

462 *NM v Smith* case 251.

463 *NM v Smith* case 252.

to know about the employee's condition and thus requires disclosure of such information from the employee.

3.8 The limitation of constitutional rights

3.8.1 Rationale for the limitation of rights

In a democratic state where the Constitution is the supreme law of the country, it is important that there must be a balance between the rights and duties which citizens enjoy for democracy to function.[464] This will entail limiting the rights of other people in the public's interest through a general limitation clause. Rautenbach and Malherbe argue that there can be no peace and order in any society when people's rights are exercised absolutely without limitations.[465] However, it is important to take into account that the limitation of rights must not be arbitrary but needs to be in line with the Constitution, taking into account values such as human dignity, equality and freedom.[466] Devenish explains the background of the general limitation clause, and particularly what it entails and its purpose.[467] He outlines that:

> "It is widely accepted in the domestic law of most countries, in international law and according to international and other human rights documents, that only a very limited number of rights, if any [,] are absolute. These include freedom from torture, the abuse and exploitation of children and possibly freedom from servitude, freedom of conscience, belief, thought and opinion. The overwhelming majority of human rights and liberties which are of necessity are restricted by inherent duty, which should be perceived as the inextricable counterpart of a corresponding right, to respect the rights of others. The classical example in this instance is that freedom of speech does not allow one person to defame another nor would it [call for a] sanction [to be imposed on] a person shouting fire in a full theatre when there is no fire".[468]

This means that there must be a link between a right and the means by which it is limited in order for it to be considered as a lawful and justifiable limitation.

In addition, section 38 of the Constitution provides that anyone whose rights have been infringed can seek appropriate relief from a court or tribunal. Section 36(1) and section 38 of the Constitution set out the tone for dealing with the issue of the limitation clause,

---

464 Section 2 of the Constitution of the Republic of South Africa, 1996.

465 Rautenbach and Malherbe *Constitutional Law* Sixth Edition 156.

466 Section 36(1) of the Constitution of the Republic of South Africa, 1996.

467 Devenish GE *A commentary on the South African Constitution* 121 (Butterworths, Durban 1998).

468 Devenish *A commentary on the South African Constitution* 121.

which is applicable in the relationships between the state and private individuals, as well as in the relationships between private individuals themselves. The next step will be to look into the limitation clause and also to make an inquiry as to whether it is valid or not.

3.8.2 The general limitation clause in terms of section 36(1) of the Constitution of the Republic of South Africa, 1996

Section 8 of the Constitution is important in describing the relationship between the state and private individuals.[469] This section facilitates a more realistic way of dealing with the rights of all people and balancing them with the obligations of the state. For example, section 14 of the Constitution does not grant people an absolute right as the state can violate the right to privacy of the individual with the aim of protecting the public's interests.

Similar to any other rights contained in the Constitution, the right to privacy can be limited in terms of section 36(1) thereof. This section provides the general limitation clause and states that the rights in the Bill of Rights may be limited only in terms of the 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. This limitation ought to be effected while taking into account factors such as the nature of the right, this means the purpose of the right, the importance of the purpose of the limitation, which has to do with the reason behind limiting the right, the nature and extent of the limitation, which has to do with an inquiry (which is normally done by the court), into looking at the way the limitation took place, the relation between the limitation and its purpose, meaning that there must be a balance between the infringement of a right and its purpose in order for the limitation to be justifiable, and the less restrictive means to achieve the purpose, which means that the limitation must achieve benefits which are proportional to the impact of that limitation.[470] However, it

---

469 Section 8(1) of the Constitution of the Republic of South Africa, 1996 states that the Bill of Rights applies to all laws. The Bill of Rights binds all the branches and spheres of government bodies. This means that it must be followed by: (a) the legislatures, which is a body that makes law, (b) the executive, which is the body that carries out law, (c) the judiciary, which are the courts. Section 8(2) of the Constitution of the Republic of South Africa, 1996 states that the Bill of Rights applies to all matters between citizens and government. This means it applies vertically between citizens and government. The Bill of Rights also applies horizontally in matters which arise between people or businesses.

470 Section 36(1)(a)-(e) of the Constitution of the Republic of South Africa, 1996. See De Vos and Freedman (eds) *South African Constitutional Law in Context* 369, in which De Vos and Freedman

is important to note that in *National Coalition for Gay and Lesbian Equality and Another v Minister of Justice and Others*,[471] the court held that the limitation of gay rights on moral grounds was not proportional to the benefits that were aimed to be achieved. In this case the court held that, the enforcement of private moral views of a section of the community, which is based to a large extent on prejudice, cannot qualify to be a legitimate purpose.[472] There is nothing, in the proportionality enquiry to weigh against the extent of the limitation, and its harmful impact on gays. In this case the court stated that there is no justification for the limitation of gay rights.[473]

The operation of section 36 of the Constitution can be illustrated using the example of a medical practitioner who discloses the health status of a patient that has acquired the Ebola virus, to other people. In this instance, the disclosure can be justified as acting in the public interest in order to curb the spread of the virus. Furthermore, an equitable balance exists between the purpose of the disclosure and the limitation of the right to privacy, given the dangerous nature of the Ebola virus. Thus, such a disclosure would be aimed at protecting the public's interest and ensuring that the particular patient is placed in quarantine. This will not amount to a violation of the right to privacy of the patient but can be considered as a protected disclosure, in terms of section 36(1) of the Constitution.

The same view can be reached in the case of an employee living with cancer who discloses his or her health condition to the employer, and the employer discloses such information to fellow employees in order to understand his or her health status and provide the employee living with cancer with the necessary support in the workplace. In terms of section 4 of the Health Professions Guidelines on Confidentiality: Protecting and Providing Information, where health practitioners are required to make

---

argue that there is no hard and fast rule for determining whether the purpose of the limitation is considered constitutionally legitimate. However, broadly speaking the constitutional values of openness, democracy, freedom, equality and dignity will play a role in determining what a legitimate purpose is. This shows that courts will judge each case based on its own merits and decide what constitutes a legitimate purpose. This is the correct approach which needs to be adopted in order to ensure that the law is in line with the public interest and ensure that the public interest is upheld at all times.

471 *National Coalition for Gay and Lesbian Equality and Another v Minister of Justice and Others*, (CCT11/98) [1998] ZACC 15, 1999 (1) SA 6, 1998 (12) BCLR 1517 (9 October 1998).

472 *National Coalition for Gay and Lesbian Equality and Another v Minister of Justice and Others*, case para 37.

473 *National Coalition for Gay and Lesbian Equality and Another v Minister of Justice and Others*, case para 38.

a disclosure on the health of the patient, they need the consent of the patient, and they ought to try to keep the data anonymous, so as to avoid revealing the identity of the patient, and they should also keep disclosures to the minimum and in line with the purpose it aims to serve in order for such a disclosure to be protected.[474]

In our law there are cases in which the role and legitimacy of section 36 of the Constitution has been described in detail. For example, In *S v Manamela* the court stated that:

> "In essence, the court must engage in a balancing exercise and arrive at a global judgment on proportionality and not adhere mechanically to a sequential check-list. As a general rule, the more serious the impact of the measure on the right, the more persuasive or compelling the justification must be. Unfortunately, the question is one of degree to be assessed in the concrete legislative and social setting of the measure, paying due regard to the means which are realistically available in our country at this stage, but without losing sight of the ultimate values to be protected. Each particular infringement of a right has different implications in an open and democratic society based on dignity, equality and freedom. There can be accordingly no absolute standard for determining reasonableness".[475]

However, the issue of protected disclosure in our law is a complicated matter and needs to be judged based on the facts of each case. Our courts have rejected a number of cases on the basis that the disclosure of the health status of a person is unlawful and does not amount to protected disclosure, and thus not justified in terms

---

474 Section 4 of the Health Professions Guidelines on Confidentiality: Protecting and Providing Information 2008 (HPCSA Guidelines) 7. Furthermore, with regard to disclosures see Bendix S *Labour Relations: A Southern African Perspective* 297 (Juta Publishers, Cape Town 2015).

475 *S v Manamela and Another* 2000 (3) SA 1 (CC) and the land mark case of *S v Makwanyane*, "the court stated that the limitation of constitutional rights for a purpose that is reasonable and necessary in a democratic society involves weighing up of competing values and ultimately an assessment based on proportionality. This is implicit in the provisions of section 33(1)(c) of the Interim Constitution. The fact that different rights have different implications for democracy, and in the case of our Constitution, for an open and democratic society based on freedom and equality, means that there is no absolute standard which can be laid down for determining reasonableness and necessity. Principles can be established, but the application of those principles to particular circumstances can only be done on the case by case basis. This is inherent in the requirement of proportionality, which calls for the balancing of different interests. In the balancing process, the relevant considerations will include the nature of the right that is limited, and its importance to an open and democratic society based on freedom and equality, the purpose for which the right is limited and the importance of that purpose to such a society, the extent of the limitation, its efficacy, and particularly where the limitation has to be necessary, whether the desired ends could reasonably be achieved through other means less damaging to the right in question. In the process, regard must be had to the provisions of section 33(1)(c) of the Interim Constitution, and the underlying values of the Constitution, bearing in mind that as a Canadian Judge has said, the role of the court is not to second-guess the wisdom of policy choices made by legislators".

of section 36 of the Constitution. For example in the case of *NM v Smith*,[476] in which the HIV status of three people was published in a book without their consent, as discussed earlier in the chapter, the court rejected the argument raised by the respondent that the HIV status of the three applicants was known by the public, as the court held that such disclosure was not in the public's interest and thus did not amount to a protected disclosure.[477]

In *Maje v Botswana Life Insurance*,[478] the plaintiff sued the defendant company for publishing her photograph in the company's newsletter and thereby depicting her as being HIV-positive. The defendant company argued that it was in the public's interest to make such a disclosure, and the court dismissed such reasoning on the basis that the publication was offensive and had caused her humiliation.[479] The conduct of the defendant company did not amount to a protected disclosure and was not in the public's interest, but it amounted to an actionable offence.[480] Based on these cases, it is very important that for a disclosure to be justifiable in terms of section 36 of the Constitution in order for it to be protected. In addition, the disclosure must be in the public's interest and thus it can be argued that such a disclosure must serve a certain purpose which is in the public's interest before it can be considered as justifiable in terms of section 36 of the Constitution.

In the context of an employee living with cancer who has disclosed his or her medical condition to the employer, and the employer uses this information to the disadvantage of the employee such as humiliation and gossip with fellow colleagues, then such conduct will amount to the violation of the right to privacy of the employee and will not be justifiable in terms of section 36 of the Constitution.[481] It can be argued that the

476 *NM v Smith* case 250.

477 *NM v Smith* case 250.

478 *Maje v Botswana Life Insurance* [2001] 2 BLR 626.

479 *Maje* case 626.

480 *Maje* case 627.

481 Section 36 of the Constitution of the Republic of South Africa, 1996. Further, it is important to define what a protected disclosure means for the purposes of this study. Protected disclosure means the disclosure of information to specific individuals or bodies such as employers, legal advisors, members of cabinet, the public protector or auditor general. For information to qualify as a protected disclosure it is important to note that it must not be rumours or personal opinion. The requirements that must be fulfilled by the employee in this context, in order for what he or she discloses to be a protected disclosure includes: the disclosure must be made in good faith, the must be a reasonable belief, and that the information disclosed is substantially true. See McGregor M *et al*, Labour *Law Rules* 85 (Creda Communications, Cape Town 2012).

limitation clause is a neutraliser in keeping harmony between the rights and the limitation of the rights of human beings, as clearly argued by Rautenbach and Malherbe.[482]

3.9 Remedies available to an employee living with cancer in the South African context

3.9.1 Statutory remedies

The employee living with cancer, who has suffered unfair discrimination or has experienced unfair labour practices at the hands of the employer and fellow employees, has access to specific legal remedies. The remedies that are available to the employee are outlined in section 191(1) of the Labour Relations Act.[483] Section 191(1) of the Labour Relations Act also provides for the body which the employee living with cancer must approach to seek relief and the time frame which has to be adhered to when lodging a claim.

Section 191(1)(a) states that if there is a dispute about the fairness of a dismissal, or a dispute about an unfair labour practice, the dismissed employee or the employee alleging the unfair labour practice may refer the dispute in writing to either a council, if the parties to the dispute fall within the registered scope of that council, or the commission, if no council has jurisdiction.[484] A referral in terms of section 191(1)(a) must be made within 30 days of the date of dismissal or, if it is a late date, within 30 days of the employer making a final decision to dismiss or uphold the dismissal.[485] A referral made in terms of section 191(1)(b) must be made within 90 days of the date of the act or omission which allegedly constitutes the unfair labour practice.[486] Section 191(2) further states that, if an employee shows good cause at any time, the council

---

482 Rautenbach and Malherbe *Constitutional Law* Sixth Edition 156.

483 Section 191(1)(a) Labour Relations Act 66 of 1995. When dealing with resolving labour law disputes, it is important to note the view of Grogan, who states that South Africa has one of the most sophisticated systems for labour law dispute resolution processes in the world. This is due to the fact that despite legislation being put in place to resolve labour disputes such as the Labour Relations Act, certain types of disputes are left to the parties to resolve by agreement if possible and if not by industrial action. This is indeed a diverse system which is not imposed on parties but rather the responsibility of how the parties want to resolve their dispute is left to them to decide in the process. See Grogan J *Labour Litigation and Dispute Resolution* 4 (Juta Publishers, Cape Town 2014).

484 Section 191(1)(a)(i)-(ii) of the Labour Relations Act 66 of 1995.

485 Section 191(1)(a) of the Labour Relations Act 66 of 1995.

486 Section 191(1)(b) of the Labour Relations Act 66 of 1995.

or the commission may permit the employee to refer the dispute after the relevant time limit in subsection 191(1) has expired. Subject to subsections 191(1) and (2), an employee whose contract of employment is terminated by notice, may refer the dispute to the council or the commission once the employee has received that notice.[487]

Section 191(3) states the employee must satisfy the council or commission that a copy of the referral has been served on the employer. Section 191(4) provides that the council or the commission must attempt to resolve the dispute through conciliation. Section 191(5)(a) outlines that if a council or a commissioner has certified that the dispute remains unresolved, or if 30 days has expired since the council or the commission received the referral and the dispute remains unresolved, the council or commission must arbitrate the dispute at the request of the employee, if the employee has alleged that the reason for the dismissal is related to the employee's conduct or capacity, unless the employee referred the dispute to the Labour Court for adjudication because the employee alleges that the reason for dismissal is based on the employer's operational requirements.[488] The council or commission must also arbitrate the dispute at the request of the employee, if the employee has alleged that the employer has made continued employment intolerable or the employer provided the employee with substantially less favourable conditions or circumstances at work after a transfer in terms of section 197 or section 197A, unless the employee alleges that the contract of employment was terminated for a reason contemplated in section 187.[489] Furthermore, the council or commission must also arbitrate the dispute at the request of the employee, if the employee does not know the reason for the dismissal or the dispute concerns an unfair labour practice.[490]

Section 191(5)(b) outlines that if a council or a commissioner has certified that the dispute remains unresolved, or if 30 days has expired since the council or the commission received the referral and the dispute remains unresolved, the employee may refer the dispute to the Labour Court for adjudication if the employee has alleged that the reason for the dismissal is either automatically unfair, based on the employer's

487 Section 191(2)-(2A) of the Labour Relations Act 66 of 1995.
488 Section 191(5)(a)(i) read with section 191(5)(b)(ii) of the Labour Relations Act 66 of 1995.
489 Section 191(5)(a)(ii) of the Labour Relations Act 66 of 1995.
490 Section 191(5)(a)(iii)-(iv) of the Labour Relations Act 66 of 1995.

operational requirements, or the employee's participation in a strike that does not comply with the provisions of Chapter IV, because the employee refused to join, was refused membership of or was expelled from a trade union party to a closed shop agreement.[491]

Section 191 of the Labour Relations Act is instrumental in ensuring that the rights of employees are not violated and their rights to fair labour practices are protected. Labour Relations Act also promotes the use of Alternative Dispute Resolution in the sense that the employee must exhaust these measures first before approaching the Labour Court about the dispute at hand. Further, is important to take into account that in this study reference will only be made to mediation, due to the pivotal role it plays in resolving labour disputes and other disputes outside the labour market. Due to its reconciliatory approach, mediation is currently recommended as an alternative dispute resolution measure which can reduce the high back lock of litigation cases in our courts. Based on these reasons advanced above, they serve as justification for the discussion of mediation in this study, at the exclusion of other forms of alternative dispute resolution mechanisms.

3.9.2 Alternative Dispute Resolution (ADR)

3.9.2.1 Mediation as a dispute resolution mechanism of the past

Mediation is often misunderstood as a dispute resolution process of the modern world.[492] Yet the process has been utilised for many years in the fields of labour law and commercial law. The process of mediation is actually an ancient process which has been in existence for a very long time, dating back from the time when people were discovered on earth.[493] Mediation has traditionally been used as a means of dispute resolution in several cultures, to accomplish societal cohesion regardless of

---

491 Section 191(5)(b)(i)-(iv) of the Labour Relations Act 66 of 1995. See also Finnemore M *Introduction to Labour Relations in South Africa* 285 (LexisNexis, Durban 2013).

492 This misconception arises from the development of mediation as a way of resolving disputes between different people from all walks of life. These include: labour disputes, commercial disputes, family disputes and medical disputes, and is evident from the recently drafted mediation rules for magistrate courts, with the sole aim of introducing court based mediation.

493 Mantle M *Mediation: A Practical Guide for Lawyers* (Edinburgh University Press, Edinburgh 2011).

individual or communal conflicts.[494] It was used to ensure peace in communities between the disputing parties.[495]

In the case of culture and tradition, African societies resorted to having respected notables in society to mediate disputes which arose between people.[496] This was done through the process of assembling a moot or neighbourhood meeting which would provide an informal mechanism for resolving a wide variety of interpersonal disputes between members of the community or neighbours.[497] The dispute would be resolved by a moot which is often an old man or woman with knowledge and understanding of the culture of a particular community, and who acted as a mediator to help the parties resolve their conflicts cooperatively.[498] The role of the notable and the tradition of the moot varied from one community to another, due to the diverse nature of the African continent, but they shared the same sentiments of restoring the relationship between the parties to the dispute without the intervention of the courts.[499]

In the African culture, maintaining peace and social relations is important for the survival and growth of society in which emphasis is not placed on the individual but on the broader community as a whole.[500] This principle is embedded in the African concept of *Ubuntu*, which is a normative source of indigenous law and implies co-existence of human rights and freedoms on the one hand, and collective duties on the other hand. It places emphasis on the role of the individual as a member of the community.[501] Furthermore, *Ubuntu* implies a spirit of humanness and includes virtues such as compassion, forgiveness and human dignity.[502] Mediation aims to achieve just this between the parties to restore their relationship in a compassionate and justifiable

494 Fiadjoe A *Alternative Dispute Resolution: A Developing World Perspective* 4 (Cavendish Publishing, London 2004).

495 Randolph P and Strasser F *Mediation: A psychological insight into conflict resolution* 3 (Bloomsbury Academic, London 2004).

496 Taylor A and Folberg J *Mediation: A comprehensive guide to resolving conflicts without litigation* 2 (Jossey-Bass Publishers, San Francisco 1984).

497 Taylor and Folberg *Mediation: A comprehensive guide to resolving conflicts without litigation* 2.

498 Gibbs W "The Kpelle Moot: A therapeutic model for informal justice settlement" 1963 (33) *Africa* 4.

499 Gulliver PH *Disputes and Negotiations: A cross-cultural perspective* 3 (Academic Press, New York 1979).

500 Gibbs 1963 (33) *Africa* 5.

501 Van Niekerk GJ and Wildenboer L *The Origins of South African Law* 177 (UNISA, Pretoria 2010).

502 Van Niekerk and Wildenboer The *Origins of South African Law* 177.

manner.[503] *Ubuntu*, as an indigenous law source, was recognised in *S v Makwanyane*,[504] where the Constitutional Court was of the view that in interpreting the Bill of Rights, indigenous values ought to be put to effect and thus develop a specific South African understanding of human rights and indigenous law as a system of law in our country.

Currently, mediation is used in different types of industries which range from commercial disputes of big corporations, to labour disputes between employers and employees conducted through the CCMA.[505] Mediation is also used in family law disputes, particularly where the parties are about to get divorced and there are children involved. In this case mediation will be recommended for the purpose of protecting the best interests of the children in terms of section 28 of the Constitution. However, it is important to note that mediation in family law disputes is not a process that was introduced recently, but it was used in both African and religious cultures to resolve disputes between husband and wives since ancient times, this was through the intervention of old people from the families of both the husband and wife.[506]

3.9.2.2 Mediation as a dispute resolution mechanism of today

The use of Alternative Dispute Resolution (ADR) processes, such as mediation is now on the rise and highly recommended by the courts and law makers.[507] Mediation is very important in resolving a dispute between two parties since the parties are in charge of the proceedings and can appoint their own mediator, who is an independent person and who does not have some form of interest in the dispute in question.[508] In this process, the parties will come to an agreement which suits them and their

503 Meruelo 2008 (29) *JLM* 292.

504 *S v Makwanyane* 1995 (6) BCLR 6655 (CC).

505 The Commission for Conciliation, Mediation and Arbitration (CCMA) is the body that deals with resolving disputes between the employer and employee. It consists of its own commissioners who are trained to resolve the disputes between the parties. See section 112 of the Labour Relations Act 66 of 1995.

506 Goodwin P *Global Studies: Latin America* 248 (McGrow-Hill Publishers, New York 2006), and see Gulliver *Disputes and Negotiations: A cross-cultural perspective* 4, in which the role of family members in resolving disputes between members of the family amicably through the process of mediation is explored.

507 Meruelo NC "Mediation and Medical Malpractice: The need to understand why patients sue and a proposal for a specific model of mediation" 2008 (2) *JLM* 287.

508 Meruelo 2008 (2) *JLM* 287.

respective needs. The entire process of mediation is confidential, which is not the case when it comes to litigation.[509]

This process of mediation will ensure that the dispute is resolved much faster and less costly to the employee, in contrast to litigation which takes long and is expensive.[510] Mediation will most importantly ensure that the relationship between the employer and the employee is sustained and protected throughout the entire process of resolving the dispute between the disputing parties, which may not be the case with litigation.[511]

The litigation process is hostile, as parties look at each other in court like enemies in a battle field where there is a winner and a loser. In mediation the process changes and the parties become involved like allies who try to understand the issue objectively.[512] This is extremely important in medical negligence cases and labour disputes where emotions tend to overshadow reason.[513]

---

509 Meruelo 2008 (2) *JLM* 288.

510 Howard M *Civil Litigation and Dispute Resolution: Vocabulary Series* 4 (Legal English Books Publishers, London 2013).

511 Howard *Civil Litigation and Dispute Resolution: Vocabulary Series* 5.

512 Salamon R *Handbook of Emotions* 3 (Guildford Press Publishers, London 1993).

513 The writings of the famous Greek philosopher, Aristotle (384-322 BC), prove these sentiments. He was of the view that the process of mediation is scientific and methodical. His comments on mediation can be traced back 2300 years ago. According to Aristotle every person is in conflict with the self. Emotions and reason creates an unequal personality in the sense that reason is like master and emotions like a servant. Emotions are primitive, unintelligent and sometimes bestial, while reason or rationality is wisdom and usually in control of the situation. Emotions need to be suppressed as they make a person subjective. Rationality should be cultivated for a person to be objective. Mediation had its genesis also in religious practices. This is clear from the Christian faith as outlined in the New Testament in which mediation as a process of dispute resolution is recognised, where Paul the apostle spoke to the congregation at Corinth and said that people should not take their disputes to the court, but ought to rather appoint people in their own community to settle their disputes. Mediation is consistent with, if not central to, the biblical values of forgiveness, reconciliation and communal values. Thus there is biblical foundation and approval for mediators able to bring about peaceful coexistence between people. In Matthew 5 verse 9 the scriptures state that "blessed be the peacemakers for they shall be called the sons of God". The Hindu people in India also made use of traditional mediation process by engaging in what was called the panchayat justice system. According to this system the way of resolving disputes is between people at village level, as opposed to the whole cultural group this is more efficient and ensures that relations continue to be maintained between people. In the Islamic faith the traditional pastoral societies in the Middle East also make use of mediation to resolve disputes among people. The pastor plays a significant role in resolving disputes between the disputants. These are not the only religions that use mediation as a means of dispute resolution in ancient times, and even today but they serve as important and practical examples of the role of mediation in dispute resolution. See also Salamon *Handbook of Emotions* 3.

The growth of non-traditional mediation processes as outlined above has led mediation to a point in which it can be classified or considered as either rights-based or interest-based.[514] The rights-based mediation process entails that the mediator proposes a solution according to what the court could have decided.[515] More focus is on the immediate dispute in a legal context rather than on the underlying dispute or conflict.[516] It is up to the parties to either accept or reject the decision delivered to them.[517] Further, it is important to note that the rights-based process is the type of system that is utilised by applying the law and involves the application of known rules and legal principles.[518] The rights-based process resembles the court process but is much quicker and cost-efficient compared to litigation.[519] However, an exclusive emphasis on rights encourages positional bargaining and undercuts the value of the mediation process.[520] This has been the main reason why the interest-based approach is widely preferred for purposes of mediation.[521]

Interest-based mediation is considered as more of a therapeutic process.[522] This is because it closely resembles the traditional model of mediation which attempts to help disputing parties understand the underlying needs and interests of one another. In interest-based mediation processes, more focus is placed on the underlying conflict which gave rise to the dispute.[523] The interest-based mediation model is more attractive for aggrieved parties as it places emphasis on the interests of the parties involved.[524] Using this method, the underlying interests of the parties are considered in protecting their rights and upholding the law through the process of mediation. In practise, this method has shown to be the least expensive compared to the rights-

514 Fiadjoe *Alternative Dispute Resolution: A Developing World Perspective* 61.
515 Fiadjoe *Alternative Dispute Resolution: A Developing World Perspective* 61
516 Fiadjoe *Alternative Dispute Resolution: A Developing World Perspective* 61.
517 Fisher R *Mediation Training Course Handbook* 54 (Springer, London 1997).
518 Fiadjoe *Alternative Dispute Resolution: A Developing World Perspective* 62.
519 Meruelo 2008 (29) *JLM* 293.
520 Fiadjoe *Alternative Dispute Resolution: A Developing World Perspective* 63.
521 Fiadjoe *Alternative Dispute Resolution: A Developing World Perspective* 64.
522 Van Gramberg B *Managing Workplace Conflict: Alternative dispute resolution in Australia* 70 (Federation Press, Sydney 2006).
523 Van Gramberg *Managing Workplace Conflict: Alternative dispute resolution in Australia* 70.
524 Van Gramberg *Managing Workplace Conflict: Alternative dispute resolution in Australia* 71.

based approach and further compared to litigation.[525] Mediation is carried out on an interest-based approach in our South African law of ADR.[526]

The utilisation and effective use of ADR measures such as mediation through the Commission for Conciliation, Mediation and Arbitration (CCMA) has been explored in a wide variety of cases in South Africa. It is necessary to mention a few of those cases in order to show that indeed employers and employees make use of this important mechanism for purposes of resolving their disputes. The following discussion should also serve as an informative tool to reveal the effectiveness, or not, of ADR procedures.

3.9.3 Synopsis of cases decided by the Commission for Conciliation, Mediation and Arbitration (CCMA)

3.9.3.1 Decisions regarding unfair labour practises

3.9.3.1.1 Num obo Moeng v Douglas Colliery [2007] BALR 647 (CCMA)

In the case of *Num obe Moeng v Douglas Colliery*,[527] the employee as applicant in this case, alleged that the employer had committed an unfair labour practice in terms of section 186(2) of the Labour Relations Act due to the fact that the employer refused to promote him. The applicant claimed that the respondent had declined his application for promotion on numerous occasions when he made such applications, although he met all the requirements needed for him to be promoted.[528] The respondent employer claimed that the applicant employee was not even short listed for the position in question, but it was based on the recommendation of the National Union of Mine Workers (NUM) that he be given the exposure for future possible opportunities.[529]

The two candidates who were shortlisted declined the post and the applicant was taken to undergo a psychometric evaluation to see if he will be capable of executing the duties of this new position, but it was found that the applicant in question lacked the necessary skills required for an employee to be given the said position. The position was thus re-advertised for more applications.[530] The commissioner was of the

525 Van Gramberg *Managing Workplace Conflict: Alternative dispute resolution in Australia* 71.
526 Van Gramberg *Managing Workplace Conflict: Alternative dispute resolution in Australia* 72.
527 *Num obe Moeng v Douglas Colliery* [2007] BALR 647 (CCMA).
528 *Num obe Moeng* case 648.
529 *Num obe Moeng* case 648
530 *Num obe Moeng* case 649.

view that to appoint or promote employees lies squarely within the prerogatives of management of the company, as long as this is done in the manner which is fair and equitable. The commissioner found that the respondent employer acted reasonably by not appointing the applicant to the said position.[531] The commissioner further stated that the conduct of the employer does not constitute unfair labour practices, as he acted in a reasonable way and in the best interest of the company.[532]

3.9.3.1.2 Skwatsha v Department of Education [2008] 21 ILJ 27 (CCMA)

Another case of interest which was referred to the CCMA was the case of *Skwatsha v Department of Education*.[533] In this case the applicant employee brought a claim against the respondent employer on the basis of unfair labour practices in terms of section 186(2) of the Labour Relations Act. The aggrieved employee claimed that he had made applications on numerous accounts for promotion with regard to the various positions which where advertised by the employer, and yet he never received any response in this regard for years.[534] However, he was called in for an interview for a position which he did not apply for in the first place.[535] He later found out that the interview that he attended was in actual fact in relation to the position which he currently occupied and it meant that if he was not successful, he would lose his job.[536]

The commissioner found that the respondent employer committed an unfair labour practice in terms of section 186(2) of the Labour Relations Act and ordered the applicant to make a list of the positions which he had applied for in the company and to which he never received any response.[537] The respondent employer was expected to provide reasons as to why the applicant employee was not given feedback in connection to his applications. Furthermore, the employer was required to elaborate if those positions were filled and if the people who occupy them were suitably qualified, experienced and whether all the rules and principles of employment equity were complied with upon their employment. [538] The respondent employer failed to furnish

---

531 *Num obe Moeng* case 650.
532 *Num obe Moeng* case 650.
533 *Skwatsha v Department of Education* [2008] 21 ILJ 27 (CCMA).
534 *Skwatsha* case 28.
535 *Skwatsha* case 28.
536 *Skwatsha* case 29.
537 *Skwatsha* case 30.
538 *Skwatsha* case 31-32.

these reasons and the commissioner ruled in favour of the applicant employee and was of the view that the applicant employee ought to be considered for promotion in the company as a result of the unfair labour practice he experienced, since he was appropriately qualified and experienced for the relevant position.[539]

3.9.4 The effectiveness of existing legal remedies in the instances of unfair labour practices imposed on employees living with cancer

The provisions of section 191(1) of the Labour Relations Act as outlined above clearly show that employees, who experience some form of discrimination in the workplace, can in actual fact take the matter further through the various legal recourses which are available to them, which in the first instance involves taking the employer to the CCMA. These various remedies uphold the rights of employees to fair labour practices, and ensure that they are free from any form of unfair discrimination in the workplace. Furthermore, these ADR mechanisms are significant in ensuring that the basic fundamental rights to human dignity, equality and freedom are protected on the basis of the provisions of the Constitution.[540]

Therefore, employees living with cancer can seek redress against the employer as a result of the unfair discrimination or unfair labour practices which they might experience in the workplace on grounds of cancer. It is clear that such problems arise out of the employer's ignorance or lack of knowledge about cancer. Furthermore, the fact that employees living with cancer are not specifically mentioned in the legislative texts regarding labour law contributes to this ignorance. The use of ADR mechanisms will put an end to ignorance and thus employees living with cancer who are aggrieved by unfair labour practices are encouraged to pursue these remedies in order to curb the unfairness and stigma which they experience in the employment environment. This is because remedies, such as mediation have been tried and tested in labour disputes and have produced good results. It can be argued that the ADR mechanisms in labour disputes have become efficient and successful, this is even recognised today in medical law disputes where ADR processes are now recommended as alternatives to resolve the high levels of medical litigation, which is a serious problem. More about

539 *Skwatsha* case 33-36.

540 Section 2 of the Constitution of the Republic of South Africa, 1996.

the role of ADR mechanisms in medical negligence cases will be explored later on in the thesis.

3.10 Conclusion

Both the government and civil society should fully educate the community about the causes and treatment of cancer, in a similar way as the programs offered on HIV and AIDS.[541] This will undoubtedly serve to prevent the imposition of unfair labour practices and unfair discrimination on employees living with cancer in the workplace.

[541] Wagstaff A "Stigma: breaking the vicious cycle" 2013 *World Cancer* 24.

Chapter 4: The protection of employees living with cancer against unfair discrimination in the workplace in the United Kingdom and in America

4.1 Introduction

The protection against unfair discrimination in the workplace of employees living with cancer has been explored in the previous chapter. This chapter compares the South African legal position to that of the English legal system. South Africa and the United Kingdom share legal historical ties, in fact, the South African legal system has, in some areas, significantly been shaped and influenced by the English legal system.[1] Owing to this historical connection and some commonalities between the two jurisdictions, an assessment of relevant laws may be instructive for South Africa, which may assist in improving existing laws and policies in South Africa, aimed at the legal protection of employees living with cancer.

As far as the United Kingdom is concerned, the Equality Act[2] will be assessed. The Equality Act provides protective measures that also apply to persons living with cancer in employment contexts, offering protection from unfair discrimination which they may experience on the basis of their health status. The Equality Act has put the United Kingdom ahead of South Africa by making provision for the protection of persons living with cancer and recognising cancer as a progressive medical condition which can result in a disability.[3]

The discussion will first explore anti-discrimination laws which protect persons living with cancer or employees against discrimination based on their medical condition in the United Kingdom. Further, some of the inconsistencies between the legal approaches in the United Kingdom and South Africa will be outlined. Reference will also be made, where relevant and appropriate, to some examples from the United

1 Joubert WA (ed) *LAWSA* 8-9 (LexisNexis Butterworths, Durban 2004).

2 Equality Act of 2010.

3 Section 3 of the Equality Act of 2010.

States of America, as the United States, in general, has taken great strides to recognise the vulnerability of employees living with cancer in its legal system.

As such, a discussion about the challenges facing employees living with cancer in the workplace will be incomplete without reference to the American system.[4] Due to the United States' global position as a world leader, lessons can be drawn from its jurisprudence when it comes to the protection of employees living with cancer in the workplace. America has flexible legal instruments in place, such as the Americans with Disabilities Amendment Act (ADAA), which has been described as a very important legislation aiming towards the protection of people who suffer from disabilities, which include cancer.[5]

4.2 Legal position relating to the protection of employees with cancer in the United Kingdom

Discrimination towards employees living with cancer in the United Kingdom has been rising steadily over the past few years. Some of these cancer-stricken employees may be denied sick leave and consequently may miss some of their doctor's appointments.[6] Furthermore, employees living with cancer are often harassed by employers and fellow employees to an extent where they feel like abandoning their jobs.[7] The British government has thus identified a number of considerations which can assist employees living with cancer to be fully rehabilitated and capable of returning to work after being diagnosed with cancer.[8] Among other things, these include, providing fast and cost effective treatment to employees living with cancer, providing personal and psychological agencies to employees living with cancer in helping them to cope with cancer symptoms in order to build self-confidence of their ability and skills to work, providing empowerment to the employee to set achievable goals which will boost their self-confidence, having the employer modify the workplace

4 Russell G "Sickness Absence and Disability Discrimination" 2013 (14) *TUC* 4.

5 Russell 2013 (14) *TUC* 4-5, Americans with Disabilities Amendment Act (ADAA) 2008.

6 Bailey C and Corner J *Cancer Nursing Care in Context* Second Edition 623 (Blackwell Publishers, London 2009).

7 Devane 2013 (1) *Macmillian Cancer Support* 11.

8 Devane 2013 (1) *Macmillian Cancer Support* 12.

in the phase of the employee returning to work in order to assist the employee to perform his or her duties.[9]

Over 100 000 people of working age are diagnosed with cancer every year in the UK,[10] and almost half of those people continue to work when they are diagnosed with cancer and have to make changes to their working habits, with around four out of ten of them changing jobs or leaving work altogether due to the unfair discrimination in the workplace.[11] Some of the injustices that employees face as a result of cancer include how they tend to not be allowed some time off from work in order to see their doctors.[12] This has resulted in the government providing effective treatment mechanisms to persons living with cancer, with the aim of alleviating discrimination in order for employees living with cancer to return to work soon and not require further time off or reasonable accommodation.[13] It is important for employees living with cancer to, as far as possible, continue to work and earn a living. Blanpain describes the importance of work in the life of any human being and further states that:

> "Work is a fundamental aspect in the life of any person, it gives the individual means of financial support and most importantly, it gives one a contributory role to society. A person's work is an essential component of his or her sense of identity, self-worth, and emotional well-being. Accordingly, the working conditions where a person works are very important in shaping or developing the

9 Devane 2013 (1) *Macmillian Cancer Support* 13.

10 Hope 2013-05-02 *Mail Online* 2.

11 Hope 2013-05-02 *Mail Online* 2. Examples of the two incidences in which employees living with cancer suffered unfair discrimination in the workplace in the United Kingdom owing to their cancer include: In 2006 a designer and studio manager never got the justice that he deserved due to the injustices he suffered in the hands of the employer. Jack had colon cancer that resulted in him being unfairly discriminated against by the employer. The employer refused Jack time off, he constantly reduced his salary when he was not at work, though he was working from home, took away some of his responsibilities, harassed him and constantly abused him verbally. All of this occurred despite the commitment of Jack working day and night and additionally, working at home, which led to unrecognised efforts. When Jack approached management for assistance he was informed that he can sell his house or car to comply with his medical bills. Owing to the depression, ailing health, financial and work stress which Jack had endured, he died on his way to work. Another unfair discrimination case of cancer in the workplace occurred in 2010. A man by the name of Paul Ware, who was diagnosed with blood cancer, asked for time off from the employer and as a result, his employment was terminated. The employer reasoned that he was not fully committed to the company as a result of his cancer. He questioned this decision in the equality court, but due to expensive legal costs, he was forced to accept a settlement from the employer, which was very low.

12 Bailey C and Corner J *Cancer Nursing Care in Context* 624.

13 Bailey C and Corner J *Cancer Nursing Care in Context* 624.

> whole compendium of psychological, emotional and physical elements of a person's dignity and self-respect".[14]

Considering the importance of employment in the general make up of any human being, it is important that the right to work for employees living with cancer be protected through legislative reform, among other things, for purposes of their survival in both society and in the workplace. Furthermore, the government developed means to protect disabled employees and employees living with cancer in the workplace from unfair discrimination. A similar position was adopted in the United States through the Amended Americans with Disabilities Act.[15] Cancer is recognised as a progressive condition which could result in an employee living with cancer to be considered disabled. As stated already, cancer targets everybody, especially people of working age.[16] This shows that contrary to the erroneous perception that exists, cancer does not only target persons of a more mature age.[17]

However, as outlined earlier, South Africa has not yet developed a framework recognising cancer management in the workplace. It is in this regard that South Africa should take note of the developments in the United States and the United Kingdom in improving the current situation.

4.2.1 Equality Act of 2010

The aim of the Equality Act,[18] is to bring harmonisation, simplification and modernisation of equality laws, through the express declaration that every human being is entitled to equal protection and benefit under the law regardless of their

---

14 Blanpain R *The Changing World of Work* 23 (Kluwer Law and Taxation Publishers, Boston 2009).

15 Section 3 of the Amended Americans with Disabilities Act of 2008.

16 Blanpain *The Changing World of Work* 24.

17 Krebs LU and Pelusi J "Understanding Cancer-Understanding the Stories of Life and Living" 2015 (20) *JCE* 12.

Equality Act 2010 seeks to take away any form of discrimination which people suffering from disability can experience on the hands of other people such as the employer. The Disability Discrimination Act 1995 (DDA) is important to take into account, as it was one of the first pieces of legislation in the United Kingdom that was used to fight unfair discrimination on the basis of disability in the workplace. The Disability Discrimination Act 1995 was replaced in 2005, but finally in 2010 the Equality Act 2010 was developed which is considered as a combination of various pieces of legislation which fight unfair discrimination in one legislation. According to the Equality Act 2010, cancer is recognised as a disability and all people with cancer are protected by this legislation.

background or social being.[19] The Equality Act makes provision for protective feature under section 4, which include age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.[20] Hepple argues that the reason why the Equality Act provides a specific list of prohibited grounds of discrimination is because the open-ended approach to defining the prohibited grounds is subject to abuse and criticism.[21] It is argued that the one adopted by the European Convention on Human Rights is not clear and specific.[22]

Hepple's view is correct because having a specific list of prohibited grounds makes it easy for people to immediately know and understand their rights, and it gives them certainty without having first to make an inquiry regarding the interpretation of the law in order to establish the rights to which they are entitled. Similar to the position in the United Kingdom, South African law also makes provision for the prohibition of unfair discrimination on the basis of the grounds which have been outlined in terms of the Equality Act, through section 9 (e.g the equality clause) of the Constitution.[23] The understanding of "disability", however, differs in these two jurisdictions. In terms of section 6 of the Equality Act,[24] in the United Kingdom, a person is said to have a disability if he or she has a physical or mental impairment, and the impairment has a substantial and long term adverse effect on the person's ability to carry out normal day to day activities.[25] This definition of disability was taken further by the British Council

---

19 Section 2 of the Equality Act 2010. The importance and broad scope of the Equality Act as outlined above is affirmed by the reasoning of Ashtiany, who argued that the Equality Act is one of the pieces of legislation that makes the United Kingdom one of the progressive countries across the globe. This is attributed to the fact that the Equality Act is a codification and simplification of existing laws because it brings together 9 major pieces of legislation and around 100 statutory instruments. Ashtiany further argues that the reach of the Equality Act is far greater than the codification and simplification of existing laws, because the intention of this Act is to bring together a coherent set of provisions for the 21st century and to enhance the existing law at the same time. This argument is indeed correct because this Act makes provision for the rights of all people in spite of their socio-economic status, disability or ill health because that the aim of this Act is to attain equality as outlined in the purpose of the Act. See Ashtiany S "The Equality Act 2010: Main Concepts" 2011 (11) *IJDL* 29-30.

20 Section 4 of the Equality Act 2010.

21 Hepple B "The New Single Equality Act in Britain" 2010 (5) *TERR* 12.

22 Hepple 2010 (5) *TERR* 12.

23 Section 9(3) of the Constitution of the Republic of South Africa, 1996 states that the state may not unfairly discriminate directly or indirectly against anyone on one or more grounds including race, gender, sexual orientation, age, religion, belief, disability, culture, language and birth.

24 Section 6 of the Equality Act 2010.

25 Section 6(1)(a)-(b) of the Equality Act 2010. The aspect of a substantive and adverse effect was also discussed in the case of *Swift v Chief Constable of Wiltshire, SCA Packaging Ltd v Boyle* HL 2009. In this case the court made an inquiry as to what constitutes a substantive and

Organisations for Disabled people, an organisation which champions for the rights of disabled people in society.[26] In terms of the British Council of Organisations for Disabled People, disability is defined as "the disadvantage or restriction of activity caused by a society which takes little or no account of people who have impairments and thus excludes them from mainstream activities".[27]

In terms of the UN Convention on the Rights of Persons with Disabilities, it is argued that a disability is an evolving concept which is not stagnant, and therefore has to be accommodated by the adaptation of legislation.[28] The Convention state that since the definition of a disability is evolving, it must not be seen as something that resides within an individual as a result of his or her impairment. Disability must be understood within the context of the interaction between an individual with his or her environment.[29] This understanding is recommended, because currently in the 21st century, health conditions such as cancer may lead to disability, because of the impact cancer may have on the individual's interaction with his or her environment, and more specifically, the workplace.

4.2.2 Unfair discrimination

Section 15 of the Equality Act, prohibits unfair discrimination arising from disability and declares it unlawful. Section 15(1)(a)-(b) of the Equality Act states that a person or

adverse effect which could have an impact on the ability of an employee to continue or do work, and the court held that the following questions needs to be answered in the affirmative for the condition of one to be recognised as a disability that has the ability to substantively and adversely affect the ability of an employee to do work. Firstly, was there impairment on the employee? Did the impairment have a substantial adverse effect on the ability of the employee to do work? Did the adverse effect cease to have a substantial adverse effect on the ability of the employee to continue to do work and if so, when was this? Lastly, an inquiry will deal with the aspect as to whether the same adverse effect on the employee is likely to occur again in the near future.

26 The British Council was established in 2006 as an advisory body with the aim of protecting and championing for the rights of disabled people due to the hostile environment they experience in the workplace through discrimination. This Organisation has grown incredibly and has committed staff members that are well qualified and it provides guidance as well as advice to employers and government as to how employees who suffer from disabilities need to be treated and protected from unfair discrimination. See British Council guide on promoting disability equality 2009 11.

27 British Council of Organisations of Disabled People *British Council guide on promoting disability equality* http://britishcouncil.org/sites/default/files/promoting_disability_equality.doc (Date of use: 22 October 2016).

28 Hendricks A "Selected Legislation and Jurisprudence: UN Convention on the Rights of Persons with Disabilities" 2007 (14) *Eur. J. Health. L* 273.

29 Hendricks 2007 (14) *Eur. J. Health. L* 274.

employer discriminates against a disabled person or employee if that person or employer treats a disabled person in a way that he or she cannot show that the treatment is a proportionate means of achieving a legitimate aim.[30] However, section 15(2) of the Equality Act states that subsection (1) above does not apply if a person or employer shows that he or she did not know, and could not reasonably have been expected to know, that the person or employee had the disability.[31]

The English legal system, just like its South African counterpart draws a distinction between direct and indirect discrimination which both fall under the broad umbrella of unfair discrimination as already discussed. In terms of section 13(1) of the Equality Act, direct discrimination occurs when a person or employer treats another in a less favourable way than he or she would treat others.[32] For a better understanding of direct discrimination in this context, Phillips argues that an inquiry as to what constitutes a less favourable way of treatment on the part of the employer in treating an employee living with cancer in comparison with other employees, can lead to discrimination.[33]

According to Phillips, to determine if a worker has been treated less favourably, a comparison must be made between how the employer has treated other workers or could have treated them in the same circumstances as the employee living with cancer.[34] Phillips argues that if the actions of the employer put the employee living

---

30 Section 15(1)(a)-(b) of the Equality Act 2010.

31 Section 15(2) of the Equality Act 2010. Furthermore, it is important to note that in the United Kingdom last year a 40 year old woman worked as a senior IT specialist for an IT company, Wipro, for a period of 10 years. She worked hard and secured several business deals for the company, but she experienced unfair discrimination on the basis of her gender, as sexist remarks were made to her and she was not paid equal to her male counterparts. The victim was harassed in the company and when she raised these issues to management she was not assisted at all. This resulted in the resignation of the victim because working conditions became unbearable for her, but her resignation was never accepted, however she was fired four days after her intended resignation. She brought a claim on the basis of unfair discrimination and claimed an amount of one million pounds as relief for the pain and suffering she suffered. The court ruled in her favour in 2015 and cautioned the company about its unfair discrimination process, which needs to be changed in order to accommodate female employees. With this judgment companies will also reconsider their policies when it comes to the treatment of women and ensure that they are treated equally to their male counterparts. See Sood V "Wipro sued by former employee in UK for sexual discrimination" 2015 *The Guardian* 6.

32 Section 13(1) of the Equality Act 2010.

33 Phillips C "Deviant Disabilities: The Exclusion of Drug and Alcohol Addiction from the Equality Act 2010" 2012 (21) *SLS* 395.

34 Phillips 2012 (21) *SLS* 395.

with cancer at the disadvantage in comparison with other employees who do not have cancer, then in such a case the treatment of the employer will likely be classified as less favourable and amount to direct discrimination.[35] Furthermore, Phillips takes his argument further by stating that a less favourable way of treatment on the part of the employer can also include being deprived of a choice or being side-lined of an opportunity in the workplace.[36] This seems correct, especially on the part of employees living with cancer, as they face the possibility of exclusion in the workplace and may not be considered for promotion even if they are eligible for promotion, in addition to other aspects which can be considered to constitute unfair labour practices on the part of the employer.[37]

Direct discrimination is prima facie unlawful and must be discouraged, but there are instances in which direct discrimination can be considered as lawful and this is made clear in terms of section 13(2) of the Equality Act where a disabled person is treated more favourably than a person who is not disabled.[38] Furthermore, direct discrimination can be justified on the basis of age discrimination, but in that case, the burden of proof will rest on the respondent, who in that context, would be the employer. The employer as the respondent must prove that the discrimination is a proportionate means of achieving a legitimate aim.[39] This will be considered as an exception to the general rule and can serve the interests of the disabled person, and specifically, for our purpose, an employee living with cancer.

Section 19(1) of the Equality Act defines indirect discrimination as the instance when an employer applies a neutral provision, criterion or practice which puts employees sharing a protected characteristic such as cancer, at a particular disadvantage.[40] Section 19(2) of the Equality Act states that in order to prove that indirect discrimination has indeed taken place, a four staged inquiry is necessary and includes the following: Firstly, the employer applies the same criterion, provision or practice equally to everyone within the relevant group, including a particular employee. Secondly, the

35 Phillips 2012 (21) *SLS* 396.
36 Phillips 2012 (21) *SLS* 398.
37 John *Dismissal, discrimination and unfair labour practices* 52.
38 Section 13(2) of the Equality Act 2010.
39 Collins H "Discrimination, Equality and Social Inclusion" 2003 (66) *MLR* 18-20.
40 Section 19(1) of the Equality Act 2010.

employer applies the practice, criterion or provision which puts employees who share the employee's protected characteristic at a particular disadvantage when compared with employees who do not have those characteristics. Thirdly, the employer applies the practice, criterion or provision which puts the employee at the disadvantage. Lastly, the employer cannot prove or show that the provision, criterion or practice is a proportionate means of achieving a legitimate aim in the workplace.[41] These guidelines serve as a yardstick for an employee who has suffered indirect discrimination to assess the merits of their case and to also check their prospects of success by ensuring that all four requirements of indirect discrimination are fulfilled.

The four-staged inquiry will help to save money and time for the affected employee in the sense that they would not approach a court or tribunal without having assessed the merits of their case based on these requirements. Unfortunately, in South Africa the employee cannot go to court or CCMA for purposes of claiming relief while knowing whether or not their case will succeed because there are no measures or detailed requirements which would serve as a guideline, similar to those found in English law. These guidelines, as provided in the Equality Act, serve as an aid to help the affected employee who has suffered discrimination to formulate his or her claim of alleged discrimination. It is often difficult to prove indirect discrimination because it is often institutionalised.[42] It must be kept in mind that indirect discrimination remains unlawful even if the employer lacked intention to discriminate through his or her practice, criterion or provision, unless such discrimination can be objectively justified by the employer.[43] In the case where the employer is able to objectively justify the indirect discrimination, the employer is less likely to be held liable by the court or tribunal.[44]

---

41 Section 19(2) of the Equality Act 2010. Further, is important to take into account that the employer is prohibited to discriminate in terms of section 39(1)-(3) of the Equality Act 2010, which states that an employer must not discriminate against or victimise an employee, through arrangements on the basis of whom to offer to employ, or impose terms on whom to employ, that are contrary to the Act and which aim to discriminate, and refusing to employ people on the basis or on terms that are discriminatory. An employer must not victimise employees on terms that are contrary to the provisions of equality such as refusing to promote disabled employees, or setting out terms that aim to demote disabled employees and ultimately coming up with provisions that will result in disabled employees being dismissed in the workplace.

42 McCrudden C "Institutional Discrimination" 1982 (2) *OJLS* 303.

43 Hannett S "Equality at the Intersections: The Legislative and Judicial Failure to Tackle Multiple Discrimination" 2003 (23) *OJLS* 66.

44 Hannett 2003 (23) *OJLS* 67.

Section 40 of the Equality Act prohibits harassment and victimisation of employees whose objective is to humiliate and degrade the dignity of other employees in the workplace, on the basis of their disability, and it declares such conduct unlawful.[45] One can assert that the reason for the protection of disabled employees against harassment in the workplace is because disabled employees include employees living with cancer, are often subjected to harassment due to them living with cancer.[46]

The Equality Act protects employees living with cancer from the point of diagnosis onwards and its scope covers every aspect in the workplace which includes recruitment, terms and conditions of employment, requirements for promotions, staff benefits, harassment and unfair discrimination of employees living with cancer in the workplace.[47] This is attributed to the fact that cancer or cancer treatment has the effect to render an employee living with cancer disabled, which can either be temporary or long term, and which calls for protection from unfair discrimination on the part of employers.[48] This view is affirmed by Kraus, Stoddard and Gilmartin,[49] who are medical specialists in the field of cancer. They argue that malignant neoplasms comprise the highest percentage of fifteen chronic health conditions leading to activity limitations.[50] Cancer is the ninth most common cause of temporary or permanent work limitations among patients.[51] The type of cancer in question serves as the strongest indication of whether the employee will have short or long term impairment, as cancers

45 Section 40 of the Equality Act 2010.

46 Hannett 2003 (23) *OJLS* 68.

47 Section 6 of the Equality Act 2010.

48 Feuerstein M *Work and Cancer Survivors* 136-137 (Springer, New York 2009).

49 Kraus EK *et al, Chartbook on Disability in the United States* 38 (National Department of Education, National Institute on Disability and Rehabilitative Research, Washington DC 1996).

50 Kraus *et al, Chartbook on Disability in the United States* 38.

51 Kraus *et al, Chartbook on Disability in the United States* 38. The issue of cancer being an impairment has been recognised by Schedule 1 Part 1 of the Equality Act 2010, which states that impairment could be recognised as long-term in the following circumstances: The impairment has lasted for 12 months, or is likely to last for 12 months, or is more likely to last for the rest of the life of the person affected in this case persons living with cancer. In the case of the impairment ceases to cause an adverse effect on the ability of the patient to continue to do daily activities such as performing or taking part in employment, the impairment is to be treated as continuing in order to prevent it from reoccurring which is most the case in cancer cases. The treatment of the impairment will not be necessary to continue in cases where it is clear that it has been treated and also will not reoccur in future. Lastly, it is important to note that not all impairments can be classified as permanent or long-term but this will be judged based on the facts and circumstances of each case which is encountered in the process.

such as cancer of the nervous system, leukaemia, and lung cancer have been known to cause lower employment rates and an inability to work.[52]

This means that employees living with cancer suffering from these types of cancers may experience long term impairments, which have long term adverse effects on their ability to carry out normal day to day activities and thus rendering them unable to work. Consequently, this amounts to a disability. In the United Kingdom, several cases were brought before the court on the basis of unfair discrimination. For instance, in the case of *J v DLA Piper UK LLP*,[53] the applicant was a woman who was working for the defendant company. She was suffering from depression which made her unable to do her work effectively. She argued that the depression amounted to a disability, and provided all the necessary medical evidence to prove her claim, to which the employer objected.[54] The court found in favour of the applicant and argued that the employer unfairly discriminated against her on the basis of her disability, because her depression rendered her unable to work, which amounted to a disability.[55]

4.2.3 Reasonable accommodation on the part of employers in terms of the Equality Act of 2010

In terms of section 20(1) of the Equality Act, there is a duty on the part of the employer to reasonably accommodate a disabled employee and three factors need to be met for this duty to be fulfilled by the employer.[56] However, is important to note that before the employer can be in a position to provide reasonable accommodation for the employee living with cancer, the employee must communicate with the employer and fellow employees about his or her health condition. This is not a legal obligation but rather a personal decision which rests with the employee, and which is important in

---

52 Kraus *et al*, *Chartbook on Disability in the United States* 39-40.

53 *J v DLA Piper UK LLP* [2010] UKEAT/0263/09/RN.

54 *J v DLA Piper UK LLP* 264.

55 *J v DLA Piper UK LLP* 265.

56 Section 20(1) of the Equality Act 2010. The duty to reasonably accommodate disabled employees applies to different stakeholders in the employment context as provided by section 39(1) of the Equality Act to include, employers, principals, firm or proposed firm, partnership, a person who has the power to make appointments either on his or her personal capacity or for a public office, a trade union organisation, an employment service provider and a pension scheme. This shows that the duty to accommodate is not only the duty that is vested in an employer but other role players in the employment context are also affected by this duty in the first place.

ensuring that the employer accommodates the employee.[57] The right to privacy of the employee must not be compromised by making such a disclosure because the aim of the disclosure is to ensure that reasonable accommodation is provided for the employee, and that the employee is not abused.[58] As a consequence, the employee must have it at the back of his or her mind that some fellow employees can treat him or her differently because they still view cancer as a death sentence. It is the duty of both the employer and the employee living with cancer to educate fellow colleagues about the implications of cancer and that one can lead a productive life despite having to live with cancer.[59] However, the reality is that due to the ignorance of employers and fellow employees, especially in competitive working environments, employees living with cancer are refusing to disclose their health condition to employers and fellow employees because they feel that they may be marginalised and treated differently.[60]

Non-disclosure results in employees living with cancer not receiving reasonable accommodation from employers because the employer is not aware of the position of the employee. This problem can be resolved by greater awareness and support about cancer in the workplace among other things.[61] In the position where the employer is not aware of the health status of the employee, such an employer cannot be said to be discriminating against the employee. However, the employer needs to satisfy the requirements which are set in section 15(2) of the Equality Act, which states that an employer must prove that he or she did not know that the employee concerned was disabled or suffering from a health deformity and could not reasonably expected to know that the employee concerned was suffering from a disability in order for the unfavourable treatment on the part of the employer towards the employee not to amount to discrimination on the basis of disability.

---

57 Carlson G and Allen S "To conceal or disclose a disabling condition? A dilemma of employment transition" 2003 (19) *JVR* 20.

58 Carlson and Allen 2003 (19) *JVR* 22.

59 Robert PM and Harlan SL "The Social Construction of Disability in Organizations: Why Employers Resist Reasonable Accommodation" 1998 (25) *Work and Occupation* 398.

60 Robert and Harlan 1998 (25) *Work and Occupation* 399. See also Wadham J *et al, The Equality Act 2010* 210 (Oxford University Press, London 2012).

61 Mello JA "Employment and Public Policy Issues Surrounding Medical Marijuana in the Workplace" 2013 (117) *JBE* 663.

This standard is similar to the reasonable standard of how a reasonable person in the same position of the employer would have acted if he or she did not know the state of health of the employee. Therefore, an objective test is applicable.[62] This standard is fair to both parties as employer and employee, without expecting or putting a burden on the employer to look into the personal life of the employee to find out what diseases the employee may be suffering from, because is a private matter and can result in the violation of the right to privacy of the employee concerned. From this assessment, it is very clear that the objective standard strikes a balance between the duty of the employer to reasonably accommodate employees and the right to privacy of the employees concerned, leaving the employee with the autonomy to decide whether or not to disclose their health status or disability to the employer and fellow employees.

Research shows that in the United Kingdom, employers act as barriers in the successful re-integration of employees living with cancer in the workplace and this is all attributed to their negative attitude towards cancer.[63] Employers regard employees living with cancer as a burden to the company, and view them as unable to maintain the working demands which are required by the company.[64] Due to this misconception on the part of employers, it is important that employers pursue training that will help them to better understand cancer, which in turn will yield positive results when it comes to the employment retention of employees living with cancer in the workplace.

Reasonable accommodation is the cornerstone of the Equality Act, and requires employers to take positive steps in ensuring that disabled employees can access employment.[65] The duty of reasonable accommodation applies to all employers irrespective of the size of the company, but the question of what is reasonable accommodation may vary according to the needs or circumstances of the employer.[66] In terms of section 20(3) of the Equality Act, the first factor of reasonable accommodation on the part of the employer is that where a provision, criterion or practice of the employer puts a disabled employee at a substantial disadvantage in

62 Gorney M *Plastic and Reconstructive Surgery* 181 (Springer, London 2010).

63 Anema JR *et al*, "Barriers and facilitators for return to work in cancer survivors with job loss experience: a focus group study" 2015 (22) *EJCC* 210.

64 Anema JR *et al*, 2015 (22) *EJCC* 211.

65 Section 20(1) of the Equality Act 2010.

66 Section 20(2) of the Equality Act 2010.

relation to a relevant matter in comparison with employees who are not disabled, the employer ought to take reasonable steps to avoid such a disadvantage.[67]

The second factor in section 20(4) of the Equality Act requires that where a physical feature puts a disabled employee at a substantial disadvantage in comparison with employees who are not disabled, reasonable steps need to be taken to prevent the disadvantage.[68] Section 20(5) of the Equality Act states that it is the duty of the employer to reasonably accommodate disabled employees and to take such steps as it is reasonable to have to provide auxiliary aid, where a disabled employee would, but for the provision of an auxiliary aid, be put at a substantial disadvantage in comparison with employees who are not disabled.[69]

In terms of section 20(6) of the Equality Act, the first and third factor of reasonable accommodation relates to the provision of information, and provides that the steps which are reasonable for the employer to take include steps to ensure that the information required by the employee is provided in an accessible format.[70] Section 20(9) of the Equality Act in addition states that to avoid a substantial disadvantage includes removing the physical feature in question, altering it, or providing a reasonable means of avoiding it in terms of this section or applicable schedule.[71]

Section 21(1) of the Equality Act provides that failure by the employer to comply with his or her duty to reasonably accommodate disabled employees amounts to discrimination and a violation of the duty to reasonably accommodate disabled employees.[72]

It is interesting to note that the factors used to assess whether or not the employer has made reasonable adjustment to work as discussed above, share a common element with the three yardsticks which serve as criteria to determine reasonable accommodation in the South African context.[73] This is one of the examples that

67 Section 20(3) of the Equality Act 2010.
68 Section 20(4) of the Equality Act 2010.
69 Section 20(5) of the Equality Act 2010.
70 Section 20(6) of the Equality Act 2010.
71 Section 20(9) of the Equality Act 2010.
72 Section 21 (1) of the Equality Act 2010.
73 Section 15(2) of the Employment Equity Act 55 of 1998.

demonstrate the legal-historical links between the two jurisdictions. Both jurisdictions impose a legal duty on employers to accommodate disabled employees through removing physical barriers in the workplace in order to give better access to disabled employees, including by giving employees time off for treatment, amongst others.[74]

The definition of disability above does not explain the meaning of physical or mental impairment, which suggests that, this clearly means that the legislation is based on the medical model of disability.[75] It appears from the provisions of the Equality Act that it aims to move away from the social model of disability which has resulted in dire consequences for disabled individuals for many years, due to the stigma and ignorance of society in this regard.[76] This signals a new phase of interpreting and understanding the concept of disability, demonstrated by the manner in which the Equality Act treats progressive conditions. In terms of Schedule 1 of the Equality Act, where a person suffers from a progressive condition such as cancer, multiple sclerosis or HIV and AIDS, amongst others, and as a result of that condition, has an impairment which has an effect on his or her ability to carry out normal day to day activities, but that effect is not yet a "substantial" adverse effect, such a person is then nevertheless to be treated as having an impairment which has a substantial adverse effect if the condition is likely to result in that person having an impairment in future.[77]

Based on the above, cancer should be viewed as a progressive medical condition which develops gradually in the body and depending on its state in the individual, may result in disability, especially during late stages of the condition, which would be recognised by the Equality Act as either a temporary or permanent impairment. This understanding squarely fits into the new medical model of disability, which is a shift away from the social model of disability.[78]

---

74 Section 15(2) of the Employment Equity Act 55 of 1998 and Section 20(1) of the Equality Act 2010.

75 Section 6 of the Equality Act 2010.

76 Cathy J *et al*, "Employment patterns of long term cancer survivors" 2002 (11) *Psycho Oncology* 188.

77 In terms of section 1 of the Equality Act 2010, it is important to take into account that a progressive condition refers to those conditions which are likely to change, develop and deteriorate over time, such as cancer because is a disease that does not remain static but develops on a daily basis due to its aggressive nature.

78 Peters S and Gabel S "Presage of a paradigm shift? Beyond the social model of disability toward resistance theories of disability" 2010 (19) *Disability and Society* 586.

It is for this reason that section 20(1) of the Equality Act makes provision for employers to make reasonable accommodation to employees living with cancer for the purposes of helping them continue with executing their duties in the workplace upon their return to work.[79] This is evident in the case of *Superintendent of Motor Vehicles v British Columbia Council of Human Rights*.[80] In this case, the duty of the employer to reasonably accommodate employees who suffered from a disability formed the crux of the case. The court held that all employers and those who are governed by human rights legislation are now required to accommodate employees who suffer from any form of disability and to remove any discriminatory policy that is in place.[81] This would ensure that people who suffer from any form of disability are in the position to be employed and given a fair opportunity to take part in the main stream economy, just like their abled bodied counterparts.[82]

The duty of the employer to reasonably accommodate was also questioned in the case of *Archibald v Fife Council*.[83] In this case, the employee was a council worker who worked as a road sweeper for the council. He could no longer walk and was disabled, unable to perform his daily activities. As part of a reasonable accommodation by the employer, he was deployed to do a job he was not qualified to do.[84] However, the employee performed well in the new job and he was allowed to apply for the said position, despite having no formal qualifications. He was subjected to the same selection process as those who were qualified, which resulted in him not getting the position. The court held that, the conduct of the employer did not amount to reasonable accommodation by merely allowing the employee to act in the position and to further apply for that position without ultimately giving him the position. The employer would have provided reasonable accommodation if the employee was given the job and as such, the court described the conduct of the employer as unlawful.[85]

4.3 Remedies available to employees in the United Kingdom

79 Section 20 (1) of the Equality Act 2010.
80 *Superintendent of Motor Vehicles v British Columbia Council of Human Rights* (1999) 3 SCR 868.
81 *Superintendent of Motor Vehicles* case 868.
82 *Superintendent of Motor Vehicles* case 869.
83 *Archibald v Fife Council* [2004] ICR 954, [2004] UKHL 32.
84 *Archibald v Fife Council* case 32-33.
85 *Archibald v Fife Council* case 34.

When an employee living with cancer has suffered or experienced unfair discrimination in the workplace due to his or her condition, from both the employer and fellow employees, the affected employee living with cancer can first try to communicate with the employer through a trade union representative or human resources manager in order to resolve the dispute between them.[86] This process will come in handy for the concerned employee because it will allow the employee to gather as much information as possible, which will be beneficial in instances where the matter needs to go for trial. Further, making use of the internal process of dispute resolution will be cheaper than litigation, which is generally expensive, and both parties will reach an agreement or compromise which both parties will be happy with in an internal dispute resolution.[87] The compromise contract to be discussed between the parties as a way of resolving the dispute in terms of the Equality Act will be discussed later on in the study.

The employee living with cancer can seek redress in terms of section 124(1) of the Equality Act, which states that this section applies if an employment tribunal finds that there has been a contravention of a provision referred to in section 120(1) of the Equality Act.[88] Section 124(2) of the Equality Act, provides that a tribunal may make a declaration as to the rights of the complainant and the respondent in relation to the matters which the proceedings relate to. The tribunal may also order the respondent to pay compensation to the complainant and or make an appropriate recommendation.[89] Section 124(3) of the Equality Act, states that an appropriate recommendation is one which states that, within a specified period the respondent ought to take specified steps to obviate or reduce the adverse effect of any matter to which the proceedings relate.[90] Furthermore section 124(7) of the Equality Act states that if a respondent fails without reasonable excuse to comply with an appropriate recommendation in so far as it relates to the complainant, the tribunal may, if an order was made under subsection (2)(b), increase the amount of compensation paid, and if no such order was made, make one.[91]

---

86 Cathy *et al*, 2002 (11) *Psycho Oncology* 190.
87 Meruelo 2008 (2) *JLM* 287.
88 Section 124(1) of the Equality Act 2010.
89 Section 124(2)(a)-(b) of the Equality Act 2010.
90 Section 124(3) of the Equality Act 2010.
91 Section 124(7) of the Equality Act 2010.

Furthermore, regarding dispute resolution, the Equality Act can be read in conjunction with section 146 of the Employment Statutory Code of Practice Act 2010, which states that nothing in this Act prevents the parties from settling their dispute or potential dispute before it is decided by the Employment Tribunal or civil court. An agreement of this nature may include any terms the parties agree to and may cover compensation, future actions by the respondent employee, costs and other lawful matters.[92] Section 146(2) of the Employment Statutory Code of Practice Act takes this further by stating that offers for conciliation by parties to the dispute are encouraged even if the matter is already before the Employment Tribunal or civil court.[93]

Section 147 of the Employment Statutory Code of Practice Act, states that a claim or a potential claim to the Employment Tribunal can also be settled by way of a qualifying compromise contract, which is similar to the process of mediation where both parties to the dispute walk out as winners. However, contracts that seek to eliminate or exclude the application of this Act are unenforceable. For example, this Act does not apply to a compromise contract that does not fulfil the requirement that it must be made in writing.[94] Furthermore, Wilmott argues that in light of the various remedies that a court can impose on the employer for discrimination, employers face the risk of damaging their reputation and losing key talent.[95] This is due to the fact that, despite having to live with cancer, these employees are not deprived of their skills and should consequently not be made to quit work, as argued earlier in the study, as work forms part and parcel of the healing process of the employee living with cancer.[96] This is attributed to the fact that going back to work makes the employee living with cancer have a sense of purpose and that the employee has a life apart from cancer, which is a great psychological boost to the well-being of the employee.[97] Wilmott's arguments, are very correct that employers must not only guard against being fined for

92 Section 146 of the Employment Statutory Code of Practice Act of 2010.

93 Section 146(2) of the Employment Statutory Code of Practice Act of 2010.

94 Section 147 of the Employment Statutory Code of Practice Act of 2010.

95 Wilmott JH "Employment Discrimination in Organizations: Antecedents and Consequences" 2006 (32) *Journal of Management* 787.

96 Wilmott 2006 (32) *Journal of Management* 788.

97 Wilmott 2006 (32) *Journal of Management* 789.

discrimination on the basis of cancer , but must also guard against the protection of their reputation, which is important for the future development of their companies.

There is great similarity between the South African and the English jurisprudential model as this relate to the remedies that are available to the aggrieved employee living with cancer. Similar mechanisms that allow for the employment of legal bodies, such as the Employment Tribunal in the United Kingdom are available in South Africa, known as the Commission for Conciliation and Arbitration (CCMA).[98] Furthermore, the English legal system makes provision for settling disputes between the employer and the employee through a compromise contract, which is similar to the process of mediation that is used in most labour disputes in South Africa, as the South African process of mediation has historical links to the English legal system.

4.4 Americans with Disabilities Amendment Act (ADDA) of 2008

More than 800 000 people are diagnosed with cancer every year in America, and of this number approximately 400 000 will be cured of the cancer.[99] The American Cancer Society states that 90% of employees living with cancer face discrimination in

---

98 Section 191(1) of the Labour Relations Act 55 of 1995.

99 Streicher K "Cancer-Based Employment Discrimination: Whether the Proposed Amendment to Title VII Will Provide An Effective Anti-Discrimination Remedy" 2010 (62) *Ind.L.J* 827. Furthermore, in America the position regarding the protection of persons living with cancer generally, and employees living with cancer in particular, was best described by Professor Epstein, who was a scientist in the field of medicine. According to Epstein, cancer remains one of the deadliest diseases known to mankind across the globe, and beyond the millions of lives which are claimed by cancer, millions of more people live in fear of being diagnosed with the disease. This is all attributed to the stigma and less investment that is placed on cancer research and treatment by governments across the globe, including the United States of America. Epstein, in collaboration with some of his colleagues in the medical field argued for a more aggressive approach or assault when it comes to the preventable causes of cancer that people are unknowingly exposed to daily, especially at home and in the working environment. The causes of cancer which people are often exposed to, result in socio-economic problems which persons living with cancer experience because they end up unemployed as a result of the cancer. This can result in a dent on the economy of the state due to the high rise of unemployment. The analogy of Epstein has resulted in making the American government to take heed of the cancer epidemic and to device the necessary legislation, in particular the Americans with Disabilities Amended Act, with the aim of protecting the rights of persons living with cancer, in particular employees living with cancer against unfair discrimination in the workplace. This is to dispel the myths as well as the stigma that surrounds the area of cancer. See Epstein SS *Cancer- Gate: How to Win the Losing Cancer War* 5-29 (Baywood Publishing Company, New York 2005). In this book Epstein provides an analysis of the American struggle against cancer, in relation to reducing the incidence and mortality rate, and he proposes a complex strategy on how to fight the war against cancer. It is currently evident in the American system, that the contribution made by Epstein when it comes to the fight against cancer is recognised by the government and as a result of this, America today has made great strides when it comes to cancer regulation and it will be outlined later in the chapter.

the workplace due to the employers' ignorance regarding cancer.[100] This confirms the view that cancer survivors' struggle with cancer follows them out from the hospital into the workplace.[101] Employees living with cancer experience different forms of discrimination in the workplace, which may include job denial, wage reduction, denial of a promotion and outright dismissal.[102]

In the United States, employers often justify their conduct of discrimination by ignorantly arguing that cancer is contagious, and that other employees will not be keen to work with an employee living with cancer, in addition to arguing that an employee living with cancer will be unproductive and will thus be a liability to the company.[103] All of these arguments were revealed to be unfounded and based on incorrect perceptions or ignorance.[104] Employees living with cancer in South Africa suffer from similar types of discrimination in the workplace, and the justifications of employers resemble those of some of the English employers. This indicates that false perceptions and ignorance regarding cancer are shared by employers across the world alike. The need for legal intervention to address these perceptions and their harmful impact is hence evident.

Much focus has been placed on this area of the law in America. Section 3 of the Americans with Disabilities Amendment Act (ADAA), defines disability as a physical or mental impairment that substantially limits one or more major life activities of an individual, and record for such impairment is necessary for the purpose of this Act, in order to be considered as a disability.[105] Further, section 3(2) of the Amended Americans with Disabilities Act states that, major life activities for the purposes of this Act include operation of a major bodily function, including but not limited to the

---

100 Streicher 2010 (62) *Ind.L.J* 827-828.

101 More cancer survivors return to work after being diagnosed with cancer but will be subjected to discrimination and their ability to work questioned by employers due to their cancer. See Bazamore L "Employment Discrimination against Cancer Survivors: A Proposed Solution" 2001 (31) *Vill. L.Rev* 1550.

102 Streicher 2010 (62) *Ind.L.J* 827-829.

103 Canfield L "Persons living with cancer Prognosis: How Terminal are their Employment Prospects?" 2001 (38) *Syracuse Law Review* 801.

104 Wheatly P "Employability of Persons with a History of Treatment of Cancer" 1975 (31) *CANCER* 441.

105 Section 3 of the Amended Americans with Disabilities Act of 2008.

functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions.[106]

Benfer argues that the definition of the term substantially limits the rights of disabled persons and should be given a broader interpretation as intended by the Americans with Disabilities Amendment Act.[107] Such a broad interpretation will allow a number of chronic diseases which can cause disability to be incorporated under the category of disability.[108] Benfer provides a list of chronic diseases which can substantially limit the ability of an individual to work, and those which are recognised by the Americans with Disabilities Amendment Act such as cerebral palsy, HIV and AIDS, Hepatitis B and cancer.[109]

Benfer correctly advances an argument which leads to cancer being recognised as a disability in terms of the Americans with Disabilities Amendment Act.[110] This is evident from the case of *Ellison v Software Company*.[111] Miss Ellison was an employee of the defendant company and had breast cancer. She had surgery and was required to go for radiation six days a week as part of her treatment, which caused her to go to work late on a daily basis. This however, did not prevent her from executing her duties in the company because she worked during her lunch breaks and often left the office late in order to catch up with some work. During this period of receiving treatment, Miss Elliot received a lower performance appraisal and she was told that she would be demoted, this is despite all the efforts she has put in ensuring that her work was up to date.[112] She was later dismissed by the employer, and she brought a claim against the employer to assert that she has been unfairly discriminated against on the basis of her cancer, which amounted to disability.

The court dismissed her claim on the basis that cancer does not amount to disability in terms of the then Americans with Disabilities Act of 1990 (ADA), which was replaced

106 Section 3(2) of the Amended Americans with Disabilities Act of 2008.

107 Benfer EA "*The American with Disabilities Amendment Act: An overview of recent changes to the American with Disabilities Act"* 2009 *ASC* 6.

108 Benfer 2009 *ASC* 6-7.

109 Benfer 2009 *ASC* 6.

110 Benfer 2009 *ASC* 7.

111 *Ellison v Software Company*, Inc, 85 F3d 187 (5th Cir. 1996).

112 *Ellison v Software Company*, case 188.

by the current legislation of Americans with Disabilities Amendment Act.[113] In determining whether a person living with cancer is indeed disabled, a court must consider cancer in its active state, whether or not an individual is in remission.[114] This decision by the court was widely criticised on the basis that it is troubling because it excluded employees living with cancer from the protection of the law. Employers discriminated against employees living with cancer in America, and the ignorant belief of cancer being contagious made it worse for employees living with cancer to even finding employment.[115] The impact of this is that employers may tend to view employees living with cancer as liabilities, because they are likely to become ill at work, perform poorly and also to be absent frequently or all the time.[116] Such harsh treatment towards employees living with cancer constitutes a violation of their basic human rights, because work has been an important component of the survival of human beings from the beginning of time.[117]

Morrell,[118] correctly states that work is a symbol of independence, competence and accomplishment which any human being desires on earth, because work does not only provide for the needs of physical desires in order to survive but work actually serves as a means to define one's self or establish one's sense of worth in life. In the context of cancer, it has been argued earlier in the study that work actually forms part and parcel of the healing process of the employee living with cancer. Excluding them from working actually means taking away their self-worth and basic human rights as asserted by Morrell.

---

113 *Ellison v Software Company*, case 188.

114 Section 3 of the Amended Americans with Disabilities Act of 2008.

115 Morrell JJ "Aids and Cancer: Critical employment discrimination issues" 1990 (15) *J.Corp.L* 851.

116 Morrell 1990 (15) *J.Corp.L*851.

117 Feldman M *Wellness and Work, in Psychosocial stress and cancer* 173 (Copper Publishers, New York 2000).

118 Morrell 1990 (15) *J.Corp.L*855. See further Wheatley C "The Employability of Persons with a History of Cancer 1974 (33) *CANCER* 441-445, in this article Wheatley provides that a Metropolitan Life Insurance Company did a study of its employees who were known to have cancer and confirmed that the work performance of employees with cancer is nearly similar to the work performance of employees without cancer. The company concluded that cancer employees were excellent employees and this is when Wheatley argues that, for cancer employees to thrive in the workplace they must be given an opportunity and provided with all the necessary support in the workplace.

As will be seen from the cases referred to below, some of the US cases dismissed the claims of employees living with cancer on the ground that cancer is not a disability.

For example, in *Lynos v Heritage House Restaurant Inc*,[119] the employee, a kitchen manager of the employer, who was diagnosed with cancer of the uterus, was dismissed by her employer after her medical condition became known. She then brought a claim against the employer on the basis of unfair discrimination due to her medical condition (e.g cancer), asserting that her condition amounted to a disability.[120] The employee argued that despite being diagnosed with cancer, she was still efficient and capable to do her work without any problems. The High Court, however, dismissed her application and ruled in favour of the employer. The reasoning of the court was that the applicant was not disabled or handicapped because she was still able to do her work and cancer does not amount to disability in terms of the law.[121]

Korn,[122] argued that the problem with cancer is that it has compounded issues which society in general and the legal system in particular are not willing to discuss.[123] This is due to the fact that society views disability as a static physical problem and cancer unfortunately does not fit into that pattern. In its active state, cancer substantially limits the normal cell growth function and thus an individual with cancer is protected by the Americans with Disabilities Amendment Act.[124] Korn asserts that cancer is viewed in a similar dichotomous manner, in the sense that we think that a person living with cancer will most probably die and less likely to be cured, and this is a wrong perception.[125] From the *Elliot* case and the arguments presented by Korn, it is clear that at some point in the American jurisprudence there was a denial and exclusion of persons living with cancer from the protection of the law, which resulted in unfair discrimination of persons living with cancer and employees. This example may be

119 *Lynos v Heritage House Restaurant Inc* 89 III App NE 270 (1982).
120 *Lynos v Heritage House Restaurant Inc* case 271.
121 *Lynos v Heritage House Restaurant Inc* case 271.
122 Korn JB "Cancer and the ADA: Rethinking disability" 2001 (74) *S. Cal L Rev* 400.
123 Korn (74) *S. Cal L Rev* 400-401.
124 Benfer 2009 *ASC* 13.
125 Korn 2001 (74) *S. Cal L Rev* 404.

compared to the situation in some African countries where HIV and AIDS denial led to devastating consequences, as discussed already in chapter three.[126]

Scott,[127] believes that this definition of disability by the Americans with Disabilities Amendment Act restored the definition of disability of the initial Americans with Disability Act of 1990, while at the same time broadening the definition of disability to include both physical and mental impairment which can render a person disabled. He further argues that this approach of including both the physical and mental impairment will be of great benefit for the people, as many people will be protected from being unfairly discriminated against by both employers and society.[128] One can attest to this argument that such a flexible definition of disability is one that is required in South Africa, where disability is still mainly dependent on the physical impairment of the patient. To incorporate a flexible definition of disability which recognises both mental and physical impairments which substantially limit the ability of the patient or employee in the South African jurisprudence, will be helpful in broadly covering different types of deformities and assisting with the problem of recognising some deformities at the expense of others. For example, the recognition of HIV and AIDS as a disability due to its effect on people, while leaving behind health deformities such as cancer that can have the same or more adverse effects than HIV and AIDS amount to unfairness, as cancer can either render a person temporarily or permanently disabled.[129]

The Americans with Disabilities Amendment Act regards cancer as a disability in instances where it substantially limits the ability of an individual to do daily activities or if at some point the cancer limited the ability of an individual to do daily activities.[130] Whether an individual employee will be covered by the provisions of the Americans

---

126 Nattras N "Aids Denialism vs Science" 2007 (31) *Sketical Inquiry* 109.

127 Scott SC *Principles and Applications of Assessment in Counselling* 314 (Brookes and Cole Publishers, New York 2013).

128 Scott *Principles and Applications of Assessment in Counselling* 314-315. Furthermore, one can argue that these assertions by Scott resemble or take into context what Senator Tom Harkin said when the Americans with Disabilities Act was adopted in 1990. He stated that: "The ADA is based on a single premise that disability is a single natural part of human experience. Disability in no way diminishes the right of people to live independently, enjoy self-determination, make choices, pursue meaningful careers, and enjoy full inclusion and integration in the economic, political, social, cultural and educational mainstream of American society". See Harkin T "The Americans with Disabilities Act: Four years later - commentary on blanck" 1994 (79) *IOWA.L.R* 936.

129 Curtis M *et al, Glass Office Gynaecology* 533 (Wolters Kluwer Publishers, New York 2014).

130 Section 3 of the Amended Americans with Disabilities Act of 2008.

with Disabilities Amendment Act is a question of fact and is determined on a case by case basis. An employee living with cancer who does not experience a substantial limit of their ability to do daily activities will not be deemed to have a disability. From this reasoning, it is apparent that in the American context, cancer will constitute as a disability if it has an effect or impact on the ability of the individual to do daily activities. Moreover, it is also clear that a diagnosis of cancer does not automatically render that persons living with cancer is a disabled person.

4.4.1 Reasonable accommodation on the part of employers

The Americans with Disabilities Amendment Act also imposes a duty on employers to make reasonable accommodation for employees living with cancer who are categorised as disabled and are affected by it in their ability to do daily activities.[131] According to Karlan and Rutherglen, [132] the main objective of reasonable accommodation is twofold, firstly it plays a role to define the class of people that are protected and secondly it prohibits discrimination of qualified people who have a disability. They define the role of the duty to provide reasonable accommodation through the repealed Americans with Disabilities Act, but their assertion of what reasonable accommodation aims to achieve is still relevant today, because the aim is to ensure substantive equality is achieved in the workplace despite the disability or medical condition of the employee, as stated in terms of section 6(1) of the Amended Americans with Disabilities Act. Before an employer is in a position to make reasonable adjustment of work, the employee living with cancer must have informed the employer about his or her state of health.[133] This is a personal decision of the employee living with cancer, and the right of the employee living with cancer to privacy should be respected and not violated by a forced disclosure in the hands of the employer.

---

131 Section 6(1) of the Amended Americans with Disabilities Act of 2008, states that a public institution or a private person who owns a company is required by law to provide reasonable accommodation or reasonable modification to policies, procedures or practices to an individual who meets the definition of disability as provided for in terms of section 3 of the Amended Americans with Disabilities Act.

132 Karlan PS and Rutherglen G “Disabilities, Discrimination, and Reasonable accommodation” 1996 (41) *Duke Law Journal* 4.

133 Karlan and Rutherglen 1996 (41) *Duke Law Journal* 5.

It is very important that the right of the employee living with cancer to privacy is protected at all times. This will avert discrimination because it can be argued that to not disclose the health status of the employee to third parties will in actual fact prevent unfair discrimination.

This argument is substantiated by Roberts,[134] when she argues that there is a relationship between privacy law and the law of anti-discrimination, because privacy law on the one hand deals with the protection of sensitive information of a person, and law of anti-discrimination on the other hand aims to prevent a disadvantage on the basis of the protected status of a person. Roberts advances this view by outlining that if law makers can recognise that the protection of the right to privacy can avert future wrong doings, such as unfair discrimination, the problem of discrimination in society in general and in the workplace in particular would cease to exist.[135] These arguments by Roberts support the idea that if we develop better communication skills and understanding among us as human beings, this will result in broad-mindedness, and the violation of the right to privacy and the result of unfair discrimination would slowly be eroded in recognising the human dignity of fellow human beings. This may find expression in the notion of reasonable accommodation, which includes efforts to alter or change working conditions or hours in order to allow the employee living with cancer to continue working effectively in the organisation without any form of hardships.[136]

For example, it has been demonstrated that employees living with breast cancer who receive reasonable accommodation recover much faster than employees who did not receive any form of workplace accommodation, although potential bias will be possible in the opposite direction if poor health results in more accommodation being required.[137] Reasonable accommodation on the part of the employer should not result

---

134 Roberts JL "Protecting privacy to prevent discrimination" 2015 (56) *Wm. & Mary L. Rev* 2097.

135 Roberts 2015 (56) *Wm. & Mary L. Rev* 2097-2098.

136 Section 6(2) of the Amended Americans with Disabilities Act of 2008.

137 Female breast cancer survivors constitute the largest percentage of all cancer survivors which is twenty two per cent in America. In America eighty three per cent of breast employees living with cancer continue to work despite having the cancer, and the type of accommodation they receive ranges from flexible working hours and time off for treatment. See Dahman B *et al*, "Work continuation while treated for breast cancer: The role of workplace accommodations" 2015 (68) *ILR Rev. J Work and Policy* 925. See also the work of Colombo S "Battling Cancer: Law and Life" 2001 (24) *Harv Women's L.J* 1-5. In this article Colombo an American who is a lawyer and academic was diagnosed with breast cancer, and the article is about her personal experience with cancer. She explains the stigma, discrimination that was exerted to her and how the law can be

in undue hardships for the employer, such as incurring costs in the process or lowering standards by the employer, but nonetheless, a qualified employee who suffers from disability is the one that is entitled to reasonable accommodation.[138] This view has been confirmed in the case of *Schemidt v Methodist Hospital of Indiana*,[139] where an employee was diagnosed with bilateral optic atrophy which affected her vision. She was working as an assembly line worker, and she underwent surgery which resulted to her being able to return to work.[140] The employer provided her with all the necessary support and reasonable accommodation to allow her to continue with her work, which included getting a big computer screen for her and other necessary aids to support her vision. The dispute between the applicant and the employer arose when the applicant made a request for the purchase of a new computer for her with better technological applications, which the employer was unable to afford due to operational requirements.[141] The court held that when an employer provides a reasonable accommodation in terms of the law, which is in line with the operational requirements of the company, then the actions of the employer are lawful.

However, in the case of *EEOC v Southlake Comm. Mental Health Centre Inc*,[142] the conduct of the employer was found not to amount to reasonable accommodation and not in line with the operational requirements of the company. In this case, the applicant was an employee of the defendant company and was diagnosed with breast cancer. After undergoing surgery, the applicant requested leave in order to recover from the surgery, but the employer refused to grant her that leave.[143] She stayed home for a few weeks in order to recover from the surgery, despite the rejection of her leave application. Upon her return to work she was fired for absenteeism.[144] The court ruled in favour of the applicant on the basis that the conduct of the employer amounted to unfair discrimination on the basis of the breast cancer of the applicant, and that the

used as an aid to assist people with cancer from suffering great injustices in society and in the workplace, such as providing for reasonable accommodation and prohibiting unfair discrimination among other things.

138 Section 6(3) of the Amended Americans with Disabilities Act of 2008.

139 *Schemidt v Methodist hospital of Indiana,* 89 F.3d 342 (1996).

140 *Schemidt v Methodist hospital of Indiana,* case 89.

141 *Schemidt v Methodist hospital of Indiana,* case 90.

142 *EEOC v Southlake Comm. Mental Health Centre Inc* NO.2:10-CV-00444 (11 March 2013).

143 *EEOC v Southlake Comm. Mental Health Centre Inc* case 444.

144 *EEOC v Southlake Comm. Mental Health Centre Inc* case 445.

employer failed to provide reasonable accommodation to the applicant as required by law.[145]

This case and others not mentioned in this study show that employers cannot hide behind the pretence of operational requirements of the company or act in an unreasonable manner to deny an employee reasonable accommodation in order to continue to work despite their medical condition. This reasoning is in line with the analogy of Webber,[146] in which he states that reasonable accommodation and undue hardship are simply two sides of the same coin, and that the only time to limit the employer's obligation of providing reasonable accommodation is when the accommodation causes undue hardship for the employer. The defence regarding unreasonable accommodation which most employers tend to argue does not exist because during the process of reasonable accommodation, there is a balancing act between the rights of the employee and the interests of the company, which result in common ground being attained, as there is no interest that outweighs the other during this process.

Emphasis to protect the right to privacy and the reasoning behind the protection of this right can also be drawn from the work of Warren and Brandeis.[147] They both argue that the right to privacy gives people the right to be left alone in peace. This means that the right allows people to be free from outside scrutiny in order to maintain their independence and sense of self-worth while simultaneously living with other people in the community.[148] The reasoning of Warren and Brandeis reinforces the observation made above, namely that protecting the right to privacy of the employee living with cancer will in turn protect the employment status of the employee as part of his or her self-worth because work forms part and parcel of the healing process of the employee living with cancer. Due to the fact that the right to privacy is so central in the legal system, it enjoys numerous forms of legal protection. This means that an individual or a employee living with cancer whose right to privacy has been infringed can be able

145 *EEOC v Southlake Comm. Mental Health Centre Inc* case 446.

146 Webber MC "Unreasonable Accommodation and Undue Hardship" 2010 (62) *FLA.L.Rev* 1123.

147 Warren SD and Brandeis LD "The Right to Privacy" 2000 (4) *Harv. L Rev* 193. See also Hodges AC "Working with Cancer: How the law can help survivors maintain employment" 2015 (90) *Wash. L. Rev* 1039 to 1062.

148 Warren and Brandeis 2000 (4) *Harv. L Rev* 193-194.

to bring a claim or institute a claim under the law of delict (in South Africa) or tort law (as is the position in the USA), or on the grounds of a breach of confidentiality and further lodge a claim under constitutional and criminal law for the said violation.[149] These are some of the forms of relief which an aggrieved employee may resort to. The different remedies or relief available to employees living with cancer in America will be discussed in more detail later in this chapter.

Briefly, to illustrate a claim for the violation of the right to privacy relating to an employee with health problems, the case of *Lanxon v Crete Carrier Corp,*[150] merit mentioning. In this case, the employee was a review officer of the company for many years. The employer found out from a third party that the employee suffered from seizures. The employer communicated the medical condition of the employee to all the employees of the company through emails and phone calls.[151] The employer argued that his conduct was lawful and did not amount to the violation of the right to privacy of the employee, because the employee did not voluntarily disclose his medical condition in order to be protected by the law.[152]

Such argument by the employer was dismissed on the basis that it does not matter if the employee disclosed his medical condition or not. The employer had no right to communicate to all the employees of the company the medical condition of the employee. The employer's actions amounted to the violation of privacy, and the employer did not use the information in order to advance the interests of the employee and therefore, the conduct of the employer was found to be unlawful.[153]

Furthermore, in the case of *Doe v U.S Postal Services*,[154] the employee disclosed to the employer that he was diagnosed with HIV and AIDS. Upon making such a disclosure, the employer requested the employee to submit the necessary supporting documents, in order to verify his medical condition which the employee in fact submitted.[155] Thereafter, having confirmed that indeed the employee was diagnosed

149 Daniel JS "A Taxonomy of Privacy" 2006 (154) *PL.REV* 527.
150 *Lanxon v Crete Carrier Corp* NO.4 CV 3182, 2001, WL 1589627 at 11 (13 December 2001).
151 *Lanxon v Crete Carrier Corp* case 11.
152 *Lanxon v Crete Carrier Corp* case 11-12.
153 *Lanxon v Crete Carrier Corp* case 12-13.
154 *Doe v U.S Postal Services*, 317 F.3d 339, 341 (D.C Cir 2003).
155 *Doe v U.S Postal Services*, case 341.

with HIV and AIDS, the employer disclosed the medical condition of the employee to all the employees in the company. Such a disclosure by the employer was not meant to provide reasonable accommodation to the employee, but resulted in the employee being subjected to stigmatisation and discrimination by fellow employees, and finally the employee's decision to leave his job.[156] The conduct of the employer was found to be unlawful and was a violation of the right to privacy of the employee, because the disclosure made by the employer to fellow employees was not related to the job.[157] According to the decision in this case, the law does not expect the employer to provide merely any form of reasonable accommodation which the employee demands, and which is not in line with the employer's operational requirements.

Despite the protection of employees living with cancer against any form of discrimination in terms of section 6(3) of the Americans with Disabilities Amendment Act, there is nothing that prevents the employer from dismissing the employee living with cancer in cases of incompetence or insubordination on the part of the employee living with cancer.[158] This confirms that an employee living with cancer is not exempted from dismissal on the basis of incompetence or insubordination. The employee living with cancer is not in the position to use his or her medical condition of cancer as a reason for poor service, incompetence or insubordination, because this will bring the law into disrepute and will not be in the interest of the employer.

4.4.2 Legal remedies available to an employee living with cancer in America

In the American context, an employee who has suffered in the hands of the employer due to his or her disability may claim relief in terms of section 6(3)(b) of the Americans with Disabilities Amendment Act. This provision states that the authority to issue regulations which has been granted to equal employment opportunity commission, the

156 *Doe v U.S Postal Services*, case 342.

157 *Doe v U.S Postal Services* case 342-343.

158 Section 6(4) of the Amended Americans with Disabilities Act of 2008. Furthermore, it is important to take into account the case of *Wilson v Maryland-Nat'l Capital Park & Planning Commission*, 1999 WL 279878 (6 May 1999), as an example. In this case a police officer was diagnosed with cancer of the bladder, and had a successful surgery. He returned to work, and the employer provided him with all the necessary reasonable accommodation in order for him to continue with his work, such as allowing him time off to go see the doctor during working hours. Despite, the support of the employer provided to the employee he was performing in an unsatisfactory manner and the employer dismissed him on the basis of incapacity. The conduct of the employer was found to be reasonable and in the interest of the company, the claim of the employee that the employer discriminated against him on the basis of his cancer was dismissed by the court.

attorney general and the secretary of transportation under this Act, includes the authority to issue regulations implementing the definition of disability and to provide relief to this effect.[159] This simply means that under the Americans with Disabilities Amendment Act, the attorney general and the secretary of transportation have the authority to grant relief to employees who have experienced unfair discrimination due to a disability as a result of cancer.

From the above assessment, to summarise the position in the United States: Cancer is viewed as a medical condition that falls under the category of a flexible medical disability which comprises both the physical and the mental impairment, because of the potential to render an employee permanently or temporarily unable to continue to work. However, is important to take into account that the fact that when one has cancer, it does not mean that such a person is disabled and it must be proven that the cancer substantially limits the ability of the individual employee to perform his or her daily activities, in order to be regarded as a disability.[160]

4.4.3 Theoretical lessons for the South African legal system in dealing with persons or employees living with cancer

Despite the similarities between South Africa, the United Kingdom and the United States in placing an obligation on the part of employers to reasonably accommodate employees with disabilities in the workplace,[161] only the United Kingdom and the United States appear to be ahead when it comes to efficiently protecting employees living with cancer. This development is owing to the recognition that cancer falls into the social and medical definition of disability due to its effect on the ability of the employee to continue with work.[162] However, this is not yet the position in South Africa,

---

159 Section 6(3)(b) of the Amended Americans with Disabilities Act of 2008.

160 Section 6(3)(b) of the Amended Americans with Disabilities Act of 2008.

161 For example, in the South African context we have the provision of section 15(2)(c) of the Employment Equity Act 55 of 1998, which imposes this duty and in the United Kingdom we have section 20(1) of the Equality Act 2010 which imposes a legal obligation on the part of employers to accommodate employees with disabilities. Lastly, in America we have the provisions of section 6(1) of the Amended Americans with Disabilities Act of 2008, which imposes a similar obligation as that of South Africa and the United Kingdom on the part of employers to reasonably accommodate employees with different forms of disabilities.

162 Section 6 of the Equality Act 2010 and Section 3 of the Amended Americans with Disabilities Act of 2008.

as cancer does not feature in any legislation as one of the disabilities, despite its severity on the ability of employees living with cancer to continue work.

To reiterate the legal position in South Africa: in order to be considered as having a disability, an employee living with cancer may argue that the broad interpretation of disability includes cancer by way of reasonable inference. The effect of the disease will also play a very significant role in this regard. Considerations such as whether the cancer has the effect of substantially affecting the ability of an employee living with cancer to perform his or her work or daily activities will need to be considered.[163] This approach, as argued in the previous chapter, is too burdensome on the part of the employee living with cancer, because he or she must first argue that cancer amounts to a disability and then move to the next step of proving the effects of the cancer on their ability to do work and thus leads to a disability.

For the abovementioned reasons, it is submitted that the legal approach in the United Kingdom and America is more advanced than the South African position, because these jurisdictions recognise cancer as a disability, and the only thing that the employee living with cancer will need to prove in these systems is the effect of the cancer on their ability to do work, whether temporary or long-term.[164]

The statutes referred to in this chapter point to a liberal interpretation of cancer, whilst at the same time, safe-guarding the abuse of such recognition only in cases where it has the effect of substantially limiting the ability of the individual employee to work. From this view, it is apparent that not all persons living with cancer are considered disabled. Only for those persons for whom the cancer has impacted on their ability to work or perform daily activities, will cancer be viewed as a disability. In South Africa, as discussed already, the current definition of the concept of disability is restrictive and limited and excludes cancer. Whether South African provisions will become more inclusive in time in recognising cancer as a medical and a social disability, is a question that needs to be revisited as soon as possible.

---

163 Section 1 of the Employment Equity Act 55 of 1998 defines people with disabilities as people who have a long term or recurring physical or mental impairment which substantially limits their prospects of entry into, or advancement in employment.

164 Section 6 of the Equality Act 2010 and Section 3 of the Amended Americans with Disabilities Act of 2008.

4.5 Conclusion

The recognition of cancer as a disability in both the United Kingdom and America is an important step towards the protection of employees living with cancer in particular, and persons living with cancer generally. This, in turn, will ensure that equity and the right to human dignity of persons living with cancer as employees are protected.

Chapter 5: The role of the Cancer Association of South Africa (CANSA) and the importance of the National Cancer Registry (NCR) regarding the treatment of cancer

5.1 Introduction

People diagnosed with cancer are entitled to medical treatment and rehabilitation from cancer. This forms part of the right to access to health care services as enshrined in terms of section 27 of the Constitution of the Republic of South Africa (hereinafter referred to as 'the Constitution').[1] Therefore, persons living with cancer can seek health services from health establishments in order to deal with cancer, as this forms part of their right of access to health care services as protected by the Constitution. An in-depth analysis with regard to the right to health care services in the context of persons living with cancer forms the basis of this chapter.

The role which the Cancer Association of South Africa (CANSA) plays by raising awareness and addressing cancer in South Africa will also be addressed in this chapter. The function of CANSA is to educate the public about cancer and raise awareness on how to live with cancer and maintain a happy lifestyle despite incurring such an affliction. The role of the National Cancer registry (NCR) is also relevant in this chapter, as the NCR is tasked with advising the government about issues relating to cancer. The NCR is also maintaining an effective cancer registry in South Africa in addition to providing the government with information that is vital for purposes of planning and budgeting for cancer.[2]

The importance of a body such as the NCR in South Africa is based on the fact that cancer was previously relegated as a lower priority non-communicable disease. However, the changing epidemiology of non-communicable diseases has suddenly

---

1 The Constitution of the Republic of South Africa, 1996 guarantees the right of access to health care services which includes reproductive health care to everyone as a basic and fundamental right which is enjoyed by every person in terms of section 27.

2 Singh E *et al,* "South African National Cancer Registry: Effect of withholding data from private health system on cancer incidence estimates" 2015 (105) *SAMJ* 107.

propelled cancer into the spotlight and in turn makes the role of the NCR critical and vital in addressing cancer.

Cancer was previously considered as a problem experienced in developed countries only. It is now recognised that socio-economically disadvantaged societies, such as those in South Africa, are more severely affected by cancer.[3] Cancer is now considered the fourth leading cause of deaths and accounts for up to 7% of mortality in South Africa.[4] These statistics show that cancer affects any society or human beings irrespective of their background or socio-economic standing.

To complete the chapter, an analysis of the role of the cancer registry in reporting cancer incidences will be considered. It should be noted at the outset that the record of the registry is subject to the duty to observe persons living with cancer's right to privacy. In this thesis, an argument will be proposed that a balance needs to be maintained between the duties of the cancer registry and the right to privacy of persons living with cancer. Both the registry's duty and the patient's rights are instrumental towards the overall fight against cancer and no one should trump the other, except in certain exceptional circumstances.

5.2 Cancer treatment in the context of the right to access to health care services

Section 27(1) of the Constitution guarantees everyone the right to access of health care services, which includes reproductive health care, and that no one may be refused emergency medical treatment.[5] The government has a duty to fulfil this obligation to provide health services to the people based on reasonable availability of resources, including the private health care sector, to a greater or lesser extent, particularly in emergency medical treatment.[6] This means that if health practitioners deny people medical treatment or emergency medical treatment, their actions would amount to a violation of the right to access to health care as protected by the Constitution.

3 Singh *et al*, 2015 (105) *SAMJ* 108.
4 Singh *et al,* 2015 (105) *SAMJ* 108.
5 Section 27(1) of the Constitution of the Republic of South Africa, 1996.
6 Section 27(2) of the Constitution of the Republic of South Africa, 1996.

Violating the protection of socio-economic rights, enshrined in the Constitution, goes against the purpose for which these rights were designed because chapter two of the Constitution is aimed at addressing the imbalances and injustices of the past.[7] Further, to unfairly and unjustifiably deny or violate socio-economic rights constitutes a contravention of section 7(2) of the Constitution, which states that the government must respect, promote, protect and fulfil the rights in the Bill of Rights.[8] This provision clearly outlines the duty of government not only to refrain from interfering with the enjoyment of these rights, but to also promote, protect and enhance their realisation as part of its constitutional mandate.

The debate as to whether socio-economic rights are justiciable or not, has long been settled in the South African context, evident from landmark court judgments, such as the case of *Soobramoney v Minister of Health, Kwazulu Natal*.[9] This case will be discussed later in this chapter under paragraph 5.2.1.3 below.

In this chapter, the focus will not be on the justiciability of socio-economic rights, but rather on the role of the courts in protecting socio-economic rights such as the right to access to health care services. Brand argues that socio-economic rights can be enforced by the courts in two ways, firstly through their law making powers of interpreting legislation and developing the rules of common law and secondly, the courts ought to adjudicate constitutional and other challenges experienced in state

7 Chapter Two of the Constitution of the Republic of South Africa, 1996 contains the Bill of Rights and a human rights charter that aims for the protection of civil, political and socio-economic rights of all the people in South Africa. The rights in the Bill of Rights apply to all laws, including common law, and bind all the branches of government including the executive, legislature, judiciary, provincial governments and municipal councils across the Republic.

8 Section 7(2) of the Constitution of the Republic of South Africa, 1996 states that the state must protect, respect, promote and fulfil the rights in the Bill of Rights. Further, is important to take into account that the inclusion of a comprehensive Bill of Rights on the final Constitution of the Republic of South Africa, 1996 has fundamentally influenced the law and its application in general in South Africa. The Bill of Rights enshrines the fundamental rights of all people in South Africa, and obliges or compels the government to respect, promote and fulfil such rights. The aim or objective of the Bill of Rights is to protect the individual or person, who is generally in a subordinate position with the government against its excessive power. One can say that the role of the Bill of Right is to prevent the arbitrary limitation, infringement and curtailment of people's rights and prescribes strict requirements for the lawful limitation of such rights by the government. See Bekink B *Principles of South African Constitutional Law* 1 81 (LexisNexis, Johannesburg 2012).

9 *Soobramoney v Minister of Health, Kwazulu Natal* 1998 (1) SA 765 (CC).

procedures that are intended to advance socio-economic rights.[10] The interpretation stated by Brand on the role of the courts in enforcing socio-economic rights is in line with section 8(2) to section 8(3) of the Constitution, when it relates to the application and enforcement of the rights in the Bill of Rights.[11]

The case of *Treatment Action Campaign v The Minister of Health*[12] serves as a fundamental and instrumental case to the provision of section 27 of the Constitution. In this case, the applicants sought an order against the Minister of Health and the health authorities of all nine provinces, except for the Western Cape. The order requested was to compel the Minister and all health authorities in the eight provinces to implement an effective national programme to prevent or reduce mother to child transmission of HIV, which would include the dispensing of Nevirapine to pregnant women who are HIV positive, and to their babies. Nevirapine is described as an antiretroviral drug that can prevent or inhibit the spread of HIV.[13] The applicants in this case described to the court the alarming rate of mother to child transmission and the impressive reduction that would be achieved by administration of the drug.[14] It was claimed in court that a single dose of the drug can reduce this form of transmission by 50 per cent, but this allegation was disputed by the respondents who maintained that the success rate was probably considerably lower.[15] The respondents further in

---

10 Brand D "Introduction to socio-economic rights in the South African Constitution" in Brand D and Heyns C (eds) *Socio-economic Rights in South Africa* 1-2 (Butterworths, Durban 2005).

11 Section 8(2) of the Constitution of the Republic of South Africa, 1996 states that a provision in the Bill of Rights binds a natural and a juristic person, if and to the extent that it is applicable taking into account the nature of the right and the nature of the duty imposed by the right. Section 8(3) of the Constitution of the Republic of South Africa, 1996 states that when applying a provision of the Bill of Rights to a juristic or a natural person in terms of subsection 2 a court, (a) in order to give effect to a right in the Bill of Right must apply, or if necessary develop, the common law to the extent that legislation does not give effect to that right, and (b) may develop rules of the common law to limit the right, provided that the limitation is in accordance with section 36(1). It's important to further take into account the fact that socio-economic rights are not only confined to the prerogatives of the legislature, executive and the judiciary. These rights can also be enforced through chapter nine institutions which are established by the Constitution and support democracy, this includes the Human Rights Commission and the Public Protector which are both dealing with significantly the protection and enforcement of socio-economic rights. For example, in terms of section 184 of the Human Rights Commission Act, it sets out the main function of the commission which are as follows: (a) promote respect for human rights and a culture of human rights, (b) promote the protection, development and attainment of human rights and, (c) monitor and assess the observance of human rights in the Republic.

12 *Treatment Action Campaign v The Minister of Health* 2002 (4) BCLR 356 (T).

13 *TAC* case 357.

14 *TAC* case 357.

15 *TAC* case 358-359.

general contended that immediate implementation of antiretroviral treatment in these cases would be impossible because of insufficient financial resources.[16]

Judge Botha came to the conclusion, with regard to section 27 of the Constitution, that a countrywide prevention programme of this kind is an ineluctable obligation of the state.[17] Moreover, Nevirapine would be affordable if the programme is properly planned. What was required in the opinion of the court was a plan striving towards comprehensive coverage and implementation of Nevirapine. The court accordingly made an order to this effect.[18] The court also made it clear that to order an immediate roll out of the drug would be impossible and not practical, and as a result of this view, it ordered the respondents to report back to it within three months regarding the status of planning for the implementation of the roll-out of the drug. In this case, the court ruled in favour of the applicants.[19]

This decision of the High Court was confirmed by the Constitutional Court,[20] as it reasoned that government policy which provides for the availability of the Nevirapine drug in only certain areas of public hospitals was inflexible and unconstitutional. Government was ordered to roll out the administration of Nevirapine nationally for the purposes of preventing mother to child transmission of HIV.[21]

Furthermore, section 27(2) of the Constitution, provides that government must take reasonable legislative and other measures within its reasonable resources, to achieve the progressive realisation of each of these rights.[22] What constitutes “reasonable resources” will be determined on the basis of the facts of each case. Despite the fact that the right to access to health care services is constitutionally enshrined, it is still important to note that there are considerable inequalities that exist with regard to access to health care services. These inequalities are largely caused by the discrepancies found in health resources and barriers to access health, such as vast

16 *TAC* case 360.

17 *TAC* case 361.

18 *TAC* case 362-363.

19 *TAC* case 364.

20 *Minister of Health and Others v Treatment Action Campaign and Others* (NO 2) (CCT8/02) [2002] ZACC 15, 2002 (5) SA 721, 2002 (10) BCLR 1033 (5 July 2002).

21 *Minister of Health* case 1034.

22 Section 27(2) of the Constitution of the Republic of South Africa, 1996.

distances, high travelling costs from rural areas, long queues and disempowered patients.[23] For example, in the case of *Soobramoney v Minister of Health, Kwazulu Natal*,[24] the court dealt with the issue of unavailability of health services in the circumstances of a patient who was suffering from kidney failure, but had been denied treatment in the relevant public hospital. The conduct of the hospital was found to be justified due to the lack of resources.

5.2.1 Public and private health care in South Africa

In South Africa, similar to the position in most developing countries, the provision of health services is divided into two sectors, namely the private health care sector and the public health care sector. In South Africa, these two systems of health treatment were established during the apartheid era and are still sustained in the modern day democratic South Africa.[25] In order to contextualise the two systems of health care, it is necessary to provide a brief history relating to how these two systems of health care were formed during the apartheid era. During apartheid, the quality and nature of health care services were based on three factors, namely race, location and income.[26] Homelands were formed with the aim of formally separating people in different areas, and thus the same principle was applied to health care services, which were inadequately and poorly administered to the majority of black people in the homelands.[27]

During the period of apartheid, the church played a significant role in the administration of health services to the majority of the people, due to the failure of the then government in providing health care services to the people in the public sector setting.[28] The formation of the private sector came into existence as a result of the economic downturn and the pressure which was placed on the government by the

23 Chersich M *et al*, "Inequalities in access to health care in South Africa" 2011 (32) *JPHP* 2-3.

24 *Soobramoney v Minister of Health, Kwazulu Natal* 1998 (1) SA 765 (CC).

25 Beck S "Health Policy, Health Services, and Cancer Pain Management in the New South Africa" 1999 (17) *JPSM* 17.

26 McIntyre D *et al,* "The health and health system of South Africa: historical roots of current public health challenges" 2009 (374) *Lancet* 817.

27 Tollman SM and Kautzky K "A Perspective on Primary Health Care in South Africa" 2008 (2) *SAHR* 20.

28 Tollman and Kautzky 2008 (2) *SAHR* 20-21.

medical industry, resulting in the government having to regulate the health sector.[29] Through the regulation of the health sector, the private health sector arose as an institution of health services. Before delving into how the treatment of cancer is effected in South Africa, it is important to have a better understanding of how the two health care systems really work and how these contribute to the social and economic wellbeing of the people of South Africa.

5.2.1.1 Private health care services

It is estimated that only fifteen per cent of the South African population has access to private hospital treatment.[30] In private hospitals, cancer and other health related treatments are found to be effective and functional.[31]Such efficiency and effectiveness are achieved by means of readily available drugs and the presence of state of the art treatment machines.[32] Private health care is accessed by those with access to insurance or medical aid funding, or those who can afford to pay for it directly from their own pockets.[33] Private health treatment, compared with the public health treatment, accounts for the largest share of total health financing which comprises of medical aid schemes and private out of pocket payments made by patients.[34] Private health treatment is generally viewed as the best available, and is seen to be the most effective with regard to cancer treatment.[35]

However, there are challenges with regard to private health care, as it is generally expensive to access, and thus is not easily accessible to the indigent who need the quality of care offered in private institutions.[36] As a consequence, some medical aid schemes are not willing to pay for cancer treatment in private institutions, due to the high cost associated with treatment in the private health care system. One example of

29 Naylor CD "Private medicine and the privatization of health care in South Africa" 1988 (11) *Soc Science Med* 1153.

30 Reynolds 2013- 05- 17 *Mail and Guardian* 5.

31 Reynolds 2013- 05- 17 *Mail and Guardian* 5.

32 Reynolds 2013-05-17 *Mail and Guardian* 5-6.

33 Chersich M *et al,* "Inequalities in access to health care in South Africa" 2011 (32) *JPHP* 102.

34 Akazili J and Ataguba J "Health care financing in South Africa: Moving towards universal coverage" 2010 (28) *CEM* 75.

35 Akazili and Ataguba 2010 (28) *CEM* 75.

36 Akazili and Ataguba 2010 (28) *CEM* 76.

this situation is the case of a woman who died in 2007 of breast cancer because her medical fund, Global Health, refused to pay for her treatment.[37]

Section 27 of the Constitution also binds private hospitals to provide medical treatment to patients, in cases of an emergency situation.[38] In addition, section 5 of the National Health Act supports the position that both private and public health establishments cannot deny anyone emergency medical treatment.[39] Pieterse argues that the constitutional obligation placed on both private and public hospitals to provide emergency medical treatment, is a direct and immediate entitlement.[40] The question as to what constitutes emergency treatment has been left open by the Constitution. This has had serious financial implications on private hospitals as they are obliged to render emergency medical treatment to people who cannot guarantee the necessary payment.[41] Since the question of what constitutes emergency medical treatment has been left open by the Constitution, it is assumed to be a question of fact, which will be decided on a case by case basis. However, in the landmark case of *Soobramoney v Minister of Health (Kwazulu Natal)*,[42] discussed in detail below, the court defined

37 See Adams 2007-05-31 *Star* 1. The Competition Tribunal commented on the state of health care in South Africa and how the private health care system has become a lucrative business. "The provision of adequate health care to all the citizens of the country is clearly an important plank in the government's efforts to tackle poverty and inequality. High and middle income earning South Africans (and this would include a significant proportion of those in employment) receive health care through South Africa's sophisticated private health care system comprising the full gamut of general practitioners, specialists, hospitals and pharmacies. Private health care is funded by an array of medical schemes serviced by the administration companies, data processing companies and managed care companies that are an integral part of South Africa sophisticated 'first world' private health care system. However, majority of the population (and this includes a significant number of those in the lower reaches of formal employment) rely on the public health system for meeting its needs. The reality, and possibly the only agreed certainty in the fraught debate surrounding the provision of health care in South Africa is that the private health care system, and most notably, although not exclusively, the private hospital network, is characterised by significant excess capacity while the public health care system is simultaneously resource-constrained and increasingly unable to cope with the demands which it faces. A major thrust of the government's efforts to improve health care provisioning is thus to utilise the excess capacity in the private health care system, to reduce the demands on the public health care system, to move a strata of those presently reliant on public health care over to the private health care system." *Medicross Healthcare Group (Proprietary) Limited and Prime Cure Holdings (Proprietary) Limited, Case No*.11/LM/Mar05, paragraph 52 and 53.

38 Section 27 of the Constitution of the Republic of South Africa, 1996.

39 Section 5 of the National Health Act 61 of 2003.

40 Pieterse M "Enforcing the right not to be refused emergency medical treatment: Towards appropriate relief" 2007 (18) *Stellenbosch Law Review* 75-76.

41 Pieterse M "Legislative and executive translation of the right to have access to health care services" 2010 (10) *Law Democracy and Development* 243.

42 *Soobramoney* case 1697.

emergency medical treatment as a "sudden catastrophe which calls for immediate attention".[43] The broad and flexible nature of this definition is supported because it caters for all forms of health emergencies without excluding the other.

Due to the seriousness of the obligation to provide emergency medical treatment, and the inconsistencies of some private hospitals in implementing and realising this socio-economic right to health care, specific legislation was enacted, which deserves mention. Item 3(b) of the Schedule to the Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000 reinforces the obligation imposed on private hospitals to render emergency treatment to a patient, by prohibiting the discriminatory refusal of emergency treatment.[44] As a consequence, a person living with cancer in an emergency situation may be admitted to a private hospital to receive treatment, and unfortunately, that particular hospital will be permitted to bill the patient for the services which they have rendered without taking into account whether the patient can afford the bill or not.

The obligation of private hospitals to admit patients (including persons living with cancer) in emergency situations, is further stressed by the Hospital Association of South Africa, this association has incorporated a draft code of ethics for private hospitals across the country.[45] In the draft code of ethics for private hospitals, emergency treatment is defined as "treatment that is necessary to stabilise an emergency medical condition".[46] The code requires private health establishments to render such treatment ethically without any form of discrimination and subject to reasonable compensation. This definition of emergency medical treatment as provided for by the Hospital Association of South Africa is in line with the definition that was

43 *Soobramoney* case para 36.

44 Item 3(b) of the Schedule to the Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000.

45 Proposed Code of Ethics for Private Hospitals – Hospital Association of South Africa (HASA) *Private Hospital Review 2008: Examination of Factors Impacting on Private Hospitals* (2008) 67.

46 Clause 1 of the Proposed Code of Ethics for Private Hospitals – Hospital Association of South Africa (HASA) *Private Hospital Review 2008: Examination of Factors Impacting on Private Hospitals* (2008) 67.

provided by the court in the *Soobramoney* case, because both definitions cover all forms of medical emergencies.[47]

5.2.1.2 Public health care services

Public health treatment in South Africa is administered to seventy five per cent of the population which is largely located in urban and rural areas.[48] The public health treatment of cancer and other related illnesses is characterised by inadequate treatment facilities, less or unavailable drugs, crowding of patients, and unqualified staff and abuse of patients by staff.[49] The public health treatment system is often seen as the exact opposite of private health treatment in the country. For example, persons living with breast cancer have to wait for weeks before undergoing surgery in the Groote Schuur Hospital situated in Cape Town,[50] due to the unavailability of funds from the National Department of Health. Not enough staff is available and in addition to this, defective, as well as old equipment is used to assist patients.[51] The city of Durban is presently experiencing a shortage of oncologists, to an extent that one oncologist is responsible for thousands of cancer patients, resulting in poor health afforded to persons living with cancer in need of urgent health care.[52] There has been an admission on the part of the National Department of Health that country wide, a shortage of oncologists exists and this is a call for concern when it comes to the treatment of cancer in South Africa.[53] If this problem is not resolved as soon as possible, it would mean that millions of persons living with cancer in South Africa relying on public health will either lose their lives or will be denied access to health care services due to a shortage of oncologists in the country. This will be contrary to the fundamental right of access to health care as enshrined in the Constitution. These

47 See *Soobramoney* para 36 and Clause 1 of the Proposed Code of Ethics for Private Hospitals – Hospital Association of South Africa (HASA) *Private Hospital Review* 67.

48 Falkson G and Beck S "Prevalence and Management of Cancer Pain in South Africa" 2001 (94) *Pain* 76.

49 Chersich *et al,* 2011 (32) *JPHP* 102-103.

50 Smetherham 2002-10-17 *Cape Times* 3.

51 Smetherham 2002-10-17 *Cape Times* 4.

52 Charlton 2018-01-17 *Timeslive* 6.

53 In addition to a shortage of oncologists in Durban hospitals towards the treatment of cancer, there is a shortage of oncology machines towards the treatment of cancer. The Human Rights Commission was called to intervene with the aim of ensuring that the rights of persons living with cancer who rely on public health care are not violated because this is a serious concern. Please refer to Charlton 2018-01-17 *Timeslive* 6.

obstacles, in addition to the physical pain that persons living with cancer experience, cause a lot of distress for them and their families, and are unfortunately beyond their control.[54]

Proper measures need to be taken to avoid or prevent the government from disregarding the realisation of the right of access to health care services for all South Africans. However, this has proven to be an impossible task in the case of cervical cancer, where the screening process has already perpetuated and reinforced inequality with regard to the availability of such facilities.[55] This is because cancer screening facilities are available only to a select few in South Africa. For instance, women in rural areas who live far away from clinics are deprived of this service, while those located in cities and urban areas, situated closer to hospitals and clinics will have better access to these health care services.

Around 3800 women who rely on public health treatment, die of cervical cancer every year in South Africa.[56] This is a high percentage, pointing to a potential problem in the public health care system. CANSA has stressed the importance of making screening programmes widely available for women for purposes of early detection of any cancer in order to reduce the number of deaths caused by cancer.[57] Patients making use of public hospitals may compel the hospital to provide treatment to them, but this may be limited, as the state will provide the treatment based on its available resources in accordance with section 27 of the Constitution.

5.2.1.3 Soobramoney v Minister of health (Kwazulu Natal) 1998 (1) SA 765 (CC)

This case involved a patient who in need of dialysis treatment on a weekly basis, as he was suffering from kidney failure and needed treatment in order to survive.[58] The state argued that there were not enough facilities to offer this treatment as it was expensive.[59] The state, however, would provide treatment based on available

54 Patijn J *et al*, "High Prevalence of Pain in Patients with Cancer in a Large Population-Based Study in the Netherlands" 2007 (132) *Pain* 312.

55 Denny L, Kuhn L and Batra P "Utilisation and Outcomes of Cervical Cancer Prevention Services Among HIV-Infected Women in Cape Town" 2010 (100) *SAMJ* 39.

56 Express "More Services Needed to Fight Cancer" 2006 (23) *University of Free State* 8.

57 Express 2006 (23) *University of Free State* 9.

58 *Soobramoney* case 1697.

59 *Soobramoney* case 1697.

resources in order to preserve the life of the patient in question.[60] The court further reasoned that the decision of the Minister of Health was made in good faith and through rational decision-making, found to be in the best interest of the public, and therefore did not warrant any interference by the court.[61] The court ruled in favour of the Minister and refused to compel the hospital to act in the manner that the patient anticipated, but confirmed that the decision of the hospital in question was based on its available resources in its provision of treatment, and as expected in terms of section 27 of the Constitution.[62]

Based on the provision of section 27(2) of the Constitution and the *Soobramoney* judgment, it is clear the right of access to health care services, as guaranteed in terms of section 27(1) of the Constitution, is not absolute in the sense that it is dependent on the availability of reasonable resources.[63] As to what really constitutes reasonable resources is a question of fact and needs a precise definition. The vagueness of reasonableness in this context entails that a patient's fate in a public health establishment would depend on the available resources, without the hospital being held liable for a lack thereof. The public health establishment may argue that it acted within the limits of its reasonable resources to save the life of the patient. The issue of reasonable resources in the provision of health services is a form of a qualified step to the provision of health services, requiring closer investigation as to what it entails, and the effect it has on the overall right to health care services as provided for in the Constitution.

The first step in addressing the vagueness of the concept of reasonable resources as stated in section 27 of the Constitution is to accept the position that was followed in the case of *Government of Republic of South Africa and others v Grootboom*.[64] In this

60 *Soobramoney* case 1698.

61 *Soobramoney* case 1701.

62 *Soobramoney* case 1697.

63 Section 36(1) of the Constitution of the Republic of South Africa,1996 states that the rights in the Bill of Rights may be limited only in terms of the 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 the relevant factors including, the nature of the right, the importance of the purpose of the limitation, the nature and extent of the limitation, the relationship between the limitation and its purpose and less restrictive means to achieve the purpose.

64 *Government of Republic of South Africa and others v Grootboom*, (CCT11/00) [2000] ZACC 19, 2001 (1) SA 46, 2000 (11) BCLR 1169 (4 October 2000), in this case the facts involve the eviction

case, the standard of reasonableness was adopted to test the relevant legislation regarding its fulfilment or realisation of socio-economic rights. The case is relevant for this discussion since the right to have access to health care services is also a socio-economic right and forms the point of discussion at present. According to the court, any measures which are adopted with the aim of fulfilling socio-economic rights ought to encompass a standard that is reasonable in both their conceptualisation and implementation.[65] This simply means that there must be a clear allocation of tasks and responsibilities to different stakeholders in government, and appropriate financial and human resources must be made available in order to realise socio-economic rights. This reasoning of the court regarding the duty of government to fulfil socio-economic rights is in line with the International Covenant on Economic, Social and Cultural Rights (ICESCR), of which South Africa is a member and a party to.[66] This international human rights instrument states that, in order for a state party to be able to attribute its failure to meet at least its minimum core obligations to a lack of resources, it must demonstrate that every effort has been made to use all resources that are at its disposition in an effort to satisfy, as a matter of priority those minimum obligations.[67]

The most important aspect which the court highlighted in the *Soobramoney* case is that legislation or policy which is aimed at the realisation of socio-economic rights must

of informal residents in a private owned land which was reserved for the construction of low costs houses. The residents opposed their eviction by the government on the basis that the government was obliged to provide it with alternative or temporary shelter as enshrined by the Constitution, until they acquired permanent accommodation with their off springs. The court held that the government was obliged to provide temporary or alternative shelter, on demand, to children and parents and in instances where parents are unable to accommodate their own children. The court further reasoned that this duty by the government to provide shelter to the people is independent and the state must take reasonable legislative and other measures within its disposal to realise this goal. In this case the court concluded by outlining that the state was obliged to provide temporary accommodation to the evicted dwellers without taking into account the aspect of availability of resources, this was due to the fact that the was a crisis and an emergency. The appeal court however, was in disagreement with the court of a quo when it came to this decision.

65 *Grootboom* case 1169.

66 International Covenant on Economic, Social and Cultural Rights (CESCR) Adopted and opened for signature, ratification and accession by General Assembly Resolution 2200 A (XXI) of 16 December 1966 and came into force on 3 January 1976 in accordance with article 27 of the United Nations.

67 International Covenant on Economic, Social and Cultural Rights (CESCR) Adopted and opened for signature, ratification and accession by General Assembly Resolution 2200 A (XXI) of 16 December 1966 and came into force on 3 January 1976 in accordance with article 27 of the United Nations.

be transparent and communicated effectively to all the parties concerned, in order for it to be effectively implemented without confusion. However, this is unfortunately the current state of affairs particularly in South Africa's public health system.[68] Pieterse argues that the non-fulfilment of the right to access to health care services of patients in public health care is not only attributed to inadequate legislation and health policy, but is also due to failures to translate and interpret the right to its correct meaning and aim.[69] Pieterse's view is correct, as this problem has arisen in the context of determining what constitutes reasonable resources as provided for in terms of section 27(2) of the Constitution.[70]

The major challenge in both private and public hospitals in South Africa is the shortage of qualified staff. This challenge results in a frustration of the relationships between patients and medical personnel.[71] In the context of cancer, the shortage of staff will result in the unavailability of necessary resources and support to deal with the demands of the oncology unit.[72] The problem of shortage of staff is not only a challenge in South Africa, between the private and public health care centres, but affects the entire African continent and it has become a major factor in crippling health care systems on the continent.[73]

In Africa, 10 000 medical professionals graduate each year, but within five years, about half of them leave for Europe in search of greener pastures.[74] Most African graduates leave their countries due to low salaries, restricted career development options, and work overload, which is a common feature in the African health care systems.[75] Change is urgently required, which may be done by providing career

68 *Grootboom* case 1170, Pieterse 2010 (10) *Law Democracy and Development* 250-251.

69 Pieterse 2010 (10) *Law Democracy and Development* 250-251.

70 Pieterse 2010 (10) *Law Democracy and Development* 252.

71 Venter M, Venter C and Botha K "Cancer Treatment in South Africa: A Narrative Literature Review" 2012 (22) *JPA* 462.

72 Venter *et al*, 2012 (22) *JPA* 463.

73 Venter *et al,* 2012 (22) *JPA* 464.

74 Adewole IF *et al*, "Challenges and opportunities in cancer control in Africa: A perspective from the African Organisation for Research and Training in Cancer" 2013 (14) *Series* 147.

75 Adewole *et al*, 2013 (14) *Series* 147. Further, the shortage of medical practitioners has put a lot of pressure in the medical industry, and this is evident by the fact that training medical students, work excessive hours in order to meet or breach this shortfall. This has resulted in dire consequences for these medical practitioners, at some point losing their lives due to the pressure and fatigue that comes with the profession. For example in Cape Town, recently a medical student was involved in an accident due to fatigue and she lost her life due to working

counselling in medical schools and professional institutions, as well as the provision of mentorship programmes to students. Offering incentives to generate an interest and commitment among young medical professionals in order for them to stay in Africa and not go abroad is also a mechanism that may possibly alleviate the problem.[76]

5.2.3 Cancer treatment in both public and private health system

The composition of private and public health systems in the treatment of cancer and other health issues is not only a problem in South Africa but is also a global issue. In the United Kingdom, patients have reported bad experiences and treatment in the public health domain, compared to the private health sector.[77] The justification to the problem raised by the UK government was that public health establishments have to treat many patients, and yet there are inadequate facilities for the effective administration of treatment to patients.[78] This is also the position in South Africa, as it has been stated that the public health care caters for approximately seventy five per cent of patients.[79] The public health care system is desperately in need of assistance to be better equipped to give quality treatment to patients, as well as for purposes of assisting in upholding the preservation of the right to life as enshrined in section 11 of the Constitution.[80] The public health care sector is the most important sector in which the government plays a key role in preserving and protecting a number of fundamental human rights relating to health and health care.

long hours. This has resulted in the government to provide new guidelines with regard to the working conditions of these medical practitioners who are still in training, and this proposed plan will start to be implemented as from next year. eNCA "SA junior doctors call for new regulations on working hours" https://www.enca.com/south-africa/sa-junior-docs-call-for-new-regulations-on-working-hours (Date of use: 23 October 2016).

76 Adewole *et al*, 2013 (14) *Series* 147.

77 Lyratzopoulos G, Abel G and Saunders C "What Explains Worse Patient Experience in London? Evidence from Secondary Analysis of the Persons living with cancer Experience Survey" 2014 (4) *BMJ OPEN* 1.

78 Lyratzopoulos *et al,* 2014 (4) *BMJ OPEN* 2.

79 Lyratzopoulos *et al,* 2014 (4) *BMJ OPEN* 3.

80 Section 11 of the Constitution of the Republic of South Africa, 1996 which guarantees the right to life and is important to take into account the fact that this right is only applicable to an individual whose physical existence is at stake. The right to life is not a right of prospective parents to create life, whose right to make decisions in relation to reproduction is covered by the right to personal freedom and security in terms of section 12, and nor does the right to life apply for purposes of scientific research which are regulated by the right to freedom of scientific research in section 16(1).

It is argued that cancer is best treated in the private health care sector when a patient has medical insurance or financial means to access the best medical treatment.[81] The circumstances are very unfortunate for the millions of people who rely on the public health care system for treatment, because it is overburdened and poorly administrated.[82] The treatment of cancer involves screening tests for early detection of cancer, chemotherapy, radiation therapy, and surgery, not to mention psychological assistance that the patient often needs, which are all costly to acquire.[83] Persons living with cancer must have money or medical insurance in order to get effective treatment, which means that only few people who rely on the private health care will get effective treatment. However, this is of no consolation to many others with limited resources to their disposal.

Based on the abovementioned factors, cancer appears to be a disease arguably better dealt with by the affluent, as they are the ones who are able to seek the necessary treatment to survive from cancer, and they are generally more knowledgeable and educated on the topic of cancer.[84]

On the African continent, the challenges of the public health care sector, which stem from the lack of staff, dysfunctional health equipment, corruption and less inadequate financial resources caused by a lack of political will, ignorance by government and international funding agencies which ought to offer support to persons living with cancer.[85] In view of the assessment of cancer treatment in Africa as a whole, Emerson's idea that the first wealth of any nation is its health, has been compromised due to the poor administration of cancer treatment.[86] In accordance with Emerson's argument, if a country is healthy then it can achieve its goals of addressing socio-economic challenges, which won't be possible if a country is crippled by the challenges, financially or otherwise, of a disease such as cancer.

---

81 Ellis 2003-02-04 *Star* 6.

82 Ellis 2003-02-04 *Star* 6.

83 Gabriel *Man and Wound in the Ancient World: A History of Military Medicine from Sumer to the Fall of Constantinople* 43.

84 Lllidge T, Sikaro K and Price P *Treatment of Cancer Fifth Edition* 20 (CRC Press, New York 2008).

85 Ryder RW *et al*, "Cancer Care Challenges in Developing Countries" 2012 (11) *Cancer* 3627.

86 Emerson RW *et al*, *Health for Life* 31 (Human Kinetics Publishers, Canada 2014).

In Africa, the competing burdens of diseases such as HIV and AIDS, tuberculosis and malaria adversely impact on a government's efforts to address cancer, both with regard to political and public health planning.[87] The lack of attention given to cancer and its treatment mechanisms has resulted in cancer becoming one of the most deadly and silent killers on the African continent.[88] The current lack of decisive political will to address cancer on the African continent is attributed to a similar alleged lack of focus initially accorded the HIV and AIDS pandemic by governments on the continent around the 1990s.[89] Patients suffered and millions of lives were lost as a result of the HIV and AIDS pandemic. This was because African leaders, at the time, were engaged in a non-scientific debate on whether HIV caused AIDS, refuting affirmative scientific evidence.[90] The major contributing factor to the lack of decisive leadership regarding HIV and AIDS was the issue of denial. Cohen argues that denial is a common thread that causes people, organisations, governments and societies to avoid fully acknowledging reality when they encounter information that is disturbing or threatening to their beliefs or life as they know it.[91]

Denial is hence a coping mechanism to deal with disturbing emotions, such as guilt or anxiety associated with the realisation of unbearable diseases like HIV and AIDS and cancer.[92] To prevent the continuous and unfortunate loss of lives, and to avoid the perpetuation of the mistake made in Africa regarding HIV and AIDS due to denial,[93] cancer advocates and lobby groups such as CANSA should take note of critical lessons learnt by their HIV and AIDS counterparts and find strategies to engage governments in similar interactions to facilitate the development of a focused,

87 Ryder *et al*, 2012 (11) *Cancer* 3628.

88 Parker RK and White RE "Oesophageal cancer: an overview of a deadly disease" 2007 (1) *AAS* 1-2.

89 Patterson AS *The African State and the AIDS Crisis* 240 (Ashgate Publishers, New York 2005).

90 Patterson *The African State and the AIDS Crisis* 241.

91 Cohen S *The Elementary Forms of Denial: In States of Denial* 3-4 (Polity Press, Cambridge 2001).

92 Mackintosh D "The politicisation of HIV and AIDS in South Africa: Responses from the Treatment Action Campaign and South African government, 1994-2004" 2009 (204) *CSSR* 8.

93 Patterson *The African State and the AIDS Crisis* 242.

sustainable and scalable national strategic plan for cancer on the basis of grounded and well-researched evidence.[94]

A useful tool that could be employed in the treatment of cancer in South Africa is the comprehensive multi-disciplinary and multi-sectorial approach to HIV and AIDS, introduced by President Zuma.[95] This presents an opportunity for the national HIV and AIDS and cancer political advocates to partner up as the two diseases in some instances occur concurrently in the same patient. It would be highly cost effective to develop and implement integrated research and treatment plans.[96] Such intervention will assist in dealing with the effective and necessary treatment of cancer which is urgently required in South Africa and in Africa as a whole.[97]

The complex and expensive nature of cancer treatment necessitates closer collaboration between the two spheres of health care systems in order to deal with cancer cases. The collaboration which takes place between these two spheres of health care service systems in ensuring that health care services are provided to all people despite their socio-economic standing, is what Goudge correctly describes as the "public-private mix".[98] Collaboration may take the form of the private health care system teaching the public health care system a few things, and vice versa. This can also take the form of a bilateral relationship between the two spheres of health care.[99]

Furthermore, the recently proposed National Health Insurance is a measure that is aimed at closing the gap between the two spheres of health services, by ensuring that access to health care is a social right which is not dependent on the economic standing of the individual.[100] The National Health Insurance proposal issued by the government

---

94 Lynch T *et al, Hospice and Palliative Care in Africa: a review of developments and challenges* 516 (Oxford University Press, London 2006).

95 Asante-Shongwe K "Perspective of an Advocate-political advocacy in African cancer dialogue" 2013 (8) *Proceedings* 2.

96 Lynch *et al, Hospice and Palliative Care in Africa: a review of developments and challenges* 517.

97 Immunology 2006-11-22 *Business Day* 5, Oncology 2008-07-14 *Business Day* 4.

98 Goudge J *Public-Private Mix* 5 (Oxford University Publishers, London 2000).

99 McCready D *et al,* "How Can Diagnostic Assessment Programs can be implemented to Enhance Inter-Professional Collaborative Care for Cancer?" 2014 (9) *BioMed Central* 1-2.

100 The National Health Insurance (NHI) White Paper outlines the aim and purpose of the National Health Insurance. This white paper outlines the fact that South Africa is in the process of introducing an innovation of health care financing that will have far-reaching consequences on the health of South Africans. The National Health Insurance commonly referred to as the NHI will ensure that everyone has access to appropriate, efficient and quality health care services. It will be phased in over a period of 14 years, and this will entail major changes in the service delivery

of South Africa is in line with the goal of the World Health Organisation (WHO) drive for universal international health care in developing countries.[101] Whether the proposed National Health Insurance will succeed is a question of fact and time. The National Health Insurance proposal has received wide criticism from academics, political parties and private institutions due to its exclusion of the private health care sector, and the huge financial strain it will have on the fiscal position of the country.[102] For purposes of this study, the debate as to whether the National Health Insurance scheme will be a success or not will not be considered. However, for the sake of a comprehensive understanding of the current state of our health care system, it is important to outline the government's interventions in ensuring that all people have a social right to health care services, despite their economic status.

Coming up with an effective treatment mechanism for cancer on the African continent will not be an easy task. In order to create an effective mechanism, partnerships need to be established and bridges be built across countries, economies and professions so as to establish joint efforts aimed at making that mechanism effective.[103] A strategic cancer control mechanism will have to be developed in Africa, guided by best practices elsewhere, as well as on what is unique in the region for purposes of cancer management.[104] Such a mechanism would have to ideally be situated within strong, robust and sustainable health care systems that offer quality health care to all people, irrespective of their social or economic standing. However, to achieve this will demand financial investment particularly for cancer and new leadership, critical thinking, and understanding of cancer.[105]

structures, administrative and management systems. The NHI is intended to bring about reform that will improve service provision. It will promote equity and efficiency so as to ensure that all South Africans have access to affordable, quality health care services regardless of their socio-economic status.

101 World Health Organisation (WHO) 2008 The World Health Report: *Primary Health Care- Now More than Ever* 20.

102 Surender R "The Drivers of Universal Health Care in South Africa: The Roles, Ideas, Institutions and Actors" 2014 (19) *UNRISD* 14.

103 Asante-Shongwe 2013 (8) *Proceedings* 2.

104 Asante-Shongwe 2013 (8) *Proceedings* 3.

105 Adewole *et al,* 2013 (14) *Series* 142.

5.3 The importance of the National Cancer Registry (NCR) in South Africa

5.3.1 Introduction

The National Cancer Registry (NCR) is one of the institutions in the country that plays an active role towards the entire process of curbing cancer and using diverse means to plan for the management of the disease. The NCR is an institution that ensures that a country plans and develops means in dealing with the pandemic of cancer. This organisation plays a major and effective role towards the treatment and education of cancer. The major responsibility which rests on the NCR indicates that, if this institution is not functional or otherwise provides incorrect information about the cancer pandemic, there will be dire consequences for all the parties affected by cancer, resulting in many people losing their lives due to the government's lack of preparation which would be caused by the incorrect information that the government receives from the NCR. In 2014 it was estimated that cancer claims the lives of 8.2 million people across the world, which equals the number of the population existing in countries such as Haiti and Rwanda.[106]

One of the major factors that make Africa the leading contributor towards the cancer epidemic is the poor infrastructure and organisation of the various cancer registries.[107] This clearly indicates that the first step to fight cancer in any country, particularly on the African continent, is heavy investment in a cancer registry in order to make it functional and efficient in executing its important mandate of providing information to the government for purposes of planning ahead for cancer management.

Due to the important duty that the NCR executes, it is important to consider the history of the NCR, the various functions it performs, the challenges which this body experiences and how effective measures can be implemented to make it functional and operative. Recommendations on how to make the NCR effective will be crafted on the basis of an analysis of the national cancer registries of South Africa, and that

---

106 Stewart BW World Cancer Report 20 (International Agency for Research on Cancer, Lyon 2014).

107 Skeet RG *et al, Cancer Registries: Principles and Methods* 185 (IARC Scientific Publications, Lyon 1991).

of the United Kingdom, which is considered as one of the best in the world due to the support it gets from government to help it execute its mandate.[108]

5.3.2 The history and role of the National Cancer Registry (NCR)

The National Cancer Registry (NCR) was established in 1986 as a pathology-based cancer registry depending on the voluntary reporting from both public and private pathology registries.[109] The establishment of the registry was for the sole purpose of collecting and compiling information regarding cancer treatment, the number of people receiving treatment, and the age, sex and population groups of patients. The NCR serves as the main source of data collection for cancer statistics in the country.[110] Therefore, the main function of the NCR is to collect and classify information on all cancer cases for the purposes of producing statistics on the occurrence of cancer in a defined population, and in this case the South African population.[111] In addition to gathering statistics, the NCR has to provide a framework for purposes of assessing and controlling the impact of cancer in the population of South Africa.[112]

Reporting on cancer was not a legal requirement when the NCR was established, and this resulted in information only being received from the private pathology sector whereas the public pathology sector did not show interest in the matter.[113] Currently, this is no longer the position, as cancer reporting is now considered a legal requirement due to the high mortality rate of cancer and the important role that is played by the NCR. The legal requirement to report cancer incidences will be explored later on in the chapter.

At this point, it is very important to understand what cancer registration really entails. Cancer registration is defined as the process of continuing, systematic collection of

---

108 See Yip K *et al*, "Using routinely collected data to stratify prostate persons living with cancer into phases of care in the United Kingdom: implications for resource allocation and the cancer survivorship programme" 2015 (112) *British Journal of Cancer* 1594 and the United Kingdom Cancer Registration http://www.ukacr.org/registration-organisation (Date of use: 18 April 2015).

109 Vorobiof DA and Ruff P "Cancer in South Africa and the role of the National Cancer Registry" 2011 (2) *ASCO POST* 16.

110 Vorobiof and Ruff 2011 (2) *ASCO POST* 17.

111 Vorobiof and Ruff 2011 (2) *ASCO POST* 18.

112 Skeet *et al*, *Cancer Registries: Principles and Methods* 7.

113 This new regulation which makes cancer reporting on the part of medical practitioners compulsory is introduced by the National Health Act 61 of 2003, on Regulations Relating to Cancer Registration. Republic of South Africa 26 April 2011, more about the extent of this reporting duty by medical practitioners will be explored in detail later in the thesis.

information or data on the occurrences and characteristics of reportable neoplasms with the purpose of assisting with assessing and controlling the effect of cancer on the population.[114] Before considering the role and functions of the NCR, it is important to outline that the first attempt to find out the estimated number of people affected by cancer was made in Europe, at the turn of the century.[115]

In Germany, an attempt was made in 1900 to register all persons living with cancer who were under medical treatment in order to find out how many people were in actual fact affected by cancer. Questionnaires were distributed to medical practitioners to record the prevalence of cancer on 15 October 1900.[116] The same move was adopted by various countries including Denmark, Netherlands and Spain, to name a few.[117] However, the efforts to get statistics about the people who were affected by cancer were not successful.[118] This was due to poor collaboration rendered by physicians who were not interested in the venture. Later on, America conducted similar kinds of surveys to ascertain cancer statistics.[119] It was only in 1926 that the first effective population based cancer registry was formed in Hamburg, Germany.[120] This registry operated through three nurses who visited hospitals and medical practitioners in the city at regular intervals. They recorded the names of new persons living with cancer and transferred data to a central index in the health department. This index was compared to official death certificates at least once a week.[121]

Other countries such as the United Kingdom, Canada, Australia and Scotland developed their own cancer registries subsequent to the German one, which served as a guideline for these various countries to establish and form their cancer registries.[122] The International Association of Cancer Registries (IACR) was formed

114 Skeet *et al, Cancer Registries: Principles and Methods* 23.

115 Silva IS *Cancer Epidemiology: Principles and Methods* 385 (International Agency for Research on Cancer Publishers, Paris 1999).

116 Silva *Cancer Epidemiology: Principles and Methods* 386.

117 Silva *Cancer Epidemiology: Principles and Methods* 386.

118 Silva *Cancer Epidemiology: Principles and Methods* 387.

119 Gottschalk HR *et al*, *Cancer Registry Management: Practices and Principles* 2 (National Cancer Registrar's Publishers, New York 2004).

120 Silva *Cancer Epidemiology: Principles and Methods* 387.

121 Silva *Cancer Epidemiology: Principles and Methods* 387.

122 Silva *Cancer Epidemiology: Principles and Methods* 388.

later in the years and learned greatly from the works of the German registry.[123] The IACR was established in 1966 and its main objective is to develop and standardise the collection methods across registries to make their data as comparable as possible.[124] IACR works hand in hand with the World Health Organisation (WHO) and is part of a body that serves to inform the WHO about the extent of the cancer pandemic in the world.[125] This registry also advises the WHO as to how to tackle cancer on a global scale.[126]

The NCR is defined as an institution of national system used for collecting, recording, validating, storing, managing, analysing, interpreting and reporting the data of all persons with cancer on a national basis regardless of age.[127] Furthermore, the National Health Act defines cancer registration as the process of continuous, systematic collection and storage of a defined data set on the biographical information of all persons diagnosed with cancer, and of the characteristics of cancer including its treatment and outcomes.[128] At this point, it is very important to note that there are two types of cancer registries, namely the hospital-based and the population-based cancer registries.[129] These are the two forms of registries currently used in our country, both of them with their own set of advantages and disadvantages, dealt with in detail below.

5.3.3 The hospital-based and the population-based cancer registries

The hospital-based cancer registry deals with the recording of information on persons living with cancer admitted in a particular hospital.[130] The main aim of this kind of registry is to contribute to patient care through the provision of readily accessible information of the people who have cancer, the treatment they received and the effect or result of the treatment.[131] The hospital-based cancer registry was established in 1926 with the aim of overseeing cancer incidences in hospital settings, so that means

123 Fang J and Lee K *Historical Dictionary of the World Health Organisation* 207 (Scare Crew Publishers, London 2013).

124 Fang and Lee *Historical Dictionary of the World Health Organisation* 208.

125 Fang and Lee *Historical Dictionary of the World Health Organisation* 208.

126 Fang and Lee *Historical Dictionary of the World Health Organisation* 209-210.

127 Section 1 of the National Health Act 61 of 2003.

128 Section 1 of the National Health Act 61 of 2003.

129 Gail H and Benichou J *Encyclopedia of Epidemiologic Methods* 127 (John and Wiley Publishers, New York 2000).

130 Gail and Benichou *Encyclopedia of Epidemiologic Methods* 127.

131 Gail and Benichou *Encyclopedia of Epidemiologic Methods* 128.

could be devised for the treatment of cancer in hospitals.[132] The hospital-based registry is still relevant and important when it comes to planning for and treating cancer in present times.

A population-based registry deals with the collection of information on all new cases of cancer occurring in a well-defined population.[133] This means that a population-based registry deals with gathering information about cancer of all the inhabitants or residents of the country.[134] The population-based cancer registry was instituted in the late stages of the twentieth century with the aim of recording cancer incidences in defined communities, and this system of cancer registration has grown dramatically.[135] Initially, the population-based cancer registry was developed with the aim of determining cancer patterns and trends, and currently its scope has broadened to such an extent that it can be used to follow the registered persons living with cancer and determine the survival rate of these patients.[136] This significant growth in the role of a population-based cancer registry reveals that this system plays an effective role when it comes to the planning and evaluation of cancer incidences in the country.

5.3.4 The role of the National Cancer Registry (NCR)

Section 3 of the National Health Act[137] outlines the objectives of the National Cancer Registry, which includes the collection, recording, validation, storage, management, analysis, interpretation and reporting of data relating to cancer, and the provision of information to organs of state and the public for education and training, awareness raising and research, as well as for planning, including the prioritization of cancers and interventions in this regard.

The function of the NCR is important, and the information which it gathers must be relevant and up to date, so as to ensure that there is effective planning and budgeting for purposes of treating cancer, teaching people about cancer and really seeing how

---

132 Lowenstein C *Cancer Registries and Medical Records: Rich Data Resources* 8 (Statistical Method Publishers, Boston 2010).

133 Vysas D *Comprehensive Textbook of Surgery* 281 (Jaypee Brothers Medical Publishers, New Delhi 2012).

134 Vysas Comprehensive *Textbook of Surgery* 282.

135 Parkin DM "The evolution of the population-based cancer registry"2006 (6) *Nature Reviews Cancer* 604.

136 Parkin 2006 (6) *Nature Reviews Cancer* 605.

137 Section 3(a) & (b) of the National Health Act 61 of 2003.

many people are affected by this disease.[138] The activities of the NCR may have a far-reaching impact on the quality of care being given to the population, through the information it distributes. The efforts of the NCR will become more effective if hospitals and medical practitioner's co-operate with the NCR by providing this institution with information about persons living with cancer that they have treated. This is in accordance with the request of the Minister of Health, Dr Aaron Motsoaledi in 2011, e.g. for both hospital sectors and medical personnel to report cancer cases to the NCR.[139] The NCR makes use of two means to perform its functions for the purposes of gathering information from health establishments, namely to actively collect data and passively report such data.[140] The active collection of data entails the registry staff visiting various health establishments and abstracting the data by means of special forms during these visits.[141] Passive reporting deals with health professionals completing the notification forms developed and distributed by the NCR, or sending copies of discharge abstracts to the NCR.[142] From the role and functions of the NCR, it is clear that South Africa makes use of the population-based registry as the focus is on all South African citizens. The government adopted the population-based registry in 2011 due to the advantages of this system to effectively deal with the problem of cancer.

The advantages of making use of the population based-registry include the following:

(a) It describes the extent and nature of the cancer burden in the community and assists in the establishment of public health priorities,
(b) The information gathered by the registry may be used by the government as a source of material for etiological studies,
(c) It helps in monitoring and assessing the effectiveness of cancer control activities in the country.[143]

---

138 Parkin 2006 (6) *Nature Reviews Cancer* 606.

139 Silva *Cancer Epidemiology: Principles and Methods* 388.

140 Silva *Cancer Epidemiology: Principles and Methods* 388.

141 Silva *Cancer Epidemiology: Principles and Methods* 388.

142 Silva *Cancer Epidemiology: Principles and Methods* 389.

143 Vysas Comprehensive *Textbook of Surgery* 282. Furthermore, the introduction of the population-based cancer registry will ensure that South African statistics are now included in global cancer reports, which are produced by the International Agency for Research on Cancer (IARC). South Africa was excluded from participating as pathology-based surveillance data in the past, and was not included in the reports of the IARC. Currently, with the move to the adoption of the population-based cancer registry, South Africa will now become one of the 7 African countries included in the IARC report, and the other African countries that are reported in the IARC include: Zimbabwe, Nigeria, Uganda, Gambia, Reunion Algeria and Mali.

Despite the adoption of the population-based registry in South Africa, more attention ought to be given to the problem of cancer and the plight of persons living with cancer in order to improve the health of the people of South Africa. This should include a holistic approach that addresses research, effective management and prevention modalities in order to ensure that all stakeholders are involved in the process of fighting cancer.[144]

5.3.5 The balance between the patient's right to privacy and the functions of the National Cancer Registry (NCR)

The right to privacy of the patient is maintained and respected in terms of section 14 of the Constitution,[145] which guarantees and protects the right of any person to privacy. In addition to section 14 of the Constitution, section 14 of the National Health Act protects the confidentiality of persons whose names are submitted to the NCR and under no circumstances will they be made public. Furthermore, the National Health Act states that all information concerning the patient or user of health facilities, including information in relation to his or her health status, treatment or stay in hospital, is confidential.[146] The right to confidentiality of health and medical information is thus guaranteed by the National Health Act in South Africa. This right was highlighted in the *Tshabalala-Msimang and Another v Makhanya and Others* case,[147] where the court stated that section 14(1) of the National Health Act imposes a duty of confidence with regard to the information in a person's health records. Section 14(1) of the National Health Act makes it crucial and obligatory to protect the information in a person's health records against unauthorised disclosure. Both the Constitution and the National Health Act indicate that private information contained in the health records of a patient is worth protecting as an aspect of autonomy and dignity to the extent that law should punish people who unlawfully reveal such private information.

144 Stefan DC "Why cancer is not a priority in South Africa?" 2015 (105) *SAMJ* 103-104.

145 Section 14 of the Constitution of the Republic of South Africa, 1996 provides for the right to privacy, including protection against search and seizure and the privacy of correspondence. In addition section 10 of the Constitution of the Republic of South Africa, 1996 protects the right to human dignity.

146 Section 14 of the National Health Act 61 of 2003.

147 *Tshabalala-Msimang and Another v Makhanya and Others* case para 27.

The Protection of Personal Information Act 4 of 2013, to show the importance of this right, furthermore strengthens the right to privacy. Section 2(a) of the Protection of Personal Information Act sets out the purpose of this Act by stating that it is aimed at giving effect to the constitutional right to privacy, by safeguarding personal information when it is processed by a responsible party. Nonetheless, the purpose of the Act is subject to justifiable limitations aimed at balancing the right to privacy against other rights, particularly the right of access to information, and protecting important interests, including free flow of information within the Republic and across international borders.[148] In medical terms, the right to privacy means that the medical practitioner must at all times respect the fact that the patient is entitled to the treatment and the circumstances surrounding his or her medical condition being kept confidential and not disclosed to anyone else without the patient's consent. Failure to adhere to these requirements would constitute a contravention of the right to privacy, as protected by the Protection of Personal Information Act.[149]

Based on the cursory outline above relating to the protection of the right to privacy, it can be deduced that a patient in this context has a number of different avenues at his or her disposal for the enforcement of his or her right to privacy. Despite the fact that the Constitution is the supreme law of the country, it has been clearly pointed out that section 2 of the Protection of Personal Information Act aims to enforce the constitutional right to privacy. This means that the Constitution is the primary source for the patient to enforce his or her right to privacy, but due to the broad nature of the right, secondary relief in the form of the Protection of Personal Information Act, will specifically deal with the protection of personal information of a person to the exclusion of other statutes which deal with the right to privacy.[150]

However, a patient's right to privacy and confidentiality of information may be limited either in the case where the patient consents to disclosure of their personal information and such consent is obtained in writing.[151] The right to privacy may also be limited where a court or any law requires disclosure to take place, or instances where non-

148 Section 2(a) of the Protection of Personal Information Act 4 of 2013.
149 Section 2(a) of the Protection of Personal Information Act 4 of 2013.
150 Section 2 of the Protection of Personal Information Act 4 of 2013.
151 Section 14(1) of the National Health Act 61 of 2003.

disclosure presents a serious threat to public health.[152] Section 11(1) of Personal information Act provides grounds on which personal information may be disclosed in a lawful and justifiable manner. This includes incidences when disclosure is made with the consent of the person concerned, and the correct procedures of the law are followed, and the disclosure serves a legitimate purpose and is in the public's interest.[153] Our courts also protect the right to privacy and confidentiality of patients who make use of health establishments. For example, in the case of *NM and Others v Smith and Others*,[154] discussed in chapter three of this thesis, the right to privacy of three persons was violated via the publication of their names and HIV status in a book, without their consent. The court found that such conduct was unconstitutional and violated the right to privacy of the applicants in this case.[155] Furthermore, the outcome of the case of *Castell v De Greef,*[156] is important for the reason that a subjective, patient centred test for informed consent is in line with the fundamental rights to self-determination and individual autonomy. Issues of privacy for example similarly affect information about a person's health status in terms of cancer.[157]

Slabbert argues that an invasion of privacy emanates in the case where the doctor, without consent from the patient, conducts an HIV test and then communicates the result to the patient.[158] The right to privacy is generally violated when there is a disclosure of a person's personal information without their consent. The latter involves a violation of the doctor's duty of confidentiality.[159] The dual purpose and function of a doctor's duty of confidentiality includes the protection of the patient's right to privacy as well as the duty to secure public health.[160] Medical examination without consent is only permissible in cases where the person who is examined waives their right to privacy for the purpose of examination.[161]

---

152 Section 14(1) of the National Health Act 61 of 2003.

153 Section 11(1) of the Protection of Personal Information Act 4 of 2013.

154 *NM and Others V Smith and Others* (CCT69/05) [2007] ZACC 6, 2007 (5) SA 250 (CC), 2007 (7) BCLR 751 (CC) (4 April 2007).

155 *NM and Others V Smith and Others* case 751-752.

156 *Castell v De Greef* case 425.

157 Carstens and Pearmain *Foundational Principles of South African Medical law* 32.

158 Slabbert *Medical Law in South Africa* 16.

159 Slabbert *Medical Law in South Africa* 16.

160 Slabbert *Medical Law in South Africa* 16.

161 Carstens and Pearmain *Foundational Principles of South African Medical law* 32.

The right to privacy of the patient can thus be described as integral to the doctor-patient relationship and only under exceptional and justifiable instances will the NCR breach this right, for example in the abovementioned cases, or where the general limitation clause, section 36(1) of the Constitution, applies.[162] This ensures that a balance is struck between the right to privacy of the patient and the duty of the NCR to execute its mandate effectively.

The role of the NCR has been the subject of criticism and controversy in the past years, because of the outdated and inaccurate data that the registry kept.[163] This was attributed to the fact that hospitals and health practitioners were not willing to share information with the NCR, because they would run the risk of being sued for breach of confidentiality on the basis of the doctor-patient relationship.[164] The effect of withholding information from the NCR resulted in a four per cent decrease in the work of the NCR as the national cancer monitors/observers, leading to devastating consequences of ineffective planning and ultimately, lives lost as a consequence thereof.[165] This problem was resolved when the National Health Act was amended to allow health establishments and medical practitioners to share cancer statistics with the NCR, without running the risk of being held liable for breach of confidentiality.

An updated and correct cancer information register is very important for purposes of planning and budgeting for the prevalence of cancer in South Africa.[166] It is important to note that since 2011, the act of reporting cancer has become mandatory in the sense that every health worker who comes across a new case of cancer has a duty to report it to the NCR.[167] In order to enforce this compulsory duty on the part of health workers, penalties such as suspension, among other things, are imposed on health

---

162 Section 36(1) of the Constitution of the Republic of South Africa, 1996.

163 Pile 2010-03-26 *Financial Mail* 26.

164 Pile 2010-03-26 *Financial Mail* 27.

165 Kellett P *et al*, "South African National Cancer Registry: Effect of withholding data from private health systems on cancer incidence estimates" 2015 (2) *SAMJ* 107.

166 Flanagan 2008-11-14 *Star* 10.

167 National Health Act 61 of 2003 Regulations Relating to Cancer Registration, Republic of South Africa (26 April 2011). The Health workers role when it comes to the reporting of cancer is to ensure that a notification form is completed for every case of cancer diagnosis. Furthermore, the health worker must be required to fill in as much information of the patient during consultation with the patient, without running the risk of violating the right of the patient to privacy. The notification forms must be submitted to the NCR within 3 months of the cancer diagnosis by the health worker and this duty rests with health workers, who are both in the public and private health sector.

care workers who fail to report a cancer diagnosis.[168] In addition to this duty, health care workers ought to maintain confidentiality in the cancer registration process by ensuring the preservation of anonymity for the individual patient who has been reported to the registry, and also for those officials making such reports. By keeping the personal details of the affected parties confidential, it becomes easier to ensure that the cancer registry information is of the best quality. Confidentiality can also guarantee that the data submitted to the cancer registry is utilised in the best possible way for the benefit of persons living with cancer, as well as cancer control and for medical research.[169]

The NCR tends to experience other challenges that deter it from performing and functioning appropriately and effectively. One of the discouraging elements is the problem of shortage of staff, with only 15 people employed by the NCR who process about 80 000 cases of cancer per year.[170] This is a problem that requires the Department of Health to intervene, and ensure that more people are deployed to assist in capturing these cases. Currently, the NCR has new management under the leadership of Dr B Kistnasamy as its executive director.[171] He was appointed in 2009 and a new team of management joined him to the venture of ensuring that the NCR is operational and functional again in order to execute the important function of adequate recording of cancer cases.[172] This has resulted in more staff being recruited to assist the NCR to meet the deadlines for the annual reporting of cancer cases.

Both the public and the private sector hospitals now co-operate with the NCR by providing it with information about persons living with cancer, as cancer is regarded as a notifiable condition in South Africa as part of the regulation of health care.[173] This

---

168 National Health Act 61 of 2003 on Regulations Relating to Cancer Registration, Republic of South Africa (26 April 2011).

169 Section 14 of the National Health Act 61 of 2003.

170 Bhengu 2011-05-20 *Financial Mail* 57.

171 NHLS *NIOH Annual Review 2012-2013* 4 (National Health Laboratory Services, Pretoria 2013).

172 NHLS *NIOH Annual Review 2012-2013* 5.

173 Section 14 of the National Health Act 61 of 2003. See Kellett P *et al*, "Repeability of manual coding of cancer reports in the South African National Cancer Registry, 2010" 2013 (3) *SA J Epidemiol Infect* 157-165, in which it was discussed that manual coding which ensures that there is quality assurance is an important method for the NCR to use to gather information. This will ensure that the information of the NCR is up to date, thus allowing the government to plan for cancer more effectively.

means that both public and private laboratories can notify the NCR about cancer incidences without running the risk of being held liable for the violation of the right to privacy of the patient in terms of the Constitution, the Protection of Personal Information Act and the National Health Act.[174] Another improvement relating to the functioning of the NCR under new leadership is the introduction and development of a hospital-based cancer registry. This project is earmarked to begin at the Ekurhuleni District Hospital in Gauteng, and will thereafter be implemented countrywide, as the aim of this project is to ensure that cancer statistics are reported with ease both by hospitals in the public sector and the private sector.[175]

These developments indicate that South Africa is gradually moving from a population-based registry to a hospital-based registry to assess which hospitals are most burdened by cancer and which treatment measures can be provided to patients.[176] The reason for the implementation of the hospital-based registry is that the information collected can be utilised for clinical research and for epidemiological purposes, among other things.[177] One of the main advantages of the hospital-based registry as opposed to the population-based registry is that it provides ready and instant access to medical records, which are the primary source of cancer cases.[178] The data collected through the hospital-based registry is usually more extensive than the data collected by the population-based registry.[179] In light of these developments, it is very important to note that the hospital-based registry, currently being introduced in South Africa, will not replace the population-based registry, which is presently operational. The latter cannot and should not be seen to replace the first-mentioned, because both registries target separate groups of people.[180]

---

174 Section 14 of the Constitution of the Republic of South Africa, 1996 and Section 14 of the National Health Act 61 of 2003 both guarantees the right to privacy of the patient and maintains that all information concerning the health of the patient must remain confidential, unless stated otherwise.

175 AFCRN http://afcrn.org/membership/membership-list/87-ncrsa (Date of use: 2 May 2014).

176 Vysas Comprehensive *Textbook of Surgery* 282.

177 Silva *Cancer Epidemiology: Principles and Methods* 385.

178 Silva *Cancer Epidemiology: Principles and Methods* 386.

179 Silva *Cancer Epidemiology: Principles and Methods* 387.

180 The population-based cancer registry targets the broader community, this includes all the inhabitants of the country and while the hospital-based cancer registry targets a specific number or group of people in a particular area that is the hospital. See Silva *Cancer Epidemiology: Principles and Methods* 385.

Nonetheless, the hospital-based registry has its disadvantages, despite the advantage of being efficient and accurate. These disadvantages include the following:[181]

(a) The hospital-based registry is institution-based and not population-based. This implies that no attempt is made to register all cancer incidences occurring in any defined population, and thus the incidence rate of cancer cannot be accurately determined. Patients who are hospitalised in more than one hospital are counted more than once in each of the relevant hospital tumour registers where they are treated. Information may not be shared among hospitals caring for the patient at different times. Further, the hospital registries may only reflect shifts by patients or doctors from one institution to another due to the changes in numbers of any type of cancer or patient characteristics. In addition, cancer incidences of one hospital or in a group of hospitals may not be representative of all cancer cases that are occurring in the area. For example, certain institutions are referral centres for specific types of cancer or for particularly difficult or extensive tumours and cannot be used to determine the statistics of a wide group of persons affected by all types of cancer.
(b) To be able to ascertain incidents of death is likely to be less possible and thus incomplete in a hospital-based registry, than in population-based registry because of limited sharing of information among hospitals, and limited access to and use of other sources such as death certificates.
(c) In contrast to most population-based registries, hospital-based registries make little attempt to standardise their methods of collecting data across all hospitals, and therefore results in a lot of difficulties when having to compare their findings.

5.3.6 Challenges of Cancer Registries in the African Continent

The cancer epidemic is on the rise as it is estimated that there will be a seventy eight per cent increase of cancer cases in South Africa in the year 2030.[182] Therefore, all the necessary interventions should be put in place to assist in dealing with the disease. The NCR has a role to play here, because the first step is to have effective and up to date records showing the extent of the problem, in order to come up with effective interventions and solutions.[183] The challenges of the NCR, outlined above in relation

181 Smart CR and Herman M *Central Cancer Registries: Design, Management and Use* 42 (Harwood Academic Publishers, Chur 1994).

182 Health 24 http://www.health24.com/Medical/Cancer/Facts-and-figures/South-Africa-78increase-in-cancer-by-2030-20120721 (Date of use: 11 February 2014).

183 Health 24 http://www.health24.com/Medical/Cancer/Facts-and-figures/South-Africa-78-increase-in-cancer-by-2030-20120721 (Date of use: 11 February 2014).

to inadequate staff and its lack of functionality, are part of the reason why cancer is one of the deadliest diseases in Africa and in the rest of the world.[184]

The African Organisation for Research and Training in Cancer (AORTIC) is a multidisciplinary organisation that was formed by concerned African health care workers and scientists in 1983 with the sole aim of promoting cancer care and control in the African continent.[185] The AORTIC holds the view that cancer is so prevalent in the African continent because it is usually discovered late, and also because of the limited health resources that are available. Furthermore, there is a major gap in Africa regarding the knowledge that people have about cancer, and this is attributed to the fact that in Africa there are no functional cancer registries that are available to collect reliable cancer-related information that will allow planning for the disease to happen in time and well in advance.[186] In addition, despite the logistical challenges of a cancer registry in the developing world, there are external factors that can work as obstacles that prevent such a body to execute its mandate. These factors are discussed in the subsequent sub-paragraphs.

a) Lack of basic health services

The functioning of a cancer registry depends on the availability of proper health services for diagnosis and treatment of cancer incidences. In the developing world, particularly in Africa, health services are scanty and tend to be restricted in urban areas. For people who are in need of medical services, the quality of diagnostic information may be poor and based on clinical examination. This is the case in South Africa, where health services are largely found in cities and urban areas and most people in rural areas are completely unable to access health services or experience a lack thereof.[187]

184 Pile 2010-03-26 *Financial Mail* 26.
185 Rodrigues B "The Challenge of Cancer in Africa" 2013 *Cancer Control* 120.
186 Rodrigues 2013 *Cancer Control* 121.
187 Sutcliffe SB and Elwood JM *Cancer Control* 342 (Oxford University Press New York 2010).

b) Lack of proper denominators

Population-based registries require information on the size and the nature of the population being investigated, which is information that requires the availability of census data. In South Africa, this means that Statistics South Africa must work with the NCR by helping them to obtain all the necessary information to help them do their work very well.[188]

c) Identity of individuals

The ability to distinguish individuals from events of hospital admissions is very important for a cancer registry. This means that the registry must have sufficient information on each individual to avoid multiple registrations of the same person.[189]

d) Lack of follow-up

Active follow-up usually means that the registry attempts to contact physicians or patients on a regular basis to see if the patients are still alive. The challenge with this method is that it is expensive, and thus most registries rely on passive follow-up, that is matching death certificates to the people within their pre-existing date and assuming patients are alive as the common norm. Active follow-up is impossible in the developing world due to lack of resources and infrastructure on the part of the registry. To add salt to a wounded sore, another challenge in the developing world is the unreliable postal service, a serious problem in South Africa. This results in the proliferation of inaccurate addresses, as people move from one place to the other in search of economic stability and mobility.[190]

All of these abovementioned factors play a role towards the hindrances in establishing an effective cancer registry, and hence measures should be put in place to ensure that cancer registries are operational and functional in South Africa. All of this will become possible through the support and co-operation of the government, health care professionals and the population in general, while taking into account that heavy financial investment is required and imperative for both health care services and cancer. Health care and cancer registries co-exist and ought to collaborate with one another in the fight against cancer, taking into consideration that the first step to

188 Sutcliffe and Elwood *Cancer Control* 343.
189 Sutcliffe and Elwood *Cancer Control* 344.
190 Skeet *et al*, *Cancer Registries: Principles and Methods* 186-187.

address cancer effectively begins with a functioning and well-equipped cancer registry.[191]

5.4 The history and the role of the cancer registry of the United Kingdom in controlling cancer

5.4.1 Introduction

As mentioned earlier, cancer registration was first recognised in Europe, and as a result, cancer registration in European countries is very efficient and functional.[192] The United Kingdom's success and progress in this regard may be ascribed to its long history of running a cancer registry. Therefore, their registry has already experienced and provided solutions to common challenges which come up in such a process.

One may argue that the registration of persons living with cancer has developed as a slow process with many challenges and obstacles. Some of the challenges include the lack of co-operation between health professionals, and concerns regarding the violation of the right to privacy of the patient.[193] A cancer registry is established for the purposes of cancer control, which does not only involve medical and scientific aspects, but also includes public health and economic factors. These are the values that made the United Kingdom Association of Cancer Registries become the best functional cancer registry.[194]

5.4.2 History of the Cancer Registry in the United Kingdom and the functions of the Registry

In the United Kingdom, the first venture which was unsuccessful towards finding out the exact figures on how many people were affected by cancer took place in the form of a cancer census in 1728.[195] The project failed and did not achieve its anticipated results due to the lack of support and unwillingness of both patients and health professionals that were participating.[196] It was only after the 1990s that the cancer registry became functional and regarded as a health priority, after lessons learnt from

191 Sutcliffe and Elwood *Cancer Control* 345.

192 Gottschalk *et al*, *Cancer Registry Management: Practices and Principles* 2.

193 This was also a challenge in South Africa, but the amendment of section 14 of the National Health Act 61 of 2003 brought clarity and closure to the issue of the right to privacy of the persons living with cancer.

194 Gottschalk *et al*, *Cancer Registry Management: Practices and Principles* 2.

195 Gottschalk *et al*, *Cancer Registry Management: Practices and Principles* 3.

196 Skeet *et al*, *Cancer Registries: Principles and Method* 3.

Germany was acknowledged, the latter the first country in the world to have an up and running cancer registry.[197]

In 1990, when technological advances were made in the modern world, the need to make cancer registration more efficient and scientific arose.[198] This resulted in new methods being used in connection to cancer registration, taking into account the technological advances and quality assurance with respect to the information that was being supplied by the registries to the community and scientific community.[199] These developments created a necessity for the collaboration of various stakeholders to provide uniform and accurate data about cancer in the United Kingdom, and to ensure that no duplication of information occurs in the first place. Therefore, a uniform body had to be formed to oversee cancer registration in the United Kingdom, through ensuring focus in cancer registration and making sure that cancer registries were aware of any legislation or cross-national issues that could affect their role or function.[200] The body responsible for this is the United Kingdom Association of Cancer Registries (UKACR).[201]

The United Kingdom Association of Cancer Registries (UKACR) was formed in 1992, with the mandate of providing cancer registration with a unified voice, and to bring consistency in performing its functions, in order to prevent the duplication of information, which was the major problematic factor before it was formed.[202] Some of the functions of the UKACR include, focusing on national programmes in cancer registration and to establish a uniform representation of views with respect to cancer registries in the United Kingdom.[203] In addition to that, the UKACR ought to promote co-operation between the cancer registries regarding policy matters that concern

197 Silva *Cancer Epidemiology: Principles and Methods* 385.

198 Skeet *et al*, *Cancer Registries: Principles and Method* 3.

199 Skeet *et al*, *Cancer Registries: Principles and Method* 82.

200 Jensen OM *et al, Cancer Registration: Principles and Methods* 95 (IACR Scientific Publishers, London 1991).

201 UKACR Formation http://www.ukacr.org/content/ukacr-history (Date of use: 16 April 2014).

202 Williams DT *Cancer Registry Handbook: a guide to the use of cancer registries London: United Kingdom Association of Cancer Registries* 28 (Scientific Publishers, London 1994).

203 Williams *Cancer Registry Handbook: a guide to the use of cancer registries London: United Kingdom Association of Cancer Registries* 29.

cancer registration.[204] The UKACR should also facilitate the development of a framework to assist with the operation of special interest groups and regional registries, and ought to develop ways to stimulate change in cancer registration, information procedures, and practices and research based on cancer registry data in order to make the work of the registry more functional.[205]

Ever since the establishment of the UKACR in the United Kingdom, researchers, government, civil society and the broader society in the United Kingdom have agreed that the UKACR has contributed immensely to cancer registration. This they have done through the development and different types of co-operation that they have facilitated in the process of cancer registration. In addition, the UKACR has worked to improve the consistency and accuracy of cancer registration data by means of coding and classification of issues.[206] They have ensured the availability of speedily, accurate cancer information and statistics for the United Kingdom, by agreeing to the interface document for transmission of data to and from the office of national statistics.[207] They have taken the initiative of improving quality assurance through the development of national performance indicators. Additionally, they have worked to improve their efficiency standards through training the registry staff by means of a training manual, and cancer specific training packs, and by providing their staff with days off for purposes of studying.[208] The UKACR has also taken measures to ensure that potentially identifiable information as well as the confidentiality of patients is protected through the development of comprehensive guidelines for instances of information release. They further work towards safeguarding the use of cancer registry information through the development of guidelines for the standardisation of reported results and the establishment of a forum for sharing the latest epidemiological research.[209]

In the year 2008, the United Kingdom had already established eleven cancer registries across the country, and eight regional registries for the purposes of ensuring that there

---

204 Williams *Cancer Registry Handbook: a guide to the use of cancer registries London: United Kingdom Association of Cancer Registries* 30.

205 UKACR http://www.ukacr.org/content/about-ukacr (Date of use: 16 April 2014).

206 UKACR http://www.ukacr.org/content/about-ukacr (Date of use: 16 April 2014).

207 Kunklerl ML *et al*, "Recent Cancer survival in Europe: a 2000-2002 period analysis of EUROCARE-4 data" 2007 (8) *Lancet Oncology* 784.

208 Kunklerl ML *et al*, 2007 (8) *Lancet Oncology* 785.

209 Kunklerl ML *et al*, 2007 (8) *Lancet Oncology* 786.

is enough staff to ensure that accurate figures and data is collected right in time.[210] Owing to the high demand and increase of cancer in United Kingdom, the role and importance of cancer registration is shared among various departments. The Department of Health, National Assembly of Wales Department of Health and Social Care, Scottish Executive Health Department and the United Kingdom Association of Cancer Registries (UKACR) all form part of cancer registration facilities.[211] This affirms the view that cancer registration is a public health issue in the United Kingdom and these combined efforts assist to maintain the standard of the United Kingdom in having one of the most efficient and comprehensive cancer registries in the world.[212]

The role of the UKACR in the United Kingdom has indeed played a very important and significant role towards the entire process of cancer registration. This body has brought a form of uniform and efficient co-operation between all stakeholders, and has most importantly restored confidence and respect for the process of cancer registration in the United Kingdom, which was once flawed and disorganised.[213] Therefore, when the United Kingdom claims that it has developed one of the best cancer registries in the world, it is indeed justified, all of which can be attributed to the phenomenal organisation and professional way which the UKACR approaches cancer registration as the first step towards the fight against cancer.[214]

South Africa and other African countries can learn a thing or two from the English model and in the process develop its own means of cancer registration. However, based on the discussion of cancer registration above, it is obvious that committed investment through infrastructure, competent leadership and adequate training of staff is essential for the survival and functioning of a cancer registry.[215] Once all of these elements have been given due regard and made a priority in Africa, it will present the first step towards addressing the burden of cancer and reducing the scourge of cancer in Africa which is currently rife compared to other parts of the world.

---

210 Office for National Statistics "Cancer Statistics and registration in the United Kingdom" 2008 (38) *Series MB1* 28.

211 Office for National Statistics 2008 (38) *Series MB1* 29.

212 Gottschalk *et al*, *Cancer Registry Management: Practices and Principles* 2.

213 UKACR http://www.ukacr.org/content/about-ukacr (Date of use: 16 April 2014).

214 UKACR http://www.ukacr.org/content/about-ukacr (Date of use: 16 April 2014).

215 Gottschalk *et al*, *Cancer Registry Management: Practices and Principles* 2.

5.5 The role of the Cancer Association of South Africa (CANSA)

The Cancer Association of South Africa (CANSA) is a non-profit company,[216] established with the main aim of being the leader towards the fight against cancer in South Africa. It offers a unique integrated service to the public, which involves holistic cancer care and support to all people affected by cancer. It is important to note that CANSA is the only non- profit organisation dedicated to the fight against cancer in South Africa.[217] CANSA was established in 1931 by a group of concerned medical professionals, with the aim of raising awareness about cancer.[218] CANSA provides awareness by educating people about cancer, and the early detection thereof, as well as the benefits of a healthy lifestyle towards averting cancer. Part of this awareness entails informing people on the prospects and availability of treatment and psychological support to persons living with cancer and their families.[219]

CANSA has established care centres around the country,[220] and in this way, CANSA will achieve its aim of educating communities through the provision of information about cancer and providing them with support medically, socially and emotionally.[221] CANSA believes that care, knowledge, and support will empower communities to live more positively with cancer. In accordance with this value, CANSA places emphasis on the following views or factors:[222]

(a) Providing information about cancer through the various CANSA information centres which are located across the country.
(b) Empowering communities to assist in rendering their services to their own communities, to alleviate the pressure on their families. This is due to the fact that the focus of patient care is on the family as the primary unit of care.
(c) Providing comprehensive patient services which includes:
    (i) Nursing

216 Section 8(1) read with section 10 and Schedule 1 of Companies Act 71 of 2008.
217 CANSA http://www.givengain.com/cause/1056/ (Date of use: 14 January 2014).
218 CANSA http://www.givengain.com/cause/1056/ (Date of use: 14 January 2014).
219 CANSA http://www.givengain.com/cause/1056/ (Date of use: 14 January 2014).
220 CANSA http://www.uicc.org/membership/cancer-association-south-africa (Date of use: 14 January 2014).
221 Annual Report "The role of the Cancer Association of South Africa in volunteer involvement" 1998 (2) *CANSA* 37.
222 Annual Report 1998 (2) *CANSA* 37.

By rendering medical information, advice to the family of the patient and patient, training the family to care for the patient and how to manage the pain and symptoms of the patient.

(ii) Social Work

Provide emotional care and support to patients and families through individual counselling and various support groups.

(iii) Interim Homes

Provide accommodation, food and transport to and out of patients undergoing cancer treatment in hospitals.

(iv) Special Needs

CANSA also takes into account that, despite the medical treatment which patients need, patients have other special needs which ought to be taken care of by the organisation. This can range from wigs, medical appliances, toiletry and prosthesis to name a few.

CANSA provides overall care and support to persons living with cancer, with an aim of diminishing the impact of cancer.

One of the main factors which CANSA prides itself in, is investing in research relating to cancer, aimed at finding effective ways to deal with cancer and advise the government about how to tackle cancer, whether in the form of legislation, or treatment mechanisms. In showing its commitment to research and learning, CANSA spends around six million rand annually on research.[223] The services which CANSA renders to the public through raising awareness about cancer provide health advancement about cancer and research, mostly undertaken by professional staff of the organisation. However, apart from its professional staff, it is essential for CANSA to have volunteers in order to assist with the day to day functioning.[224] Therefore, apart from heavily investing in research, CANSA also prides itself in recruiting volunteers to help with their day to day operations and to complement the work of their paid staff.[225]

223 The role of CANSA investing in research is significant because it will result in the production of independent research which is not bias, and neither will it be a governmental cancer research funding engine. This position of CANSA is no doubt sustainable for South Africa until the cancer problem is resolved. See Albrecht C "A bibliometric analysis of research publications funded partially by CANSA during a 10 year period (1994-2003)" 2009 (1) *SAFP* 73-75 and CANSA accessible at http://www.cansa.org.za/cancer-research/ (Date of use: 14 January 2014).

224 Annual Report 1998 (2) *CANSA* 39.

225 Annual Report 1998 (2) *CANSA* 39.

There are a number of reasons why CANSA needs the assistance of volunteers in its fight against cancer. Volunteers expand the services of CANSA in areas where paid staff lack or are unable to reach more patients and clients timeously. Volunteers provide cost effective ways to render services while also offering extra man-power, expertise and experience. Volunteers bring new skills and experience into CANSA, and enhance community participation in CANSA's mission to fight cancer.[226] Furthermore, volunteers lessen the workload of professional staff to enable them to concentrate on other major responsibilities. These volunteers are also marketing assistants for CANSA and help to spread awareness about cancer. They represent the various cultures in which CANSA renders services in order to make sure that all the relevant needs of the patients are interpreted correctly and are sufficiently met.[227]

Volunteers are a bridging gap between CANSA and the community who further broaden the vision and perspectives held within CANSA.[228] More importantly, volunteers support the staff of CANSA, and give a higher status to the establishment of CANSA by raising the profile and visibility of CANSA.[229]

Due to the vast and important role that volunteers bring to CANSA, the organisation recruits a wide variety of volunteers for the purposes of executing different functions. This includes the administrative volunteers who support CANSA personnel and ensure the uninterrupted flow of administrative tasks, such as photocopying.[230] Health promotion volunteers assist with CANSA's supporting health programmes which are aimed at reducing the incidence of cancer, by enabling people to increase control and improve their own health.[231] These volunteers further assist CANSA by giving health promotion awareness to schools, community groups, businesses and other relevant bodies.[232] The patient service volunteers render services to patients and families through means of a holistic approach, which includes identifying and utilizing resources to address the needs of patients.[233] Fundraising volunteers initiate and

226 Annual Report 1998 (2) *CANSA* 40.
227 Annual Report 1998 (2) *CANSA* 41.
228 Annual Report 1998 (2) *CANSA* 41.
229 Annual Report 1998 (2) *CANSA* 42.
230 Annual Report 1998 (2) *CANSA* 42.
231 Annual Report 1998 (2) *CANSA* 43.
232 Annual Report 1998 (2) *CANSA* 43.
233 Annual Report 1998 (2) *CANSA* 44.

develop fundraising projects, to assist CANSA in achieving their income goals to sustain their services, and this includes assessing the tasks of relevant projects.[234]

Lastly, there are also public relations and marketing volunteers who promote the image, vision and mission of CANSA. These volunteers also communicate and liaison with sponsors, the media, and the public, through media communication, presentation and media publications.[235] CANSA is also effectively involved in organising and commemorating events such as the World Cancer Day, to raise awareness about cancer and show South Africans that cancer is not a myth or a disease that affects only certain class of people. They seek to make it known that cancer is a global disease that affects everyone.[236] This goes hand in hand with the recently hosted world cancer summit in Cape Town, where some of the pertinent issues with regard to cancer were discussed.[237] At this conference, Mrs Junes Van Rensburg, the CEO of CANSA stressed the importance of accurate data and a functional NCR as a first step to dealing with cancer. The Minister of Health, Dr Motsoaledi, who was also present at that conference committed the National Health Department to join forces with CANSA and the international community to fight cancer.[238]

CANSA organises the cancer week from the 2nd to the 6th of August every year, to educate members of the public about cancer.[239] In this campaign trail, emphasis is placed on breast cancer, and in this regard, CANSA offers advice to patients, screening process and opportunities for the early detection of cancer.[240] This campaign is constructed to help people understand breast cancer and to give them hope that it can be overcome to an extent where one can live a normal life again. In this aspect, a famous South African actress, Lillian Dube, who has overcome breast cancer herself, has formed an initiative with CANSA, with the purpose of spreading

234 Annual Report 1998 (2) *CANSA* 45.
235 Annual Report 1998 (2) *CANSA* 45.
236 Harrilall 2005-02-04 *Natal Witness* 6.
237 Uicc http://www.uicc.org/experts-come-together-close-cancer-divide-2025 (Date of use: 15 January 2014).
238 Uicc http://www.uicc.org/experts-come-together-close-cancer-divide-2025 (Date of use: 15 January 2014).
239 CANSA 2004-08-27 *Daily News* 6.
240 CANSA 2004-08-27 *Daily News* 7.

the message that breast cancer can be beaten and is not a death sentence or a myth.[241]

The role played by CANSA is fundamental and important towards the education and eradication of cancer in South Africa.[242] However, the survival of the 83-year old non-profit organisation will continue to be strengthened with the support and co-operation of government, civil society and business as well as its volunteers who ensure that patients receive the best medical care and advice about cancer.[243]

5.6 Conclusion

It is clear that in order to adequately provide treatment to all persons living with cancer, the government must invest in a functional cancer registry that can ensure proper planning for the sufficiency of health care services for persons living with cancer. It is a grave mistake not to support the cancer registry especially when cancer statistics show a steady increase on the African continent. In order to address cancer, the South African government needs to invest in an effective and efficient cancer registry, in addition to raising awareness about cancer and educating communities and civil society about the disease.

241 CANSA http://www.cansa.org.za/actress-is-cancer-survivor/ (Date of use: 15 January 2014).
242 Annual Report 1998 (2) *CANSA* 37.
243 CANSA http://www.cansa.org.za/actress-is-cancer-survivor/ (Date of use: 15 January 2014).

Chapter 6: Medical negligence in the context of oncology

6.1 Introduction

The doctor-patient relationship is at the centre of the lives of persons living with cancer as well as the international struggle against cancer. Persons living with cancer have to undergo medical care in order to be healed of the disease and ultimately overcome the cancer affliction. As such, aspects of medical law form part of the issue of cancer and law, and thus, an investigation into the legal aspects involved in the doctor-patient relationship forms the basis of this chapter. In this context, the doctor-patient relationship takes the form of a relationship between the patient and an oncologist, who specialises in the prevention, diagnosis and treatment of cancer.[1] In this chapter, the issue of medical malpractice in the relationship between the oncologist and the patient will be the focal point of discussion. Therefore, issues of consent, professional negligence, medical malpractice litigation and the remedies for medical malpractice are all addressed in this chapter.

6.2 The legal nature of the relationship between the oncologist and the patient

6.2.1 The basis of the relationship between the oncologist and the patient

The relationship between the oncologist and the patient is based on a contract.[2] For a contract to be valid there must be consensus between the parties to the contract.[3] Carstens and Pearmain argue that consent is a precursor to a contract between a patient and medical practitioner.[4] This means that consensus between the patient and oncologist serve the basis of determining the terms of reference which the medical

---

1 Ellsworth *100 Questions & Answers to Prostate Cancer* 81.

2 Carstens P and Pearmain D *Foundational Principles of South African Medical Law* 308 (Lexis Nexis Durban 2007) in which the authors clearly outline how a contract is concluded or formed between patients and medical practitioners either in the public or private health establishment. Furthermore, please refer to Madden RG *Essential law for Social Workers* 135 (Columbia University Press, New York 2003).

3 Carstens and Pearmain *Foundational Principles of South African Medical Law* 308 and Basavanthappa BT *Fundamentals of Nursing* 541 (Jaypee Brothers Medical Law Publishers, New Delhi 2004). Consent is critical in a contract between patient and medical practitioner and without consent in the contract between the two then such a contract is declared null and void.

4 Carstens and Pearmain *Foundational Principles of South African Medical Law* 313.

practitioner is bound to follow, and must not deviate because it can result in the medical practitioner being held liable for breach of contract. Since the requirement of consensus is at the heart of a contract, and the contract is entered into voluntarily, the oncologist can refuse to accept a patient for a medical consultation which falls outside his or her area of expertise.[5] In addition, as most oncologists are independent contractors, they are at liberty to refuse to treat certain patients but their liberties in this regard are subject to certain qualifications.[6] The oncologist must not exercise his or her rights in an arbitrary manner by refusing to accept a patient who is in desperate need of medical intervention.[7] Furthermore, the oncologist who has already started to treat a patient cannot simply abandon him or her, and should rather ensure that the patient has fully recovered or is referred to another medical practitioner in order to continue receiving medical attention.[8] Likewise, an oncologist cannot refuse to accept a patient on the grounds of race, colour, religion or nationality, as this would constitute unfair discrimination, which is prohibited in terms of section 9 of the Constitution of the Republic of South Africa (hereinafter referred to as 'the Constitution').[9]

The relationship between the patient and the oncologist is not only based on a contract, but it forms part of the law of obligations which includes both the law of contract and the law of delict.[10] If no contract exists between the oncologist and the patient, the relationship between the two will be governed by the law of delict, instead of the law of contract.[11] In terms of both the law of contract and the law of delict, the oncologist has a duty of care, which can emanate from the same act or omission on

---

5 Swanepoel M Law*, Psychiatry and Psychology: A Selection of Constitutional, Medico-Legal and Liability Issues* 315-316.

6 Wax ACH *Patient's Rights* 451 (YOZMOT Publishers, London 2002).

7 Wax *Patient's Rights* 451.

8 It is important to note that a medical practitioner is free to choose or decide which patients he or she will serve or treat. However, the medical practitioner is expected to justify his or her conduct should unnecessary suffering or death occur as a result of his or her refusal to attend to a patient. In emergency situations the medical practitioner is bound to provide the necessary medical intervention to the patient in need, under all the circumstances. This shows that in an emergency situation the medical practitioner cannot exercise his or her discretion when it comes to treating the patient but is bound by his or her oath of office, which is to save lives and provide health care for people in need of care. See Strauss *SA Doctors, Patient and Law A Selection of Practical Issues* 3 (Van Schaik Publishers, Pretoria 1980).

9 Section 9 of the Constitution of the Republic of South Africa, 1996.

10 Mcquoid-Mason DJ *Medical Professions and Practice: The practice of medicine* LAWSA 30 (LexisNexis, Durban 2008).

11 Mcquoid-Mason *Medical Professions and Practice: The practice of medicine* LAWSA 31.

his or her part, and can be remedied in terms of contractual as well as delictual liability.[12] As such, in the instances where the oncologist contravenes any of the patient's rights and fails to adhere to his or her own obligations in terms of the law, the oncologist may incur liability under contract law and delictual law. There are certain requirements which have to be fulfilled before any of these obligations may be expected, imposed or enforced against an oncologist, and the important one for the purposes of this study, is the requisite of consent.[13] The concept of consent will be discussed next.

6.2.2 The formation of consent in the oncologist and patient relationship

Consent can be established between an oncologist and a patient either verbally, tacitly or in written form, where the patient will normally enter into an agreement with the medical practitioner and assent to it by way of signing it.[14] It is therefore important to define consent as it is the key to the conclusion of a valid agreement. In a medical context, consent refers to the permission that a patient gives to the oncologist to act in a certain way in the performance of his or her duties, which includes: carrying out a diagnosis, performing surgery, and carrying out various therapeutic and non-therapeutic procedures.[15]

Consent can take two different forms, which are ordinary consent and informed consent.[16] Informed consent refers to permission which the patient gives the oncologist as he or she is aware of the benefits and risks of, and alternatives to the proposed surgery.[17] Ordinary consent refers to the instance where a procedure is performed on the patient without the patient actually giving his or her consent thereto.[18]

---

12 Mcquoid-Mason DJ *Medical Professions and Practice: The practice of medicine* LAWSA 32.

13 Carstens and Pearmain *Foundational Principles of South African Medical Law* 313 and The requirements of a valid contract are the following: Consent, Capacity to act, Lawfulness, Performance, Possibility and Security. See Maxwell CJ and Van Huyssteen LF *Contract Law in South Africa* 346 (Kluwer Law International Publishers, New York 2015).

14 Verschoor T and Claassen NJB *Medical Negligence in South Africa* 115 (Digma Publishers, Johannesburg 1992).

15 Shelkar R *Medical Negligence and Compensation* 27 (Kamal Publishers, New Delhi 2010).

16 Kale-Smith G *Medical Assisting made Incredibly Easy: Administrative Competencies* 68 (Lippincott Williams & Wilkins Wolters Kluwer Publishers, Philadelphia 2008).

17 Further see Van Oosten 1995 (1) *De Jure* 166, in which reference to the aspect of informed consent is extensively considered.

18 Gorney *Plastic and Reconstructive Surgery* 184.

In short, ordinary consent is illegal and may be considered as assault or battery.[19] It is important to emphasise that mere submission to a particular procedure does not constitute consent on the part of the patient merely because the willingness of the patient to undergo a certain type of surgery cannot be established as a matter of fact.[20] However, if a patient is capable of manifesting his or her will to submit to medical treatment with full knowledge of the advantages and disadvantages thereof, without any resistance, then it can be inferred that the patient consented to such treatment.[21] This rule would not apply to people who lack the capacity to act responsibly, including children and those suffering from mental illness.[22] In addition, certain requirements need to be fulfilled in order for consent to be valid and enforceable in our law. These requirements can be summarised as follows: [23]

(a) Information about a particular medical intervention such as radical mastectomy in cancer treatment must be provided to the patient by the oncologist.
(b) The patient must be a major and must be able to understand what the oncologist will be explaining about the medical intervention in question, and if he or she does not understand, he or she must be able to seek some kind of clarity.
(c) The patient needs to voluntarily consent to the medical intervention and without any form of coercion or deception on the part of the medical practitioner.
(d) The patient must be of a sound mind and must not be suffering from any kind of mental illness that could diminish his or her understanding of what is involved in the medical intervention which is proposed at that time.
(e) The patient needs to consent to the medical intervention before undergoing such treatment.

The case of *Isaacs v Pandie*, which serves as authority with regards to the validity of consent.[24] The court emphasised the need for the patient to have time to consider and understand the information in order to establish valid consent, as this case involved a woman in her thirties who was subjected to an unwanted sterilisation procedure

19 Gorney *Plastic and Reconstructive Surgery* 185.
20 Horan M *et al, Geriatric Medicine for Old-Age Psychiatrists* 16 (Taylor & Francis Publishers, Abingdon 2006).
21 Horan *et al, Geriatric Medicine for Old-Age Psychiatrists* 17.
22 Strauss SA *Legal Handbook for Nurses and Health Personnel* 9 (King Edward VII Trust, Cape Town 1992).
23 Basavanthappa *Fundamentals of Nursing* 541.
24 *Isaacs v Pandie* (12217/07) [2012] ZAWCHC 47 (16 May 2012).

following the birth of her fourth child.[25] Although the plaintiff repeatedly informed her doctor that she did not want a sterilisation procedure, and she specifically noted in writing that she did not consent to sterilisation, it was still performed on her. The court held that before a doctor starts any treatment, he or she must ensure that the patient has been given sufficient information and time to consent thereto.[26] The information must be given in a way that the patient understands in order to enable them to make an informed decision. In this case the defendant medical practitioner was held liable for acting without the consent of the plaintiff.[27]

The common law rules relating to contractual and delictual standards of consent, certain statutory measures have also been introduced to regulate the terms and conditions of the doctor-patient relationship, and to ensure that the patient is protected from any unfair practices which may arise out of such a relationship. These statutory measures will be discussed in detail under the subsequent paragraphs. In addition, this study will also deal with the statutory regulations relating to consent. This discussion will be limited to the National Health Act, which regulates the health system of South Africa, and the Consumer Protection Act which classifies a person living with cancer as a consumer and an oncologist as a supplier of medical services for persons living with cancer.[28] These two statutory provisions affirm and strengthen the relationship between the oncologist and persons living with cancer and they will also be discussed in-depth below.

6.2.3 Statutory regulation of consent

6.2.3.1 Consent in terms of the National Health Act 61 of 2003

The National Health Act also stresses the importance of a patient having to give prior consent for any medical intervention which they may undergo. Section 7 of the National Health Act, provides that health services may not be provided to a health care user without the user's informed consent, unless the user is unable to give informed consent and such consent is given by another person, mandated by the user in writing to grant such consent on his or her behalf, or authorised to give such consent, when

25 *Isaacs v Pandie* case 47.

26 *Isaacs v Pandie* case 48.

27 *Isaacs v Pandie* case 49.

28 Section 6 of the National Health Act 61 of 2003 and Section 48 (1) of the Consumer Protection Act 68 of 2008.

no person is mandated or authorized to give such consent.[29] Section 6 of the National Health Act places an obligation on the part of every health care professional to inform a user with regard to the user's health status, except in circumstances where there is substantial evidence that the disclosure of the user's health status would be contrary to the best interest of the user.[30] For example, it will not be in the best interests of persons living with cancer to disclose a diagnosis to him or her if it could result in a negative effect on the overall treatment of the patient.

Furthermore, section 6(1) of the National Health Act lists the kind of information that a medical practitioner or health provider must disclose to the patient, and this information includes the following:

(a) The range of diagnostic procedure and treatment options generally available to the user.
(b) The benefits, risks and consequences generally associated with each option.
(c) The user's right to refuse health services and an explanation of the implications and risks of such refusal.
(d) The medical professional must inform the user of this information regarding his or her health in the language that the user understands and in a manner which takes into account the user's level of literacy. [31]

It is important to note that the principle of informed consent which forms the basis of the relationship between the patient and the medical practitioner is ignored or not taken into account in public health establishments in most cases. This is mostly attributed to the fact that people who access health services in public health establishments are socio-economically disadvantaged and with less education, making them vulnerable to unethical conduct on the part of medical practitioners and nurses. The attitude of both medical practitioners and nurses in the public health sector of ignoring such a fundamental principle and aspect of consent violates the right to

29 Section 7 of the National Health Act 61 of 2003.

30 Section 6 of the National Health Act 61 of 2003. See also McQuoid-Mason DJ "Medical Profession and Medical Practice: The Practice of Medicine" 2008 (17) *LAWSA* 2, in which he discussed in detail the duty of medical practitioners to inform patients about their state of health, with qualifications attached to this duty such as not disclosing the health status of the parties if it is contrary to the interests of the patient.

31 Section 6 (1) of the National Health Act 61 of 2003.

human dignity of patients and in this context patients living with cancer.[32] Furthermore, failure by both medical practitioners and nurses in the public sector has resulted in patients bringing claims for medical negligence or malpractice against the state due to the conduct of hospital staff. This has resulted in the public health sector being crippled to due to the billions of rands it is paying out as a result of medical negligence claims.[33] This will result in public health services to the population of South Africa as guaranteed by the Constitution be either restricted or denied which will be contrary to the Constitution as enshrined due to lack of resources. In summary this means that failure to respect or uphold the informed consent of patients in the public health setting, is a double edge sword because both the patient and the health department stand to lose due to this era in judgment or negligence.

6.2.3.2 Consent in terms of the Consumer Protection Act 68 of 2008

The Consumer Protection Act regulates the relationship between a patient and an oncologist by virtue of the fact that a patient falls under the definition of a consumer and a medical practitioner falls under the definition of a supplier, as stipulated under the Act.[34] In terms of section 48(1)(a) of the Consumer Protection Act, a consumer, who is a patient for purposes of this study, has a right to fair, just and reasonable terms and conditions. Medical practitioners, as health providers or suppliers must not offer to supply, or enter into a contract to supply any goods or services at a price or terms that are unreasonable, unfair and unjust towards their patients.[35] Section 48(1)(c) of the Consumer Protection Act further regulates the relationship between the medical

---

32 Section 10 of the Constitution of the Republic of South Africa, 1996.

33 Oosthuizen and Carstens 2015 (78) *THRHR* 388.

34 In terms of section 1 of the Consumer Protection Act, the consumer is defined as follows: A person to whom goods or services are marketed in the ordinary course of the supplier's business, A person who has entered into a transaction with a supplier in the ordinary course of the supplier's business, unless the transaction is exempt from the application of this Act by section 5(2) or in terms of section 5(3), If the context requires or permits, a user of those particular goods or a recipient or beneficiary of those particular services, irrespective of whether that user, recipient or beneficiary was a party to a transaction concerning the supply of those particular goods or services, A franchise in terms of a franchise agreement to the extent applicable in terms of section 5(6)(b)-(e). Further, is important to have an understanding about the Consumer Protection Act, is to outline the purpose or objective of it through outlining the provisions of section 3(1) of the Consumer Protection Act which states that the main objective of the Act is to redress the socio-economic inequalities of the past which had their origins in the discriminatory laws practised during the apartheid era. Such laws ensured that all consumers were not treated in the same way. The Act therefore sets out to promote the interests of all consumers equally, and to ensure that they are protected against unfair business practices performed by suppliers of goods or services.

35 Section 48(1)(a) of the Consumer Protection Act 68 of 2008.

practitioner as a supplier and the patient as a consumer, by outlining that a medical practitioner must not require a patient to waive any rights, assume any obligation or waive any liability of the medical practitioner on terms that will prejudice the relevant patient.[36]

The aspect of disclosure of information on the part of the medical practitioner is also covered in the Consumer Protection Act.[37] Due to the fact that patients are now consumers, the Consumer Protection Act makes provision for what is termed as fundamental consumer rights in terms of sections 8, 9, 10, 11 and 12, which provide for the right to equality in the market place and protection against discriminatory marketing, the right to privacy, the right to choose, the right to disclosure of information, the right to fair and responsible marketing, the right to fair and honest dealings, the right to fair, just and reasonable terms and conditions, the right to fair value, good quality and safety, and the right to accountability by the supplier.[38] One can attest to the fact that these rights form the backbone of the Consumer Protection Act, and ensure that the interests of all consumers are protected and upheld in all cases and under all circumstances.

In terms of section 58(1) of the Consumer Protection Act, the supplier of any activity or facility that is subject to any risk of an unusual character or nature, or which a consumer could not reasonably be expected to contemplate, in the circumstances, or subject to risk that could result in serious injury or death, must specifically bring that risk to the attention of the patient. From this provision of the Consumer Protection Act, it is clear that medical practitioners as service providers are required to warn consumers as patients about the risks, or potential risks and the nature of the risks involved in the medical intervention that must be performed or rendered to the patient as a consumer. The Consumer Protection Act accounts for the socio-economic

---

36 Section 48(1)(c) of the Consumer Protection Act 68 of 2008. Further it is important to note or take into account which type of agreement prejudices consumers, and this includes an excessively one-sided agreement in favour of the supplier, which is adverse to the consumer as the patient, in this case to a point of being inequitable, or where the patient as consumer to relied on misleading and deceptive statements (to his or her detriment) on the part of the medical practitioner as the supplier of medical services. See section 49(2) of the Consumer Protection Act 68 of 2008.

37 Section 11 of the Consumer Protection Act 68 of 2008.

38 Sections 8, 9, 10, 11 and 12 of the Consumer Protection Act 68 of 2008.

disparities of the South African society, where most people are uneducated and poor. This is evident from section 49(2) of the Consumer Protection Act, in which it states that a service provider — who in this case is a medical practitioner — must warn the consumer about the risks of a medical intervention in plain and understandable language in order to allow patients with low or average literally skills and minimal knowledge, the opportunity to learn about consumer affairs in order to enable them to understand fully.[39]

6.2.4 Commentary on the role of consent in the oncologist and patient relationship

It is submitted that the Consumer Protection Act has solved a serious problem. In the past, a common defence which medical practitioners used to invoke for non-disclosure of the risks associated with the medical procedure administered was that the relevant patient is illiterate and not in a position to understand the nature of the medical procedure at hand.[40] Previously, this matter was provided for under section 6(2) of the National Health Act, which provided that the level of literacy or illiteracy of the patient should not be used as an excuse not to acquire consent for a medical intervention.[41] This further asserts that the attainment of consent from a patient is very important and the educational background of the patient must not be used as an excuse not to obtain such consent, as medical practitioners used to do in the past. This view was correctly identified by Verschoor and Claassen who argued that such practice had the effect of diminishing consent, and could result in the patient instituting a claim for breach of contract and a delictual claim in the case where a patient suffers damage in the process.[42] As a consequence of the coming into effect of the Consumer Protection Act, a medical practitioner may not escape liability in instances where he or she has not taken the time to act in accordance with the provisions of the Act. A medical practitioner ought to obtain consent from a patient prior to administering medical attention, and that consent ought to be given upon the fulfilment and adherence to the statutory obligations placed upon the medical practitioner.

39 Section 49 (2) of the Consumer Protection Act 68 of 2008.
40 Section 11 of the Consumer Protection Act 68 of 2008.
41 Section 6(2) of the National Health Act 61 of 2003.
42 Verschoor and Claassen *Medical Negligence in South Africa* 58.

The most important thing with regard to the provisions of the Consumer Protection Act is to guard the autonomy of the patient and ensure that his or her own bodily integrity is protected and not violated by the medical practitioner involved.[43] The autonomy of the patient concerning the integrity of his or her body has been recognised for a long time in our law. Pienaar[44] argues that the move towards the protection of the autonomy of the patient turns its back on paternalism in the context of risk disclosures by medical practitioners, and introduces a subjective element to the inquiry of whether or not certain risks should be disclosed. The effect of this shift is that the best person or judge of what is reasonable in terms of disclosure now becomes the patient, and is no longer the medical practitioner.[45]

The argument raised by Pienaar is based on the reasoning of Van Oosten, who states that this shift has a power emphasis, from a profession-orientated test of disclosure to a patient-orientated test of disclosure. Van Oosten further states that this shift presents a radical departure from existing law and is an important judicial development in the sphere of the doctor's duty to inform.[46] The position is quite clear that reasonable disclosure on the part of a medical practitioner means that a doctor is not expected to be meticulous about all the complications which might arise, but is obliged to warn the patient about the material risks that are inherent in the proposed medical intervention.[47]

Omitting to inform a patient of the material aspects of the proposed procedure can amount to professional negligence in the form of medical malpractice.[48] Negligent omissions and acts committed by medical practitioners can result in the patient instituting a civil or criminal action against the oncologist for assault or *crimen iniuria*,

---

43 Section 10 of the Constitution of the Republic of South Africa, 1996.

44 Pienaar L "Investigating the Reasons behind the Increase in Medical Negligence Claims" 2016 (19) *PER/PELJ* 13-14.

45 Pienaar 2016 (19) *PER/PELJ* 14.

46 Van Oosten FFW "Castell v De Greef and the Doctrine of Informed Consent: Medical Paternalism ousted in favour of Patient Autonomy" 1995 (1*) De Jure* 166.

47 A material risk can be defined as when a reasonable person in the patient's position, who when warned about the probability of the risk, is likely to attach significance to it, and in this instance the medical practitioner is reasonably aware that the patient if warned of the risk, would attach significance to it. See the case of *Castell v De Greef* case 426.

48 Tingle J *et al, Texts, Cases and Materials on Medical Law and Ethics* 74 (Routledge Publishers, New York 2012).

i.e. the violation of the patient's dignity.[49] The oncologist can also be held liable for breach of contract if he or she was acting as an independent contractor.[50] If not, then the hospital where the oncologist worked would be held liable for the breach of contract.[51]

The aggrieved patient can also as a consumer resort to section 4(1) of the Consumer Protection Act which states that any person following the guidelines given in the Consumer Protection Act, can approach a court, tribunal or the National Consumer Commission with a complaint that his or her rights have been infringed, impaired or threatened. These bodies have powers vested in them by the Consumer Protection Act, to offer an efficient vehicle for consumers to seek redress for the violation of their rights under this Act by one or more suppliers. Despite the valuable statutory mechanisms which have been provided to allow consumers to lodge their complaints, the process is not always without complications,[52] for example, while protecting the interests and rights of consumers, the Commission sometimes fails to fully grasp the content of the Consumer Protection Act. This is evidenced in the erroneous decisions it makes in some cases, as well as the drafting of sub-standard documents, and the unprofessional conduct displayed by members of the Commission when they are faced with a lawyer from the side of the opposing party.[53]

---

49 Tingle *et al, Texts, Cases and Materials on Medical Law and Ethics* 74.

50 Tingle *et al, Texts, Cases and Materials on Medical Law and Ethics* 75.

51 Tingle *et al, Texts, Cases and Materials on Medical Law and Ethics* 75. The contractual relationship between the doctor and patient mostly arises or takes place in private practice, while in the public health setting there is no contractual relationship between the medical practitioner and the patient concerned. This is due to the fact that in public health patients receive health services from the state due to legislation such as section 27 of the Constitution of the Republic of South Africa, 1996 which guarantees the right to health care services for everyone. In this case, there is no need for a contract between the medical practitioner and patient to exist, because the legislation (in this context the Constitution) governs the relationship between the state and its citizens through the provision of health services. A patient that suffers medical malpractice in the hands of negligent medical practitioners acting on behalf of the state, is able to lodge a claim against the state on the basis of the law of delict, and supported by the provisions of the right to health care services as protected by the Constitution. See Carstens and Pearmain *Foundational Principles of South African Medical Law* 411.

52 Section 4(1) of the Consumer Protection Act 68 of 2008.

53 Monty S "Consumer Commission - procedural opp" 2012 *Business Day* 1. The Consumer Commission is taking great strides in protecting the interests of consumers. For example, in the recent incident involving Ford Kugas, the Consumer Commission found that Ford Motors contravened the law by not informing customers about the problems which existed in their vehicles. As a result, Ford has had to recall all the relevant vehicles from customers in order to do inspections

6.2.5 Examples of case law relating to consent

It is clear that patients are now empowered by the law and have the authority to make a valid decision on the basis of the information which they ought to receive from the medical practitioner. As a consequence of these legal developments, patients can have a reasonable expectation to have the medical practitioner give an explanation regarding the medical procedure which the latter prescribes to them. Several cases have been decided on this point of law and a synopsis thereof will follow in the subsequent paragraphs.

6.2.5.1 Stoffberg v Elliot 1923 CPD 148

In *Stoffberg v Elliott*,[54] the plaintiff claimed damages for assault. The defendant, acting as a visiting surgeon at the hospital, performed surgery on the plaintiff who was suffering from cancer of the penis. The plaintiff argued that he did not consent to the procedure entailing the removal of his penis. The defendant surgeon was under the false impression that all administrative work, including obtaining the consent of the patient had been taken care of, but this was not the case.[55] The defendant surgeon was not found liable because he was a visiting medical practitioner and the hospital was the one that was held liable on the basis that the medical staff was negligent and was supposed to inform the surgeon about all the relevant information.[56] The court held that every human being has certain absolute rights that are protected under the law.[57] Although those rights are not protected by statute, nor do they arise out of a contract between the parties, they nevertheless ought to be observed out of a sense of respect for the dignity and integrity of each and every person. As such, any interference with a person's body without their consent is morally wrong and illegal.[58] Therefore, if an oncologist performs a procedure on persons living with cancer without the latter's consent, in our law, it constitutes an offence.

6.2.5.2 Philips v De Klerk 1983 TPD (Unreported)

for safety purposes. See Hosken G "Ford broke the law by not informing Consumer Commission about Kuga death" 2017 *Times live* 3.

54 *Stoffberg v Elliot* 1923 CPD 148.

55 *Stoffberg v Elliot* case 148.

56 *Stoffberg v Elliot* case 149.

57 *Stoffberg v Elliot* case 149.

58 *Stoffberg v Elliot* case 150.

In the case of *Phillips v de Klerk,*[59] it was stated that a doctor was not supposed to give the patient a blood transfusion without his consent. The patient had refused to give his permission on the basis of his religious grounds, but the doctor ignored this instruction and proceeded with the blood transfusion.[60] In this particular case, there was no threat against the public's health or wellbeing, and so the conduct of the doctor was found to be unlawful.[61]

6.2.5.3 Correira v Berwind 1986 (4) SA 60 (Z)

In *Correira v Berwind*,[62] the plaintiff went for kidney surgery under the care of the defendant surgeon. After the surgery, the plaintiff experienced pain and suffering as well as urinary problems.[63] As such, the plaintiff instituted a claim against the defendant for negligence, and argued that there were no sufficient grounds for the defendant to do the surgery. The plaintiff further argued that during the surgery, proper care and skill was not provided by the defendant. As a result, the plaintiff had to go for corrective surgery and the defendant was held liable.[64] However, the court refused to recognise the professional duty of the medical practitioner to bring about healing in the patient. However, the court recognised the right of the patient to self-determination, i.e. the freedom to decide whether or not to accept medical intervention irrespective of the medical practitioner's views on the matter.[65] The court further held that even where no contract exists between a patient and a doctor, there would be no bar in the patient founding his or her claim on the basis of delictual liability because, independent of any contract, a doctor owes a patient the duty of care to perform medical operations with professional skill as to avoid injuring the patient.[66] Therefore, despite the fact that the relationship between an oncologist and patient is based on a contract, person living with cancer does not need to prove the existence of a contract between himself or herself and the responsible oncologist in order to institute a claim for damages against

59 *Phillips v De Klerk* 1983 TPD (Unreported).
60 *Phillips v De Klerk* case 240.
61 *Phillips v De Klerk* case 241.
62 *Correira v Berwind* 1986 (4) SA 60 (Z).
63 *Correira v Berwind* case 60.
64 *Correira v Berwind* case 60.
65 *Correira v Berwind* case 60.
66 *Correira v Berwind* case 61.

the oncologist, through other means, such as by instituting a claim on the basis of a delict.

6.2.5.4 Minister of Safety and Security v Xaba [2003] (2) SA 703 (D)

Consent on the part of the patient was also emphasised in the case of *Minister of Safety and Security v Xaba*,[67] which involved a claim where the police sought a court order to compel the accused to undergo surgery in order to remove the bullet in the body of the accused which could be used as evidence against the accused.[68] The court rejected the application on the basis that such an order would violate the constitutional rights to bodily and psychological integrity of the accused, which includes the right to security and control over one's body.[69] This decision affirms the view that each and every person is entitled to protection and security over their body, enforced on the basis of voluntariness and consent as guaranteed by law.

6.2.5.5 Christian Lawyers Association v National Minister of Health and Others 2004 (4) SA 31 (T)

In *Christian Lawyers Association v National Minister of Health and Others*,[70] the court also affirmed the autonomy of the patient as far as his or her physical integrity is concerned in cases of medical intervention.[71] In this case the court examined the women's right to provide informed consent to an abortion, and the court was of the view that the right of the woman as a patient to provide consent to an abortion is a fundamental expression of the right to individual self-determination of the woman concerned.[72] The court further reiterated that this right to self-determination is reflected in South Africa's Bill of Rights in various provisions, including the right to bodily and psychological integrity which includes the right to make decisions concerning reproduction and the right to security and control over the body, and the rights to dignity and privacy.[73] The court was of the view that in the instance where a

67 *Minister of Safety and Security v Xaba* [2003] (2) SA 703 (D).
68 *Minister of Safety and Security v Xaba* case 703.
69 *Minister of Safety and Security v Xaba* case 703.
70 *Christian Lawyer's Association v National Minister of Health and Others* 2004 (4) SA 31 (T).
71 *Christian Lawyer's Association v National Minister of Health and Others* case 31.
72 *Christian Lawyer's Association v National Minister of Health and Others* case 32.
73 *Christian Lawyer's Association v National Minister of Health and Others* case 32.

patient provides her consent for an abortion, then there is nothing wrong or illegal with the medical procedure in question.[74]

6.2.5.6 Premier of KZN v Sonny 2011 (3) SA 424 (SCA)

The duty imposed on medical practitioners to disclose and communicate effectively with patients was emphasised in the case of *Premier of KZN v Sonny*.[75] In this case, the court held that when a medical practitioner fails to disclose the risks which come with the medical intervention which he or she prescribes, such an omission amounts to negligence.[76] Furthermore, the court stated that having regard to the foreseeable consequence of some breakdown in communication or gross misunderstanding that may occur in public health establishments, and in this case a clinic, it was necessary for a doctor to at least give the relevant communication in writing, or cause such written communication be given to the patient.[77] In this way it would be possible for the patient to return to the clinic and allow the medical practitioner to inform the patient about the risks which are attached to the intervention which the patient underwent.[78]

It is a well-known fact in law that medical intervention without the client's consent is unlawful, except in cases where there are grounds for ruling otherwise.[79] In South African law, if a patient consents to medical intervention, it falls into the category of the justification of *volenti non fit iniuria* which rules out any wrongfulness in the act.[80] However, there are exceptions to this general rule whereby a patient's consent for medical intervention is not required and the oncologist will not be held liable for failing to secure the consent of the patient before going ahead with the operation. One such instance is if the patient is suffering from a terrible illness and it is in the public's interest for him or her to receive treatment.[81] Here the patient would be compelled by statute

74 *Christian Lawyer's Association v National Minister of Health and Others* case 33.

75 *Premier of KZN v Sonny* 2011 (3) SA 424 (SCA).

76 *Premier of KZN v Sonny* case 425.

77 *Premier of KZN v Sonny* case 425.

78 *Premier of KZN v Sonny* case 426.

79 Kale-Smith *Medical Assisting made Incredibly Easy: Administrative Competencies* 69.

80 If a medical intervention is performed without the consent of the patient, the health practitioner or hospital where he or she works will be held liable in terms of a civil claim, criminal action and/or breach of contract based on the contract that exists between the parties. See Swanepoel *Law, Psychiatry and Psychology: A Selection of Constitutional, Medico-Legal and Liability Issues* 316.

81 Kale-Smith *Medical Assisting made Incredibly Easy: Administrative Competencies* 69.

to submit to the operation.[82] If a patient's illness is not a threat to the health or wellbeing of other members of the public, then the medical practitioner cannot treat the relevant patient without his or her consent.[83]

Another exception to the general rule about consent is in an emergency situation where the patient is unconscious but needs urgent medical treatment.[84] In such an incident, the medical practitioner may intervene without first getting the patient's consent.[85] Finally, medical treatment could also be provided in the absence of consent if the patient lacks the capacity to give consent, due to them being of young age or being mentally disabled.[86] In such circumstances, the parent or guardian would normally give the necessary consent on behalf of the child or mentally incapacitated person.[87]

The illustration of cases above shows how important it is for a medical practitioner to obtain the consent of a patient before applying any sort of medical intervention on the patient, except in cases of emergency. Therefore, consent is required in order for a medical practitioner to escape legal liability under certain circumstances. If consent has not been properly acquired and there are no grounds for ignoring the general principle, then the medical practitioner, to put it bluntly, does not have a leg to stand on.[88] This simply means that when consent does not in actual fact comply with the *boni mores* of society, where consent is obtained illegally or is contrary to the personal convictions of the patient, then the medical practitioner cannot escape liability.

Apart from the fact that the rules of consent serve as an effective safeguard in litigation levelled against a medical practitioner, it is also a reminder that the patient has a right

82 Kale-Smith *Medical Assisting made Incredibly Easy: Administrative Competencies* 69.
83 Kale-Smith *Medical Assisting made Incredibly Easy: Administrative Competencies* 70.
84 Verschoor and Claassen *Medical Negligence in South Africa* 57.
85 Verschoor and Claassen *Medical Negligence in South Africa* 57.
86 Verschoor and Claassen *Medical Negligence in South Africa* 58.
87 Verschoor and Claassen *Medical Negligence in South Africa* 58. Further, please see Section 19 (1) of the Children's Act 38 of 2005 and Section 60 of the Mental Health Care Act 17 of 2002.
88 Van Oosten 1995 (1) *De Jure* 166.

to self-determination and freedom of choice.[89] Ensuring that a medical procedure will generally not go ahead without the consent of the patient also helps to ensure that the patient applies his or her mind in a rational way and makes an informed decision, having weighed up both the pros and cons involved.[90] If an oncologist does not obtain proper, voluntary consent from the patient, he or she could be found to have acted negligently.[91] Despite the importance of consent in a contract between patient and medical practitioner, the medical practitioner, in this case an oncologist, has more power due to the unequal bargaining powers between them.[92] Carstens and Pearmain argue that the patient is the one with less power because of his or her state of mind, as well as health, which can result in him or her giving consent in order to get treatment. On the other side, the medical practitioner, due to the economic as well as educational position over the patient, yields more power.[93] This view of Carstens and Pearmain is correct, particularly when one is to look at persons living with cancer who access public hospitals. They are mostly from impoverished groups with poor educational backgrounds and socio-economically disadvantaged to a greater extent. This does not mean that these patients are oblivious to their rights, but they are generally in desperate need of medical treatment, with the aspect of consent to medical intervention either non-existent or compromised. The government needs to look at this aspect in line with section 27 of the Constitution,[94] which deals with access to health care services. This is because the principles of consent form part to the realisation of this fundamental right to access of health services as provided in the Bill of Rights.[95]

Negligence is also addressed in this chapter – what it means, its historical roots, the test for and proof of negligence, and how a skill deficiency on the part of the oncologist

89 Section 12(2)(c) of the Constitution of the Republic of South Africa, 1996 which states that everyone has the right to bodily and psychological integrity which includes the right not to be subjected to medical or scientific experimentation without their informed consent.

90 Carstens PA http://new.samls.co.za/node/410 (Date of use: 2 June 2014).

91 Basavanthappa *Fundamentals of Nursing* 540.

92 Carstens and Pearmain *Foundational Principles of South African Medical Law* 377.

93 Carstens and Pearmain *Foundational Principles of South African Medical Law* 377.

94 Section 27 of the Constitution of the Republic of South Africa, 1996.

95 Chapter 2 of the Constitution of the Republic of South Africa, 1996 is the Bill of Rights and makes provision for fundamental human rights, which includes the right to have access to health care services as provided for in terms of section 27 of the Constitution.

could possibly constitute negligence. A number of cases relating to negligence are also discussed to illustrate and reinforce various theories and arguments pertaining to medical malpractice as a form of professional negligence. This discussion will focus on the standard of care expected from an oncologist due to the fact that cancer is a specialised medical condition. The duty or standard that is applicable to an oncologist will be investigated and compared to other medical practitioners in order to understand the role as well as the relationship between an oncologist and the person living with cancer. Recommendations will be made to illustrate how negligence could be mitigated or avoided by both the oncologist and the person living with cancer during the duration of their interaction.

6.3 Negligence

6.3.1 Definition of negligence

Negligence is not just a legal term applicable to the medical profession, nor is it confined simply to professional occupations.[96] This is because, as is outlined by Carstens and Pearmain, professional negligence embraces all forms of negligence or misconduct on the part a medical practitioner, which are committed either intentionally or negligently. This includes confidential and fiduciary duties between the doctor and patient relationship, which in turn is considered as a reflection of the broader occupation of health care.[97] It is a very broad concept that is applied to many different situations each day. In lay man's terms, negligence refers to harm that a person suffers at the hands of another who should have taken steps to guard against the possibility of harm occurring.[98] At this point is very important to note that an error of judgment on the part of a medical practitioner does not constitute negligence.[99] This is due to the fact that when an oncologist makes an error in clinical judgment, this mistake will not constitute negligence as long as the misjudgement could reasonably have been made by any oncologist under the same circumstances.[100] In this case, the conventional

96 Scott W *The General Practitioner and the Law of Negligence* 3 (Cavendish Publishing Limited, London 1995).

97 Carstens and Pearmain *Foundational Principles of South African Medical Law* 599.

98 Scott *The General Practitioner and the Law of Negligence* 4.

99 This was the view that was taken in the English case of *Whitehouse v Jordan and Another* (1981) 1 All ER 267 (HL).

100 Vij K *Textbook of Forensic Medicine and Toxicology: Principles and Practices* 470 (Elsevier Publishers, New Delhi 2009).

negligence test will be applied with the view that only misjudgement that is obviously or exceptionally below the standard of care would be classified as negligence on the part of the oncologist.[101] Our courts accept medical mistakes because the law regards it excusable that ordinary human fallibility can exclude liability.[102] The kinds of mistakes which constitute negligence are those where the conduct of the defendant medical practitioner is considered to have gone beyond the bounds of what is expected of the reasonably skilful and competent doctor.[103] The aforementioned view was emphasised in the English case of *Whitehouse v Jordan and Another*.[104] The court held that a surgeon's mere error in judgment does not constitute negligence.[105] The court further held that, to say that a surgeon has committed an error in clinical judgment is wholly ambiguous and does not indicate whether he has been negligent or not.[106] While some errors or clinical judgments may be completely consistent with the due exercise of professional skill, other acts or omissions in the course of exercising clinical judgment, may be so glaringly below the proper level of skill required and therefore can make a finding of negligence inevitable.[107]

6.3.2 The concept of negligence as developed in South African case law

In a medico-legal context, negligence refers to the failure of a doctor to act in accordance with the medical standards which have been set and are practised by any ordinary, reasonable doctor in the same field.[108] Where a patient undergoing medical treatment suffers great injury or dies due to a lack of care and skill on the part of the doctor, the doctor would be regarded as negligent.[109] For negligence to exist, certain elements normally need to be proved by the injured party. The plaintiff must prove the

---

101 Van der Heever P *The application of the doctrine of a loss of a chance to recover in medical law* 34 (Pretoria University Press, Pretoria 2007).

102 Van der Heever *The application of the doctrine of a loss of a chance to recover in medical law* 35.

103 Van der Heever *The application of the doctrine of a loss of a chance to recover in medical law* 35.

104 *Whitehouse v Jordan and Another* (1981) 1 All ER 267 (HL). See *R v Meiring* 1927 AD 41, in which the reasonable standard of care was affirmed as a simple and standard practice with which medical practitioners must comply with in order to avoid liability in the form of negligence.

105 *Whitehouse v Jordan and Another* case 267.

106 *Whitehouse v Jordan and Another* case 267.

107 *Whitehouse v Jordan and Another* case 268.

108 Kaushal AK *Medical Negligence and Remedies with special reference to Consumer Protection Law* 22 (Universal Book Traders, New Delhi 1995).

109 Kaushal *Medical Negligence and Remedies with special reference to Consumer Protection Law* 22.

existence of a legal duty on the part of a medical practitioner, a breach of the alleged legal duty, and damage caused by a breach of the legal duty.[110] The following cases will deal with negligence on the part of medical practitioners, which is a breach of their duty to care patients.

6.3.2.1 Richter and Another v Estate Hamman 1976 (3) SA 266 (C)

In *Richter and Another v Estate Hamman*,[111] the first plaintiff was married to the second plaintiff, a Mrs Richter, who had a diploma to teach retarded children. When she was young, the second plaintiff fell and hurt her coccyx, she was treated for the injury and recovered.[112] Years later when she was much older, the second plaintiff fell again and sustained the same type of injury to her coccyx.[113] She went to Dr Levy for treatment but the treatment turned out to be completely ineffective. Since Dr Levy's treatment did not work, she went to Dr Butler for an X-ray and he prescribed the removal of her coccyx and treatment in the form of a course of pills.[114] The second plaintiff was not happy about this at all.[115]

The second plaintiff was then told by a friend to go to Dr Hamman who was a well-known neurosurgeon, and asked Dr Levy to refer the first plaintiff to that doctor.[116] This was done and she was examined by Dr Hamman who injected her with saline and novocaine, neither of which proved to be effective.[117] This prompted Dr Hamman to inject phenol on the patient's one side to alleviate the pain but this was also ineffective.[118] A second injection was administered two days after the first injection.[119] As a result of the treatment, the second plaintiff lost control of her bladder and bowel functions, and experienced loss of sexual feelings, and a loss of power in her right leg.[120]

---

110 Kaushal *Medical Negligence and Remedies with special reference to Consumer Protection Law* 23.

111 *Richter and Another v Estate Hamman* 1976 (3) SA 266 (C).

112 *Richter and Another v Estate Hamman* case 266.

113 *Richter and Another v Estate Hamman* case 266.

114 *Richter and Another v Estate Hamman* case 267.

115 *Richter and Another v Estate Hamman* case 268.

116 *Richter and Another v Estate Hamman* case 268.

117 *Richter and Another v Estate Hamman* case 268.

118 *Richter and Another v Estate Hamman* case 269.

119 *Richter and Another v Estate Hamman* case 269.

120 *Richter and Another v Estate Hamman* case 269.

The second plaintiff instituted an action against Dr Hamman on the basis of negligence because of the fact that Dr Hamman had failed to warn her about the dangers inherent to the procedure.[121] In addition, she claimed, the doctor had failed to look at her medical history in relation to the functioning of her bladder.[122] When the case was eventually heard, the court held that as Dr Hamman had died in the meantime and a claim was being made against his estate, proper care and skill had to be exercised in making a ruling.[123] Dr Hamman was a very experienced neurosurgeon who had made a name for himself in the medical profession.[124] Also, two expert witnesses, Dr Rose-Innes and Prof de Villiers were of the view that the consequences of the injections administered to the second plaintiff were completely unexpected.[125] The court held that if Dr Hamman did not inform the second plaintiff about the risks associated with the injections, it would have constituted negligence.[126] However, the plaintiffs' claim was rejected with costs because they failed to prove that Dr Hamman had been negligent.[127]

6.3.2.2 Pringle v Administrator, Transvaal 1990 (2) SA 379 (W)

In South Africa, the principle of conventional negligence was considered in the case of *Pringle v Administrator, Transvaal*,[128] in which the court was of the view that the surgeon, in performing the surgery on the patient, did not commit an error of clinical judgment.[129] This was owing to the fact that if a reasonable surgeon was exposed to the same circumstances of the defendant surgeon, they could have acted in a reasonable way to avert the damage to the patient. In this case the defence of error of clinical judgment was rejected by the court on the basis that the defendant surgeon failed to act in a way that a reasonable surgeon could have acted in the same circumstances, and thus the defendant surgeon was found to be liable.[130] This case

121 *Richter and Another v Estate Hamman* case 270.
122 *Richter and Another v Estate Hamman* case 270.
123 *Richter and Another v Estate Hamman* case 270.
124 *Richter and Another v Estate Hamman* case 270.
125 *Richter and Another v Estate Hamman* case 270.
126 *Richter and Another v Estate Hamman* case 271.
127 *Richter and Another v Estate Hamman* case 271.
128 *Pringle v Administrator, Transvaal* 1990 (2) SA 379 (W).
129 *Pringle v Administrator, Transvaal* case 379.
130 *Pringle v Administrator, Transvaal* case 380.

is discussed further in the chapter under the discussion of the doctrine of *res ipsa loquitur*, which is used as an aid to prove negligence.

From the above, it is clear that the degree of care and skill expected to be displayed by a general practitioner is not similar to that expected to be displayed by an expert, such as an oncologist.[131] In cases where the negligence of an oncologist needs to be determined, the test is not how an ordinary and reasonable doctor could have acted in the same circumstances, but rather how a reasonable oncologist could have acted to prevent the patient from sustaining injury or harm.[132] Surgical negligence can take many different forms, including the failure on the part of the oncologist to inform the patient prior to the surgery about the risks that are associated with the procedure in question.[133]

A medical practitioner can also be held liable where he or she deviates from the treatment that had been agreed upon with the patient.[134] If the oncologist thinks it might be necessary to deviate from the agreed medical procedure, then he or she must first obtain consent from the patient or, if this is not possible, from one of the patient's family members.[135] The aforementioned view was confirmed in the case of *Esterhuizen v Administrator, Transvaal.*[136] In this case, the court held that the medical practitioner was not allowed to deviate from the agreed treatment as the patient enjoyed autonomy when it came to making decisions regarding medical treatment.[137] The medical practitioner was held liable because his conduct was viewed as unlawful.[138] The same conclusion was reached in the case of *Castell v De Greef*.[139] The court held the view that the surgeon's failure to inform the patient about the risks

131 Verschoor and Claassen Medical *Negligence in South Africa* 15.

132 A specialist like a surgeon is required in law to have a higher degree of care and skill in respect of matters that fall within his or her area of expertise than a general practitioner in a comparable situation. See Verschoor and Claassen Medical *Negligence in South Africa* 15.

133 Vij *Textbook of Forensic Medicine and Toxicology: Principles and Practices* 470.

134 Goyal RC and Sharma DK *Hospital Administration and Human Resource Management* 550 (Asoka Publishers, New Delhi 2013).

135 Basavanthappa *Fundamentals of Nursing* 541.

136 *Esterhuizen v Administrator, Transvaal* 1957 (3) SA 710 (T).

137 *Esterhuizen v Administrator, Transvaal* case 710.

138 *Esterhuizen v Administrator, Transvaal* case 711.

139 *Castell v De Greef* 1994 (1) SA 408 (C).

of the procedure constituted negligence. The *Castell v De Greef* case will be considered in more depth later in this chapter, under the discussion of negligence on the part of a surgeon.

6.4 The history and development of medical negligence

Medical negligence has a long and complex history.[140] Evidence of medical negligence can, in fact, be traced back to ancient civilisations, such as those in Egypt, Assyria, Babylon and Mesopotamia.[141] All these countries were united in their belief that disease was punishment from the gods and therefore a supernatural phenomenon.[142] To restore people to normal health, the causes of the disease needed to be treated.[143]

During these ancient times, medical practice was considered a noble profession and serious respect was bestowed on those who practised it.[144] If a surgeon or physician was negligent in performing certain procedures, the punishment would be very severe as life was considered to be precious and valuable, and deserving of respect and all efforts to preserve it.[145] The kinds of punishment that were meted out to negligent surgeons in those days included life imprisonment, and the negligent surgeon being handed over to the family of the injured patient so that they could exact their own form of punishment.[146] In extreme cases, a surgeon's body parts were cut off.[147]

When medical negligence was proved in those ancient times, money was not a dominant factor and regular people had few legal rights.[148] However, things really started to change in the 18th and 19th centuries when cases of medical negligence

140 Swanepoel M "The Development of the Interface between Law, Medicine and Psychiatry: Medico-Legal Perspectives in History" 2009 (12) *PER/PELJ* 2.
141 Swanepoel 2009 (12) *PER/PELJ* 2.
142 Swanepoel 2009 (12) *PER/PELJ* 2.
143 Swanepoel 2009 (12) *PER/PELJ* 3.
144 Carstens and Pearmain *Foundational Principles of South African Medical Law* 607.
145 Carstens and Pearmain *Foundational Principles of South African Medical Law* 608.
146 Carstens and Pearmain *Foundational Principles of South African Medical Law* 609.
147 Carstens and Pearmain *Foundational Principles of South African Medical Law* 610.
148 Carstens and Pearmain *Foundational Principles of South African Medical Law* 618.

were investigated in the United States of America and Britain.[149] Round about that time, people were starting to acquire rights and were becoming more independent. More emphasis was also being placed on the surgeon-patient relationship.[150] The view was that lawyers should be brought on board to institute legal actions in order to inflate their clients' (and their own) wealth, and as ordinary citizens became more aware of their rights and how they were protected under the law, the number of medical negligence cases began to grow.[151] Now, in the modern world, oncologists need to be very careful in all their dealings with patients to avoid legal liability.[152] This development has resulted in giving the aggrieved patient different avenues to seek relief for the harm which they may have suffered in the hands of the medical practitioner. These forms of relief include instituting a civil claim for damages, lodging a criminal case for assault and lastly, the aggrieved party can resort to lodging a complaint with the Health Professions Council of South Africa (HPCSA), against the negligent medical practitioner for his or her name to be removed from the roll of medical practitioners.[153]

---

149 Price K "The Art of Medicine Towards a History of Medical Negligence" 2010 (375) *The Lancet* 192.

150 Price 2010 (375) *The Lancet* 193.

151 Price 2010 (375) *The Lancet* 193.

152 Price 2010 (375) *The Lancet* 194.

153 Coetzee LC and Carstens P "Medical Malpractice and Compensation in South Africa" 2011 (86) *Chicago-Kent Law Review* 406. A brief background about the Health Professions Council of South Africa (HPCSA) is important for a better understanding of this regulatory body when it comes to our health system. The HPCSA was established by the Health Professions Act, and replaced the old South African Medical and Dental Association of South Africa. The HPCSA can best be described as the custodian of the medical profession which ensures that the prestige, status and dignity of the profession and the public interest are always upheld. See the Health Professions Act 56 of 1974. The main functions of the HPCSA can be found in section 3 of the Health Professions Act. These functions include: to co-ordinate the activities of the professional boards established in terms of the Act, to act as an advisory and communicating body for such professional boards, promote and regulate inter-professional liaison between health professions in the public interest, determine strategic policy with regard to the professional boards and health practitioners for matters such as finance, education, training, registration, ethics and professional conduct, disciplinary procedure, scope of the professions, inter-professional matters and maintenance of professional competence, consult and liaise with relevant authorities on matters affecting the professional boards in general, assist in the promotion of the population of the Republic, subject to legislation regulating health care providers and consistency with national policy determined by the Minister, to control and to exercise authority in respect of all matters affecting the education, and training of persons in and in the manner of the exercise of the practices pursued in connection with, the diagnosis, treatment or prevention of physical or mental defects, illnesses or deficiencies in human kind, promote liaison in the field of education and training both in the Republic and elsewhere, and to promote the standards of such education and training in the Republic, advice the Minister on any matter falling within the scope of this Act in order to support the universal norms and standards of health professions, with greater emphasis on professional practice, democracy, equity, accessibility and community

6.4.1 Case law on the development of medical negligence

South African medical law is profusely peppered with medical negligence cases which contribute to the rich and fascinating history of this field.[154] At least some of these cases deserve mention here.

6.4.1.1 Lee v Schonnenberg 1877 7 Buch 136

The old case of *Lee v Schonnenberg,*[155] is a classic example of medical negligence. The plaintiff in this case lost both his legs in an accident. It is not known what the nature and extent of the treatment was that was provided by the defendant but the plaintiff claimed that the defendant was negligent in carrying out his professional duties, and therefore claimed damages.[156] Since there were few relevant South African cases to refer to, the court had to rely on the precedent set by an English case, *Lamphier v Phipos*,[157] which had been decided in 1835. In this case, the judge made the following ruling in response to the charge of medical negligence:

> "There can be no doubt that a medical practitioner, like any professional man, is called upon to bear a reasonable amount of skill and care in any case to which he

involvement, communicate to the Minister information of public importance acquired by council in the course of the performance of its function under this Act, serve and protect the public in matters involving the rendering of health services by persons practising a health profession, exercise its powers and discharge its responsibilities in the best interest of the public and in accordance with national health policy determined by the Minister, be transparent and accountable to the public in achieving its objective and when performing its functions and exercising its powers, uphold and maintain professional and ethical standards within the health professions, ensure the investigation of complaints concerning persons registered in terms of this Act and to ensure that appropriate disciplinary action is taken against such persons in accordance with this Act in order to protect the interest of the public, ensure that persons registered in terms of this Act behave towards users of health services in a manner that respect their constitutional rights to human dignity, bodily and psychological integrity and equality, and that disciplinary action is taken against persons who fail to act accordingly, submit to the Minister a five year strategic plan within six months of the council coming into office which includes details as to how the council plans to fulfil its objectives under the Act, every six months a report on the status of health professions and on matters of public importance that have come to the attention of council in the course of the performance of its functions under this Act and an annual report within six months of the end of the financial year and ensure that an annual budget for the council and professional boards is drawn up and that the council and the professional boards operate within the parameters of such budget.

154 Swanepoel 2009 (12) PER/*PELJ* 2.

155 *Lee v Schonnenberg* 1877 7 Buch 136.

156 *Lee v Schonnenberg* case 137.

157 *Lamphier v Phipos* 1835 42 All ER 421.

has to attend, and where it is shown that he has not exercised such skill and care, he will be liable in damages."[158]

6.4.1.2 Kovalsky v Kriege 1910 20 CTR 822

Another very popular case in South Africa which was reported in 1910 is the case of *Kovalsky v Kriege*.[159] This case centred on the question of a surgeon's medical negligence. A 9-month old baby had been circumcised for religious reasons but the surgery led to complications.[160] The child began to bleed excessively and the surgeon had to come to his assistance.[161] The surgeon provided treatment but it was not appropriate in the circumstances because later on the child developed gangrene in his private parts, which could not be reversed. A claim was instituted on behalf of the child against the surgeon for medical negligence, claiming that the surgeon had failed to demonstrate the necessary care and skill in treating the child, and had in fact abandoned the child because he had not checked whether the initial bleeding had stopped nor followed up on the child's general wellbeing after the circumcision.[162]

The court considering this case referred to the earlier cases of *Lee v Schonnenberg* discussed above,[163] and the English case of *Lamphier v Phipos*.[164] Both these cases served as precedents to the current case. The court came to the conclusion that the surgeon was indeed negligent because he had failed to act in a way that a reasonable surgeon in the same circumstances should have acted.[165] As a result of the *Kovalsky* case,[166] the standard that is now used to determine the negligence, or otherwise, of a medical practitioner is the reasonable standard of care or skill that another expert in the given field would demonstrate if he or she were confronted by the same circumstances.[167]

---

158 These two cases form an important basis for the determination of medical negligence in South Africa and offer valuable precedents that many cases have referred to over the years. See Carstens and Pearmain Foundational *Principles of South African Medical Law* 619.

159 *Kovalsky v Kriege* 1910 20 CTR 822.

160 *Kovalsky v Kriege* case 822.

161 *Kovalsky v Kriege* case 822.

162 *Kovalsky v Kriege* case 823.

163 *Lee v Schonnenberg* 1877 7 Buch 136.

164 *Lamphier v Phipos* 1835 42 All ER 421.

165 *Lamphier v Phipos* case 422.

166 *Kovalsky v Kriege* case 823.

167 *Kovalsky v Kriege* case 823.

6.4.1.3 R v Schoor 1948 (4) SA 349 (C)

About 38 years after the *Kovalsky* case,[168] the case of *R v Schoor* was reported.[169] A young doctor, V, was an assistant to Dr R who had a medical practice.[170] Dr R had another assistant E.[171] E was busy with some patients and asked V to administer an injection of a new serum into some of the patients.[172] When V asked E what quantity he should give to the patient, E told him to administer 9 cc of the drug, which he was instructed to mix with water. V assumed that each pack contained 0.99g of the drug but this was not the case.[173] He failed to read the labels on the drug and administered an incorrect dosage, leading to the death of two patients due to an overdose.[174] V was charged with culpable homicide and was found guilty because he failed to act in a way that a reasonable person or expert in the same position could have acted to protect the patient from harm.[175]

6.4.1.4 S v Mahlalela 1966 (1) SA 226 (A)

In the case of *S v Mahlalela*,[176] a herbalist was charged with murder for the death of a child. He had given a child some herbs which he had mixed with beer.[177] The mixture turned out to be poisonous, and thus caused the death of the child.[178] The court held that the defendant was an expert in the field of herbs and could have foreseen that these herbs might be so toxic as to bring about death, and therefore should have taken reasonable steps to avoid such an occurrence.[179] He failed to do so and was convicted with culpable homicide.[180]

6.4.1.5 S v Burger 1975 (4) SA 877 (A)

168 *Kovalsky v Kriege* case 823.
169 *R v Schoor* 1948 (4) SA 349 (C).
170 *R v Schoor* case 349.
171 *R v Schoor* case 350.
172 *R v Schoor* case 350.
173 *R v Schoor* case 351.
174 *R v Schoor* case 351.
175 *R v Schoor* case 351.
176 *S v Mahlalela* 1966 (1) SA 226 (A).
177 *S v Mahlalela* case 226.
178 *S v Mahlalela* case 226.
179 *S v Mahlalela* case 227.
180 *S v Mahlalela* case 227.

In *S v Burger*,[181] the appellant was convicted for culpable homicide. In considering his appeal, the Appellate Division pointed out that, in order for a conviction of culpable homicide to stand, there must be negligent conduct on the part of the accused. The court went further to express that such negligent conduct may take the form of a surgeon failing to exercise the necessary care during a medical operation.[182] It was held that it is not necessary for a surgeon to perform to the very highest standard of skill but rather to a reasonable standard, as a prudent person in the same situation would have done. This view reflects the objective test to determine the negligence of a surgeon.[183]

More recent cases will be discussed in this chapter but the abovementioned cases represent the many years of deliberation regarding the subject of medical negligence in South Africa. In fact, one cannot speak about medical negligence in South Africa without making reference to these cases. They also serve as important precedents when it comes to modern day investigations into medical negligence.[184]

6.5 Test for medical negligence

6.5.1 Preventability and foreseeability

Negligence in a medical context means the failure by a medical practitioner to act in a way that a reasonable person in the same situation could have acted to prevent a particular event from taking place.[185] The test for negligence therefore involves aspects of both preventability and foreseeability of harm.[186] In other words, a medical practitioner must see to it that harm does not occur by foreseeing the harm before it takes place and by taking steps to prevent it, as well as, thereby protecting the patient from its ill effects.[187]

---

181 *S v Burger* 1975 (4) SA 877 (A).

182 *S v Burger* case 879.

183 *S v Burger* case 879.

184 These are the cases that are central when it comes to medical negligence in the South African context as outlined in the text. One can argue that these cases are the backbone of medical negligence in South Africa, in addition to *Lee v Schonnenberg* 1877 7 Buch 136, among other cases as discussed in this chapter.

185 Gorney *Plastic and Reconstructive Surgery* 181.

186 Gorney *Plastic and Reconstructive Surgery* 182.

187 Swanepoel *Law, Psychiatry and Psychology: A Selection of Constitutional, Medico-Legal and Liability Issues* 318.

6.5.2 The objective test

The test for negligence is an objective test which requires the determination of whether a reasonable person in the same position as the accused or defendant would act in the same way.[188] The reason why reference is made to both the defendant and the accused is because negligence on the part of a medical practitioner could lead to both civil and criminal proceedings.[189] If the defendant or the accused can prove to the court that a reasonable person in the same situation could have acted in the same way that he or she did in the actual circumstances, then the defendant or accused will not be found to be negligent.[190] The reasonable man is defined not as a perfect man, but as the man of average intelligence, knowledge, competence, care, skill and prudence.[191]

The objective test used to determine medical negligence was first formulated in 1838 by CJ Tindall in the English case of *Lamphier v Phipos*.[192] Tindall maintained that every person who enters into a learned profession undertakes to bring to the practice a reasonable degree of care and skill.[193] However, an attorney does not undertake to win all his or her cases, nor does a surgeon undertake to achieve a 100% success rate in all his or her operations. Furthermore, neither of these two professionals undertakes to use the highest possible degree of skill. After all, there are many others who have superior education to, and greater advantages than the defendant or accused.[194] What the defendant or accused does undertake is to exercise a fair and reasonable level of skill when performing a medical procedure, and so what needs to be determined is whether the injury to a patient was occasioned by a lack of such skill on the part of the defendant or the accused.[195]

Where medical practitioners are concerned, it is not necessary for the practitioner to have the highest level of knowledge or technology at his or her disposal in order to

188 Slabbert MN *Medical Law in South Africa* 186 (Aspen Publishers, New York 2011).

189 Slabbert *Medical Law in South Africa* 186.

190 Hanna G *Outdoor Pursuits Programming: Legal Liability and Risk Management* 24 (University of Alberta, Press Canada 1991).

191 Laster K *Law as Culture* 209 (Federation Press Publishers, Sydney 2001).

192 *Lamphier v Phipos* 1835 42 All ER 421.

193 *Lamphier v Phipos* case 421.

194 *Lamphier v Phipos* case 422.

195 Verschoor and Claassen *Medical Negligence in South Africa* 13.

care for a patient.[196] However, it is important for him or her to have a profound knowledge of the medical intervention before undertaking it.[197] It is clear then, that the test to determine the negligence of a physician is not the same as the test used to determine the negligence of an expert like an oncologist.[198] The test to determine whether the oncologist was negligent in a particular case is whether another oncologist in the same position could have acted in the same way.[199]

This test was confirmed in the 1924 case of *Van Wyk v Lewis*.[200] The court stated that a medical practitioner is not expected to bring the highest degree of professional expertise to the case to which he or she is assigned, but is obliged to bring reasonable skill and care thereto.[201] In deciding what is reasonable, the court will have to give consideration to the general level of skill and care that is exercised by members of that particular branch of medicine to which the medical practitioner belongs.[202] As with other cases, the *Lewis* case has come to serve as a precedent in our law when determining the professional standard that is required from a medical practitioner.[203] In the 1953 case of *R v Van der Merwe,*[204] Roper J was of the view that when a general practitioner is tried, the test is not what a specialist must do to prevent harm because a general practitioner is not required to possess the same degree of skill, care, knowledge and experience as a specialist.[205]

The test to determine negligence on the part of a specialist such as an oncologist is the famous Bolam test which was developed by the courts in the United Kingdom.[206]

---

196 Verschoor and Claassen *Medical Negligence in South Africa* 14.

197 Barnes A *et al, Health Care Law: Desk Reference* 114 (Library Congress, New York 2001).

198 Barnes *et al, Health Care Law: Desk Reference* 115.

199 Barnes *et al, Health Care Law: Desk Reference* 116.

200 *Van Wyk v Lewis* (1924) AD 438.

201 *Van Wyk v Lewis* case 438.

202 *Van Wyk v Lewis* case 439.

203 *Van Wyk v Lewis* case 439.

204 *R v Van der Merwe* 1953 (2) PHH 124 (W).

205 *R v Van der Merwe* case 125.

206 It is important to know what the Bolam test is and how it was developed to be used as a test for medical negligence. The Bolam test was adopted from the English tort law, and is used to assess medical negligence. The Bolam test states that the law imposes a duty of care between a doctor and a patient, but the standard of care is a matter of medical judgment. Under this test, for the plaintiff to succeed with a medical negligence claim, he or she must prove the following: he or she must show that there was a duty of care between the medical practitioner and the patient,

According to this test, a doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art.[207] This test is applicable to all medical practitioners, including oncologists.[208] The rationale for the test originated in the case of *Maynard v West Midlands RHA*.[209] According to the court, a judge is not in a position to choose between the opinions of two expert witnesses in a case where such witnesses are in conflict with one another.[210] The court was of the view that as long as there is a school of thought in place which determines that the conduct of the defendant or accused is reasonable, then the judge is bound to find the defendant or accused not guilty of negligence.[211]

6.6 Proof of medical negligence on the part of the oncologist

6.6.1 The onus of proof

The proof of medical negligence is based on two different premises, which normally depend on the nature of the claim that is brought forward.[212] This is because negligence can form the basis of both a civil claim and a criminal action against the guilty party.[213] In civil proceedings, the onus of proof will rest on the plaintiff to show on a balance of probabilities that the defendant doctor was negligent and responsible for causing the harm that the plaintiff suffered.[214] The plaintiff often finds it difficult to provide such proof because of the various challenges which he or she may face in understanding the law as well as the nature of the medical practice involved in his or her case.[215] It is best for the plaintiff to seek the assistance of an expert in the field of medicine to improve his or her chances of succeeding with the claim.[216] In criminal cases, the onus of proof rests on the state to prove its case beyond a reasonable

---

and that the act or omission of the doctor breached the said duty of care which resulted in negligence. See Herring J *Medical Law and Ethics 3rded* 106 (Oxford University Press, New York 2010).

207 Herring *Medical Law and Ethics 3rded* 107.

208 Herring *Medical Law and Ethics 3rded* 107.

209 *Maynard v West Midlands RHA* 1985 1 All ER 635.

210 *Maynard v West Midlands RHA* 636.

211 *Maynard v West Midlands RHA* 636.

212 Otto SF "Medical Negligence" 2004 (8) *SAJR* 20.

213 Basavanthappa *Fundamentals of Nursing* 541.

214 Kelbrick R *Civil Procedure in South Africa* 270 (Aspen Publishers, New York 2010).

215 Kelbrick *Civil Procedure in South Africa* 271.

216 Kelbrick *Civil Procedure in South Africa* 271.

doubt.[217] Since the state often finds this difficult to do, an expert witness is required to assist the court to determine the standard of a reasonable man in the circumstances of the accused.[218]

6.6.2 The proof of negligence in the case of an oncologist and a person living with cancer

The plaintiff in a civil claim must prove that a surgeon was negligent in respect of the following:

a) The surgeon owed a duty of care to the patient. The surgeon owes a duty of care to the plaintiff when a reasonable person can foresee the possibility of an injury resulting from surgery.
b) The duty of care was breached by the surgeon. In the case of the surgeon, the test is that a reasonable person in the same position as the surgeon could have foreseen that there would be risks in performing the surgery.
c) The patient who is the plaintiff was injured due to the negligent breach by the surgeon. The negligent conduct of the surgeon must be the actual cause of injuries sustained by the plaintiff.[219]

Based on the above formulation, it can be deduced that in the instance of an oncologist who operates on a person living with cancer, negligence is present if the oncologist owes a duty of care to the plaintiff when a reasonable person can foresee the possibility of an injury resulting from the applied surgery. The applicable test is that a reasonable person in the same position as the oncologist could have foreseen that there would be risks in performing the surgery. Once the elements of foreseeability and preventability have been established, there is a breach of the duty of care on the part of the oncologist. If the patient who is the plaintiff was injured due to the negligent breach by the oncologist and that negligent conduct is the actual cause of injuries sustained by the plaintiff, then it can be said that the oncologist was negligent. Once the plaintiff has succeeded in proving all these elements, the court must find the

---

217 Mokoena MT *A Guide to Bail Applications* 27 (Juta Publishers, Cape Town 2012).

218 Otto 2004 (8) *SAJR 21.*

219 LaMance K ''Plastic Surgery Malpractice'' available at http://www.legalmatch.com/law-library/article/plastic-surgery-malpractice.html (Date of use: 23 March 2012).

oncologist guilty.[220] The plaintiff in such cases would be entitled to be compensated for all the loss which he or she has suffered due to the negligent conduct of the oncologist.[221]

6.7 *Res ipsa loquitur*

6.7.1 Definition of the *res ipsa loquitur* doctrine

Due to the many technical aspects and formalities surrounding both the law and the medical profession, which often results in the plaintiff being unable to discharge his or her onus of proof in negligence cases, a need has been identified for the plaintiff to obtain assistance in this regard.[222] The *res ipsa loquitur* doctrine was established to alleviate some of the burden on the plaintiff.[223] This is a rule of evidence and does not form part of substantive law, and so permits a supposition of probable cause based on circumstantial evidence.[224] The doctrine was first introduced by Boran Pollack in 1863 because of an incident that occurred at the time.[225] It happened that a barrel of flour fell out of a two storey building onto a pedestrian walking in the street.[226] The defendant, who was the owner of the building could not offer any explanation as to the cause of the incident, and was therefore found to be negligent on the basis of the *res ipsa loquitur* doctrine.[227]

The *res ipsa loquitur* doctrine means that the evidence speaks for itself.[228] In the above case, the plaintiff showed that the existence of damage pointed to the negligence of the defendant.[229] The plaintiff did not have to go to great lengths to prove the

---

220 Kennedy I and Grubb A *Medical Law* 526 (Butterworths Publishers, London 2000).

221 Kennedy and Grubb *Medical Law* 527.

222 Van Dokkum N "*Res ipsa loquitur* in medical malpractice law" 1996 (15) *Medicine and Law* 227.

223 Van Dokkum 1996 (15) *Medicine and Law* 228.

224 Van Dokkum N "The evolution of medical malpractice in South Africa" 1997 (41) *Journal of African Law* 75.

225 Pollack http://www.healthlibrary.com/reading/law/part2.html (Date of use: 15 July 2016).

226 Pollack http://www.healthlibrary.com/reading/law/part2.html (Date of use: 15 July 2016).

227 Patel B "Medical Negligence and Res Ipsa Loquitur in South Africa" 2008 (1) *SAJBL* 58.

228 Please refer Van der Heever P and Carstens P *Res Ipsa Loquitur& Medical Negligence: A Comparative Survey* 7 (Juta Publishers, Cape Town) and Patel 2008 (1) *SAJBL* 59 in which the doctrine of *Res Ipsa Loquitur* is explained in detail.

229 Scott *The General Practitioner and the Law of Negligence* 2nd ed 101.

negligence of the defendant because the injuries sustained by the plaintiff were sufficient in proving this. Most plaintiffs resort to the *res ipsa loquitur* doctrine, and yet this does not relieve them of the onus of proving negligence on the part of the defendant.[230] This is because as argued by Van der Heever and Carstens how cogently such facts speak for themselves will depend on the particular circumstances of each case.[231] Thus, the role and aim of *res ipsa loquitur* as argued by Van der Heever and Carstens can be best described as merely to make an inference where the action of the defendant is concerned.[232] If the defendant fails to rebut the inference made by the plaintiff, then the plaintiff will have succeeded in proving his or her case, and the defendant will be found guilty of negligence.[233] Due to the important role of this doctrine in assisting the plaintiff with his or her claim, various medical law scholars have different views as to what it exactly entails. It is important to outline these legal opinions for a comprehensive understanding of this doctrine.

In the first instance, Strauss defines this doctrine as follows:

> "It is well known that this doctrine rests within the fundamental principle that mere proof by the plaintiff of an injurious result caused by an instrumentality which was in the exclusive control of the defendant medical practitioner, or following the happening of an occurrence solely under the defendant's control [,] gives rise to a presumption of negligence on the part of the latter. The damage or injury must be of such a nature that it would ordinarily not occur except for negligence. The *res ipsa loquitur*: the thing speaks for itself, does not necessarily mean that the burden of proof has shifted to the defendant. [However, if] the defendant fails to [render] an acceptable or reasonable account of the events, the court might readily come to the conclusion that the defendant was negligent."[234]

Van den Heever argues that this doctrine can best be summed as follows:

> "[This] doctrine constitutes a rule of evidence peculiar to the law of negligence and is an exception [,] or perhaps more accurately [,] a qualification of the general

---

230 Scott *The General Practitioner and the Law of Negligence* 2nded 102.

231 Van der Heever and Carstens *Res Ipsa Loquitur& Medical Negligence: A Comparative Survey* 7.

232 Van Dokkum 1997 (41) *Journal of African Law* 78.

233 Please refer to both Van der Heever and Carstens *Res Ipsa Loquitur& Medical Negligence: A Comparative Survey* 9 and Mason JK, Smith RA and Laurie GT *Law and Medical Ethics* 6thed 295 (LexisNexis Butterworths, London 2002).

234 Strauss SA *"The Physician's Liability for Malpractice: A Fair Solution to the Problem of Proof?"* 1967 (24) *SALJ* 419.

> rule that negligence is not to be presumed, but must be affirmatively proved. By virtue of this doctrine, the law recognises that an accident or injurious occurrence is of itself sufficient to establish *prima facie* the fact of negligence on the part of the defendant, without further or direct proof thereof, thus casting upon the defendant the duty to come forward with an exculpatory explanation, rebutting or otherwise overcoming the presumption or inference of negligence on his [or] her part".[235]

It is apparent from the descriptions rendered by these two commentators that they both share the common view that the defendant ought to be given an opportunity to advance an explanation about what occurred, and failure to do so will result in an inference being drawn that the defendant was negligent in the particular case.

6.7.2 Application of the *res ipsa loquitur* doctrine in case law

6.7.2.1 English case law

6.7.2.1.1 Cassidy v Ministry of Health [1951] 2 KB 343

One of the first cases in which the *res ipsa loquitur* doctrine was applied is *Cassidy v Ministry of Health*.[236] The plaintiff went to hospital to have an operation to correct a Dupuytren's contracture experienced in two fingers.[237] The plaintiff left the hospital with four stiff fingers and a practically useless hand as a result of the surgery – an eventuality that would have been avoided if proper care had been exercised.[238] The defendant surgeon was held liable for the patient's injuries as a result of negligence,[239] the plaintiff was left injured instead of being healed after the surgery and it was clear that the medical practitioner was negligent.

6.7.2.2 South African case law

6.7.2.2.1 Gifford v Table Bay Dock and Breakwater Management Commission 1874 Buch 926 118

---

235 Van den Heever P *The Application of the Doctrine of Res Ipsa Loquitur to Medical Negligence Cases: A Comparative Survey* 6 (LLD Thesis, University of Pretoria, 2002). Further it is important to take into account that the author in his thesis stated the requirements for the application of the doctrine of *res ipsa loquitur*, in which he states that firstly, the occurrence must be such a nature that it does not ordinarily happen unless someone is negligent, and secondly, the instrumentality must be within the exclusive jurisdiction or control of the defendant in order for this doctrine to find application.

236 *Cassidy v Ministry of Health* [1951] 2 KB 343.

237 *Cassidy v Ministry of Health* case 343.

238 *Cassidy v Ministry of Health* case 343.

239 *Cassidy v Ministry of Health* case 344.

In South Africa, *res ipsa loquitur* doctrine was first applied in the case of *Gifford v Table Bay Dock and Breakwater Management Commission*.[240] This case involves a claim lodged by the plaintiff as master and captain of a vessel known as the China.[241] The plaintiff instituted legal proceeding against the defendant on the basis that the China was wrecked when it fell while under the care and control of the defendant. In this case there was no actual evidence that indicated that the defendant was negligent in handling the vessel, and the court resolved this case through the application of the *res ipsa loquitur* doctrine. The court made reference to the English law in order to award damages to the plaintiff for the loss suffered due to the negligence of the defendant.[242]

However, years later the position seems to have changed when it comes to the application of this doctrine in South African law, as it was rejected in two leading cases as a means of resolving medical negligence cases.

6.7.2.2.2 Van Wyk v Lewis 1924 AD 438

In the case of *Van Wyk v Lewis*,[243] the patient underwent surgery but the physician failed to remove a swab from the patient's body, leaving the patient in a great deal of pain. The court refused to find the surgeon negligent, because the court was of the view that a swab left in the patient's body did not serve as evidence that the surgeon was negligent.[244]

6.7.2.2.3 Pringle v Administrator, Transvaal 1990 (2) SA 379 (W)

Another case, in which the *res ipsa loquitur* was rejected, is the case of *Pringle v Administrator, Transvaal*.[245] The plaintiff had undergone surgery as a result of lung problems that she had been experiencing.[246] There were complications during the surgery which Dr S performed on the plaintiff, resulting in the plaintiff suffering brain damage, losing her eyesight and losing her ability to work.[247] The complications were

---

240 *Gifford v Table Bay Dock and Breakwater Management Commission* 1874 Buch 926 118.

241 *Gifford v Table Bay Dock and Breakwater Management Commission* case 118.

242 *Gifford v Table Bay Dock and Breakwater Management Commission* case 119.

243 The *res ipsa loquitur* has no absolute application in cases that involve negligence. In the case of the surgeon not acting in a certain way vis-à-vis a patient, it does not amount to negligence, in some cases it can be a life-saving move. See *Van Wyk v Lewis* (1924) AD 438.

244 *Van Wyk v Lewis* case 439.

245 *Pringle v Administrator, Transvaal* 1990 (2) SA 379 (W).

246 *Pringle v Administrator, Transvaal* case 379.

247 *Pringle v Administrator, Transvaal* case 379.

as a result of her losing blood during the operation. The court found that Dr S was indeed negligent as he had torn the superior vena cava of the plaintiff.[248] Dr S was found liable for the injuries to the plaintiff on the basis of his conduct and the court confirmed the view expressed in the *Van Wyk* case that there was no room for the application of the *res ipsa loquitur* doctrine in this matter and rejected it as means of proving negligence.[249]

However, it is important to note that the South African position, when it comes to excluding the application of the *res ipsa loquitur* doctrine in medical negligence cases, was subjected to criticism by both Carstens and Van den Heever because of the important role that is played by this doctrine in resolving complex medical malpractice cases or claims. The authors argued that despite the refusal by the courts to apply this doctrine, the door has not been entirely closed for the application of this doctrine in medical malpractice cases, as they argue that it can only be applied in cases where there is a form of alleged negligence derived from something absolute, and the occurrence could not reasonably have taken place without negligence. [250] Furthermore, the two authors put emphasis on the point that the doctrine can be excluded in cases where regard is given to the surrounding circumstances to establish the presence or absence of negligence.[251] This can be interpreted to mean that the decision as to whether to apply the *res ipsa loquitur* doctrine or not, must be judged on the facts of each case and not be absolutely excluded in our law, as has been the case in the two cases discussed above.

The *res ipsa loquitur* doctrine is in line with the principles of procedural equality, in which both parties are afforded an opportunity to state their side of the story in the legal proceedings. This principle supports constitutional consideration as the supreme law in the land which allows for the application of this doctrine in medical negligence

248 *Pringle v Administrator, Transvaal* case 380.

249 *Pringle v Administrator, Transvaal* case 381.

250 Van den Heever The *Application of the Doctrine of Res Ipsa Loquitur to Medical Negligence Cases: A Comparative Survey* 65 and Carstens and Pearmain *Foundational Principles of South African Medical Law* 27.

251 Van den Heever The *Application of the Doctrine of Res Ipsa Loquitur to Medical Negligence Cases: A Comparative Survey* 65 and Carstens and Pearmain *Foundational Principles of South African Medical Law* 27.

cases.[252] However, the position in South African law regarding the applicability of the *res ipsa loquitur* doctrine only became clear in the year 2009 when the first step towards the future position of this doctrine was taken in medical negligence cases, as well as later in the year 2014 when the High Court in *Lungile Ntsele v MEC for Health, Gauteng Provincial Government,*[253] cemented the role and importance of this doctrine in resolving complex medical negligence cases.

6.7.2.2.4 Lungile Ntsele v MEC for Health, Gauteng Provincial Government [2013] 2 All SA 356 (GSJ)

Lungile Ntsele v MEC for Health, Gauteng Provincial Government case involved a plaintiff who instituted legal proceedings on behalf of her minor child against the employees of the defendant health establishment.[254] The plaintiff brought a claim of negligence that she and her minor child experienced at the hospital from the employees of the defendant health establishment, which resulted in the minor child of the plaintiff to suffer from cerebral palsy.[255] In this case the plaintiff requested for the issue of damages and negligence to be separated and such an order was granted by the court.[256] To succeed with her claim on behalf of her minor child, the plaintiff had to prove negligence on the part of the defendant and causation which resulted to the harm to her minor child. The plaintiff showed that the employees of the defendant were negligent as they did not exercise proper care in treating her and provided circumstantial evidence that the court was satisfied with.[257] On the basis of the proven facts, an inference could be drawn that the negligence of the employees of the defendant was the factual cause of the injuries that were sustained by the plaintiff's child.[258]

---

252 Carstens PA "Judicial Recognition of the Application of the maxim *Res Ipsa loquitur* to a case of Medical Negligence: *Lungile Ntsele v MEC for Health, Gauteng Provincial Government* (Unreported as yet, case number: 2009/52394 (GSJ) Dated 24 October 2009)" 2013 *Obite*r 349.

253 *Lungile Ntsele v MEC for Health, Gauteng Provincial Government* (2009/52394) [2012] ZAGPJHC 208, [2013] 2 All SA 356 (GSJ) (24 October 2012).

254 *Lungile Ntsele v MEC for Health, Gauteng Provincial Government* case 356.

255 *Lungile Ntsele v MEC for Health, Gauteng Provincial Government* case 356.

256 *Lungile Ntsele v MEC for Health, Gauteng Provincial Government* case 357.

257 *Lungile Ntsele v MEC for Health, Gauteng Provincial Government* case 358.

258 *Lungile Ntsele v MEC for Health, Gauteng Provincial Government* case 359.

The burden of proof now shifted to the defendant to prove that its employees were in actual fact diligent and not negligent, but the defendant failed to prove this on the basis that it failed to call its employees to testify in court and the expert witness of the defendant was found to be bias.[259] Furthermore, the defendant failed to provide the medical records of the plaintiff in court and did not state a valid reason as to why this has been the case.[260] The court found that for the defendant to require the plaintiff to be precise and clear about what really happened to her 15 years ago would be unreasonable of the court to allow.[261] The court drew an inference on the basis that since the defendant was unable to prove that the staff members were not the actual cause of the minor suffering from cerebral palsy, it would be in the interest of justice to apply the *res ipsa loquitur* doctrine. The defendant was held liable for the damages that the plaintiff had suffered as a result of his negligence.[262]

This judgment is supported and welcomed as a breakthrough to a long-term confusion in medical law. Carstens affirms this by pointing out that the *res ipsa loquitur* doctrine was applied in line with section 27 of the Constitution, which deals with the right of access to health care services.[263] Furthermore, this doctrine extends to the relationship of both the patient and the medical practitioner on the basis of the contract between the two parties.[264] this affirms that the application of the *res ipsa loquitur* is in line with the provisions of the Constitution, hence the case of *Lungile Ntsele*, is the first case which applied the *res ipsa loquitur* doctrine in medical negligence cases in the new constitutional dispensation in South Africa.

The landmark case on the *res ipsa loquitur* doctrine is *Cecilia Goliath v Member of the Executive Council for Health Eastern Cape*,[265] where the court confirmed the

---

259 *Lungile Ntsele v MEC for Health, Gauteng Provincial Government* case 359.
260 *Lungile Ntsele v MEC for Health, Gauteng Provincial Government* case 359.
261 *Lungile Ntsele v MEC for Health, Gauteng Provincial Government* case 359.
262 *Lungile Ntsele v MEC for Health, Gauteng Provincial Government* case 360.
263 *Lungile Ntsele v MEC for Health, Gauteng Provincial Government* case 361.
264 Carstens PA "Judicial Recognition of the Application of the maxim *Res Ipsa loquitur* to a case of Medical Negligence: *Lungile Ntsele v MEC for Health, Gauteng Provincial Government* (Unreported as yet, case number: 2009/52394 (GSJ) Dated 24 October 2009)" 2013 *Obiter* 357-358.
265 *Cecilia Goliath v Member of the Executive Council for Health Eastern Cape* (085/2014) [2014] ZASCA 182 (25 November 2014).

importance of this doctrine in our law. This case will be discussed in detail below in order to show the reasons and as well as the criticism which is levelled against previous cases by authors such as Carstens and Van den Heever, in shaping our jurisprudence when it comes to the importance and role of the *res ipsa loquitur* doctrine.

6.7.2.2.5 Cecilia Goliath v Member of the Executive Council for Health Eastern Cape (085/2014) [2014] ZASCA 182

The case of *Cecilia Goliath v Member of the Executive Council for Health Eastern Cape*,[266] arose as a result of the negligent conduct of an employee of the respondent, a health institution. The employee performed an operation on the appellant and left a swab inside the patient's body after the procedure was completed.[267] Later on the appellant experienced pain and returned to the hospital after a couple of weeks for examination and she was experiencing swelling as well.[268] At the hospital she was told that there was nothing wrong with her and was discharged without having been told to come back to the hospital for further treatment or examination in order to ascertain what might be wrong with her.[269]

Upon her return home she was still in great pain and decided not to go back to the respondent health establishment for treatment and examination.[270] Instead, she decided to go to another hospital to check what might be wrong with her.[271] In the second hospital it was confirmed that the was a swab left inside her during the surgery she underwent in the care of the respondent, which was the main reason she was experiencing great pain on her abdomen and she had to undergo laparotomy surgery.[272] Due to this the appellant decided to sue the respondent for negligence as proper care was not afforded to her during the operation.[273] She claimed that the medical practitioner as well as the nursing staff should have exercised care in such a way that they would make sure that all the operating equipment which was used during

266 *Cecilia Goliath v Member of the Executive Council for Health Eastern Cape* case 182.
267 *Cecilia Goliath v Member of the Executive Council for Health Eastern Cape* case 182.
268 *Cecilia Goliath v Member of the Executive Council for Health Eastern Cape* case 182.
269 *Cecilia Goliath v Member of the Executive Council for Health Eastern Cape* case 183.
270 *Cecilia Goliath v Member of the Executive Council for Health Eastern Cape* case 183.
271 *Cecilia Goliath v Member of the Executive Council for Health Eastern Cape* case 184.
272 *Cecilia Goliath v Member of the Executive Council for Health Eastern Cape* case 184.
273 *Cecilia Goliath v Member of the Executive Council for Health Eastern Cape* case 184.

the surgery was all in place before closing her up at the end of the surgery, because that is how a reasonable medical practitioner could have acted in order to prevent harm.[274]

Furthermore, the appellant in this case argued that she has incurred financial loss because of the corrective surgery that she had to go through in order to correct the mistake of the respondent doctor and claimed damages to this effect.[275] However, the respondent in this case as the Department of Health, objected to the claims of the appellant on the basis that she received good care and that there was no form of negligence displayed by the employees of the respondent in administering treatment to the appellant, but that the standard of a reasonable doctor was actually applied in this case.[276] The court of *a quo* dismissed the claim of the appellant who was the plaintiff, on the basis that the plaintiff failed to discharge her onus of proof on a balance of probabilities, to show that the conduct of the medical practitioner and nursing staff who were involved in performing surgery were in actual fact negligent.[277]

However, the court *a quo* granted the appellant leave to appeal its decision on the basis that it is bound by the decision of *Van Wyk*, in which the application of the *res ipsa loquitur* doctrine was rejected by the court.[278] The court further reasoned that revising the application of the *res ipsa loquitur* doctrine would be in the interests of justice, as argued by scholars like Carstens and Van den Heever above. This is because if the *res ipsa loquitur* doctrine was applied in this case, the decision of the court could have been different due to the fact that if the defendant was unable to provide a reasonable explanation for the issue at hand, then the court could have ruled in favour of the appellant.[279]

Based on these reasons of the court of *a quo*, the appellant lodged an appeal to the Appeal Court on the basis of the *res ipsa loquitur* doctrine, to establish the liability of

274 *Cecilia Goliath v Member of the Executive Council for Health Eastern Cape* case 185.
275 *Cecilia Goliath v Member of the Executive Council for Health Eastern Cape* case 185.
276 *Cecilia Goliath v Member of the Executive Council for Health Eastern Cape* case 185.
277 *Cecilia Goliath v Member of the Executive Council for Health Eastern Cape* case 186.
278 *Cecilia Goliath v Member of the Executive Council for Health Eastern Cape* case 186.
279 *Cecilia Goliath v Member of the Executive Council for Health Eastern Cape* case para 6.

the respondent.[280] During the appeal, both the appellant and her doctor who performed the corrective surgery testified as to the possibility of when the swab was left inside the body of the appellant, which was a testimony that was not given during the trial.[281] Furthermore, during cross examination, the respondent did not adduce evidence which could rebut the version of the appellant and her doctor to show that she had received reasonable care while in hospital.[282] There was no explanation as to why the respondent did not testify in court through its medical staff in order to challenge the testimony of the appellant. The court held that a reasonable inference could be drawn that the respondent was avoiding having to call in its employees to testify as that may have revealed unfavourable facts about what actually happened on the day of the operation and could have been detrimental to its case.[283] After having weighed all the evidence and circumstances of the case, the court found that the appellant had indeed discharged her onus of proof on a balance of probabilities.[284] The appeal of the appellant was successful and the application of the *res ipsa loquitur* resulted in the appellant receiving an amount of R250, 000 as damages for the loss which she suffered as a result of the negligence of the respondent.[285]

These two cases have brought about legal certainty and clarity about the state of application of the *res ipsa loquitur* doctrine in our law. It is clear that this remedy now forms part of our law, which was the position before the case of *Van Wyk* and there is no longer any confusion about the role of this doctrine. This clarification was much needed due to the fact that this remedy is an important tool in our law as outlined in the above cases, particularly in solving complex medical negligence cases where the defendant is unable to provide reasonable explanations about the actual cause of injury which the plaintiff has suffered due to negligence.

280 *Cecilia Goliath v Member of the Executive Council for Health Eastern Cape* case para 6-7.
281 *Cecilia Goliath v Member of the Executive Council for Health Eastern Cape* case para 6-7.
282 *Cecilia Goliath v Member of the Executive Council for Health Eastern Cape* case para 7.
283 *Cecilia Goliath v Member of the Executive Council for Health Eastern Cape* case 188.
284 *Cecilia Goliath v Member of the Executive Council for Health Eastern Cape* case 189.
285 *Cecilia Goliath v Member of the Executive Council for Health Eastern Cape* case para 21.

6.8 Medical negligence in the context of cancer

6.8.1 The negligence of a surgeon/oncologist in the case of a person living with cancer

6.8.1.1 Castell v De Greef 1994 (1) SA 408 (C)

One of the leading cases of medical negligence with regard to cancer in South Africa is *Castell v De Greef*.[286] The plaintiff was admitted to hospital for a mastectomy and the surgery was performed by the defendant, a surgeon.[287] The operation involved the plaintiff undergoing a couple of operations on her breasts to remove lumps that were linked to breast cancer, which was a condition that ran in her family.[288] The plaintiff originally consulted her doctor about the problems she was having with her breasts and was referred to the defendant surgeon by her doctor.[289] When the defendant had examined the plaintiff, to arrive at a diagnosis he recommended that she undergo a mastectomy.[290] After discussing the matter with the defendant surgeon and her husband, the plaintiff decided to go ahead with the surgery.[291]

Immediately after the surgery, everything seemed to be in order. However, two hours later, complications were evident when the plaintiff's breast turned black and she experienced some pain.[292] Her state of health deteriorated further after she was discharged from hospital, and she experienced pain in the area that was treated during the surgery, as well as a discharge that had a very unpleasant odour.[293] The plaintiff returned to the defendant surgeon in connection with these complications and he prescribed painkillers while also recommending corrective surgery.[294] The second surgery was performed not by the defendant surgeon himself but by another surgeon working at the same hospital. After the corrective surgery, the plaintiff recovered and instituted a civil claim for the expenses she had had to incur in having to do this additional procedure.[295] For the pain, suffering and embarrassment she had to endure,

286 *Castell v De Greef* 1994 (1) SA 408 (C).
287 *Castell v De Greef* case 408
288 *Castell v De Greef* case 408.
289 *Castell v De Greef* case 409.
290 *Castell v De Greef* case 409.
291 *Castell v De Greef* case 409.
292 *Castell v De Greef* case 409.
293 *Castell v De Greef* case 410.
294 *Castell v De Greef* case 410.
295 *Castell v De Greef* case 410.

she instituted a specific action against the defendant surgeon on grounds that he had been negligent, failing to act in a way that a reasonable individual in the same profession could have acted.[296]

In the court *a quo*, the presiding officer, Scott J, stated that a surgeon does not have to perform to the highest possible standards but ought to adhere to a reasonable standard of care which reasonable people in the same profession would adhere to.[297] The fact that complications arise in surgery does not mean that care has not been exercised by the surgeon.[298] For the purposes of this case, expert witnesses were called in to give their testimonies and all of them said that it was not inappropriate for the plaintiff to have had this type of surgery.[299] However, they agreed that if the surgeon had made use of the pedicle flap, the complications could have been prevented.[300] The argument that the defendant did not warn the plaintiff about the risks was rejected by the court on grounds that not all risks could be foreseen by the surgeon and the patient herself should have been cautious about agreeing to the procedure.[301]

In the court *a quo*, the claim of the plaintiff was dismissed with costs in favour of the defendant surgeon. However, on appeal, Ackermann J was of the view that the defendant was negligent in not taking steps to prevent the infection from setting in.[302] The surgeon only took corrective action 12 days after the occurrence.[303] Ackermann J found it appropriate to compensate the plaintiff for the pain, suffering and embarrassment she had suffered as a result of the operation. The appeal was accordingly successful.[304]

296 *Castell v De Greef* case 411.
297 *Castell v De Greef* case 411.
298 *Castell v De Greef* case 411.
299 *Castell v De Greef* case 411.
300 *Castell v De Greef* case 411.
301 *Castell v De Greef* case 412.
302 *Castell v De Greef* case 412.
303 *Castell v De Greef* case 412.
304 *Castell v De Greef* case 413.

6.8.1.2 P v Pretorius (74157/2013) [2016] ZAGPPHC 602 (14 July 2016)

Another relevant case dealing with medical negligence is *P v Pretorius*,[305] which involved the alleged negligence of a general practitioner who is the defendant herein. In this case an oncologist diagnosed the plaintiff with cancer and suggested chemotherapy as treatment therefore, but the plaintiff instead opted for Insulin Potentiation Therapy (IPT) treatment offered by a general practitioner as an alternative method since he was uncomfortable with undergoing chemotherapy.[306] The plaintiff underwent IPT treatment which he then suspended after three months and continued later. Consequently, the patient went into remission.[307] The court found that the defendant had performed a comprehensive and proper examination and that he had properly ascertained the medical history of the plaintiff, as well as acted in accordance with the results of pathology report of the plaintiff.[308] The court further found that the defendant had explained the nature of IPT to the plaintiff and also referred the latter to a patient who had been successfully treated using IPT.[309] The court held that the fact that the plaintiff was not cured by the treatment which the defendant administered did not in itself justify an inference that the latter was negligent and did not act with the necessary diligence and skill expected from practitioners practising in his branch of speciality.[310] The court emphasised that in order to properly analyse the defendant's treatment of the plaintiff, it would be useful to have regard to the general skill and diligence possessed and exercised by practitioners that have the same expertise as the defendant, and yet *in casu* this evidence was not produced by the plaintiff.[311] On the evidence the court could not come to a finding of negligence because the plaintiff could not show that the defendant was negligent on a balance of probabilities. Therefore, the plaintiff's claim was dismissed with costs.[312] This case clearly reveals how medical negligence is proven by means of an objective test on the standard of reasonableness, and how the fact that a patient is not healed cannot bring about an inference of negligence.

---

305 *P v Pretorius* (74157/2013) [2016] ZAGPPHC 602 (14 July 2016).
306 *Pretorius* case para 7.
307 *Pretorius* case para 7.
308 *Pretorius* case para 84.
309 *Pretorius* case para 86.
310 *Pretorius* case para 88.
311 *Pretorius* case para 89.
312 *Pretorius* case para 90-91.

6.8.2 Medical negligence in the form of misdiagnosis

In cancer situations, most malpractice claims seem to arise from the misdiagnosis of patients and thus constitute negligence, which is a major problem all over the world.[313] For example in America, delayed diagnosis or misdiagnosis of breast cancer is the major reason for medical malpractice cases in the area of cancer cases.[314] This is evident from the 3500 cases which are heard by the courts annually on the basis of misdiagnosis or late diagnosis of breast cancer cases.[315] This is a call for concern and proper care on the part of oncologists is required in order to prevent the increase of misdiagnosis cases. Misdiagnosis or delayed diagnosis means that an oncologist failed to act in a way a reasonable person in the same position could have acted, to see or know whether the patient does or does not have cancer.[316] Failure to diagnose breast cancer is one of the leading causes of medical malpractice claims unlike many other diseases in the United Kingdom.[317] As a result, there lies a great responsibility on the part of lawyers to carefully select a case in order to succeed with a claim.[318]

However, it is important to note that having a legal practitioner acquire background knowledge about cancer does not substitute the role that should be played by medical experts in the case, such as an oncologist or radiologist in the proceedings.[319] Negligence of a misdiagnosis of a person living with cancer has a devastating effect on the patient, to an extent where the patient has to undergo treatment such as

313 Jaslow R http://www.cbsnews.com/news/most-common-medical-malpractice-claims-for-missed-cancer-heart-attacks/ (Date of use: 7 January 2014).

314 Kern KA "The delayed diagnosis of breast cancer: medico-legal implications and risk prevention for surgeons" 2008 (12) *The Breast* 148-149.

315 Vijh R and Morgan JL "Trends in malpractice litigation in relation to the delivery of breast care in the National Health Service" 2013 (22) *The Breast* 965. Further, is important to take into account that there is a significant increase when it comes to litigation with respect to breast care delivery by medical practitioners, oncologists in this context. This has resulted in insurers paying out large sums of money, and making oncologists practising defensive medicine with the aim of averting litigation and which is not in the interests of medical practitioners. See Anand RVV "Malpractice litigation in patients in relation to delivery of breast care in the NHS" 2008 (17) *The Breast* 148.

316 Cranor F *Toxic Torts: Science, Law and the Possibility of Justice* 365 (Cambridge University Press, London 2006).

317 Cranor *Toxic Torts: Science, Law and the Possibility of Justice* 366.

318 Freider MI *et al*, "Selecting and Presenting a Failure to Diagnose Breast Cancer Case" 2001 (20) *AM. J.Trial Advoc* 253.

319 Freider MI *et al*, 2001 (20) *AM. J.Trial Advoc* 254.

chemotherapy, which leads to the pain and suffering, medical expenses and loss of income in case of a patient who is no longer working.[320] An important aspect that needs to be taken into consideration by both patients and lawyers when it comes to misdiagnosis is that failure to diagnose or erroneous diagnosis is not actionable, unless the patient is in the position to prove that such failure to diagnose or erroneous diagnosis has resulted in him or her being injured.[321] There must be a link or causation between the misdiagnosis and the harm that the patient has suffered for a claim of misdiagnosis to succeed. This view is supported by the reason that misdiagnosis or failure to diagnose does not amount to negligence in all cases, due to the fact that courts are willing to accept that no human being, including medical practitioners, is infallible and thus this reality must be accepted as a part of life.[322]

This was the position of Herlinda Garcia, a 54 year old woman, who was misdiagnosed with breast cancer by her doctor.[323] After she had gone for a gruelling period of seven months of chemotherapy treatment, she went to see another doctor to treat her for anxiety, and she got a shock of her life when she was told by the second doctor that she did not have cancer at all.[324] The first doctor was held liable for negligence and ordered to pay her $367,500 for all the loss she has suffered as a result of the negligence of the doctor.[325]

Furthermore, it is important to take into account that misdiagnosis is a broad concept which includes under dosing, overdosing, prescribing the wrong drug, choosing the

---

320 Freider MI *et al*, 2001 (20) *AM. J.Trial Advoc* 254.

321 In *Barnett v Chelsea and Kensington Hospital Management Committee* (1986) 1 ALL ER 1068, the plaintiff was the wife of the deceased and brought a claim of negligence against the defendant on the basis of misdiagnosis which she claimed resulted in the death of the deceased. However, the claim of the plaintiff was dismissed on the basis that the cause of death of the deceased was not misdiagnosis on the part of the defendant, but in actual fact the deceased would have died soon because of his critical medical condition. There was no link between the misdiagnosis and the death of the deceased, hence the application was dismissed.

322 Dutton I *The Practitioner's Guide to Medical Malpractice in South African Law* 104 (Siber Ink Publishers, Cape Town 2015). Further, the view that courts are willing to accept the fact that all human begins are fallible, which includes medical practitioners who are not exempted from this reality was confirmed in the case of *Crivon v Barnet Group Hospital Management Committee* 1959 in the English court.

323 Castillo M http://www.cbsnews.com/news/woman-gets-chemo-only-to-find-out-she-never-had-cancer/ (Date of use: 7 January 2014).

324 Castillo M http://www.cbsnews.com/news/woman-gets-chemo-only-to-find-out-she-never-had-cancer/ (Date of use: 7 January 2014).

325 Castillo M http://www.cbsnews.com/news/woman-gets-chemo-only-to-find-out-she-never-had-cancer/ (Date of use: 7 January 2014).

wrong dose frequency, omitting a drug or dose and neglecting to add premedication or supportive care medication.[326] This shows that misdiagnosis in cancer can take different forms and which can result in dire consequences for patients. This is evident in the fact that such medical errors are claiming the lives of 7000 people annually,[327] all of which could be prevented if medical practitioners were to exercise the required degree of care and skill when they exercise their duties.

Liability on the basis of misdiagnosis of persons living with cancer is also applicable in American and English law, which further recognises liability for late diagnosis of cancer and improper administration of cancer treatment to the patient. This is because a doctor owes a duty of care to the patient, and must act in a reasonable way when treating a patient in the same way that another doctor in the same position could have acted.[328] The South African legal system is influenced by the English model, and these rules or principles are also applicable in South Africa. In South Africa, however, a lot of cases of death caused by cancer are related to late diagnosis of cancer by the medical practitioner.[329]

6.8.2.1 Example of South African case law on negligent misdiagnosis

6.8.2.1.1 Esterhuizen v Administrator Transvaal, 1957 (3) SA 710 (T)

A case which is of interest in relation to cancer negligence is the case of *Esterhuizen v Administrator Transvaal*.[330] This case involved a 10 year old child who was diagnosed with Kaposi's sarcoma cancer.[331] The child was initially treated with superficial radiation therapy with the consent of her parent. However, following the recurrence of the cancer she was subjected to radical radiation therapy which resulted in severe burns on her body and resulted in the amputation of her limbs.[332] The parent of the child brought an action for damages as a result of the negligence of the medical

326 Swanepoel C "Medication errors in oncology: a literature review" 2013 (80) *SAfr Pharm J* 48.

327 Swanepoel 2013 (80) *SAfr Pharm J* 49.

328 Breakstone http://www.bwglaw.com/lawyer-attorney-1368134.html (Date of use: 8 January 2015).

329 Omenah A and Buckle G "Factors influencing time to diagnosis and initiation of treatment of endemic Burkitt Lymphoma among children in Uganda and western Kenya: a cross sectional survey" 2013 *BioMed* 2-4.

330 *Esterhuizen v Administrator* Transvaal, 1957 (3) SA 710 (T).

331 *Esterhuizen v Administrator* Transvaal, case 710.

332 *Esterhuizen v Administrator* Transvaal, case 710.

practitioner and on the basis that the parent of the child did not provide consent for the medical intervention in question.[333] The court held that while the superficial radiation therapy was duly performed with the consent of the parent of the victim, the second procedure which resulted in extensive burns on the child was performed without the consent of the parent of the child.[334]

The defendant medical practitioner raised the defence of implied consent, in the sense that owing to the prior consent given by the parent of the child to the first medical intervention, it meant that it was no longer necessary for the parent to give consent for the second medical procedure and that he was acting in the best interests of the child.[335] The court rejected this defence. The court reasoned that owing to the fact that radical radiation therapy is different from the prior superficial radiation therapy, it was necessary for the parent of the child to be informed about the dangers inherent in the new treatment, before such implied consent could be considered as valid.[336] The court ruled in favour of the plaintiff who was the parent of the child and found that the medical practitioner in question was negligent, in the sense that he failed to act in a way that a reasonable person in the same situation which he was exposed to could have acted in order to prevent the harm or loss from taking place.[337]

6.8.2.2 An example from American case law

6.8.2.2.1 McRae v Group Health Plan Inc. 753 N.W.2d 711 (Minn. 2008)

In the case of *McRae v Group Health Plan*,[338] Mr Mc Rae was the plaintiff and a misdiagnosis on the part of the defendant surgeon changed his life.[339] The plaintiff went to the medical practitioner for a routine check-up and during the process he alerted the practitioner about the skin lesion on his left leg, and after conducting a shave biopsy the defendant practitioner confirmed that the lesion was benign. Three years later, due to the pain the plaintiff was suffering from, the defendant had to re-evaluate his biopsy and informed the plaintiff that there was a misdiagnosis on his part

333 *Esterhuizen v Administrator* Transvaal, case 711.
334 *Esterhuizen v Administrator* Transvaal, case 711.
335 *Esterhuizen v Administrator* Transvaal, case 712.
336 *Esterhuizen v Administrator* Transvaal, case 712.
337 *Esterhuizen v Administrator* Transvaal, case 713.
338 *McRae v Group Health Plan* 753 N.W.2d 711, 714-15 (Minn.2008).
339 *McRae v Group Health Plan* case 753.

and the plaintiff was in actual fact suffering from melanoma cancer. The cancer had already developed to an extent that it was too late to treat it and as a result of this, the plaintiff later died because of the cancer.[340] However, Mrs Mc Rae brought this claim against the defendant on the basis of misdiagnosis on the part of the defendant.[341] The defendant raised the defence that her claim had prescribed as four years had gone by since the cause of action arose.[342] The court dismissed the claim of the plaintiff on the basis of prescription, but there was no question or dispute that the defendant medical practitioner was indeed negligent on the basis of misdiagnosis.[343]

6.8.2.3 Examples of case law regarding contributory negligence on the part of the patient

At this point it is necessary to note that when a patient fails to carry out medical instructions, such failure does not constitute contributory negligence on the part of the patient.[344] This aspect of contributory negligence on the part of the patient will be explored below and substantiated with various cases in which the doctrine of contributory negligence as a defence by negligent medical practitioners was rejected by the courts.

6.8.2.3.1 Crossman v Stewart (1977) 5 CCLT 45 (BCSC)

To the contrary, the court in *Crossman v Stewart*,[345] reached a different decision on the issue of a patient's failure to adhere to medical instruction that were issued by the medical practitioner. In this case the plaintiff was held liable on the basis of contributory negligence.[346] The patient in this case had obtained a prescription from an unorthodox source and was using the prescribed medication on a prolonged basis without consulting a medical practitioner.[347] As a result of using that particular drug, the plaintiff ended up being blind. The patient instituted a legal claim and argued that it was the negligence of the medical practitioner that caused her blindness.[348] In this

340 *McRae v Group Health Plan* case 755.
341 *McRae v Group Health Plan* case 755.
342 *McRae v Group Health Plan* case 756.
343 *McRae v Group Health Plan* case 756.
344 *Esterhuizen v Administrator* Transvaal, case 714.
345 *Crossman v Stewart* (1977) 5 CCLT 45 (BCSC).
346 *Crossman v Stewart* case 45.
347 *Crossman v Stewart* case 46.
348 *Crossman v Stewart* case 47.

case the court held that due to the fact that the patient used drugs from an unorthodox source without consulting the medical practitioner, her actions amounted to contributory negligence and there was no liability on the part of the medical practitioner.[349]

6.8.2.3.2 Dr Julian Baldor and First Palma Ceia Hospital v JT Rogers 10 N.C 165 1999

In the case of *Dr Julian Baldor and First Palma Ceia Hospital v JT Rogers*,[350] the plaintiff was an elderly farmer who was suffering from cancer (carcinoma) and the defendant surgeon was responsible for treating the plaintiff.[351] The defendant only used to give medicines and injections to the plaintiff as a way of treating his cancer, and the condition of the plaintiff was always deteriorating despite the treatment offered by the defendant. The plaintiff argued that the conduct of the defendant surgeon was negligent on the basis that he deviated from the reasonable standard, which a reasonable surgeon in his position could have adhered to by taking measures such as treating the plaintiff with surgery, radiation and chemotherapy as these are acceptable means to treat cancer.[352]

The defendant failed to treat the plaintiff and contributed to the deterioration of the plaintiff's health and the plaintiff argued that the defendant neglected him during this time and hence his condition became worse by the day.[353] The defendant objected to these claims and argued that he acted in a way a reasonable surgeon could have acted in the same circumstances, and the plaintiff's contributory negligence of not listening to instructions was the main reason for his health becoming worse.[354] The defence of the defendant was dismissed on the basis that not adhering to medical instructions do not constitute contributory negligence and the defendant was found

349 *Crossman v Stewart* case 48.
350 *Dr Julian Baldor and First Palma Ceia Hospital v JT Rogers* 10 N.C 165 1999.
351 *Dr Julian Baldor and First Palma Ceia Hospital v JT Rogers* case 165.
352 *Dr Julian Baldor and First Palma Ceia Hospital v JT Rogers* case 166.
353 *Dr Julian Baldor and First Palma Ceia Hospital v JT Rogers* case 167.
354 *Dr Julian Baldor and First Palma Ceia Hospital v JT Rogers* case 168.

liable for his negligence in not affording the plaintiff the correct medical procedure.[355] The defendant was ordered to compensate the plaintiff $65 000.[356]

It is important to note that once it has been established that an oncologist was negligent in performing the medical intervention, the patient's contributory negligence is no defence to liability and it will only be taken to account for the purposes of the apportionment of damages or for the mitigation of sentence.[357] The degree of negligence also has no effect on liability, although it may merely influence the quantum of damages.[358] It is necessary to outline and emphasise that the onus of proving the requirements of a particular cause of action and the damages claimed, rests with the plaintiff on a balance of probabilities.[359]

Zarick argues that the reason why misdiagnosis is a major factor which results in medical malpractice claims is due to the nature of the disease. A misdiagnosis of cancer or a delayed diagnosis of cancer can literally be the difference between life and death of the patient.[360] This argument is supported by the scientific analogy that the earlier the cancer is detected, the better the chances are for the patient to recover, but a delay in detecting cancer through misdiagnosis can result in dire consequences, as argued by Zarick.[361] One thing that needs to be taken into account in the context of misdiagnosis is that a misdiagnosis in itself it does not constitute a cause of action for the patient. The patient can only bring a claim for misdiagnosis if he or she has suffered loss or injury and has succeeded in proving that the medical practitioner's conduct was negligent, and was in fact the cause of harm or injury, only then will the issue of liability

355 *Dr Julian Baldor and First Palma Ceia Hospital v JT Rogers* case 168.

356 *Dr Julian Baldor and First Palma Ceia Hospital v JT Rogers* case 169.

357 The defence of contributory negligence in medical malpractice points to the fact that a patient has certain rights and duties, just like a medical practitioner, which emanate from the contract between the patient and medical practitioner. One duty which the patient must display is the duty of care towards the medical practitioner and to himself or herself as a patient with a reasonable standard. If the patient breaches this duty of care and if his or her actions result in damage to himself or herself, then the patient will be liable on the basis of contributory negligence, and the damages of the patient against the defendant medical practitioner will be reduced accordingly. See Zarick AL "Damage Deferred: Determining When a Cause of Action Begins to Accrue from a Cancer Misdiagnosis Claim" 2010 (41) *U.Tol.L.Rev* 483.

358 Zarick 2010 (41) *U.Tol.L.Rev* 483-484.

359 Zarick 2010 (41) *U.Tol.L.Rev* 485.

360 Zarick 2010 (41) *U.Tol.L.Rev* 485.

361 Zarick 2010 (41) *U.Tol.L.Rev* 486.

arise.[362] This position has been confirmed in the case of *Mitchell v Dixon*,[363] in which it was held that a surgeon can be held liable if a diagnosis is wrong and it does not only encompass a mistake but is also coupled with negligence.[364] In the 21st century as people rely on genetic information to make informed decisions about their state of health, it has become clear that misdiagnosis could be a leading cause of litigation. This view has been confirmed in the context of America, where it has been stated that 50% of medical malpractice claims emanates from misdiagnosis on the part of medical practitioners.[365] To avert this from increasing to other parts of the world, including South Africa where there is a problem of misdiagnosis particularly in cancer cases, medical practitioners will need to apply new techniques and procedures coupled with the proper standard of care in order to meet the technological advances and to enable them to avoid liability.

6.9 *Imperitia Culpae Adnumeratur*

It was the Romans who established the doctrine of *imperitia culpae adnumeratur* in order to make a distinction between '*dolus*' which refers to intention and '*culpa*' which refers to both negligence and incompetence.[366] These concepts tended to overlap, and thus give rise to confusion. However, establishing a clear distinction between the two terms helped the Roman jurists.[367] According to the *imperitia culpae adnumeratur* doctrine, ignorance or incompetence on the part of a medical practitioner amounted to negligence.[368] However, Boberg rejects this as the meaning of this doctrine on the

362 Zarick 2010 (41) *U.Tol.L.Rev* 486.

363 *Mitchell v Dixon* 1914 AD 15.
Mitchell v Dixon case 16. See Straus SA *Doctor, Patient and Law* 243 (Van Schaik Publishers, Pretoria 1991), in which he argues that if a doctor were to fail in observing proper standards of care in examining a patient or if a doctor knows that he or she is not properly equipped to make an examination of the patient, and fails to refer the patient to another medical practitioner who is equipped, in this case the medical practitioner can be held liable for his or her negligence. Another case of interest when it comes to misdiagnosis, it was decided in the case of *Coppen v Impey* 1916 CPD 309, in which the doctor wrongly diagnosed the patient as the plaintiff in this case with TB who in actual fact was not suffering from this illness based on the expert witness. In this case the court held that a medical practitioner is not expected to display the highest degree of care or skill but a reasonable skill. The medical practitioner, in this case is found to be negligent and failed to exercise the necessary skill when treating the patient.

365 Paul C *Limitations of Actions* 215 (Indiana Publishers, New York 2008).

366 Buckland AW *A textbook of Roman Law from Augustus to Justinian* 556 (Cambridge University Press, Cambridge 1950).

367 Buckland *A textbook of Roman Law from Augustus to Justinian* 556.

368 This meaning can best be illustrated by the literal meaning of this doctrine in latin to refer to: *Digest: Ad Legem Aquiliam 50 17 32 "(Gaius 7 Ad Edictuum Provinciale): Imperitia Culpae Adnumeratur", Inst Just 4 3 7: "Imperitia culpae adnumeratur, veluti si medicus ideo servum*

basis that it is misleading because a lack of skill in itself does not lead to negligence.[369] He argues that no human being can be skilful in everything and that this is applicable to medical practitioners as well.[370] Furthermore, as a continuation of the argument put forth by Boberg, Carstens accepts that in Roman law the onus of proof rested with the plaintiff to show that the loss which he or she suffered was due to the conduct of the defendant.[371] However, Carstens recognises that proving medical negligence was a very difficult task for the plaintiff to achieve.[372]

Due to the discrepancies which both the abovementioned authors outline when it comes to this doctrine, an acceptable meaning or understanding of this doctrine can be derived from Voet's opinion, in which he states that:

> "A reasonable person has no special skills [,] and lack of skill or knowledge is not *per se* negligence. However, it is negligent to engage voluntarily in any potentially dangerous action unless one has the skill and knowledge usually associated with the proper exercise of their duties connected with such an activity".[373]

From the assessment of the reasoning of these various authors above, what the doctrine actually implies can be summarised as follows: when a medical practitioner engages in conduct which he or she lacks skill in, but nevertheless continues to perform such an act whilst knowing of his or her own lack of skill therein, then that medical practitioner will be held liable for negligence.

The doctrine of *imperitia culpae adnumeratur* was also applied in Roman-Dutch law when the negligence of a medical practitioner was considered by the courts.[374] The doctrine holds that a medical practitioner will be held negligent if he or she makes a false representation to a patient by attesting to his or her skills, knowledge and ability

---

tuum occiderit, quod eum male secuerit aut perperam ei medicamentum dederit", D 9 2 7 8 "(Ulpianus 18 Ad Edictum) Proculus ait, si medicus servum iperite secuerit vel ex locato vel exlege Aquilia competere actionem", D 9 2 7 8 "(Gaius 7 Ad Edictum Provinciale): Idem iuris est si medicamento perperam usus fuerit".

369 Boberg P *The Law of Delict: Acquilian Liability* 347 (Juta Publishers, Cape Town 1984).

370 Boberg P *The Law of Delict: Acquilian Liability* 347.

371 Carstens and Pearmain *Foundational Principles of South African Medical Law* 614.

372 Boberg *The Law of Delict: Acquilian Liability* 348.

373 Voet *The Acquilian Law* 23.

374 Swanepoel 2009 (12) PER/*PELJ* 16-17.

to perform a particular medical procedure while knowing that this is not true.[375] The very same principle applies to cancer treatment, be it surgery or chemotherapy.[376] If an oncologist carries out a procedure without proper knowledge and skill, while knowing about his or her own deficiencies, he or she will be held liable in terms of the *imperitia culpae adnumeratur* doctrine.[377]

This doctrine of *imperitia culpae adnumeratur* has been applied in various South African law cases but only one which is the land mark case in our law when it comes to this doctrine will be discussed for the purposes of this study. In *S v Mkwetshana*,[378] the accused was a hospital intern doing his community service. The deceased (effectively the complainant in this case), had been a patient suffering from asthma.[379] One morning, a nurse at the hospital noticed that the complainant was having difficulty breathing and the accused, the only doctor available at the time, was called to assist.[380] When the accused arrived at the complainant's bedside, she was in a terrible state and foaming at the mouth. The accused administered 20cc of aminophylline to help the defendant's breathing but there was no improvement. He then decided to administer 20cc of the drug paraldehyde because he was under the impression that the defendant was having an epileptic seizure. In addition, the accused gave the defendant another dose of the original drug.[381] The defendant's condition improved and the accused left her, but she subsequently passed away. It was established that the cause of death was a lethal overdose of the first drug that the accused had administered.[382] The accused was found guilty of culpable homicide on the basis that he was negligent in the administration of the drug. The case went on appeal with the defence being raised that while the accused lacked experience, he was responding to an emergency situation and took the best decisions he could in the circumstances.[383] The court rejected the defence because the accused, knowing that he lacked the

375 Otto 2004 (8) *SAJR* 20.
376 Otto 2004 (8) *SAJR* 21.
377 Otto 2004 (8) *SAJR* 22.
378 *S v Mkwetshana* 1956 (2) SA 493 (N).
379 *S v Mkwetshana* case 493.
380 *S v Mkwetshana* case 493.
381 *S v Mkwetshana* case 494.
382 *S v Mkwetshana* case 495.
383 *S v Mkwetshana* case 495.

necessary knowledge and skill, could have called for assistance from a nurse or someone else at the hospital, but failed to do so. The appeal was therefore dismissed.[384]

6.10 The role of expert witnesses in litigation proceedings

6.10.1 Foundations for the use of expert witnesses in litigation proceedings

Some things just cannot be decided by a court alone, particularly when the subject matter relates to a specialised field of endeavour like engineering, chemistry or psychology.[385] Similarly, oncology is a specialised profession, and only an expert can perform this kind of treatment.[386] Therefore, for a plaintiff to succeed in proving the negligence of an oncologist, expert witnesses in the field of oncology are required as they are the only ones who, given their knowledge and credentials, can effectively judge the conduct of other oncologists.[387] In this section of the study, the importance of expert witnesses in helping the courts to prove negligence on the part of an oncologist will be discussed. In the absence of experts with a wealth of knowledge and experience in cancer treatment cases, it can be difficult to expose negligent behaviour.[388]

At this point it is important to state that the role of expert witnesses in assisting with resolving medical negligence cases can be traced as far back as 1530 AD in Rome as was exercised by the humanist school.[389] The Romans were aware of the important role that expert witnesses would play in medical negligence cases.[390] Since then, the

384 *S v Mkwetshana* case 496.

385 Schwikkard PJ and Van der Merwe SE *Principles of Evidence* 2nded 89 (Juta, Cape Town 2002).

386 Schwikkard and Van der Merwe *Principles of Evidence* 2nded 90.

387 Schwikkard and Van der Merwe *Principles of Evidence* 2nded 91.

388 Expert witnesses play a very critical role in helping the court to understand a particular or specific field which the court does not understand for the purposes of arriving at a just decision, taking into account that the accused person or a defendant in a civil case is entitled to fair trial as enshrined and protected in terms of Section 35(2) of the Constitution of the Republic of South Africa, 1996.

389 *Constitutio Criminalis Carolina* http://www.latein-agina.de/explorer/hexen1/carolina.htm (Date of use: 12 August 2016).

390 *Constitutio Criminalis Carolina* http://www.latein-agina.de/explorer/hexen1/carolina.htm (Date of use: 12 August 2016).

role of expert witnesses has been generally pivotal in litigation and is still a process that forms part of our legal system even to this very day.

6.10.2 Describing the function of expert witnesses

An expert witness is defined as someone with special knowledge, skill, experience, training and education in a particular field, which permits him or her to testify to an opinion that will assist the court to resolve the question that is beyond the understanding and competence of a lay person.[391] Therefore, an expert witness is a person who makes his or her knowledge available to the court in order to help the court understand the issues of a case and reach a sound and just decision.[392] The expert witness will also assist the court to make a fair decision in relation to three categories or factors which can result in negligence of the medical practitioner, this includes breach of duty, causation and the quantum of damages, because expert evidence is required in order to prove or dispute these factors.[393]

Taking into account the expert's qualifications and years of experience, it can be concluded that the kind of evidence given by an expert witness has a probative value. However, the court is not bound by this kind of evidence and can choose to disregard it.[394] Expert evidence is one of the exceptions to the general rule that opinion evidence is inadmissible. The general rule is that opinion evidence is inadmissible due to the fact that it is generally irrelevant and not reliable.[395] In the case of an expert witness, opinion evidence may be admissible provided that such evidence will provide the court with scientific information which falls outside the knowledge and experience of the court, with the aim of assisting the court to make an equitable decision.[396] However, if the expert evidence deals with matters or outlines issues which the court can decide

391 Grobler S "The Role of the Expert Witness" 2007 (5) *The South African Gastroenterology Review* 11.

392 Grobler 2007 (5) *The South African Gastroenterology Review* 12.

393 Grobler 2007 (5) *The South African Gastroenterology Review* 13.

394 Carstens 2002 (65) *THRHR* 435.

395 Schwikkard and Van der Merwe *Principles of Evidence* 2nded 92-93.

396 Crosby E "Medical malpractice and anesthesiology: literature review and role of the expert witness" 2007 (54) *CJA* 227.

on its own, then in such a case the evidence will be found to be irrelevant and thus inadmissible.[397]

A lawyer who calls in an expert witness must brief him or her regarding the questions which he or she will be asked by the court. The lawyer must explain how the expert witness must conduct himself or herself in court, including dressing in such a way as to suggest a high degree of professionalism.[398] All this helps to build the witness's confidence and encourages the court to take him or her seriously. An expert witness giving testimony in court is somewhat like a teacher. The witness must teach the court about the subject matter and answer questions in an appropriate manner. It is important that the expert witness does not prevaricate when answering questions that he or she sticks to the point and uses simple language by refraining from using medical jargon, and does not get emotional.[399] Once the testimony is over, the expert witness should feel confident that he or she has earned the court's respect.[400]

As civil cases demand that the plaintiff bears the onus of establishing proof of the defendant's negligence, the plaintiff should do so by calling in an expert who will prove that the reasonable standard test was violated.[401] However, it will be unfair to judge a medical practitioner on the basis that he or she has violated the standard of reasonable care, without making reference or inquiry as to what really caused the medical practitioner to be negligent. This is due to the fact that medical negligence may occur despite the best intention and reasonable care provided by the medical practitioner,[402] all because of the environment and the realities in which medical practitioners often find themselves. These realities cannot be ignored but need to be taken into consideration.[403] The institutional weaknesses in public hospitals, which include maladministration, poor management due to the constraints caused by lack of

397 Crosby 2007 (54) *CJA* 228.

398 Gomez JC "Silencing the hired guns: Ensuring honesty in medical testimony" 2005 (26) *J Leg Med* 385.

399 Gomez 2005 (26) *J Leg Med* 386.

400 Haeck and Gorney *Risk, Liability and Malpractice What Every Plastic Surgeon Needs to Know* 134.

401 Schwikkard and Van der Merwe *Principles of Evidence* 2nded 92.

402 Reason J "Human error: models and management" 2000 (320) *BMJ* 768.

403 McQuoid-Mason D "Establishing liability for harm caused to patients in a resource deficient environment" 2010 (100) *SAMJ* 574.

resources, fewer infrastructures and human resource development all play a critical role on the overall performance of medical practitioners in administering health services to patients.[404] Based on the administrative challenges which medical practitioners face on a daily basis, it is clear that the solution to reduce high litigation claims in public health care lies with fixing the administration aspect and making it functional in order to avert the high rise of medical negligence claims. In most cases, the defendant will try and rebut the evidence but in order to succeed, he or she will also need one or more expert witnesses in the same league as those acting for the plaintiff.[405]

In South Africa, expert witnesses are being used on a daily basis, and many play a key role in producing hard and conclusive evidence that practitioners, especially in the medical field, acted negligently and inflicted unnecessary suffering on their clients.[406] The *Castell v De Greef* case,[407] is a classic example of how expert witnesses can bring a case to a well-justified conclusion, because the expert witness showed that indeed the defendant surgeon was negligent when he or she was performing surgery on the plaintiff.[408] It is necessary to point out that the rise of medical negligence claims in South Africa against medical practitioners reveals a need for guidelines, standards, training and the accreditation of expert witnesses, which is currently the position in countries such as the United Kingdom and the United States of America.[409] The ideal situation would be for an independent expert witness to jointly advise the two parties to the case on specialised medical matters in order to assist the court to arrive at a just decision which is in the interests of justice.[410] However, expert witnesses are usually contracted by one of the parties to the case and often caught in the middle of the two opposing views to the case. These circumstances may diminish the objectiveness and professionalism of expert witnesses as this will result in expert

404 McQuoid-Mason 2010 (100) *SAMJ* 575.

405 Keith DL "Medical Expert Testimony in Texas Medical Malpractice Cases" 1991 (1) *BLR* 5.

406 Keith 1991 (1) *BLR* 6.

407 *Castell v De Greef* 1994 (1) SA 408 (C).

408 *Castell v De Greef* case 408.

409 Scharf GM *The Medico-Legal Pitfalls of the Medical Expert Witness* 85 (LLM dissertation, University of South Africa 2014).

410 Scharf *The Medico-Legal Pitfalls of the Medical Expert Witness* 86.

witnesses becoming bias.[411] This is the major problem which typically results in expert witnesses being sued for providing incorrect or misleading evidence in court.[412] Some of the other problems which are experienced in the exercise of involving expert witnesses are briefly discussed in the subsequent paragraphs.

6.10.3 Negative aspects affecting the role of the expert witness

6.10.3.1 Professionalism and bias

Owing to the role which expert witnesses play in relation to being on the side of the party that has called him or her to testify in court, expert witnesses are now called "jukeboxes" because they sing the tunes that they are paid to sing and thereby compromise the standard of their profession.[413] This is unfortunate as the role of expert witnesses now contrarily diminishes their professions as this activity is encouraged by attorneys who call these expert witnesses to testify in court.[414] Attorneys currently work in an adversarial way and look to assert the tier of facts with the most articulate, understandable, presentable and persuasive expert, rather than the best scientist available in order to meet the interests of justice.[415] This type of conduct is totally in contrast to science, which requires an expert to focus solely on the evidence without the influence of the parties' goal regarding the case at issue, and this type of conduct on the part of expert witness is known as the "hired gun" practice which is not in the interests of the administration of justice.[416]

6.10.3.2 Financial encumbrances

Another challenge which is currently being experienced in practice is that expert witnesses no longer show interest in coming to court to give testimony due to the inconvenience which comes with giving testimony in court. This includes that it is time consuming to prepare for a trial and results in a detrimental financial loss for the

411 Scharf *The Medico-Legal Pitfalls of the Medical Expert Witness* 87.

412 Gomez 2005 (26*) J Leg Med* 387.

413 Gomez 2005 (26*) J Leg Med* 388.

414 Gomez 2005 (26*) J Leg Med* 389.

415 Jensen EG "When "hired guns" backfire: The witness immunity doctrine and the negligent expert witness" 1993 (65) UMKC *Law Rev* 185.

416 Jensen 1993 (65) UMKC *Law Rev* 186.

practitioner concerned.[417] An expert witness is provided with a subsistence allowance for loss of income to the amount of R1500, as determined by the Minister of Justice and Correctional Services from time to time.[418] This amount is not in line with the income of the expert witness, which will result in the expert witness experiencing a loss of income due to giving testimony in court.

6.10.3.3 Unpleasantness of cross-examination

The vigorous nature of cross examination procedure in court, which is confrontational and robust, is one of the leading factors that make expert witnesses not show an interest in giving testimony in court. This can be attributed to the fact that most expert witnesses cannot handle the pressure which comes with cross examination. Yet, it is mainly the duty of the legal practitioner who calls the expert witness to prepare him or her for cross examination.[419] However, due to the dynamics of practice it can be argued that a legal practitioner who called the expert witness cannot prepare him or her for everything which may take place in court, because the opposing party can take a different direction in emphasising their point and in order to show the weaknesses of the expert witness.

The abovementioned factors leave aggrieved patients with a problem because they are unable to prove medical negligence claims on their own, due to the technical nature of medicine.[420] Furthermore, the courts are said to believe that the unavailability of expert witnesses is due to a form of a conspiracy between medical practitioners to the effect that they will remain silent and not testify against each other in court.[421] For

---

417 Oosthuizen WT and Carstens PA "Re-evaluating medical malpractice: A patient safety approach" 2015 (78) *THRHR* 387.

418 GN 394 Government Gazette 30953 of 11 April 2008.

419 Strauss 1967 (26) *SALJ* 420.

420 Oosthuizen and Carstens 2015 (78) *THRHR* 388.

421 Oosthuizen and Carstens 2015 (78) *THRHR* 388. Further, as a mechanism to encourage the availability of expert witnesses in court, Hookman proposes the report of the expert witness can be discussed with the expert witness of the defence team before the trial and this can take place when the exchange of discovery takes place between the parties. This will result in better preparation on the part of expert witnesses, and the testimony in court will be much faster and effective. An undertaking of this nature and assurance by legal practitioners can serve as an aid to resolve or break down the conspiracy silence which medical practitioners have assumed, and it will be in the interests of the administration of justice to ensure the availability of expert witnesses. See Hookman *Medical Malpractice Expert Witnessing* 258.

courts to resolve medical malpractice cases and other cases which involve specialised skill, our legal system and compensation system must be reformed in such a way that the interests of expert witnesses are taken into consideration. Taking care to properly accommodate expert witnesses will undoubtedly be in the interests of the administration of justice, because it will allow for the claims of patients to be easily and speedily resolved by the courts. This is because, among other factors which could result in a delay in court proceedings, there would be no reason to add onto that delay due to the unavailability of expert witnesses for a particular case.

6.11 Compensation

6.11.1 Introduction

Once the patient-plaintiff has proven that the defendant oncologist was negligent while performing the medical intervention, the plaintiff is entitled to relief in the form of compensation paid by the defendant.[422] The amount of compensation that a patient who has suffered injury or loss at the hands of a negligent oncologist can claim will be discussed in this section of the study.

Compensation becomes payable once a patient, who is also the plaintiff in a civil case, has successfully proved all the elements that evidence an oncologist's negligence and, further, that he or she has actually suffered injury or loss as a result of such negligence.[423] In the sections below, we will explore the meaning of compensation, its origins and fundamental purpose. The various forms of loss that a patient or plaintiff can suffer at the hands of an oncologist will also be considered. Unfortunately, the upsurge in the number of claims for medical compensation in South Africa has given rise to a culture in which patients are increasingly seeing opportunities for making money, even when their justification for doing so is weak.[424] This trend as well as the duty of government to discourage such a culture in the interests of a dynamic and world class health sector will be addressed in this section.

---

422 Oosthuizen and Carstens 2015 (78) *THRHR* 388.

423 Powers MJ and Harris NH *Medical Negligence* 2nded 416 (Butterworths, United Kingdom 1994).

424 Frederick SL "*Pain and Suffering Guidelines: A Cure for Damages Measurement "Anomie,"* 1989 (22) *MICJR* 330.

6.11.2 Definition of compensation

The word compensation is derived from the Latin term *compensare* which means to weigh together.[425] It denotes a careful balancing of all the factors arising from a particular dispute, and the determination of a fair formula to help offset the loss of the affected party.[426]

Compensation generally involves one party making a payment to the other that is commensurate with the loss or damage which the latter experienced.[427] It is designed to counter balance the loss that the one party suffered due to the failure of the other party.[428] Compensation need not only be of a financial nature, it can be some other form of redress that succeeds in highlighting the wrongdoing of a negligent or criminal party, and restores the image and reputation of the party whose rights and dignity were compromised.[429]

In cancer surgery-related disputes, a patient or plaintiff who suffers at the hands of a negligent oncologist or surgeon may receive compensation. This is aimed at restoring him or her to the position which he or she would have been in had there been no negligence.[430] Even though the compensation may manifest as an amount of money being paid over, it is also an acknowledgement on the part of the oncologist of his or her negligence or wrongdoing and the fact that he or she must take responsibility for his or her own actions.[431]

In medical law, a claim for compensation is a claim of personal injury.[432] Such a claim can be brought by any person who suffers harm due to the negligence of a medical practitioner.[433] In the case of a minor, the parents or guardian can bring a claim on the

---

425 Frederick 1989 (22) *MICJR* 331.

426 Powers and Harris *Medical Negligence* 2nded 417.

427 Radin MJ "Compensation and Commensurability" 1993 (43) *JSTOR* 56.

428 Hawkins JM *The Oxford Senior Dictionary* 121 (Oxford University Press, Britain 1987).

429 Radin 1993 (43) *JSTOR* 57.

430 Radin 1993 (43) *JSTOR* 57.

431 Bag RK *Law of Medical Negligence and Compensation* 2nd ed 313 (Eastern Law House, New Delhi 2001).

432 Bag *Law of Medical Negligence and Compensation* 2nd ed 314.

433 Pandit MS "Medical negligence: Coverage of the profession, duties, ethics, case law, and enlightened defense - A legal perspective" 2009 (25) *IJU* 372.

minor's behalf. If the injuries sustained are so severe as to cause the death of the patient, the executor of the deceased person's estate can initiate the claim for compensation.[434] Even people who suffer from mental illness can be represented in a claim for compensation by a curator or family member.[435] It is important to remember that whereas there may be overwhelming evidence that an oncologist acted negligently, if it cannot be established that the patient or the plaintiff suffered loss or damage as a result of that negligence, any claim for compensation would be invalid.[436]

6.11.3 The purpose of compensation

In the eyes of the law, compensation has two main objectives: firstly, it serves the interests of the party who suffered injury or loss by forcing the wrongdoer to pay him or her, a sum of money as damages to enable the aggrieved party to continue with his or her life in the best way possible.[437] Secondly, it promotes and advocates for fairness and justice by ensuring that the party who inflicted harm on another bears the full weight of what he or she has done.[438]

As an oncologist's negligence can put limitations on someone's ability to enjoy or lead a productive life, compensation helps to fill the gap in the person's ability to earn an income, carry out professional and family duties, and act in the capacity which he or she was born with.[439] The trauma experienced by a patient at the hands of a negligent oncologist can be very severe. For example, the need for corrective surgery can be just as distressing as the initial surgical procedure because it is risky and there is no guarantee of success at the end of the day.[440] In fact, corrective surgery may even produce new complications. Trauma has both a physical and a psychological dimension to it, and the nature and amount of compensation awarded should account for this.[441]

---

434 Pandit 2009 (25) *IJU* 373.

435 Pandit 2009 (25) *IJU* 374.

436 Bag *Law of Medical Negligence and Compensation* 2nd ed 315.

437 Barrister PB *Compensation for Personal Injuries* 3 (Oxford University Press, New York 2002).

438 Barrister *Compensation for Personal Injuries* 4.

439 Clellan FM *Medical Malpractice: Law, Tactics, and Ethics* 117 (Temple University Press, Philadelphia 1994).

440 Clellan *Medical Malpractice: Law, Tactics, and Ethics* 118.

441 Clellan *Medical Malpractice: Law, Tactics, and Ethics* 119.

Compensation features strongly in the law of contract and offers a solution for a breach of contract by restoring the party that experienced loss or damage to the financial position which he or she would have been in, had the breach not occurred.[442] In medical negligence cases, however, financial compensation may be a poor substitute for the loss of a limb or mobility or even life.[443] Since emotions get stirred up in cases of this nature, a plaintiff may well conclude that the compensation offered is hopelessly inadequate.[444] At least the compensation mechanism ensures that a defendant oncologist does not get away with negligence without being punished or without being held accountable for his or her negligent acts, as this offers a painful reminder of his or her sub-standard conduct.

If a plaintiff is dissatisfied with the compensation which he or she is offered by the courts, he or she could also lodge a complaint with the HPCSA to initiate independent disciplinary proceedings against the negligent oncologist.[445] If the HPCSA finds the said oncologist guilty of negligence, it can order the oncologist to pay a fine or even strike him or her off the roll of oncologists.[446] This is evident from the fact that the HPCSA has issued 283 fines to medical practitioners, and in the process suspended 137 of them for misconduct.[447] Medical practitioners are increasingly playing a role when it comes to the insufficient care and mismanagement of patients. The incompetence of medical practitioners has become a serious problem.[448] Over and above going the compensation route, another way of bringing pressure on the negligent oncologist to bear the consequences of his or her actions is to initiate a

---

442 Carroll R *Civil Remedies: Issues and Developments* 93 (The Federation Press, Sydney 1996).

443 Carroll Civil *Remedies: Issues and Developments* 94.

444 Scott The *General Practitioner and The Law of Negligence* 256.

445 HPCSA Complaint Procedure http://www.hpcsa.co.za/conduct_complaint.php (Date of use: 20 July 2012).

446 HPCSA Complaint Procedure http://www.hpcsa.co.za/conduct_complaint.php (Date of use: 20 July 2012).

447 Health Professions Council of South Africa: Annual Report 2010-2011 27.

448 Health Professions Council of South Africa: Annual Report 2011 33. Further, it is important to note that the Registrar of the HPCSA acknowledged in this report that medical errors through the negligence of medical practitioners is worrying and a call for concern. This has resulted in both the HPCSA and the Department of Health forming an alliance with the aim of investigating these claims as well as ensuring that medical negligence claims are reduced in the process. For example, in March 2012 the HPCSA was on a national drive of bringing awareness to both medical practitioners and patients about their rights and duties, and how they can be able to work together as partners in the health sector.

criminal case, accusing the oncologist or surgeon of assault.[449] Such a complaint may be brought with a supporting claim that the medical practitioner acted in contravention of section 10 of the Constitution which states that everyone has inherent dignity and the right to have their dignity respected and protected under the law.[450]

To succeed in a criminal case alleging assault, the complainant must prove three things: the act of application of force by the accused, the unlawfulness of the act (i.e. there were no grounds to justify the way the accused acted), and lastly, intention, which indicates that the accused aimed to cause harm to the complainant.[451] Once the state has proved all the elements of the crime of assault beyond a reasonable doubt, the accused will be convicted of assault and sentenced to a fine or imprisonment in line with the severity of the case.

6.11.4 Types of compensation a plaintiff can receive on proof of medical negligence

The types of loss that a victim of medical negligence can experience vary. Apart from a compromised physical state following a surgical procedure, the plaintiff might suffer economic loss. For example, the loss of a job or ability to earn money from a productive endeavour, and coupled with having to foot the bill for follow-up medical procedures or treatment probably for years into the future.[452] He or she might also experience a loss of confidence or desire to interact with people, which would be a sign of emotional or psychological distress.[453] It is important to establish as precisely as possible the nature of the loss so that the courts can work out a fair amount for compensation. There are two forms of compensation, also known as damages: general damages and special damages.[454] Each type of compensation is associated with particular forms of injury or loss.

6.11.4.1 General damages

---

449 Anderson J and Heath M *Criminal Law Guidebook* 93-100 (Oxford University Press, Australia 2010).

450 Section 10 of the Constitution of the Republic of South Africa, 1996.

451 Anderson and Heath *Criminal Law Guidebook* 98.

452 Mau SD *Hong Kong Legal Principles: Important Topics for Students and Professionals* 2nd ed 246 (Hong Kong University Press 2013).

453 Mau *Hong Kong Legal Principles: Important Topics for Students and Professionals* 2nd ed 247.

454 Mau *Hong Kong Legal Principles: Important Topics for Students and Professionals* 2nd ed 248.

General damages (also referred to as intrinsic damage) are the damages that a patient claims for pain, suffering and a loss of amenity to which a specific financial value cannot be attached.[455] General damages also cover physical disability resulting from the oncologist's negligence, such as the loss of a breast following surgery.[456] General damages are considered to be a form of non-economic damages because no precise financial value can be given to this kind of loss, suffering or impairment.[457]

General damages are difficult to determine because they do not flow from measurable forms of loss.[458] English courts adopted an approach of granting a plaintiff who was seeking general damages a conventional sum of money because of the impossibility of accurately arriving at an award for pain, loss and suffering as it was decided in the case of *H West & Sons Ltd v Shephard*.[459] It is for this reason that general damages are seen to revolve around non-pecuniary loss.[460] This view was confirmed in *Media 24 Ltd v SA Taxi Securitisation (Pty) Ltd*,[461] where the issue in dispute related to the publication of defamatory information. In this case the court held that a distinction between general and special damages is used for practical purposes and general damages can amount to non-patrimonial loss in most cases.[462] In this case, the defendant defamed the plaintiff entity by publishing false information about the latter, and this constituted general damages because the plaintiff was a corporation and suffered non-patrimonial loss due to the defamatory publication.[463]

In the case of *Wright v British Railways Board*,[464] it was decided that any figure arrived at in the form of compensatory general damages would be artificial.[465] Thus if the aim is to mete out justice in a reasonable manner, without the plaintiff making excessive

---

455 Scott *The General Practitioner and the Law of Negligence* 256.

456 Scott *The General Practitioner and the Law of Negligence* 256.

457 Morissette EL *Personal Injury and the Law of Torts for Paralegals* 61 (Aspen Publishers, New York 2009).

458 Morissette *Personal Injury and the Law of Torts for Paralegals* 62.

459 *H West & Sons Ltd v Shephard* [1964] AC 326.

460 *H West & Sons Ltd v Shephard* case 310.

461 *Media 24 Ltd v SA Taxi Securitisation (Pty) Ltd* 2011 (5) SA 329 (SCA).

462 *Media 24 Ltd v SA Taxi Securitisation (Pty) Ltd* case 329.

463 *Media 24 Ltd v SA Taxi Securitisation (Pty) Ltd* case 330.

464 *Wright v British Railways Board* [1983] 2 AC.

465 *Wright v British Railways Board* case 2.

demands, the figure must be based on experience and the awards given in comparable cases.[466] At the same time, the courts need to exercise care and skill in ensuring that the plaintiff is fully compensated for his or her loss, in its many dimensions. The use of expert witnesses, such as psychologists, can help the court to understand the extent to which the plaintiff has suffered psychologically and thus determine the best way to tackle the issue of compensation.[467]

6.11.4.2 Special damages

Special damages (also referred to as extrinsic damage) are defined as compensatory damages that are specific to the individual plaintiff.[468] Unlike general damages which are not based on true economic value, special damages include medical expenses, loss of wages and patrimonial loss.[469] Special damages must be specifically pleaded and proper justification must be given thereto.[470] This is in contrast to general damages which need not be specifically pleaded as they are presumed by law.[471]

Special damages arise from pecuniary loss and are the consequence of a plaintiff having suffered at the hands of a negligent surgeon.[472] Special damages are more easily assigned monetary value than general damages because the harm or loss that they are designed to compensate is easier to measure.[473] The issue of special damage was discussed in the case of *Shatz Investment (Pty) Ltd v Kalovyrnas*,[474] where a farmer contracted the defendant as a service provider to repair a tractor for the farmer, who was the plaintiff in this case. The plaintiff informed the defendant that he needed the tractor in time to plough his fields to prepare for the rainy season.[475] The defendant failed to deliver the tractor on time and the plaintiff lost his harvest due

---

466 Powers and Harris *Medical Negligence* 2nd ed 415.

467 Newman R "The role of the Psychologist expert witness: Provider of Perspective and Input" 1992 (2) *Neuropsychological Review* 243-244.

468 Stark TL *Negotiating and Drafting contract Boilerplate* 266 (ALM Publishing, New York 2003).

469 Stark Negotiating *and Drafting Contract Boilerplate* 267.

470 Okrent CJ *Torts and Personality Law* 4thed 53 (Delmar Cengage Learning, New York 2010).

471 Okrent *Torts and Personality Law* 4thed 54.

472 Berman P and Berman S *Represent Yourself in Court: How to Prepare and Try a Winning Case* 7thed 62 (Nolo Publishers, New York 2010).

473 Berman and Berman *Represent Yourself in Court: How to Prepare and Try a Winning Case* 7thed 63.

474 *Shatz Investment (pty) Ltd v Kalovyrnas* 1976 (2) SA 545 (A).

475 *Shatz Investment (pty) Ltd v Kalovyrnas* case 545.

to the failure of the defendant. The court held that the loss that suffered by the plaintiff constituted special damages and the defendant was liable for breach of contract as he failed to deliver the tractor on time.[476] Further, the issue of special damage was discussed in thcase of *Dhlomo v Natal Newspapers*,[477] in which it was held that it is very important to draw a distinction between general and special damages in order for the court to provide appropriate relief.[478] In this case, the claim was for defamation of a juristic person based on the publication of defamatory information. The court held that injury to the reputation of a company constituted general damages, and that loss of profit due to the defamatory allegations constituted special damages based on the facts of the case.[479]

6.11.5 The rise of compensation claims in medical negligence cases

There has been a dramatic rise in the number of claims for compensation for medical negligence. [480] This signals the emergence of compensation culture that is characterised by more and more people seeking compensation from medical practitioners, even when their complaints do not justify a claim for damages.[481] While the pursuit of compensation is an attractive concept for many people, it also conjures up pictures of greedy and irresponsible lawyers who are instituting claims on behalf of their clients against a growing pool of medical practitioners having to defend themselves against this legal onslaught.[482] To the contrary, it can be argued that such cynicism is misplaced because lawyers do not devise laws, they interpret and apply them. Consequently, they would only put in a compensation claim if they believed that they had a sufficiently solid case that was likely to have a successful outcome.[483]

Furthermore, the increase in medical negligence claims is attributed to the fact that there is a drop of professionalism on the part of medical practitioners, when dealing with patients. Although there are different views when it comes to this fact, the HPCSA

476 *Shatz Investment (pty) Ltd v Kalovyrnas* case 546.
477 *Dhlomo v Natal Newspapers* 1989 (1) SA 945 (A).
478 *Dhlomo v Natal Newspapers* case 945.
479 *Dhlomo v Natal Newspapers* case 946.
480 Wardrop M "The NHS faces a £15.7 billion bill to settle a rising number of clinical negligence claims" 2012 (7) *The Telegraph* 1.
481 News "Doctors lose patience as suits spike" 2012 (2) *City Press* 1-3.
482 http://www.collinsattorneys.com/lawyer-attorney-1448126.html (Date of use: 28 March 2015).
483 Barrister Compensation *for Personal Injuries* 2.

has confirmed this drop on the part of medical practitioners.[484] Patients are now aware of their rights and the possibility enforcing their rights through litigation, which is what lawyers need in order to grow their practice and to claim relief for harm that the patient has suffered.[485] Development in our law has also contributed towards the rise of medical negligence claims, because legislation and case law is now patient centred in such a way that the interests and rights of patients are clearly entrenched and protected in our law and defend the autonomy of the patient.[486]

In South Africa, too, the number of claims being made against negligent medical practitioners is steadily rising.[487] In fact, the growth in medical negligence cases is roughly 10 times the economic growth rate of the country.[488] For example, to indicate the rise of medical negligence claims in our law, the Gauteng Department of Health faced claims to the amount of R1.28 billion during the 2012/2013 financial year, which was an increase up from the R573 million during the 2009/2010 financial year.[489] Most disputes that have ended up in litigation are linked to gynaecological and obstetric procedures.[490] The incidence of claims against oncologists is currently quite low.[491]

---

484 Jordaan E and Ismail R "Appeal Court Sets the Record Straight" 2014 (11) *Without Prejudice* 24.

485 Jordaan and Ismail 2014 (11) *Without Prejudice* 25.

486 For example the Constitution of the Republic of South Africa, 1996, the National Health Act 61 of 2003, and recently the Consumer Protection Act 68 of 2008. All these statutes contain provisions which aim to protect the user of services, (including health services) which in this context which is the patient. Further, The Children's Act 38 of 2005 empowers children to take independent decisions regarding their health, provided that certain requirements are met. The Mental Health Care Act 17 of 2002 contains a patient's charter that *inter alia* states that a patient is entitled to be informed of his or her rights. The new Protection of Personal Information Act 4 of 2013 may also impact on the way that health care providers do business, how medical practitioners handle confidential information of patients and ensure that the right to privacy of patients is not violated.

487 Malherbe J “Counting the cost: The consequences of increased medical malpractice litigation in South Africa” 2013 (103) *SAMJ* 1-3.

488 Malherbe 2013 (103) *SAMJ* 1.

489 Oosthuizen and Carstens 2015 (78) *THRHR* 369. Further, according to the Medical Protection Society (MPS) which serves as a medical insurance scheme for health practitioners, the scheme has paid the highest claim for medical negligence in 2014 which amounted to R24 million emanating from one case. This was the highest claim this body had to settle and the head of the MPSA argued that the disadvantage of such high claims is that medical practitioners are shying away from specialising in certain field to avoid litigation. Such practice by medical practitioners will also adversely affect patients because they will be a shortage of qualified medical practitioners as a result and patients will not receive adequate health care. See Dhai E “Medico-legal litigation: Balancing spiralling costs with fair compensation” 2015 (8) *SAJBL* 2.

490 Clements RV “Risk Management and Litigation in Obstetrics and Gynaecology” 2002 (12) *JRSM* 625.

491 Clements 2002 (12) *JRSM* 626.

However, when cancer cases do make it to court, the monetary value of claims is often very high indeed.[492]

The compensation culture is just as noticeable in the United Kingdom and other countries as it is in South Africa.[493] Many people rather foolishly pursue compensation to make quick money without taking the merits of their case into account.[494] Former British Prime Minister, Tony Blair, openly denied the existence of a compensation culture in the UK, particularly in the health sector. Following his remarks, reports came out revealing that litigation for medical negligence was actually on the rise which flew in the face of the message which Blair was trying to convey.[495] Unfortunately, an unbridled compensation culture gives the whole notion of compensation, particularly in the medical field, a bad name, as it gives the impression that those seeking compensation are only motivated by greed.[496] It also overshadows the true purpose of compensation, which is to give redress to those who have been injured at the hands of others.[497]

The Canadians are particularly enthusiastic when it comes to instituting actions against medical practitioners. In a study conducted in Canada it was found that seventy one per cent of those who bring claims for compensation are women, which is not surprising as women are more likely to feel dissatisfied with the outcome of surgical procedures, and are often the most victims of misdiagnosis.[498]

Medical practitioners in Brazil are also feeling the heat from medical negligence claimants because these practitioners have to carry the cost of lawsuits and provide compensation to plaintiffs if they succeed with their claims.[499] One way for the

---

492 Pepper MS and Slabbert MN "Is South Africa on the verge of a medical malpractice litigation storm?" 2011 (4) *SAJBL* 29.

493 Pepper and Slabbert 2011 (4) *SAJBL* 30.

494 Blair T "Tony Blair's speech on compensation culture" 2005 *The Guardian* 1-3.

495 Blair 2005 *The Guardian* 4.

496 Harpwood V *Medicine, Malpractice and Misapprehensions* 181 (Routledge Cavendish, Britain 2007).

497 Harpwood *Medicine, Malpractice and Misapprehensions* 182.

498 Callaghan WB "Professional liability of plastic surgeons in Canada" 1997 (5) *CJPS* 230-231.

499 Da Silva DB "The Increasing Growth of Plastic Surgery Lawsuits in Brazil" 2010 (34) *APS* 541.

oncologists to reduce their medical liability is to offer to perform the corrective surgeries that are often necessary following an unsatisfactory initial procedure.[500] Oncologists might also try and reach an out-of-court settlement with the plaintiff which could trim the eventual cost of the case and make for a quicker solution than would be possible if the matter was only heard in the courts.[501]

In South Africa, it is commonly wealthy people who are able to meet hefty legal fees if need be, that are mainly involved in lodging medical negligence claims.[502] The rise in this sort of litigation is largely attributed to a growing body of people who know their rights and have the means to defend themselves from a legal point of view. They are also the ones who tend to succeed in their claims.[503] These days it is less about medical practitioners being negligent than it is about patients becoming increasingly demanding and vocal about their rights.[504] The South African government has been called on to intervene and devise suitable legislation that would regulate how compensation is determined as claims against state-owned medical facilities are running into millions of rand every year, dealing a big blow to already over-burdened state coffers.[505] Another way of keeping costs in check would be for medical practitioners and their patients to opt for mediation and arbitration rather than drawn out, expensive court proceedings.[506] This could be managed through the establishment of a statutory national litigation authority or council where litigation claims could be considered in some cases and settled through alternative dispute resolution processes such as mediation and arbitration, among other reliefs which are available through this process.

The rising incidence of medical negligence claims is weighing heavily on the minds and pockets of the medical profession itself.[507] Surgeons, for example, who have

---

500 Da Silva 2010 (34) *APS* 542.

501 Da Silva 2010 (34) *APS* 543.

502 Kaersvang D "Equality in South Africa: Legal access for the Poor" 2008 (15) The *Journal of the International Institute* 1.

503 Kaersvang 2008 (15) The *Journal of the International Institute* 2.

504 Neligan PC and Gurtner GC Plastic *Surgery: Principles* 52 (Elsevier Publishers, Illinois 2012).

505 Bateman C "Payouts Against Doctors Spiralling Upwards" 2005 (95) *SAMJ* 376.

506 Bateman 2005 (95) *SAMJ* 377.

507 Bateman 2005 (95) *SAMJ* 378.

excellent reputations and blemish-free records, are nevertheless experiencing some collective reputational damage.[508] Others are practising defensive medicine to reduce the risk of claims, with some succumbing to feelings of anxiety and anger, none of which is good for the doctor-patient relationship and for the consistency of good work in the operating theatre.[509] However, it is important to note that defensive medicine practiced by medical practitioners has dire consequences on patients because it affects the quality of care and the utilization of resources which results in inferior health care being administered to patients, for example the misdiagnosis of persons living with cancer.[510] Based on this view, it is clear that one can argue that defensive medicine which medical practitioners often practice to avoid being sued for medical malpractice is an elusive concept, because one medical practitioner's defensive medicine may be another's careful medicine which forms part of his or her daily routine as a medical practitioner.[511]

6.12 Conclusion

With so many variables at stake when setting out to determine negligence, it is important for a plaintiff to have a strong legal team and, if necessary, expert testimony. Medical practitioners, in turn, need to take the necessary precautions to ensure that patient disappointments do not escalate into full-blown cases which could put practitioners' reputations at risk and expose them to the unpleasant and expensive ramifications of civil and criminal claims, especially when unnecessary litigation with an aim to get financial compensation is becoming a problem in South Africa. Medical negligence claims are avoidable, especially in instances where there is foreseeability and preventability of damage.

508 Mavroforou A, Giannoukas A and Michalodimitrakis E "Medical Litigation in Cosmetic Plastic Surgery" 2004 (3) *ML* 479.

509 Mavroforou, Giannoukas and Michalodimitrakis 2004 (3) *ML* 480.

510 Barry MJ "Medical Malpractice Implications of PSA Testing for Early Detection of Prostate Cancer" 2008 (25) *J.L.Med & Ethics* 235.

511 Barry 2008 (25) *J.L.Med. & Ethics* 236.

Chapter 7: Recommendations and Conclusion

7.1 Summary: Overview of the chapters

The stigma and the myths that are informed by stereotypes and lack of information among other things, results in the violation of fundamental human rights of people living with cancer, as a result of the unfair discrimination that is being perpetuated due to the stigma and ignorance towards this medical condition. All of this happen despite a legal framework in place to protect, as well as to promote, fundamental rights for all people, including persons living with cancer. However, these legal provisions are not implemented effectively because insuffient protection is afforded to persons living with cancer.

Chapter one of the thesis addressed specific and general approaches in relation to the stigma, ignorance and culture surrounding cancer, and outlined how most, if not all of these stereotypes, are wrong and contrary to the fundamental rights of persons living with cancer. As pointed out in this chapter, cancer is mystified in the sense that it is regarded as a death sentence of a person living with it. This type of conduct towards persons living with cancer results in a violation of fundamental rights of persons living with the disease as briefly outlined in the chapter, and extended in detail further on in the thesis. Furthermore, this chapter set the scene for the development of the various themes in subsequent chapters, and mapped out the direction and structure of the thesis, including describing the context of the thesis.

The second chapter of the thesis explained the clinical and historical perspectives of cancer. This is attributed to the fact that the thesis is multi-disciplinary in nature, including the fact that a clinical and historical understanding of cancer is imperative for a comprehensive understanding of this medical condition, as well as to dispel the myths and stigma among other things. Different and common types of cancers were described, focusing on the leading causes of death, which included breast cancer, lung cancer, colorectal cancer, cervical cancer, prostate cancer, liver cancer and pancreatic cancer. Cancer is detected late in most instances due to various factors,

which includes stigma, denial and ignorance detrimental to the overall health of people living with cancer, which is of concern.

In light of the health and socio-economic position of persons living with cancer, chapter three of the thesis discussed the rights of persons living with cancer in order to participate in employment or trade context, as enshrined in the Constitution. Additionally, it has been extensively outlined that work or employment forms part and parcel of the healing process for persons living with cancer. This means that employment is one of the recommended therapeutic processes which persons living with cancer must not be denied, due to discrimination and ignorance which emanate from the stigma around cancer, on the part of employers and fellow employees. The chapter also examines the possibility of redress for unfair labour practices and unfair discrimination relating to cancer in terms of section 9 (3) of the Constitution. It is argued that unfair labour practices and discrimination redress is necessary for persons living with cancer. This should be possible on the basis of disability. Drawing from local and international case law and literature, it is submitted that persons living with cancer who are discriminated against because of their illness should be in a position to rely on and effectively exercise their fundamental rights, which include, amongst others, the right to choose their own occupation or trade, the right to equality, which prohibits unfair discrimination, based on a person's medical condition and disability. Despite the Constitutional provisions and protections as outlined, this chapter sketched the reality that persons living with cancer continue to suffer unfair discrimination in society, generally and specifically in the workplace, resulting in their exclusion from mainstream societal activities.

Chapter four of the thesis adopts a comparative approach by comparing legal provisions relating to the labour law context from different jurisdictions, notably South Africa, the United Kingdom and the United States of America. Both the United Kingdom and America have taken bold strides in accommodating employees living with cancer in the workplace, through the development of legislation such as the Equality Act in the United Kingdom, and the Americans with Disabilities Amendment Act in the United States. In both jurisdictions, cancer is recognised as a progressive medical condition, resulting in disability, which is unfortunately not yet the position in South Africa. The South African legislator could be guided by these foreign perspectives, where development of local legal instruments with the aim of

accommodating persons living with cancer are necessary to ensure an inclusive workplace. This is where persons from different backgrounds, gender, disability, race and culture meet to become one, bearing in mind the pluralistic nature of the South African community or society.

Chapter five of the thesis discussed the right of access to health care services as enshrined in the Constitution. One of the recommendations made in this chapter is that the South African government should implement proper legislative and budgetary measures to improve the progressive realisation of this right to persons living with cancer. This would include access to essential subsidised treatment, such as chemotherapy. The vicious cycle of societal stigma, ignorance and discrimination means that persons living with cancer are ashamed or reluctant to seek medical help, and even if they do, find themselves at the back of the queue for such services. Moreover, this chapter provided a discussion on the National Cancer Registry (NCR) towards the realisation of the right to health care services for persons living with cancer. This is because the NCR based on the information it receives and collects, has a duty to provide the government with information to plan accordingly to the treatment of cancer in the country. It was argued and recommended in this chapter that the information as supplied by the NCR needs to be updated regularly, without compromising the fundamental rights and privacy of patients. Since cancer is a complex and diverse medical condition as discussed above, this chapter also interrogated the role of civil society bodies who are involved in the fight against cancer, including the Cancer Association of South Africa (CANSA). The Cancer Association of South Africa (CANSA), which is a non-profit organisation striving to protect the rights and interests of persons living with cancer across the country. This is done by investing in research, raising awareness about cancer to different societies and workplaces across the country, as well as offering support through medical and psychological care to persons living with cancer, including their family members.

Chapter six explores the complex topic of medical negligence, particularly in relation to cancer. The evidentiary requirements relating to how medical negligence is determined in court with the assistance of expert witnesses was discussed. It was noted in the chapter that despite the important role which expert witnesses play in medical malpractice claims, currently, most expert witnesses are reluctant to come forward to testify due to the challenges of money, the nature of court procedures and

the administrative burden associated with preparing for trial. It was recommended that the Minister of Justice and Correctional Services should attempt to resolve the aspect of payment for expert witnesses, and the hostility of court proceedings must be discouraged in order to allow expert witnesses to come forward to testify in court. If no expert witnesses are willing to testify in court, it means that complex medical negligence cases cannot be resolved, resulting in a backlog of cases and the aggrieved party being denied proper relief in the administration of justice.

The chapter also touches on important legal principles which serve as aids to assist the unsophisticated plaintiff to discharge his or her onus of proof on a balance of probabilities such as the *res ipsa loquitur doctrine*, which means that the circumstances speaks for themselves. This doctrine was rejected in a number of cases in our law in the past,[1] but currently the correct position that has been adopted and is supported in the thesis is that this is an acceptable doctrine that does not discharge the onus of proof on the part of the plaintiff, as its detractors argued.[2] In actual fact, this doctrine aims to assist or aid the plaintiff to prove his or her case against the defendant who cannot provide a reasonable explanation about what really transpired in order for the plaintiff to be harmed during surgery.

The role of the Health Professions Council of South Africa (HPCSA) is also highlighted, because of its strategic role as the overall regulatory body for all medical specialists in South Africa. The HPCSA, as a regulatory body, aims to restore the reputation and dignity of the medical profession, and also aims to ensure that medical practitioners who bring the medical profession to disrepute are disciplined accordingly. Nonetheless, patients can seek other forms of relief against the negligent medical practitioner, which include instituting either a civil or a criminal claim. This chapter also referred to compensation as a means of bringing relief to those who have suffered at the hands of negligent medical practitioners. Although it is sometimes difficult to quantify when the nature of the loss relates to general pain and suffering,

---

1 This doctrine was rejected was in the *Van Wyk v Lewis* case 438, which has been dealt with extensively in this thesis.
In both the cases of *Lungile Ntsele v MEC for Health, Gauteng Provincial Government* case 356 and *Cecilia Goliath v Member of the Executive Council for Health Eastern Cape* case 182 the importance of this doctrine was discussed and has also been highlighted extensively in this thesis.

compensation goes some way towards putting the lives of victims of medical malpractice back on track and helping them to face the future with more enthusiasm.

Unfortunately, the aspect of compensation has become tainted through the growth of a compensation culture led by those who are determined to cash in on the negative experiences of those at the hands of medical practitioners. The problem with this compensation culture is that it discourages medical practitioners from giving their patients better health care, resulting in the rise of the practice of defensive medicine. Furthermore, this culture of compensation defeats the main aim of compensation, which is to restore or rehabilitate the injured party, because people who do not have legitimate claims tend to want to seek relief in the form of compensation. Finally, chapter seven presents the conclusion and recommendations of the study.

7.2 Recommendations

The thesis makes the following recommendations.

7.2.1 Recommendations for legal reform towards the protection of persons living with cancer

The current legal framework in South Africa should be optimally used to protect persons living with cancer from unfair discrimination, and other social ills which come with this disease, and affecting those suffering from it. This can only be done if the law is given a progressive interpretation, consistent with international standards and obligations, seeing that South Africa is signatory to certain international instruments and organisations, which encourage progressive change and protection of fundamental rights, such as the International Labour Organisation (ILO),[3] amongst others. The advantages of a reformed legal system, which protects the rights of persons living with cancer, cannot be overstated. This will require, amongst others,

[3] South Africa was re-admitted as a party to the International Labour Organisation (ILO) in 1994 and withdrew its membership in 1964 due to political pressure to end apartheid. This means South Africa, spent approximately 30 years in isolation from the international labour organisation, but with the advent of democracy all of this came to an end, because South Africa was readmitted to the ILO again in order to champion for the interests of all workers on a global scale. See International Labour Organisation http://www.dirco.gov.za/foreign/Multilateral/inter/ilo.htm (Date of use: 6 October 2016).

the implementation of provisions in terms of which cancer is recognised as a progressive condition, which can lead to a disability depending on the facts of each case. Currently, cancer is not recognised as a disability, despite its effect being similar to diseases like HIV and AIDS to a lesser or greater extent.

The cancer epidemic is not merely a national problem but a global one that cannot be addressed by relying on legal rules only. Cancer is a disease that has been in existence for centuries but its effect is increasingly felt in the modern world, as it is spreading daily and claiming the lives of millions of people. This reality amplifies the argument that cancer regulation requires more than just legal rules and instruments to ensure and provide the framework for the protection of persons living with cancer. This point leads to the discussion of the second recommendation of the thesis.

7.2.2 Recommendations with respect to cancer and disability in the context of the Social Assistance Grant

Taking into account the complexity of the medical and means tests for accessing and determining disability grants under the Social Assistance Act, the thesis recommends that government should consider implementing and providing a chronic disease grant. This will benefit persons living with cancer, who in most cases find themselves without an income. Such a grant would also help people who suffer from different chronic diseases to have funds and in turn to improve their health care and well-being.

7.2.3 Recommendations for increased awareness and education about cancer in society and the workplace

Awareness and educational campaigns through various mediums for example, radio, television and newspapers are required to bring to an end the superstitious beliefs, ignorance and stigma that is attached to cancer. Due to the diversity of the South African community with different cultural backgrounds and beliefs, the task of raising awareness about cancer is not an easy task. A substantial and robust educational campaign aimed at behaviour change is essential in order to address society's lack of knowledge and to eliminate the stigma that cancer is a death sentence. The educational campaign about cancer should adopt both a formal and an informal approach with the aim of ensuring that all members of society are reached and informed. The successful transformation of society rests on the acknowledgement that persons living with cancer are part of our society, and that cancer can be cured.

Engagements through the media and public dialogues will raise consciousness regarding cancer amongst the public, and ensure that all the stigmas in relation to cancer be dispelled, and persons living with cancer are accommodated both in society as well as in the workplace. In fact, this endeavour requires innovative and novel approaches and other methodologies that can be assembled through the research and development of a cancer study.

7.2.4 Recommendations on discriminatory conduct relating to persons living with cancer

Government is required to explore and find opportunities to review and amend existing laws in order to address the predicaments facing persons living with cancer. If government is to tackle the issue of unfair discrimination against persons living with cancer effectively, it needs to take focused action to ensure the effective implementation of equality and anti-discriminatory laws. This thesis submits that historically, persons living with cancer have always found themselves at a disadvantage in society and that a time has come for proactive measures to attend to the challenges facing this very specific and unique group of people. It is recommended in the thesis that equal access to socio-economic and political opportunities for persons living with cancer will, over time, serve to lessen the myths, stereotypes and other false notions that surround cancer.

7.2.5 Recommendations relating to the access to health care needs of persons living with cancer

The aggressive and dangerous nature of cancer as outlined in the thesis resulting in the deaths of millions of people is a call for concern. The right to access to health care services is constitutionally enshrined, and if implemented effectively can reduce the number of people losing their lives due to cancer. This thesis recommends that persons living with cancer should take the first step as a collective and approach the court to challenge government's failure to progressively realise their right to access to health care services by neglecting to provide treatment, such as chemotherapy, among other health treatments. Although one may argue that persons living with cancer are no different from other classes of people with other chronic health conditions such as diabetics, the thesis submits that other chronic health conditions are not subjected to the same stigma and ignorance such as cancer, which makes the

lives of persons living with cancer almost unbearable. The stigmatisation of and discrimination against persons living with HIV are not as those relating to persons living with cancer, who have special needs such as focused counselling and therapy due to the detrimental effect of cancer on the entire well-being of a person living with the disease.

7.2.6 Recommendations for non-governmental organisations and the National cancer registry (NCR) in the fight against cancer

Non-governmental organisations can assist persons living with cancer to establish their own organisations be it in national, provincial and local level, with the purpose of making their voice heard. With facilitation and capacity building, such associations run by persons living with cancer may strengthen lobbying and advocacy efforts aimed at bringing about policy, legal and practice change in South Africa and Africa. Existing organisations such as the Cancer Association of South Africa (CANSA), working with persons living with cancer in South Africa and Africa, should also be strengthened by extending their reach into rural and urban communities. Increased funding for these organisations must be encouraged in order to boost the research and collaborative efforts of such bodies with the aim of fighting the problem of cancer globally due to the detrimental effect of this medical condition in the world. It was also recommended that government must ensure that the National Cancer Registry (NCR), through the provision of more resources, is rolled out to all nine provinces for its effective functioning in recording cancer statistics. Furthermore, collaborative and working efforts with other registries from other countries in the African continent should be encouraged, as well as enhance the position, reach and authority of the NCR in reporting cancer statistics.

7.2.7 Recommendations in relation to the rising compensation culture due to medical malpractice

The increasing number of medical malpractice claims have crippled the health care sector in South Africa, and this has had a negative effect on the government to realise socio-economic rights, such as the right of access to access to health care services. This thesis recommends that this culture of compensation be addressed by adopting dispute resolution as an alternative to litigation, as well as measures adopted to

improve communication between the patient and the medical practitioner. Briefly, this means that the use of simple language and simplified documents concerning the doctor-patient relationship.

7.3 Final Remark

Government and civil society should be sensitised to the unique position of the special minority group of persons living with cancer. The first and most important step in providing adequate legal protection to this marginalised segment of society, is to raise awareness about the condition and the severe disadvantages, obstacles, threats, and limitations that persons living with cancer face on a daily basis.

Bibliography

Legislation

South Africa

Basic Conditions of Employment Act 75 of 1997.

Children's Act 38 of 2005.

Class Areas Act of 1925.

Companies Act 71 of 2008.

Constitution of the Republic of South Africa, 1996.

Consumer Protection Act 68 of 2008.

Employment Equity Act 55 of 1998.

Health Professions Act 56 of 1974.

International Covenant on Economic, Social and Cultural Rights (CESCR) Adopted and opened for signature, ratification and accession by General Assembly Resolution 2200 A (XXI) of 16 December 1966.

Labour Relations Act 66 of 1995.

Medicines and Related Substance Control Act 101 of 1965.

Mental Health Care Act 17 of 2002.

Mines and Works Act of 1926.

National Health Act 61 of 2003.

Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000.

Protection of Personal Information Act 4 of 2013.

Social Assistance Act 13 of 2004.

United Kingdom

Employment Statutory Code of Practice Act of 2010.

Equality Act of 2010.

United States of America

Americans with Disabilities Amendment Act of 2008 (ADAA).

Disability Discrimination Act 1995 (DDA).

Regulations

Government Notice R394 Government Gazette 30953 of 11 April 2008.

Green Paper: National Health Insurance in South Africa Policy Paper 5 of 2011.

Regulations Relating to Cancer Registration GN R380 in GG 34248 issued in terms of the National Health Act 61 of 2003 dated 26 April 2011.

White Paper on Integrated National Disability Strategy: The Social Model of Disability 1997.

Practice Rules & Guidelines

Health Professions Guidelines on Confidentiality: Protecting and Providing Information 2008 (HPCSA Guidelines).

Proposed Code of Ethics for Private Hospitals – Hospital Association of South Africa (HASA) *Private Hospital Review 2008: Examination of Factors Impacting on Private Hospitals* (2008).

UN Standard Rules on the Equalization of Opportunities for Persons with Disabilities Adopted by UN General Assembly Resolution 48/96 of 20 December 1993.

Case Law

Canada

Crossman v Stewart (1977) 5 CCLT 45 (BCSC).

Law v Canada (Minister of Employment and Immigration) 1 SCR 497 (1999).

South Africa

Administrator of Natal v Edouard 1990 (3) SA 581 (A).

Affordable Medicines Trust v Minister of Health of RSA 2005 6 BCLR 529 (CC), 2006 3 SA 247 (CC).

Aries v CCMA & others (2006) 27 ILJ 2324 (LC).

Association of Professional Teachers & Another v Minister of Education & Others (1995) 16 ILJ 1048 (LC).

C v Minister of Correctional Services 1996 (4) SA 292 (T).

Castell v De Greef 1994 (1) SA 408 (C).

Cecilia Goliath v Member of the Executive Council for Health Eastern Cape (085/2014) [2014] ZASCA 182 (25 November 2014).

Christian Lawyer's Association v National Minister of Health and Others 2004 (4) SA 31 (T).

Coetzee v Comitis and Others 2001 (1) SA 1254 (C).

Coppen v Impey 1916 CPD 309.

Correira v Berwind 1986 (4) SA 60 (Z).

Council for Scientific & Industrial Research v Fijen (1996) 17 ILJ 18 (A).

Cyber Scene Ltd and Others v i-Kiosk Internet and Information (Pty) Ltd 2000 (3) SA 806 (C).

Department of Correctional Services v POPCRU 2011 32 ILJ 2629 (LAC).

Department of Justice v CCMA & Others [2004] 4 BLLR 297 (LAC).

Dhlomo v Natal Newspapers 1989 (1) SA 945 (A).

Dlamini & Others v Green Four Security [2006] 11 BLLR 1074 (LC).

Esterhuizen v Administrator, Transvaal 1957 (3) SA 710 (T).

Gifford v Table Bay Dock and Breakwater Management Commission 1874 Buch 926.

Government of Republic of South Africa and others v Grootboom, (CCT1100) [2000] ZACC 19, 2001 (1) SA 46, 2000 (11) BCLR 1169 (4 October 2000).

Harksen v Lane NO and Others (CCT9/97) [1997] ZACC 12, 1997 (11) BCLR 1489, 1998 (1) SA 300 (7 October 1997).

Harmse v City of Cape Town (2003) 6 BLLR 557 (LC).

Hoffmann v South African Airways (CCT 19/00) [2000] ZACC 17, 2001 (1) SA 1, 2000 (11) BCLR 1235, [2000] 12 BLLR 1365 (CC) (28 September 2000).

HOSPERSA obo Venter v SA Nursing Council (2006) 6 BLLR 558 (LC).

Imatu & Another v City of Cape Town [2005] 11 BLLR 1048 (LC).

Investigating Directorate: Serious Economic Offences v Hyundai Motor Distributors (Pty) Ltd: In re Hyundai Motor Distributors (Pty) Ltd v Smit NO 2001 (1) SA 545 (CC).

Isaacs v Pandie (12217/07) [2012] ZAWCHC 47 (16 May 2012).

Jackson v NICRO 1976 3 SA 1 (A).

Jansen van Vuuren NO v Kruger 1993 (4) SA 842 (A).

Joint Affirmative Management Forum v Pick n Pay Supermarket (1997) 18 ILJ 1149 (CCMA).

Kennedy and Arnold v Ireland [1987] IR 587.

Kievits Kroon Country Estate (Pty) Ltd v Mmoledi 2012 11 BLLR 1099 (LAC).

Kovalsky v Kriege 1910 20 CTR 822.

Kylie v CCMA and others (2010) 31 ILJ 1600 (LAC).

Lee v Schonnenberg 1877 7 Buch 136.

Leonard Dingler Employee Representative Council v Leonard Dingler (Pty) Ltd (1998) 19 ILJ 285 (LC).

Lungile Ntsele v MEC for Health, Gauteng Provincial Government (2009/52394) [2012] ZAGPJHC 208, [2013] 2 All SA 356 (GSJ) (24 October 2012).

Maje v Botswana Life Insurance [2001] 2 BLR 626.

MEC for Education, Kwazulu Natal v Pillay 2008 1 SA 474 (CC).

Media 24 Ltd v SA Taxi Securitisation (Pty) Ltd 2011 (5) SA 329 (SCA).

Medicross Healthcare Group (Proprietary) Limited and Prime Cure Holdings (Proprietary) Limited, Case No.11/LM/Mar05.

Minister of Finance and Other v Van Heerden, (CCT 63/03) [2004] ZACC 3, 2004 (6) SA 121 (CC), 2004 (11) BCLR 1125 (CC), [2004] 12 BLLR 1181 (CC) (29 July 2004).

Minister of Health and Others v Treatment Action Campaign and Others (NO 2) (CCT/802) [2002] ZACC 15, 2002 (5) SA 721, 2002 (10) BCLR 1033 (5 July 2002).

Minister of Safety and Security v Xaba [2003] (2) SA 703 (D).

Mistry V Interim National Medical and Dental Council and Others (CCT1397) [1998] ZACC 10, 1998 (4) SA 1127, 1998 (7) BCLR 880 (29 May 1998).

Mitchell v Dixon 1914 AD 15.

Murray v Minister of Defence [2008] 6 BLLR 513 (SCA).

National Coalition for Gay and Lesbian Equality and Another v Minister of Justice and Others, (CCT11/98) [1998] ZACC 15, 1999 (1) SA 6, 1998 (12) BCLR 1517 (9 October 1998).

National Education Health & Allied Workers Union v University of Cape Town (2003) 24 ILJ 95 (CC).

National Media Ltd ao v Jooste 1996 (3) SA 262 (A).

National Union of Mineworkers v Anglo American Platinum LTD & Others [2012] 12 BLLR 1252 (LC).

NEHAWU & Others v University of Pretoria [2006] 27 ILJ 117 (LAC) .

NM and Others V Smith and Others (CCT69/05) [2007] ZACC 6, 2007 (5) SA 250 (CC), 2007 (7) BCLR 751 (CC) (4 April 2007).

NM v Smith 2007 (5) SA 250 (CC).

Num obe Moeng v Douglas Colliery [2007] BALR 647 (CCMA).

Numsa *and Others v Gabriel (Pty) Ltd* (2002) 23 ILJ 2088 (LC).

Nxele v Chief Deputy Commissioner, Corporate Services, Department of Correctional Services & Others (2008) 29 ILJ 2708 (LAC).

O'Keeffe v Argus Printing and Publishing Company Ltd 1954 (3) SA 244 (C).

P v Pretorius (74157/2013) [2016] ZAGPPHC 602 (14 July 2016).

Phera v Education Labour Relations Council and others (2012) 33 ILJ 2839 (LAC).

Phillips v De Klerk 1983 TPD (Unreported).

Premier of KZN v Sonny 2011 (3) SA 424 (SCA).

Pringle v Administrator, Transvaal 1990 (2) SA 379 (W).

R v Schoor 1948 (4) SA 349 (C).

R v Van der Merwe 1953 (2) PHH 124 (W).

Richter and Another v Estate Hamman 1976 (3) SA 266 (C).

S v Burger 1975 (4) SA 877 (A).

S v Mahlalela 1966 (1) SA 226 (A).

S v Makwanyane and Another (CCT3/94) [1995] ZACC 3, 1995 (6) BCLR 665, 1995 (3) SA 391, [1996] 2 CHRLD 164, 1995 (2) SACR 1 (6 June 1995).

S v Manamela and Another 2000 (3) SA 1 (CC).

S v Mkwetshana 1956 (2) SA 493 (N).

SA Police Services v Salukazana & Others (2010) 31 ILJ 2465 (LC).

SACTWU & others v Discreto (a division of Trump and Springbok Holdings) [1998] 19 ILJ 1451 (LAC).

Shatz Investment (Pty) Ltd v Kalovyrnas 1976 (2) SA 545 (A).

Skwatsha v Department of Education [2008] 21 ILJ 27 (CCMA).

Solidarity obo Kern v Mudau & Others [2007] 6 BLLR 566 (LC).

Soobramoney v Minister of Health (Kwazulu Natal) (CCT32/92) [1997] ZACC 17, 1998 (1) SA 765 (CC) 1997 (12) BCLR 1696 (26 November 1997).

Soobramoney v Minister of Health, Kwazulu Natal 1998 (1) SA 765 (CC).

Soumbasis v Administrator, Orange Free State Unreported 1989 (OPD).

South African Defence Force Union v Minister of Defence 1999 (6) BCLR 615 (CC).

South African Transport and Allied Workers Union v Old Mutual Life Assurance Company South Africa Limited (C198/2004) [2006] ZALC 51 (6 April 2006).

Standard Bank of South Africa v Commission for Conciliation, Mediation and Arbitration and Others (JR 662/06) [2007] ZALC 98, [2008] 4 BLLR 356 (LC) (25 December 2007).

Standard Bank of South Africa v Commission for Conciliation, Mediation and Arbitration and Others (JR 66206) [2007] ZALC 98, [2008] 4 BLLR 356 (LC) (25 December 2007).

Steward Wrightson (Pty) Ltd v Thorpe 1977 (2) SA 943 (A).

Stoffberg v Elliot 1923 CPD 148.

Swart v Mr Video (Pty) Ltd (1998) 19 ILJ 304 (LC).

Treatment Action Campaign v The Minister of Health 2002 (4) BCLR 356 (T).

Treatment Action Campaign v The Minister of Health 2002 TPD (unreported).

Tshabalala-Msimang v Makhanya [2008] 1 All SA 509 (W).

Van Wyk v Lewis (1924) AD 438.

Wasteman Group v South African Municipal Workers' Union [2012] 8 BLLR 778 (LAC).

WL Ochse Webb & Pretorius (Pty) Ltd *v Vermeulen* (1997) 18 ILJ 361 (LAC).

Wright v British Railways Board [1983] 2 AC.

Wyeth SA (Pty) Ltd v Manqele & others (2005) 26 ILJ 749 (LAC).

United Kingdom

Archibald v Fife Council [2004] ICR 954, [2004] UKHL 32.

Barnett v Chelsea and Kensington Hospital Management Committee (1986) 1 All ER 1068.

Cassidy v Ministry of Health [1951] 2 KB 343.

J v DLA Piper UK LLP [2010] UKEAT/0263/09/RN.

Lamphier v Phipos 1835 42 All ER 421.

Maynard v West Midlands RHA 1985 1 All ER 635.

Superintendent of Motor Vehicles v British Columbia Council of Human Rights (1999) 3 SCR 868.

Swift v Chief Constable of Wiltshire, SCA Packaging Ltd v Boyle (HL) 2009 169.

Tolly v Fry and Sons Ltd [1931] AC 333, [1931] UKHL 1.

Whitehouse v Jordan and Another (1981) 1 All ER 267 (HL).

Wilson v Maryland-Nat'l Capital Park & Planning Commission, 1999 WL 279878 (6 May 1999).

United States of America

Doe v U.S Postal Services, 317 F.3d 339, 341 (D.C Cir 2003).

Dr Julian Baldor and First Palma Ceia Hospital v JT Rogers 10 N.C 165 1999.

EEOC v Southlake Comm. Mental Health Centre Inc NO.2:10-CV-00444 (11 March 2013).

Ellison v Software Company, Inc. 85 F3d 187 (5th Cir. 1996).

H West & Sons Ltd v Shephard [1964] AC 326

Lanxon v Crete Carrier Corp NO.4 CV 3182, 2001, WL 1589627 at 11 (13 December 2001).

Lynos v Heritage House Restaurant Inc 271.

McRae v Group Health Plan 753 N.W.2d 711, 714-15 (Minn.2008).

Ontario Public Services Employees Union v Ontario (Ontario Human Rights Commission) 2015 ONCA 495.

Schemidt v Methodist hospital of Indiana, 89 F.3d 342 (1996)

Books

A

Ackerknecht EH *A Short History of Medicine* (John Hopkins University Press, London 1982).

Acton A *Pancreatic Cancer: New Insights for the Health Care Professional* (Scholarly Edition Publishers, New York 2011).

Acton QA *Breast Cancer: New Insights for Health Care Professional* (Scholarly Edition Publishers, New York 2011).

Adler I *Primary Malignant Growths of the Lungs and Bronchi* (Longmans and Green Publishers, London 1912).

Albores-Saavendra J and Henson DE *Pathology of Incipient Neoplasia* (Oxford University Press, New York 2001).

Alcoma IE and Cramer SD *Prostate cancer* (InfoBase Publishing, New York 2006).

Anderson J and Heath M *Criminal Law Guidebook* (Oxford University Press, Australia and New Zealand 2010).

Ambasa-Shisanya CR *Cultural Determinants of Adoption of HIV and AIDS Prevention Measures and Strategies among Girls and Women in Western Kenya* (Ethiopian Publishers, Addis Ababa 2009)

American Psychiatric Association *Practice Guidelines for the Treatment of Psychiatric Disorders* (Library Congress Publishers, Washington DC 2006).

Ang KK and Cox JD *Radiation Oncology: Rationale, Technique, Results* (Mosby Elsevier, New York 2003).

Armitage KB, Sajatovic M and Loue S *Encyclopedia of Women's Health* (Kluwer Academic Publishers, New York 2004).

B

Bag RK *Law of Medical Negligence and Compensation* 2nd ed (Eastern Law House, New Delhi 2001).

Barrister PB *Compensation for Personal Injuries* 1st ed (Oxford University Press, New York 2002).

Barofsky I, *Work and illness: the persons living with cancer* (Praeger Press, New York 1989).

Barnes A *et al*, *Health Care Law: Desk Reference* (Library Congress, New York 2001).

Barton MA, Nicholas DR and Veach TA *Cancer and the Family Life Cycle a Practitioners Guide* (Brunner Routledge Publishers, New York 2013).

Basavanthappa BT *Fundamentals of Nursing* (Jaypee Brothers Medical Law Publishers, New Delhi 2004).

Basson AC *et al*, *Essential Labour Law* 5th ed (Labour Law Publications Centurion, Pretoria 2009).

Bailey C and Corner J *Cancer Nursing Care in Context* 2nd ed (Blackwell Publishers, London 2009).

Baum M *Breast Cancer The Facts* (Oxford University Press, New York 1988).

Bayless D *Advanced Therapy in Gastroenterology and Liver Disease* (BC Decker Publishers, Ontario 2005).

BC Public Service *A Managers Guide to Reasonable Accommodation* (Columbia Press, Columbia 2008).

Bekink B *Principles of South African Constitutional Law* (LexisNexis, Johannesburg 2012).

Bendix S *Labour Relations: A Southern African Perspective* 6th ed (Juta Publishers, Cape Town 2015).

Berman P and Berman S *Represent Yourself in Court: How to Prepare and Try a Winning Case* 7thed (Nolo Publishers, California 2010).

Beuchemin N and Hout J *Metastasis of Colorectal Cancer* (Springer Business and Science Media, London 2010).

Billing DM *Lippincott's Content Review for NCLEX-RN* (Wolters Kluwer Health Publishers, China 2009).

Blanpain R *The Changing World of Work* (Kluwer Law and Taxation Publishers, Boston 2009).

Blyton P and Noon M *The Realities of Work: Experiencing work and employment in contemporary society* (Palgrave Publishers, London 2007).

Boberg P *The Law of Delict: Acquilian Liability* (Juta Publishers, Cape Town 1984).

Bonavida B *Sensitization of Cancer Cells for Chemo/Immuno/Radiotherapy* (Humana Press, New York 2008).

Brand D & Heyns CH (eds) *Socio-economic Rights in South Africa* (Pretoria University Law Press, Pretoria 2005).

Brassey M *et al*, *The New Labour Law* (Juta, Cape Town 1987).

Buckland AW *A textbook of Roman Law from Augustus to Justinian* (Cambridge University Press, Cambridge 1950).

C

Caner A and Lemoigne Y *Radiation Protection in Medical Physics* (Springer, New York 2011).

Cantor D *Cancer in the Twentieth Century* (Johns Hopkins University Press, New York 2008).

Carnevali D and Reiner A *The Cancer Experience* (J.B Lippincott Company, London 1990).

Carroll R *Civil Remedies: Issues and Developments* (The Federation Press, Sydney 1996).

Carson EC *Oncogene Proteins: New Research* (Nova Science Publishers, New York 2008).

Carson VB, King DE and Koeing HG *Handbook of the Religion and Health* (Oxford University Press, New York 2012).

Carstens P and Pearmain D *Foundational Principles of South African Medical Law* (LexisNexis Butterworths, Durban 2007).

Carvalho L and Stewart J *The Everything Health Guide to Living with Breast Cancer* (Library of Congress Cataloging in Publication, New York 2009).

Chall LP *Sociological Abstracts Volume 45, Issue* 1 (Smith Mark Publishers, New York 1997).

Chan HSL *Understanding Cancer Therapies* 76 (University Press of Mississippi, Mississippi 2007).

Cheng L and Bostwick DG *Urologic Surgical Pathology* (Mosby Elsevier, Philadelphia 2008).

Ching DC and Feig BW *The M.D Anderson Surgical Oncology Handbook* 288 (Lippincott Williams & Wilkins Publishers, Philadelphia 2012).

Chun Yu J *Stereocontrolled Olefin Synthesis in Preparation of Biologically Active Isoprenoid Organophoshorus Compounds* 9 (PhD Thesis University of Lowa 2007)

Clark WR *The New Healers: The Promise and Problems of Molecular Medicine in the 21st Century* (Oxford University Press, Oxford 1997)

Clavien PA *Malignant Liver Tumours: Current and Emerging Therapies* (Wiley-Blackwell Publishers, New Jersey 2011).

Clellan FM *Medical Malpractice: Law, Tactics, and Ethics* 117 (Temple University Press, Philadelphia 1994).

Cockburn E *Mummies, Diseases, and Ancient Cultures* 12 (Cambridge University Press, London 1980).

Cody RL *et al*, *Breast Cancer Collaborative Management* (Lewis Publishers, New York 1988).

Cohen S *The Elementary Forms of Denial: In States of Denial* (Polity Press Cambridge, 2001).

Cornwall C *Catching Cancer: The Quest for its Viral and Bacterial Causes* (Rowman and Littlefield Publishing Group, London 2013)

Corporation MC *Diseases and Disorders, Volume 1* (Paul Bernabeo, Malaysia 2008).

Cranor F *Toxic Torts: Science, Law and the Possibility of Justice* (Cambridge University Press, New York 2006).

Currie I and Del Waal J *The Bill of Rights Handbook* 6th Edition (Juta Publishers, Cape Town 2013).

Curtis M *et al, Glass Office Gynaecology* (Wolters Kluwer Publishers, New York 2014).

D

Daniel BR *et al*, *Breast Cancer Recurrence and Advanced Disease Comprehensive Expert Guidance* (Duke University Press, New York 2010).

Daoud SS *Cancer Proteomics: From Bench to Bedside* (Humana Press, New York 2008).

David J *Cancer Care* (Chapman and Hall, London 1995).

Davis D *The Secret History of the War on Cancer* (Library Cataloguing Congress, New York 2009).

Deakin S and Wilkinson F *The Law of the Labour Market: Industrialization, Employment and Legal Evolution* (Oxford University Press, New York 2005).

Devenish GE *A commentary on the South African Constitution* (Butterworths, Durban 1998).

DeMatteo RP and Abou-Alfa GK *100 Questions and Answers About Liver Cancer* (Jones & Bartlett Publishing, New York 2012).

De Vos P and Freedman W (eds) *South African Constitutional Law in Context* (Oxford University Press, Cape Town 2014).

Dominguez-Munoz JE *Clinical Pancreatology for practising Gastroenterologists and Surgeons* (Blackwell Publishers, London 2005).

Donegan WL "History of Breast Cancer" in Winchester DJ and Winchester DP *Breast Cancer* 2nd ed (BC Decker Inc, Ontario 2006).

Donehower RC *Colon Cancer 2007* (John Hopkins University Press, Maryland 2007)

Drury SB *Terror and Civilization: Christianity, Politics, and the Western Psyche* (Palgrave Macmillian Publishers, New York 2006).

Dunea G, Last JM, and Lock S *The Oxford Illustrated Companion to Medicine* (Oxford University Press, New York 2001).

Dutton I *The Practitioner's Guide to Medical Malpractice in South African Law* (Siber Ink Publishers, Cape Town 2015).

E

Elderson M and Turkington N *The Encyclopaedia of Women's Reproductive Cancer* (Library of Congress Cataloging Publication, New York 2005).

Ellsworth P *100 Questions & Answers to Prostate Cancer* (Jones and Bartlett Publishers, Canada 2009).

Emerson RW *et al*, *Health for Life* (Human Kinetics Publishers, Canada 2014).

Epstein SS *Cancer- Gate: How to Win the Losing Cancer War* (Baywood Publishing Company, New York 2005)

Etowa JB and Mc Gibbson EA *Anti-Racist Health Care Practice* (Canadian Health Scholars Press, Toronto 2009)

F

Fang J and Lee K *Historical Dictionary of the World Health Organisation* (Scarecrew Publishers, London 2013).

Feldman M *Wellness and Work, in Psychosocial stress and cancer* (Copper Publishers, New York 2000).

Feuerstein M *Work and Cancer Survivors* (Springer, New York 2009).

Fiadjoe A *Alternative Dispute Resolution: A Developing World Perspective* (Cavendish Publishing, London 2004).

Finlay JL and Carroll WL *Cancer in Children and Adolescents* (Jones and Bartlett Publishers, Canada 2010)

Finnemore M *Introduction to Labour Relations in South Africa* (LexisNexis, Durban 2013).

Fraumeni J and Schottenfeld D *Cancer Epidemiology and Prevention* (Oxford University, New York 2006)

Frei E *et al*, *Cancer Medicine* (Peoples Publishing House, New Delhi 2010).

Friedberg E *Cancer Answers* (W H Freeman and Company, London 1993).

G

Gabnz PA *Cancer Survivorship Today and Tomorrow* (Springer, New York 2007).

Gabriel RA *Man and Wound in the Ancient World: A History of Military Medicine from Summer to the Fall of Constantinople* (Potomark Book Publishers, New York 2012).

Gail H and Benichou J *Encyclopedia of Epidemiologic Methods* (John and Wiley Publishers, New York 2000).

Gibbons JH *Genetic Monitoring and Screening in the Workplace* (Government Printing, Washington DC 1991).

Godellas CV, Millikan KW and Saclarides TJ *Surgical Oncology: An Algorithmic Approach* (Springer, New York 2009).

Goodwin P *Global Studies: Latin America* (McGrow-Hill Publishers, New York 2006).

Gorman RF *Great Events from History: The 20th Century, 1901-1940* (Springer, New York 2007).

Gorney M *Plastic and Reconstructive Surgery* (Springer, London 2010).

Gottschalk HR, Burch M, Menck HR and Hutchison CL *Cancer Registry Management: Practices and Principles* (National Cancer Registrar's Publishers, New York 2004).

Goudge J *Public-Private Mix* (Oxford University Publishers, London 2000).

Goyal RC and Sharma DK *Hospital Administration and Human Resource Management* (Asoka Publishers, New Delhi 2013).

Greenwald P *et al, Cancer Prevention and Control* (Marcel and Dekker Publishing, New York City 2001).

Grobstein RH *The Breast Cancer Book* (Yale University Press, London 2005).

Grogan J *Employment Rights* (Juta Publishers, Cape Town 2010).

Grogan J *Labour Litigation and Dispute Resolution* (Juta Publishers, Cape Town 2014).

Grogan J *Workplace Law* 8th ed (Juta Publishers, Cape Town 2005).

Grogan J Workplace Law 10th ed (Juta Publishers, Cape Town 2009).

Gulliver PH *Disputes and Negotiations: A cross-cultural perspective* (New York Academic, Press 1979).

Guthrie D *A History of Medicine* (Thomas Nelson and Sons Publishers, London 1960).

H

Haeck P and Gorney M *Risk, Liability and Malpractice: What Every Plastic Surgeon Needs to Know* (Elsevier Saunders, Philadelphia 2011)

Haines C *The New Prescription: How to Get the Best Health Care in a Broken System* (Health Communications Publishers, New York 2011).

Hanna G *Outdoor Pursuits Programming: Legal Liability and Risk Management* (University of Alberta Press, Canada 1991).

Harpwood V *Medicine, Malpractice and Misapprehensions* (Routledge Cavendish, Britain 2007).

Harmer V *Breast Cancer Nursing Care and Management* (Wiley-Blackwell Publishers, London 2011).

Harte J, Holdren C, Schneider R and Shirley C Toxics *A to Z: A Guide to Everyday Pollution Hazards* (University of California Press, California 1991).

Hawkins JM *The Oxford Senior Dictionary* (Oxford University Press, Britain 1987).

Hayat MA *Methods of Cancer Diagnosis Therapy and Prognosis: Colorectal Cancer* (Springer, New York 2009)

Heney D, Young B and Dixon-Woods M *Rethinking Experiences of Childhood Cancer* (Open University Press, United Kingdom 2005).

Hennenfent B *The Prostatitis Syndromes: Approaches to Treating Bacterial Prostatitis* (Springer, New York 1996)

Herring J *Medical Law and Ethics* 3rded (Oxford University Press, New York 2010).

Honeyball S *Great Debates in Employment Law* (Palgrave Macmillan Publishers, New York 2011).

Horan M *et al, Geriatric Medicine for Old-Age Psychiatrists* (Taylor & Francis Publishers, Abingdon 2006)

Hostad J and Foyle L *Innovations in cancer and palliative care education* (Radcliffe Publishing, London 2007).

Howard M *Civil Litigation and Dispute Resolution: Vocabulary Series* (Legal English Books Publishers, London 2013).

Huber J *Cancer with Joy: How to Transform Fear into Happiness and Find the Bright Side Effects* (Morgan James Publishers, New York 2012).

Hunter D and Colditz GA *Cancer Prevention: The Causes and Prevention of Cancer* (Kluwer Academic Publishers, New York 2002).

Hunter KW and Wakefield L *Metastasis* (IOS Press Publishers, Netherlands 2009).

Hurt A *Bullet with your name on it* (Clerisy Press, New York 2007).

Hunter R *Indirect Discrimination in the Workplace* (The Federation Press, Sydney 1992).

I

Ingwerson K, Wilkes G and Barton-Burke M *Cancer Chemotherapy A Nursing Process Approach* (Jones and Barttler Publishers, Canada 2001).

J

Jaftha T, Cohen LH and Pervan V *Oncology for Health-Care Professionals* (Creda Press, Cape Town 1995)

Jameson L and De Groot LJ *Endocrinology* (W.B Saunders Company, Philadelphia 2001).

Jekel J, Katz D, Elmore J and Wild D *Epidemiology, Biostatistics and Preventative Medicine* (Elseiver, Philadelphia 2007).

Jensen OM *et al, Cancer Registration: Principles and Methods* (IACR Scientific Publishers, London 1991).

John G *Dismissal, discrimination and unfair labour practices* (Butterworths, Durban 2008).

Jones JS *Prostate Cancer Diagnosis: PSA, Biopsy and Beyond* 208 (Springer, New York 2013).

Joubert WA (ed) LAWSA 8-9 (LexisNexis Butterworths, Durban 2004).

K

Kale-Smith G *Medical Assisting made Incredibly Easy: Administrative Competencies* (Lippincott Williams & Wilkins Wolters Kluwer Publishers, Philadelphia 2008).

Kaushal AK *Medical Negligence and Remedies with special reference to Consumer Protection Law* (Universal Book Traders, New Delhi 1995).

Kelbrick R *Civil Procedure in South Africa* (Aspen Publishers, New York 2010).

Kennedy I and Grubb A *Medical Law* (Butterworths, Publishers London 2000).

Kibwika P *Learning to make change: Developing Innovation Competence for Recreating the African University of the 21st Century* (Wageningen Academic Publishers, Netherlands 2006).

Klawiter M *The Biopolitics of Breast Cancer: Changing Cultures of Disease and Activism* (University of Minnesota Press, Minnesota 2008).

Knegt R and Westerveld M *The Employment Contract as an Exclusionary Device* (Intesertia Publishers, London 2008).

Knol JB *Surviving a competitive health care market: Strategies for the 21st century* (McGrow Hill Publishers, New York 1995).

Knowles LL and Prewitt KP *Institutional and Ideological Roots of Racism: In A. Aguirre Sources: Notable Selections in Race and Ethnicity*. 2nd ed (Connecticut Dushkin: McGraw Hill, Publishers New York 1998).

Koblenz L *From sin to science: The cancer revolution of the nineteenth century* (Columbia University, PhD thesis, 2013).

Kraus EK *et al, Chartbook on Disability in the United States* (National Department of Education, National Institute on Disability and Rehabilitative Research, Washington DC 1996).

L

Ladwig GB and Ackley BJ *Nursing Diagnosis Handbook: An Evidence-Based Guide to Planning Care* (Mosby Elsevier, Philadelphia 2014).

Lange JW *The Nurse's Role in Promoting Optimal Health of Older Adults: Thriving in the Wisdom Years* 208 (Nursing Joane Patzek DaCunha, New York 2012)

Larson CA *Positive Options for Colorectal Cancer: Self-Help and Treatment* (Hunter House Publishers, California 2005).

Laster K *Law as Culture* (Federation Press Publishers, Sydney 2001).

Lawson R *Research and discovery: Landmarks and Pioneering in American Science* (Wiley-Blackwell Publishers, London 2008).

Lee JH *Meningiomas: Diagnosis, Treatment and Outcome* (Springer, New York 2007).

Leff V *Humanist* (Rationalist Press Association Limited, London 1975).

Lehu PA, Grunbaum A and Westheimer RK *Sexually Speaking : What Every Women Needs to Know about Sexual Health* (John Wiley and Sons Publishers, New York 2012).

Lennan E and Keen A *Women's Cancers* (Wiley-Blackwell Publishers, United Kingdom 2011).

Linz U *Ion Beam Therapy: Fundamentals, Technology, Clinical Applications* (Springer, London 2011)

Lllidge T, Sikaro K and Price P *Treatment of Cancer* 5th ed (CRC Press, New York 2008)

Loesser JD and Fitzgibbon DR *Cancer Pain* (Morgan James Publishers, New York 2012).

Lotz MM, Moses MA and Pories SE *Cancer* (Greenwood Publishers, New York 2009).

Lowenstein C *Cancer Registries and Medical Records: Rich Data Resources* (Statistical Method Publishers, Boston 2010).

Lynch T, Hunt J, Clark D and Wright M *Hospice and Palliative Care in Africa: a review of developments and challenges* (Oxford University Press, London 2006)

M

Madden RG Essential law for Social Workers 135 (Columbia University Press, New York 2003).

Magner LN *A History of Medicine* (Marcel Dekker Publishers, New York 1992).

Manigault K *Victory in the Workplace: Inspiration for the Working World* (Xulon Press Publishers Inc, Florida 2003).

Manning J *Health, Humanity and Justice: Emerging Technologies and Health Policy in the 21st* century (Health Publishers, Atlanta 2010).

Mantle M *Mediation: A Practical Guide for Lawyers* (Edinburgh University Press, Edinburgh 2011).

Mason JK, Smith RA and Laurie GT *Law and Medical Ethics* 6thed (LexisNexis Butterworth's London 2002).

Mason JK, Smith RA and Laurie GT *Law and Medical Ethics* 8thed (Oxford University Press New York 2011).

Margotta R *The History of Medicine* (Smith Mark Publishers, New York 1996)

Martin J *Profiting from Multiple Intelligences in the Workplace* (Gower Publishers, United Kingdom 2001).

Martin LL *et al*, *Lessons from the black working class* (Library Congress Publishing, California 2015).

Martinez RL Childhood Cancer Survivors Workplace Experiences (Master of Arts Rice University, Texas 2010)

Mau SD *Hong Kong Legal Principles: Important Topics for Students and Professionals* 2nd ed (Hong Kong University Press, Hong Kong 2013).

Maxwell CJ and van Huyssteen LF *Contract Law in South Africa* (Kluwer Law International Publishers, New York 2015).

Mays JA *See One, do One, Teach One* (Xlibris Corporation Publishers, New York 2011)

Mc Lain RF *Cancer in the Spine Comprehensive Care* (Humana Press, New York 2006).

McGregor M *et al*, Labour *Law Rules* (Creda Communications, Cape Town 2012).

Mcquoid-Mason DJ *Medical Professions and Practice: The practice of medicine* LAWSA (LexisNexis Publishing, Durban 2008)

Meredith M *Born in Africa: The Quest for the Origins of Human Life* (Simon and Schuster Publishers, London 2011)

Miller K *Adjuvant Therapy* (IOS Publishers, London 2004).

Mokoena MT *A Guide to Bail Applications* (Juta Publishers, Cape Town 2012).

Mookeng MJ *Factors influencing cervical cancer screening programme implementation within private health care sectors in Soshanguve* (LLM dissertation, University of South Africa, 2005).

Morissette EL *Personal Injury and the Law of Torts for Paralegals* 61 (Aspen Publishers, New York 2009).

Mukherjee M *The Emperor of all the Maladies: A Biography of cancer* (Scribner Publishers, New York 2010).

Mulvihill SJ, Tempero M, Rosenbaum EH and Dollinger M *Everyone's Guide to Cancer Therapy: How Cancer is Diagnosed, Treated and Managed Day to Day* 276-277 (Library Congress Publishers, Washington DC 1991).

N

Neal DM, Thirunavukarasu P and Bartlett DL *Surgical Oncology: Fundamentals, Evidence-based Approaches and New Technology* (Jaypee Brothers Medical Publishers, New Delhi 2011).

Neethling J, Potgieter JM and Visser PJ *Neethling's Law of Personality* (LexisNexis Butterworths, Durban 2005).

Nel P *et al*, *Human Resources Management* (Oxford University Press, Cape Town 2001).

Neligan PC *Plastic Surgery: Craniofacial, Head and Neck Surgery* (Elsevier Publishers, Illinois 2013).

Neligan PC and Gurtner GC Plastic *Surgery: Principles* (Elsevier Publishers, Illinois 2012).

Nester S *Mammography Review for Technologists* (Rainbow Publishers, New York City 2014).

Ngwena C G Disabled people and the search for equality in in the workplace: An appraisal of equality models from a comparative perspective (LLD thesis UFS, Bloemfontein 2010).

NHLS *NIOH Annual Review 2012-2013* (National Health Laboratory Services, Pretoria 2013).

Norton W and Hudis W *Breast Cancer* (BC Decker Publishers, Ontario 2006)

O

O'Brian R *Crippled Justice: The history of modern disability policy in the workplace* (University of Chicago Press, Chicago 2001).

Ohaegbulam FU *Towards an understanding of the African experience from historical and contemporary perspectives* (University Press of America Publishers, Maryland 1990).

Okrent CJ *Torts and Personality Law* 4thed (Delmar Cengage Learning, New York 2010).

Olivier MP and Smit N "Disability" in Joubert WA (ed) LAWSA 13(2) *Labour Law and Social Security Law* (Butterworths, Durban 2002).

Oloson J *The History of Cancer: An Annotated Bibliography* (Greenwood Publishing Group, Westport 1964).

Orr T *Liver Cancer: Current and Emerging Trends in Detection and Treatment* (Rosen Publishing Group, New York 2009).

P

Page J, Louw M and Pakkiri D *Working with HIV and AIDS* (Juta Publishers, Cape Town 2006).

Patterson AS *The African State and the AIDS Crisis* (Ashgate Publishers, New York 2005)

Paul C *Limitations of Actions* (Indiana Publishers, New York 2008).

Paul N *Living with Hepatitis C for Dummies* (Wiley Publishers, India 2005).

Peet A *Mark's Basic Medical Biochemistry* (Lippincott Williams & Wilkins, China 2011).

Pellow DN, Sonnenfeld DA and Smith T *Challenging the Chip: Labour Rights and Environmental Justice in the Global Electronics Industry* (Temple University Press, Philadelphia 2006).

Perry MC *The Chemotherapy Source Book* (Lippincott Williams & Wilkins, Baltimore 2008)

Peters T and Hamilton W *Cancer Diagnosis in Primary Care* (Churchill Livingstone Publishers, London 2007).

Port DR *Previvors: Facing the Breast Cancer Gene and Making Life-Changing Decisions* (Penguin Group Publishers, New York 2010).

Porter M, McCaffery P, Lowis G and Van Teijlingen E *Midwifery and the Medicalization of Childbirth: Comparative Perspectives* (Nova Science Publishers, New York 2004).

Porter R and Bynum WF *Companion Encyclopedia of the History of Medicine* (Routledge, London 1997).

Porter R and Bynum WF *Companion Encyclopaedia of the History of Medicine* (Routledge Publishers, London 2009).

Powers MJ and Harris NH *Medical Negligence* 2nded (Butterworth's United Kingdom 1994).

Proctor RN *The Nazi War on Cancer* (Princeton University Press, Princeton 2000)

Pulley R and Mantin P *Medicine Through the Ages* 112 (Stanley Thornes Publishers Ltd, Surrey 1997)

Q

Quah SR, Heggenhougen HK and Van Look RFA *Sexual and Reproductive Health: A Public Perspective* (Elsevier Academic Publishers, Illinois 2011).

R

Randolph P and Strasser F *Mediation: A psychological insight into conflict resolution* (Bloomsbury Academic, London 2004).

Rao DG *Introduction to Biochemical Engineering* (Tata McGraw Hill Publishers, Evanston 2010).

Rautenbach IM & Malherbe EFJ *Constitutional Law* (LexisNexis, Durban 2009)

Rautenbach IM and Malherbe EFJ *Constitutional Law* 6th ed (LexisNexis, Durban 2012).

Redsell S and Hastings A *The Good Consultation Guide for Nurses* (Radcliffe Publishers, London 2006).

Rees AM *Consumer Health USA* (The Oryx Press, Phoenix 1997)

Reid T and Green JE *Genetically Engineered Mice for Cancer Research design, analysis, pathways, validation and pre-clinical testing* (Springer, New York 2012)

Reynolds E, Neill K and Krieger L *World History: Perspective on the Past* (Mc Dougal Littell Publishers, New York) 1997.

Rollin C *The ancient history of the Egyptians, Carthaginians, Assyrians and Babylonians* (W. Clowes and Sons, London 1850).

Romaine D and Rothfeld G *The Encyclopaedia of Men's Health* (Amaranth, New York 2005).

Roy RH *Short Textbook of Surgery* (Jaypee Brothers Medical Publishers, India 2011).

Rycroft A and Le Roux R *Reinventing Labour Law: Reflecting on the first 15 years of the Labour Relations Act and the future challenges* (Juta Publishers, Cape Town 2012).

S

Sabel MS *Essentials of Breast Cancer* (Mosby Elseiver Publishers, New York 2009).

Salamon R *Handbook of Emotions* (Guildford Press Publishers, London 1993).

Saldana J and Puntes V *Nanotechnology: Balancing the Promises* (Nanowick Publishers, New York 2009).

Sanders S and Eccles S *So You Want to be a Brain Surgeon?* (Oxford University Press, New York 2009).

Saur L *Encyclopaedia of World Problems and Human Potential* (Publication Union Michigan University, Michigan 1986).

Scharf GM *The Medico-Legal Pitfalls of the Medical Expert Witness* (LLM thesis, Unisa 2014).

Schwikkard PJ and Van der Merwe SE *Principles of Evidence* 2nded (Juta, Cape Town 2002).

Scott RN *Cancer The Facts* (Oxford University Press, New York 1979).

Scott RW *Legal Aspects of Documenting Patient Care for Rehabilitation Professionals* (Jones & Bartlett Publishers, London 2006).

Scott W *The General Practitioner and the Law of Negligence* (Cavendish Publishing Limited, London 1995).

Scott SC *Principles and Applications of Assessment in Counselling* (Brookes and Cole Publishers, New York 2013).

Sheldon KL *A Nurse's Guide to Caring for Cancer Survivors: Colorectal Cancer* (Jones and Bartlett Publishers, Canada 2010).

Shelkar R *Medical Negligence and Compensation* (Kamal Publishers, New Delhi 2010).

Shimkin MB *Contrary to Nature: Being an Illustrated Commentary on some Persons and Events of Historical Importance in the Development of Knowledge Concerning* Cancer (Government Printing Office, Washington DC 1977).

Silva IS *Cancer Epidemiology: Principles and Methods* (International Agency for Research on Cancer Publishers, Paris 1999).

Skeet RG, Muir CS, MacLennan PR and Jensen OM *Cancer Registries: Principles and Methods* (IARC Scientific Publications, Lyon 1991).

Slabbert MN *International Encyclopaedia of Laws: Medical Law* (Kluwer Law Publishers, Alphen an den Rijn 2014).

Smart CR and Herman M *Central Cancer Registries: Design, Management and Use* (Harwood Academic Publishers, Chur 1994).

Smith C and Murthy P *Women's Global Health and Human Rights* (Jones and Bartlett Publishers, Canada 2010).

Smith NE and Timby BK *Introductory Medical-Surgical Nursing* (Lippincott Williams & Wilkins, China 2014).

Smith RA Global HIV and AIDS *Politics, Policy, and Activism: Persistent Challenges and Emerging Issues* (Library Congress Publishers, Washington DC 2013).

Smit N *et al, Law@Work* 3rd Edition (LexisNexis, Durban 2015).

Spencer H *Pathology of the Lung* (Pergamon Press, New York 1977)

Stark TL *Negotiating and Drafting contract Boilerplate* 266 (ALM Publishing, a division of American lawyer media 2003).

Steenkamp A *et al*, *Labour Relations Law: A Comprehensive Guide* 651 (LexisNexis, Durban 2011)

Sterglou-Kita M *et al*, "The provision of reasonable accommodations following cancer: survivor, provider, and employee perspective" 2015 (26) *J Cancer Surviv* 1-2.

Stoler MH, Reuter V, Oberman HA, Greenson JK and Carter D *Stenberg's Diagnostic Surgical Pathology* (Lippincott Williams & Wilkins, New York 2004).

Stoll BA *Risk Factors in Breast Cancer* 3 (William Heinemann Medical Books Publishers, New York 1976).

Strauss SA *Doctors, Patient and Law A Selection of Practical Issues* 3 (Published by J L Van Schaik Pretoria 1980).

Straus SA *Doctor, Patient and Law* 243 (JL van Schaik Publishers Pretoria, 1991).

Strauss SA *Legal Handbook for Nurses and Health Personnel* (King Edward VII Trust, Cape Town 1992).

Strehle M and Popp J *Biophotonics: Visions for Better Health Care* (Wiley Publishers, London 2006).

Sutcliffe SB and Elwood JM *Cancer Control* (Oxford University Press, New York 2010).

Swanepoel M *Law, Psychiatry and Psychology: A Selection of Constitutional, Medico-Legal and Liability Issues* (LLD thesis, University of Pretoria, 2009).

Slabbert MN *Medical Law in South Africa* (Aspen Publishers, New York 2011).

Szyf M *DNA Methylation and Cancer Therapy* (Kluwer Academic/Plenum Publishers, Netherlands 2005).

T

Taylor A and Folberg J *Mediation: A comprehensive guide to resolving conflicts without litigation* (Jossey-Bass Publishers, San Francisco 1984).

Taylor CR and Chandrasoma P *Concise Pathology* (McGraw Hill Publishers, New York 1997).

Tingle J *et al*, *Texts, Cases and Materials on Medical Law and Ethics* (Routledge Publishers, London 2012).

Tobler C *Indirect Discrimination: A Case Study into the Development of the Legal Concept of Indirect Discrimination in the Workplace* (Hart Publishing, United Kingdom 2005)

Townsend DW and Shreve P *Clinical PET-CT in Radiology: Integrated Imaging in Oncology* (Springer, New York 2011)

Turksen K *Human Embryonic Stem Cell Protocols* (Hamana Press, New York 2006).

V

Vaeth JM *Intraoperative Radiation Therapy in the Treatment of Cancer* (Karger Publishers, New York 1997).

Van Custem E, Tepper JE, Levin B, Kern SE, Daly JM and Kelsen D *Principles and Practice of Gastrointestinal Oncology* (Lippincott Williams & Wilkins, Philadelphia 2008).

Vandenhole W *Non-discrimination and Equality in the View of the UN Human Rights Treaty Bodies* (Hart Publishing, United Kingdom 2005).

Van den Heever P *The Application of the Doctrine of Res Ipsa Loquitur to Medical Negligence Cases: A Comparative Survey* (LLD Thesis University of Pretoria, 2002).

Van der Heever P and Carstens P *Res Ipsa Loquitur& Medical Negligence: A Comparative Survey* 7 (Juta Publishers, Cape Town 2011).

Van der Heever P *The application of the doctrine of a loss of a chance to recover in medical law* (Pretoria University Press, Pretoria 2007).

Van Gramberg B *Managing Workplace Conflict: Alternative dispute resolution in Australia* (Federation Press, Sydney 2006).

Van Niekerk A, Christianson M, McGregor M, Smith E, Paul B and Van Eck S *Law@Work* 3rd ed (LexisNexis, Durban 2015).

Van Niekerk GJ and Wildenboer L *The Origins of South African Law* (Unisa, Pretoria 2010).

Vasuthevan S, Dennill K and De Haan M *The health of South Africa* (Juta Publishers, Cape Town 2007).

Veitz J, Ulrich B, Heald RJ and Buchler MW *Rectal Cancer Treatment* (Springer, New York 2005).

Venter B and Levy A *Labour Relations in South Africa* (Oxford University Press, Cape Town 2009).

Verschoor T and Claassen NJB *Medical Negligence in South Africa* (Digma Publishers, Johannesburg 1992).

Vij K *Textbook of Forensic Medicine and Toxicology: Principles and Practices* (Elsevier Publishers, New Delhi 2009).

Voet J *The Acquilian Law* 23.

Vysas D *Comprehensive Textbook of Surgery* (Jaypee Brothers Medical Publishers, New Delhi 2012)

W

Wadham J *et al, The Equality Act 2010* (Oxford University Press, London 2012).

Wagener DJ *The History of Oncology* (Springer, Uitgeverij 2009).

Walker S *Development of the Gastrointestinal Tract* (BC Decker Publishers, Canada 1999).

Watson JD *The Double Helix: A Personal Account of the Discovery of the Structure of DNA* (Atlantic Monthly Publishers, Washington DC 1968).

Watts C *Emerging Concepts in Neuro-Oncology* (Springer, London 2013).

Wax ACH *Patient's Rights* (YOZMOT Publishers, London 2002).

Waxman J and Bower M *Lecture Notes: Oncology* (Black Well Publishers, London 2010).

Webb S *Intensity-Modulated Radiation Therapy* (IOP Publishing, London 2001).

Webb S *The Physics of Three Dimensional Radiation Therapy: Conformal Radiotherapy, Radiosurgery and Treatment Planning* (IOP Publishing, London 1993).

Webster JG *Minimally Invasive Medical Technology* (IOP Publishing, London 2001).

Wegner DM and Lane JD Emotion, Disclosure and Health (Pennebaker Publishers, Washington DC 1995).

Welvarrt K, Blumgart J and Kreuning J *Colorectal Cancer* (University Press, Leiden 1980).

Whittemore S *The Human Body how it works: The Respiratory System* (InfoBase Publishing, New York 2009).

Williams DT *Cancer Registry Handbook: a guide to the use of cancer registries London: United Kingdom Association of Cancer Registries* (Scientific Publishers, London 1994).

Winchester DP and Winchester DJ *Breast Cancer* (Walsworth Publishing Company, Missouri 2006).

Witzel M *Origins of the World's Myths* (Oxford University Press, Oxford 2013).

Wookman S, Roux T and Bishop M *Constitutional Law of South Africa: Student Edition* (Juta Publishers, Cape Town 2007).

X

Xu J and Gerhold M *First International Symposium on Semiconductor and Plasmonics-Active Nanostructures for Photonic Devices and Systems* (Electrochemical Society Publishers, New York 2009).

Journal articles

A

Adami HO, Magnuson A, Holmberg L, Dickman PW, Andersson SO, Andren O and Johansson JE "Natural history of early, localized prostate cancer" 2004 (9) *JAMA* 2713.

Adams JE "Judicial and regulatory interpretation of the employment rights of people with disabilities" 1991 (22) *JARC* 28.

Adewole IF, Denny L, Dangou J, Harford J, Rebbeck TR, Odedina F and Morshason-Bello IO "Challenges and opportunities in cancer control in Africa: A perspective from the African Organisation for Research and Training in Cancer" 2013 (14) *Series* 147.

Ahnen DJ and Levine JS "Clinical practice: Adenomatous polyps of the colon" 2006 (24) *NEJM* 2551.

Akazili J and Ataguba J "Health care financing in South Africa: Moving towards universal coverage" 2010 (28) *CEM* 75.

Alberts DS "A Unifying Vision of Cancer Therapy for the 21st Century" 1999 (17) *JCO* 13.

Alberts DS, Schilsky RL and Kelloff GJ "Colorectal adenomas: a prototype for the use of surrogate end points in the development of cancer prevention drug" 2004 (11) *CCR* 3908.

Aleaga ZG, Diaz RR, Perez SR, Prado YID, Hernandez MCR "Synchronous bilateral breast cancer in a male" 2013 (7) *Encancer* 5.

Amir Z, Neary D and Luker A "Cancer Survivors views of work three years post diagnosis: A United Kingdom perspective" 2008 (12) *EJOJ* 192.

Anand RVV "Malpractice litigation in patients in relation to delivery of breast care in the NHS" 2008 (17) *The Breast* 148.

Anema JR *et al*, "Barriers and facilitators for return to work in cancer survivors with job loss experience: a focus group study" 2015 (22) *EJCC* 210.

Annual Report "The role of the Cancer Association of South Africa in Volunteer involvement" 1998 (2) *CANSA* 37.

Asante-Shongwe K "Perspective of an Advocate-political advocacy in African cancer dialogue" 2013 (8) *Proceedings* 2.

Ashforth BE and Humphrey RH "Emotional Labour in Service Roles: The influence of identity" 1993 (18) *Academy of Management Review* 85.

Ashtiany S "The Equality Act 2010: Main Concepts" 2011 (11) *IJDL* 29-30.

Au J *et al*, L "Synergistic effect between alcohol consumption and familial susceptibility on lung cancer risk among chinese men" 2012 (7) *AFSLC* 1.

B

Banks E, Verkasalo PK and Key TJ "Epidemiology of Breast Cancer" 2001 (2) *Lancet Oncology* 133.

Banning M "Employment and Breast Cancer: a meta-ethnography" 2011 (20) *EJCC* 708.

Barry MJ "Medical Malpractice Implications of PSA Testing for Early Detection of Prostate Cancer" 2008 (25) *J.L.Med & Ethics* 235.

Bartlett P "Legal madness in the Nineteenth century" 2001 (14) *Soc Hist Med* 108.

Batra SK, Metha PP, Hauke R and Mimeault M "Recent advances in cancer stem/progenitor cell research: therapeutic implications to overcome resistance to the most aggressive cancers" 2007 (11) *JCMM* 981.

Barrow M "Portraits of Hippocrates" 1972 (16) *Medical History* 85-88.

Bateman C "Payouts Against Doctors Spiralling Upwards" 2005 (95) *SAMJ* 376.

Bazamore L "Employment Discrimination against Cancer Survivors: A Proposed Solution" 2001 (31) *Vill. L.Rev* 1550.

Beasley RP *et al,* "Familial Aggression of Colorectal Cancer in Egypt" 1998 (77) *IJC* 812.

Beck S “Health Policy, Health Services, and Cancer Pain Management in the New South Africa” 1999 (17) *JPSM* 17.

Benfer EA “The American with Disabilities Amendment Act: An overview of recent changes to the American with Disabilities Act” 2009 *ASC* 6.

Bernard RB “Reasonable accommodation in the workplace: To be or Not to be?” 2014 (17) PER/PELJ 2871.

Blach CM *et al*, “Patient Risk Factors and Surgical Morbidity after Regional Lymphadenectomy in 204 Melanoma Patients” 1983 (51) *Cancer* 2152.

Bosch FX, Manos MM, Munoz N, Sherman M, Jansen AM, Peto J, Schiffman MH, Moreno V, Kurman R and Shah KV “Prevalence of human papillomavirus in cervical cancer: a worldwide perspective” 1995 (87) *JNCI* 796.

Bradley CJ, Robert N and Barnes AJ “Job attributes, job satisfaction and the return to health after breast cancer diagnosis and treatment” 2013 (23) *Psycho-Oncology* 158.

Bradshaw D *et al*, “The burden of non-communicable diseases in South Africa” 2009 (374) *Series* 940.

Brewer NT,Smith JS, Gottlieb SL and Salz T “The association between cervical abnormalities and attitudes toward cervical cancer prevention” 2010 (19) *JWH* 2014.

Burchell JM “Media Freedom of Expression Scores as Strict Liability Receives the Red Card: National Media Ltd v Bogoshi” 1999 SALJ 1.

C

Callaghan WB “Professional liability of plastic surgeons in Canada” 1997 (5) *CJPS* 230-231.

Cambrosio A and Keating P “The art of medicine 21st century oncology: a tangled web” 2013 (382) *Perspectives* 45.

Cancer Journey Advisory Group “Research Related to the Workplace Support for Cancer Survivors: Perspective of Employers” 2012 (4) *CPAC* 44.

Canfield L “Persons living with cancer Prognosis: How Terminal are their Employment Prospects?” 2001 (38) *Syracuse Law Review* 801.

Capasso L “Antiquity of Cancer” 2005 (113) *Int. J Cancer* 3.

Carlson G and Allen S “To conceal or disclose a disabling condition? A dilemma of employment transition” 2003 (19) *JVR* 20.

Carstens P "Setting the Boundaries for Expert Evidence in Support or Defence of Medical Negligence: *Michael and AN Other v Linksfield Park Clinic (Pty) Ltd* 2001 (3) SA 1188 (SCA)" 2002 (65) *THRHR* 430.

Carstens PA "Judicial Recognition of the Application of the maxim *Res Ipsa loquitur* to a case of Medical Negligence: *Lungile Ntsele v MEC for Health, Gauteng Provincial Government* (Unreported as yet, case number: 2009/52394 (GSJ) Dated 24 October 2009)" 2013 *Obiter* 349.

Carstens PA and Coetzee LC "Medical malpractice and compensation in South Africa" 2011 (86) *Chicago-Kent Law Review* 1263.

Cathy J *et al*, "Employment patterns of long term cancer survivors" 2002 (11) *Psycho Oncology* 188.

Chaussee M A Discussion Paper "Creativity, Innovation and Economic Growth in the 21st Century" 2004 *BIAC* 3.

Chersich M *et al,* "Inequalities in access to health care in South Africa" 2011 (32) *JPHP* 2.

Cherng C, Wang J, Ho S and Ger L "The Prevalence and Severity of Cancer Pain: A Study of Newly-Diagnosed Persons living with cancer in Taiwan" 1998 (15) *JPSM* 285.

Chevalier T and Novell S "Chemotherapy for non-small cell lung cancer: Part 1, Early stage disease" 2003 *Oncology* (17) 357.

Church JM "Endoscopy of the colon, rectum and anus" 1995 (4) *Igaku-Shoin* 270.

Cilliers L and Retief FP "History of Medicine: Breast Cancer in Antiquity" 2011 (101) *SAMJ* 10.

Clements RV "Risk Management and Litigation in Obstetrics and Gynaecology" 2002 (12) *JRSM* 625.

Coebergh JW and Jansen-Heijnen MLG "The changing epidemiology of lung cancer in Europe" 2003 (41) *Lung Cancer* 245.

Collins H "Discrimination, Equality and Social Inclusion" 2003 (66) *MLR* 18.

Collins NL and Miller LC "Self-disclosure and liking: A meta-analytic review" 1994 (116) *Psychological Bulletin* 457.

Colombo S "Battling Cancer: Law and Life" 2001 (24) *Harv Women's L.J* 1.

Cooley ME "Symptoms in Adults with Lung Cancer: A Systematic Research Review" 2000 (19) *JPSM* 137.

Cooper AF, Low E and Grunfeld EA "Cancer survivors and employers perceptions of working following cancer treatment" 2010 (60) *Occupational Medicine* 612.

Cowan DH “O. Harold Warwick: Canada’s first medical oncologist” 2011 (18) *PMC* 117.

Crosby E “Medical malpractice and anesthesiology: literature review and role of the expert witness” 2007 (54) *CJA* 227.

D

Dahl AA *et al*, “Change in Employment Status of 5-year Cancer Survivors” 2012 (10) *EPHA* 1-2.

Dahman B *et al*, “Work continuation while treated for breast cancer: The role of workplace accommodations” 2015 (68) *ILR Rev. J Work and Policy* 925.

Daniel JS “A Taxonomy of Privacy” 2006 (154) *PL.REV* 527.

Davenport JH and Abitbol MM “Sexual dysfunction after therapy for cervical carcinoma” 1974 (119) *JOG* 181.

De Ruysscher DKM, Fennell DA and Van Meerbeeck JP “Small-cell lung cancer” 2011 (378) *Seminar* 1741.

Dearnaley D “Small-cell lung cancer” 1995 (345) *The Lancet* 1285.

Demetrious T, Papavramidis T and Papavramidis T “Ancient Greek and Greco-Roman Methods in Modern Surgical Treatment of Cancer” 2010 (17) *ASO* 666.

Denny L, Kuhn L and Batra P “Utilisation and Outcomes of Cervical Cancer Prevention Services among HIV-Infected Women in Cape Town 2010 (100) *SAMJ* 39.

DeSantis C, Centre MM and Jemal A “Global Patterns of Cancer Incidences and Mortality Rates and Trends” 2010 (19) *CEBP* 1893.

Devane C “Making the Shift, Providing Specialist Work Support to People with Cancer” 2013 (1) *Macmillian Cancer Support* 11.

Dhai E “Medico-legal litigation: Balancing spiralling costs with fair compensation” 2015 (8) *SAJBL* 2.

Diamantis A and Grammaticos PC “Useful known and unknown views of the father of modern medicine, Hippocrates and his teacher Democritus” 2008 (11) *HJNM* 2.

Digest: Ad Legem Aquiliam 50 17 32 "(Gaius 7 Ad Edictuum Provinciale): Imperitia Culpae Adnumeratur" *Inst Just 437.*

Doyal L and Hoffman M “The growing burden of chronic diseases among South African women” 2009 (27) *CME* 458.

Dresen-Frings MHW and De Boer AGEM “Employment and the common cancers: return to work of cancer survivors” 2009 (59) *Occupational Medicine* 378.

Du Plessis LM “The Ideal Legal Practitioner” 1981 *De Rebus* 424.

Da Silva DB “The Increasing Growth of Plastic Surgery Lawsuits in Brazil” 2010 (34) *APS* 541.

E

Express “More Services Needed to Fight Cancer” 2006 (23) *University of Free State* 8.

Elias C, Herdman C and Sherris J “Beyond our borders cervical cancer in the developing world” 2001(175) *WJM* 231.

F

Falkson G and Beck S “Prevalence and Management of Cancer Pain in South Africa” 2001 (94) *Pain* 76.

Farley SP *et al*, “Work disability associated with cancer survivorship and other chronic conditions” 2008 (17) *Psycho-Oncology* 91-92.

Feng L, Ma D, Chen Z, Zhang Q, Hu T, Xiang Q, Zhou H, Yang R, Li S and Jia Y “Knowledge about cervical cancer and barriers of screening program among women in wufeng country, a high incidence region of cervical cancer in china” 2013 (8) *Plos One* 1.

Ferlay J, Pisani P and Parkin DM “Estimates of the worldwide incidence of 25 major cancers in 1990” 1999 (80) *IJC* 827.

Fesko SL “Working it out: Workplace Experiences of Individuals with HIV and Cancer” 1999 (5) *ERIC* 4.

Fiander A and Rieck G “The effect of lifestyle factors on gynaecological cancer” 2006 (20) *BPRCOG* 227.

Finley LM “Transcending Equality Theory: A way out of the maternity and the workplace debate” 1986 (86) *CLR* 1118.

Fow NR, “Cancer rehabilitation: An investment in survivorship: As more people survive the disease, focus shifts on improving quality of life” 1996 (9) *REHAB Manage* 48.

Fraumeni JF *et al,* “International trends and patterns of primary liver cancer” 2001 (94) *IJC* 290.

Frederick SL “*Pain and Suffering Guidelines: A Cure for Damages Measurement "Anomie,"* 1989 (22) *MICJR* 330.

Freider MI *et al*, "Selecting and Presenting a Failure to Diagnose Breast Cancer Case" 2001(20) *AM. J.Trial Advoc* 253.

G

Gambhir SS and Thakor AS "Nanooncology: The Future of Cancer Diagnosis and Therapy" 2013 (63) *CJC* 395-397.

Gibbs W "The Kpelle Moot: A therapeutic model for informal justice settlement" 1963 (33) *Africa* 4.

Goldberg PA *et al,* "Incidences and histological features of colorectal cancer in the Northern Cape province, South Africa" 2010 (48) *SAJS* 109.

Golbey RB *et al*, "Treatment of primary and secondary liver cancer by hepatic artery ligation and infusion chemotherapy" 1973 (178) *Cancer of the Liver* 162.

Gomez JC "Silencing the hired guns: Ensuring honesty in medical testimony" 2005 (26*) J Leg Med* 385.

Grant WB "A Multicountry Ecological Study of Cancer Incidence Rates in 2008 with Respect to Various Risk-Modifying Factors" 2014 (6) *Nutrients* 164.

Grobler S "The Role of the Expert Witness" 2007 (5) *The South African Gastroenterology Review* 11.

Guadin N and Terresse V "Latest world cancer statistics: Global cancer burden raises to 14.1 million new cases in 2012: Marked increase in breast cancers addressed" 2013 (223) *WHO* 1.

H

Hajdu SI "A Note From History: Landmarks in History of Cancer Part 1" 2010 *Cancer* 1097.

Hajdu SI "A Note From History: Landmarks in History of Cancer, Part 3" 2011 *Cancer* 1156.

Hajdu SI "A Note From History: Landmarks in History of Cancer, Part 4" 2012 *Cancer* 4914.

Hajdu SI and Vadmal M "A Note from History: Landmarks in History of Cancer, Part 6" 2013 *Cancer* 4058.

Hannett S "Equality at the Intersections: The Legislative and Judicial Failure to Tackle Multiple Discrimination" 2003 (23) *OJLS* 66.

Harkin T “The Americans with Disabilities Act: Four year later- commentary on blanck” 1994 (79) *IOWA.L.R* 936.

Harris JR and Bellon JR “Chemotherapy and Radiation Therapy for Breast Cancer: What is the Optimal Sequence?” 2005 (23) *JCO* 5.

Haslam C, Kalawsky K, Bains M, Munir F and Yarker J “The role of communication and support in return to work following cancer-related absence” 2010 (19) *Psycho-Oncology* 1078.

Hassan R “Overview of Mesothelioma” 2011 *NCI* 1.

Hays DM, “Adult survivors of childhood cancer” 1993 (10) *Cancer Supplement* 3306.

Hendricks A “Selected Legislation and Jurisprudence: UN Convention on the Rights of Persons with Disabilities”5 2007 (14) *Eur. J. Health. L* 273-274.

Hellman S “Natural History of Small Breast Cancers” 1994 (12) *JCO* 2229.

Hepple B “The New Single Equality Act in Britain” 2010 (5) *TERR* 12.

Hoffman B “Cancer Survivors at Work: A Generation of Progress” 2005 (55) *CACJC* 272.

Hodges AC “Working with Cancer: How the law can help survivors maintain employment” 2015 (90) *Wash. L. Rev* 1039.

Hoogsteden HC, Hoop B, Westeinde SC and Van Klaveren RJ “Stem cells and the natural history of lung cancer: implications for lung cancer screening” 2009 (7) *Perspective* 2217.

Hume JW and Adlard AW “Cancer knowledge of the general public in the United Kingdom: survey in a primary care setting and review of the literature” 2003 (15) *Clinical Oncology* 174.

I

Iberts DS “A Unifying Vision of Cancer Therapy for the 21st Century” 1999 (17) *JCO* 13.

Ikram S, Oliveira C, Sousa S and Prates C “Prostate metastatic bone cancer in an Egyptian Ptolemaic mummy, a proposed radiological diagnosis” 2011 (1) *IJP* 101.

ILO “The price of exclusion: the economic consequences of excluding people with disabilities from the world of work: Employment working paper” 2009 (43) *ILO* 2.

J

Jemal A and Naishadham SR “Cancer Statistics” 2012 (62) *CA Cancer J* 10

Jemal A, Siegel R and Center M “Cancer in Africa” 2008 *WHO* 2.

Jensen EG “When “hired guns” backfire: The witness immunity doctrine and the negligent expert witness” 1993 (65) *UMKC Law Rev* 185.

Jordaan E and Ismail R "Appeal Court Sets the Record Straight" 2014 (11) *WP* 24.

K

Kaersvang D “Equality in South Africa: Legal access for the Poor” 2008 (15) *The Journal of the International Institute* 1.

Karlan PS and Rutherglen G “Disabilities, Discrimination, and Reasonable accommodation”1996 (41) *Duke Law Journal* 4.

Kay S “Congress Report” 1992 (82) *SAMJ* 214.

Keith DL “Medical Expert Testimony in Texas Medical Malpractice Cases” 1991 (1) *BLR* 5.

Kellett P *et al*, “Repeability of manual coding of cancer reports in the South African National Cancer Registry, 2010” 2013 (3) *SA J Epidemiol Infect* 157.

Kellett P *et al*, “South African National Cancer Registry: Effect of Withholding data from private health systems on cancer incidence estimates” 2015 (2) *SAMJ* 107.

Kemmner W, Andrade-Navarro MA, Huska MR and Fehlker M “Concerted down-regulation of immune-system related genes predicts metastasis in colorectal carcinoma” 2014 (14) *BMC* 64.

Kennedy F, “Returning to work following cancer: a qualitative explanatory study into the experience of returning to work following cancer” 2007 (16) *Europ J Cancer Care* 17.

Kern KA “The delayed diagnosis of breast cancer: medico-legal implications and risk prevention for surgeons” 2008 (12) *The Breast* 148-149.

Kim M *et al,* “Mild obesity, physical activity, calorie intake and the risks of cervical intraepithelial neoplasia and cervical cancer” 2013 (8) *Plos One* 1.

Kim TH *et al,* “Socioeconomic disparity in cervical cancer screening among Korean women: 1998-2010” 2013 (13) *BMC* 533.

Kisting S and Bruan L “Asbestos-Related Diseases in South Africa: The Social Production of an Invisible Epidemic” 2006 (96) *AJPH* 1386.

Kok A “The promotion of equality and prevention of unfair discrimination act: Why the controversy?” 2001 (2) *TSAR* 294.

Korn JB “Cancer and the ADA: Rethinking disability”2001 (74) *S. Cal L Rev* 400.

Krebs LU and Pelusi J “Understanding Cancer-Understanding the Stories of Life and Living” 2015 (20) *JCE* 12.

Kunklerl ML *et al*, “Recent Cancer survival in Europe: a 2000-2002 period analysis of EUROCARE-4 data” 2007 (8) *Lancet Oncology* 784.

L

Lagergren J and Lagergren P “Recent developments in oesophageal adenocarcinoma” 2013 (63) *CA Cancer J Clin* 232.

Lance Armstrong Foundation “A National Action Plan for Cancer Survivorship: Advancing Public Health Strategies” 2004 (4) *CDC* 6.

Le Roux R “The new unfair labour practice” 2012 *Acta Juridica* 43.

Leyvraz S, Perry MC, Turrisi AT, Monnerat C and Stupp R “Small-cell lung cancer: state of the art and future perspectives” 2004 (45) *Lung Cancer* 105-106.

Lindbohm ML *et al*, “Comparative Study of Work Ability between Cancer Survivors and their Referents” 2007 (43) *EJC* 914.

Lindbohm ML *et al*, “The impact of education and occupation on the employment status of cancer survivors” 2004 (40) *EJC* 2488.

Lorigan P, Blackhall F, Lowe M and Molassiotis A “A qualitative exploration of a respiratory distress symptom cluster in lung cancer: Cough, breathlessness and fatigue” 2011 (71) *Lung Cancer* 94.

Lu A *et al*, “Cervical Cancer Screening and Prevention for HIV-Infected Women in the Developing World” 2010 *CECAP* 1.

Lund F “Social Security and the Changing Labour Market: Access for Non-Standard and Informal Workers in South Africa” 2002 (28) *Social Dynamics* 177.

Lyratzopoulos G, Abel G and Saunders C “What Explains Worse Patient Experience in London? Evidence from Secondary Analysis of the Persons living with cancer Experience Survey” 2014 (4) *BMJ OPEN* 1.

M

Mackintosh D "The politicisation of HIV and AIDS in South Africa: Responses from the Treatment Action Campaign and South African government, 1994-2004" 2009 (204) *CSSR* 8.

Malherbe J "Counting the cost: The consequences of increased medical malpractice litigation in South Africa" 2013 (103) *SAMJ* 1-3.

Managing Cancer in the Workplace "Guidelines for employers and workmates" 2009 (2) *Cancer Society of New Zealand* 1.

Manamela T "Failure to obey employer's lawful instructions and reasonable instructions: Operational perspective in the case of a dismissal: *Motor Industry Staff Association and Another v Silverton Spraypainters and Panelbeaters (Pty) Ltd*" 2013 (25) SA Merc LJ 424**.**

Marumoagae MC "Disability Discrimination and the Right of Disabled Persons to Access the Labour Market" 2012 (15) *PER* 351.

Matthews FE, Flecher O, Gilham C and Peto J "The cervical cancer epidemic that screening has prevented in the UK" 2004 (364) *Articles* 249.

Mavroforou A, Giannoukas A and Michalodimitrakis E "Medical Litigation in Cosmetic Plastic Surgery" 2004 (3) *ML* 479.

Mazumdar M *et al*, "Employment After a Breast Cancer Diagnosis: A Qualitative Study of Ethnically Diverse Urban Women" 2012 (37) *J Community Health* 763.

McCalla AF "Challenges to World Agriculture in the 21st Century" 2001 (4) *Spring* 1.

McCready D *et al,* "How Can Diagnostic Assessment Programs be Implemented to Enhance Inter-Professional Collaborative Care for Cancer?" 2014 (9) *BioMed Central* 1-2.

McCrudden C "Institutional Discrimination" 1982 (2) *OJLS* 303.

McGannon E, and Church J "Family history of colorectal cancer: How often and how accurate it is recorded" 2000 (43) *DCR* 1540.

McIntyre D *et al,* "The health and health system of South Africa: historical roots of current public health challenges" 2009 (374) *Lancet* 817.

McKeena MA *et al*, "Workplace discrimination and cancer"2007 (29) *Work* 313.

McPherson KM, Porter D, Whitehead LC, Cameron L, Brown P and Bennett JA "Changes in employment and household income during the 24 months following a cancer diagnosis" 2009 (17) *Support Care Cancer* 1057.

McQuoid-Mason D "Establishing liability for harm caused to patients in a resource deficient environment" 2010 (100) *SAMJ* 574.

Mehnert A “Employment and Work-Related Issues in Cancer Survivors” 2011 (2) *CRO* 109.

Mehnert A, “Employment and work-related issues in cancer survivors” 2011 (77) *Crit Rev Oncol Hematol* 109.

Mehnert A *et al*, “Employment challenges for cancer survivors” 2013 (1) *Cancer* 2151.

Mello JA “Employment and Public Policy Issues Surrounding Medical Marijuana in the Workplace” 2013 (117) *JBE* 663.

Morrell JJ “Aids and Cancer: Critical employment discrimination issues” 1990 (15) *J.Corp.L* 851.

Meruelo NC “Mediation and Medical Malpractice: The need to understand why patients sue and a proposal for a specific model of mediation” 2008 (2) JLM 287.

Moodley M “Cervical cancer in Southern Africa: The challenges” 2009 (1) *SAJGO* 11.

Moneer M, Taha FM and Zeeneldin AA “Past and future trends in cancer and biomedical research: a comparison between Egypt and the World using PubMed-indexed publications” 2012 (5) *BMC* 6.

Monte MJ, Rosales R, Martinez-Becerra P, Castona B and Marin JJG “Chemotherapy in the treatment of primary liver tumours” 2008 (6) *Cancer Therapy* 712.

Murphy DG *et al*, “My road ahead study protocol: a randomised controlled trial of an online psychological intervention for men following treatment for localised prostate cancer” 2014 (14) *BMC* 83.

N

Nadifi S *et al*, “Relationship between family history of breast cancer and clinicopathologica, features in Moroccan patients” 2013 (23) *EJHS* 151.

Nattras N “Aids Denialism vs Science” 2007 (31) *Skeptical Inquiry* 109.

Naylor CD “Private medicine and the privatization of health care in South Africa” 1988 (11) *Soc Science Med* 1153.

Newman R “The role of the Psychologist expert witness: Provider of Perspective and Input” 1992 (2) *Neuropsychological Review* 243.

Ngwena C “Interpreting Aspects of the Intersection between Disability, Discrimination and Equality: Lessons for the Employment Equity Act from Comparative Law. Part I (Defining Disability)” (2005) 16(2) *Stell L.R* 211.

Ngwena C and Pretorius L "Conceiving Disability, and Applying the Constitutional Test for Fairness and Disability: A Commentary on *IMATU v City of Cape Town*" (28) 2007 *ILJ* 747.

NSCLC Meta-Analysis Collaborative Group "Chemotherapy in addition to supportive care improves survival in advanced non-small cell lung cancer: a systematic review and meta-analysis of individual patient data from 16 randomized controlled trials" 2008 (26) *JCO* 4617.

Nyokong T and Ogbobu R "The effect of ascorbic acid on photophysical properties and photodynamic therapy activities of zinc phthalocyanine-single walled carbon nanotube conjugate on MCF-7 cancer cells" 2015 (151) *Molecular and Biomolecular Spectroscopy* 177.

O

Office for National Statistics "Cancer Statistics and registration in the United Kingdom" 2008 (38) *Series MB1* 28.

Omenah A and Buckle G "Factors influencing time to diagnosis and initiation of treatment of endemic Burkitt Lymphoma among children in Uganda and western Kenya: a cross sectional survey" 2013 *BioMed* 2.

Oosthuizen WT and Carstens PA "Re-evaluating medical malpractice: A patient safety approach" 2015 (78) *THRHR* 387.

Otto SF "Medical Negligence" 2004 (8) *SAJR* 20.

Osann KE "Lung cancer in women: the importance of smoking, family history of cancer, and medical history of respiratory disease" 1991 (51) *Cancer Research* 4893.

Oxford University Press "Scaling up cancer diagnosis and treatment in developing countries: what can we learn from the HIV and AIDS epidemic" 2012 (21) *Annals of Oncology* 680.

P

Pandit MS "Medical negligence: Coverage of the profession, duties, ethics, case law, and enlightened defense - A legal perspective" 2009 (25) *IJU* 372.

Parker RK and White RE "Oesophageal cancer: an overview of a deadly disease" 2007 (1) *AAS* 1-2.

Parkin DM "The evolution of the population-based cancer registry" 2006 (6) *Nature Reviews Cancer* 604.

Patel B “Medical Negligence and Res Ipsa Loquitur in South Africa” 2008 (1) *SAJBL* 58.

Patijn J, Van Kleef M, Schouten H and Kessels A “High Prevalence of Pain in Patients with Cancer in a Large Population-Based Study in the Netherlands” 2007 (132) *Pain* 312.

Pepper MS and Slabbert MN “Is South Africa on the verge of a medical malpractice litigation storm?” 2011 (4) *SAJBL* 29.

Peters S and Gabel S “Presage of a paradigm shift? Beyond the social model of disability toward resistance theories of disability” 2010 (19) *Disability and Society* 586.

Phillips C “Deviant Disabilities: The Exclusion of Drug and Alcohol Addiction from the Equality Act 2010” 2012 (21) *SLS* 395.

Pienaar L “Investigating the Reasons behind the Increase in Medical Negligence Claims” 2016 (19) *PER/PELJ* 13-14.

Pieterse M “Enforcing the right not to be refused emergency medical treatment: Towards appropriate relief” 2007 (18) *Stell L.R* 75-76.

Pieterse M “Legislative and executive translation of the right to have access to health care services” 2010 (10) *LDD* 243.

Plimmer HG “The Parasitic Theory of Cancer” 1903 (2) *BMJ* 1511.

Price K “The Art of Medicine Towards a History of Medical Negligence” 2010 (375) *The Lancet* 192.

Proctor RN “The history of discovery of the cigarette- lung cancer link: evidentiary traditions, corporate denial and global toll” 2012 (21) *Tobacco Control* 87.

Proctor RN “The Nazi war on tobacco: ideology, evidence and possible cancer consequences” 1997 (71) *BHM* 435.

Proctor RN “Tobacco and the global lung cancer epidemic” 2001 (1) *Perspective* 83.

R

Rachel C “Compassion in the Workplace? Discrimination against an Employee with Cancer” 2006 (12) *IJPN* 554-555.

Radin MJ “Compensation and Commensurability” 1993 (43) *JSTOR* 56.

Randolph F “Surgery in the 1700s” 2009 *Science Scribe* 3.

Reason J “Human error: models and management” 2000 (320) *BMJ* 768.

Roberts JL “Protecting privacy to prevent discrimination” 2015 (56) *Wm. & Mary L. Rev* 2097.

Robert PM and Harlan SL “The Social Construction of Disability in Organizations: Why Employers Resist Reasonable Accommodation” 1998 (25) *Work and Occupation* 398.

Rodrigues B “The Challenge of Cancer in Africa” 2013 *Cancer Control* 120.

Roos A “Personal Data Protection in New Zealand: Lessons for South Africa” 2008 (4) *PER* 191.

Russell G “Sickness Absence and Disability Discrimination” 2013 (14) *TUC* 4.

Ryder RW, Nouemssi JPE, Atenguena E, Ndom P and Price AJ “Cancer Care Challenges in Developing Countries” 2012 (11) *Cancer* 3627.

S

Sasieni P, Cuzick J, Landy R and Castanon A “Cervical Screening at age 50-64 years of age and the risk of cervical cancer at the age of 65 years and older: population based case control study” 2014 (11) *PLOS Medicine* 13.

Seifart CKU *et al*, “Reintergrating Persons living with cancer into the Workplace” 2012 (109) *Medicine* 703.

Sellers WR and Singh D “Gene expression correlates of clinical prostate cancer behaviour” 2002 (1) *Cancer Cell* 203.

Shaw WS and Feuerstein M, “Generating workplace accommodations: lessons learned from the integrated case management study” 2004 (3) *J Occup Rehabil* 16.

Shields MB “Morgagni’s Cataract” 2013 (17) *SCOPE* 1-5.

Singh E *et al,* “South African National Cancer Registry: Effect of withholding data from private health system on cancer incidence estimates” 2015 (105) *SAMJ* 107.

Sjostorom-Mattson J *et al*, “Male breast cancer: A survey at the Helsinki University Central Hospital during 1981-2006” 2010 (49) *Acta Oncologica* 322.

Skipper PL *et al*, “Cancer survivors at work: Job problems and illegal discrimination” 1989 (16) *Oncology Nursing Forum* 41.

Smith EJ "Medicine, the law and juvenile delinquency" 1936 (27) *J Criminal L & Criminology* 505.

Soressi M, Dibble HL, McPherron SP and Olszewski DI “Middle Egypt in Prehistory: A Search for the Origins of Modern Human Behaviour and Human Dispersal” 1989 (43) *Expedition* 31.

Spechler SJ “Barrett oesophagus and risk of oesophageal cancer: A clinical review” 2013 (310) *JAMA* 627.

Sprangers MAG *et al,* “Cancer, fatigue, and the return of patients to work- a prospective cohort study” 2003 (39) *European Journal of Cancer* 1562.

Stefan DC “Why cancer is not a priority in South Africa?” 2015 (105) *SAMJ* 103-104.

Stefanandis C, Karamanou K and Androutsos G “William Harvey (1578-1657): Discoverer of Blood Circulation” 2012 (53) *HJC* 6-7.

Steineck G, Henningsohn L, Dickman PW, Lundqvist E and Bergmark K “Vaginal changes and sexuality in women with a history of cervical cancer” 2005 (340) *NEJM* 1383.

Strauss SA “The Physician’s Liability for Malpractice: A Fair Solution to the Problem of Proof?” 1967 (24) SALJ 419.

Streicher K “Cancer-Based Employment Discrimination: Whether the Proposed Amendment to Title VII Will Provide An Effective Anti-Discrimination Remedy” 2010 (62) *Ind.L.J* 827.

Stringer CA, Scruggs RP, Race GJ, Matthews CM, Lieberman ZH, Fay JW, Evans WP, Aronoff BE and Stone MJ “History of the Baylor Charles A. Summons Cancer Centre” 2003 (16) *BUMC* 31.

Surender R “The Drivers of Universal Health Care in South Africa: The Roles, Ideas, Institutions and Actors” 2014 (19) *UNRISD* 14.

Swanepoel C “Medication errors in oncology: a literature review” 2013 (80) *SAfr Pharm J* 48.

T

Thomson SR and Coetzee EDT "Inherited colorectal cancer: A plea for a national registry" 2013 (51) *SAJS* 41-42.

Timmons A and Sharp L "The financial impact of a cancer diagnosis" 2010 (2) *NCR* 3.

Tollman SM and Kautzky K "A Perspective on Primary Health Care in South Africa" 2008 (2) *SAHR* 20.

Tsungawa K and Hashizume M "Robotic Surgery and Cancer: the Present State, Problems and Future Vision" 2004 (34) *JJCO* 228.

Tubaro A *et al*, "The influence of family history on prostate cancer risk: implications for clinical management" 2010 (107) *BJU* 716.

Tunceli K, Vasey JJ and Short PF Employment Pathways in a Large Cohort of Adult Cancer Survivors" 2005 (6) *Cancer* 1292.

U

UCL School of Pharmacy "Patient's Needs, Medicines and Innovation and the Global Public's Interests" 2013 *UCL* 3.

V

Van Dokkum N "*Res ipsa loquitur* in medical malpractice law" 1996 (15) *Medicine and Law* 227.

Van Dokkum N "The evolution of medical malpractice in South Africa" 1997 (41) *Journal of African Law* 75.

Van Hagen P, Hulshof MC and Van Lanschot JJ "Preoperative chemo radiotherapy for oesophageal or junctional cancer" *2012 (366) N Engl J Med* 2074.

Van Jaarsveld M "An Employees Contractual Obligation to Promote Harmonious Relationships in the Workplace- When Are the Stakes too High? Some Pointers from the Judiciary" 2007 (19) *SA Merc LJ* 205.

Van Oosten FFW "Castell v De Greef and the Doctrine of Informed Consent: Medical Paternalism ousted in favour of Patient Autonomy" 1995 (1*) De Jure* 166.

Van Reenen TP "Equality, Discrimination and Affirmative Action: An Analysis of Section 9 of the Constitution of the Republic of South Africa" (1997) 12 *SA Public Law* 159.

Veller M “Department of Surgery, University of Witwatersrand- a brief history” 2006 (44) *SAJS* 45-46.

Venter M, Venter C and Botha K “Cancer Treatment in South Africa: A Narrative Literature Review” 2012 (22) *JPA* 462.

Venturino A and Colloca G “The evolving role of familial history for prostate cancer” 2011 (50) *Acta Oncologica* 14.

Verbeek JH *et al*, “Cancer survivors and unemployment: a meta-analysis and meta-regression” 2009 (301) *JAMA* 753.

Vettori S “The role of human dignity in the assessment of fair compensation for unfair dismissals” 2012 (15) *PER/PELJ* 102.

Vijh R and Morgan JL “Trends in malpractice litigation in relation to the delivery of breast care in the National Health Service” 2013 (22) *The Breast* 965.

Vorobiof DA and Ruff P “Cancer in South Africa and the role of the National Cancer Registry” 2011 (2) *ASCO POST* 16.

W

Wagstaff A “Stigma: breaking the vicious cycle” 2013 *World Cancer* 24-27.

Wardrop M “The NHS faces a £ 15.7 billion bill to settle a rising number of clinical negligence claims” 2012 (7) *The Telegraph* 1.

Warren SD and Brandeis LD “The Right to Privacy” 2000 (4) *Harv. L Rev* 193.Webber MC “Unreasonable Accommodation and Undue Hardship” 2010 (62) *FLA.L.Rev* 1123.

Wecht CH "The history of legal medicine" 2005 (33) *J Am Acad Psychiatry Law* 245.

Weeks JC *et al,* “Employment Among Survivors of Lung Cancer and Colorectal Cancer” 2010 (28) *JCO* 1700.

Wheatly P *“*Employability of Persons with a History of Treatment of Cancer” 1975 (31) *CANCER* 441.

Wheldon TE “Radiation physics and genetic targeting: new directions for radiotherapy” 2000 (45) *PMB* 78.

Wilmott JH “Employment Discrimination in Organizations: Antecedents and Consequences” 2006 (32) *Journal of Management* 787.

Witschi H “Profiles in Toxiology: A short History of Lung Cancer” 2001 (64) *Toxicological Sciences* 5.

Wood J and Martin-Hirsch P “Clinical Evidence Cervical Cancer” 2009 *BMJ* 1.

Y

Yamamoto N, Endo M, Naito T, Nakamura Y, Tsuya A, Murakami H, Takahashi T, and Kaira K "Long-term survivors of more than 5 years in advanced non-small cell lung cancer" 2010 (67) *Lung Cancer* 120.

Yip K *et al,* "Using routinely collected data to stratify prostate persons living with cancer into phases of care in the United Kingdom: implications for resource allocation and the cancer survivorship programme" 2015 (112) *British Journal of Cancer* 1594.

Z

Zakowski MF "Lung Cancer in the Era of Targeted Therapy A Cytologist's Perspective" 2013 (137) *APLM* 1816.

Zarick AL "Damage Deferred: Determining When a Cause of Action Begins to Accrue from a Cancer Misdiagnosis Claim" 2010 (41) *U.Tol.L.Rev* 483.

Zeng-chen MA, Ye-Quin YU, Tang ZY and Zhou XD "Clinical Evaluation of Cryosurgery in the treatment of primary liver cancer: Report of 60 cases" 1988 (61) *Cancer* 1889.

Zimmerman MR and David R "Cancer: an old disease, a new disease or something in between?" 2010 (10) *Perspective* 728.

Reports

Annual Report "The role of the Cancer Association of South Africa in Volunteer involvement" 1998 (2) *CANSA* 37.

Beattie A *Sustainable health care financing in Southern Africa: Papers from the EDI health policy seminar held in Johannesburg, South Africa, June 1996* (Library of Congress Cataloguing in Publication, New York 1998).

Health Professions Council of South Africa: Annual Report (2010-2011).

Stewart BW World Cancer Report (International Agency for Research on Cancer, Lyon 2014).

World Health Organisation (WHO) The World Health Report: *Primary Health Care-Now More than Ever* (2008).

World Health Organisation (WHO) "World Cancer Factsheet" 2008/*ARC*.

Newspaper articles

Adams 2007-05-31 *Star* 1.

Bhengu 2011-05-20 *Financial Mail* 57.

Blair T "Tony Blair's speech on compensation culture" 2005 *The Guardian* 1-3.

Boseley S 2014-01-14 *The Guardian* 3.

CANSA 2004-08-27 *Daily News* 6.

Charlton 2018-01-17 *Timeslive* 6.

Cheng 2007-09-28 *Star* 13.

Ellis 2003-02-04 *Star* 6.

Flanagan 2008-11-14 *Star* 10.

Galliet 2010-04-13 *Business Day* 7.

Gulf News 2013-05-03 *Daily Mail* 3.

Hallett 2002-02-16 *Natal Witness* 8.

Harrilall 2005-02-04 *Natal Witness* 6.

Hlongwane 2008-07-20 City *Press* 2.

Hope 2013-05-02 *Mail Online* 2.

Immunology 2006-11-22 *Business Day* 5.

Macrae F "Cancer is purely man-made say scientists after finding almost no trace of disease in Egyptian mummies" 15-10-2010 *Daily Mail* 13.

Monty S "Consumer Commission - procedural opp" 2012 *Business Day* 1.

News "Doctors lose patience as suits spike" 2012 (2) *City Press* 1-3.

Oncology 2008-07-14 *Business Day* 4.

Pather 2004-10-06 *Daily News* 10.

Pile 2010-03-26 *Financial Mail* 26.

Radebe 2013-05-15 *Citizen* 29.

Reynolds 2013- 05- 17 *Mail and Guardian* 5.

Ridyard 2003-10-30 *Citizen* 25.

Sartorius B "Shocking Cancer facts and statistics" *Herold* (10/01/2017).

Smetherham 2002-10-17 *Cape Times* 3.

Sood V "Wipro sued by former employee in UK for sexual discrimination" 2015 *The Guardian* 6.

Witness 2007-02-01 *Witness* 6.

Internet sources

A

AFCRN
http://afcrn.org/membership/membership-list/87-ncrsa
(Date accessed: 2 May 2014).

B

British Council of Organisations of Disabled People 2009
http://britishcouncil.org/sites/default/files/promoting_disability_equality.doc
(Date accessed: 22 October 2016).

Breakstone
http://www.bwglaw.com/lawyer-attorney-1368134.html
(Date accessed: 8 January 2015).

Breast Cancer Statistics Worldwide
http://www.worldwidebreastcancer.com/learn/breast-cancer-statistics-worldwide/
(Date accessed: 4 March 2014).

Botha Y "Social Assistance Amendment Bill [B5-2010]: Briefing by the Department of Social Development" at https://pmg.org.za/committee-meeting/11437/ (Date accessed: 30 October 2015).

C

Cancer Impacts in the Workplace
http://www.cancer.org.au/content/pdf/AboutCancer/support/workingwithcancer_sect2.pdf
(Date accessed: 31 March 2014).

Cancer Net

http://www.cancer.net/coping/age-specific-information/cancer-olderadults/cancer-treatment
(Date accessed: 12 January 2014).

Cancer Net
http://www.cancer.net/coping/relationships-and-cancer/cancer-and-workplace-discrimination
(Date accessed: 3 February 2014).

Cancer Net
http://www.cancer.net/navigating-cancer-care/cancer-basics/cancer-care-team/types-oncologists
(Date of use: 19 February 2014).

Cancer Net
http://www.cancer.net/survivorship/life-after-cancer/cancer-and-workplace-discrimination
(Date accessed: 28 March 2014).

Cancer Research UK
http://www.cancerresearchuk.org/cancer-help/about-cancer/cancer-questions/how-many-different-types-of-cancer-are-there
(Date accessed: 13 January 2014).

Cancer Research UK
http://www.cancerresearchuk.org/cancer-info/cancerandresearch/all-about-cancer/what-is-cancer/is-cancer-a-modern-disease/
(Date accessed: 21 February 2014).

Cancer Research UK
http://www.cancerresearchuk.org/cancer-info/cancerstats/incidence/commoncancers/uk-cancer-incidence-statistics-for-common-cancers
(Date accessed: 25 February 2014).

Cancer Research UK
http://www.cancerresearchuk.org/cancer-info/spotcancerearly/key-signs-and-symptoms/whyisearlydiagnosisimportant/why-is-early-diagnosis-important
(Date accessed: 5 March 2014).

Cancer Research UK
http://www.cancerresearchuk.org/cancer-help/about-cancer/cancer-questions/the-disability-discrimination-act-and-cancer
(Date accessed: 31 March 2014).

CANSA
http://www.uicc.org/membership/cancer-association-south-africa

(Date accessed: 14 January 2014).

CANSA
http://www.givengain.com/cause/1056/
(Date accessed: 14 January 2014).

CANSA
http://www.cansa.org.za/actress-is-cancer-survivor/
(Date accessed: 15 January 2014).

CANSA
http://www.cansa.org.za/letter-to-corporates-world-cancer-day-4-feb-2014/
(Date accessed: 22 March 2014).

CANSA
http://www.cansa.org.za/letter-to-corporates-world-cancer-day-4-feb-2014/
(Date accessed: 10 February 2016).

Carstens PA
http://new.samls.co.za/node/410
(Date accessed: 2 June 2014).

Castillo M
http://www.cbsnews.com/news/woman-gets-chemo-only-to-find-out-she-never-had-cancer/
(Date accessed: 7 January 2014).

Coghlan
http://www.newscientist.com/article/dn19591-briefing-cancer-is-not-a-disease-of-the-modern-world.html
(Date accessed: 10 January 2014).

Colon Cancer
http://www.medicinenet.com/colon_cancer/page2.htm
(Date accessed: 10 January 2014).

Constitutio Criminalis Carolina
http://www.latein-agina.de/explorer/hexen1/carolina.htm
(Date accessed: 12 August 2016).

D

Deans
http://www.lib.uwo.ca/archives/virtualexhibits/historyofmedicine/Deans/warwick.html
(Date of use: 25 February 2014).

Department of Oncology
http://www.oncology.cam.ac.uk/treatments/specialties.html

(Date accessed: 19 February 2014).

E

eNCA
SA junior doctors call for new regulations on working hours
https://www.enca.com/south-africa/sa-junior-docs-call-for-new-regulations-on-working-hours
(Date accessed: 23 October 2016).

H

Harold Warwick
http://www.inmemoriam.ca/view-announcement-195264-o-harold-warwick.html
(Date accessed: 25 February 2014).

Health 24
http://www.health24.com/Medical/Cancer/Facts-and-figures/South-Africa-78-increase-in-cancer-by-2030-20120721
(Date accessed: 11 February 2014).

Health 24
http://www.health24.com/Medical/Cancer/News/Enpowering-cancer-patients-in-the-workplace-20130509
(Date accessed: 16 July 2014).

Hippocrates
http://www.greekmedicine.net/whos_who/Hippocrates.html
(Date accessed: 3 March 2014).

History in an Hour
http://www.historyinanhour.com/2010/12/08/brief-history-of-cancer/
(Date accessed: 19 February 2014).

Hope Navigators
http://www.hopenavigators.com/managing-matters/after-care-matters/returning-to-work-after-cancer
(Date accessed: 28 March 2014).

HPCSA Complaint Procedure
http://www.hpcsa.co.za/conduct_complaint.php
(Date accessed: 20 July 2012).

I

International Labour Organisation

http://www.dirco.gov.za/foreign/Multilateral/inter/ilo.htm
(Date accessed: 6 October 2016).

J

Jaslow R
http://www.cbsnews.com/news/most-common-medical-malpractice-claims-for-missed-cancer-heart-attacks/
(Date accessed: 7 January 2014).

John Hunter Biography (1728-1793)
http://www.madehow.com/inventorbios/88/John-Hunter.html
(Date accessed: 22 February 2014).

K

Knowledgebase
http://www.sandtononcology.co.za/knowledgebase/articles/32-a-snapshot-of-cancer-pain-from-south-africa
(Date accessed: 13 January 2013).

L

LaMance K ‘‘Plastic Surgery Malpractice’’
http://www.legalmatch.com/law-library/article/plastic-surgery-malpractice.html
(Date accessed: 23 March 2012).

M

MacMillan Cancer Support
http://www.macmillan.org.uk/Cancerinformation/Livingwithandaftercancer/Workandcancer/Supportforemployees/Workcancer/Your%20rights/Protectionfromdiscrimination.aspx
(Date accessed: 29 March 2014).

Macmillan
http://www.macmillan.org.uk/Aboutus/News/Latest_News/Riseincancerpatientsfacingdiscriminationatwork.aspx
(Date accessed: 11 February 2016).

Macmillan-Cancer-Support
http://www.macmillan.org.uk/Cancerinformation/Livingwithandaftercancer/Workandcancer/Supportforemployees/Workcancer/Your%20rights/Protectionfromdiscrimination.aspx
(Date of use: 29 March 2014).

Myers F
http://www.prweb.com/releases/2013/9/prweb11074685.htm

(Date accessed: 21 February 2014).

N

National Cancer Institute
http://www.cancer.gov/cancertopics/types/lung
(Date accessed: 8 January 2014).

National Cancer Institute
http://toxsci.oxfordjournals.org/content/64/1/4.full
(Date accessed: 10 January 2014).

NCR
http://www.nioh.ac.za/?page=national_cancer_registry&id=41
(Date accessed: 12 January 2014).

News Medical
http://www.news-medical.net/news/20130905/Peru-Liver-cancer-affects-young-people-and-children-who-do-not-have-related-risk-factors.aspx
(Date accessed: 11 January 2014).

NUMSA
http://www.numsa.org.za/article/south-africas-youth-unemployment-crisis/
(Date accessed: 18 April 2016).

O

Oncology
http://www.mmc.org/mmc_body.cfm?id=3208
(Date accessed: 19 of February 2014).

P

Pollack B Negligence *per se* – the doctrine of *res ipsa loquitur*,
http://www.healthlibrary.com/reading/law/part2.html
(Date accessed: 15 July 2016).

R

Richardson D "Distinguished Professor Nyokong honoured with $100 000 science award."
http://activateonline.co.za/professor-nyokong-awarded-prestigious-award/
(Date accessed 18 March 2017).

S

SAHNOS
http://www.sahnos.co.za/B_DocCnr_SKay.asp
(Date accessed: 25 February 2014).

Silber G “A Chronic Disease Grant for South Africans” at
http://www.tac.org.za/community/files/file/etmag/ET27English.pdf (Date accessed: 15 July 2015).

Sir Joseph Lister
http://campus.udayton.edu/~hume/Lister/lister.htm
(Date accessed: 24 February 2014).

T

The Glitter of Gold
http://www.sahistory.org.za/archive/glitter-gold
(Date of use: 22 February 2014).

The History of Cancer
http://www.cancer.org/acs/groups/cid/documents/webcontent/002048-pdf.pdf
(Date of use: 19 February 2014).

The State of Oncology in 2013
http://www.i-pri.org/oncology2013/
(Date of use: 24 February 2014).

The Truth about Cancer
http://www.pbs.org/wgbh/takeonestep/cancer/resources-cancer_and_work.html
(Date accessed: 28 Mach 2014).

Thom
http://www.health-e.org.za/2011/09/15/poor-access-to-cancer-treatment/
(Date accessed: 12 January 2014).

U

Uicc
http://www.uicc.org/experts-come-together-close-cancer-divide-2025
(Date accessed: 15 January 2014).

UK Cancer registration
http://www.ukacr.org/registration-organisation
(Date accessed: 18 April 2015).

UKACR Formation
http://www.ukacr.org/content/ukacr-history
(Date accessed: 16 April 2014).

University of Glasgow
http://www.gla.ac.uk/about/givingtoglasgow/21st-centurychallenges/
(Date accessed: 20 February 2014).

W

WHO
http://www.who.int/mediacentre/factsheets/fs297/en/
(Date accessed: 13 January 2014).

WHO
http://www.who.int/bulletin/volumes/90/3/12-030312/en/
(Date accessed: 1 April 2014).

Willey N
http://www.workforce.com/articles/21366-dealing-with-demotions-from-hrs-perspective
(Date accessed: 16 May 2016).